Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

Te Pūrongo ā Tau Annual Report

JULY 2020 - JUNE 2021

Hapū Ora

Wāhi mahi ora

Hapori Ora

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

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

Hauora Matua ki Te Tai Aorere (Nelson Bays Primary Health) operates as a Charitable Trust.

Nelson Bays Primary Health is a primary health provider and commissioning network for primary and community service in the Nelson Bays region. Nelson Bays Primary Health operates as a Charitable Trust, incorporated in 2004.

Nelson Bays Primary Health is an organisation which is committed to the delivery of primary and community health and embedded in its principles are:

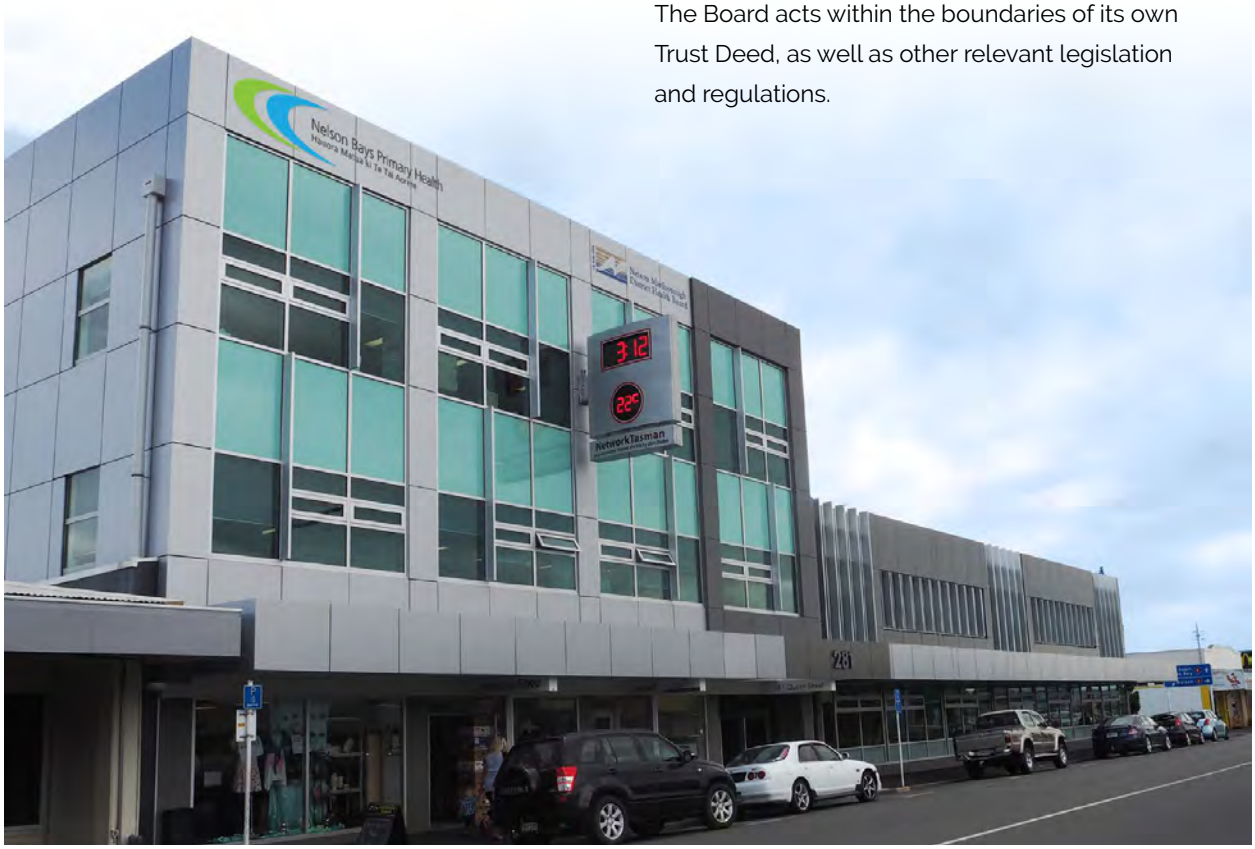
- Te Tiriti o Waitangi and focused in equity
- Centered in its people and communities
- Accessible primary health care
- Integrated primary and community care
- A strong primary and general practice partnership
- Strong and supportive networks with community and community non-government organisations and cross government partnership

Healthy people, healthy workforce, healthy community

The Nelson Bays Primary Health Board is made up of community, Māori and health 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
- 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.



General Practices

The 22 general practices contracted to Nelson Bays Primary Health during 2020/21 are as follows:

NELSON

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

MAPUA, MOTUEKA, GOLDEN BAY

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

RICHMOND, WAKEFIELD

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

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 2020/21 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 2020/21, 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

Manaakitanga Integrity	Rangatiratanga Excellence	Whānaungatanga Respect	Mātauranga Innovation	Wairuatanga Inclusion

STRATEGIES

PROTECTION HEALTHY PEOPLE

A. Support healthy living in the home
B. Ensure health information is accessible and understandable
C. Promote and support strong clinical governance and leadership
D. Ensure service planning and include consumer and community involvement
E. Ensure legal obligations are adhered to

PARTICIPATION HEALTHY WORKFORCE

A. Implement best practice governance, cultural competency and management
B. Work in partnerships to avoid duplication of services
C. Enable our workforce to operate at the top of their scope
D. Ensure sustainable and high quality service provision across the region
E. Focus on prevention, early detection and self-management to reduce disease progression

PARTNERSHIP HEALTHY COMMUNITY

A. Work in partnership with our key communities to ensure an inclusive whole-of-system approach
B. Address inequalities and gaps in services, particularly for our most vulnerable and high needs populations
C. Achieve all relevant health targets and indicators
D. Support evidenced-based models of care that have proven health outcomes

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

Manaakitanga Integrity	Rangatiratanga Excellence	Whānaungatanga Respect	Mātauranga Innovation	Wairuatanga Inclusion

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

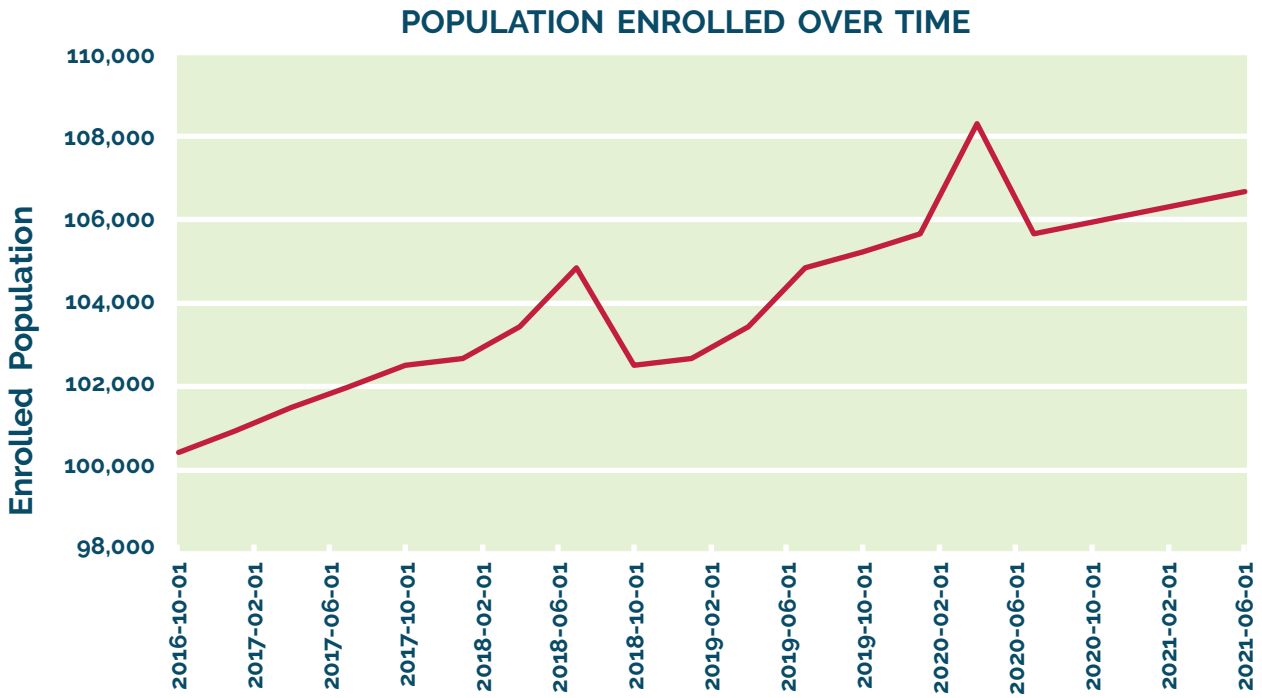
At the end of June 2021, 106,764 people were enrolled with Nelson Bays Primary Health.

NELSON BAYS PRIMARY HEALTH

Population enrolled over time

QUARTER	TOTAL POPULATION	% CHANGE
2021-07-01	106,764	0.32%
2021-04-01	106,420	0.18%
2021-01-01	106,230	0.34%
2020-10-01	105,867	0.20%
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%

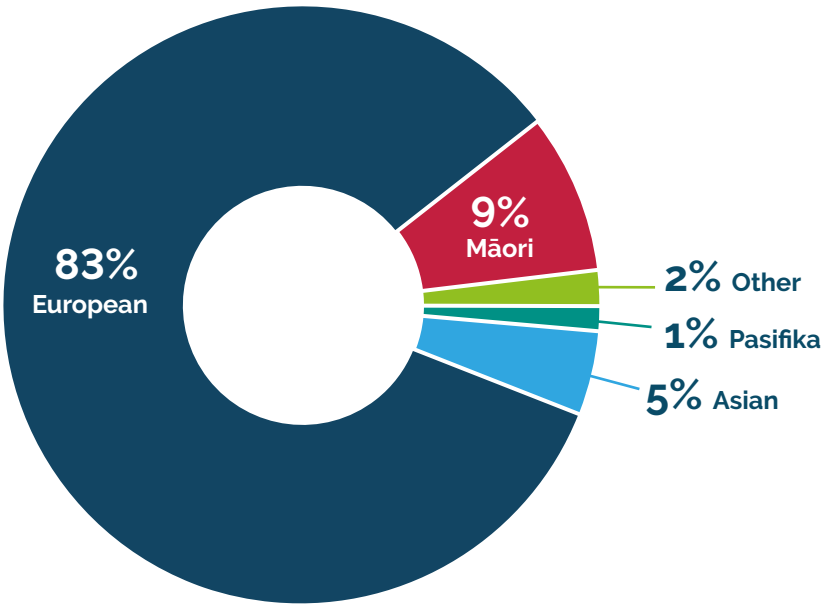
QUARTER	TOTAL POPULATION	% CHANGE
2019-01-01	102,670	0.15%
2018-10-01	102,519	-2.22%
2018-07-01	104,842	1.36%
2018-04-01	103,431	0.74%
2018-01-01	102,670	0.15%
2017-10-01	102,519	0.52%
2017-07-01	101,989	0.47%
2017-04-01	101,507	0.56%
2017-01-01	100,940	0.52%
2016-10-01	100,420	



NELSON BAYS
PRIMARY HEALTH

Ethnicity

ETHNICITY	NUMBER	PERCENTAGE
Asian	4,881	5%
European	89,116	83%
Māori	9,252	9%
Other	2,075	2%
Pasifika	1,440	1%
TOTAL	**106,764**	**100%**

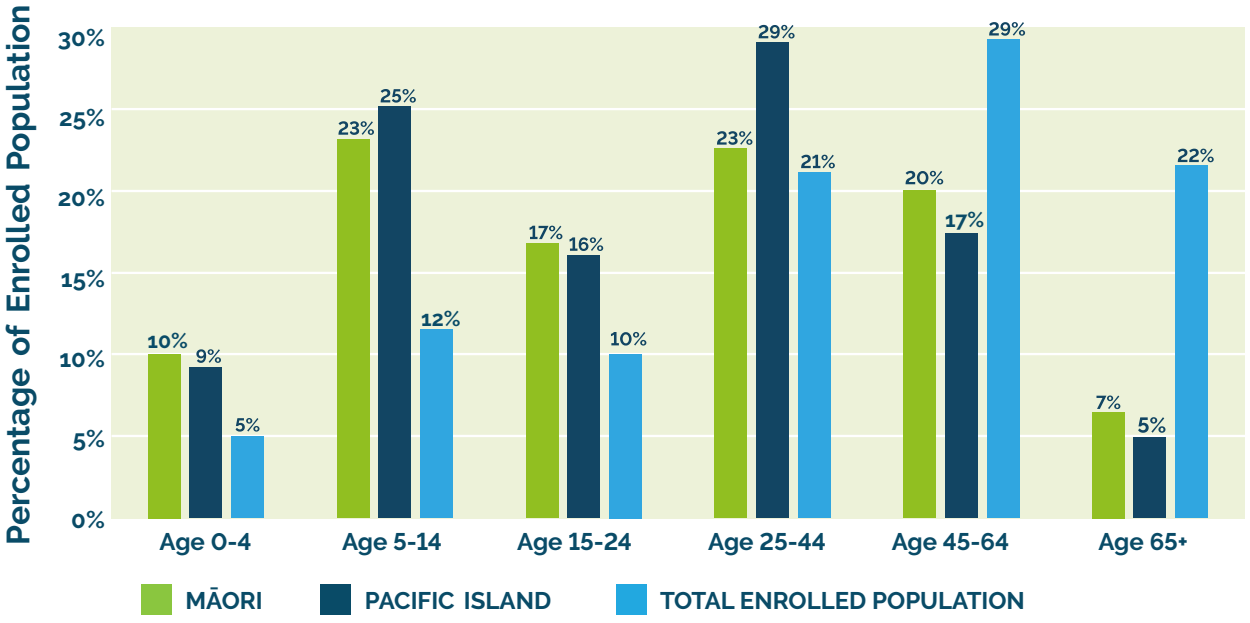


Nelson Bays

Enrolled Population

NELSON BAYS PRIMARY HEALTH

Age group percentage of enrolled population

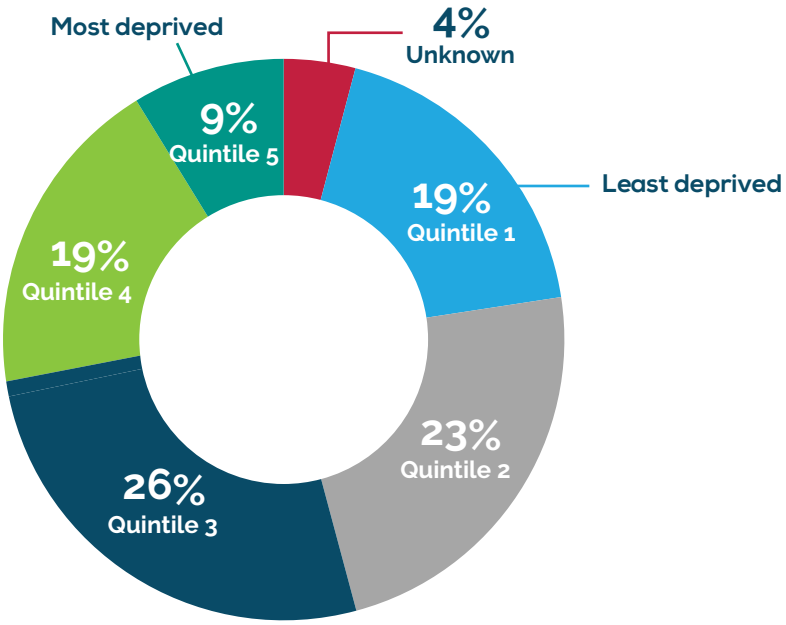


AGE	MĀORI	PERCENTAGE	PACIFIC ISLAND	PERCENTAGE	TOTAL ENROLLED POPULATION	PERCENTAGE
00-04	968	10%	126	9%	5,155	5%
05-14	2,113	23%	355	25%	13,211	12%
15-24	1,533	17%	224	16%	10,995	10%
25-44	2,148	23%	412	29%	22,752	21%
45-64	1,884	20%	250	16%	30,969	29%
65+	606	7%	73	5%	23,682	23%
TOTAL	**9,252**	**100%**	**1,440**	**100%**	**106,764**	**100%**

NELSON BAYS
PRIMARY HEALTH

Deprivation by quintile

QUINTILE	NUMBER	PERCENTAGE
Unknown	3,888	4%
1 (Least Deprived)	20,170	19%
2	24,873	23%
3	28,244	26%
4	20,447	19%
5 (Most Deprived)	9,142	9%
TOTAL	**106,764**	**100%**



Chairperson's and Chief Executive's Report

Mihi ki te rangi

Mihi ki te whenua

Mihi ki te hunga mate

Mihi ki te hunga ora

Haumi e hui e – Tāiki e!

On behalf of the Board and Chief Executive of Hauora Matua ki Te Tai Aorere (Nelson Bays Primary Health), we have pleasure in presenting the Annual Report and audited financial statements for the year ended 30 June 2021.

As we reflect on this last year, many words come to mind. For the organisation, adaptability and challenge are just a few. It has been an exceptionally busy one in health, but Nelson Bays Primary Health has demonstrated its partnerships across the many aspects of health and community services. And notwithstanding the challenges of the year, we have continued to strive to meet our commitment to health and wellbeing for our community.

BOARD MEMBERS 2020/2021

Sarah-Jane Weir
INDEPENDENT CHAIRPERSON

Kim Ngawhika
DEPUTY CHAIRPERSON/ MĀORI REPRESENTATIVE

Blair Carpenter
COMMUNITY REPRESENTATIVE

Carol Hippolite
MĀORI REPRESENTATIVE

The Annual Report 2020/21 provides an overview of the connected health services we have delivered over the last year to our community. We are proud of the role that we play in delivering primary care in our region and of the role of primary care in delivering health outcomes to our community. We know that the closer to home we can deliver services and the more integrated health is with over all wellbeing, the better.

We do not have to go far in our region to see an example of a connected integrated health care model – Golden Bay Community Health. This rural health service has demonstrated its leadership in accessible health care and enhanced delivery model enabled by telehealth. The service has responded by leading changing models of care and taking up the challenge of delivering to Mohua (Golden Bay) communities which previously the community would have had to travel some distance to receive.

It is important to acknowledge the tremendous pressures on many of those working in primary health, with longer working hours, complexity of health needs, closed borders leading to staffing shortages and constrained funding (to name but a few). This is reflected particularly in general practice where many of the general practice teams, general practitioners, nursing staff and administrators describe significant pressure in the workload every day.

