TE WAIORA Nelson Marlborough Health

# Quality Account

Patient stories and healthcare initiatives in Nelson Marlborough

2016

# CONTENTS



We have endeavoured to ensure that information in this Quality Account is accurate at the time of printing.

# WELCOME TO OUR 2016 QUALITY ACCOUNT

**What is it?**

This publication intends to inform our communities about the Health and Quality outcomes delivered by the Nelson Marlborough District Health Board (Nelson Marlborough Health) in the 2015-16 year.

**Message from the Board**

It is my pleasure to present this year's Quality Account. These patient stories and healthcare initiatives provide a snapshot of some of the work undertaken within the Nelson Marlborough Health system on any given day.

I would like to thank our consumer representatives, Robyn Beckingsale and Paula Hucklesby, for working alongside us to ensure the stories are readable and not tied up in medical jargon and acronyms.

The stories are about prevention, diagnosis, illness and treatment that affect real people.

They are also about our dedicated staff who always look to improve the service we provide, for ways to make it more convenient, apply new technologies and communicate effectively.

The stories are also about how we learn from events that were not as they should have been – to find the cause, make changes and ensure we don't repeat our mistakes. Our commitment to continuous improvement and working together, challenging each other and finding a better way, is something Nelson Marlborough Health does very well.

Everyone comes to work, every day, to make a difference. As a community we should celebrate this.

Happy reading

Jenny Black
Chairman,
Nelson Marlborough Health

## Consumer advisors' message

As consumer advisors, Paula and I are very happy to represent the people of Nelson Marlborough who use the health system.

Our input has been to keep the medical jargon to a minimum, and generally keep the focus on you and how the system works for you.

We hope you enjoy the quality improvements and healthcare initiatives outlined here. We also invite you to share your views via the Nelson Marlborough Health website about any topic...you will be heard.

Robyn Beckingsale &
Paula Hucklesby

# A DAY IN THE LIFE OF NELSON MARLBOROUGH HEALTH

# OUR PEOPLE

**52** people receive support and advice to quit smoking

**33** women are screened for breast cancer

**1159** people visit a GP

**37** radiology tests are completed (CT and MRI)

**10** older people receive a comprehensive clinical assessment

**50** over 65 year-olds are vaccinated against influenza (during 'flu season)

**6** children receive a Before School Check

**5** babies complete their vaccinations for the eight-month-old age group

**35** people receive a cardiovascular risk assessment

**8** people receive a green prescription (a referral for increased physical activity)

**41** women are screened for cervical cancer

With a population of almost 145,000 (2013 Census data), Nelson Marlborough makes up 3.2 per cent of the New Zealand population. By 2033 our population is expected to grow by an additional 14,000 people.

The Nelson Marlborough population is older than the New Zealand average with eight per cent of residents aged 75 years and older, compared to the national average of six per cent.

Our largest proportionate population growth is among our older people. Nelson Marlborough's 75+ population is expected to more than double, with Tasman projected to nearly triple, by 2033.

We have a significantly lower proportion of Maori (ten per cent in 2016) and Pacific (one per cent) people compared to the national average. However, 50 per cent of our Maori population is under 25, so Maori make up a larger proportion of our children and young people (nearly 18 per cent). At three per cent, our Asian population is projected to experience the largest percentage growth, more than doubling by 2033.

The majority of our region's population (87 per cent) comprises people who identified as Europeans in the 2013 Census, with small numbers of people with Middle Eastern, Latin American and West African origin.

*Source: Nelson Marlborough Health Needs and Service Profile 2015*

# HEALTH TARGETS

## Nelson Marlborough Health results April – June 2016.

| | Target | Achieved |
|---|---|---|
| **Shorter Stays in ED**<br>95 per cent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. This target measures the flow of acute (urgent) patients through public hospitals and home again. | 95% | 96% |
| **Improved Access to Elective Surgery**<br>The volume of elective (planned) surgery will be increased by an average of 4,000 discharges per year for all DHBs. | 100% | 105% |
| **Faster Cancer Treatment**<br>85 per cent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer. This target will increase to 90 per cent of patients by June 2017. | 85% | 76% |
| **Increased Immunisation**<br>95 per cent of infants aged eight-months will have completed six weeks, three months and five months immunisation events on time. | 95% | 91% |
| **Better Help for Smokers to Quit**<br>90 per cent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. | 90% | 90% |
| **More Heart and Diabetes Checks**<br>90 per cent of the eligible population will have had a heart and diabetes check in the last five years. | 90% | 91% |

Health Targets are a set of national performance measures designed by the Ministry of Health to improve the performance of health services. They provide a focus for action.

Three of the six targets focus on prevention initiatives and the other three on patient access to services. This section shows how we are tracking against those targets.

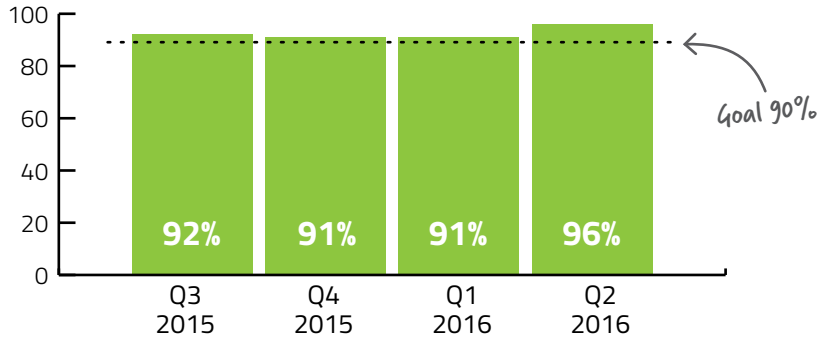
# QUALITY AND SAFETY MARKERS

The Health Quality and Safety Commission drives improvement in the safety and quality of New Zealand's healthcare.

