**DHB Office**
**Braemar Campus**

Private Bag 18
Nelson, New Zealand

7 September 2021

Via Email:

**Response to a request for official information**

Dear

Thank you for your request for official information as received 29 June 2021 by Nelson Marlborough Health (NMH)[1], followed by the necessary extension of time 24 August 2021, where you seek the following information.

1. ***A copy of your DHB's Planned Care Three Year plan (the one that needed to be signed off by Ministry of Health in 2020)***

NMH response: Please see attached *Nelson Marlborough Health Planned Care Services Plan 2020 – 2023.*

2. ***The latest update on delivery of any existing or new community/general practice based initiatives under your DHB's Planned Care Three Year Plan***

NMH response: There are no updates at this time.

This response has been provided under the Official Information Act 1982. You have the right to seek an investigation by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or free phone 0800 802 602. If you have any questions about this decision please feel free to email our OIA Coordinator OIArequest@nmdhb.govt.nz I trust that this information meets your requirements. NMH, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released. If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider.

Yours sincerely

Lexie O'Shea
**Chief Executive**

Encl: *Nelson Marlborough Health Planned Care Services Plan 2020 – 2023* (21 pages)

[1] Nelson Marlborough District Health Board

# Nelson Marlborough Health Planned Care Services Plan 2020 – 2023

Information Act request.

This docum

## Contents

Executive overview and Summary ... 2
Planned Care Strategic vision and values ... 2
Health for Tomorrow 2017 ... 2
Primary and Community Health Strategy 2017 ... 2
Ki Te Pae Ora Framework ... 3
Ambitions for Planned Care ... 5
Our Population ... 6
Assessment of priorities for improvements in Planned Care ... 7
Summary of proposed Planned Care Activity ... 9
Strategic Priority #1: Understanding health need ... 11
Strategic priority #2: Balance national consistency and local context ... 13
Strategic Priority #3: Simplifying pathways for service users ... 15
Strategic Priority #4: Optimising sector capacity and capability ... 17
Strategic Priority #5: Fit for the Future ... 19

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

## Executive overview and Summary

A whole of system approach to deliver planned care in Nelson Marlborough to contribute to our local strategic vision that "All people live well, get well and stay well (*Kaiao te tini, ka ora te mano, ka noho ora te nuinga*)" is outlined in this three year plan. It aligns with the government ambition to revise the planned care model to deliver improved equity and achieve integrated primary and secondary care health delivery.

## Planned Care Strategic vision and values

The Nelson Marlborough Health (NMH) Planned Care vision is informed by the frameworks of the National Health Strategy ambition that "New Zealanders live longer, healthier and more independent lives" and our local health vision that "All people live well, get well, stay well. *Kaiao te tini, ka ora te mano, ka noho ora te nuinga*".

### Health for Tomorrow 2017

Our vision for the future of health and health care, Health for Tomorrow (2017) strategy, articulates three overarching goals for the local population we are working to deliver.

- **Improved health, independence, participation, and equity**

We will foster good health through supporting our communities to develop ownership and responsibility for their health. It means we will work with our communities to make sure we support individual choices and support behaviour change. We will also involve our community in making decisions about allocation of services to address health inequity.

- **Improved quality, safety, and experience of care**

We are committed to ensuring we provide safe, quality care that delivers the right balance of hospital and community services using an integrated, multi-agency approach.

- **Best value of public system health resources**

We must make the best use of public resources in delivering health and care services. Our trained and competent workforce will include all health workers, informal caregivers, and volunteers. It is our workforce who will enable us to flexibly respond to the future. We will also develop and maintain the right infrastructure to address the changing needs of our population.

Achieving this vision means developing, delivering, reviewing, and adapting programmes of integrated care that provide a consistent experience across the network of services that will meet people's health and care needs. It will also improve, promote, and protect the health and wellbeing of the Nelson Marlborough population and reduce, and ultimately eliminate, existing inequities.

### Primary and Community Health Strategy 2017

With a focus on primary care and community health, the Primary and Community Health Strategy (2017) is guided by the following principles:

- **Integration / *Pāhekotanga:*** Health, social care, voluntary organisations, and consumer groups work alongside each other to provide better care. Providers work together in a virtual or physical space, so care is experienced as seamless.
- **Equity / *Matatikatanga***: People's health care needs are met through the provision of quality health care that is safe and delivers equity of outcomes. Funding models enable people with

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

high health needs or those who are disadvantaged to receive the same services and attain equity of health outcomes.

