Nelson Marlborough
District Health Board
TE WAI ORA

FROM GOOD TO GREAT

Nelson Marlborough
Health Services Plan

2015/16
– 2017/18

Our Vision

Towards Healthy Families

Our Mission

Working with the people of our community to promote, encourage and enable their health, wellbeing and independence.

Our Goals

Improved health, independence, participation and equity
We will ensure that we build 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.

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 from public system health resources
We will ensure the best use of public resources in delivering health and care services. We are committed to ensuring a workforce that includes all health workers, informal caregivers and volunteers who are trained and competent and will allow us flexibility to respond to the future. We will develop and maintain an optimal infrastructure which is regularly refreshed to address the changing needs of our population.

Our Values

Respect - We care about and will be responsive to the needs of our diverse people, communities and staff.

Innovation - We will provide an environment where people can challenge current processes and generate new ways of working and learning.

Teamwork - We create an environment where teams flourish and connect across the organisation for the best possible outcome.

Integrity- We support an environment which expects openness and honesty in all our dealings and maintains the highest integrity at all times.

Contents

Foreword

We are delighted to present the *2015 Nelson Marlborough Health Services Plan*, which outlines the medium term (5-10 year) objectives for the Nelson Marlborough health system. The Health Services Plan was informed by the *Nelson Marlborough Health Needs and Service Profile*, an analysis of who the people are in our community, and their health and wellbeing needs.

We are proud of the healthcare we currently provide to our community. We acknowledge that some members of our community struggle to access healthcare, and this is not good enough for our consumers or our wider community. We are committed to **improving population health outcomes, and reducing health inequalities.**

Financially, Nelson Marlborough DHB is now achieving a financial surplus despite operating in a challenging environment with increasing demand and supply pressures. We will continue to **support health system clinical and financial sustainability**.

We believe the people in our community deserve the best possible health care, and we have developed a plan that will **lift our health system performance from good to great**.[1]

The actions to achieve these outcomes are detailed in this *Health Services Plan*, and are supported by the Nelson Marlborough Workforce Plan and a specific primary care strategy.

To be successful, we need to work with the people of our community to sustain what is working well and identify and resolve service issues, and understand what is needed to support people to stay healthy and prevent future health issues.

Please share your feedback and take advantage of the opportunities to work alongside us to improve health care for our community.

Naka noa.

Jenny Black
Chair
NMDHB

Chris Fleming
Chief Executive
NMDHB

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[1] The term 'good to great' was popularised in the book by James C Collins *Good to Great: Why Some Companies Make the Leap…and Others Don't* (William Collins, 2001) that describes how organisations transition from being average to great, and how some fail to make the transition. In this Plan, the term refers to our commitment to lifting the performance of the Nelson Marlborough health system.

Executive summary

Introduction

The Nelson Marlborough health system comprises interconnected and interdependent organisations and practitioners who work together to meet the population health, personal health, and disability support needs of our district as a whole, and our local communities. Nelson Marlborough DHB (NMDHB) has overall responsibility for the performance of the health system, and is responsible for the provision and/or funding of the majority of health services in the district.

This *Health Services Plan* (HSP) is designed to deliver on three medium term objectives for the Nelson Marlborough health system:

•   Improve population health outcomes, and reduce health inequalities;
•   Support health system clinical and financial sustainability;
•   Lift health system performance from good to great.

The HSP links the long term direction described in NMDHB's *Health for Tomorrow* with the short term focus of the DHB's annual plan. It also provides a strategic context for more detailed service, capacity (workforce, facilities, and technology), and financial planning.

The HSP details the actions over the first 3 years (2015/16-2017/18) that will ensure the Nelson Marlborough health system takes the critical early steps that will head it in the desired direction. These 3-year actions are presented as an Implementation Roadmap.

The HSP has been informed by the *Nelson Marlborough Health Needs & Service Profile*, and will be followed by the *Nelson Marlborough Facilities Implications Report*.

The *Health Needs & Service Profile* shows that the Nelson Marlborough population has relatively good health and good access to health and disability support services, compared to others in New Zealand. Likewise, our health system performs well compared with other DHB areas.

The Nelson Marlborough population has a higher life expectancy than the New Zealand average, and lower amenable mortality. Our population ranks relatively low on most health risk factors, but still has 15,000 smokers, and 34,000 adults who are obese - 6,000 of them morbidly obese. Our children (0-14 years) are generally at lower risk and in better health than their national counterparts.

Health inequalities are apparent in our population's outcomes. Males have a lower life expectancy than females. Māori in Nelson Marlborough do better than Māori elsewhere in New Zealand on most health indicators, but a large gap still exists in the majority of health indicators compared with non-Māori.

Nelson Marlborough is predicted to have a relatively stable population size, with low future growth expected. The largest proportionate growth will be in the elderly, with the 75+ age group increasing at 4.5% per annum, similar to the New Zealand average.

Health system sustainability

The Nelson Marlborough health system is operating in a challenging environment, with intensifying demand and supply pressures challenging its clinical and financial sustainability.

Projection of future demand for NMDHB specialist services through to 2035 shows that if current utilisation rates and models of care were to continue unchanged, then Nelson Hospital bed numbers would have to increase by 68%, and Wairau Hospital by 48%. This growth reflects the impact of ageing of the Nelson Marlborough population, and is unsustainable both clinically and financially.

For the Nelson Marlborough health system to be sustainable, it must be able to provide ongoing access for the resident population (and visitors to our district) to safe, effective and efficient services. Sustainability also requires that the district's health system is capable of anticipating and responding to the changing operating environment, and contributing to the wider wellbeing of our communities.

'Future-proofing' of the Nelson Marlborough health system will require different resource allocation patterns, and adoption of new ways of working that improve access, make better use of the available workforce, and improve service performance.

Faced with immediate pressures and recognising that these are intensifying, the DHB has taken action over recent years to build stronger foundations for our health system, including:

- NMDHB's shared vision with the mana whenua of our district for Māori health in 2038, and joint commitment to its implementation. The DHB receives strategic advice on the planning and delivery of Māori health services from the Iwi Health Board. The focus is on reducing inequalities, and achieving Whānau Ora outcomes through collaboration
- Development and updating of *Health for Tomorrow*, a long-term framework to guide NMDHB's planning and development, and progress towards the vision of 'healthy families'
- Changes to NMDHB's senior leadership structure and personnel, with a focus on strengthening organisational performance and accountability, and clinical leadership and governance
- The decision by the Board of NMDHB to set the objective of lifting the already 'good' performance of our health system to 'great'. This objective, reflected in the HSP, will mean improving performance in areas where the Nelson Marlborough health system currently rates below the national average; and prioritising the areas in which we aspire to superior ('world class') performance
- The turn-around in our financial performance over the past 2 years, with a move from deficit to surplus allowing new investment in immediate service priorities, and initiation of financial reserves to ensure affordability of future capital investment, including in Nelson Hospital facilities
- NMDHB's work with the other four South Island DHBs through the South Island Alliance to align patient pathways, introduce more flexible workforce models, and improve patient information systems, to better connect the DHBs' services and clinical teams. The work is clinically led, with multi-disciplinary representation from community and primary care services, hospital and specialist services, and consumers
- Establishment of Te Tau Ihu Top of the South Alliance (ToSHA) as a formal partnership between NMDHB and the two PHOs in Nelson Marlborough (Kimi Hauora Wairau Marlborough PHO, and Nelson Bays Primary Health). ToSHA leads a work programme of population health improvement and service transformation that will contribute to the DHB's overall goals
- Completion of NMDHB's Top of the South Review with a focus on configuration of core secondary care services (medicine, surgery and orthopaedics). Implementation is now underway to adopt a 'one service, two sites model', covering all 24/7 acute and elective services across Nelson and Wairau hospitals
- Development of two NMDHB infrastructure plans - the *Nelson Marlborough Workforce Plan*, and the *NMDHB Information Technology Strategy*.

Strategic direction of the Nelson Marlborough health system

The future direction of the Nelson Marlborough health system presented in this HSP builds on its current relatively good performance and the strengthened foundations developed over recent years. Six strategic priorities are set for the Nelson Marlborough health system that will build momentum towards the DHB's goals and objectives. For each priority, 'headline actions' for the 3 years from 2015/16 to 2017/18 are identified that will build momentum towards the HSP objectives. These headline actions are then consolidated as an 'implementation roadmap'. Together the goals, objectives, priorities, headline actions, supporting infrastructure and the key performance indicators comprise the Nelson Marlborough health outcomes framework.

THE PROPOSED FUTURE DIRECTION FOR OUR HEALTH SERVICES

GOALS

Improved health, independence, participation and equity
Improved quality, safety and experience of care
Best value from public health system resources

HSP OBJECTIVES

Improve population health outcomes, and reduce health inequalities
Support the health system's clinical and financial sustainability
Lift health system performance from good to great

STRATEGIC PRIORITIES

STRENGTHEN district-wide integrated service planning and delivery.

IMPLEMENT new models of integrated primary and community health care.

EXTEND the scope of care pathways, and review tertiary service partnerships.

INCREASE focus on promotion and prevention, and target resources to high needs populations.

ACHIEVE excellence in clinical care in NMDHB hospitals.

PRIORITISE service and capital investment, and reinforce performance and accountability.

SUPPORTING INFRASTRUCTURE

CORPORATE

- Community and consumer engagement
- Productive partnerships
- Facilities development
- Alignment with the DHB planning cycle

- Information and communication technology
- Transport and accommodation
- Workforce development

CLINICAL

GOVERNANCE

Priority 1.   Strengthen district-wide integrated service planning and delivery

Top of the South specialist services

1.   Reiterate the core principles and characteristics of the Top of the South model

2.   Develop and implement a scheduled roll-out plan for the model across the specialist services, and mechanisms for sharing learnings across services

3.   Adopt a programme management approach to implementation, and support integrated service development with project management and analytical resources

Top of the South Health Alliance (ToSHA)

4.   Review the ToSHA work programme to ensure congruence with the HSP

5.   Build the profile of ToSHA by communicating its role, processes and achievements

6.   Consider whether extending the scope of the alliance model is best achieved through broadening ToSHA's scope and membership, or establishing equivalent alliance structures in other service areas, and implement the preferred approach

7.   Define the role, membership, support infrastructure and development path for locality networks that will operate within the alliance framework to foster integrated models of care and professional collegiality.

Priority 2.   Implement new models of integrated primary & community health care

1.   Develop a Nelson Marlborough Primary & Community Care Strategy, including a 'generic' integrated model with general practice at the core; multi-disciplinary teams with personnel working at the top of their scopes, alignment of primary and community services, and specialist support; and use of planned and structured care

2.   Develop an implementation plan for the Nelson Marlborough Primary & Community Care Strategy

3.   Extend the scope and scale of proven initiatives that avoid ED attendances and acute admissions through improved access to primary & community health services

4.   Prioritise development of a locality network for Marlborough, and implement initiatives that improve access to primary care for high needs populations, and decrease unnecessary use of Wairau Hospital ED

5.   Determine and implement the appropriate organisational arrangements that reflect the broad-based teams that will be needed to deliver on the Nelson Marlborough Primary & Community Care Strategy.

Priority 3.   Extend the scope of care pathways, and review tertiary service partnerships

1. In the context of the Nelson Marlborough Primary & Community Care Strategy, review utilisation of general practice care pathways, and consider how to accelerate uptake including possible use of clinical audit and feedback

2. Plan and action staged movement to 'whole system' care pathways, incorporating care within NMDHB's integrated secondary services, referrals from secondary to tertiary services, and discharge back to primary & community care

3. In the context of Top of the South implementation and South Island Alliance planning, define and reinforce each NMDHB integrated specialty service's tertiary partnership(s), within a district-wide framework

4. Consider the medium-long term potential for lifting NMDHB specialist clinical service capability, and factor this into service and facility planning.

Priority 4.   Increase focus on health promotion and prevention, and target resources to high needs populations

1. Build awareness of the NMDHB's Treaty partnership, the role of the Iwi Health Board, and the focus of Iwi strategic plans

2. Promote greater understanding of health inequalities across the Nelson Marlborough health system, and recognition that reducing inequalities is the responsibility of all health and support services

3. Through the annual Māori Health Plan, strengthen capture and reporting of information about health inequalities, the initiatives the Nelson Marlborough health system is taking to address them, and the specific measures and targets used to assess progress

4. In the context of the Nelson Marlborough Primary & Community Care Strategy, identify and implement strategies to ensure primary health care services are well coordinated to meet the needs of Māori and other high needs groups

5. Align planning and delivery of public and personal health services to lift outcomes and reduce inequalities in priority areas including:

    a. Oral health
    b. Child and youth health
    c. Obesity (including nutrition and physical activity)
    d. Smoking cessation
    e. Long term conditions
    f. Health of older people
    g. Cancer care
    h. Mental health
    i. Rural community health

6. Develop clear position statements on public health issues to provide a mandate and platform for intersectoral action, particularly in relation to health determinants. For example, explore the option of adding fluoride to the water supply to improve oral health.

7. Explore with partner organisations the potential for further development of existing forums that will strengthen intersectoral action to address the determinants of health.

Priority 5.   Achieve excellence in clinical care in NMDHB hospitals

1. Develop a NMDHB quality and performance improvement strategy, including concerted action in a small number of key performance areas to reach best practice (world class) levels in specialist services, and review annually

2. Review leading international models of specialist service delivery, and apply learnings through staged rollout in Nelson Marlborough, with a particular focus on those activities that could be undertaken in ambulatory and community settings

3. Provide the information and resources to support the NMDHB specialist services where the opportunity for performance improvement and or/service redesign is highlighted

4. Identify current and potential telehealth use across the district, and prioritise development opportunities

5. Undertake service planning to resolve key clinical service issues, including:

    a. Capability, capacity and role of Nelson Hospital ICU
    b. Configuration, capacity and process improvement of the NMDHB radiology service
    c. Configuration and capacity of the Nelson Hospital adult medicine service, including whether to develop an acute assessment unit (AAU)
    d. Intersection of mental health services with personal health and intellectual disability support services
    e. Intersection of emergency department (ED) and general practice services

6. Continue development and implementation of the NMDHB clinical governance framework, with agreement on a staged evolution to an integrated NM health system approach across the DHB and PHOs.

Priority 6:   Prioritise service and capital investments, and reinforce performance and accountability

1. Develop a prioritisation framework, to be used annually in setting of budgets and activity targets, disinvestment, and allocation of new service and capital resources

2. Develop a framework for progressive movement to longer term funding commitments to give greater certainty and autonomy to service providers (including NGOs and Provider Arm specialist services) who consistently meet performance expectations in prioritised areas

3. Define required DHB capability for whole of system commissioning for integrated care, with a staged implementation programme

4. In the context of the Nelson Marlborough Primary & Community Care Strategy, consider development of a shared 'health intelligence unit' across the DHB and PHOs to inform planning, and performance monitoring and improvement.

Supporting infrastructure

Delivery of the HSP's strategic priorities and headline actions will be supported by enabling infrastructure in the following domains:

- Community and consumer engagement
- Productive partnerships
- Facilities development
- Information & communications technology
- Transport and accommodation
- Workforce development.

Implementing the HSP

This HSP outlines an ambitious programme of work, but one that NMDHB considers essential to building momentum towards the goals of improving population outcomes, reducing inequalities, and ensuring system sustainability. A plan is only of real value if it is implemented. Hence even though the HSP has been developed with a 20-year horizon, its focus is on the Roadmap for action over the next 3 years, with momentum being built from year 1 (2015/16).

A structured and disciplined approach to implementation will be of critical importance. Translation of the HSP into action will have the following dimensions:

- Monitoring of key performance indicators and targets
- Corporate governance
- Executive management
- Clinical leadership and governance
- Programme management
- Communications & engagement
- Alignment with the DHB planning cycle.

1. Introducing the Health Services Plan

1.1 Purpose and focus

In developing this Health Services Plan ('HSP'), Nelson Marlborough District Health Board ('NMDHB') has sought to ensure that it:

- Responds to the health needs of the Nelson Marlborough population, and performance of the Nelson Marlborough health system (as reflected in the Health Needs & Service Profile[2]);
- Reflects government policies and contemporary best practice;
- Is practical and achievable;
- Has been developed with engagement of the clinical community and other stakeholders;
- Reflects a commitment to high quality and safe health services; and
- Is based on best practice benchmarks.

The Nelson Marlborough HSP is focused on making significant progress towards the DHB's three long term 10-20 year goals:

- Improved health, independence, participation and equity;
- Improved quality, safety and experience of care; and
- Best value of public system health resources.

To achieve these goals, the HSP is designed to deliver on three medium term (5-10 year) objectives:

- Improve population health outcomes, and reduce health inequalities;
- Support health system clinical and financial sustainability;
- Lift health system performance from good to great.

The HSP links the long term direction described in NMDHB's *Health for Tomorrow* (see Section 3.2) with the short term focus of the DHB's annual plan. It also provides a strategic context for more detailed service, capacity (workforce, facilities, and technology), and financial planning.

