
# SYSTEM LEVEL MEASURES Improvement Plan

Top of the South Health Alliance

2020/21 Financial Year

# Executive Summary

The Top of the South Health Alliance (ToSHA) is committed to improving the health of everyone in the Nelson Marlborough region. To do this, and to support the implementation of the refreshed New Zealand Health Strategy, we have jointly developed an Improvement Plan for System Level Outcome Measures.

The organisations involved in the development and/or implementation of this plan are:

- Nelson Marlborough District Health Board (https://www.nmdhb.govt.nz/)
- Nelson Bays Primary Health Organisation (https://nbph.org.nz/)
- Marlborough Primary Health Organisation (https://www.marlboroughpho.org.nz/)
- Te Piki Oranga (other Well Child providers including Plunket are engaged at quarterly forums) (https://www.tpo.org.nz/)
- INP Medical Clinic (https://www.inp.co.nz/)
- Whanake Youth (https://www.whanakeyouth.org.nz/)

# Purpose

This document shows how the System Level Measures Improvement Plan 2020/21 will build on progress and continue to improve health outcomes across the Nelson Marlborough region.

The plan includes:

- Specific improvement milestones that show improvement for each of the six system level measures (SLMs).
- Brief descriptions of activities to be undertaken by alliance partners (primary, secondary, and community) to achieve the milestones.
- Contributory measures for each of the SLMs chosen to monitor local progress against the activities.
- Signatures of all district alliance partners to demonstrate an integrated and partnership approach to the development and implementation of the improvement plan.

# Background

System Level Measures are outcome focused measures that provide a framework for continuous quality improvement and system integration. They are set nationally and focus on children, youth and vulnerable populations. System Level Measures aim to improve health outcomes for people by supporting District Health Boards to work in collaboration with health system partners (primary, community and hospital).

The six System Level Measures are:

1. ambulatory sensitive hospitalisation (ASH) rates for 0–4 year olds **(keeping children out of hospital)**
2. acute hospital bed days per capita **(using health resources effectively)**
3. patient experience of care **(person-centred care)**
4. amenable mortality rates **(prevention and early detection)**

5. babies living in smokefree homes **(a healthy start)**
6. youth access to and utilisation of youth appropriate health services **(youth are healthy, safe and supported)**

## Process & Approach

A whole of system alliance was appointed to oversee our system level measures across our Nelson Marlborough Community and develop our System Level Measures Improvement Plan 2020/21. This group is comprised of senior staff members from across the organisations involved (Table 1). The group convened to review the data relating to each of the System Level Measures. Where equity gaps were apparent, the group focussed their improvement milestone, quality improvement activities, and contributory measures specifically on addressing these gaps.

Each System Level Measure has been assigned a Quality Improvement Champion. The Champions have strong existing networks, work with senior managers and clinical leaders to review Nelson Marlborough-specific data for each of the measures. The Champions shared the draft System Level Measures Plan with their stakeholders for feedback from areas relevant to outcomes and activities.

Progress against this plan will be overseen, and advice provided as needed on strategic direction, by the ToSHA committee. We, the Chief Executives of the Top of the South Health Alliance, pledge our commitment to the delivery of this improvement plan.

| *Signature* | *Signature* | *Signature* | *Signature* |
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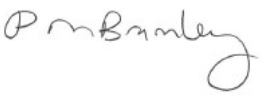
|  |  |  |  |
| Beth Tester | Sara Shaughnessy | Anne Hobby | Peter Bramley |
| Chief Executive | Chief Executive | Tumuaki / General Manager | Chief Executive |
| Marlborough Primary Health | Nelson Bays Primary Health | Te Piki Oranga | Nelson Marlborough Health |

