E87

TE WAIORA Nelson Marlborough Health

Statement of Intent

incorporating the 2019/20 Statement of Performance Expectations

Pursuant to Sections 25 and 38 of the New Zealand Public Health and Disability Act 2000; Section 139 of the Crown Entities Act 2004; Section 49 of the Crown Entities Amendment Act 2013; New CE Act s149C

2019/20–2022/23

Our Vision/ Tō tātou Manako

"All people live well, get well, stay well"
"Kaiao te tini, ka ora te mano, ka noho ora te nuinga"

Our Mission/ Tō tātou kaupapa

"Working with the people of our community to promote, encourage and enable their health, wellbeing and independence"
"Kei te mahitahi tātou hei whakapiki te oranga me te motuhaketanga o to tatou hapori"

Our Values/ Ō tātou whanonga pono

Nelson Marlborough Health Statement of Intent

Produced June 2019
Pursuant to Sections 25 and 38 of the New Zealand Public Health and Disability Act 2000; Section 139 of the Crown Entities Act 2004; Section 49 of the Crown Entities Amendment Act 2013; New CE Act s149C.

Nelson Marlborough Health, Private Bag 18, Nelson

TABLE OF CONTENTS

Section 1: Strategic Direction (SOI)

1.1 Message from the Chairs and Chief Executive

The resilience and wellbeing of our community relies on our ability to tackle the challenges of the present while planning for the future. We are encouraged by Nelson Marlborough Health's agility and innovation. Our staff continue to adapt to new challenges and go the extra distance; constantly thinking about how they can improve the quality of the services we provide.

However, they cannot do it alone. We know there is inequity in our population health outcomes, particularly for Māori, people with disabilities and those on low incomes. To reduce these inequalities we need to commit to activities that consider the wider determinants of health, not just traditional health services. Determinants are often the underlying causes of illnesses and include: income, education, physical environment, employment, culture, housing and neighbourhoods, and personal behaviour.

To improve population health we must continue to work with local authorities, government departments and community agencies with a role to play in these wider determinants. We also understand that as climate change related alterations in weather begin to affect many of these determinants, such cross-sectoral collaboration will become increasingly important. Addressing the wider determinants of health is also consistent with Nelson Marlborough Health's obligations as a Treaty partner and our commitment to engaging with the principles of Te Tiriti o Waitangi.

One way we can continue to improve the health of local people is through the Models of Care Programme. In 2018-19 this multi-year health system transformation programme considered new models of care and identified specific activities and themes. In 2019-20 and beyond, we are excited the programme will be focussing on the design and delivery of these specific activities and key system enablers. In this way, we will be able to continue to meet demand for health services and improve health outcomes as our social and physical environments change.

This Statement of Intent sets out the strategic objectives that Nelson Marlborough Health intends to achieve within the next few years to ensure that the population of Nelson Marlborough continues to 'live well, get well, and stay well'.

Jenny Black

Chair

Alan Hinton

Deputy Chair

Peter Bramley

Chief Executive

Dawn McConnell

Iwi Health Board Chair

Hon Dr David Clark,

Minister of Health

1.2 Message from our Partners

As members of the Top of the South Health Alliance (ToSHA), our organisations have participated in the production of the Statement of Intent 2019/20. We will continue to work collaboratively with Nelson Marlborough Health to provide the best possible health and care services for the people of Nelson, Tasman and Marlborough.

We are pleased to advise that our respective Boards endorse the Nelson Marlborough Health Statement of Intent 2019/20.

Angela Francis
Chief Executive
Nelson Bays Primary Health

Beth Tester
Chief Executive
Marlborough Primary Health

Anne Hobby
Tumuaki - General Manager
Te Piki Oranga

1.3 Strategic Intentions and Priorities

This Statement of Intent for 2019/20 articulates Nelson Marlborough Health's strategic intentions and priorities for the next three-four years. As per sections 139 and 141 of the *Crown Entities Act 2004*, this Statement of Intent explains:

a) the nature and scope of Nelson Marlborough Health's functions and intended operations *(see section 1.3- Introducing Nelson Marlborough Health)*
b) how the entity intends to manage its functions and operations to meet its strategic intentions *(section 1.3 – Our strategic priorities; Our key areas of focus; Appendix A: Priorities Matrix)*
c) how the entity proposes to manage its organisational health and capability *(section 2 - Managing our Business)*
d) how the entity proposes to assess its performance *(sections 1.4 Making a Difference – A System View and section 3 –Statement of Performance Expectations.)*

Introducing Nelson Marlborough Health

Nelson Marlborough Health (NMH) covers the top of the South Island including Nelson City, the Tasman District and the Marlborough District. In 2018/19 it was projected to serve 150,770 people with the greatest growth occurring in the population aged 75 years and over. Nelson Marlborough have a lower proportion of Māori (10.6 percent) and Pacific (1.7 percent) people and fewer people in the most deprived section of the population, compared with the New Zealand average.

While our population has relatively good health, with good access to both primary and secondary health and disability services, the most vulnerable in our community experience poorer health outcomes – Māori, youth, and people living with mental health conditions or a disability[1]

The local Māori population is young with just over half (52 percent) aged less than 24 years and only 6 percent aged over 65 years. This highlights the need for a different approach to health services which target the younger Māori population, rather than general health services developed for the mostly older, non- Māori population.

[1] Nelson Marlborough Health Needs and Service Profile 2015 http://www.nmdhb.govt.nz/quicklinks/news-and-publications/published-documents/health-needs-assessmentshealth-services-plan/

On average Māori residents of Nelson Marlborough are 16 percent more likely to be earning under $20,000 than Non-Māori. Almost half of the Māori population (46 percent) reside in 40 percent of the most deprived areas of Nelson Marlborough. This trend is consistent across children (0-19 years). Māori residents are therefore more likely to have higher health care needs associated with poorer living conditions.

Māori residents die younger than non-Māori. If Māori living in Nelson Marlborough had a life expectancy similar to that of Māori nationally there would be a 7.4 year shortfall for Māori males, and a 7.2 year shortfall for Māori females. Heart disease is the leading cause of avoidable mortality in Nelson Marlborough for both Māori and non-Māori. Lung cancer is ranked second among Māori residents, while suicide is second for non-Māori (and third for Māori).

These significant equity gaps highlight the need for a population health approach to services which focus on these groups.

Population health approaches and services

The ageing population is driving up service demand across the NMH districts. If current models of care and service configuration are maintained, growth in demand will exceed capacity, significant expansion of physical and associated staffing capacity will be required, and the equity gap identified above will persist. As noted above, the Māori population are generally younger than the non-Māori population so continuing to fund treatment and rehabilitation services at the expense of prevention and early intervention will continue to increase poorer health outcomes for Māori relative to non-Māori, resulting in widening inequity.

To address ongoing demand and address these gaps we will continue to develop new models of care. These will impact the existing ways of working, workforce development, adoption of new systems and technology, and facility development. This approach will also benefit the determinants of health, including the environment and climate, as we maximise the potential of digital technology to deliver health services.

Our strategic priorities

NMH also have a number of strategic priorities. To meet both the current and future needs of the Nelson Marlborough region, NMH needs to consider how health services are provided to ensure transparency and efficiency while providing patient-centred care.

NMH has identified six priorities to guide action across our health system over the next few years:

1. **Achieve health equity** – Improve health status of those currently disadvantaged, particularly Māori
2. **Drive efficient, effective and safe healthcare** – support clinical governance, innovation and invest to improve

3. **One team** – to achieve joined-up care within health and across local authority and social services
4. **Workforce** – develop the right workforce capacity, capability and configuration
5. **Technology** – digital enablement to allow better information sharing, more efficent health care delivery and better personal outcomes
6. **Facilities Development** - planning for a redevelopment of Nelson Hospital

These priorities were selected based on evidence about needs, current performance, and future gains. We referenced local and national health and social sector strategies, reviewed the data and listened to feedback from key internal and external stakeholders.