While the HSP has a 20-year horizon, it details the actions over the first 3 years (2015/16-2017/18) that will ensure the Nelson Marlborough health system takes the critical early steps that will head it in the desired direction. These 3-year actions are presented as an Implementation Roadmap in this Plan.

> The Nelson Marlborough Health Services Plan will shape service configuration, models of care, resource allocation and capacity development for the district's health system over the next 10-20 years.

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[2] Refer to the Health Needs & Service Profile on the NMDHB website: http://nmdhb.govt.nz/PublishedDocuments.aspx

1.2   Planning context

Development of the HSP is the second milestone in a three-phase planning process. It has been preceded by the *Nelson Marlborough Health Needs & Service Profile*, and will be followed by the *Nelson Marlborough Facilities Implications Report.*

Figure 1 :   Planning context for the Nelson Marlborough HSP
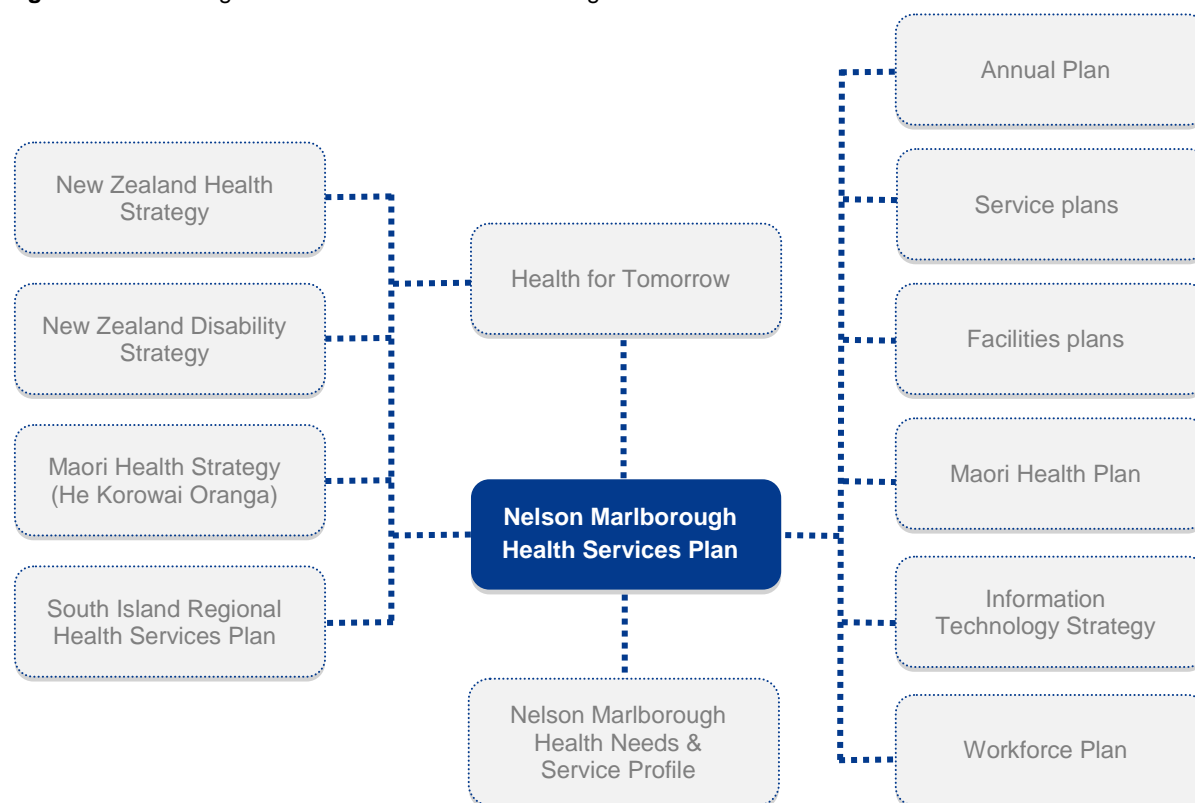
The *Nelson Marlborough Health Needs & Service Profile*

The *Profile* considers:

*   The demographic, geographic, socio-economic and epidemiological factors that shape demand for services;
*   Current utilisation and configuration of services, and the performance of these services against national and regional benchmarks and targets; and
*   Projection of future demand based on agreed demographic and performance parameters.

It shows that the Nelson Marlborough population has relatively good health and good access to health and disability support services, compared to others in New Zealand. Key findings from the *Profile* are summarised in Table 1.

Table 1 : Key findings from the *Nelson Marlborough Health Needs & Service Profile*

- Nelson Marlborough has a relatively stable population size, with low future growth expected. The largest proportionate growth will be in the elderly, with the 75+ age group increasing at 4.5% pa, similar to the New Zealand average
- The population has a higher life expectancy than the New Zealand average, and lower amenable mortality. Males have a lower life expectancy than females
- The population is relatively less deprived than the New Zealand average
- Nelson Marlborough has lower proportions of Māori, Pacific and Asian people than New Zealand
- Māori in Nelson Marlborough do better than Māori elsewhere in New Zealand on most health indicators, but a large gap still exists in the majority of health indicators compared with non-Māori. The impact of long term conditions begins 10 years earlier for Māori than non-Māori
- Children (0-14 years) are generally at lower risk and in better health than their national counterparts. Specific concerns include child abuse, dental health, and outcomes for Māori children
- The Nelson Marlborough population ranks relatively low on most risk factors, but still has 15,000 smokers, and 34,000 adults who are obese - 6,000 of them morbidly obese
- More than 6,000 people in Nelson Marlborough have diabetes, and prevalence is growing. The incidence of coronary heart disease is falling, but it remains the single largest cause of health loss
- General practice coverage and quality is similar to the New Zealand average. Cost is noted as a barrier to access by one-third of Nelson Marlborough people surveyed
- Most hospital care for Nelson Marlborough residents is provided within the district. Unplanned admission rates are lower than the national average. Planned admission rates are slightly above the New Zealand average, indicating reasonable access to elective surgery. Ambulatory sensitive hospitalisation rates are lower than the New Zealand average, apart from for Māori children
- Emergency department (ED) attendance rates are higher than nationally, and are particularly high at Wairau Hospital
- Youth (15-24 year olds) are at higher risk than their national counterparts – e.g. for injury, ED attendance and pregnancy. Tobacco smoking initiation remains a concern, as does alcohol misuse
- The elderly (age 75+) appear to have good access to hospital and community-based services, with good support for 'ageing in place'
- Birth numbers are stable. 1 in 5 mothers are obese, increasing their obstetric risk. Caesarean section rates are relatively high, and are climbing
- Access to specialist mental health services is similar to the national average. Māori have a higher need for and use of mental health services than non-Māori
- People aged under age 65 use disability support services in Nelson Marlborough at a higher rate than the New Zealand average. Both residential care and non-residential support utilisation rates are high

The *Nelson Marlborough Facilities Implications Report*

Future demand for NMDHB specialist services has been projected through to 2035. This analysis shows that, if current utilisation rates and models of care were to continue unchanged, then Nelson Hospital bed numbers would have to increase by 68%, and Wairau Hospital by 48%. This growth reflects the impact of ageing of the Nelson Marlborough population, and is unsustainable both clinically and financially.

Changes in models of care will be essential. Some services may no longer be based on a hospital campus; others may be better relocated there. Some NMDHB-provided services may be better delivered by primary care providers, NGOs, another DHB, or the private sector; other NMDHB-funded services may be better suited to local DHB provision. Some services will increase in their capacity requirements (such as those for older people); others may have static or reduced future needs (such as paediatrics and maternity). Adoption of more sophisticated clinical and information technologies will support increased service delivery in the community and home.

The *Facilities Implications Report* will provide a bridge between service and facility development. While it will consider implications for health service facilities generally, its predominant focus is on the DHB's Nelson Hospital campus, where clinical buildings are older and have seismic risks, and the overall campus is poorly designed for current and future uses.

NMDHB is preparing for a significant Nelson Hospital capital redevelopment programme. The large majority of that construction is expected to begin at the earliest in 2018/19. A learning and development centre will be built in intervening years, and will require a long-term campus configuration framework to ensure it is in an appropriate location.

The *Facilities Implications Report* will be followed by more detailed planning and decision making, including resolution of key Nelson Hospital specialist service issues (discussed in Section 5 of the HSP), development of a site master plan, and linkage with national capital planning processes.

Future-proofing of the Nelson Marlborough health system will require different resource allocation patterns, and adoption of new ways of working that improve access, make better use of the available workforce, and improve service performance.

1.3   Development of the Health Services Plan

Recognising that sustainable health service delivery requires strong relationships between primary, community and specialist services, the HSP has been developed through an organisational partnership approach. Senior DHB and PHO leaders are members of the Steering Group overseeing development of the *Health Needs & Service Profile*, the HSP, and the *Facilities Implications Report*. The process being followed in HSP development is displayed in Figure 2.

Figure 2 : HSP development process

Health Needs & Service Profile

1

Review of national, regional and local policies, plans and reports

2

Interviews with senior clinical and managerial personnel

3

Draft priorities, actions and enablers reviewed at workshops with NMDHB Board and senior clinical and managerial personnel

4

Plan drafted, reviewed and approved for sector engagement

5

Sector engagement and feedback

6

Plan finalisation and approval

The HSP's strategic direction has been developed using an outcomes-focused approach based on the Triple Aim framework, a well-recognised international approach that ensures population health, patient experience of care, and value for money improvements are considered simultaneously in health system planning and decision-making (Figure 3).

Figure 3 : The New Zealand Triple Aim framework (*Health Quality & Safety Commission*)

1.4 National context

Features of the national policy and planning environment that the Nelson Marlborough health system operates in are summarised in Appendix 1.

2.   Health system sustainability

As outlined in Section 1.1, one of the objectives of the HSP is to support the clinical and financial sustainability of the health system. For the Nelson Marlborough health system to be sustainable it must be able to provide ongoing access for the resident population (and visitors to our district) to safe, effective and efficient services. Sustainability also requires that the district's health system is capable of anticipating and responding to a changing operating environment, and contributing to the wider wellbeing of our communities.

As is the case in all DHBs (and in all developed nations' health systems), the Nelson Marlborough health system is operating in a challenging environment, with intensifying demand and supply pressures challenging its clinical and financial sustainability (illustrated in Figure 4).

Figure 4 :   Demand and supply pressures that impact on health system sustainability

Supply pressures

Demographic changes
Chronic conditions
Health inequalities
Access
Public expectations

Clinical and financial sustainability

Demand pressures

Quality and Safety
Workforce constraints
New technologies
Infrastructure
Funding constraints
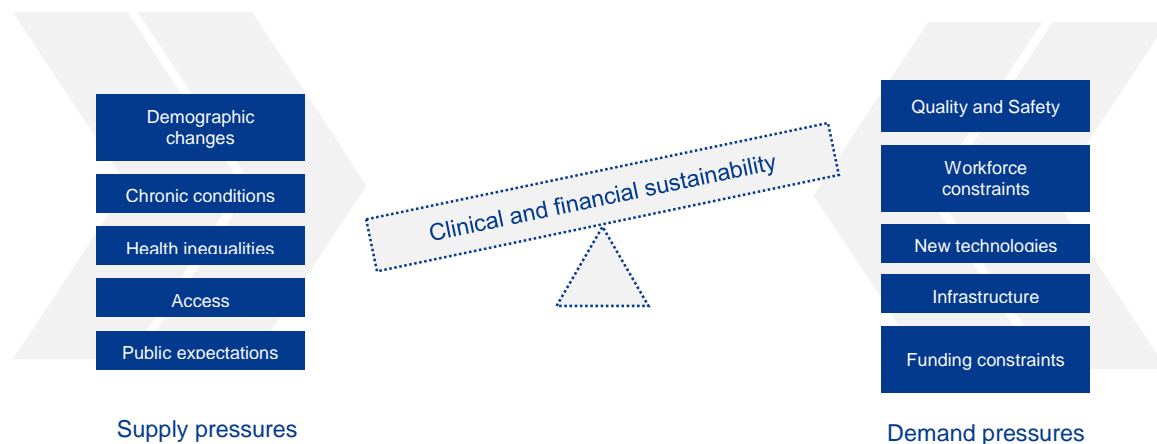
In addition to these general demand and supply pressures, the Nelson Marlborough health system also faces some particular challenges. These are summarised in Table 2.

Responses to these pressures vary between health systems, but there is a common focus on trying to obtain better value from existing resources through:

- Whole-of-system approaches with integration of care across organisational and professional boundaries
- Aligning population and personal health strategies
- New models of care and workforce roles
- Constraining growth in hospital capacity, and placing emphasis on community-based care
- Performance improvement through reduced variation in clinical practice and 'back room' efficiencies
- Use of enabling technologies.

This HSP describes how the Nelson Marlborough health system will respond to the pressures we face.

Table 2 :   Pressures facing the Nelson Marlborough health system, as identified by health system leaders

Demand pressures	
Population and needs	Population ageing bringing increased demand, and the need for resource reallocation between services
	Rural population decline
	Changing family structures
	Increasing risk (including lifestyles), incidence and complexity of long term conditions
	Ability of health system to respond to changing needs
	Increasing ethnic diversity - refugees and family reunification; temporary horticulture workers
	Limited work opportunities for young people - they either leave, or 'hang around' with associated social issues
	Environmental sustainability, including the impacts of energy use, carbon emissions, population shifts, disease pattern changes, and extreme weather events
Inequalities	Persistent inequalities in access and outcomes for some groups in our community
	Risk factors for Māori & Pacific young people – particularly smoking and obesity
Communities	Rising population expectations of health care
	Need to raise health literacy levels to improve health behaviours, identify problems early, and seek help
	Involve the community more strongly in prioritisation and planning
	Choose communication media to suit the different age groups, e.g. the 'social media generation'
Government expectations	National policies, goals and targets are driving the health system
	Funding growth has slowed at the same time that demand is increasing
Supply pressures	
Hospital configuration	Workforce and cost pressures arising from maintaining two acute hospitals with a similar range and complexity of services
New technologies	Advancing treatment technologies are sustaining life in old age. Do older people want this? What are their end-of-life goals?
	Funding increases do not keep pace with the innovations available, and which the community expect to be publicly funded
	Allows monitoring and treatment in new settings, e.g. the home
	Increased IT demands as new models of care require new technologies, and advances in technology are driving opportunities for new models of care

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Supply pressures cont'd	
Workforce	Workforce ageing requires proactive planning to transfer institutional knowledge, development of new models of care to respond to workforce shortages, and new business models for the next generation
	Reliance on volunteers, and on those on lower incomes to deliver much of the care
	Extending the workforce to work at the top of their scope
Health services integration	Blending the different cultures of community health and general practice
	Breaking down professional group and parochial (Nelson/Blenheim) 'silos'
	Need to develop new ways of working with local and government agencies, and consumer groups to develop more efficient, effective and sustainable services
Geography	Delivery of services to rural areas poses challenges of time and distance; limited transport; higher delivery costs; and ensuring a skilled workforce in rural communities
Facilities	Strengthening of earthquake prone buildings and structures is required. We need to prioritise repairs and replace core hospital infrastructure that has reached the end of its useful life

3. Strengthening the foundations of the Nelson Marlborough health system

Faced with immediate pressures and recognising that these are intensifying, we have taken action over recent years to build stronger foundations for our health system. This section of the HSP briefly describes the components of the health system, and then the foundational elements on which future development will be based. These foundations are centred on the people – individual patients/clients, their families/whānau, their communities and the whole Nelson Marlborough population - that the health system serves. Our commitment to improving health outcomes for people is reflected in NMDHB's vision – 'Towards Healthy Families'.

