Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

Annual Report

JULY 2019 - JUNE 2020



















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
Hauora Health Centre
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

MURCHISON

Murchison Health 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 te mea nui o te ao? He tāngata, he tāngata, he tāngata

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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 ensure the provision of essential primary health services, mostly through general practices, to people who are enrolled with a general practice (family doctor). Nelson Bays Primary Health provides services either directly, through its contracted providers, or in partnership with other services. All activity is to:

- Increase access, achieve equity and improve health outcomes for whānau, hapū and iwi Māori living in the Nelson Tasman rohe
- Focus on improving and maintaining the health of the population throughout Nelson Bays region

Healthy people, healthy workforce, healthy community

The Nelson Bays Primary Health Board is made up of community, 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 to achieve equity and improve health outcomes for whānau, hapū and iwi Māori living in the Nelson Tasman rohe**

General Practices

The 23 general practices contracted to Nelson Bays Primary Health during 2019/20 are as follows:

NELSON

- Harley Street Medical
- Hauora Health Centre
- 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

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

MURCHISON

- Murchison Health centre

COST OF ACCESSING PRIMARY CARE SERVICES

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 2019/20 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 2019/20, 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 QUADRUPLE AIM OUTCOMES OF

BETTER OUTCOMES	LOWER COSTS	IMPROVED CLINICAL EXPERIENCE	IMPROVED PATIENT EXPERIENCE

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

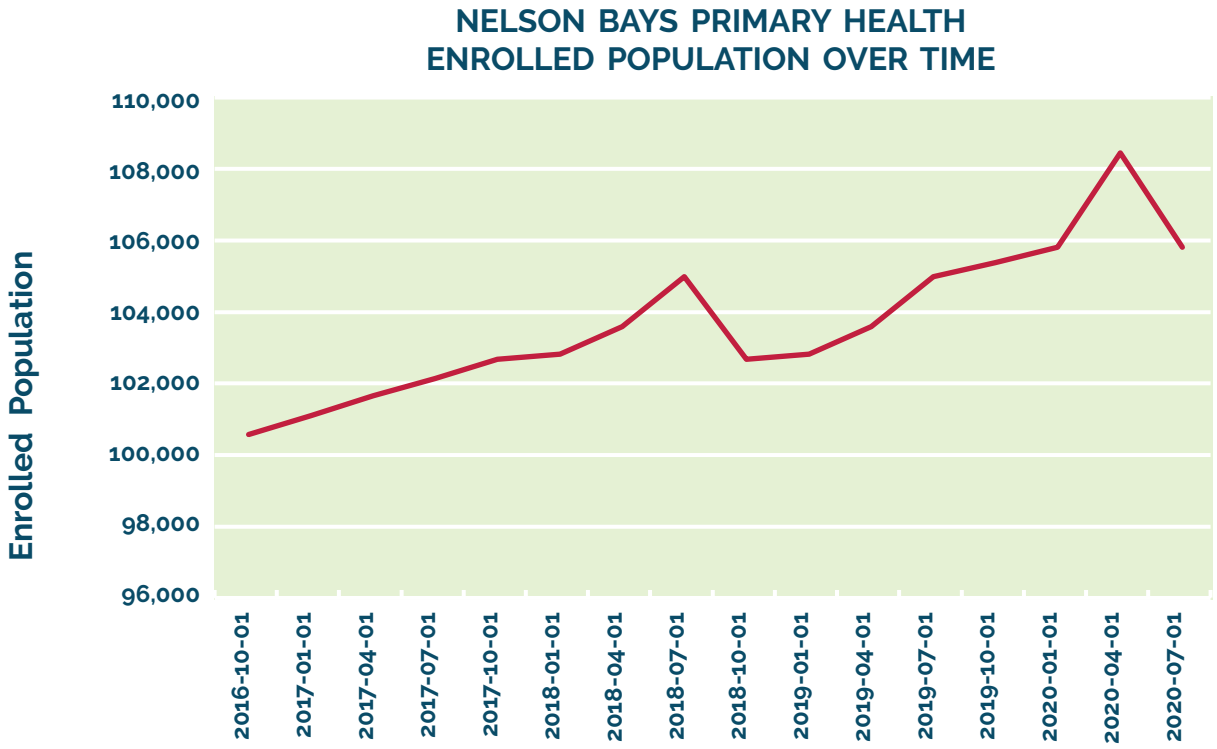
Nelson Bays

Enrolled Population

At the end of June 2020, 105,657 people were enrolled with Nelson Bays Primary Health.

NELSON BAYS
PRIMARY HEALTH
Enrolled Population

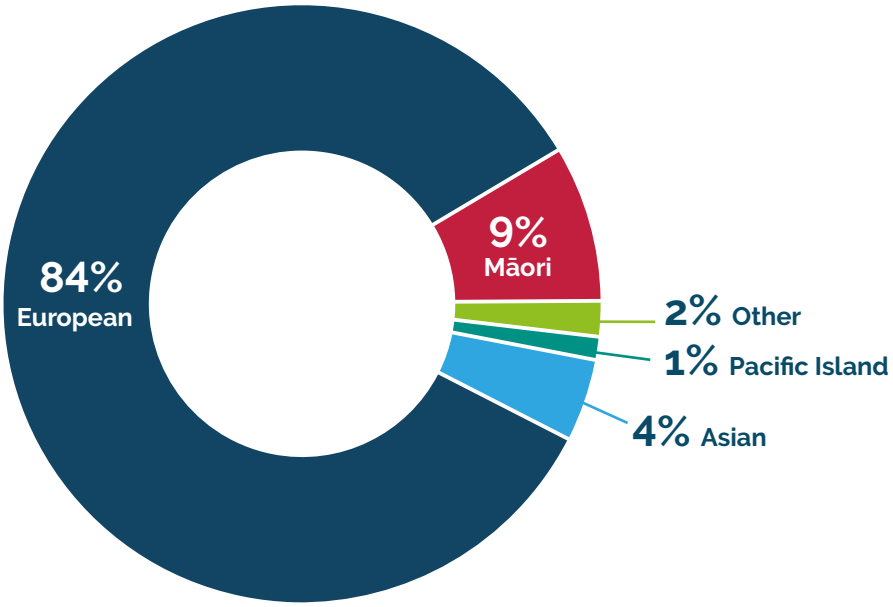
QUARTER	TOTAL POPULATION	% CHANGE
2020-07-01	105,657	-2.44%
2020-04-01	108,298	2.50%
2020-01-01	105,654	0.41%
2019-10-01	105,227	0.37%
2019-07-01	104,842	1.36%
2019-04-01	103,431	0.74%
2019-01-01	102,670	0.15%
2018-10-01	102,519	0.78%
2018-07-01	104,842	0.46%
2018-04-01	103,431	0.78%
2018-01-01	102,670	0.58%
2017-10-01	102,519	-2.05%
2017-07-01	101,989	0.74%
2017-04-01	101,507	0.15%
2017-01-01	100,940	0.78%
2016-10-01	100,420	0.47%



NELSON BAYS
PRIMARY HEALTH

Ethnicity

ETHNICITY	NUMBER	PERCENTAGE
Asian	4,660	4%
European	88,656	84%
Māori	9,023	9%
Other	1,923	2%
Pacific Island	1,395	1%
TOTAL	**105,657**	**100%**

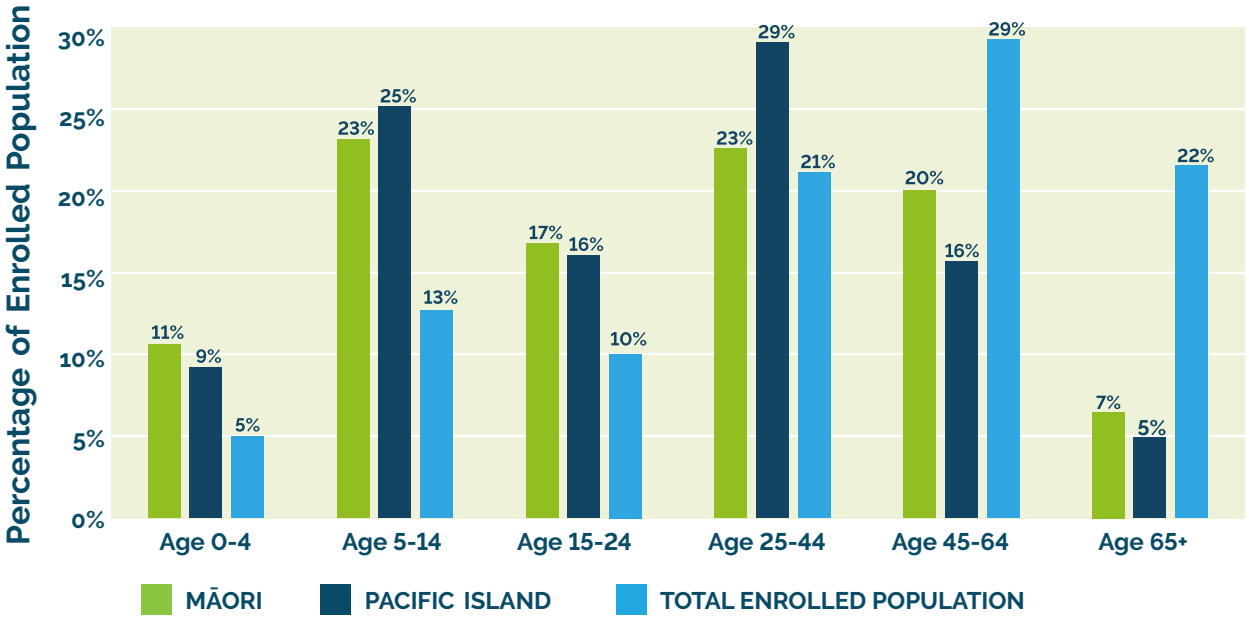


Nelson Bays

Enrolled Population

NELSON BAYS PRIMARY HEALTH

Age group % of enrolled population

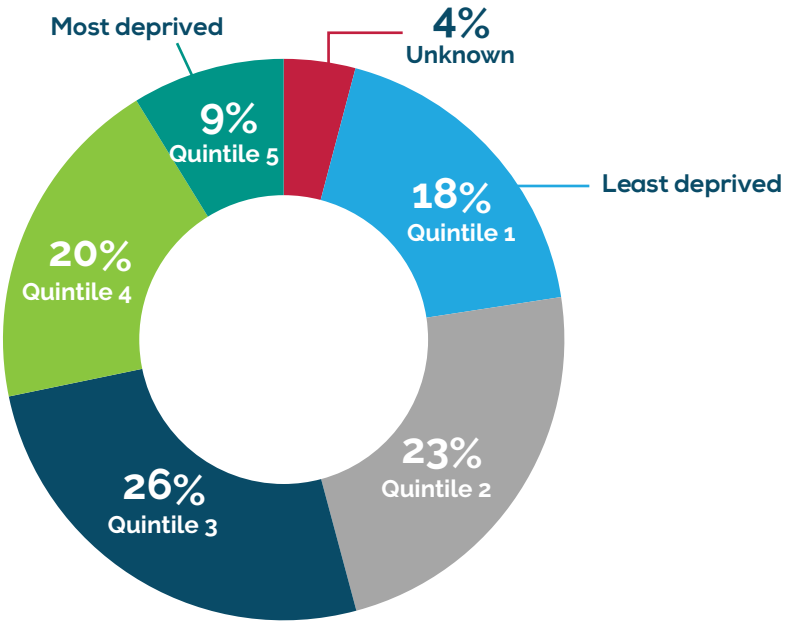


AGE	MĀORI	PERCENTAGE	PACIFIC ISLAND	PERCENTAGE	TOTAL ENROLLED POPULATION	PERCENTAGE
00-04	958	11%	130	9%	5,223	5%
05-14	2,083	22%	351	25%	13,349	13%
15-24	1,509	17%	224	16%	11,065	10%
25-44	2,040	23%	406	29%	22,319	21%
45-64	1,845	20%	219	16%	30,942	29%
65+	588	7%	69	5%	22,759	22%
TOTAL	**9,023**	**100%**	**1,399**	**100%**	**105,657**	**100%**

NELSON BAYS
PRIMARY HEALTH

Deprivation by quintile

QUINTILE	NUMBER	PERCENTAGE
Unknown	4,353	4%
1 (Least Deprived)	19,504	18%
2	24,565	23%
3	27,386	26%
4	20,562	20%
5 (Most Deprived)	9,287	9%
TOTAL	**105,657**	**100%**



Chairperson's Report

Kia Ora Koutou,

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 2020.

This Annual Report highlights the services that Nelson Bays Primary Health has provided and demonstrates the ways in which we have improved the lives of our community. I commend the report to you as it allows the reader to hold our Board to account in using its resources wisely and promote continuous improvement in those services.

This year has been a time of welcomes and sad farewells:

- Firstly, in June we welcomed Sara Shaughnessy as our new Chief Executive. Sara is a New Zealander with senior experience in Australasia throughout the primary and secondary sectors. She was appointed after an extensive search which attracted over 25 high quality candidates. Both myself and the Board are looking forward to working with Sara over the coming years and are confident that she will guide us through the fundamental changes envisaged within the recently released New Zealand Health and Disability Review
- Our previous Chief Executive, Angela Francis, resigned in April due to illness. Angela had lead NBPH over a period of 5 years, guiding us through a period of renewal both in the Golden Bay region as well as a closer focus on meeting the needs of our population most in need. I wish to thank Angela for her service and wish her well for the future
- Dr Sue Stubbs, Clinical Director, resigned from the Board in January due to the ill health of a family member. It was extremely sad to lose the wisdom and professionalism of Sue and the clinical leadership that she provided the Board over a period of 4 years. Our thoughts and best wishes go to her and her family
- Stuart Hebberd, Board Appointed Trustee, resigned from the Board in June, having served 7 years as a Trustee. During his tenure, Stuart was instrumental in promoting several key initiatives such as the Community Connectedness project and the introduction of group sessions for many services,

BOARD MEMBERS 2019/2020

John Hunter
CHAIRPERSON

Kim Ngawhika
DEPUTY CHAIRPERSON/
MĀORI REPRESENTATIVE

Blair Carpenter
COMMUNITY
REPRESENTATIVE

Carol Hippolite
MĀORI REPRESENTATIVE

thereby enabling these services to both meet the needs of our enrolled population sooner and in a way that improved the support to them

There have been several things to note during the year:

- The outbreak of COVID-19 internationally and onto our shores has stressed the healthcare sector, along with the rest of the economy and population. Thanks to the national and local strategies put in place, we have been spared the worst of the medical impacts of the pandemic. Nelson Bays Primary Health has performed well during this period, establishing one of the largest and best reported testing facility (Community Based Assessment Centre, or CBAC) in New Zealand. We extend our thanks to all of our staff and general practitioners who throughout this period needed to change the way in which they delivered services. In particular, I acknowledge the leadership of our Acting Chief Executive, Karen Winton, and General Manager Primary Care, Charlotte Etheridge. COVID-19 has not run its course. We are highly likely to be dealing with outbreaks over the next 2 to 3 years as the country's borders are reopened. The economic effect on future health spend will be significant
- Nelson Bays Primary Health has spent $400,000 over the last two years supporting the implementation of the Health Care Home model initiative in cooperation with both Nelson Marlborough Health and Marlborough Primary Health. This initiative now covers 56% of the general practices in our region. The outcomes of this project are intended to provide:
  - 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

  The value of this initiative has been demonstrated by the innovation exhibited by our general practices during the COVID-19 pandemic including the triaging of patients, significant telemedicine (telephone or video) consults for patients and flexibility in responding to provision of health care to patients during the alert level 3 and 4 lockdown periods. I would like to thank all of our general practitioners and general practice staff for their professionalism and efforts during this trying period
- Our vulnerable population (VIP) initiative has been a profound success, linking patients back into the health system through helping those in need to establish/reestablish contact with general practice where debt with the practice has resulted in patients being unwilling to approach their health practitioners. This initiative has been budgeted to continue in the coming year.

The loss in the current year arises from the above planned health initiatives, costs from the COVID-19 response as well as from implementation of a new Patient Management System at Golden Bay Community Health. We are budgeting for a further loss in the upcoming year as the rollout of the strategic health initiatives are completed.

The strength of Nelson Bays Primary Health is demonstrated by the balance sheet shown in the Financial Statements 2019/20 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.

Once again, I'd like to thank the groups of people without whom Nelson Bays Primary Health 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 past Chief Executive together with Karen Winton who has ably stood in as Acting Chief Executive; the management and staff who provide the energy and commitment needed to develop, deliver or support 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 Nelson Bays Primary Health.

Ngā Mihi,

John Hunter
CHAIRPERSON

Graham Loveridge
CLINICAL DIRECTOR/
PROVIDER REPRESENTATIVE

Helen Kingston
COMMUNITY
REPRESENTATIVE

Sarah Green
PROVIDER REPRESENTATIVE

Stuart Hebberd
BOARD APPOINTED
TRUSTEE (until June 2020)

Sue Stubbs
PROVIDER REPRESENTATIVE
(until February 2020)

A welcome message from the Incoming Chief Executive

Kia Ora Koutou,

I am pleased that over the next years we can work together to strengthen primary care services in the Nelson Bays region. I wish to acknowledge the Iwi groups of this region and thank them for their welcome and support. I also wish to acknowledge our health care partners in the region including Nelson Marlborough Health, Marlborough Primary Health and Te Piki Oranga, together we can support the vision for an integrated health service for this region.

I want to acknowledge the general practices and primary care services across Nelson Bays each for having a focus on the delivery of primary health services which are based on equity, the person and their whānau at the centre of the systems and improving health outcomes.

I look forward to hearing from you and am happy to be contacted to hear your thoughts and views. I would welcome a meeting with you at the many community forums.

My email is: sara.shaugnessy@nbph.org.nz

I want to take the time to thank the Nelson and Tasman communities who have welcomed me back to Aotearoa.

Ngā Mihi,

Sara Shaughnessy
CHIEF EXECUTIVE

Acting Chief Executive's Report

Kia Ora Koutou,

The last year has again brought new opportunities and challenges for Nelson Bays Primary Health, as well as for the wider health system itself, with the COVID-19 pandemic significantly impacting on the wider community and how health systems responded. This event highlighted how the development of a 'one system approach' can reduce barriers to access and provide for effortless sharing of resources across services and agencies within our community.

Our partners within the health system include our 23 general practices, Nelson Marlborough Health and Marlborough Primary Health and the value of these relationships remains crucial for the continued responsiveness required and was instrumental for the rapid initial set up of the Community Based Assessment Centres across both Nelson Bays and Marlborough.

While this pandemic continues to provide uncertainty, the ability to provide flexible and agile services throughout the lockdown period and beyond has also provided further opportunities for the health system to align and imbed improved approaches to ensure patient centred care remains the priority for our communities.