The six priorities are supported by targeted actions in key focus areas, many of which emphasise building capacity and capability in primary and community settings and concentrate on integrating service models (see Appendix A: Priorities Matrix). Every year we will see an improvement in the priority areas, but the priorities will not be 'fixed' quickly.

Our key areas of focus

Our key areas of focus for 2019-20 are those which we believe will impact the determinants of health, health equity and ultimately wellbeing. They include:

- recognising the importance of cultural connectedness for health and how integrating the principles of the Treaty of Waitangi can lead to increased equity and improved health outcomes
- focussing on improving the health of Māori through Maori-specific and mainstream services (including embedding Hauora Direct, establishing Hapū Wānanga, and strengthening Whare Ora)
- investing in child wellbeing and supporting parents, with a cross sector approach to the first 1000 days at local and regional levels (via Hauora Alliance).
- ensuring young people feel safe and supported by health services through strengthening school-based health services, using the Youth Advisory panel to support future service improvements and development, and promoting *The Plan* to encourage sensible attitudes towards alcohol
- reviewing and improving access to mental health and addiction services, including responding to findings from the Mental Health & Addictions Inquiry and reducing harm caused by methamphetamine
- increasing access to primary healthcare through advancing Health Care Home, improving access to professional advice, strengthening care coordination, and maximising the role of community pharmacy
- a joined up and coordinated cross-sector programme approach to key issues in the region, particularly on housing, youth, refugees and migrants
- service improvements that target acute demand, patient flow, perioperative efficiency and the deteriorating patient. Improving cooperation to benefit people whose health

and/or disability needs fall between current services, maximising support for those living with dementia, and implementing a Nelson-Wairau service delivery model are further areas for improvement.

In addition to these priorities and key focus areas, NMH has a number of key strategies and action plans which support the SOI, including:

- Annual Plan 2019/20
- Public Health Annual Plan for 2019/20
- System Level Outcome Measures Improvement Plan 2019/20
- Primary and Community Health Strategy (short term local health direction)
- Health for Tomorrow (long term local health system strategy).

This SOI also reflects our commitment to

- Treaty of Waitangi
- New Zealand Health Strategy
- He Korowai Oranga (Māori Health Strategy)
- The Healthy Ageing Strategy
- The United Nations convention on the Rights of People with Disabilities.
- 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing)

1.4 Making a Difference – A System View

To achieve equity by meeting the health needs of everyone in our community, and do so in a way that is clinically and financially sustainable, requires collaboration across our local health system and joint working with other sectors such as welfare, justice and local government.

Working with our Alliance partners, we have jointly developed a plan to improve our performance (System Level Measures Improvement Plan 2019/20) and understand where we are making a difference as measured by the following System Level Outcome Measures.

Keeping children out of hospital

WHY IS THIS A PRIORITY?

Ambulatory Sensitive Hospitalisations (ASH) refer to mostly acute admissions regarded as avoidable if treated earlier in a primary care setting. Prevention of avoidable admissions can be extended to include housing, health literacy, urban design, welfare and education – the social determinants of health.

The ASH rate for children aged 0-4 years in Nelson Marlborough is lower than the national average, which is positive. However, analysis of the overall rate has revealed that the ASH rate for Māori children is significantly higher than for other children in our region.

The top conditions that contribute to the higher ASH rate for Māori children are dental conditions, asthma, respiratory infections and gastroenteritis. Consumption of sugary drinks, poor access to oral health care and primary care, exposure to second-hand smoke, and poor housing are known drivers associated with these conditions. Activities which address these drivers will be important for reducing inequity within our ASH rates.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

National Measure	**Ambulatory Sensitive Hospitalisations (ASH) rate per 100,000 population, for 0-4 year olds.**			
Local Milestone	ASH rates for Māori children aged 0-4 years reduce to less than 4,000 by30 June 2020			
Base	Target			
2017/18	2018/19	2019/20	2020/21	2021/22
3,288	<4,000	<4,000	<4,000	<4,000

Using Health Resources Effectively

WHY IS THIS A PRIORITY?

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

Nelson Marlborough Health has the best rate of acute hospital bed days for all DHBs. However, rates remain higher for Māori and Pacific peoples than for non-Māori and non-Pacific, and for those aged over 75 years. The main drivers of overall acute hospital bed days in Nelson Marlborough are events associated with stroke and other cerebrovascular conditions and respiratory infections/inflammations. For Māori, the conditions driving the acute hospital bed days rate also include heart failure and shock, and cellulitis (bacterial skin infections). Nelson Marlborough Health's Models of Care Programme, and in particular the development of shared care planning and Health Care Homes in primary care are some of the activities planned to address these rates in 2019/20.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

National Measure	**Acute hospital bed days rate per 1,000 population domiciled within a DHB**			
Local Milestone	Reduce the age standardised acute hospital bed days rate for Māori from 275 per 1,000 population to 232 per 1,000 population by 30 June 2020			
Base	Target			
2017/18	2018/19	2019/20	2020/21	2021/22
275	232	<232	<232	<232

Person-centered care

WHY IS THIS A PRIORITY?

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

This measure provides information about how people experience health care and may highlight areas that Nelson Marlborough Health needs to have a greater focus on, such as health literacy and communication.

Primary care
Response rates for the primary care survey among Māori people in Nelson Marlborough Health remain low - ~ 15% for Marlborough practices and ~17% in Nelson practices. Nelson Marlborough Health aim to improve these response rates so we have a better understanding of how to improve person-centred care for this population groups.

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

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

The response rate for the inpatient hospital survey in Q4 2018 was around 23%. The results from this survey showed that 61% of patients reported receiving enough information on medication side-effects to watch for when they went home from hospital. For the same quarter, 66% of patients responded receiving enough information from the hospital on how to manage their condition after discharge. These results are comparable with the New Zealand average but Nelson Marlborough Health have a number of activities planned to improve them.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

National Measure	**Primary care survey scores for four domains: Communication, Partnership, Coordination, Physical and Emotional needs.**			
Local Milestone	Increase response rates of Māori to the primary care survey to greater than or equal to 20% by 30 June 2020			
Base	Target			
2017/18	2018/19	2019/20	2020/21	2021/22
<17%	20%	20%	20%	20%

National Measure	**Hospital inpatient survey scores for four domains: Communication, Partnership, Coordination, Physical and Emotional needs.**			
Local Milestone	70% of respondents report receiving enough information on medication side effects and condition management upon discharge from hospital by 30 June 2020			
Base	Target			
2017/18	2018/19	2019/20	2020/21	2021/22
61%	70%	70%	70%	70%

Prevention and early detection

WHY IS THIS A PRIORITY?

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

Nationally, amenable mortality rates for Māori and Pacific peoples tend to be higher than for other population groups. We can assume this is the case for Nelson Marlborough also, even though we are unable to confirm this due to small numbers. In Nelson Marlborough Health the overall amenable mortality rate in 2015 was 67.7 per 100,000, with the main contributing conditions being coronary artery disease (43 deaths), COPD (21 deaths) and suicide (19 deaths).

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

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

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

The rate for Māori is not available because rates are suppressed where there are less than 30 deaths. However, in 2015 ten Māori people died from a potentially preventable condition. These numbers are disproportionately high for the size of the population. Therefore the focus is on reducing inequity within our amenable mortality rate by targeting actions towards Māori premature deaths.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

National Measure	**Deaths under age 75 from causes classified as amenable to health care**			
Local Milestone	Reduce amenable mortality rates for Māori to zero by 30 June 2023			
Base	Target			
2015	2018/19	2019/20	2020/21	2021/22
10	0	0	0	0

Healthy start

WHY IS THIS A PRIORITY?