As we signaled that at the start of the financial year, we ran at a small loss for the year due to the rollout of the strategic health initiatives we have informed you about in past Annual Reports. In particular, we continue to support the Health Care Home initiative and have invested into DataCraft to ensure our ability to capture quality data from our general practice network. However, the financial strength of Nelson Bays Primary Health is demonstrated by its balance sheet at set out in the Annual Report. We continue to operate as a going concern and we note that once again we are budgeting for a small loss in the upcoming year as we strengthen our services and our organisation to play our part in meeting both the significant health challenges and opportunities that lie ahead.

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Debbie Harrison
PROVIDER
REPRESENTATIVE

Graham Loveridge
PROVIDER
REPRESENTATIVE

Helen Kingston
COMMUNITY
REPRESENTATIVE

Sarah Green
PROVIDER
REPRESENTATIVE

There can of course be no review of the past year without reference to the ongoing effects of the COVID-19 pandemic. For us, it has meant continuing to provide the primary care and community response to ensure our communities are safe. This COVID-19 programme of testing and immunisation is an example of the resiliency and strength of our integrated partnerships in health care with Nelson Marlborough Health, Marlborough Primary Health and Te Piki Oranga.

This past year also saw the government announce and begin to implement the major health care reform. While the changes announced to the health system create uncertainties for people and organisations, we are pleased to see the centrality of both equitable health outcomes and primary health care reforms and we look forward to playing our part in arriving at the outcomes.

With a dedicated team, Nelson Bays Primary Health continues to focus on safely delivering equitable health services to our community. Acknowledging the underlying health systems will change but that the pace of change for primary health is uncertain, we remain committed to continuing to perform and support health outcomes for the people in our region.

"He iti hau marangai e tu te pāhokahoka" Ngātahi

Nelson Bay Primary Health is positioned to play an integral role in the future change and has welcomed the opportunity to be part and influence the reforms to ensure primary and community care is top of the agenda.

Our organisation has demonstrated that we deliver services to our community which have real outcomes and are based on needs. This Annual Report summarises the extent and delivery of these services across primary and community care. We wish to thank our staff for their hard work and dedication. As you are aware, many of our staff come to work as they are passionate about ensuring equitable health care to our communities.

We acknowledge the departure in December 2020 of John Hunter, Nelson Bays Primary Health's long serving chairperson. John's contribution to the organisation has ensured a strong and stable position for the organisation which has been of immense value over this very uncertain year. We also acknowledge Peter Bramley, the previous Chief Executive of Nelson Marlborough Health who moved on to another role in December 2020.

EXECUTIVE LEADERSHIP TEAM 2020/2021

Sara Shaughnessy
CHIEF EXECUTIVE

Charlotte Etheridge
GENERAL MANAGER
PRIMARY CARE

Donna Hahn
ACTING DIRECTOR
OF NURSING

Emily-Rose Richards
EXECUTIVE ASSISTANT/
BOARD SECRETARY

We acknowledge the hard work of our dedicated Executive Leadership Team who have experienced a year in health care like no other and have risen to every challenge and the great efforts of our Board Members who generously give their time and experience and have been a great support to both of us as we settle into our new roles.

In closing, we also want to acknowledge all those others who we rely on and with whom we liaise, seek advice and support from and deliver our services with. We rely on many members of our community who give to our advisory groups; all our partners in health care including Nelson Marlborough Health, Te Piki Oranga, general practice, non-governmental organisations, our neighbouring primary health organisations, government agencies, our local councils and other community groups. Together it makes it possible for us to perform our part in providing health care and supporting wellbeing.

Kia tau te mauri

Ki runga i te rangimaarie

I ngā wā katoa

Āmine

Ngā Mihi,

Sarah-Jane Weir
CHAIRPERSON

Sara Shaughnessy
CHIEF EXECUTIVE

Linzi Birmingham
GENERAL MANAGER GOLDEN BAY COMMUNITY HEALTH

Te Ata Munro
KAIWHAKAHAERE AHUREA

Trudi Price
HUMAN RESOURCES/ SUPPORT SERVICES MANAGER

Wolfgang Kloepfer
FINANCE MANAGER

Clinical Governance Committee Chair's Report

The Nelson Bays Primary Health Clinical Governance Committee met regularly over the 2020/21 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.

The Clinical Governance Committee has been well supported by the Nelson Bays Primary Health executive, in particular Sara Shaughnessy, Charlotte Etheridge, Donna Hahn and Emily-Rose Richards.

Over the year, the Clinical Governance Committee has considered and taken action on a number of issues, such as:

COVID-19

- Testing – as the year progressed, Community Based Assessment Centres closed and testing largely moved into general practice and the Medical and Injury Centre. The Clinical Governance Committee, in conjunction with the Nelson Marlborough Health Clinical Technical Advisory Committee and HealthPathways, provided guidance on protocols, criteria and use/supply of personal protective equipment
- Vaccinating – as the Pfizer vaccine became available in early 2021, the Clinical Governance Committee gave input to the vaccine rollout, vaccination centres run by Nelson Bays Primary Health and staffing from Nelson Bays Primary Health and the general practices

Communication with hospital services and clinicians

- This proved a major focus of the Clinical Governance Committee's efforts with significant results in improving flow of information
- MediMap – the Clinical Governance Committee approved the move to this single source of prescribing for patients in the community with potential for multiple prescribers
- Standardising advice and medication on discharge letters from hospital clinicians – the Clinical Governance Committee gave input to wording, types of advice, layout of letters etc.
- Emergency department to general practice communication – the Clinical Governance Committee gave advice on timing and channel of communication

Stopping of copying of routine lab tests ordered by hospital clinicians to general practitioner

- This was the outstanding achievement of the Clinical Governance Committee in the past year. General practitioner workloads have increased significantly and inboxes were clogged with results ordered by hospital clinicians. The majority of general practitioners were keen to stop this practice and following letters from the Clinical Governance Committee to Nelson Marlborough Health's Clinical Governance Committee and Heads of Department, the routine lab results are no longer being copied to the general practitioner. Feedback from general practitioners has been overwhelmingly positive with no apparent reduction in quality of care but the protocol will be reviewed in November 2021

Devolution of services/care

- While this had been a focus last year it became less so this year – partly due to some more workable pathways and partly due to lack of capacity in general practice and no clear funding following the patient. This will continue to come up on case by case basis

Care Plus redesign/rename
– Te tiaki ngawari (Flexible Care)

- The Clinical Governance Committee approved the redesign of Care Plus to give much more flexibility with ability to focus funding on longer consults/ mental health/care planning. This has been well received in general practice

General practitioner access to MRI

- The Clinical Governance Committee approved the adoption of a programme to educate and credential general practitioners to be able to access to ACC funded MRI for knee, lower back and cervical spine injuries

Overview of Nelson Bays Primary Health programmes

- The Clinical Governance Committee received reports on the various programmes run by Nelson Bays Primary Health, including Rheumatology, Chronic Pain and Mental Health (Brief Intervention, Primary Mental Health Initiative and Health Improvement Practitioner). There continues to be substantial pressure on mental health services and the Pain Service cannot meet demand

Presentations

- The Clinical Governance Committee received presentations including Bowel Screening, Breast Cancer follow up, Assisted Dying, Suicide Prevention, Clinical Trials and made responses to those presenters

Meetings with practice owners and directors

- The Clinical Governance Committee, with help from the Nelson Bays Primary Health executive, ran two face to face/zoom meetings – in November 2020 and June 2021 for general practice owners and directors. This is the group that makes the decisions in general practice. Both meetings were well attended and achieved consensus on issues such as lab results. Occasional meetings like this will be called as sufficient issues arise

Key messages

- The Clinical Governance Committee Chair communicated activities of the Clinical Governance Committee and clinical issues to general practice teams, Nelson Marlborough Health and Marlborough Primary Health Clinical Governance Committees and to the Nelson Bays Primary Health Board

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 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 Chris Knight for his contribution to our group over many years.

It would be remiss of me not to mention the elephant in the room that is COVID-19. We have however managed through a mix of good planning and perhaps a little luck, survived relatively unscathed these past 12 months. In February 2021, the Pfizer COVID-19 vaccine began its roll out and this had a significant impact on Nelson Bays Primary Health's kaimahi. I would like to acknowledge our staff and their dedication and hard work over this period.

This year has also seen the release of the Health and Disability Report which threatened to shake the current system immeasurably by developing more effective Te Tiriti based partnerships within health and disability and thus create a system that works more effectively for Māori. The fact that Māori health outcomes are significantly worse than those for other New Zealanders represents a failure of the current health disability system, so this is a space worth watching.

Again, Te Tumu Whakaora encouraged 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 principles 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

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 an after-hours facility and 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 30 June 2021, the Medical and Injury Centre has seen in excess of 32,000 patients. This represents and increase of about 15% to the previous year
- The Medical and Injury Centre has again increased its workforce to accommodate the increased numbers of patients who often also present with higher complexities
- The Medical and Injury Centre has a strong link with Nelson Marlborough Health and is working closely 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
- The nurse practitioner position has been increased to manage people's health needs in collaboration with other health care professionals
- The Nelson Bays Primary Health social worker continues to be available for community visits
- 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 2020/21

- Health and Safety Committee meetings are held at least bi-monthly at each location
- Health and Safety incident reporting, investigations and management are supported by the online systems
- Regular hazard and risk inspections occur, managed by Health and Safety Representatives with follow up to minimise or eliminate any identified risks and hazards
- Health and Safety Committee administer ongoing review of Health and Safety policies, procedures, and documentation with recommendations to management as needed
- Health and Safety emergency evacuation drills are conducted regularly with involvement from all facility users
- Worker engagement is demonstrated by reporting incidents and identified risks, with numbers remaining very low
- Health and Safety remains a standard agenda item at all meetings and in-house presentations
- Collaboration and partnering on Health and Safety matters occurs with Nelson Marlborough Health at all locations
- Comprehensive Health and Safety induction programmes are arranged for new employees
- Health and Safety Lead Representatives actively contribution to the annual review of the 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 9.8% achieved to year end 30 June 2021. This compares admirably with the average annual staff turnover rate of 16.9% 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 2021. There are 234 employees in total: 119 based at Golden Bay Community Health, 62 based at Richmond office and 53 employed to support delivery of the COVID-19 response programme. Of these:

- 11% are full time employees
- 54% are part time employees
- 35% are casual employees

EMPLOYEE ENGAGEMENT

The annual Employee Workplace Satisfaction Survey was completed in March 2021. 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 2021 ratings show that our organisation and team satisfaction levels continue to be very positive, reflected in average satisfaction ratings and commentary submissions.

- ✓ The total average satisfaction rating in both Richmond and Golden Bay Community Health locations was positive, achieving 4.41 or higher out of 6
- ✓ 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 dedication of our team members to their work, our organisation and to the community remains strong, with employees at both locations reporting average satisfaction ratings of above 5 out 6 related to the work being done making a difference in our community.

*Source: The New Zealand Staff Turnover Survey 2019, Lawson Williams in partnership with Human Resources Institute of New Zealand. This is the most recent report available at the time of collation.

COVID-19 Response Report

OVERVIEW

Nelson Bays Primary Health in collaboration with our partners Nelson Marlborough Health, Marlborough Primary Health, Public Health, Te Piki Oranga, Nelson Tasman Pasifika Trust and other community agencies, led the primary and community response to COVID-19 in our region throughout the past year.

The COVID-19 response is split into two programmes – COVID-19 testing and COVID-19 immunisation.

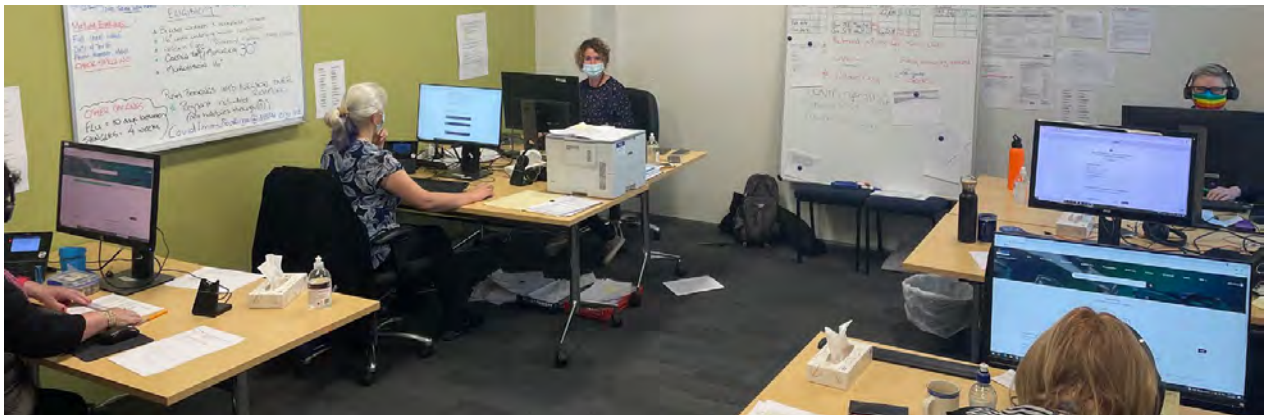
COVID-19 TESTING PROGRAMME

Throughout the year, COVID-19 testing continued in general practice, the Medical and Injury Centre and weekly testing was provided by the Nelson Bays Primary Health team at Port Nelson for the ongoing requirements for border testing.

COVID-19 IMMUNISATION PROGRAMME

In March 2021, the COVID-19 testing programme extended to a COVID-19 immunisation programme. The Ministry of Health implemented the following sequential tiered approach:

- **Group 1**
  - Tier 1a – border and MIQ workers
  - Tier 1b – family members and household contacts of border and MIQ workers
- **Group 2**
  - Tier 2a – frontline healthcare workers who could be exposed to COVID-19 while providing care
  - Tier 2b – frontline healthcare workers who may expose vulnerable people to COVID-19 and at-risk people living in settings with a high risk of transmission or exposure to COVID-19
- **Group 3**
  - Tier 3a – people aged 75+
  - Tier 3b – people aged 65+
  - Tier 3c – people with underlying health conditions or disabilities
- **Group 4**
  - The remainder of the general population



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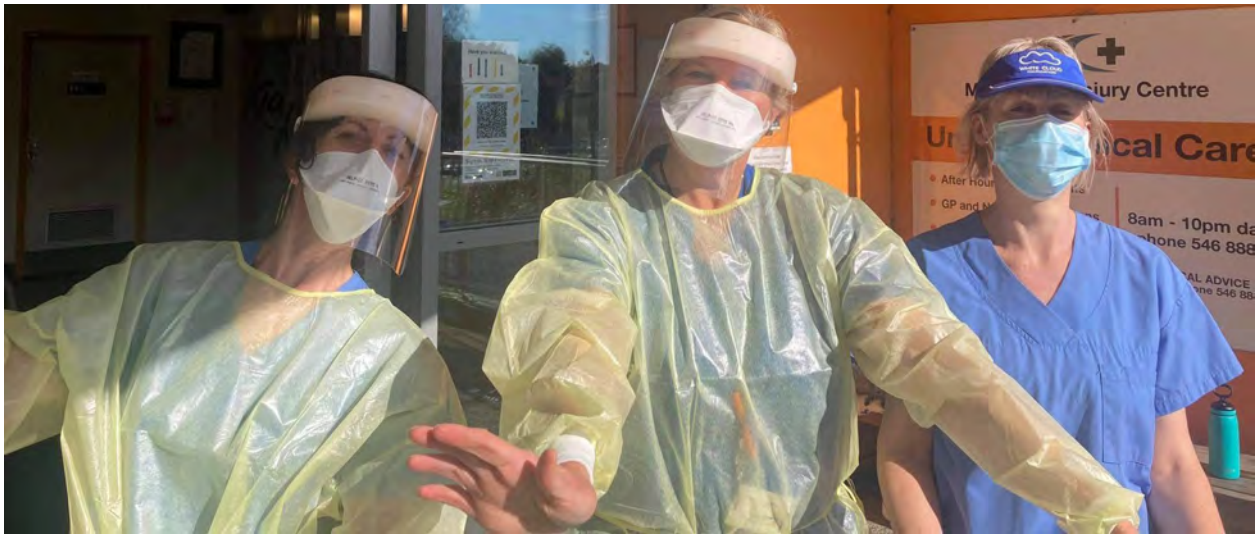
COVID-19 Response Report Continued



OVERVIEW OF THE PROGRAMME:

- A call centre was established to coordinate bookings for the clinics
- Various vaccination clinics were held each week
- All general practices and pharmacies were offered the opportunity to receive the vaccine in the first tiers
- Management implemented an emergency response structure to ensure the processes and appropriate resources were in place
- The workforce was mainly made up of staff from across general practice, Nelson Bays Primary Health, community pharmacy, Nelson Marlborough Health and Public Health
- Additional staffing and education for the clinics was sought through the pipeline with Nelson Marlborough Health and an expression of interest process sent out to our community partners
- Nelson Bays Primary Health is part of the leadership team to forecast and plan the delivery of the COVID-19 immunisations
- The vaccines and consumables logistics are maintained for all static and mobile clinics
- Quality, safety and clinical governance functions established to support the service
- Occupational Health and Safety functions to ensure site safety for staff and patients
- Developed local protocols

Pop up clinics were held in the following locations:

- Murchison
- Motueka
- Golden Bay
- Port Nelson
- Nelson Hospital
- Richmond Health Hub
- Local marae (run by Te Piki Oranga)
- Local workplaces
- Aged Residential Care Facilities and Disability Support Services (run by Public Health)

Static clinics were setup in the following locations:

- 16 Paru Paru Road, Nelson
- 253 Queen Street, Richmond

The static clinics were functional 5 to 7 days a week with fixed staffing from June 2021. We continue to offer pop up clinics into communities and support Te Piki Oranga with their whānau clinics. The feedback from the public is heartening and they value Nelson Bays Primary Health's contribution and approach.