- **Supported Self-management / *Tokowhaiarotanga:*** People are supported to manage their own health. They have better access to health information and tools for managing their own health and the health of their family and whānau.
- **Accessibility / *Putanga Hauora*:** People are able to access health care when and where needed. Most health care will be delivered in the community. When needed, specialist care will be available with clear pathways to get this care.
- **Technology / *Hangarautanga Hauora:*** Technology is used effectively to support a seamless system, assist people to understand and take ownership of their health, and enhance access to services.
- **Evidence-led / *Taunakitanga*:** Decisions about health care and the planning of future services are made based on local health intelligence and evidence. Design will take place at a local level, and keep a district-wide view, to meet the health needs of our communities.

The objective of the programme is to: "Improve and transform the way health care is provided in Nelson Marlborough. Our health services need to meet the needs of our community, especially Māori and vulnerable populations, and meet increased demand. We need health services that are safe, high quality, and take advantage of new technology."

## Ki Te Pae Ora Framework

Finally, our strategic framework has been reaffirmed in 2020 with the following NMH Change programme, *Ki Te Pae Ora – Towards a healthy future*. Like the rest of Aotearoa New Zealand, the response to the Covid-19 pandemic accelerated system changes that were responsive and flexible in keeping the local population safe and healthy.

In mid-2020, all these approaches were brought together in a single programme that will drive us to a healthy future. This new Ki Te Pae Ora programme includes our continuous quality improvement programme and mental health and addictions integration programme. Ki Te Pae Ora principles are:

| | |
|---|---|
| **Equitable outcomes** | Policies, practices and environments will **improve Maori health, and reduce inequity,** particularly for our vulnerable communities. This will require ensuring a holistic, preventative, strengths based and proactive approach to be taken with genuine engagement with communities. We will identify needs and engage with targeted services to prevent and address inequity. |
| **Healthy communities** | **Strengthen the ongoing management of COVID-19** and other infectious diseases in our community. The physical distancing requirements will impact on how we offer services and therefore we need to plan how episodes of care are delivered.<br>We will continue to develop innovative and sustainable ways to contribute more strongly to supporting healthy environments by being focussed on **working well together to achieve wellbeing**, across social and health systems. |
| **Personalised, Flexible and Responsive.** | Care delivered **flexibly in the most ideal and safest setting** for person and whanau.<br>People will be able to **easily access and navigate** the support and services they need with care closer to home, with a streamlined journey when accessing services across the continuum.<br>Taking a holistic approach to need, looking beyond the presenting issues and problems at hand, with processes that effectively support this. |

This document was released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

| | |
|---|---|
| | Hospitals that are well equipped, connected to the wider system and staffed to handle complex episodic care, when that care is appropriate within the wider continuum.<br>All our systems will promote and support alternatives to face-to-face (F2F) care when appropriate. Follow-up care should prioritise virtual technology wherever possible. |
| **Person and whanau centred** | People will be able to access the information and supports they need in order to better manage their own health.<br>**People and whanau are our partners in the design of health services**. We will ensure that the patient journey is prioritised to reduce time between care decision moments. Coordinated approaches to care are actively pursued, and patient journeys are well planned. |
| **Sustainable** | Health services will better meet community health needs that require immediate response, as well as **planned and coordinated care,** now and in the future.<br>Systems and processes are clinically appropriate, financially sustainable, environmentally sustainable, meet legislative requirements and foster positive **wellbeing within and across our workforce.** |
| **An integrated and connected system** | Responses are designed and **integrated across the health and social system.**<br>We will work to develop processes to share and analyse data, intelligence and information to support **collaborative decision making.** Impact of changes on all stakeholders needs to be considered.<br>The information needed for safe care will be readily available across the system. |
| **Safe, skilled and compassionate workforce** | Services are designed to allow everyone to continue to learn, use and further develop their skills, knowledge and experience to maximum effect/impact, to support the wellbeing of our teams to **provide safe and compassionate care**.<br>Our workforce is empowered and enabled to be **responsive, flexible, and agile** and assisted with adaptive decision making to adopt new ways of working. |
| **Health, Safety & Wellbeing** | Work arrangements care for staff to ensure NMH provides a **safe working environment, safe systems** of work and supervises tasks to ensure staff have and use the skills required to protect themselves and others.<br>Staff wellbeing is considered in all workplace arrangements. |

Planned Care is one of the core activity focus areas of our Ki Te Pae Ora transformation programme that builds on the successes and learnings from our former Models of Care programme.

