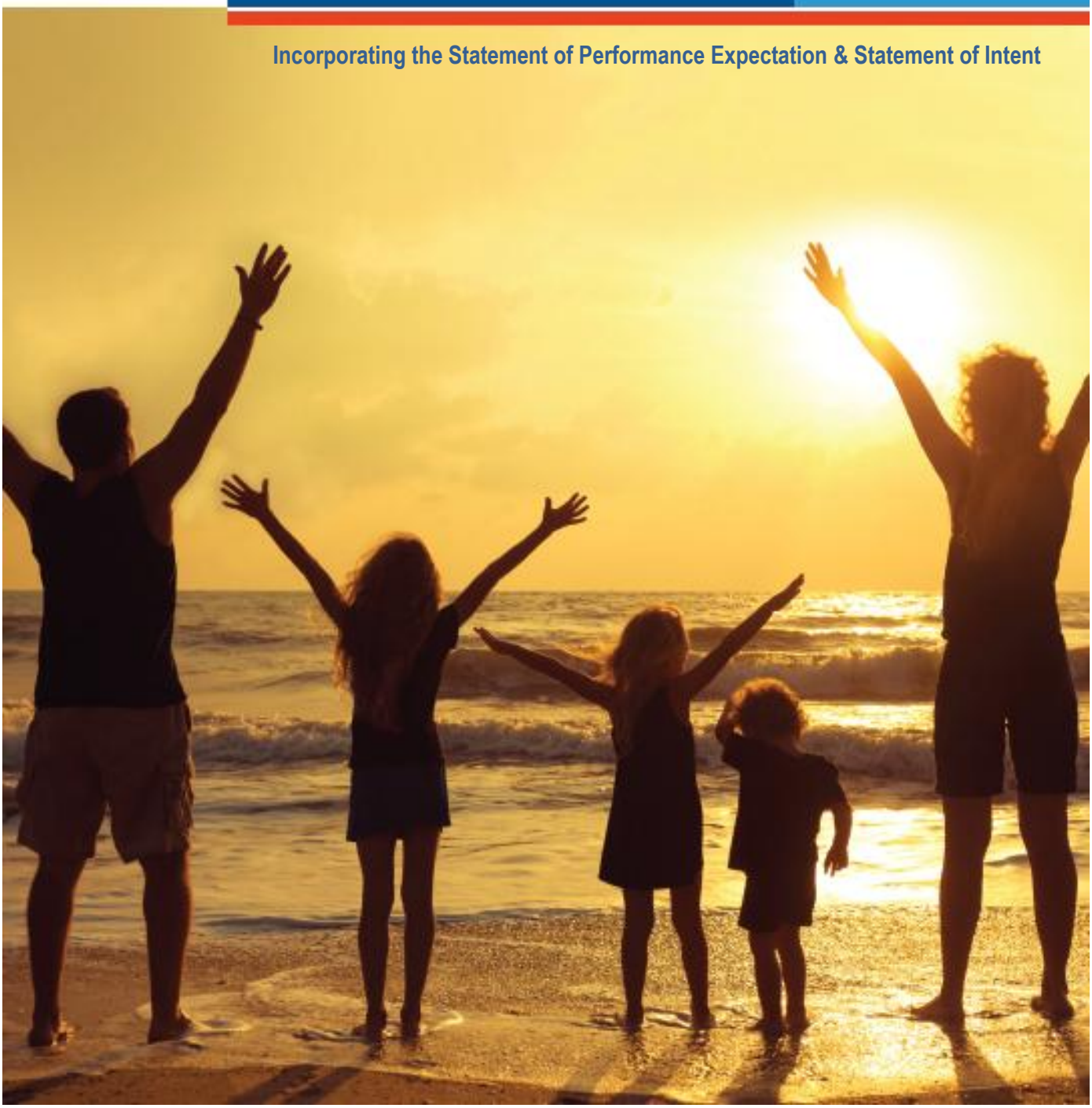
Nelson Marlborough District Health Board

Annual Plan 2016/17

Incorporating the Statement of Performance Expectation & Statement of Intent



Our Vision

"Leading the way to health-conscious families"

Our Mission

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

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.

Nelson Marlborough Health Annual Plan & Statement of Intent

Produced June 2016
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

Letter of Approval from Minister

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

26 OCT 2016

Ms Jenny Black
Chairperson
Nelson Marlborough District Health Board
Private Bag 18
Nelson 7042

jenny.black@nmdhb.govt.nz

Dear Ms Black

Nelson Marlborough District Health Board 2016/17 Annual Plan

This letter is to advise you I have approved and signed Nelson Marlborough District Health Board's (DHB's) 2016/17 Annual Plan for three years.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional $2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year. In order to ensure that the Strategy is informing DHB planning, and in order to ensure value and high performance throughout the health sector, I am considering changes to streamline annual plans in the future and you will be engaged in this process.

Living Within our Means
In order to assist the Government to remain in surplus in 2016/17, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

I am pleased to see that your DHB is planning a surplus for 2016/17 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2016/17.

National Health Targets

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment* health target and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

System Integration including Shifting Services

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Nelson Marlborough DHB has committed to improve the capacity/capability of primary care teams through implementing nurse prescribers and health care assistants, improve primary options for acute care, and complete its primary care strategy and develop a work plan by 31 October. I look forward to being advised of your progress with this throughout the year. If this activity triggers the service change protocols you will need to follow the normal service change process.

Cross-government Initiatives and Collaboration

Delivery of Better Public Services continues to be a key focus for the Government. Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change

that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc Mr Peter Bramley
Acting Chief Executive
Nelson Marlborough District Health Board
Private Bag 18
Nelson 7042

peter.bramley@nmdhb.govt.nz

SIGNATORY PAGE

Nelson Marlborough Health is one of 20 DHBs nationally, established under the *New Zealand Public Health and Disability Act 2000* (including subsequent amendments). Each DHB is a Crown Agent under the *Crown Entities Act 2004* and is responsible to the Minister of Health and the Minister of Finance for the health and independence of a geographically defined population.

This Annual Plan has been prepared to meet the requirements of both governing Acts and the relevant sections of the *Public Finance Act*. This Plan sets out Nelson Marlborough Health's goals and objectives and describes what the DHB intends to achieve in 2016/17 in terms of improving the health, wellbeing, and independence of our population and in delivering on the expectations of the Minister of Health. This Annual Plan also contains service and financial forecast information for the 2016/17 year and the three subsequent years.

Sections of this Annual Plan are extracted to form a stand-alone Statement of Intent document which is presented to Parliament. The Statement of Intent consists of the Introduction and Strategic Intentions (module 1), Statement of Performance Expectations (module 3), Financial Performance (module 4), and Stewardship (module 5) sections of the Annual Plan. As a public accountability document, the Statement of Intent is used at the end of every financial year to compare the DHB's planned performance with our actual performance. The audited results are then presented in the DHB's Annual Report.

To provide health services that are better, sooner and more convenient and achieve the best health outcomes for the Nelson Marlborough population, the DHB is committed to 'whole of system' collaborative working at a local and regional level using alliances. This includes the local 'Top of the South Health Alliance' (ToSHA), and the South Island Alliance.

In line with this collaborative approach, the actions in this Annual Plan represent a joint commitment by Nelson Marlborough Health, Nelson Bays Primary Health Organisation, and Kimi Hauora Marlborough Primary Health Organisation to working together to provide the best health services and achieve the best health outcomes for the Nelson Marlborough population, and to deliver on the expectations of the Minister. The two PHOs are partners in the Nelson Marlborough Health's Annual Plan process, which included active participation in an Integration workshop to make sure we have an aligned and integrated annual plan, and a prioritisation workshop to share information about the financial challenges and identify further efficiencies and savings initiatives. PHO representatives also contributed to specific plans, most notably Increased Immunisation, Healthy Hearts & Living Well with Diabetes, the Primary & Community Care System Integration Plan, and the ToSHA System Integration Plan.

The actions in this Annual Plan also reflect key commitments to the regional alliance. The full South Island Regional Health Services Plan (of which Nelson Marlborough Health is a signatory) can be found on the South Island Alliance Programme Office website: www.sialliance.health.nz

Nelson Marlborough Health also has Maori Health and Public Health Action Plans for 2016/17, both of which are companion documents to this Annual Plan. These documents set out further actions and activity to improve population health and reduce inequalities, and are available on our website: www.nmdhb.govt.nz

Together, working in partnership, we will continue to demonstrate real gains in health and independence outcomes for the Nelson, Tasman, Marlborough population, and will do so within the funds provided to us by Government for this purpose.

Jenny Black
Chair
Nelson Marlborough Health

Alan Hinton
Deputy Chair
Nelson Marlborough Health

Chris Fleming
Chief Executive
Nelson Marlborough Health

Hon Dr Jonathan Coleman
Minister of Health

Letter of Support from Kimi Hauora Marlborough PHO

Marlborough Primary Health
KIMI HAUORA WAIRAU I SEEKING WELLBEING IN MARLBOROUGH

Marlborough Community Health Hub
22 Queen Street
P O Box 1091, Blenheim 7240
Ph: (03) 520 6200 Fax: (03) 578 1198

12th May 2016

Chris Fleming
Chief Executive Officer
Marlborough District Health Board
PO Box 19
Nelson

Dear Chris

Nelson Marlborough District Health Board Annual Plan 2016/17

I am pleased to advise the board of Kimi Hauora Wairau Marlborough Primary Health Organisation (KHWMPHO) endorses the 2016/17 Nelson Marlborough District Annual Plan. The collegial development of the plan between this KHWMPHO, Nelson Bays Primary Health and the NMDHB can only continue to advance a seamless integrated approach to care across the district.

Yours sincerely

David Taylor
Chair
Kimi Hauora Wairau MPHO

Letter of Support from Nelson Bays PHO

NELSON BAYS
PRIMARY HEALTH

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PO Box 1776, Nelson 7040
Tel: 03 539 1170 Free: 0800 731 317 Fax: 03 539 4958
www.nbph.org.nz

23 May 2016

Ms Jenny Black
Chair
Nelson Marlborough District Health Board
PO Box 19
NELSON

Dear Jenny

Nelson Marlborough District Health Board's Annual Plan 2016/17

I am pleased to advise that Nelson Bays Primary Health Board endorses the Nelson Marlborough District Annual Plan.

The District Health Board's inclusion of Nelson Bays Primary Health and Kimi Hauora Wairau in jointly developing the plan will ensure we progress the delivery of seamless integrated health services to our communities.

Regards

John Hunter
CHAIR

CONTENTS

EXECUTIVE SUMMARY

FORWARD FROM CHAIR, DEPUTY CHAIR, AND CHIEF EXECUTIVE

Nelson Marlborough Health is a strongly performing and financially prudent organisation that provides a valuable and valued service to our community.

The people of the Nelson Marlborough region generally enjoy a higher standard of health and wellbeing than most New Zealanders. The Nelson Marlborough Health Needs and Service Profile 2015 confirmed that the local population is relatively less deprived than the New Zealand average; has a higher life expectancy than the New Zealand average; Maori in Nelson Marlborough are doing better than Maori elsewhere in New Zealand; and children (0-14 years) are generally at lower risk and in better health than their national counterparts.

While progress is being made in improving the health of our community, we have quite a way to go to address the health inequities present. Although Maori in our region are doing better than Maori elsewhere in New Zealand, the health gap between Maori and non-Maori remains.

Everyone in our region is entitled to live well, stay well, get well and die well. Health inequity, particularly due to ethnicity, is unacceptable.

In recognition of our current level of performance and knowing we can always do better, our challenge is to go from good to great. We owe it to the population we serve to continually strive to do better.

Many of the factors that influence the health status of people within our community – education, income, housing and environment - are outside the direct control of the district health board. Yet they are areas we can influence and where we must work with our partners in the public service.

Obesity is a common precursor for ill health so tackling obesity is a key focus area for 2016-17. We will continue to reduce the impact sugar is having on our health, and have an action plan to prevent and manage obesity in children. Following the removal of sugar-sweetened beverages (SSBs) in March 2014, we have strengthened our policy and will remove artificially-sweetened beverages (ASBs), juices, flavoured waters and pre-packaged 'smoothie' drinks from our hospitals.

During 2016/17 we will work with our local councils on key health promotion / prevention activities such as the removal of SSBs and ASBs, addressing the issue of fluoridation in our water, and reducing alcohol related harm.

We will continue to work across organisational boundaries so the people of our region experience a seamless health service. This includes having the right information technology and infrastructure in place as the foundation for delivering care closer to home and putting communities and the needs of consumers and patients at the centre of health care. Information technology systems to be implemented during 2016/17, such as the Patient Information Care System (PICS) and Health Connect South (HCS), will enable many of our paper-lite initiatives so that tomorrow's patients get a better experience at a lower operational cost, enabling as much of the scarce health dollar to be spent on actual care as possible. We will also continue to shift services from secondary to primary care, and will realise gains from investing in community health hubs in both Nelson and Blenheim.

Over the previous two years we delivered savings initiatives and received favourable funding outcomes. This allowed us to be able to fund new initiatives, including introduction of registrars in the Medicine service, additional nursing and allied health resources, and investment in community based initiatives, additional aged care, as well as greater health promotion and prevention initiatives.

For the coming year our unfavourable share of the population based funding, and the current financial performance of our DHB against demanding financial targets, creates a significant challenge. Our funding shortfall comes at a time when we are facing increases in demand due to the impacts of our aging population, along with service and quality / safety priorities, as well as service enhancements which we would ideally undertake in order to benefit the Nelson Marlborough Health System.

To invest we need to save. The challenge to our clinical and managerial leads was to review all our services and functions to identify efficiency opportunities, investment opportunities which will deliver tangible financials gains, and disinvestment options. Our ability to stay within budget will enable further investment in key infrastructure and initiatives that allow us to continually improve how we deliver health services, and deliver on our commitment to live within our means.

Our success in the short term will be measured by our achievement of the health targets, and in the long term by the improved health and wellbeing of the people of the Nelson Marlborough region.

He waka eke noa* – we are all in this together.

*A canoe which we are all in with no exception.

INTRODUCING THE NELSON MARLBOROUGH HEALTH SYSTEM

1.1 WHAT WE DO

1.1.1 National Context

The Minister of Health with Cabinet and the Government develop policy for the health and disability sector. The Minister is supported by the Ministry of Health and its business units and, advised by the Ministry, Health Workforce New Zealand, and other ministerial advisory committees. Accident services are funded by the Accident Compensation Corporation (ACC). Health and disability services in New Zealand are delivered by a complex network of organisations and people. Each has their role in working with others across the system to achieve better, sooner, more convenient services for all New Zealanders.

The Treaty of Waitangi states the Crown's responsibility to Maori, and guarantees Maori equal access to national resources. In order to recognise and respect the Treaty principles, we have a responsibility to enable Maori to participate in decision making and the delivery of health and disability services, and work collaboratively towards equitable health outcomes for Maori.

1.1.2 Regional Context

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

The vision of the Alliance is a sustainable South Island health and disability system – best for people, best for system. The Alliance is focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services, as close to people's homes as possible.

By using our combined resources to jointly solve problems, we are better positioned to respond to changes in the technology and demographics that will have a significant impact on the health sector in the coming years.

1.1.3 Our DHB – Structure and Funding

The Nelson Marlborough health system operates as an interconnected and interdependent group of organisations to meet the varied health needs of the Nelson Marlborough population. The Strategy, Planning & Alliance Support team has overall responsibility for assessing the population's health needs and the mix of services required to meet those needs, through a process of consultation and prioritisation.

Nelson Marlborough Health is responsible for the provision or funding of the majority of health services in our district. These services include:

- 2 secondary hospitals – Nelson and Wairau (Blenheim)
- 1 rural hospital – Murchison
- 1 psycho-geriatric hospital – Alexandra (Nelson)
- 1 Maori health provider – Te Piki Oranga
- 5 home-based support providers
- 2 Primary Health Organisations – Nelson Bays Primary Health and Kimi Hauora Wairau Primary Health (Marlborough)
- 34 General Practices (including the Integrated Family Health Centre in Golden Bay)
- 31 pharmacies
- 26 residential care facilities (rest homes)
- 58 homes for people with disabilities
- 2 hospices.

We also provide funding to Non-Governmental Organisations (NGOs) and other community groups. We hold and monitor contracts with each provider to ensure value for money and ensure services are high quality, safe, responsive, coordinated, efficient and meet the patient's expectations of the care provided.

We are one of the two DHBs still providing a disability support service (DSS) for people with physical and intellectual disabilities. Canterbury DHB is the only other DHB providing a disability support service, through a subsidiary company called Brackenridge.

1.1.4 Nature and Scope of Functions

Nelson Marlborough Health receives funding from Government to purchase and provide health and disability services for the local population. 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 a local, regional and national level, and importantly our community;
- **Fund** the majority of the health and support care services 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 dollar invested (value for money) by ensuring services are high quality, safe, responsive, coordinated, efficient and meet the expectation of the patient's experience of the care provided;
- **Promote, protect, and improve** our population's health and wellbeing through an evidence-based 'whole of system' approach that includes health impact assessments, health promotion, and public health protection interventions;
- **Provide** hospital specialist and community services for our population. We have a 'One Service, Two Sites' approach for hospital specialist services, and also provide a disability support service (DSS);
- **Integrate** health service activity in our region with an appropriate level of management and administrative support required for an organisation of the size of Nelson Marlborough Health.

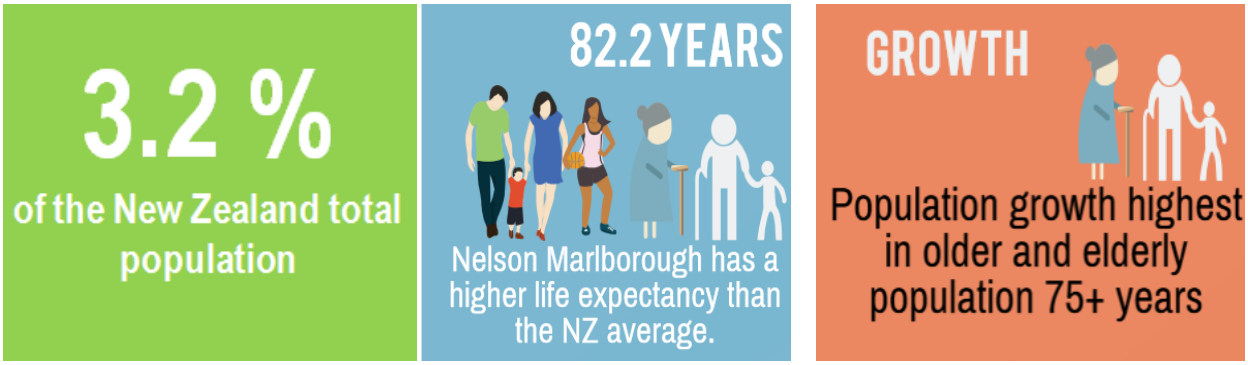
1.2 OUR CHALLENGES

1.2.1 Our Health Profile

To provide the right health services to our community, we need to know what health services the people of our community require. In 2015 we commissioned a Health Needs Analysis and Service Profile for the Nelson Marlborough region by Health Partners Consulting Group (now Ernst & Young).

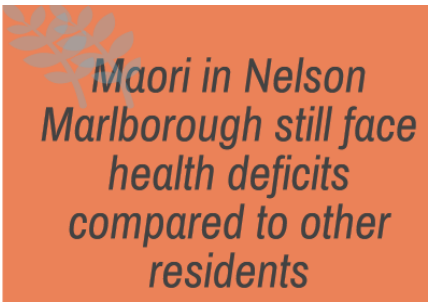
Building on past health needs assessment work, the report summarises the quantitative analyses around the health and well-being of our local community, and underpins the Nelson Marlborough strategic health planning process that will guide future service and facility development. While progress is being made in the health of our community, the Health Needs Analysis demonstrates we have quite a way to go to address the health inequities present.

Nelson Marlborough Health covers the top of the South Island, including Golden Bay, Nelson, Picton and Blenheim. We serve an estimated resident population of 144,500 in 2015, which is about 3.2% of the New Zealand population. Nelson Marlborough has a significantly lower proportion of Maori (10%) and Pacific (1%) people in comparison to the national average.



The Nelson Marlborough population has generally good health compared to others in New Zealand, with a higher life expectancy than the New Zealand average, and lower amenable mortality. We have a relatively stable population, with low population growth expected. Overall, the Nelson Marlborough population is growing at about half the rate of New Zealand, with 9% growth expected in the 20 years from 2013 to 2033, compared to 17% for New Zealand. The largest proportionate growth is in the elderly, and Nelson Marlborough's 75+ population is projected to more than double, a slightly higher rate than for New Zealand as a whole. Tasman is projected to have the largest 75+ growth, and the largest percentage growth, nearly tripling by 2033. Care of the elderly will be an increasing proportion of the DHB's work.

The Nelson Marlborough population is relatively less deprived than the New Zealand average. Maori in our region are doing better than Maori elsewhere in New Zealand on most health indicators, but a large gap still exists in the majority of health indicators compared with non-Maori in Nelson Marlborough. For example, the impact of chronic conditions for Maori begins 10 years earlier than non-Maori.



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 Maori children. 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 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.

Nelson Marlborough's rate per 1,000 people in community residential care is almost twice the New Zealand average – 3.1 compared with 1.7. This likely reflects the legacy of Ngawhatu and Braemar hospitals in Nelson, where historically people with moderate to complex disability needs resided. Following the de-institutionalisation process in the 1990s, residents of the hospital would have primarily been relocated to community residential homes (there are ~60 in Nelson today).

The people in our community have generally good access to health and disability support services, with general practice coverage and quality similar to the New Zealand average. Unplanned admission rates are lower than the national average, and planned rates are slightly above the New Zealand average, indicating reasonable access to elective surgery. Emergency Department (ED) attendance rates are higher than nationally, and are particularly high at Wairau Hospital, which may be linked to lower after-hours access to primary care. Access to mental health and addiction specialist services is similar to the national average, and the elderly (age 75+) appear to have good access to hospital and community-based services, with good ageing in place support.

The Health Needs Analysis and Service Profile 2015 is a critical foundation for ensuring our services are responsive and relevant, and will form part of an outcomes framework that will allow us to measure our progress in improving people's health across our key health and wellbeing priorities.

1.2.2 Our Risks and Opportunities

The effective management of risks and opportunities is essential to the success of Nelson Marlborough Health. We must ensure that the investments we plan and deliver are not at the expense of our strong financial track record, and that we continue to focus our efforts in the right place to make savings efficiently and sustainably.

