TOSHA
TOP OF THE SOUTH HEALTH ALLIANCE

SYSTEM LEVEL MEASURES

Improvement Plan

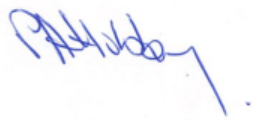
Top of the South Health Alliance

2021/22 Financial Year

Signatories to the Top of the South Health Alliance(ToSHA) SLM Plan 2021/22

Beth Tester, Chief Executive
Marlborough Primary Health

Sara Shaughnessy, Chief Executive
Nelson Bays Primary Health



Anne Hobby, Tumuaki/General Manager
Te Piki Oranga

Lexie O'Shea, interim Chief Executive
Nelson Marlborough Health

The development of this System Level Measures Improvement Plan (SLM Plan) was guided by the following key principles from Nelson Marlborough Health's (NMH) *Ki te Pae Ora Programme*:

- **Delivering care to achieve equity** - improve Māori health, support vulnerable communities
- **Healthy communities** –innovation and sustainable ways to achieve a healthy environment
- **Person and whanau centred** – people empowered to manage their own health, information for safe care available where needed
- **Flexible and Responsive** – easy to access, looking at whole of need, enabling digital solutions
- **Sustainable and whole of system approach** - an integrated and connected system – designed across health and social systems, patient journey is smooth across organisational boundaries
- **Safe, skilled and compassionate workforce**

The SLM Plan comprises integration and improvement work undertaken across Nelson Marlborough Health through our Alliance leadership team, Top of the South Health Alliance (ToSHA). The SLM Plan has been developed to drive the implementation of the Ministry of Health's System Level Measures framework and it will be submitted to the Ministry of Health as an appendix to Nelson Marlborough Health's Annual Plan 2021/22.

The System Level Measures are set, defined and monitored nationally. ToSHA has locally set and agreed the improvement milestones, contributory measures, and actions in our key priority areas. Each System Level Measure milestone and contributory measure in the SLM plan is based on analysis of local trends to appropriately address the needs and priorities of our population. All measures, including contributory measures, will be broken down by ethnicity so that we can monitor equity on a population basis.

Most activities identified using the SLM Framework and detailed in the plan are developed and lead by the Ki te Pae Ora Programme and the networks and sub-groups of ToSHA. Wellbeing and proactive programmes in the community, planned care, unplanned care, and public health are the four key workstreams of the alliance. The membership of ToSHA includes representation from across the Nelson Marlborough (NM) health system and includes the two PHOs that operate in Nelson Marlborough: Marlborough Primary Health and Nelson Bays Primary Health, as well as Te Piki Oranga, a kaupapa Māori primary health provider.

Members of the Top of the South Health Alliance (ToSHA) are:

- Cathy O'Malley (GM, Strategy, Primary & Community)
- Andrew McGlashen (Pharmacist)
- Anne Hobby (Tumuaki/General Manager
- Te Piki Oranga)
- Kirsty Martin (GM, IT Corporate Support)
- Lexie O'Shea (Chief Executive-interim)
- Pat Davidson (GM, Clinical Services, Corporate support)
- Beth Tester (Chief Executive, Marlborough Primary Health)
- Sara Shaughnessy (Chief Executive, Nelson Primary Health)
- Ditre Tamatea (GM, Maori Health & Vulnerable Populations)
- Jane Kinsey (GM, DSS and Mental Health Services)
- Ros Gellatly (Clinical Director, Primary & Integration)
- Nick Baker (Chief Medical Officer, Models of Care)
- Graham Loveridge (Clinical Director, Nelson Bays PHO)
- Guy Gardiner (Clinical Director, Marlborough PHO)
- Hilary Exton (Director, Allied Health)
- Stephen Bridgman (Medical Officer of Health, Public Health Physician)

In addition to ToSHA, the following people were engaged for their specialist clinical and subject-area expertise:

