Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

Annual Report

JULY 2018 - JUNE 2019

healthy people

healthy workplace

healthy community

Our Region

MAPUA/MOTUEKA/ GOLDEN BAY PRACTICES

Mapua Health Centre
The Doctors Motueka
Greenwood Health
Golden Bay Community Health

RICHMOND/WAKEFIELD PRACTICES

Florence Medical Centre
Richmond Health Centre
Tasman Medical Centre
Wakefield Health Centre

NELSON PRACTICES

Harley Street Medical
Medical and Injury Centre
Nelson City Medical Centre
Nelson East Family Medical Centre
Nelson Family Medicine
Rata Medical
St Luke's Health Centre
Stoke Medical Centre
Tahunanui Medical Centre
Tima Health
Titoki Medical
Toi Toi Medical Centre

MARLBOROUGH

Renwick Medical Centre

What is the most important thing in the world?

It is the people, it is the people, it is the people

He aha temea nui o te ao? He tāngata, he tāngata, he tāngata

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continues over...

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Welcome to Nelson Bays Primary Health

Hauora matua ki te tai aorere

Nelson Bays Primary Health operates as a Charitable Trust.

The role of Nelson Bays Primary Health is to lead and coordinate primary health care in Nelson and Tasman (Nelson Bays), to strive for health equity and to improve health outcomes for all people. These services include not only first line services to restore people's health when unwell, but also, in conjunction with the local community and other health care providers, targeted programmes, which aim to improve and maintain good health of our population throughout the region.

The Nelson Bays Primary Health Board is made up of community, Iwi/Māori and provider representation from the Nelson Bays region. The role of the Board is to provide leadership, set the organisation's strategic direction and vision, sign off policies, organisational performance measures and appoint, delegate authority to, and monitor the Chief Executive. The Board acts within the boundaries of its own Trust Deed, as well as other relevant legislation and regulations.

> ... we strive for health equity and to improve health outcomes for all people...

General Practices

The 21 General Practices currently contracted to Nelson Bays Primary Health are as follows:

NELSON

- Harley Street Medical
- Medical and Injury Centre
- Nelson City Medical Centre
- Nelson East Family Medical Centre
- Nelson Family Medicine
- Rata Medical Centre
- St Luke's Health Centre
- Stoke Medical Centre
- Tahunanui Medical Centre
- Tima Health
- Titoki Medical
- Toi Toi Medical

MAPUA, MOTUEKA, GOLDEN BAY

- Mapua Health Centre
- The Doctors Motueka
- Greenwood Health
- Golden Bay Community Health

RICHMOND, WAKEFIELD

- Florence Medical Centre
- Richmond Health Centre
- Tasman Medical Centre
- Wakefield Health Centre

MARLBOROUGH

- Renwick Medical Centre

COST OF ACCESSING PRIMARY CARE SERVICES

This year we saw the introduction of reduced Community Services Card fees. The Community Services Card entitles the holder and their family to a reduction in the cost of seeing a doctor. Nelson Bays Primary Health was one of few PHO's across New Zealand that had 100% uptake from 1 December 2018 of their General Practices signing up to this scheme.

A full list of General Practice fees is on the Nelson Bays Primary Health website:
http://nbph.org.nz/gp-fees-table

He Mihi

He hōnore, he korōria ki te Ātua
He maunga rongo ki te mata o te whenua
He whakaaro pai ki ngā tāngata katoa

kia ā tātou tini mate, kua riro atu ki tua o te arai, ki te okiokinga i o tātou tūpuna haere, haere, haere. Kapiti hono tātai hono te hunga wairua ki a rātou. Kapiti hono tātai hono tātou te hunga ora tēnā tātou.

E ngā mana, e ngā reo, e ngā karangatanga maha tēnā koutou, tēnā koutou, tēnā koutou katoa.
E mihi kau ana ki ngā mana whenua o tēnei rohe ki Te Ātiawa, Ngāti Tama, Ngāti Kuia, Ngāti Koata, Ngāti Rārua, Ngāti Toarangatira.

Ko te kaupapa Nelson Bays Primary Health, Pūrongo-a-Tau 2018/19 i whakaatu ā mātou mahi o te tau. Nā reira e mihi atu ana ki a rātou katoa mō ngā mahi kua mahia e rātou ki te tutuki o mātou tumanako kia piki te ora, kia piki te kaha ki roto ki tēnā, ki tēnā o tātou katoa. Heoi anō e hara i te toa takitahi engari he toa takitini kē. Nā reira tēnā koutou, tēnā koutou, tēnā tātou katoa.

ENGLISH VERSION

Honour and glory to God
Peace on earth
Goodwill to all people

We acknowledge and farewell all those who have passed on beyond the veil of darkness to the resting place of our ancestors. The lines are joined the deceased to the deceased. The lines are joined the living to the living.

To the authority and the voices, of all people within the communities greetings to you all.
We acknowledge the Mana Whenua iwi,
Te Ātiawa, Ngāti Tama, Ngāti Kuia, Ngāti Koata, Ngāti Rārua, and Ngāti Toarangatira in the
Nelson Tasman region.

This is the annual report of Nelson Bays Primary Health 2018/19, presenting our work accomplished over the last 12 months.
We acknowledge all of the work undertaken by everyone in the primary health sector that helped to achieve the health outcomes. Success is not the work of one, but the work of many.

About Nelson Bays

our vision

Healthy people...

Healthy workforce...

Healthy community

Kia piki te ora o
ngā tāngata katoa

our values

Integrity
Manaakitanga

Excellence
Rangatiratanga

Respect
Whānaungatanga

Innovation
Mātauranga

Inclusion
Wairuatanga

our goals

Improved quality, safety and experience

Best value for money

Improved health and equity

Whakapiki ake ngā take hau-maru, kounga hauora hoki i waenganui i te hāpori

Primary Health

our mission

Everyone working in unison
to achieve the vision

Kia whakakotahi te hoe
o te waka

our guiding principle

What is the most important thing in the world?

It is the people, it is the people, it is the people

He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata

NELSON BAYS PRIMARY HEALTH (NBPH)

Strategic Plan
2016-2021

MISSION Everyone working in unison to achieve the vision
Kia whakakotahi te hoe o te waka

VISION healthy people... healthy workforce... healthy community!

VALUES

Integrity Manaakitanga	Excellence Rangatiratanga	Respect Whānaungatanga	Innovation Mātauranga	Inclusion Wairuatanga

STRATEGIES

PROTECTION HEALTHY PEOPLE	PARTICIPATION HEALTHY WORKFORCE	PARTNERSHIP HEALTHY COMMUNITY
A. Support healthy living in the home	A. Implement best practice governance, cultural competency and management	A. Work in partnership with our key communities to ensure an inclusive whole-of-system approach
B. Ensure health information is accessible and understandable	B. Work in partnerships to avoid duplication of services	B. Address inequalities and gaps in services, particularly for our most vulnerable and high needs populations
C. Promote and support strong clinical governance and leadership	C. Enable our workforce to operate at the top of their scope	C. Achieve all relevant health targets and indicators
D. Ensure service planning and include consumer and community involvement	D. Ensure sustainable and high quality service provision across the region	D. Support evidenced-based models of care that have proven health outcomes
E. Ensure legal obligations are adhered to	E. Focus on prevention, early detection and self-management to reduce disease progression	

ACHIEVING TRIPLE AIM OUTCOMES OF

IMPROVED QUALITY SAFETY AND EXPERIENCE	BEST VALUE FOR MONEY	IMPROVED HEALTH AND EQUITY

OUR GUIDING PRINCIPLE What is the most important thing in the world?
It is the people, it is the people, it is the people...
He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata

NELSON BAYS PRIMARY HEALTH (NBPH)

Māori Health Strategic Plan 2016-2021

VISION/ARONUI To increase access, achieve equity and improve health outcomes for whānau, hapū and iwi Māori living in the Nelson Tasman rohe

VALUES

Integrity Manaakitanga	Excellence Rangatiratanga	Respect Whānaungatanga	Innovation Mātauranga	Inclusion Wairuatanga

STRATEGIES

WHĀNAUNGATANGA CONNECTIONS PARTNERSHIPS

A. All services and initiatives whānau-focused, empowering iwi Māori to achieve rangatiratanga focus

B. Strong connections between NBPH and iwi Māori to support them to maintain healthy lifestyles exist

C. Strengthened relationships with marae as a key point of connection with iwi

D. Strengthened relationships with Te Piki Oranga and other Māori community health providers exist

E. Strategies that preserve, maintain, develop and utilise mātauranga Māori to enable whānau ora exist

WHAI ORANGA PREVENTION QUALITY PROTECTION

A. Improved Māori health outcomes through emphasis on prevention, early detection, maintenance and self-management

B. All NBPH staff are appropriately supported and trained to support iwi Māori

C. Pukengatanga - High quality service provision across the rohe for the benefit of iwi Māori and colleagues exist

D. Cultural competencies and referral pathways programmes are implemented to improve access and engagement with Māori patients and whānau

E. The diversity of the workforce and representation of Māori in Primary Care exist

MATAURANGA LEARNING PARTICIPATING

A. Māori whānau are engaged in lifestyle changes, enabling healthier futures

B. Population health promotion initiatives that address healthy lifestyle choices and health literacy in marae and other Māori environments exist

C. Social determinates of health to be foremost in future national policy and funding decisions through NBPH influence on central government

D. All NBPH service planning include a Māori health perspective

ACHIEVING OUTCOMES OF

ACHIEVING RANGATIRATANGA	BUILDING ON MĀORI HEALTH GAINS	ACHIEVING EQUITY

OUR GUIDING PRINCIPLE **People are our most valuable asset, they are our physical wealth and a reflection of our physical and spiritual health. We must empower, develop, value and retain them.**
He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata

Nelson Bays

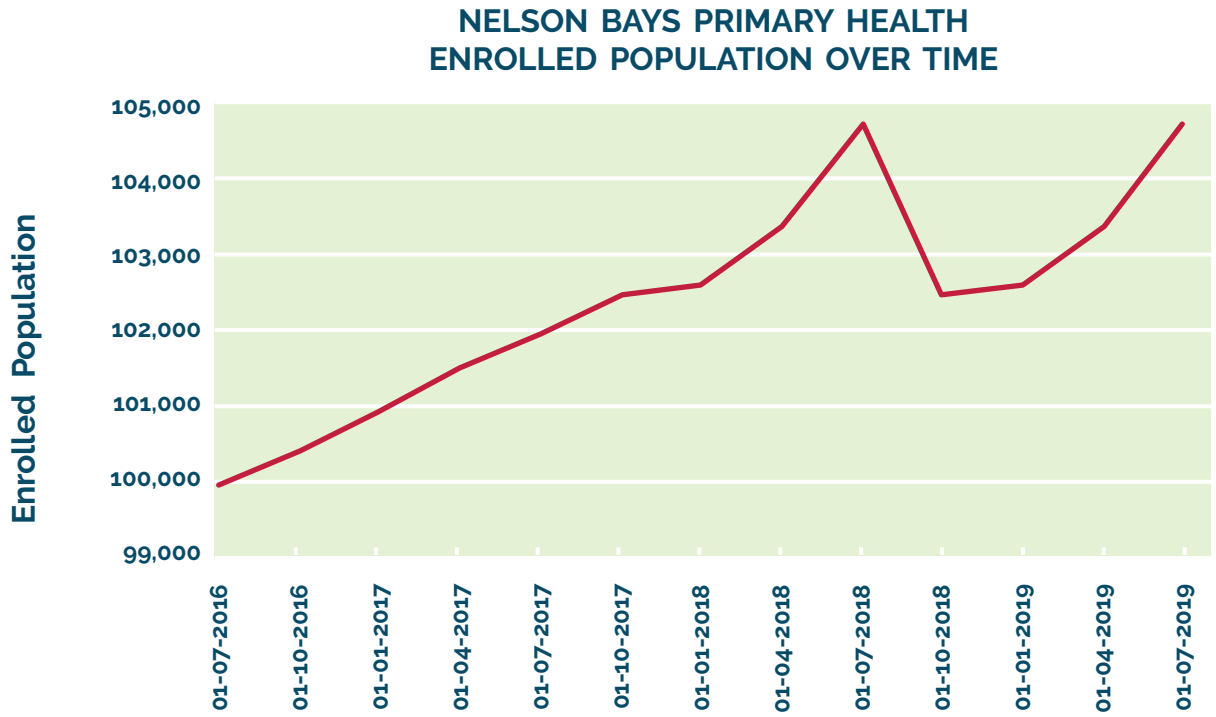
Enrolled Population

At the end of June 2019, 104,842 people were enrolled with Nelson Bays Primary Health

NELSON BAYS PRIMARY HEALTH

Enrolled Population

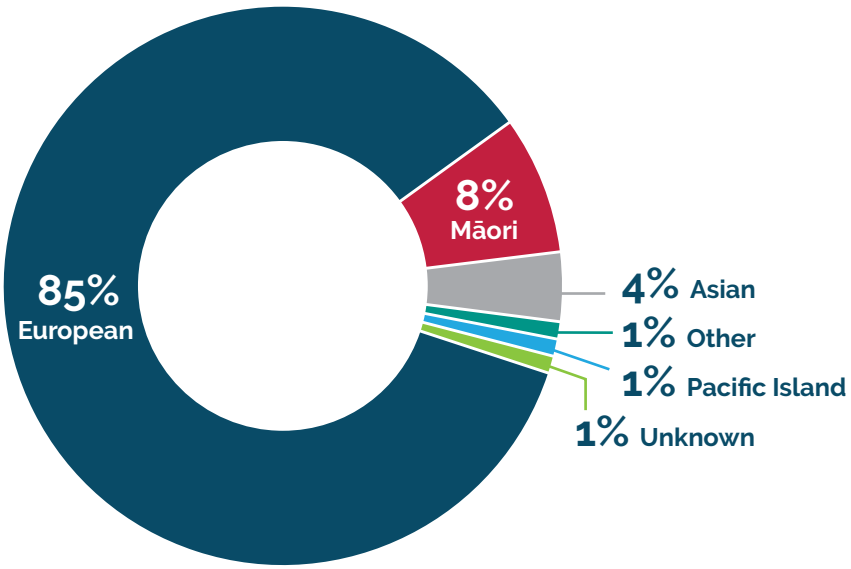
QUARTER	TOTAL ENROLLED POPULATION	% CHANGE
1/07/2019	104,842	1.35%
1/04/2019	103,431	0.74%
1/01/2019	102,670	0.15%
1/10/2018	102,519	-2.27%
1/07/2018	104,842	1.35%
1/04/2018	103,431	0.74%
1/01/2018	102,670	0.15%
1/10/2017	102,519	0.52%
1/07/2017	101,989	0.47%
1/04/2017	101,507	0.56%
1/01/2017	100,940	0.52%
1/10/2016	100,420	0.46%
1/07/2016	99,954	



NELSON BAYS
PRIMARY HEALTH

Ethnicity

ETHNICITY	NUMBER	PERCENTAGE
Māori	8,855	8%
Asian	4,201	4%
European	88,668	85%
Pacific Island	1,302	1%
Other	1,279	1%
Unknown	537	1%
TOTAL	**104,842**	**100%**

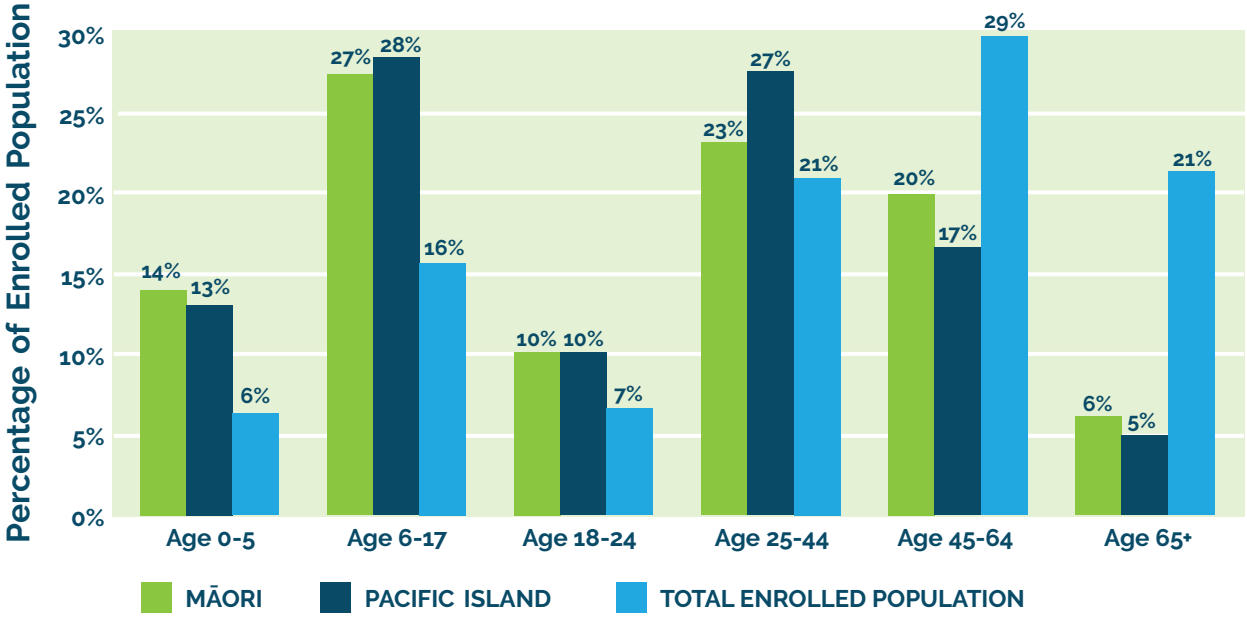


Nelson Bays

Enrolled Population

NELSON BAYS PRIMARY HEALTH

Age group % of enrolled population

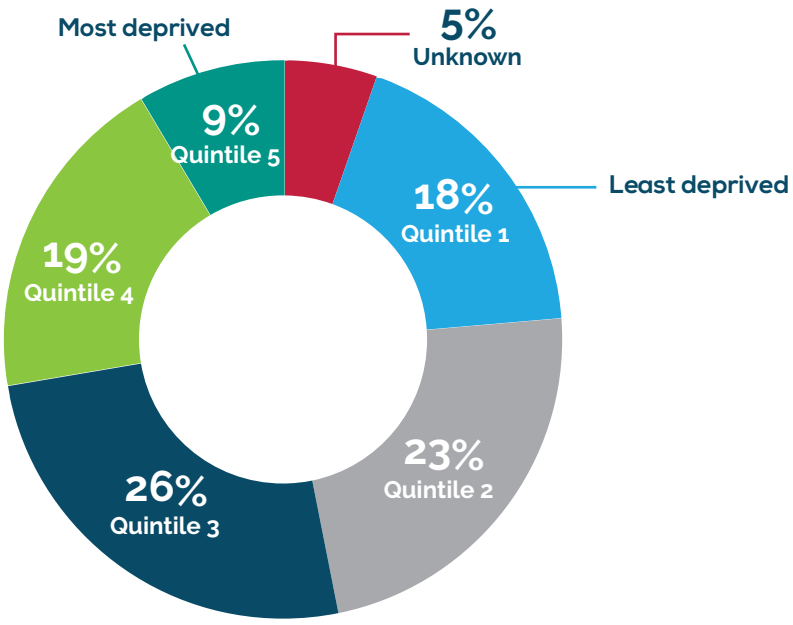


AGE	MĀORI	PERCENTAGE	PACIFIC ISLAND	PERCENTAGE	TOTAL ENROLLED POPULATION	PERCENTAGE
00-05	1,223	14%	169	13%	6,589	6%
06-17	2,410	27%	366	28%	16,316	16%
18-24	892	10%	133	10%	6,932	7%
25-44	2,030	23%	355	27%	21,764	21%
45-64	1,755	20%	214	17%	31,074	29%
65+	545	6%	65	5%	22,167	21%
TOTAL	**8,855**	**100%**	**1,302**	**100%**	**104,842**	**100%**

NELSON BAYS
PRIMARY HEALTH

Deprivation by quintile

QUINTILE	NUMBER	PERCENTAGE
Unknown	5,582	5%
1 (Least Deprived)	19,200	18%
2	24,380	23%
3	26,668	26%
4	20,047	19%
5 (Most Deprived)	8,965	9%
TOTAL	**104,842**	**100%**



Chairman's Report

> ... our retained earnings have enabled us to invest in new unfunded services into the future and to withstand unexpected events that affect us from time to time.

It is with pleasure that, on behalf of our Board, I present Nelson Bays Primary Health's Annual Report and Financial Statements for the year ended 30 June 2019.

This Annual Report highlights the services that our Primary Health Organisation has provided to the community over the last financial year. Through the activity reporting in the Annual Report, you are now able to track our progress in improving the health outcomes of our community. I invite you to read the report which demonstrates the ways in which we have improved the lives of all those in our community.

BOARD MEMBERS 2018/2019

John Hunter
CHAIRMAN

Sarah Green
DEPUTY CHAIR
PROVIDER REPRESENTATIVE

Blair Carpenter
COMMUNITY
REPRESENTATIVE

Carol Hippolite
MĀORI REPRESENTATIVE

The strength of our Primary Health Organisation is demonstrated by the balance sheet shown in the Financial Statements at the end of the Annual Report. Our retained earnings have enabled us to invest in new unfunded services into the future and to withstand unexpected events that affect us from time to time.