Quality and Safety Markers (QSMs) help us to evaluate and determine whether we have achieved a desired change in practice and harm reduction.

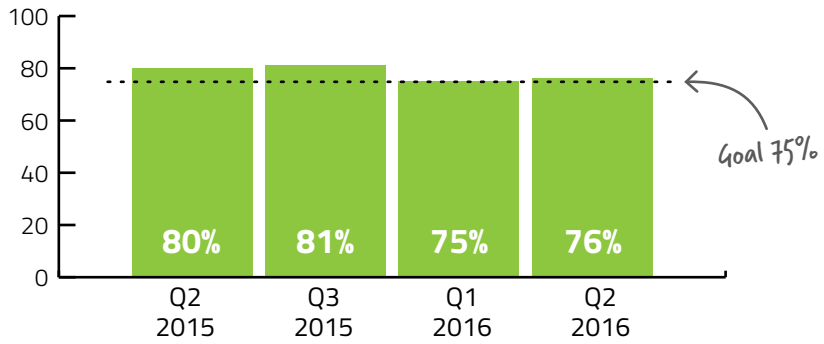
## Falls Prevention

Older patients assessed for risk of falling.



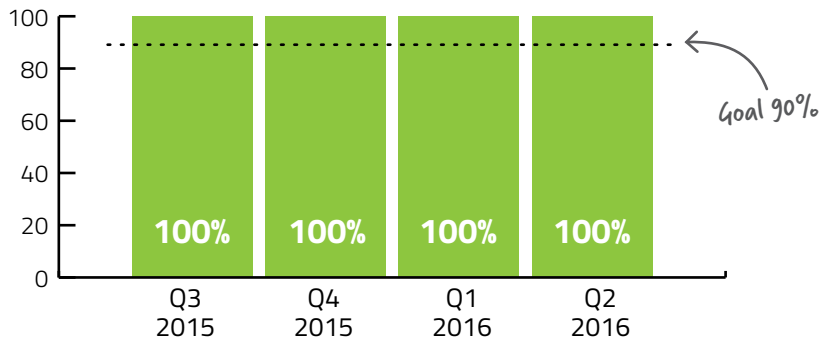

## Hand Hygiene

Good hand hygiene prevents healthcare-related infections. This measures compliance with five hand cleansing moments: before patient contact; before a procedure; after a procedure; after patient contact; and after contact with patient surroundings.




## Surgical Site Infection

Percentage of hip and knee arthroplasty procedures were given appropriate skin preparation.



# ADVERSE EVENTS – WHEN THINGS GO WRONG

An adverse event (previously known as a 'serious' or 'sentinel' event) is one that results in the need for significant additional medical treatment, is life-threatening or has led to an unexpected death or major loss of function.

The way in which we report and investigate adverse events underpins the culture of transparency and trust we strive for.

Event reporting also supports continuous quality improvement initiatives.


It is important that we learn as much as we can from events, and translate that into change and improvement.

## Alison's story

Alison and her husband were attending an outpatient appointment at Wairau Hospital. At home Alison used a walker and when she was out she used a walking stick.

As they were returning to their car Alison's ankle gave way and she fell in the corridor and fractured her hip. Later that same day she went to theatre and the hip fracture was repaired. After a two-week period of rehabilitation Alison was discharged home.

The fall was reported to the Health, Quality and Safety Commission because the level of injury was significant, requiring surgical intervention and a prolonged hospital stay, and an internal review was conducted.

**The review looked at:**

- Patient factors, including Alison's age, health, and general mobility.
- Environmental factors. Was the floor wet or slippery that day? Was there a handrail available? Had Alison and her husband been able to access the mobility parks closer to the entrance, or had she had to walk a considerable distance? Were there wheelchairs available at the main entrance at the time of their visit?
- Communication factors – did Alison and her husband know ahead of the appointment that assistance with mobility was available?

**The review team made several recommendations which have now been implemented:**

- That an audit be undertaken of mobility parks, their usage and availability
- That signage be erected at the front entrance indicating the location of wheelchairs for public use
- That all outpatient appointment cards include information about mobility assistance available to people when they arrive at the hospital.

# EMERGENCY AT THE HOSPITAL? CALL 7777 OR 8888

When there's an emergency situation in the hospital, it's important the right people turn up at the right place, at the right time.

In 2015 we refined our hospital emergency call process. Until this work was done, when a 7777 (Nelson) or 8888 (Wairau) call was made, up to 35 medical staff could be called to one incident.

"When a Medical Emergency Team was needed it wasn't clear who should or shouldn't be going – there were no set rules and when too many people attended it confused the situation," project co-ordinator Lin Roberts said.

By analysing the types of emergencies prompting 7777 or 8888 calls, the project team identified six distinct emergency teams: adult, child, obstetric, neonatal, trauma and difficult airway. The processes associated with helicopter, security and fire emergency calls remained unchanged and were not part of the project.

Under the revised procedure, when an emergency call is made the operator will answer "Emergency" and ask the caller to identify the 'TLC'; T for the team they need; L for their exact location and C for a brief description of the patient's condition.