**Table 1: System Level Measures Improvement Group and Champions**

| Name | Organisation | Role | SLM Champion |
|---|---|---|---|
| Sara Shaughnessy | Nelson Bays PHO | Chief Executive | ALL System Level Measures |
| Beth Tester | Marlborough PHO | Chief Executive | Patient Experience of Care - Primary |
| Anne Hobby | Te Piki Oranga | Tumuaki / General Manager | - |
| Cathy O'Malley | Nelson Marlborough Health | General Manager Strategy, Primary and Community | Youth Access to and Utilisation of Youth-appropriate Health Services (10-24 year olds): Sexual and Reproductive Health.<br><br>Amenable Mortality |
| Elizabeth Wood | Mapua Health Centre; and Nelson Marlborough Health | General Practitioner; and Clinical Director Community & Chair of Clinical Governance | Patient Experience of Care - Secondary |
| Jo Mickleson | Nelson Marlborough Health | Pharmaceuticals Manager | |
| Jill Clendon | Nelson Marlborough Health | Adon & Op Manager - Ambulatory Care, District Nurses NN | Youth Access to and Utilisation of Youth-appropriate Health Services (10-24 year olds): Sexual and Reproductive Health. |
| Lauren Ensor | Nelson Marlborough Health | Health Promotions Manager | Youth Access to and Utilisation of Youth-appropriate Health Services (10-24 year olds): Sexual and Reproductive Health. |
| Ditre Tamatea | Nelson Marlborough Health | General Manager for Māori & Vulnerable Populations | Ambulatory Sensitive Hospitalisations (0-4 years) |
| Debbie Fisher | Nelson Marlborough Health | Operations Manager / Associate Director Of Midwifery | Babies in Smoke free homes |
| Lexie OShea | Nelson Marlborough Health | General Manager Clinical Services | Acute Hospital Bed Days |

## Keeping children out of hospital

**Ambulatory Sensitive Hospitalisation (ASH) rates in 0–4 year olds** seeks to reduce admission rates to hospital for a set of diseases and conditions that are potentially avoidable through prevention or management in primary care.

The overall non-standardised ASH rate for 0-4 year olds in Nelson Marlborough has decreased from 4,175 in December 2018 to 3,864 per 100,000 population in December 2019 and remains lower than the national total. However, the rate for tamariki identifying as Māori continues to increase; rising from 5,249 per 100,000 population in the 12 months to December 2018 to 6,087 in the twelve months to December 2019. In terms of ASH events, this equates to a rise for Māori from 95 events in 2018 to 112 in 2019. Meanwhile, the rate for non-Māori and non-Pacific populations continues to decrease.

Increases in ASH rates for Māori children in Nelson-Marlborough are driven by dental conditions (1,902 per 100,000 population/35 events) and asthma (1,413 per 100,000 population/26 events). 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.

| National Measure | Ambulatory Sensitive Hospitalisations (ASH) rate per 100,000 population, for 0 - 4 year olds. |
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| Local Milestone | ASH rates for Māori children aged 0-4 years fall 15% by 30 June 2021 (from 6,087 in December 2019 to 5,174 by 30 June 2021) |
| Activities | Contributory Measures |
| 1. Employ a Public Health Nutritionist by Q1. | Improved nutrition/reduced sugar consumption in ECE settings |
| 2. NMH Community Oral Health, Heart Foundation, NMH Public Health Nutritionist and Enviroschools Facilitator to co-design a plan for working with ECE centres to strengthen parental engagement in improving determinants of oral health and nutrition by Q2. | Enrolment rate of preschool children in oral health services. |
| 3. Facilitate the establishment of Tuakana-teina (elder teaching younger) relationships to promote Mana atua/Wellbeing (Strand 1 of Te Whāriki), with a specific focus on teaching good oral health and nutrition in ECE settings and link this with *Project Menemene.* | Hospital admissions for children <5 years with dental carries as primary diagnosis. |

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| 4. Co-design a plan with local Communities of Learning (CoL) and schools to respond to the national review of the Health Promoting in Schools programme, with a particular focus on how this will impact key social and health determinants – (e.g., nutrition and oral health). Engagement with CoL and schools by Q1 and Plan designed by Q4. | Hospital admissions for children <5 years with dental carries as primary diagnosis. |
| 5. Explore the feasibility of Hauora Direct referral to whānau ora navigator to advocate on behalf of a whānau with respect to improving determinants of asthma and respiratory conditions instead of referrals to multiple agencies (e.g., Housing NZ, Tenancy services GP etc.). Feasibility study completed by Q2 and Action plan for support implemented by Q4. | Hospital admissions for children aged five years with a primary diagnosis of asthma.<br><br>Referral rates to whānau ora navigator. |
| 6. Change the fluoride model of care to apply fluoride twice each year for Māori, Pacific and high risk children and start earlier from 1 year of age starting Q2. | 78% of Māori preschool children enrolled with the Child Oral Health Service receive fluoride twice each year. |
| 7. Any presentation to GP or Hospital for children with asthma/respiratory symptoms, aged between 0-4 years, are provided info sheet on prevention/treatment which includes info on where to go for info on ventilation and heating, tenancy advice/help, immunisation, adherence to medication, smoking cessation referral.<br>• Health Promotion team will put together a patient information sheet for practices by Q1.<br>• PHOs liaise with practices to roll out the information sheet by Q2.<br>• PHOs and Health Promotion team to evaluate uptake/use of information sheet by Q4.<br>8. | Hospital admissions for children aged five years with a primary diagnosis of asthma.<br><br>Children fully immunised by 8 months, 24 months and 5 years. |