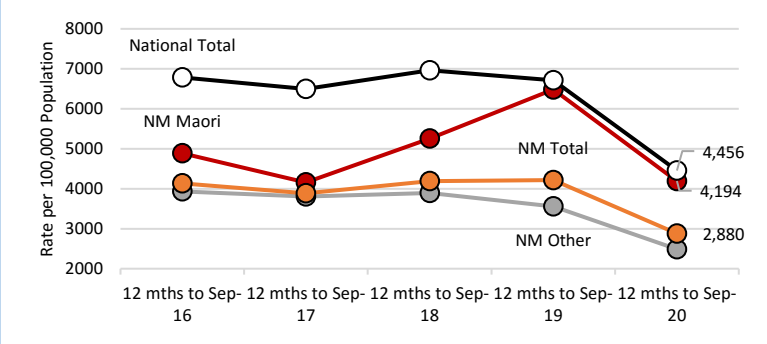
Keeping children out of hospital	• Lauren Ensor (Health Promotions Manager) • Donna Hayday (Oral Health Educator) • Andrew Goodger (Sector Relationships/Contract Manager, Primary & Community) • Phil Sussex (Clinical Director Community Oral Health Service) • Gill Bird (Professional Advisor/Dental Therapist) • Dee Hollingsworth (Professional Advisor/Dental Therapist)	• Lorraine Staunton (Kaiwhakahaere Ratonga – Service Delivery/Operations Manager, Te Piki Oranga) • Hilary Genet (Health Promotion-Housing) • Ricki-Lea Aitchison (House Surgeon, Yr 3 and GP) • Kim Fergusson (Nelson Bays Primary Health)
Using health resources effectively	• Jill Clendon (Adon & Op Manager - Ambulatory Care, District Nurses) • Kirsten Nalder (Project Coordinator – Acute Demand) • Jo Mickleson (Pharmaceuticals Manager) • Tonia Talbot (Primary Care Dietitian, NBPH) • Kim Fergusson (Nelson Bays Primary Health)	• Simone Newsham (Service Manager, Support Works) • Chelsea Martin (Sector Relationships/Contract Manager, Health of Older People) • Ngaire-Dawn Munro (Kaiatawhai liaison, NBPH)
Person-centred care	• Scott Starling (Improvement data analyst) • Lorraine Staunton (Kaiwhakahaere Ratonga – Service Delivery/Operations Manager, Te Piki Oranga)	• Lorraine Staunton (Kaiwhakahaere Ratonga – Service Delivery/Operations Manager, Te Piki Oranga) • Lauren Ensor (Health Promotion Manager)

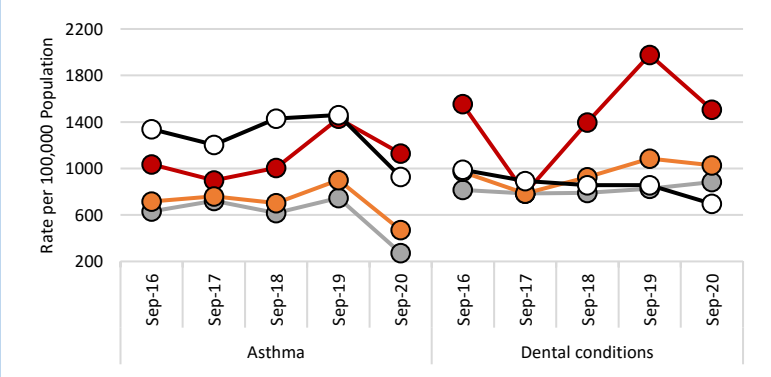
	• Lydia Mains (Pūkenga Kaiwhakahaere - Site Manager (Motueka), Pepe Tamariki Pou Tangata - Service Champion: Mothers and Babies, Te Piki Oranga)	• Lorraine-Moss Smith (Sector Relationships and Contract Manager, Mental Health)
Prevention and early detection	• Donald Hudson (Manager, Data & Analytics) • Alexandra Grieg (Public Health Medicine Specialist) • Ngaire-Dawn Munro (Kaiatawhai liaison, NBPH)	• Kim Fergusson (Nelson Bays Primary Health) • Tonia Talbot (Primary Care Dietitian)
Healthy start	• Kelly Atkinson (Team Leader – Smokefree) • Debbie Fisher (Core Midwife, Maternity Unit NN)	• Rickie-Lea Aitchison (House Surgeon, Yr 3 and GP)
Youth are healthy safe and supported	• Jill Clendon (Adon & Op Manager - Ambulatory Care, District Nurses) • Nicola Thompson (CNM, Clinical Nursing) • Karen Crook (Sexual Health Nurse Service Coordinator) • Lauren Ensor (Health Promotions Manager) • Reuben Molnar (Health Promoter – Youth)	• Jayne Wallace (Health Pathways Coordinator) • Steph Anderson (Community Nurse, Victory Community Centre) • Lee Ann O-Brien (Whanake Youth) • Jessica Irvine (INP Medical)

Keeping children out of hospital

System level measure: ASH rates per 100,000 for 0-4 years

Nelson Marlborough Health have prioritised the first 1,000 days of life to help ensure children get the best start to life, stay healthy and well, and meet their full potential throughout their lives.





Nelson Marlborough Health shows continued achievement of lower rates for ASH, 0-4 age group, All conditions, than the National rate.

There is evidence of an equity gap between Māori and Others which has continued to exist since June 2017.

The conditions with the greatest equity gap between Māori and Others, for NM, are:

- Asthma
- Dental conditions

Of concern is the ASH rate for 0-4 with Dental conditions showing a sustained NM rate for Māori above the National rate. The NM rate is also above the National Rate since June 2017.

Consumption of sugary drinks, access to oral health care and primary care, exposure to second-hand smoke, and poor housing are known drivers associated with these conditions.

Milestone: Our aim is to reduce ASH rates in 0-4 years per 100,00 children by 15% for Māori by 30 June 2022 (from 6,714 in 2019 to 5,707per 100,00 children by June 2022).