Having a clear understanding of our risks and opportunities, and their potential impacts, allows us to manage proactively:

- **Persistent Inequities**: We continue to experience persistent inequities in access to health services and health outcomes for some members of our community, especially Maori and youth.
- **Infrastructure Development Requirements**: Nelson Hospital is nearing the end of its economic life and is no longer fit for purpose, requiring significant earthquake strengthening and redesign to accommodate modern models of care and health service delivery. We are developing a business case for the Nelson Hospital rebuild, in accordance with the broader strategic facilities master plan for the Nelson Marlborough health system.
- **Demographics and Population Shifts**: The Nelson Marlborough region has an ageing population and care of the elderly will be an increasing proportion of the DHB's work. Older people tend to be higher users of health services and have more complex health needs, which will impact across all services and not just the Health of Older People budget. The Nelson Marlborough workforce is also ageing so we need to proactively plan for their exit from the workforce, and develop new models of care to respond to workforce shortages.
- **Funding and Finances**: Funding rate increases do not keep pace with healthcare innovations available which the community increasingly expect to be publicly funded - we need to work in partnership with our community to make tough decisions about services, and work with our alliance partners to develop more sustainable solutions.
- **Pharmacy Changes**: To improve pharmacy services in our region within the funding available we believe it is necessary to change our model of Community Pharmacy Services.
- **Golden Bay Integrated Family Health Care Centre**: Providing services in rural and remote localities with seasonally dependent populations remains an ongoing challenge.
- **System Integration Risk**: We will continue to shift services from secondary to primary care to ensure the right care is provided at the right place by the right person at the right time. Experience has shown that it is difficult to shift services, and even more difficult to shift services without incurring significant additional costs.
- **Quality, Safety and Inter-District Flows (IDFs):** As a secondary care provider, Nelson Marlborough Health must provide for patients requiring tertiary level care to be treated outside the region. Predicting annual volumes and therefore budgeting for IDFs is problematic, and collaboration with other DHBs is necessary to ensure that Nelson Marlborough Health approves the elective treatment of Nelson Marlborough residents outside our region.
- **Diagnostics:** Diagnostics is a health service that is vulnerable in that it is difficult to staff, particularly for Sonographers, and there are concerns that current service provision is at risk. New contracts are being developed, there are changes to the service, and there are increased expectations from the Ministry of Health about service delivery and access.
- **Public Trust and Confidence:** Nelson Marlborough Health provides a valuable and valued service to our community. High profile and emotive public health issues, such as Fluoridation in the public water supply and reducing access to added sugar and sugar sweetened beverages, may provoke a backlash from those that perceive these initiatives are indicative of a 'nanny state' and the erosion of personal choice and responsibility. There is also a need to manage expectations of the community about levels of access to healthcare and support services.
- **Industrial Relations**: Cost pressures will impact on the ability to meet staff member's remuneration expectations. Staff members are also feeling the pressure of increased work volumes and the drive for further cost reductions.

OUR STRATEGIC DIRECTION

WHAT ARE WE TRYING TO ACHIEVE?

1.3 OUR STRATEGIC CONTEXT

New Zealand's health system is generally performing well against international benchmarks. However, an ageing population and a growing burden of long-term conditions is driving increased demand for health services, while financial and workforce constraints limit increasing capacity.

Alongside these health sector drivers, there is growing acknowledgement of the social determinants of health and conversely, the role good health plays in social outcomes. Health outcomes for our communities are interlinked with issues of education, employment, housing and justice, and services will increasingly be asked to take a broader view of wellbeing.

These pressures mean health services cannot continue to be provided in the same way. While hospitals continue to be a setting for highly specialised care, we need to move away from the traditional health model.

There are clear opportunities that are supporting evolution in our health sector through aspects such as shifts towards earlier intervention, investment and preventative care, home and community based care, and new technology and information systems. Further change towards integrating and better connecting services, not only across the health sector, but inter-sectorally, is needed to achieve better health outcomes with available resources.

1.4 NATIONAL DIRECTION

Acknowledging these challenges and opportunities, New Zealand's long term vision for health services will be articulated through the New Zealand Health Strategy. The Strategy intends to support New Zealander's to 'live well, stay well, get well' and sets out five themes to give focus for change in health services:

People powered: understanding people's needs and partnering with them to design services; empowering people to be more involved in their health and wellbeing; building health literacy and supporting people's navigation of the system

Closer to home: more integrated health services and better connections with wider public services; investment early in life; care closer to home; focus on wellness and prevention

Value and high performance: focus on outcomes, equity, people's experience, best-value use of resources; strong performance measurement; culture of improvement; transparent use of information to share learning; use of investment approaches to address health and social issues[1]

One team: operating as a team in a high trust system; flexible use of the health and disability workforce; leadership and workforce development; strengthening the role of consumers/communities; linking with researchers

Smart system: information reliable, accurate and available at point of care; data and systems that improve evidence-based decision making and clinical audit; standardised technology

More specifically, health services are guided by a range of population or condition specific strategies, including He Korowai Oranga (Maori Health Strategy), 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing), Health of Older People Strategy (currently being updated), Primary Care Health Strategy, Rising to the Challenge (Mental Health and Addiction Service Development Plan – to be updated in 2016), Cancer Strategy and Diabetes Strategy.

In supporting people to 'live well, stay well, get well'[2], DHBs are expected to commit to Government priorities to provide better public services. In particular, 'better, sooner, more convenient health services', but the health sector also contributes to the achievement of other Government priorities, including a number of Better Public Service results areas, and the building of a more productive economy.

[1] In line with the Productivity Commission's report *More Effective Social Services (2015)*, an investment approach takes into account the long-term impact of an initiative on government spending and quality of life when making funding decisions.
[2] In the Ministry of Health's Statement of Intent this is articulated as: New Zealanders live longer, healthier, more independent lives and the health system is cost-effective and supports a productive economy.

Nelson Marlborough Health is committed to implementation of the NZ Health Strategy. Detailed actions for the four existing planning priorities that were also identified as being a focus in the Strategic Roadmap of Actions (Obesity, Long Term Conditions, Service Configuration including Shifting Services and IT) can be found on the following pages:

Strategy Planning Priority	Page Reference
Obesity (within the Child Health plan)	Page 40
Long Term Conditions (within the Living Well with Diabetes and Cardiovascular Heart Disease plan)	Page 41
Service Configuration including Shifting Services	Pages 50 & 51
Information Technology	Page 57

Alongside these longer-term commitments, the Minister of Health's annual Letter of Expectation signals annual priorities for the health sector. In 2016/17 the focus is on:

- New Zealand Health Strategy: DHBs need to be focused on the critical areas to drive change that are identified in the Strategy
- living within our means: DHBs must continue to consider where efficiency gains can be made and look to improvements through national, regional and sub-regional initiatives
- working across government: cross-agency work to support vulnerable families and improve outcomes for children and young people is a priority, along with health's contribution to Better Public Service Results
- national health targets: while health target performance has improved, this needs to remain a focus for DHBs, particularly the Faster Cancer Treatment target
- tackling obesity: DHBs are expected to deliver on the new health target to address childhood obesity and show leadership in working to reduce the incidence of obesity
- shifting and integrating services: DHBs need to continue to work with primary care to move services closer to home and achieve better co-ordinated health and social services
- health information systems: DHBs need to complete current national and regional IT investments and DHB, PHO and primary care input is sought into the co-design process of the Health IT Programme 2015-2020.

1.5 REGIONAL DIRECTION

In delivering its commitment to better public services and better, sooner, more convenient health services the Government also has clear expectations of increased integration and regional collaboration between health service providers (and other social service agencies).

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for slightly over 1 million people, or 24 percent of the New Zealand population.

While each DHB is individually responsible for the provision of services to its own population, we recognise that working regionally enables us to better address our shared challenges. The South Island Alliance improves the systems within which health services are provided by the individual South Island DHBs. Now entering its sixth year, the Alliance has proven to be a successful model for the South Island, bringing clinicians, managers, CEOs, primary care, aged residential care and consumers together to work towards a shared vision of *best for people, best for system.*

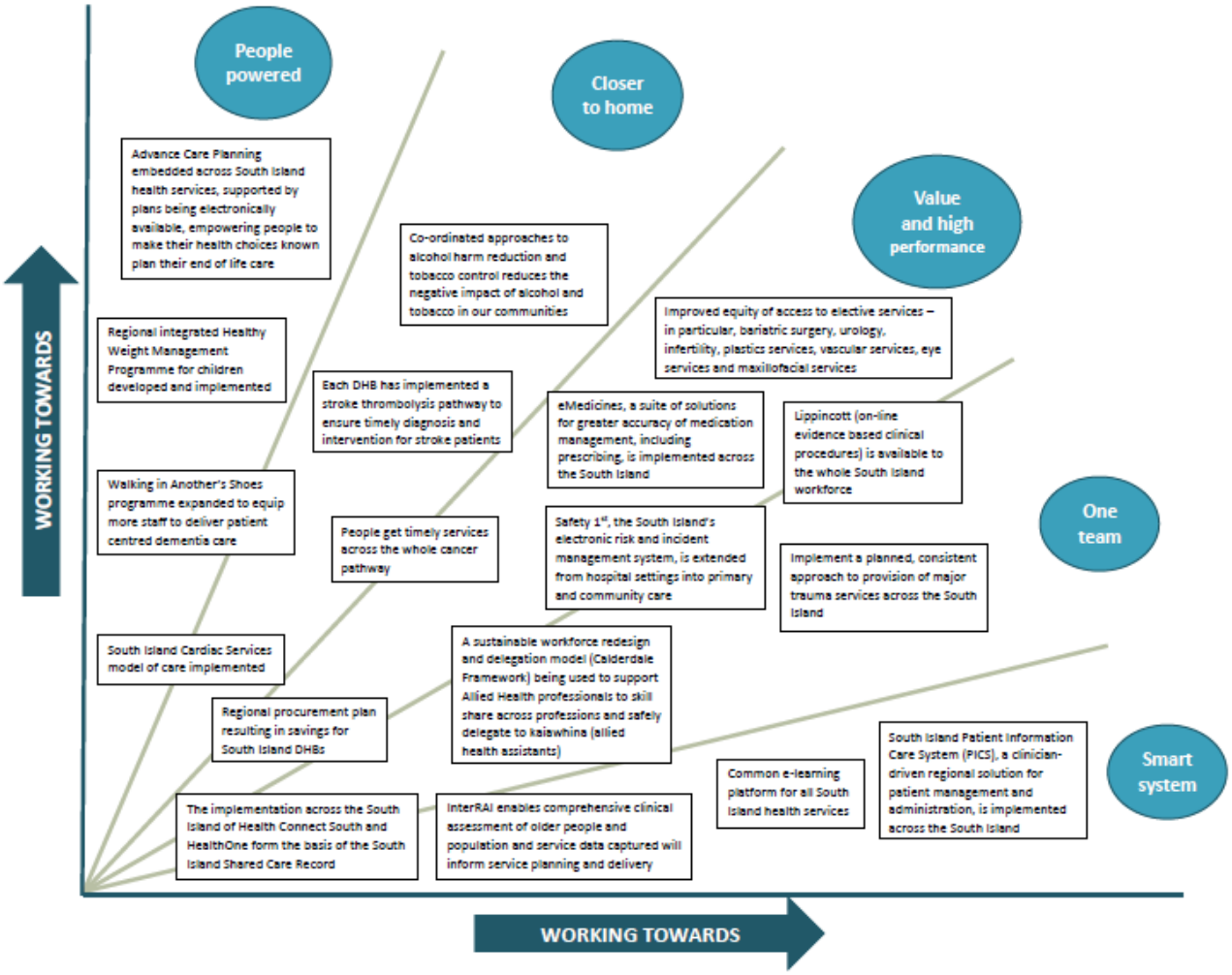
The Alliance outcomes framework defines what success looks like for South Island health services, and outcomes measures will be implemented this year to track if we are heading in the right direction (see 'Improving Health Outcomes for Our Population' below)

The *South Island Health Services Plan* outlines the agreed regional activity to be implemented through our seven priority service areas: Cancer, Child Health, Health of Older People, Mental Health and Addiction, Information Services, Support Services, and Quality and Safety Service Level Alliances. In addition to this, regional workstreams will focus on: cardiac services, elective surgery, palliative care, public health, stroke, major trauma services and hepatitis C. Workforce planning, through the South Island Workforce Development Hub and regional asset planning, will contribute to improved delivery in all service areas.

All South Island DHBs are involved in the service level alliances and work streams and lead at least one priority area. For Nelson Marlborough Health, our Chief Executive leads the Child Health Services and Health of Older People Services workstreams. And our Medical Officer / Public Health Physician is the Clinical Lead for the Public Health Services workstream.

Nelson Marlborough Health is committed to the implementation of both the New Zealand Health Strategy and the *South Island Health Services Plan.* Activity planned and prioritised in the coming year is in line with the direction of the New Zealand Health Strategy and the priorities expressed by the Minister of Health.
This alignment is shown through a South Island version of the Health Strategy Roadmap fan diagram below, and Nelson Marlborough Health actions are aligned with this Roadmap.

Figure One: *South Island Health Services Plan* Roadmap



1.6 NELSON MARLBOROUGH HEALTH LOCAL DIRECTION

Our DHB Vision

"Towards Healthy Families"

Our DHB Mission

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

Our Local Direction

Health for Tomorrow (formerly known as Health 2030) is the Nelson Marlborough health system's strategic commitment to deliver our vision of healthy families. Health for Tomorrow sets out the approach we will take to plan and deliver the health and care services we must have to meet the health needs of our communities, and achieve our vision.

Progress towards our vision is supported by the *Health Services Plan 2015*, 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.

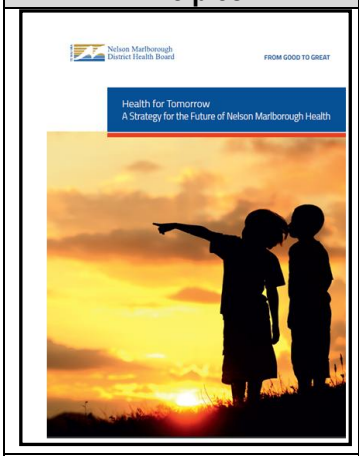
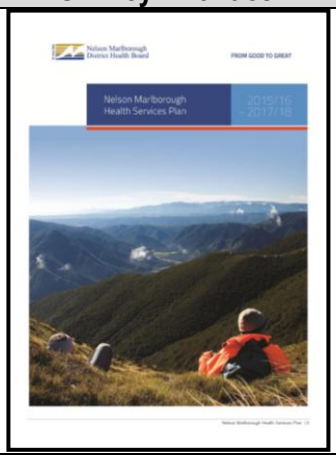
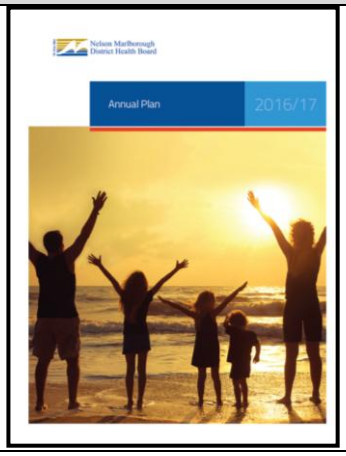
The *Health Services Plan* (HSP) is designed to deliver on three medium term objectives for the Nelson Marlborough health system:

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

We believe the people in our community deserve the best possible health care. We have developed a plan that will lift our health system performance from good to great, including primary care with the development of a Primary & Community Care strategy.

Health for Tomorrow incorporates the values of Nelson Marlborough Health, the principles that guide how we plan and deliver health and care services, and the priorities for the Nelson Marlborough health system. The *Health Services Plan* provides a strategic context for more detailed service, capacity (workforce, facilities, and technology), and financial planning. How we will achieve each of the priorities is reflected in more detail in this Annual Plan.

Figure 2. Strategy and Planning: Nelson Marlborough Health Local Direction

Long Term ***Health for Tomorrow*** **Principles**	**Medium Term** ***Health Services Plan*** **Six Key Priorities**	**Short Term** ***Annual Plan 2016-17*** **2016/17 Actions from the Health Services Plan**
		
• Building and supporting healthy communities • Delivering programmes of integrated care • Robust and shared Quality and Safety processes – coordinated clinical governance across the system • Focus on measures that shine a light on quality and safety • System-wide facility and infrastructure planning • Having a workforce with the right mix of skills, knowledge and experience • Delivering connected information systems with people at the centre	• Increase focus on health promotion and prevention, and target resources to high needs populations • Strengthen district-wide integrated service planning and delivery • Implement new models of integrated primary and community health care • Achieve excellence in clinical care in hospitals • Prioritise service and capital investments, and reinforce performance and accountability • Extend the scope of health pathways, and review tertiary service partnerships	• Continue to roll-out the Top of the South specialist services model • Define locality network(s) that will operate with the ToSHA alliance framework • Develop an implementation plan for the Nelson Marlborough Primary & Community Care Strategy • Continue to reduce ED attendance • Plan and action staged movement to 'whole system' care pathways (primary, secondary, tertiary) • Align planning and delivery of public and personal health services to lift population outcomes and reduce inequalities in priority areas • Develop an Nelson Marlborough Health quality and performance improvement strategy • Identify current and potential telehealth use across the district, and prioritise implementation of development opportunities • Undertake service planning to resolve key clinical service issues • Develop a prioritisation framework, to be used annually in setting of baseline budgets and activity targets, disinvestment, and allocation of resources; and • *Deliver the Board approved 'save to invest' programme*

IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

1.4 HOW WILL WE KNOW IF WE ARE MAKING A DIFFERENCE?

DHBs are expected to deliver against the national health system outcomes: 'All New Zealanders lead longer, healthier and more independent lives' and 'The health system is cost effective and supports a productive economy' and to their objectives under the New Zealand Public Health and Disability Act to 'improve, promote and protect the health of people and communities'.

As part of this accountability, DHBs need to demonstrate whether they are succeeding in achieving these goals and improving the health and wellbeing of their populations. There is no single indicator that can demonstrate the impact of the work DHBs do. Instead, we have chosen a mix of population health and service performance indicators that we believe are important to our stakeholders and that together, provide an insight into how well the health system and the DHB is performing.

In developing our strategic framework, the South Island DHBs identified three shared high-level outcome goals where collectively we can influence change and deliver on the expectations of Government, our communities and our patients by making a positive change in the health of our populations.

Alongside these outcome goals are a number of associated outcomes indicators, which will demonstrate success over time. These are long-term indicators and, as such, the aim is for a measurable change in health status over time, rather than a fixed target.

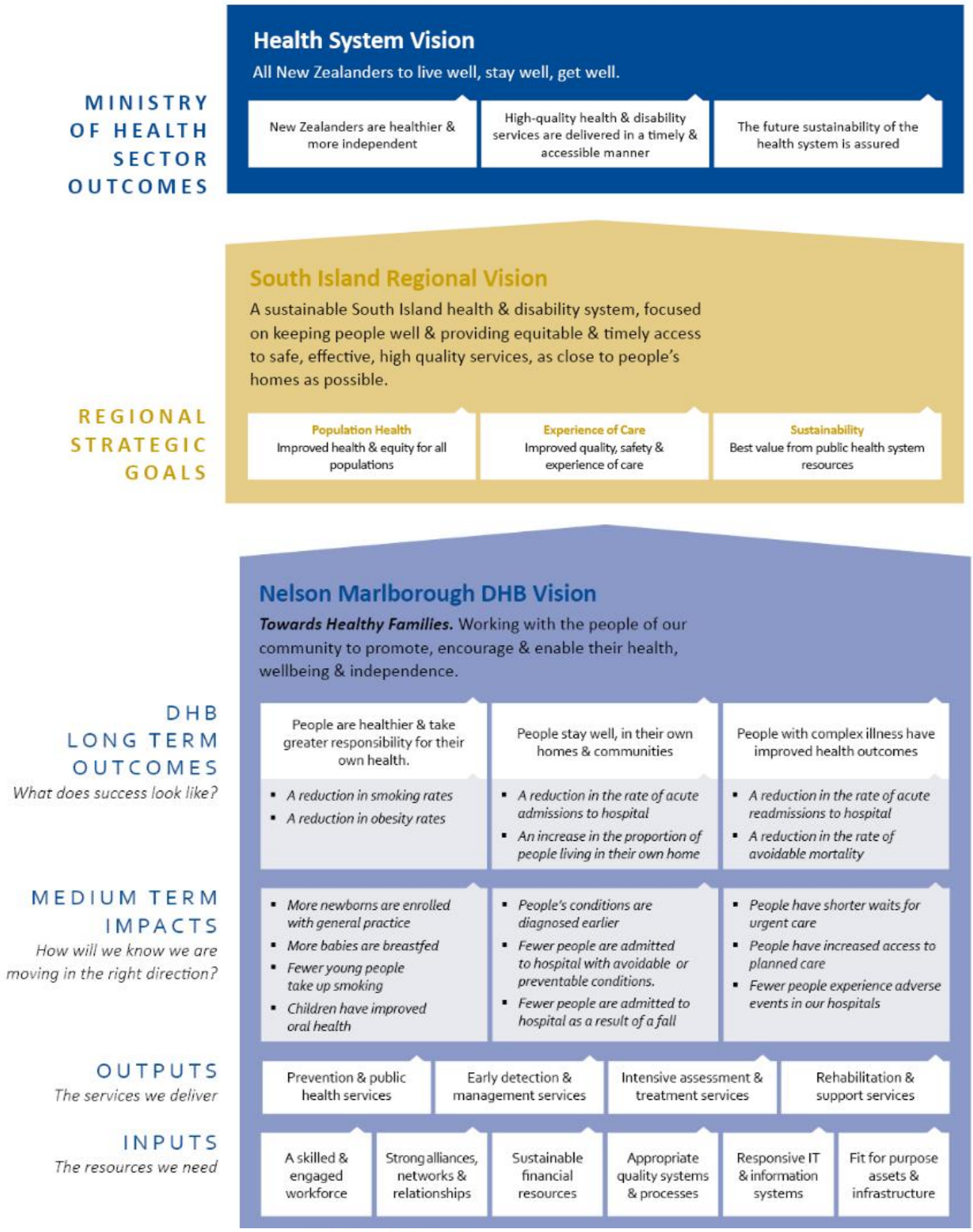
- **Outcome 1: People are healthier and take greater responsibility for their own health**
  - A reduction in smoking rates.
  - A reduction in obesity rates.
- **Outcome 2: People stay well, in their own homes and communities**
  - A reduction in the rate of acute medical admissions.
  - An increase in the proportion of people living in their own homes.
- **Outcome 3: People with complex illness have improved health outcomes**
  - A reduction in the rate of acute readmissions to hospital.
  - A reduction in the rate of avoidable mortality.

The South Island DHBs have also identified a core set of associated medium-term indicators. Because change will be evident over a shorter period of time, these indicators have been identified as the headline or main measures of performance. Each DHB has set local targets in order to evaluate their performance over the next four years and determine whether they are moving in the right direction. These impact indicators will sit alongside each DHB's Statement of Performance Expectations and be reported against in the DHB's Annual Report at the end of every year.

The outcome and impact indicators were specifically chosen from existing data sources and reporting frameworks. This approach enables regular monitoring and comparison, without placing additional reporting burden on the DHBs or other providers.

As part of our obligations as a DHB, we must also work towards achieving equity and to promote this, the targets for each of the impact indicators are the same across all ethnic groups.

The following intervention logic diagram demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) will have an impact on the health of their population and ultimately result in achievement of the desired longer-term outcomes and the expectations and priorities of Government.



Te Tiriti O Waitangi

We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Maori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

1.4.1 STRATEGIC OUTCOME GOAL 1

People are healthier and take greater responsibility for their own health

Why is this outcome a priority?

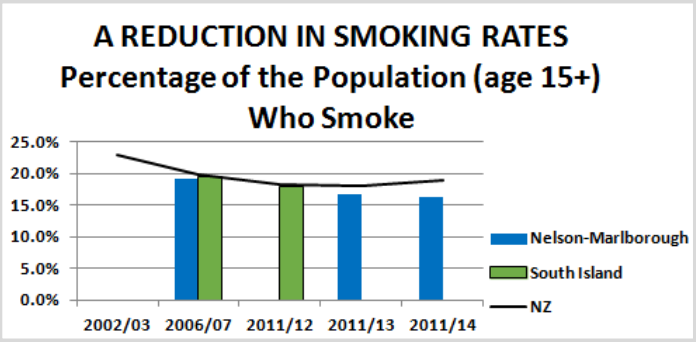
New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and hospital and specialist services. The likelihood of developing long-term conditions increases with age, and with an ageing population, the burden of long-term conditions will grow. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on managing long-term conditions. These conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Public health and prevention services that support people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of our population.

Overarching Outcome Indicators

SMOKING

Percentage of the population (15+) who smoke



Tobacco smoking kills an estimated 5,000 people in NZ every year. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke and a risk factor for six of the eight leading causes of death worldwide.