## Using Health Resources Effectively

**Acute hospital bed days per capita** measures the use of hospital resources, predominantly relating to adults and older people. Acute care is urgent or unplanned health care that a person receives for an illness or injury. 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 vital.

The age standardised acute hospital beds rate for Nelson Marlborough Health decreased from 260.0 per 1,000 population to 250.2 per 1,000 between the year to December 2018 and year to December 2019. However, this decrease was not seen in all ethnic groups; rates for Māori increased from 270.6 to 335.3 per 1,000 population and rates for Pacific increased from 234.8 to 353.0 per 1,000 population. 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 (DRG B70) and respiratory infections/inflammations (E62). For Māori, in addition to Stroke and Other Cerebrovascular Disorders and Respiratory Infections/Inflammations, the conditions making the greatest contribution to the acute hospital bed days rate in the year to December 2019 were Major Affective Disorders (DRGU63).

| National Measure | Acute hospital bed days rate per 1,000 population domiciled within a DHB |
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| Local Milestone | Reduce the age standardised acute hospital bed days rate for Māori by 15% from 335.3 per 1,000 population to 285.0 per 1,000 population by 30 June 2021 |
| Activities | Contributory Measures |
| 1. Implement *Swoop Team* (or similar) by Q1 to provide rapid response to those with an acute exacerbation of a chronic condition at home or in care *(also in Acute Demand section of Annual Plan).* | Acute admission and readmission rates to hospital by ethnic group.<br><br>Number of referrals to Swoop Team received. |
| 2. Health Care Home Programme will:<br>• Implement the HCH model (or modular elements of HCH) in additional general practices by Q4 and impact report produced by Q4. The HCH model of care has been reviewed to align to Pae Ora as a vision and set of values grounded in equity across all domains of the model. Practices ensure that information resonates with people in terms of language and visual presentation, | Acute admission and readmission rates to hospital by ethnicity.<br><br>Percentage of enrolled Māori population belonging to HCH practices. |

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| enhancing the cultural skills and competencies of staff, including understanding unconscious bias inherent in many services.<br><br>• Proactively manage patients in primary care through the introduction of risk stratification, early identification of cohorts of patients, triaging and standardised processes for urgent access and extended roles within the General Practice teams (*Also in Acute Demand and primary health care integration sections of the Annual Plan*). | Number of care plans shared between key team members. |
| 3. Strengthening Coordinated Care will increase care coordination for the most complex and vulnerable patients by:<br>• Implementing and supporting an evidence based consistent approach to identify the most complex and vulnerable patients by Q1.<br>• Locality Care Coordinators (LCC) will facilitate multidisciplinary meetings and support team integration for vulnerable populations at localities by Q3. | Number of MDT meetings and patients referred to or by Locality Care Coordinators. |
| 4. Pilot self-management education 'taster' sessions in Marlborough/Nelson with Te Piki Oranga clients that are culturally relevant, appropriate and accessible for participants and family/whanau/support person by Q2 *(also in Acute Demand section of Annual Plan)*. | Number of Taster' sessions held<br><br>Acute admission and readmission rates to hospital. |
| 5. Work with pharmacists to remind patients to make a follow-up appointment with their General Practitioner after Hospital discharge from Q1 *(also in Acute Demand section of Annual Plan and Prevention and early detection section of this SLM Plan)*. | Reduced acute admission and readmission rates to hospital.<br><br>Number of pharmacists reminding patients to make follow-up appointments. |
| 6. Nelson Bays Primary Health to undertake work-force development by Q2 with Te Piki Oranga Kaimahi and Pukenga Manaaki and Pasifika Community Based Nurse to enable consistent health literacy messaging across a range of providers who interact with whānau and high needs populations, and to promote options that support/enhance self- | Number of work force development sessions delivered.<br><br>Acute admission and readmission rates to hospital. |