Last year, we invested substantial sums of monies into unfunded initiatives that we believe will best meet the long term needs of our community as well as the immediate needs of the most disadvantaged. These included:

- $200k into the establishment of the first three Health Care Homes. Through this investment, we anticipate seeing improvements in the coming year in the form of:
  - Better patient access to urgent and unplanned care
  - Proactive care for those with more complex need
  - Improved routine and preventative care for patients
  - Improved business efficiency and sustainability for the General Practices
- We intend to provide a further $200k in the current year to assist a further six General Practices to undertake the Health Care Home initiative
- In addition to the existing unfunded investments to address the needs of the our most vulnerable (in the form of a Social Worker and primary mental health services), we have commenced an initiative whereby vulnerable families who feel unable to see their doctor because of cost, or past debt with their General Practice, receive financial assistance for them to restart their relationship with their Doctor

The Golden Bay Community Health continues to invest in options to overcome service limitations caused by the remoteness of the Golden Bay region. New exciting initiatives include Telehealth and e-prescribing. Recruiting a full complement of permanent General Practitioner staff remains challenging, though investment in Nurse Practitioners, revised models of care and locums has assisted the position.

During the year, Lisa Lawrence and Philip Chapman stood down as Trustees after serving on our Board since 2005. Lisa and Philip have been instrumental in guiding and developing our Primary Health Organisation from its early stages. Both personally and on behalf of the Board, I would like to acknowledge their contribution and commitment. I would like to welcome Carol Hippolite and Blair Carpenter to our Board as strong replacements for Lisa and Philip.

Once again, I'd like to thank the groups of people without whom our Primary Health Organisation would be unable to function. These include the Board who give their time and experience out of a sense of civic duty; Angela Francis our Chief Executive, the Management and staff who provide the energy and commitment needed to develop and deliver the services for our community; the many individuals who give up their time to participate in our advisory groups and; the Non-Governmental Organisations and the community groups providing essential health services in collaboration with our Primary Health Organisation.

Ngā Mihi,

John Hunter
CHAIRMAN

Graham Loveridge
PROVIDER REPRESENTATIVE

Helen Kingston
COMMUNITY REPRESENTATIVE

Kim Ngawhika
MĀORI REPRESENTATIVE

Stuart Hebberd
PROVIDER REPRESENTATIVE

Sue Stubbs
PROVIDER REPRESENTATIVE

Chief Executive's Report

Kia Ora Koutou,

Whilst it has been a year of challenge for Nelson Bays Primary Health, there have been significant achievements. This report highlights some of our achievements moving us closer to achieving our vision of "healthy people….healthy workforce….healthy community".

Over the last year, some of the challenges within primary care, in particular General Practice, included:

- Increasing complex conditions
- Ageing population resulting in the need for resource reallocation
- Limited mental health services
- Increasing risk (including lifestyles), incidence and complexity of long term conditions
- Increased ethnic diversity – refugees and migrants
- Persistent inequalities in access and outcomes for the most vulnerable in our community
- A growing number of people unable to afford or access primary health services

Therefore, Nelson Bays Primary Health continued to focus on:

- Prioritizing and improving access to services for our most vulnerable people
- Maintaining and valuing relationships with Community Groups, Iwi and General Practice Teams
- Influencing the social determinants of health where possible
- Adopting a patient-centered approach for all our services

EXECUTIVE LEADERSHIP TEAM 2018/2019

Angela Francis
CHIEF EXECUTIVE

Emily-Rose Richards
EXECUTIVE ASSISTANT /BOARD SECRETARY

Karen Winton
GENERAL MANAGER HEALTH SERVICES

- Focusing on health prevention/promotion and supporting our community to be engaged and active participants in their health outcomes
- Upskilling and supporting our primary care workforce

The above approach resulted in a refinement of service design and delivery that has enhanced the health status for the population as demonstrated throughout this report. It also emphasised the need for ongoing collaboration with our key partners.

For example, a collaborative approach with Marlborough Primary Health and Nelson Marlborough Health continued in our joined–up approach working towards health system integration (Models of Care) and the ongoing implementation of the district-wide Health Care Home initiative. In addition, the joint approach adopted for service design/delivery across the district continued with Nelson Bays Primary Health and Marlborough Primary Health sharing joint appointments. Bi-annual joint Board meetings continued, as did the sharing of information with our Clinical Governance Committees across the region.

Additional Nelson Bays Primary Health achievements include:

- New strategic priorities were implemented to support our most vulnerable people, for example the VIP Vulnerable People project and the Community Connectors project
- Nelson Bays Primary Health continued to provide a variety of services for our Golden Bay Community including telehealth appointments being implemented
- The annual Stakeholder Satisfaction Survey highlighted a continued improvement trend with the majority (74%) of respondents in 2019 answering "Yes" to their expectations being met for the support and service provided by Nelson Bays Primary Health. This is an improvement on 2018 results (51%)
- The annual staff satisfaction survey was the highest on record with 10 out of 10 themes scoring four or more out of six
- Staff turnover rates were low, evidenced by monthly results consistently tracking below New Zealand's national average (all industries combined) and 8 – 10% below the healthcare industry rate
- A breakeven financial result was achieved as demonstrated in the financial report 2018/19 year
- Nelson Bays Primary Health programmes and services highlighted achievement against all contracted revenue and targets as evidenced throughout this report

In closing, I would like to acknowledge and thank our staff, without whom our achievements would not have been possible. Thanks also to our key partners including our General Practice teams, Marlborough Primary Health, Nelson Marlborough Health and our community providers. I would also like to acknowledge John Hunter and the Nelson Bays Primary Health Board for their ongoing support throughout the last 12 months.

Ngā Mihi,

Angela Francis
CHIEF EXECUTIVE

Linzi Birmingham
GENERAL MANAGER
GOLDEN BAY
COMMUNITY HEALTH

Trudi Price
HUMAN RESOURCES/
SUPPORT SERVICES MANAGER

Wolfgang Kloepfer
FINANCE MANAGER

Clinical Governance Committee Chair's Report

The Nelson Bays Primary Health Clinical Governance Committee met regularly over the 2018/19 year. The Committee has representation from General Practitioners, Primary and Practice Nurses, Practice Managers, Pharmacy, Māori health, as well as from the Board, Management and Nelson Marlborough Health. We are also pleased to have a Consumer Representative on this Committee.

The Clinical Governance Committee has a role in overseeing the clinical quality of services that are provided under Nelson Bays Primary Health and act as an advisory committee to the Nelson Bays Primary Health Board. The Clinical Governance Committee aims to apply a quality lens over services alongside Te Tumu Whakaora who apply their Māori health lens.

Over the past year, the Committee has considered many initiatives including

- Improving services in primary care for mild to moderate mental health conditions
- Introducing and encouraging uptake of electronic laboratory ordering and electronic prescribing
- Initiatives to improve access to health care for vulnerable populations, and in improving connections for patients with their community
- Encouraging and monitoring the treatment of Hepatitis C with the new medications available
- Improving access for Long Acting Reversible Contraception, especially in rural populations
- Moving suitable services from secondary care into primary care, with appropriate resources. In particular the committee has been developing a checklist of consideration factors so as to be able to provide a structured response to these requests

The Clinical Governance Committee is watching with interest, the introduction of the Health Care Home model in General Practices. This model looks at new ways of working via the domains of urgent and unplanned care, proactive care, routine and preventive care, and business efficiency. It explores the greater use of technologies, and utilising a wider team in General Practice that might include the community pharmacist, social worker, dietitian, health coach, counselling etc. Three Nelson Bays practices have now commenced this journey with more to follow in the coming year.

Our Clinical Governance Committee Chair continues to share key messages, and to meet periodically, with the Chairs of Marlborough Primary Health and Nelson Marlborough Health's Clinical Governance Committees as part of a more unified approach across the top of the south.

Dr Sue Stubbs
CLINICAL GOVERNANCE COMMITTEE CHAIR

Te Tumu Whakaora Chair's Report

Unuhia, unuhia
Unuhia ki te uru tapu nui
Kia wātea, kia māmā, te ngākau, te tinana,
te wairua i te ara takatā
Koia rā e Rongo, whakairia ake ki runga
Kia tina! TINA! Hui e! TĀIKI E!

Ki ngā tini aitua o ia whānau, e kui koro mā haere,
haere ki te putaketanga o Rehua haere,
moe mai rā, okioki ai.

Ki a koutou te kanohi ora o ngā Iwi
tēnā koutou, tēnā koutou, tēnā koutou katoa

Te Tumu Whakaora is the advisory group to the Board of Nelson Bays Primary Health that has a focus on supporting Nelson Bays Primary Health to improve health outcomes for whānau, hapū and iwi Māori. The Committee draws membership from General Practitioners, Primary and Practice Nurses, Pharmacy, consumer groups and Iwi. Our lens is a distinctly Māori world-view.

Some of the responsibilities of Te Tumu Whakaora include:

- Providing tikanga and a Māori health view to support Nelson Bays Primary Health programmes and services
- Provide Māori clinical leadership, advice and insight to Nelson Bays Primary Health on all relevant clinical and community services
- Seeking clinical and social, cultural and other evidence to support improvement of Māori health outcomes in the wider community
- Advising and working on specific activity to support the improvement of Māori health in the Nelson Tasman region

Firstly, I would like to acknowledge on behalf of Te Tumu Whakaora the long service of Lisa Lawrence whom retired from Nelson Bays Primary Health Organisation as a Trustee and as Chair of Te Tumu Whakaora in 2018. Lisa's knowledge of Nelson Bays Primary Health has been invaluable and her commitment for Māori voice and presence has been instrumental in ensuring services for Māori are available to our whānau in this rohe.

The 'Welcome Back' package in the VIP – Vulnerable Populations Project has been a particular highlight for Te Tumu Whakaora. This project embraces both the 'vulnerable populations' and 'hidden populations' a topic that is frequently discussed during our hui. We are delighted that the 'Welcome Pack' project allows whānau suffering financial hardship and the opportunity for our unenrolled population's opportunity to access and address their health needs. This project acknowledges General Practice costs as one of the many factors that are barriers to health faced by our vulnerable populations. Te Tumu Whakaora endorses this programme and will support continuation of this type of affirmative action going forward.

Te Tumu Whakaora would like to welcome Te Ata Munro to the position of Senior Cultural Advisor. Te Ata brings many taonga to this position and to Nelson Bays Primary Health. We look forward to working with her and I encourage all Nelson Bays Primary Health Board members and staff to support, engage and participate with Te Ata in Te Ao Māori.

I have the utmost appreciation of the work undertaken by our members, who provide valuable insight to the areas of strength and pockets of challenge within our district. The roopu has performed solidly to provide internal support, respond to identified community needs and provide a diversity in strengths-based perspective necessary to support mainstream services to work effectively with Māori. The following whakatauki perhaps epitomizes the collaborative nature of our roopu and the combined strengths we bring together to support our whānau, hapu me ngā iwi katoa.

Naku te rourou, nau te rourou, ka ora ai te iwi
With your basket and my basket the people will live

Kim Ngawhika
TE TUMU WHAKAORA CHAIR

Our Team

Joint Venture - Medical and Injury Centre

The Medical and Injury Centre Limited is an equal joint partnership between Nelson Bays Primary Health and the General Practice Network in the Nelson region, represented by Nelson Bays General Practice Limited.

The Medical and Injury Centre provides a high quality and accessible Urgent Care medical service for the population of greater Nelson, in addition to also operating as a General Practice with an enrolled population. The Medical and Injury Centre is open seven days a week from 8am to 10pm and is located next to the Emergency Department of Nelson Hospital on 98 Waimea Road, Nelson.

The Medical and Injury Centre's mission is to provide exceptional medical services to residents and visitors of the Nelson Bays area, alongside our General Practice partners and the Hospital.

URGENT & AFTER HOURS MEDICAL CARE

98 Waimea Road
8am - 10pm daily

For MEDICAL ADVICE after 10pm
Phone: 03 546 8881

PROGRESS/ACHIEVEMENTS

- For the year ending June 2019, there were 29,526 patients seen compared to 26,686 patients seen the previous year
- The Medical and Injury Centre has continued and expanded the pilot with Nelson Marlborough Health to work even closer with the Emergency Department, so that patients are seen by the appropriate service and long waiting times can be avoided
- Nurses are trained to initiate minor limb injury x-ray requests to improve patient flow and reduce waiting times and the Nurse Practitioner position has been increased to manage people's health needs in collaboration with other health care professionals
- Medical and Injury Centre has increased its workforce to include a Healthcare Assistant and a Nursing Entrance to Practice Programme Nurse
- The Nelson Bays Primary Health Social Worker is available for community visits or appointments within the Medical and Injury Centre clinic
- The Medical and Injury Centre worked alongside Nelson Marlborough Health and St John during the Bay Dreams Concert in January
- The Medical and Injury Centre has maintained both Cornerstone and Urgent Care Accreditation

Health and Safety Workforce

HEALTH AND SAFETY

Health and Safety is an integral part of all contracts, services and programmes provided by Nelson Bays Primary Health. Nelson Bays Primary Health has an employee participation agreement at both localities (Richmond and Golden Bay), as well as volunteer Health and Safety representative committees.

DURING 2018/19

- Health and Safety Committee meetings were held at least bi-monthly on each site
- Robust Health and Safety incident reporting, investigations and management occurred with the online reporting system
- On-the-job health and safety training was held, specific to individual roles and responsibilities
- Regular identification of hazards and management of the identified hazards were supported by the Health and Safety Committees, management and facility users
- Health and Safety Committee involvement contributed to the ongoing maintenance and updating of all Health and Safety policies, procedures and documentation
- Worker engagement was evident in the reporting of potential risks as well as incidents, with the number of actual incidents remaining low. Health and Safety remains a standard agenda item for discussion in management and staff meetings
- Health and Safety Lead Representatives actively participate in the annual review of Business Continuity and Emergency Management Plans for their respective locations

EMPLOYEE AND WORKFORCE

Our Workforce as at 30 June 2019

One measure of a healthy and stable workforce is to look at staff departure (turnover) rates in comparison to national averages in the same industry. Nelson Bays Primary Health has a low staff turnover rate, with 14.0% achieved to year end 30 June 2019. This compares admirably with the average annual staff turnover rate of 18.2% reported for health care providers across New Zealand* indicating team stability and an ability to embed knowledge and skill depth across our team.

Here's a closer look at our current team composition.

157 Employees = 103 based at Golden Bay Community Health + 54 based in Richmond

- 15% are full time employees
- 85% are part time or casual employees

EMPLOYEE ENGAGEMENT

The annual Employee Workplace Satisfaction Survey was completed in February 2019. This anonymous survey checks the internal health of our own organisation, as employees rate their level of satisfaction with Nelson Bays Primary Health as an employer. The 2019 ratings show that our organisation and team satisfaction levels continue to go from strength to strength, with results even better than reported in the previous year.

✓ The average total satisfaction rating reported from both Richmond and Golden Bay Community Health were positive, achieving 4 or higher out of 6, and increase when compared to last year

✓ The average total satisfaction ratings were the highest reported since location specific ratings began in 2016

✓ In Richmond, a remarkable 100% of survey questions average ratings, reflected positive employee satisfaction, achieving scores 4 or higher out of 6

✓ In Golden Bay Community Health, a highly commendable 97% of survey question average ratings were similar or haver improved when compared to the results of the previous year

The dedication of our teams to their work, our organisation and to the community we serve remains evident.

*Source: The New Zealand Staff Turnover Survey 2018, Lawson Williams in partnership with Human Resources Institute of New Zealand.

Key Relationships

Nelson Bays Primary Health's stakeholder relationships are central to all that we are and all that we do.

IWI

The Chief Executive undertakes visits to Iwi in our region to maintain a proactive 2-way relationship and support awareness-raising of Nelson Bays Primary Health's role and work underpinned by Nelson Bays Primary Health's Treaty obligations. This action supplements the direct cultural engagement activities undertaken by the Iwi representatives on the Nelson Bays Primary Health Board, Te Tumu Whakaora as well as the activities of Nelson Bays Primary Health's Tikanga Advisor and Kaumatua. Emerging engagement with individual Iwi is positive and proactive. This also provides opportunities for development of programmes that best fit the needs of their whanau along with an improved understanding of where Nelson Bays Primary Health needs to modify service design.

GENERAL PRACTICES

The Chief Executive has undertaken bi-annual visits to each General Practice to maintain a proactive 2-way relationship with practice owners and their practice teams. This action supplements the clinician-to-clinician engagement undertaken by the Nelson Bays Primary Health Board level and associated clinicians (such as the Chair of Clinical Governance Committee/Clinical Director and supporting clinical champions on Nelson Bays Primary Health committees and working groups). This has proved effective as demonstrated by the stakeholder feedback in the recent stakeholder survey. From these visits, Nelson Bays Primary Health gained valuable insight into community needs from the general practice perspective and was able to focus on promoting improved outcomes within its wider circle of influence.

COMMUNITY GROUPS

In addition to the valued groups mentioned above, the Chief Executive and management undertook a programme of community group visits/meetings. The purpose of these meetings was to raise awareness of the role and objectives of Nelson Bays Primary Health to hear and listen about issues or concerns these groups have and strengthen relationships with these vital members of the

extended community which is why Nelson Bays Primary Health has community representation on its Board and Clinical Governance Committee.

In addition, Management took all opportunities to attend relevant community meetings to ensure a high profile and two-way dialogue with our enrolled population. This action supplemented the specific community engagement work undertaken by Nelson Bays Primary Health's Board.

Community groups visited in this financial year included:

- Over 100 older adult community exercise groups have been visited and awarded the 'tick of approval' e.g. meets Ministry of Health, Health Quality and Safety Commission and ACC criteria for community falls prevention
- Involvement in the Positive Ageing Expo (with over 2,000 participants), Age Concern Nelson Tasman; Senior Volunteers Programme; Age Connect and social isolation within our ageing population, community meetings about Dementia planning for the future, community meetings as part of the Pigeon Valley Fire response and civil defence emergency management planning and updates during the extended civil emergency our region was in during February and March 2019 along with planning meetings for the Bay of Dreams event held in Nelson in January 2019

Continues over...

Key Relationships Continued

- Refugee and Migrant Resettlement Group; Red Cross Refugee Services orientation programme; Newly arrived quota refugee welcome functions; Ministry of Business Innovation and Employment regional meetings for refugee and migrant updates
- Nelson Marlborough Falls Alliance Group meetings facilitated by Nelson Bays Primary Health – membership includes: Nelson Marlborough Health, Nelson Bays Primary Health, Marlborough Primary Health, ACC, St John Ambulance, Telehealth representatives, Community Pharmacy, Gerontologists, Allied Health, Nurse Practitioner (primary care)
- Nelson Tasman Pacific Community Trust, worked in partnership to develop and deliver Diabetes Education sessions as well as Health Navigator services for Pacific people
- Te Piki Oranga, regular meetings with General Manager and Nurse Managers at Whakatu and Te Āwhina, to foster better communication and relationships. Recent meeting resulted in contracting Te Piki Oranga to deliver Heart and Diabetes checks to Māori men and this included gifting Te Piki Oranga with a Point of Care test kit so bloods could be collected and analysed to check for diabetes and cholesterol levels
- Nelson Asthma Society, regular meetings including attending their Annual General Meeting
- Tahunanui Community Centre meetings which resulted in Nelson Bays Primary Health supporting the interim Tahunanui Community Board to get the facility back on its feet and open to the public again
- Hapai Taumaha Haputanga/Crisis Pregnancy Support meeting which resulted in Nelson Bays Primary Health supporting this vital service with a small donation
- MenzShed regional newsletter, Nelson Bays Primary Health supported with regular health articles for publication
- Refugee Special Interest Group meetings where all primary care health providers working with former refugee clients, meet regularly to keep connected and discuss solutions to the numerous challenges facing this group
- Other community newsletters that Nelson Bays Primary Health supported with relevant and topical health-related articles were: Age Concern, Grey Power Nelson, Murchison news, Mudcakes and Roses and Active Ageing network

NELSON BAYS PRIMARY HEALTH COMMUNITY CONNECTOR PROJECT

The impact of social isolation and loneliness has increased significantly in recent times with large bodies of research highlighting it as a serious public health issue for all members of the population. An innovative project developed in the United Kingdom to address these issues has proven it has the potential to make a significant difference to these related health and wellbeing issues and lessen Emergency Department admissions.

The project is based around three core components:

- A comprehensive and up to date online community directory of local interest groups and support services. Nelson Bays Primary Health has a strong commitment from both Nelson City Council and Tasman District Council to support Volunteer Nelson to develop the directory
- Developing community connectors
- Health Connectors – supporting community health providers to embed Connector functions into their roles

Each component works in synergy with the health connectors who are employed health workers based in primary care and the community as well as community connectors who are general members of the public that "signpost" individuals towards social or interest groups and services. In addition General Practices will be able to provide "social prescriptions" to the health connectors and local social/interest groups.

Nelson Bays Primary Health is leading the project in the Nelson Tasman region to involve the wider community, initially, through consultation. There has been a significant interest and support from the Councils through to local Non-Government Organisations who are keen to be a part of the project.

> The impact of social isolation and loneliness has increased significantly in recent times ... highlighting it as a serious public health issue

VULNERABLE POPULATIONS PROJECT

Nelson Bays Primary Health called a community hui on 4 September 2018, to consult and learn about our vulnerable population and their health needs. Over 40 people attended from across the Nelson Bays region. The first priority for this group was to define what Vulnerable meant, so for the purpose of this project, the group agreed on: *anyone at any time with an unfilled primary care need.*

Gaps were then identified in health services for this population and then suggestions and ideas were discussed about opportunities to close those gaps. What resulted was the development of the VIP project and the delivery of this started in February 2019. Refer to the Strategic Initiatives section for further detail.