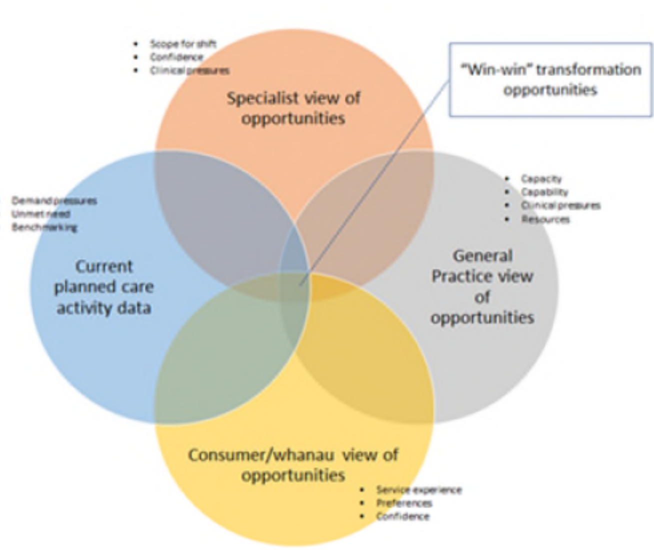
This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

## Ambitions for Planned Care

Nelson Marlborough Health ambitions for Planned Care are ensuring that Nelson Marlborough people get integrated healthcare that safely meets their needs, regardless of who they are or where they live in our region. There will be a focus on early intervention programmes that can prevent or delay the need for more complex healthcare. This does not man 'one-size" fits all. They will receive care at the most appropriate time to support improved health and minimise ill-health, discomfort, and distress. People will get to the right place with the right provider without delay.

We will build on what is working well, including strong community spirit and determination, and a skilled and dedicated network of hospital and community healthcare service providers. This will reshape the way NMH supports the people of Nelson, Tasman and Marlborough to live well, stay well and get well.

We will continue to engage with General Practice teams, specialist services, Maori Health providers and whānau, consumers, and community organisations. NMH has already received many ideas to improve the way we deliver primary health and care services and improvements with the interface with hospital and secondary health care services:




- Proactive equity focused decision making, and prioritisation needs to be embedded across the system
- Strengthen systems to target need and engage
- To the extent possible, separate planned care from unplanned care to increase the reliability of planned care as it is not disrupted by unplanned care.
- Smooth the patient journey and experience of care – patient-focused planning, multiple activities in a single visit
- Enhance support of primary and community services
- Increase the scope of services, through delivery models to support enhanced self-care and more follow-up care out-of-hospital settings
- New ways of doing things, increasing professional interfaces across the system less reliance on binary activities like outpatient appointments
- Stronger focus on shared care for patients with complex medical and surgical needs e.g. post-operative care for person with many comorbidities
- Unlocking digital potential for the future to support - self-care, health literacy, record keeping and sharing, easy access for advice, virtual care, wearable devices, patient held care platforms, artificial intelligence

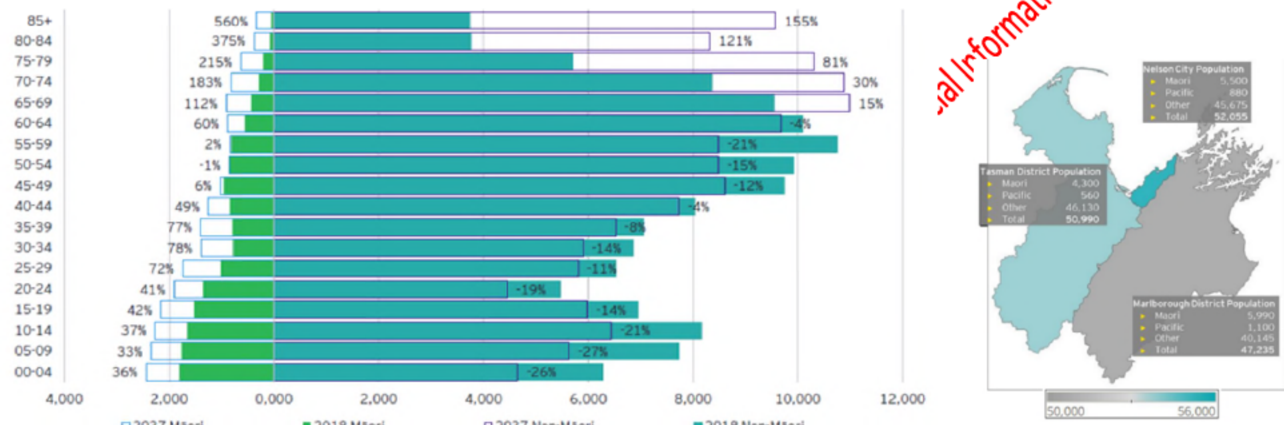
This document is released by Nelson Marlborough Distri- ...rmation Act request.