The impact for our general practices and community continues to raise significant concerns which Nelson Bays Primary Health are assessing regularly and planning responsiveness with other community agencies and our partners in health. This continued re-evaluation and response is even more critical in the current environment and aligns with our organisational vision of:

"healthy people…. healthy workforce…. healthy community"

Over the last year, some of the challenges within general practice included:

- Significant financial and staffing impacts related to COVID-19
- Adaptation of virtual health within short timeframes to meet patients' needs
- Providing valuable support at the Community Based Assessment Centres
- Higher acuity of patient needs related to not seeking early intervention
- Ageing population resulting in the need for resource reallocation
- Limited mental health services despite increasing demand
- 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 to access primary health services

Therefore, Nelson Bays Primary Health focused on:

- Maintaining a patient-centered approach across all of our services
- Engaging more with our health partners and strengthening our one system approach
- Rapidly changing our staffing structure to respond to the community needs during the pandemic
- Delivering care via community run clinics in areas of need, inclusive of local maraes
- Being a part of the system wide psychosocial response, inclusive of ongoing work around the homelessness issue for our region

Continues over…

Acting Chief Executive's Report Continued

- Providing increased support for our stakeholders, especially our general practice teams
- Increasing the focus on equity and consumer engagement
- Reviewing services and programmes to meet changing community needs
- Maintaining and valuing relationships with all community groups and Iwi
- Continuing to influence the social determinants of health wherever possible
- 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 approaches demonstrate a recognition of the need for ongoing refinement of service design and delivery which continue to enhance the health status for the population, as demonstrated throughout this report. There is an emphasis on the work still to be done in collaboration and partnership with our key partners and our community.

Nelson Bays Primary Health continues to be engaged with wider opportunities, such as the Models of Care programme work and the expansion of the district-wide Health Care Home model initiative. Joint approaches have continued district wide with service design/delivery across the district between Nelson Bays Primary Health and Marlborough Primary Health. Bi-annual joint Board meetings continue, as well as participation in each other's Strategic Planning days and the sharing of information with our Clinical Governance Committees.

Additional Nelson Bays Primary Health achievements include:

- The Vulnerable Populations (VIP) project which was initiated to support our most vulnerable population, has proven to support the engagement or re-engagement of patients with their general practice as well as supported the reduction of debt for this client group
- Nelson Bays Primary Health continued to provide a variety of services via telehealth platforms for both our Nelson and Golden Bay Community during the COVID-19 lockdown period
- The annual Stakeholder Satisfaction Survey highlighted a continued improvement trend with the majority (80%) of respondents in 2020 answering they agree their expectations are being met for the support and service provided by Nelson Bays Primary Health. This is a favourable improvement on 2019 results (74%), especially when there was a much higher number of respondents this year
- The annual staff satisfaction survey continued to demonstrate 10 out of 10 themes scoring 4.35 or more out of 6. There was an 80% improvement noted compared to 2019
- Staff turnover rates remain lower than New Zealand's national average (all industries combined) – 2 to 4% below the healthcare industry rate
- A breakeven financial result was achieved as demonstrated in the financial report 2019/20

In closing, I would like to acknowledge and thank our staff, without whom our crisis response and state of emergency achievements during COVID-19 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 personally acknowledge John Hunter and the Nelson Bays Primary Health Board for their ongoing support throughout the last 12 months while I was in the Acting Chief Executive role. And I would also like to welcome our new Chief Executive, Sara Shaughnessy, who brings with her a wealth of experience to continue the progress on growth and development of Nelson Bays Primary Health within the wider health system.

Ngā Mihi,

Karen Winton
ACTING CHIEF EXECUTIVE/DEPUTY CHIEF EXECUTIVE

Clinical Governance Committee Chair's Report

The Nelson Bays Primary Health Clinical Governance Committee met regularly over the 2019/20 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 and provided input on clinical issues including:

- COVID-19 – this was the dominating issue for much of the first half of 2020 and preoccupied all the health care providers in the region. The liaison between general practice, Nelson Bays Primary Health, Nelson Marlborough Health, pharmacy and the Clinical Technical Advisory Group enhanced the response for our region
- Devolution of services from secondary care to primary care – this will continue to be a major focus for the committee
- Change of model for the provision of primary mental health services provided by Nelson Bays Primary Health – introduction of the Focused Acceptance and Commitment Therapy model
- Virtual consultations – in general practice and Nelson Bays Primary Health's Rheumatology and Mental Health services
- ACC Escalated Care Pathway for acute back pain
- Community Connectedness project
- Health Care Home model
- Fracture risk identification project from emergency department and fracture clinic
- Care Plus – changes to improve flexibility and focus on patient centered care

The Health Care Home model was extended to more general practices during the year and most other general practices rapidly adopted some of the initiatives with the onset of COVID-19. The intention is that these changes will enhance patient care as general practice moves into a world of increasing clinical and social complexity that challenge the existing models of general practice.

The secondary care (hospital) services in our region are struggling to meet demand and there is increasing pressure coming from Nelson Marlborough Health for general practice to take on some of this load by devolving specific services from secondary care to primary care. The Clinical Governance Committee sees its role is to enhance the quality and equity of care provided to patients while also protecting general practice from unplanned workloads, un-negotiated cost shifting and shifting of services without adequate scoping, education and audit of outcomes.

The Clinical Governance Committee continues to interact with the Clinical Governance Committees at Golden Bay Community Health, Marlborough Primary Health and Nelson Marlborough Health, with the aim to coordinate approaches across Te Tau Ihu.

Dr Graham Loveridge
CLINICAL GOVERNANCE COMMITTEE CHAIR

Te Tumu Whakaora Chair's Report

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

Te Tumu Whakaora acknowledges the work of our outgoing Chief Executive, Angela Francis and extends a warm mihi to our new Chief Executive, Sara Shaughnessy to Nelson Bays Primary Health.

Te Tumu Whakaora has had great engagement this year from highly valued Māori members of our community. I take this opportunity to acknowledge a long time member Dr Tim Phillips for his contribution to our group over the past four years and welcome Dr Ricki-Lea Aitchison (GP Mapua Health) and Maria Briggs who is the Māori Clinical Nurse Specialist at Nelson Marlborough Health.

There are a number of projects we are proud to be involved in this year but a highlight is the VIP project (Vulnerable Populations) which came from an idea sparked within our roopu. This project is supporting our most vulnerable people to access a doctor and to obtain prescription medications. The project removes barriers to accessing which can include reducing debt at a general practice, funding a consultation and funding prescription medications at a pharmacy.

It also supports access to dental services and referrals onto other support services. Within this annual report we have included details of this project under the Strategic Initiatives section which demonstrate the value this project has for our whānau. We will continue to keep a close watch on progress.

Te Tumu Whakaora encourage the Board and Management to embrace te ao Māori (the Māori world). We encourage the use of Te Reo Māori in every part of your daily practice, whether this be big or small. We encourage the Board and Management to put more thought into developing pathways for Māori within the organisation and within leadership.

Finally, we encourage you to embrace practice that reflects the values and principals of Te Tiriti for the better of all whānau for 'ma te kotahitanga e whai kaha ai tātau (in unity we have strength).

Kim Ngawhika (B Ed, MMgt)
TE TUMU WHAKAORA CHAIR

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 8.00am to 10.00pm 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 2020, there were 27,889 presentations compared to 27,756 presentations the previous year. COVID-19 had a considerable impact between March to May 2020 with reduced presentations over this period
- 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
- The Medical and Injury Centre has increased its workforce to include a healthcare assistant and a nurse through the Nurse Entrance to Practice programme
- The Nelson Bays Primary Health social worker is available for community visits
- 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 2019/20

- Health and Safety Committee meetings were held at least bi-monthly on each site
- Health and Safety incident reporting, investigations and management occurred, supported by 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
- Health and Safety systems are actively supported by the Health and Safety Committees, management and facility users
- Health and Safety Committee involvement contributed to the ongoing reviews of 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

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 14.6% achieved to year end 30 June 2020. 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 enabling knowledge and skill to be embedded over time across our team.

Here's a closer look at our current team composition as at 30 June 2020. There are 171 employees in total: 111 based at Golden Bay Community Health, 60 based at Richmond office:

- 13% are full time employees
- 68% are part time employees
- 19% are casual employees

EMPLOYEE ENGAGEMENT

The annual Employee Workplace Satisfaction Survey was completed in February 2020. 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 2020 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 total average satisfaction rating in both Richmond and Golden Bay Community Health locations was positive, achieving 4.7 or higher out of 6; this is an increase for both sites when compared to last year
- ✓ The total average satisfaction rating in both locations was the highest reported since location specific ratings began in 2016
- ✓ A remarkable 100% of the 34 average question ratings in both locations reflected positive employee satisfaction, achieving scores of 4 or higher out of 6
- ✓ The Richmond location had a commendable 89% of the question average ratings achieved that were similar or improved when compared to the results of the previous year; at the Golden Bay Community Health location, a highly commendable 94% of question average ratings reflected similar or improved employee satisfaction levels when comparing the results with 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. This is the most recent report available at the time of collation; 2019 reporting was delayed due to the impacts of COVID-19.

COVID-19 Response Report

1 MARCH 2020 – 30 JUNE 2020

OVERVIEW

Bubbles. Physical distancing. Community Based Assessment Centres. Swabs. Self-isolation. Quarantine. Personal Protective Equipment. Pandemic. Flattening the curve. Lockdown. Rāhui. Cluster. Community spread. Contact tracing. Asymptomatic. These are all some of the new language our community and our workforce are now very familiar with.

Nelson Bays Primary Health in collaboration with Nelson Marlborough Health, lead the primary and community response to COVID-19.

On 14 March 2020 the Ministry of Health notified Nelson Marlborough Health that a community response plan needed to be in place by 16 March 2020.

Between 16 March 2020 and 22 March 2020, a team from Nelson Bays Primary Health and Nelson Marlborough Health; identified and confirmed locations for the community based assessment centres sites and began the process of implementing the response plan. This plan included getting site locations fit for purpose, staffing all sites, information and data systems in place and compatible, training staff, developing patient pathways, establishing stringent infection prevention and control processes, linking to health pathways, community promotions and national response information.

Unite against COVID-19

OBJECTIVES:

- **Alert Level 1** – Be Prepared and protect our community against COVID-19
- **Alert Level 2** – Reduce the risk of community transmission
- **Alert Level 3** – Restrict the risk of community transmission
- **Alert Level 4** – Lockdown to reduce community transmission

The community based assessment centre sites were ready to go by 8.00am 23 March 2020 (a mammoth effort).

Nelson Bays Primary Health needed to provide accurate COVID-19 data to the Ministry of Health so a member of staff was part of the COVID-19 Clinical Governance Group who developed and supported the implementation of the COVID-19 'Health Information Standards Organisation' which was an online assessment to support consistent quality data collection. The purpose is to ensure that all data collected and used in the 'contact tracing process' was well-defined, properly structured and coded, and interoperable (another mammoth effort).

The community based assessment centres were an integral component in supporting and training general practice teams. The intention was to build confident and highly skilled teams so that when the community based assessment centres closed on 12 June 2020, the general practice network confidently picked up the workload and continues testing and assessing for COVID-19 symptoms in general practice (another mammoth effort and sustainability for whatever the future holds).

Continues over...

COVID-19 Response Report Continued

How well did we do?

KEY PERFORMANCE INDICATORS

Community Based Assessment Centres		
• Nelson/Tahunanui	Date operational:	23 March 2020
• Motueka	Date operational:	23 March 2020
• Victory	Date operational as assessment centre: Date operational as full community based assessment centre:	30 March 2020 25 April 2020
• Golden Bay	Date operational:	23 March 2020
Business as usual sites		
• Medical and Injury After-hours Centre		
• Murchison		
Mobile community based assessment centres units		
	7 mobile events were completed in - Whakatu Marae (2) - Okiwi Bay - Wai West - Te Awhina Marae - Brook Valley Camping Ground (2)	
Virtual Education Sessions:		
	For general practice teams and held via online platforms (e.g. Zoom)	Four sessions held, that catered for 1,000 views

Redeployment of staff within the community based assessment centres		
Employment Location (where did staff come from)	**Number**	**Percentage**
• General practice	96	64
• Nelson Bays Primary Health	27	18
• Victory Community Centre	4	2.7
• Nelson Marlborough Health	8	5.3
• Casual	15	10
TOTAL	**150**	**100**

This does not include Golden Bay and the business as usual sites.

KEY PERFORMANCE INDICATORS FROM COVID-19 COMMUNITY BASED ASSESSMENT CENTRES

COVID-19 assessments and swabbing completed		
Location	**Number**	**Percentage**
• Nelson Community Based Assessment Centre	3,028	52
• Motueka Community Based Assessment Centre	635	11
• Medical and Injury Centre	458	7.9
• Golden Bay Community Centre	197	3.4
• General practice	1,489	25.7
TOTAL	**5,807**	**100**

** Nelson and Motueka Community Based Assessment Centres closed between 5 June 2020 and 12 June 2020.*

Gender of those being assessed/swabbed at Community Based Assessment Centres		
	Number	**Percentage**
• Female	3,275	56.4
• Male	2,276	39.2
• Unknown (or gender neutral)	256	4.4
TOTAL	**5,807**	**100**

Ethnicity of those being assessed/swabbed at Community Based Assessment Centres		
	Number	**Percentage**
• Asian	181	3.1
• European or other	4,699	81
• Māori	574	9.9
• Middle Eastern	43	0.7
• Pasifika	90	1.5
• Unknown (or refused to answer)	220	3.8
TOTAL	**5,807**	**100**

Age Band of those being assessed/swabbed at Community Based Assessment Centres		
	Number	**Percentage**
• 0 – 9 years	273	4.7
• 10 – 19 years	544	9.4
• 20 – 29 years	728	12.5
• 30 – 39 years	814	14
• 40 – 49 years	932	16
• 50 – 59 years	1,073	18.5
• 60 – 69 years	785	13.5
• 70 – 79 years	452	7.8
• 80+ years	206	3.6
TOTAL	**5,807**	**100**

Continues over...

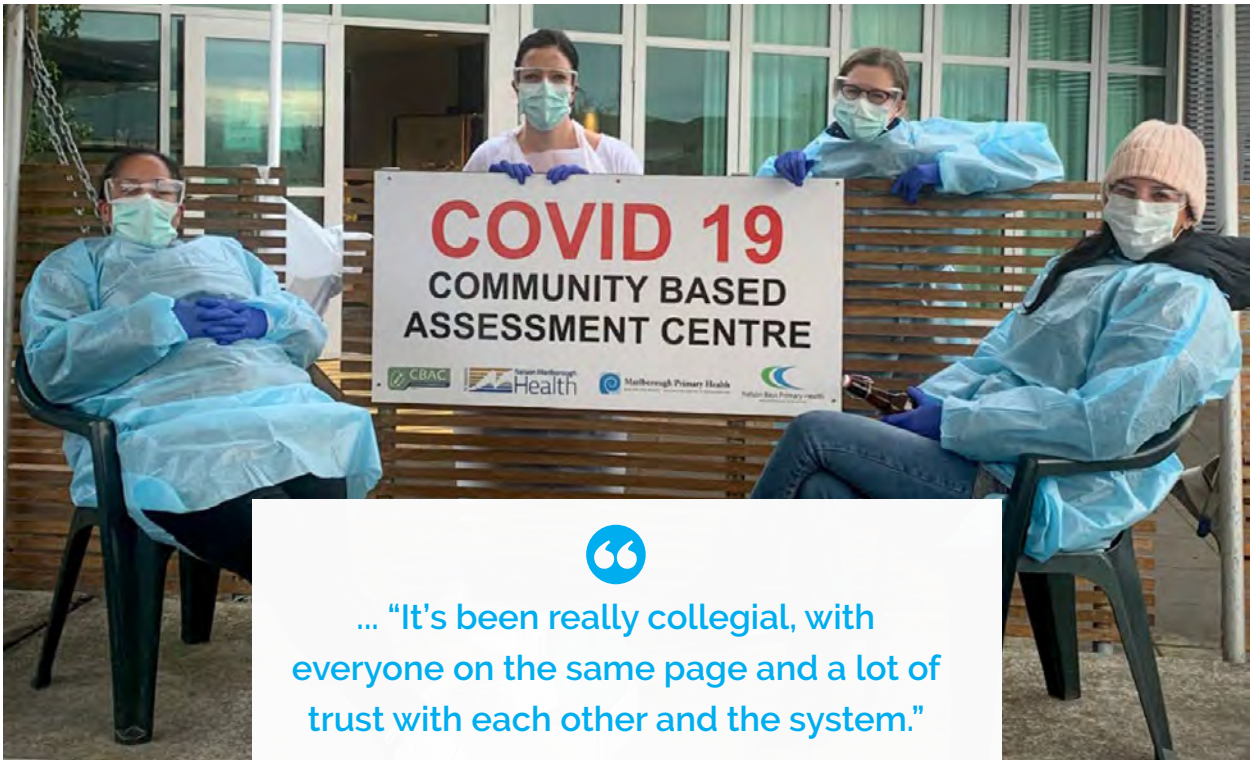
COVID-19 Response Report Continued

MĀORI HEALTH ACTIVITIES

- 574 people being assessed and/or swabbed for COVID-19 identified as Māori
- 90 people being assessed and/or swabbed for COVID-19 identified as Pasifika
- Community based assessment centre site established in Victory and included welfare support services and referral

SUCCESS STORIES

Charlotte Etheridge, General Manager Primary Care at Nelson Bays Primary Health, describes the Tahunanui community based assessment centre as the 'Rolls-Royce' of community based assessment centre. On a side note, infectious disease specialist Dr Richard Everts describes Charlotte as the "Jacinda Ardern of the community based assessment centre team in Nelson" for her leadership, organisation skills, kindness and humour. Charlotte says that, from the day the Tahunanui community based assessment centre site opened on 23 March 2020, staff were offering the full response – screening, assessment and testing/swabbing. "We knew what community based assessment centres needed to be, but not necessarily what they looked like. And we knew they had to be operational, in a short space of time. "To make it happen it came down to being able to work together quickly – Nelson Marlborough Health, and the Primary Health Organisations – and in a high-trust environment," Charlotte says. "One of the biggest positives is the trust we have shared in each other. There were so many critical steps to making the community based assessment centre work, from the infrastructure, IT and Wi-Fi and equipment (thanks to Pete Kara, Bev Nicolls and David Stichbury) to the clinical pathways which Elizabeth Wood, Dave Dixon and Richard Everts did a great job with." Then there were the staff. The front-liners whose masked, gloved and gowned presence become synonymous with COVID-19. Wielding clipboards and questions, they met people in their cars and assured worried, unwell people that the nasal swab would be uncomfortable but had to be done.



> ... "It's been really collegial, with everyone on the same page and a lot of trust with each other and the system."