The operator then pages the members of the appropriate emergency team or teams. Each team has a designated colour which is especially useful when a staff member calls and states a 'green emergency' to the operator rather than a 'paediatric'.

Once the revised procedure was approved by the clinical governance committee, Lin commenced a comprehensive communication and training plan.

After each emergency call audit forms are completed and detailed information is collected. This information is presented to the resuscitation committee and any issues are followed up.

"The new process speeds up our ability to send the correct team to the emergency because a pager message goes out to a predetermined list."

Laureen McLean,
Team Leader for Teleops.

# HEALTHCARE INITIATIVES IN ACTION

## Juices and 'diet' drinks removed from hospital cafes and patient meals


First it was the removal of sugar-sweetened beverages in March 2014. Then we took the next step and stopped stocking artificially-sweetened beverages, sugar-added juices, flavoured waters and pre-packaged 'smoothie' drinks.

Since 1 May 2016 these drinks are no longer available from hospital cafes, shops and vending machines, nor are they served to patients. Instead, patients and visitors are offered a range of water, coconut water, plain milk, plain milk alternatives (such as almond milk), teas and coffee.

Chief Executive Chris Fleming says artificially-sweetened beverages may be free of calories but not of consequences: "They encourage sugar craving and sugar dependence, and are strongly associated with dental erosion due to their high acidity."

He says the move sends a clear message regarding our commitment to the health of people in our region. All 20 of the country's DHBs have now removed sugar-sweetened drinks for sale on-site.

## Care pathway improves patients' experience

Access to information and involvement in decisions and consents are a key part of the Enhanced Recovery after Surgery (ERAS) programme for hip or knee joint replacement.

The ERAS care pathway uses a series of interventions to improve the patient's experience, and their recovery, so they can go home earlier and return to normal activities sooner.

The patient, family and whanau all play an active role in the ERAS process. For example, surgical dates are mutually agreed and there's comprehensive pre-surgery patient education to teach patients how to use crutches and other loan equipment.

To ensure a patient understands and takes part in the ERAS pathway, there's a collaborative multidisciplinary approach throughout a patient's journey – from the pre-admission stage through to post-surgery recovery.

### Terry's ERAS journey

Terry Delany's second hip replacement was a very different experience from his first.

He says he wasn't well prepared for the first operation eight years ago, struggled to get out of bed and took a comparatively long time to recover.

"The next time I was much better informed, as well as knowing what to expect," says Terry. "It was a really easy experience... smooth and seamless with no problems."

Terry also found it was particularly helpful to be able to take home the right equipment he needed on the day he was discharged without having to go and pick it up afterwards.

# KEEPING OUR KIDS SAFE

## A safe place for our babies to sleep

Pepi-Pod or wahakura for newborns may be offered to whanau before they leave hospital as part of a safe sleep plan.

The portable beds, put to the test during the Christchurch earthquakes, help reduce the risk of babies being accidentally suffocated while sleeping in an adult bed.

Their use is also reducing the rates of Sudden Unexpected Death in Infancy (SUDI, also known as SIDS or cot death).

Special Care Baby Unit Charge Nurse, Maureen Higgs, says babies need to have a smokefree environment and their own safe bed.

"Preferably in a bassinet or cot, on a firm flat surface, face up and face clear, with no toys in the sleep space or loose blankets they can pull over their face," she says.

Pepi-Pods may be offered to parents who smoke and those who wish to co-sleep with their babies.

Nelson Marlborough Health has provided around 20 free Pepi-Pod beds in the last four years to vulnerable infants in our region. The 'Change for our Children' website has more information about Pepi-Pods.

**Make every sleep a safe sleep**

- Place the baby in their own bed to sleep
- Stop smoking during pregnancy and after the baby is born
- Position baby on their back with face clear
- Encourage breastfeeding.

## The Well Child Tamariki Ora book now also a user-friendly app

The digital age has come to the Well Child Tamariki Ora My Health Book (commonly referred to as the Plunket book). Now there is a Well Child mobile device app to help busy parents keep track of their children's Well Child checkups and immunisations.

Once the app is downloaded, a parent or caregiver can enter a child's date of birth and the app, using the device calendar, will automatically set reminders.

Paediatrician Dr Nick Baker says the app will help families keep kids well by getting the right care at the right time.

"Keeping up to date with issues like immunisation and dental care is vital to prevent diseases and stop future problems," he says.

The Well Child app will not replace the Well Child Tamariki Ora, My Health Book, but has been designed to sit alongside it.

# REDUCING NUMBERS AT WAIRAU ED

People in Marlborough are making smart choices about their healthcare and taking the pressure off Wairau Hospital's Emergency Department (ED).

A year ago, too many people were going to the Wairau Hospital Emergency Department (ED) for things that could have been seen by their GP or other primary health professional. The rate of ED presentations in Marlborough was close to double the national average, at 490 presentations per 1,000 people annually.

A joint project by Nelson Marlborough Health, Marlborough Primary Health Organisation and general practices worked at several levels to change what appeared to be an engrained Marlborough habit of 'getting it checked out at ED'.

"It is a fraught business to attempt to list the conditions that merit ED care and those that do not, but some clearly fall into the could-be-seen-elsewhere category," says Dr Andrew Morgan, Wairau Hospital clinical head of emergency.

A year-long campaign involving media, social media and word of mouth marketing has spread the message that it is not appropriate to go to ED with a cold, a sprained ankle, a niggly sore back, an ingrown toenail or other non-emergency conditions.