## Our Population

Nelson Marlborough Health has a strong understanding of the health needs of our local populations. The Nelson Marlborough Needs Assessment (2015) was refreshed in 2019 as part of the preparation of the Indicative Business Case for a new Nelson Hospital and informs our planned care approach.

Nelson Marlborough Health (NMH) covers the top of the South Island including Nelson city, the Tasman district and the Marlborough district, serving 158,600 people. There are significant rural communities including Golden Bay, Murchison, Marlborough Sounds, Nelson Lakes, and Ward/Awatere Valley.

The population is relatively stable in overall size, with low future growth forecast compared to the New Zealand average. However, the greatest growth is occurring in the population aged 75 years and over, forecast to increase 4.5% per annum.




Nelson Marlborough has a lower proportion of Māori (11 per cent) and Pacific (1.9 percent) people and fewer people in the most deprived section of the population, compared with the New Zealand average. Overall, 5.2% of the Nelson Marlborough population lived in deprivation deciles 9 and 10, compared with the average for New Zealand of 20%.

While our population has relatively good health, with good access to both primary and secondary health and disability services, the most vulnerable in our community experience poorer health outcomes – Māori, youth, and people living with mental health conditions or a disability:

- The local Māori population is young with just under half (45.7 percent) aged less than 24 years and only 5.2 percent aged over 65 years.
- On average Māori residents of Nelson Marlborough are 16 percent more likely to be earning under $20,000 than Non-Māori.
- Almost half of the Māori population (46 percent) reside in 40 percent of the most deprived areas of Nelson Marlborough. This trend is consistent across children and youth (0-19 years). Māori residents are therefore more likely to have higher healthcare needs associated with poorer living conditions.
- Māori residents die younger than non-Māori. If Māori living in Nelson Marlborough had a life expectancy similar to that of Māori nationally, there would be a 7.4 year life expectancy shortfall for Māori males, and a 7.2 year shortfall for Māori females. Coronary artery disease is the leading cause of avoidable mortality in Nelson Marlborough for both Māori and non-Māori. Chronic obstructive pulmonary disease (COPD) is ranked second among Māori residents, while suicide is second for non-Māori (and third for Māori).

This document is released by Nelson Marlborough District Health ... ial Information Act request.

## Assessment of priorities for improvements in Planned Care

The past three years have seen a concentrated focus on establishing a system-wide transformation programme to redesign and reconfigure the Nelson Marlborough health system. With strong board, executive and clinical support, the Models of Care programme consulted widely to identify, establish, and progress transformative changes. An engaged Clinical Working Group composed of primary care doctors and nurses, hospital specialists and nurses, mental health and addictions, community pharmacy, allied health, public health, and executive leaders collaborate to identify planned care opportunities and develop and test innovative solutions.

This process has run in tandem with the development of an indicative business case for a new Nelson Hospital facility, also with strong clinical participation, which recognised the need for planned care changes across the system to ensure a hospital that was configured and sized to meet current and future health needs.

Planned Care services, traditionally known as 'Electives,' encompass medical and surgical care for people who do not need to be treated right away. Well over $1 billion of DHB's funding nationwide is for non-acute medical or surgical care, which is defined as health care that is provided more than 24 hours after a decision to proceed with treatment.

Previously, this non-acute care was named elective services. However, that approach was too narrowly focused on procedures performed in hospitals. A broader approach is needed to improve people's health and wellbeing, and to better meet the priorities of achieving equity and sustainability for the health and disability system. This includes taking a whole of person approach to planning people's care in all settings. This document therefore considers all aspects of planned care in all settings, including health education, early interventions, and pro-active primary care management of Long-Term Conditions. Planned care journeys frequently occur across a number of services so smoothing these journeys is an important improvement step.

The new approach has six strategic priorities:

- Understanding health need – both in terms of access to services and health preferences, with a focus on understanding inequities that we can change
- Balancing national consistency and local context – ensuring consistently excellent care, regardless of where you are or where you are treated
- Simplifying pathways for service users – providing a seamless health journey, with a focus on providing consumer-centred care in the most appropriate setting
- Optimising sector capacity and capability – optimising capacity, reducing demand on hospital services, and intervening at the most appropriate time
- Fit for the future – planning and implementing system support for long term performance and improvement.
- Working to strengthen the integration of Mental Health & Addictions with physical health.

Well organised Planned Care will better enable DHBs to provide more timely care in the most appropriate settings with the right workforce, including services that can be delivered in primary care and community settings.

This document is released by Nelson Marlborough District Health Board as part of a response to an official information Act request.