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-day 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	2017/2018		2018/2019		2019/2020	
Referrals						
• Numbers referred	283* *Includes 50 Marlborough referrals as no regional service available		151* *Includes 3 Marlborough referrals (service now provided in Marlborough		177	
• Ethnicity	**Māori** 13	**Non-Māori** 270	**Māori** 6	**Non-Māori** 145	**Māori** 2	**Non-Māori** 175
Heart Guide Aotearoa						
• Number of referrals choosing this option	8		8		3	

Continues over…

Community Cardiac Rehabilitation Healthy Hearts Continued

PROGRAMME MEASUREMENT	2017/2018		2018/2019		2019/2020	
Healthy Hearts						
• Number of sessions delivered	13		10		7	
• Number of people who attended this option	136		82		70	
• Gender of those attending	**Male** 102	**Female** 34	**Male** 60	**Female** 22	**Male** 49	**Female** 21
• Age range	**Under 65yrs** 49	**Over 65yrs** 87	**Under 65yrs** 35	**Over 65yrs** 47	**Under 65yrs** 19	**Over 65yrs** 51
• Ethnicity	**Māori** 6	**Non-Māori** 130	**Māori** 4	**Non-Māori** 78	**Māori** 1	**Non-Māori** 69
Additional family/ Whānau or support person attending	74		40		31	
Total number of participants (including family)	210		122		101	
Programme Outcomes (On Completion)						
• Participants who report increased knowledge of their cardiovascular disease	99%		100%		99%	
• Participants who report increased confidence to recognise and respond to their symptoms (manage their condition)	99%		97%		98%	
Patient Self-Reported Follow-Up Outcomes (results of follow-up at 6-months with an average 59% response rate)						
• Are taking medication as prescribed (Concordant)	94% (38-46% do not collect medications after a major cardiac event. Reference: Atlas of Healthcare)		85% (38-46% do not collect medications after a major cardiac event. Reference: Atlas of Healthcare)		86% (38-46% do not collect medications after a major cardiac event. Reference: Atlas of Healthcare)	
• Presented to Emergency Department with cardiac related symptoms	0% (Evidence suggests a 40-50% reoccurrence rate i.e. presenting to Emergency Department with symptoms)		0% (Evidence suggests a 40-50% reoccurrence rate i.e. presenting to Emergency Department with symptoms)		0% (Evidence suggests a 40-50% reoccurrence rate i.e. presenting to Emergency Department with symptoms)	
• Have maintained heart healthy eating habits/ improved eating habits	98%		95%		96%	
• Are participating in regular physical activity levels/ increased levels	91%		85%		94%	
Overall Uptake Rate (referral/attendance)						
• Percentage of people engaging in a rehabilitation choice	51% (National average is 12-20%)		60%		40% (not an accurate indication as patients unable to book during Covid-19)	

MĀORI HEALTH ACTIVITIES

- There were 2 Māori referred
- There was 1 Māori and 1 whānau who attended

Continued collaboration with Te Piki Oranga over the past year to support increased knowledge through regular "train the trainer" information sessions to kaimahi on common heart issues such high blood pressure and cholesterol. This collaboration has led to a regular aqua session for Māori called Maatapuna, which is supported by Nelson Bays Green Prescription lifestyle facilitators.

PARTICIPANT FEEDBACK

"Essential for anyone suffering heart problems. Very professional and friendly. I learnt heaps."

"I realise I was wrong about statin medications, and have returned to my prescription."

"Lots of interaction between the group, open to sharing of everyone's stories, laughter. Very informative."

SIGNIFICANT SUCCESS

- This programme is contributing to zero unplanned emergency department presentations for cardiac related symptoms (reducing hospital visits)
- Medication concordance (taking medication as prescribed) is much higher than the national average
- Engagement rates to this programme continue to be higher than the national average
- Over 90% of people attending this programme have improved eating and physical activity levels

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
- With declining Prediabetes referrals, a new delivery model has been piloted to increase options and flexibility for individuals and whānau. Options include; telephone support, group support within type 2 diabetes education sessions, or through Green Prescription group information sessions *(StayWell)*. These sessions address a range of modifiable risk factors associated with long-term conditions such as diabetes, and facilitate peer-supported problem-solving techniques to promote sustainable behaviour change
- All patients receive three postal questionnaires over a 12-month period to monitor long-term outcomes
- Quality improvements are informed following a Plan, Do, Study, Act (PDSA) process

COVID-19 IMPACT:

- Planning has gone into each stage of COVID-19 alert levels to find alternative ways to support whānau referred, which included:
  - Telehealth consultations and resources posted to whānau once identified what was needed. These resources included; electronic resources, diabetes and health-related web-based services such as Health Navigator and Diabetes NZ and local key contacts if relevant.
- In response to Ministry of Health public gathering restrictions, 3 community-based diabetes group information sessions were postponed
- From March to June, staff were re-deployed to the COVID-19 Community-Based Assessment Centres (CBAC)
- People with Diabetes are classified as "high risk' for COVID-19 symptoms so re-commencement of group diabetes information sessions at alert level 1 have been re-designed to improve infection control and provide reassurance to participants

How well did we do?

KEY PERFORMANCE MEASURES

PROGRAMME MEASUREMENT	2017/2018		2018/2019		2019/2020	
Type 2 Diabetes Referrals						
• Numbers referred	106		132		86	
• Ethnicity	**Māori** 14	**Non-Māori** 92	**Māori** 21	**Non-Māori** 111	**Māori** 9	**Non-Māori** 77
Type 2 Diabetes Education sessions						
• Number of sessions held after-hours	9		9		4	
• Total number of sessions delivered	9		9		4	
• Number of patients attended	59		73		28	
• Gender of those attending	**Male** 26	**Female** 33	**Male** 35	**Female** 38	**Male** 15	**Female** 13
• Ethnicity of those attending	**Māori** 4	**Non-Māori** 55	**Māori** 15	**Non-Māori** 58	**Māori** 0	**Non-Māori** 28
• Additional family/ Whānau or support person attending	20		22		10	
• **Total number of participants** (including family)	79		95		38	
Programme Outcomes (on completion of session)						
• Participants who report increased knowledge of Diabetes	99%		100%		100%	
• Participants who report increased confidence in self-management	99%		100%		98%	
Patient Self-Reported Follow-Up Outcomes (results of follow-up at 6-months with an average 36% response rate)						
• Has improved HbA1c (if tested/known)	92%		90%		50%	
• Has moderate levels of diabetes distress	12%		0%		0%	
• Maintained healthy eating habits/ improved eating habits	79%		97%		85%	
• Is participating in regular physical activity levels/ increased levels	85%		62%		73%	
Pre-Diabetes Education referrals						
• Referrals received	135		91		29	

Continues over...

Community Diabetes Education Type 2 and Pre-diabetes Continued

PROGRAMME MEASUREMENT	2017/2018		2018/2019		2019/2020	
• Ethnicity of referrals	**Māori** 8	**Non-Māori** 1276	**Māori** 6	**Non-Māori** 85	**Māori** 1	**Non-Māori** 28
Pre-Diabetes Education sessions						
• Number of sessions delivered in general practice	5		1		New delivery model	
• Total number of sessions delivered (after-hours options)	13		6		11	
• Number of patients attended	95		73		29 (pre-diabetes)	
• Gender of those attending	**Male** 42	**Female** 53	**Male** 35	**Female** 38	**Male** 11	**Female** 18
• Ethnicity of those attending	**Māori** 5	**Non-Māori** 90	**Māori** 10	**Non-Māori** 63	**Māori** 2	**Non-Māori** 27
• Additional whānau or support person attending	41		19		0	
• **Total number of participants** (including family)	136		92		29	
Programme Outcomes (On Completion)						
• Participants who report increased knowledge of Pre-Diabetes	100%		100%		86% of participants felt supported to initiate and sustain good lifestyle choices	
Patient Self-Reported Follow-Up Outcomes (results of follow-up at 6-months with an average 48% response rate)						
• Has improved HbA1c (if tested/known)	79%		100%		75% reported improved health outcome	
• Reported healthy eating habits/ improved eating habits	97%		91%		75% reported choosing healthier food options	
• Reported adequate physical activity levels/increased levels	88%		91%		61% reported maintaining regular physical activity levels	

MĀORI HEALTH ACTIVITIES

- A Diabetes information session was scheduled to be held in collaboration with Te Piki Oranga at Community House in Motueka in March. Unfortunately, this was postponed due to COVID-19
- On-going hui with Te Piki Oranga kaimahi to explore opportunities to support the needs of Māori
- 9 of the referrals for type 2 diabetes identified as Māori

PERSONAL SUCCESS FEEDBACK

"The most useful part of the session for me was understanding blood test results and medications, knowing small changes are positive, knowing my journey is personal and ask me about me instead of worrying about statistics."

"Good to know the direct effect of diet/exercise on diabetes/blood sugars. What dietary changes will assist our health."

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 support navigation into a community strength and balance group
- Build relationships and issue the 'Tick of Approval' to community group leaders who meet the ACC strength and balance criteria
- Support 'Approved' group leaders to meet and maintain ACC Live Stronger for Longer 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 ACC Live Stronger for Longer criteria.

The community falls prevention links closely to the Nelson Marlborough Health In-Home Falls Prevention programme and the Fracture Liaison pathways in our region, creating the whole of system joined up approach to primary, community and secondary services aimed at preventing falls and fractures for people over 65 years of age, or those with an increased risk of falling.

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

PROGRAMME OUTCOMES

For our regions approved instructors there has been some consolidation of classes and reduction in the number of classes being offered. All classes continue to provide variety while still maintaining strength and balance Live Stronger for Longer criteria. Nelson Bays Primary Health is proud to support these dedicated instructors who care so much for their class participants. All instructors supported their older participants through all COVID-19 alert levels and provided reassurance and safe environments on resumption of classes.

Some highlights this year have included:

- 'Parky Moves' affiliated with 'Counterpunch Parkinson New Zealand' and launched in the Tasman region
- For places in our region, we know from participant feedback that they engage in more than one type of class a week. Participants also report that due to our weather and geographical location they also exercise outdoors, which provides them with other benefits along with social opportunities found in all these activities. Therefore, our older adult communities are active on multiple days per week, doing a variety of different activities all designed to improve strength and balance and therefore live stronger for longer and reducing falls
- Nelson Bays Primary Health Community Falls Prevention team developed a new Community Group Strength and Balance booklet to create a wider reach within our older population and showcase more classes. We also contributed regularly to the ACC website https://www.livestronger.org.nz/home/find-class/find-a-class-near-you/
- As a lead agency, we had the privilege of being chosen by ACC to participate in the ACC 'Live Stronger for Longer' study. In this study ACC wanted to understand the benefits of community group strength and balance classes and how they reduce falls and fracture in older people. This study will be a world first because it aims to look at how all approved strength and balance classes are working on a national level. This study will help guide current and future initiatives supporting older people across New Zealand to continue living the life they want. Participant's that filled out the study were eager to reflect the benefits gained from the classes they attend
- Outcomes from the ACC Falls and Fracture dashboard show that during the past 12 months:

  In the Nelson Marlborough region there were 329 fewer falls, which is 3.2% below the national average. (Note: success for this programme is a reduction). This is a huge success and Nelson Bays Primary Health acknowledges the 'teams' that have all contributed to this success

Continues over...

Community Falls Prevention Continued

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018		2018/2019		2019/2020	
Referrals						
• Numbers referred	273		270		216	
• Ethnicity	**Māori** 28	**Non-Māori** 245	**Māori** 3	**Non-Māori** 267	**Māori** 3	**Non-Māori** 213
Upright and Able Education						
• Number of sessions delivered	16		16		11 Sessions cancelled due to COVID-19 restrictions for older adults	
• Number of people attended	174		168		139	
Falls Awareness Promotions						
• Number of sessions delivered	9		7		4	
• Number of people attending	168		Awareness sessions have been delivered in a number of ways to; the community, general practice staff and other health providers			
Community Group Strength and Balance						
• Total number of groups approved	75		138		177	
• Number of Kaupapa Māori groups approved	4		The number of Groups remain the same		The number of Groups remain the same, but participants numbers have grown (pre COVID-19)	
• Number of training sessions provided to 'approved' group leaders	4		4		2 Regular updates and support provided during lockdown. Support also provided with re-starting classes as risks remain high for older adults	

TARGETS (YEAR)

	Year	Target	Actuals
Approved Classes	2017/18	45	70
Approved Places	2017/18	1,200	1,461
Approved Classes	2018/2019	No set target for classes but have had an overwhelming response of new and existing instructors in our region wanting to be part of the "Live Stronger for longer" campaign	138
Approved Places	2018/2019	4,000	3,071
Approved Classes	2019/2020	No set target	177
Approved Places	2019/2020	Numbers continue to fluctuate due to instructors merging classes, closing classes and adjusting class numbers to ensure safety of participants. COVID-19 has had an impact on sustainability of classes.	2,944

MĀORI HEALTH ACTIVITIES

- Nelson Bays Primary Health continue to network and explore opportunities with local instructors on growing classes and building community connections. We are fortunate in our region to have inspiring instructors who currently lead our Noho Pakari Tū Kaha and Te Oranga Pai Classes

OTHER NOTABLE COMMENTS

- Nelson Bays Primary Health continues to lead and support The Active Aging Network. This is a network of community instructors who provide strength and balance classes, Nelson Marlborough Health In-home Falls Prevention programme staff and Fracture Liaison Service staff. Although classes were shut down during COVID-19 lockdown and at various alert levels, the number of enquires for information and updates as we returned to level 1 was a testament to the profile and the impact these classes have established within our community

APPROVED STRENGTH AND BALANCE PROGRAMME

LIVE STRONGER FOR LONGER
PREVENT FALLS & FRACTURES

Community Fracture Liaison Service Falls Prevention

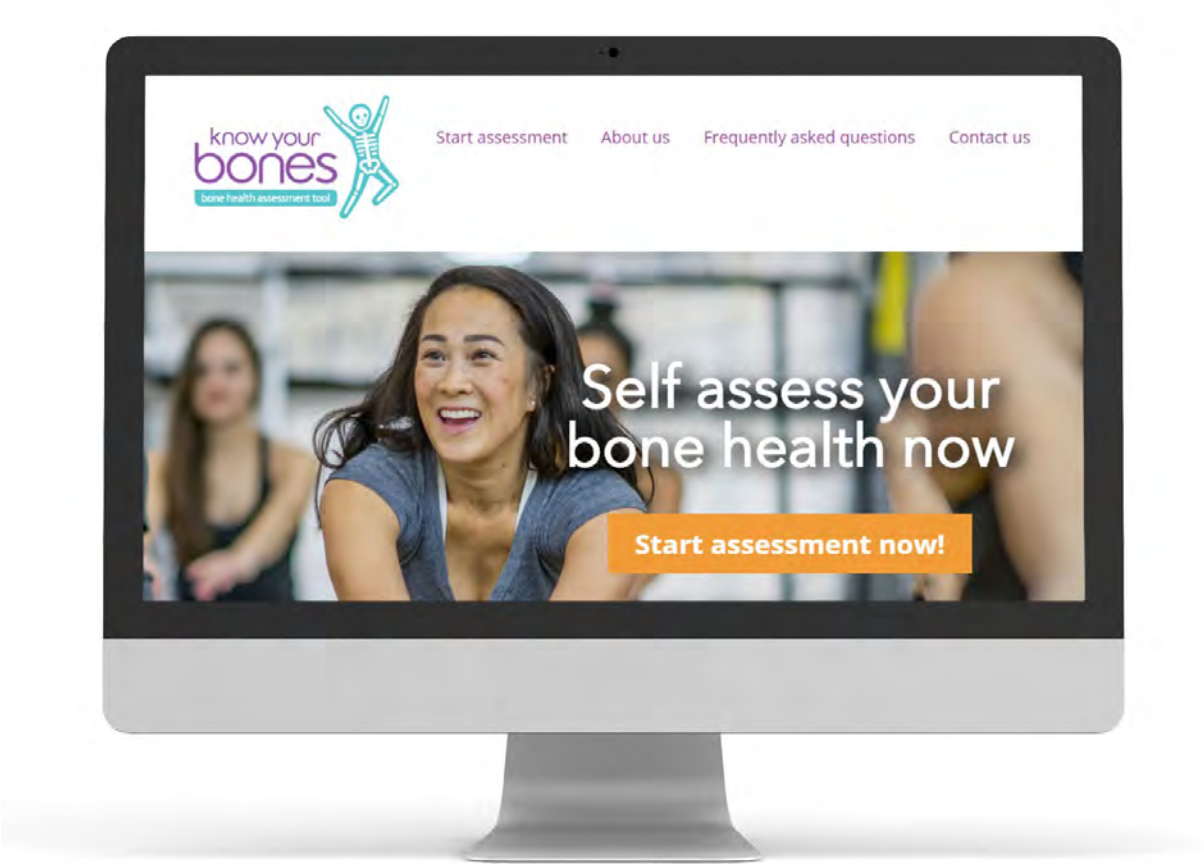
PURPOSE To reduce the impact and incidence of hip fractures (fractured neck of femur) in older adults.

OBJECTIVE

- Identify potential osteoporotic fractures (fragility fractures) in the Emergency Department and inform the general practice of potential risks via a sustainable pathway
- Monitor fractured neck of femur 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.



A national on-line consumer self-assessment tool ("Know Your Bones") was launched in June 2020 from Bone Health New Zealand (Osteoporosis New Zealand) which has increased national awareness of osteoporosis.

12 Month Outcomes

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018		2018/2019		2019/2020	
Nelson Emergency Department Data						
• Number identified in the Emergency Department with potential osteoporotic fracture	291+		369		412	
• Ethnicity	**Māori** 4	**Non-Māori** 287+	**Māori** 4	**Non-Māori** 365	**Māori** 14	**Non-Māori** 398
• Gender of those identified	**Male** 93	**Female** 198	**Male** 110	**Female** 259	**Male** 110	**Female** 302
Fractured Neck of Femur						
• Number of hip fractures identified in Nelson (fragility)	67 (incomplete data)		105		80 (fragility fracture data)	
Workforce Development						
• Number of education sessions	**# Group** 12	**# People** 135	**# Group** 21+	**# People** 90+	**# Group** 15	**# People** 156
• Percentage increasing knowledge of topic	99.8%		100%		99.5%	
• Percentage increasing confidence to address topic	99.8%		100%		99%	
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 general practices)		Available to all general practices	
• Number of screens completed within general practice	Trials only to date		31		8 (total of 39)	

PROGRAMME TARGETS (YEAR)

Target	Achievement
The target is 614 patients identified in emergency department when patient presents with potential fragility fracture	412 (best estimate from available data). As the pathway continues to become more established, the screening age was dropped to reflect international best practice in screening for fragility fractures. COVID-19 restrictions have potentially seen less fractures occur; however, we may see a rebound effect in July – September 2020

Continues over...

Community Fracture Liaison Service Falls Prevention Continued

PROGRAMME OUTCOMES

- Focus this year has been on increasing consumer and healthcare providers awareness and knowledge of osteoporosis
- Nelson Marlborough Health are working on developing a sustainable, consistent and reliable method of informing patients and their general practice when a fragility fracture is identified. A pilot project is underway with Nelson Hospital fracture clinic and Nelson Bays Primary Health with the aim of 'flagging' patients with potential fragility fracture and notifying patient and general practice to consider a full falls and fracture screening assessment
- A national on-line consumer self-assessment tool ("Know Your Bones") was launched in June 2020 from Bone Health New Zealand (Osteoporosis New Zealand) which has increased national awareness of osteoporosis. This in turn is anticipated to further support our Fracture Liaison Service model in Nelson Marlborough
- The electronic assessment tool, developed by Nelson Bays Primary Health, for Falls and Fracture Risk Screening in primary care, was successfully rolled out last year. It will take ongoing education support and pathway development to have this integrated into 'business as usual'. The assessment is not incentivised which continues to 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
- Wider system pathways in secondary care, primary care and the community are continuing to grow and strengthen, connecting bone health and falls prevention awareness and management

MĀORI HEALTH ACTIVITIES

- 14 people identifying as Māori had a potential osteoporotic fracture, compared to 398 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 (or fragility fractures) at the same rates as non-Māori

BONE HEALTH NEW ZEALAND

PROTECT YOUR BONES FOR A STRONGER FUTURE

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 whānau 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. Provide One-to-One Primary Care Dietitian appointments within general practice and other 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	2017/2018		2018/2019		2019/2020	
Primary Care Dietitian: 1:1 Consultations general practice and Nelson Bays Primary Health)						
• Number of 1:1 individuals booked into clinic	917		904		752	
• Number attended	815		792		666	
• 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 Te Piki Oranga	7		10		7	
• Number attended	23		14		11	
• Number of did not attends	0		0		0	

Continues over...