This has been a whole of service approach, with many of our executives and staff involved in and supporting the clinics.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2020/21	
COVID-19 Testing Programme		
Number of COVID-19 tests provided	19,650	
Ethnicity • Māori • Pasifika • New Zealand European • Asian • Middle Eastern/Latin American	 332 1,928 16,389 779 222	
Gender • Female • Male	 10,418 9,232	
COVID-19 Immunisation Programme		
Number of COVID-19 immunisations provided	37,193	
	Dose 1	**Dose 2**
Doses provided	21,626	15,567
Ethnicity • Māori • Pasifika • New Zealand European • Asian	 988 137 19,817 684	 756 106 14,381 324
Gender • Female • Male	 12,445 9,181	 9,181 6,386
As of 30 June 2021, Nelson Marlborough Health was performing at 143% of the vaccination plan		

MĀORI / PASIFIKA ACTIVITIES

- 332 people swabbed for COVID-19 identified as Māori
- 1,928 people swabbed for COVID-19 identified as Pasifika
- 1,744 doses of the COVID-19 immunisation were delivered for those identified as Māori
- 243 doses of the COVID-19 immunisation were delivered for those identified as Māori

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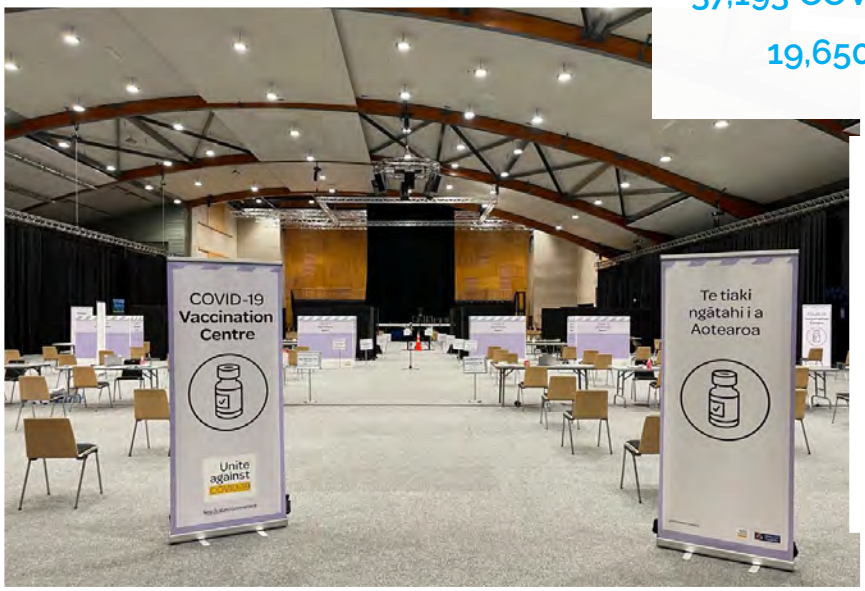
37,193 COVID-19 immunisations provided

19,650 COVID-19 tests provided



Everyone working in unison to achieve the vision
AROHA AND AWHI FOR ESSENTIAL WORKERS

Ngā Waka Hauora Health Services

Hauora Hāpai 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 and a community pharmacist. Referral is activated on discharge from the 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	2018/19		2019/20		2020/21	
Referrals						
• Numbers referred	151		177		160	
• Ethnicity	**Māori** 6	**Non-Māori** 145	**Māori** 2	**Non-Māori** 175	**Māori** 4	**Non-Māori** 156
Heart Guide Aotearoa						
• Number of referrals choosing this option	8		3		6	

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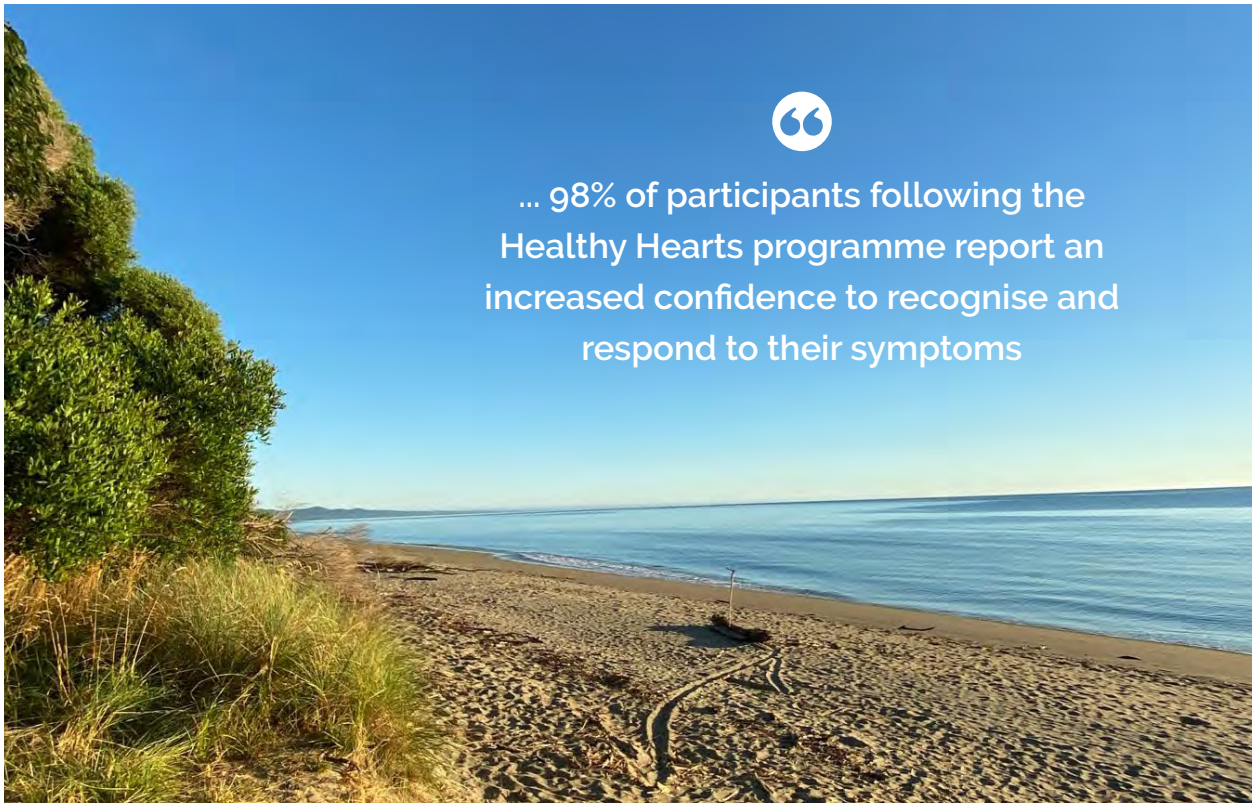
Community Cardiac Rehabilitation Healthy Hearts Continued

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
Healthy Hearts						
• Number of sessions delivered	10		7		10	
• Number of people who attended this option	82		70		85	
• Gender of those attending	**Male** 60	**Female** 22	**Male** 49	**Female** 21	**Male** 62	**Female** 23
• Age range	**Under 65yrs** 35	**Over 65yrs** 47	**Under 65yrs** 19	**Over 65yrs** 51	**Under 65yrs** 21	**Over 65yrs** 64
• Ethnicity	**Māori** 4	**Non-Māori** 78	**Māori** 1	**Non-Māori** 69	**Māori** 2	**Non-Māori** 83
Additional family/whānau or support person attending	40		31		43	
Total number of participants (including whānau/family)	122		101		134	
Programme Outcomes (On Completion)						
• Participants who report increased knowledge of their cardiovascular disease	100%		99%		98%	
• Participants who report increased confidence to recognise and respond to their symptoms (manage their condition)	97%		98%		98%	
Patient Self-Reported Follow-Up Outcomes (results of follow-up at 6-months with an average 63% response rate)						
• Are taking medication as prescribed (Concordant)	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)		88% (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	95%		96%		88%	
• Are participating in regular physical activity levels/ increased levels	85%		94%		90%	
Overall Uptake Rate (referral/attendance)						
• Percentage of people engaging in a rehabilitation choice	60% (National average is 12-20%)		40% Affected by COVID-19		56%	



MĀORI HEALTH ACTIVITIES

- 2% of referrals were for Māori and 2% of attendees were Māori. Referrals are activated on discharge from the hospital and it appears that very few Māori come to the attention of the cardiac nurse specialists, hence the low referral rates. High rates of Māori engage with the Heart Function Service
- Continued collaboration and kōrero with Te Piki Oranga has continued over the past year to strengthen connections and relationships. This collaboration has led to a regular aqua session for Māori called Mātāpuna, which is supported by Nelson Bays Primary Health's Green Prescription lifestyle facilitators

PARTICIPANT FEEDBACK

"Having attended a Healthy Hearts seminar, I felt it important to write to say how much I enjoyed and appreciated what was a thoroughly informative and well-constructed programme. In addition to the excellent, well-illustrated presentations that allowed and encouraged questions and observations from the attendees, the opportunity to meet and chat with others with heart-related conditions was much appreciated. The opportunity for anyone who has had a heart-related event should be actively encouraged to attend one of Nelson Bays Primary Health's Healthy Hearts seminars."

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 88% 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 (haemoglobin A1c is commonly used to indicate a person's average blood glucose levels)

PROGRAMME OVERVIEW

- Type 2 diabetes education is delivered in the community and is mainly held on Saturdays. Sessions are peer-reviewed by diabetes nurse specialists at Nelson Marlborough Health and this primary - secondary partnership works extremely well
- 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* process

How well did we do?

KEY PERFORMANCE MEASURES

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
Type 2 Diabetes Referrals						
• Numbers referred	132		86		124	
• Ethnicity	**Māori** 21	**Non-Māori** 111	**Māori** 9	**Non-Māori** 77	**Māori** 9	**Non-Māori** 115
Type 2 Diabetes Education sessions						
• Number of sessions held afterhours	9		4		10	
• Total number of sessions delivered	9		4		10	
• Number of patients attended	73		28		74	
• Gender of those attending	**Male** 35	**Female** 38	**Male** 15	**Female** 13	**Male** 31	**Female** 43
• Ethnicity of those attending	**Māori** 15	**Non-Māori** 58	**Māori** 0	**Non-Māori** 28	**Māori** 4	**Non-Māori** 70
• Additional whānau/family or support person attending	22		10		32	
• **Total number of participants** (including whānau/family)	95		38		106	
Programme Outcomes (on completion of session)						
• Participants who report increased knowledge of diabetes	100%		100%		100%	

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
• Participants who report increased confidence in self-management	100%		98%		98%	
Patient Self-Reported Follow-Up Outcomes (results of follow-up at 6-months with an average 42% response rate)						
• Has improved HbA1c (if tested/known)	90%		50%		100%	
• Maintained healthy eating habits/ improved eating habits	97%		85%		94%	
• Is participating in regular physical activity levels/increased levels	62%		73%		88%	
Pre-Diabetes Education Referrals						
• Referrals received	91		29		40	
• Ethnicity of referrals	**Māori** 6	**Non-Māori** 85	**Māori** 1	**Non-Māori** 28	**Māori** 3	**Non-Māori** 37
Pre-Diabetes Education Sessions						
• Total number of sessions delivered (after-hours options)	6		11		2*	
• Number of patients attended	73		29		15	
• Gender of those attending	**Male** 35	**Female** 38	**Male** 11	**Female** 18	**Male** 4	**Female** 11
• Ethnicity of those attending	**Māori** 10	**Non-Māori** 63	**Māori** 2	**Non-Māori** 27	**Māori** 0	**Non-Māori** 15
• Additional whānau or support person attending	19		0		2	
• **Total number of participants** (including family)	92		29		17	
Programme Outcomes (On Completion)						
• Participants who report increased knowledge of pre-diabetes	100%		86%		100%	
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)	100%		75% reported improved health outcome		No data available as programme on hold for first three quarters	
• Reported healthy eating habits/ improved eating habits	91%		75% reported choosing healthier food options		As above	
• Reported adequate physical activity levels/increased levels	91%		61% reported maintaining regular physical activity levels		As above	

**Pre-Diabetes/Stay Well sessions were on hold for the first three quarters of the year due to workforce capacity – sessions recommenced in May 2021.*

Continues over...

Community Diabetes Education Type 2 and Pre-diabetes Continued

MĀORI HEALTH ACTIVITIES

- A type 2 diabetes education "taster session" was held specifically for Māori men, in collaboration with Te Piki Oranga's Dietitian and Nelson Marlborough Health's Māori Diabetes Nurse. Onward referrals were made to Green Prescription and Te Piki Oranga for further support. Positive feedback received from participants and a follow up session was requested. The Kaiatawhai Service also assisted with transport costs for participants to this session, helping to reduce barriers to access *"I just wanted to thank you both for the opportunity to collaborate and educate some of the most – if not the most vulnerable people in our community. Although only two of the men came to our hui, it was excellent to see them engage and understand the messages that we were trying to give them about diabetes."*
- The Nelson Marlborough Health Māori Diabetes Nurse supported and co-facilitated two of the self-management diabetes education sessions. As a result, all sessions are now opened with a karakia and mihi and kai is blessed
- The coordinator attended a mihi whakatau at Te Piki Oranga in Whakatū. This was an opportunity to connect with Kaimahi and discuss our services and programmes, referral pathways and how to improve access for Māori
- The coordinator is involved in the Integrated Diabetes Pathways Project. The project vision is people and their whānau living well with type 2 diabetes. It is envisaged that the project will lead to opportunities to co-design culturally appropriate and accessible self-management education sessions, that will support increased engagement and improved outcomes for Māori

OTHER ACTIVITIES:

- Information sessions on pre-diabetes and healthy food choices were delivered to the former refugee community (Colombian and Chin/Kayah) in collaboration with Red Cross
- Pre-diabetes awareness sessions were delivered to Stoke Companions and Stoke Seniors
- Attended the Tongan Sports Day where 37 people engaged in a diabetes awareness quiz and onward referrals were made to the Pasifika community nurse to arrange heart and diabetes checks
- Diabetes Action Month – quiz circulated to general practices, Te Piki Oranga, Public Health and Nelson Bays Primary Health staff. The quiz was to raise awareness of diabetes and diabetes self- management options – 30 people participated
- A diabetes awareness session was delivered to the deaf community – 15 people attended and very positive feedback was received

PERSONAL SUCCESS FEEDBACK

"All the information was very comprehensive and well delivered. Great resources and displayed information. Great venue, food, drinks and snacks. Thank you for the important work you do."

"This session has given me confidence in myself and knowing I'm not alone with my diabetes. I got even more out of this session than the last time I attended."

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/ exercise programs
- 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 until recently, 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 and Safety Commission and Ministry of Health.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
Referrals						
• Numbers referred	270		216		137	
• Ethnicity	**Māori** 3	**Non-Māori** 267	**Māori** 3	**Non-Māori** 213	**Māori** 4	**Non-Māori** 133
Upright and Able Education						
• Number of sessions delivered	16		11 (Sessions cancelled due to COVID-19 restrictions for older adults)		9	
• Number of people attended	168		139		85	
Falls Awareness Promotions						
• Number of sessions delivered	7		4		5	
• Number of people attending	Delivered in a number of ways to the community, general practice staff and other health providers				60	

Continues over...

Community Falls Prevention Continued

Community Group Strength and Balance			
• Total number of groups approved	138	177	*199
• Number of Kaupapa Māori groups approved	4	4	6 (Addition of 2 water based programs through Green Prescription called Mātāpunā)
• Number of training sessions provided to 'approved' group leaders	4	2 (Regular updates and support provided during lockdown. Support also provided with re-starting classes as risks remain high for older adults)	1 (This was largely due to COVID-19 restrictions and the Falls Prevention Coordinator role being vacant for 5 months)

TARGETS (YEAR)

Places/Classes	Year	Target	Actuals
Approved Classes	2018/19	No set target for classes but have had an overwhelming response from new and existing instructors in our region wanting to be part of the "Live Stronger for longer" campaign	138
Approved Places	2018/19	4,000 as per ACC	3,071
Approved Classes	2019/20	No set target	177
Approved Places	2019/20	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
Approved Classes	2020/21	No set target. Instructors and facility providers of classes continue to want to be part of the "Stronger for longer" ACC initiative	199* 139**
Approved Places	2020/21	1,940 as per ACC contract	3905* 2796**

**Cumulative number of classes and places approved to date.*

***Number of classes and places currently available.*

PROGRAMME OUTCOMES

For our regions approved instructors, there is continued consolidation of classes and reduction in the number of classes or places 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.

STRENGTH AND BALANCE CLASSES IN OUR 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 12 months from April 2020 to March 2021 in the Nelson Marlborough region there were 355 fewer falls, which is 4% below the national average, a reduction of 0.8% on the previous year. This is a huge success and Nelson Bays Primary Health acknowledges the 'teams' that have all contributed to this success

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. The Green Prescription team have also added a water-based programs available twice a week which proved to be very popular

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 or running on fewer "place" availability during COVID-19's various alert levels, there continued to be enquires for information about the Stronger for Longer approval process from instructors, and the availability of classes from participants
- This further demonstrates the positive effect that these classes have established within our community

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

SERVICE OVERVIEW

There are three 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 living with type 2 diabetes, Healthy Hearts, Noha Ora stay well 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)

How well did we do?

KEY PERFORMANCE MEASURES

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
Primary Care Dietitian: 1:1 – consultations held at general practice and Nelson Bays Primary Health						
• Number of 1:1 individuals booked into clinic	904		752		974	
• Number attended	792		666		854	
• Ethnicity of those booked	**Māori** 11%	**Non-Māori** 89%	**Māori** 11%	**Non-Māori** 89%	**Māori** 13%	**Non-Māori** 87%
Primary Care Dietitian: 1:1 – clinics held at Te Piki Oranga						
• Number of clinics at Te Piki Oranga	10		7		8	
• Number attended	14		11		13	
• Number of did not attends	0		0		5	
Self-Management Group Education Sessions						
	Groups	**People**	**Groups**	**People**	**Groups**	**People**
• Type 2 Diabetes	7	96	4	38	11	74
• Healthy Hearts	10	131	7	101	10	85
• Pulmonary Rehabilitation	3	65	1	20	3	78
• Other, including Noho Ora	3	53	7	67	12	153
Total	**23**	**345**	**19**	**226**	**35**	**390**

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
Workforce Development						
• Number of education sessions	**Groups** 10	**People** 129	**Groups** 6	**People** 65	**Groups** 8	**People** 54
• Percentage increasing knowledge of topic • Percentage increasing confidence to address topic	Those who attended reported a 100% increase in knowledge		Those who attended reported a 100% increase in knowledge		All reported increased knowledge	
Programme Outcomes (At Completion)						
• Type 2 diabetes – percentage of participants have improved knowledge	100%		100%		100%	
• Healthy Hearts – percentage of participants have improved knowledge	100%		99%		98%	
• Noho Ora/Stay Well – percentage of participants have improved knowledge	N/A		N/A		100%	
Programme Outcomes (self-reported at 6-months after attending)						
• Type 2 diabetes – percentage of people who have improved eating habits	60%		85%		94%	
• Healthy Hearts – percentage of people who have improved eating habits	100%		96%		90%	

TARGETS (YEAR)

- While the 2020/21 year has continued to be impacted by the COVID-19 pandemic, the service has been able to meet and exceed all expected targets for patient engagement, self-management group education and workforce development

Target	Achievement
In-person patients booked into a clinic: 800	This year, 974 individuals were booked into dietitian clinics. 88% of patients booked engaged with the service. A third of referrals were for individuals living in larger bodies, over 1/5 for IBS and 1/6 for pre and type 2 diabetes.
Group education sessions: 20	35 group education sessions were delivered this year. The COVID-19 pandemic continued to have an impact on delivery with some rescheduling of sessions and limiting of numbers to enable physical distancing. It has been positive to return to exceeding this target and to be able to engage with the community in a dynamic way again.