Opportunity	Actions	Contributory Measures
Children admitted to hospital for asthma, respiratory and dental conditions are at greater risk of repeat admission. However, if we	• Circulate information pamphlets via PHOs and Health Pathways to	• Rate, number and ethnicity of asthma, respiratory, and dental

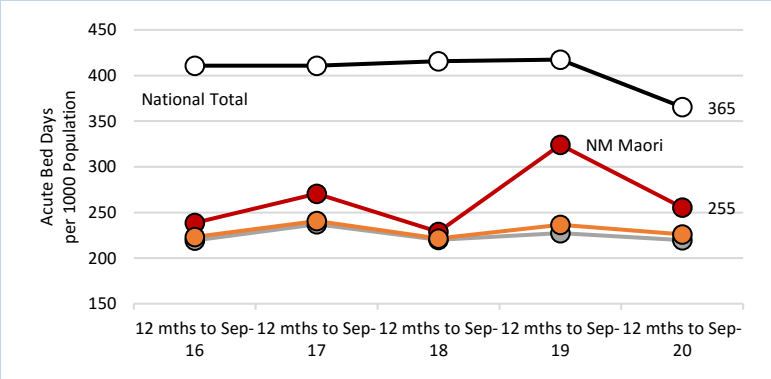
can intervene by offering **greater levels of support and education to the family** in primary and secondary settings, there is an opportunity to prevent repeat admissions.	practices and emergency departments to provide patients greater levels of support and educate family in primary and secondary settings. This is important for reducing repeat admissions and addressing the drivers of asthma within the community (*see Health Quality & Safety Priority area of the Annual Plan 2021/22*)	related ED attendances and hospital admissions for 0-4 years. • Children fully immunised by 8 months, 24 months and 5 years. • Children caries free at 5 years of age (CW01) • Improving the number of children enrolled and accessing the Community Oral health service (CW03) • Oral health: Mean DMFT score at school year 8 (CW02)
Children who are not regularly seen, or are not enrolled, in the Community Oral Health Service are more likely to require treatment in a hospital setting. Also there are some children who are unable to be accurately assessed and treated in a community oral health clinic due to nervousness, or other reasons, and are referred for sedation or general anaesthetic in secondary care. There is an opportunity to a) ensure all our children are being enrolled and seen in the community, particularly among Maori and other priority groups, and b) utilise techniques to support a child's comfort in being examined and treated in community oral health clinics.	• Te Piki Oranga will provide a list of all 0-4 year olds currently enrolled with them to Community Oral Health to cross-check whether they are enrolled and when their last examination was. • Te Piki Oranga to explore the potential of using beneficiaries list from Ministry of Social Development to cross-check with GP enrolment. • Where examination and treatment in the community is proving difficult, clinicians will offer multiple short appointments for the child to become comfortable with the setting and offer alternative ways of carrying out examinations (i.e sitting on parent's lap on the dental chair). Health navigators and interpreters	• Hospital admissions for children < 5 years with dental caries as a primary diagnosis.

	will also be utilised when needed. If a child has been diagnosed as being on the autistic spectrum the clinician will discuss ways of making the child feel comfortable with the parents/care giver and make notes on the child's file for other clinicians to be aware of, however all attempts will be made for the child to remain under the care of the familiar clinician.	

Using Health Resources Effectively

System level measure: Acute hospital bed day rates per 1,000 population

Nelson Marlborough Health is focussed on reducing and effectively managing acute demand through improved prevention, early intervention and integration initiatives.



Acute Hospital Bed Days (by DHB of Service, age standardised to Census 2013) is consistently below the National rate, for all ethnicities.

There is evidence of a reduction in the equity gap between Māori and Others since September 2019.

The main drivers of overall acute hospital bed days in Nelson Marlborough are age, socio-economic deprivation and events associated with stroke and other cerebrovascular conditions and respiratory infections/inflammations.

Effective management of long-term illnesses and disease prevention in primary care prior to hospitalisation and the provision of effective care in the community after discharge have the potential to reduce hospital bed days. For example, access to primary care, streamlined diagnostic and treatment processes, discharge planning and community-based health and restorative care. Good communication between clinicians across the health care continuum is also vital.

Milestone: Our aim is to reduce the age standardised Acute Hospital Bed Days rate for Māori by 5% from 324.0 per 1,000 population (in 2019) to 307.8 by 30 June 2022.

Opportunity	Actions	Contributory Measures
There is an opportunity to treat some **acute patients in primary care settings** rather than in the hospital through developing a new model of care.	• Evaluate and revise the Acute Community Response Model to provide rapid response to those with an acute exacerbation of a	• Acute admissions and readmission rates to hospital by ethnic group.