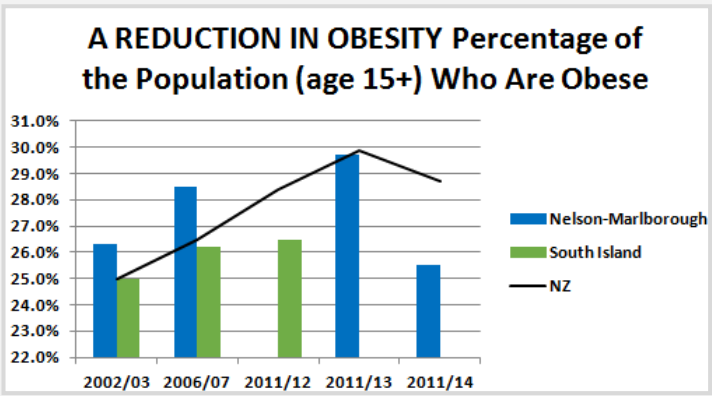
In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity to not only improve overall health outcomes but also to reduce inequalities in the health of our population.

Data Source: National Health Survey[3]

OBESITY

Percentage of the population (15+) who are obese



There has been a rise in obesity rates in New Zealand in recent decades. The 2011/13 NZ Health Survey found that 30% of adults and 10% of children are now obese.

This has significant implications for rates of cardiovascular and respiratory disease, diabetes and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.

Supporting our population to achieve healthier body weights through improved nutrition and physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.

Data Source: National Health Survey[4]

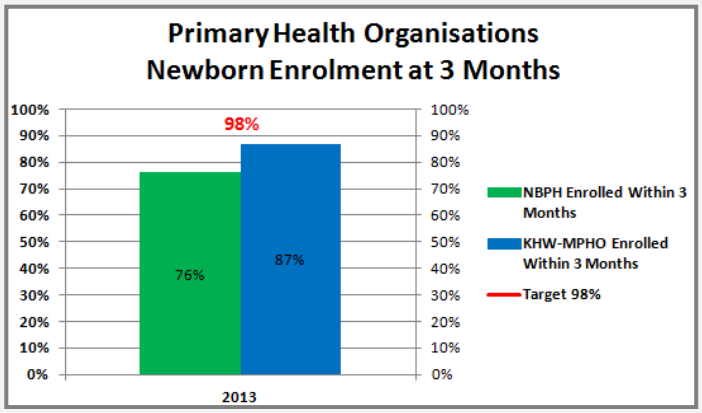
[3] The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2012/13. However the 2011/12 and 2012/13 surveys were combined in order to provide results for smaller DHBs – hence the different time periods presented. Results are unavailable by ethnicity. The 2013 Census results (while not directly comparable) indicate rates for Māori, while improving, are twice that of the total population – 30.7% of Canterbury Māori are regular smokers in 2013 compared to 14.5% of the total population.

[4] The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people.

Intermediate Impact Indicators – Main Measures of Performance

NEWBORN ENROLLMENT -

Percentage of newborn babies enrolled with a general practice at 12 weeks



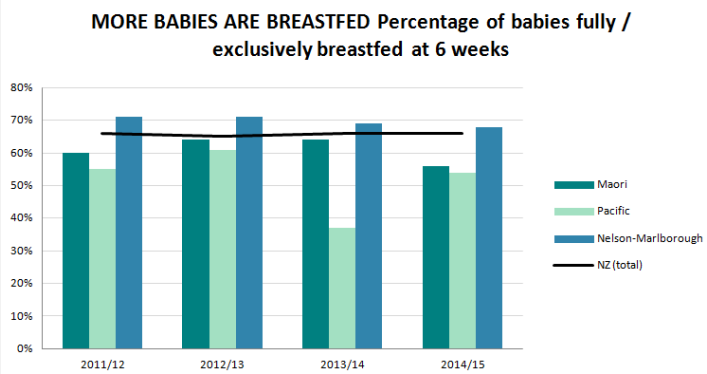
2013/14	2015/16	2016/17	2017/18	2018/19
	Target: 98%	98%	98%	98%

Enrolment of a newborn baby with their general practice soon after birth is important so they can receive essential health care, including immunisations, on time. Late enrolment means a baby may start their immunisations late, exposing them to preventable diseases like whooping cough and measles. This could also lead to delays in receiving further immunisations. Earlier enrolment helps minimise this risk.

An increase in newborn enrolments is seen as an early indicator for immunisation rates, and overall general child health.

BREASTFEEDING

Percentage of 6-week-old babies exclusively or fully breastfed



2014/15	2016/17	2017/18	2018/19	2019/20
Actual: 68%	Target: 75%	75%	75%	75%

Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

Breastfeeding also contributes to the wider wellbeing of mothers and bonding between mother and baby.

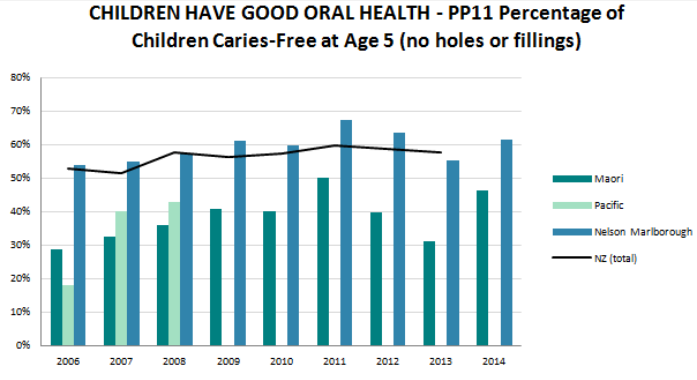
An increase in breastfeeding rates is seen as a proxy indictor of the success of health promotion and engagement activity, appropriate access to support services and a change in both social and environmental factors influencing behaviour and support healthier lifestyle choices.

Data Source: Plunket via the Ministry of Health[5]

[5] *Because provider data is currently not able to be combined performance data from the largest provider (Plunket) is therefore presented. While this covers the majority of children, because local WellChild/Tamariki Ora providers target Maori and Pacific mothers results for these ethnicities are likely to be under-stated.*

ORAL HEALTH

Percentage of 5-year-olds caries free (no holes or fillings)



2014/15	2016/17	2017/18	2018/19	2019/20
Actual: 61.3%	Target: 65%	65%	65%	65%

Oral health is an integral component of lifelong health and impacts a person's self-esteem and quality of life.

Good oral health not only reduces unnecessary hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which then has lasting benefits in terms of improved nutrition and health outcomes.

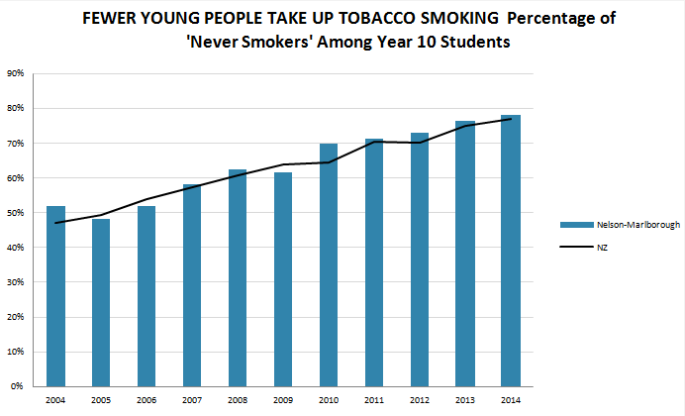
Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy indicator of equity of access and the effectiveness of services in targeting those most at risk.

The target for this measure has been set to maintain the total population rate while placing particular emphasis on improving the rates for Māori and Pacific children.

Data Source: Ministry of Health Oral Health Team

SMOKING

Percentage of year-10-students who have 'never smoked'



2014/15	2016/17	2017/18	2018/19	2019/20
Actual: 78%	Target: 80%	82%	84%	86%

Most smokers begin smoking before 15 years of age, with the highest prevalence of smoking amongst younger people. Reducing smoking prevalence across the total population is therefore largely dependent on preventing young people from taking up smoking.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of health promotion and engagement activity and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.

Because Māori and Pacific have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides significant opportunities to improve long-term health outcomes for these populations.

Data Source: National Year 10 ASH Snapshot Survey[6]

[6] *The ASH Survey has been used to monitor student smoking since 1999 and is run by Action on Smoking and Health and provides an annual point preference snapshot of students aged 14 or 15 years at the time of the survey – see www.ash.org.nz.*

1.4.2 STRATEGIC OUTCOME GOAL 2

People stay well in their own homes and communities

Why is this outcome a priority?

When people are supported to stay well in the community, they need fewer hospital-level or long-stay interventions. This is not only a better health outcome, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes at a lower cost than countries with systems that focus on specialist level care.

General practice can deliver services sooner and closer to home and through early detection, diagnosis and treatment, deliver improved health outcomes. The General Practice team is also vital as a point of continuity, particularly in terms of improving the management of care for people with long-term conditions and reducing the likelihood of acute exacerbations of those conditions resulting in complications of injury and illness.

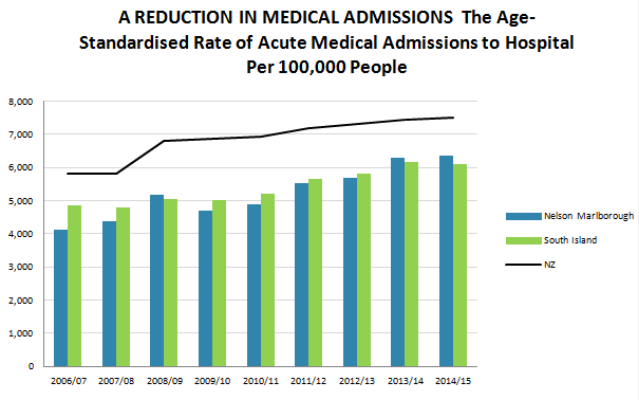
Health services also play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, allied and personal health providers and pharmacists. These providers also have prevention, early intervention and restorative perspectives and link people with other social services that can further support them to stay well and out of hospital.

Even where returning to full health is not possible, access to responsive, needs-based pain management and palliative services (closer to home and families) can help to improve the quality of people's lives.

Overarching Outcome Indicators

ACUTE HOSPITAL ADMISSIONS

Rate of acute (urgent) medical admissions to hospital (age standardised, per 100,000)



Long-term conditions (cardiovascular and respiratory disease, diabetes and mental illness) have a significant impact on the quality of a person's life.

However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and death.

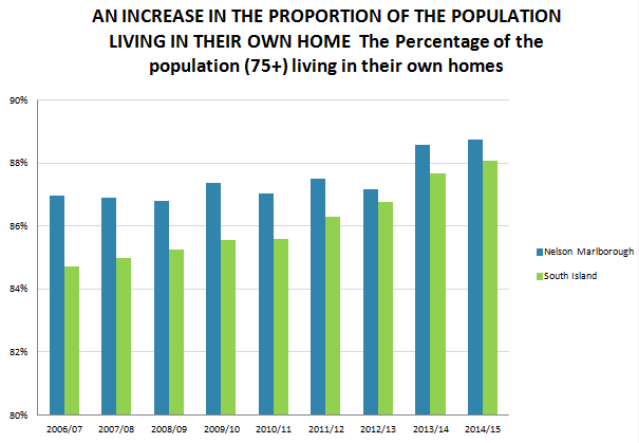
Lower acute admission rates can be used as a proxy indicator of improved conditions management they can also be used to indicate the accessibility of timely and effective care and treatment in the community.

Reducing acute admissions also has a positive effect by enabling more efficient use of specialist resources that would otherwise be taken up by reacting to demand for urgent care.

Data Source: National Minimum Data Set

PEOPLE LIVING AT HOME

Percentage of the population (75+) living in their own home



While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.

Living in ARC is also a more expensive option, and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes.

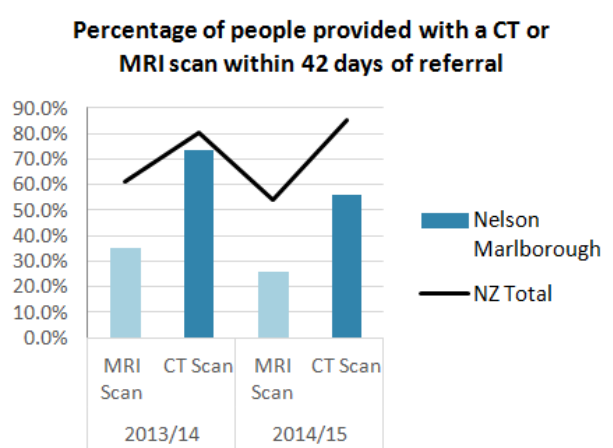
An increase in the proportion of older people supported in their own homes can be used as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

Data Source: SIAPO Client Claims Payment System

Intermediate Impact Indicators – Main Measures of Performance

EARLIER DIAGNOSIS

Percentage of people waiting no more than six weeks for their CT or MRI Scan



2014/15	2016/17	2017/18	2018/19	2019/20
CT Actual: 56%	Target: 95%	95%	95%	95%
MRI Actual: 26%	Target: 85%	85%	85%	85%

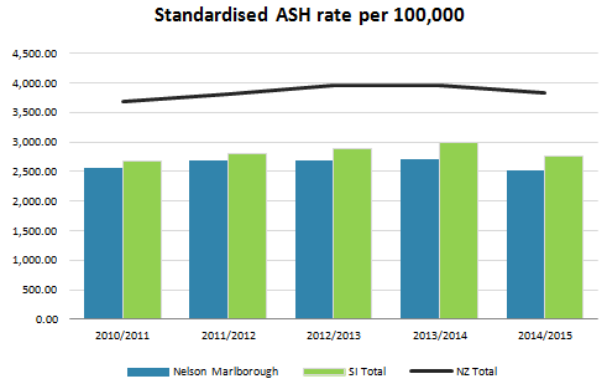
Diagnostics are an important part of the healthcare system and timely access, by improving clinical decision making, enables early and appropriate intervention, improving quality of care and outcomes for our population.

Timely access to diagnostics can be seen as a proxy indicator of system effectiveness where effective use of resources is needed to minimise wait times while meeting increasing demand.

Data Source: Individual DHB Patient Management Systems

AVOIDABLE HOSPITAL ADMISSIONS

Ratio of actual vs. expected avoidable hospital admissions for the population aged 45-64 (ASH – SI1)



2014/15	2016/17	2017/18	2018/19	2019/20
Actual: 2,524	Target: N/A	N/A	N/A	N/A

Given the increasing prevalence of chronic conditions effective primary care provision is central to ensuring the long-term sustainability of our health system.

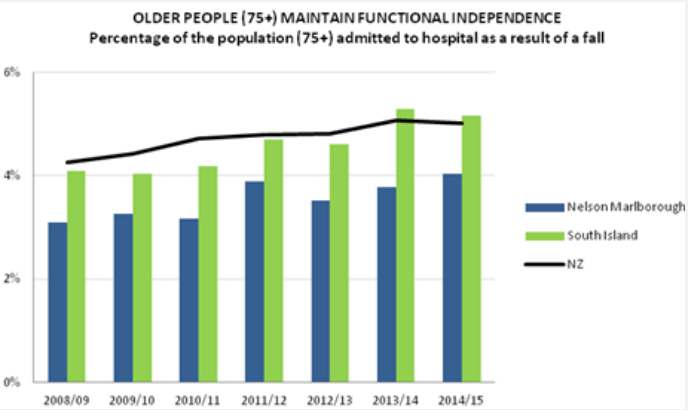
Keeping people well and supported to better manage their long-term conditions by providing appropriate and coordinated primary care should result in fewer hospital admissions - not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

Lower avoidable admission rates are therefore seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system.

Data Source: Ministry of Health Performance Reporting SI1[7]

FALLS PREVENTION

Percentage of the population (75+) admitted to hospital as a result of a fall



2014/15	2016/17	2017/18	2018/19	2019/20
Actual: 7.7%	Target: N/A	N/A	N/A	N/A

Approximately 22,000 New Zealanders (aged over 75) are hospitalised annually as a result of injury due to falls. Compared to people who do not fall, these people experience prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.

With an ageing population, a focus on reducing falls will help people to stay well and independent and will reduce the demand on acute and aged residential care services.

Solutions to reducing falls span both the health and social service sectors and include appropriate medications use, improved physical activity and nutrition, appropriate support and a reduction in personal and environmental hazards.

Lower falls rates can therefore be seen as a proxy indicator of the responsiveness of the whole of the health system to the needs of our older population as well as a measure of the quality of the individual services being provided.

Data Source: National Minimum Data Set

[7] *This indicator is based on the national performance indicator SI1 and covers hospitalisations for 26 conditions which are considered preventable including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The target is set to maintain performance below the national rate, which reflects less people presenting. There is currently a definition issue with regards to the use of self-identified vs. prioritised ethnicity and while this has no impact on total population result it has significant implications for Maori and Pacific breakdowns against this measure. The DHB continues to communicate with the Ministry around resolving this issue.*

1.4.3 STRATEGIC OUTCOME GOAL 3

People with complex illness have improved health outcomes

Why is this outcome a priority?

For people who do need a higher level of intervention, timely access to quality specialist care and treatment is crucial in supporting recovery or slowing the progression of illness. This leads to improved health outcomes with restored functionality and a better the quality of life.

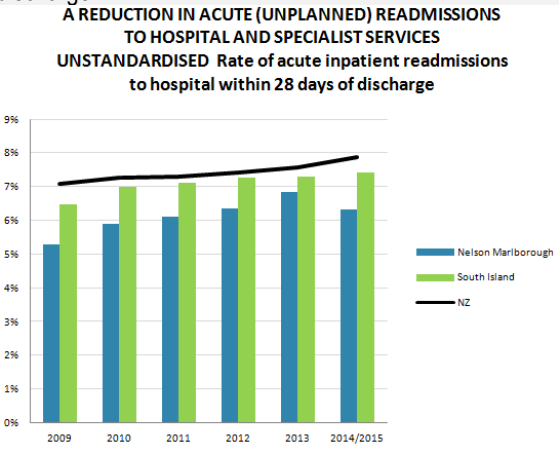
As providers of hospital and specialist services, DHBs are operating under growing demand and workforce pressures. At the same time, Government is concerned that patients wait too long for specialist assessments, cancer treatment and elective surgery. Shorter waiting lists and wait times are seen as indicative of a well-functioning system that matches capacity to demand by managing the flow of patients through its services and reduces demand by moving the point of intervention earlier in the path of illness.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population into the future. It also reflects the importance of the quality of treatment. Adverse events, unnecessary waits or ineffective treatment can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that have a negative impact on the health of our population.

Overarching Outcome Indicators

ACUTE READMISSIONS

Rate of acute readmissions to hospital within 28 days of discharge



Unplanned hospital readmissions are largely (though not always) related to the care provided to the patient.

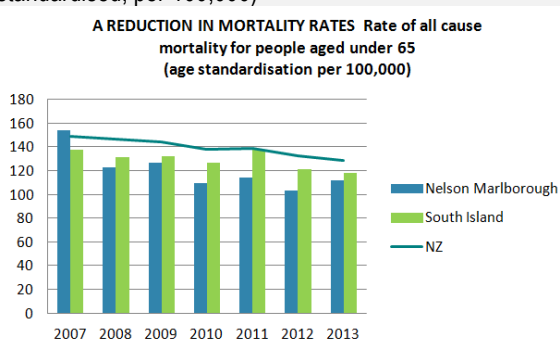
As well as reducing public confidence and driving unnecessary costs - patients are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

Because the key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge – they are a useful maker of the quality of care being provided and the level of integration between services.

Data Source: Ministry of Health Performance Data OS8[8]

AVOIDABLE MORTALITY

Rate of all-cause mortality for people aged under 65 (age standardised, per 100,000)



Timely and effective diagnosis and treatment are crucial factors in improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases treatment options and the chances of survival.

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced.

A reduction in avoidable mortality rates can be used as a proxy indicator of responsive specialist care and improved access to treatment for people with complex illness.

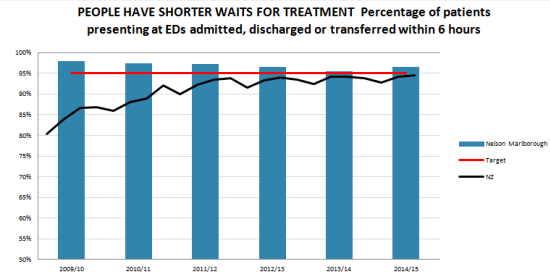
Data Source: National Mortality Collection - 2010 Update.[9]

[8] *This indicator is based on the national performance indicator OS8. The DHB has identified a number of data inconsistencies with the when comparing local data, particularly where patients transferring between hospitals are coded as readmissions. The DHB continues to work with the Ministry to resolve this issue and is tracking trends internally to identify any performance issues.*

Intermediate Impact Indicators – Main Measures of Performance

WAITS FOR URGENT CARE

Percentage of people presenting at ED who are admitted, discharged or transferred within six hours



2014/15	2016/17	2017/18	2018/19	2019/20
Actual: 96.5%	Target: 95%	95%	95%	95%

Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.

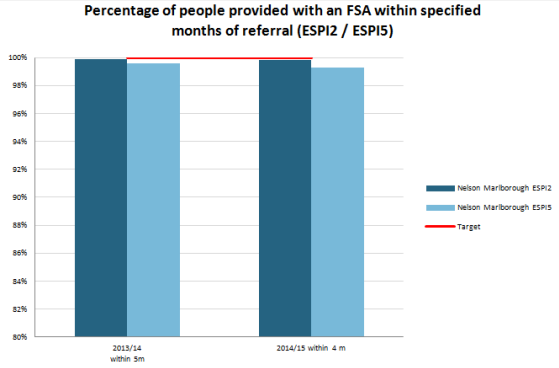
Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Enhanced performance will not only improve patient outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.

Solutions to reducing ED wait times span not only the hospital but the whole health system. In this sense, this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.

Data Source: Individual DHB Patient Management Systems[10]

ACCESS TO PLANNED CARE

Percentage of people receiving their specialist assessment (ESPI 2) or agreed treatment (ESPI 5) in under four months



2014/15	2016/17	2017/18	2018/19	2019/20
Actual: >100%	Target: 100%	100%	100%	100%

Planned services (including specialist assessment and elective surgery) are an important part of the healthcare system and improve people's quality of life by reducing pain or discomfort and improving independence and wellbeing.

Timely access to assessment and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.

Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is a marker of how responsive the system is to the needs of the population.

Data Source: Ministry of Health Quickplace Data Warehouse[11]

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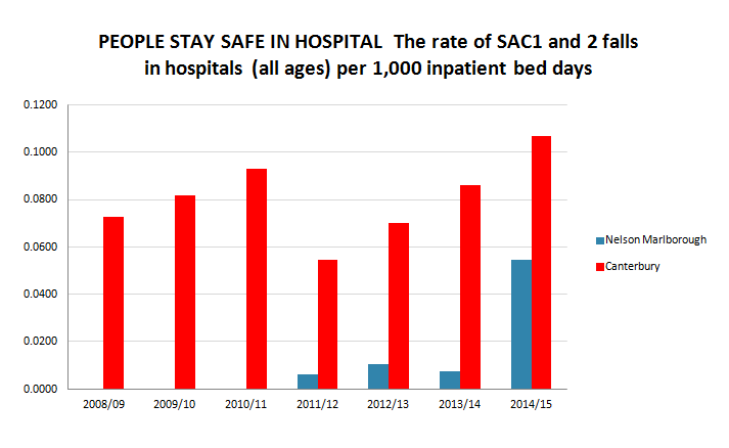
[9] *National Mortality Collection data is released four years in arrears and the data presented was released in 2014.*

[10] *This indicator is based on the national DHB Health Target 'Shorter Stays in ED' introduced in 2009 – in line with the health target reporting the annual results presented are those from the final quarter of the year.*

[11] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHB are provided with individual performance reports from the Ministry of Health on a monthly basis. In line with the ESPIs target reporting the annual results presented are those from the final quarter of the year.*

ADVERSE EVENTS

Rate of Severity Assessment Code (SAC) Level 1 & 2 falls in hospital (per 1,000 inpatient bed-days)



2014/15	2016/17	2017/18	2018/19	2019/20
Actual: 0.055%	Target: N/A	N/A	N/A	N/A

Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems and improve outcomes for patients in our services.