Community Nutrition Service Primary Care Dietitians Continued

PROGRAMME MEASUREMENT	2017/2018		2018/2019		2019/2020	
Self-Management Group Education Sessions						
	Groups	**People**	**Groups**	**People**	**Groups**	**People**
• Type 2 Diabetes	8	71	7	96	4	38
• Healthy Hearts	12	210	10	131	7	101
• Pulmonary Rehabilitation	3	60	3	65	1	20
• Other	*	*	3	53	7	67
Total	**23**	**341**	**23**	**345**	**19**	**226**
Child Obesity Prevention						
• Eat Move Grow	**Groups** 6	**People** 67	**Groups** 3	**People** 34	**Groups** 1	**People** 8
• Ethnicity of those attending	**Māori** 4	**Non-Māori** 63	**Māori** 0	**Non-Māori** 34	**Māori** 0	**Non-Māori** 8
Workforce Development						
• Number of education sessions	**Groups** 8	**People** 120	**Groups** 10	**People** 129	**Groups** 6	**People** 65
• Percentage increasing knowledge of topic	Not surveyed		Those who attended reported a 100% increase in knowledge		Those who attended reported a 100% increase in knowledge	
• Percentage increasing confidence to address topic	Not surveyed					
Programme Outcomes (At Completion)						
• Type 2 diabetes – percentage of participants have improved knowledge	99%		100%		100%	
• Healthy Hearts – percentage of participants have improved their knowledge	99%		100%		99%	
• Eat Move Grow percentage of parents have improved their knowledge	100%		100%		100%	
Programme Outcomes (Self-reported at 6-months after attending)						
• Type 2 diabetes – percentage of people who have improved eating habits	79%		60%		85%	
• Healthy Hearts – percentage of people who have improved eating habits	98%		100%		96%	
• Eat Move Grow, percent of children (at one year):						
– more physically active	100%		67%		N/A as already active	
– spending less time on screens	60%		67%		N/A as minimal screen time already	
– eating more fruit and vegetables	80%		83%		100%	

TARGETS (YEAR)

- This year has been unusual due to the impact of the COVID-19 pandemic and resulting New Zealand lockdown. This situation had a significant impact on the number of patients referred and groups that were able to engage with the Community Nutrition Service. During lockdown the dietitians transitioned to providing remote telehealth appointments, however the Primary Care Dietitians were also redeployed to the Community Based Assessment Centre which limited the number of telehealth appointments available for semi-urgent dietitian referrals

Target	Achievement
For one to one patient booked into a clinic the target is 800	This year 752 were booked into a clinic. Due to the COVID-19 pandemic and redeployment of the dietitians, an additional 158 patient appointment times were cancelled. Had these been filled, the service would have exceeded the target, achieving 910 patient appointments
For group education sessions the target is 20	This year 19 sessions were held. A further 6 programmes were cancelled due to the pandemic
For childhood obesity prevention programmes the target is 8	This year we achieved one completed programme but 8 whānau have benefited from this. In spite of regular promotion, the service has not received sufficient referrals to run further programmes. However, in addition to Eat Move Grow, we provided 2 'first foods and establishing good eating habits and behaviours' information sessions for infants <1 year old and their whānau
For workforce development sessions the target is 8	This year we achieved 6 with 2 sessions cancelled due to COVID-19

MĀORI HEALTH ACTIVITIES

- 11% of referrals identified as Māori
- Bi-monthly clinic provided at Te Piki Oranga in Motueka
- The Primary Care Dietitians have regular kōrero with the Te Piki Oranga Dietitian to update on each service's activities, including discussions on individual cases when needed. Where appropriate, patients are referred to Te Piki Oranga Dietitian and Te Piki Oranga services for kaupapa Māori dietary guidance and support for long term health conditions
- The service worked collaboratively with the Te Piki Oranga Dietitian to provide workforce education to Te Piki Oranga Whakatu Kaimahi on childhood nutrition

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 Dietitian team has been involved with the Health Module within the New migrant (refugee) orientation programmes. This has provided an excellent opportunity to deliver healthy lifestyle messages to the new refugees being settled in Nelson

PARTICIPANT FEEDBACK

Healthy Hearts: *23 attendees specified that the Dietitian session on the cardioprotective diet was the most useful part of the session. A further 29 participants stated that all information provided was the most useful*

Type 2 Diabetes Information Sessions: *18 attendees identified the diabetes dietary information as the most useful part of the Type 2 Diabetes education sessions. A further six attendees stated that all the education components were most useful*

"Good to know the direct effect of diet and physical activity on diabetes and blood sugars. What dietary changes will assist with our health."

"I learnt that I can eat carbohydrate foods and am confident now to loosen up about "diets" so I will not fall into extremes."

"One year on from the Eat Move Grow programme all is well in our family. We continue to have happier and calmer meal times, with more fruit and vegetables and plenty of water to drink."

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

The Nelson Bays Community Podiatry Service contracts a private Podiatrist 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	2017/2018		2018/2019		2019/2020	
• Total number of patient consultations	2,443		2,495		2,187	
• Consultations by ethnicity	**Māori** 359	**Non-Māori** 2,084	**Māori** 325	**Non-Māori** 2,170	**Māori** 282	**Non-Māori** 1,905
Where were patients seen	**Clinics held**		**Clinics held**		**Clinics held**	
• Marae clinic (Whakatu and Te Āwhina)	8		8		8	
• Hospital clinic	85		90		75	
• Mapua clinic	47		47		44	
• House calls	35		42		34	
• Golden Bay clinic	8		8		6	
• Other	1 (rest home)		-		-	
Number who did not attend	295		282		211	
Number who declined	15		30 (estimate)		-	
With support from Te Piki Oranga nurses	Works in partnership with Te Piki Oranga at all Marae clinics		Works in partnership with Te Piki Oranga at all Marae clinics		Works in partnership with Te Piki Oranga at all Marae clinics	

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Orthotics	31	28	25
Vascular surgeon	13	5	2
District Nurse	50	8	5

TARGETS (YEAR)

- The target is to see 2,540 patients. The impact of COVID-19 and 7 weeks of lockdown resulted in cancellation of some clinics with a subsequent drop in patients seen to 2,187

MĀORI HEALTH ACTIVITIES

- 282 of the people who accessed the service identified as Māori
- 48 of the people who accessed the service identified as Pasifika
- 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 and whānua 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 (282 Māori accessed in one year)
- This year the wait time has temporarily increased to 7.5 months, due to cancelled clinics. Great efforts are being made to re-schedule appointments and reduce the wait time

SUCCESS STORIES

*"*Andrew (*name has been changed) recently moved to Nelson into a shared flatting situation. On noticing Andrew's sore feet, one of his flat mates insisted that he attend the community podiatry appointment which was based at the marae. Upon attending the podiatry appointment, it was discovered that Andrew had not engaged with a health care provider at all for many years. Andrew discussed some worrying symptoms of increased thirst and sudden weight loss with the marae nurses on-site, which prompted some blood tests. Results showed that Andrew had undiagnosed diabetes in addition to very high "at risk" feet.*

In a single podiatrist appointment, Andrews feet were made comfortable, he was enrolled with a general practice, diagnosed with diabetes, and started on appropriate medication and diabetes management. Andrew has since gained employment, and continues to receive treatments and care through the marae-based services. He is incredibly grateful for receiving these services that have transformed his life."

This is a great example of the person-centred care available through this service model, and the difference that can be made to a person's overall long-term health and well-being.

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

- 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 engaged in the service
- Increase engagement and relevance for Māori and other vulnerable populations.
- Using a postal survey, monitor the long-term health outcomes of those who engaged

Rongoā Kākāriki GREEN PRESCRIPTION

> **... Green Prescription is a service that guides patients to improved health through better understanding of behaviours, physical activity and nutrition**

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, long-term conditions such as obesity, pre-diabetes, diabetes, heart disease and/or pain.

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

- Mātāpuna: Originally started as a pilot in 2019, this is now an established, collaborative Green Prescription and Te Piki Oranga aqua session that offers a sustainable option to Kaumātua. It is a series of group aquatic sessions that addresses the 4x E's of: exercise, education, emotional support and enjoyment
- StayWell: A 3-hour interactive workshop targeting prevention and 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 and supports behaviour change to become imbedded into daily life. This programme involves education and various physical activities along with the group social interactions and peer support. The programme is delivered in partnership with local aquatic and/or gym facilities around the region
- Condition specific programmes such as; Living with Type 2 Diabetes; Upright and Able for falls prevention; The Joint Programme for osteoarthritis; or Healthy Hearts for cardiac rehabilitation
- Patients can choose to attend which options best support their individual needs

COVID-19

Despite the impact of COVID-19 affecting referral rates and programme delivery, it has provided exciting new opportunities to expand the range of delivery methods. Early indications show that remote delivery methods (virtual/telehealth) supported with increased accessibility to local physical activity options, have the potential to meet the needs of a wider, more diverse population base.

How well did we do?

KEY PERFORMANCE MEASURES

PROGRAMME MEASUREMENT	2017/2018		2018/2019		2019/2020	
Green Prescription Referrals						
• Numbers referred	1,733		1,201		1,159	
• Ethnicity	**Māori** 211	**Non-Māori** 1,522	**Māori** 123	**Non-Māori** 1,078	**Māori** 96	**Non-Māori** 1,063
• Gender	**Male** 462	**Female** 1,271	**Male** 443	**Female** 758	**Male** 436	**Female** 723
KickStart						
• Number of people attending KickStart	552		642		788	
• Number of programmes delivered	13		12		10	
StayWell						
• Number of people attending	252		203		94	
• Number of sessions delivered in general practice	2		0		0	
• Number of sessions delivered in the community	20		22		11	
• Total number of sessions delivered	22		22		11	
Condition Specific programmes e.g. Type 2 Diabetes; Pre-Diabetes; Falls Prevention; The Joint Programme; Healthy Hearts						
• Number of people attending	710		459		546	
Outcomes (at completion)						
• Percentage of participants that:						
– Understand why they need to be active	93%		88%		89%	
– Have made positive changes to food since beginning Green Prescription	77%		83%		79%	
– Feel supported to initiate and sustain good lifestyle choices	89%		95%		86%	
Outcomes (6 months after completion)						
• Percentage of participants that:						
– Are still regularly active	79%		74%		61%	
– Are still choosing healthier food options	77%		83%		75%	
– Report improved health outcome	82%		75%		75%	

Continues over...

Green Prescription Continued

TARGETS (YEAR)

- The target is to receive 1,200 Green Prescription referrals per year. We achieved 1,159 referrals

MĀORI HEALTH ACTIVITIES

- 8% of referrals identified as Māori, with an average engagement rate of 41%
- Equitable access and increased engagement for Māori and vulnerable populations has been a focus this year with direct consultation asking; "What do our Māori and vulnerable populations need?"
- Use of 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
- Ongoing relationship building and partnerships with key Māori stakeholders have provided opportunities for integration, such as:
  - Regular korero with kaimahi and whānau to build trust to support the needs of a variety of communities
  - Continued collaboration between Green Prescription and Te Piki Oranga resulting in the successful Mātāpuna programme. Instructor and Te Puna Hauora Navigator at Te Piki Oranga have commented that *"Mātāpuna is tracking well and our attending whānau are really engaged."*
  - Ongoing discussions with Te Piki Oranga in Motueka to extend Mātāpuna sessions for their whānau

PERSONAL SUCCESS STORIES

"Kickstart was a great place to start to learn and to try new things, I've made lots of changes that are helping me lose/maintain my weight."

"Love the programme – it's useful for anyone and I'm ready to go out alone."

"I've started changing what I eat for lunch and my anxiety and stress levels have been going down by regularly exercising."

"I've learnt about saturated fats which made me change my diet. I also asked for help to stop smoking because I was getting out of breath when exercising. I have been smoke-free for 6 months and that helps my exercising."

"Great interactive approach to getting people to look deeper into their lifestyle."

"I wanted to lose weight to help my diabetes and my GP suggested green prescription. I found the facilitators to be enthusiastic with infectious attitude to healthy living. I will put to use the things I have learned over this time."

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

Victory Community Centre

PURPOSE To provide funding to support improved 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, including enrolling or re-enrolling at a general practice.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Service Outcomes			
• Number of clients accessing the service	456	256+	384
• 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 abuse 3. Sexually transmitted infections and pregnancy 4. Lack of housing 5. Re-engaging with the screening systems	1. Mental health problems 2. Poverty 3. Poor housing 4. Support for former refugees with unmet health needs 5. Increased levels of complex health issues for all populations
Percentage of referrals broken down by:			
Ethnicity: • European • Māori • Pasifika • Other (e.g. former refugee)	 33% 34% 2% 31%	 54% 35% 1% 10%	 62% 20% 1% 17%
Reason for clients accessing the service **:			
• Health assessments • Mental Health • Social issues • Housing issues • Education • Other	456 50 36 18 35 4	256 10+ 7+ Not specified 54 46 (influenza vaccinations)	384 25 25 15 100 130 (Influenza vaccinations)

Continues over...

Victory Community Centre Continued

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
• Number of assessments completed	456	256	384
• Number of unenrolled clients supported to enrol in general practice	16	9	11
• Number of clients supported to access other services	78	79	252
• Number of refugee families supported	11	139	58
• Number of information sessions delivered	7	4	24 4 Haputanga Wananga 2 menstrual cups 1 VIP vouchers 4 medical students 5 practice nurses 2 Hepatitis C community 6 stressbusters

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

MĀORI HEALTH ACTIVITIES

- 77 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' (e.g. former refugee), 30% Māori families and 28% other ethnicity families enrolled at the school. This service ensures that this highly vulnerable population has 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

- The Victory Community Centre community nurse is now well embedded in the role and has strong relationships with a variety of agencies
- A monthly multi-agency meeting around vulnerable children (initiated by Victory Community Centre) continues and now has a local paediatrician in attendance
- A strong connection continues with Red Cross Refugee Services, Te Piki Oranga, Nelson Tasman Pasifika Community Trust, Nelson Bays Primary Health and Nelson Marlborough Health, Victory Pharmacy and general practices
- There was a significant uptake of our local community accessing an influenza vaccination (130 people) supported by Nelson Bays Primary Health's immunisation facilitator and supporting local community groups including: people for the Chin community, local residents of Victory, teachers and support staff of the school, Pasifika Kaumatua. Two clinics were held in Franklyn Village
- COVID-19 was a difficult time for the Centre to be a 'community', however this was overcome quickly with the establishment of the Toi Toi community based assessment centre based initially at the Harvey Norman carpark and then moved to Victory Square to be closer to those that needed it the most. Victory Community Centre staff were instrumental in establishing the processes and working at the station not only for assessments and testing, but also responding to welfare needs
- Victory Community Centre continues to see an increase in the complexity of health needs (including mental health issues), and has worked hard with clients to coordinate and facilitate appropriate care across the health system
- A number of people we have worked with for addressing health and social needs, are now involved in the Centre as volunteers that contributes to the person's wellness, allowing for a holistic health approach to them and us

Mental Health

Adult Alcohol and Other Drug Service Victory Community Centre

PURPOSE To provide an adult Alcohol and Other Drug Service based in primary care in the Nelson/Tasman area.

OBJECTIVE

To deliver a service that initiates brief interventions and connections to appropriate providers across primary care with the intended outcome of meeting unmet health or wellness outcomes. This role is also designed to support general practices and other associated primary care services with alcohol and other drug issues and to provide workforce education, resources and best practice approaches.

PROGRAMME OVERVIEW

The intention of this innovative community-based service is to improve access to health services across vulnerable populations, with an emphasis on addressing addictions and co-existing disorders by being a flexible and mobile service. The service works closely with the Youth Alcohol and Other Drug Service at Nelson Bays Primary Health, along with other health providers including Nelson Marlborough Health's Addictions team.

The criteria is for people 25 years and older and provides brief intervention support and education to address mild to moderate addiction and co-existing disorders. These interventions are mainly in the form of one-on-one counselling sessions. This initiative is funded by Nelson Bays Primary Health and the contracted provider is Victory Community Centre. The service delivery started in March 2019.

In the first months, the service concentrated on raising awareness and linkages within the community and primary care space. Most of the general practices have been visited (75%) as well as numerous community agencies. Strong connections have developed with many primary care agencies including Red Cross, Community Action on Youth and Drugs, Nelson Marlborough Health's public health team, Whākatu Marae, Te Piki Oranga, Pasifika Community Trust and Supporting Families to name but a few.

A pilot service offering a "rapid response" to clients with alcohol and other drug concerns has recently been developed with a local Victory general practice. Services are additionally available once a week at the Tahunanui Community Hub in an attempt to increase access.

The COVID-19 lockdown and resulting restrictions impacted the number of referrals received. During this period services were offered via phone and Zoom.

The service constantly asks how can any member of the community know about this service and how can that person make contact easily with the clinician?

How well did we do?