	chronic condition at home or in care (see *Acute Demand* priority area in Annual Plan).	• Number of referrals to Acute Community Response Model
Health Care Homes (HCH) is grounded in the enhanced model of care which is underpinned by the principles of equity, consistency and measurable changes. It enables patients to be proactively managed in primary care, reducing the risk of hospitalisation from acute conditions (such as cerebrovascular and respiratory conditions). HCH's enable risk stratification, early identification of cohorts of patients, triaging and a standardised process for urgent access and extended roles within General Practice teams. They also provide information that resonates with people in terms of language and visual presentation and enhances the cultural skills and competencies of staff (including understanding of unconscious bias inherent in many services).	• Implement the Health Care Home (HCH) enhanced model of care, focussing on equity and patient participation, across General Practices in Nelson Marlborough. This will include implementation of Building Block modules in 80-100% of practices not currently contracted to implement the full model over the next 2 years. • Tranche 3a to commence in October 2021. EOI will go out to all non-HCH contracted practices in July 21. • Tranche 3b to commence in February 2022 to remaining practices. • Achieving equity for Māori, Māori aspirations, and tikanga, including an alignment to Pae Ora (Healthy Futures) as a vision, a new set of values grounded in equity, and incorporation of whakawhanaungatanga (creating connection/relationship) in the delivery of care within 50% practices by June 22.	• Number of practices participating in HCH building blocks model. • Percentage of population engaged with a HCH practice reported by ethnicity. • Percentage of practices with 'achieving equity for Māori, Māori aspirations, and tikanga, including an alignment to Pae Ora (Healthy Futures)' as a vision and/or a new set of values grounded in equity, and incorporation of whakawhanaungatanga (creating connection/relationship) in the delivery of care.
Strengthening Coordinated Care and shared information increases care coordination for the most complex and vulnerable patients.	• Embed and support an evidence based and consistent approach to identifying the most complex and	• Number of LCC facilitated cross-sector multidisciplinary meetings (MDTs) and complex case reviews

	vulnerable patients through establishing a Strengthening Coordinated Care dashboard by November 2021 (refer *Long Term Conditions section of Annual Plan 2021/22*). • Locality Care Coordinators (LCC) to connect services and teams to ensure collaborative care planning and delivery. LCC's to facilitate cross-sector multidisciplinary meetings (MDTs) and complex case reviews for vulnerable populations and complex clients identified within localities. • Development of a coordination of care role embedded within 50% of general practice teams with a focus on socially complex, high needs and vulnerable populations by June 22 • Co-create acute care plans/summaries for tangata waiora to support interagency care and reduce acute admissions by Q4.	for vulnerable populations and complex clients identified by ethnicity within localities. • Percentage of general practice teams with a coordinated care role embedded. • Percentage of tangata waiora with acute care plans/summaries.
Providing **culturally appropriate information** on the lifestyle factors that drive certain health conditions (eg, stroke and cerebrovascular disease, respiratory infections/inflammations) and supporting people to make lifestyle changes, can reduce hospitalisations associated with these conditions. There is an opportunity to encourage further participation in these sessions	• PHOs will design and deliver culturally appropriate lifestyle information sessions. • PHOs will collect and promote patient stories from participants in the lifestyle sessions so far.	• Number of people engaged and actively improving their lifestyle: post programme, 3 months and 12 months.

by collecting and promoting the success stories of past participants.		• Acute admission and readmission rates to hospital for respiratory or cerebrovascular conditions.
Consistent messaging around the drivers and management of health conditions (such as stroke and other cerebrovascular conditions and respiratory infections/inflammations) is important for effective self-management. There is an opportunity to improve health literacy messaging in this space, particularly among Māori and other priority groups.	• PHOs will work together to establish a district-wide approach to workforce health literacy training that ensures consistent messaging across a range of providers that interact with Māori and other priority populations. • PHOs will co-design a plan with patients to address the results from point of care testing (via Green Prescriptions)	• Number of workforce development sessions delivered • Acute admission and readmission rates to hospital

Person-centred care

System level measure: Patient experience of care

It is vital that patients are involved and partnered with in their care, and there is a particular need to improve this for our Māori patients in both hospital and primary care settings.

Patient experience of care – Hospital

The table below shows the lowest performing questions for Nelson Marlborough DHB in February 2021.

⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
Patient definitely had enough information about how to manage their condition or recovery after they left hospital.	Feb 2021	65.6%	(57.2%-74.0%)	122
Patient was definitely told the possible side effects of the medicine (or prescription for medicine) they left hospital with, in a way they could understand.	Feb 2021	70.2%	(60.4%-80.0%)	84
Hospital staff definitely talked with the patient about whether they would have the help they needed when they left the hospital.	Feb 2021	72.7%	(63.4%-82.0%)	88
Towards the end of the patient's visit, they were definitely kept informed as much as they wanted about what would happen and what to expect before they could leave the hospital.	Feb 2021	76.9%	(69.4%-84.4%)	121
Patient always kept informed as much as wanted about treatment and care.	Feb 2021	77.0%	(69.7%-84.3%)	126

Questions in which Māori results for Nelson Marlborough DHB were significantly lower than the non-Māori, non-Pacific results.

⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
Patient was definitely told what the medicine (or prescription for medicine) they left the hospital with was for.	Feb 2021 Māori ⚠	78.6%	(57.1%-100%)	14
	Non-Māori, non-Pacific	94.4%	(89.7%-99.1%)	90
Hospital staff definitely included patient's family/whānau or someone close to patient in discussions about the care received during visit.	Feb 2021 Māori ⚠	60.0%	(35.2%-84.8%)	15
	Non-Māori, non-Pacific	90.7%	(84.1%-97.3%)	75
Patient definitely trusted and had confidence in the doctors.	Feb 2021 Māori ⚠	60.0%	(35.2%-84.8%)	15
	Non-Māori, non-Pacific	88.2%	(81.9%-94.5%)	102

The Health Quality & Safety Commission conducts the New Zealand Patient Experience Surveys (NZPEx) programme. The Adult Hospital Survey has four Topics of focus; Inpatient Experience, Hospital Environment, Surgery and Discharge.

Discharge has been selected for this SLM Plan as this area has consistently shown potential for improvement.

Response values are the % who answered 'Yes'.

Nelson Marlborough responses are lower for patients *being given enough information to manage their condition or recovery after they left hospital* and *Patient was definitely told the possible side effects of the medicine (or prescription for medicine) they left hospital with, in a way they could understand* than the National average and are lower in Nov-20 compared with Aug-20.

Milestone: Our aim is for 70% of respondents to the inpatient hospital survey reporting they have received enough information on medication side effects and condition management upon discharge from hospital by 30 June 2022.

Patient experience of care – Primary Care

The Adult Primary Care Survey has the following Topics of focus; Services Used, Access to Care (Continuity, Wait Times, Barriers), Most

The table below shows the lowest performing questions for Nelson Marlborough DHB in February 2021.

⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
The patient was accurately advised about the wait time for their consultation.	Feb 2021	26.6%	(24.0%-29.2%)	1076
The patient was able to get an appointment on the same day or the next working day.	Feb 2021	27.3%	(24.6%-30.0%)	1053
The patient was always told, in a way they could understand, by someone at their GP / nurse clinic or pharmacy what to do if they experienced side effects.	Feb 2021	58.0%	(54.7%-61.3%)	848
The patient was always told, in a way they could understand, by someone at their GP / nurse clinic or pharmacy what the possible side effects of their medication are.	Feb 2021	60.7%	(57.5%-63.9%)	868
The patient was always told, in a way they could understand, by someone at their GP / nurse clinic or pharmacy what could happen if they didn't take the medicine.	Feb 2021	66.5%	(63.3%-69.7%)	828

Questions in which Māori results for Nelson Marlborough DHB were significantly lower than the non-Māori, non-Pacific results.

⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
Patient had NOT been given conflicting information by different doctors or health care professionals in the last 12 months.	Feb 2021 Māori	75.0%	(64.7%-85.3%)	68
	Non-Māori, non-Pacific	85.0%	(82.5%-87.5%)	762
In the last 12 months, there was never a time when the patient wanted health care from a GP or nurse, but couldn't get it.	Feb 2021 Māori	73.5%	(64.0%-83.0%)	83
	Non-Māori, non-Pacific	84.0%	(81.8%-86.2%)	1047
The patient did not mind the wait (availablity of appointment).	Feb 2021 Māori	67.2%	(55.4%-79.0%)	61
	Non-Māori, non-Pacific	78.6%	(75.8%-81.4%)	840
The patient was always told, in a way they could understand, by someone at their GP / nurse clinic or pharmacy what the possible side effects of their medication are.	Feb 2021 Māori	47.1%	(35.2%-59.0%)	68
	Non-Māori, non-Pacific	62.0%	(58.6%-65.4%)	793

Recent Experience, Medication, Medical Tests, ED, Hospital Stays and Long-Term Condition Management.

Access to Care – Continuity and Wait Times topics were selected for SLM plan.

Response values are the % who answered positively, for all of Nelson Marlborough versus Nationally.

Māori were less likely than non-Maori & non-Pacific in NM to answer positively to the questions about timely access to health care services and possible side-effects of medication. Māori were more likely (34.5%) than 'other' ethnic group (17.4%) to report there was a time they did not visit a GP or nurse because of cost, and to report that cost was a barrier to picking up a prescription (16.8%).

Milestone: Our aim is to achieve a 5% reduction in the proportion of Māori patients reporting they could not access health care from a GP or nurse when they wanted it by 30 June 2022.

Opportunity	Activity	Contributory Measures
Te Piki Oranga and other Māori health providers have a good understanding of the barriers their patients face when accessing primary health care and ideas for addressing them. There is an opportunity for Primary Health Organisations (PHOs) to collaborate with these providers to help develop solutions for their own primary care practices.	• PHOs will work with iwi providers to understand and address barriers to accessing primary care and pharmaceuticals. • PHOs will co-design a project (or series of projects) alongside Te Piki Oranga and other Māori health providers to	• Responses to "There was never a time when the patient wanted health care from a GP or nurse, but couldn't get it in the last 12 months"