Good child health is important not only for children and families now, but also for good health later in adulthood. It is important that child health is a priority because children do not make their own lifestyle decisions and are vulnerable to the situation into which they are born.

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

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

This measure was revised by the Ministry of Health on 31 October 2018 (numerator and denominator definitions changed). The result is that all registered births are recorded in the denominator, not just those enrolled with/contacted by the Well Child Tamariki Ora Provider. This means that the proportion of babies living in "smoking" houses according to the new measure could be due to EITHER:

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

Therefore, to increase the proportion of babies recorded as living in smokefree homes, we also need to increase the proportion of registered births enrolled with WCTO providers (and ensure this data is being captured/reported to the Ministry of Health). In Nelson Marlborough for the year to December 2017, only 74% of registered births were enrolled with a WCTO provider and only 54% of newborns in Nelson Marlborough could be confirmed as living in smokefree households at six weeks postnatal.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

National Measure	Babies living in a smokefree households at six weeks post-natal (up to 56 days of age).			
Local Milestone	66% of households are smokefree at six weeks postnatal by 30 June 2020			
Base	Target			
2018	2018/19	2019/20	2020/21	2021/22
66%	66%	>66%	>66%	>66%

Youth are healthy, safe and supported

WHY IS THIS A PRIORITY?

Youth have their own specific health needs as they transition from childhood to adulthood. Evidence shows that youth are not in the habit of seeking the services or advice of a registered health practitioners when unwell. Generally they cope with illness with advice from friends and whanau as they see fit. Attending a health clinic is often viewed as a last resort instead of a reasonable first choice.

Research shows that youth whose healthcare needs are unmet can lead to increased risk for poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours in terms of drug and alcohol abuse and criminal activities. It is therefore a priority of Nelson Marlborough Health to increase youth access to primary and preventive health care services. To do this we will work further with local youth to understand what health services they need and the barriers to accessing services.

For 2019/20 Nelson Marlborough Health have chosen to specifically focus on supporting young people to manage their sexual and reproductive health safely and receive youth friendly care.

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

In 2016, a substantially higher proportion females aged 20-24 years in Nelson Marlborough were likely to have been tested (35.7%) than males (9.1%). Coverage rates for Māori youth of all ages are comparable, or greater than Pacific peoples and youth identifying as European or other. Meanwhile, Asian youth experience the lowest coverage rates (only 3.4% of males and 14.3% of females aged 20-24 years had been tested).

HOW WILL WE DEMONSTRATE OUR SUCCESS?

National Measure	Young people manage their sexual and reproductive health safely and receive youth-friendly care - Chlamydia testing coverage for 15-24 year olds			
Local Milestone	Increase the percentage of males aged 20-24 years being tested for Chlamydia from 9.1% in 2016 to at least 35.7% (ie, bring male rates in line with female rates) by 30 June 2020			
Base	Target			
2016	2018/19	2019/20	2020/21	2021/22
9.1%	N/A	35.7%	35.7%	35.7%

Section 2: Managing our Business (SOI)

2.1 Managing our Business

Partnership with Public Health Unit

As part of their stewardship role DHBs have statutory responsibilities to improve, promote and protect the health of people and communities. Nelson Marlborough Health are committed to working in partnership with our public health unit and will continue supporting their work in health promotion/improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system, and in their undertaking of regulatory functions.

Organisational performance management

Nelson Marlborough Health's performance is assessed on both financial and non-financial measures, which are measured and reported at Board and Executive levels of the organisation. These are reported daily, weekly, fortnightly or monthly as appropriate.

Funding and financial management

Nelson Marlborough Health's key financial indicator is operating expenditure. This is assessed against and reported through Nelson Marlborough Health's performance management process to the Board and Executive Leadership Team every month. Further information about Nelson Marlborough Health's planned financial position for 2019/20 and out years is contained in the section 4 Financial Performance Summary.

Investment and asset management

Nelson Marlborough Health is committed to advancing and maturing its asset management planning with a view to a more strategic approach to asset maintenance, replacement and investment. A revised Asset Management Plan (AMP) is under development and will be informed by the National Asset Management Plan currently being developed by the Ministry of Health. The AMP reflects the joint approach taken by all DHBs and current best practice.

Shared service arrangements and ownership interests

Nelson Marlborough Health does not hold any controlling interests in a subsidiary company. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

Nelson Marlborough Health has a formal risk management and reporting system which utilises the Quantate risk management system and monthly reporting to the Executive Leadership Team and quarterly reporting to the Audit and Risk Committee. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement

Nelson Marlborough Health's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

2.2 Building Capability

This section outlines the capabilities that Nelson Marlborough Health will need over the next three to five years, and plans to support improvements in capability.

Capital and infrastructure development
The most significant capital and infrastructure investment for Nelson Marlborough Health will be the rebuild of Nelson Hospital. The current unsuitable design of buildings and infrastructure is impacting on the quality of care, hindering new ways of working and constraining capacity. Some buildings at Nelson Hospital are in poor condition, putting health, safety and ongoing service delivery at risk. The way the healthcare system works at present is restricting the sector's ability to meet current and emerging health care needs and increasing demand. The four-stage Better Business Case planning process was estimated to take two-three years. The draft Indicative Business Case was approved in May 2019, and was been submitted to the regional investment committee, Ministry of Health and Treasury. An updated IBC is expected to be submitted to the MOH in April 2020. The further business cases will be developed over the next two to three years before construction begins on the multi-million dollar improvements.

Information technology and communications systems
The list of new key projects for the coming year are outlined in the DHB Activity table in section 2. Nelson Marlborough Health IT projects are aimed at supporting regional and national health objectives of closer to home integrated care, equity, and early intervention. A focus is also applied to reducing technical debt, improving the robustness of our infrastructure, and maximising current investments.

As part of our regional application portfolio, projects continuing into the year ahead and described in the 2018-2021 South Island Health Service Plan as regional enablers, are:

- With CDHB, prioritise and implement further SI PICS foundation functionality.
- Develop mental health care plans in Health Connect South, and mental health specific data collection forms in SI PICS.
- Complete the eTriage implementation, which adds online triage functionality onto eReferrals received in Health Connect South (HCS).
- Replace the local install of WinDOSE with the regional instance of ePharmacy, as part of the eMedicines roadmap.
- Complete the radiology eOrdering roll-out, which enables ordering and signing off radiology tests and results online.

- Roll-out eObservations (Patientrack) hospital wide. This application supports zero paper EWS, observations, progress notes, nursing, allied health and medical assessments, checklists, handover documents and summaries.

In addition, Nelson Marlborough Health continues to expand the scope of eRecords (scanned documents) as an enabler for a complete electronic health record in conjunction with HCS and HealthOne.

Application portfolio management for existing information assets is managed through an annual rolling programme of CAPEX requests, for example replacing older PCs, adding new licences due to growth, and an ongoing programme to upgrade software that is reaching end-of-life.

Nelson Marlborough Health is committed to constructively engaging with the Ministry and other health sector members in the establishment of a programme of IT security maturity activities. This includes reporting on activities in the ICT operational assurance plan and the Health Information Security Framework (HISF) to the audit & risk committee. An independent audit of HISF compliance was completed in 2018.

Workforce

During the 2019/20 year NMH will be focusing on understanding the culture and leadership profile needed to have a workforce equipped to deliver to future models of care. This will involve developing an understanding of the way in which jobs of the future will be designed, how interdisciplinary teams will work, and the type of leadership that will be needed.

An organisational development strategy will be created to support these objectives and resourcing within the organisational development function will be organised to deliver accordingly.