Programme Enablers are important and include any improvements or initiatives that help us achieve the objectives for consumers. Programme Enablers include radiology and access to diagnostics, referral and information system improvements, Virtual Care infrastructure, Health Pathways, workforce development and specialist advice and/or support to general practice.

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

## Summary of proposed Planned Care Activity

| Strategic Focus area | Year 1 (2020/2021) Actions establishing the foundations | Year 2 (2021/2022) Actions building successful programmes | Year 3 (2022/2023) Actions embedding changes |
|---|---|---|---|
| **Strategic Priority 1**<br>*Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed.* | Improve data capture and quality to deepen understanding of local health needs and inform planning.<br><br>Include an equity lens in all analysis.<br><br>Develop systems that support equity identification and delivery in referral and triage processes. | Develop and improve planned care programmes based on equity data, making sure barriers to access are reduced and outcomes improved. Develop better systems to identify individual need and early warning systems for escalating needs. | Prioritise investment in care for those who experience the greatest disparity in health outcomes. |
| **Strategic Priority 2**<br>***Balance national consistency and the local context*** | Continue to participate in the South Island Alliance and identify opportunities for regional pathways development.<br><br>HealthPathways will be localised or developed as a key enabler to support implementation of changes in care pathways including settings of care | Develop opportunities to enhance and improve the national framework with the Ministry of Health. Continue using health pathways as a tool to transform care, increase consistency and support equity. | Local pathways support appropriate planned care delivery locally. Regional and national pathways support consistency and equity. |
| **Strategic Priority *3***<br>*Support consumers to navigate their health journeys* | Investigate opportunities to empower people to self-manage their health.<br><br>Develop the locality approach that brings together health and care services into networks delivering care closer to home using a shared patient information platform. | Embed the locality approach with locality care coordinator roles supporting joined up care for those with greatest needs and least ability to organise their own care. | |
| **Strategic Priority 4**<br>***Optimise sector capacity and capability*** | Most health care will be delivered in the community. When needed, specialist care will be available with clear pathways to get this.<br><br>Work with clinical services, primary care, and community partners to identify opportunities to shift services closer to home, ensuring all parts of the system are working to the top of their capability. | Remote consultations (virtual video/phone) delivered in primary and secondary care, evidenced by savings in patient and clinician time, and reduced carbon emission impact. Patient portals developing an increasing role. The principles used within the health care home are | Increase options for people to access care, including continued development of telehealth and non-synchronous consultations. Patient portals support two-way communication across the system. |

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

| Strategic Focus area | Year 1 (2020/2021) Actions establishing the foundations | Year 2 (2021/2022) Actions building successful programmes | Year 3 (2022/2023) Actions embedding changes |
|---|---|---|---|
| | Participate in effective regional planning across South Island to maximise collective resource and minimise duplication<br><br>Continued investment and consolidation of the Health Care Home approach in general practice. More of the local population enrolled with practices that support system wide quality improvement model based on Health Care Home principles.<br>Establish a clinical network of physiotherapy providers, focused on preventative, early rehabilitation of Musculo-skeletal impairment, to provide timely access to appropriate physiotherapy services, and to provide workforce sustainability | increasingly seen to add value within the whole health system. | |
| **Strategic Priority 5**<br>*Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.* | Identify opportunities to deliver new models of care that support well-being and proactive care, including health awareness campaigns that support the community.<br><br>Progress a Joint Health System Planning programme with primary and community and cross-sector partners to ensure all planned care services are clinically and financially sustainable. Business modelling will form part of any new model of care development.<br><br>Develop nursing and allied health capacity and capability to support model of care change across Haematology, Ophthalmology, Orthopaedics, Neurology and Vascular care. | Design community programmes informed by partnership with local communities to minimise health risk and increase quality of life for those living with long term health conditions. | Evaluate community programmes to support continuous improvement of approach. |