Figure 5 : Foundations of the Nelson Marlborough health system
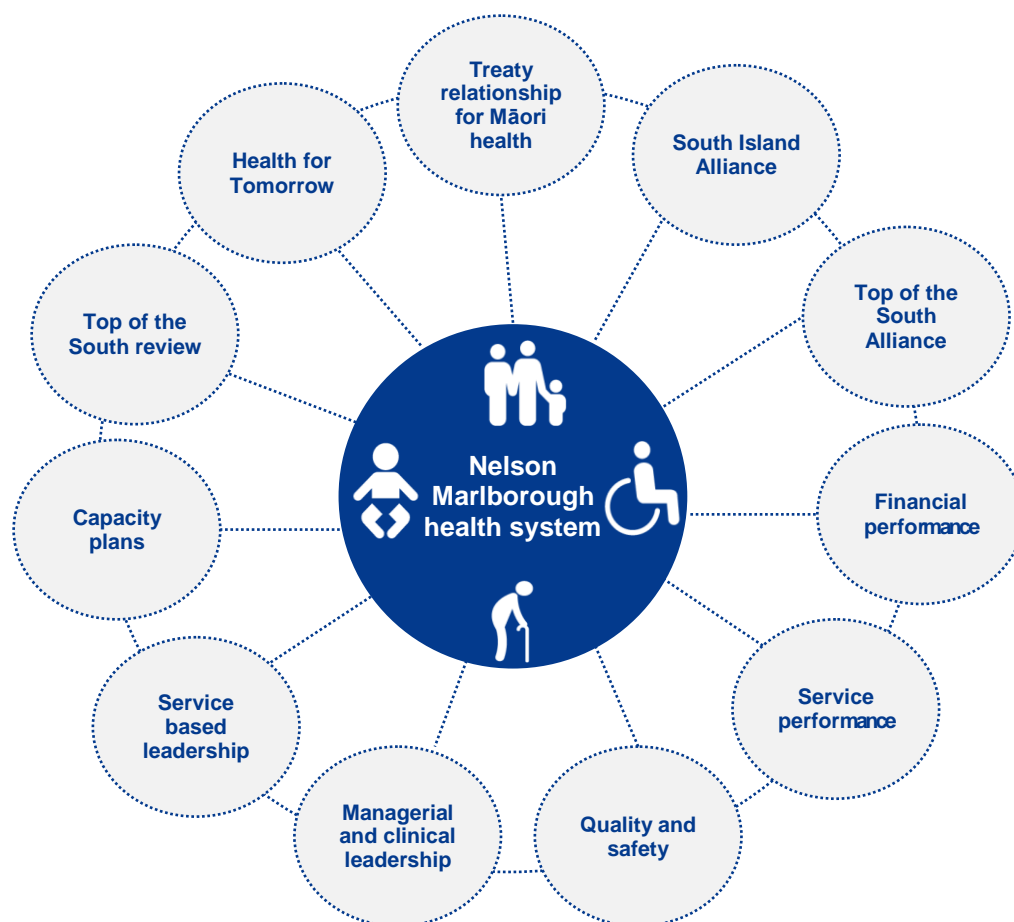
3.1 The Nelson Marlborough health system

The Nelson Marlborough health system comprises interconnected and interdependent organisations and practitioners who work together to meet the population health, personal health, and disability support needs of our communities.

NMDHB has overall responsibility for the performance of the Nelson Marlborough health system, and is responsible for the provision and/or funding of the majority of health services in the district. These services include:

- Two secondary hospitals – Nelson Hospital and Wairau Hospital (Blenheim)
- Two rural health centres – Golden Bay Integrated Health Centre, and Murchison Hospital & Health Centre

- One psychogeriatric hospital – Alexandra (Nelson)
- One Māori provider – Te Piki Oranga[3]
- Two PHOs – Nelson Bays Primary Health, and Kimi Hauora Wairau Primary Health (Marlborough)
- 36 general practices
- 29 pharmacies
- Five home-based support providers
- 26 aged residential care facilities
- Community based nursing and mental health services
- Residential and community disability support services for people with physical and intellectual disabilities
- Public health services (health protection and health promotion).

3.2   Foundations of the future health system

Māori health

NMDHB's relationship with the mana whenua of our district is expressed through the joint agreement titled 'He Kawenata.' Together the NMDHB and Iwi Health boards are stewards of a shared vision for Māori health in 2038, and are committed to its implementation. That vision is:

Kia korowaitia aku mokopuna ki te korowaitanga hauora Healthy whānau are wealthy whānau – achieving our full potential and determining our future.

The health sector plays an important role in supporting the rights of Māori to achieve equitable outcomes in health and social wellbeing.

The DHB works in partnership with Māori communities throughout Nelson Marlborough in a spirit of cooperation that encompasses the principles of the Treaty of Waitangi:

- Partnership: Working together with iwi, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services;
- Participation: Involving Māori at all levels of the sector in planning, development and delivery of health and disability services; and
- Protection: Commitment to the goal that Māori enjoy at least the same level of health as non-Māori and the safeguarding of Māori cultural concepts, values and practices.

The DHB receives strategic advice on the planning and delivery of Māori health services from the Iwi Health Board, which has guided the development of the *Nelson Marlborough Māori Health Plan*[4], supported by the DHB, Kimi Ora Wairau PHO, Nelson Bays Primary Health, and Te Piki Oranga, the single Māori health provider for Nelson Marlborough.

The *Māori Health Plan* specifies how national initiatives to achieve better health outcomes for Māori will be implemented locally, and also addresses the needs of Māori in Nelson Marlborough through local initiatives. The focus is on reducing inequalities, and achieving Whānau Ora outcomes through collaboration.

The Iwi Health Board has a particular focus on the Māori clinical workforce, and growth within the regulated and non-regulated workforces.

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[3] NMDHB contracts solely with Te Piki Oranga for Māori health services. Another Māori provider organisation, Te Hauora O Ngati Rarua, also operates in Nelson Marlborough through contracts with the Ministry of Health.
[4] Refer to the Maori Health Plan on the NMDHB website: http://nmdhb.govt.nz/PublishedDocuments.aspx

The DHB is working with Te Piki Oranga to embed it into the Nelson Marlborough health system and develop services to be delivered under the Whānau Ora framework.

Health for Tomorrow

Health for Tomorrow[5] (originally titled *Health 2030*) was developed by the DHB in 2009, and updated in 2012 and again in 2014 as a long-term framework to guide NMDHB's planning and development, and progress towards the vision of 'healthy families'. *Health for Tomorrow* incorporates the values of NMDHB, the principles that guide how we plan

> *Health for Tomorrow* presents the values of NMDHB, the principles that guide how we plan and deliver health and support services, and the long term goals of the Nelson Marlborough health system.

and deliver health and support services, and the long term goals of the Nelson Marlborough health system (displayed on the inside front cover of the HSP).

Health for Tomorrow also presents the framework we use in our whole-of-system approach to addressing the different categories of health need of the Nelson Marlborough population (see Figure 6).

Figure 6 : The *Health for Tomorrow* framework

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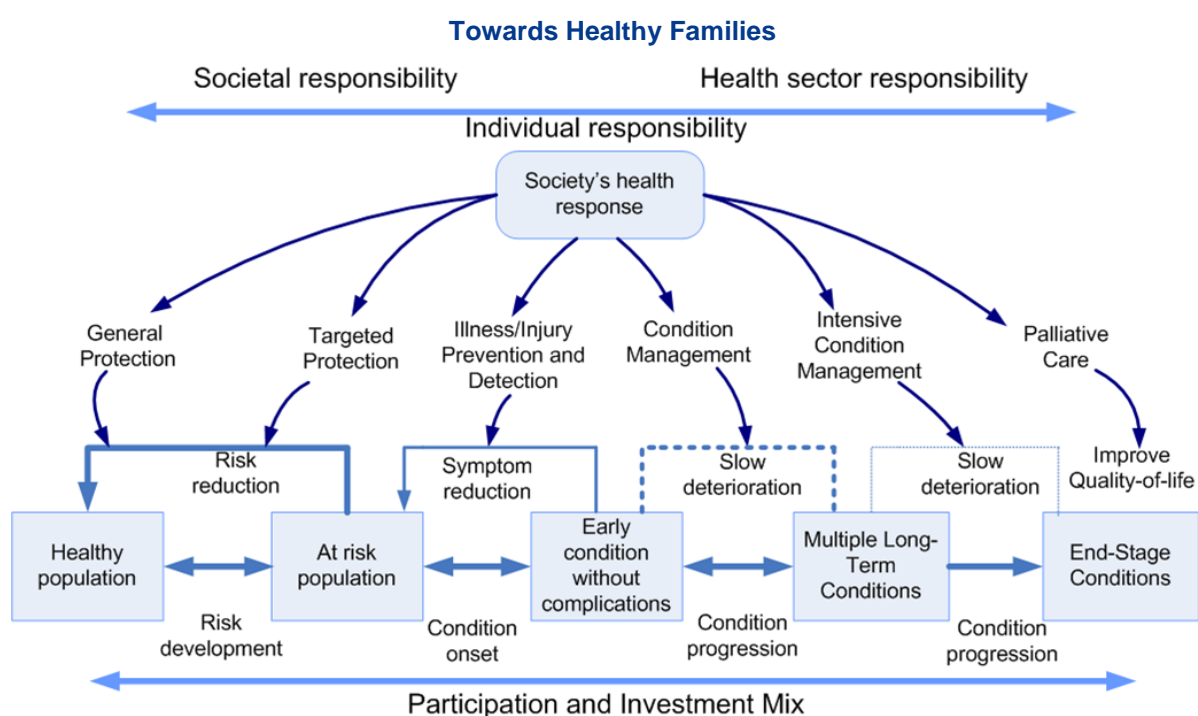
[5] Refer to Health for Tomorrow on the NMDHB website: http://nmdhb.govt.nz/PublishedDocuments.aspx

Managerial and clinical leadership

Significant changes in NMDHB's senior leadership structure and personnel have been made in recent years, with a focus on strengthening organisational performance and accountability, and clinical leadership and governance. The Executive Leadership Team (ELT) has been reformed to lead the transformation of the Nelson Marlborough health system. Although the overall number of ELT members has been reduced, the importance of strong clinical leadership and clinical governance has been reinforced, with an emphasis on creating a no-blame culture based on organisational values and personal responsibility to create an environment in which excellence in clinical care will flourish.

Service performance

As reflected in the *Health Needs and Service Profile*, the Nelson Marlborough health system benchmarks well with comparator DHBs and the New Zealand average on most indicators of efficiency and effectiveness. This generally good performance exists across both primary & community care, and specialist services (see Table 3 for a summary of performance against selected indicators).

The opportunity exists in the next phase of health system development to lift our performance from 'good' to 'great'. This will mean:

- Improving performance in areas where the Nelson Marlborough health system currently rates below the national average;
- Prioritising the areas in which we aspire to superior ('world class') performance;
- Selecting benchmarks that reflect international best practice; and
- Applying proven quality improvement methodologies in a sustained manner.

> As identified in the *Health Needs & Service Profile*, the Nelson Marlborough health system performs at or above the New Zealand average for many indicators. NMDHB's Board has now set the objective of lifting performance from 'good to great' across the Triple Aim dimensions of population health outcomes, patient experience, and efficiency of resource use.

Financial performance

NMDHB has achieved a turn-around in our financial performance with a move from deficit to surplus over the past 2 years. The DHB reported a net operating surplus in 2014/15 of $1.7M, following a net surplus of $4.4M in 2013/14. Prior to this, we had experienced a cumulative operating deficit of $13M between 2009/10 and 2012/13.

This financial recovery was achieved through efficiencies and tight cost management, without significant impacts on patient access, or service quality and safety. It has allowed new investment in immediate service priorities, and initiation of building financial reserves to ensure affordability of future capital investment, including in Nelson Hospital facilities as discussed above (Section 1.2).

We estimate that redevelopment of Nelson Hospital will require between $90M and $150M of capital expenditure. A significant proportion of the capital will be self-funded, with the remainder being Crown financed through the National Capital Committee. The redevelopment will have an operating expenditure impact arising from depreciation, interest costs and capital charges. For example, if the Nelson Hospital redevelopment were to cost $120M-130M, the operating expenditure impact would be approximately $9M per year.

The DHB has some cash reserves but will need to continue building them through efficiency savings each year to finance our share of redevelopment costs as well as the impacts on operating expenditure. Some of these savings will be generated by national initiatives, to which each DHB is required to contribute.

Table 3 : Performance of the Nelson Marlborough health system compared with the New Zealand average for selected indicators

Sector	Indicator	Performance
Primary & community	Unmet need for general practice access	X
	Heart & diabetes checks	X
	Aged residential care use	√
Hospital & specialist	Medical and surgical hospitalisation rate	√
	Mental health hospitalisation rate	√
	Average length of stay (ALOS)	√
	Unplanned readmission rate	√
	Day surgery rate	0
	Elective surgery rate	√
	Caesarean section rate	X
	Outpatient service access (specialist and allied health)	0
Whole system	Ambulatory sensitive hospitalisations (ASH)	√
	Emergency department use	X
	Dental caries in children < 5 years	X
	Child abuse notifications	√

Notes: For a full set of performance indicators and interpretation of them see the Nelson Marlborough Health Needs & Service Profile *(the source of these results). Performance rating: √ = better than average; 0 = similar to average; x = worse than average*

The South Island Alliance

Government policy is for increased regional collaboration and alignment between DHBs in the interests of improved integration and quality of care, and reduced service vulnerability and cost. Effective regional governance, accountability and decision-making set the direction for integrated models of care, which in turn inform effective planning of information and communications technology (ICT), workforce and capital investments to enable a sustainable health system.

While each DHB is individually responsible for its own population, working regionally enables us to better address our shared challenges, and support improved patient care and more efficient use of resources.

The South Island Alliance was established in 2011 by Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs, which together fund and provide services for just over 1 million people (almost 24% of the total New Zealand population). The South Island Alliance formalises the partnership between the five DHBs, and was developed further in 2013 with a framework that ensures all regional activity aligns to agreed goals.

The shared vision of '*Best for People, Best for System'* envisages a sustainable South Island health and disability system focused on keeping people well and providing equitable and timely access to safe, effective, high quality services, delivered as close to people's homes as possible. Closely aligned to the national direction, the shared outcome goals of the South Island Alliance are:

• Improved health and equity for all populations
• Improved quality, safety and experience of care
• Best value for public health system resources.

The success of the South Island Alliance relies on improving patient flows and the coordination of health services across the South Island by aligning patient pathways, introducing more flexible workforce models, and improving patient information systems to better connect the services and clinical teams involved in a patient's care. Regional activity is implemented through service level alliances and workstreams based around priority service areas[6]. The work is clinically led, with multi-disciplinary representation from community and primary care, hospital and specialist services, and consumers.

In addition, a regional approach is being taken to planning and development of ICT, support services, quality and safety, facility planning and workforce planning, which will contribute to improved delivery across all service areas.

In developing their Alliance framework, the South Island DHBs have identified four collective outcomes (see Figure 7) where individual DHB performance will contribute to regional success, together with a core set of associated long-term outcome indicators which will demonstrate whether the DHBs are making a positive change in the health of their populations. To achieve these outcomes, the DHBs have agreed a number of strategies that will be delivered through regional initiatives and the collective activity of all five South Island DHBs. Each DHB sets 3-year local targets for each indicator in their annual plans.

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[6] Service areas that are currently prioritised for South Island focus include cancer; child health; health of older people; mental health; cardiac services; elective surgery; palliative care; neurosurgery; public health; major trauma; rheumatic fever, deliver a spinal cord impairment and stroke.

Figure 7 : South Island DHB outcome areas and indicators

Outcome 1: People are healthier and taking greater responsibility for their own health	Outcome 2: People stay well in their own homes and communities	Outcome 3: People with complex illness have improved health outcomes	Outcome 4: People experience optimal functional independence and quality of life
▶ A reduction in smoking rates ▶ A reduction in obesity rates	▶ A reduction in acute medical admissions	▶ A reduction in the acute readmission rate ▶ A reduction in all-cause mortality rates	▶ An increase in the proportion of population over 75 living in their own homes

Top of the South Health Alliance

Te Tau Ihu Top of the South Health Alliance (ToSHA) is a formal partnership between NMDHB and the two PHOs in Nelson Marlborough - Kimi Hauora Wairau Marlborough PHO, and Nelson Bays Primary Health – in line with Government policy that mandates DHB and PHO alliances.

ToSHA leads a programme of population health improvement and service transformation that will contribute to the DHB's overall goals. The prioritised workstreams for 2015/16 are:

- Primary care access to diagnostics
- Acute demand management
- Diabetes and CVD self-management and integrated care
- A 'healthy start' for children
- Medicines management
- Integrated rural service models
- Primary and public health collaboration
- Primary care strategy
- Health of older people strategy.

Top of the South Review

NMDHB's Top of the South Review was completed in early 2014 with a focus on configuration of core secondary care services (medicine, surgery and orthopaedics). The key decision was to adopt a 'one service, two sites model', covering all 24/7 acute and elective services across Nelson and Wairau hospitals. Unnecessary service duplication across the sites is to be avoided, and some staffing changes introduced.

Other decisions arising from the Review included:

- Each specialty service will be organised as a single clinical team operating across the whole district, rather than separately for each hospital
- The focus will be on strengthening of generalist services as opposed to pursuing sub-specialisation. The generalist senior medical officers (SMOs) employed by the DHB will have a sub-specialty interest to complement their generalist skills. SMOs will predominately based at Nelson Hospital, and will visit other centres as the model of care allows
- Registrar positions will be increased in Nelson Hospital, with the expectation that Wairau Hospital will also be included as a placement in the future

- The scope of practice for nursing and allied health professionals will be increased
- There will be equitable patient access across the two sites. Some services (including surgical procedures) will be provided only in Nelson because of its higher clinical capability, however most patients will be able to be seen at their local hospital for both outpatient and inpatient care. In some cases, Nelson SMOs will travel to Wairau to offer outpatient clinics; in others, patients may need to travel to access care
- Senior leadership positions will be spread across both Nelson and Blenheim.

Implementation of decisions resulting from the Review is underway.

Specific service initiatives

A number of the DHB's specialist services have taken initiatives to develop a whole of system and population health focus. An example is the Nelson Marlborough maternal and child health integration project, which began in 2014. It is focused on innovations that support the provision of integrated services for pregnant women and children aged 0-6 years, including a particular emphasis on engaging and supporting vulnerable families.