NELSON BAYS PRIMARY HEALTH CONTESTABLE FUNDING POOL

Nelson Bays Primary Health has two contestable funding pools that community groups may apply through to secure small amounts of funding. These being:

1. Community Initiative – to financially support new Health Promotion initiatives within the community, on successful application. Community Initiatives grants of up to $1,000 are awarded to successful applicants. There were four successful applications awarded this year
2. Workforce Development – to financially support community or volunteer organisations to undertake health promotion staff training on successful application. Workforce Development grants of up to $500 are awarded to successful applicants. There were two successful applications awarded this year

NELSON BAYS PRIMARY HEALTH COMMUNITY SUB-CONTRACTS

There are also community organisations that Nelson Bays Primary Health has direct contracts with for more specific initiatives. These include contracts with:

- Red Cross Refugee services
  - for quota refugee interpretation and translation services
- Victory Community Centre
  - for Health Navigator services
- Nelson Tasman Pacific Community Trust
  - for Pacific Health Navigator service
- Whanake Youth
  - for targeted Youth Health Service
- Nelson Asthma Society
  - for respiratory rehabilitation and Asthma promotion and prevention services
- Age Concern Nelson Tasman
  - for Community and Whānau facilitator services
- Motueka Community House
  - for navigation services
- Mohua Social Services
  - for social worker services in Golden Bay
- Mapua Podiatry
  - for a specialist podiatry service linked to diabetes foot complications

Funding recommendations as always, are based on available funding.

NELSON BAYS PRIMARY HEALTH ANNUAL GENERAL MEETING ATTENDEES

At the Annual General Meeting in 2019, it was pleasing to note the level of interest and engagement with many of our community groups.

Continues over...

Key Relationships Continued

STAKEHOLDER SURVEY RESULTS (1 JULY 2018 – 30 JUNE 2019)

With these community relationships, Stakeholder feedback is important to Nelson Bays Primary Health. Annually we undertake a Stakeholder survey to canvas views on a range of areas. The Stakeholder results are shown below.

The Stakeholder survey was distributed to a wide range of health service providers and community groups, some of whom are mentioned above. This takes the form of an electronic survey where we measure the impact our organisation has on these groups. It is also provides a quality improvement process.

It is acknowledged that the Stakeholder Satisfaction Survey was distributed just prior to the unforeseen fire events and state of civil emergency in February 2019. This fire event impacted the whole Nelson/Tasman region. As the clear focus was to provide support to those in need within our community, the participation rate in this survey was noteably lower this year. Therefore the key findings from the 2019 survey are taken as indicative only. These survey findings are shared below.

In 2019 the largest portion of survey respondents (59.1%) were in General Practice followed by Community Organisations (18.2%). These two respondent groups were similarly represented in 2018 survey participation results.

> ...the Stakeholder Satisfaction Survey was distributed just prior to the unforeseen fire events... therefore the participation rate in this survey was noteably lower this year

The vast majority of respondents (90%) had contact or made use of Nelson Bays Primary Health services on four or more occasions in the last year. This is an increase when compared to the 2018 result of 84%.

As with previous survey results, the 2019 survey indicated positive satisfaction results in majority of areas:

- The majority (74%) of respondents in 2019 answered "Yes" to their expectations being met for the support and service provided by Nelson Bays Primary Health. This is an improvement on 2018 results (51%)
- A positive satisfaction trend is shown as respondents were asked to compare the level of Nelson Bays Primary Health service to 1 year ago. The vast majority (84.2%) of respondents rating this question felt that service was similar or had improved in the last year
- When asked to compare the level of Nelson Bays Primary Health service to three years ago a strong majority (75%) of respondents rating this question felt that Nelson Bays Primary Health was similar or had improved in the last three years. This was a stronger result than reported in the 2018 survey outcomes, when 63% of respondents indicated a similar or positive improvement in service levels compared to three years ago
- When asked about satisfaction levels by location, a strong majority (75%) of respondents indicated they were somewhat or very satisfied with the service and support provided at both Richmond and Golden Bay locations. This was an improvement on 2018 results for both locations
- Worthy of note is that all respondents (100%) acknowledge that the work of Nelson Bays Primary Health makes a positive difference in the community, rating this question as three or more out of five

Overall these 2019 results indicate that Nelson Bays Primary Health is recognised by Stakeholders as being on the right path in serving our community.

Health Services

Health Promotion

Community Cardiac Rehabilitation Healthy Hearts

PURPOSE To reduce the potential for another acute heart event (i.e. secondary prevention) and to improve quality of life.

OBJECTIVE

- Improve knowledge of cardiovascular disease
- Improve confidence to be able to recognise and respond to symptoms using health literacy skills and resources
- Promote better understanding about the importance of taking medication
- Reduce unplanned cardiac related Emergency Department presentations
- Increase long-term lifestyle modifications that improve heart health

PROGRAMME OVERVIEW

Nelson Bays Primary Health deliver a community-based Cardiac Rehabilitation and self-management programme delivered in partnership with the cardiology team at Nelson Marlborough Health. Referral is activated on discharge from hospital.

Two delivery options are available:

- Healthy Hearts – a one-off six hour group education session held in the community. Sessions can be split into two half days if preferred (usually offered to those following surgery)
- Heart Guide Aotearoa – home-based work-book option with telephone support and follow up

How well did we do?

KEY PERFORMANCE MEASURES

NB: the purpose of this programme is to reduce a second heart attack, so success would be reduced referrals.

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Referrals						
• Numbers referred	152		283* *Includes 50 Marlborough referrals as no regional service available		151* *Includes 3 Marlborough referrals (service now provided in Marlborough)	
• Ethnicity	**Māori** 10	**Non-Māori** 142	**Māori** 13	**Non-Māori** 270	**Māori** 6	**Non-Māori** 145
Heart Guide Aotearoa						
• Number of referrals choosing this option	3		8		8	

Continues over...

Community Cardiac Rehabilitation Healthy Hearts Continued

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Healthy Hearts						
• Number of sessions delivered	11		13		10	
• Number of people who attended this option	88		136		82	
• Gender of those attending	**Male** 70	**Female** 18	**Male** 102	**Female** 34	**Male** 60	**Female** 22
• Age range	**Under 65yrs** *	**Over 65yrs** *	**Under 65yrs** 49	**Over 65yrs** 87	**Under 65yrs** 35	**Over 65yrs** 47
• Ethnicity	**Māori** 4	**Non-Māori** 84	**Māori** 6	**Non-Māori** 130	**Māori** 4	**Non-Māori** 78
Additional Family/ Whānau or support person attending	45		74		40	
Total number of participants (including family)	133		210		122	
Programme Outcomes (on completion)						
• Participants who report increased knowledge of their cardiovascular disease	99%		99%		100%	
• Participants who report increased confidence to recognise and respond to their symptoms (manage their condition)	98%		99%		97%	
Patient Self-Reported Follow-Up Outcomes (average 56% response rate)						
• Are taking medication as prescribed (Concordant)	97% (38%-46% do not collect medications after a major cardiac event. Highest rates among Māori, Reference: Atlas of Healthcare)		94% (38%-46% do not collect medications after a major event. Highest rates among Māori, Reference: Atlas of Healthcare)		85%	
• Presented to Emergency Department with cardiac related symptoms	9% (Evidence suggests there is a 40-50% reoccurrence rate i.e. presenting to ED with symptoms)		0% (Evidence suggests there is a 40-50% reoccurrence rate i.e. presenting to ED with symptoms)		0%	
• Have maintained heart healthy eating habits/ improved eating habits	70%		98%		95%	
• Are participating in regular physical activity levels/ increased levels	69%		91%		85%	
Overall Uptake Rate (referral/attendance)						
• Percentage of people engaging in a rehabilitation choice	60% (National average is 12-20%)		51%		60%	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Te Piki Oranga receiving their Point of Care gift.

MĀORI HEALTH ACTIVITIES

- There were 6 Māori referred
- There were 4 Māori and 2 whānau who attended

A new initiative has commenced in partnership with Te Piki Oranga in June 2019, to support cardiovascular risk assessment and information sessions that address lifestyle factors and self-management.

PARTICIPANT FEEDBACK

"Understanding the risks and making choices for my future will help me achieve my goal to get back to better health. This day has given me great support, just what I needed."

"Learnt a great deal today particularly around diet, my medications and my understanding and management of cholesterol."

SIGNIFICANT SUCCESS

- The national report from All New Zealand Acute Coronary Syndicate's (ANZACS) Quality Initiative in December 2018, showed Nelson/Marlborough cardiac patients had the highest national (statin) rate of patients taking their prescribed medication one-year post event (88.3%).
- Nelson Marlborough Health's Cardiology Nurse Specialists are now seeing a decrease in people presenting with heart events requiring intervention; subsequently there has been a reduction in referrals to Healthy Hearts. This is evidence of successful prevention (in both initial and repeated heart events)

Community Diabetes Education Type 2 and Pre-diabetes

PURPOSE To empower people with Pre-Diabetes or Type 2 Diabetes to be actively engaged in managing their condition and reducing the risk of long-term complications.

OBJECTIVE

- Deliver group sessions to meet the preference of those referred e.g. afterhours, within General Practice, or in a community venue
- Build knowledge to decrease diabetes-related distress and build better understanding to help manage diabetes (Type 2 or Pre-Diabetes) using health literacy techniques
- Build confidence to support life-long healthy choices
- Reduce the risk of long-term complications by improving HbA1c levels

PROGRAMME OVERVIEW

- **Type 2 Diabetes Education** is delivered at various locations in the community and held mainly on Saturdays. Sessions are peer-reviewed by Diabetes Nurse Specialists at Nelson Marlborough Health and this primary- secondary partnership works extremely well
- **Reversing Pre-diabetes** is a one-off 2.5-hour session held in a community venue or within General Practice after-hours. Sessions are co-presented with the Green Prescription team
- All patients receive three postal questionnaires over a 12 month period to monitor outcomes
- Quality improvements are informed following a Plan, Do, Study, Act (PDSA) process

How well did we do?

KEY PERFORMANCE MEASURES

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Type 2 Diabetes Referrals						
• Numbers referred	97		106		132	
• Ethnicity	**Māori** 1	**Non-Māori** 96	**Māori** 14	**Non-Māori** 92	**Māori** 21	**Non-Māori** 111
Type 2 Diabetes Education sessions						
• Number of sessions held after-hours	7		9		9	
• Total Number of sessions delivered	8		9		9	
• Number of patients attended	52		59		73	
• Gender of those attending	**Male** *	**Female** *	**Male** 26	**Female** 33	**Male** 35	**Female** 38
• Ethnicity of those attending	**Māori** *	**Non-Māori** *	**Māori** 4	**Non-Māori** 55	**Māori** 15	**Non-Māori** 58
• Additional Family/ Whānau or support person attending	17		20		22	
• **Total Number of participants** (including family)	69		79		95	
Programme Outcomes (on completion)						
• Participants who report increased knowledge of Diabetes	100%		99%		100%	
• Participants who report increased confidence in self-management	97%		99%		100%	
Patient Self-Reported Follow-Up Outcomes (combined results of 3 & 6 month follow-ups) average 57% response rate						
• Has improved HbA1c (if tested/known)	80%		92%		90%	
• Has moderate levels of diabetes distress	*		12%		0%	
• Maintained healthy eating habits/ improved eating habits	*		79%		97%	
• Is participating in regular physical activity levels/ increased levels	*		85%		62%	
Pre-Diabetes Education referrals						
• Referrals received	106		135		91	

Continues over...

Community Diabetes Education Type 2 and Pre-diabetes Continued

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
• Ethnicity of referrals	**Māori** 10	**Non-Māori** 96	**Māori** 8	**Non-Māori** 127	**Māori** 6	**Non-Māori** 85
Pre Diabetes Education sessions						
• Number of sessions delivered in General Practice	3		5		1	
• Total Number of sessions delivered (all after-hours)	12		13		6	
• Number of patients attended	82		95		73	
• Gender of those attending	**Male** 23	**Female** 59	**Male** 42	**Female** 53	**Male** 35	**Female** 38
• Ethnicity of those attending	**Māori** 4	**Non-Māori** 78	**Māori** 5	**Non-Māori** 90	**Māori** 10	**Non-Māori** 63
• Additional Family/Whānau or support person attending	29		41		19	
• Total number of participants (including family)	111		136		92	
Programme Outcomes (on completion)						
• Participants who report increased knowledge of Pre-Diabetes	100%		100%		100%	
Patient Self-Reported Follow-Up Outcomes - over this reporting period (combined results of 3 & 6 month follow-ups) average 48% response rate						
• Has improved HbA1c (if tested/known)	91%		79%		100%	
• Reported healthy eating habits/improved eating habits	*		97%		91%	
• Reported adequate physical activity level/increased level	*		88%		91%	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MĀORI HEALTH ACTIVITIES

- There were two Diabetes Kōrero sessions held at Te Awhina Marae, in collaboration with Te Piki Oranga, Green Prescription and our Community Dietitian for those with, at risk of, or supporting someone with diabetes. **A total of 48 Māori attended the sessions**
- 21 of the referrals for type 2 diabetes identified as Māori
- 6 of the attendees for the Pre-Diabetes education session identified as Māori

PERSONAL SUCCESS FEEDBACK

"We are so privileged to have such an informative course offered to us for free. Also, to know how we score and understanding HBA1c, and having the chance to do something to reverse Pre-Diabetes is life changing. Thank you."

"Loved learning about the risks of diabetes and how simple it is to challenge these risks."

"My knowledge regarding diabetes was very limited. Now I understand what it is, how it affects one's body and what can be done to be a healthier and more positive person."

Community Falls Prevention

PURPOSE To reduce the incidence and impact of falls among the 65+ age group.

OBJECTIVE

- Deliver a 'one-off' Upright and Able education session to address community falls prevention referrals and to support navigation into a community strength and balance group
- Build relationships and 'approve' community group leaders who meet the strength and balance criteria established by an expert advisory group for Accident Compensation Corporation (ACC), Health Quality and Safety Commission and Ministry of Health
- Support 'Approved' group leaders to meet and maintain criteria through training and development sessions

PROGRAMME OVERVIEW

Nelson Bays Primary Health was chosen by ACC as the 'Lead Agency' for the Nelson Marlborough region to 'approve' community group leaders that meet the nine evidenced-based criteria.

The community falls prevention programme linked closely with the Nelson Marlborough Health 'In-Home' Falls Prevention programme and the Fracture Liaison pathways, creating a whole of system joined up approach to primary, community and secondary services aimed at preventing falls and fractures.

The intended audience for community falls prevention are 65 years and over who are mobile, living independently and able to participate safely in group strength and balance exercise classes. The intention is to prevent falls by living stronger for longer and is part of a national initiative developed by ACC, Health Quality and Safety Commission and the Ministry of Health.

PROGRAMME OUTCOMES

Classes delivered by an approved leader continue to grow, as does the variety of exercises provided within classes. We currently have 69 individual approved instructors with majority delivering multiple classes per week.

Participant feedback tell us people engage in more than one *type* of class a week. This can at times include exercising outdoors, (eg outdoor gym equipment etc) which provides additional benefits and maintains enthusiasm to continue. The biggest benefit other than falls prevention, is the social opportunities and connecting with others within community group strength and balance classes.

TARGETS (YEAR)

- The target was to have 4,000 approved 'places' (how many people can attend). We achieved 3,071
- There is no set target for approved leaders but there was an overwhelming response of new and existing leaders in our region wanting to be approved.

Continues over...

Community Falls Prevention Continued

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Referrals						
• Numbers referred	353		273		270	
• Ethnicity	**Māori** 1	**Non-Māori** 352	**Māori** 28	**Non-Māori** 245	**Māori** 3	**Non-Māori** 267
Upright and Able Education Session						
• Number of sessions delivered	20		16		16	
• Number of people attended	140		174		168	
Falls Awareness Promotions						
• Number of awareness promotions	8		9		7 (5 Nelson and 2 Marlborough)	
Community Group Strength and Balance						
• Total Number of groups approved	*		75		138	
• Number of kaupapa Māori groups approved	*		4		4	
• Number of training sessions provided	*		4		4	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MĀORI HEALTH ACTIVITIES

- 3 of the referrals received identified as Māori
- There is one new instructor approved for the kaupapa Māori group

Community Nutrition Service Primary Care Dietitians

PURPOSE To support individuals to make culturally appropriate, safe and nutritious food choices to prevent and manage long term conditions and other nutritional related conditions.

OBJECTIVE

- Allocate dietitian clinic hours to every General Practice in the Nelson Bays region allowing eligible patients to access dietitian support
- Build knowledge and confidence of our community, and our workforce through training and development in evidenced-based nutrition topics
- Deliver an evidenced-based, culturally appropriate programme to families which supports the health target 'Raising Healthy Kids'

SERVICE OVERVIEW

There are four components to the service:

1. Workforce development for Primary Care health workers including Nelson Bays Primary Health, Nelson Marlborough Health and Te Piki Oranga staff
2. Group self-management education for prevention and management of long term conditions including Eat Move Grow Programme, Living with Type 2 Diabetes, Healthy Hearts and Pulmonary Rehabilitation
3. One-to-One Primary Care Dietitian appointments within the General Practice and other appropriate Primary Health Care Providers (e.g. Te Piki Oranga)
4. Deliver an evidenced-based programme to address childhood obesity prevention in pre-schoolers and their whānau (Eat Move Grow)

How well did we do?

KEY PERFORMANCE MEASURES

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Primary Care Dietitian: 1:1 Consultations (General Practice and Nelson Bays Primary Health)						
• Number of 1:1 individuals booked into clinic	942		917		904	
• Number attended	*		815		792	
• Ethnicity of those booked	**Māori** 11%	**Non-Māori** 89%	**Māori** 11%	**Non-Māori** 89%	**Māori** 11%	**Non-Māori** 89%
Primary Care Dietitian: 1:1 Clinics held at Te Piki Oranga						
• Number of clinics at Marae	6		7		10	
• Number attended	11		23		14	
• Number who did not attend	*		0		0	

Continues over...

Community Nutrition Service Primary Care Dietitians Continued

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Self-Management Group Education Sessions						
	Groups	**People**	**Groups**	**People**	**Groups**	**People**
• Type 2 Diabetes	7	55	8	71	7	96
• Healthy Hearts	10	124	12	210	10	131
• Pulmonary Rehab	6	110	3	60	3	65
• Other	*	*	*	*	3	53
Total	**23**	**289**	**23**	**341**	**23**	**345**
Child Obesity Prevention						
	Groups	**People**	**Groups**	**People**	**Groups**	**People**
• Eat Move Grow	3	30	6	67	3	34
• Ethnicity of those attending	**Māori** *	**Non-Māori** *	**Māori** 4	**Non-Māori** 65	**Māori** 0	**Non-Māori** 34
Workforce Development						
• Number of education sessions	**Groups** 10	**People** 127	**Groups** 8	**People** 120	**Groups** 10	**People** 129
• % increasing knowledge of topic	*		*		Those who were surveyed reported a 100% increase in knowledge	
• % increasing confidence to address topic	*		*			
Programme Outcomes (At Completion)						
• Type 2 diabetes – percentage of participants have improved knowledge	100%		99%		100%	
• Healthy Hearts – percentage of participants have improved their knowledge	99%		99%		100%	
• Eat Move Grow percentage of parents have improved their knowledge	100%		100%		100%	
Programme Outcomes (12 Months After Completion)						
• Type 2 diabetes – percentage of people who have improved eating habits	88%		79%		60%	
• Healthy Hearts – percentage of people who have improved eating habits	71%		98%		100%	
• Eat Move Grow, percent of children:						
– more physically active	66%		100%		67%	
– spending less time on screens	33%		60%		67%	
– eating more fruit and vegetables	66%		80%		83%	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

TARGETS (YEAR)

- The target for one to one patients booked into clinic is 800. This year 904 were booked into a clinic
- The target for Group Education sessions is 20. This year 23 sessions were held
- The target for Childhood Obesity Prevention programmes is 8. This year we achieved 3
- The target for Workforce Development sessions is 8. This year we achieved 10

MĀORI HEALTH ACTIVITIES

- 11% of referrals identified as Māori
- Monthly clinic provided at Te Piki Oranga, Motueka (initiated January 2017)
- A kōrero on type 2 diabetes and healthy kai for whānau was held at Te Piki Oranga, Te Awhina Marae, Motueka in June, with 23 people attending
- The Primary Care Dietitians attended the Hauora Direct event in June. Referrals for the service were generated from this event
- The Primary Care Dietitians have a regular kōrero with the Te Piki Oranga Dietitian to update on each service's activities including discussions on individual cases when needed
- The Dietitians sought feedback from the Te Piki Oranga Dietitian on the content of the Eat Move Grow programme and have adapted this accordingly

Nelson Bays Primary Health's Primary Care Dietitians – Tonia Talbot and Deepti.

OTHER VULNERABLE GROUPS

- The Primary Care Dietitians continue to support former refugees through individual clinic appointments for a range of conditions, including Type 2 diabetes, restricted eating in children and appropriate childhood growth. Interpreters and language specific resources are used in these consultations
- The Primary Care Dietitians have provided two workforce developments sessions this year to the Red Cross resettlement and cross cultural workers on "healthy food choices for families", and "growing healthy children"

PARTICIPANT FEEDBACK

"After having been a lifetime dieter and recently diagnosed with Diverticulitis my Doctor booked me into see the Dietitian. I thought I was going to get yet another diet to follow. Instead, to my relief and delight the Dietitian talked to me about Mindful eating and hunger awareness. Gosh it was like a light had gone on and a huge weight had been lifted of my shoulders".

"I found the Dietitian amazing and the way she explained it all made such great sense"

"The Dietitian talked to me about exercise and as I had an old injury I thought the gym or pool was out of reach, but we discussed a Green Prescription, which I am excited to say I am attending and enjoying.