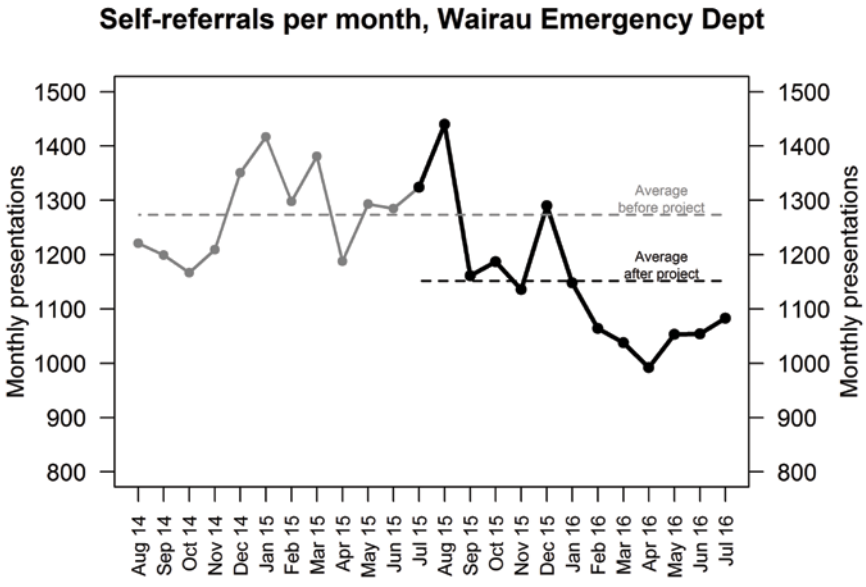
A study of people presenting at the ED found that many had not sought advice from their GP or pharmacist before going there. So the project team promoted the options available in the community and encouraged people to seek advice when they were not clearly dealing with emergency cases. The roles of GPs and the urgent after-hour GP service, GP practice nurses, physiotherapists, pharmacists and Healthline were highlighted.

The public were not the only ones being asked to change. The ED staff also faced their own considerable culture change. They started by telling people with GP-level conditions that while they would be seen that day, they should go to a GP for such conditions next time.

In November 2015, a redirection policy was introduced. Under this policy, a nurse continues to check patients arriving at the ED and evaluates the urgency of their condition. Anyone who would get better care in a primary health setting is helped to make an appointment with a GP instead of being seen in the ED. This process is ongoing and is being monitored by ED staff and general practices.

Dr Morgan says he supported the project because it was in the best interest of individual patients and the wider community.

"People get optimal care when their primary healthcare needs are seen to in a primary health setting (a general practice) – and their emergency health needs are seen to in an emergency setting," he says. "It's promising to see that presentations at the ED have stopped climbing steadily compared to the same month the year before and in some months have even fallen. The overall result is a better health outcome for everyone. "

# ALTERNATIVE PATHWAYS FOR TREATING DRUG AND ALCOHOL ABUSE IN YOUTH

When a young person is harmed or gets into trouble due to drug or alcohol use, they may be referred to the Nelson Marlborough Health Addictions Service.

Referrals are made by school counsellors, the hospital Emergency Department, families, GPs, Corrections staff and by the person needing help.

Youth Addiction Clinician Debbie Christie says a team of health professionals use a screening process to determine if the young person should receive help through the Primary Health Organisation (PHO) Alcohol and Drug Service or through the Nelson Marlborough Health Addictions Service, which falls under secondary mental health services.

Debbie says the distinction between the two pathways is significant.

"A primary health alcohol and drug clinician offers brief intervention using talk-based therapy and education," she says. "The Mental Health and Addictions Service provides a comprehensive assessment, a treatment plan, possible use of medication and if required referral to a residential rehabilitation centre."

Debbie says someone with significant issues with substance abuse is likely to be referred to the Addictions Service whereas a young person, who may be at a stage in their life where they are just exploring drugs and alcohol, may not need this full service.

"Previously there was no alternative pathway, so a young person who turned up in ED due to excess alcohol consumption would have been referred straight to the Addiction Service," Debbie says, "and going through a specialist mental health service can be stigmatising for some young people."

Now that referrals are screened, interventions can be provided by the most appropriate service.

"Young people using drugs and alcohol minimally, or only experimentally, no longer need to be seen in a secondary service, but we are still addressing their use and ensuring we minimise any harm."

The shared screening process has also enhanced the working relationship and created a smoother transition between the two services.

"We are getting the right help, to the right people in the right place. This enables us to develop other areas as we are not swamped with lots of young people that don't need to be with the service."

In the six months from October 2015 to April 2016 there were 133 referrals to the Addictions Service and 32 referrals to the PHO alcohol and drug service. The referral triage system was put in place early in 2015.

> "We are getting the right help, to the right people in the right place."
>
> Debbie Christie
> Youth Addiction Clinician

# ELECTRONIC DRUG CHARTS WORKING WELL

The cloud-based medication charting system, Medi-map, is making it much easier to track changes to prescription medications for rest home patients.

The system is also making hand-written medicine charts obsolete for some rest homes, GPs and pharmacies that traditionally hold hard copies of patient drug charts – each of which could be slightly different.

The Medi-map system however, creates an individualised electronic drug chart for patients, which is stored on the internet (the 'cloud'). This means the prescriber, rest home and pharmacy are linked by Medi-map in a shared interface, where all users are looking at the same chart. The electronic charts are 'live' and can be updated in real-time to ensure accuracy.