The rate of falls is particularly important, as patients are more likely to have a prolonged hospital stay, loss of confidence, conditioning and independence and an increased risk of institutional care.

Achievement against this measure is also seen as a proxy indicator of the engagement of staff and clinical leaders in improving processes and championing quality.

Data Source: Individual DHB Quality Systems[12]

[12] *The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest consequence and likelihood.*

DELIVERING ON PRIORITIES AND TARGETS

2.1 PRIORITIES AND TARGETS

The key strategic outcomes our health system is working towards are clustered into the themes of Cross Government Initiatives, Long Term Conditions, System Integration, and Health System Plans as follows:

The Nelson Marlborough Health System Key Strategic Outcomes

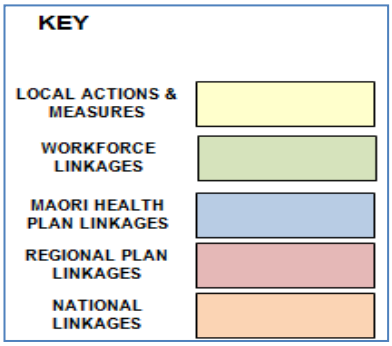
2016/17 Plans																				
Cross Government Initiatives			**Long Term Conditions**			**System Integration**										**Health System Plans**				
Youth Health & Wellbeing (including Reducing Unintended Teenage Pregnancy and Prime Minister's Youth Mental Health Project)	Increased Immunisation	Child Health (including Obesity / Healthy Weight, Supporting Vulnerable Children, and Rheumatic Fever). Refer also to 'Stewardship' section for Child Protection Policies and Children's Worker Safety Checking	Living Well with Diabetes and Cardiovascular Disease	Better Help for Smokers to Quit (Tobacco)	Rising to the Challenge	Cancer Services	Stroke Services	Cardiac Services	Health of Older People	Service Configuration including Shifting Services	System Level Outcome Measures	Shorter Stays in ED	Whanau Ora	Improved Access to Diagnostics	Improved Access to Elective Surgery	Improving Quality & Clinical Governance	IT & Infrastructure	Workforce	Disability Support Services (DSS)	Delivering on Regional Priorities

The following section pulls the national, regional, and local priorities together. Each plan sets out the key actions needed beyond business as usual to achieve the higher-level results that Nelson Marlborough Health expects to achieve, and identifies measures that provide evidence of progress towards achievement.

The plans have been developed with consideration for the New Zealand Health Strategy themes of:

- People powered
- Closer to home
- Value and high performance
- One team
- Smart system.

The actions in the plans are colour coded to clearly identify the linkages between the specific plans to deliver a single integrated and aligned plan for the Nelson Marlborough health system. The key is shown below:



2.1.1 CROSS GOVERNMENT INITIATIVES

All social sector agencies need to be innovative, responsive and work together in order to provide services that best meet the needs of priority populations. For DHBs, many of the factors that influence the health status of people within our community – education, income, housing and environment - are outside our direct control. Yet they are areas we can influence and where we must work with our partners in the public service.

A system that provides Better Public Services is one that has:

- More responsive mental health services for youth
- Fully immunised children
- Early identification and support for vulnerable children
- Children with a healthy weight and good oral health
- Decreasing incidence of rheumatic fever.

Please refer to the action plans below:

Action Plan		Page Number
Youth Health & Wellbeing (including Reducing Unintended Teenage Pregnancy and Prime Minister's Youth Mental Health Project)	The plan outlines a continuum of services that is acceptable, accessible and responsive to young people, including school based services, mental health and addiction services, and primary care services.	• Page 38
Increased Immunisation	The plan outlines how we will achieve the Immunisation Health Targets: 95 percent of eight-month-olds and two-year-olds are fully immunised; 95 percent of four-year-olds are fully immunised by age 5 by June 2017; At least 70 percent of all 12-year-old girls will have completed all doses of their HPV vaccine	• Page 39
Child Health (including Obesity / Healthy Weight, Supporting Vulnerable Children, and Rheumatic Fever)	The plan outlines how the service will work with their wider sector, including Primary Care providers, Lead Maternity Carers, Well Child Tamariki Ora, and Community Oral Health services to achieve improved Child Health and ensure we are meeting the requirements of the Vulnerable Children's Act and the new Obesity target.	• Page 40

2.1.2 LONG TERM CONDITIONS

The prevalence of long term conditions is increasing in Nelson Marlborough, causing premature mortality and morbidity, which is directly or indirectly linked with the underlying disease. Maori and Pacific people, people living in low socioeconomic circumstances, people with disabilities and people with mental health and addictions issues are disproportionately affected by some long term conditions, with a more significant impact from ill health and earlier mortality.

Our emphasis is on providing evidence-based services that are people-centred and closer to where people live, learn, work and play. Our services focus on wellness and prevention, early identification, and integrating management and treatment in community-based services.

Please refer to the action plans below:

Action Plan		Page Number
Living Well with Diabetes and Cardiovascular Heart Disease	The plan outlines how we will continue to implement actions that will support delivery of the diabetes plan, and how we will continue to deliver cardiovascular services to utilise the final year of Budget 2013 funding, with a focus on Maori and groups with inequitable health outcomes.	• Page 41
Better Help for Smokers to Quit (Tobacco)	The plan reinforces our commitment to achieve the Government's Smokefree 2025 goal, supported by the achievement of the Smokefree goals, and implementation of the Tobacco Control Plans so that less than 5 percent of the Nelson Marlborough population will be a current smoker. The plan outlines how we will achieve the smoking related Health Targets: 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months; 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered advice and support to quit.	• Page 42
Rising to the Challenge	The plan outlines actions and measures to deliver on Mental Health as a regional priority, including Children of Parents with a Mental Illness or Addiction (COPMIA). We will also make better use of resources, improve integration between primary and specialist services, cement and build on gains in resilience and recovery, and deliver increased access for all age groups.	• Page 43 & 44

2.1.3 SYSTEM INTEGRATION

A health system that is well integrated provides a sustainable system where people receive services from the right person, at the right time and in the right place. A sustainable health system into the future requires one team providing:

- Care closer to home
- Early intervention
- Hospital avoidance interventions
- Reducing acute demand.

Nelson Marlborough Health is committed to whole of system collaborative working at a local and regional level using alliances. Our main alliance is the 'Top of the South Health Alliance' (ToSHA), and our inclusive and collaborative planning process involves staff from the DHB, PHOs and other health providers (e.g. Te Piki Oranga).

To achieve the best health outcomes for the Nelson Marlborough population, we must deliver better public health services to meet the heath needs of our community. Better health services improve the lives of all New Zealanders by being well coordinated and focused on the needs of the patient, while also being sustainable.

Please refer to the action plans below:

Action Plan		Page Number
Cancer Services	The plan outlines how we will improve equity for patients along the cancer pathway, and achieve the Faster Cancer Treatment Health Targets: 85 percent of patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks, increasing to 90 percent by June 2017.	• Page 45
Stroke Services	The plan outlines how we will improve stroke prevention, stroke event survival, and reduce subsequent stroke events; and improve access to organised acute and rehabilitation stroke services.	• Page 46
Cardiac Services	The plan outlines how the Cardiac Services department will operate within the central cardiac network's minimum standards of access to secondary cardiac care and deliver cardiac services within the specified timeframes.	• Page 47
Health of Older People	The plan aims to ensure older people and their whanau are valued partners in an integrated health and social support system that supports wellbeing and control over their circumstances.	• Page 48 & 49
Service Configuration including Shifting Services	The plan outlines how the DHB and two PHOs in the Nelson Marlborough region will work together to improve the integration of services, including shifting services, to ensure patients receive more effective and coordinated services closer to home and provided by one team.	• Page 50 & 51
System Level Outcomes Measures	Nelson Marlborough Health, in collaboration with Nelson Bays PHO and Kimi Hauora Marlborough PHO, commits to provide a jointly developed and agreed Improvement Plan to the Ministry of Health by 20 October 2016.	• Page 52
Shorter Stays in Emergency Departments	The plan outlines how we will implement *A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand*, and continue to achieve the Emergency Department Health Target: 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours of presentation.	• Page 53
Whanau Ora	The plan outlines our commitment to a heightened focus to achieve accelerated process towards Whanau Ora and health equity within the five priorities: mental health, asthma, oral health, obesity and tobacco, and how we will actively engage and collaborate with Whanau Ora Commissioning Agencies.	• Page 54
Improved Access to Diagnostics	The plan outlines how we aim to achieve waiting time targets, our participation in activity relating to implementation of the National Patient Flow (NPF) system, and how we will continue to work with regional and national clinical groups to contribute to development of improvement programmes.	• Page 55
Improved Access to Elective Surgery	The plan outlines how we will improve access to elective services by delivering our agreed volume schedule to deliver the Electives Health Target, maintain reduced waiting times for elective First Specialist Assessment (FSA) and treatment, and improve equity of access to services, so patients receive similar access regardless of where they live.	• Page 56

2.1.4 HEALTH SYSTEM PLANS

Nelson Marlborough Health is a strongly performing and financially prudent organisation. To maintain our record of solid financial performance and good service delivery, we understand that we need to save to invest. Keeping to budget is important as it allows investment into new and more health initiatives, and will reduce the financial 'hangover' that often follows significant infrastructure investment, such as the planned rebuild of Nelson Hospital.

The challenge to our clinical and managerial leads was to review all our services and functions to identify efficiency opportunities, investment opportunities which will deliver tangible financials gains, and disinvestment options. The Board subsequently approved a programme of savings initiatives, which are reflected in this plan as appropriate.

National Entity Priority Initiatives

Although a local Workforce or IT plan was not required by the Ministry, because many of these actions are reflected in the South Island regional plan, we thought it was important to include the key actions for the year ahead in this Annual Plan and note our commitment to national entity priority initiatives.

Our IT & Infrastructure plan includes preparation for the implementation of the national Oracle solution and the national Food Services business case. We will continue to transfer local infrastructure to one of two National Infrastructure Platforms (NIP) in Auckland or Christchurch, and will implement a local linen contract as an alternative to the NZ Health Partnerships collective contract. We will continue to implement the South Island Patient Information Care System (PICS) to replace our legacy Patient Administration System, work towards electronic Prescribing and Administration (ePA), and we will participate in the National Health IT Board Electronic Health Record (EHR) engagement process.

Our Workforce plan outlines how we will optimise workforce capacity, create a productive workplace culture, and deliver advanced workforce capability. We are also working as a South Island region to increase participation of Maori and Pacific people in the health workforce, implement community based attachments for prevocational trainers, increase the number of sonographers, and establish specialist roles, such as new palliative care specialist nurses and educators, nurse practitioners, clinical nurse specialists, nurses performing endoscopies, and medical physicists.

Other Annual Plans for our Health System

Public Health aims to improve the health of communities and to reduce inequalities in health status, and the focus is around the social and physical environments in which we live as well as on programmes to develop more healthy activities. The Maori Health service aims to improve Maori health outcomes. Both Public Health and Maori Health produce individual annual plans.

As Public Health and Maori Health are key components of the health system in our region, we need to ensure the objectives and actions for the year ahead in their annual plans are aligned with the Nelson Marlborough Health annual plan. Through collaborative working and the sharing of information, we are comfortable that we have a cohesive plan for our health system.

Action Plan		Page Number
IT & Infrastructure	This plan outlines how we will continue to invest in improving our clinical IT systems to enhance care delivery, and provide patients in Nelson Marlborough with secure access to their personal health information. The plan also outlines how we will manage and develop our infrastructure assets to support health system transformation, sustainability, safety and security.	• Page 57
Workforce	This plan outlines how we will develop a capable and engaged workforce to support the transformation of the Nelson Marlborough health system. Building on the Nelson Marlborough Health's Workforce Strategy developed during 2014-15, we will integrate the strategy with the workforce plan for the South Island region.	• Page 58
Improving Quality and Clinical Governance	The plan outlines how we will drive quality improvement, including Quality Safety Markers and developing an annual Quality Account for our community. The plan also outlines the actions needed to create a no-blame culture based on	• Page 59

	organisational values and personal responsibility to create an environment in which excellence in clinical care will flourish.	
Disability Support Services (DSS)	As one of the two DHBs still providing a disability support service (DSS) for people with physical and intellectual disabilities, this plan outlines how we will deliver on the two priorities for 2016-17 – developing a person-centred culture and future service provision.	• Page 60 & 61
Delivering on Regional Priorities	We are working with other DHBs in the South Island region to implement a single and integrated clinical pathway for hepatitis C care, implement a regional major trauma system to ensure more patients survive major trauma and recover with a good quality of life, and prevent and manage rheumatic fever.	• Page 62

Youth Health & Wellbeing

OWNER / CHAMPIONS:
GM Mental Health & Addictions / Clinical Director Mental Health – Community (Themes 2, 4,)
Service Manager Women, Child & Youth / Clinical Director Women Child & Youth (Themes 1,3,5)

OUTCOME GOAL 1: A continuum of services that is acceptable, accessible and responsive to young people

ACTION THEME 1: School Based Health Services

ACTION 1: Maintain school-based health services in Alternative Education and Teen Parent Unit and explore options to extend, e.g. working with Marlborough education agencies to have input in planning for new college in Blenheim to incorporate facilities able to be utilised by health services.

MEASURE 1: SBHS maintained.

ACTION 2: Implement "Youth Health Care in Secondary Schools: A framework for continuous quality improvement" in one further education setting.

MEASURE 2: QIF implemented in 1 further setting by 30/6/17

ACTION 3: Support the extension of 'Teen Health Fest' to Marlborough schools

MEASURE 3: Teen Health Fest held in Youth Week 2017

ACTION THEME 2: Improve Access to CAMHS & Youth AOD services through wait time & integrated case

ACTION 4: Continued focussing on meeting waiting time

MEASURE 4: 80% of children & youth access specialist services within 3wks of referral & 95% within 8wks by 30/06/17

ACTION 5: Work collaboratively across MH & Addictions to develop integrated care plans for young people with MH and AOD issues

MEASURE 5: Evidence of integrated care plans

ACTION THEME 3: Reducing Teenage pregnancy

ACTION 6: Continue the ECP service; monitor & respond to any trends & concerns including effectiveness in reaching Maori and Pasifika youth

MEASURE 6: Service evaluation report by 30/6/17

ACTION 7: Work to increase community nursing capacity & capability in providing ECP & contraception to young people.

MEASURE 7: Increase nurses endorsed to provide ECP and have standing orders to support access to contraception by 3/17

ACTION 8: Support improved delivery of sexual & reproductive health education in schools through workforce development for teachers

MEASURE 8: Three training sessions by 30/06/17

ACTION 9: Complete & compile data of a district-wide youth survey regarding access to health services.

MEASURE 9: Report analysed by 30/9/16

ACTION 10: Review access to sexual health services for rural youth

MEASURE 10: Access reviewed by 31/03/17

ACTION 11: Develop a sexual and reproductive health plan covering the continuum from prevention to management and support.

MEASURE 11: Plan is developed and actions identified with key stakeholders within health and with cross sector partners

ACTION THEME 4: Youth Primary Mental Health & Addictions

ACTION 11: Explore issues & opportunities in access to counselling services for young people, including on-line options.

MEASURE 11: Options identified and promoted by 31/12/16

ACTION 12: Develop information, resources & pathways for LGBTI youth

MEASURE 12: Resources & pathways in place 30/06/17

ACTION THEME 5: Improving the responsiveness of primary care to youth

ACTION 13: Maintain the Youth Health alliance group to ensure implementation of Annual Plan actions & to plan & oversee future improvements in youth health service delivery & access

MEASURE 13: Agreed initiatives are implemented by 30/06/17

ACTION 14: Extend 'Teen Health Fest' to a non-school setting targeting young Maori

MEASURE 14: Teen Health Fest delivered by 30/05/17

ACTION 15: Review enrolment processes for transfer of young people to adolescent oral health providers

MEASURE 15: Higher adolescent enrolment rates by 31/03/17

ACTION 16: Work in Marlborough to establish a Well Youth Forum for networking and collaboration between key

MEASURE 16: Forum established by 31/12/16

ACTION 17: Implement agreed key service improvement initiatives to address gaps & effectiveness identified through youth engagement.

MEASURE 17: Two initiatives implemented by 30/06/17.

See also: Mental Health & Addictions; Child Health; Better Help for Smokers to Quit; System Integration Maori Health Plan

CONTEXT There is an important relationship between healthy social & emotional development early in life, and later health & wellbeing. Mental health problems & substance misuse often first appear in adolescence. Mental health & AOD problems at a young age can have long-term detrimental effects on physical & mental wellbeing. NMDHB works to increase resilience & improve outcomes for young people in community & primary settings by intervening early, and in specialist Mental Health and Addiction Services, by improving access & decreasing waiting times for services. Developing integrated services for youth also contributes to achieving better wellbeing for young people. All work seeks to improve health outcomes for Maori and Pacific young people. Ongoing workforce development is important in improving the youth-friendliness of health services.

Increased Immunisation

OWNER / CHAMPION: Service Manager – Public Health, Rural Health and District Nursing

OUTCOME: Reduction in death and health consequences in vulnerable

- **MEASURE**: 95% of 8 month olds, 2 year olds & four-year-olds (by age 5) are fully immunised by June 2017.

OUTCOME: Reduced incidence of vaccine-preventable disease

- **MEASURE**: 70% of eligible girls receive dose 3 of the HPV (Human papillomavirus) vaccination
- **MEASURE**: 75% of those 65 and over are immunised for influenza

ACTION: Provide tools for health professionals working with parents choosing to decline or delay immunisation and training to participate in difficult conversations

- Number of active decliners in 16-17 are less than in 15-16
- Up to 3 training sessions offered for health professionals working with decliners
- 100% of practices are documenting reasons people choose to delays or decline immunisation
- At least 2 meetings with LMCs/Well Child Providers a year with a focus on working with those who choose to decline immunisation

ACTION: Ensure systems and professional development in place for Health Providers to ensure high vaccination rates

- District Immunisation Facilitators attend at least 1 midwifery forum to promote immunisation and educate on vaccine preventable diseases (VPDs) by 30/06/17
- 100% of practices using the Timeline Tool or equivalent and 100% of practices in Nelson/Tasman using the patient dashboard
- Minimum of 6 ImmPHO newsletters produced annually covering articles on HepB, Influenza, HPV, Pertussis and Measles and other topical information
- Practices represented at Immunisation Special Interest Group (ISIG) meetings and "Talk Immunisation Programme"

ACTION: Work with Te Piki Oranga (TPO) and PHO Liaison Services to ensure capacity to deliver immunisation clinics on Marae and in community clinics and promote immunisation

- 10 Community & Marae based immunisations clinics delivered by 30/6/17
- Training (including 'talk immunisation' and promoting national standards for vaccinator courses) to Maori, Pacific & Refugee health providers

ACTION: Promote pathways for referrals to Te Piki Oranga (TPO), OIS and PHO navigation services to improve immunisation uptake

- 95% of Maori, Pacific & high needs population are immunised on time, reported quarterly
- Monthly meetings between Outreach Immunisation Services & register services to determine caseload & prioritisation

ACTION: Increase HPV immunisation rates by promotion, and workforce development to expand the range of organisations promoting immunisations

- Te Piki Oranga promotes HPV vaccinations
- Online learning tools are promoted
- Health provider education and PHO newsletters include HPV information addressing known parental concerns

ACTION: Work across sectors to increase vaccination rates

- Processes developed to provide vaccinations for whanau in contact with the Ministry of Social Development by 30/11/16

ACTION: Immunisation Governance Group provides leadership and guidance to the Immunisation Operations Group

- Governance Group meets at least quarterly
- Governance Group monitors and reports on 4 year old immunisation status

ACTION: Continue to promote and support a 4 step communications plan for the community that promotes best practice key immunisation messages

- 10 editorials in Marlborough community newspapers addressing vaccine preventable diseases across the district by 30/06/16
- Minimum of 6 newsletters provided to all practices by year end
- Pregnancy packs promote vaccinations for pregnant women

ACTION: Promote early enrolment processes with Lead Maternity Carers and General Practices.

- 98% of newborns enrolled by 3 months by 1/10/16

ACTION: Children presenting at ED and inpatients are assessed for immunisation status and immunisation offered and undertaken before discharge

- A process for determining immunisation status in ED, inpatients & selected outpatient services is implemented by 31/12/16

CONTEXT: Immunisation can prevent a number of diseases. It not only provides individual protection but also population-side protection by reducing the incidence of infectious diseases and preventing the spread to vulnerable people. Low immunisation rates have previously enabled breakthrough of diseases like measles and whooping cough. Our district-wide Immunisation Facilitation Plan provides the operational activity we will undertake to ensure high vaccination rates. A key focus is to understand why people decline immunisations and to work to provide people with clear, consistent information about immunisations.

SEE ALSO: Maori Health Plan, Public Health Plan & District Immunisation Facilitation Plan (available – NMDHB Strategy Planning & Alliance Support Team); Child Health Module

Child Health

OWNER / CHAMPION: Service Manager – Women Child & Youth: Clinical Director – Women Child & Youth

OUTCOME: Children and their families have access to high quality child health services and improved health outcomes

ACTION THEME 1: Enacting the Children's Action Plan

ACTION: Continue to offer training on E-Prosafe & National Child Protection Alert System (NCPAS) to primary care with appropriate training and embedded and promoted pathways

- Systems available and training occurs by 31/06/17

ACTION: Violence Intervention Programme (VIP) training completed in 3 more DHB departments & offered in primary care

- In-house & the offer for primary care training occurs by 1/4/17

ACTION: Exceptions & remedial actions reported for audit scores < 80/100 for the child & partner abuse components of the VIP

- 100% reporting maintained

ACTION: Staff who have contact with children will have safety checks undertaken

- 100% of new 'non-core' staff working with children have safety checks from 1/7/16, and100% of existing core staff by 30/6/17

ACTION: A dashboard of child health indicators is developed

- Dashboard reported to the Child & Youth Alliance Group by 30/11/16

ACTION THEME 2: Prevention of Sudden Unexpected Death in Infancy (SUDI)

ACTION: Undertake actions to reduce the risk of SUDI

- Safe Sleep audit completed in NMDHB maternity and child inpatient settings by 30/11/16
- Risk assessment and Safe Sleep planner implemented by maternity units by 30/06/17
- Workforce development undertaken by 30/6/17

ACTION THEME 3: Continual improvement of Child services

ACTION: Reduce the incidence and facilitate the effective follow up of rheumatic fever case

- Continue to provide progress reports on our regional prevention plan including case review of any new cases.
- Implement a package of care for whanau that have children with rheumatic fever by 1/10/16

ACTION THEME 4: A healthy weight is achieved for more children in Nelson Marlborough

ACTION: Referral processes to nutrition, activity and lifestyle interventions for children are embedded in B4SC programme

- By December 2017, 95% of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity & lifestyle interventions
- Single point of entry for child referrals achieved by 30/6/17
- Consumer champions available for whanau by 30/11/16

ACTION: Existing primary care providers supported to realign services to further support healthy weight in children

- Primary providers trained in Triple P by 31/10/16 including providing wrap around services with social service providers
- Healthy weight health literacy project completed by 31/6/17
- Kaiatawhai service has healthy weight focussed KPIs by 1/9/16
- Clued Up Kids introduced to Nelson with a healthy weight component by 31/12/16
- Health pathways defined for different cohorts of children for referral to MEND, Active Families, Triple P and other community programmes by 31/10/16

ACTION: Support pregnant women to maintain a healthy weight

- CME session on guidelines held for GPs by 30/11/16
- National guidelines for the screening, diagnosis & management of gestational diabetes implemented in primary care by 30/6/17

ACTION: Sugar-sweetened beverage policies promoted in childcare and schools

- Childcare and schools have policies implemented by 1/2/17

ACTION: Infants are enrolled and engaged in primary services

- 98% of 3 month olds, including Maori, enrolled with a GP & WCTO by 1/9/16
- 95% of preschoolers, including Maori, are enrolled in the community oral health service at Dec 2016

ACTION: Investigate options to improve tamariki attendance rates at community oral health hubs

- Agreed options are implemented by 31/12/16

ACTION: Children's team processes embedded

- Referral pathways relevant for Nelson & Wairau developed

ACTION: WCTO Quality Improvement initiatives implemented

- Quarterly regional actions achieved

ACTION THEME 5: Improve access to pregnancy & breastfeeding support services for Maori women –

- 80% of Maori infants are exclusively or fully breastfed at 2 weeks by 30/06/17, 75% at 6 weeks; 60% at 3 months

ACTION: Increase support to Maori women to breastfeed

- LC hours increased in Marlborough by 31/7/16
- Increased education during pregnancy and postnatally

ACTION: Breastfeeding week promotion undertaken

- Maori health and community providers participate in breastfeeding promotional activities

ACTION: Explore expanding reach of antenatal programmes

- Antenatal programme framework agreed by 30/11/16

CONTEXT: To have healthy adults we need to ensure we have healthy children; healthy children also need healthy caregivers and whanau. The Maternity Quality and Safety Plan details much of what NMDHB is doing to ensure coverage of high quality maternity and child health services and improving access and support to vulnerable families. We are working across sectors to establish functional, effective linkages to support families with no gaps in service provision.