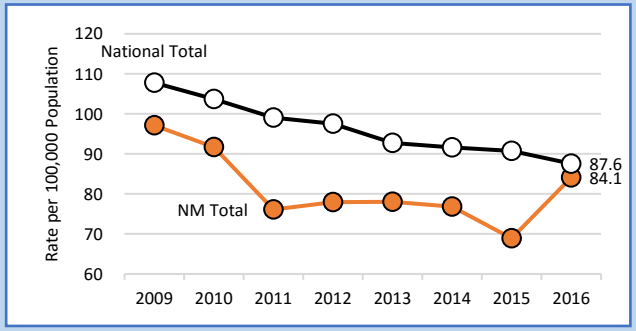
	address enrolment barriers (eg, how to deal with patients without addresses, children visiting from other PHOs, possibility of electronic versus hardcopy enrolment of newborns, enable Te Piki Oranga to accept referrals from ERMs).	
Patient portals and open notes provide a secure record of a patient's health status and management plan. However, not all patients have equal access to this information for a variety of reasons including practice choice and digital literacy. Patient portals enable patients to •request repeat prescriptions •book appointments •see lab results •see current diagnosis •see a list of medical conditions •see a list of the medications •see immunisation and vaccination history •receive reminders and recalls from the practice team •send and receive secure messages to and from a patient's doctor or a practice nurse. In New Zealand, the most common patient portals are Manage My Health, Health 365 and Connect Med**.** In addition to the above, OpenNotes enables patients to see a doctor's clinical notes as well as all of the above options.	• PHOs will trial the use of volunteers in waiting rooms to sit with patients and their whanau and talk through how to access their information via a patient portal. • PHOs will Encourage more general practices to adopt and promote the use of open notes among their patients.	• Number of practices with 'open notes' for patients • Proportion of patients in practices using patient portals and/or open notes. • Responses to "Did the [HCP] involve you as much as you wanted to be in making decisions about your treatment and care??" • Responses to "Patients had NOT been given conflicting advice by different doctors or health professionals in the last 12 months" • Responses to "Patient was definitely told what medication they left hospital with was for"

Discharge summaries following secondary care provide a standardised mechanism for communicating with a patient following their discharge from hospital. Small changes to the current discharge summary to enable house surgeons (RMOs) to indicate when/whether patients require follow up care and how this should occur (eg, please phone practice within 2 days, 4 weeks or 6 months) would provide the necessary information to help them manage their condition after discharge.	• PHOs and the NMH Quality improvement Team will co-design a set of check boxes by Q2-Q3 2020-21 • NMH Information Technology team will make the changes to the discharge forms by Q4 2021-22.	• Responses to "do you feel you received enough information from the hospital on how to manage your condition after your discharge?"

Prevention and early detection

System level measure: Amenable mortality rates

We are enhancing the management of long-term conditions and targeting prevention approaches and support for Māori to reduce disparities.



Standardised Rate Ratio (SRR)
Amenable Mortality for Nelson Marlborough based on 2012-2016 data

1.7 Māori

1.0 Non-Māori, non-Pacific

Adjusting for differences in age structures, using pooled data 2012-2016, the age-standardised amenable mortality rate (ASR) per 100 000 people aged 0-74 for Nelson Marlborough, was 1.7 times higher among Māori people than among New Zealanders of other ethnicities.

Compare the SRR with all New Zealand, where the ASR is 2.6 times higher among Māori people than among New Zealanders of other ethnicities.

Coronary artery disease, chronic obstructive pulmonary disease (COPD) and suicide are the main contributing conditions for Māori. Effective health interventions at an individual or population level could prevent these conditions, including access to diagnostic and secondary care services.

Milestone: Our aim is to reduce equity gaps in amenable mortality rates for Māori by 30% by 30 June 2023.

Opportunity	Actions	Contributory Measures
We can **improve the management of long-term conditions** in primary care.	• PHOs and Te Piki Oranga will co-design initiative/s alongside emergency department, iwi, Marae, Workwell, and employers to improve uptake of CVDRA and management (see *Long Term*	• Proportion of Māori participating in current dietician clinics • Proportion of participants in dietician clinics with improvements in BMI, blood

	Conditions section of Annual Plan 2020/21). • Nelson Marlborough Health is improving the management of people with long term conditions through undertaking an Integrated Diabetes Pathways Project (IDPP) to develop clear, timely, appropriate diabetes care & pathways that will contribute to improved health outcomes, therefore reducing the impact on individuals, whanau and health resources (refer *Long Term Conditions section of Annual Plan 2021/22*). • Determine whether Māori with COPD a) have access to the appropriate medication to control their COPD and b) understand how to use the medication through community pharmacy Medicine Use Reviews (MURs) (refer *Pharmacy section of Annual Plan 2021/22*)	pressure, cholesterol, HbA1c at 12 months • Proportion of diabetes population aged 15-74 in the PHO that have completed a Diabetes Annual Review (DAR) in the previous 12 months (SS13 Focus Area 2: Diabetes Services) • Proportion of practices using PHO diabetes information in patient consultations • Ambulatory sensitive hospitalisation rates for COPD by ethnicity (SS05)
We can **intervene early in the life course** to support children (and their whanau) to make healthy choices (healthy food, drink and exercise).	• Support the implementation of Healthy Active Learning in priority settings by the Healthy Active Learning Advisor, Heart Foundation Nutrition Advisor and Free and Healthy School Lunch Advisor working together to support Healthy Food Environments in Early Learning	• Number of ELS's and schools with water only and nutrition policies • Proportion of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based