KEY PERFORMANCE MEASURES

PROGRAMME MEASUREMENT	2018/2019 Service started in March 2019	2019/2020
Referral data:		
Number of referrals received	10	100
• Number of Male: Female referrals	7:6	54:46
• Number of group education sessions provided	6	28

PROGRAMME MEASUREMENT	2018/2019 Service started in March 2019	2019/2020
• Neighbourhood of residence	*	• Victory: 27% • Nelson: 28% • Stoke: 15% • Richmond: 9% • Tasman: 9% • Unknown: 10% • Other (Christchurch, Wellington): 3%
• Number in employment/study	*	44%
• Number who presented with co-existing conditions	*	62% of referrals self-reported co-existing condition(s): • Depression: 43% • Anxiety: 28% • Bipolar: 9% • PTSD: 7% • Pain: 5% • Head Injury: 5% • Dementia: 4% Other health conditions reported: Asthma, Cardiac, Stroke and/or other physical health issues
• Referral sources	*	• Nelson Marlborough Health Addictions Service: 52% • External agencies: 17% • Self-referrals: 15% • Direct from GP: 11% • Victory Community Centre: 2% • Family support: 3% • Whākatu Marae social worker: 29%

**New measurement to Nelson Bays Primary Health in 2019/20 and previous financial year's data not available.*

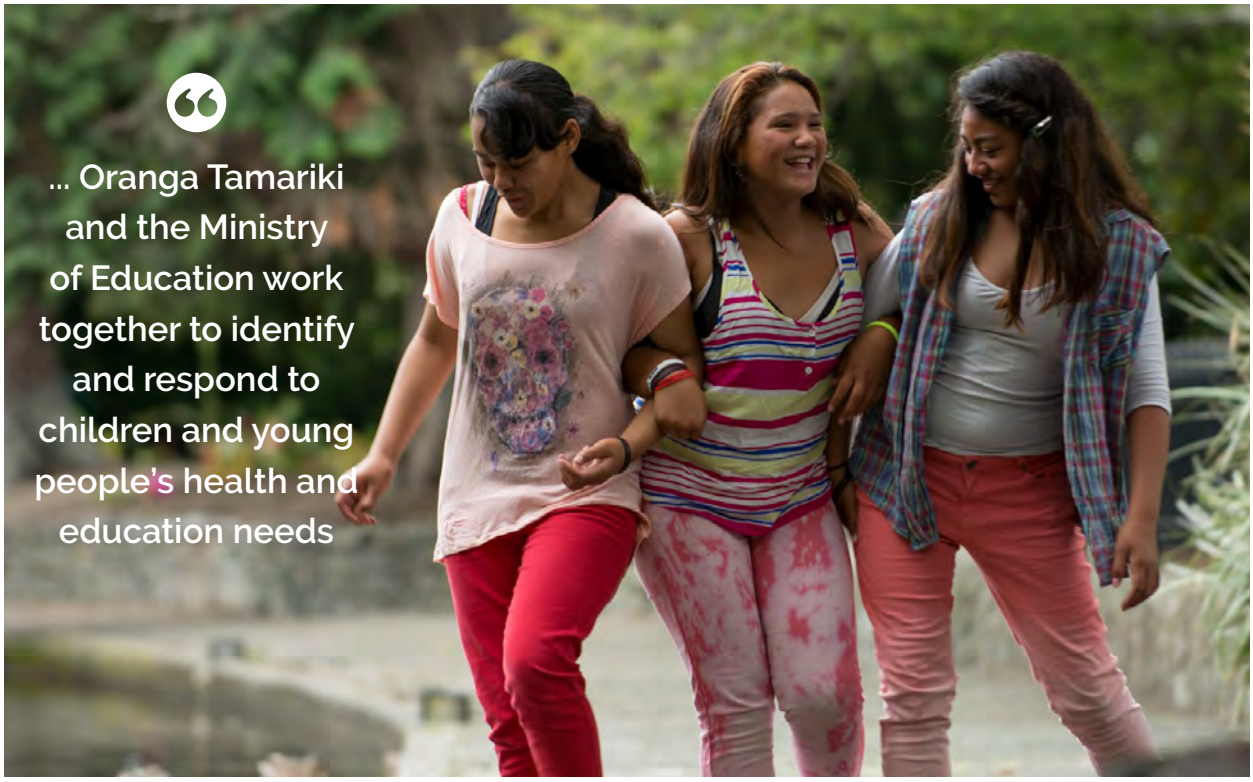
MĀORI HEALTH ACTIVITIES

- 29% of referrals identified as Māori

VULNERABLE POPULATION

- Partnerships developed with Red Cross Refugee Services, Community Action on Youth and Drugs and Multicultural Council Nelson Tasman
- Workshops currently being offered to the former refugees arriving from Columbia, who often arrive in Nelson with unique and complex issues
- Working from the Victory Community Centre site allows for an accessible and responsive service and a strong link to the community navigator for migrants and former refugees

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 a 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	2017/2018	2018/2019	2019/2020
Number of referrals received from Oranga Tamariki	55	93	62
Number of assessments Nelson Bays Primary Health engaged in (health assessments undertaken)	64	63	46
Number of inter-service panel meetings held	65	62	46
Strategies implemented to reduce any gaps identified	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	Advocatedwith appropriate service providers to provide more referral details for Gateway Health Assessments. Referrals now include Tuituia reports, Family Group Conference reports and Social Work reports. The Gateway Services Contract is currently undergoing a review and quality improvement process

MĀORI HEALTH ACTIVITIES

- There were 35 Māori referredto 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/orvia 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	2017/2018	2018/2019	2019/2020
• Number of referrals to this service	19	15	14
• Number of packages of care completed (clients can have more than 1 package of care)	21	7	11
• Average number of days from referral to package of care	18	21	3

MĀORI HEALTH ACTIVITIES

- 7 children referred identified as Māori

Persistent Non-Malignant Pain Programme

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

OBJECTIVE

- To provide a sustainable, evidenced based Persistent Non-Malignant Pain Programme in a community setting involving pain assessment and management, aiming for reduced prevalence and effects of persistent pain for the client and their whānau
- Intervention aims to:
  - Reduce reliance on medications (including Opioids) and on Emergency Department presentations
  - Minimise any emotional distress experienced as a result of living with persistent pain
  - Build clients self-management skills and confidence to live with persistent pain
  - Increase the client's overall activity participation

PROGRAMME OVERVIEW

The service is delivered by a multi-disciplinary specialist team, providing individual and group pain management interventions using a holistic model. During 2019/2020, the average duration of referred clients pain experience was 8.5 years. The two key questions asked at the time of initial assessment are:

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

The service then works with the client to address and respond to these answers.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Number of referrals received	275	288	285
Number of Māori participants	22	8	12
Number of groups completed	1	2	1 (1 group cancelled due to COVID-19)
Number of clients engaged with counsellor/clinical psychologist	56	62	76
Clients' perceived improved level of workability	8%	4%	4%
Clients' enhanced ability to undertake activities in and around the home	18%	9%	0% (maintained participation in activities)
Clients' increased ability to cope with pain without medications	14%	6%	14%
Clients' reduction in opioid use	16%	48%	12.5%

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 within a timely manner

PROGRAMME OVERVIEW

The Primary Mental Health Initiative 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 per patient. Referrals are received fromgeneral 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 Nelson Bays Primary Health clinicians who work from 281 Queen Street, Richmond and 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 at their final appointment. This provides a means to clinically evaluate outcomes. A drop in scoring indicated a positive health outcome.

COVID-19

During Covid-19 lockdown the Brief Intervention Service waitlist dropped from 155 service users to 20 in the months of April to May 2020.This was due to delivery changes such as a changed approach to referrals that generated a more responsive service. The service also worked from the beginning, middle and end of the waitlist. Those on the bottom were offered a traditional counselling approach via telehealth, and those recently referred had counsellors delivering a Focused Acceptance Commitment Therapy (FACT) approach via telehealth. A temporary increase in administration support during this time meant that the service could focus solely on responsiveness to referrals and patient need.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Primary Mental Health Initiative			
• Referrals	2,421	1,726	2,647
• Average drop of PHQ-9 scores from beginning of treatment to end of treatment	6.4	1.25	1.00
• Time on Primary Mental Health Initiative Service waitlist (days)	7	7	7
Clients referred			
• Male	**	**	766
• Female	**	**	1,800
• Not Identified	**	**	81
Brief Intervention Service			
Referrals	944	1,369	1,030
Average drop of PHQ9 scores from beginning of treatment to end of treatment	8.0	7.5	4.8
Time on Brief Intervention Service waitlist (days)	28	46	70
Client Outcomes for Brief Intervention Service			
• Percentage of improvement	*	80%	87.5%
• Percentage of clients who would recommend the service	*	100%	87.5%
• Positive changes occurred due to counselling	*	80%	87.5%
Clients referred			
• Male	**	**	338
• Female	**	**	692

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

** *New measurement to Nelson Bays Primary Health in 2019/20 and previous financial years data not available.*

MĀORI HEALTH ACTIVITIES

- 281 of the referrals identified as Māori under the Primary Mental Health Initiative
- 73 of the referrals identified as Māori under the Brief Intervention Service

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 appropriate services for young people with mild to moderate alcohol and/or drug use or abuse.

PROGRAMME OVERVIEW

The service uses a youth participation model. This model is flexible and meetsthe needs of young people and is aligned to:

- Nelson Bays Primary Mental Health Brief Intervention and Targeted Youth Health Services in Nelson Tasman.
- Nelson Marlborough Health Addictions services
- Child and Adolescent Mental Health services

The service supports 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 Strengths and Difficulties questionnaire (SDQ) or the Substance Use and Choices Scale (SACS). The expected maximum intervention is up to four sessions i.e. a brief intervention model. 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	2017/2018	2018/2019	2019/2020
Number referred	125	150	128
Number of clinics held	312	372	334
Number of group education sessions provided	48	42	28
Patient feedback via survey			
1. Did you find the service helpful? (Rate 1-10 scale: 0=not at all, 5=somewhat, 10=very helpful)	*	80%	94%
2. Have you achieved your goals? (Rate 1-10 scale: 0=not at all, 5=somewhat, 10=completely)	*	80%	56%
3. Would you tell your mates about this service? (Rate 1-10 scale: 0=no, 5=possibly, 10=definitely)	*	60%	94%
Comparison of alcohol/drug use from start of treatment to end of treatment (percentage improvement)	65% reduction	44% reduction	56% reduction

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

MĀORI HEALTH ACTIVITIES

- There were 46 Māori referred to the service (36%)

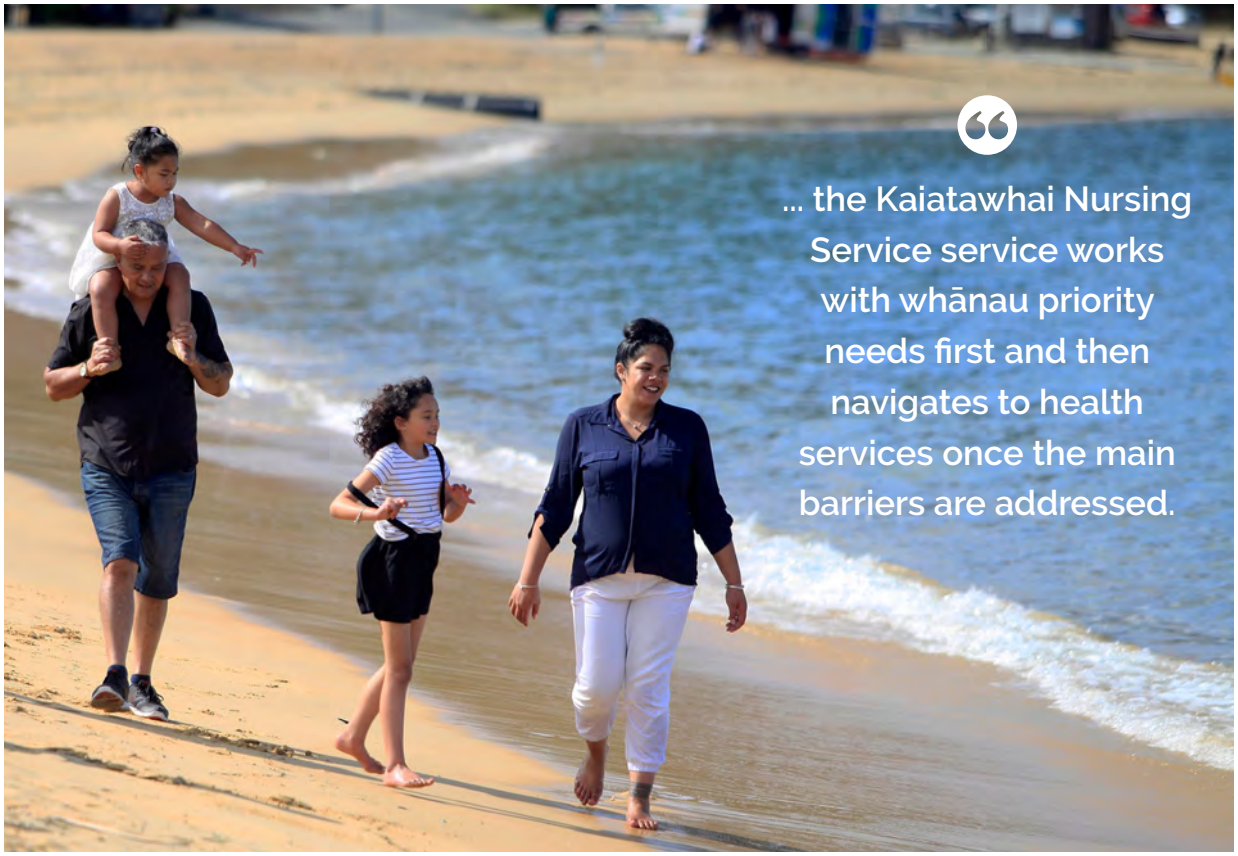
VULNERABLE POPULATION

- There were 5 Pasifika referred to the service (4%)

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 services at general practice
- To develop collaborative relationships across the primary health community
- To provide a navigation and case management service

PROGRAMME OVERVIEW

- Nelson Bays Primary Health's Kaiatawhai Service works with general practices and other primary health providers, to support the health and well-being of vulnerable patients/clients in the Nelson Tasman region. The service supports whānau enrolled, or eligible to be enrolled, with a general practice to access: 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
- It should be noted that while the referral is for a specific person or reason, a whānau ora approach is provided, so it is common to work with the whole whānau when addressing the referral and respond to all unmet health needs

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
• Number of referrals	276	256	322
• Number of health assessments completed	44	93	37
• Number of patients referred to other providers	61	42	24
• Number of patients supported to be enrolled in general practice	14	5	3
• Number of community organisations liaised with for the service	79	106	43
Referrals by ethnicity			
• European	151	167	193
• Māori	97	70	83
• Pasifika	14	8	11
• Asian	9	5	13
• Other/Unknown	5	6	22
Referrals by gender			
• Male	63	49	36
• Female	213	207	286
Referrals by age			
• 0-14	11	16	12
• 15-24	34	20	23
• 25-49	149	133	203
• 50-75	79	79	84
• 75+	3	8	0
Reason for referrals*			
• Support to engage in Health Screening	184	201	289
• Access to Health Services	122	83	90
• Mental Health	11	20	21
• Education	26	30	38
• Other (Court, Housing New Zealand, Probation)	12	18	10
Of those referred**			
• Unable to contact	11	25	32
• No longer in the area	3	5	15
• Declined	11	24	35
• Deceased	0	2	0

** Clients may be referred for more than one reason.*

*** These numbers are based on the number of referrals discharged from Kaiatawhai Service.*

Continues over...

Kaiatawhai Nursing Service Continued

MĀORI HEALTH ACTIVITIES

- 83 of the referrals identified as Māori compared to 70 in the previous year
- All people who identified as Māori were offered Te Piki Oranga services. Two patients were referred onto their services
- 52 people who identified as Māori declined a referral to Te Piki Oranga services

PATIENT OUTCOMES / SUCCESS STORIES

- Often referrals come in for one reason, but the underlying issue is other contributing factors such as: living situations, housing (or lack of it), family violence, financial, employment etc. The service works with whānau priority needs first and then navigates to health services once the main barriers are addressed. This can take considerable time but can also support long term success
- Cost of accessing health services remains the biggest barrier to those that were referred. This can include cost of travel, cost of time off work, cost of medications, or embarrassment when debt is an issue at the general practice or pharmacy

COVID-19

- Between March to June 2020, the Kaiatawhai Nurse was seconded into the community-based assessment centre in Tahunanui. This work included:
  - Triaging Nurse – first point of contact when people arrived in their cars. This involved an assessment and putting people at ease. The assessment was able to identify high-needs patients and triage them appropriately. This included identifying welfare needs
  - Health Care Assistant – working with the general practitioners and documentation which included; work certificates, swab details, Medlab information, education and onward referrals
  - Administration Support – included a number of different tasks such as communicating results, taking contact information from triage nurse, preparing documentation, ensuring strict hygiene practices and manning the 'call-centre'
  - Supported patients to access general practice or pharmacy services

During Lockdown:

- Attend Wai-West (a recognised seasonal worker site) to discuss COVID-19. This involved education about COVID-19 symptoms and prevention measures, along with our Infectious Disease Specialist providing recommendations to living quarters to keep each other safe during this time
- Kaiatawhai Nurse also supported the mobile community based assessment centre team that visited workplaces, both Marae and rural locations. The service also supported influenza clinics at Te Āwhina Marae, Franklyn Village and several other locations to reach vulnerable populations

Kaiatawhai Social Work Service

PURPOSE To improve access to Primary Health 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:
  - Identify unmet social determinants of health needs (e.g. housing, insulation, personal or family health, debt, violence, abuse or neglect)
  - Reduce isolation and/or other social issues
- 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 to service delivery. The aim is to work alongside patients to help them identify goals and work towards improved health outcomes. The service also provides advocacy, navigation and links patients to community groups and/or non-government organisations when they require ongoing support.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Total number of referrals received	55	160	113*
• Number of social work assessments completed	20	72	64
• Number of patients referred to other primary health providers/ non-government organisations or community group	15	47	32
• Number of patients supported to be enrolled in general practice	5	8	1
• Number of community organisations liaised with for the service	30	46	46
Referrals by ethnicity			
• European	28	98	69
• Māori	20	44	23
• Pasifika	4	2	4
• Asian	3	3	8
• Other/Unknown	0	13	9
Referrals by gender			
• Male	23	54	42
• Females	32	106	71

Continues over...

Kaiatawhai Social Work Service Continued

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Referrals by age			
• Under 15	5	8	12
• 15-24	5	12	10
• 25-49	20	54	42
• 50-75	19	71	33
• 75+	6	15	16
Reason for referrals			
	• Parenting • Work and Income • Mental health • Alcohol and other drug brief intervention • Social support • Housing • Safety planning	• Housing • Ministry of Social Development Advocacy • Parenting • Social isolation • Health navigation • General practice enrolment • Combined health and social navigation • Mental health • Alcohol and other drug abuse	• Housing • Ministry of Social Development Advocacy • Parenting • Social isolation • Health navigation • General practice enrolment • Combined health and social navigation • Mental health
Of those referred how many were;			
• Unable to be contacted	5	32	31
• No longer in the area	1	0	1
• Declined	4	11	13
• Deceased	0	1	1

**No referrals were received during COVID-19 Level 4 Lockdown.*

MĀORI HEALTH ACTIVITIES

- 15.9% of referrals identified as Māori
- The service has been building cultural competency, including supporting waiata and karakia every morning

OTHER VULNERABLE GROUPS

- The service has a strong focus on former refugee communities. The service has a strong relationship with Victory Pharmacy and Red Cross Refugee Services. The work done with the former refugee families is often complex and time consuming so a collaborative effort contributes to improved outcomes

PATIENT OUTCOMES/SUCCESS STORIES

- The service has had a lot of success when advocating for clients with Work and Income, ensuring the client is receiving correct entitlements
- The service has worked alongside the Beneficiaries and Unwaged Workers Trust to have a client assisted living payment reinstated
- The service has helped patients clear general practice debt, utilising the vulnerable population (VIP) programme vouchers, along with accessing Ministry of Social Development funding
- The service has worked successfully alongside various non-government organisations such as (but not limited to), Age Concern, Christians Against Poverty, Barnardos, Victory Pharmacy and Victory Community Centre, to increase and solidifying community networks, which is essential for the delivery of this service

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. General 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.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Service Outcomes			
• Number of patients registered in care plus	7,353	7,551	7,577
• Number of reviews completed	17,618	17,158	16,334
Registrations broken down by ethnicity			
• Māori	11%	11%	11%
• Pasifika	1%	1%	1%
• Other	88%	88%	88%

MĀORI HEALTH ACTIVITIES

- We are seeing a growing number of Māori registered on care plus compared to previous years. In quarter 1 there were 848 Māori registered, and by quarter 4 that had increased to 874

Diabetes Annual Review

PURPOSE To provide subsidised or fully subsidised appointment at general practice annually, for adults diagnosed with diabetes, that reviews their care and management of diabetes. The aim being to monitor this long-term condition and reduce diabetes complications.