SEE ALSO: Immunisation & Stewardship sections; Maori Health Plan; Public Health Plan; Maternity Quality & Safety Plan;

Healthy Hearts and Living Well with Diabetes

OWNER / CHAMPION: Alliance Support Manager – Personal Health; Chair–CVD & Diabetes Working Group

OUTCOME: All people with Cardiovascular Disease (CVD), at risk of CVD, and those with diabetes & pre-diabetes receive optimal care

- **MEASURE**: Maintain 90% of the eligible population have had their CVD risk assessed in the last 5 yrs
- **MEASURE**: The proportion of patients with HbA1c above 64mmol/mol decreases in 2016-17

ACTION THEME 1: Engagement between providers and improved quality of care contribute to improved outcomes

ACTION: Continue integration of primary and secondary services to increase the capability & capacity of the primary care workforce & develop advanced nursing models of care

- Maori Health Providers receive training and expert nurse support for diabetes and cardiac care from 1/7/16
- Specialist nurses are linked to Practices and provide education and support for diabetes and cardiac care from 1/7/16
- Increase in Practices undertaking insulin initiations in 16-17
- Education plan for diabetes and CVD is developed encompassing an integrated approach to education for primary and secondary services by 31/7/16

ACTION: Quality standards for diabetes care and quality standards of care for those with established CVD are implemented

- Detailed workplan for standards implementation by 31/7/16

ACTION: Health pathways developed for pre-diabetes, CVD and diabetes focussed on integrated care and an approach for Maori and groups with inequitable health outcomes

- Pathways in place by 31/12/16

ACTION: Services to manage complications meet the needs of people with diabetes

- 3750 community podiatry consultations made by 30/06/17
- 1200 community nutrition consultations made by 30/06/17
- Retinal screening service reviewed to determine if the service is meeting the needs of those with diabetes by 30/06/17

ACTION THEME 2: The health care workforce is able to better support people's needs

ACTION: Education plan for diabetes and CVD is developed, encompassing an integrated approach to education

- Education plan is developed by 30/08/16

ACTION: Self management resources are provided to health care providers across primary and secondary care

- Education resource is developed by 30/08/16

ACTION THEME 3: People at risk of CVD and diabetes have excellent Access to Primary Health Care

ACTION: Maori Health Providers undertake CVD risk assessments and link with General Practice

- 90% of Maori men in the 35-44 age group have had a risk assessment in the last 5 year by 31/12/16
- Referral pathways to Kaupapa Maori/Pacific services are further developed

ACTION: A health promotion plan is developed to encompass Te Piki Oranga, DHB. PHOs & NGOs

- Health promotion plan is implemented by 30/06/17

ACTION THEME 4: Reliable, timely and useful information is communicated to inform planning, delivery and monitor effect

ACTION: Analyses are undertaken to ensure quality of care

- Audit of outcomes of 10 pre-diabetic screenings completed
- Cross system data disseminated to stakeholders 6 monthly
- Consumer and GP teams experiences of care evaluated
- Connection diagram of clinical advisors and teams developed
- Investigate the potential of reporting stratified HbA1c information in Nelson/Tasman

ACTION THEME 5: Self management is enhanced by ensuring people have access to appropriate education and information

ACTION: Self management pathways are established for those with pre-diabetes, type 1 & 2 diabetes, high risk CVD/with established disease, & those with established disease

- Pathways in place by 30/11/16

ACTION: Utilise MoH Budget funding to fund self-management courses and deliver nurse led care for diabetes

- Patient surveys show an increase in confidence and ability for those with diabetes to self manage during 16-17
- Additional nurse led clinics are held according to plan in 16-17

ACTION: An individual care planning template is developed

- Planning template in use by 1/12/16

CONTEXT: CVD is substantially preventable with lifestyle advice and treatment for those at moderate or high risk. Diabetes is a major, and increasing, cause of disability and premature death. The number of people with diagnosed diabetes across our district is approximately 5,800 and there are approximately 46,000 people who are considered eligible for a CVD risk assessment. Our Top of the South Health Alliance (ToSHA) CVD and Diabetes Working Group has developed a framework and workplan using the above action themes to ensure all those at risk or with CVD and those with diabetes and pre-diabetes receive optimal care.

SEE ALSO: Cardiovascular Disease and Diabetes Framework (available from the Strategy Planning & Alliance Support Team; Maori Health Plan; Long term conditions module.

Better Help for Smokers to Quit (Tobacco)

OWNER / CHAMPION: Service Manager, Public Health

OUTCOME: Reduction in the harm to people caused by smoking

➢ **OUTCOME**: Smokefree 2025: By 2025 < 5% of the DHB's population will be a current smoker.

➢ **MEASURE**: Maintain ≥ 90% of PHO enrolled patients who smoke offered advice & support to quit in the last 15 months

➢ **MEASURE**: Maintain ≥90% of pregnant women (who identify as smokers) offered advice and support to quit

➢ **MEASURE**: Maintain ≥95% of hospitalised smokers being provided with brief advice & support to quit

ACTION THEME 1: Supporting smokefree with Maori & Pacific

ACTION: Work with Maori & Pacific leadership to role model smokefree behaviours; undertake engagement and health promotion activity at hui, sporting events and marae

➢ Promotion & engagement activities undertaken each quarter

ACTION: Provide education tailored to midwives to support their conversations, in particular with Maori women and whanau.

➢ Education sessions with midwives held by 30/6/17
➢ Patient story video available by 31/12/16

ACTION: Work with agencies that work with Maori youth to support smokefree messages and develop ABC & cessation support capability

➢ Youth agencies deliver smokefree messages by 31/3/17

ACTION: Work with the Pacifica community to substantially decrease smoking rates

➢ Kavacation programme continues in Marlborough
➢ Develop a business case for a Tasman Smokefree Pacifica role by 30/11/16

ACTION THEME 2: A smokefree environment in the community, with a focus on pregnant women and mental health service users

ACTION: Work with organisations to develop more smokefree locations and organisations that have Smokefree 2025 policies

➢ An increase in smokefree locations and organisations with Smokefree 2025 policies established by 30/6/17

ACTION: Develop the quality of the quitcard service and referral pathways to services

➢ Referral pathways to quitcard providers developed by 31/12/16

ACTION: Further staff training to support quality ABC interactions

➢ Training programme for primary care is completed by 30/6/17

ACTION: Improve information flow between GPs, LMC's and smoking cessation services and strengthen referral pathways

➢ Increase in referrals to cessation providers by 30/6/17

ACTION: Utilise smokefree ambassadors in youth organisations and develop capability in youth organisations

➢ Youth agencies delivering smokefree messages by 31/3/17

ACTION: Improve use of ABC and access to NRT for mental health consumers accessing community health NGO services

➢ NGO providers can access NRT for service users by 31/12/16

ACTION: Monitor efficacy of smokefree pregnancies initiatives

➢ Evaluation completed by 30/6/17

ACTION THEME 3: A smokefree environment in secondary care

ACTION: Provide staff training on the ABC approach at orientation and increase utilisation of e-learning

➢ 100% of new clinical staff attending orientation receive training
➢ e-learning incorporated by all hospital areas by 31/8/15

ACTION: Promote referral pathways and embed ABC conversations in outpatients

➢ Measurement and baseline established for referrals from outpatients by 30/10/15

ACTION: Continue a quality focus of the ABC approach in secondary care emphasising offering of cessation services

➢ Quality audits show an increase in 'gold' results by 30/6/17

ACTION: Develop an inpatient resource describing the DHB Smokefree policies and options for cessation support

➢ Resource in use by 31/12/16

ACTION: Focus on ABC conversations in outpatients

➢ Champion identified & measurements of activity begin by

CONTEXT: Smoking kills an estimated 5,000 people in New Zealand every year, and smoking-related diseases are a significant cost to New Zealand. There is strong evidence that brief advice and cessation therapies are effective at prompting quit attempts and quitting success. Despite declining rates smoking is still a major public health issue and is inequitably higher in Maori and Pacific people. There are also concerning numbers of pregnant women smoking. We are working to maintain our achievement of the health targets, reduce smoking prevalence, reduce health harm caused by smoking and aspire towards a 'smokefree Nelson Marlborough' by 2025.

SEE ALSO: Primary Care Module; Tobacco Control Plan; Public Health Service Annual Plan; Maori Health Plan (plans available from Strategy, Planning & Alliance Support).

Mental Health & Addictions (Rising to the Challenge 2012-2017: The Mental Health & Addiction National Service Development Plan) – page 1 of 2

OWNER / CHAMPIONS:
GM Mental Health & Addictions
Clinical Directors Mental Health (Specialist & Community)

OUTCOME GOAL 1: A continuum of services is accessible and responsive

OUTCOME GOAL 2: Resilience and recovery for people with mental illnesses is supported

ACTION THEME 1: Better Use of Resources/Value for Money

ACTION 1: Implement the new model of care through Service Integration which incorporates:
- Dedicated crisis team (including review of pathway for Police referrals)
- Redesign community teams
- Review the model of case management
- Better definition of clinical and non-clinical support roles
- integrate the inpatient units
- Strengthening nursing leadership in the inpatient setting

MEASURE 1: Completion as per a staged action plan by 30/6/17

ACTION 2: Progress development of a single shared care plan across Mental Health & Addiction specialist and NGO services.

MEASURE 2: Shared care plan process established by 30/06/17

ACTION 3: Redevelop the Addictions continuum of care to increase local options and capacity

MEASURE 3: Model of care for residential addictions services redeveloped by 31/12/16

ACTION 4: Commence positioning the directorate to implement the Ministry of Health Outcomes and Commissioning Frameworks

MEASURE 4: Staged action plan developed

ACTION THEME 2: Build on Resilience Gains and Recovery

ACTION 5: Ensure flexible, individualised packages of care that address key needs to support recovery (e.g. vocational support, physical health and access to appropriate accommodation)

MEASURE 5: No. of individual packages of care

ACTION 6: Continue to implement agreed actions from the Directorate and Residential Reviews

MEASURE 6: Complete a staged plan of agreed actions by 30/06/17 (see also Action 1)

ACTION 7: Continue work to reduce seclusion with Te Pou's Six Core Strategies and monitor seclusion rates by demographic groups

MEASURE 7: No. of seclusion events and hours reduces.
Peer support workforce available for post-seclusion de-briefing for consumers.
Further workforce training in Safe Practice & Effective Communication

ACTION 8: Strengthen relationships with MSD & social housing providers to support access to appropriate accommodation for consumers

MEASURE 8: Formal relationship established with MSD and regular liaison meetings occur

ACTION THEME 3: Increasing Access

ACTION 9: Standardise COPMIA processes & initiatives across Directorate services, including utilising resources from 'Supporting Parents, Healthy Children'

MEASURE 9: Audit COPMIA practice to ensure alignment 31/03/17

ACTION 10: Explore opportunities to extend access to support services after discharge from Specialist Services with defined eligibility and as capacity allows

MEASURE 10: Contracts are modified with re-defined eligibility and processes by 30/06/17

ACTION 11: Audit the pathway for selection of Community Treatment Order (CTOs) clients, and identify opportunities for alternative pathways, particularly for Maori.

MEASURE 11: Implement any agreed actions from the audit by 31/12/16

ACTION 12: Further develop the referral pathway to Kaupapa Maori services

MEASURE 12: Referral pathway agreed & any changes implemented by 31/12/16

Contribution to Rising to the Challenge 2012-2017 (The Mental Health & Addiction Service Development Plan) continued... page 2 of 2

ACTION THEME 4: Improve Primary and Specialist Integration

ACTION 13: Through Service Integration, align specialist teams with general practices to ensure:

- Strengthening of liaison and input with General Practice Teams to support GP management of care
- MH&A consumers are enrolled with a GP
- consumers' physical health needs are addressed & they have access to lifestyle support services as required
- Consumers are receiving care in the most appropriate setting

MEASURE 13: Enrolment with GP is offered to and facilitated for all Mental Health & Addictions consumers as needed.

ACTION 14: Extend implementation of the decision support tool for depression & anxiety to support best practice treatment.

MEASURE 14: Decision support tool extended to primary care by 30/06/17

ACTION THEME 5: Workforce Development

ACTION 15: Provide the peer support workforce with training in Co-Existing Problems and seclusion debriefing

MEASURE 15: Two training sessions provided for peer workforce

ACTION 16: Education and training is provided to strengthen the community support work workforce, to complement the case management model

MEASURE 16: Two training sessions provided for community support workforce

ACTION 17: Support wider utilisation of electronic information systems across MH&A specialist services

MEASURE 17: MH&A clinical workforce trained in using Concerto by 31/12/16

SEE ALSO: Maori Health Plan; Prime Minister's Youth Mental Health Project

ACTION THEME 6: Suicide Prevention

ACTION 18: Review current statistical & demographic information to identify emerging trends to inform health promotion and service delivery

MEASURE 18: Desktop review completed & Suicide Prevention Action plan reviewed also taking into account the Ministry update of the national strategy

ACTION 19: Implement workplace suicide prevention initiatives, with a focus on primary industries.

MEASURE 19: At least one initiative implemented by 30/06/16

ACTION 20: Continue to offer workforce development opportunities for the Mental Health sector (including specialist, NGO, primary) as well as community and government agencies

MEASURE 20: Two workshops or training sessions in suicide prevention provided

CONTEXT: One in five New Zealanders experiences a significant mental health or addiction issue in any one year, however often these issues go unrecognised. Especially significant are depression and alcohol misuse. NMDHB works alongside individuals, families, whanau, communities and providers of services, to ensure that: young people have a healthy beginning and can subsequently flourish; all people can learn and draw strength from the challenges they face; people with mental health or addiction issues can rapidly recover when they are unwell; and social isolation or exclusion as a result of adverse experiences and illness is minimised. Mental Health & Addictions services works for continuous improvement in the integration between primary care, NGOs and Specialist Mental Health and Addiction services. The Directorate has a Reference Group of key stakeholders from across the Mental Health & Addictions continuum, which supports planning and decision-making on strategic developments. We support improving responsiveness and accessibility with a workforce that is sustainable, flexible and fit for purpose. The DHB Board has visibility of NGO issues and works with the providers to look at the overall business model, underlying costs and strategic development.

Cancer

OWNER / CHAMPION: Service Manager Medical Services / Service Manager Specialist Services *(prostate cancer)*

OUTCOME GOAL: Patients with cancer have access to services that optimise good health and independence

OUTCOME MEASURE: Health Target: 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by June 2017
OUTCOME MEASURE: PP 30: 31 day indicator – improvement in the proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management)
OUTCOME MEASURE: Improved quality of data & data collection including FCT records submitted & number of records declined (<10%)

OUTCOME MEASURE: All patients, ready-for-treatment, wait less than 4 weeks for radiotherapy or chemotherapy

OUTCOME MEASURE: National prostate cancer care guidance implemented by June 2016

ACTION THEME 1: Workforce & Systems

ACTION: Continue to support the development of the Cancer Nurse Coordinator (CNC) role

MEASURE: CNC effects change and participates in cross functional service development processes

ACTION: Implement workforce findings necessary to ensure flexible, sustainable and comprehensive cancer services (TBC)

MEASURE: Workload measures fall within nationally accepted benchmarks (TBC)

ACTION: Embed the Cancer Steering Group as a key governance body

MEASURE: Steering Group meets regularly to review initiatives and provide guidance

ACTION: Implement, in conjunction with the Southern Cancer Network (SCN), local IT and workforce initiatives associated with the National Cancer Health Information Strategy (CHIS)

MEASURE: Local information initiatives implemented as required to facilitate the CHIS

ACTION: Support the establishment of the SI Psychosocial and Supportive Care clinical and social work service, and the regional Steering Group.

MEASURE: Implementation and alignment of services to regional access criteria by 30 September 2016
MEASURE: Contribution and attendance at Steering Group meetings

ACTION THEME 2: Faster Cancer Treatment

ACTION: Finalise agreement to implement MOSAIQ (Oncology Patient Information Management System) after the implementation of PICS

MEASURE: MOSAIQ Business Case developed & agreed by 30/12/16

ACTION: Work with the Elective Services process to facilitate clear identification of patients waiting for surgical treatment for cancer

MEASURE: Patients cancer treatment identified as part of the Elective Services process

ACTION: Lead Head & Neck and Maori Cancer Pathway National Service Improvement Initiatives in conjunction with SCN and other S.I. DHBs

MEASURE: Local initiatives implemented in accordance with agreed timeframes by 30/05/17; SI initiatives by 1 June 2017

CONTEXT: Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Radiotherapy and chemotherapy have been proven to be effective in reducing the impact of a range of cancers and improving treatment outcomes. The national indicators will therefore be used to measure the timeliness of cancer treatment across the entire patient journey, and are representative indicators of specialist treatment efficiency and patient health outcomes.

ACTION THEME 3: Cancer Pathway Improvement

ACTION: In conjunction with SCN review 2 services against draft National Standards
ACTION: Continue to implement previous tumour standard review findings

MEASURE: Joint review of tumour standards complete by 30/6/17
MEASURE: Implementation of prioritised findings by 30/06/2018

ACTION: Continue to explore need and options for an appropriate cancer facility by participating in facilities planning

MEASURE: Facility options identified by 30/06/17

ACTION: Implement regionally agreed Multidisciplinary Meetings (MDM) priorities (TBC)

MEASURE: Increased participation in other venue MDMs by local clinical staff, and attendance by external clinicians in local MDM meetings for relevant patients and tumour streams (TBC)

ACTION: Implementation of the Ministry of Health Prostate Cancer Management and Referral guidance during 2016/17

MEASURE: Ministry of Health Prostate Cancer Management and Referral Guidance by 30/06/2017

ACTION: Review findings of IDF mapping processes

MEASURE: Improved NMDHB/CDHB IDF cancer pathways & processes

SEE ALSO: Maori Health Plan; Diagnostic Services; Elective Services, IT and Infrastructure; Long Term Conditions

Stroke Services

OWNER / CHAMPION: Alliance Support Manager: HOP /Clinical Lead Stroke

OUTCOME GOAL 1: To improve outcomes for patients following a stroke event

OUTCOME MEASURE 1: 6% of stroke patient's Thrombolysed

ACTION THEME 1: Thrombolysis

- **ACTION**: Thrombolysis delivered within NMDHB Stroke Guidelines
- **MEASURE**: Eligible stroke patients are offered Thrombolysis according to stroke guidelines

MEASURE: Right drug, right place, right person.
- Reported annually by peer review
- Quarterly reports to MoH/SIAPO

- **ACTION**: Develop stroke Thrombolysis quality assurance procedures
- **MEASURE**: 100% of 12 monthly Thrombolysis audits completed as per the national registry data collection

- **ACTION**: Participate in the national thrombolysis register
- **MEASURE**: Review National thrombolysis register involvement, pathway and audit annually

- **ACTION**: Participate in MOH telestroke pilot for 6 months June-December 2016.
- Explore resources to continue if successful
- **MEASURE:** Audit of results from telestroke pilot.

SEE ALSO: Workforce, Cardiac Services

OUTCOME GOAL 2: To improve access to organised stroke services

OUTCOME MEASURE 2: 80% of stroke patients admitted to organised stroke services with demonstrated stroke pathway

ACTION THEME 2: Organised Stroke Services

ACTION: An Acute Stroke Service is provided by an interdisciplinary team, including a dedicated stroke nurse. The IDT meet regularly to review patient management and rehabilitation optimisation

MEASURE: Development and implementation of Acute Stroke Service IDT, demonstrating regular patient management review by December 2016.

ACTION: Quality Assurance measures are addressed through stroke audits and engagement in research

MEASURE: A quality assurance plan including audit plans and research evidence is developed by June 2017.Progress is reported by Stroke Steering Group Quarterly

ACTION: IDT staff members complete a minimum of 8hrs formal stroke education per annum. Wider education is made available for other staff within the service

MEASURE: Education is achieved by June 2017.Progess is reported by Stroke Steering Group Quarterly

- **ACTION:** Support and participate in regional and national stroke networks
- **MEASURE**: NMDHB representation at regional and national stroke networks quarterly with associated reporting

OUTCOME GOAL 3: Eligible stroke patients receive appropriate rehabilitation services

OUTCOME MEASURE 3: 80 percent of patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission.

ACTION THEME 3: Rehabilitation

ACTION: All Stroke patients receive a MDT assessment within 72 hours to assess their rehabilitation needs.

MEASURE:
80% of appropriate acute stroke patients are transferred to in-patient rehabilitation service within 7 days of admission, reported by Nelson and Wairau.
- Quarterly report to MOH/SIAPO

- **ACTION**: Develop a consistent outcome measure across inpatient settings for stroke patients. Review results for each inpatient area quarterly
- **MEASURE**: Consistent Functional Independent Measure implemented inpatient settings by Dec 2016. Report progress quarterly

CONTEXT: Stroke results in the blood supply from the brain being cut off, which can lead to damage and permanent disability – the degree of which depends on the length of the stroke, therefore an immediate and appropriate response is essential. Stroke prevention includes interventions around key risk factors of diabetes, smoking and hypertension. NMDHB continues to focus on improving our response to stroke thrombolysis, and transient ischaemic attack, by active involvement with both national and South Island Stroke Steering Groups. The 2015/2016 focus is to continue to develop organised Stroke Services in both Nelson and Wairau Hospitals.

2016 Annual plan for Nelson Marlborough cardiology department

The department will operate within the central cardiac network's minimum standards of access to secondary cardiac care and provide the following cardiac services within the specified timeframes.
An annual departmental report will be published by the department auditing our activity related to these activities.