The integration project has a consumer advisory panel to assist in identifying action areas to achieve an integrated maternal and child health service. This partnership works to:

- Identify the core health team;
- Develop tools for coordinated care;
- Develop a consumer-friendly child health calendar;
- Undertake integrated workforce development;
- Establish resource centres in the community; and
- Complete accreditation of family friendly services.

NMDHB infrastructure plans

The **Nelson Marlborough Workforce Plan** (2015) draws together national, regional and local initiatives, across all the major health and support workforce groups within the Nelson Marlborough health system. Eight action areas are identified in the Plan:

- Strengthen health and disability workforce intelligence to provide high quality advice and support
- Develop workforce alliances, partnerships and regional approaches
- Improve recruitment and retention through regional solutions and locally tailored programmes
- Strengthen diversity of the workforce and representation of Māori, and of Pacific and migrant populations
- Align workforce development activities to meet population need
- Identify, create and share training, education and development opportunities
- Enable the workforce to be change ready, improvement focused and flexible
- Co-design resources and tools that equip the workforce to empower people.

The **NMDHB Information Technology Strategy** (2015) presents a 10-year pathway to achieving 'digital hospitals', and systematically moving away from paper-based transactional processing. The Strategy's goals are to:

- Deliver initial capability in an achievable timeframe ('paper-lite in 5 years'), that will set the direction toward digital hospitals over 10 years
- Give initial priority to initiatives that have a relatively high payback

- Partner with clinical champions to lead the initiatives
- Leverage NMDHB investment in regional software solutions, ensuring a long-term payback.

Key early initiatives on the pathway towards 'paper-lite' include:

- Adopting e-referral triaging
- Adopting Health-One, which will enable GPs and pharmacists to share patient records with hospital clinicians electronically, reducing the reliance on ad hoc access and requesting of paper-based information
- Electronic receipt of pre-admission patient and clinician information, and using it to trigger upstream workflow
- Re-engineering ED processes to systematically remove paper
- Introducing digital devices at the bed-side in Wairau Hospital as a proof of concept prior to wider spread
- Reducing the requesting and use of paper medical charts by systematically capturing source information electronically
- Leveraging the regional clinical portal (HCS) to minimise other paper-based procedures.

Each of these initiatives will be subject to an approved business case, and will be seeking capital or operating investment. During 2015/16 initiatives for the remaining 4 years of the paper-lite strategy will be identified.

4. Strategic direction for the Nelson Marlborough health system

4.1 Priorities and actions

The future direction of the Nelson Marlborough health system presented in this HSP builds on its current relatively good performance and the strengthened foundations developed over recent years. The stage is now set for:

- Increasing capacity to meet the forecast future health needs of the population
- Determining the pathway towards *Health for Tomorrow*
- Investment in prioritised services and populations
- Adoption of new models of care
- Lifting system performance in key outcome areas
- Investment in enabling infrastructure
- Maintaining DHB operating surpluses to build reserves to minimise the costs of future capital investment.

Six strategic priorities are set for the Nelson Marlborough health system that will build momentum towards the DHB's goals and objectives goals. These are shown in Figure 8.

Each of the six strategic priorities is described in this section of the HSP. For each priority, 'headline actions'[7] for the 3 years from 2015/16 to 2017/18 are identified that will build momentum towards the HSP objectives. These headline actions are presented for each priority, and then consolidated as an 'implementation roadmap' (Appendix 3).

The HSP focuses on the actions that NMDHB (in many cases in collaboration with partner organisations) will take over the next 3 years. While the HSP does refer to particular services and localities, it does not prescribe solutions for specific issues in particular services, facilities or communities, or for particular population groups. Those will be the focus of more detailed locality and district-wide service and capacity planning that will be informed by the HSP's priorities, and the trends in model of care redesign described below (Section 4.2). Similarly the strategic priorities, headline actions and indicators are intended to focus efforts, rather than capture all achievements and associated activity undertaken in each priority area.

4.2 Redesign of models of care

Health systems are redesigning their models of health care and disability support in response to the sustainability challenges they face (see Section 2), and the availability of new diagnostic, treatment, monitoring, information and communication technologies. While the detail of the redesign varies by service and the community being served, broad trends are apparent[8]. These include:

- Design of models of care around patients rather than health professionals and facilities;
- Simplifying access to health care services for both patients and health professionals;

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[7] The term 'headline' is used to indicate that these are key strategic actions. They will be amplified as a project plan is developed for each.
[8] For further discussion of these trends, see:
Transforming our health care system. Naylor C et al. The King's Fund (2015).
http://:www.kingsfund.org.uk:sites:files:kf:field:field_publication_file:10PrioritiesFinal2.pdf
Trends in Service Design and New Models of Care. Ministry of Health (2010).
http://www.moh.govt.nz/notebook/nbbooks.nsf/0/43C4C9001223BCBDCC257B10007AC681/$file/trends-service-design-new-models-care-jul2010.pdf

- Focusing on health promotion, prevention and enabling more patients with long term conditions to self-manage their conditions;
- Shifting services between professional groups so that clinicians practise at the top of their scopes;
- Establishing integrated care pathways and shared care planning across professional groups, organisations and levels of care ('a joined up system');
- Consolidation of primary and community services into larger health networks, with multi-disciplinary teams, co-location, and services integrated with local hospitals in smaller rural areas;
- Deepening the relationship between specialist services and primary care to enable whole-of-person care in community settings;
- Streamlining the role of hospital and specialist services in the health care system as niche providers of high-end, episodic care;
- Increasing the proportion of specialist activity that is provided in ambulatory care settings;
- Clustering of hospitals to share resources and expertise, and networking of practitioners across hospital sites; and
- Consolidation of sub-specialist services across networked hospital sites to create critical mass, with outreach to ensure access for local populations.

Hospitals continue to be a key setting for highly specialised care, with the importance of timely access to care being paramount. However, the increased prevalence of long term conditions and the ageing of the population are triggering health systems to move away from traditional episodic and reactive approaches to support maintenance of good health for longer.

Rather than wait for people to become acutely unwell or require institutionalised care, emphasis is being given to services that support people to stay well in community settings and living in their own homes for as long as possible. This has brought a focus on better integration of services – both 'horizontally' across primary and community services and between hospitals, and 'vertically' across primary and secondary (specialist) care. Integration of care is intended to deliver benefits in all dimensions of the Triple Aim (Figure 3): patient access, experience and outcomes; population outcomes; and resource use.

Within these models of integrated care the pivotal place of primary health care is emphasised:

- General practice as co-ordinator and care manager – the 'medical home' for patients;
- A greater role in prevention and supporting self-management;
- Taking on some traditionally hospital- and specialist-based services;
- Improved access to diagnostic testing and specialist support;
- General practice linking with community services in multi-disciplinary teams; and
- Consolidation into larger health centres and services.

These trends are reflected in the Government's 'Better, Sooner, More Convenient' policy, and in specific service strategies such as 'ageing in place' and 'shifting services'. For example, a principle that underpins the shifting services policy is that only those services that need to be delivered from a hospital setting will be, unless the costs of change (to all parties) are prohibitive.

The aim is to promote a more seamless and better integrated patient journey across community, primary, and hospital sectors, greater use of primary and community care, and care being provided closer to the patient's home. New models of integrated care will most important for the services listed in Priority 4:

- Oral health
- Child and youth health
- Obesity (including nutrition and physical activity)
- Smoking cessation
- Long term conditions
- Health of older people
- Cancer care
- Mental health
- Rural community health.

Figure 8 : The HSP's strategic priorities will build momentum towards NMDHB's vision, goals and objectives
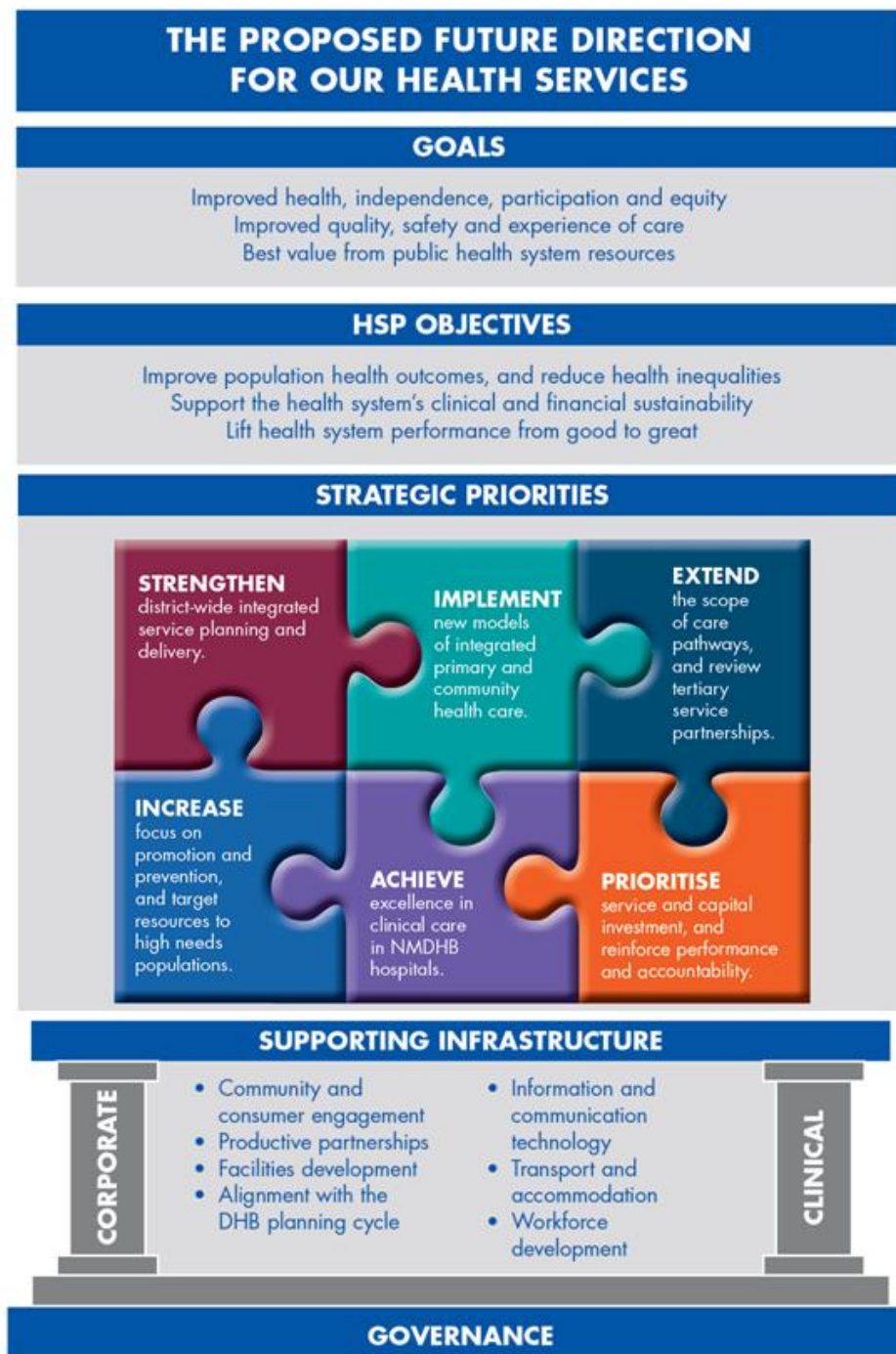
Headline actions

Top of the South specialist services

1. Reiterate the core principles and characteristics of the Top of the South model
2. Develop and implement a scheduled roll-out plan for the model across the specialist services, and mechanisms for sharing learnings across services
3. Adopt a programme management approach to implementation, and support integrated service development with project management and analytical resources

Top of the South Health Alliance (ToSHA)

4. Review the ToSHA work programme to ensure congruence with the HSP
5. Build the profile of ToSHA by communicating its role, processes and achievements
6. Consider whether extending the scope of the alliance model is best achieved through broadening ToSHA's scope and membership, or establishing equivalent alliance structures in other service areas, and implement the preferred approach
7. Define the role, membership, support infrastructure and development path for locality networks that will operate within the alliance framework to foster integrated models of care and professional collegiality.

Discussion

Top of the South clinical services development

As discussed in Section 3.2, implementation of the Top of the South Review is underway. The immediate aim is to develop a unified system of secondary care that delivers services in the two hospitals (Nelson and Wairau), is sustainable and based on a generalist senior medical officer (SMO) workforce. Beyond this, the intention is to build a strong sense of a single Nelson Marlborough health system, with consistent models of service delivery.

Feedback from DHB clinicians has identified the need to be more explicit about the principles of the 'one service, two sites' model that will be applied across all specialist services, how the model is intended to be fully operationalised, and how learnings will be spread across services.

In recognition of the significant culture change and challenges to be addressed in successfully implementing the model, a more deliberate approach will be taken, with increased support for clinical directors as they work with their teams on integrated service development across the two hospitals. A programme management approach will be adopted, including development of project plans for staged implementation in each service and across sites. Issues to be considered in planning the integrated service will include:

- The model of care for the service, including the intersection between specialty and sub-specialty, definition of care pathways (see Priority 3); and the case complexity to be managed at each site based on its clinical capability
- The mix of acute and elective inpatient, day case and outpatient activity on each site (including visiting clinics)
- Arrangements for patient transport and appointment scheduling when travel is required

- Arrangements for clinician travel where required for visiting clinics, and the responsibilities of visiting clinicians
- The staffing complement for each site, and cover for key staff during planned and unplanned leave (in particular addressing support from Nelson for Wairau clinicians, because of the Wairau Hospital's smaller staffing complement)
- How to ensure equitable patient access, and how that is aligned with production planning
- Moving key clinical roles from local to district-wide.

Role of ToSHA

As noted in Section 3.2, the alliance agreement between the DHB and PHOs is the vehicle for creating an integrated system of care through shared outcomes, a joint work programme, and shared decision-making. The DHB and PHOs participate as equal members of the alliance, and decisions are made by consensus on issues within the alliance's defined scope.

The alliance framework is intended to create a high trust, low bureaucracy environment, and represents a deliberate move to a 'shared agenda' rather than 'arms-length' funding arrangements that hold providers independently accountable. Among the goals of the DHB/PHO alliance are promotion of clinical leadership, alignment of clinical and financial accountability, and clinically led decision-making in health services planning and delivery.

The Top of the South Alliance (ToSHA) was established in Nelson Marlborough in 2013, and is now building momentum through its work programme (described in Section 3.2). However, ToSHA has a relatively low profile within the Nelson Marlborough health system, and its role and focus are not well understood. NGOs in particular question why they are not part of the ToSHA structure; or alternatively, why the alliance framework is not being applied in their relationship with NMDHB – particularly in service areas with significant NGO presence such as palliative care, mental health, and health of older people.

NMDHB will review its approach to alliancing, and consider whether:

- The alliance model should be applied more widely in building effective relationships and integrated care initiatives with other provider groups; and if so
- Should this be through ToSHA by broadening membership and scope, or through other service-specific structures?; and
- Is there the opportunity to use the alliance model in intersectoral partnerships?

The role and work of ToSHA will be communicated more explicitly to relevant audiences (inside the DHB and externally), including how its role is differentiated from DHB decision-making bodies.

Professional collegiality and multi-disciplinary teamwork

Clinical leaders in the Nelson Marlborough health system observe that opportunities for development of collegial relationships across specialist services, and with primary & community practitioners have declined over recent years. These personal relationships are seen as critical to the effective functioning of the health system, and to the trust and confidence that must underpin effective implementation of integrated care.

Opportunities to support development of stronger personal linkages of practitioners will be pursued, through CPD programmes, integrated specialist service development, care pathway development, locality networks, and performance improvement initiatives.

Through ToSHA, NMDHB and the PHOs will support the development and ongoing role of locality networks. These collectives of local practitioners will provide a vehicle for identifying and resolving local issues, for planning and development of local health services across the various provider organisations and professional groups, for sharing resources, and for engaging with community stakeholders. They will build on the informal relationships that already exist within local communities and professional networks, and are an opportunity to apply the alliance model at the local level. Locality networks will be of particular importance in rural areas, given the demographic and geographic characteristics of Nelson Marlborough.

Particular areas of focus for locality networks are covered in strategic priorities 2 and 4.

Practitioners within both primary and secondary care also observe that relatively 'siloed' patterns of clinical practice prevail, and that progress towards better integration of care will rely on effective teamwork across professional groups to address the needs of particular population groups and health need. Successful teams are those with a common purpose and goals, a clear structure and membership, commonly understood processes, and supportive infrastructure – such as shared patient records and/or care plans, and defined care pathways. Support for increased teamwork across professional groups will be included in the Nelson Marlborough Workforce Plan's work programme.

> Successful teams are those with a common purpose and goals, a clear structure and membership, commonly understood processes, and supportive infrastructure.