This document released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

## Strategic Priority #1: Understanding health need

| Priorities | Actions | Definition of success in Year One | Definition of success in Year Two | Definition of success in Year Three |
|---|---|---|---|---|
| Understanding population health needs, with a focus on equity. | Improve data capture and quality to deepen understanding of local health needs and inform planning.<br><br>Incorporate recording and reporting of ethnicity, mental health, disability and deprivation across planned care services and activities.<br><br>Support wider use of Tableau workbooks and Data Visualisations in everyday service decision-making and delivery | An integrated system dashboard that incorporates National Patient Flow indicators with service demand, delivery and projections will be readily available to health and care providers and services. Information becomes increasingly timely to guide care delivery day to day. | Data collection, performance and activity reporting will include ethnicity and deprivation as standard.<br><br>Detailed population information supports the targeting of need to increase equity. | Service development and organisation will be informed by accurate data and intelligence allowing successful integration and equity delivery.<br><br>Localities know increasingly detailed information about community needs and the impacts of targeted interventions. |
| Applying understanding of health needs to improve equity in service planning and delivery. | Ensure planned care services are based on a solid understanding of the health needs of the local population. | Decrease in non-attendance rates for Māori and vulnerable populations in services where equity has been identified as a key issue. | Equity will be embedded in the approaches to developing and delivering planned care. | Health equity gains will be visible for all planned care activity, and equity gaps will be closed. |
| An overview of population data is used to recognise trends in needs for individuals to support the targeting of need and engagement | Methodologies developed and a few key areas of risk for adverse outcomes recognised e.g. 1st thousand days and suicide risk | Wider use of community early warning scores becoming routine supporting proactive care. | Planned care is delivered to those with high needs in advance of need for acute care. | Few individuals miss out on proactive care. |
| Understanding the patient experience and embedding consumer/whānau participation in planned care design. | Incorporate co-design principles and approach into all planned care improvement and transformation. | DHB Consumer Engagement Framework refreshed and co-design evident in Year One Ki Te Pae Ora projects. | Successful co-design approaches used appropriately in Ki Te Pae Ora Planned Care initiatives. | Co-design embedded in planned care development, implementation, and evaluation. |

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

| Adopt a collaborative cross-sector approach to deliver programmes that understand and address the wider determinants of health. | Strengthen links with cross-sector partners – Ministries of Social Development and Education, NZ Police and other partners. | Deliver regular community engagement opportunities with cross-sector partnerships.<br><br>Continued participation in the Top of the South Impact Forum. | Cross-sector collaboration is embedded in the Ki Te Pae Ora programme and localities. |
|---|---|---|---|
| Improved workforce planning to meet population needs | Identify current and future gaps in our workforce by profession and plan to meet those gaps while ensuring our workforce reflects the populations that we serve | DHB Workforce Plan completed | Future workforce needs are clearly promulgated to enhance local training processes to grow our future workforce locally based on the pipeline needs. |

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

## Strategic priority #2: Balance national consistency and local context

| Priorities | Actions | Definition of success in Year One | Definition of success in Year Two | Definition of success in Year Three |
|---|---|---|---|---|
| Evidence-Led / *Taunakitanga* | Understand unwarranted variation in access, with a focus on standardising intervention rates against national peer comparators. | Understand difference in standard intervention rates (SIR) with an initial focus on vascular surgery and orthopaedics and general surgery.<br><br>Continued analysis and comparison of SIR to identify opportunities. | Programmes developed to address identified variation resulting in SIR rates aligning more favourably with peer comparators.<br><br>Programmes developed to improve SIR rates identified in preceding year. | NMH services will be delivering SIR rates aligned with exemplar peers, while understanding variations in service model delivery.<br><br>Unwarranted variations in SIR by population subgroup is reduced while variation based on need is increased. |
| Balancing local and regional context | Continue to participate in the South Island Alliance and identify opportunities for regional pathways development. | Regional planned care pathways delivered that maximise planned care opportunities. | Local pathways support appropriate planned care delivery locally. Continue using HealthPathways as a tool to transform care, increase consistency and support equity. | Continued participation in South Island Planned Care initiatives. |
| Work with the Ministry of Health to ensure the national planned care framework aligns with new models of delivering planned care locally | Ensure alignment between changes in models of care are reflected through the national framework. | Opportunities to enhance and improve the national framework are identified with the Ministry of Health. | Action plan developed to ensure current and future funding, reporting, and planned care delivery is nationally aligned. | National and local frameworks and models aligned, and mechanisms in place to ensure continued alignment. |
| Improve access to diagnostics to ensure patients get timely access to the diagnostics needed to formulate and deliver treatment | Increase the access to diagnostics available to general practice to support streamlined care pathways, including community follow-up and monitoring.<br><br>Install additional radiology equipment at Nelson Hospital to support delivery of planned care. | Diagnostic services for those living in rural and remote areas will be able to be accessed locally to where they live, focussed on Golden Bay.<br><br>Diagnostic access will support the delivery of follow-up planned care in the community. | Continued development of access for those living rurally and remotely.<br><br>Investigate and develop diagnostic access required to support planned care being separated from unplanned (acute) care. | Access to diagnostics will be delivered aligned with patient need in pathways that facilitate patients getting to the care they need without unavoidable delay. |