Continues over...

Community Nutrition Service Primary Care Dietitians Continued

Target	Achievement
Multi-week/childhood obesity prevention programmes: 4	After the COVID-19 pandemic lockdowns of 2020, the team did not return to providing Eat Move Grow. The service had not been receiving sufficient referrals to run the programme, with 17 referrals over the entire 2020/21 year for children with fussy eating, high/low body weight, or constipation. A minimum of 8 referrals in one quarter is desirable to provide a programme and unfortunately this was not achieved. Referrals were received sporadically and geographically dispersed over the Nelson Tasman region. To assist whānau/families with these nutrition concerns, the service provided face-to-face family clinic appointments for all referrals received, as well as four playcentre 'first foods and establishing good eating habits and behaviours' information sessions for infants < 1 year old and their whānau. These sessions are designed as an Eat Move Grow prevention programme.
Workforce development sessions: 8	This year we achieved 8 sessions with topics ranging from adult nutrition guidelines update, vegetarian/vegan diets, pregnancy and early life nutrition, nutrition and mental health.

MĀORI HEALTH ACTIVITIES

- 13% of the 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 the Te Piki Oranga dietitian and Te Piki Oranga services for kaupapa Māori dietary guidance and support for long term health conditions
- Workforce education for Pūkenga Atawhai at Te Piki Oranga Whakatū, regarding the community nutrition service and common nutritional challenges of shared clients

OTHER VULNERABLE GROUPS

- The primary care dietitians continue to support former refugees through individual clinic appointments for a range of conditions, including type 2 diabetes, restricted eating in children and appropriate childhood growth. Interpreters and language specific resources are used in these consultations
- The primary care dietitians worked with Red Cross to provide new migrant healthy eating sessions for both the Colombian and Kayah communities. Sessions were well attended, interactive and positive feedback received
- Established a dietitian clinic at Victory Community Centre in May 2021 to enable better access for those within the community. To date these clinics have been well attended by whānau and new migrant families living within the Victory, Toi Toi and Washington Valley communities
- Working alongside public health nurse with former refugees providing integrated health care for former refugee families with primary school aged children needing nutrition support

PARTICIPANT FEEDBACK

Healthy Hearts: *45 attendees specified that the dietitian session on the cardioprotective diet was the most useful part of the session. A further 23 participants stated that all content was the most useful.*

Type 2 Diabetes Information Sessions: *45 attendees identified the diabetes dietary information as the most useful part of the type 2 diabetes education sessions. A further 17 attendees stated that all the education components were most useful.*

Noho Ora/Stay Well: *9 of the 16 participants said the dietary information was the most useful part of the sessions.*

Feedback:
"It was good to get some information about healthy lifestyle and diet, in particular how to plan and balance food in your regular meal".

"All presenters were excellent and provided important information. It (Healthy Hearts) should be recommended to all post cardiac event".

"All the information was very comprehensive and well delivered. Great to learn about food groups and what to look out for".

"Very reassuring to know we are on track with our "diet".

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 and other high-risk conditions whose feet are compromised.

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 in Nelson is Mapua Podiatry (Justin Powell, Podiatrist) also recognised as The Nelson Hospital Podiatry Service. 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, although home visits are undertaken for special circumstances.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
• Total number of patient consultations	2,495		2,187		2,243	
• Consultations by ethnicity	**Māori** 325	**Non-Māori** 2,170	**Māori** 282	**Non-Māori** 1,905	**Māori** 322	**Non-Māori** 1,921
Where were patients seen	**Clinics held**		**Clinics held**		**Clinics held**	
• Marae clinic (Whakatū and Te Āwhina)	8		8		8	
• Hospital clinic	90		75		84	
• Mapua clinic	47		44		49	
• House calls	42		34		34	
• Golden Bay clinic	8		6		6	
• Other	-		-		-	
Number who did not attend	282		211		245	
Number who declined	30 (estimate)		7		7	
With support from Te Piki Oranga nurses	Works in partnership with Te Piki Oranga staff with stop smoking and type 2 diabetes education promoted		Works in partnership with Te Piki Oranga staff with stop smoking and type 2 diabetes education promoted		Works in partnership with Te Piki Oranga staff with stop smoking and type 2 diabetes education promoted	

Continues over...

Community Podiatry Service Continued

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
Orthotics	28	25	25
Vascular surgeon	5	2	2
District nurse	8	5	5

TARGETS (YEAR)

- The target for this contract is to see 2,540 patients. This year the service achieved 2,243 with 245 'did not attends'. Some clinics were affected by changes in the COVID-19 alert levels. A significant increase in administration has occurred throughout the lockdowns and is continuing

MĀORI HEALTH ACTIVITIES

- 322 of the people who accessed the service identified as Māori
- 49 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 Whakatū Marae (Bishopdale Campus)
- Marae podiatry clinics are delivered in partnership with Te Piki Oranga and are hugely valued by Māori who attend. The Te Piki Oranga nurses work on a triage system where they perform a foot check while offering toe nail cutting services and kōrero with clients about other issues. The client then sees the podiatrist if the client meets referral criteria (complicated foot problems)

SUCCESSES / CHALLENGES

- Demand continues to be strong. 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 (322 Māori accessed in one year)
- This year the wait time is finalised at 6 months (average wait time 8.5 months for the year), due to the heavy rescheduling of clients who missed appointments during lockdown and catching up on waiting list exaggerated by the lockdowns

SUCCESS STORIES

"An example of the service is illustrated by new client 'A' who recently moved to Nelson. He moved into a flat with other family. One of the flat mates had a regular appointment due with the service. She saw client A's feet and insisted that he take her podiatry appointment at the Marae. Upon attending it was discovered this client had no medical help at all and upon the nurses doing a few tests discovered had undiagnosed diabetes (HbA1c 130) with very high-risk feet, drinking water continuously and underweight. In a single appointment we returned his feet to being comfortable, enrolled him with a general practice and was prescribed appropriate medication to manage his diabetes. Consequently, this patient gained employment and continues to have treatments associated with the marae. This man is incredibly grateful for the life changing service he received which has transformed his life."

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.

The Fracture Liaison Service contract ceased as of 30 June 2021.

How well did we do?

KEY PERFORMANCE INDICATORS

The outcome data is not able to be reported on due to the discontinuation of the contract with Nelson Marlborough Health.

The Fracture Liaison Service and Regional Falls Prevention coordination has been in a holding pattern for much of the year with uncertainty over continuation of the contract.

ACTIVITIES

- Chaired Fracture Liaison Network of New Zealand national education day and annual general meeting
- Osteoporosis article in community newsletters (Asthma and Age Concern), digital promotion on local general practice 'health TV' in waiting rooms
- Continuation of pilot project (Nelson Bays Primary Health/Nelson Marlborough Health) in the Nelson Hospital fracture clinic to screen for and flag up potential osteoporotic (fragility) fractures and falls risks. Linking secondary and primary pathway to existing components for the Fracture Liaison Service pathway. Aligning with Models of Care and the Health Care Home philosophy
- Linked with Nelson Marlborough Health to amend the discharge letter templates to have 'bone health check' tick box as auto-prompt
- Promotion of consumer 'arm' of Osteoporosis New Zealand to drive consumer awareness and self-management/use of 'Know Your Bones' tool
- Communication with Fracture Liaison Network of New Zealand, ACC and Osteoporosis New Zealand regarding regional and national trends and activities
- Osteoporosis New Zealand/ACC led Fracture Liaison Service workshop to review the current best practice key point indicators of the Fracture Liaison Service
- Attended the Nelson Tasman Positive Ageing Expo – shared a stand with the Nelson Marlborough Health in-home falls prevention team. Multiple enquiries regarding osteoporosis-risk and self-management; advice provided that improved medication adherence

Continues over...

Community Fracture Liaison Service Falls Prevention Continued

MĀORI HEALTH ACTIVITIES

- Development and engagement with the national Fracture Liaison Service database would support identification of equity gaps in fragility fracture care and occurrence
- The community group strength and balance opportunities linked with Te Piki Oranga and Whakatū Marae
- Ongoing work to identify, connect and engage with vulnerable population regarding both falls and osteoporosis

SUCCESS STORIES

- Whole of system approach and connection across primary and secondary health system
- Recognition by ACC of role of Nelson Bays Primary Health Fracture Liaison Service clinician in the national approach
- The Nelson Bays Primary Health Fracture Liaison Service and Regional Falls Prevention Coordinator has been pivotal in growing and strengthening pathways in secondary care, primary care and the community, using a joined up, whole of system approach. The coordinator has also chaired the Nelson Marlborough Falls Alliance, supported the Community Group Strength and Balance staff across the region and supported a successful business case to continue the Live Stronger for Longer initiative

FEEDBACK FROM MEMBERS OF THE COMMUNITY

"You have given me hope. I thought I was going to end up in a wheelchair and die, but now I know I can do something about it, and I need to make a plan. Thank you so much".

"I didn't realise I could sit, read, check my emails while I wait 30 minutes after taking my pill – I will take them then."

"I did what you told me a few years ago – diet, exercise, medication, lifestyle – and I've gone from osteoporotic to Osteopenia."

Green Prescription (Rongoā kākāriki)

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

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 many 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 four E's of: exercise, education, emotional support and enjoyment
- Poudi: A new programme designed for the Nepalise/Bhutenese Refugee community. The Green Prescription team were approached throughout the year to provide a free weekly pool class based at the Nelson Hospital physiotherapy pool for the former refugee community, in collaboration with the Victory Pharmacy, their interpreters and the Nelson Physiotherapy department. This programme has been well received by the participants
- Move More, Feel Better: A Mens only programme pilot, in collaboration with the Victory Community Centre, Victory boxing and Te Waka Hauora. Currently this programme is on hold, in the meantime we are offering concession cards to some of our clients
- StayWell: Recently redesigned to a two hour interactive workshop targeting prevention and reducing 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.

Continues over...

Green Prescription (Rongoā kākāriki) Continued

How well did we do?

KEY PERFORMANCE MEASURES

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
Green Prescription Referrals						
• Numbers referred	1,201		1,159		916	
• Ethnicity	**Māori** 123	**Non-Māori** 1,078	**Māori** 96	**Non-Māori** 1,063	**Māori** 130	**Non-Māori** 786
• Gender	**Male** 443	**Female** 759	**Male** 436	**Female** 723	**Male** 332	**Female** 584
KickStart						
• Number of people attended	642		788		314	
• Number of programmes delivered	12		10		33	
Mātāpuna						
• Number of people attended	*		*		443	
• Number of programmes delivered	*		*		63	
Poudi						
• Number of people attended	*		*		34	
• Number of programmes delivered	*		*		5	
Move More, Feel Better						
• Number of people attended	*		*		9	
• Number of programmes delivered	*		*		5	
StayWell						
• Number of people attended	203		94		17	
• Number of sessions delivered in general practice	0		0		0	
• Number of sessions delivered in the community	22		11		2	
• Total number of sessions delivered	22		11		2	
Condition Specific Programmes (Type 2 Diabetes, Pre-Diabetes, Falls Prevention, The Joint Programme, Healthy Hearts)						
• Number of people attending	459		546		134**	
Outcomes (at completion)						
• Percentage of participants that: – Understand why they need to be active	88%		89%		95%	

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
– Have made positive changes to food since beginning Green Prescription	83%	79%	90%
– Feel supported to initiate and sustain good lifestyle choices	95%	86%	84%
Outcomes (6 months after completion)			
• Percentage of participants that:			
– Are still regularly active	74%	61%	76%
– Are still choosing healthier food options	83%	75%	80%
– Report improved health outcome	75%	75%	68%

**New programme in 2020/21.*

***Lower number this year due to focus on the Mātāpuna and Poudi programmes.*

TARGETS (YEAR)

- The target is to receive 1,200 Green Prescription referrals per year. This year, we achieved 916 referrals

Katie Woller, Healthy Lifestyles Facilitator from the Green Prescription team.

Continues over...

Green Prescription Continued

MĀORI HEALTH ACTIVITIES

- 12% of referrals identified as Māori, with an average engagement rate of 65.75%
- 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 two weekly Mātāpuna programmes. Participant engagement in this programme has increased. The instructor and Te Puna Hauora Navigator at Te Piki Oranga have commented that "*Mātāpuna is tracking well and our attending whānau are really engaged*."

PERSONAL SUCCESS STORIES

"Great programme, hope it is helping others too" – 57 year old female

"Marvelous programme! It has helped me lose a lot of weight." – 70 year old male

"Doctors should promote Green Prescription more, I found out through a friend." – 65 year old female

"Very well done, continued going with a regular group after for motivation." – 66 year old female

"A friend encouraged me to join KickStart as I felt I needed to lose weight and change my eating habits. I enjoyed the benefits of water aerobics which helped with my mobility."

"Lovely instructors at Green Prescription, thank you. This has inspired me to join an aqua class."

"I enjoy the Mātāpuna programme mostly because of the physical and mental wellbeing this class provides." – 66 year old male

"I came as support with my cousin and found it was great for my hip problem. I found the class lifted my spirits and I feel better in myself, I am moving better and am more motivated. I plan to do other pool classes."

"I suffered badly with depression and this has helped me greatly. Great people that are very supportive. I will be joining another class."

"I developed osteoarthritis in my feet and walking is painful, aqua exercises has less impact on my joints and now I am more flexible and do not suffer the pain."

"The health plan I received at the first session made me take an honest look at myself and take responsibility for improving my health. I love meat fat and cutting that out is work in progress."

"A big thank you for your time, I enjoyed the group setting. The food and diet changes are easy to grasp but the pool sessions are more impacting as I now am regularly active."

"Enjoyed the KickStart sessions. The chats about nutrition and stress especially. The exercise sessions were great! Also, the other participants were good to talk with and the facilitators were full off good and helpful information."

"Patient has reported with his general practitioner that he currently attends the gym and pool twice a week using the Green Prescription KickStart card. It has helped him immensely and has managed to lose 8kg. It has been the most effective intervention for his chronic pain that he has found in the last four years and has reduced his presentations to primary care drastically." – Feedback from a general practice

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	2018/19	2019/20	2020/21
Service Outcomes			
• Number of clients accessing the service	256+	384	333
• The top five issues identified	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	1. Psychological issues 2. Complex health issues in the elderly 3. Health needs of former refugees 4. COVID-19 vaccination access for vulnerable communities 5. Poverty
Percentage of referrals broken down by:			
Ethnicity: • European • Māori • Pasifika • Other (e.g. former refugee)	 54% 35% 1% 10%	 62% 20% 1% 17%	 55% 29% 1% 15%
Reason for clients accessing the service:*			
• Health assessments • Mental health • Social issues • Housing issues • Education	256 10+ 7+ 0 54	384 25 25 15 100	333 27 0 11 0

Continues over...

Victory Community Centre Continued

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
• Number of assessments completed	256	384	333
• Number of unenrolled clients supported to enrol in general practice	9	11	3
• Number of clients supported to access other services	79	252	233
• Number of refugee families supported	139	58	Several hundred have been vaccinated now
• Number of information sessions delivered	4	24	8

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

MĀORI HEALTH ACTIVITIES

- 97 clients identified as Māori

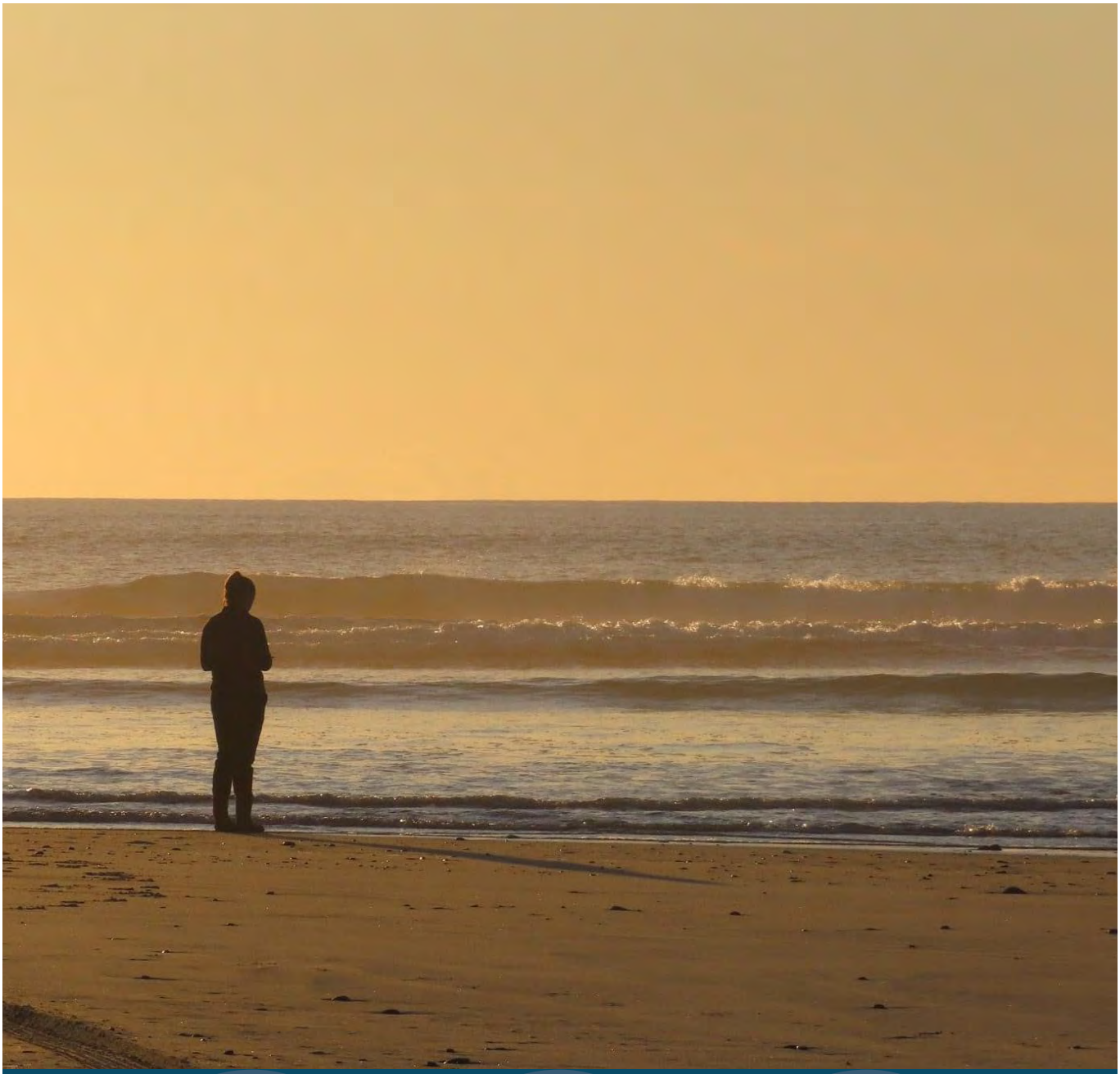
SUPPORTING VULNERABLE GROUPS

- The Victory Community Centre staff work closely with the 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 remains a vital point of connection and engagement for our local community to access health needs, food, support to engage with activities and agencies
- A monthly multi-agency meeting around vulnerable children (initiated by Victory Community Centre) continues and now has a local paediatrician in attendance and includes Victory Primary School and Nelson Intermediate Schools
- A strong connection continues with Multicultural Nelson Tasman, Red Cross Refugee Services, Te Piki Oranga, Nelson Tasman Pasifika Community Trust, Nelson Bays Primary Health, Nelson Marlborough Health, Victory Pharmacy and general practices
- There were two COVID-19 vaccination clinics held to address specific former refugee ethnicities
- The Victory Community Centre continues to provide activities and connections for the wider community at affordable prices
- The 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
- The Victory Community Centre maintains strong connections with agencies across Nelson. In the health space, the Victory Community Centre works closely with the Victory Pharmacy, the local general practices, Nelson Bays Primary Health and Nelson Marlborough Health
- There is now a Public Health Nurse based at the Victory Community Centre for 8 hours a week, actively covering refugee health as well as a nurse from Whanake Youth for 5 hours a week
- The Victory Community Centre celebrated Matariki with a hāngi and festival that attracted over 900 people on the night. This is held in conjunction with Victory Primary School and helped by many volunteers from across the community