- > 70% compliant
- < 70% compliant
- < 50% compliant

1. Non Acute chest pain

1. Accept referral for stable patients with suspected angina in the following time scales <3/12, Progressive symptoms <2/12, Rapidly progressive symptoms <1/12
2. Ensure that referred patients where appropriate have been adequately assessed with either non-invasive testing to a level that can satisfactorily rule out prognostic coronary artery disease or referred for invasive angiography
3. Perform above within an audited clinical governance structure that includes an accredited cardiologist.

2. Acute Chest Pain

1. Provide an accelerated chest pain pathway through the emergency department
2. Ensure all appropriate patients admitted with acute coronary syndrome receive angiography within 3 days and are captured in ANZACS-QI
3. Review and audit the NMDHB Accelerated Chest Pain Pathway by 31st March 2017

3. ST elevation myocardial infarction

1. Where ever possible provide primary percutaneous intervention within 120 minutes from first medical contact
2. In patients who cannot receive timely Primary percutaneous intervention thrombolysis will be administered as soon as possible
3. Patients in whom rescue percutaneous intervention would be considered in the event of failed thrombolysis will receive prompt thrombolysis and immediate transfer to a PCI centre

4. Standardised intervention rates

The implementation of these access criteria will maintain SIRs at

Angiography	34.7 per 10,000
Angioplasty	12.5 per 10,000
Cardiothoracic surgery	6.5 per 10,000

5. Provide access to cardiac holter monitoring

1. Provide either direct access to holter monitoring or FSA +/- holter monitoring <3/12 routine, < 2/12 Semi urgent and < 1/12 urgent for patients with
   - Symptoms consistent with sustained tachycardia
   - Syncope
   - Exercise induced pre syncope/palpitations

In patients with atrial fibrillation we will
Provide access to holter monitoring<3/12 routine, < 2/12 Semi urgent and < 1/12 urgent for
1. difficulties in determining rate control
2. Difficulty determining paroxysmal AF

Offer FSA <3/12 routine, < 2/12 Semi urgent and < 1/12 urgent for
1. patients in whom rhythm control including cardioversion is considered
2. patients <55 years of age
3. patients in whom rate control and or symptoms cannot be controlled
4. patients with abnormal resting ECG (in addition to AF) or significant finding on echocardiogram
5. patients who have contra-indication or intolerance of standard rate control therapies

6. Provision of echocardiographic services

Echocardiography of IHD
ACS
1. Left ventricular assessment will occur in all high risk patients prior to discharge and as part of routine follow up for other ACS patients
2. In patients in whom the initial EF<45%, and implantable cardioverter-defibillator implantation may be considered or further revascularisation is planned further imaging will occur after three months of maximally titrated medication

Post CABG
1. With known LV dysfunction (EF ≤ 45%) follow up echo will occur once the patient has been stabilised heart failure medication > 6 weeks post operation

Echocardiography for continued management of heart failure
TITRATION PHASE:
- Echocardiography will be performed (approx. 3 months) at the end of the titration phase, post revascularisation and or post MI when initial EF<45% in order to determine candidacy for implantable cardioverter-defibillator therapy

FOLLOW UP:
- Echocardiography will be performed with change in clinical status or cardiac exam
- Baseline and serial re-evaluation will be performed in patients undergoing therapy with cardiotoxic agents
- Screening evaluation for will be provided for assessment of structure and function in first-degree relatives of a patient with an inherited cardiomyopathy

Atrial Fibrillation
Provide Access to echocardiography <3/12 routine, < 2/12 Semi urgent and < 1/12 urgent for
1. New diagnosis of AF if would influence management
2. Change in clinical status
3. Suspected underlying structural heart disease or LV dysfunction

Suspected structural or valvular heart disease
1. To provide a pathway for the assessment of valvular and structural heart disease that provides
2. access <3/12 in asymptomatic patients, < 2/12 exercise induced symptoms, < 1/12 rest or minimally provoked symptoms
3. A verified report from an accredited cardiologist or CSANZ level 1 trained physician

Prosthetic and valvular heart disease
We will provide access to echocardiography follow up for patients with prosthetic valves and valvular heart disease that is below the threshold for surgical intervention at intervals I line with the central region minimum standards for access to secondary care investigations

7.Heart Failure

1. Provide access to a heart failure pathway for unstable or stable symptomatic patients with elevated biomarkers (NT-proBNP ≥ 300 pg/ml or BNP ≥ 100 pg/ml) as an urgent referral (< 2 weeks)
2. Provide access to a heart failure pathway for symptomatic stable patients with intermediate biomarkers (NT-proBNP ≥ 125 pg/ml or BNP ≥ 35 pg/ml) as a semi-urgent referral (< 2 months)
3. Maintain a clinical governance structure that provides access to a multi-disciplinary heart failure service to provide patient support/education and access to advanced diagnostics and treatment in suitable patients

8.Secondary prevention for IHD

Work with primary care to provide a community and evidence based secondary prevention programme tailored to individual patient needs and geographic location.

New initiatives for 2016 financial year to aid compliance with minimum standards to be written up in 2016 annual report

Pre hospital thrombolysis pathway

The cardiology department has worked closely with St John and in February 2106 will role out a pre hospital thrombolysis pathway which will be consultant cardiologist directed paramedic delivered

Local provision of implantable defibrillators

The cardiology department has appointed an electrophysiological specialist with the intention of improving timely access to device implantation and continued viable of the current pacemaker implantation service

CT coronary angiography

The cardiology department is developing a business case for the utilisation of its two new CT scanners for the provision of coronary CT. This service would compensate for the los of Nuclear cardiac services, reduce patient transfers within the DHB and the need for invasive coronary angiography

Implement South Island ECG data storage solution

NMDHB has engaged with the South Island alliance to install the approved provider software enabling the electronic capture, storage and sharing of all electrocardiographic data.
The NMDHB Cardiology service will review the current process and develop actions to improve registry data collection.

Health of Older People Action Plan (HOP) 1 of 2

OWNER / CHAMPION: Alliance Support Manager: HOP
GM Strategy, Planning and Alliance Support

OUTCOME GOAL 1: People with Dementia and their families receive timely diagnoses and access to appropriate supports and services.

OUTCOME MEASURE 1: Appropriate utilisation of dementia support services and referrals to community providers and support services

OUTCOME GOAL 2: Safe independent Living

OUTCOME MEASURES 2
- Increase in % of people receiving HBSS support & reduction in % receiving residential care.
- Number of people who receive long-term home & community support services that have had an InterRAI assessment & care plan

OUTCOME GOAL 3: Comprehensive Clinical Assessment in residential care and in home settings (InterRAI)

OUTCOME MEASURES 3
- All clients in home care settings have an InterRAI assessment at least 3yrly.
- All residential care clients have an InterRAI assessment at least 6mthly.

➢ **ACTION**: Develop an overarching Health of Older People Strategy and start to pilot initiatives that improve service coordination and care delivery for older people
➢ **MEASURE**: Health of Older People Strategy implementation begun by December 2016

ACTION THEME 1: Continue to support and implement dementia care pathways

➢ **ACTION**: Work regionally to improve community awareness and understanding of Dementia
➢ **MEASURE**: Review of supports and specialist services for dementia completed by Dec 2016 to identify gaps in service.

➢ **ACTION**: Continue to include referral to Alzheimer's Associations for support post-diagnosis
➢ **MEASURE**: Referral to Alzheimer's Associations, increase and are included in the Dementia pathway

➢ **ACTION**: Support the delivery of Walking in Another's Shoes Dementia Training
➢ **MEASURE**: Two WIAS programmes completed by June 2017

➢ **ACTION**: Continue audits of antipsychotic medication usage in D3 ARC.
➢ **MEASURE**: Audit results analysed and results feedback to Aged Care Facilities and prescribers by June 2017

ACTION THEME 2: Invest in initiatives for Home and Community Support Services for Older People

➢ **ACTION**: NMDHB will commit to implement actions agreed upon from the settlement plan.
➢ **MEASURE**: Actions agreed upon by ned of September 2016.

➢ **ACTION:** Participate in regional HBSS working groups/meetings as required.
➢ **MEASURE**: NMDHB representation as required at regional working groups/meetings/teleconferences.

➢ **ACTION**: Identification of persons >65yrs who would benefit from other community based programs to improve /maintain independence
➢ **MEASURE**: 100% of persons>65yrs who are referred to NASC or Allied Health are screened for suitability of community based early interventions, e.g. falls prevention, green prescription etc.

➢ **ACTION**: Work with Te Piki Oranga to identify Maori clients with unmet needs in the community. Removal of barrier to appropriate services for Maori by recognising <65yr old disability needs, long term chronic conditions or 'alike in age and interest'.
➢ **MEASURE**: Reduction in volume of > 65yr old Maori and <65yr old Maori with long term chronic conditions seen in acute care settings without community support. Quarterly report. Equity and access to services for Maori in ARC and HBSS services.

ACTION THEME 3: All ARRC facilities fully trained / competent in InterRAI

➢ **ACTION**: InterRAI Educators appointed by Central TAS work alongside NMDHB to ensure competent use of InterRAI assessment tools
➢ **MEASURE**: 100% of ARRC facilities trained and utilising InterRAI as per Aged Residential Care Contracts

➢ **ACTION**: Continue to develop & improve service by comparing NMDHB performance using InterRAI measures with other DHBS
➢ **MEASURES**
- 100% InterRAI assessments completed within NASC guidelines
- Quarterly InterRAI report comparing performance with other South Is DHBs

➢ **ACTION:** InterRAI Educators undertake audits of NMDHB InterRAI assessments and care plans as per national recommendations
➢ **MEASURE**: 100% assessors meet InterRAI competency

➢ **ACTION:** InterRAI report produced on the drivers of 65yrs+ admissions to residential and hospital care
➢ **MEASURE**: One report completed six monthly

CONTEXT: Around 26, 800 people aged 65 years and over live in the Nelson/Marlborough district, this number is expected to increase by 33% to approximately 40, 000 people in 2026. The majority of these older people live independently at home. For the past six years NMDHB has worked to support and encourage older people to remain in their homes and communities where it is safe, practical and affordable to do so, as this ultimately has numerous health and social benefits for them and their whanau.

SEE ALSO: IT and infrastructure, Long Term Conditions, Workforce development, System Integration and Public Health Plan

Health of Older People Action Plan (HOP) 2 of 2

OUTCOME GOAL 4: Reduce acute demand through rapid response and discharge management.

OUTCOME MEASURE 4: Preventable readmission rates for 65+/75+ population is lower than the national average.

ACTION THEME 4: Development of discharge planning and rapid response review findings

- **ACTION**: Participate in the development & implementation of a district wide discharge care protocol for complex patients
- **MEASURE:** Protocol for Early Supported Discharge finalised and implemented by Dec 2016.
- **ACTION**: Review pre-admission questionnaire to ensure it reflects the needs of older people and includes frailty factors
- **MEASURE**: Pre-admission questionnaire updated by Sept 2016
- **ACTION:** Review and work with ARRC to remove barriers to urgent respite after hours.
- **MEASURE:** Plan for management of urgent respite response completed by December 2016

OUTCOME GOAL 5: Reduction in morbidity of Osteoporosis.

OUTCOME MEASURE 5: Increase in volumes prescribed biphosphonates for > 65 yrs. Current volume for 2015 - 1859.

ACTION THEME 5: Implementation of Fracture Liaison Service

- **ACTION**: People with Fragility Fractures identified and referred to General Practitioner via fracture liaison service
- **MEASURE**: Number of people per quarter referred to General Practitioner for follow-up after fragility fracture
- **ACTION**: Increase number of people attending falls prevention intervention
- **MEASURE**: Increase in number of people attending falls prevention programmes in Nelson and Wairau (incl Allied Health Services).
- No of people referred to a strength and balance retaining service (numerator) and no. seen by a strength and balance retaining service (denominator)
- **ACTION**: Increase Vitamin D prescription
- **MEASURE**: 100% of ARRC facilities meeting Vit D target of 70%
- **ACTION**: Enhanced recovery after surgery for fracture neck of femur pathway
- **MEASURE**: Improved patient flow to discharge, decreased wait times for theatre, reduced bed day stay on ward, return to original residence

OUTCOME GOAL 6: System Integration for Health of Older People

OUTCOME MEASURE 6: NMDHB provides older people and their whanau an integrated health system that supports wellbeing and control over their circumstances

ACTION THEME 6: Develop a sustainable integrated health system that has one team providing early intervention closer to home for older people.

- **ACTION**: Restructure of NASC service to provide rapid response and rehabilitation programmes to support the restorative model, reduce acute demand and support hospital avoidance. Partnership with ACC
- **MEASURE**: Business case for restructure completed by July 2016. Contracting with ACC and HBSS September 2016. Implementation by January 2017
- **ACTION**: Integration of nursing staff providing care to older persons, through education and work experience assignments between ARRCs and Assessment Treatment and Rehabilitation Unit. (GAP programme)
- **MEASURE**: GAP programme is piloted through two ARRC by December 2016
- **ACTION**: Transitional ministry established in Nelson Hospital and offered to patients transitioning to ARRC as part of the Multi-disciplinary team approach. Explore option of replica service in Marlborough
- **MEASURE**: Pilot of Transitional Ministry in Wairau by Feb 2017

CONTEXT – FRACTURE LIAISON SERVICE: The Fracture Liaison Service (FLS) is owned by primary care and supported by secondary care. Although there is no dedicated FLS Coordinator, a hospital staff member reviews fragility fractures. For patients that meet the criteria, a letter is sent to their GP outlining the recommended treatment e.g. Falls Prevention programme, Vitamin D prescription, and so on. To monitor effectiveness, FLS volumes are tracked, biphosphanates prescribing rates are tracked (for the population) and Vitamin D reports from ACC are regularly reviewed. **Note:** Poly-pharmacy is supported for residents in Aged Residential Care facilities because of the link between multiple medications and increased likelihood of falling.

System Configuration: Primary and Community

OWNER / CHAMPION: CE Kimi Hauora Marlborough PHO, CE Nelson Bays Primary Health, GM Strategy Planning & Alliance Support

OUTCOME GOAL 1: Primary care capability and capacity is improved

OUTCOME GOAL 2: Services are integrated and consumer focused to improve navigation, and inter-sectorial working ensures the best use of available resources and outcomes for patients, with a specific focus on improving Maori access and equity

OUTCOME GOAL 3: Improve population health outcomes by tackling key drivers of morbidity

ACTION: The Primary and Community Care Strategy to deliver extended general practice and modern models of care is completed, with agreement from stakeholders on a work plan

- Primary care strategy completed by 31/7/16
- Work plan for implementation of strategy in place by 31/10/16

ACTION: The capacity of primary care is enhanced by multi-disciplinary team work and adoption of emerging healthcare roles

- Nurses are identified and begin training towards being nurse prescribers (NPs): 3 NPs and 1 Diabetes Nurse Specialist Prescriber in place by Q2: Additional nurses training towards becoming prescribers by Q3
- Health Care Assistants (HCAs) are considered for inclusion in multi-disciplinary teams as part of the MOC changes in Primary: 2 practices with HCAs by Q2: further practices with HCAs by Q4

ACTION: Further integration of services for those with chronic conditions is delivered, with a focus on Maori and Pacific islanders in the first instance

- Diabetes specialist nurses operate within primary care by 30/6/17
- A culturally acceptable self-management service for CVD and diabetes is enabled district wide by 30/6/17
- A culturally acceptable model of chronic condition management is agreed by 31/12/16

ACTION: An approach to improving capacity of primary care to manage those with mild or moderate mental health issues is agreed, with emphasis placed on improving access for Maori

- Model agreed by 30/8/16

ACTION: Initiatives to reduce demand on secondary care services and to deliver care at the right place for the right person at the right time are put in

- ED5000 Project oriented as a locality network with a work plan in place by Q1; Approach to other locality networks agreed by ToSHA by Q2; Acute demand in Wairau reduced by Q4.
- Respiratory services are in place within options for care by 31/7/16, with specific focus on Maori access and compliance
- New services are identified for delivery in primary care under options for care by 31/7816
- An understanding of what services should be delivered within primary care under a co-charge model is agreed by 31/8/16

ACTION: Further integration of services is enabled through the development of IT infrastructure

- Health One is in place for selected providers by 31/12/16

ACTION: Co-location of services is further enabled to aid integration of services

- More services are delivered out of the Richmond and Blenheim health hubs, including Maori services.
- Recommendations from the Primary Care Strategy delivering co-location and integration are included in the work plan by 31/10/16

ACTION: Implement the consumer engagement strategy

- Consumer engagement strategy implementation started by 30/7/16

ACTION: Initiatives are put in place that ensure the sustainability of pharmacy services, sector capacity to deliver high level clinical services and further integration of services

- Forecast expenditure to gain a whole of system perspective of pharmaceutical baseline and demand and savings opportunities by 30/9/16
- A business case for benefit sharing of community pharmacy pharmaceutical spend is developed by 30/9/16
- A consultation for a new model for Golden Bay pharmacy services is undertaken by 31/8/16 & implement changes (depending on consultation results) by 31/3/17
- New pharmacy agreements offered that support recommendations in the Pharmacy Action Plan to make better use of pharmacists and their expertise in the safe & effective use of pharmaceuticals by 31/3/17
- support national work to develop a National Framework for Pharmacist Services and to commit to implementation of locally agreed services to meet the needs of our population.
- support the development of options for a sustainable solution to the pharmaceutical margin and other supply chain issues, including by 30/6/17
- Contributions made to a Ministry business case for an integrated pharmacy minor ailments service along with other DHBs by 31/3/17
- participation in a national process to plan the commissioning of pharmacist services in the community that cost-effectively matches modern supply to community need

CONTEXT: NMDHB, Kimi Hauora Wairau Marlborough PH, Nelson Bays Primary Health and Te Piki Oranga form the Top of the South Health Alliance (ToSHA) which aims to achieve transformation change utilising collaborative effort towards a single health system for the Nelson Marlborough region to ensure the people of our communities receive health care that is better, sooner and more convenient. A Primary & Community Care Strategy is being developed, and will shape the direction of primary care in our region. A significant number of agreed initiatives appear in the Health system integration page that follows.

SEE ALSO: Long term conditions, Immunisation, Child Health, Youth Health, Access to Diagnostics, Mental health & Addictions, Workforce development, Secondary services and IT& Infrastructure.

System Configuration: Top of the South Health Alliance

CONTEXT: Nelson Marlborough DHB is working collaboratively with its two local PHOs, and Iwi provider, through the Top of the South Health Alliance (ToSHA). Significant effort has been undertaken in the 15/16 year to complete a primary and community health strategy that will guide direction and actions for the future. Together with Nursing, Allied Health, and Pharmacy service representatives, ToSHA is strategically positioning itself to consider the major areas where it can demonstrate significant impact and transformational change through collaboration across the system, including work on a new model of service delivery for primary care. The following represent the key strategic outcomes of the Primary and Community health strategy.

1. **Integration**: Health, social care, voluntary organisations and consumer groups work alongside each other to provide better care. Providers work together in a virtual or physical space so care is experienced as seamless.
2. **Equity**: People's healthcare needs are met through the provision of quality healthcare that is safe and delivers equity of outcomes. Funding models enable people with high health needs or those who are disadvantaged to receive the same services and attain equity of health outcomes.
3. **Self-responsibility:** People take responsibility for their own health. They have better access to health information and tools for managing their own health and the health of their family and whānau.
4. **Accessibility:** People are able to access healthcare when and where needed. Most health care will be delivered in the community. When needed, specialist care will be available with clear pathways to get this care.
5. **Technology**: Technology is used effectively to support a seamless system, assist people to understand and take ownership of their health and enhance access to services.
6. **Evidence-led:** Decisions about health care and the planning of future services are made based on local health intelligence and evidence. Design will take place at a local level, and keep a district-wide view, to meet the health needs of our communities.

Primary and Community Strategy – Complete and begin implementation of new model of care, and agreed strategic workplan utilising $250k of agreed funding.

- Q1: establish peer general practice groups with access to data to identify areas for improvement & to plan services
- Q2: complete a plan for general practice pilot sites implementing new care models
- Q3 extend Health Pathways to include all community providers
- Q4 begin Implementation of the recommendations of the Mental Health Services Review

Medicine Management Group– Quality improvement focus on medicine prescribing & use. Support alternative model of service incentivisation across the system as detailed elsewhere in this document

Acute Demand Management – Utilise $150k of agreed funding to: reduce unplanned presentations to secondary care through: better understanding GP capacity, and incentivising primary patient care, establish the provision of additional primary acute services in Blenheim, and develop integrated respiratory services.

- Q1: implement integrated respiratory services district wide
- Q2: agree additional primary acute services
- Q3: implement new primary acute services
- Q4: agree 17-18 investment strategy

Health of Older People – Implementation of the strategic initiatives agreed at ToSHA, including initiatives aimed at supporting keeping people at home for longer, a supportive discharge process, rapid response (return to the home), or a peaceful death (as required), as outlined elsewhere in this document.

Rural Services – Develop plans for point of care testing for each rural area; further the integration of nursing and other services

- Q1: governance and resourcing for POC planning identified (consider development of locality planning as part of this process)
- Q2: point of care testing quality plans complete for each rural area / locality
- Q3: funding strategy determined for point of care testing in rural areas
- Q4: plan for integration of rural nursing services completed

Long Term Conditions – Develop and agree a Long Term conditions framework for two aspects of care such as health literacy and self management. Apply framework to future care in CVD, diabetes, respiratory and other LTCs. Focus to include self-care principles. To be completed by Q3 2017.

Access to Diagnostics – review pilot for direct access radiology, consider extending GP access to other modes (eg CT or ultrasound, as per the radiology work programme detailed elsewhere in this document.

- Q1: Expand MRI capacity to meet demand
- Q2: Review access criteria for the minor limb voucher scheme
- Q3: Explore the option of expansion of the voucher scheme to ultrasound in Marlborough
- Q4: Review health pathways access criteria for CT

Promoting Health – working group established to develop and implement an alcohol harm reduction strategy by Q2 2016.

System Level Outcome Measures Plan

Nelson Marlborough Health, in collaboration with Nelson Bays PHO and Kimi Hauora Marlborough PHO, commits to provide a jointly developed and agreed Improvement Plan to the Ministry of Health by 20 October 2016.

The Improvement Plan submitted to the Ministry will include:

- Improvement milestones for the four system level measures (total acute hospital bed days, ASH rates for 0-4 year olds, patient experience of care and amenable mortality).
- A set of locally agreed contributory measures for each of the four system level measures.
- District alliance stakeholder agreement with the Improvement Plan, Improvement Milestones and contributory measures quantitative end-of-year goals. All stakeholders, including the DHB provider arm, will sign the submitted Improvement Plan.

Shorter Stays in Emergency Departments (ED)

OWNER / CHAMPION: Service Manager Medical Services, Clinical Director ED

OUTCOME GOAL: Patients have timely and appropriate access to ED services

OUTCOME MEASURE: 95% of patients are admitted, discharged, or transferred from Wairau and Nelson Hospital Emergency Departments within six hours (reported by ethnicity as required)

ACTION THEME 1: **Using Information to Inform Process Improvement**

ACTION: Development of process improvement methodology

MEASURE: ED Clinical Governance Group (including Primary Care) established by 31/12/15

ACTION: Implement a safe transport pathway for patients attending ED after hours

MEASURE: After hours transport pathway implemented by 31 May 2017

ACTION THEME 2: **ED Quality Framework**

ACTION 1: Continued measurement and analysis of ED mandatory quality framework measures
ACTION 2: Continued and expanded measurement of non-mandatory measures, as prioritised and recommended by the Clinical Governance group

MEASURE 1: Implementation of prioritised service improvement activity by June 2017
MEASURE 2: Design & development of an annual ED Quality measures report completed by 31 December 2016

V3 3 May

SEE ALSO: System Integration, Cancer Services; IT & Infrastructure, Workforce, Health of Older People

CONTEXT: The ED target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals and home again. It is an important measure of the quality of emergency and urgent care in our public hospitals because: minimum time spent waiting in ED is important for patients; long stays in emergency departments are linked to overcrowding of the ED; long stays can lead to negative clinical outcomes for patients, such as increased mortality and longer inpatient lengths of stay; and compromised standards of privacy and dignity for patients. NMDHB has consistently reached the national target for wait times in our emergency departments. To continue to achieve the ED target requires collaborative working with primary care to avoid unnecessary ED presentations.