This document released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request

| Priorities | Actions | Definition of success in Year One | Definition of success in Year Two | Definition of success in Year Three |
|---|---|---|---|---|
| | | | | |
| Standardise pathways of care for people in our sub-region | HealthPathways will be localised or developed to support implementation of changes in care pathways including settings of care. | HealthPathways keep pace with and reflect the pathways of care available across the sub-region and supports the targeting of care and prioritisation needed to reduce inequity. | | |
| Optimise pathways of care for patients travelling across the district and region for care | Agree clear pathways for patients including expanding telehealth and technology opportunities<br><br>Develop pathways and processes to maximise the use of telehealth for Allied Health service delivery. | More patients get more care in single visits to multiple services.<br>Telehealth and technology opportunities continue to expand. | Patient focussed booking allows people to get care when they can attend reducing system waste while improving care. | Care delivery designed based on the needs of the patient as well as the needs of individual services |

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

## Strategic Priority #3: Simplifying pathways for service users

| Priorities | Actions | Definition of success in Year One | Definition of success in Year Two | Definition of success in Year Three |
|---|---|---|---|---|
| Supported Self-Management / *Tokowhaiarotanga* | Investigate opportunities to empower people to self-manage their health and support the uptake of patient information portal use, local and online support, and collaboration with service providers. | Extended community support roles scoped and operational for initial areas identified - Parkinson's disease, haematology, and diabetes. | Self-management approaches extended to support earlier intervention in people's health journey. | Supported self-management incorporated into planned care.<br><br>Digital platforms and patient portals support self-care with timely professional input. |
| Integration / *Pāhekotanga*<br>**Make it easy for patients to receive the right care in the right place at the right time by the right person** | Develop the locality approach that brings together health and care services into networks delivering care closer to home using a shared patient information platform.<br><br>Enable more choice for patients/whānau by continuing to support uptake of telehealth opportunities, including patient booking. | Health Care Home approach and quality improvement delivered across general practices in Nelson Marlborough supporting integrated care.<br><br>Locality pilots delivered in Motueka, Victory, Marlborough, and Stoke.<br><br>Telehealth consultations show a 3% increase in volume from the 2019/20 baseline. | Embed the locality networks across Year One pilot sites.<br><br>Year on year growth in telehealth use and increase in out of district telehealth consultations towards a 2029/30 target of 30%. | Extend the locality approach across the Nelson Marlborough region.<br><br>Year on year growth in telehealth use and increase in out of district telehealth consultations towards a 2029/30 target of 30%. |
| Equity of health outcomes increased | Prioritise investment in care for those who experience the greatest disparity in health outcomes.<br><br>Pro-actively prioritise vulnerable patients across the patient journey. Embed in referral and triage systems | Service access will be improved for Māori and vulnerable population through Kaupapa Māori services, including expanded navigator capacity. | Continued embedding of culturally based models of service delivery in key clinical areas. | Equity of access and outcomes is improved for Māori and vulnerable people. |
| Promote community delivery of mental health and addictions services | Broaden access to mental health planned care by integrating well-being practitioners into primacy care. | Model of well-being practitioners will have been delivered in three pilot sites and across Marlborough. | Mental health, particularly for those experiencing mild to moderate mental ill-health, will | Equity outcomes delivered in mental health and addictions. |

This document released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

| Priorities | Actions | Definition of success in Year One | Definition of success in Year Two | Definition of success in Year Three |
|---|---|---|---|---|
| | Work to meet the expectations for access to mental health and addiction services. | Implementation of Nikau Hauora Hub model for delivery of mental health services in the community. | be integrated, and delivered in general practice.<br>Digital support tools with safety net options increasingly used. | |