Oranga Hinengaro 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 with people 25 years and older and works in a similar way to the youth alcohol and other drug service at Nelson Bays Primary Health. The service works closely with other health providers including the Nelson Marlborough Health addictions services and delivers a clinical service that 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 has been funded by Nelson Bays Primary Health since March 2019 and is contracted to the Victory Community Centre.

In the past year, the service has continued to focus on establishing itself within the health arena. As the awareness of the service increased, access to the service became the primary area of attention. Since March 2021, referrals have been received via the electronic referrals management system. This has resulted in a significant increase in visibility and ease of referral from primary health services with a resulting increase in overall number of referrals. The service continues to work closely with the Nelson Marlborough Health addictions service, the youth alcohol and other drug service at Nelson Bays Primary Health and has links to Te Piki Oranga's alcohol and other drug service.

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	2018/19	2019/20	2020/21
Referral data			
Number of referrals received	13*	100	146
Clients referred			
• Male	7	54	84
• Female	6	46	62
• Number of group education sessions provided	6	28	18

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
• Client Satisfaction Survey Results	**	**	90% found the service helpful, easy to access, the clinician supportive and the clinician professional 80% reduced their alcohol use, 70% reduced their use by 75%, 20% reduced by 100% and 20% reduced by 50% 10% reduced their cannabis use and 10% stopped using cannabis 100% would recommend the service to a friend/family

**Service started in March 2019.*

**New measurement to Nelson Bays Primary Health in 2020/21 and previous financial years data not available.*

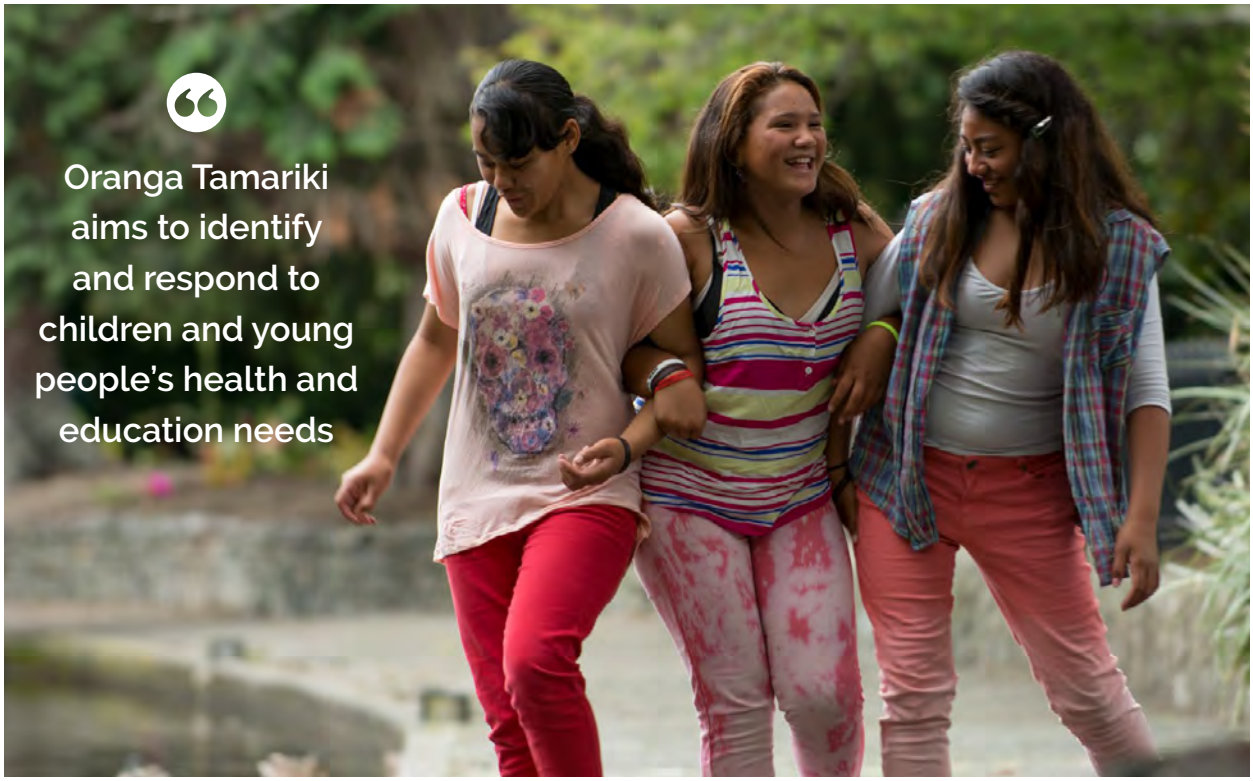
MĀORI HEALTH ACTIVITIES

- 16% of total referrals identified as Māori
- Ongoing links with Te Piki Oranga and referrals received from Te Piki Oranga
- The clinician completed a 10 week te reo Māori course

VULNERABLE POPULATION

- Good working relationships have been developed with Red Cross, Community Action on Youth and Drugs and Multicultural Nelson Tasman with workshops already offered to former refugees from Columbia and the Kayah community. Future workshops are being planned for the Chin community
- Working from the Victory Community Centre site allows for an accessible and responsive service and a close working relationship with 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	2018/19	2019/20	2020/21
Number of referrals from Oranga Tamariki received	93	62	65
Number of assessments Nelson Bays Primary Health engaged in (health assessments undertaken)	63	46	84
Number of inter-service panel meetings held	62	46	83
Strategies implemented to reduce any gaps identified	Paediatrics engaged locum clinicians to clear the wait list.	The gateway coordinator assertively followed up with Oranga Tamariki social workers to provide more information and background on children and their whānau in referrals for health assessments. The social workers are providing more comprehensive referrals including Tuituia reports, family group conference reports and social work reports. The Nelson Bays Primary Health Gateway Services contract was reviewed and the aim of the new contract is to reduce wait times for children requiring health assessments.	Paediatrics engaged Dr Pat Tuohy, locum paediatrician to clear the wait list. The number of health assessments completed reflects in the increased number of inter-service panel meetings held. Five new therapists have been contracted in the last 6 months.

MĀORI HEALTH ACTIVITIES

- There were 30 Māori referred to the service

VULNERABLE POPULATION

- Gateway health assessments focus only on vulnerable children who are in Oranga Tamariki care or have care and protection issues

ORANGA TAMARIKI
Ministry for Vulnerable Children

Mental Health Services to Children in Care

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

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
Number of referrals to this service	19	15	14
Number of packages of care completed (clients can have more than one package of care)	21	7	9
Average number of days from referral to packages of care	18	21	14

MĀORI HEALTH ACTIVITIES

- There were five children who identified as Māori referred to the service

PASIFIKA HEALTH ACTIVITIES

- There were two children who identified as Pasifika referred to the service

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 client's 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 2020/21, the average duration of referred clients pain experience was seven 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 questions.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
Number of referrals received	288	285	256
Number of Māori participants	8	12	16
Number of groups completed	2	1*	3
Number of clients engaged with counsellor/clinical psychologist	62	76	75
Clients perceived improved level of workability	4%	4%	16%
Clients enhanced ability to undertake activities in and around the home	9%	0% (maintained participation in activities)	4%
Clients increased ability to cope with pain without medications	6%	14%	3%
Clients reduction in opioid use after discharge	48%	12.5%	21%

**One group cancelled due to COVID-19.*

MĀORI HEALTH ACTIVITIES

- There were 16 participants who identified as Māori

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 three to four sessions per patient. Referrals are received from general practice or Māori health providers. This service is available to all age groups.

The Brief Intervention Service accepts referrals from general practice or Māori health providers for clients aged 16 years and over. This service is staffed by 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.

For much of this year, the Brief Intervention Service has worked within the Richmond Health Hub.

The team have continued to offer telehealth although the majority of clients opted to be seen in-person

The wait times are higher this year for the Brief Intervention Service as two of the mental health clinicians were based in general practices as part of the wellbeing pilot based on the Te Tumu Waiora 'To head towards wellness' model of care. Nelson Bays Primary Health's Social worker from the Kaiatawhai Service joined the team to assist with brief interventions using a focused acceptance commitment therapy approach. The social worker also assisted the team by triaging referrals.

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.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
Primary Mental Health Initiative			
• Referrals	1,726	2,647	2,499
• Average drop of PHQ-9 scores from beginning of treatment to end of treatment	1.25	1.00	**
• Time on wait list (days)	7	7	7
Clients referred			
• Male	*	766	749
• Female	*	1,800	1,750
• Not identified	*	81	0
Brief Intervention Service			
Referrals	1,369	1,030	736
Average drop of PHQ-9 scores from beginning of treatment to end of treatment	7.5	4.8	4.2
Time on wait list (days)	46	70	122
Client outcomes			
• Percentage of improvement	80%	87.5%	77.8%
• Percentage of clients who would recommend the service	100%	87.5%	94.5%
• Positive changes occurred due to counselling	80%	87.5%	77.8%
Clients referred			
• Male	*	338	230
• Female	*	692	506

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

*** No data collected in 2020/21.*

MĀORI HEALTH ACTIVITIES

- 274 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 meets the 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 or the substance use and choices scale. The expected maximum intervention is up to four sessions (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	2018/19	2019/20	2020/21
Number referred	150	128	183
Number of clinics held	372	334	382
Number of group education sessions provided	42	28	34
Patient feedback via survey			
1. Did you find the service helpful?	80%	94%	100%
2. Have you achieved your goals?	80%	56%	64%
3. Would you tell your mates about this service?	60%	94%	100%
Comparison of alcohol/drug use from start of treatment to end of treatment (percentage improvement)	44% reduction	56% reduction	64% reduction

MĀORI HEALTH ACTIVITIES

- There were 54 Māori referred to the service (30%)

VULNERABLE POPULATION

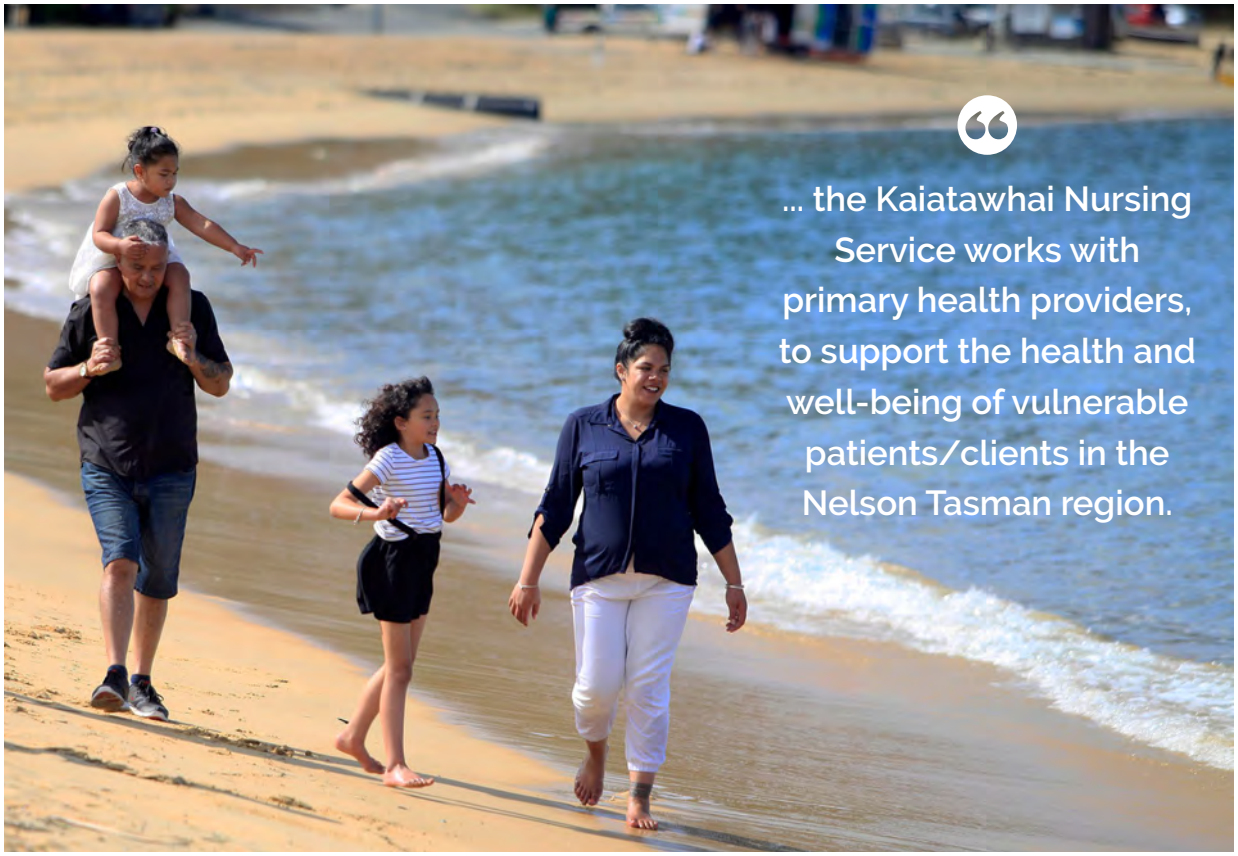
- There was one Pasifika referred to the service

Te Wahanga Kaiatawhai

Kaiatawhai Service

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 Nursing 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	2018/19	2019/20	2020/21
• Number of referrals	256	322	200
• Number of health assessments completed	93	37	34
• Number of patients referred to other providers	42	24	4
• Number of community organisations liaised with for the service	106	43	20
Referrals by ethnicity			
• European	167	193	132
• Māori	70	83	36
• Pasifika	8	11	10
• Asian	5	13	6
• Other/Unknown	6	22	16
Referrals by gender			
• Male	49	36	24
• Female	207	286	176
Referrals by age			
• 0-14	16	12	0
• 15-24	20	23	28
• 25-49	133	203	111
• 50-75	79	84	11
• 75+	8	0	50
Reason for referrals*			
• Support to engage in health screening	201	289	147
• Access to health services	83	90	37
• Mental health	20	21	22
• Education	30	38	56
• Other (court, housing New Zealand, probation)	18	10	14
Of those referred**			
• Unable to contact	25	32	5
• No longer in the area	5	15	3
• Declined	24	35	7
• Deceased	2	0	0

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

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

Continues over...

Kaiatawhai Nursing Service Continued

MĀORI HEALTH ACTIVITIES

- 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
- 36 of the referrals identified as Māori
- All people who identified as Māori were offered the Te Piki Oranga service
- Supported Te Piki Oranga to book Māori whānau into the Marae based COVID-19 immunisation clinic
- Lack of health understanding and transportation are barriers for some whānau
- Supported Mohua Māori whānau-based COVID-19 vaccination clinic which was well received by whānau, focusing on Manaakitanga with waiata
- With the new Kaiatawhai Nurse, we have been able to offer and deliver cervical screening in an appropriate/cultural manner

PATIENT OUTCOMES / SUCCESS STORIES

"A mother was referred to the Kaiatawhai Nursing Service as her child was not immunised. We had some trouble contacting her as she was couch surfing. While we were supporting the mother with the childhood vaccinations, she disclosed that her living situation was not great. We included our Kaiatawhai Social Worker who supported the mother into emergency accommodation, a review was done of her current finances and found that she was eligible for more money via Work and Income. This also helped with the mother's mood. The Kaiatawhai Service team helped with clearing her debt so that she felt like she could make her own appointment at any time with regularly fortnight payments to general practice and supported her by setting up an account at the local pharmacy where she could still access medications for herself when needed. The mother was taken to the Victory Community Centre which provides free kai, food parcels and other services such as the koha shed. She was welcomed at Victory and they will provide ongoing support, if needed. Te Piki Oranga services were also suggested, however the mother was in a much better place stating she had enough support at the time."