WHANAU ORA

OWNER / CHAMPION:
GM Maori Health & Whanau Ora

OUTCOME GOAL: Achieve accelerated progress towards Whanau Ora and health equity

ACTION THEME 1: Mental Health

Reduced rate of Maori committed to compulsory treatment relative to non-Maori

ACTION 1: Audit the pathway for selection of Community Treatment Order (CTOs) clients, and identify opportunities for alternative pathways, particularly for Maori.

MEASURE 1: Implement any agreed actions from the audit by 28/04/17 (see Mental Health)

ACTION 2: Further develop the referral pathway to Kaupapa Maori Mental Health services

MEASURE 2: Referral pathway agreed & any changes Implemented by 30/06/17 (see Mental Health)

ACTION THEME 2: Ambulatory Sensitive Hospitalisations

Reduced asthma and wheeze admission rates for Maori children (0-4years) relative to non-Maori

ACTION 3: Increase PHO enrolment for newborns; promote better asthma management through general practices and Well Child/Tamariki Ora services; continue the Healthy Homes projects targeting Maori families with respiratory conditions

MEASURE 3: Monitor progress for enrolment rates and ASH rates for respiratory conditions quarterly

ACTION THEME 3: Oral Health

Increase the number of Maori children caries-free at age 5 and reduce the inequality compared to non-Maori children

ACTION 4: Increase enrolment; Review clinical pathways for COHS with a view to developing an approach to improving utilisation; promote tooth-brushing, reduced consumption of sweetened drinks; support fluoridation of water supplies

MEASURE 4: Review baseline utilisation rates of COHS in the community on a quarterly basis; Increase the number of community health settings with healthy oral health policies

ACTION THEME 4: Addressing childhood obesity

95% of obese Maori children identified at the B4SC will be offered referral for assessment & intervention

ACTION 5: Embed referral processes with community services; Align services to support the collection and reporting of healthy weight for children; Support healthy weight in pregnancy; promote policies to reduce consumption of sweetened beverages

MEASURE 5: Action plan implemented. (see Child Health)

ACTION THEME 5: Tobacco

95% of all pregnant Maori women are smokefree at 2 weeks postnatal

ACTION 6: Implement a range of initiatives to equip and support midwives to offer smokefree support to pregnant women; Monitor and evaluate the smokefree incentives initiative

MEASURE 6: Action plan implemented (see Tobacco)

ACTION THEME 5: Engagement & Collaboration

ACTION 7: Work with and identify at least one project with Te Putahitanga (Whanau Ora commissioning agency) that can advance the Whanau Ora approach across Te Waipounamu

MEASURE 7: One joint project completed and in place by 30/6/17

SEE ALSO: Maori Health Plan – other national Maori Health priorities are Ethnicity data quality, Access to care – PHO enrolment, Child Health – Breastfeeding; Cancer screening; Immunisation; Rheumatic fever; SUDI. Local priorities are Workforce Development; Promoting Health; CVD & Diabetes

Improved Access to Diagnostics

OWNER / CHAMPION: Service Manager Specialist Services / HOD Radiology *(Radiology)* / Service Manager Surgical Services / Gastroenterologist *(Colonoscopy / Endoscopy)* Service Manager Medical Services *(Coronary Angiography)*

OUTCOME GOAL 1: More effective and efficient district wide service delivery
OUTCOME GOAL 2: Effective engagement with community partners

OUTCOME MEASURE: 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within six weeks (42 days)

ACTION THEME 1: **Radiology Improvement and Engagement**

ACTION: Continue reviewing patient pathways & streamlining of referral management

MEASURE: Radiology leadership team review 3 pathways by May 2017

ACTION: Communicate wait time information to Referrers via Healthpathways website

MEASURE: Improved referrer visibility of referrer guidelines and wait time data

ACTION: Progress implementation of improved primary care access to radiology

MEASURE: 90% of GPs have access to plain film imaging in hours and after hours

ACTION: Contribute to & attend meetings of relevant regional & national improvement groups

MEASURE: Contribution/attendance at 90% of relevant meetings

ACTION: Jointly lead diagnostic laboratory RFP and supplier selection with Southern DHB

MEASURE: Preferred supplier selected 1Q 2017

ACTION: Participate in activity relating to development and implementation of National Patient collection and submission to allow reporting to the NPF as required

MEASURE: Patient level data is reported into the National Patient Flow collection, in line with specified requirements

CONTEXT: Good quality and timely diagnostics – primarily imaging and diagnostic laboratory testing, but also hearing and vision assessments – with best practice reporting and clinical analysis, enable better diagnoses and faster identification of disease or injury impact, which ultimately lead to better health outcomes/prognoses for consumers

OUTCOME GOAL 3: Improved performance relative to service targets

OUTCOME MEASURE: 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days
OUTCOME MEASURE: **70 %** of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days
OUTCOME MEASURE: Surveillance colonoscopy – **70%** of people waiting for surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days

ACTION THEME 2: **Colonoscopy / Endoscopy**

ACTION: Review local and regional demand and participate in S.I. Alliance regional approach to bowel screening

MEASURE: Attendance at relevant meetings & sharing of data and analysis

ACTION: Implement and maintain direct entry access Colonoscopy for urgent diagnostics across district

MEASURE: Approval & appointment of Specialist Clinical Nurse Colonoscopy by March 2017 to triage district wide referrals

ACTION: Implement action plan to improve endoscopy and colonoscopy services

MEASURE: Improvement in endoscopy and colonoscopy services achieved by 30 June 2017 including:

- Appointment of new SMO Clinical Lead for Endoscopy by July 2016
- Appointment of a new Endoscopy Clinical Coordinator role by August 2016
- Introduction of nurse led triage using National Colonoscopy Criteria by October 2016
- Introduction of constant audit of surveillance waitlist against national criteria
- Greater use of locum Endoscopists while recruiting for vacant Gastroenterologist role
- District wide utilisation of capacity planning tool Endoscopy to ensure correct patients are booked in order of priority and timeframes

OUTCOME MEASURE: 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)

ACTION THEME 3: **Coronary Angiography**

ACTION: Review forward planning and scheduling for angiography

MEASURE: Access to elective angiography is improved

SEE ALSO: Elective Services, Cardiac Services, Workforce Planning

Improved Access to Elective Services

OWNER / CHAMPION: Service Manager Surgical Services

OUTCOME GOAL 1: Standardised systems and processes

OUTCOME MEASURE 1: Delivery against agreed volume schedule, including a minimum of 7,517 elective surgical discharges and MOH Ortho Initiative additional elective joints (27) / orthopaedic (49) discharges in 2016/17 towards the Electives Health Target

OUTCOME GOAL 2: All elective referrals go through a transparent and equitable triaging process in a timely manner

OUTCOME MEASURE 1: All patients are prioritised using the most recent national or nationally recognised tools within stated Elective Services Performance Indicator (ESPI) time frames
OUTCOME MEASURE 2: Elective services standardised intervention rates are appropriate across each service area

OUTCOME GOAL 3: All treatment in accordance with assigned priority and waiting time

OUTCOME MEASURE 1: ESPI expectations are met
OUTCOME MEASURE 2: Patients wait no longer than four months for first specialist assessment or treatment
OUTCOME MEASURE 3: Meet FCT times

ACTION THEME 1: Delivery and Quality of Care

ACTION: Continue to identify, implement and monitor process / system improvements

MEASURE: Reduction and maintaining day of surgery controllable cancellations rate to < 5%

ACTION: Embed direct access for patients requiring colonoscopy with a high suspicion of cancer (urgent diagnostic)

MEASURE: Colonoscopy waiting time target of 14 days met

ACTION: Review Plastics and Vascular surgical specialities and align service delivery appropriate to needs

MEASURE: Plastics and Vascular surgery services reviewed, aligned and implemented June 2017

ACTION: Implement GP Special Interest services district wide

MEASURE: Increased accessibility to breast familial GP clinics by December 2016

ACTION THEME 2: Demand / Capacity Analysis

ACTION: Outpatient Referral Outcomes report regularly reviewed to manage access to FSAs

MEASURE: The difference between accepted referrals and capacity across Elective Services is on average no greater than 5%

ACTION: Continue to implement new/updated national CPAC tools

MEASURE: 100% uptake of new orthopaedic web based CPAC tool by Dec 2016

SEE ALSO: Cancer Services; Diagnostic Services, Cardiac Services

ACTION THEME 3: Timely Patient Access

ACTION: Implement linking of patient events & appointments across the entire patient journey

MEASURE: 80% of scheduled FSA reports for each specialist per service available

ACTION: Participate in activity relating to development and implementation of the National Patient Flow system, including amending data submissions as required

MEASURE: Patient level data needs and gap analysis is undertaken to identify phase two data reporting requirements and fit with PICS

ACTION: Subject to PICS project implementation, continue to implement / contribute to the South Island PICS initiative

MEASURE: PICS implemented in 2017

CONTEXT: Elective surgery operations improve quality of life for patients suffering from those significant medical conditions that can be delayed by effective surgical interventions, for example: a hip replacement can reduce pain and increase function; and a cataract operation may ensure someone can drive their car. Our electives system ensures appropriate access to first specialist assessments, reduces waiting times for people requiring elective surgery, improves prioritisation / selection of patients, appropriately manages elective discharges, and reduces the need for follow-up visits. We consistently achieve the national target for elective surgery as well as achieving above or at the standardised discharge ratios and we have planning processes in place to ensure that this is maintained. It is anticipated that given Nelson Marlborough's population growth and ageing population that the demand for elective surgery will continue to grow.

IT and Infrastructure

OWNER / CHAMPION: General Manager IT & Infrastructure and CDC Community Based Services; also General Manager Finance & Performance (*)

Infrastructure assets in Nelson Marlborough are managed and developed to support health system transformation, sustainability, safety and security

Clinicians in Nelson Marlborough access relevant information at the point of care and use information systems to enhance care delivery; Patients in Nelson Marlborough securely access their personal health information which is shared with their health practitioners

SUSTAINABLE HEALTH SYSTEM INFRASTRUCTURE

- Engage with services to develop the Nelson Hospital re-build plan; and complete the strengthening work at Wairau Hospital

Measures

- Treasury business case for Nelson Hospital site redevelopment commenced early 2016
- Complete strengthening work & fit-out of Arthur Wicks ($5m) by December 2016
- Produce conceptual design for the Learning & Development Centre by May 2016

- Implement a local linen contract (as an alternative to the NZ Health Partnerships collective contract)
- **Measure**: Local linen contract implemented by end June 2016

- Prepare for implementation of the national Oracle solution*
- **Measure**: Participation by NMDHB in NZ Health Partnerships work to define the roll-out plan and pathway for national Oracle solution

- Prepare for implementation of the national Food Services business case*
- **Measure**: National food services commenced by end June 2016

PAPER-LITE PROGRAMME

- Move towards paper-lite as a foundational requirement for moving towards being digital hospitals

Measures

- Develop Tele-Health strategy by June 2017
- e-Laboratory result sign-off by June 2016
- e-Triage for receiving and managing all referrals electronically complete by April 2017
- e-Radiology result sign-off system to be implemented by July 2016
- Develop and implement a business case to stop all paper medical charts by June 2018
- Pilot the use of tablets for bedside care by December 2016
- Implement electronic medicines and electronic prescribing subject to business case approval starting March 2017
- Prepare for implementation of the National Maternity Information System Platform in 2017-18
- Implement Patientrack to systematically replace bedside observations, paper-based capture & paper-based workflow, subject to business case approval, starting 1 July 2017

- Implement regional Patient Information Care System (PICS)
- **Measure**: PICS implemented first half 2017

SINGLE ELECTRONIC RECORD

- Participate in NHITB EHR (electronic health record) engagement process
- **Measure**: Participation by Nelson Marlborough DHB

CONTEXT: IT and Infrastructure plays a key role in ensuring our health system offers the best possible care. Well-designed systems help reduce costs, improve efficiency and give patients better, safer treatment. NMDHB is committed to working collaboratively locally within Nelson Marlborough, regionally with other South Island DHBs, and nationally with the guidance of the IT Board to move services to more effective platforms. Having the right IT and Infrastructure in place is the foundation for delivering care closer to homes and putting communities and the needs of consumers and patients at the centre of health care.

SEE ALSO:

Workforce Action Plan

OWNER / CHAMPION:
General Manager Human Resources

CAPACITY	CULTURE:	CAPABILITY:
OUTCOME GOAL: **Optimise Workforce capacity**	OUTCOME GOAL: **Productive Workplace Culture**	OUTCOME GOAL: **Advanced Workforce Capability**
OUTCOME MEASURE: Increased capacity	OUTCOME MEASURE: Increased staff engagement	OUTCOME MEASURE: Increased capability
➢ **ACTION 1**: Establish and implement process for staff secondments and rotations	➢ **ACTION 1**: Employer-union partnerships enhanced by jointly working on improving staff engagement initiative	➢ **ACTION 1**: Integrate the Leadership Domains framework into NMDHB's people development processes & programs.
➢ **MEASURE 1**: Undertake at least two secondments as a trial to refine process and commence roll-out following that	➢ **MEASURE 1**: Partnership assessed by unions and employer representatives involved	➢ **MEASURE 1**: Leadership Domain framework integrated into HR processes and leadership development programs.
➢ **ACTION 2**:In-house mentoring program developed	➢ **ACTION 2**: Engagement initiative to assist staff feeling more appreciated for the contribution they make	➢ **ACTION 2**: Work with other South Island DHB's to achieve a sustainable workforce through changing models of care:
➢ **MEASURE 2**: Program includes training and guiding material and is implemented and evaluated	➢ **MEASURE 2**:Staff survey records an increased score on this aspect	➢ **MEASURE 2**: nurse specialist, sonography & prevocational medical training places increased according to regional plan.
➢ **ACTION 3**:"Grow our Own" project implemented further via school programs, scholarships, and work experience	➢ **ACTION 3**: Enhance overall staff wellbeing culture	➢ **ACTION 3**: Complete an inventory and catalogue of all learning opportunities provided with NMDHB.
➢ **MEASURE 3**: Evidenced support for more Maori, Pacific & low socio-economic groups entering the Health workforce	➢ **MEASURE 3**: Establishing a wellbeing framework	➢ **MEASURE 3**: Catalogue completed by June 30, 2017.

Improving Quality & Clinical Governance

General Manager Clinical Governance Support and Chief Medical Officer

OUTCOME GOAL: **Improved quality, safety and experience of care for patients, consumers and their families within an environment in which excellence in clinical care will flourish**

OUTCOME MEASURE 1: **35% response rate for the Patient Experience Survey**
OUTCOME MEASURE 2: **80% of patients have confidence and trust in the staff treating them** (overall question in Patient Experience Survey)
OUTCOME MEASURE 3: **All Quality Safety Marker (QSM) targets achieved and improved upon**

Culture & Vision

- **ACTION**: Continue to promote and implement the NMDHB clinical governance framework: safe, skilled and compassionate
- **MEASURE**: NMDHB clinical governance framework publicised and work plan for implementation developed by June 2016

- **ACTION**: Share patient stories & promote patient safety across the organisation at all levels
- **MEASURES**::
- Patient story to the Board at each meeting, presented by patients whenever possible
- Patient stories booklet published by October 2016
- Patient stories included in the Quality Account published by the end of November 2016
- Patient Safety Week 2016 key messages promoted
- Two departments participate in the HQSC 'Partners in Care' program

- **ACTION**: Development of a professional behaviour framework
- **MEASURE**: Professional behaviour framework developed by August 2016

Information & Reporting

- **ACTION**: Regular review of patient experience survey results and development of an action plan

MEASURES
- Quarterly patient experience reviews completed and appropriate actions taken
- PHOs supported to implement the patient experience survey

- **ACTION**: Demonstrate a commitment to QSM targets and regularly review data to sustain and improve on achievements
- **MEASURE**: Quarterly patient QSM reviews completed and appropriate actions taken

- **ACTION**: Implementation of the self-audit tool for creating an environment for clinical excellence to flourish
- **MEASURE**: Clinical excellence self-audit tool applied from March 2017

- **ACTION**: Develop KPIs for clinical governance so we know how we're doing
- **MEASURE**: 6 KPIs developed by November 2016

Capacity & Capability

- **ACTION**: Strengthen clinical leadership and quality improvement by providing appropriate training and resources, grow connections across the system helped by new intranet site

- **MEASURES**:
- Training in Quality Improvement tools and methodology provided to at least 50 staff
- Staff culture survey reports staff feel appreciated, involved and have chance to develop

- **ACTION**: Implement the consumer engagement strategy
- **MEASURE**: Consumer engagement strategy implementation commenced by July 2016
- **ACTION**: Develop an implementation plan to create a Just Culture
- **MEASURE**: Just Culture programme implementation commenced by November 2016

CONTEXT: NMDHB continues to strive to create a culture where innovation and excellence will flourish. The Clinical Governance Committee is a key enabler for change, and has responsibility for robust and transparent quality governance of our health system. We are guided by the work of the Health Quality & Safety Commission, and are embedding its recommendations through our Clinical Directors and the guidance of our Clinical Governance Committee, which includes our PHO partners, is informed by consumers, and developed with our South Island Alliance partners. We are committed to patient safety and improving on our QSM target results, and intend our services to provide continuously improving quality, safety, and experience of care to the patient and consumer, to improve the health and equity of all populations served by us, and to provide better value for our public health system resources.

SEE ALSO: Workforce plan and Stewardship section.

DISABILITY SUPPORT SERVICES – WORK PLAN 2016/17

Mission:

Supporting people to live the best possible life.

Values

Respect, Integrity, Teamwork, Innovation

Guiding Principles

Person centred, staff supportive, evidence based, system minded, funding fit, continuous quality improvement

The Current Situation

Person-centred culture and future service provision are our key priorities. DSS is aligning with government objectives to ensure the people we support have greater choice and control over their own lives.

The DHB culture survey identified priority areas which are being addressed:

- I can contribute to important decisions that affect my work (Nelson Marlborough Health)
- I feel appreciated for the contribution I make (DSS + Nelson Marlborough Health)
- I am receiving the right level of supervision (DSS)
- I have not felt bullied by other team members in the last 12months (DSS + Nelson Marlborough Health)
- I am happy with my career development options (Nelson Marlborough Health)

More people have died through natural attrition this year than expected which has left us with a number of vacancies. This has necessitated us to reorganise to fill the vacant beds to help DSS sustain financial viability because of the associated loss of income. We have a number of referrals that represent a different client group with different needs and different levels of funding so the current bed vacancies are not suitable.

Maintaining financial viability within current funding levels is an ongoing challenge due to the lack of funding increase to cover inflation, the significant loss of funding as a result of reassessments of people on individual funding packages that DSS support, and the current bed vacancies.

As a business unit that is required to live within its funding DSS is implementing a number of strategies to ensure viability – review of rosters to ensure appropriate staffing levels to hours funded, identify those houses that are not contributing and establish strategies to ensure they are able to contribute, and resolve issues relating to services that DSS is currently subsidising. These strategies will result in some significant change in how rosters are structured so that DSS is able to successfully respond to the new funding model.

The following are the actions we will be implementing in the 16/17 year, and are aligned to the principles of DSS.

Guiding Principle	Issue	Target	Vision
Person centred **Individuals have a voice and are heard.** *Is the strategy evidence based?* *(Liz/Karon)*	1. Not all individuals have a current lifestyle plan. 2. The role of the key worker is not well understood. 3. Not all responses to challenging behaviour are based on a positive intervention strategy	1. 100% of ILPs are reviewed within 12 months 2. Every person has a key worker who has been orientated to the role. 3. Responses to challenging behaviour are clearly planned and consistently applied in a timely manner	1. The individual has ILP goals driven by them and reflect their goals and aspirations 2. Individuals are assisted by key workers to maximize choice, independence and wellbeing 3. All staff recognize challenging behaviour is a form of communication that needs a appropriate positive response

	4. Individual involvement in developing the service is token	4. Individuals participate in and influence service development	4. Individuals influence service development

Guiding Principle	Issue	Target	Vision
Staff supportive **For staff to feel valued, supported and trained to achieve person centred active support.** *Is the strategy evidence based?* *(Gerrie/Martin/ Janet)*	1. The SILC review in regard to culture has made a number of recommendations. 2. Inconsistent understanding of roles and DSS Mission 3. Not every staff member has a current performance plan 4. Current communication processes need to be improved 5. Staff learning and development must align with the overall service development 6. Staff are not full trained in the individual support hours assessment process.	1. The recommendations are implemented within the agreed timeframes. 2. Management Team including Team Leaders consistently apply the DSS Mission 3. 100% of all staff will have a current performance plan that reflects the requirements of the service 4. Communication systems are fully reviewed and re developed to ensure consistency of message 5. Learning and development programme is aligned with the work plan 6. Key staff are identified and trained to support the needs assessment process.	1. Staff acknowledge an improvement in culture across the service in line with the recommendations and organizational values 2. All staff can explain the DSS Mission and their role in achieving it 3. All staff understand and are working towards achieving the DSS Mission 4. Staff confirm that the communication processes are working for them 5. Staff are fully engaged in their professional development and complete the required qualifications for working in the sector 6. Level of funding will cover actual costs of service provision to individuals.
Systems Minded **Does the proposed change make our systems more efficient and effective?** *Is the strategy evidence based?* *(Keith/Fran)*	1. Full implementation of computerization of the service 2. Health & Safety legislation is changing. (Fran) 3. Transport system is not working to everyone's satisfaction	1. Actor, Safety 1st and lines of communication are fully implemented 2. DSS is working within the H&S legislative requirements. 3. Review of the internal transport system will be completed	1. All systems and processes that can be computerized are completed 2. No staff injuries sustained at work 3. Transport is managed efficiently and effectively across the whole service
Funding Fit **Proposed strategies are affordable and financially sustainable** *Is the strategy evidence based?* *(Vicki/Liz/Karon/Martin)*	1. DSS must remain financially viable by covering all costs within revenue 2. Our rosters are not consistently aligned to service need 3. Current annual work plan is not reflecting the long term requirements of service development 4.Proposed Ministry funding model may result in reduced funding 5. Current assessments are underestimating actual hours of individual needs.	1. DSS will overall achieve an 8% contribution to overhead and indirect costs 2. Rosters are aligned with service need 3. Five to ten year service development plan will be established 4. That DSS gains a full understanding of the impact of the new funding model 5. Key staff will be identified from each house to be trained in supporting individuals when they are being reassessed.	1. DSS is financially viable to be fully independent within funding received 2. Rosters match service user needs 3. Services are developed to ensure service long-term viability 4. DSS is able to cover all costs within the new funding model 5. Every individual supported by DSS has their hours of support need accurately reflected in allocated funding.
CQI **Improvement across the Service is obvious** *Is there a commitment to continuously improving quality?* *(Fran/Keith)*	1. Safety 1st needs to meet the needs of DSS (Fran) 2. Achieving certification and contractual standards is a mandatory requirement 3. There is an unacceptably high rate of medication errors 4. Not enough staff understand the potential of CQI	1. All staff actively use the Safety 1st system and the resulting reports. 2. DSS achieves Certification in 2016 and meets all contractual standards 3. 95% Right medication 4. We develop Quality Reps for each Group and upskill and involve other staff who are interested in CQI.	1. The Safety 1st system is relevant to DSS. 2. Staff are fully engaged in CQI activities across the service so that it is treated as business as usual 3. Individuals receive 100% Right medication 4. Staff initiate quality improvement opportunities.