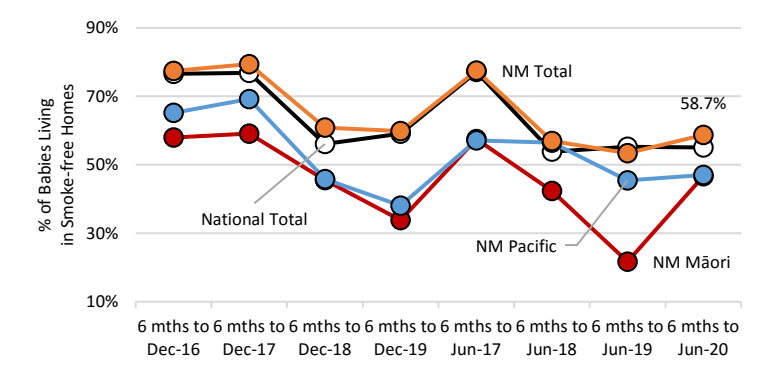
	Services (ELSs') and schools. Prioritisation of support will have an equity lens, supporting firstly ELS and schools with high Māori populations and low income families (see *Healthy Food and Drink* priority area in Annual Plan).	nutrition, activity and lifestyle interventions (CW10).
We aim to **prevent suicides** in Nelson Marlborough Health.	• Improving capability of ED staff to provide timely appropriate care through the introduction of the ED Nurse Educators. • Full adoption of the Hinengaro pathway (Pathway for triage, assessment and care for people who present to ED with MH&A issues) • Suicide prevention coordinator to lead and coordinate implementation of the suicide prevention action plan, with a specific focus on developing strengthened evidence-based pathways of support for people identified at risk due to previous or current trauma/adverse childhood experiences by Q4 2021-22.Te Waka Hauora to implement Māori Suicide Prevention Programme. • Roll out of Te Tumu Waiora Model (including Health & Wellbeing Practitioners) and	• Self-harm presentations to ED, and rates and number of hospitalisations, by age groups and ethnicity • Improved wait time for patients requiring mental health and addictions services who present to ED • ED length of stay

	credentialising programme for primary care nurses.	

Healthy Start

System level measure: proportion of babies who live in a smokefree household at 6 weeks postnatal.

We are focussed on ensuring that whanau are supported in their smoking cessation journey as part of their overall health care needs



Nelson Marlborough shows continued achievement of National % rates of Babies living in smoke-free homes, 6-weeks post-natal.

The equity gap for both Māori and Pacific Peoples compared with Others is showing significant improvement in the 6 months to June 2020.

Smoking during pregnancy and exposure to smoking in early childhood strongly influence pregnancy and early childhood health outcomes. This measure promotes the roles which collectively service providers play in the infant's life and the many opportunities for smoking interventions to occur. It also enables the health sector to connect infants and their family/whanau with maternity and childhood health care such as immunisations.

Milestone: Our aim is to further increase the proportion of babies living in smoke-free homes postnatal by 15% from 46.6% to 53.6% for Māori by 30 June 2022.

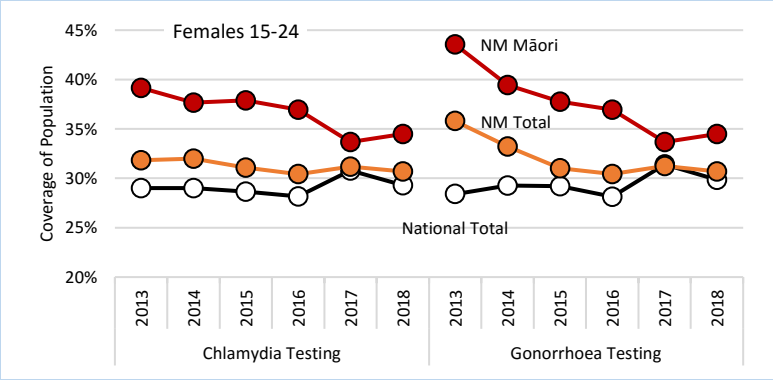
Opportunity	Actions	Contributory Measures
Pepi First's Hapu Wananga is a Kaupapa Maori pregnancy and parenting programme which covers everything whanau need to know about how to look after their Pepi during pregnancy and after birth, including cultural issues, breastfeeding, safe-sleep, immunisation, smokefree, GP enrolment and domestic violence.	• NMH Stop Smoking Service and NMH Maternity staff will collaborate on the promotion and implementation of the automatic referral (opt out only) of hapū māmā to the Pēpi First service programme by partners that have regular contact with hapu mama	• Referral rates to Pēpi First • Newborn enrolment with General Practice (CW07) • Child Health (Breastfeeding) (CW06) • Increased immunisation at two years (CW08)