The 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

- The Kaiatawhai Nurses continue to support the Ministry of Health's testing of our Port/Border workers within our community (2 – 3 times weekly)
- The Kaiatawhai Nurses are currently supporting the COVID-19 vaccination rollout. This work includes:
  - Authorised Independent Vaccinators – patient details checked and confirmed, health screening questions asked, education and support given and vaccination completed with patient consent
  - Pod Nurse – supporting Authorised Independent Vaccinators with preparation of documentation/COVID-19 Immunisation Register for patients, ensuring hygiene practices are maintained
  - Recovery Nurse – post vaccination advice and care given whilst waiting 20 minutes post vaccine

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:
  - Reduce isolation and/or other social issues
  - Identify unmet social determinants of health needs (e.g. housing, insulation, personal or family health, debt, violence, abuse or neglect)
- To develop collaborative relationships within and across the primary health care community
- To provide navigation through collaborative relationships

PROGRAMME OVERVIEW

The Kaiatawhai Social Work Service provides a holistic assessment based on Te Whare Tapa Wha, along with a strength based approach to support people. The aim is to work alongside them to help identify goals and improve health outcomes. We recently established an interdisciplinary team meeting within Nelson Bays Primary Health. The team brings complex referrals for discussion and provides input to address the health needs which incorporates the services at Nelson Bays Primary Health and in the community. Client confidentiality is maintained and we will extend an invitation to our community partners in the future. This is an exciting development and we wish to grow and develop this approach in the future.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
• Number of referrals	160	113	94
• Number of social work assessments completed	72	47	50
• Number of patients referred to other primary health providers/ non-government organisations community groups	47	32	50
• Number of patients supported to be enrolled in general practice	8	1	8
• Number of community organisations liaised with for the service	46	46	46
Referrals by ethnicity			
• European	98	69	55
• Māori	44	18	28
• Pasifika	2	4	2
• Asian	3	8	8
• Other/Unknown	13	9	1
Referrals by gender			
• Male	54	42	59
• Female	106	71	35

Continues over...

Kaiatawhai Social Work Service Continued

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
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 • Brief intervention alcohol and other drug	• Housing • Ministry of Social Development advocacy • Parenting • Social isolation • Health navigation • General practice enrolment • Combined health and social navigation • Mental health • Brief intervention alcohol and other drug

MĀORI HEALTH ACTIVITIES

- The service is actively engaged with the Te Waka Hauora team, assisting with the Hauora Direct project. This includes working alongside the Public Health nurses, Housing Direct team and general practice. We assisted a number of whānau members to engage in primary health by enrolling them with a general practice. We are looking forward to being able to assist Te Waka Hauora in future health initiatives. As a result of this collaboration, we have been able to strengthen connections with the Housing First team, some of whom now feel comfortable to contact the social worker to access the Vulnerable Populations (VIP) project funding and to link vulnerable people to general practice
- We have supported the Kaiatawhai nurses while they have been involved in the COVID-19 response, including working closely with general practice, Te Piki Oranga and coordinating with Public Health to provide outreach health screening and vaccinations

OTHER VULNERABLE GROUPS

- The service maintains a strong focus on former refugee communities. We have relationships with Victory Pharmacy and Red Cross. The work done with these vulnerable families is often complex and time consuming as we work to fill this gap
- Another exciting shift this year, was having the social worker move into the Mental Health team. The social worker has taken on the task of triaging referrals for the Brief Intervention Service. This development means that patients from vulnerable client groups can be identified and offered other services in the community. This comes in the form of a social work assessment and onward referrals in the community and via the interdisciplinary team. This has been particularly effective for those with young children in their care. An early intervention for these clients means that their children benefit from having a supported and engaged parent. We also offer focused acceptance commitment therapy to these clients which mirrors the interventions being delivered by health improvement practitioners in general practice

PATIENT OUTCOMES/SUCCESS STORIES

- Working with parents to make sure they are supported while they wait to receive therapeutic interventions
- Helping patients clear practice debt, utilising Vulnerable Populations (VIP) funds and accessing Ministry of Social Development funding
- Working successfully alongside various non-government organisations such as Age Concern, Christians Against Poverty, Barnardos, Victory Pharmacy, Victory Community Centre
- Increasing and solidifying community networks
- Supporting teams across Nelson Bays Primary Health to deliver considered holistic primary health interventions

Ratonga Rata General Practice

Advance Care Plans

PURPOSE Advance care planning is a process that assists an individual to identify their personal preferences and consider treatment and care options that can be incorporated into plans for their future health care if they become unable to make decisions for themselves.

It is relevant to all people, however is most applicable to patients with a life limiting illness. It involves the individual discussing these issues with their health care professionals and family members.

OBJECTIVE

- To empower people to fully participate in planning their own care
- To enhance the care of people and their families/whānau by ensuring that their wishes are followed at the end of life or in the event of serious illness
- To provide easy and reliable access for primary, secondary and community care clinicians to the patient's wishes to guide treatment and care if the patient is no longer able to express wishes directly

PROGRAMME OVERVIEW

General practices are able to be funded to provide eligible patients with an advance care plan to support their future health decisions. 95% of all plans are developed within general practice.

Where an advance care plan is added in Health One, it is accessible by any health care staff member who has clinical access to Health One or Health Connect South.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2020/21*
Number of advance care plans completed	212
Age	
21 – 40	1
41 – 60	6
61 – 80	81
81 – 100	124
Registrations broken down by ethnicity	
• Māori	2.5%
• Pasifika	0.5%
• New Zealand European	97%
• Other	0%
Number of advance care plans developed within general practice	212
Number of advance care plans finalised on Health Connect South	284

**This is the first year this programme has been reported on.*

MĀORI HEALTH ACTIVITIES

- 2.5% of those who accessed the service identified as Māori

Te Tiaki Ngawari (Flexible Care) (formerly known as "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

The criteria and structure changed in January 2021, from an allocation/packages of care model to a flexible funds allocation model. Eligible patients are able to access subsidised appointments (at the discretion of their general practice) to support them with their chronic (or long term) condition or terminal illness.

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. There is no longer a limit on the amount of "packages" a patient can use, it is at the general practice's discretion as to how much funding they claim for each patient based on their needs. The new structure has been well received by general practice as they are able to utilise their allocation to full capacity and better support their patients.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
Service Outcomes			
• Number of patients registered in care plus	7,551	7,577	8,405*
• Number of reviews completed	17,158	16,334	3,831*
Registrations broken down by ethnicity			
• Māori	11%	11%	11%
• Pasifika	1%	1%	1%
• Other	88%	88%	88%

**These numbers are from 1 July 2020 – 6 January 2021.*

Since the model change in January 2021, there have been 16,009 consults. Of these consults, 1,504 were received by Māori patients. Given we have not had a full year of the new model it is hard to compare the data against previous years.

Diabetes Annual Review

PURPOSE To provide a subsidised or fully subsidised appointment at general practice annually, for adults diagnosed with diabetes, to review their care and management of diabetes. The aim is 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 attacks 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 (haemoglobin A1c is commonly used to indicate a person's average blood glucose levels) 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 is to detect early signs of complications and to support people living with diabetes. This appointment allows for a 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	2019/20	2020/21
Number of reviews completed	2,443	2,646
Ethnicity of those having a diabetes annual review		
• Māori	175*	224
• Pasifika	34*	43
• New Zealand European	1,827*	2,240
• Other	76*	139
Number of reviews where a distress score was recorded	1,338	1,327
Number of patients with a mod-serious diabetes distress score	94	83

**Due to the implementation of the 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)

Emergency Contraception Pill

PURPOSE The basis of the service will be the provision of a free emergency contraceptive pill consultation and free supply of Postinor-1 to women, who are eligible for publicly funded health and disability services within New Zealand.

OBJECTIVE

- Reduce the number of childbirth related diagnoses, including medical terminations of pregnancy
- Improved engagement with sexual health services by Māori and Pasifika women
- Improved access to and awareness of contraception options (not just emergency contraceptive pill) and improved awareness of sexually transmitted diseases
- Wider accessibility to the emergency contraceptive pill

PROGRAMME OVERVIEW

The programme includes free emergency contraceptive pill and emergency contraceptive pill consultations through the following providers:

- Accredited pharmacists
- General practices (including practice nurse)
- Sexual health services

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2020/21*
Service Outcomes	
Number who have accessed the service	1,632
Age Range	
0-15	71
16-17	265
18-24	605
Over 25	691
Ethnicity	
Māori	213
Non-Māori	1,419

**This is the first year this programme has been reported on.*

MĀORI HEALTH ACTIVITIES

- 15% of those who accessed this service identified as Māori

Long Acting Reversable Contraception

PURPOSE The purpose of this service is to decrease the high rates of unplanned pregnancy, which can negatively impact physical and mental health and social wellbeing

OBJECTIVE

- Increase the equity of access to contraception for low income women and those living in deprivation
- Reduce poor health and social outcomes for women and infants associated with an unplanned pregnancy and birth
- Provide more women with support so they can make a decision about their fertility and when to have children

PROGRAMME OVERVIEW

Free consultation and procedure for the insertion and removal (providing the insertion was funded by Nelson Bays Primary Health) of the Mirena intrauterine device (IUD), Copper IUD and Subdermal Implant (Jadelle) for the eligible population at general practice that choose to deliver the service. The device is not funded so the client may be charged for the device.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2020/21*	
Long Acting Reversible Contraceptive		
Service Outcomes **	**Insertions**	**Removals**
Quintile 5	43	3
Community Services Card	140	8
High Risk	132	9
Age		
Under 25	89	7
Over 25	172	10
Type of device		
Copper IUD	159	4
LIUS (Mirena)	72	6
Subdermal	30	7
Ethnicity		
Māori	45	1
Pasifika	6	1
Non-Māori	210	15
Low Cost Access Consultation		
Service Outcomes **		
Quintile 5	96	
Community Services Card	287	
High Risk	154	
Age		
Under 25	171	
Over 25	252	

PROGRAMME MEASUREMENT	2020/21*
Type of consultation	
Pre long acting reversible contraception consult	112
Oral pill	68
Depo provera	221
Other	22
Ethnicity	
Māori	85
Pasifika	23
Non-Māori	315

** This is the first year this programme has been reported on.*

*** People can indentify as more than one category.*

MĀORI HEALTH ACTIVITIES

- 8% of those who accessed the long acting reversible contraception service identified as Māori
- 20% of those who accessed the low cost access consultation service identified as Māori

Palliative Care

PURPOSE To reduce the financial burden on the patient and/or their whānau 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 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	2018/19	2019/20	2020/21
Number of new registrations	320	336	394
Referrals broken down by ethnicity			
• New Zealand European • Māori • Other	87% 4% 9%	82% 6% 12%	87% 4% 9%
Referrals broken down by gender			
• Male • Female	59% 41%	52% 48%	52% 48%
Service provided			
• General practitioner home visit • Prescription • General practitioner consult • Hospice visit • Post death visit • General practice other	26% 31% 26% 3% 6% 8%	25% 32% 21% 3% 7% 12%	21% 35% 26% 1% 6% 11%

MĀORI HEALTH ACTIVITIES

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

Primary Options for Care

PURPOSE The aim of primary 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, Pasifika 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	2018/19	2019/20	2020/21
Total Claims	1,739	3,446*	21,612
Claims by gender			
• Male	830	1,438*	9,163
• Female	909	2,008*	12,449
Percentage of referrals by age			
• 0-4	1%	3%*	6%
• 5-19	7%	12%*	16%
• 20-34	11%	16%*	20%
• 35-49	17%	18%*	20%
• 50-64	27%	23%*	21%
• 65+	37%	28%*	17%

Continues over...

Primary Options for Care Continued

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
No co-payment charged for			
• Community services card holders	302	556*	4,552
• High user health card holders	5	3*	878
• Māori/Pasifika	107	188*	2,436
• Quintile 5	122	174*	43
• Other at general practice discretion	80	93*	43
Services provided			
• IV antibiotics	299	207	222
• IV fluids for dehydration	272	172	137
• Venesection for haemochromatosis	224	337	362
• Spirometry – diagnostic	357	342	456
• Chronic obstructive pulmonary disease acute management	56	69	68
• Insulin initiation	31	49	61
• Management of deep vein thrombosis	15	17	19
• Zoledronic acid infusions	20	196	302
• Ad hoc services	24	231	123
• Entonox (pain)	124	156	162
• Polycythaemia vera	22	17	41
• Iron infusion	231	438	605
• Migraine treatment	21	15	20
• Hyperemesis	28	24	23
• Paediatric intranasal fentanyl	15	17	6

**Figures reported have increased post COVID-19 implementation.*

MĀORI HEALTH ACTIVITIES

- 10% of people who accessed a service identified as Māori, which is the same as last year

OTHER VULNERABLE PEOPLE

- As our former refugee population increases, the need for primary options for care increases 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 perform 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.

Continues over...

Skin Lesion Removal Service Continued

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
• Minor skin lesion removal in general practice	692	788	808
• Intermediate skin lesion service	275	428	508
• Number of patients referred from general practice	2,085	2,259	2,509
Referrals broken down by ethnicity			
• European • Not specified • Māori • Pasifika	91% 6% 2% 1%	72% 26% 2% 0%	90% 7% 2% 1%
Percentage of Referrals broken down by age			
• 0-4 • 5-14 • 15-24 • 25-44 • 45-64 • 65+	0% 1% 1% 5% 25% 68%	0% 1% 1% 5% 23% 70%	0% 0% 0% 6% 20% 74%
Triage destination of referrals received			
• Advice only • Cancelled • Declined • Dermatology department • Ear, nose and throat • General surgical • Ophthalmology • Other – plastics • Referred to general practice (minor) • General practitioners with special interest (intermediate)	5% 4% 3% 1% 21% 18% 2% 1% 30% 15%	6% 4% 4% 1% 13% 13% 2% 0% 33% 24%	5% 2% 7% 2% 13% 14% 2% 0% 33% 22%

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
- 35 Māori were referred to the service in 2020/21

Smoking Cessation

PURPOSE Reduce the prevalence of smoking in Nelson Marlborough and reduce the harm to health caused by smoking.

OBJECTIVE

The service aims to reduce:

- Tobacco related morbidity and mortality
- Serious impacts of smoking during pregnancy
- Smoking prevalence and consumption of tobacco for Māori and Pasifika to make a major contribution to reducing inequalities in life expectancy and quality of life

The service aims to reduce the impact of smoking on people who smoke and their whānau by:

- Supporting people who smoke to quit
- Increasing the chance of success for a quit attempt
- Working collaboratively with health and other services important to the service user
- Delivering the service in a culturally appropriate manner, ensuring that the cultural integrity of each individual is acknowledged and respected
- Providing an open and accessible service to all people who smoke, particularly pregnant women, Māori and Pasifika

PROGRAMME OVERVIEW

The programme enables general practices to be able to provide behaviour change techniques and prescribe medication to support smoking cessation for eligible patients.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2020/21*
Service Outcomes	
Number who have accessed the service	11,529
Registrations broken down by ethnicity	
• Māori	17%
• Pasifika	2%
• New Zealand European	78%
• Other	3%
Number of patients who have received smoking cessation behaviour support and medication**	12,821

**This is the first year the programme has been reported on.*

***This includes patients who may have received both smoking behaviour support and medication.*

MĀORI HEALTH ACTIVITIES

- 17% of those who accessed this service identified as Māori

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 health 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 upskill 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 ongoing 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 the 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.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
Pegasus small groups			
• Number of Pegasus small groups completed	4	3	5
• Average number of doctors engaged in the Pegasus model	37	38	23
• Average rating of the overall quality of the meetings	4.4/5	4.5	4.3
• Average rating of the quality of information provided (resource material)	4.3/5	4.3	4.4
• Average rating of the importance and relevance of the content	4.3/5	4.4	4.6
Multidisciplinary sessions			
• Number of multidisciplinary sessions completed	7	5	4
• Average quality rating of the sessions	4.6/5	4.5/5	*
• Average rating of the quality of information provided (resource material)	3.5/5	4.4/5	*
Continuing nurse education sessions			
• Number of continuing nurse education sessions completed	4	3	0
Nurse personal development fund • Number of applications received	38	30	15
• Number of applications accepted	32	24	12
Quality education sessions			
• Number of cornerstone accredited sessions delivered	8	4	1
• Percentage of general practices who have achieved accreditation	• Foundation accredited: 2 general practices • Cornerstone accredited: 19 general practices	• Foundation accredited: 2 general practices • Cornerstone accredited: 20 general practices	• Foundation accredited: 3 general practices • Cornerstone accredited: 20 general practices

** There were no ratings requested in 2020/21.*

Ratonga ā Tapuhi
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.

Nelson Bays Primary Health / Nelson Asthma Society at the Positive Ageing Expo.

OBJECTIVE

- Promote and support the wellbeing and self-management of people living with respiratory disease through the Nelson Bays Primary Health respiratory nurse one-on-one consultation, Nelson Asthma Society's better breathers classes, pulmonary rehabilitation programme and via other community events
- Provide an evidenced-based pulmonary rehabilitation programme
- Support primary care providers to provide evidence-based care to their patients with respiratory disease. This is done through professional development sessions with health professionals and through consultation with Nelson Bays Primary Health's respiratory nurse from patient education/management review in respiratory clinic
- Support spirometry providers in primary care to ensure quality spirometry is obtained
- Provide education and link in with community stakeholders to ensure consistent messaging regarding 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.

Pulmonary rehabilitation programme February/March 2021.