Implementation Roadmap: Priority 1 – Strengthen district-wide integrated service planning and delivery

Headline actions		2015/16				2016/17				2017/18			
Time-limited actions	Ongoing actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Top of the South specialist services													
1. Reiterate the core principles and characteristics of the Top of the South model			▓	▓									
2. Develop and implement a scheduled roll-out plan for the model across the specialist services, and mechanisms for sharing learnings across services			▓	▓	▓	▓							
3. Adopt a programme management approach to implementation, and support integrated service development with project management and analytical resources			▓	▓	▓	▓							
Top of the South Health Alliance													
4. Review the ToSHA work programme to ensure congruence with the HSP				▓									
5. Build the profile of ToSHA by communicating its role, processes and achievements			▓	▓	░	░	░	░	░	░	░	░	░
6. Consider whether extending the scope of the alliance model is best achieved through broadening ToSHA's scope and membership, or establishing equivalent alliance structures in other service areas, and implement the preferred approach					▓	▓	░	░	░	░	░	░	░
7. Define the role, membership, support infrastructure and development path for the locality networks that will operate within the alliance framework to foster integrated models of care and professional collegiality						▓	▓	░	░	░	░	░	░

Priority 2. Implement new models of integrated primary & community health care

Headline actions

1. Develop a Nelson Marlborough Primary & Community Care Strategy, including a 'generic' integrated model with general practice at the core; multi-disciplinary teams with personnel working at the top of their scopes, alignment of primary and community services, and specialist support; and use of planned and structured care
2. Develop an implementation plan for the Nelson Marlborough Primary & Community Care Strategy
3. Extend the scope and scale of proven initiatives that avoid ED attendances and acute admissions through improved access to primary & community health services
4. Prioritise development of a locality network for Marlborough, and implement initiatives that improve access to primary care for high needs populations, and decrease unnecessary use of Wairau Hospital ED
5. Determine and implement the appropriate organisational arrangements that reflect the broad-based teams that will be needed to deliver on the Nelson Marlborough Primary & Community Care Strategy.

Discussion

A Primary & Community Care Strategy

The Nelson Marlborough health system has begun the process of shifting the balance from episodic and acute care, towards more effective prevention and management of long term conditions. Primary & community health services have contributed to the relatively good results of the wider health system, as evident in primary health care and avoided hospitalisation measures (see sections 6 and 7 of the *Nelson Marlborough Health Needs & Service Profile*). As with hospital services, however, there is the opportunity to do even better.

Primary & community health services face the dual challenges of increasing demand arising from population ageing and increasing prevalence and complexity of long term conditions, and supply constraints relating to an ageing workforce and the current configuration of services.

The opportunity now exists for the Nelson Marlborough primary health care sector to take the lead in promoting and adopting new models of care that will better meet community health needs and support system sustainability. Primary care development has been relatively slow in Nelson Marlborough compared with other some other parts of New Zealand. Reasons for this suggested by Nelson Marlborough stakeholders include a history of a predominant focus on hospital and specialist services; high needs populations having a low profile through being relatively small in number and 'hidden' within the overall community; and the health system lacking a widespread understanding of the need for change, and a unifying whole system strategic direction.

However, there is evidence of a new commitment and energy emerging:

- ToSHA is building momentum through a more effective partnership approach, and a more strategic approach to its work programme;
- NMDHB has a new executive team that recognises the need for more effective relationships with primary care and NGOs, and greater emphasis on community based service delivery;
- General practitioners are increasingly open to taking a greater and more effective role in the wider health system;
- Some general practices are strengthening their services through clinical and operational innovation;

- Rural health services are developing integrated service models (such as Golden Bay Integrated Health Centre); and
- NMDHB public health and district nursing have co-located with the PHOs in Richmond and Blenheim.

The Nelson, Tasman and Marlborough communities are supportive of a strengthened role for primary and community care to assist them to live well, stay well and get well, and enable access to services closer to home. The communities are also a good source of ideas for the Primary & Community Care Strategy, particularly about prevention and early intervention to reduce avoidable hospital admissions (see Appendix 3 Community engagement feedback).

The time is now right for development of a Nelson Marlborough Primary & Community Care Strategy that describes the future role of primary & community services within the wider Nelson Marlborough health system, how the capacity of services will be increased to meet future demand, and how those services can contribute more effectively to the population health and system sustainability goals.

> It will be particularly important that general practice is closely engaged in Primary & Community Care Strategy development, given its key role in the system as the health care home, and the unique business model it operates within.

Risk stratification

Risk stratification is a concept that is widely used in both public and personal health to assist with targeting resources and efforts in a planned and coordinated manner. It is a process of identifying the disease burden and determining health risk status across the population, and is reflected in the *Health for Tomorrow* framework of five levels of risk (see Section 3.2):

1. Healthy population
2. At risk population
3. Early conditions with complications
4. Multiple long term conditions
5. End-stage conditions.

The opportunity now exists to begin to apply this framework in a more systematic manner in Nelson Marlborough to better address patient and population health needs. This can be done through application of a risk stratification tool to general practices' enrolled population registers. This in turn would allow design and implementation of integrated interventions appropriate to each risk cohort, and individuals within each cohort.

Figure 9 illustrates a typical risk stratification population profile, and tailoring of the care model to reflect the level of risk. Evidence suggests that patients in the very high risk category often do not have conditions that are amenable to primary care-based interventions, and that it is the next two groups – high and moderate risk - who would benefit most from an integrated model of care and shared care plans.

The risk stratification process can begin with use of a relatively simple stratification tool that can be refined and extended as experience of integrated care grows in Nelson Marlborough.

Figure 9 :   Risk stratification and models of care.
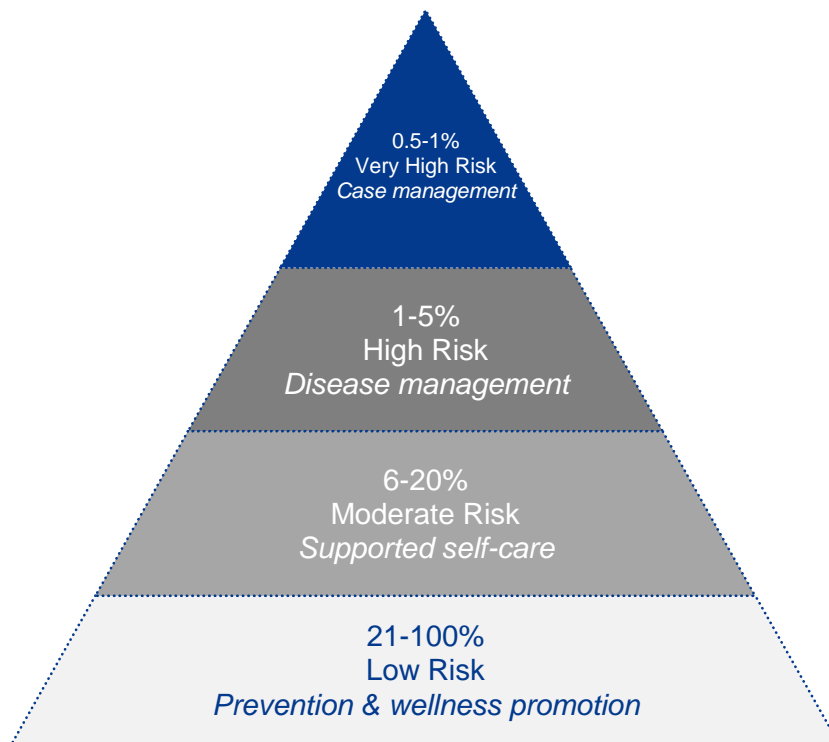
Note that the percentages of the population in each group are not necessarily representative of the Nelson Marlborough population, and are for illustrative purposes only

Model of care change

Work is underway through ToSHA on a number of initiatives relating to how general practice, community pharmacy, and DHB community services (particularly nursing) can work more effectively together (see Section 3.2). This will contribute to development of a 'generic' model of the multi-disciplinary primary & community team, key elements of which are likely to include:

• Reinforcement of the role of general practice as the patient's core 'health care home' and setting for continuity of care;
• Better alignment of the various community and practice nursing workforces, including reorientation of NDHB district nursing services from a predominant focus on support for hospital discharges, to an equal emphasis on community needs as part of a multi-disciplinary primary care team; and
• Recognition of the important role that allied health professionals (including pharmacists) play within contemporary models of primary & community service delivery.

Specific areas of opportunity that are apparent from experience in New Zealand and internationally include:

• Locality planning and networks as a vehicle for building effective working relationships between local practitioners, and for local service improvement (see Priority 1);
• Multi-disciplinary teams, with core membership from general practice, nursing and allied health;
• Nurse-led services, including support for uptake of advanced nursing roles such as nurse specialists and nurse practitioners in community settings;
• Use of care navigation and case management models for patients with complex health and social needs that are amenable to primary & community care, with specialist support (e.g., Whānau Ora);

- Extension of clinical pathways to encompass discharge as well as referral (see Priority 3); Improving use of communication technologies for telehealth, such as increased use of 'virtual' consultations with GPs and specialists;
- Improving GP access to radiology investigations;
- Minimising the need for specialist referrals and follow-up visits through development of the 'GP with a special interest' (GPSI) role;
- Shifting traditionally hospital-based services to community settings, with appropriate knowledge transfer and support, where these services are higher volume and do not require scarce resources and complex technologies that are best located centrally;
- Better coordination of general practice services with Māori health and NGO services (e.g., Well Child Tamariki Ora; mental health; palliative care; aged care); and
- Accelerated spread of proven primary & community initiatives to increase the breadth and depth of their coverage (as is currently occurring with Primary Options to Acute Care – POAC).

> Use of demonstration sites, evaluation and managed spread of successful innovation will be important aspects of model of care redesign and health service reconfiguration.

Moving to planned and structured care

As discussed above, the platform for shifting the balance away from ad hoc and episodic care to planned and structured care is formed through understanding of the different levels of health need in the local community through use of health risk profiling, and tailoring of models of care and resource intensity to match need. Care plans based on the risk profile can then be personalised to individual patients based on their particular health and social needs, family support networks, and cultural preferences. The care plan can be shared and maintained across the multi-disciplinary team.

Early actions for moving to planned and structured care include:

- Identify an appropriate methodology for risk stratification, and ensure baseline data is of appropriate quality. The methodology can include a mix of hospital and general practice based risk criteria, but the tool is best applied to the enrolled general practice population in line with the 'health care home' concept;
- Factor into design of the care model learnings from experience in Nelson Marlborough and elsewhere in New Zealand, and in rural and urban settings;
- Identify evidence-based models of care for different risk profiles and population groups (e.g., Maori, Pasifika, frail older people; adults with diabetes or COPD, former refugees);
- Define the scope and mix of health professionals needed at each level of risk stratification and associated models of care;
- Identify varying methods of patient contact, including nurse-led clinics, home visits, mobile clinics, and 'virtual consults' (e.g., telephone, email), and the suitability for different patient groups;
- Undertake a task and activity analysis to identify appropriate clinical and support staff input to models of care, and identify staff substitution opportunities to improve efficiency and free-up the time of more specialised professionals;
- Size the resource and utilisation intensity for the different models of care to inform resource and funding allocation; and
- Align with urgent, after-hours and acute care, home-based services, and nursing/allied health integration initiatives.

Figure 10 : Shifting the balance towards primary care provides good value for money

In 2013/14, NMDHB funding was applied to:

Primary care, general practice - $30M
- ▸ 355,000 funded GP visits and prescriptions
- ▸ Average cost of $70

Secondary care, ED attendances - $8M
- ▸ 50,000 funded attendances
- ▸ 20,000 attendance triage 4&5 (less urgent)
- ▸ Average cost of $251 (3.5 times the cost of one GP visit)

Secondary care, acute hospitalisations - $67M
- ▸ 18,000 funded admissions
- ▸ Average cost of $4,500 (63 times the cost of one GP visit)
- ▸ 10% of these admissions were preventable (cost of $8.1M)

Tertiary care, tertiary hospitalisations - $40M
- ▸ 3,000 funded admissions
- ▸ 12% of all hospitalisations
- ▸ 37% of hospital cost

Continuum of care

Notes: All figures are indicative; ED & hospital costs are at national IDF prices; hospital admissions are for medical and surgical services; GP costs exclude co-payments

Use of Wairau Hospital ED

Marlborough residents make significantly more use of Wairau Hospital ED services than their counterparts in Nelson and Tasman do of Nelson Hospital ED. Around 54% of ED attendances at Wairau Hospital were triaged as level 4 or 5, compared with 37% at Nelson Hospital; attendances at Wairau were less likely to lead to admission; and they were more likely to occur after-hours. This suggests that a greater number of people attending Wairau ED could be effectively cared for in primary & community settings, rather than the resource intensive emergency care environment of the Hospital. Understanding of the drivers of this pattern of service use, and design of alternative pathways to care will be a priority for a Marlborough locality network.

Organisational form

Effective delivery of the Nelson Marlborough Primary & Community Care Strategy will require new workforce roles, new ways of working, new pathways, and new working relationships between professional groups. PHOs currently are essentially general practice organisations, with some extension of services at the margins (e.g., through allied health and community workers). Lifting performance through new integrated models of care is likely to require new organisational arrangements to marshal the resources of general practice, pharmacy, DHB community services, and NGOs.

Implementation Roadmap: Priority 2 - Implement new models of integrated primary & community health care

Headline actions		2015/16				2016/17				2017/18			
Time-limited actions	Ongoing actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Develop a Nelson Marlborough Primary & Community Care Strategy, including a 'generic' integrated model of care with extended general practice at the core; multi-disciplinary teams with personnel working at the top of their scopes, alignment of primary and community services, and specialist support; and use of planned and structured care			███	███	███								
2. Develop an implementation plan for the Nelson Marlborough Primary & Community Care Strategy					███	███	░░	░░	░░	░░	░░	░░	░░
3. Extend the scope and scale of proven initiatives that avoid ED attendances and acute admissions through improved access to primary & community health services				███	███	███	███	░░	░░	░░	░░	░░	░░
4. Prioritise development of a locality network for Marlborough, and implement initiatives that improve access to primary care for high needs populations, and decrease unnecessary use of Wairau Hospital ED						███	███	░░	░░	░░	░░	░░	░░
5. Determine and implement the appropriate organisational arrangements that reflect the broad-based teams that will be needed to deliver on the Nelson Marlborough Primary & Community Care Strategy							███	███	░░	░░	░░	░░	░░

Headline actions

1. In the context of the Nelson Marlborough Primary & Community Care Strategy, review utilisation of general practice care pathways, and consider how to accelerate uptake including possible use of clinical audit and feedback
2. Plan and action staged movement to 'whole system' care pathways, incorporating care within NMDHB's integrated secondary services, referrals from secondary to tertiary services, and discharge back to primary & community care
3. In the context of Top of the South implementation and South Island Alliance planning, define and reinforce each NMDHB integrated specialty service's tertiary partnership(s), within a district-wide framework
4. Consider the medium-long term potential for lifting NMDHB specialist clinical service capability, and factor this into service and facility planning.

Discussion

Care pathways

An important service integration initiative currently underway in Nelson Marlborough is development and application of care pathways to improve the management of common conditions in primary care, and ensure high quality referrals are made to hospital specialists. HealthPathways[9] is the web-based system that provides locally appropriate guidelines and clinical information to allow primary care clinicians to plan patient care across the system. This avoids duplication of diagnostics, supports a high conversion of specialist assessment to treatment, and offers an improved patient experience.

Care pathways are a quality improvement tool intended to support patient access and standardisation of care. There is strong evidence from Nelson Marlborough and elsewhere that the success of care pathways is dependent on a high engagement approach across primary and specialist practitioners, which contributes to relationship building between clinicians as well as ownership and application of the pathway content. Another characteristic of successful quality improvement programmes is clinical audit, and feedback to individual practitioners of how their care compares with expected norms and the practice of peers. This has been shown to be a driver of quality improvement by encouraging reflective practice. To date uptake of care pathways by Nelson Marlborough GPs has been variable. Through ToSHA, consideration will be given to introduction of a review and feedback programme to promote uptake of pathways.

In addition, clinicians in NMDHB see the opportunity to build upon the HealthPathways foundation by extending its scope in two new dimensions:

•   Care pathways within specialist services and across the two hospital sites to contribute to service integration and standardisation as part of Top of the South implementation (see Priority 1); and
•   Care pathways to support planned discharge from specialist services to primary & community care.

> Nelson Marlborough's care pathways will move inside the hospitals and consider how patients are best managed within specialist services and across departments, and best discharged back to primary & community care.

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[9] http://nm.healthpathways.org.nz/LoginFiles/Logon.aspx?ReturnUrl=%2f

Development of these whole system care pathways would ensure consistent practice (based on evidence where available, or alternatively expert consensus), more effective reconnection of patients with primary care, and reduced clinical variation across the whole system. NMDHB will scope the potential to take this broader approach to care pathways.