To continue our kaupapa of increasing the development of our Māori workforce, NMH will continue developing and implementing strategies to attract, retain and support Māori employees. Alongside this, a focus on growing cultural competence in the general workforce will continue through the orientation and professional development of employees.

NMH has a number of initiatives in place to engage with union stakeholders. The bipartite meetings, joint consultative committee and staff engagement working together forums will continue enabling workforce challenges to be considered collectively.

Co-operative developments

Nelson Marlborough Health works and collaborates with a number of external organisations and entities, including:

- Nelson Marlborough Health is a member of the South Island Alliance which enables the region's five DHBs to work collaboratively to develop more innovative and efficient health services than could be achieved independently

- The Top of the South Health Alliance (ToSHA) is comprised of Nelson Marlborough Health, Nelson Bays PHO, Kimi Hauora Marlborough PHO, and Te Piki Oranga, and is our key vehicle for effecting transformational health system change
- Our relationship with the tangata whenua of our district is expressed through the partnership with the Iwi Health Board and joint agreement titled 'He Kawenata'
- The Top of the South Impact Forum (ToSIF) is a cross-sector alliance of senior leaders from sectors such as health, police, education, welfare, housing, and local government
- NZ Health Partnerships Limited has the broad aim to enable DHBs to collectively maximise shared services opportunities for the benefit of the sector, and Nelson Marlborough Health is committed to supporting NZHP's work and the local implementation of business cases
- The Nelson Marlborough Hospitals' Charitable Trust (trading as The Care Foundation) holds trust funds for the benefit of public hospitals
- The Marlborough Hospital Equipment Trust provides equipment and other items from public donations raised by Trust
- Churchill Private Hospital Trust provides private medical and surgical services in Marlborough
- Nelson Marlborough Health has an agreement with Pacific Radiology to provide a joint MRI service from the Nelson and Wairau hospital sites
- Nelson Marlborough Health has an agreement with Christchurch Radiology Group to provide a visiting radiology service at Wairau Hospital site
- Top of the South Cardiology Limited has an agreement with Nelson Marlborough Health to provide private cardiology services from Nelson Hospital
- Nelson Marlborough Health is a partner in the Golden Bay Health Alliance for an Integrated Family Health Centre with Nelson Bays Primary Health Trust and Golden Bay Community Health Trust – Te Hauora O Mohua Trust.

Section 3: Statement of Performance Expectations (SPE)

3.1 Statement of Performance Expectations

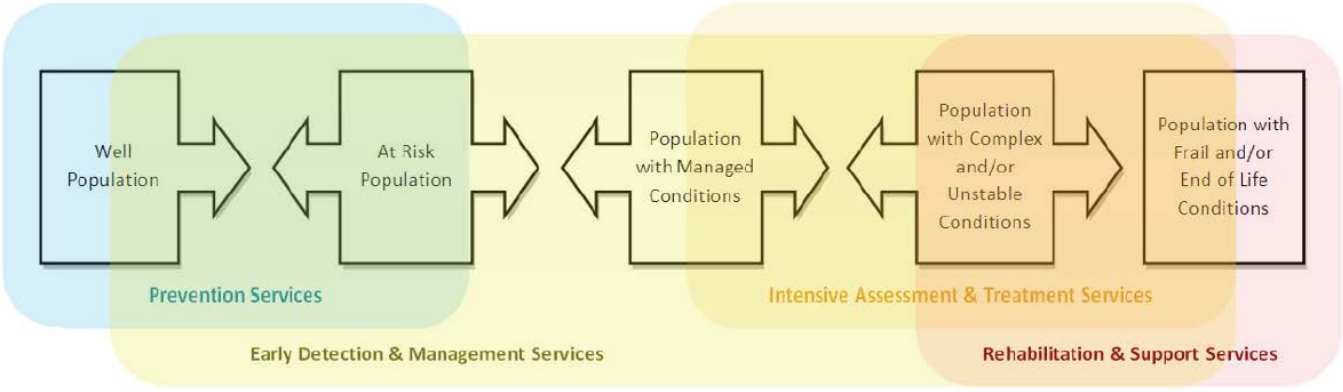
We aim to provide the best healthcare and achieve the best health outcomes for our community, and we need to monitor our performance to evaluate the effectiveness of the decisions we make on behalf of our population, and ensure we are achieving the outcomes required for our community.

To be able to provide a representative picture of performance, our services ('outputs') have been grouped into four 'output classes' that are a logical fit with the stages of the continuum of care and are applicable to all DHBs:

- Prevention Services;
- Early Detection and Management Services;
- Intensive Assessment and Treatment Services; and
- Rehabilitation and Support Services.

Figure 1. Scope of DHB Operations – Output Classes against the Continuum of Care.

Our outputs cover the full continuum of care for our population.



There is no single over-arching measure for each output class because we use performance measures and targets that reflect volume (V), quality (Q), timeliness (T), and service coverage (C). The output measures chosen cover the activities with the potential to make the greatest contribution to the health of our community in the short term, and support the longer-term outcome measures.

Baseline data from the previous year has been provided to show we have set targets that challenge us to provide the best possible service to our community, and build on our previous successes (or areas where we know we need to do better).

Achieving Health Equity

All of the measures will be reported by ethnicity to ensure we maintain our focus and are on track to achieve equitable health outcomes for the people of Nelson Marlborough and ensure all people live well, get well and stay well.

3.2 Output classes

Prevention Services

Output Class Description

- Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising of services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.
- Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.
- Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.
- On a continuum of care these services are public wide preventative services.

Significance for the DHB

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase.

By improving environments and raising awareness, these prevention services support people to make healthier choices, reducing major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. Tobacco smoking, drug and alcohol misuse, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These risk factors are preventable through a supportive environment, improved awareness and greater personal responsibility for health and wellbeing. Prevention services support people to address any risk factors that contribute to both acute events (e.g. alcohol-related injury), as well as long-term conditions development (e.g. obesity, diabetes).

High health need and at-risk population groups (Māori, low socio-economic, disabled people and those with mental health issues) who are more likely to be exposed to environments less conducive to making healthier choices are a focus. Preventative services are our best opportunity to target improvements in the health of these high need populations, to reduce inequalities in health status and improve population health outcomes.

Outputs: Short Term Performance Measures 2019-20

Measures **Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)**	**Notes**	**Actual 2017/18**	**Target 2018/19**	**Target 2019/20**	**Target 2020/21**	**Target 2021/22**
Percentage of enrolled women (20-69) who had a cervical smear in the last 3 years [SS08]	V	81%	>85%	>80%	>80%	>80%
Percentage of enrolled high-needs women (20-69) who had a cervical smear in the last 3 years [SS08]	V	71%	>85%	>80%	>80%	>80%
Percentage of women (45-65) having mammography within 2 years [SS07]	V	80%	>80%	>70%	>70%	>70%
Percentage of newborn hearing screening completed within 1/12 birth	V	99%	>95%	>99%	>99%	>99%
Percentage of two year old children fully vaccinated (PP21)	C	89%	>95%	>95%	>95%	>95%
Percentage of over 65 year olds vaccinated for seasonal influenza (PP21)	V	61%	>75%	>75%	>75%	>75%
Percentage of eligible children receiving Before (B4) School Checks	V	103%	100%	100%	100%	100%
Number of clients seen by the primary mental health service - youth	Q	579	NEW	>580	>580	>580
Number of clients seen by the primary mental health service - adults	Q	3231	NEW	>3300	>3300	>3300
Shorter waits for non-urgent mental health services for 0-19 year olds: 80% of people seen within 3 weeks [MH03]	T	New	>80%	>80%	>80%	>80%

Early Detection and Management Services

Output Class Description

- Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.
- These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.
- On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Significance for the DHB

New Zealand is experiencing an increasing rate of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Examples include diabetes and cardiovascular disease, and some population groups suffer from these conditions more than others.