"Thank you so very much I feel like this has been life changing for me and I am excited about my future health and wellbeing. I am extremely grateful for this service."

EAT MOVE GROW PROGRAMME FEEDBACK

"Very clear information around healthy behaviours for children and finding out how to create calmer mealtimes. Very informative around physical activity.

"Morning teas were a fun opportunity for my son. Good reminder to keep things positive and with wide variety. Our biggest change/focus will be on making mealtimes more relaxing, less pressure."

Community Podiatry Service

PURPOSE To deliver a specialist podiatry service that includes assessment and care of diabetes related foot problems that can lead to ulceration or potential amputation. The overall aim is to reduce the incidence of ulcerations and amputations within the Nelson Tasman population who have diabetes.

OBJECTIVE

- Deliver a podiatry service that:
  - Is a primary care service that prevents ulcerations (early intervention)
  - Addresses high risk diabetes foot symptoms, that could lead to ulceration or amputations
  - Is culturally appropriate and engages Māori and other vulnerable populations with diabetes
- Patient education opportunities are provided regarding good foot care and risk factor awareness as appropriate.

SERVICE OVERVIEW

Nelson Bays Primary Health contracts a private podiatry service to deliver this contract across the Nelson Tasman region. The current provider is Nelson Bays (Mapua) Podiatry. This free service is accessed via a referral. An eligibility criterion ensures the service targets those that need it the most and have been identified as having diabetes related foot problems. The service is delivered mainly via clinics, as listed below, although home visits are undertaken for special circumstances.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
• Total number of patient consultations	2,484		2,443		2,495	
• Consultations by Ethnicity	**Māori** 312	**Non-Māori** 2,172	**Māori** 359	**Non-Māori** 2,084	**Māori** 325	**Non-Māori** 2,170
Where were patients seen	**Clinics held**		**Clinics held**		**Clinics held**	
• Marae clinic (Whakatu and Te Awhina)	8		8		8	
• Hospital clinic	80		85		90	
• Mapua clinic	44		47		47	
• House calls	26		35		42	
• Golden Bay clinic	8		8		8	
• Other	0		1 (rest home)		-	
Number who Did Not Attend	*		295		282	
Number who declined	15		15		30 (estimate)	

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Patient education opportunities provided:			
With support from Te Piki Oranga nurses	Works in partnership with Te Piki Oranga staff at all Marae clinics	Works in partnership with Te Piki Oranga staff at all Marae clinics	Works in partnership with Te Piki Oranga staff Stop Smoking and type 2 diabetes education promoted
Onward referrals were sent to:			
Orthotics	30	31	28
Vascular surgeon	2	13	5
District Nurse	*	50	8

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

TARGETS (YEAR)

- The target for this contract is to see 2,540 patients. This year the service achieved 2,495

MĀORI HEALTH ACTIVITIES

- 325 of the people who accessed the service identified as Māori
- 55 of the people who accessed the service identified as Pasifika
- A Total of 380 high risk clients seen by the podiatrist service
- 8 clinics have been held at Te Piki Oranga based at Te Āwhina Marae and Whakatu Marae
- Marae podiatry clinics are delivered in partnership with Te Piki Oranga and are hugely valued by Māori who attend. The Te Piki Oranga Nurses work on a triage system where they perform a foot check while offering toe nail cutting services and kōrero with clients about other issues. The client then sees the Podiatrist, if the clients meet referral criteria (complicated foot problems)

SUCCESSES / CHALLENGES

- Demand continues to be strong with the Service covering hospital clinics by default (being the only funded Podiatry service in Nelson). Nelson Marlborough Health have advertised for a secondary care Podiatrist, but recruitment was not successful.
- Strong relationships with Te Piki Oranga continue with Marae clinics accessing 'at risk' clients who would normally miss regular health checks.
- Marae clinics are an example of a successful model for engaging Māori (325 Māori accessed in one year)
- This year has seen a reduction in wait times to 4.5 months, the lowest waiting time in two years

Fracture Liaison Service Falls Prevention

PURPOSE To reduce the impact and incidence of hip fractures (fractured neck of femur) in older adults.

OBJECTIVE

- Identify potential osteoporotic fractures (fragility fractures) in the Emergency Department and inform the General Practice of potential risks
- Monitor fractured neck of femur (NOF) rates
- Support our primary care workforce to increase knowledge of bone health, osteoporosis, fragility fractures and falls prevention through workforce development
- Develop an evidence-based electronic Falls and Fracture Risk Screening tool for primary care to support early identification and management of osteoporosis and/or fragility fractures

PROGRAMME OVERVIEW

The Nelson Bays Primary Health Fracture Liaison Service is a sustainable model that builds primary care pathways and supports early identification, treatment and management of osteoporotic fractures. The service connects primary, secondary and community services and pathways for a joined-up, whole of system approach.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Nelson Emergency Department Data						
• Number identified in ED with potential osteoporotic fracture	282		291+		369	
• Ethnicity	**Māori** 3	**Non-Māori** 279	**Māori** 4	**Non-Māori** 287+	**Māori** 4	**Non-Māori** 365
• Gender of those identified	**Male** 79	**Female** 203	**Male** 93	**Female** 198	**Male** 110	**Female** 259
Fractured Neck of Femur (# NOF)						
• Number of hip fractures (fragility) identified in Nelson Hospital	*		67 (incomplete data)		105	
Workforce Development						
• Number of education sessions	**Groups** 12	**People** *	**Groups** 12	**People** 135	**Groups** 21+	**People** 90+
• % increasing knowledge of topic	*		99.8%		100%	
• % increasing confidence to address topic	*		99.8%		100%	
Data from Bone Health Screening Tool						
• Number of primary care practices using the screening tool	*		5 General Practices are piloting the screening tool		21 (all Practices)	
• Number of screens completed	*		Trials only to date		31	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

PROGRAMME TARGETS (YEAR)

Target is: 614 patients identified at Emergency Department when patient presents with potential fragility fracture.

Actuals: 369 (best estimate). When Nelson Marlborough Health (NMH) implemented South Island PICS (hospital patient management system) the fragility fracture data was affected. NMH are still working on resolving this issue, hence the best estimate.

PROGRAMME OUTCOMES

- An electronic assessment tool for Falls and Fracture Risk Screening in primary care has been successfully rolled out this year. It will take time, ongoing education support and pathway development to have this integrated into 'business as usual'. The assessment is not funded (as yet), which does impact motivation of some practices to complete. However; Nelson Bays Primary Health is one of only two regions in New Zealand to have this tool available in primary care
- Nelson Marlborough Health are working on a consistent and reliable method of informing the patients General Practice when a fragility fracture is identified
- Wider system pathways in secondary care, primary care and the community are continuing to grow, connecting bone health and falls prevention awareness and management

MĀORI HEALTH ACTIVITIES

- Four people identifying as Māori had a potential osteoporotic fracture, compared to 365+ for non-Māori
- It would appear, based on the data and evidence from the University of Otago review of Nelson Marlborough Māori Health Profile in 2011-2013, and the Longitudinal cohort of New Zealanders living in advanced age (LiLACS) study that Māori do not develop osteoporosis at the same rates as non-Māori

Green Prescription

PURPOSE Green Prescription is a service that guides patients to improved health through better understanding of behaviours, physical activity and nutrition. This is achieved by empowering patients using effective self-management support so they gain motivation and confidence to make life-long healthy choices.

OBJECTIVE

- Through Green Prescription programme options, build knowledge and confidence for patients to be:
  - Physically active on a regular basis
  - Motivated to make healthier food choices
  - Able to initiate and sustain healthy lifestyle choices
- Monitor and evaluate patients who have attended
- Using a postal survey, monitor the long-term health outcomes of those who attended

PROGRAMME OVERVIEW

Green Prescription is a referral option that General Practitioners, Practice Nurses, and other health professionals can utilise to promote and support healthy lifestyles for those at risk of, or with, common health issues and long-term conditions (such as pre-diabetes, diabetes, heart disease and pain).

A 'referral seekers' option is also available; followed up with endorsement from a health professional.

Green Prescription has options available to suit the patient's needs and availability which includes:

- StayWell – a 3-hour interactive workshop designed to reduce the risk of developing common health issues and long-term conditions by increasing motivation, exploring personal beliefs and lifestyle behaviours, setting goals, and developing healthy lifestyle plans
- KickStart – a multi-week programme, that builds confidence through a cohesive group, and behaviour change by attending weekly. This programme involves education and a sample of various physical activities. Delivered in partnership with aquatic/gym facilities around the region
- Condition specific self-management sessions such as; Living with Type 2 Diabetes; Upright and Able for falls prevention; The Joint Programme – osteoarthritis hip and knee; or Healthy Hearts-cardiac rehabilitation

Sourced: The Ministry of Health – "Need help to get ACTIVE" pamphlet - www.health.govt.nz

How well did we do?

KEY PERFORMANCE MEASURES

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Green Prescription Referrals						
• Numbers referred	1,802		1,733		1,201	
• Ethnicity	**Māori** 214	**Non-Māori** 1,588	**Māori** 211	**Non-Māori** 1522	**Māori** 123	**Non-Māori** 1078
• Gender	**Male** 512	**Female** 1,290	**Male** 462	**Female** 1271	**Male** 443	**Female** 758
KickStart (7 week programme run every school term)						
• Number of people attending KickStart	478		552		642	
• Number of programmes delivered	12		13		12	
StayWell (one-off workshop)						
• Number of people attending	52		252		203	
• Number of sessions delivered in General Practice	1		2		0	
• Number of sessions delivered in the community	6		20		22	
• Total Number of sessions delivered	7		22		22	
Condition Specific self-management programme choice e.g. Type 2 Diabetes; Pre-Diabetes; Falls Prevention; The Joint Programme; Healthy Hearts						
• Number of people attending	977		710		459	
Outcomes (at Completion)						
• Percentage of participants that:						
- understand why they need to be active	100%		93%		88%	
- have made positive changes to food since beginning Green Prescription	63%		77%		83%	
- feel supported to initiate and sustain good lifestyle choices	100%		89%		95%	
6 Months After Completion						
• Percentage of participants that:						
- are still regularly active	78%		79%		74%	
- are still choosing healthier food options	97%		77%		83%	
- report improved health outcome	88%		82%		75%	

Continues over...

Green Prescription Continued

TARGETS (YEAR)

- The target is to receive 1200 Green Prescription referrals per year. We achieved 1,201 referrals.

PERSONAL SUCCESS STORIES

"I've lived badly for a long time and it caught up with me when I ended up in hospital. I needed to change and that's now what I'm doing, thanks to Green Prescription." New Zealand European Male 34yrs.

"I came along to support my husband; however, the programme has been very beneficial to my own health. I plan to continue to make healthier choices." Māori woman 51yrs.

"I've lost 4kgs since I started and changed my eating habits. I now actually eat more, but it's healthy food I'm choosing. My brother will be joining me in the next programme." Māori male 51yrs.

Rongoā Kākāriki GREEN PRESCRIPTION

MĀORI HEALTH ACTIVITIES

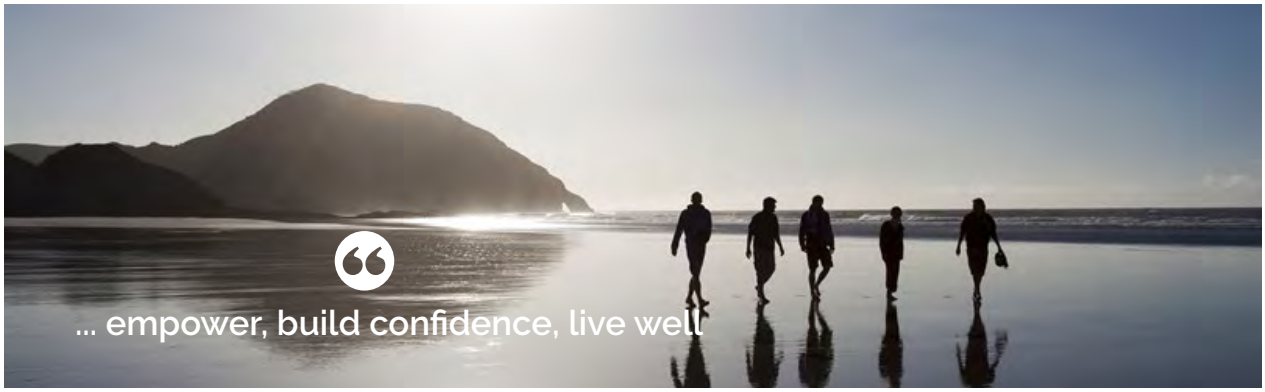
- Equitable access and increased engagement for Māori has been a focus this year using a 'Plan, Do, Study, Act' cycle of improvement to inform the process
- Increased referral pathways have been developed reducing barriers (real and perceived) to bring the service closer to patients and whānau
- 10.1% of referrals identified as Māori, with an average engagement rate of 47%
- Ongoing relationship building and partnerships with key Māori stakeholders have provided opportunities for integration, such as;
  - Regular kōrero and ako initiatives with staff and whānau at Te Piki Oranga offices (Whakatu and Te Awhina Marae)
  - Strengthened whakawhānaunga and trust between Te Piki Oranga and Green Prescription and developed a way forward to support the needs of communities
  - Discussions with Te Waka Hauora staff and Te Korowai Trust have led to the consideration and planning of specific, multi-week Green Prescription programmes for later in 2019

Bee Williamson of the Health Promotion Team talking at a Green Prescription programme.

Sourced: The Ministry of Health – "Need help to get ACTIVE" pamphlet - www.health.govt.nz.

The Joint Programme Managing Osteoarthritis

PURPOSE To improve the quality of life by reducing pain for people living with osteoarthritis.



OBJECTIVE

- Build knowledge about osteoarthritis and pain management using health literacy skills and resources
- Build confidence of those attending to:
  - self-manage osteoarthritis symptoms
  - manage weight, increase physical activity, improve bone health through better nutrition and address the emotional stress of chronic pain
- Build an understanding of gout and its management

PROGRAMME OVERVIEW

The Joint Programme is a two and a half hour group session for people with osteoarthritis and is designed to empower and build confidence to live well. The session includes interactive discussions and information on:

- Improving nutrition to maintain healthy bones and manage weight
- Keeping mobile/exercise regularly to support joints and manage pain
- Taking pain medication regularly as prescribed

The programme has undergone a significant redevelopment this year which included adding an emotional/stress topic to help cope with chronic pain. Changes also included adding a focus on bone health and moving away from weight loss, in line with latest evidence and specialist advice.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Referrals						
• Numbers referred	177		216		124	
• Ethnicity of referrals	**Māori** 1	**Non-Māori** 176	**Māori** 5	**Non-Māori** 211	**Māori** 7	**Non-Māori** 117
• Gender of referrals	**Male** 32	**Female** 145	**Male** 49	**Female** 167	**Male** 22	**Female** 102

Continues over...

The Joint Programme Managing Osteoarthritis Continued

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Programme Delivery The Joint Programme attendance						
• Ethnicity of participants	**Māori** 0	**Non-Māori** 117	**Māori** 5	**Non-Māori** 153	**Māori** 3	**Non-Māori** 81
• Gender	**Male** *	**Female** *	**Male** 34	**Female** 124	**Male** 15	**Female** 69
• Number attending	117		158		84	
• Number of sessions delivered	8		12		7	
Outcomes (at Completion)						
• Percentage of participants that:						
- increased their knowledge of Osteoarthritis	99%		96%		100%	
- increased their confidence to manage Osteoarthritis	93%		95%		90%	
12 months After Completion						
• Percentage of participants who:						
- are managing pain better	73%		78%		76%	
- have increased physical activity levels	33%		53%		55%	
- have changed eating habits to improve bone health	57%		60%		54%	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MĀORI HEALTH ACTIVITIES

- Seven referrals identified as Māori
- Three people identifying as Māori participated in the group sessions.
- A series of interactive "train the trainer "sessions have been delivered at Whakatu Marae for Te Piki Oranga kaimahi (nurses and pukenga manaaki). This has been a joint effort across the Health Promotion team and Rheumatology service. The first session was on the diagnosis and management of gout. Work is underway to develop a resource in Te Reo as a result of this. It's hoped there is an increased awareness for testing of uric acid levels within those most at risk i.e. Māori.

PERSONAL SUCCESS STORIES

Personal feedback received at the end of the session:

"It was so comforting being part of a group of people who understand osteoarthritis pain; everyone had great ideas. The session was fun, friendly and very informative. I'm sure I can manage my osteoarthritis much better now because I feel more confident."

Personal feedback received 6-months after attending:

"I am now walking 20 minutes a day. The session helped me to manage my pain and now I don't blame the 'system' for not helping me. I feel more in control of my life".

Victory Community Centre

PURPOSE To provide funding to improve access to primary health care services for Victory residents.

OBJECTIVE

- To enable Victory Community Centre to:
  - Reduce and/or remove barriers that prevent the Victory Community accessing primary health care services
  - Identify patient and whānau health and social service needs
  - Support whānau to navigate health and social services
  - Support whānau to maintain good health and wellness through appropriate information and resources

PROGRAMME OVERVIEW

To provide a health and social service coordination role to identify needs, gaps and barriers, then facilitate patient pathways to access primary health care to address unmet health needs. The service supports whānau to better understand their health condition or health needs and supports access to primary health care and wellness support services.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Service Outcomes			
• Number of clients accessing the service	341	456	256+
• The top five issues identified	*	1. Lack of housing 2. Lack of support 3. Unaffordable medical and dental services 4. Unaffordable sexual health and contraception 5. Addiction issues	1. Mental Health (anxiety and low mood) 2. Substance use problems 3. Sexually transmitted infections and pregnancy 4. Lack of housing 5. Re-engaging with the screening systems
Percentage of referrals broken down by:			
Ethnicity:			
• European	*	33%	54%
• Māori	32%	34%	35%
• Pasifika	4%	2%	1%
• Other	*	31%	10%
Reason for clients accessing the service **			
• Health assessments	341	456	256
• Mental Health	13	50	10+
• Social issues	8	36	7+
• Housing issues	2	18	Not specified
• Education	10	35	54
• Other	*	4	46 (influenza vaccinations)

Continues over…

Victory Community Centre Continued

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
• Number of assessments completed	341	456	256
• Number of unenrolled clients supported to enrol in General Practice	23	16	9
• Number of clients supported to access other services	133	78	79
• Number of refugee families supported	*	11	139
• Number of information sessions delivered	*	7	4

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

***Clients may have more than one reason for referral to the service.*

MĀORI HEALTH ACTIVITIES

- 91 clients identified as Māori

SUPPORTING VULNERABLE GROUPS

The Victory Community Centre staff work closely with Victory Primary School who have 42% new New Zealander families, 30% Māori families and 28% other ethnicity families enrolled at the school. This service ensures that this highly vulnerable population, have easy access to health and social support.

Victory Community Centre is a community centre located in Nelson's multi-cultural Victory village. The centre offers: a range of health services, a large programme of activities and events, advocacy and support for community members, a place to gather and meet other people.

VICTORY COMMUNITY CENTRE UPDATE

- A combined Navigator/Community Nurse role was established in September, which further supports the navigation to, and delivery of health services in order to meet the needs of the community. A period of training, orientation and networking has been the focus since September
- Work continues alongside Red Cross refugee services, Te Piki Oranga, Nelson Tasman Pasifika Community Trust, Nelson Bays Primary Health and Nelson Marlborough Health, along with General Practices and Pharmacies
- There was a significant uptake of our local community accessing an influenza vaccination (46 people) – supported by Nelson Bays Primary Health immunisation facilitator
- The Centre has seen an increase in the complexity of health needs (including mental health issues) this year, and has worked hard with clients to coordinate and facilitate appropriate care across the health system
- Through working closely together with clients, measurable health outcomes, such as improvements in mood have been noted

Mental Health

Gateway Health Assessment Service

PURPOSE To ensure every child/young person who comes to the attention of Oranga Tamariki (formerly Child, Youth and Family) receives an assessment that helps build a complete picture of the child/young person's needs, and ensures that they get access to the right health and education services to address their needs.

OBJECTIVE

- Nelson Bays Primary Health, Nelson Marlborough Health, Oranga Tamariki and the Ministry of Education work together to identify and respond to children and young people's health and education needs
- To provide a platform for Health, Education and Social Services to assess the needs of each individual client
- Work through the recommendations of the Interagency Service Agreement and gather feedback from the client/family (via the Social Worker as necessary)

PROGRAMME OVERVIEW

All referrals for the service originate with Oranga Tamariki when children/young people come into care or go through Family Group Conference proceedings. Professionals participating in Gateway from all three Ministries recognise that these clients are the most vulnerable members of our community, and that the welfare, interests and safety of children and young people are the first and paramount considerations.

Health information for each client is collated into a file, along with a detailed education profile completed by the education provider. A physical exam is performed by a paediatrician and reviews the file. The paediatrician summarises the findings and recommendations into a health report, which forms the basis of an Interagency Service Agreement. The Interagency Service Agreement is then reviewed at a monthly multidisciplinary meeting where local services are provisioned based on the needs identified at the assessment.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
• Number of referrals from Oranga Tamariki received	58	55	93
• Number of assessments Nelson Bays Primary Health engaged in (health assessments undertaken)	48	64	63
• Number of inter-service panel meetings held	38	65	62
• Strategies implemented to reduce any gaps identified	Rack card developed	Liaison with Oranga Tamariki on a regular basis. Reminders sent to Paediatrics regarding children's reports	Paediatrics have engaged locum clinicians to clear the wait list

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MĀORI HEALTH ACTIVITIES

- There were 55 Māori referred to the service

VULNERABLE POPULATION

- Gateway Assessment focuses only on vulnerable children who are in Oranga Tamariki care or have care and protection issues

ORANGA TAMARIKI
Ministry for Vulnerable Children

Mental Health Services to Children in Care

PURPOSE To facilitate and coordinate the delivery of appropriate mental health services to meet mental health needs (behavioural and/or emotional) for children and young people in the care of Oranga Tamariki (previously Child, Youth and Family) and/or via a Gateway Assessment. The service is for those 18 years and under.