Clinical pharmacist Greg Oldridge says this solves the potential issue of medication being unintentionally omitted from a patient discharge summary.

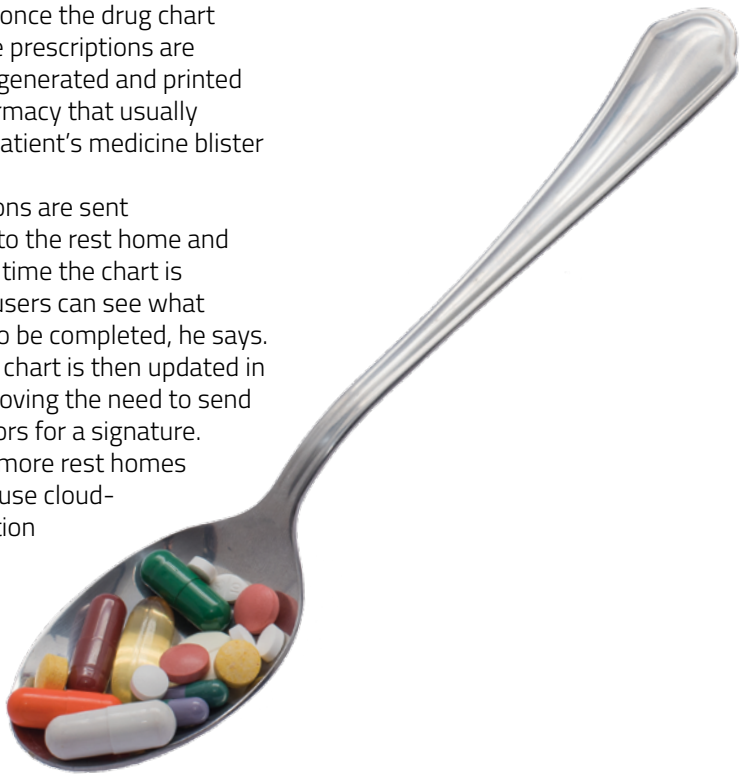
"With Medi-map, when a patient is discharged, a doctor can access the drug chart directly online and make changes – this way it remains the 'one source of truth."

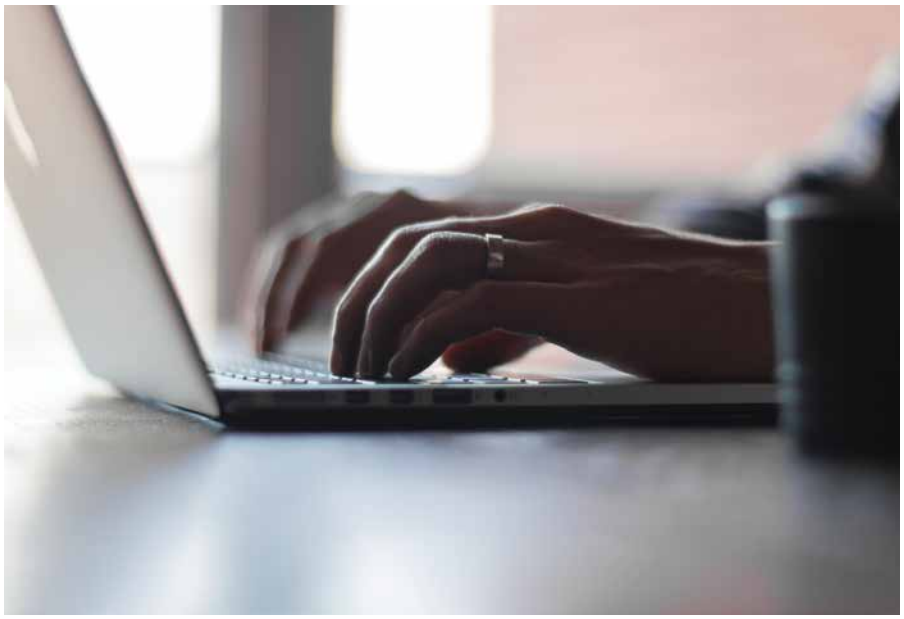
Greg says once the drug chart is updated, the prescriptions are automatically generated and printed out in the pharmacy that usually prepares the patient's medicine blister packs.

Notifications are sent automatically to the rest home and pharmacy any time the chart is updated, and users can see what actions need to be completed, he says.

The single chart is then updated in real-time, removing the need to send charts to doctors for a signature.

He hopes more rest homes will sign up to use cloud-based medication charting and management systems.