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| management/behaviour change, with particular note to respiratory and heart conditions (drivers of acute demand*, also in Acute Demand section of Annual Plan)*. | |
| 7. PHOs to collaborate with Te Piki Oranga to help locate Māori Men (30-45) who are eligible for CVDRA, and provide point of care testing/CVDRA in home/ TPO clinics or other community engagement opportunities by Q2. | PHO enrolled Māori within the eligible population who have had a CVD risk recorded in the last five years. |

## Person-centred care

The **patient experience of care measurement tools in primary and secondary care** give insight into how patients experience the health care system, and how integrated their care was. Evidence suggests that patient experience is positively associated with adherence to recommended medication and treatments, engagement in preventive care such as screening services and immunisations and ability to use health resources available effectively.

This measure provides information about how people experience health care and may highlight areas that Nelson Marlborough Health needs to have a greater focus on, such as health literacy and communication. Please note that due to the transition of the survey between providers, primary care data was unable to be updated so we have developed activities that continue to improve the outcomes identified for improvement last year.

**Primary care**

The transition to a new survey provider along with the impact of COVID-19 have disrupted the 2020 February and May patient experience surveys for primary care and resulted in limited access to historical data. In the interim, Nelson Marlborough Health have agreed with the Ministry of Health's System Level Measures Improvement Team to review and reflect on the survey data published for 2019 in the Atlas of Healthcare Variation to inform[1] the activities in this plan. The responses to the following questions indicate areas where equitable access and outcomes could be improved for Māori:

In the twelve months prior to the survey, 14.1% of respondents in Nelson Marlborough indicated there was a time when they wanted health care from a GP or nurse but could not get it. Similarly, 18.5% of patients indicated that there was a time they did not visit a GP or nurse because of cost, with Māori (34.5%) more likely to report this than the 'other' ethnic group (17.4%). Responses to these questions were explored further:

- Could you tell us why cost stopped you from seeing a GP or nurse? – Māori were more likely than other ethnic groups to report that the appointment was too expensive (92.6%), they couldn't take time off work (27.8%) or the cost of travel was too great (13.0%).
- Has cost stopped you from picking up a prescription? – Māori were more likely than other ethnic groups to answer 'yes' (16.8%)
- Have you been involved in decisions about your care and treatment as much as you wanted to be? Māori were less likely than other ethnic groups to answer 'yes' (68.2%).

The activities to improve patient experience in primary care therefore focus on addressing these barriers.

[1] https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/health-service-access/

**Secondary care**

With respect to secondary care, and the the inpatient survey, Nelson Marlbourgh Health has identified communication and coordination as domains in which we could improve[2]. In particular, patients have indicated that they could be better informed about medication side-effects upon discharge and receive more information from the hospital on how to manage their condition after discharge. This corresponds to the responses received to the survey questions:

- Did a member of staff tell you about medication side effects to watch for when you went home?
- And do you feel you received enough information from the hospital on how to manage your condition after your discharge?

The response rate for the inpatient hospital survey in Q4 2019 was around 24%. The results from this survey showed that 54% of patients reported receiving enough information on medication side-effects to watch for when they went home from hospital. For the same quarter, 66% of patients responded receiving enough information from the hospital on how to manage their condition after discharge. These results are comparable with the New Zealand average.

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| National Measure | Primary care survey and Hospital inpatient survey responses for four domains: Communication, Partnership, Coordination, Physical and Emotional needs. |
| Local Milestone | • 5% reduction in Māori reporting barriers to accessing primary care and pharmaceuticals by 30 June 2021.<br>• 70% of respondents to the inpatient hospital survey report receiving enough information on medication side effects and condition management upon discharge from hospital by 30 June 2021. |
| Activities | Contributory Measures |
| 1. PHOs will work with iwi providers to understand and address barriers to accessing primary care with a report identifying barriers and solutions completed by Q4. | Rates of Māori reporting unmet need for primary health care.<br><br>Number of collaborative projects initiated. |
| 2. NBPH will work with community agencies to provide a 'Vulnerable Populations' (VIP) project to target Māori, Pacific and other vulnerable people who cannot afford to access General Practice services, which would improve enrolment of children in GPs and WCTO | Enrolment rates of Māori children in Primary Care.<br><br>Enrolment rates of Māori children with WCTO providers. |