OBJECTIVE

- To facilitate and coordinate the delivery of mental health services
- Encourage the use of the Mental Health Packages of Care and ensure access to a Mental Health Package of Care within appropriate timeframes

PROGRAMME OVERVIEW

Nelson Bays Primary Health ensures a seamless service delivery of the mental health 'Packages of Care' of children and young people. The service is made up of the following components:

- Participation at the Gateway Assessment panel meeting in Nelson
- Undertaking service planning across the district
- Coordinating the delivery of Oranga Tamariki endorsed interventions in Nelson
- Liaison with other relevant services and practitioners – Ministry of Health, Oranga Tamariki, Child and Adolescent Mental Health Service and Strengthening Families

How well did we do?

KEY PERFORMANCE INDICATORS

MENTAL HEALTH SERVICES – CHILDREN IN CARE	2016/2017	2017/2018	2018/2019
• Number of referrals to this service	*	19	15
• Number of Packages of Care completed (clients can have more than 1 Package of Care)	*	21	7
• Average number of days from referral to Package of Care	*	18	21

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MĀORI HEALTH ACTIVITIES

- 1 child referred identified as Māori

Persistent Non-Malignant Pain Programme

PURPOSE To enable clients to self-manage their persistent pain more effectively.

OBJECTIVE

To provide sustainable, evidenced based Persistent Non-Malignant Pain Programme assessment and management in a community setting, which aims to have a positive effect for the client, on whole families (whānau) and reduce prevalence and effects of persistent pain. Intervention aims to:

- Increase the client's overall activity participation
- Minimise any emotional distress experienced as a result of living with persistent pain
- Reduce reliance on medications (including Opioids) and on Emergency Department presentations

PROGRAMME OVERVIEW

The service is delivered by a multi-disciplinary specialist team, providing individual and group pain management interventions using a holistic model. During 2018/19, the average duration of referred clients pain experience was 8 years. Two key questions asked at the time of initial assessment:

- Why is the client presenting in this way at this time?
- What can be done to reduce the clients distress and disability?

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
• Number of referrals received	*	275	288
• Number of Māori participants	13	22	8
• Number of groups completed	2	1	2
• Number of clients engaged with counsellor/ clinical psychologist	*	56	62
Improvement			
• Clients' perceived improved level of workability	*	8%	4%
• Clients' enhanced ability to undertake activities in and around the home	*	18%	9%
• Clients' increased ability to cope with pain without medications	*	14%	6%
• Clients' reduction in opioid use	*	16%	48%
Client follow-up 6 months after intervention			
Six-month follow-up questionnaires were posted to clients who completed intervention. Whilst the data indicates only slight on-going improvement in the domains measured, it is suggestive that participants are continuing to employ the recommended self-management strategies which is positive. Response rate was low, with only 43% returned questionnaires. The service will transition to using an online tool for future data collection, with the view of increasing client participation.			

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Primary Mental Health Initiative and Brief Intervention Service

PURPOSE To ensure that people with mild to moderate mental health problems have access to appropriate services as soon as possible, within available resources. The role of the primary care mental health practitioners is to ensure that individuals return to their full level of functioning by identifying and subsequently managing a mental health problem.

OBJECTIVE

- To improve coping strategies of people with mild to moderate mental health challenges
- To address referrals in a timely manner

PROGRAMME OVERVIEW

The Primary Mental Health Initiative Service is delivered by sub-contracted providers across the Nelson Tasman region. The providers comprise of Psychologists, Counsellors and Psychotherapists, who provide between 3 – 4 sessions. Referrals are via General Practice or Māori Health Providers. This service is available to all age groups.

The Brief Intervention Service accepts referrals from General Practice or Māori Health Providers for clients aged 16 years and over. This service is staffed by clinicians who work from the Richmond site, with one of these based in Motueka one day a week. The clinicians are trained in counselling and three are also Registered Nurses.

The PHQ-9 is a multipurpose assessment tool for screening, diagnosing, monitoring and measuring severity in depression. It is a measure that is used by General Practices and Sub-contractors both in the Primary Mental Health initiative and in the Brief Intervention Service. This scoring is completed with a patient for their initial visit and again by their selected therapist at their final appointment. This provides a means to clinically evaluate any improvement in outcome.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Primary Mental Health Initiative			
• Referrals	1,767	2,421	1,726
• Average drop of PHQ-9 scores from beginning of treatment to end of treatment	*	6.4	1.25
• Time on Primary Mental Health Initiative Service waitlist	*	One week	One week
Brief Intervention Service			
Referrals	938	944	1,369
• Average drop of PHQ9 scores from beginning of treatment to end of treatment	*	8.0	7.5
• Time on Brief Intervention Service waitlist (days)	*	28	46
Client Outcomes for Brief Intervention Service			
• Percentage of improvement	**	**	80%
• Percentage of clients who would recommend the service	**	**	100%
• Positive changes occurred due to counselling	**	**	80%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

*** New measurement to Nelson Bays Primary Health in 2018/19 and previous financial years data not available.*

MĀORI HEALTH ACTIVITIES

- 327 of the referrals identified as Māori under the Primary Mental Health Initiative

Youth Alcohol and Other Drug Service

PURPOSE To provide Alcohol and Other Drug and Mental Health Brief Intervention treatment, therapy, support and care coordination service for young people in Nelson/Tasman.

OBJECTIVE

To deliver a responsive Youth Alcohol and Other Drug Brief Intervention service which is mobile and supports access to Alcohol and Other Drug and Mental Health Services for young people with mild – moderate alcohol and/or drug use.

PROGRAMME OVERVIEW

The service uses a youth participation model. The service is flexible to meet the needs of young people and is aligned to the Nelson Bays Primary Mental Health Brief Intervention and Targeted Youth Health Services, the Nelson Marlborough Health Addictions services, and Child and Adolescent Mental Health services.
The service accepts referrals for children and young people with alcohol and other drug disorders with co-existing anxiety, depression, phobias and behavioural disorders if clinically appropriate. The service includes screening and the use of brief assessment tools such as the Substance Use and Choices Scale (SACS). The expected maximum intervention is up to four sessions. These interventions are mainly in the form of one-on-one counselling sessions.

Liaison and consultation to other providers of health services and linkages with school guidance counsellors for referrals both ways are maintained.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
• Number of young people referred to the Youth Alcohol and Other Drug Service	*	125	150
• Number of clinics held	*	312	372
• Number of group education sessions provided	*	48	42
Patient feedback at 3 months (via survey)			
1. Percentage of those who found the service helpful	**	**	80%
2. Percentage of those who have achieved their goals	**	**	80%
3. Percentage of those who would tell their mates about this service	**	**	60%
• Comparison of Substance Use and Choices Scale from start of treatment to end of treatment (% improvement)	*	65%	44.3%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*
*** New measurement to Nelson Bays Primary Health in 2018/19 and previous financial years data not available.*

MĀORI HEALTH ACTIVITIES

- There were 41 Māori referred to the service

Kaiatawhai Health

Kaiatawhai Nursing Service

PURPOSE To improve access to Primary Health Care services and reduce inequalities for Māori and other vulnerable population groups.

OBJECTIVE

- To improve access and uptake of health screening at a General Practice
- To develop collaborative relationships across the primary health care community
- To provide a navigation and case management service

PROGRAMME OVERVIEW

Nelson Bays Primary Health's Kaiatawhai service works with General Practices and primary health care providers, to support the health and well-being of their patients/clients in the Nelson Tasman region. The service supports whānau enrolled with a General Practice to access health screenings such as: cardiovascular risk assessments, cervical smears, mammograms, vaccinations and diabetes annual reviews. The aim is to reduce inequities in health for Māori and other vulnerable populations.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
• Number of referrals	323	276	256
• Number of health assessments completed	*	44	93
• Number of patients referred to other primary health providers	*	61	42
• Number of patients supported to be enrolled in General Practice	*	14	5
• Number of community organisations liaised with for the service	*	79	106

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Referrals by Ethnicity			
• European	*	151	167
• Māori	*	97	70
• Pasifika	*	14	8
• Asian	*	9	5
• Other/Unknown	*	5	6
Referrals by gender			
• Male	*	63	49
• Female	*	213	207
Referrals by Age			
• 0-14	*	11	16
• 15-24	*	34	20
• 25-49	*	149	133
• 50-75	*	79	79
• 75+	*	3	8
Reason for referrals **			
• Support to engage in Health Screening	*	184	201
• Access to Health Services	*	122	83
• Mental Health	*	11	20
• Education	*	26	30
• Other (Court, Housing New Zealand, Probation)	*	12	18
Of those referred;			
• Unable to contact	*	11	25
• No longer in the area	*	3	5
• Declined	*	11	24
• Deceased	*	0	2

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*
*** Clients may be seen for more than one reason.*

MĀORI HEALTH ACTIVITIES

- 70 of the referrals identified as Māori compared to 97 in the previous year
- 10 people who identified as Māori were referred to Te Piki Oranga services
- 40 people who identified as Māori declined a referral to Te Piki Oranga services

Continues over...

Kaiatawhai Nursing Service Continued

PATIENT OUTCOMES / SUCCESS STORIES

Case Study for a whole whānau (Māori):

A mother was referred to Kaiatawhai Service in July 2018. The service was unable to make contact initially, but by perseverance and creativity the attempts were finally successful and a plan was put in place. As a result, the following outcomes were achieved for the whole whānau:

- Two children successfully navigated to eye examinations – both children required glasses and support was provided to access funding to get the glasses
- One child needed a hearing test, appointment at Audiology Department made and attended
- Two referrals for Mum to see a General Practitioner and get a referral to Gynaecology (successfully)
- One referral to budgeting services and Te Piki Oranga budgeting services have engaged with whānau

Pigeon Valley Fire Navigator work:

For February and March, the Kaiatawhai service was seconded into a navigation role to support people impacted by the Pigeon Valley fires. This role included:

- Responding to 38 referrals into the navigator service
- Attending six community meetings to support community connections and identify areas of support needed
- Supporting the development of public health notices to go into media
- Supporting patients to access General Practice or Pharmacy services
- Providing an 0800 number and responding 24/7 to calls coming to this number
- Providing an email address healthsupport@nbph.org.nz for fire impacted people to ask questions or seek help

During the Pigeon Valley Fire:

- 297 people impacted by the fire were able to access a free General Practice visit
- Wakefield Health Centre was evacuated and relocated into Richmond, well out of the fire's path. The Health Centre was able to maintain normal business thanks to the support from Nelson Bays Primary Health collective staff effort


... 297 people impacted by the fire were able to access a free General Practice visit
NELSON TASMAN FIRE
NUMBERS AT A GLANCE
20 FEB 2019
2343HA
FIRE GROUND
35.4KM
PERIMETER
3272
PEOPLE
REGISTERED WITH
CIVIL DEFENCE
60
POLICE
MEN AND WOMEN
200+
FIREFIGHTERS
ON THE GROUND
1277 PROPERTIES
ON STANDBY TO EVACUATE
3558
PEOPLE
83 PROPERTIES
STILL
EVACUATED
ESTIMATED 230 PEOPLE
NINE
HELICOPTERS
46 ANIMALS
AT THE SHOWGROUNDS
ZERO
RAINFALL
SINCE THE FIRE STARTED
15 DAYS AGO
SOURCES:

Kaiatawhai Social Work Service

PURPOSE To improve access to primary care services and reduce inequalities for Māori and other vulnerable population groups by aiming to address the social determinants of health.

OBJECTIVE

- To work with those referred to assist and empower them to:
  - Reduce isolation and /or other social issues
  - Identify unmet social determinants of health needs (e.g. housing, insulation, personal or family health, debt, violence, abuse or neglect)
- To develop collaborative relationships within and across the primary health care community
- To provide a navigation and case management service through collaborative relationships

PROGRAMME OVERVIEW

The Kaiatawhai Social Work Service provides a holistic social work assessment which is based on 'Te Whare Tapa Whā' along with a strengths-based approach. The aim is to work alongside patients to help them identify goals and improve health outcomes. The service also provides advocacy, navigation and links patients to community groups and/or non-government organisations when they require ongoing support.

> ... the Kaiatawhai Social Work Service was successful at getting 20 people into emergency or permanent housing during the year

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018 (new services)	2018/2019
• Number of referrals	55	160
• Number of Social Work assessments completed	20	72
• Number of patients referred to other primary health providers/Non-Government Organisation Community Groups	15	47
• Number of patients supported to be enrolled in General Practice	5	8
• Number of community organisations liaised with for the service	30	46
Referrals by ethnicity		
• European	28	98
• Māori	20	44
• Pasifika	4	2
• Asian	3	3
• Other/Unknown	0	13
Referrals by gender		
• Male	23	54
• Females	32	106
Referrals by age		
• Under 15	5	8
• 15-24	5	12
• 25-49	20	54
• 50-75	19	71
• 75+	6	15
Reason for referrals		
	• Parenting • Work and Income • Mental Health • Alcohol and Drug Brief Intervention • Social Support • Housing • Safety Planning	• Housing • Ministry of Social Development Advocacy • Parenting • Social Isolation • Health Navigation • GP Enrolment • Combined Health and Social Navigation • Mental Health • Brief Intervention Alcohol and Other Drug

Continues over...

Kaiatawhai Social Work Service Continued

PROGRAMME MEASUREMENT	2017/2018 (new services)	2018/2019
Of those referred how many were;		
• Unable to be contacted	5	32
• No longer in the area	1	0
• Declined	4	11
• Deceased	0	1

MĀORI HEALTH ACTIVITIES

- 24.5% of the referrals identified as Māori
- There have been discussions with Kaimahi at Whakatū Marae about how we can work collaboratively to meet the health needs of their most vulnerable whānau

OTHER VULNERABLE GROUPS

We are working collaboratively/with former refugees to ensure that families with complex health and social issues are being transitioned out of Red Cross support and into the community. There are bi-monthly meetings involving the Red Cross, Public Health, Victory Pharmacy and relevant General Practices.

PATIENT OUTCOMES/SUCCESS STORIES

- The service was successful at getting 20 people into emergency or permanent housing during the year
- Three of these referrals have, after getting a house/a roof over their heads, progressed to addressing their addiction issues

General Practice

Care Plus

PURPOSE To provide subsidised appointments at a General Practice that allow enrolled and eligible patients who have, high needs because of chronic (or long term) condition or terminal illness, affordable access to intense clinical management.

OBJECTIVE

- To support long term condition management and reduce barriers to accessing essential health care for those meeting eligibility criteria
- To reduce inequalities and target those that need it the most
- To provide flexibility with the criteria so General Practices can make a clinical judgement based on need
- To provide allocations to each General Practice every quarter, as a way of staying within our financial constraints

PROGRAMME OVERVIEW

Eligible patients are offered an initial comprehensive assessment, where their health needs are explored. An individual care plan is developed in partnership with the patient and realistic, achievable health and quality of life-related goals are set, with follow-up appointments to monitor progress as needed. Practices are able to maximise the use of Care Plus by using both short and long term 'packages of care' depending on the patient's need. A 'package of care' consists of up to four appointments and each patient is able to utilise up to two 'packages of care' per year.

Quintile 5 represents people living in the most deprived areas.

The introduction of the Community Services Card initiative on 1 December 2018 has impacted Care Plus in a positive way. For people with a Community Services Card (and their dependants), they can now access their doctor at reduced costs. This has allowed Practices more flexibility to reach their 'high-needs' populations.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Service Outcomes			
• Number of patients Registered in Care Plus	6,900	7,353	7,551
• Number of reviews completed	16,860	17,618	17,158
Registrations broken down by ethnicity			
• Māori	11%	11%	11%
• Pasifika	1%	1%	1%
• Other	88%	88%	88%
Registrations broken down by high needs			
• Māori, Pasifika, quintile 5	*	1,830	1,130
• Quintile 4	*	5,523	1,905
• Quintile 3	*	0	2,027
• Other	*	0	2,489

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MĀORI HEALTH ACTIVITIES

- We are seeing a growing number of Māori registered on Care Plus compared to previous years. In quarter 1 there were 782 Māori registered, and by quarter 4 that had increased to 873

OTHER VULNERABLE GROUPS

- In quarter 1, there were 96 Pacific people registered in Care Plus, and by quarter 4, that had increased to 108

Workforce Education

PURPOSE

Continuing Medical Education
To provide high quality continuing medical education for Nelson Bays Primary Health aligned General Practitioners, by funding and supporting a Royal New Zealand College of General Practitioners approved education programme along with an Education Facilitator to maintain approved provider status.

Continuing Nurse Education
To provide the primary healthcare nursing workforce of Nelson Bays with quality ongoing professional development (education) relevant to the health needs of our population, ensuring up to date clinical excellence.

Quality Education
To up-skill the General Practice workforce in order to enhance the quality of leadership, systems and processes within General Practice, as required under Cornerstone Accreditation 'Aiming for Excellence' framework.

OBJECTIVE

Continuing Medical Education

- To ensure that Nelson Bays General Practitioners are kept up-to-date with current best practice and evidence-based medicine through the Pegasus small-group model
- To ensure that Nelson Bays General Practitioners are skilled and knowledgeable
- To ensure that identified learning needs are met

Continuing Nurse Education

- To ensure that the nursing workforce is skilled and knowledgeable and kept up to date with current best practice
- To promote the use of self-reflection and portfolio development

Quality Education

- To deliver sessions that are required under the Cornerstone Accreditation 'Aiming for Excellence' framework to support General Practices meet accreditation standards

PROGRAMME OVERVIEW

Continuing Medical Education

Continual professional development is an on-going requirement for Doctors as outlined by the Medical Council of New Zealand. To maintain a current practising certificate, Doctors must meet recertification and continual professional development requirements. To support this, Nelson Bays Primary Health provides both Royal New Zealand College of General Practitioners endorsed Multidisciplinary team events and Pegasus small group meetings on a monthly and bi-monthly cycle.

Continuing Nurse Education

Continuing nurse education is an ongoing requirement as set out by the New Zealand Nursing Council. To achieve an annual practising certificate all Nurses, need to demonstrate 20 hours a year (60 hours over three years) of professional development. This learning is done increasingly as part of the interdisciplinary health professional team or from visiting educational institutions (as offered by Nelson Bays Primary Health), clinical peer review, online training or local and national education programmes.

Quality Education

Quality Education sessions are combined learning opportunities for the whole General Practice team. Nelson Bays Primary Health have online training opportunities (e.g. Privacy Act) as well as face to face opportunities. Each General Practice is encouraged to register with Practice Managers and Administrators Association of New Zealand (PMAANZ). A PMAANZ affiliated General Practice is able to access funding up to $100 per year to support their administrative team. Nelson Bays Primary Health continues to facilitate monthly Practice Manager meetings to support quality and accurate information exchanges.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Pegasus small groups			
• Number of Pegasus small groups completed	*	4	4
• Average Number of Doctors engaged in the Pegasus model	*	51	37
• Average rating of the overall quality of the meetings	*	4.5/5	4.4/5
• Average rating of the quality of information provided (resource material)	*	4.4/5	4.3/5
• Average rating of the importance and relevance of the content	*	4.5/5	4.3/5
Multidisciplinary sessions			
• Number of multidisciplinary sessions completed	*	6	7
• Average rating of the quality of the sessions	*	4.3/5	4.6/5
• Average rating of the quality of information provided (resource material)	*	4.1/5	3.5/5
Continuing Nurse Education Sessions			
• Number of Continuing Nurse Education sessions completed	15	10	4
Nurse Personal Development Fund			
• Number of applications received	*	27	38
• Number of application accepted	*	26	32
Quality Education Sessions			
• Number of Cornerstone Accredited sessions delivered	*	9	8
• Percentage of General Practices who have achieved Accreditation	*	Foundation Accredited = 9.5% Cornerstone Accredited = 90.5%	Foundation Accredited: = 9.5% Cornerstone Accredited: = 90.5%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Palliative Care

PURPOSE To reduce the financial burden on the patient and/or their family in the terminal phase of their illness and support quality of life by providing continuity of care with the General Practice team.

OBJECTIVE

- To support patients to remain at home during the terminal phase of their illness
- To reduce the financial burden on the patient/whānau in the terminal phase of their illness
- For General Practice teams to provide a coordinated domiciliary palliative care service based on the needs of the individual and family/whānau

PROGRAMME OVERVIEW

This service is available to patients who have been diagnosed with a terminal illness and whose death is expected within the next 6 – 12 months. Patients registered onto the programme are allocated a package of care. The package of care provides General Practitioner or Practice Nurse consultations, home visits, discharge meetings and post death family visits. There is a separate agreement for those enrolled in rural Motueka and Golden Bay General Practices.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Number of new Registrations	*	334	320
Referrals broken down by ethnicity			
• New Zealand European	86%	85%	87%
• Māori	5%	5%	4%
• Other	9%	10%	9%
Referrals broken down by gender			
• Male	47%	54%	59%
• Female	53%	46%	41%
Service provided			
• General Practitioner Home visit	31%	30%	26%
• General Practitioner Prescription	29%	29%	31%
• General Practitioner Consult	28%	30%	26%
• Hospice visit	4%	4%	3%
• Post death visit	8%	7%	6%
• General Practice Other	*	*	8%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MĀORI HEALTH ACTIVITIES

- 4% of those who accessed the service identified as Māori

Primary Options for Care

PURPOSE The overarching aim of 'Options for Care' is to reduce the growth in secondary care services by allowing General Practice to provide responsive services to patients. The aim is being to have a positive impact on health outcomes.