By promoting regular engagement with health services we support people to maintain good health through earlier detection and management services based in the community. These services provide an opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self-management (avoidance of complications, acute illness and crises). These services deliver coordination of care, ultimately supporting people to maintain good health.

Outputs: Short Term Performance Measures 2019-20

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2017/18	Target 2018/19	Target 2019/20	Target 2020/21	Target 2021/22
Percentage of people in the district enrolled with PHO – Nelson	C	99%	>99%	100%	100%	100%
Percentage of people in the district enrolled with PHO – Marlborough	C	97%	>99%	>99%	>99%	>99%
Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years) [CW05]	C, V	New	>85%	>85%	>85%	>85%
Percentage of children <5 years enrolled in DHB funded dental services [CW03]	C	86%	85%	>=95%	>=95%	>=95%

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2017/18	Target 2018/19	Target 2019/20	Target 2020/21	Target 2021/22
Percentage of secondary care patients whose medicines are reconciled on admission	C,Q	48%	>25%	>50%	>50%	>50%
Percentage of people provided with a CT scan within 42 days of referral	T	81%	100%	95%	95%	95%
Percentage of people provided with an MRI scan within 42 days of referral	T	48%	100%	95%	95%	95%
Supporting Parents; Healthy Children: Information about parenting and children's needs is included in the initial assessment and wellbeing plan for adults with a mental health and / or addiction issue as applicable	C	New	100%	100%	100%	100%
Post-discharge community care for mental health inpatients: Follow-up within 7 days	Q T	New	100%	100%	100%	100%

Intensive Assessment & Treatment Services

Output Class Description

- Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital'. These services are generally complex and provided by healthcare professionals that work closely together.
- They include:
  - Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
  - Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
  - Emergency Department services including triage, diagnostic, therapeutic and disposition services
- On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Significance for the DHB

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention (e.g. removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain) or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Responsive services and timely treatment services also support improvements across the whole system and give people confidence that complex intervention will be available when needed. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm, and provide improved outcomes for people in our services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Quality improvement in service delivery, systems and processes will improve patient safety, reduce readmission rates, and better support people to recover from complex illness and / or maximise their quality of life.

Government has set clear expectations for the delivery of elective service volumes, a reduction in waiting times for treatments, and increased clinical leadership to improve the quality of care. To meet these expectations we are introducing innovative clinically led service delivery models and reducing waiting time within our hospital services.

Outputs: Short Term Performance Measures 2019-20

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2017/18	Target 2018/19	Target 2019/20	Target 2020/21	Target 2021/22
Acute inpatient average length of stay (days)	Q	2.30	<2.30	2.30	2.30	2.30
Percentage of elective and arranged surgery undertaken on a day case basis	Q	66%	>68%	>68%	>68%	>68%
Percentage of people receiving their elective & arranged surgery on day of admission	Q	99%	>98%	>99%	>99%	>99%
Percentage of total deliveries in primary birthing units	Q V	5%	>7%	>7%	>7%	>7%
Women registering with an LMC by week 12 of their pregnancy	T	80%	>80%	>80%	>80%	>80%

Standardised Intervention Rate for major joint replacement	V	26 per 10,000	>21 per 10,000	>21 per 10,000	>21 per 10,000	>21 per 10,000
Standardised Intervention Rate for cataract procedures	V	29 per 10,000	>27 per 10,000	>27 per 10,000	>27 per 10,000	>27 per 10,000
Reduce seclusion events per month	Q, V	New	<4	<4	<4	<4

Rehabilitation and Support Services

Output Class Description

- Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by NASC Services for a range of services including palliative care, home-based support and residential care services.
- On a continuum of care these services will provide support for individuals.

Significance for the DHB

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life. As a result, people stay active and positively connected to their communities. People whose needs are adequately met will also be less dependent on hospital and residential services and less likely to experience acute illness, crisis or deterioration of their conditions. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and independence.

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general by reducing acute demand, unnecessary ED presentation, and the need for more complex intervention. These services also support the flow of patients and improved recovery after an acute illness or hospital admission – helping to reduce readmission rates and supporting people to recover from complex illness and/or maximise their quality of life.

Living in aged residential care has been associated with more rapid functional decline than 'ageing in place' and is a more expensive option. Resources can be better utilised providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital services.

Nelson Marlborough Health has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area and we use the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

Outputs: Short Term Performance Measures 2019-20

Measures **Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)**	**Notes**	**Actual 2017/18**	**Target 2018/19**	**Target 2019/20**	**Target 2020/21**	**Target 2021/22**
The percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment	Q	86%	>80%	>86%	>86%	>86%
Percentage of older people living in ARC	C	4%	<4%	<4%	<4%	<4%
Improving Mental Health services using transition (discharge) planning and employment: Child and Youth with a transition (discharge) plan. [MH02]	Q	90%	>95%	>95%	>95%	>95%

Section 4: Financial Performance (SOI and SPE)

Introduction

Nelson Marlborough Health (NMH) has displayed a strong commitment in the last few years to operating within its means whilst delivering its operational commitments, the Government's expectations and the Board's priorities.

The past few years have seen NMH absorb a number of significant cost increases that were well in excess of increases in revenue. In this context, delivery of a surplus position has been a significant achievement that NMH is committed to continuing. This is a key commitment for NMH and we have a strong record of financial delivery whilst remaining focussed on good patient outcomes. Whilst we expect that new challenges will emerge in 2019/20 and the following years, we remain in good shape to face these challenges.

Although we are reporting a deficit operating result for the first two years covered by this Plan the intention for NMH is to continue to target a better than breakeven operating result as we move toward the redevelopment of the Nelson Hospital.

The risks to achieving this position, changes that must be made and challenges to overcome are outlined through this section of the Plan.

At the time of writing fiscal budgets have not been agreed with the Ministry of Health and Minister of Health and are subject to change.

Financial Performance Summary

The NMH is committed to living within its means by delivering a breakeven operating financial result whilst maintaining a tight level of fiscal control over cost pressures. However the cost pressures within the health sector over the last and the next two financial years mean that we are reporting a deficit position. The prospective financial statements presented later in this Plan show that NMH has a strong pathway back to a small surplus position within our operating surplus – effectively this is our 'business as usual' fiscal result. We have shown separately, the costs and associated savings arising from the investments within the Models of Care transformation programme – this shows that an additional year is required to deliver an organisational net surplus across the organisation

Critically, to ensure the health system is financially sustainable, we are focussed on making the whole of system work properly and achieving the best possible outcomes for our investment. This is work that NMH has been focussing on, and investing in, over recent years to meet the challenges faced across the health system.

Constraining Our Cost Growth

Constraining cost growth has been critical to our success in delivering surpluses in recent years and remains a key focus for the financial management disciplines into the future. If the pressure that an increasing share of our funding continues to be directed into meeting the growing cost of

providing services, our ability to maintain current levels of service delivery will be at risk whilst placing restrictions in our ability to invest in new equipment, technology and new initiatives that allow us to meet future demand levels.

It is also critical that we continue to reorient and rebalance our health system. By being more effective and improving the quality of the care we provide, we reduce rework and duplication, avoid unnecessary costs and expenditure and do more with our current resources. We are also able to improve the management of the pressure of acute demand growth, maintain the resilience and viability of services and build on productivity gains already achieved through increasing the integration of services across the system.