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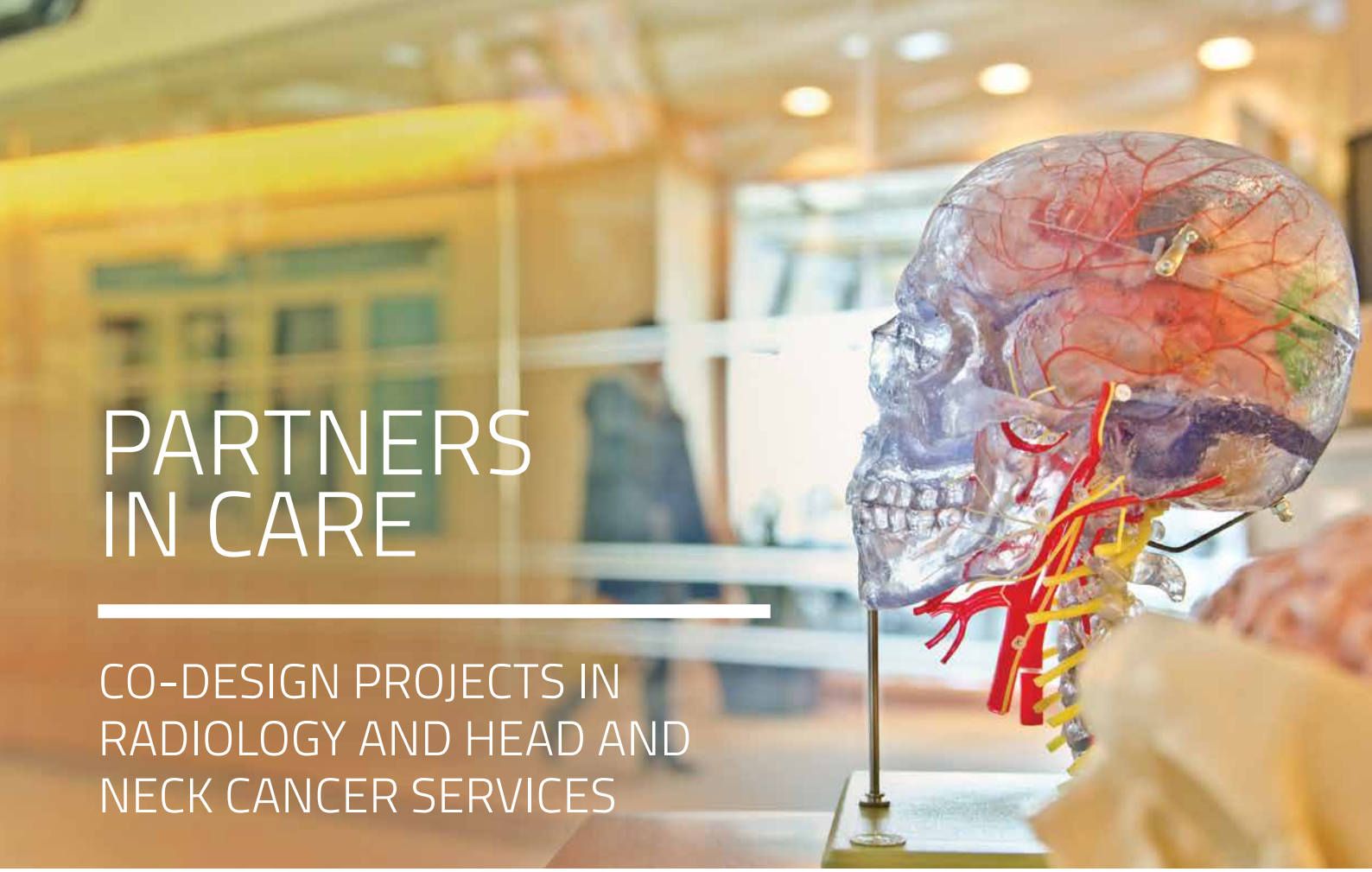


# PARTNERS IN CARE

## CO-DESIGN PROJECTS IN RADIOLOGY AND HEAD AND NECK CANCER SERVICES

Partners in Care is a Health Quality & Safety Commission plan to promote change within the health sector.

Under the plan consumers are seen as key partners and provide valuable input about how services can be improved, where priorities should be set and where quality issues arise in the delivery of health services.

Two Nelson Marlborough Health Partners in Care projects are using co-design methods to improve the patient experience in the radiology department and in head and neck cancer services.

**Radiology patients 'co-design' improvements to service**

A new approach to finding out how people feel about radiology services at Nelson Hospital has proved effective.

Shona Niven, former Radiology Team Leader says the team looked closely at each patient's experience in the department and 'co-designed' improvements to the service they offer.

"The essence of co-design is having patients as part of your team – they are alongside you," she says. "So rather than assuming we knew where the issues were, we asked our patients for their feedback."

Jane Besley, Charge Nurse Manager Cardiology, says staff used different methods to capture people's experience with radiology services.

"We surveyed people about their journey through the Radiology Department – in the waiting room, and before or after their procedure," Jane says. "It's very much a patient-centred approach."

Jane says the responses were overwhelmingly positive.

"One bit of feedback asked for more 'blokey' magazines in the waiting rooms, for instance ones about hunting, fishing or cars, and that's an easy fix."

The patient comments are put up on notes on the corridor wall in the Radiology Department so patients and staff can see the feedback. In addition to the survey the team also conducts one-on-one interviews.

**Project smooths head and neck cancer treatment pathway**

Patients' care often involves more than one organisation – including those outside of their region. The co-ordination of this care is critical to ensure that patients receive appropriate care and have a positive experience.

Using co-design methods to develop a questionnaire, head and neck cancers patients helped identify the strengths and opportunities for service improvement.

Speciality Clinical Nurse ENT Maura Foley said the feedback from patients identified three 'touch points' of concern around transport to Christchurch, attendance at multidisciplinary team meetings and support expectations once a patient returns to Nelson.

As a result of the consumer feedback Maura says the service has designed more patient-centred, user-friendly processes and resources to improve the patient experience.

"We've got a better understanding of what it is like for patients to travel between regions for treatment," she says.

"The project has strengthened links across all the teams involved and it has provided an opportunity to ensure all parts of the service are better aligned."