OBJECTIVE

- To allow patients that would otherwise be referred to the hospital or other District Health Board funded specialist services, to be treated and supported in General Practice
- To improve service integration across the health system
- To monitor and manage contractual obligations and ensure equity of access within financial constraints

PROGRAMME OVERVIEW

General Practices can provide over 15 services under the Primary Options for Care contract, which would otherwise be delivered in the Hospital. Service providers can charge a co-payment on services where this is allowed, but it is expected that there will be some patients who receive free services (e.g. no co-payment is charged) for those with:

- a Community Services Card
- a High User Health Card
- High needs patients defined as Māori, Pacific, Quintile 5

Primary Options for Care is available to patients who are enrolled with a Nelson Bays Primary Health General Practice and eligible for funded services.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Services provided			
• IV antibiotics	485	537	299
• IV fluids for dehydration	**	**	272
• Venesection for Haemochromatosis	249	301	224
• Spirometry – diagnostic	323	335	357
• Chronic Obstructive Pulmonary Disease acute management	16	23	56
• Insulin Initiation	13	30	31
• Management of Deep Vein Thrombosis	9	14	15
• Zoledronic Acid Infusions	4	13	20
• Ad Hoc Services	14	29	24
• Entonox (Pain)	58	84	124
• Polycythaemia Vera	9	10	22
• Iron Infusion	**	**	231
• Migraine treatment	**	**	21
• Hyperemesis	**	**	28
• Paediatric Intranasal Fentanyl	**	**	15

Continues over...

Primary Options for Care Continued

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Total number of services provided under Options for Care	**1,180**	**1,376**	**1,739**
Claims broken down by ethnicity			
• New Zealand European	74%	78%	75%
• Māori	6%	5%	7%
• Pasifika	1%	0%	1%
• Asian	1%	1%	2%
• Other/Unknown	18%	16%	15%
Claims by gender			
• Male	*	748	830
• Female	*	628	909
Percentage of Referrals by age			
• 0-4	*	1%	1%
• 5-19	*	6%	7%
• 20-34	*	12%	11%
• 35-49	*	17%	17%
• 50 -64	*	28%	27%
• 65+	*	36%	37%
Number of co-payments charged for			
• Community Services Card holders	**	**	302
• High User health card holders	**	**	5
• Māori/Pacific	**	**	107
• Quintile 5	**	**	122
• Other at General Practice discretion	**	**	80

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

*** New measurement to Nelson Bays Primary Health in 2018/19 and previous financial year's data not available.*

MĀORI HEALTH ACTIVITIES

- 7% of people who accessed the service identified as Māori which is an increase from last year

OTHER VULNERABLE PEOPLE

- As our former refugee population increases, so to does the need for Primary Options for Care use (former refugees are generally classified under Asian and Other ethnicity)

Skin Lesion Removal Service

PURPOSE To provide high quality skin lesion removal services within primary care, reduce waiting times for skin lesion removals and reduce the burden of non-melanoma skin cancer on secondary services.

OBJECTIVE

- To enable increased access to services closer to home
- To work in collaboration with Nelson Marlborough Health to reduce demand on secondary care

PROGRAMME OVERVIEW

The service includes General Practitioners who provide minor skin lesion removal in General Practice and General Practitioners with Special Interest/skills who preform Intermediate skin lesion removal. If the lesion is more advanced or complex, a referral is received and triaged by the Skin Lesion General Practice Advisor and Specialist Dermatologist who prioritise referrals and provide high level advice on management of all lesions referred.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Minor Skin Lesion Removal in General Practice	*	*	692
Intermediate Skin Lesion service	*	*	275
Number of patients referred from General Practice	1,714	1,766	2,085
Referrals broken down by ethnicity			
• European	90%	86%	91%
• Not specified	8%	8%	6%
• Māori	2%	2%	2%
• Pacific Island	0%	0%	1%
Percentage of referrals broken down by age			
• 0-4	1%	1%	0%
• 5-14	1%	1%	1%
• 15-24	2%	1%	1%
• 25-44	7%	6%	5%
• 45-64	26%	25%	25%
• 65+	63%	66%	68%
Triage destination of referrals received			
• Advice only	15%	9%	5%
• Cancelled	3%	4%	4%
• Declined	3%	4%	3%
• Dermatology Department	9%	7%	1%
• Ear, Nose and Throat	22%	21%	21%
• General Surgical	20%	20%	18%

Continues over...

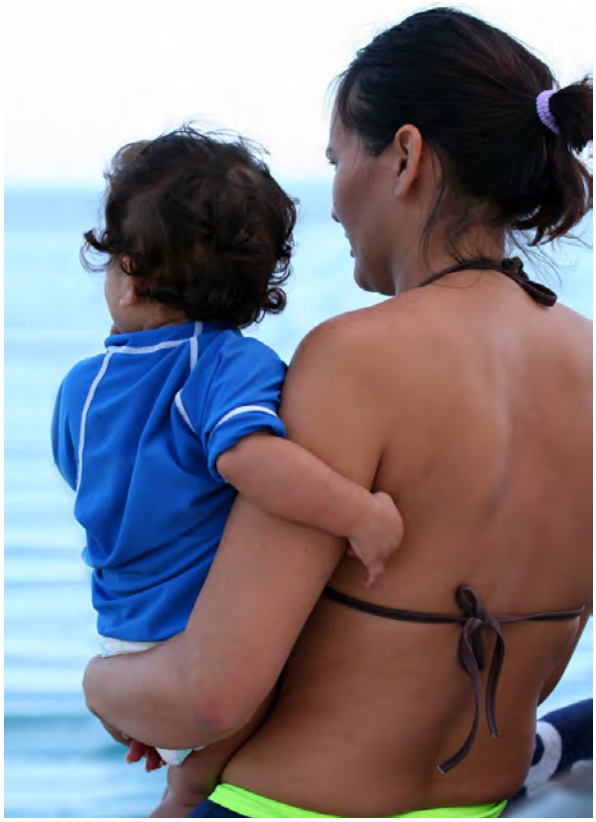
Skin Lesion Removal Service Continued

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Triage destination of referrals received			
• Ophthalmology	1%	3%	2%
• Other – Plastics	0%	1%	1%
• Referred to General Practice (Minor)	23%	27%	30%
• General Practitioners with Special Interest (intermediate)	4%	4%	15%

**New measurement to Nelson Bays Primary Health in 2018/19 and previous financial year's data not available.*

MĀORI HEALTH ACTIVITIES

- Malignant melanoma risk is linked with ultraviolet radiation exposure (particularly sunburn) as well as genetic characteristics, like fair skin. Other risk factors include a large number of moles. This means, darker skinned people are less at risk of melanoma
- 43 Māori were referred to the service in 2018/19 compared to 30 in 2017/18



PATIENT OUTCOMES/SUCCESS STORIES

Received from a patient who received an intermediate skin lesion service from Dr Mark Fry:

"Thank you for your text today. Good to know the margins are clear and no further treatment required. I would like to thank you for the wonderful service I received. The referral was attended to promptly. I received a letter explaining that I would be contacted by a specialist and that very evening you phoned and explained the procedure. A date for the removal of the lesion was made. It was hugely convenient to attend your clinic at Wakefield. The whole removal procedure was done promptly, efficiently and with care. The support from Nurse Rebecca was excellent. The sutures have been removed today and the neat wound has healed beautifully. I would recommend this service to anyone requiring removal of a skin lesion. Many thanks."

Nursing Services

Community Respiratory Health Service

PURPOSE To provide a specialist community-based respiratory service focused on education and healthy lifestyle support in line with current best practice.

OBJECTIVE

- Provide an evidenced-based Pulmonary Rehabilitation programme
- Promote and support healthy lifestyles, symptom management and trigger awareness via The Nelson Asthma Society's Better Breathers Clubs
- Support Primary Care providers to upskill and manager their patients with respiratory conditions
- Link with community stakeholders to ensure consistent messaging around respiratory conditions

SERVICE OVERVIEW

The service provides a respiratory nurse specialist for one-on-one appointments either in-home or in a clinic setting, and a sub-contract with the Nelson Asthma Society, allows a partnership model to provide promotion, support groups (Better Breathers) and Pulmonary Rehabilitation Programmes.

... participants six-months after completion of a Pulmonary Rehabilitation course showed ...

- **100% reporting no respiratory related hospital admissions**
- **100% reporting having increased physical activity**
- **66% now taking medications correctly**
- **55% managing stress better**

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018		2018/2019	
Referrals				
• Total number of referrals received	217		272	
– Respiratory Nurse Clinic	46		71	
– Pulmonary Rehabilitation	92		176	
– Spirometry	79		25	
• Adult	206		262	
• Paediatric	11		10	
• Reason for referral				
– Asthma	3%		21%	
– Chronic Obstructive Pulmonary Disease	77%		77%	
– Other respiratory conditions	20%		2%	
• Ethnicity of referrals	**Māori** 22%	**Non-Māori** 82%	**Māori** 15%	**Non-Māori** 85%
• Number of spirometry completed in primary care	334		359	
Attendance for Respiratory Nurse Specialist clinics				
• Number attended clinic	49		48	
• Ethnicity of those seen	**Māori** 10	**Non-Māori** 39	**Māori** 2	**Non-Māori** 46
• Number of people who did not attend	2	2	5	2
• Where were clients seen	**Clinic** *	**Home** *	**Clinic** 95%	**Home** 5%
• Self-management and Action Plan discussed with patient	90%		98%	
• Number of whānau/group education sessions delivered	8		3	
Pulmonary Rehabilitation Programme Measurement				
• Number of Pulmonary Rehabilitation programmes delivered	4		3	
• Percentage of participants who completed course	*		89%	
• Participants who report increased confidence in self-management	*		95%	
• Participants who report improved exercise tolerance	*		89%	

Continues over...

Community Respiratory Health Service Continued

PROGRAMME MEASUREMENT	2017/2018		2018/2019	
• Participants who improved Chronic Obstructive Pulmonary Disease Assessment Test score	*		73%	
• Participants who were motivated to continue improving their fitness	*		100%	
Results of participant follow-up at six-months after completion of Pulmonary Rehabilitation course (28 participants)	• 100% reported no respiratory related hospital admissions in last six months • 100% reported having increased physical activity • 66% are now taking medications correctly • 55% are managing stress better			
• **Ethnicity of attendees**	**Māori** 9%	**Non-Māori** 91%	**Māori** 12%	**Non-Māori** 88%
Workforce Development (Consultancy)				
• Number of professional development sessions to health professionals	**Sessions** 7	**Attended** 99	**Sessions** 5	**Attended** 43
• Consultancy advice provided to health professionals	6		12	
• Engagement with community services	4		5	

** Contract changes in 2017/18 with different reporting targets – no data to match for previous financial years.*

MĀORI HEALTH ACTIVITIES

- Nine people identifying as Māori were referred to this service. However, the attendance rate of Māori is low compared to those referred. This will be a focus in the coming year
- Those who hold a Community Services Card or vulnerable in any way are offered home/school visits or assistance with transport

PERSONAL SUCCESS STORIES

"I can now go walking with my family and am not left at home because of my shortness of breath."

"My cough has nearly gone and now I feel confident to make other improvements to my health."

"I can breathe easier and can do more now that I know how to manage my symptoms."

Director of Primary Healthcare Nursing

PURPOSE The role of the district wide Director of Primary Healthcare Nursing is to lead and provide professional support to primary and community nurses, to support and advise Primary Health Organisation/District Health Board Managers and clinicians, and to contribute to the strategic direction for primary healthcare nursing.

OBJECTIVE

- Supporting the nursing workforce to participate in collaborative practice models
- Facilitating training and competency development to prepare and maintain nurses, including Advanced Practice Nurses
- Nurses providing more access for Māori and vulnerable people and contributing to improving health outcomes
- Nurses focusing on people self-managing their own care and disease prevention
- Identifying and minimising barriers to nurses fulfilling their roles and scopes of practice

Christine Andrews
Director of Primary Healthcare Nursing

PROGRAMME OVERVIEW

This position is a key driver of the nursing workforce resource which enables improvement in people's health and population health outcomes. Primary care nurses work actively in key priority areas keeping people out of hospital. Our nursing challenge is to improve the health of individuals, families and communities through health promotion, disease prevention and treatment, immunisation and screening, mental health interventions, care coordination and navigation.

ACHIEVEMENTS

The past year's highlights include:

- Developing more settings for Nurse Practitioner employment
- 15 Registered Nurses completed the Ara Institute of Canterbury graduate paper 'Managing and Caring for People with Diabetes in the Clinical and Community Setting'
- 17 Registered Nurses completed the second Mental Health and Addictions Credentialing for Primary Healthcare Nurse's Course
- Twice the previous year's number of primary healthcare nurses were funded for post-graduate study
- Nurses are participating in Health Care Home practice development
- Quarterly Practice Nurse Leaders' meetings contributed to improving nursing practice
- Using Standing Orders on Health Pathways is becoming the norm

> **... primary care nurses work actively in key priority areas; keeping people out of hospital.**

Immunisation Facilitation Service

PURPOSE To increase immunisation coverage across the Nelson Bays eligible population. The aim is to improve the health of all New Zealanders by protecting them from vaccine preventable diseases through an effective immunisation programme.

OBJECTIVE

- To provide up-to-date, accurate information to providers and the public about vaccines
- To ensure integrity of the cold-chain, through effective monitoring and audit
- To support providers to develop their recall systems and immunisation quality plans
- To work proactively across the region to reduce our immunisation decliner rates
- To monitor and assess authorised vaccinators ensuring safe administration of vaccinations

SERVICE OVERVIEW

Nelson Bays Primary Health is contracted to provide professional immunisation leadership in a collaborative partnership between Nelson Marlborough Public Health Services and community health organisations including General Practice.

The Immunisation Regional Steering Group provides the strategic leadership for increasing immunisation coverage as well as sharing information, training/education, communication and other areas of common interest, where health gains can best be achieved through collaboration or cooperation.

Cold Chain is the process that ensures all vaccines are stored within the +2˚C to +8˚C temperature range at all times during transportation or storage, from the point of manufacture through to administering. The process is to ensure integrity of the vaccine that is safe and effective when given to the patient.

How well did we do?

KEY PERFORMANCE INDICATORS

IMMUNISATION TARGETS – Aiming for heard immunity which is >90% target population immunised

Immunisations	Achieved	Narrative
• 8-month old immunisations	87%	9.2 % Decliner rates
• 2-year-old immunisations	87%	10.9 % decliner rates
• Pertussis (whooping cough)	87%	Outbreak of pertussis in 2017 still continues
• Measles (Measles, Mumps and Rubella)	87%	Measles outbreak remains current. No reported cases in Nelson Tasman
• Influenza	23%	Our region experienced the biggest uptake nationally

PROGRAMME MANAGEMENT

Education and Promotion	Achievements	2018/19
• Workforce	89%	Influzena vaccinations uptake to Nelson Bays Primary Health employees
• Nelson Bays Primary Health Immunisation Newsletter	6	Produced and circulated
• Resource development and distribution	3	New Influzena resources developed in three refugee languages
• Public Promotion	6	Two influenza campaigns, Measles vaccinations, Pertussis vaccinations and two childhood vaccinations
• Outbreak notifications	4	Meningococcal, Measles, Pertussis, Influenza
Health Provider Support	**Number Completed**	**Narrative**
• General Practice	160	Face to face visits, education and transport of vaccines
• Supporting other Health Providers	150	Lead Maternity Carers, Occupational Health Nurses, Public Health staff, Te Piki Oranga nurses, Nelson Hospital staff, Pharmacists
Vaccinator Training & Accreditation	**Number Completed**	**Narrative**
• Total Clinical Assessments completed	53	
Cold Chain Management	**Number Completed**	**Narrative**
• Total Accreditations completed	26	
• Validations and Cold Chain monitoring	35	
High Needs Influenza Programme	**Number Completed**	**Narrative**
• Total number of people receiving a high needs influzena immunisation	1,034	High Needs Population included: • Māori • Pacific • Refugee • Whānau of children with Chronic Condition (Whānau cocooning) • Whānau living with pregnant woman or child under 6-months • Mental health diagnosis • Un-enrolled with mental health diagnosis
• Number of Māori immunised via this programme	248	
• Number of Pacific people immunised via this programme	59	
• Number of people identifying as from a refugee background	306	
• Other high needs/vulnerable people	411	

**New contract received in 2018/19 with different reporting targets – no data to match for previous financial years.*

MĀORI HEALTH ACTIVITIES

- Activities targeting Māori included:
  - Vaccination Authorisation of two Te Piki Oranga Nurses
  - Two influenza clinics held at Te Piki Oranga and Whakatu Marae
  - Home visits with Kaiatawhai Service for vaccinations
  - Home visits with Public Health Immunisation Outreach Service
  - Working in partnership with Te Waka Hauora and Hauora Direct

Lactation Service

PURPOSE To provide Lactation Consultant Services and specialist breastfeeding support for Mums who meet the referral criteria.

OBJECTIVE

- To support increased breastfeeding upon discharge from the maternity unit and up to six months post-natal
- To provide one on one consultations and advice to build the mother's confidence and knowledge
- To support workforce development towards increased confidence, knowledge and skills around breastfeeding

SERVICE OVERVIEW

To provide a Lactation Consultant across the Nelson Tasman region. The service provides education and lactation advice or support in the hospital, in primary care, or close to where Mums live.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Referrals						
• Numbers referred	267		268		241	
• Ethnicity of referrals	**Māori** 5%	**Non-Māori** 95%	**Māori** 8%	**Non-Māori** 92%	**Māori** 6%	**Non-Māori** 94%
Attendance						
• Numbers seen	267		268		241	
	Clinics	**Seen**	**Clinics**	**Seen ****	**Clinics**	**Seen**
– Community clinic	*	*	26**	50%	92	55%
– Postnatal ward	*	*	0	18%	0	14%
– Special Care Baby Unit	*	*	0	18%	0	14%
– Home	*	*	0	13%	0	10%
– Other	*	*	0	0%	0	7%
Waitlist						
Average time to be seen	1 week		1 week		1 week	
Workforce Development (Consultancy)						
• No. of education sessions	**Sessions** 7	**Attended** 75	**Sessions** 10	**Attended** 57	**Sessions** 14	**Attended** 90
Specialist areas/issues addressed						
• Complexities addressed	*		11		11	
• Onward referrals	15 *		9**		110	

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Onward referrals to:			
– Paediatrician	8%	3%	8%
– General Practitioner	12%	15%	32%
– Dentist (lip /tongue ties)	*	9%	6%
– Breast pumps	5%	2%	6%
– Other (e.g. Post Natal Depression)	*	*	13%
Outcomes			
• % Mums fully breastfeeding on discharge	66%	67%	69%
• % Mums partially breastfeeding on discharge	27%	28%	27%
• % Mums ceased to breastfeed on discharge	1%	3%	4%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

***Data gathered from April 2018*

MĀORI HEALTH ACTIVITIES

- Referrals for Māori women has averaged at 6% of all referrals to the service
- Nelson Bays Primary Health's Lactation Consultant continues to work in close collaboration with Te Piki Oranga's Lactation Consultant/Well Child Nurse to achieve higher breastfeeding rates in culturally appropriate ways

SUCCESS

"Babies discharged from hospital / Maternity centre, have an 85-90% exclusive breastfeeding rate in our local region", says Associate Director of Midwifery - Operations Manager at Nelson Marlborough Health.

Telephone Nurse Triage Service (Homecare Medical)

PURPOSE To provide quality telephone advice and assistance by Registered Nurses for the Nelson Bays population during the hours that participating General Practitioners (GP) or other providers are unavailable and have diverted their telephones to Homecare Medical.

OBJECTIVE

- Provision of quality telephone advice and assistance service after-hours.

PROGRAMME OVERVIEW

Registered Nurse telephone triage is provided on a 24/7 basis, including public holidays. Homecare Medical provides:

- Customised triage protocols as required
- Phones are answered in the General Practice name to preserve provider relationships with their patients
- Coverage for when the General Practice is closed
- Emergency General Practice reception (when phone lines are cut or a natural disaster occurs)

How well did we do?

KEY PERFORMANCE INDICATORS

CALL ANALYSIS	2018/19			
	JULY TO SEPT	OCT TO DEC	JAN TO MARCH	APRIL TO JUNE
Total Calls	913	1,128	1,272	1,008
Handover to on-call General Practitioner	297	261	312	229
Handover to after-hours primary care	86	146	165	134
Handover to Emergency Department	29	43	28	35
Handover to ambulance	50	63	75	44
Handover to non-health service	0	0	0	0
Other outcomes, exercise self-care and contact General Practitioner next day	260	338	397	309
Number of administration/practice information calls	191	277	295	257

ETHNICITY	Number	Percentage
Asian	42	1%
European	2,403	56%
Maori	311	7%
Middle Eastern/Latin American/African	12	1%
Pacifica	51	1%
Other Ethnicity:	120	2%
Unknown	1,383	32%
TOTAL	**4,322**	**100%**

Specialist Services

Infectious Diseases Service

PURPOSE To reduce the incidence and optimise the treatment of infectious diseases and antibiotic-resistant organisms in Nelson and Marlborough.