NMH has already committed to a number of mechanisms and strategies to constrain cost growth and rebalance our health system. We will continue to focus on these initiatives, which have contributed to our considerable past success and given us a level of resilience that will be vital in the coming year:

a) Reducing unwarranted variation, duplication and waste from the system;
b) Doing the basics well and understanding our core business;
c) Investing in clinical leadership and clinical input into operational processes and decision-making;
d) Developing workforce capacity and supporting less traditional and integrated workforce models;
e) Realigning service expenditure to better manage the pressure of demand growth; and
f) Supporting unified systems to shared resources and systems.

An important expectation of DHBs is for them to work together and collaborate nationally and with our regional neighbours.

Regionally we continue with the implementation of the regional services planning. Its outcomes are reflected in this plan. Many information systems and technology projects are being delivered as regional projects and we are progressing with a greater focus on regional procurement initiatives.

NMH is committed to supporting NZHP's work and the local implementation of the initiatives agreed by the collective DHBs. Estimates have been included in the finances in respect of these initiatives.

Assumptions

In preparing our forecasts the following key assumptions have been made:

a) NMH's funding allocations will increase at no less than the indicative funding advice from the Ministry of Health. Core funding received for the out year revenue will increase by the same nominal dollar value as received for 2019/20 in line with MOH requirements.

b) Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives.

c) MECA settlements have been budgeted at levels equivalent to or not less than the NZNO MECA that occurred in the 2018/19 financial year. Settlements in excess of the amount budgeted are assumed to be cost neutral with the additional costs covered by additional Government funding.

d) Expenditure in relation to the Supporting Equitable Pay for Care and Support Workers settlement, including the costs associated with the revaluation of employee entitlements for the DHB staff covered by the settlement will be fully funded.

e) No additional compliance costs have been budgeted, as it is assumed these will be cost neutral or fully funded. It is also assumed that the impact of any legislative changes, sector reorganisation or service devolvement (during the term of this Plan) will be cost neutral or fully funded.

f) Any revaluation of land and buildings will not materially impact the carrying value or the associated depreciation costs.

g) IDF volumes and prices are at the levels identified by the Ministry of Health and advised within the Funding Envelope adjusted for expected reductions in volumes.

h) Staff vacancies (existing and as they occur in future) will be reassessed to ensure the positions are still required, affordable and alternatives explored before vacancies are filled. Improved employee management can be achieved with emphasis in areas such as sick leave, discretionary leave, staff training and staff recruitment/turnover.

i) External provider increases will be made within available funding levels, after allowance for committed and demand-driven funding.

j) Price increases agreed collaboratively by DHBs for national contracts and any regional collaborative initiatives will be within available funding levels and will be sustainable.

k) Any increase in treatment related expenditure and supplies is maintained at affordable and sustainable levels and the introduction of new drugs or technology will be funded by efficiencies within the service.

l) All other expense increases including volume growth will be managed within uncommitted funds available or deferred.

m) The DHB will meet the mental health ring fence expectations.

At the time of writing this Plan we are waiting on a number of final funding levels for a range of MOH contracts. Therefore there may be material implications to the fiscal projections included within this Plan that cannot be determined until all the funding advice is available.

Asset Planning and Sustainable Investment

Asset management planning

NMH is committed to advancing and maturing its asset management planning with a view to a more strategic approach to asset maintenance, replacement and investment. A revised Asset Management Plan (AMP) is under development and will be informed by the National Asset Management Plan currently being developed by the MOH. The AMP reflects the joint approach taken by all DHBs and current best practice.

Capital Expenditure

NMH has significant capital expenditure committed over the coming years. Based on NMH's fiscal position, we estimate that we will fund an annual total of $8.7M of general capital expenditure across the three years within this Plan. In addition, investment is allowed for major or strategic projects including the commencement of the Nelson hospital development. With this level of capital investment, the remaining capital expenditure funding available will be very tight. To manage this level of capital expenditure will require discipline and focus on the DHB's key priorities.

Business Cases

The NMH understands that approval of this Plan is not approval of any specific capital business case. Some business cases will still be subject to a separate approval process that includes the Ministry of Health and Treasury officials prior to a recommendation being made to the Minister of Health.

The Board also requires management to obtain final approval in accordance with delegations prior to purchase or development commencing.

NMH is aware of several business case initiatives in varying stages of development at the time of writing. The draft Indicative Business Case (IBC) for the Nelson Hospital Development was submitted to the MOH in June 2019 and a further iteration of the IBC is expected to be submitted in April. NMH expects to commence work on the Detailed Business Case in the 2020/21 financial year.

Asset Valuation

NMH completed a full revaluation of its property and building assets at 30 June 2018 in line with generally accepted accounting practice requirements with the next revaluation due in June 2023.

Debt and Equity

Over the last two years the MOH and Treasury, along with all DHBs undertook a review of the core debt facilities within DHBs. This resulted in the core debt portfolio of DHBs being converted to Equity in February 2017 leaving the DHB with no core debt. For NMH this lead to the conversion of $55.5M of debt being converted to Equity.

In addition to the core debt facilities NMH has a number of finance lease facilities covering a range of clinical equipment and information technology assets. We do not have the option to purchase the asset at the end of the leased term and no restrictions are placed on us by any of the financing lease arrangements.

NMH has a finance lease arrangement relating to the Golden Bay Community Health Centre ("GBCHC"). This relates to the 35-year lease arrangement entered into by NMH to lease the GBCHC from the Golden Bay Community Health Trust. We have in turn sub-leased the GBCHC to the Nelson Bays Primary Health Trust. Further disclosures on this arrangement were made in our 2014/15 Annual Report.

Additional Information and Explanations

Disposal of Land and Other Assets

NMH actively reviews assets to ensure that it has no surplus assets. No significant assets are scheduled for disposal during the period covered by this Plan as a result of being declared surplus except land declared surplus adjacent to the Wairau hospital site. At the time of writing we are progressing with the requirements to complete the disposal in line with the requirements for the disposal of surplus Crown land. The approval of the Minister of Health is required prior to the DHB disposing of land. The disposal process is a protective mechanism governed by various legislative and policy requirements.

Activities for Which Compensation is Sought

No compensation is sought for activities sought by the Crown in accordance with Section 41(D) of the Public Finance Act.

Acquisition of Shares

Before NMH or any associate or subsidiary subscribes for, purchases, or otherwise acquires shares in any company or other organisation, the Board will consult the responsible Minister/s and obtain their approval.

Accounting Policies

The accounting policies adopted are consistent with those disclosed in the 2017/18 Annual Report which can be found on the NMH website.

Prospective Financial Statements

The projected financial statements for NMH are shown on the following pages. The actual results achieved for the period covered by the financial projections are likely to vary from the information presented, and the variations may be material. The financial projections comply with section 142(1) of the Crown Entities Act 2004 and are compliant with Generally Accepted Accounting Principles (GAAP). The information may not be appropriate for any other purpose.

The statement of prospective financial performance, as shown below, shows the 2019/20 financial year plus the following three financial years to reflect the current pathway determined for the MOC programme. The remaining financial statements, however, are show the prospective financial results for the 2019/20 and the following two financial years in line with statutory requirements.