## One foot ahead in diabetic foot ulcer care

A  Nelson Marlborough Health initiative has reduced diabetic foot ulcer-related amputations and hospital admissions for infection.

Foot ulceration is a common diabetes-related complication and is the leading cause of all amputations. However, up to 80 per cent of amputations are preventable when foot ulcer care is delivered by a specialised, multidisciplinary team.

## Before 2010

In 2009 Nelson Marlborough Health diabetes speciality staff noted diabetic ulcer wounds were not healing and the number of amputations was rising. At this time there was no dedicated diabetic foot ulcer clinic and most diabetes patients received wound care only. This helped some patients but it was not enough for others.

Diabetes Clinical Nurse Specialist, Frances Horner says there were a number of issues in diabetic foot ulcer care at that time. These included the lack of a dedicated diabetic foot ulcer clinic; no common pathway for the treatment of such ulcers; no referral for diabetes management review; poor self-care among people with diabetic foot ulcers, and a lack of targeted preventative measures.

## The trial clinic began

In 2010 a multidisciplinary team decided to trial a diabetic foot ulcer clinic to reduce ulcer healing time and reduce the amputation rate.  The clinic used existing services as no new funding was available.  The service offered at the clinic was in line with best evidence practice, started in 1986 in the UK by Professor Edmonds and others.

The trial clinic ran between 2010 and 2012.

## What did we do at the clinic?

People with diabetic foot ulcers were referred to the clinic and seen urgently for assessment and treatment plans.

Patients were assessed for the underlying cause of the ulcer.  If the blood flow was not good enough, they were referred for vascular surgery. They were also assessed for underlying nerve damage and infection.

## Types of diabetes

There are two main types of diabetes.

### Type 1

Type 1 more often develops in childhood and requires daily insulin injections.

### Type 2

Type 2, which usually develops in adulthood, makes up more than 90 per cent of today's diabetes burden. Type 2 diabetes may be prevented through healthy eating and being active.

An essential aspect of diabetic wound care is to reduce pressure, also known as offloading. Offloading was done using a variety of methods – total contact cast, airboot, orthotic shoes or total contact insoles.

Treatment plans also included continued wound care along with optimising their diabetes management.

By having so many services involved in wound care, the clinic provided a unique facility.

## The results

Data gathered between August 2010 and May 2011 from the patients referred to the clinic showed a high wound healing rate was achieved. It also proved that quick access to specialist care improved outcomes for people.

**Wound healing:** 88 per cent of ulcers healed in the trial period between August 2010 and May 2011. The re-ulceration rate was low at 18 per cent during a two year follow up.

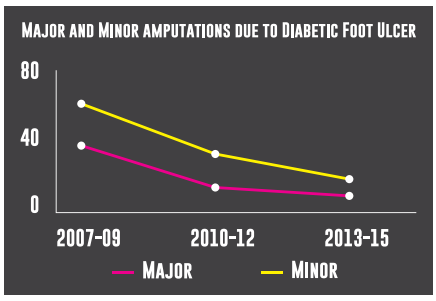
**Specialist referral:** People were seen by podiatry, orthotic, orthopaedic, dietary, psychology, and dermatology specialists. They were also seen by district and specialist wound nurses. 18 per cent were identified with 'critical ischaemia' or reduced blood flow and required urgent vascular surgery. 30 per cent had high risk factors they were unaware of.

**Diabetes review required:** 60 per cent needed diabetes management support and were supported by the specialist diabetes team. High patient motivation led to improved outcomes and improved self-care.

**Reduction of amputations:** There was a reduction of amputations by 45 per cent.

## What happened next?

The clinic ceased operation at the end of 2012 due to lack of funding. Care for diabetic foot ulcers is still provided but at reduced capacity. Patients are picked up through different services and only some people are seen by the diabetes team.




## In 2016?

While the service today is better than prior to 2010, the care of diabetic foot ulcers is not as good as when the clinic was running. Now the service is only seeing the tip of the iceberg.

Progress slowed with the departure of the sole-charge Nelson Marlborough Health vascular surgeon, but is expected to pick up again with the appointment of a new surgeon.

## Future focus

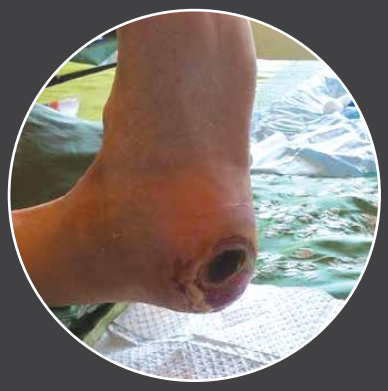
The focus is on identifying high-risk patients early in primary and community healthcare settings and educating them about foot self-care to prevent foot ulcers and ultimately an amputation.

The success of the trial clinic supports the goal of a permanent, funded, multidisciplinary foot ulcer clinic.

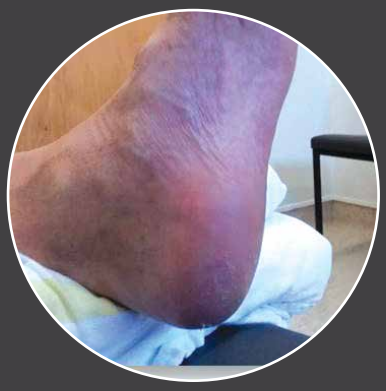
The diabetes services will continue to aim for low amputation and re-ulceration rates and will maintain a strong focus on the patient, family and target groups (such as men living home alone).