OBJECTIVE

- Access to specialist input is provided within a timely manner
- Improve systems by:
  - Antibiotic stewardship – monitor the local infectious disease epidemiology and guide colleagues to prescribe rational and cost-effective antimicrobials for primary and secondary-care patients
  - Infection prevention and control - guide primary and secondary care services and colleagues to prevent acquisition and spread of infectious organisms
  - Microbiology laboratory - optimize requesting of laboratory tests and guide the laboratory staff to provide up-to-date, accurate and cost-effective testing of samples and effective reporting of results
- Workforce Development - ensure a healthy and informed workforce and maintain connections with national and international colleagues and activities
- Complete research - undertake selected, high-quality, high-impact studies of important local problems then publish and present the results nationally and internationally for the benefit of other health-care services and patients.

SERVICE OVERVIEW

The Infectious Diseases Specialist provides a service across the Nelson Marlborough region that encompasses clients within both primary and community settings. This role includes an emphasis on education and training to increase knowledge and provide appropriate resources for the overall reduction of infections and reduce the reliance on antibiotics if they are not required.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017			2017/2018			2018/2019		
• Total number of telephone consultations	1,083			1,392			1,395		
• Number of clients seen	490			523			658		
• Number of new referrals	126			139			173		
• Ethnicity of new referrals	**Māori** 7	**Non-Māori** 119		**Māori** 8	**Non-Māori** 131		**Māori** 8	**Non-Māori** 165	
• Patient waiting time from referral to first contact (compared to national target)	< 120 days			< 120 days			< 120 days		
• Breakdown of where patients seen: Virtual, clinic, hospital	**Virtual** 355	**Clinic** 104	**Hospital** 31	**Virtual** 416	**Clinic** 75	**Hospital** 32	**Virtual** 545	**Clinic** 89	**Hospital** 24
Workforce Development									
• Number of Teaching presentations	32			8			11		
• Number of audits in Nelson/Marlborough	10			2			2		

TARGETS

- The target for waiting times is less than 120 days. All patients were seen in less than 120 days
- The target for teaching presentations is more than 10 per year. There were 11 delivered
- Did Not Attends – less than 5%

MĀORI HEALTH ACTIVITIES

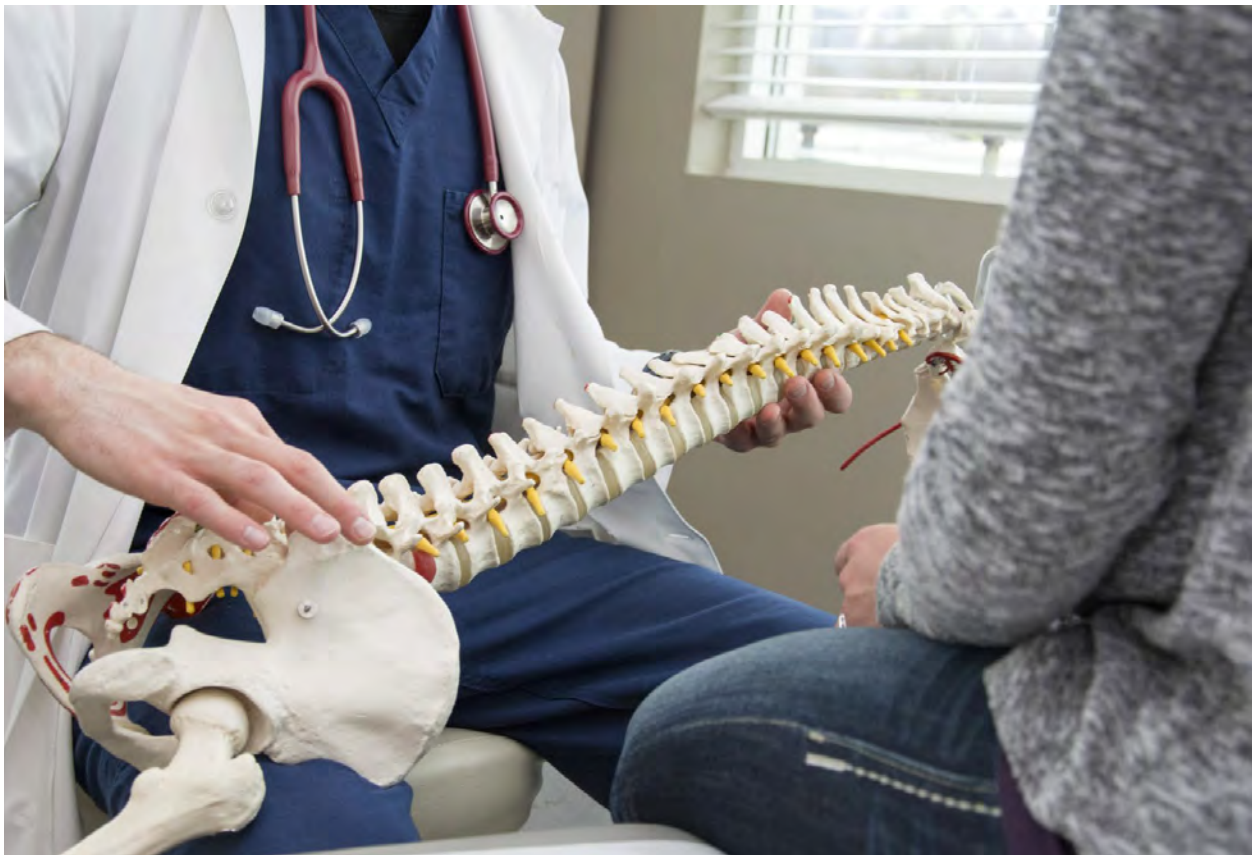
- 8 new patients identified as Māori

OTHER VULNERABLE GROUPS

- 1 new patient identified as Pasifika

Rheumatology Specialist Service

PURPOSE To provide a community-based Rheumatology Specialist model for the management of people with complex inflammatory/rheumatoid conditions. To also provide support and resources for primary care physicians.



OBJECTIVE

To provide a community-based specialist service that:

- Provides patient centred care
- Achieves a timely follow up service by addressing the follow-up appointment overdue list
- Meets the Ministry of Health expectations for Elective Services
- Maintains robust staffing levels of clinicians providing regular clinics

SERVICE OVERVIEW

Nelson Bays Primary Health have been contracted to provide a General Practitioners Special Interest Rheumatology service for the Nelson Marlborough region. Nelson Bays Primary Health employ a specialist Rheumatologist and specialist nursing staff to run the service. This service is free to all patients.

The service has undergone a number of changes over the last two years, but is now adequately staffed with a satisfactory number of General Practitioners involved with Special Interests along with a locum Rheumatologist to provide back up as required. There is currently still a significant number of patients on the follow-up wait-list, but the Rheumatologist is continuing to review and return clients back to their own General Practitioner wherever suitable.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018		2018/2019	
Client Outcomes	**Nelson**	**Marlborough**	**Nelson**	**Marlborough**	**Nelson**	**Marlborough**
• Average time from referral to clinic for first specialist appointment	*	*	95 days	90 days	90 days	90 days
• Average time for follow up appointments	*	*	18 months	18 months	18 months	18 months
• Number of clients seen:						
– First specialist appointments	*	*	366	147	367	141
– Follow up appointments	*	*	1,127	479	1,065	408
Service Outcomes						
• Compliance to meet the 100% Ministry target (timeframe for referral)	80%	85%	80%	100%	100%	95%
• Number of General Practitioners with Special Interest within service	4	2	5	2	4	2
Referrals	**Māori**	**Non-Māori**	**Māori**	**Non-Māori**	**Māori**	**Non-Māori**
• Total referral numbers	60	306	38	475	31	477
• Age breakdown:						
– 10-19 years	*	*	2	8	2	9
– 20-30 years	*	*	2	27	2	28
– 30-40 years	*	*	13	58	10	40
– 40-50 years	*	*	9	83	8	70
– 50-59 years	*	*	3	107	2	112
– 60-69 years	*	*	3	114	3	111
– 70-79 years	*	*	4	70	3	70
– 80 + years	*	*	2	8	1	37
Treatments and Referrals						
• Biologics usage compared to National usage	*		182 total patients (3% higher than National figures)		176 (In-line with National figures)	
• Infusions			5		13	

Continues over...

Rheumatology Specialist Service Continued

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
Number of referrals made to:			
• Pain service	*	8	12
• Green Prescription	*	4	15
• Brief Intervention service	*	2	1
• Physiotherapy	*	10	24
• Hand therapy	*	4	16
• Dietitian	*	4	1
• Orthotics service	*	0	8
• Orthopaedics	*	3	6

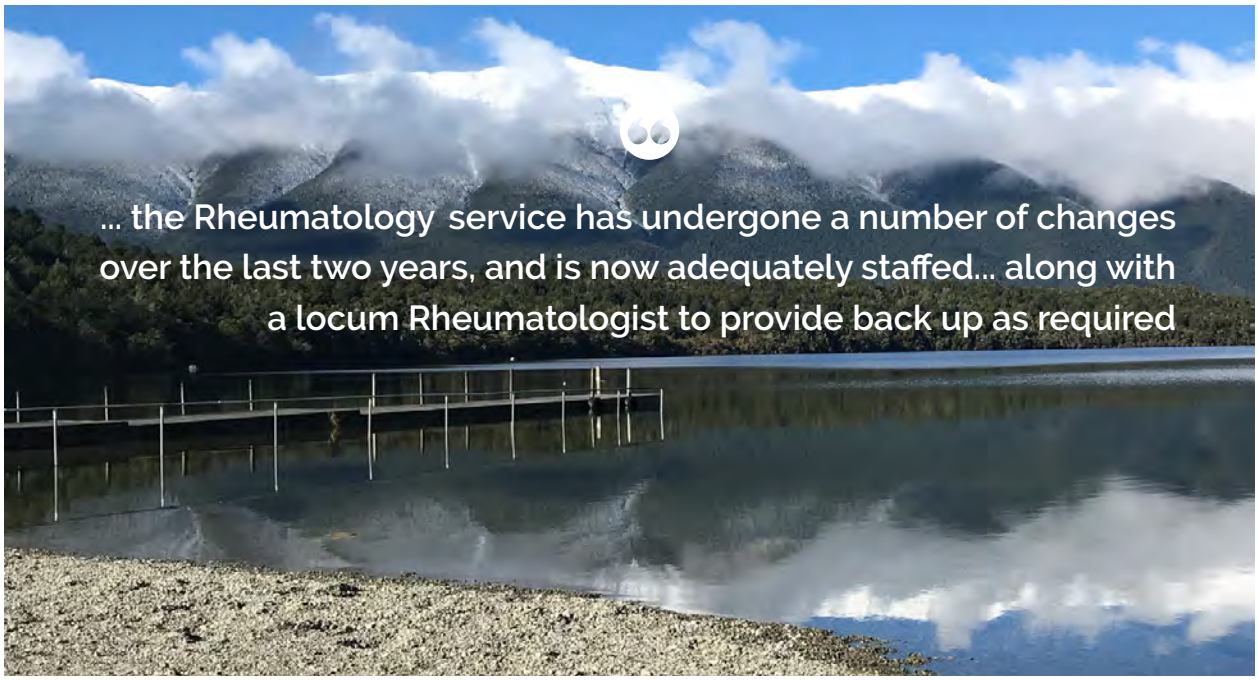
**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

TARGETS

- Provide 500 first specialist appointments / 508 were provided
- Provide 1,150 follow up appointments / 1,473 were provided

MĀORI HEALTH ACTIVITIES

- 31 of the referrals identified as Māori
- A presentation was provided by the Rheumatology Specialist Nurse for Te Piki Oranga at Whakatu Marae in conjunction with the Health Promotion team regarding Gout. This was well received and had a positive health outcome for one attendee
- Fast-track referral system in place for Māori Health Providers, for a specialist nurse review: No referrals received this year



Strategic Initiatives

Health Care Home Model (new)

PURPOSE To support General Practice teams to deliver an improved and more sustainable primary care service through the implementation of the Health Care Home Model of Care.

A Health Care Home practice enhances the patient and whānau experience, creates a more attractive working environment for the workforce and proactively works with the person, their whānau and other providers to keep the person well in their own homes and communities.

OBJECTIVE

- To provide improved access and options for people through enhanced same day Clinical Assessment and Treatment (General Practitioner Triage), increased use of the patient portal and proactive management of patients with chronic conditions and complex care needs
- To enable more control of the workday for General Practice teams through a continuous quality improvement approach, new ways of working and supporting a culture of innovation
- To promote sustainable General Practices for their enrolled population and General Practice owners through changes to the way acute demand is managed, changes to patient and staff work flow and innovative ways of using existing and new workforce

PROGRAMME OVERVIEW

The Health Care Home model is being implemented district wide through Nelson Bays Primary Health and Marlborough Primary Health in partnership with Nelson Marlborough Health. Nationally, over 150 General Practices are implementing the model.

Across the Top of the South, five General Practices were selected in late September 2018 to be the first group of Health Care Home General Practices.

In October 2018, these General Practices commenced year-one of a three-year programme and are systematically improving care for their enrolled population over the following four core domains:

- Managing urgent and unplanned care effectively
- Shifting from reactive to proactive care for those with more complex health or social needs
- Ensuring routine and preventative care is delivered conveniently, systematically and aimed at keeping people as well as they can be
- Ensuring that this is all done with greater business efficiency for long-term sustainability

HEALTH CARE HOME MODEL

Sourced from www.healthcarehome.co.nz – Pinnacle Midlands Health Network.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MANAGEMENT	2018/2019 (new service this year)
Service Outcomes	
• Number of Practices engaged	• Five General Practices district wide (Stoke Medical; The Doctors Motueka; Greenwood Health; Omaka Health Centre and Civic Health)
• Clinical Assessment and Treatment (General Practitioner Triage)	• 28 – 57% of patients requesting a same day appointment are being managed without the need to come in for an appointment • All five General Practices have implemented Clinical Assessment and Treatment (General Practitioner Triage)
• A fully functional Patient Portal (online access to your General Practice)	• 16 – 34% more patients are accessing the services available through the patient portal. This includes being able to make appointments, view test results, order repeat prescriptions and email their doctor directly • In three of the General Practices, patients can now view their medical notes
• Percentage of population	• 37,625 enrolled patients (26% of the district's enrolled population are involved with the Health Care Home programme)

**New service to Nelson Bays Primary Health in 2018.*

PATIENT / PROVIDER FEEDBACK

Patient voice: Re GP-Triage – *"I rang for an appointment and was advised that there were no routine appointments available. I was happy to wait until the following day, but the receptionist suggested that I could be called by a GP to be triaged. I spoke to the GP who felt that with the symptoms I had, it was better that I was seen today. This is an excellent service"*

Patient voice: Re the Self Check in Kiosk – *"I love the self-check-in Kiosk. It feels like I don't have to interrupt other people when I arrive and it's so easy"*

Patient Voice: Re a Patient who was supported to get access to the patient portal and told that she would have access to her notes – *"that will be awesome because I get home and my husband asks me what the doctor said, and I can't remember – now I can show him"*

Provider voice: Re GP-Triage: *"I rang patient X off the Triage list and after assessment, I was able to provide a prescription and to contact us if not improving. That saved both her and my time. The patient recovered well and did not need to attend for a consult"*

Provider voice: Re Admin Process Improvement: *"The new flow at the front desk makes it easy for me to drop off paperwork. I find it helpful that scanning is now done immediately, and letters are available at consultations"*

Provider voice: Re Team Huddles: *"The team huddles have provided an excellent addition to practice communication, particularly during the implementation of our new Patient Management System and when flu vaccine became restrictive. The huddles are always well attended and have become an integral part of the day"*

VIP – Vulnerable Populations Project (new)

PURPOSE The VIP project targets Māori, Pacific and other high risk or vulnerable populations. It is intended for those who are unable to pay to see a General Practitioner and whom without the vouchers would not visit.

OBJECTIVE

- To provide welcome back packs (e.g. General Practice and Pharmacy vouchers) to those identified as vulnerable
- To repay General Practice debt of up to $150 if this is a barrier to accessing General Practice
- To support travel for the vulnerable person to attend appointments
- To support dental services if identified as the health need
- To work in partnership with other organisations to provide a wrap-around service based on the person's needs

PROGRAMME OVERVIEW

Nelson Bays Primary Health called a community hui on 4 September 2018, to consult and learn about our vulnerable population and their health needs. Over 40 people attended from across the Nelson Bays region. The first priority for this group was to define what Vulnerable meant, so for the purpose of this project, the group agreed on: *anyone at any time with an unfilled primary care need.*

Gaps were then identified in health services for this population and then suggestions and ideas were discussed about opportunities to close those gaps. What resulted was the development of the VIP project and the delivery of this started in February 2019.

The project consists of:

- Lead Community Agencies, who have General Practice and Pharmacy vouchers to issue to those identified
- The Lead Community Agencies are:
  - Salvation Army, Nelson
  - Motueka Community House, Motueka
  - Mohua Social Services, Golden Bay
- The Lead Community Agencies role is to:
  - Monitor distribution of vouchers and support people to engage/enrol with General Practice
  - Phone the General Practice to book the appointment
  - Identify if debt at the General Practice is a barrier and work with the person and practice to manage this
  - Provide travel assistance if identified as a barrier
  - Identify any dental health needs and support applications to Fifeshire Foundation to fund dental work needed

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT 4 months of delivery	Motueka	Golden Bay	Nelson	TOTAL
General Practice and Pharmacy Vouchers issued	51	19	10	80
Ethnicity of those receiving a voucher				
• Māori	14	4	1	19
• Non-Māori	37	15	9	61
Number of people not enrolled	4	5	8	17
Travel assistance provided				
• Number of people	10	14	0	24
• Total amount of travel provided	$290	$55	0	$840
General Practice Debt identified				
• Number of people with debt	20	7	2	29
• Total amount of debt repaid	$1,650	$1,040	$384	$3,074
• Number with remaining debt	1	4	2	7
General Practice Claims (includes debt and appointment)	$4,404	$1,474	$738	$6,617
Dental applications				
Number of dental health needs identified	11	5	0	16
• Number of applications submitted	2	2		4
• Total amount of dental work applied for	$1,950	$2,285		$4,235
Partnerships with other agencies/referrers	15	10	2	27
Monthly free lunch provided (Kai Kōrero) • Number attending	69	6	0	75
This service has been modified and made available to Renwick General Practice (a Nelson Bays Primary Health General Practice in Marlborough)				
• Number of vouchers issued				8
• General Practice claims (includes debt and appointment)				$530

Unexpected findings:

- Pharmacy debt is a significant issue with people unable to afford prescription co-payments *"Client left the chemist because they wouldn't dispense the medicine ($5 worth) as client had a debt there"*
- General Practice debt, while expected, is a lot more prevalent than anticipated
- Some people are taking advantage of the vouchers, but with careful monitoring, this is easily identified and acted upon
- Travel, especially for Motueka and Golden Bay people, is a significant barrier to attending or accessing appointments in Richmond or Nelson (Hospital)
- Motueka people are not eligible for Nelson Marlborough Health travel assistance and some Golden Bay people don't meet eligibility criteria for the same travel assistance '
- Relationships between General Practices and the Lead Agencies is now strong and functional. They are working together for the benefit of the patient

Continues over...

VIP – Vulnerable Populations Project (new) Continued

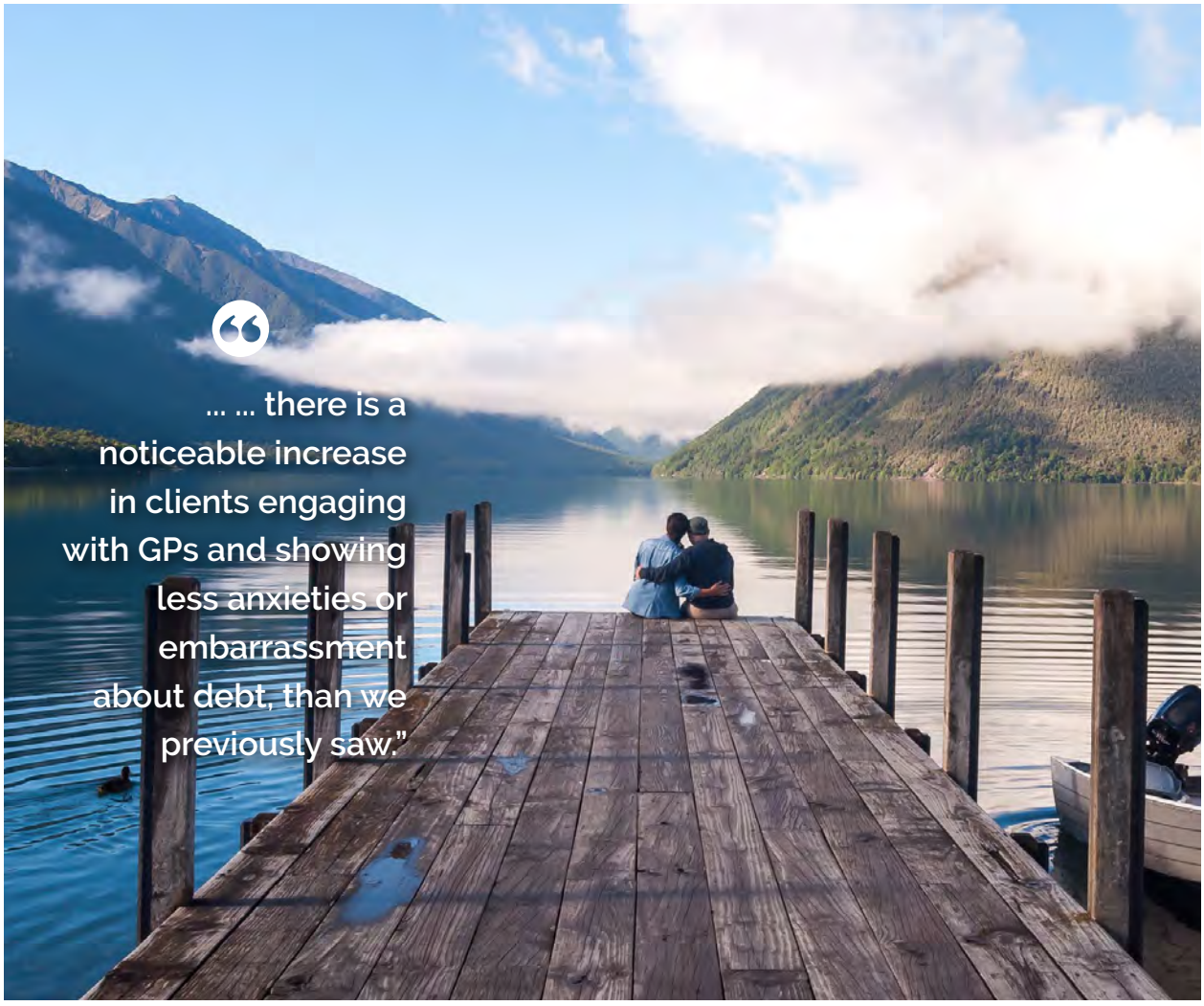
PATIENT OUTCOMES / SUCCESS STORIES

- *"Many have come back in and thanked us for helping them and they feel that they can now set up small fortnightly payments at their Doctors."*
- *"There is a noticeable increase in clients engaging with General Practices and showing less anxieties or embarrassment about debt, than we previously saw."*
- *"One client still has not presented her photo ID (to successfully enrol) and didn't turn up for her appointment at the General Practice. I think the level of chaos in her life still makes Dr appointments a very low priority, even when the appointment is free."* (our social worker continues to work with this client)

Reason for non-enrolment:

- Four people are new to the area, others have not been to their General Practice for a long time, and two have moved from Motueka to Nelson and can no longer access their previous General Practice

Nelson Bays Primary Health is mindful that the Lead Agencies play a critical role in identifying, navigating and supporting these VIP people to get what they need. We thank them and acknowledge them.