[2] https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3936/

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| providers. | |
| 3. Improve the number of GPs that have open notes and the proportion of patients accessing them by Q4. | Response rates of Māori to the question 'Have you been involved in decisions about your care and treatment as much as you wanted to be?' |
| 4. Ensure scripts match discharge summaries through the use of *Medsman* within Health Connect South with a trial underway by Q3. | Response rates of Māori to the question 'Do you feel you received enough information from the hospital on how to manage your condition after your discharge?' |
| 5. Work with pharmacists to remind patients to make a follow-up appointment with their General Practitioner after Hospital discharge by Q1 *(also in Acute Demand section of Annual Plan and Using Health Resources Effectively in SLM Plan).* | Response rates of Māori to the question 'Do you feel you received enough information from the hospital on how to manage your condition after your discharge?' |
| 6. PHOs/Primary Care practices/HCH and NMH Quality Improvement Team to co-design check boxes for house surgeons to indicate on discharge summaries when/whether patients require-follow up care and where this should occur (e.g. please phone practice within 2 days, 4 weeks, 6 months).<br>• Initial meeting held by Q1.<br>• Final checklist confirmed by Q2-Q3.<br>• Checklist rolled out by Q4. | Response rates of Māori to the question 'Do you feel you received enough information from the hospital on how to manage your condition after your discharge?' |

## Prevention and early detection

**Amenable mortality** is a measure of the effectiveness of health care-based prevention programmes, early detection of illnesses, effective management of long-term conditions and equitable access to health care. It is a measure of premature deaths that could have been avoided through effective health interventions at an individual or population level. Health care service improvement across the system, including access to diagnostic and secondary care services, may lead to a reduction in amenable mortality.

Nationally, amenable mortality rates for Māori and Pacific peoples tend to be higher than for other population groups. We can assume this is the case for Nelson Marlborough also, even though we are unable to confirm this due to small numbers. In Nelson Marlborough Health the amenable mortality rate in 2016 was 84.1 per 100,000 (196 deaths), with the main contributing conditions being coronary artery disease (54 deaths), suicide (20 deaths) and female breast cancer (18 deaths).

The rate for Māori is not available because rates are suppressed where there are less than 30 deaths. However, in 2016 twenty-three people identifying as Māori died from a potentially preventable condition, predominantly coronary disease (6 people), chronic obstructive pulmonary disease (3) and suicide (2).

Coronary artery disease is thought to begin with damage or injury to the inner layer of a coronary artery, sometimes as early as childhood. The damage may be caused by various factors, including:

- Smoking
- High blood pressure
- High cholesterol
- Diabetes or insulin resistance
- Sedentary lifestyle

In order to address amenable mortality, and specifically amenable mortality from coronary artery disease, it will be important to implement activities that address the above risk factors.

| National Measure | Deaths under age 75 years ('premature' deaths) from causes classified as amenable to health care (there is currently a list of 35 causes) |
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| Local Milestone | Reduce equity gaps in amenable mortality rates for Māori by 30% by 30 June 2023 |
| Activities | Contributory Measures |
| 1. PHOs to collaborate with Te Piki Oranga to help locate Māori Men (30-45) who are eligible for CVDRA, to undertake screening, and follow-up with management by Q1 *(refer Long Term Conditions section of Annual Plan and Using Health Resources Effectively in SLM Plan 2020-21).* | Proportion of Māori Men (30-45) who are eligible for CVDRA receiving CVDRA. |
| 2. Nelson Bays Primary Health extending dietitian clinics to Te Awhina Marae by Q3 *(refer Long Term Conditions section of Annual Plan 2020-21).* | Number of Māori attending dietician clinics at Te Awhina Marae.<br><br>Proportion of attendees reporting improved diet at six months follow-up.<br><br>Proportion of attendees with improvements in BMI, blood pressure, cholesterol, HbA1c at 12 months. |
| 3. PHOs to provide data to general practices about their patients with diabetes each quarter to enable the practice to use this as a reflection and quality improvement tool that improves diabetes management *(refer Long Term Conditions section of Annual Plan 2020-21).* | Primary Health Organisation (PHO) enrolled people aged 15 to 74 years with diabetes by most recent HbA1c level within the past 12 months. |