OBJECTIVE

- The focus of this programme is to prevent and manage complications of diabetes such as amputations, heart attack or blindness
- Patients meeting the age and diagnosis criteria are invited to attend a free annual appointment to review their diabetes. One of the major objectives is to aim for an HbA1c of (less than) 64mmol/mol. This will reduce the likelihood of experiencing diabetes complications

PROGRAMME OVERVIEW

Eligible patients are offered an annual review that monitors diabetes blood tests (HbA1c), and numerous other diabetes markers, including foot checks and diabetes distress. The aim being to detect early signs of complications and to support people living with diabetes. This appointment allows for medication review, onward referrals to lifestyle management or diabetes education services, dietitian referrals or the opportunity for an enhanced review if a follow up appointment is needed to closely monitor abnormal results.

Diabetes distress measures the amount of impact the patient is feeling about their diabetes. Living with diabetes can be tough and can lead to feeling overwhelmed, which if not addressed can lead to other complications.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/2019	2019/2020
Number of patients with diabetes diagnosis. This is all patients with a diabetes diagnosis including children	3,904 Atlas of healthcare PHO analysis/ Diabetes 2018	*
Number of reviews completed	2,773	2,443
Ethnicity of those having a diabetes annual review		
• Māori	223	175**
• Pasifika	48	34**
• New Zealand European	2,383	1,827**
• Other	118	76**
Number of reviews where a distress score was recorded	1,569	1,338
Number of patients with a mod-serious diabetes distress score	74	94

** Measurement un-available on Health Quality and Safety Commission Atlas of Healthcare.*

*** Due to implementation of new patient management systems at various general practices, some data is missing.*

COVID-19

- Diabetes annual reviews were not able to be completed during COVID-19 alerts level 2, 3 or 4 (note: numbers therefore are reflective of inability to provide full services)

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 to 12 months. Patients registered onto the programme are allocated a package of care. The package of care provides for 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	2017/2018	2018/2019	2019/2020
Number of new registrations	334	320	336
Referrals broken down by ethnicity			
• New Zealand European	85%	87%	82%
• Māori	5%	4%	6%
• Other	10%	9%	12%
Referrals broken down by gender			
• Male	54%	59%	52%
• Female	46%	41%	48%
Service provided			
• General practitioner home visit	30%	26%	25%
• Prescription	29%	31%	32%
• General practitioner consult	30%	26%	21%
• Hospice visit	4%	3%	3%
• Post death visit	7%	6%	7%
• General practice other	0%	8%	12%

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

MĀORI HEALTH ACTIVITIES

- 6% of those who accessed the service identified as Māori. This is up from 4% last year

Primary Options for Care

PURPOSE The overarching aim of 'options for care' is to reduce the demand for secondary care services, by allowing general practice to provide a responsive and timely service to patients. The aim is to intervene early and contribute towards 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 or 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	2017/2018	2018/2019	2019/2020
Services provided			
• IV antibiotics	537	299	207
• IV fluids for dehydration	*	272	172
• Venesection for haemochromatosis	301	224	337
• Spirometry – diagnostic	335	357	342
• Chronic obstructive pulmonary disease acute management	23	56	69
• Insulin initiation	30	31	49
• Management of deep vein thrombosis	14	15	17
• Zoledronic acid infusions	13	20	196
• Ad hoc services	29	24	231
• Entonox (pain)	84	124	156
• Polycythaemia vera	10	22	17
• Iron infusion	*	231	438
• Migraine treatment	*	21	15
• Hyperemesis	*	28	24
• Paediatric intranasal fentanyl	*	15	17

Continues over...

Primary Options for Care Continued

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Claims by gender			
• Male	748	830	1,438**
• Female	628	909	2,008**
Percentage of referrals by age			
• 0-4	1%	1%	3%**
• 5-19	6%	7%	12%**
• 20-34	12%	11%	16%**
• 35-49	17%	17%	18%**
• 50 -64	28%	27%	23%**
• 65+	36%	37%	28%**
No co-payment charged for;			
• Community services card holders	*	302	556**
• High user health card holders	*	5	3**
• Māori/Pacific	*	107	188**
• Quintile 5	*	122	174**
• Other at general practice discretion	*	80	93**

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

** *These figures include the addition of COVID-19 claims which came into effect in quarter 4 of this year, so figures are not a true representation of options for care usage.*

MĀORI HEALTH ACTIVITIES

- 10% of people who accessed a service identified as Māori, which is an increase from last year

OTHER VULNERABLE PEOPLE

- As our former refugee population increases, so too does the need for primary options for care use as quota refugees come with complex health needs (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	2017/2018	2018/2019	2019/2020
• Minor skin lesion removal in general practice	*	692	788
• Intermediate skin lesion service	*	275	428
• Number of patients referred from general practice	1,766	2,085	2,259
Referrals broken down by ethnicity			
• European	86%	91%	72%
• Not specified	8%	6%	26%
• Māori	2%	2%	2%
• Pacific Island	0%	1%	0%
Percentage of Referrals broken down by age			
• 0-4	1%	0%	0%
• 5-14	1%	1%	1%
• 15-24	1%	1%	1%
• 25-44	6%	5%	5%
• 45-64	25%	25%	23%
• 65+	66%	68%	70%
Triage destination of referrals received			
• Advice Only	9%	5%	6%
• Cancelled	4%	4%	4%
• Declined	4%	3%	4%
• Dermatology department	7%	1%	1%
• Ear, nose and throat	21%	21%	13%
• General surgical	20%	18%	13%

Continues over...

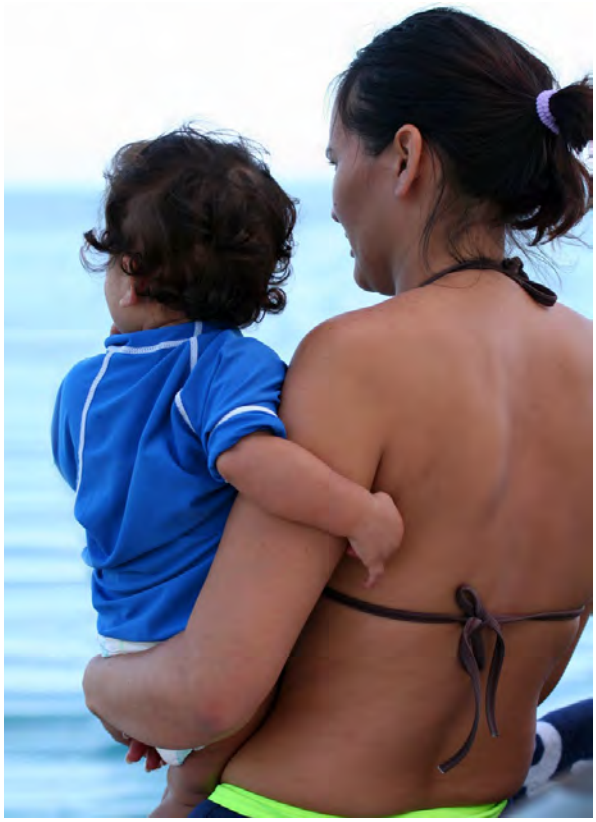
Skin Lesion Removal Service Continued

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Triage destination of referrals received			
• Ophthalmology	3%	2%	2%
• Other – plastics	1%	1%	0%
• Referred to general practice (minor)	27%	30%	33%
• General practitioners with special interest (intermediate)	4%	15%	24%

**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 2019/20



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."

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. A Practice Managers and Administrators Association of New Zealand 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.

Continues over...

Workforce Education Continued

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Pegasus small groups			
• Number of Pegasus small groups completed	4	4	3
• Average number of doctors engaged in the Pegasus model	51	37	38
• Average rating of the overall quality of the meetings	4.5/5	4.4/5	4.5
• Average rating of the quality of information provided (resource material)	4.4/5	4.3/5	4.3
• Average rating of the importance and relevance of the content	4.5/5	4.3/5	4.4
Multidisciplinary sessions			
• Number of multidisciplinary sessions completed	6	7	5
• Average quality rating of the sessions	4.3/5	4.6/5	4.5/5
• Average rating of the quality of information provided (resource material)	4.1/5	3.5/5	4.4/5
Continuing nurse education sessions			
• Number of continuing nurse education sessions completed	10	4	3
Nurse personal development fund • Number of applications received	27	38	30
• Number of applications accepted	26	32	24
Quality education sessions			
• Number of cornerstone accredited sessions delivered	9	8	4
• Percentage of general practices who have achieved accreditation	• Foundation accredited = 9.5% • Cornerstone accredited = 90.5%	• Foundation accredited: 2 general practices • Cornerstone accredited: 19 general practices	• Foundation accredited: 2 general practices • Cornerstone accredited: 20 general practices

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 manage 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		2019/2020	
Referrals						
• Total number of referrals received	**217**		**272**		**213**	
Source of referrals:						
• Respiratory nurse clinic	46		71		55	
• Pulmonary rehabilitation	92		176		124	
• Spirometry	79		25		24	
• Other	0		0		10	
• Adult	206		262		195	
• Paediatric	11		10		18	
• Paediatric	11		10		18	
• Reason for referral						
– Asthma	3%		21%		22%	
– Chronic obstructive pulmonary disease	77%		77%		75%	
– Other respiratory conditions	20%		2%		3%	
• Ethnicity of referrals	**Māori** 22%	**Non-Māori** 82%	**Māori** 15%	**Non-Māori** 85%	**Māori** 12%	**Non-Māori** 88%
• Spirometry completed in general practice	334		359		332	
Attendance at Respiratory Nurse Specialist Clinics						
• Number attended	49		48		52	
• Ethnicity of those attending	**Māori** 10	**Non-Māori** 39	**Māori** 2	**Non-Māori** 46	**Māori** 10	**Non-Māori** 42
• Number who did not attend	2	2	5	2	1	2
• Where clients were seen	**Clinic** *	**Home** *	**Clinic** 95%	**Home** 5%	**Clinic** 70%	**Home** 30%
• Self-management and action plans developed	90%		98%		95%	
• Number of whānau/group education sessions delivered	8		3		2	
Pulmonary Rehabilitation Programme Measurement						
• Number of Pulmonary Rehabilitation programmes delivered	4		3		2 (plus 1 shortened due to COVID-19)	
• Ethnicity of attendees in Pulmonary Rehabilitation	**Māori** 9%	**Non-Māori** 91%	**Māori** 12%	**Non-Māori** 88%	**Māori** -	**Non-Māori** 100%

Continues over...

Community Respiratory Health Service Continued

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
• Percentage of participants who:			
– Completed a programme	*	89%	76% (2 programmes)
– Increased confidence to self-manage	*	95%	96%
– Improved exercise tolerance	*	89%	95%
– Are motivated to continue improving their fitness	*	100%	98%
– Improved Chronic Obstructive Pulmonary Disease assessment score	*	73%	90%
Results of participant follow-up, six-months after completion of Pulmonary Rehabilitation	• 100% reported no respiratory related hospital admissions • 100% reported having increased physical activity levels • 66% are now taking medications correctly • 55% are managing stress better		

Workforce Development (Consultancy)						
• Number of professional development sessions to health professionals	**Sessions** 7	**Attended** 99	**Sessions** 5	**Attended** 43	**Sessions** 7	**Attended** 38
• Consultancy advice provided to health professionals	6		12		3	
• Engagement with community services	4		5		9	

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

MĀORI HEALTH ACTIVITIES

- Engagement or attendance rates for Māori is low and this is acknowledged. A significant amount of work went into engaging and relationship building with Māori Health Providers this year for better engagement and development of appropriate service delivery continues:
  - 12% of referrals overall are for Māori
  - 10 Māori attended a respiratory nurse clinic
  - No Māori attended Pulmonary Rehabilitation programmes this year

PULMONARY REHABILITATION PERSONAL SUCCESS STORIES/ FEEDBACK"

"Stayed well this winter, didn't miss any sessions. Very good course enjoyed it very much."

"This course has recharged my batteries. My friends/ family now call me the Energiser Bunny and are frequently saying "she's back". Thank you, thank you."

"I think the way you are running these sessions is done very well. Everyone is friendly, understanding and helpful."

"For quite some time I have had problems with fluid in my legs. This has now gone away."

"I thoroughly enjoyed this programme and certainly notice an improvement in my activity levels, breathing and general mental well-being."

"Doing this course has saved my life. I have learnt how to breathe correctly when very unwell with pneumonia. Feeling much more confident."

"Lung function has improved by 1% and respiratory specialist says this is a very good response. This is all down to the Better Breathers group and regular exercise class attendance. Proof exercise helps with respiratory conditions."

Director of Primary Healthcare Nursing

Most primary care nursing across Nelson Bays Primary Health is accessed through general practice, however there is a broad group of community nurses who collaborate and coordinate around people's health care – generally outside the hospital. Practice nurses also partner up with Nelson Marlborough Health nurses e.g. diabetes, mental health, district and public health.

The range of activities for some primary care nurses can be quite focussed e.g. Plunket nursing, however in general practice a nurse needs to have skills and knowledge of a wide range of health promotion, prevention and surveillance activities, disease management, wellness and cultural care.

Everyday activity of practice nurses (from aged zero to end of life) includes immunisations, coaching, venepuncture, intravenous infusions, wound care, physical assessments, measuring respiratory functioning, B4 school checks for our 4 years old, nursing care such as taking cervical smears, diabetes annual reviews, breast examinations and mammogram recalls, palliative care, minor surgery, phone calls, advice, triage and influenza vaccinations.

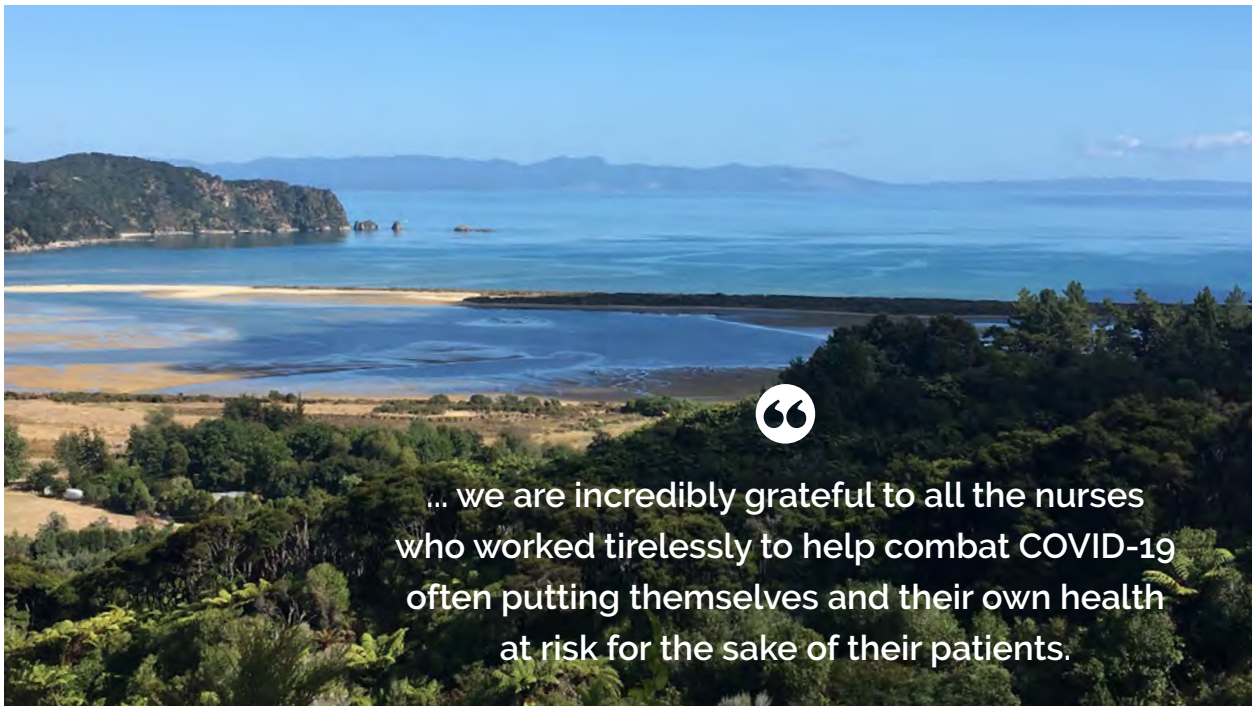
To help meet nurse's needs Nelson Bays Primary Health delivered a calendar of professional development and encouraged post graduate study.

Over the last year we also:

- Increased access to people's mental health care by delivering more credentialing enabling nurses to have their clinical knowledge and skills in mental health and addiction assessed and recognised by Te Ao Maramatanga, New Zealand College of Mental Health Nurses
- Fostered nurse leadership with a fantastic "Coaching Workshop" delivered by Bev McClelland, Organisational Development Consultant, Counties Manukau District Health Board
- Chaired the South Island Alliance Nurse Practitioners in Primary Care Project. Congratulations to our latest Nurse Practitioner in Golden Bay, credentialed by Nursing Council New Zealand this year

We are incredibly grateful to all the nurses who worked tirelessly to help combat COVID-19 often putting themselves and their own health at risk for the sake of their patients.

Our goal has always been (and still is) that the health care environment should enable primary nurses to provide integrated comprehensive care to individuals and population groups in Nelson/Tasman/Golden Bay settings to strengthen and enhance the primary health care team.



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

This photo represents Nelson Bays Primary Health working together with many community groups. In this photo you will see Valerie Preston-Thomas from Nelson Bays Primary Health, Public Health Nurses from Nelson Marlborough Health, Staff from Nelson Marlborough Health's Te Waka Hauora group, Steph Anderson, Community Nurse from Victory Community Centre and staff from Franklyn Village. All brought together to provide an influenza vaccination clinic.