STATEMENT OF PROSPECTIVE FINANCIAL PERFORMANCE

	2017/18 Actual $000	2018/19 Forecast $000	2019/20 Projection $000	2020/21 Projection $000	2021/22 Projection $000	2022/23 Projection $000
Revenue	**498,254**	**525,939**	**551,156**	**564,481**	**577,887**	**591,651**
Operating Expenditure						
Workforce costs	188,697	206,782	222,820	230,057	237,530	245,247
Outsourced services	16,352	18,047	18,642	18,828	19,016	19,207
Clinical Supplies	38,606	41,146	38,812	39,242	39,677	40,116
Infrastructure and Non-clinical supplies	27,199	37,807	28,894	26,144	23,538	24,510
External providers	160,237	171,003	173,772	177,595	181,502	185,494
Inter-district flows	45,330	46,977	46,890	47,922	48,976	50,054
Interest	346	332	352	356	359	363
Depreciation & amortisation	11,888	13,036	15,056	15,056	15,056	15,056
Capital charge	9,376	11,072	10,460	10,564	10,670	10,777
Total expenditure	**498,031**	**546,202**	**555,698**	565,764	576,324	590,824
Operating surplus/(deficit)	**223**	**(20,263)**	**(4,542)**	(1,283)	1,563	827
Impairment of intangible assets	(2,255)	(302)				
Operating surplus/(deficit) after impairments	**(2,032)**	**(20,565)**	**(4,542)**	**(1,283)**	**1,563**	**827**
MOC initiatives operating expenditure			(1,500)	(4,271)	(5,372)	(4,856)
MOC initiatives operating savings				1,125	3,203	4,029
Net surplus/(deficit)	**(2,032)**	**(20,565)**	**(6,042)**	**(4,429)**	**(606)**	**0**
Other comprehensive revenue or expenses						
Item that will be reclassified to surplus/(deficit):						
Financial assets at fair value through other comprehensive revenue and expense						
Items that will not be reclassified to surplus/(deficit):						
Gain/(Loss) on property revaluation	33,262					
(Impairment)/revaluation of property, plant & equipment						
Total other comprehensive revenue or expenses	33,262	0	0	0	0	0
Total comprehensive income	**31,230**	**(20,565)**	**(6,042)**	**(4,429)**	**(606)**	**0**

STATEMENT OF PROSPECTIVE MOVEMENTS IN EQUITY

	2017/18 Actual $000	2018/19 Forecast $000	2019/20 Projection $000	2020/21 Projection $000	2021/22 Projection $000
Equity at beginning of the year	**156,838**	**187,521**	**166,409**	**159,820**	**154,844**
Comprehensive income					
Net surplus/(deficit)	(2,032)	(20,565)	(6,042)	(4,429)	(606)
Other comprehensive income	33,262	0	0	0	0
Total comprehensive income	**31,230**	**(20,565)**	**(6,042)**	**(4,429)**	**(606)**
Owner transactions					
Equity injections					
Equity repayments	(547)	(547)	(547)	(547)	(547)
Total owner transactions	**(547)**	**(547)**	**(547)**	**(547)**	**(547)**
Equity at end of the year	**187,521**	**166,409**	**159,820**	**154,844**	**153,691**

STATEMENT OF PROSPECTIVE FINANCIAL POSITION

	2017/18 Actual $000	2018/19 Forecast $000	2019/20 Projection $000	2020/21 Projection $000	2021/22 Projection $000
Non current assets					
Property, plant & equipment	197,886	197,681	191,115	184,549	177,983
Intangible assets	10,376	11,509	10,518	9,528	8,538
Prepayments	55	36	36	36	36
Other financial assets	1,707	1,715	1,715	1,715	1,715
Total non current assets	**210,024**	**210,941**	**203,384**	**195,828**	**188,272**
Current assets					
Cash & cash equivalents	18,468	6,315	6,508	10,325	18,343
Other cash deposits	19,950	21,284	21,284	21,284	21,284
Debtors & other receivables	18,021	19,222	19,222	19,222	19,222
Inventories	2,715	2,742	2,742	2,742	2,742
Prepayments	414	1,188	1,188	1,188	1,188
Assets held for sale	465	465	465	465	465
Total current assets	**60,033**	**51,216**	**51,409**	**55,226**	**63,244**
Total assets	**270,057**	**262,157**	**254,793**	**251,054**	**251,516**
Equity					
Crown equity	82,467	81,920	81,373	80,826	80,279
Revaluation reserve	86,476	86,476	86,476	86,476	86,476
Retained earnings	18,579	(1,986)	(8,028)	(12,457)	(13,063)
Total equity	**187,522**	**166,410**	**159,821**	**154,845**	**153,692**
Non current liabilities					
Interest bearing loans & borrowings	8,172	7,664	7,664	7,184	6,704
Employee entitlements	9,406	9,870	9,870	9,870	9,870
Total non current liabilities	**17,578**	**17,534**	**17,534**	**17,054**	**16,574**
Current liabilities					
Creditors & other payables	30,142	47,932	47,158	48,875	50,970
Employee benefits	33,851	29,330	29,330	29,330	29,330
Interest bearing loans & borrowings	490	501	500	500	500
Provisions	474	450	450	450	450
Total current liabilities	**64,957**	**78,213**	**77,438**	**79,155**	**81,250**
Total liabilities	**82,535**	**95,747**	**94,972**	**96,209**	**97,824**
Total equity & liabilities	**270,057**	**262,157**	**254,793**	**251,054**	**251,516**

STATEMENT OF PROSPECTIVE CASH FLOWS

	2017/18 Actual $000	2018/19 Forecast $000	2019/20 Projection $000	2020/21 Projection $000	2021/22 Projection $000
Cash flows from operating activities					
Receipts from Ministry of Health & patients	491,902	523,143	551,152	564,476	577,883
Interest received	1,745	1,550	1,700	1,720	1,741
Payments to employees	(181,248)	(190,504)	(217,489)	(228,034)	(235,486)
Payments to suppliers	(292,272)	(318,522)	(316,311)	(314,898)	(316,923)
Capital charge paid	(9,376)	(11,073)	(10,460)	(10,564)	(10,670)
Interest paid	0	0	0	0	0
Net GST paid	547	(174)	0	0	0
Net cash inflow from operating activities	**11,298**	**4,420**	**8,592**	**12,700**	**16,545**
Cash flows from investing activities					
Sale of property, plant & equipment	107	103	0	0	0
Cash inflow on maturity of investments	0	0	0	0	0
Acquisition of property, plant & equipment	(10,646)	(11,678)	(6,500)	(6,500)	(6,500)
Acquisition of intangible assets	(2,415)	(2,289)	(1,000)	(1,000)	(1,000)
Acquisition of investments	585	(1,334)	0	0	0
Net cash inflow / (outflow) from investing activities	**(12,369)**	**(15,198)**	**(7,500)**	**(7,500)**	**(7,500)**
Cash flows from financing activities					
Loans raised	0	0	0	0	0
Finance leases raised	0	0	0	0	0
Equity injections	0	0	0	0	0
Equity repaid	(547)	(547)	(547)	(547)	(547)
Repayment of borrowings	(1,475)	(828)	(352)	(836)	(480)
Repayment of finance lease liabilities	0	0	0	0	0
Net cash outflow from financing activities	**(2,022)**	**(1,375)**	**(899)**	**(1,383)**	**(1,027)**
Net increase/(decrease) in cash & cash equivalents	**(3,093)**	**(12,153)**	**193**	**3,817**	**8,018**
Cash & cash equivalents at 1 July	21,561	18,468	6,315	6,508	10,325
Cash & cash equivalents at 30 June	**18,468**	**6,315**	**6,508**	**10,325**	**18,343**

SUMMARY OF REVENUE & EXPENSES BY OUTPUT CLASS

	2017/18 Actual $000	2018/19 Forecast $000	2019/20 Projection $000	2020/21 Projection $000	2021/22 Projection $000
Revenue					
Prevention services	8,226	8,683	9,099	9,319	9,540
Early detection & management services	123,542	130,406	136,659	139,962	143,286
Intensive assessment & treatment services	261,177	275,690	288,908	295,893	302,920
Support services	105,309	111,161	116,491	119,307	122,140
Total revenue	**498,254**	**525,939**	**551,156**	**564,481**	**577,887**
Expenses					
Prevention services	7,752	8,205	8,590	8,780	8,978
Early detection & management services	119,544	126,400	129,509	132,166	134,898
Intensive assessment & treatment services	264,714	300,125	303,211	308,237	313,606
Support services	106,021	111,472	114,389	116,581	118,843
Total expenses	**498,031**	**546,202**	**555,698**	**565,764**	**576,324**
Net contribution					
Prevention services	474	478	509	539	562
Early detection & management services	3,998	4,006	7,150	7,797	8,389
Intensive assessment & treatment services	(3,537)	(24,435)	(14,303)	(12,344)	(10,686)
Support services	(712)	(311)	2,102	2,726	3,298
Net surplus / (deficit)	**223**	**(20,263)**	**(4,542)**	**(1,283)**	**1,563**