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| | Proportion of practices using PHO diabetes information in patient consultations. |
| 4. Hold self-management education 'taster' sessions by Q1 in Marlborough with Te Piki Oranga clients that are culturally relevant, appropriate and accessible for participants and family/whanau/support person *(refer Long Term Conditions section of Annual Plan 2020-21).* | Primary Health Organisation (PHO) enrolled people aged 15 to 74 years with diabetes by most recent HbA1c level within the past 12 months.<br>Proportion of Māori with diabetes who engage in self-management programmes. |
| 5. Expand pool-based activity programme (Maatapuna) by Q2 in a partnership between Nelson Bays Primary Health and Te Piki Oranga, removing barriers to increasing physical activity levels (*refer Long Term Conditions section of Annual Plan 2020-21*). | Proportion of attendees reporting improved physical activity at six months follow-up.<br>Proportion of Māori engaging in increasing activity programmes district wide. |

## Healthy start

**Babies living in smokefree homes** aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whanau environment (i.e., a healthy start). The measure aligns with the first core contact which is when the handover from maternity to Well Child Tamariki Ora (WCTO) providers and general practitioners occurs.

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 infants' 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 immunisation.

This measure was revised by the Ministry of Health on 31 October 2018 (numerator and denominator definitions changed). This resulted in all registered births being recorded in the denominator, not just those enrolled with/contacted by the WCTO provider. This means that the proportion of babies living in "smoking" houses according to the new measure could be due to EITHER:

- living in a household where someone smokes OR
- having not received a WCTO provider visit/enrolment

Therefore, to increase the proportion of babies recorded as living in smokefree homes, we also need to increase the proportion of registered births enrolled with WCTO providers (and ensure this data is being captured/reported to the Ministry of Health). In Nelson Marlborough from January 2019 to June 2019, 66.9% of registered births were enrolled with a WCTO provider and only 53.4% of newborns in Nelson Marlborough could be confirmed as living in smokefree households at six weeks postnatal (this compares with a national average of 55.3%). The rate for Māori is a lot lower; only 40.1% of new born Māori were enrolled with a WCTO provider and only 21.7% of Māori newborns in Nelson Marlborough could be confirmed as living in smokefree households at six weeks postnatal. This is lower than the national rate for Māori which is 34.4%. Rates also decline with increasing deprivation.

| National Measure | Babies living in a smokefree household at six weeks postnatal (up to 56 days of age). |
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| Local Milestone | At least 34.4% of Māori newborns in Nelson Marlborough Health live in a smokefree household at six weeks postnatal by 30 June 2021 |
| Activities | Contributory Measures |
| 1. NBPH will work with community agencies to provide a 'Vulnerable Populations' (VIP) project to target Māori, Pacific and other vulnerable people who cannot afford to access General Practice services, which would improve enrolment of children in GPs and WCTO | Enrolment rates of Māori children in Primary Care.<br><br>Enrolment rates of Māori children with WCTO providers. |

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| providers. | |
| 2. Smokefree 2025 programme to review initial Pepi First referral model by Q3 to understand how referrals from LMC midwives could be improved. | Referral rates to Pepi First by LMC midwives. |
| 3. Work with the Ministry of Health, Plunket and Te Piki Oranga to breakdown BLSH and Wellchild indicators by Q3 to identify differences based on ethnicity, rurality and/or facility and identify improvement actions for SLM Plan 2021/22. | Awareness of ethnicity, rurality and facility differences in BLSH and Wellchild indicators. |
| 4. LMCs, midwives and Hauora Direct to promote vaping as a quit smoking aid with whanau living in the same household as pregnant women underway by Q3. (*refer Smokefree 2025 section in Annual Plan 2020-21*). | Referral rates of whanau living with pregnant women to smoking cessation services (including the use of vaping as a quit smoking tool). |
| 5. Promote the Pēpi First programme to "wrap-around support" partners each quarter (e.g. iwi social service providers, budget advisors, LMCs and other health and social service providers) that have regular contact with hapū māmā; ensure referral pathways from Hapū Wānanga, Hauora Direct and other targeted health services (*refer Smokefree 2025 section of Annual Plan*). | Referrel rates to Pēpi First. |
| 6. Explore integrated IT solutions to reduce barriers to parents, GPs and LMCs to enrolment (*refer Maternity and Early years section of Annual Plan*).<br>• Initial stakeholder meeting held by Q1.<br>• Feasibility of Hauora Direct or other IT solutions to address this need determined by Q2.<br>• Alternative non-IT options explored by Q4 if necessary. | WCTO enrolment rates. |
| 7. WCTO will work closely with maternity services to notify each late/non referral so NMH can address barriers to timely enrolment with an initial stakeholder meeting held by Q1 (*refer Maternity and Early years section of Annual Plan*). | WCTO enrolment rates. |