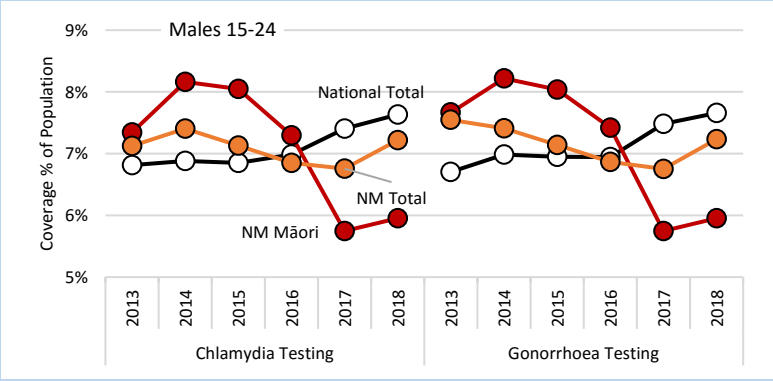
	from quarter 1 (eg, iwi social service providers, budget advisors, lead maternity carers (LMCs) and other health and social service providers) • Pēpi First will be promoted at all district-wide Wānanga Hapūtanga, by kaimahi from Te Waka Hauora, Te Piki Oranga and NMH. Registrations will be processed on site at each wānanga from quarter 1. • NMH Stop Smoking Service and NMH Maternity staff will review whether referrals to Pepi First by LMCs are increasing, and if not, identify and implement a solution to address this.	• Better help for smokers to quit (maternity) (CW09)
Nelson Marlborough Health are exploring strategies and incentives that support the development of Smokefree whānau and homes including progressing incentives for whānau and **vape to quit options**. These actions will support both individual and whānau efforts to quit and to maintain a smokefree environment for tamariki and hapū māmā.	• Vape to quit and whānau incentive programmes in place by Q2 (see *Te Aho o Te Kahu-Cancer Control Agency* and Smokefree *2025* priority areas of Annual Plan 2021-22).	• Number of Māori enrolled in vape to quit programme

Youth are healthy, safe and supported

System level measure: youth access to and utilisation of youth appropriate health services.

We want young people to manage their sexual and reproductive health safely and receive youth friendly care.





Nelson Marlborough has chosen Sexual and Reproductive Health – Chlamydia (& Gonorrhoea) testing coverage for 15 to 24 year olds as the primary measure for this SLM.

It is common practice to offer sexually active youth STI testing upon visiting a general practice or sexual health clinic. Chlamydia is one of the infections that is screened for as part of this testing. In this way, chlamydia testing coverage not only indicates coverage of STI testing, but it can also indicate the ability of young people to receive youth-friendly care and manage their sexual and reproductive health safely.

Generally, older youth were more likely to have received an STI test than younger youth – reflecting reported rates of sexual activity.

However, males are significantly less likely to receive an STI test than females even though males have higher self-reported rates of sexual activity (Youth19 Rangatahi Smart Survey, Table 1, pg 5).

Testing coverage for Māori females is consistently better than the National coverage and that of all Nelson Marlborough females aged 15 to 24.

However, Māori males in Nelson Marlborough have much lower coverage than both National and all Nelson Marlborough males aged 15 to 24. There is clear evidence of an equity gap between Māori and all males in Nelson Marlborough.

Milestone: Increase the percentage of males aged 15-24 years being tested for Chlamydia by 15% for all ethnic groups by 30 June 2022.

Source: STI laboratory data as of 26/11/2019 (https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/data-support-system-level-measures/youth-slm--4)		
Opportunity	**Actions**	**Contributory Measures**
Female rangatahi visit primary care services to obtain contraception, while males can obtain condoms over the counter without a prescription from the supermarket. This means that female rangatahi are more likely to discuss their sexual and reproductive health with their GP and this is reflected in rates of STI screening coverage (ie, Chlamydia testing). Most sexual health clinics (eg, INP Medical) have also historically been orientated towards females rather than males. There is an opportunity to reduce the gap between males and females by providing **confidential, easier to access, outreach services to male rangatahi**.	• The Health Promotion team, alongside Workwell, will develop a coordinated approach to engage workplaces to promote publicly funded health services (including STI testing) to their employees, focussing initially on Port Nelson. • Promote the Victory Community Centre outreach clinic to male rangitahi by circulating pamphlets to medical centers and including it on Health Pathways by Q1 • Te Piki Oranga will provide an A5 flyer for rangitahi with information about STI screening and where to access it.	• Number of employers/organisations taking up services offered by age and ethnic group • Number of males aged 15-24 years accessing the Victory Community Centre outreach clinic by age and ethnic group
The *Youth19 Rangatahi Smart Survey-Initial Findings: Sexual and Reproductive Health of New Zealand Secondary School Students (2020)* found that students who participated in the survey were calling for **better sexuality education and non-judgmental families, communities and services**. There is an opportunity to improve workforce training within all health care settings.	• Family Planning Coordinator (alongside the Health Promotion Team) will run a professional development day in Term 3 (Q1 2021-22) • Family Planning Coordinator will also support lead teachers via quarterly zoom meetings to answer their questions and provide specific advice regarding how to support rangatahi males	• Number of teachers participating in quarterly zoom meetings

	to look after their sexual and reproductive health.	