STATEMENT OF PROSPECTIVE FINANCIAL PERFORMANCE - PREVENTION SERVICES

	2017/18 Actual $000	2018/19 Forecast $000	2019/20 Projection $000	2020/21 Projection $000	2021/22 Projection $000
Income	**8,226**	**8,683**	**9,099**	**9,319**	**9,540**
Operating Expenditure					
Workforce costs	4,438	**4,863**	**5,240**	**5,410**	**5,586**
Other operating costs	971	**844**	**811**	**776**	**741**
External providers & inter district flows	2,343	**2,498**	**2,538**	**2,594**	**2,651**
Total expenditure	**7,752**	**8,205**	**8,590**	**8,780**	**8,978**
Net surplus / (deficit)	**474**	**478**	**509**	**539**	**562**

STATEMENT OF PROSPECTIVE FINANCIAL PERFORMANCE - EARLY DETECTION AND MANAGEMENT SERVICES

	2017/18 Actual $000	2018/19 Forecast $000	2019/20 Projection $000	2020/21 Projection $000	2021/22 Projection $000
Income	**123,542**	**130,406**	**136,659**	**139,962**	**143,286**
Operating Expenditure					
Workforce costs	21,823	23,915	25,769	26,606	27,471
Other operating costs	8,477	7,370	7,084	6,777	6,472
External providers & inter district flows	89,244	95,116	96,656	98,782	100,955
Total expenditure	**119,544**	**126,400**	**129,509**	**132,166**	**134,898**
Net surplus / (deficit)	**3,998**	**4,006**	**7,150**	**7,797**	**8,389**

STATEMENT OF PROSPECTIVE FINANCIAL PERFORMANCE - INTENSIVE ASSESSMENT AND TREATMENT SERVICES

	2017/18 Actual $000	2018/19 Forecast $000	2019/20 Projection $000	2020/21 Projection $000	2021/22 Projection $000
Income	**261,177**	**275,690**	**288,908**	**295,893**	**302,920**
Operating Expenditure					
Workforce costs	137,678	150,873	162,574	167,855	173,307
Other operating costs	82,765	103,180	94,666	93,400	92,282
External providers & inter district flows	44,272	46,073	45,971	46,983	48,016
Total expenditure	**264,714**	**300,125**	**303,211**	**308,237**	**313,606**
Net surplus / (deficit)	**(3,537)**	**(24,435)**	**(14,303)**	**(12,344)**	**(10,686)**

STATEMENT OF PROSPECTIVE FINANCIAL PERFORMANCE - SUPPORT SERVICES

	2017/18 Actual $000	2018/19 Forecast $000	2019/20 Projection $000	2020/21 Projection $000	2021/22 Projection $000
Income	**105,309**	111,161	**116,491**	**119,307**	**122,140**
Operating Expenditure					
Workforce costs	24,759	27,132	29,236	30,185	31,166
Other operating costs	11,554	10,046	9,655	9,237	8,821
External providers & inter district flows	69,708	74,294	75,497	77,158	78,856
Total expenditure	**106,021**	**111,472**	**114,389**	**116,581**	**118,843**
Net surplus / (deficit)	**(712)**	**(311)**	**2,102**	**2,726**	**3,298**

Appendix A: Priorities Matrix

See next page

All people live well, get well, stay well

Nelson Marlborough Health Key Priorities to June 2020

Priority

Achieve health equity: Improve health status of those currently disadvantaged, particularly Māori

Drive efficient, effective, safe & sustainable healthcare: Support clinical governance, innovation & invest to improve

One Team: Achieve joined-up care and wellbeing across health, local authority and social services

Workforce: Develop the right workforce capacity,culture, capability & configuration

Information Technology: Support better information sharing, efficiency and effectiveness

Facility Development: Plan for a redevelopment of Nelson Hospital

ONGOING SERVICE DELIVERY: Continue to provide efficient, effective and safe health care every day

Te Tiriti o Waitangi / The Treaty of Waitangi

Māori Health	Mental Health & Disability	Primary & Community	Oral Health	Youth Health	Invest in Children	Service Improvement
•Embed Hauora Direct (vulnerable population assessments) •Establish Hapū Wānanga •Strengthen Whare Ora •Progress initiatives related to working towards equity workstream.	•Strengthen the stepped care model •Strengthen our response and preparedness for Enabling Good Lives system transformation •Implement Government agreed actions following the MH&A Inquiry •Reduce harm caused by methamphetamine	•Advance Health Care Home •Improve access to health professional advice •Strengthen care coordination in alignment with general practice / locality clusters •Maximise the role of community pharmacy	•Improve equity of enrolment & utilisation of oral health services	•Strengthen school based health services •Promote and facilitate *The Plan* to encourage sensible attitudes to alcohol •Use Youth Advisory Panel to support future service improvements and development •Ensure young people feel safe and supported by health services	• Ensure every child is a wanted child and child wellbeing is everyone's business •Contribute to the First 1000 days – vulnerable children are identified, pilot implemented in Motueka with linked community teams, •Parents are provided support	•Improve acute demand management across the system •Improve patient flow •Improve perioperative efficiency •Implement a Nelson-Wairau service delivery model •Maximise support for those living with dementia •Improve cooperation to benefit people whose health and/or disability needs fall between current services. •Improve pathway of the deteriorating patient

•Ensure NMH has a workforce that will support new models of care by:

1. Producing a workforce development plan that promotes staff wellbeing, a positive culture, and is clinically led with an emphasis on education, growing our own; and matching workforce to demand
2. Focussing on building Māori health workforce capacity and capability
3. Developing a workforce strategy aligning to the national workforce strategy and including attracting and retaining Māori employees and leaders

•To enable above initiatives, expand the shared care information platform for both hospital and community, and implement virtual health pilots.
•Create health intelligence systems and a culture to inform data-driven quality improvement.
•Continue to implement the Regional Service Provider Index across the South Island, and further SIPICS foundation functionality.
•Improve the resilience and security of the hospital digital infrastructure, including migration to Microsoft Office 365

•Complete the various planning stages for a redevelopment of Nelson Hospital in line with the requirements determined through the Models of Care programme and future demand projections:

- Determine interim facility requirements to address capacity and other constraints in the period until a new facility has been completed
- Submission of the Indicative Business Case and response to any review by the Ministry of Health and Treasury
- Commencement of the Detailed Business Case and detailed design phases

Deliver within our available resources

Minimise our environmental impact

Focus on experience of care and support

Models of Care

Five year programme of transformational change that will inspire new models of care to drive:

- Innovation
- Improved access and patient centred services
- Population wellbeing and equitable outcomes
- Coordination and integration of people, information and systems

Ten projects comprise the programme:

1. Towards Equity: Extension of Hauora Direct
2. Health Care Home Tranche 2
3. Contribution to the First 1,000 Days
4. Acute Demand: Medical Admissions & Planning Unit
5. Strengthening Coordinated Care
6. Virtual Health
7. Access to timely advice
8. Shared Information Platform
9. Workforce Development
10. Health Intelligence

Kaiao te tīni, ka ora te mano, ka noho ora te nuinga