Golden Bay Community Health

Golden Bay Community Health Overview

Golden Bay Community Health is a rural Integrated Health Facility providing extensive healthcare and Allied Health services to the community in Golden Bay.

The hospital wing has 24 residential care beds, a combination of rest-home and continuing care beds, in addition to this, there are 5 Flexi beds that are used for acute patient admissions, palliative and/or respite care.

The District Nursing service offers extensive services in the home or place of residence. In addition to routine nursing services, they provide palliative care for the greater community.

Our Well-Child/Public Health nursing service provides an excellent service to the community in Golden Bay. The Well Child Tamariki Ora programme provided a series of health visits and support that is free to all families for children 6 weeks up to 5 years of age. The Public Health Nursing Service offers support to children, young people and their families at schools and other rural facilities across Golden Bay

Our service aspires to promote and protect the rights of children and young people.

The General Practice team consists of General Practitioners, Nurse Practitioners, Practice Nurses, Medical Assistants, Administration and Reception staff. The medical practice offers a wide range of primary care services which includes visiting specialists' e.g. primary care dietitian clinics, paediatricians, podiatrists etc. In addition to General Practitioner/Practice Nurse services, Golden Bay Community Health also offer 24/7 emergency care to both the community and visitors to the area, with an on-site x-ray service and a highly skilled team of practitioners.

Aged Residential Care

PURPOSE To provide residential care services for residents assessed at either rest home level or hospital level care in Golden Bay.

OBJECTIVE

- To provide safe and holistic care in accordance with Aged Resident Care Standards
- To promote wellbeing and maximise health performance for individual residents
- To ensure staff are well trained and competent to provide high quality care to residents
- To maintain residential occupancy over 90%

SERVICE OVERVIEW

The Residential Service at Golden Bay Community Health has 24 dedicated beds and the capacity to flex between hospital and rest home level beds, depending on the needs of the community. The Residential Services support all aspects of resident care by a variety of professional staff including Health Care Assistants, Registered Nurses, General Practitioners and Allied Health professionals.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018			2018/2019		
To provide safe and holistic care in accordance with Aged Residential Care Standards							
• Achieve and maintain Aged Residential Care credentialing	Partial compliance	Compliant			Audit Completed in March 2019. Recommendations to be received by August 2019.		
• Compare and benchmark national performance indicators against Australian performance	*	**Falls**	**Pressure Areas**	**Medication Errors**	**Falls**	**Pressure Areas**	**Medication Errors**
		43	2	6	38	2	6
		Benchmarking against Australian standards indicates we compare favourably in the above areas			Benchmarking against Australian standards indicates we compare favourably in the above areas		
• Number of complaints	*	3			2		
• Number of residents transferred to Nelson Marlborough Health or other facilities	*	No aged care residents transferred during this period			No aged care residents transferred during this period		

Continues over...

Aged Residential Care Continued

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
To promote wellbeing and maximise health performance for individual residents			
• Quality of Life Bench-marking – quantitative • Satisfaction surveys (residents and whānau) – qualitative	*	• Achieved benchmarking for Quality of Life • Resident satisfaction survey completed June 2018 • Summary: positive experience of care received. No significant areas of improvement identified	• Achieved benchmarking for Quality of Life • Resident satisfaction survey completed March 2019 • Summary: positive feedback received from residents and families
To ensure staff are well trained and competent to provide high quality of care to the residents			
• Number of staff completed mandatory educational sessions	* *	• Registered Nurses: 11/11, Health Care Assistants: 7/25 (Next update is September 2018 to capture those not completed)	• Registered Nurses: 15/27 • Health Care Assistants: 18/29 (Next update is September 2019 to capture those not completed)
• Numbers of Health Care Assistants who have completed Level 2,3,4 Health and Wellness Certificates	*	• Level 2: 1 completed • Level 2: 0 completed • Level 4: 1 completed	• Level 2: 0 completed • Level 3: 3 underway • Level 4: 2 underway
• Level of uptake for post graduate education		• 3 Registered Nurses completed CTN701 Introduction to Clinical Teaching	• 1 Registered Nurse enrolled on the Masters Pathway
• Number of staff appraisals completed	*	**Registered Nurses** 8/11 / **Health Care Assistants** 21/26	**Registered Nurses** 24/27 / **Health Care Assistants** 23/29
To maintain residential occupancy over 90%			
• Average occupancy percentage	94%	93%	96%
• Gender and ethnicity	**Māori** * / **Non-Māori** *	**Māori** 1 / **Non-Māori** 23	**Māori** 1 / **Non-Māori** 21
	Male * / **Female** *	**Male** 5 / **Female** 19	**Male** 5 / **Female** 17
• Occupancy	416 vacant bed days	63 vacant bed days	88 vacant bed days
• Average length of stay	*	27 months	26 months
• Number of respite days/year	270	348	212
• Number of people on waiting list	*	14	16

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

District Nursing Services

PURPOSE To provide home based nursing services to the eligible population of Golden Bay (who fulfil the admission criteria as established by Nelson Marlborough Health).

OBJECTIVE

- To provide nursing expertise to the residents of Golden Bay to support the provision of care in the home
- To provide specialised nursing service to palliative care patients and their whānau
- To provide specialised nursing service to Oncology patients and their whānau while coordinating care with secondary services
- To develop and maintain a healthy and skilled nursing workforce who are competent to meet the changing needs of the Golden Bay community

SERVICE OVERVIEW

A comprehensive nursing service that provides complex care to patients in their own environment.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018		2018/2019	
To provide nursing expertise to residents of Golden Bay for the provision of care in the home					
• Number of patients enrolled in the service	119	197		177	
• Number of contacts	4,483	4,427		4,968	
• Ethnicity and gender of enrolled patients	*	**Māori** 5	**Non-Māori** 192	**Māori** 1	**Non-Māori** 176
	*	**Male** 87	**Female** 110	**Male** 90	**Female** 87
To provide specialised nursing service to palliative care patients and their whānau					
• Number of palliative patients enrolled in the service	*	6		4	
• Ethnicity of Palliative patients	*	**Māori** 1	**Non-Māori** 5	**Māori** 2	**Non-Māori** 2
To provide specialised nursing service to Oncology patients and their whānau while coordinating care with secondary services					
• Number of Oncology patients in the service	*	17		6	
Develop and maintain a healthy and skilled nursing workforce who are competent to meet the changing needs of the Golden Bay community					
• Number of post graduate studies	*	• One Post graduate paper in Oncology		• Two staff undertaking Post Graduate study 2019/20	
• Number of education sessions	*	• 44 education sessions held		• Two staff completed Advanced Care Planning Training	
• Number attending national /international conferences	*	• One attended National Palliative Care Conference		• Two staff attended Australasian Wound Care Conference	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Flexi Beds

PURPOSE To provide acute admission services for Golden Bay which includes medical and nursing intervention.

OBJECTIVE

- To provide an acute care service to adults in Golden Bay to reduce transfers to Nelson Hospital
- To provide an infusion service for patients who would otherwise require admission to Nelson Hospital
- To enhance and support the provision of chemotherapy services for Golden Bay
- To facilitate the provision of surgical services, close to home by supporting the Mobile Surgical Bus

SERVICE OVERVIEW

The Flexi beds are supported by 24 hours nursing/ medical service to provide appropriate inpatient care to the population of Golden Bay to minimise admissions to Nelson Marlborough Health.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017				2017/2018				2018/2019			
To provide an acute care service to adults in Golden Bay to reduce transfers to Nelson Hospital												
• Number of acute Admissions (excludes respites)	343				314				289			
• Age, gender and ethnicity of admissions	**Male** 148		**Female** 195		**Male** 150		**Female** 164		**Male** 129		**Female** 160	
	Māori 7		**Non Māori** 336		**Māori** 9		**Non Māori** 305		**Māori** 15		**Non Māori** 274	
	<40 20	**41-60** 53	**61-80** 124	**>80** 16	**<40** 24	**41-60** 51	**61-80** 117	**>80** 122	**<40** 55	**41-60** 52	**61-80** 95	**>80** 87
• Transfer of acute admissions to Nelson Hospital	24				28				32			
• Number and type of infusion/transfusion	**Iron**	**Pamidronate**	**Blood/blood products**		**Iron**	**Pamidronate**	**Blood/blood products**		**Iron**	**Pamidronate**	**Blood/blood products**	
	9	13	21		22	8	7		34	3	11	

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
To develop and support the provision of chemotherapy services for the Bay			
• Number of chemotherapy/ biological administered	30	35	0
• Number and type of infusion reactions	0	1	0
To facilitate the provision of surgical services close to home by supporting the Mobile Surgical Bus			
• Number of patients	37	18 ** Two clinics cancelled – one due to Takaka Hill closure and one due to insufficient appropriate patients on surgical list	40

There were 289 acute admissions in Golden Bay (in 2018/19) diverting transfers to Nelson Hospital

Primary Care

PURPOSE To provide primary care services to the population of Golden Bay by highly skilled staff such as; General Practitioners, Nurse Practitioners, Practice Nurses and phlebotomy services.

OBJECTIVE

- To promote wellness and maximise health for the enrolled population of Golden Bay through the provision of health promotion and health interventions
- To expand service options to ensure greater choice for the community to receive care closer to home
- To maximise the use of primary care funded services e.g. Care Plus to ensure equity of access
- To develop and maintain a healthy and well educated workforce who are competent to meet the changing needs of the community
- To ensure the community are satisfied with the service provision at Golden Bay Community Health
- To continue to promote and deliver an integrated health care service

SERVICE OVERVIEW

The primary care service is divided into two sections. During Monday-Fridays, full primary care services are available. The second aspect of the service is a 24-hour emergency access. This includes a triage Nurse and Doctor available during working hours and 24 hours' access to emergency medical care.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018		2018/2019	
To promote wellness and maximise health for the enrolled population of Golden Bay through the provision of health promotion and health interventions					
• System Level Measure targets					
– 8 month Immunisations (Target 95%)	*	80%		87%	
– Brief advice on smoking cessation (Target 90%)	*	92%		89%	
– Diabetes Annual Review (Target 90%)	*	73%		58%	
• Number registered and using our Patient Portal Manage My Health	*	**Registered** 1,194	**Activated** 1,040	**Registered** 1,538	**Activated** 1,315
• Waiting room times (average)	*	29 minutes		24 minutes	
• Current number of enrolled patients	*	4,980		4,955	
• Ethnicity of enrolled population		**Māori** 306	**Non-Māori** 4,674	**Māori** 299	**Non-Māori** 4,656

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
To expand service options to ensure greater choice for the community to receive care closer to home			
• New initiatives for care provided	Triage	• Supported Youth Hub development • Implementation of Medical Assistance roles	• Telehealth consultations • Accepted for Health Care Home model of health
To maximise the use of primary care funded services e.g. care plus, to ensure equity of access to health care services			
• Percentage of Care Plus use	*	100%	95%
• Options for Care	*	100%	95%
Develop a healthy and well educated workforce who are competent to meet the changing needs of the Golden Bay community			
• Number of nursing staff with specific training			
– Primary response in medical emergency	*	7	6
– Immunisations	*	6	6
– Cervical smear	*	5	4
• Number attending national / international conferences	*	4	4
Community of Golden Bay are satisfied with the service provided at Golden Bay Community Health			
• Number of complaints/ resolved	*	21/21	24/25
To continue to strengthen an integrated approach to health care provision			
• Specialist primary clinics provided on site	• Dietitian • Podiatrist • Ear Health Nurse • New Born Hearing Screen • Mole Map • Breast Screen Mobile Services • Palliative Nurse Practitioner • Alcohol and Drug Nurse Specialist	• Dietitian • Podiatrist • Ear Health Nurse • New Born Hearing Screen • Mole Map • Breast Screen Mobile Services • Palliative Nurse Practitioner • Alcohol and Drug Nurse Specialist	• Dietitian • Podiatrist • Ear Health Nurse • New Born Hearing Screen • Speech and language therapist • Mole Map • Breast Screen Mobile services • Palliative Nurse Practitioner • Mobile Surgical Bus • Alcohol and Drug Nurse Specialist • Paediatrician clinic • Telehealth consults • Expanded Medical Assistant roles developed • Travel Vaccine clinic • Cardiovascular risk assessment clinics • Nurse Practitioner • Social Worker
• Number of referrals for short term interventions (Mental Health)	*	144	132

Continues over...

Primary Care Continued

PROGRAMME MEASUREMENT	2016/2017	2017/2018	2018/2019
To ensure 24 hour access to medical services			
• Number of afterhours General Practitioner consultations (includes weekend clinics)	*	1,063	1,118
• Number of Primary response in medical emergency callouts	32	24	122

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Financial Reports

Nelson Bays Primary Health Trust

Summary Statement of Comprehensive Revenue and Expense

for the Year Ended 30 June 2019

	2019 $	2018 $
REVENUE		
Exchange		
Patient fees	704,636	737,478
Interest	121,104	123,171
Age Related care	1,490,045	1,432,309
Non-Exchange		
Hospital Funding	2,827,560	2,620,476
Management Services	835,303	871,160
Share of profit/(loss) from Joint Venture - Health Systems Solutions Limited	-	13,098
Share of profit/(loss) from Joint Venture - Medical and Injury Centre Limited	30,612	55,763
Primary Care Contract Services	26,682,341	23,699,141
Other	216,550	204,444
Total Revenue	**32,908,151**	**29,757,040**
LESS EXPENSES		
Accounting and Audit	23,853	23,207
Office & Organisation Expenses	1,633,735	1,475,297
Loss on sale of Investment	-	2,533
Board Expenses	149,656	137,613
Staffing Expenses	1,299,108	1,284,555
Primary Care Services	24,161,798	21,221,966
Golden Bay Community Health	5,638,458	5,325,735
Total Operating Expenses	**32,906,608**	**29,470,906**
NET SURPLUS	**1,543**	**286,134**
Total comprehensive revenue and expense for the year	**1,543**	**286,134**

NOTE:	2019 $	2018 $
The composition of the net surplus is as follows:		
Committed Funding Reserve. Representing contract funding to be applied to future commitments of those contracts rolling over.	(132,185)	79,639
Share of profit/(loss) from Joint Venture and interest received	151,716	192,032
Remaining surplus/(deficit)	(17,988)	14,463
NET SURPLUS	**1,543**	**286,134**

This Statement has been prepared on the basis as described on page 3

Nelson Bays Primary Health Trust
Summary Statement of Changes in Equity
for the Year Ended 30 June 2019

	Committed Funding Reserve	Retained Earnings	Total Equity
Balance as at 1 July 2017	2,349,506	1,186,579	3,536,085
Total comprehensive income for the year	79,639	206,495	286,134
Balance at 30 June 2018	**2,429,145**	**1,393,074**	**3,822,219**
Balance as at 1 July 2018	2,429,145	1,393,074	3,822,219
Total comprehensive income for the year	(132,185)	133,728	1,543
Balance at 30 June 2019	**2,296,960**	**1,526,802**	**3,823,762**

This Statement has been prepared on the basis as described on page 3

Nelson Bays Primary Health Trust
Summary Statement of Financial Position
as at 30 June 2019

	2019 $	2018 $
CURRENT ASSETS		
Cash and cash equivalents	631,901	578,697
Investments	3,547,400	3,689,417
Receivables and Prepayments	1,155,218	1,156,108
Total Current Assets	**5,334,519**	**5,424,222**
CURRENT LIABILITIES		
Payables	1,010,619	1,188,238
Employee benefits	914,199	870,866
Total Current Liabilities	**1,924,818**	**2,059,104**
WORKING CAPITAL	**3,409,701**	**3,365,118**
NON-CURRENT ASSETS		
Plant, Property & Equipment	568,666	577,920
TERM LIABILITIES	**154,605**	**120,819**
NET ASSETS	**3,823,762**	**3,822,219**
Represented by:		
Committed Funding Reserve	2,296,960	2,429,145
Retained Earnings	1,526,802	1,393,074
EQUITY	**3,823,762**	**3,822,219**

5 September 2019

Trustee:
Dated:

Trustee:
Dated:

This Statement has been prepared on the basis as described on page 3

Nelson Bays Primary Health Trust
Summary Statement of Cash Flows
for the Year Ended 30 June 2019

	2019 $	2018 $
Net cash flows from operating activities	75,820	463,295
Net cash flows from investing activities	(22,616)	(929,063)
Net increase / (decrease) in cash and cash equivalents	**53,204**	**(465,768)**
Cash and cash equivalents at beginning of period	578,697	1,044,465
Cash and cash equivalents at end of period	631,901	578,697

This Statement has been prepared on the basis as described on page 3

Nelson Bays Primary Health Trust
Notes to the Summary Financial Statements
for the Year Ended 30 June 2019

The summary financial statements for Nelson Bays Primary Health Trust for the year ended 30 June 2019 have been extracted from the full financial statements. The full financial statements were approved by the Board on 5 September 2019. The full financial statements were prepared in accordance with New Zealand Generally Accepted Accounting Practice ("NZ GAAP"). NZ GAAP, in the case of Nelson Bays Primary Health Trust, means Public Benefit Standards Reduced Disclosure Regime ("PBE Standards RDR"), as appropriate for Tier 2 not-for-profit public benefit entities. The summary financial statements are in compliance with PBE FRS 43 – Summary Financial Statements and are presented in New Zealand dollars and rounded to the nearest dollar.

The summary financial statements cannot be expected to provide as complete an understanding as provided by the full financial reports. A copy of the full financial reports can be obtained by contacting Nelson Bays Primary Health Trust.

No material events have occurred subsequent to the reporting date that require disclosure or adjustments to be made to the 30 June 2019 financial statements. (2018: none)

The auditor BDO Wellington Audit Limited has reviewed the summary financial statements for consistency with the audited full financial statements. An unmodified audit opinion has been issued. These summary financial statements have been approved for issue by the Board of Nelson Bays Primary Health Trust.

BDO Wellington Audit Limited

INDEPENDENT AUDITOR'S REPORT ON THE SUMMARY FINANCIAL STATEMENTS TO THE TRUSTEES OF NELSON BAYS PRIMARY HEALTH TRUST

The accompanying summary financial statements, which comprise the summary statement of financial position as at 30 June 2019, and the summary statement of comprehensive revenue and expense, summary statement of changes in equity and summary statement of cashflows for the year then ended, and related notes, are derived from the audited financial statements of Nelson Bays Primary Health Trust for the year ended 30 June 2019. We expressed an unmodified audit opinion on those financial statements in our report dated 5 September 2019.

The summary financial statements do not include all the disclosures included in the financial statements. Reading the summary financial statements, therefore is not a substitute for reading the audited financial statements of Nelson Bays Primary Health Trust.

The Board's Responsibility for the Summary Financial Statements
The Board is responsible for the preparation of a summary of the audited financial statements in accordance with PBE FRS-43: *Summary Financial Statements* ("PBE FRS-43").

Auditor's Responsibility
Our responsibility is to express an opinion on these summary financial statements based on our procedures, which were conducted in accordance with International Standard on Auditing (New Zealand) (ISA (NZ)) 810 (Revised, "Engagements to Report on Summary Financial Statements".

Other than in our capacity as auditor we have no relationship with, or interests in, Nelson Bays Primary Health Trust.

Opinion
In our opinion, the summary financial statements derived from the audited financial statements of Nelson Bays Primary Health Trust for the year ended 30 June 2019 are consistent, in all material respects, with those financial statements in accordance with PBE FRS-43.

Who we Report to
This report is made solely to the Trust's trustees, as a body. Our audit work has been undertaken so that we might state those matters which we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's trustees, as a body, for our audit work, for this report or for the opinions we have formed.

BDO Wellington Audit Limited

BDO Wellington Audit Limited
Wellington
New Zealand
5 September 2019

Everyone working in unison to achieve the vision

Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

Kia piki te ora o ngā tāngata katoa