Community Respiratory Health Service Continued

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
Referrals						
• Total number of referrals received	**272**		**213**		**227**	
Source of referrals:						
• Respiratory nurse	71		55		49	
• Pulmonary rehabilitation	176		124		170	
• Spirometry	25		24		8	
• Other	0		10		0	
Referrals for						
• Adult	262		195		215	
• Paediatric	10		18		12	
• Reason for referral						
– Asthma	21%		22%		20%	
– Chronic Obstructive Pulmonary Disease	77%		75%		77%	
– Other respiratory conditions	2%		3%		3%	
• Ethnicity of referrals	**Māori** 15%	**Non-Māori** 85%	**Māori** 12%	**Non-Māori** 88%	**Māori** 14%	**Non-Māori** 86%
• Spirometry completed in primary care	359		332		392	
Attendance at Respiratory Nurse Specialist Clinics						
• Number attended	48		52		49	
• Ethnicity of those who attended	**Māori** 2	**Non-Māori** 46	**Māori** 10	**Non-Māori** 42	**Māori** 5	**Non-Māori** 44
• Number who did not attend	5	2	1	2	2	2
• Where clients were seen	**Clinic** 95%	**Home** 5%	**Clinic** 70%	**Home/Phone** 30%	**Clinic** 72%	**Home/Phone** 28%
• Self-management and action plan discussed with patient	98%		95%		98%	
• Number of whānau/group education sessions delivered	3		2		17**	
Better Breathers and Pulmonary Rehabilitation						
• Number of better breather classes delivered	*		*		140	
• Number of pulmonary rehabilitation programmes delivered	3		2		3	

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
• Percentage of participants who completed pulmonary rehabilitation programme	89%		76%		78%	
• Participants who report increased confidence in self-management	95%		96%		94%	
• Participants who report improved exercise tolerance	89%		95%		88%	
• Participants who improved chronic obstructive pulmonary disease assessment test score	73%		90%		80%	
• Participants who were motivated to continue improving their fitness	100%		98%		100%	
• Ethnicity of participants	**Māori** 12%	**Non-Māori** 88%	**Māori** 0%	**Non-Māori** 100%	**Māori** 20%	**Non-Māori** 80%
• Number of professional development sessions to health professionals	**Sessions** 5	**Attended** 43	**Sessions** 7	**Attended** 38	**Sessions** 7	**Attended** 45
• Consultancy advice provided to health professionals	12		3		18	
• Engagement with community services	5		9		4	

* *New class provided in 2020/21 financial year.*

** *All sessions including those done by Nelson Bays Primary Health's respiratory nurse and the Nelson Asthma Society. Previous years reported only the respiratory nurse sessions.*

MĀORI HEALTH ACTIVITIES

- We received a small number of referrals for Māori
- We continue to work with Māori health providers to help engage and facilitate participation in our programme as appropriate

PERSONAL SUCCESS STORIES/ FEEDBACK

"The course has been very positive for me, I feel better physically and mentally regarding my diagnosis. It was the first time I looked forward to an exercise session, now feeling fitter than I have been for years. I now attend the Better Breathers Class to maintain my fitness and attend talks on respiratory health."

"I want to continually come to the course, so we can continue to benefit from it."

"Lost weight (5kgs), now breathing better, informative speakers, friendly pulmonary rehabilitation team."

"Breathing better, stronger in my body, managing my medication properly."

Director of Primary Health Nursing

We are incredibly proud of our dedicated primary and community care nurses who have worked tirelessly in these challenging times to ensure the people we serve receive equitable and sustainable healthcare to meet their many and varied needs.

As well as keeping their usual extensive workload on track, our nurses stepped up to support us to roll out our COVID-19 immunisation response. Nelson Bays Primary Health is leading the rollout in our region, alongside Nelson Marlborough Health.

Providing a response to meet the needs of our community is always our focus and the nursing teams have been instrumental in us achieving this. This includes rural, pop-up, marae based and static COVID-19 immunisation clinics at various times of the day/evening and over many weekends.

We also have an increasing number of nurse practitioners and nurses undertaking postgraduate study and some working towards a designated nurse prescriber qualification. These roles are a significant support to our general practice teams and a pro-active approach to increasing nursing skills and knowledge base.

We have tailored some of the education opportunities to meet our specific primary care needs and have brought some education providers to our region rather than our nurses having to travel to larger centres. Our nurse leaders have been instrumental in this work – we are truly fortunate to have such great support at leadership level.

Over the next year we will increase our focus on working as one health system to provide equitable care to all.

Donna Hahn
Acting Director of Nursing

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 vaccines

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 and 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 herd immunity which is >95% target population immunised)	2018/19		2019/20		2020/21	
• 8 month old immunisations	87%	9.2% decliner rates	90%	7.6% decline rate	89%	6.9% decline rate
• 2 year old immunisations	87%	10.9% decliner rates	86%	10.9% decline rate	87%	10% decliner rate
• Pertussis (whooping cough)	87%	Outbreak of pertussis in 2017 still continues	86%	Outbreak of pertussis in 2017 still continues	*	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 outbreak remains current. No reported cases in Nelson Tasman	*	Measles remains a current issue with low coverage. No reported cases in Nelson Tasman from the recent outbreak
• Influenza	23%	Our region experienced the biggest uptake ever	28%	Our region experienced the biggest uptake ever	22.3%	Our region experienced the biggest uptake ever

Continues over...

Immunisation Facilitation Service Continued

PROGRAMME MANAGEMENT	2018/19	2019/20	2020/21
Education and promotion			
• Influenza vaccinations uptake to Nelson Bays Primary Health employees	89%	89%	74%
• Nelson Bays Primary Health immunisation newsletter	6	4	3
• Resource development and distribution	3	3	3
• Public promotion	6	6	6
• Outbreak notifications	4	5	1
Health provider support			
• General practice	160	300	550
• Supporting other health providers	150	150	200
Vaccinator training and accreditation			
• Total clinical assessments completed	53	43	36
Cold chain management			
• Total accreditations completed	26	21	17
• Validations and cold chain monitoring	35	68	21
High needs influenza programme			
• Total number of people receiving a high needs influenza immunisation	1,034	2,503	**
– Number of Māori immunised via this programme	248	580	**
– Number of Pasifika immunised via this programme	59	414	**
– Number of people identifying as from a refugee background	306	723	**
– Other high needs/vulnerable people	411	786	**
• Influenza clinics held at Te Piki Oranga	***	***	2
– Number of Māori immunised	***	***	41

**The pertussis and measles percentages for the 2020/21 financial year are currently unavailable.*

***There was no 'high needs' influenza programme held during the 2020/21 financial year due to the funding stopping.*

****New service provided in the 2020/21 financial year and previous financial years data not available.*

MĀORI HEALTH ACTIVITIES

- Attendance at two Te Piki Oranga monthly Mihi Whakatu
- Two influenza clinics held at Te Piki Oranga
- Working closely with Te Piki Oranga around provisional vaccinator authorisations

Lactation Service

PURPOSE To provide lactation consultant services and specialist breastfeeding support for mums who meet the referral criteria.

OBJECTIVE

- To support increased breastfeeding rates upon discharge from the maternity unit and up to six months postnatal
- To provide one on one consultations and advice to build maternal/whānau confidence and knowledge
- To support workforce development towards increased confidence, knowledge and skills around breastfeeding

SERVICE OVERVIEW

To provide a specialised lactation consultant service across the Nelson Tasman region. The service provides education and lactation advice in the hospital, through primary care in the community, in the home or close to where mums live.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
• Numbers referred	241		243		233	
• Ethnicity	**Māori** 6%	**Non-Māori** 94%	**Māori** 3%	**Non-Māori** 97%	**Māori** 4%	**Non-Māori** 96%
Attendance						
• Numbers seen	241		243		233	
	Clinics		**Clinics**		**Clinics**	
– Community clinic	55%		32%		35%	
– Postnatal ward	14%		7%		7%	
– Special care baby unit	14%		7%		6%	
– Home	10%		34%		38%	
– Other	7%		20%		14%	
• Average time to be seen	1 week		1 week		1 week	
Workforce development (consultancy)						
• Number of education sessions	**Sessions** 14	**Attended** 90	**Sessions** 13	**Attended** 72	**Sessions** 17	**Attended** 97
Specialist areas addressed						
• Complexities addressed	11		11		11	
• Onward referrals	110		144		102	

Continues over…

Lactation Service Continued

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
Outcomes at discharge			
Percentage of mums fully breastfeeding at discharge	69%	60%	67%
Percentage of mums partially breastfeeding at discharge	27%	38%	30%
Percentage of mums who ceased breastfeeding at discharge	4%	2%	3%

MĀORI HEALTH ACTIVITIES

- Referrals for Māori women has averaged at 4% 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 required 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

PROGRAMME MEASUREMENT	2020/21			
	JULY – SEPTEMBER	OCTOBER – DECEMBER	JANUARY – MARCH	APRIL – JUNE
Total calls	984	1,274	1,156	895
Call Analysis*				
Handover to on-call general practitioner	257	230	320	239
Handover to after-hours primary care	494	618	539	427
Clinic booking	19	49	38	39
Handover to emergency department	39	55	53	38
Handover to ambulance	54	45	48	46
Other outcomes, exercise self-care and contact general practitioner next day	226	175	158	106

**Clients may access more than one service.*

ETHNICITY	Number	Percentage
Asian	29	1%
European	2,516	58%
Māori	365	9%
Middle Eastern/Latin American/African	4	0%
Pasifika	53	1%
Other	98	2%
Unknown	1,236	29%
TOTAL	**4,309**	**100%**

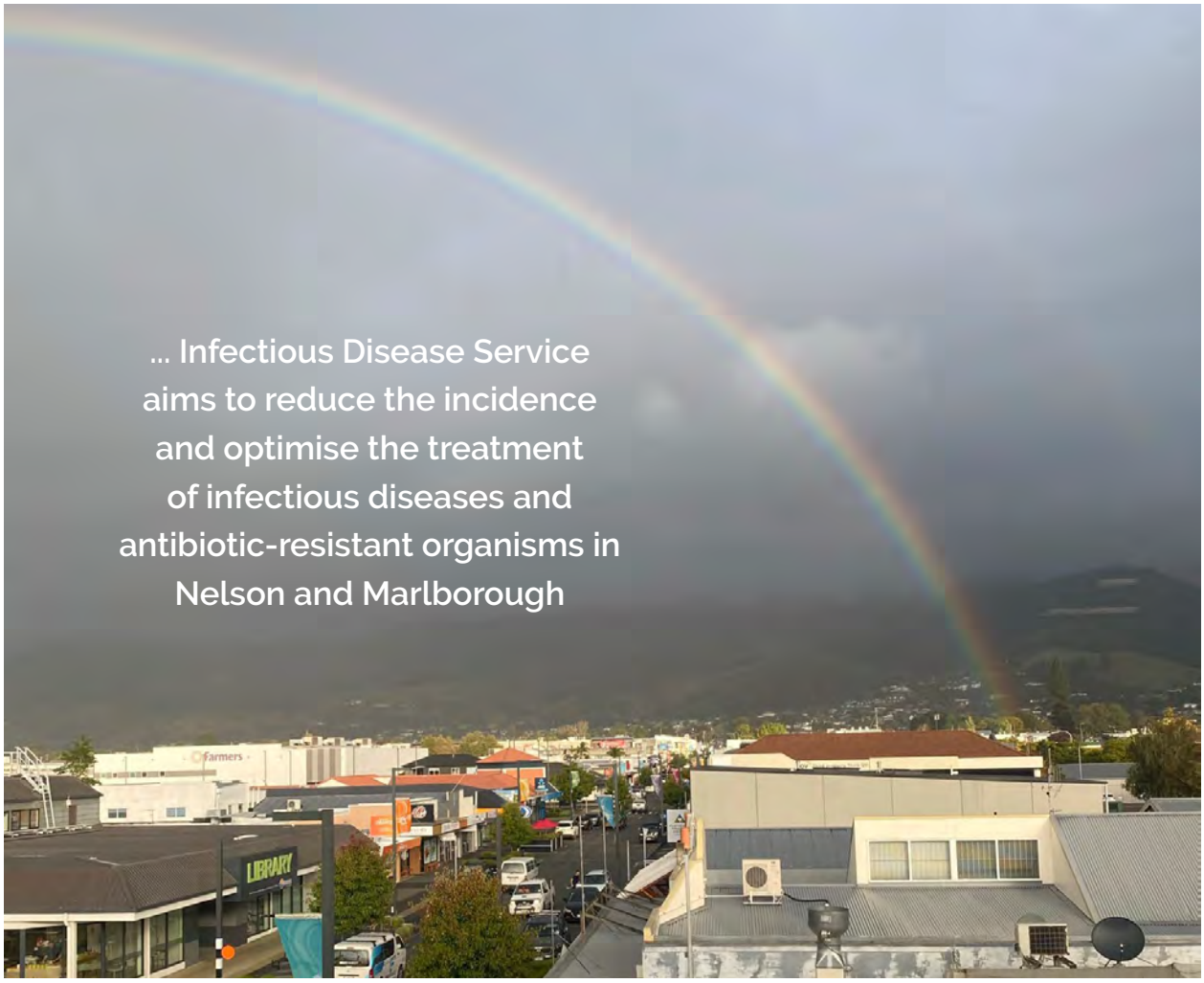
Mātonga Rata Specialist Services

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 testing; 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



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Infectious Diseases Service Continued

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19			2019/20			2020/21		
Management of patients									
• Number of telephone consultations	1,395			2,214			1,906		
• Total appointments/consults	658			751			1,023		
• Number of new outpatient referrals	173			201			297		
• Ethnicity of new referrals	**Māori** 8		**Non-Māori** 165	**Māori** 15		**Non-Māori** 186	**Māori** 18		**Non-Māori** 279
• Patient waiting time from referral to first contact (compared to national target)	< 120 days			< 120 days			< 120 days		
• Breakdown of where patients seen	**Virtual** 545	**Clinic** 89	**Hospital** 24	**Virtual** 619	**Clinic** 87	**Hospital** 45	**Virtual** 947	**Clinic** 65	**Hospital** 11
System improvement									
• Antimicrobial stewardship committee	Does not exist			Does not exist			Does not exist		
• Nelson Marlborough Health hospital antibiotic guidelines up to date	36/36			36/36			11/36		
• Number of audits in Nelson/ Marlborough	2			1			2		
• Number of teaching presentations	11			24			14		
• 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 14 delivered
- Did not attends – less than 5%

MĀORI HEALTH ACTIVITIES

- 18 new patients identified as Māori

OTHER VULNERABLE GROUPS

- 8 new patients identified as Pasifika

Rheumatology Specialist Service

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

OBJECTIVE

To provide a community-based specialist service that:

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

SERVICE OVERVIEW

Nelson Bays Primary Health is contracted to provide a general practitioner special interest rheumatology service for the Nelson Marlborough region. Nelson Bays Primary Health employs a specialist rheumatologist and a specialist nurse as the core of the service. This service is free to all patients. In Nelson we anticipate a new general practitioner starting in the next quarter and Marlborough has increased the hours of its general practitioner participating in the general practitioner special interest clinics.

We continue to use telehealth and the electronic referral management system to augment the service and to assist in our attempt to meet the need in the community. The new patients are seen in a timely manner although the need for follow up appointments continues to be more than the service has capacity for.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
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 appointments	367	141	371	137	336	73
– Follow up	1,065	408	1,319	261	1,481	425
– Compliance to meet the 100% Ministry of Health target	80%	100%	100%	95%	100%	100%
– Number of general practitioners with special interest within service	5	2	4	2	2	2

Continues over...

Rheumatology Specialist Service Continued

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19		2019/20		2020/21	
Total referrals	**Nelson**	**Marlborough**	**Nelson**	**Marlborough**	**Nelson**	**Marlborough**
• Age breakdown:						
– 10-19	2	9	7	5	11	8
– 20-30	2	28	57	31	70	21
– 30-40	10	40	182	51	193	50
– 40-50	8	70	224	64	260	71
– 50-59	2	112	360	115	392	121
– 60-69	3	111	415	121	442	121
– 70-79	3	70	316	98	352	153
– 80 +	1	37	87	28	99	22
Treatments and referrals						
• Biologics usage (number of patients)	176		160		163	
• Infusions	13		15		22	

TARGETS

- Provide 500 first specialist appointments. There were 409 provided
- Provide 1,150 follow up appointments. There were 1,906 provided

MĀORI HEALTH ACTIVITIES

- 131 of the patients identified as Māori in Nelson
- 55 of the patients identified as Māori in Marlborough
- There has been further clinic activity with Te Piki Oranga and sharing of knowledge and support for specific clients has continued
- Fast-track referral system in place for Māori health providers, for specialist nurse reviews. This continues to be utilised
- Nelson Bays Primary Health's Kaiatawhai Liaison has been instrumental in assisting with support regarding transportation and with serious impactful social issues requiring particular expertise needed in the cultural setting

He Kaupapa Rautaki 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, there are now 199 general practices implementing the model.

In 2020, the Health Care Home Collaborative launched a refined Health Care Home Building Blocks model, with a specific focus on improving equity and consumer involvement. The model is designed to improve access and outcomes, including using telehealth and a more comprehensive workforce focusing on planned and proactive care.

There are currently 14 general practices (11 in Nelson Bays, 3 in Marlborough) implementing 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	2018/19	2019/20	2020/21
Service Outcomes			
• Number of general practices engaged	• Five general practices district wide	• 14 general practices district wide	• 14 general practices district wide
• Clinical Assessment and Treatment (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 implemented clinical assessment and treatment (general practitioner triage)	• All 14 general practices are offering a triaging system for their urgent appointment requests and promoting alternative to face-to-face consultations when appropriate	• 12 general practices are offering a triage system for their urgent appointment requests • One general practice will trial triage soon • One general practice is not offering a triage system at present. • All 14 general practices are offering alternative to face-to-face consultations when appropriate
• A fully functional Patient Portal 	• 16 to 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	• All 14 general practices have a fully functional patient portal. There has been a steady increase in the number of patient activations from 32% to 35%. General practices are actively promoting the patient portal
• 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 patients district wide) • These general practices work with 54% of our enrolled Māori population (7,877 district wide)	• 53% of the enrolled population is enrolled in a general practice participating in Health Care Home (80,799 patients district wide) • These general practices work with 54% of our enrolled Māori population (7,908 district wide)

Continues over...

Health Care Home Model Continued

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
Service Outcomes			
• Equity	*	*	• All Health Care Home general practices were supported to develop and integrate a Māori Health Plan • A number of general practices have appointed an equity champion • General practices have reported on a quarterly basis a narrative update on what they are doing to provide culturally appropriate services and to strengthen cultural competency of staff • Implementation of locality care coordinators has strengthened existing relationships with Māori, Pasifika and Migrant community providers

PROVIDER AND PATIENT FEEDBACK

The following feedback has been received from general practices:

"A patient telephoned the practice for an appointment for a possible UTI. The patient was triaged and booked in for an urgent appointment. The patient gave feedback saying " I was delighted as I thought I was going to have to wait for a week to get in".

"A care plan was done for a diabetic patient who had had a stroke. The patient rang the general practice and another team member was able to manage the patient effectively as the nurse had access to the care plan. This was a great team effort and shows successful use of care plans within the practice."

"A Pasifika family of 6 who recently relocated to the region, with a newborn received the type of equitable care our practice strives to provide. With no transport to come and collect the forms, our Clinical Manager took the forms to the family one afternoon and introduced the whanau to the practice through a personal visit."

"Patients have appreciated the extra flu clinics provided throughout the week as many could not make the weekend clinics. Extended hours continue to be appreciated by our patients."