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

## Strategic Priority #4: Optimising sector capacity and capability

| Priorities | Actions | Definition of success in Year One | Definition of success in Year Two | Definition of success in Year Three |
|---|---|---|---|---|
| Separate planned care from unplanned care where possible | Identify opportunities where separation of unplanned and planned care can deliver improvements in planned care.<br><br>Continued engagement with all system partners.<br><br>Install equipment to enable diathermic uterine resection procedures to be carried out in procedure rooms, rather than in operating theatres in Nelson Hospital, releasing theatre capacity. | Investigation of opportunities to create additional theatre capacity by moving clinically appropriate activities to procedure rooms.<br><br>Creation of further consolidated cystoscopy clinics, subject to resource availability.<br><br>People entering Age-Related Resident care will have care plans that ensure they receive care in the least restrictive environment, reducing unnecessary hospital attendance. | Interim facilities solutions identified and enabled ahead of any new Nelson Hospital development.<br><br>Reductions in the volume of planned care theatre sessions cancelled / or postponed.<br><br>Where possible, planned care streamed separate from acute care with activities consolidated to ensure preparation and recovered is programmed with reliable processes. | Reduction in delays for follow-up reflects in decreased numbers of patients with overdue planned care follow-ups.<br><br>Waiting times for non-acute surgery decreased.<br><br>Durations of hospital stay are reduced with enhanced recovery and fewer unplanned events. |
| Accessibility / *Putanga Hauora* People are able to access health care when and where needed. Invest early to avoid increased health system costs | Identify opportunities to change our models of care to act earlier in the disease pathway<br><br>Most health care will be delivered in the community. When needed, specialist care will be available with clear pathways to get this. | Increase access to specialist advice for primary care and communities through access to telehealth<br><br>Continued investment and consolidation of the quality improvement approach informed by Health Care Home approach in general practice. More of the local population enrolled in Health Care Home practices. | Remote consultations (virtual video/ phone) delivered in primary and secondary care, evidenced by savings in patient and clinician time, and reduced carbon emission impact. | Increase options for people to access care, including continued development of telehealth and non-synchronous consultations.<br><br>Individuals targeted with the care they need proactively |

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

| Priorities | Actions | Definition of success in Year One | Definition of success in Year Two | Definition of success in Year Three |
|---|---|---|---|---|
| Increase scope of out of hospital services | Work with primary care to identify opportunities for increasing scope of out of hospital services that support system partner to work to the top of their capability.<br><br>Establish a clinical network of physiotherapy providers, focused on preventative, early rehabilitation of Musculo-skeletal impairment, to provide timely access to appropriate physiotherapy services, and to provide workforce sustainability<br><br>Review models of care change for melanoma and breast cancer follow-up and develop a viable business model for delivery in primary care. | Develop an agreed local framework for primary care follow-up across primary and secondary providers<br>Delivery of follow-up in primary care for priority clinical areas identified as part of framework development. Focus on primary care melanoma & breast cancer follow-ups. | Integrated follow-up pathways result in consistent follow-up and decrease risk to patients of adverse consequences from not being followed up. | Out of hospital follow-up will be established resulting in increased response capacity in hospital services.<br>Primary care follow-up will release specialist capacity to respond to first specialist appointments and reduce volume of overdue specialist follow-up. |

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

## Strategic Priority #5: Fit for the Future

| Priorities | Actions | Definition of success in Year One | Definition of success in Year Two | Definition of success in Year Three |
|---|---|---|---|---|
| A hospital site that is fit for the future | Continued development of the Clinical Services Plan and progressing business cases for new Nelson Hospital based on new models of care. | Interim Nelson Hospital site redevelopment planning is completed that reinforces the ambitions of the wider redevelopment. | Interim hospital site developed. | *tbc* |
| Strengthening investment in prevention and well-being promotion that improves lifetime health outcomes | Develop new models of planned care that meet the needs of the current and future population. | Identify opportunities to deliver new models of care that support well-being and proactive care, including health awareness campaigns that support the community. | Design community programmes informed by partnership with local communities to minimise health risk and increase quality of life for those living with long term health conditions. | Evaluate community programmes to support continuous improvement of approach. |
| Evidence-Led / *Taunakitanga* | Continue HealthPathways development to support planned care changes. | HealthPathways programme of continuous review is aligned with the Ki Te Pae Ora programme. | | |
| A system wide impact assessment framework for planned care changes | Develop a whole of system data approach that will combine primary and secondary care information to assess the system impact of changes to planned care. | Develop and consolidate a system impact set of measures. | System impact measures defined, data sources identified and development work underway to ensure data can be captured and reported. | Planned care reporting and opportunities identification will be made easier from a whole of system data and intelligence framework. |
| Improved workforce planning and development that reflects the Nelson Marlborough community and develops the skills needed to deliver transformed planned care. | Workforce analysis to identify gaps in the workforce and planning to meet those gaps.<br><br>Create entry-level Kaiāwhina positions for Allied Health Assistants with a focus on Māori, Pacifica and refugee populations.<br><br>Develop nursing and allied health capacity and capability to | Workforce development plan complete.<br>Develop a framework to strengthen partnerships with iwi and community partners. | Action plan to support delivery of the workforce development plan delivered. | Workforce reflects the local community and supports the delivery of changed models of care. |

This document released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.

| Priorities | Actions | Definition of success in Year One | Definition of success in Year Two | Definition of success in Year Three |
| --- | --- | --- | --- | --- |
| | support model of care change across Haematology, Ophthalmology, Orthopaedics, Neurology and Vascular care. | | | |

This document is released by Nelson Marlborough District Health Board as part of a response to an Official Information Act request.