### Case Study:

In 2012 a 76 year old man presented with a necrotic (dead tissue), diabetic foot ulcer on his left heel. This was due to heel pressure, poor foot self-care, isolation, nerve and blood vessel and other disorders. With off loading and working alongside the patient and his family for a number of years, the multidiscipline team were able to heal his ulcer and save his leg.



Before Treatment



After Treatment

### The risk of diabetes

Diabetes is a major contributor to the loss of health in New Zealand and accounts for 80 per cent of early deaths. One in 20 adults in Nelson Marlborough, or more than 6,000 people, has diabetes and the rate is growing. Maori are at twice the risk as non-Maori; men and those living in more deprived areas have a higher prevalence of diabetes.

People with diabetes are frequent users of public hospitals. Diabetes complications include heart disease, eye disease, renal failure and blood vessel disorder. The rate of hospitalisation for people with diabetes in Nelson Marlborough has doubled in the past 10 years and it is increasing annually by 6.7 per cent (2015 Health Needs Analysis).

# BETTER ACCESS TO SEXUAL HEALTHCARE

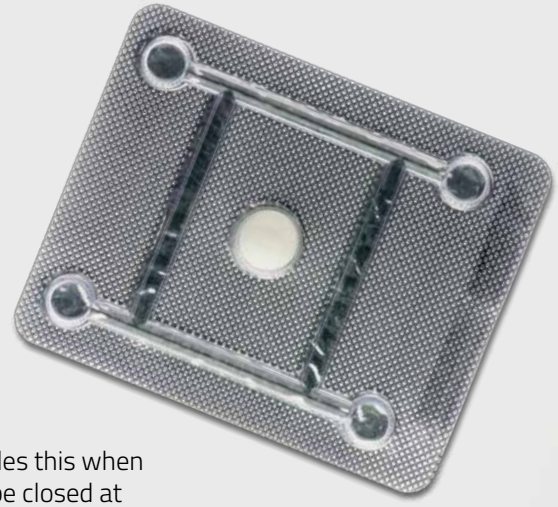
Reports of teenage girls asking pharmacists for the 'morning after pill' only to find they didn't have enough money to buy it prompted the development of the Emergency Contraceptive Pill (ECP) pilot programme by the Nelson Bays Primary Health Organisation.

A confidential service was developed in 2011 and initially provided free emergency contraception, after unprotected sexual intercourse for women under 25 through pharmacies in the Nelson-Tasman region.

In addition to the ECP, women also receive condoms and a voucher for a free, confidential sexual health appointment. The project is supported by all pharmacies and the majority of general practices in the area.

The ECP is effective when taken within 72 hours of unprotected sexual intercourse. It is not an abortifacient; it won't terminate an existing pregnancy. Because the effectiveness of the ECP declines with time, it should be taken as soon as possible.

Therefore, timely access to contraception advice and support, particularly at weekends, is important.



The ECP service enables this when other providers may be closed at weekends or after-hours.

Following the introduction of the initial service, there was a 59 per cent reduction in pregnancy terminations in women under 18 in Nelson. This result was not mirrored in Marlborough where women still had to pay around $45 for the ECP.

Buoyed by this success, in October 2015 Nelson Marlborough Health funded the expansion of this service to women in Marlborough. There is also now a wider range of providers of the free ECP, including general practices, INP Medical Nelson, Family Planning Marlborough and Maori health providers.

The resulting increased uptake of the ECP shows there is a demand for better access to sexual healthcare for women of all ages, across the district.

The service continues to be developed with further promotion and a redesign of the voucher and advertising material to appeal to the youth market.

"Every woman should have the right to access services to help control their own fertility. The ECP is only one of many ways in which we support women to control their fertility."

Dr Nick Baker,
Paediatrician.


Want to know more? See *Health for Tomorrow*, the *Health Services Plan*, and the *Annual Plan 2016/17* at nmdhb.govt.nz/published-documents

# FUTURE FOCUS 2016

To meet the health needs of almost 145,000 people in our region we need to plan. As well as making sure the services delivered today are safe and of high quality, we also need to plan for future services.

We know our population is changing, and this means changing health needs. More people live with multiple and long-term health conditions, such as diabetes and heart disease, and need healthcare. We also have more people over 65 than the average DHB, and their health needs tend to be greater, putting pressure on the health system.

We will need more GPs, nurses and hospital beds to meet this demand. We need to work smarter, using technology and more healthcare workers.

Nelson Marlborough Health has long, medium and short-term plans. The long-term plans are outlined in *Health for Tomorrow*, the specific actions for the next three years are in the *Health Services Plan*, and the *Annual Plan* is for one year only.

As well as continuing to provide current health services, the *Annual Plan 2016/17* outlines the following highlights for the coming year.

**We will:**

- support obese children to get active and eat well
- increase mental health services in the community
- provide more services from community health hubs (Richmond and Blenheim) which offer a range of health services in one location
- plan for new health roles
- increase access to patient information with patient portals (secure online sites, provided by GPs, where patients can access their health information and interact with their general practice)
- move to the 'whole of South Island' patient administration system
- achieve Health Targets and Quality Safety Marker targets
- talk with more patients and learn from their stories
- plan the Nelson Hospital rebuild
- promote water as the best choice to drink.

TE WAIORA Nelson Marlborough Health

## Tell us what you think

We need your suggestions about how we can improve the quality and safety of services. Tell us what matters to you by contacting us.

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