Tertiary service partnerships

As described in Section 3.2, the 'one service, two sites' model is now being implemented across Nelson and Wairau hospitals following the Top of the South Review. Among the issues that have emerged in this work is the variation in referral arrangements to access highly specialised services offered by other DHBs, and funded by NMDHB as inter-district flows (IDFs). This variation exists within services, and between services. For example, within a single district-wide service some patients needing tertiary care are sent to Wellington Hospital or Hutt Hospital, and others to Christchurch Hospital. Similarly, clinicians from the same specialty but different tertiary centres offer visiting clinics in Nelson and Blenheim.

Adoption of a planned approach to referrals to tertiary care will be an important aspect of the progressive move to integrated specialist services within NMDHB's Provider Arm (Priority 1), greater standardisation of care, and equitable access across localities. A district-wide framework will be developed to guide tertiary partnership development. Each specialist service will then consider with which major hospital it should have its predominant tertiary partnership. This will involve analysis of current referral patterns (i.e., where patients are sent now, for what care, and why); and of how the model of care of the current tertiary service might be improved to best meet the needs of Nelson Marlborough patients and clinicians. Travel, accommodation and coordinated scheduling for patients (and their carers) will be important considerations.

> Each specialist service will consider with which major hospital it wants to have its predominant tertiary partnership, within a district-wide framework.

Clarification of tertiary service partnerships is expected to also have benefits for the tertiary centres themselves, allowing them to plan their future capacity with greater certainty of flows from Nelson Marlborough, and expected models of care.

One issue that will arise during consideration of outward IDF referrals and specialist service pathways is whether more cases should be referred to Nelson from Wairau, rather than sent out-of-district. This will require clarification of the level of case complexity that Nelson can manage currently, and the intended development path of Nelson Hospital services. A key determinant of Nelson's clinical capability is its intensive care unit (ICU). This is discussed further in Priority 5.

As noted in the *Health Needs & Service Profile*, Nelson Marlborough already caters for a relatively high proportion (more than 90%) of its population's hospitalisations – in other words, the district has a comparatively low rate of outward referrals (and a high rate of 'self-sufficiency'). During the next phase of integrated specialist service and facility planning, consideration will be given to the feasibility of lifting Nelson Hospital's clinical capability in specific service areas. Candidate services identified in discussions to date include radiation oncology, neonatal care, and plastic surgery. Any such developments would be at the margins and undertaken as a partnership with a tertiary centre, as the projected growth in Nelson Marlborough's demand is unlikely to warrant development of autonomous clinical capability. The aim would be to allow an increased proportion of Nelson Marlborough residents to access these highly specialised services locally instead of having to travel to Canterbury, Capital & Coast or Hutt Valley DHBs.

The clinical and financial sustainability of any such local service development will be a critical consideration, relating to the challenge of maintaining lower volume specialities and higher levels of clinical support services without sufficient population catchment to warrant adequate specialist staffing and activity volumes.

Implementation Roadmap: Priority 3 - Extend the use and scope of care pathways, and review tertiary service partnerships

Headline actions		2015/16				2016/17				2017/18			
Time-limited actions	Ongoing actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. In the context of the Nelson Marlborough Primary & Community Care Strategy, review utilisation of general practice care pathways, and consider how to accelerate uptake including possible use of clinical audit and feedback					▓	▓							
2. Plan and action staged movement to 'whole system' care pathways, incorporating care within NMDHB's integrated secondary services, referrals from secondary to tertiary services, and discharge to primary & community care							▓	▓	▓	▓			
3. In the context of Top of the South implementation and South Island Alliance planning, define and reinforce each NMDHB integrated specialty service's tertiary partnership(s), within a district-wide framework						▓	▓	▓					
4. Consider the medium-long term potential for lifting NMDHB specialist clinical service capability, and factor this into service and facility planning						▓	▓	▓					

Headline actions

1. Build awareness of the NMDHB's Treaty partnership, the role of the Iwi Health Board, and the focus of Iwi strategic plans
2. Commit to reduction of health inequalities across the Nelson Marlborough health system, and reinforce reducing inequalities as the responsibility of all health and support services
3. Through the annual Māori Health Plan, strengthen capture and reporting of information about health inequalities, the initiatives the Nelson Marlborough health system is taking to address them, and the specific measures and targets used to assess progress
4. In the context of the Nelson Marlborough Primary & Community Care Strategy, identify and implement strategies to ensure primary health care services are well coordinated to meet the needs of Māori,Pacific peoples and other high needs populations
5. Align planning and delivery of public and personal health services to lift outcomes and reduce inequalities in priority areas including:
   a. Oral health
   b. Child and youth health
   c. Obesity (including nutrition and physical activity)
   d. Smoking cessation
   e. Long term conditions
   f. Health of older people
   g. Cancer care
   h. Mental health
   i. Rural community health
6. Develop clear position statements on public health issues to provide a mandate and platform for intersectoral action, particularly in relation to health determinants. For example, explore the option of adding fluoride to the water supply to improve oral health.
7. Explore with partner organisations the potential for further development of existing forums to strengthen intersectoral action that addresses the determinants of health.

Discussion

Health inequalities

Health inequalities (or disparities) is a term used to describe the poorer outcomes experienced by some groups in the population. Key factors determining the presence of health inequalities include:

• The ethnic composition of the population, with Māori and Pacific populations in particular having poorer outcomes; and
• The level of deprivation, with populations with a low socio-economic profile (i.e., high deprivation) being impacted by the 'determinants of health' such as income, housing, employment, educational attainment, and access to transport.

As shown in the *Health Needs & Service Profile*, the Nelson Marlborough population has lower proportions of Māori and Pacific people, and is relatively less deprived than the New Zealand average. In addition, Māori in Nelson Marlborough have better access and

> A large health inequalities gap still exists between Māori and non-Māori in Nelson Marlborough.

outcomes than Māori elsewhere in New Zealand, as measured by most health indicators[10]. However, a large health inequalities gap still exists between Māori and non-Māori in Nelson Marlborough.

NMDHB is committed to reduction of inequalities, and recognises that action is required at all levels of the health system, and across the continuum of care. Lifting health outcomes for high needs populations (including Māori, Pacific peoples, and people living in high deprivation areas) will take concerted district-wide effort by the DHB, working in partnership with the PHOs, Te Piki Oranga, NGOs, local councils and government agencies. It will also require change in how organisations work together, in how and where health professionals deliver services, and in patterns of resource allocation. The headline actions in priorities 2 (integrated primary & community health services), 3 (specialist services) and 6 (prioritisation) will be particularly important in this regard.

Responses to health inequalities will include:

- Continuing recognition of the special role of manawhenua, and reflection of the Treaty of Waitangi in DHB governance arrangements through the Iwi Health Board (see Section 3.2)
- Adoption of the Whānau Ora approach through the Māori Health Plan
- Working with health system and intersectoral partners to address the areas that are likely to provide the greatest population outcome gains for Nelson Marlborough as a whole, as well as reducing health inequalities - child and youth health; oral health; nutrition and physical activity; smoking cessation; alcohol harm reduction; cancer care; long term conditions; mental health; and rural community health
- Continued development of health services that target Māori, Pacific and low socioeconomic populations, including through Te Piki Oranga, and DHB, PHO and NGO services. Effective diabetes care will be particularly important
- Building awareness of the existence and impacts of health inequalities, including through communication of findings from the Health Needs & Service Profile
- Embedding cultural awareness and competence training within the district's health workforce development activities
- Boosting Māori and Pacific participation in the health workforce through the Nelson Marlborough DHB Workforce Plan (Section 3.2)
- Ensuring health services funding and delivery has an equity focus, including in prioritisation of health resource allocation (Priority 6), quality improvement activity, and information capture and reporting.

Health promotion

The Nelson Marlborough health system will continue to diagnose and treat people with injuries and established disease. However, a central theme of the HSP is a whole-of-system approach to shifting the balance away from a predominant focus on episodic care for individuals, to a population health focus characterised by better linkage of public and personal health strategies, particularly for communities, patients and families with higher levels of health needs.

This collaborative approach across primary, community and specialist services emphasises the importance of:
- Improved community health literacy;
- Intersectoral action to address the determinants of health (e.g. air quality, housing, alcohol related harm, etc);
- Prevention, early detection of health risks, and early intervention; and
- The core place in the health system of continuity of holistic primary health care, centered on general practice as the health care home.

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[10] As noted in the *Profile*, Pacific and Asian population numbers in Nelson Marlborough are too small to allow meaningful quantitative analyses. These populations are included with 'non-Māori' in the *Profile*'s analysis. Nor can refugees be separately identified in the national health data collections.

This approach is particularly important given the ageing Nelson Marlborough population; the increasing prevalence, incidence and complexity of long term conditions; and the pressing need to reduce health inequalities.

The Nelson Marlborough health system is well placed to build on existing organisational relationships and collaborative service initiatives. Cross-agency discussions will be initiated at senior levels to explore the further development of existing structures and relationships to support increased intersectoral activity to address the determinants of health and reduce inequalities. This would build on the strengths of the Nelson Marlborough communities and health system, and recognise that better outcomes can be achieved for the population through collaborative action to build healthy public policy and foster environments that support population and personal health.

Implementation Roadmap: Priority 4 - Increase focus on health promotion and prevention, and target resources to high needs populations

Headline actions		2015/16				2016/17				2017/18			
Time-limited actions	Ongoing actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Build awareness of the role of NMDHB's Treaty partnership, the role of the Iwi Health Board, and the focus of Iwi strategic plans				▓	▓								
2. Commit to reduction of health inequalities across the Nelson Marlborough health system, and reinforce reducing inequalities as the responsibility of all health and support services				▓	▓								
3. Through the annual Māori Health Plan, strengthen capture and reporting of information about health inequalities, the initiatives the Nelson Marlborough health system is taking to address them, and the specific measures and targets used to assess progress				▓	▓								
4. In the context of the Nelson Marlborough Primary & Community Care Strategy, identify and implement strategies to ensure services are well coordinated to meet the needs of Māori and Pacific peoples, and other high needs populations							▓	▓	▓				
5. Align planning and delivery of public and personal health services to lift population outcomes and reduce inequalities in priority areas including: a. Oral health b. Child and youth health c. Obesity (including nutrition and physical activity) d. Smoking cessation e. Diabetes, CVD, COPD and other long term conditions f. Health of older people g. Cancer care h. Mental health i. Rural community health				▓	▓	▓							
6. Develop clear position statements on public health issues to provide a mandate and platform for intersectoral action, particularly in relation to						▓	▓	▓	▓				

health determinants. For example, explore the option of adding fluoride to the water supply to improve oral health.											
7. Explore with partner organisations the potential for further development of existing forums to strengthen intersectoral action that address the determinants of health											

Priority 5. Achieve excellence in clinical care in NMDHB hospitals

Headline actions

1. Develop a NMDHB quality and performance improvement strategy, including concerted action in a small number of key performance areas to reach best practice (world class) levels in specialist services, and review annually
2. Review leading international models of specialist service delivery, and apply learnings through staged rollout in Nelson Marlborough, with a particular focus on those activities that could be undertaken in ambulatory and community settings
3. Provide the information and resources to support NMDHB specialist services where the opportunity for performance improvement and or/service redesign is highlighted
4. Identify current and potential telehealth use across the district, and prioritise development opportunities
5. Undertake service planning to resolve key clinical service issues, including:
    a. Capability, capacity and role of Nelson Hospital ICU
    b. Configuration, capacity and process improvement of the NMDHB radiology service
    c. Configuration and capacity of the Nelson Hospital adult medicine service, including whether to develop an acute assessment unit (AAU)
    d. Intersection of mental health services with personal health and intellectual disability support services
    e. Intersection of emergency department (ED) and general practice services
6. Continue development and implementation of the NMDHB clinical governance framework, with agreement on a staged evolution to an integrated NM health system approach across the DHB and PHOs.

Discussion

Quality and performance improvement

As noted in Section 3.2, the Nelson Marlborough health system already performs well compared with New Zealand averages. The Board of NMDHB has set the goal of lifting that performance 'from good to great'. This goal will be translated to action through the NMDHB Clinical Governance Group working with clinical and managerial leaders to prioritise performance areas where the DHB's Provider Arm will strive to achieve world-class standards, in addition to lifting performance in areas where it is below the national average (such as those identified in Table 3). Achievement in some of these areas is likely to require support from primary & community care; where this is the case, the Clinical Governance Group will work with its peer bodies in the two PHOs to explore opportunities for collaboration.

The Clinical Governance Group will work with the services involved to develop an action plan for each performance area, and identify the resources needed to support superior performance through leadership training, access to timely and robust information, and methodologies for improvement and transformational change (including reduction of waste). These resources will be made available following Board approval of the Group's action plans.

The Clinical Governance Group has an existing work programme, based on immediate developmental priorities within its framework (Figure 11). The Group's medium term work programme will be informed by the strategic priorities of this HSP, including actions relating to quality and performance improvement, multi-disciplinary teamwork, care pathways, tertiary partnerships, reducing inequalities and prioritisation. Of

Figure 11: Components of the NMDHB Clinical Governance Framework

NMDHB CLINICAL GOVERNANCE FRAMEWORK

Vision

Systems and processes are in place to support us to do the right thing so we achieve the highest possible standard of health, safe care and support for the Top of the South.

Themes

Leadership and Culture	Measurement	Workforce	Quality Initiatives
Will to Act	*Tools to Measure*	*Tools for Change*	*Harm-free Care*

Components

Leadership and Culture	Measurement	Workforce	Quality Initiatives
People centred care / Clinical leadership development	Knowing how we are doing locally, nationally and internationally / Knowing we are safe	Noticing, celebrating and appreciating success	Participate in National safety initiatives / Using what we learn to drive harm free care
Fair and Just Culture fostered / Excellent communication		Continuous professional development / Having tools for change	
Evidence based practice / Serious event management	Knowing we are improving		Integrating IT changes

Outcomes

Leadership and Culture	Measurement	Workforce	Quality Initiatives
Improved experience of care / Improved workplace safety culture	Excellent use of information to guide decisions and improve care / Information feeds into short feedback loops to accelerate improvement	Workforce skilled and confident to both provide care and bring about beneficial change	National exemplar of best practice
Safe care for all patients, clients and service users		Healthy Departments and Teams	Excellent performance on national quality and safety markers
Foster clinical governance with other health organisations	Agreed ranking system and clinician input into budget allocation for best value.		

particular importance will be the Group's initiatives to support an environment in which clinical excellence flourishes, and to reduce wastage through changes in clinical practice.

Currently each of the DHB and the two PHOs has its own clinical governance structure and approach. As part of the ongoing drive to system integration, consideration will be given through ToSHA to consolidation of these structures and associated quality and performance improvement resources into a merged body with a whole of system view.

Telehealth

An important tool for transformation of models of care and improved patient access is increased use of 'telehealth', whereby telecommunications technologies such as telephone, email and video are used to aid timely communication between health professionals, and 'virtual' patient consultations. These technologies are available now; the key next step is to identify opportunities for, and barriers to their uptake, and to develop a plan for their increased application. NMDHB will work with the PHOs to undertake a scoping exercise to map specialist service and primary care telehealth needs across the district.

Clinical service development issues

Nelson Marlborough clinical leaders have identified five key clinical service configuration issues that require resolution. These issues are described below. A work programme will be instituted to ensure guiding decisions on future configuration are made during 2015/16 to support facility planning.

1. *Capability, capacity and role of Nelson Hospital ICU*: Nelson's Intensive Care Unit (ICU) is rated as a level 1 facility, the lowest level of clinical capability on a scale of 1 to 3. In considering the redevelopment of Nelson Hospital, the intended clinical capability of its core clinical services must be clarified, with the status of the ICU being a key determinant of this. Under the current model of care, the SMO responsible for the patient undertakes the admission to the ICU and retains formal responsibility for care. Should this model of care evolve to include a role for an intensivist in the ICU, in the interests of patient safety and the potential to lift clinical capability?

   The ICU is also currently used as the setting for renal dialysis treatment, and functions as a coronary care unit (CCU) and high dependency unit (HDU). At times the CCU's lack of capacity limits elective surgical activity. Should these functions continue to be housed in the ICU?

2. *Configuration, capacity and process improvement of NMDHB's radiology services*: The current radiology service across Nelson and Wairau hospitals impacts on the efficient functioning of the hospitals and the wider system. In the context of moving to integrated specialist service and new models of care, work is underway to: upgrade and standardise critical technology; identify sustainable workforce solutions; improve responsiveness to GP-ordered diagnostics; adopt more efficient work practices (through the National Radiology Service Improvement Initiative); and consider future facility requirements.

3. *Configuration and capacity of Nelson Hospital adult medicine service*: Whilst the service achieves good efficiency performance (such as average length of stay and readmission rate), it has the potential to do even better. It currently experiences frequent over-flow of patients into surgical beds, with consequences for both services and their patients. Demand for adult medicine is forecast to grow significantly as a result of population ageing and increased incidence of long term conditions.

Future bed capacity requirements and ED functioning will be influenced by decisions on the model of care, and in particular whether to establish an acute assessment unit (AAU) to meet demand that cannot be managed in other ways. If this is to occur, where it should be located (i.e., aligned with ED or adult medicine), and what its relationship would be with coronary and high dependency care?