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| 8. Increase LMC workforce capacity in Wairau to enable LMCs to support whanau experiencing difficulties accessing WCTO services by Q4 (*refer Maternity and Early years' section of Annual Plan*). | Proportion of newborns in Wairau enrolled in WCTO services. |

## Youth are healthy, safe and supported

The **youth access to and utilisation of youth appropriate health services** SLM is made up of five domains with corresponding outcomes and national health indicators. The Alliance was expected to choose at least one domain and use the corresponding national indicator to set their improvement milestone. Nelson Marlborough Health chose the 'sexual and reproductive health' domain with the intent of achieving the outcome of young people managing their sexual and reproductive health safely and receiving youth-friendly care. The national indicator for this outcome is chlamydia testing coverage for 15-24 year olds.

It is common practice to offer sexually active youth STI testing upon visiting a general practice or a sexual health clinic. Chlamydia is one of the infections that is screened for as part of this testing. In this way, chlamydia testing coverage for 15-24 year olds not only indicates coverage of STI testing, but can also be used as an indicator of the ability of young people to receive youth-friendly care and manage their sexual and reproductive health safely.

In 2018, a substantially higher proportion of 20-24 year olds in Nelson Marlborough had received STI testing than 15 to 19 year olds and this was true for both sexes and across all ethnic groups. However, females aged 20-24 years were more likely to have been tested (37.5%) than males (10.0%). Similar equity gaps in coverage on the basis of sex exist for those aged 15-19 years and persist for all ethnic groups. Data for 2019 will be available in August 2020.

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| Outcome | Young people manage their sexual and reproductive health safely and receive youth-friendly care |
| National Measure | Chlamydia testing coverage for 15-24 year olds |
| Local Milestone | Increase the percentage of males aged 20-24 years being tested for Chlamydia from 10.0% in 2018 to at least 35.7% (i.e., bring male rates in line with female rates) by 30 June 2021. |
| Activities | Contributory Measures |
| 1. Establish a 'train the trainer' model by Q4 in collaboration with occupational health nurses in local industry to add routine STI testing alongside compulsory drug testing, focusing initially on Port Nelson (Talley's & Sealords) and ITO apprenticeship providers (i.e., building trades). *(cross reference Sexual Health section Annual Plan 2020/21).* | Number of organizations offering STI testing alongside compulsory drug testing. |

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| 2. Enable registered nurses to provide STI testing and treatment in the community by Q4 through targeting providers who provide services to high numbers of Māori first *(cross reference Sexual Health section Annual Plan 2020/21).* | Number of registered nurses providing STI testing and treatment in the community. |
| 3. Nelson Marlborough Health's Health Promotion team to work together with youth health services to scope and strengthen year 10 sexual education in high schools with reference to *Mana Tangata Whenua: National Guidelines for Sexual and Reproductive Health Promotion with Māori (cross reference Sexual Health section Annual Plan 2020/21).*<br>• Understanding of current programme/s by Q1,<br>• Areas identified for improvement identified by Q2,<br>• Revised programme in place by Q4. | Understanding of sexual and reproductive health among youth. |
| 4. Collaborate with local PHOs and primary care practices to identify ways to encourage Primary Care Practices to routinely ask about sexual and reproductive health during youth consultations by Q4. (*cross reference Sexual Health section Annual Plan 2020/21).* | Number of primary care practices routinely asking young people about sexual and reproductive health. |