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 >95% target population immunised)	2018/2019		2019/2020	
• 8 month old immunisations	87%	9.2% decliner rates	90%	7.6% decliner rates
• 2 year old immunisations	87%	10.9% decliner rates	86%	10.9% decliner rates
• Pertussis (whooping cough)	87%	Outbreak of pertussis in 2017 still continues	86%	Pertussis risk is high due to low coverage
• Measles (Measles, Mumps and Rubella)	87%	Measles outbreak remains current. No reported cases in Nelson Tasman	86%	Measles remains a current issue with low coverage. No reported cases in Nelson Tasman
• Influenza	23%	Our region experienced the biggest uptake ever	28%	Our region experienced the biggest uptake ever

PROGRAMME MANAGEMENT	2018/2019	2019/2020
Education and promotion		
• Influenza vaccinations uptake to Nelson Bays Primary Health employees	89%	89%
• Nelson Bays Primary Health Immunisation Newsletter	6	4
• Resource development and distribution	3	3
• Public promotion	6	6
• Outbreak notifications	4	5
Health provider support		
• General practice visits	160	300
• Supporting other Health Providers	150	150
Vaccinator training and accreditation		
• Total clinical assessments completed	53	43
Cold chain management		
• Total accreditations completed	26	21
• Validations and cold chain monitoring	35	68
High needs influenza programme		
• Total number of people receiving a high needs influenza immunisation	1034	2503
• Number of Māori immunised via this programme	248	580
• Number of Pacific people immunised via this programme	59	414
• Number of people identifying as from a refugee background	306	723
• Other high needs/vulnerable people	411	786

MĀORI HEALTH ACTIVITIES

- Vaccination Authorisation completedfor Te Piki Oranga Nurses
- Four influenza clinics held at Te Piki Oranga and Whākatu Marae
- Working in partnership with Te Piki Oranga and community centres
- Working in partnership with Te Waka Hauora to support 'pop-up' clinics at Franklyn Village and other high-needs and vulnerable population working or housing locations

Lactation Service

PURPOSE To provide lactation consultant services and specialist breastfeeding support for mums that meet 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	2017/2018		2018/2019		2019/2020	
Referrals						
• Numbers referred	268		241		243	
• Ethnicity of mothers referred	**Māori** 8%	**Non-Māori** 92%	**Māori** 6%	**Non-Māori** 94%	**Māori** 3%	**Non-Māori** 97%
Attendance						
• Numbers seen	268		241		243	
	Clinics	**Seen****	**Clinics**	**Seen**	**Clinics**	**Seen**
– Community Clinics	26**	50%	92	55%	67	32.5%
– Postnatal ward	0	18%	0	14%	14	6.5%
– SCBU	0	18%	0	14%	15	7%
– Home	0	13%	0	10%	69	34%
– Other	0	0%	0	7%	41	20%
Waitlist						
Average time to be seen	1 week		1 week		1 week	
Workforce Development (consultancy)						
• Education sessions	**Sessions** 10	**Attended** 57	**Sessions** 14	**Attended** 90	**Sessions** 13	**Attended** 72
Specialist area addressed:						
• Complexities addressed	11		11		11	
• Onward referrals	9**		110		144	

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Onward referrals to:			
• GP	15%	32%	14%
• Paediatrics, ENT	3%	8%	10%
• Dentist	9%	6%	8%
• Breast pumps	2%	6%	6.5%
• Other e.g. counselling, speech therapists)	*	13%	20.5%
Outcomes			
Percentage of Mums fully breastfeeding on discharge	67%	69%	60%
Percentage of Mums partially breastfeeding on discharge	28%	27%	34%
Percentage of Mums ceased to breastfeed on discharge	3%	4%	2%

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

*** Data gathered from April 2018.*

MĀORI HEALTH ACTIVITIES

- Referrals for Māori women has averaged at 3% of all referrals to the service in the last year
- Nelson Bays Primary Health's lactation consultant continues to work in close collaboration with Te Piki Oranga's lactation consultant/well child nurse as needed, to achieve higher breastfeeding rates in culturally appropriate ways

SUCCESS STORIES

"Babies discharged from hospital/maternity centre, have an 85-90% exclusive breastfeeding rate in our local region."– 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 or other providers are unavailable and have diverted their telephones to Homecare Medical.

OBJECTIVE

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

Homecare Medical
partners in connected care

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	2019/2020			
	JULY – SEPTEMBER	OCTOBER – DECEMBER	JANUARY – MARCH	APRIL – JUNE
Total calls	998	1162	1119	1092
Handover to on-call general practitioner	225	271	240	250
Handover to after-hours primary care	474	575	539	578
Clinic booking	49	42	60	36
Handover to emergency department	38	43	44	39
Handover to ambulance	52	42	41	49
Other outcomes, exercise self-care and contact general practitioner next day	160	189	195	149

ETHNICITY	Number	Percentage
Asian	32	0.7%
European	2439	56%
Māori	342	7.8%
Middle Eastern/Latin American/African	56	1.3%
Pacifica	400	9%
Other	68	1.5%
Unknown	1034	23.7%
TOTAL	**4371**	**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 for the diagnosis and treatment of patients with infection
- 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 – to provide input into the local microbiology laboratory service regarding optimal requesting of laboratory tests; performing up-to-date, accurate and cost-effective testingand 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 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	2017/2018			2018/2019			2019/2020		
Management of patients									
• Total number of telephone consultations	1,392			1,395			2,214		
• Total appointments/consults	523			658			751		
• Number of new outpatient referrals	139			173			201		
• Ethnicity of new referrals	**Māori** 8	**Non-Māori** 131		**Māori** 8	**Non-Māori** 165		**Māori** 15	**Non-Māori** 186	
• Patient waiting time from referral to first contact (compared to national target)	< 120 days			< 120 days			< 120 days		
• Breakdown of where patients seen:	**Virtual** 416	**Clinic** 75	**Hospital** 32	**Virtual** 545	**Clinic** 89	**Hospital** 24	**Virtual** 619	**Clinic** 87	**Hospital** 45

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
System improvement			
• Nelson Marlborough Health hospital antibiotic guidelines up to date	36/36	36/36	36/36 (24 expire in November 2020)
• Number of audits in Nelson/Marlborough	4	2	1
• Number of teaching presentations	8	11	24
• Full attendance at infection prevention and control committees	Yes	Yes	Yes
Workforce Development			
• Infectious Diseases Physicians meet Royal Australasian College of Physicians requirements for education and peer review	Yes	Yes	Yes

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 24 delivered
- Did Not Attends – less than 5%

MĀORI HEALTH ACTIVITIES

- 15 new patients identified as Māori

OTHER VULNERABLE GROUPS

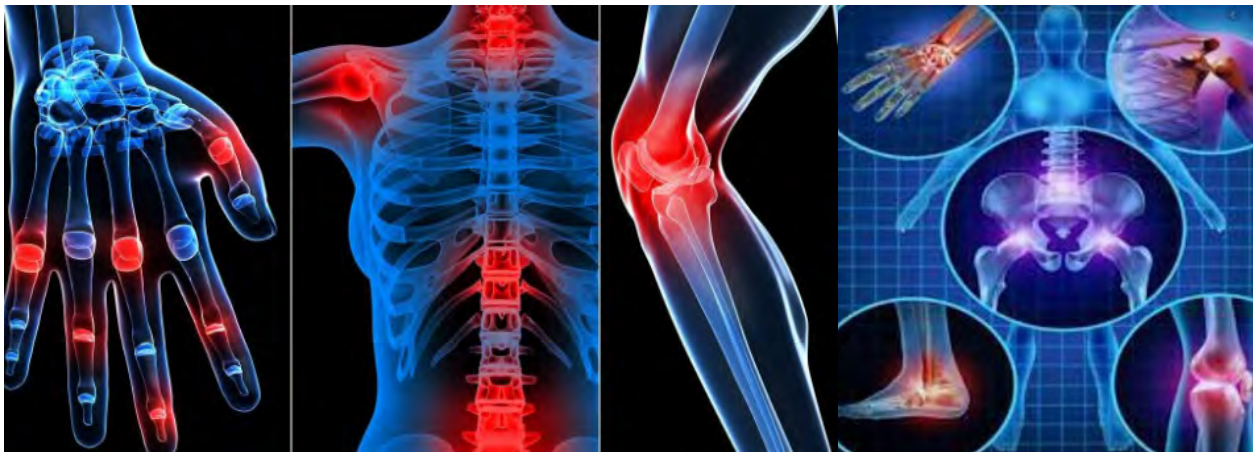
- 4 new patients identified as Pasifika

PROGRAMME NARRATIVE

- Erana Gray joined the Infectious Diseases service as a second SMO in January 2019
- There was a Tuberculosis (TB) outbreak in Motueka and Tasman in December 2019 to January 2020 – extra funding was provided by Nelson Marlborough Health for the Infectious Diseases service to help manage this
- COVID-19 affected our region from March to June 2020 – extra funding was provided by Nelson Marlborough Health for the Infectious Diseases service during this pandemic response. Erana Gray managed the hospital infection prevention and control issues and Richard Everts managed the community infection prevention and control issues. Some non COVID-19 projects were postponed but clinical work continued
- The after-hours Infectious Diseases service ceased in 2019. Some support for the infectious diseases service from Medlab South stopped in March 2020
- Workload has grown again above the funded hours and as a result, antibiotic stewardship activities have not been able to be prioritised, including antibiotic teaching, audit and guideline development
- The COVID-19 outbreak highlighted a potential for increased input into community infection prevention and control

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 practitioner 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 continues to experience change, especially with the advent of COVID-19 and the resulting lockdown. As a team we utilised this time very successfully. We used Telehealth to continue meeting the appointments that were already in place. Any spare time was used to review patient files. A significant number of patients had moved from the district without notification and could therefore be discharged from the service. Many others had elected to not begin any form of treatment, a prolonged period of time had elapsed and no further correspondence had been received from the general practitioner. Therefore, a letter was written to the patient and their general practitioner advising of the intent to discharge the patient from this service. Other patients who were overdue appointments were called and returned to the system or discharged as per clinical evaluation.

Staffing has improved with the addition of a part-time typist which has improved communication turnaround time. There is still a backlog effect due to the processes required for final letter delivery, but this is being addressed with the coming implementation of a patient management system.

There remains a significant number of patients on the follow-up wait-list, but we continue to work towards review of patients and returning patients back to their own general practitioner wherever suitable.

Dr Peter Jones,
Rheumatologist Specialist

Janet Evans,
Rheumatology
Clinical Nurse Specialist

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2017/2018		2018/2019		2019/2020	
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	90 days	90 days
• Average time for follow up appointments	18 months	18 months	18 months	18 months	18 months	18 months
• Number of clients seen: – First specialist appointment	366	147	367	141	371	137
– Follow up appointments	1,127	479	1,065	408	1,319	261
– Compliance to meet the 100% Ministry target	80%	100%	100%	95%	99%	99%
– Number of General Practitioners with Special Interest within service	5	2	4	2	4	2
Total Referrals	**Nelson**	**Marlborough**	**Nelson**	**Marlborough**	**Nelson**	**Marlborough**
• Age breakdown:						
– 10-19 years	2	8	2	9	7	5
– 20-30 years	2	27	2	28	57	31
– 30-40 years	13	58	10	40	182	51
– 40-50 years	9	83	8	70	224	64
– 50-59 years	3	107	2	112	360	115
– 60-69 years	3	114	3	111	415	121
– 70-79 years	4	70	3	70	316	98
– 80 + years	2	8	1	37	87	28
Treatments and Referrals						
• Biologics usage (number of Patients)	182		176		160	
• Infusions	5		13		15	

Continues over...

Rheumatology Specialist Service Continued

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
Number of referrals made to:			
• Pain service	8	12	25
• Green Prescription	4	15	4
• Brief Intervention service	2	1	0
• Physiotherapy and hand therapy	14	40	53
• Dietitian	4	1	2
• Orthotics service	0	8	15
• Orthopaedics	3	6	22
• Kaiatawhai service	0	0	2
• TBI health	0	0	2

TARGETS

- Provide 500 first specialist appointments. There were 484 provided
- Provide 1,150 follow up appointments. There were 1,459 were provided

MĀORI HEALTH ACTIVITIES

- 32 of the referrals identified as Māori
- The first gout clinic was held at Te Piki Oranga and this was very well received with requests for further clinics, which are currently being arranged. There is provision for further education of staff and patients alike
- Fast-track referral system in place for Māori Health Providers, for a specialist nurse review. One patient fast tracked with excellent patient outcome

Strategic Initiatives

Health Care Home Model

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 general 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.

There are currently 14 general practices (11 in Nelson Bays, 3 in Marlborough) involved in the Health Care Home model. All general practices 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 MEASUREMENT	2017/2018	2018/2019	2019/2020
Service Outcomes			
• Number of general practices engaged	*	• Five general practices district wide (Stoke Medical; The Doctors Motueka; Greenwood Health; Omaka Health Centre and Civic Health)	• 14 General Practices district wide – Tranche One commenced October 2018 – Tranche Two A commenced August 2019 (Springlands, Tahunanui, Mapua, Golden Bay) – Tranche Two B commenced January 2020 (Wakefield Health Centre, Harley Street Medical, – St Lukes, Medical and Injury Centre and Toi Toi)
• Clinical Assessment and Treatment (GP 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)	• All 14 general practices are are offering a triaging system for their urgent appointment requests and promoting alternative to face to face consultations when appropriate
• A fully functional Patient Portal	•	• 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	• Across all tranches 32% of eligible patients have activated their portal • Within Tranche One there has been an average growth of patients actively using their portal by 67% since 2018, Tranche Two A has seen an average growth of 25% since 2019
• Percentage of population	*	• 37,625 enrolled patients (26% of the district's enrolled population are involved with the Health Care Home programme)	• 59% of the enrolled population is enrolled in a general practice participating in Health Care Home (89,212 district wide) • These general practices work with 54% of our enrolled Māori population (7,877 district wide)

**New service to Nelson Bays Primary Health in 2018/19.*

Continues over...

Health Care Home Model Continued

PROVIDER AND PATIENT FEEDBACK

"General practitioner triage *has reduced the double bookings and increased access for on the day appointments. Patients are accessing the right person the first time to best meet their needs without having to come into the practice each time."* – lead nurse

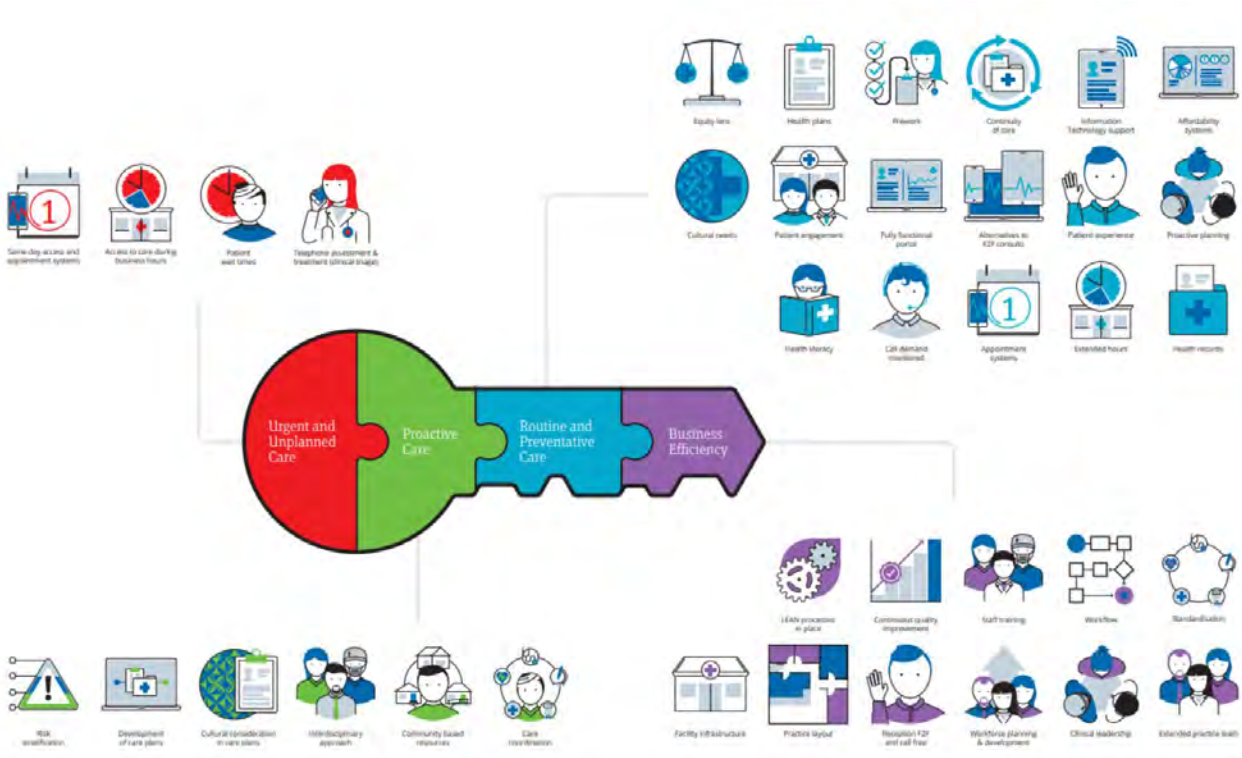
Process mapping – *"We have refined and improved efficiency in quite a few areas of our everyday practice through our process mapping sessions. This has identified efficiencies which reduces workload and frees us up to provide better care."* – lead nurse

Clinical Triage *"Thank you for having the time to see me today, I really appreciate it and am impressed with how well the phone process worked when I was called back, asked about my concerns and sorting an appointment."* – patient talking about the nurse completing a phone triage appointment and booking a general practitioner

Portal – *"I just love being able to book appointments and look at my results on the portal and I've missed not being able to do this." Was then asked if he found My Indici better than Manage My Health and he said – "It is way better, much easier to use."* – 83 year old patient

"Extended hours *'I appreciated the ability to attend the evening clinics."* – patient

HEALTH CARE SUMMARY STATISTICS



VIP – Vulnerable Populations Project

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 general practice and pharmacy vouchers to those identified as vulnerable with an unmet health need
- To repay general practice debt of up to $150 if this is a barrier to accessing general practice
- To support travel for the identified person to attend health 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 group defined what 'vulnerable' meant, so for the purpose of this project, the group agreed on: anyone at any time with an unmet primary health need.

Gaps were then identified 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 agencies based in the community, who have general practice and pharmacy vouchers to issue
- The lead agencies are:
  - Salvation Army, Nelson
  - Motueka Community House, Motueka
  - Mohua Social Services, Golden Bay
  - Victory Community Centre
- The lead 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 general practice to manage this. There is a one-off opportunity to clear $150 of patient debt if identified
  - Provide travel assistance if identified as a barrier
  - Identify any dental health needs and support applications to Fifeshire Foundation to fund dental work needed
- In December 2019, virtual vouchers were made available for general practice to access, allowing for 'any door is the right door' if patients needed this support

SERVICE OUTCOMES/SUCCESS STORIES

"When the client is willing and the need identified, we have referred to counselling, budget advice, Positive Lifestyle Programme and the Women's Centre etc." – lead agency

"Voucher requests have declined since general practices have access to virtual vouchers. However, vouchers are still very valuable for those disconnected from general practices who come to us or are referred here by others." – lead agency

Most of our families are now connected to the local general practice and last year's work of assisting people to gain a community services card means the doctor is now more affordable to our community. Creating sustainability and affordability." – lead agency

"There is a noticeable increase in clients engaging with general practices and showing less anxieties or embarrassment about debt, than we previously saw." – lead agency

"The VIP virtual general practice voucher has been a wonderful help for us and our patients, it's a really great initiative one that has helped us to claim patient debt (often very high) and has allowed us to re-engage with our patients and they are all mostly signing re direction of benefit forms so they don't get into the same situation again" – general practice

Continues over...