4. *Intersection of mental health services, intellectual disability support and personal health services*: Nelson Marlborough has a history of large psychiatric and intellectual disability institutions (Braemar; Ngawhatu). Their closure in line with the nationwide deinstitutionalisation policy has led to a relatively high number of people with intellectual disability living in the district and supported by NMDHB residential and community services. A small number of these people have high and complex needs, spanning disability support, mental health and personal health. Two key issues require resolution. First, what is the preferred model of care for the 15-20 people with high and complex needs – is it supported living in the community, or in dedicated units in a small 'village'? Secondly, should a specialist clinical service be developed by NMDHB's mental health service to assist with the behavioural and cognitive needs of these people?

An additional consideration for Nelson Hospital facility planning is whether the acute mental health facility should be located in close proximity to other acute health services in order to support a holistic acute response, or co-located with the continuum of mental health services in a dedicated 'zone'. Close proximity may be in line with increasing recognition of the need for a better integrated health system response to people with both mental and physical health problems, and particularly in those with one or more long term conditions.

5. *Intersection of ED and general practice services*: The Nelson Marlborough population makes relatively high use of ED services across both hospitals, and Wairau in particular. The reasons for this are complex, and probably relate to both demand and supply factors. Various efforts have been made to address some of these factors, including development of on-campus after-hours general practice services, and a Medical and Injury Centre on the Nelson Hospital campus.

A fresh look will be taken at Wairau ED and general practice through the locality initiative (Priority 2). Decisions on the future Nelson approach to urgent care will also be required because of facility planning's need to consider the configuration and capacity of services.

Implementation Roadmap: Priority 5 - Achieve excellence in clinical care in NMDHB hospitals

Headline actions		2015/16				2016/17				2017/18			
Time-limited actions	Ongoing actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Develop an NMDHB quality and performance improvement strategy, including concerted action in a small number of key performance areas to reach best practice (world class) levels in specialist services, and review annually						▓	▓	░	░	░	░		
2. Review leading international models of specialist service delivery, and apply learnings through staged rollout in Nelson Marlborough, with a particular focus on those activities that could be undertaken in ambulatory and community settings					▓	░	░	▓	▓	▓	░	░	▓
3. Provide the information and resources to support the NMDHB specialist services where the opportunity for performance improvement and or/service redesign is highlighted							▓	▓	░	░	░		
4. Identify current and potential telehealth use across the district, and prioritise implementation of development opportunities								▓					
5. Undertake service planning to resolve key clinical service issues, including: 　a. Capability, capacity and role of Nelson Hospital ICU 　b. Configuration, capacity and process improvement of the NMDHB radiology service 　c. Configuration and capacity of the Nelson Hospital adult medicine service, including whether to develop an acute assessment unit 　d. Intersection of mental health services with personal health and intellectual disability support services 　e. Intersection of ED and general practice services					▓	▓	▓						
6. Continue development and implementation of the NMDHB clinical governance framework, with agreement on a staged evolution to an integrated NM health system approach across the DHB and PHOs						▓	▓	░	░	▓	▓	▓	

Priority 6: Prioritise service and capital investments, and reinforce performance and accountability

Headline actions

1. Develop a prioritisation framework, to be used annually in setting of baseline budgets and activity targets, disinvestment, and allocation of new service and capital resources
2. Develop a framework for progressive movement to longer term funding commitments to give greater certainty and autonomy to service providers (including NGOs and Provider Arm specialist services) who consistently meet performance expectations in prioritised areas
3. Define required DHB capability for whole of system commissioning for integrated care, with a staged implementation programme
4. In the context of the Nelson Marlborough Primary & Community Care Strategy, consider development of a shared 'health intelligence unit' across the DHB and PHOs to inform planning, and performance monitoring and improvement.

Discussion

Prioritisation

NMDHB has largely maintained historic resource allocation patterns across its Provider Arm, and the NGOs and PHOs we fund. A first step towards a more deliberate approach was taken in 2014 with allocation of some $6M in discretionary funding, prioritised against pre-determined criteria.

Explicit and transparent prioritisation has long been an aspiration of health service funders, recognising that demand exceeds supply and that there are opportunity costs with all spending. While there is guidance available on tools and techniques[11] to achieve a disciplined approach to investment and disinvestment, there is no single best practice model.

NMDHB will develop a consistent prioritisation framework during 2015/16 to guide our allocation of service and capital funding, including use of an annual review of investments and disinvestments. This will allow a shift of resources to prioritised services and models of care, with an emphasis on supporting cost-effective delivery in community settings in line with the direction described in this HSP. It will also provide short-term transitional support where a change is being made to an existing model of care that enables improved future productivity or sustainability.

Considerations when devising the framework will include:

- Our health system's strategic direction shapes the priorities
- Prioritisation processes have been judged valid when based on principles, values and strategy, with clear decision criteria, and allowing input by affected parties through consultation
- Treaty partnership arrangements with Iwi will guide investments to improve outcomes for Māori
- In the current DHB operating environment, many priorities are set at the national level, and in some cases funding is 'tagged' for particular purposes
- Guiding principles are often in the domains of effectiveness ('does it work?'), equity (impact on inequalities), and value for money

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[11] *Best Use of Available Resources: An Approach to Prioritisation*. Joint DHB and Ministry of Health Working Group on Prioritisation (Ministry of Health, 2005). Available at:
http://www.moh.govt.nz/notebook/nbbooks.nsf/0/ce36eb1b2ab5c259cc2571450074a8e8/$FILE/best-use-of-available-resources.pdf

- Having an evidence-base to inform decision-making is important. Evidence can come from needs assessment and service analysis (such as in the Profile), service monitoring and evaluation, literature reviews, benchmarking (e.g., of cost, quality, and intervention rates) and community consultation (or qualitative market research)
- There are technical tools available to assist with assessing the merits of competing investments (e.g. programme budgeting and marginal analysis - PBMA)
- Investment decisions apply to extension of existing services, funding of new services, and adoption of new technologies
- How the funds are applied once allocated is also important (i.e., the funding model used, and the incentive structure created).

Funding commitments

Longer term certainty of funding is of considerable value for a health service organisation, be it a DHB or an NGO. Development of the HSP, the prioritisation framework, the Nelson Hospital facility master plan (and capital investment business case) and the IT Strategy will allow NMDHB to be more confident in our longer term direction and viability, and our service and capital investment portfolio. This in turn will allow us to enter into longer term funding commitments with providers (hospital departments, NGOs and PHOs) who share our strategic direction, and who have a track record of delivering high quality and cost-effective services in prioritised areas. We plan to move progressively down this path from 2016/17.

Commissioning and change management

Like many of its counterparts in New Zealand internationally (see Appendix 2), the Nelson Marlborough health system is evolving towards integrated care. Within this environment, the DHB's Planning & Funding function has moved from the traditional role of arms-length 'purchaser' to working collaboratively with professional and organisational leaders to plan, design and invest in models of care, processes and systems that support improved performance and outcomes.

> Services that work closely together should be planned, funded and managed together.

While Planning & Funding's core transactional processes and technical capabilities (e.g., contestability, contracting, funding models, monitoring, analysis and evaluation) are needed to support implementation, these will be increasingly secondary to developing 'commissioning' capability, with an emphasis on working with partners across the system and intersectorally to catalyse transformational change in line with the HSP. As demonstrated by the alliance model, integrated care will require new leadership, governance and relational skills and structures; new ways of working; and new accountability models (e.g., results/outcomes based contracts).

During 2015/16 NMDHB will assess the capabilities our organisation will need in this new commissioning environment, and design a developmental programme to build these.

Health intelligence

Effective use of health information will be a critical success factor for achieving better integration of services and improved outcomes. 'Health intelligence' is a term used to describe the output from the processes of analysing, interpreting and reporting information relating to health. Health intelligence uses a variety of inputs including national datasets, local databases, national reports, research papers and other sources. The opportunity exists to explore the feasibility of developing a single 'health intelligence unit' (HIU) to support the Nelson Marlborough health system, and particularly the DHB and PHOs.

The overall purpose of an HIU would be to ensure the collection and interpretation of information to better support strategic and operational management by taking an evidence-based approach to prioritising outcomes, setting KPIs and making decisions. The HIU would develop an information 'spine' to support good patient care, as well as population health strategies and efficient resource use. It would consolidate the district's scarce and highly specialised analytical skills and expertise to provide a holistic intelligence service to support the strategic and operational levels of the wider Nelson Marlborough health system.

Implementation roadmap: Priority 6 - Prioritise service and capital investments, and reinforce performance and accountability

Headline actions		2015/16				2016/17				2017/18			
Time-limited actions	Ongoing actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Develop a prioritisation framework, to be used annually in setting of baseline budgets and activity targets, disinvestment, and allocation of new service and capital resources					▓	▓			▓	▓			▓
2. Develop a framework for progressive movement to longer term funding commitments to give greater certainty and autonomy to service providers (including NGOs and DHB Provider Arm specialist services) who consistently meet performance expectations in prioritised areas							▓	▓	░	░	░		
3. Define required DHB capability for whole of system commissioning for integrated care, with a staged implementation programme					▓		░		▓	▓	░	░	▓
4. In the context of the Nelson Marlborough Primary & Community Care Strategy, consider development of a shared 'health intelligence unit' across the DHB and PHOs to inform planning and performance improvement							▓	▓	░	░			

5. Supporting infrastructure

Delivery of the HSP's strategic priorities and headline actions will be supported by enabling actions and infrastructure in the following domains:

- Community and consumer engagement
- Productive partnerships
- Facilities development
- Information & communications technology
- Transport and accommodation
- Workforce development.

Community and consumer engagement

Actions:

1. Incorporate information technologies into community engagement strategies to increase health literacy, galvanise action in support of healthy lifestyles, and provide feedback on proposed service initiatives
2. Review current approaches to consumer input to DHB service planning and monitoring to ensure an appropriate breadth and depth of input, and selection processes for representation.

NMDHB has a range of existing consumer and community engagement mechanisms, intended to obtain feedback from patients on their experience of care, provide input into service planning and review, and build knowledge to inform self-care and use of health services. This is an important contributor to person-centred care and support. NMDHB will review its existing consumer input mechanisms to ensure a consistent approach is taken across services, and that there are transparent and well understood processes for consumer representation.

Health literacy refers to the ability of patients to obtain, understand and use health-related information. Evidence is increasingly showing that health literacy is a key factor in population and individual health outcomes. Increasing health literacy can encourage healthy lifestyles and self-care, and improve a patient's ability to navigate the health system. This contribution of individuals and families through increased participation in care and support is often referred to as co-production'.

Use of new patient-centred information technologies can support increasing health literacy - for example, the use of easy to access, plain English service directories help consumers identify services available in their local communities and how to access them. The use of targeted campaigns, patient portals and new technologies for monitoring, assessment and treatment, together with web-based access to health education content, will be explored.

Productive partnerships

Actions:

1. Continue use of the alliance model to further develop partnerships at regional and local levels
2. Pursue opportunities to strengthen intersectoral partnerships
3. Develop locality networks as the key local infrastructure for engagement, planning and coordinated action

4. Using a formal partnership assessment tool, regularly review the effectiveness of the DHB's partnerships and locality networks, and make improvements as required
5. Consider development of a shared 'health intelligence unit' across the DHB and PHOs to inform planning and performance improvement
6. Consider further opportunities for public/private partnerships in developing and/or sharing infrastructure.

As discussed in Section 3.2, NMDHB is a member of the **South Island Alliance**, a structure that enables the region's five DHBs to work collaboratively to develop more innovative and efficient health services and infrastructure than could be achieved independently. By using our combined resources to jointly solve problems we are better positioned to respond to changes in the demographics and technology that will have a significant impact on the health system in the coming years. The actions in this HSP reflect commitments to the regional alliance.

At the local level, the **Top of the South Health Alliance** (ToSHA) is our key vehicle for effecting transformational health system change across the health system. We will invest in initiatives that provide the opportunity to enhance the integration of community, primary and secondary care across the continuum of health to enable high quality, safe, person-centred delivery.

There is increasing recognition that the **determinants of health** often lie outside the immediate scope of health system. This means that health services alone are insufficient to optimise health outcomes for populations and individuals, and reduce health inequalities. To enable movement towards a better integrated health system, relationships with local government and government agencies will be strengthened, and opportunities for joint action to address the social determinants of health will be pursued using population health strategies. Locality networks will work with local government and other parties on initiatives to address specific local needs and service issues. (See also Priority 4.)

NMDHB is party to a number of **public/private partnerships**. These include the relationship with Churchill Private Hospital Trust in Blenheim, through which we share the hospital campus, workforce and clinical infrastructure. Other partnerships included those with Pacific Radiology Group, and Manuka Street Hospital. During planning for Nelson Hospital facility development we will explore the opportunity for other public/private partnerships on the Hospital campus and in the community. Such partnerships have the opportunity to make the best use of scarce funding and workforce.

Facilities development

Actions:

1. Identify the implications of the *Health Needs & Service Profile* and HSP for hospital and community facilities
2. Develop a site master plan for the Nelson Hospital campus
3. Develop a business case for Nelson Hospital capital investment.

As discussed in Section 1.2, important aspects of NMDHB's asset management are strengthening of earthquake prone buildings and structures, replacement of core hospital infrastructure that has reached the end of its useful life, and ensuring the facilities are appropriate for future models of care. The initial focus during 2015 has been co-location of NMDHB's public health and district nursing services with the PHOs in both Nelson and Blenheim. Later in 2015/16 the first floor of the Arthur Wicks building at Wairau Hospital will be refitted to house management and administration staff, and a 'satellite' site for the Learning & Development Centre that will be developed on the Nelson Hospital site over the next 2 years as the first phase of campus redevelopment.

The *Facilities Implications Report* (Section 1.2) will support the planned redevelopment of Nelson Hospital, as well as providing guidance for facility development in primary and community settings. It will be followed by more detailed site master-planning, and then a strategic business case for investment linked with national capital planning processes.

Information & communications technology

Action:

1. Implement the South Island Patient Information Care System in NMDHB specialist services
2. Develop an implementation plan for the *NMDHB Technology Strategy*, with an emphasis on systems that will support integrated care and community based service delivery.

NMDHB is investing in information systems that enable and enhance integrated service delivery, and contribute to service effectiveness and sustainability (see Section 3.2). The most significant information system initiative in 2015/16 will be the implementation of the regional Patient Information Care System (SIPICS). SIPICS will replace the existing patient administration system, and allow increased access to relevant information at the point of care and greater use of information systems to enhance care delivery.

We are also supporting national initiatives. An example is the transfer of local infrastructure to one of two National Infrastructure Platforms (NIP) in Auckland or Christchurch. During 2014 we rolled out a 'zero client, virtual desktop infrastructure' solution, which enables us to progressively migrate all users onto a standard set of hardware and to manage our desktop users' computing requirements centrally.

Also in 2015/16, people will be able to access their own health information online via a patient portal to general practices. Patient portals enable people to manage aspects of their own health care, and can help them to become more proactive with their care. This project will require close working with the PHOs to support the implementation of patient portals by general practices, and to address potential issues about keeping health information secure.

Transport and accommodation

Actions:

1. In the context of implementation of the Top of the South Review and tertiary partnerships, identify opportunities to optimise local delivery, and support travel by clinicians and patients where it is required
2. Explore local council and NGO partnerships for the provision of transport and accommodation support for patients/clients, and their families and carers.

Difficulties with transport and accommodation cause significant barriers for patient access to services. This in turn affects the health system's ability to improve access and outcomes, and reduce health inequalities. The need for patient travel to specialist services can be minimised through initiatives such as visiting specialist clinics and telehealth. However, transport and supported accommodation are important for patients and their carers who do need to travel to centralised services.

NMDHB will work with partner organisations (including local government, ambulance services, PHOs, NGOs and tertiary service DHBs) to take a strategic approach to development of transport and accommodation services and resources. Issues to be considered in strategy development will include:

• Alternatives to ambulance for transport of patients between hospital sites;
• How transport could be improved for patients returning to their community following discharge;
• The needs of people in rural communities;

- Provision of affordable accommodation for patients and their carers who have been referred to a tertiary hospital for treatment;
- The potential for local council and NGO partnerships around the provision of transport support; and
- Transport requirements of visiting specialist service staff.

Workforce development

Actions:

1. Through a staged pathway, expand the scope of the *NMDHB Workforce Plan* beyond DHB staff to cover all health system workforce groups, with the primary care workforce being an early focus
2. Develop action plans in workforce areas arising from the HSP including leadership development and change management; succession planning; multi-disciplinary teamwork; substitution and working at top of scope; cultural awareness and competence; and increasing Māori and Pacific participation in the health workforce
3. Consider whether NMDHB professional leader roles should be expanded to include a whole-system scope.

A capable and engaged workforce is essential to support the continued development of the health system for the Nelson Marlborough community. Health professionals need to develop the competencies that enable them to work at the top of their professional scope, as a member of a multi-disciplinary team across settings of care, accessing shared care information, and contributing to the innovative redesign of services.