Health Care Home Model of Care

Summary

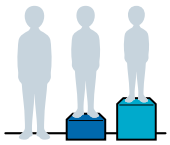
7.1 Same day access and appointment systems

7.2 Access to care during business hours

7.3 Patient wait times

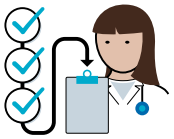
7.4 Telephone assessment & treatment (clinical triage)

When I'm unwell



10.1 Improving health equity

11.1 Routine & preventative plan



11.2 Prework

11.3 Continuity of care and whanaungatanga

11.4 Technology enablers

11.5 Iwi and social services

12.1 Affordability systems

12.2 Cultural needs

13.1 Alternatives to in person consults

14.1 Fully functional portal

15.1 Patient engagement

15.2 Patient experience

16.1 Proactive planning

17.1 Health literacy

18.1 Call demand monitored

19.1 Appointment systems

19.2 Extended hours

20.1 Health records

Need help to find a specific resource - contact our Resource Navigator on collaborative@hch.org.nz

To keep me healthy

Sourced from www.healthcarehome.co.nz

Vulnerable Populations (VIP) Project

PURPOSE The VIP project targets Māori, Pasifika 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 funding 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 work in partnership with other organisations to provide a wrap-around service based on the person's needs

PROGRAMME OVERVIEW

What began as a programme led by community agencies is now an embedded joint programme between general practice and the agencies. This supports our 'any door is the right door' approach for this vulnerable cohort of people.

Agencies now most often communicate first with the general practice and then send the person along for their visit, while still supporting those who need it to attend their appointment.

General practice identifies those who require extra support, this can include financial support and referrals back out to community agencies.

How well did we do?

KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
Number of general practice vouchers used			
• Lead agency	240	197	117
• Virtual voucher (issued by general practice)	*	211	207
• Total general practice vouchers used	240	408	324
• Total general practice vouchers used	*	60%	94%
Ethnicity of those using a general practice voucher			
• Māori	42	114	102
• Pasifika	2	20	6
• Non-Māori/Pasifika	196	274	216
Number enrolled with a general practice			
• Non-Māori	**	**	164
• Māori	**	**	81
Number with existing debt at a general practice	**43**	**254**	**238**
Number with a community services card	**67**	**277**	**225**
• Of those with a community services card, how many identified as Māori	**	**	84
Number of pharmacy vouchers used	*	**121**	**57**

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

**New measurement to Nelson Bays Primary Health in 2020/21 and previous financial years data not available.*

SERVICE OUTCOMES/SUCCESS STORIES

Communication between general practice and the community agencies has improved significantly through this programme. This supports the wrap around service we aim to provide.

"Helping a man with a very disturbing mental health history, engage with some services. Before he was living rough in total avoidance of any medical or mental health groups. It is a slow process but he is at least engaging with the nurse practitioner and health navigator." – General practice

"Helping a homeless mother with diabetes access food via community groups and to help offset some of her costs in treating her diabetes." – General practice

"The VIP voucher system continues to be an extremely valuable tool for us to use when engaging clients in health conversations. Most general practices are now very familiar with using the process but we still have to use the vouchers at times. We continue to see an increase for requests from organisations such as Te Korowai Trust and Te Piki Oranga who have some clients struggling with general practitioner access due to debt. There has been some contact from case managers in specialist Mental Health and Addiction teams who have become aware that they can access vouchers to help their clients be seen by the general practitioner. Recently we have seen some requests from Women's Refuge as well." – Victory Community Centre

"Many in our community have benefitted using the VIP service and we look forward to learning and being part of any continued use of the scheme or if it ends how to work with Golden Bay Community Health and Nelson Bays Primary Health to support the vulnerable people who continue to struggle around accessing medical services and support." – Mohua Social Services

"VIP was used to support one woman with a child who was new to the area, in emergency housing and in desperate need. Because of the doctor and pharmacy vouchers, she was able to access much needed health advice and medication. She is now in more permanent housing and engaged with the Family Service Centre as well. Within a month, the transformation is already incredible. She has gone from extremely unkempt, anxious, unwell, frightened and angry to a more relaxed, calm and friendly woman. She is now more open to accessing other support services." – Motueka Community House

Te Hauora Iwi Whānui o Mohua

Golden Bay Community Health

Golden Bay Community Health Overview

Golden Bay Community Health is a rural integrated health facility providing extensive health care 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 five flexi beds that are used for acute patient admissions, palliative and/or respite care. Our in-patient unit also offers day stay infusions for our community, which includes chemotherapy and other types of infusions. This service keeps the patient closer to home and prevent travel over to Nelson Marlborough Health.

Although disrupted by COVID-19 over the last year, we normally welcome the mobile surgical bus three times a year which 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 whānau/families for children aged 6 weeks to 5 years. The public health nursing service offers support to children, young people and their whānau/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, primary care dietitian clinics, paediatricians, diabetic clinics, respiratory and cardiovascular clinics.

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 onsite x-ray service and a highly skilled team of practitioners. Our urgent care unit provides a vital service for our rural community.

Aged Residential Care

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

OBJECTIVE

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

SERVICE OVERVIEW

The aged residential care 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	2018/19			2019/20			2020/21		
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)*			Compliant			Compliant *(spot audit completed in February 2021)*		
• Ethnicity of referrals	**Falls** 38	**Pressure Areas** 2	**Medication Errors** 6	**Falls** 94	**Pressure Areas** 0	**Medication Errors** 10	**Falls** 40	**Pressure Areas** 1	**Medication Errors** 5
• Number of complaints	2			2			4		
• Number of residents transferred to Nelson Marlborough Health or other facilities	0			2			2		

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
To promote wellbeing and maximise health performance for individual residents			
• Quality of life benchmarking – quantitative • Satisfaction surveys (residents and whānau) – qualitative	• Achieved benchmarking for quality of life • Resident satisfaction survey completed March 2019	• Achieved benchmarking for quality of life • Resident satisfaction survey completed March 2020	• Achieved benchmarking • Newly adopted patient management system in place • Resident satisfaction survey and whānau satisfaction survey completed May 2021
To ensure staff are well trained and competence to provide high quality of care to the residents			
• Number of staff completed mandatory educational sessions	• 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)	• Registered nurses: 29/36 • Health care assistants: 22/31 (Next update is October 2021 to capture those not completed)
• Number of health care assistants who have completed level 2,3,4 health and wellness certificates	• 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 2: 5 completed • Level 3: 2 completed, 9 underway • Level 4: 2 completed, 9 underway
• Level of uptake for post-graduate education	• 1 registered nurse enrolled on the masters pathway	0	0
To maintain residential occupancy over 90%			
• Average occupancy percentage	96%	97%	96%
• Gender and ethnicity	**Māori** 1 / **Non-Māori** 21 **Male** 5 / **Female** 17	**Māori** 1 / **Non-Māori** 22 **Male** 6 / **Female** 17	**Māori** 1 / **Non-Māori** 23 **Male** 8 / **Female** 16
• Occupancy	88 vacant bed days	11 vacant bed days	223 vacant bed days*
• Average length of stay	26 months	25 months	25 months
• Number of respite days/ year	212	199	318
• Number of people on waiting list	16	25	19

**Vacant beds are utilised with respite care patients, until a long-term resident is occupying the room.*

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	2018/19	2019/20	2020/21
To provide nursing expertise to residents of Golden Bay for the provision of care in the home			
• Number of patients enrolled into the service	177	160	178
• Number of contacts	4,968	3,807	3,703
• Ethnicity and gender of enrolled patients	**Māori** 1 / **Non-Māori** 176	**Māori** 2 / **Non-Māori** 158	**Māori** 5 / **Non-Māori** 173
	Male 90 / **Female** 87	**Male** 82 / **Female** 78	**Male** 97 / **Female** 81
To provide specialised nursing service to palliative care patients and their whānau			
• Number of palliative patients enrolled into service	4	14	13
• Ethnicity of palliative patients	**Māori** 2 / **Non-Māori** 2	**Māori** 0 / **Non-Māori** 14	**Māori** 0 / **Non-Māori** 13
To provide specialised nursing service to oncology patients and their whānau while coordinating care with secondary services			
• Number of oncology patients in the service	6	31	10
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	• Two staff undertaking post-graduate study • Two staff completed advanced care planning training	• One staff undertaking post graduate wound care • Two staff undertaking advanced wound debridement course	• No staff
• Number of education sessions	0	78	76
• Number attending national/international conferences	• Two staff members attended the Australasian wound care conference	• One staff member attended the wound care conference in Dunedin	• No staff

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	2018/19				2019/20				2020/21							
To provide an acute care service to adults in Golden Bay to reduce transfers to Nelson Hospital																
• Number of acute admissions (excludes respites)	289				164				196							
• Age, gender and ethnicity of admissions	**Male** 129		**Female** 160		**Male** 69		**Female** 95		**Male** 75		**Female** 121					
	Māori 15		**Non-Māori** 274		**Māori** 4		**Non-Māori** 160		**Māori** 15		**Non-Māori** 181					
	<40 55	**41-60** 52	**61-80** 95	**>80** 87	**<40** 19	**41-60** 43	**61-80** 59	**>80** 43	**<40** 30	**41-60** 46	**61-80** 60	**>80** 60				
• Transfer of acute admissions to Nelson Hospital	32				19				22							
• Number and type of infusion/ transfusion	**Iron**	**Pamidronate**	**Blood/blood products**		**Iron**	**Pamidronate**	**Blood/blood products**		**Rituximab**	**Infliximab**	**Pertuzumab\ Trastuzumab**	**Tocilizumab**	**Vitimin C Infusion**	**Pamidronate**	**Blood /blood products**	
	34	3	11		2	1	2		2	21	14	7	2	1	11	

Continues over...

Flexi Beds Continued

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
To develop and support the provision of chemotherapy services for Golden Bay			
• Number of chemotherapy/ biological administered	0	25	44
• Number and type of infusion reactions	0	1	0
To facilitate the provision of surgical services, close to home by supporting the mobile surgical bus			
• Number of patients	40	22 (clinics cancelled due to Takaka Hill roading repairs and COVID-19)	0 (clinics cancelled due to Takaka Hill roading repairs)

There were 196 acute admissions in Golden Bay (in 2020/21) 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, at their home 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 18 babies at the Golden Bay Community Health maternity unit and 13 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 23 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 whānau 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

How well did we do?

KEY PERFORMANCE INDICATORS

PATIENT REFERRALS FOR JULY 2020 TO JUNE 2021:

Month	Number	Month	Number
July 2020	34	January 2021	17
August 2020	16	February 2021	15
September 2020	15	March 2021	12
October 2020	14	April 2021	10
November 2020	11	May 2021	26
December 2020	17	June 2021	13
Total: 200 referrals			

Hello, my name is Kate Windle. I have been working as a community occupational therapist in Golden Bay for the past 19 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 an urgent care 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	2018/19		2019/20		2020/21	
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%)	87%		94%		95%	
– Brief smoking (target 90%)	89%		86%		92%	
– Diabetes annual review (target 90%)	58%		52%		70%	
• Number registered and using 'My Indici' (patient portal)	**Registered** 1,538	**Activated** 1,315	**Registered** 2,428	**Activated** 1,465	**Registered** 2,770	**Activated** 1,967
• Waiting room times (average)	24 minutes		21 minutes		21 minutes	
• Current number of enrolled patients	4,955		5,001		5,101	
• Ethnicity of enrolled population	**Māori** 299	**Non-Māori** 4,656	**Māori** 323	**Non-Māori** 4,678	**Māori** 306	**Non-Māori** 4,795

Continues over...

Primary Care Continued

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
To expand service options to ensure greater choice for the community to receive care closer to home			
• New initiatives for care provided	• Telehealth consultations • Accepted for Health Care Home model	• Virtual phone and video consultations are offered as well as in person visits	• Continued virtual phone and video consultation appointments in all general practitioner appointment books • Telehealth consultations available • Patient portal access increased to allow direct emailing between the patient and the general practitioner, as well as visible patient notes
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	95%	296 registrations (patient management system was unable to show the percentage)	71% (July to December 2020 under old allocation package model) 99.8% (January to June 2021 under new allocation model)
• Options for care	95%	77%	97%
To maximise the use of primary care funded services e.g. care plus, to ensure equity of access to health care services			
• Number of nursing staff with specific training – Primary response in medical emergency – Immunisations – Cervical smear	 6 6 4	 7 7 4	 7 8 8
• Number attending national/ international conferences	4	5	6
Community of Golden Bay are satisfied with the service provided at Golden Bay Community Health			
• Number of resolved/total complaints	24/25	7/8	5/6
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	• Dietitian • Podiatrist • Ear health nurse • Newborn hearing screen	• Dietician • Podiatrist • Ear health nurse • Newborn hearing screen

PROGRAMME MEASUREMENT	2018/19	2019/20	2020/21
	• 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	• 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	• Palliative care specialist clinic • Paediatrician clinic • Mole map • Breast screening nus • Mohua Social Services vouchers and support • Regular weekly nurse led cardiovascular risk assessment, spirometry, smear and diabetes clinics • Two medical assistants and two more in training • Speech and language therapist • Nurse prescriber now part of our team • Nurse clinic for youth at Golden Bay High School • Outreach influenza vaccinations for local organisations • Initial COVID-19 vaccination clinics for over 65 and vulnerable populations • Monthly interdisciplinary team meetings with community partners e.g. Police; Mohua Social Services; Te Whare Mahana • Well child clinics
• Number of referrals for short term interventions (mental health)	132	117	99
To ensure 24 hour access to medical services			
• Number of afterhours general practitioner consultations (includes weekend clinics)	1,118	720 (weekend clinics stopped during COVID-19)	862
• Number of primary responses in medical emergency callouts	122	24	26

Ngā Pūrongo Pūtea
Financial Reports

Nelson Bays Primary Health Trust

Summary Statement of Comprehensive Revenue and Expense

for the Year Ended 30 June 2021

	2021 $	2020 $
REVENUE		
Exchange		
Patient fees	780,034	712,226
Age Related care	1,563,051	1,514,608
Non-Exchange		
Hospital Funding	3,200,803	3,106,669
Management Services	1,285,046	1,044,333
Primary Care Contract Services	33,488,831	31,342,679
Other	383,815	275,914
Total Revenue	**40,701,580**	**37,996,429**
LESS EXPENSES		
Accounting and Audit	31,175	24,520
Office & Organisation Expenses	1,750,916	1,746,886
Board Expenses	179,847	161,330
Staffing Expenses	1,703,202	1,454,618
Primary Care Services	30,667,863	28,439,215
Golden Bay Community Health	6,471,929	6,438,954
Total Operating Expenses	**40,804,932**	**38,265,523**
Surplus / (Deficit) before interest	**(103,352)**	**(269,094)**
Finance income - Interest received	43,781	92,459
Finance income - Interest received	43,781	92,459
Surplus / (Deficit) for the year	**(59,571)**	**(176,635)**
Total comprehensive revenue and expense for the year	**(59,571)**	**(176,635)**

NOTE:	2021 $	2020 $
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.	(131,798)	182,135
Share of profit/(loss) from Joint Venture and interest received	96,887	87,859
Remaining surplus/(deficit)	(24,660)	(446,629)
NET SURPLUS	**(59,571)**	**(176,635)**

This Statement has been prepared on the basis as described on page 119

Nelson Bays Primary Health Trust

Summary Statement of Changes in Equity

for the Year Ended 30 June 2021

	Committed Funding Reserve	Retained Earnings	Total Equity
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 from Committed Funding Reserve	182,135	(182,135)	-
Balance at 30 June 2020	**2,479,095**	**1,168,032**	**3,647,127**
Balance as at 1 July 2020	2,479,095	1,168,032	3,647,127
Net surplus / total comprehensive revenue and expense	-	(59,571)	(59,571)
Transfer to Committed Funding Reserve	(131,798)	131,798	-
Balance at 30 June 2021	**2,347,297**	**1,240,259**	**3,587,556**

This Statement has been prepared on the basis as described on page 119

Nelson Bays Primary Health Trust
Summary Statement of Financial Position
as at 30 June 2021

	2021 $	2020 $
CURRENT ASSETS		
Cash and cash equivalents	843,595	1,009,465
Investments	3,004,567	3,012,779
Receivables and Prepayments	2,104,710	1,740,155
Total Current Assets	**5,952,872**	**5,762,399**
CURRENT LIABILITIES		
Payables	1,467,353	1,405,989
Employee benefits	1,384,925	1,153,872
Total Current Liabilities	**2,852,278**	**2,559,861**
WORKING CAPITAL	**3,100,594**	**3,202,538**
NON-CURRENT ASSETS		
Plant, Property & Equipment	674,650	622,023
TERM LIABILITIES	**187,688**	**177,434**
NET ASSETS	**3,587,556**	**3,647,127**
Represented by:		
Committed Funding Reserve	2,347,297	2,479,095
Retained Earnings	1,240,259	1,168,032
EQUITY	**3,587,556**	**3,647,127**

13 September 2021

Trustee: Sarah-Jane Weir
Dated: 13 September 2021

Trustee: Kim Ngawhika
Dated: 13 September 2021

This Statement has been prepared on the basis as described on page 119

BDO Wellington Audit Limited

Nelson Bays Primary Health Trust
Summary Statement of Cash Flows
for the Year Ended 30 June 2021

	2021 $	2020 $
Net cash flows from operating activities	238,634	110,630
Net cash flows from investing activities	(404,504)	266,934
Net increase / (decrease) in cash and cash equivalents	**(165,870)**	**377,564**
Cash and cash equivalents at beginning of period	1,009,465	631,901
Cash and cash equivalents at end of period	843,595	1,009,465

This Statement has been prepared on the basis as described on page 119

Nelson Bays Primary Health Trust
Notes to the Summary Financial Statements
for the Year Ended 30 June 2021

The summary financial statements for Nelson Bays Primary Health Trust for the year ended 30 June 2021 have been extracted from the full financial statements. The full financial statements were approved by the Board on 13 September 2021. 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.

On 21 April 2021, the Government confirmed the details of the health system reforms in response to the Health and Disability System Review. A Transition Unit was set up to lead the response to the Health and Disability system Review. The current implementation roadmap would suggest that legislation will be passed in early 2022 to disestablish all existing District Health Boards and merge their function into a single entity, Health New Zealand.

The Trust generates almost all revenue by contracting with Nelson Marlborough District Health Board. Guidance given by the Transition Unit states that such contracts will transfer to Health New Zealand. The Transition Unit further declared that primary and community care will be reorganised to serve the communities of New Zealand through 'localities'. Health New Zealand and the Māori Health Authority will jointly commission primary and community services through four regional divisions to such 'localities", also referred to as 'local networks'.

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 2021, 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 2021. We expressed an unmodified audit opinion on those financial statements in our report dated 13 September 2021.

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 2021 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
13 September 2021

Kia piki te ora o ngā tāngata katoa