VIP – Vulnerable Populations Project Continued

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	from January 2019	July 2019 – June 2020
Number of general practice and pharmacy vouchers issued:		
• Lead agency	240	197
• Virtual voucher (issued by general practice)	N/A	211 **Total: 408**
Ethnicity of those using a general practice voucher		
• Māori	42	114
• Pacific	2	20
• NZ European	137	237
• Other	7	37
• Number with existing debt at general practice	43	254
• Number with community services card	67	277
Total number of vouchers presented to pharmacy	145	121
Ethnicity of those using a pharmacy voucher		
• Māori	15	33
• Pacific	1	3
• New Zealand European	125	62
• Other	4	23
Lead Agency supporting:		
• Number of un-enrolled people to enrol	17	9
• Funding travel to get to appointments	28	62
• Dental applications to Fifeshire Foundation	18	25

NOTES:
- *A pharmacy voucher and a general practice voucher are issued at the same time. However, not all people will use or need a pharmacy prescription voucher*
- *Lead agencies provide a whānau ora type service where they can refer onto budget advice and/or other support services as agreed with the person and their priority needs*

PRESS RELEASE FROM: THE FEDERATION OF PRIMARY HEALTH AOTEAROA 26 MAY 2020

Federation of Primary Health Aotearoa New Zealand
Kia hauora a Aotearoa

"The Vulnerable Population Project from Nelson Bays Primary Health is just one example of how integrated health networks are successfully delivering better outcomes in pockets of our communities," say Hefford. "This initiative sees lead community agencies delivering medical centre, pharmacy and dental consult vouchers to reduce access barriers for priority populations within a wraparound service depending on need."

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 flexi beds unit also offers day stay procedures such as infusions and chemotherapy.

We welcome the mobile surgical bus three times a year that performs surgical procedures for our community with visiting surgeons and anaesthetists. The nursing team assist on the bus and with pre and post-operative care. In addition to this service we also have a range of visiting specialists and the mobile breast screening bus.

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%

Residents enjoying activities provided by staff and volunteers at Golden Bay Community Health.

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	2017/2018			2018/2019			2019/2020		
To provide safe and holistic care in accordance with aged residential care standards									
• Achieve and maintain aged residential care credentialing	Compliant			Audit Completed in March 2019. Recommendations to be received by August 2019.			Compliant		
• Compare and benchmark national performance indicators against Australian performance	**Falls**	**Pressure Areas**	**Medication Errors**	**Falls**	**Pressure Areas**	**Medication Errors**	**Falls**	**Pressure Areas**	**Medication Errors**
	43	2	6	38	2	6	94	0	10
	Benchmarking against Australian standards indicates we compare favourably in the above areas			Benchmarking against Australian standards indicates we compare favourably in the above areas			Benchmarking through a new system		
• Number of complaints	3			2			2		
• Number of residents transferred to Nelson Marlborough Health or other facilities	No aged care residents were transferred during this period			No aged care residents were transferred during this period			2		

Continues over...

Aged Residential Care Continued

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
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	• Achieved benchmarking for quality of liife • Resident satisfaction survey completed March 2020
To ensure staff are well trained and competent to provide high quality of care to the residents			
• Number of staff completed mandatory educational	• 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)	• Registered nurses: 6/14 • Health care assistants: 14/27 (Next update is September 2020 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 2: 2 completed • Level 3: 2 completed 2 underway • Level 4: 5 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	• none
• Number of staff appraisals completed	**Registered Nurses** 8/11 / **Health Care Assistants** 21/26	**Registered Nurses** 24/27 / **Health Care Assistants** 23/29	**Registered Nurses** 2/14 / **Health Care Assistants** 13/27
To maintain residential occupancy over 90%			
• Average occupancy percentage	93%	96%	97%
• Gender and ethnicity	**Māori** 1 / **Non-Māori** 23	**Māori** 1 / **Non-Māori** 21	**Māori** 1 / **Non-Māori** 22
	Male 5 / **Female** 19	**Male** 5 / **Female** 17	**Male** 6 / **Female** 17
• Occupancy	63 vacant bed days	88 vacant bed days	11 vacant bed days
• Average length of stay	27 months	26 months	25 months
• Number of respite days/year	348	212	199
• Number of people on waiting list	14	16	25

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	2017/2018	2018/2019	2019/2020
To provide nursing expertise to residents of Golden Bay for the provision of care in the home			
• Number of patients enrolled in the service	197	177	160
• Number of contacts	4,427	4,968	3,807
• Ethnicity and gender of enrolled patients	**Māori** 5; **Non-Māori** 192; **Male** 87; **Female** 110	**Māori** 1; **Non-Māori** 176; **Male** 90; **Female** 87	**Māori** 2; **Non-Māori** 158; **Male** 82; **Female** 78
To provide specialised nursing service to palliative care patients and their whānau			
• Number of palliative patients enrolled into service	6	4	14
• Ethnicity of palliative patients	**Māori** 1; **Non-Māori** 5	**Māori** 2; **Non-Māori** 2	**Māori** 0; **Non-Māori** 14
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	31
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 • Two staff completed Advanced Care Planning Training	• 1 staff undertaking Post Graduate wound care • 2 staff undertaking advanced wound debridement course
• Number of education sessions	• 44 education sessions held		• 78 education sessions held
• Number attending national/international conferences	• One staff member attended the national palliative care conference	• Two staff members care attended the Australasian wound conference	• One staff member attended wound care conference in Dunedin

Flexi Beds

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

OBJECTIVE

- To provide an acute/urgent 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	2017/2018				2018/2019				2019/2020			
To provide an acute care service to adults in Golden Bay to reduce transfers to Nelson Hospital												
• Number of acute admissions (excludes respites)	314				289				164			
• Age, gender and ethnicity of admissions	**Male** 150		**Female** 164		**Male** 129		**Female** 160		**Male** 69		**Female** 95	
	Māori 9		**Non Māori** 305		**Māori** 15		**Non Māori** 274		**Māori** 4		**Non Māori** 160	
	<40 24	**41-60** 51	**61-80** 117	**>80** 122	**<40** 55	**41-60** 52	**61-80** 95	**>80** 87	**<40** 19	**41-60** 43	**61-80** 59	**>80** 43
• Transfer of acute admissions to Nelson Hospital	28				32				19			
• Number and type of infusion/transfusion	**Iron**	**Pamidronate**	**Blood/blood products**		**Iron**	**Pamidronate**	**Blood/blood products**		**Iron**	**Pamidronate**	**Blood/blood products**	
	22	8	7		34	3	11		2	1	2	

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
To develop and support the provision of chemotherapy services for the Bay			
• Number of chemotherapy/ biological administered	35	0	25
• Number and type of infusion reactions	1	0	1
To facilitate the provision of surgical services close to home by supporting the mobile surgical bus			
• Number of patients	18 Two clinics cancelled – one due to Takaka Hill closure and one due to insufficient appropriate patients on surgical list	40	22 Two clinics cancelled – one due to Takaka Hill roading repairs and one due to COVID-19

There were 164 acute admissions in Golden Bay (in 2019/20) diverting transfers to Nelson Hospital

Midwifery Services

PURPOSE To provide safe, effective and holistic care for women and their whānau throughout their pregnancy.

OBJECTIVE

- To assist women with the birth of their babies at either the Golden Bay Community Health Maternity Unit or at their homes, or place of choice
- To facilitate access to appropriate support services within the community
- To facilitate access to specialists if required
- To offer support postnatally in the women's home

SERVICE OVERVIEW

The Midwifery Service has been under the umbrella of Golden Bay Community Health since July 2018.

This service provides 24 hour on call care for all woman and their whānau throughout their pregnancy, to ensure their birth experience matches their wishes, while also monitoring and keeping them informed so they can make the best decisions.

Developing relationships is crucial during this time to provide the care that is right for each individual and their family.

Support for after the birth of a baby is also offered, with a focus on how mum is transitioning physically and emotionally after the birth of the baby, supporting breastfeeding and monitoring the growth and development of the newborn up to 6 weeks old.

How well did we do?

KEY PERFORMANCE INDICATORS

Over the past year we have assisted at the birth of 23 babies at the Golden Bay Community Health maternity unit and 10 babies in their own home environments.

Some women are required to, or choose to have their babies at Nelson Hospital. We provide antenatal care prior to the birth and postnatal care after the birth of baby. In the last year, we provided care for 19 women who birthed in Nelson.

Occupational Therapy

PURPOSE Occupational Therapists work with people who may have an illness or a disability, to help them take part in everyday life. They consider the person's physical, mental, emotional, cultural, social and spiritual needs.

OBJECTIVE

To work with the person and their whanau to improve their abilities by learning practicing skills, or by adapting their environment e.g. providing advice on equipment or recommending housing alterations.

OVERVIEW

At Golden Bay Community Health, the Occupational Therapist assists people with disabilities to gain or maintain independence with activities of daily living. Services include:

- Assessment of daily living skills including showering, wheelchair/seating, and moving around the house
- Assessment of how a person thinks and processes information and ways of improving their abilities in order to complete tasks
- Identifying the need for equipment – the Occupational Therapist will advise on the most appropriate equipment for the client's needs, they can apply for Ministry of Health funding (through Enable New Zealand) for equipment if clients meet eligible criteria. Equipment can include wheelchairs/seating, and housing modifications

PATIENT REFERRALS FOR JULY 2019 TO JUNE 2020:

Month	Number	Month	Number
July 2019	12	January 2020	18
August 2019	18	February 2020	16
September 2019	24	March 2020	20
October 2019	22	April 2020	8
November 2019	23	May 2020	10
December 2019	13	June 2020	16

Hello, my name is Kate Windle. I have been working as a Community Occupational Therapist in Golden Bay for the past 18 years. I work part time: Monday to Wednesday.
You can self-refer or get another health professional to complete a referral to our service. The service is free of charge.

Primary Care

PURPOSE To provide primary care services to the population of Golden Bay by highly skilled staff including; 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. From Monday to Friday, 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	2017/2018		2018/2019		2019/2020	
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%		94%	
– Brief smoking (target 90%)	92%		89%		86%	
– Diabetes annual review (target 90%)	73%		58%		52%	
• Number registered and using our patient portal "My Incidi"	**Registered** 1,194	**Activated** 1,040	**Registered** 1,538	**Activated** 1,315	**Registered** 2,428	**Activated** 1,465
• Waiting room times (average)	29 minutes		24 minutes		21 minutes	
• Current number of enrolled patients	4,980		4,955		5,001	
• Ethnicity of enrolled population	**Māori** 306	**Non-Māori** 4,674	**Māori** 299	**Non-Māori** 4,656	**Māori** 323	**Non-Māori** 4678

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
To expand service options to ensure greater choice for the community to receive care closer to home			
• New initiatives for care provided	• Supported youth hub development • Implementation of medical assistance roles	• Telehealth consultations • Accepted for Health Care Home model	• Virual phone and video consultations now offered as well as in person visits
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%	296 registrations * patient management system is unable to tell us percentage
• Options for care	100%	95%	77%
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	7
– Immunisations	6	6	7
– Cervical smear	5	4	4
• Number attending national / international conferences	4	4	5
Community of Golden Bay are satisfied with the service provided at Golden Bay Community Health			
• Number of complaints/ resolved	21/21	24/25	7/8
To continue to strengthen an integrated approach to health care provision			
• Specialist primary clinics provided on site	• Dietitian • Podiatrist • Ear health nurse • Newborn hearing screen • Mole map • Breast screen mobile services • Palliative nurse practitioner • Alcohol and drug nurse specialist	• Dietitian • Podiatrist • Ear health nurse • Newborn 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	• Dietitian • Podiatrist • Ear health nurse • Newborn 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	117

Continues over...

Primary Care Continued

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
To ensure 24 hour access to medical services			
• Number of afterhours general practitioner consultations (includes weekend clinics)	1,063	1,118	720 Weekend clinics stopped during the covid period
• Number of primary response in medical emergency callouts	24	122	24

Car park clinic during COVID-19 pandemic.

Well Child Services

PURPOSE To provide well child services for Golden Bay.

OBJECTIVE

- To protect and safeguard the rights and wellbeing of children and young people
- To promote wellbeing and support for family/whānau of children and young people within the service and Golden Bay
- To ensure staff are adequately trained and supported to deliver a high standard of service
- To maintain contractual service delivery in the National Service Framework Library meeting the needs of children/young people and their family/whānau

SERVICE OVERVIEW

The well child/public health service provides an excellent and valuable service within Golden Bay to cover all core well child checks, health promotion, B4 school checks, immunisation and Tamariki Ora services for children age 6 weeks – 5 years. The public health component provides support to children and young people within the community. All services are provided free of charge to service users via a range of appointment types including telephone, video, clinic, school, community based and home visits.

Big Latch On – breastfeeding event held at Collingwood Playcentre and organised in conjunction with Playcentre.

Continues over...

Well Child Services Continued

How well did we do?

KEY PERFORMANCE INDICATORS

Events Held

- Big Latch On – breastfeeding event held at Collingwood Playcentre – organised in conjunction with Playcentre
- Parenting Seminar – 0 to 5 years old, normal development and managing behaviour, promoted Well Child service. Included Plunket parenting speaker from Motueka, successful event

Provided

- B4 School Checks with onward referrals to appropriate services as needed
- All core checks for all enrolled children within Ministry of Health time frames, despite COVID-19
- Home visits to all new babies and other families with extra needs
- Ensured all children enrolled in our service up to date with vaccines (excluding those declining)
- Clinics at Collingwood Playcentre and at the Collingwood Medical Centre to cater for families in western Golden Bay area
- Support in conjunction with Mohua Social Services, for vulnerable families
- Community liaison with facilitators of Parent to Parent and SPACE group
- In depth support for 3 high needs babies with complex needs
- Vaccinations via drive through clinics during lockdown (that usually occur in School)
- Currently working with other community leaders to implement a Parenting Program for Golden Bay

Parenting Seminar – 0 to 5 years old,

> **The well child/public health service provides an excellent and valuable service within Golden Bay.**

PROGRAMME MEASUREMENT	2017/2018	2018/2019	2019/2020
To provide safe and holistic well child care			
• Clinics held	*	*	118
• Children seen	*	*	507
• Enrolled children for the period			315
• New babies enrolled			51
• Education sessions provided	*	*	• Two Boostrix and HPV vaccine education sessions • One Parenting Seminar
• Meetings attended	*	*	• Strengthening Families • Family group conferences • Care and protection panel • Quarterly Rural Well Child Nurse • Monthly interagency meetings
To ensure staff are well trained and competence to provide high quality of care			
Staff professional development and training	*	*	• One staff completed certificate in Primary Health Nursing (Well Child) • Completed training as authorised vaccinators • Attended child protection training • Attended Plunket education days

**New measurements for 2019/20 no data available for previous financial years.*

Financial Reports

Nelson Bays Primary Health Trust

Summary Statement of Comprehensive Revenue and Expense

for the Year Ended 30 June 2020

	2020 $	2019 $
REVENUE		
Exchange		
Patient fees	712,226	704,636
Age Related care	1,514,608	1,490,045
Non-Exchange		
Hospital Funding	3,106,669	2,827,560
Management Services	1,044,333	835,303
Primary Care Contract Services	31,342,679	26,682,341
Other	275,914	247,162
Total Revenue	**37,996,429**	**32,787,047**
LESS EXPENSES		
Accounting and Audit	24,520	23,853
Office & Organisation Expenses	1,746,886	1,633,735
Board Expenses	161,330	149,656
Staffing Expenses	1,454,618	1,299,108
Primary Care Services	28,439,215	24,161,798
Golden Bay Community Health	6,438,954	5,638,458
Total Operating Expenses	**38,265,523**	**32,906,608**
Surplus / (Deficit) before interest	**(269,094)**	**(119,561)**
Finance income - Interest received	92,459	121,104
Finance income - Interest received	92,459	121,104
Surplus / (Deficit) for the year	**(176,635)**	**1,543**
Total comprehensive revenue and expense for the year	**(176,635)**	**1,543**

NOTE:	2020 $	2019 $
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.	182,135	(132,185)
Share of profit/(loss) from Joint Venture and interest received	87,859	151,716
Remaining surplus/(deficit)	(446,629)	(17,988)
NET SURPLUS	**(176,635)**	**1,543**

This Statement has been prepared on the basis as described on page 117

Nelson Bays Primary Health Trust

Summary Statement of Changes in Equity

for the Year Ended 30 June 2020

	Committed Funding Reserve	Retained Earnings	Total Equity
Balance as at 1 July 2018	2,429,145	1,393,074	3,822,219
Net surplus / total comprehensive revenue and expense	-	1,543	1,543
Transfer from Committed Funding Reserve	(132,185)	132,185	-
Balance at 30 June 2019	**2,296,960**	**1,526,802**	**3,823,762**
Balance as at 1 July 2019	2,296,960	1,526,802	3,823,762
Net surplus / total comprehensive revenue and expense	-	(176,635)	(176,635)
Transfer to Committed Funding Reserve	182,135	(182,135)	-
Balance at 30 June 2020	**2,479,095**	**1,168,032**	**3,647,127**

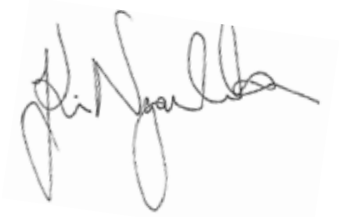
This Statement has been prepared on the basis as described on page 117

Nelson Bays Primary Health Trust
Summary Statement of Financial Position
as at 30 June 2020

	2020 $	2019 $
CURRENT ASSETS		
Cash and cash equivalents	1,009,465	631,901
Investments	3,012,779	3,547,400
Receivables and Prepayments	1,740,155	1,155,218
Total Current Assets	**5,762,399**	**5,334,519**
CURRENT LIABILITIES		
Payables	1,405,989	1,010,619
Employee benefits	1,153,872	914,199
Total Current Liabilities	**2,559,861**	**1,924,818**
WORKING CAPITAL	**3,202,538**	**3,409,701**
NON-CURRENT ASSETS		
Plant, Property & Equipment	622,023	568,666
TERM LIABILITIES	**177,434**	**154,605**
NET ASSETS	**3,647,127**	**3,823,762**
Represented by:		
Committed Funding Reserve	2,479,095	2,296,960
Retained Earnings	1,168,032	1,526,802
EQUITY	**3,647,127**	**3,823,762**

11 September 2020

Trustee:
Dated:



Trustee:
Dated:

This Statement has been prepared on the basis as described on page 117

Nelson Bays Primary Health Trust
Summary Statement of Cash Flows
for the Year Ended 30 June 2020

	2020 $	2019 $
Net cash flows from operating activities	110,630	75,820
Net cash flows from investing activities	266,934	(22,616)
Net increase / (decrease) in cash and cash equivalents	**377,564**	**53,204**
Cash and cash equivalents at beginning of period	631,901	578,697
Cash and cash equivalents at end of period	1,009,465	631,901

This Statement has been prepared on the basis as described on page 117

Nelson Bays Primary Health Trust
Notes to the Summary Financial Statements
for the Year Ended 30 June 2020

The summary financial statements for Nelson Bays Primary Health Trust for the year ended 30 June 2020 have been extracted from the full financial statements. The full financial statements were approved by the Board on 11 September 2020. 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 ("PBE Standards"), as appropriate for Tier 1 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 2020 financial statements. (2019: 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 2020, 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 2020. We expressed an unmodified audit opinion on those financial statements in our report dated 11 September 2020.

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 2020 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
11 September 2020

Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

Kia piki te ora o ngā tāngata katoa