An initial *NMDHB Workforce Plan* has been developed to address workforce challenges facing the Nelson Marlborough health system. These include:

- A high average age of the health workers and the risk of knowledge loss as staff retire;
- High retention and the associated difficulty of introducing new people into the workforce to support, learn from, and eventually replace ageing staff;
- Barriers to accessing the learning and development opportunities which are necessary to support staff to develop the required competencies to work differently; and
- A homogenous workforce that does not reflect the diversity of the local community population.

The *Workforce Plan* is linked with South Island Alliance regional planning, and national activity through Health Workforce New Zealand. This will allow the Nelson Marlborough health system to 'think globally and act locally' to benefit from emerging opportunities for rethinking of models of care and associated workforce mix.

The work programme emerging from the *Workforce Plan* will be prioritised to ensure an early focus on key aspects of the new model of care, including new workforce roles in primary & community services.

6. Implementing the HSP

This HSP outlines an ambitious programme of work, but one that NMDHB considers essential to building momentum towards the goals of improving population outcomes, reducing inequalities, and ensuring system sustainability. A plan is only of real value if it is implemented. Hence even though the HSP has been developed with a 20-year horizon, its focus is on the Roadmap for action over the next 3 years, with momentum being built from year 1 (2015/16).

A structured and disciplined approach to implementation will be of critical importance. Translation of the HSP into action will have the following dimensions.

6.1 Key performance indicators and targets

A set of key performance indicators (KPIs) for monitoring the impact of the HSP at a strategic level have been defined (Appendix 2). Baselines and targets for these KPIs will be confirmed during detailed implementation planning. Where relevant and possible, these will include reporting of performance by ethnicity to ensure a focus on reducing population health inequalities.

6.2 Corporate governance

The NMDHB Board will be the primary decision-maker and 'owner' of the HSP. Strong corporate governance commitment to the HSP is critical to supporting the Executive to ensure management and clinician time is focused on delivering on the actions. The Board will also support further development of the organisational partnerships that will be fundamental to the success of the HSP.

6.3 Executive management

The Executive Leadership Team (ELT) of NMDHB will carry a collective accountability for delivery of the HSP, and a subset of the headline actions will also be overseen by the ToSHA Alliance Leadership Team. Individual ELT members will be accountable for leading, planning and implementing each of the actions identified in the Plan. They will also be accountable for ensuring the engagement of partner organisations and the clinical community.

6.4 Clinical leadership and governance

Effective implementation of the Plan will require leaders in the Nelson Marlborough health system to have the capacity and capability to manage both current business and short term imperatives, and the longer term, strategic agenda arising from the HSP. Areas for particular focus during implementation planning will include support for the clinical leaders who will be actively engaged in driving service improvement through the NMDHB quality and performance improvement strategy (see Priority 4), and in actioning the district's priorities for integrated care. Leadership from the Clinical Governance Group will be particularly important.

6.5 Programme management

A programme management approach will be used to coordinate and report on progress of HSP implementation and achievement. Regular dashboard reports will be generated for the ELT and the Board.

The Implementation Roadmap in the HSP provides an overview of the staging and sequencing of the 'headline actions' for each of the six strategic priorities, and actions associated with the supporting infrastructure. This Roadmap will be strengthened following HSP finalisation through more detailed implementation planning, and identification of the linkages and dependencies. Implementation planning will inform the annual plan, which will be the key document for the Board's governance purposes.

6.6   Communications & engagement

Early and effective communications and engagement with key stakeholders will be critical during HSP finalisation and implementation. The communications and engagement process that has accompanied HSP development will be refreshed to focus on the next three phases - consultation on the draft plan leading to finalisation; detailed implementation planning; and staged implementation.

The objectives of the communications and engagement process will be to:

•   Engage clinical and managerial leaders from NMDHB, primary care, and NGOs, and the wider community in discussion of the draft HSP
•   Obtain feedback that will inform HSP finalisation
•   Provide stakeholders with timely, relevant and targeted communication throughout the course of HSP implementation, and opportunities to contribute.

6.7   Alignment with the DHB planning cycle

During HSP implementation planning the actions related to the priorities and the supporting infrastructure will be linked with the DHB's annual planning cycle. This will ensure that they are factored into each year's annual plan and budget, and associated monitoring and reporting.

Appendix 1: National operating environment

Legislative context

NMDHB is one of New Zealand's 20 DHBs. Each DHB is a Crown Entity, accountable to the Minister of Health. The New Zealand Public Health & Disability Act 2000 defines the role of the DHBs, and the organisation of publicly funded health and disability services. It establishes DHBs with specified geographically-defined populations, and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations. An amendment to the Act in 2010 changed the planning framework for DHBs, and emphasised the need for regional collaboration (with the four other South Island DHBs in NMDHB's case).

NMDHB receives funding from Government to purchase and provide health and disability services for our local population. As an agent of the Crown, NMDHB is committed to fulfilling its role as a Treaty of Waitangi partner. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure). The DHB and Māori have a shared role in implementing health strategies for Māori, and will relate to each other in good faith, with mutual respect, co-operation and trust.

In accordance with legislation, we use the funding to:

- **Plan** the strategic direction of the Nelson Marlborough health system in partnership with clinical leaders; alliance partners; key stakeholders at local, regional and national levels; and our community
- **Fund** the majority of the health and support care service provided in Nelson Marlborough through our partnerships, alliances and key relationships with service providers. Our focus is on 'best for patient, best for system' and achieving more health gain for funds invested (value for money) by ensuring services are high quality, safe, responsive, coordinated and efficient, and meet patients' expectations of the care provided
- **Promote, protect, and improve** our population's health and wellbeing through an evidence-based whole-of-system strategy that includes public health approaches such as health impact assessments, and health promotion and protection interventions
- **Provide** hospital specialist and community services for our population
- **Integrate** health service activity in our district.

DHBs are guided by the New Zealand Health Strategy, Disability Strategy, and Māori Health Strategy (He Korowai Oranga).

Government health policy

Better, Sooner, More Convenient[12] is the Government's over-arching policy for health services. It seeks services that put the patient first, provide seamless integrated care closer to the person's home, and are good value for money. Goals of this policy are:

- Increasing access to services and reducing waiting times
- Improving quality, patient safety and performance
- Providing better value for money.

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[12] *Better Sooner More Convenient: Health Discussion Paper* (New Zealand National Party (2007). A companion document *Better Sooner More Convenient Health Care in the Community* was published by the Ministry of Health in 2011
http://www.health.govt.nz/system/files/documents/publications/better-sooner-more-convenient-health-care_0.pdf

These goals are to be achieved by:

- Strengthening sector accountability
- Regional planning and action to address shared challenges
- Stronger leadership from the national agencies
- Flattening the funding growth path
- Emphasis on primary care.

In line with these goals, a number of major health system policy and structural changes have been made by the Government over the past 8 years in New Zealand's public health system. These include:

- Creation of a number of new national entities to strengthen health system leadership and support for DHB performance improvement and innovation. These include the National Health Board (NHB), Health Workforce New Zealand (HWNZ), National Health IT Board (NHITB), the Capital Investment Committee (CIC), the Health Quality and Safety Commission (HQSC), and the National Health Committee (NHC)
- Stronger national direction for DHBs and PHOs to deliver on policies, priorities and expectations, most notably in respect of the national Health Targets (see below)
- Expectation that each DHB will lead and champion service integration through whole system planning involving primary and community services as well as regional and sub-regional services, rather than focusing predominantly on its own Provider Arm
- Requirement for strengthening of clinical engagement and leadership to improve health service delivery
- National mandating of the alliance model for partnering between DHBs and PHOs
- Requirement for collaborative DHB regional service planning, with an updated regional plan to be produced annually
- National planning and funding by the NHB for a small number of highly specialised, low volume services
- Emphasis on regional and national DHB collaboration to gain efficiencies through shared 'backroom' services.

Continuing emphasis is also given to delivering on the six national Health Targets:

- Shorter stays in hospital emergency departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit
- More heart and diabetes checks.

The Minister of Health's annual 'Letter of Expectations' to DHBs signals specific priorities for the health sector that link with *Better Sooner More Convenient*, and that are to be responded to in the DHB's annual plan and statement of intent (SOI). In setting expectations for 2015/16 the Minister focused on: clinical leadership; integration of primary and secondary care; tackling the key drivers of morbidity; and fiscal discipline and performance management.

Other national initiatives led by the Ministry of Health that are expected to impact on the Nelson Marlborough health system over the next 3 years include:

- Supporting vulnerable children (including reducing rheumatic fever cases and assaults on children)
- Social sector collaboration (across Social Development, Education, Health and Justice)

- Youth mental health
- Whānau Ora
- National drug policy
- Shifting services
- Childhood obesity plan
- Diabetes plan
- Quality and safety of health services
- Support the health of older people
- Implementing Rising to the Challenge (the mental health and addiction service development plan)
- Smokefree 2025.

Appendix 2. Key performance indicators

KPIs for monitoring the HSP impact at a strategic level are listed below. Each measure will include a Māori subset where possible. Performance baseline, targets and reporting frequency will be determined during implementation planning.

Indicator	Measure
Population health	
1. Keeping people healthy and out of hospital	a) Acute bed days per 100 population b) ED attendances per 100 population
2. Intersectoral action to improve child oral health	% of children caries-free at age 12
3. Cardiovascular disease and diabetes risk assessment	Proportion of eligible people assessed for cardiovascular disease and diabetes risk in 5-year period
4. Reducing the impact of tobacco smoking	Smoking prevalence in adults aged 15+
Quality of care	
5. Hospital experience	a) Hospital acquired infections b) Adverse events c) Readmissions to hospitals
6. Maintaining access to elective surgery	% of National Elective Surgical Target Volume
7. Integrated care	a) % of patients with a long term condition who have a shared care plan b) Number of whole system care pathways implemented
8. Customer satisfaction	Patient satisfaction survey results
Cost and productivity	
9. Operating efficient inpatient services	a) Increase in weighted output per FTE, inpatient and outpatient b) Increase in CWDs per theatre
10. Efficient inpatient capacity use	Proportion of surgical procedures undertaken as day cases
11. Care in the community	a) Ratio of over-75s supported in their own homes to those in ARC b) Ratio of people receiving specialist mental health services in the community to those in inpatient care c) % of outpatient clinics delivered in community facilities
12. Balancing primary and specialist care	a) Specialist FSAs per 1000 population (age standardised) b) Specialist follow-ups per 1000 population (age standardised)
13. Workforce	a) Staff engagement b) % of days worked/total days available

Appendix 3. Community engagement Feedback

A series of community and staff engagement meetings were held during October 2015 to share the results of the *Health Needs & Service Profile* and obtain feedback on the *Health Services Plan* to ensure we have identified the right six strategic priorities for our community.

Community engagement meetings were held in Nelson, Blenheim, Murchison, Golden Bay and Motueka from Tuesday 6 October to Thursday 15 October. Meetings for staff members were held at Nelson Hospital, Wairau Hospital, the Marlborough Community Health Hub, and the Richmond Library. A meeting specifically for the mayors of Nelson, Tasman and Marlborough was also held. The meetings consisted of a welcome and introduction by the Board Chair, an overview of the *Health Needs & Service Profile* by the General Manager Strategy, Planning & Alliance Support, and an overview of the *Health Services Plan* by the Chief Executive.

The presentation took approximately one hour, and then participants were invited to comment and ask questions.

The overall feedback from all the meetings was positive. The audience appreciated the opportunity to learn more about plans for the health system and to provide their feedback. Information from the Health Needs and Service Profile that received the greatest reaction from the audience at the meetings included: the forecast growth in the 75+ age group, number of children leaving school with no qualification, increase in child abuse reporting, number of young people who start smoking each week, and the percentage of five year olds with dental caries / decay. The common themes that emerged were:

- Access to health services and the difficulties associated with travelling from Murchison, Golden Bay and Motueka to see specialists at Nelson and Wairau Hospitals. The smaller communities were very receptive to the idea of the establishment of a 'tele prescence' to bring services closer to home and reduce the environmental and social impact of people having to travel to specialist or outpatient appointments
- ED attendance due to a perceived problem of affordability and access to GPs, and a greater need for self responsibility
- Oral health concerns for children, and a perception of reduced access to oral health services being linked to the high rate of dental caries in children
- NGO staff expressed a desire for more engagement with the Board and senior management
- Fluoridation was raised by a small, yet vocal, group of between 15 to 20 people at the Nelson meeting.

Vision

2015/16   *2016/17*   *2017/18*

1. Strengthen district-wide integrated service planning and delivery

Reiterate the core principles and characteristics of the Top of the South model

Consider whether extending the scope of the alliance model is best achieved through broadening ToSHA's scope and membership, or establishing equivalent alliance structures in other service areas, and implement the preferred approach

Develop and implement a scheduled roll-out plan for the model across the specialist services, and mechanisms for sharing learnings across services

Define the role, membership, support infrastructure and development path for the locality networks that will operate within the alliance framework to foster integrated models of care and professional collegiality

Adopt a programme management approach to implementation, and support integrated service development with project management and analytical resources

Review the ToSHA work programme to ensure congruence with the HSP

Determine and implement the appropriate organisational arrangements that reflect the broad-based teams that will be needed to deliver on the Nelson Marlborough Primary & Community Care Strategy

Build the profile of ToSHA by communicating its role, processes and achievements

Prioritise development of a locality network for Marlborough, and implement initiatives that improve access to primary care for high needs populations, and decrease unnecessary use of Wairau Hospital ED

2. Implement new models of integrated primary & community care

Develop a Nelson Marlborough Primary & Community Care Strategy, including a 'generic' integrated model of care with extended general practice at the core; multi-disciplinary teams with personnel working at the top of their scopes, alignment of primary and community services, and specialist support; and use of planned and structured care

Plan and action staged movement to 'whole system' care pathways, incorporating care within NMDHB's integrated secondary services, referrals from secondary to tertiary services, and discharge to primary & community care

Develop an implementation plan for the Nelson Marlborough Primary & Community Care Strategy

Explore with partner organisations the potential for further development of existing forums to strengthen intersectoral action that address the determinants of health

Identify current and potential telehealth use across the district, and prioritise implementation of development opportunities

Extend the scope and scale of proven initiatives that avoid ED attendances and acute admissions through improved access to primary & community health services

Consider the medium-long term potential for lifting NMDHB specialist clinical service capability, and factor this into service and facility planning

Undertake service planning to resolve key clinical service issues

In the context of Top of the South implementation and South Island Alliance planning, define and reinforce each NMDHB integrated specialty service's tertiary partnership(s), within a district-wide framework

In the context of the Nelson Marlborough Primary & Community Care Strategy, identify and implement strategies to ensure services are well coordinated to meet the needs of Māori and Pacific

Provide the information and resources to support the NMDHB specialist services where the opportunity for performance improvement and or/service redesign is highlighted

In the context of the Nelson Marlborough Primary & Community Care Strategy, review utilisation of general practice care pathways, and consider how to accelerate uptake including possible use of clinical audit and feedback

Align planning and delivery of public and personal health services to lift population outcomes and reduce inequalities in priority areas

Continue development and implementation of the NMDHB clinical governance framework, with agreement on a staged evolution to an integrated NM health system approach across the DHB and PHOs

In the context of the Nelson Marlborough Primary & Community Care Strategy, consider development of a shared 'health intelligence unit' across the DHB and PHOs to inform planning and performance improvement

Through the annual Māori Health Plan, strengthen capture and reporting of information about health inequalities, the initiatives the Nelson Marlborough health system is taking to address them, and the specific measures and targets used to assess progress

Develop an NMDHB quality and performance improvement strategy, including concerted action in a small number of key performance areas to reach best practice (world class) levels in specialist services, and review annually

Develop a framework for progressive movement to longer term funding commitments to give greater certainty and autonomy to service providers (including NGOs and DHB Provider Arm specialist services) who consistently meet performance expectations in prioritised areas

Commit to reduction of health inequalities across the Nelson Marlborough health system, and reinforce reducing inequalities as the responsibility of all health and support services

Review leading international models of specialist service delivery, and apply learnings through staged rollout in Nelson Marlborough, with a particular focus on those activities that could be undertaken in ambulatory and community settings

Develop a prioritisation framework, to be used annually in setting of baseline budgets and activity targets, disinvestment, and allocation of new service and capital resources

Define required DHB capability for whole of system commissioning for integrated care, with a staged implementation programme

Build awareness of the role of NMDHB's Treaty partnership, the role of the Iwi Health Board, and the focus of Iwi strategic plans

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3. Extend the scope of care pathways, and review tertiary service partnerships

4. Increase the focus on health promotion and prevention, and target resources to high needs populations

5. Achieve excellence in clinical care in NMDHB hospitals

6. Prioritise service and capital investments, and reinforce performance and accountability

Nelson Marlborough
District Health Board

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Nelson Marlborough Health Services Plan
2015/16 - 2017/18