Delivering on Regional Priorities

The South Island DHB Chief Executives form the Alliance Leadership Team and take responsibility for the coordination of regional service planning under the Alliance Governance Board (the DHB Chairs). The South Island Alliance Programme Office (SIAPO) is funded jointly by the South Island DHBs to provide services such as audit, service development and project management. Regional activity is then implemented through service level alliance and workstreams, and Nelson Marlborough Health has active representatives in all the workstreams.

Hepatitis C

As requested by the Ministry of Health during 2016/17 the South Island Alliance will support the development of a model of care and implementation plan for hepatitis C services. This will include:

- An agreed clinical pathway through engagement with primary and secondary sectors across the region
- Understanding of the costs of the proposed service and, if required, the development of a business case to fund any additional resources.

Rheumatic Fever

The region has developed the South Island Rheumatic Fever Prevention Plan which will be implemented via the South Island Health Services Plan. Nelson Marlborough Health is committed to the Plan which provides a consistent approach in the management of patients with rheumatic fever. The plan ensures Nelson Marlborough patients receive a high standard of patient care, with free dental care, general practice care, and annual specialist review, for all patients who are or should be on penicillin prophylaxis. This package of care aims to optimise patients' health, and minimise the chance of relapse, bacterial endocarditis..

The South Island Public Health Partnership continues to provide a surveillance function for rheumatic fever and plays a facilitative role in ensuring each DHB has mechanisms in place to ensure the Rheumatic Fever Prevention and Management Plan is being implemented as intended. The partnership also has a Communicable Diseases Protocol Group.

At a local level, we commit to ensuring that all cases of acute and recurrent acute rheumatic fever are notified with complete case information to the Medical Officer of Health within seven days of hospital admission. For the cases reported to the Medical Officer of Health, we will undertake case reviews of all rheumatic fever cases (both first episode and recurrent). Patients with a history of rheumatic fever will receive monthly antibiotics not more than five days after their due date, and we will complete an annual audit of rheumatic fever secondary prophylaxis coverage by quarter four of 2016/17. Any systems failures identified will be reported on, and any audit issues identified will be addressed.

Major Trauma

A planned and consistent approach to the provision of major trauma services across the South Island will be achieved through:

- South Island Major Trauma Services systems and processes agreed to support people surviving major trauma and recovering with a good quality of life
- Establishing systems to collect NZ Major Trauma Minimum Dataset and NZ Major Trauma Registry
- Clinical Leadership that is well networked across the South Island
- Destination policies
- Inter hospital transfer protocols.

Spinal Cord Impairment Action Plan

Nelson Marlborough Health continues to be committed to implementing the actions in the Spinal Cord Impairment Actions Plan 2014-2019, such as the Spinal Cord Injury Destination Policy.

STATEMENT OF PERFORMANCE EXPECTATIONS

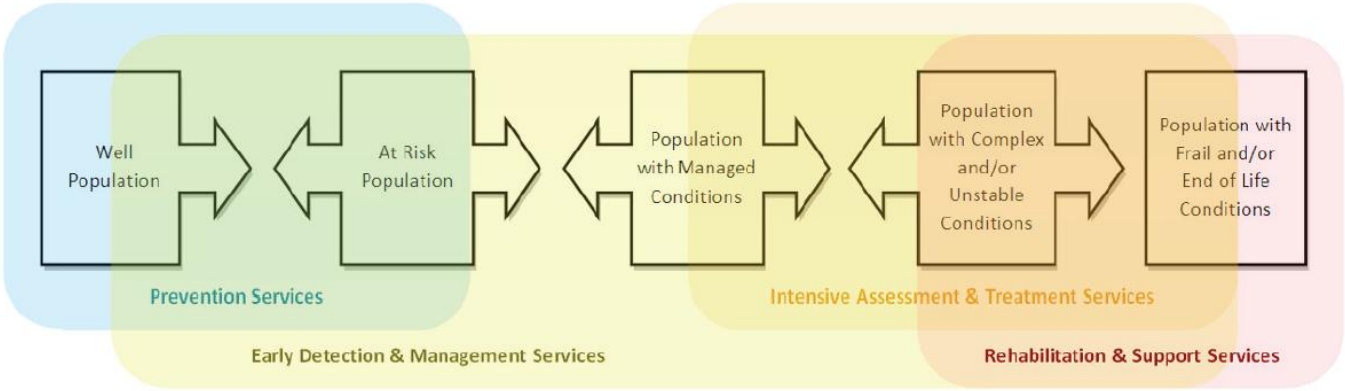
We aim to provide the best healthcare and achieve the best health outcomes for our community, and we need to monitor our performance to evaluate the effectiveness of the decisions we make on behalf of our population, and ensure we are achieving the outcomes required for our community.

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 3. 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 need to 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).

Section 4: Financial Performance provides details about revenue and expenses by each output class. And our performance against these outputs is described in our end-of-year Annual Report.

3.1 Prevention Services

Output Class Description

Preventative health services promote and protect the health of the whole population, or identifiable sub-populations, and influence individual behaviours by targeting population-wide changes to physical and social environments that engage, influence and support people to make healthier choices. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from environmental risks and communicable diseases, and individual health protection services such as immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

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, 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 (low socio-economic, Maori, 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 2015-16

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2014/15	Target 2015/16	Target 2016/17
Percentage of enrolled women (25-69) who had a cervical smear in the last 3 years – All	V	82.5	85	85
Percentage of enrolled women (25-69) who had a cervical smear in the last 3 years – Maori only	V	65.8	85	85
Percentage of enrolled women (25-69) who had a cervical smear in the last 3 years – Pacific only	V	65.4	85	85
Percentage of women (45-65) having mammography within 2 years	V	80	80	80
Percentage of newborn hearing screening completed within 1/12 birth	V	94	95	95
Percentage of two year old children fully vaccinated	C	93	95	95
Percentage of over 65 year olds vaccinated for seasonal influenza	V	65	75	75
Percentage of eligible children receiving Before (B4) School Checks	V	102	90	100
Reduction in Alcohol related harm measure – Implementation of the Alcohol Related Harm Reduction Strategy	Q	N/A	N/A	New
Number of clients seen by the primary mental health service - youth	Q	N/A	N/A	New
Number of clients seen by the primary mental health service - adults	Q	N/A	N/A	New

3.2 Early Detection and Management Services

Output Class Description

Early detection and management services maintain, improve and restore people's health. These services include detection of people at risk, and identification of disease, and well as more effective management and coordination of people with long-term conditions. These services are by nature more generalist, usually accessible from multiple providers, and at a number of different locations. Providers include general practice, community services, personal and mental health services, Maori and Pacific health services, pharmacy services, diagnostic imaging and laboratory services, and child and youth oral health services.

Primary Health Care services are offered in local community settings by teams of General Practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals, and are aimed at improving, maintaining, or restoring health. High numbers of enrolment with general practice are indicative of engagement, accessibility, and responsiveness of primary care services. These services keep people well by:

a) intervening early to detect, manage, and treat health conditions (e.g. health checks)
b) providing education and advice so people can manage their own health
c) reaching those at risk of developing long-term or acute conditions.

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 2015-16

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2014/15	Target 2015/16	Target 2016/17
Percentage of people in the district enrolled with PHO – Nelson	C	98%	99%	99%
Percentage of people in the district enrolled with PHO – Marlborough	C	96%	99%	99%
Ambulatory Sensitive Hospitalisation (ASH) rates for children age 0 – 4 years	Q	80%	95%	95%
Number of children <5 years enrolled in DHB funded dental services	C	6,745	7,242	7,242
Percentage of secondary care patients whose medicines are reconciled on admission	C,Q	27.1%	>22%	>22%
Percentage of people provided with a CT scan within 42 days of referral	T	56%	100%	100%
Percentage of people provided with an MRI scan within 42 days of referral	T	26%	100%	100%
Percentage of PMHI Extended GP consults and Packages of care used by youth	Q	n/a	15%	15%
Percentage of the eligible population who will have had their cardiovascular risk assessed in the last five years	C	89%	90%	90%

3.3 Intensive Assessment & Treatment Services

Output Class Description

Intensive assessment and treatment services are usually complex services provided by specialists and other healthcare professionals working closely together. These services are usually (but not always) provided in hospital settings which enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services, and emergency or urgent care services.

As the local provider of hospital and specialist services, Nelson Marlborough Health provides an extensive range of intensive treatment and complex specialist services to our population. We also fund some intensive assessment and treatment services for our population provided by other DHBs, private hospitals, and private providers. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. However, others are planned (elective) services and access is determined by capacity, clinical triage, national service coverage agreements, and treatment thresholds.

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 2015-16

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2014/15	Target 2015/16	Target 2016/17
Acute inpatient average length of stay (days)	Q	3.57	3.47	2.35
Percentage of elective and arranged surgery undertaken on a day case basis	Q	67.1%	60.5%	68%
Percentage of people receiving their elective & arranged surgery on day of admission	Q	97%	97%	97%
Percentage of total deliveries in primary birthing units	Q V	7.0%	7.0%	7.0%
Women registering with an LMC by week 12 of their pregnancy	T	New	N/A	80%
Ratio of patients assessed as triggering 'institutional risk' compared with ARC admissions' [Source: InterRAI].	Q	New	New	25%
Standardised Intervention Rate for major joint replacement	V	N/A	21 per 10,000	21 per 10,000
Standardised Intervention Rate for cataract procedures	V	N/A	27 per 10,000	27 per 10,000

3.4 Rehabilitation and Support Services

Output Class Description

Rehabilitation and support services provide people with the support and assistance they need to maintain or regain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives. These services are delivered following a clinical 'needs assessment' process coordinated by Needs Assessment and Service Coordination (NASC) services and include: domestic support, personal care, community nursing and community services provided in people's own homes and places of residence including day care, respite and residential care services. Services are mostly for older people, mental health clients, and for personal health clients with complex health conditions.

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering. Delivery of these services may require coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

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 2015-16

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2014/15	Target 2015/16	Target 2016/17
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	NEW	75%	80%
Percentage of older people living in ARRC	C	4%	4%	4%
Improving Mental Health services using transition (discharge) planning and employment: Child and Youth with a transition (discharge) plan	Q	98.9%	95%	98%

FINANCIAL PERFORMANCE

4.1 INTRODUCTION

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

The past few years have seen NMDHB 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 with the NMDHB is committed to continuing.

4.1.1 Living Within Our Means

A fundamental requirement of all DHBs is to live within its means. This is a key commitment for the NMDHB as stated and the NMDHB has a strong record of financial delivery whilst remaining focussed on good patient outcomes. The NMDHB expects new challenges will emerge in 2016/17 and we remain in good shape to face these challenges.

The NMDHB is committed to meeting this challenge and is submitting a better than breakeven budget for the four year period commencing on 1 July 2016 through to 30 June 2020. We are aiming for a better than breakeven result through a progressive increase in our planned surplus results as we move toward the redevelopment of the Nelson Hospital in four to five years time.

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

4.1.2 Regional and National Collaboration

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.

NZ Health Partnerships Limited ("NZHP") took over the functions of Health Benefits Limited ("HBL") on 1 July 2015 and has the broad aim to enable DHBs to collectively maximise shared services opportunities for the benefit of the sector. NZHP inherited the four national business cases developed by HBL and is working collaboratively with all DHBs to plan for the implementation of these cases. NMDHB is committed to supporting NZHP's work and the local implementation of these business cases. Estimates have been included in the finances in respect of these projects.

4.2 FINANCIAL PERFORMANCE SUMMARY

The NMDHB is committed to not only living within its means by delivering a minimum of a breakeven financial result but also build the surplus over the period of this Annual Plan that will allow us to incur the additional interest, depreciation and capital charges that will accrue following an investment of this magnitude and not fall into the trap experienced by other district health boards of struggling to find efficiency programmes with the quantum of realisable and achievable efficiencies and benefits to afford the increase in capital costs.

The budgets incorporated within this Plan build on the surpluses reported in the 2013/14 and 2014/15 years and at the time of writing we are forecasting a surplus of $1.5M for the 2015/16 financial year. For the 2016/17 financial year we are projecting a surplus of $4.0M with increasing surpluses in the following three years covered by this Plan. 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 NMDHB has been focussing on, and investing in, over the last two years to meet the challenges faced across the health system.

It is noted that the 2015/16 Annual Plan projected a higher level of surplus for the 2016/17 year than is projected within this Plan. This is primarily related to a lower increase in the revenue allocated to the NMDHB within the population based funding formula than expected. As directed by the Ministry of Health ("MOH") in the 2015/16 Annual Plan financial projections (and is consistent with the direction from the MOH for the current year as noted in the assumptions within this section of the Plan) we projected a funding increase of $14.4M for 2016/17 over the 2015/16 which after allowing for further investment resulted in a projected 2016/17

surplus of $5.4M. The funding increase received within the population based funding formula for 2016/17 was $8.7M, $5.7M lower than last years projected increase.

This lower level of funding increase has meant the NMDHB has found a level of savings and efficiencies to enable us to continue to provide for investment in new and additional services, albeit at the lower level then projected in the 2015/16 Annual Plan.

4.3. CONSTRAINING OUR COST GROWTH

Constraining cost growth is critical to our success in delivering a surplus in the 2016/17 year and the projected surpluses in the years covered by this Plan. 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.

NMDHB 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:

1. Reducing variation, duplication and waste from the system;
2. Doing the basics well and understanding our core business;
3. Investing in clinical leadership and clinical input into operational processes and decision-making;
4. Developing workforce capacity and supporting less traditional and integrated workforce models;
5. Realigning service expenditure to better manage the pressure of demand growth; and
6. Supporting unified systems to shared resources and systems.

4.4 ASSUMPTIONS

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

1. NMDHB's funding allocations will increase as per funding advice from the Ministry of Health.
2. Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives.
3. 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.
4. Any revaluation of land and buildings will not materially impact the carrying value or the associated depreciation costs.
5. IDF volumes and prices are at the levels identified by the Ministry of Health and advised within the Funding Envelope.
6. Employee cost increases are based on terms agreed in current wage agreements. Expired wage agreements are assumed to be settled on affordable and sustainable terms.
7. 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.
8. External provider increases will be made within available funding levels, after allowance for committed and demand-driven funding.
9. Price increases agreed collaboratively by DHBs for national contracts and any regional collaborative initiatives will be within available funding levels and will be sustainable.
10. 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.
11. All other expense increases including volume growth will be managed within uncommitted funds available or deferred.
12. The DHB will meet the mental health ring fence expectations.

4.5 ASSET PLANNING AND SUSTAINABLE INVESTMENT

4.5.1 Asset Management Planning

NMDHB 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 currently being developed. This revision of the AMP includes a detailed review of the asset management practices and will provide a robust platform on which to base capital investment decisions in the future. The AMP reflects the joint approach taken by all DHBs and current best practice.

4.5.2 Capital Expenditure

NMDHB has significant capital expenditure committed in 2015/16 and the next four financial years covered by this Plan.

Based on NMDHB's fiscal position, we estimate that we will fund a total of $7.35M of general capital expenditure across the four years within this Plan. In addition significant investment has been allowed for major or strategic projects in the 2014/15 financial year and the four years covered by this Plan.

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. The following table summarises the capital expenditure plan. Of note is the beginning of the Nelson Hospital redevelopment with preliminary costs for the development of the business case commencing in the 2016/17 financial year and capital costs commencing in the 2018/19 financial year.

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Baseline capital expenditure						
Land	0	0	0	0	0	0
Buildings & plant	826	2,011	2,000	2,000	2,000	2,000
Clinical equipment	1,809	3,322	2,200	2,200	2,200	2,200
Other equipment	558	500	500	500	500	500
Information technology	518	1,083	500	500	500	500
Intangible assets (software)	245	1,209	1,750	1,750	1,750	1,750
Motor vehicles	1,899	923	400	400	400	400
Total baseline capital expenditure	**5,855**	**9,048**	**7,350**	**7,350**	**7,350**	**7,350**
Major & strategic capital expenditure						
Buildings & plant	0	6,977	5,500	2,000	5,000	30,000
Clinical equipment	1,000	1,000	1,000	1,000	1,000	1,000
Clinical information systems	0	8,032	1,255	500	0	0
Total major & strategic capital expenditure	**1,000**	**16,009**	**7,755**	**3,500**	**6,000**	**31,000**
Total capital expenditure	**6,855**	**25,057**	**15,105**	**10,850**	**13,350**	**38,350**

Details of major/strategic capital planning	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Facilities related					
Seismic work		500			
Alexandra hospital refurbishment	800				
Wairau remediation	557				
Arthur Wicks refurbishment	5,400				
Learning & development centre		5,000	2,000		
Murchison	220				
Nelson hospital redevelopment preliminary phase				5,000	30,000
Total facilties	**6,977**	**5,500**	**2,000**	**5,000**	**30,000**
Clinical information systems related					
PICS BUS	400				
PICS	6,032	955			
HCS	1,600				
ePharmacy		300			
eSCRV			500		
Total clinical information systems	**8,032**	**1,255**	**500**	**0**	**0**

4.5.3 Business Cases

The NMDHB 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, National Health Information Technology Board 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.

NMDHB is aware of several business case initiatives in varying stages of development at the time of writing including:

- Learning & Development Centre
- Move to a “digital hospital” environment
- Master site plan leading to the redevelopment of Nelson Hospital and other interim and transition moves that will likely be required.

4.5.4 Asset Valuation

NMDHB completed a full revaluation of its property and building assets at 30 June 2015 in line with generally accepted accounting practice requirements, the next such review being due as at 30 June 2020.

4.6 DEBT AND EQUITY

4.6.1 Core Debt

NMDHB has a long-term debt facility of $55.5M with the National Health Board through the NZ Debt Management Office which has been fully drawn down. No repayments of this debt have been assumed to occur over the period covered by this Plan. The core debt is secured by a negative pledge. Without the NHB's prior written consent the DHB cannot perform the following actions:

- Create any security over its assets, except in certain circumstances;
- Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- Make a substantial change in the nature or scope of its business as presently conducted, or undertake any business or activity unrelated to health; or
- Dispose of any of its assets except disposals at full value in the ordinary course of business.

4.6.2 Other Debt Facilities

In addition to the core debt facilities NMDHB 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.

NMDHB 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 NMDHB 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 are made in our 2014/15 Annual Report.

4.7 ADDITIONAL INFORMATION AND EXPLANATIONS

4.7.1 Disposal of Land and Other Assets

NMDHB 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 the DHB was progressing with the requirements to commence formal consultation on the proposed disposal and the required notifications 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.

4.7.2 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.

4.7.3 Acquisition of Shares

Before NMDHB 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.

4.8 ACCOUNTING POLICIES

The accounting policies adopted are included as Appendix 8.3 to this Plan. The statement of accounting policies reflects the transition to the International Public Sector Accounting Standards for the 2014/15 year and the four years covered by this Plan.

4.9 PROSPECTIVE FINANCIAL STATEMENTS

The projected financial statements for the parent and group comprising Nelson Marlborough District Health Board 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.

4.9.1 Statement of Prospective Comprehensive Income and Expense

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Income	**443,253**	**461,572**	**470,674**	**479,128**	**487,598**	**496,086**
Operating Expenditure						
Workforce costs	163,285	170,860	174,561	177,362	180,210	183,103
Outsourced services	10,500	10,712	10,186	10,288	10,391	10,495
Clinical supplies	32,838	35,200	34,081	34,455	34,832	35,175
Infrastructure and non-clinical supplies	26,462	26,724	27,321	27,779	28,006	28,118
External providers	145,354	149,935	153,858	157,044	159,284	161,505
Inter-district flows	41,426	45,038	43,227	44,178	45,150	46,143
Interest	3,225	3,005	2,986	2,988	2,991	2,993
Depreciation & amortisation	11,192	10,745	12,517	12,517	12,517	12,517
Capital charge	7,254	7,801	7,937	8,017	8,217	8,537
Total expenditure	**441,536**	**460,020**	**466,674**	**474,628**	**481,598**	**488,586**
Net surplus / (deficit)	**1,717**	**1,552**	**4,000**	**4,500**	**6,000**	**7,500**
Other comprehensive revenue or expenses						
Item that will be reclassified to surplus/(deficit):						
Financial assets at fair value through other comprehensive revenue and expense	0	0	0	0	0	0
Items that will not be reclassified to surplus/(deficit):						
Gain/(loss) on property revaluation	6,239	0	0	0	0	0
(Impairment)/revaluation of property assets	0	0	0	0	0	0
Total other comprehensive revenue or expenses	**6,239**	**0**	**0**	**0**	**0**	**0**
Total comprehensive revenue and expense	**7,956**	**1,552**	**4,000**	**4,500**	**6,000**	**7,500**

4.9.2 Statement of Prospective Changes in Net Assets / Equity

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Equity at beginning of the year	**90,242**	**97,651**	**98,656**	**102,109**	**106,062**	**111,515**
Total comprehensive revenue and expense for the year	**7,956**	**1,552**	**4,000**	**4,500**	**6,000**	**7,500**
Owner transactions						
Capital contributions	0	0	0	0	0	0
Repayment of capital	-547	-547	-547	-547	-547	-547
Total owner transactions	**-547**	**-547**	**-547**	**-547**	**-547**	**-547**
Equity at end of the year	**97,651**	**98,656**	**102,109**	**106,062**	**111,515**	**118,468**

4.9.3 Statement of Prospective Financial Position

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Non current assets						
Property, plant & equipment	165,091	166,860	161,597	156,733	158,620	183,757
Intangible assets	7,182	6,699	9,296	11,892	14,489	17,086
Prepayments	107	43	43	43	43	43
Other financial assets	1,475	2,106	2,106	2,106	2,106	2,106
Total non current assets	**173,855**	**175,708**	**173,042**	**170,774**	**175,258**	**202,992**
Current assets						
Cash & cash equivalents	43,712	43,783	49,464	53,554	52,385	28,764
Debtors & other receivables	10,781	13,535	13,535	13,535	13,535	13,535
Inventories	2,703	2,723	2,723	2,723	2,723	2,723
Prepayments	387	588	588	588	588	588
Assets held for sale	750	487	487	0	0	0
Total current assets	**58,333**	**61,116**	**66,797**	**70,400**	**69,231**	**45,610**
Total assets	**232,188**	**236,824**	**239,839**	**241,174**	**244,489**	**248,602**
Equity						
Crown equity	28,040	27,493	26,946	26,399	25,852	25,305
Revaluation reserve	53,213	53,213	53,213	53,213	53,213	53,213
Retained earnings	16,398	17,950	21,950	26,450	32,450	39,950
Total equity	**97,651**	**98,656**	**102,109**	**106,062**	**111,515**	**118,468**
Non current liabilities						
Interest bearing loans & borrowings	57,214	56,968	47,728	52,488	51,748	56,008
Employee entitlements	10,852	10,405	10,405	10,405	10,405	10,405
Total non current liabilities	**68,066**	**67,373**	**58,133**	**62,893**	**62,153**	**66,413**
Current liabilities						
Creditors & other payables	28,996	36,072	36,410	33,812	31,914	29,314
Employee benefits	29,643	26,967	26,967	26,967	26,967	26,967
Interest bearing loans & borrowings	6,668	6,556	15,020	10,240	10,740	6,240
Provisions	1,164	1,200	1,200	1,200	1,200	1,200
Total current liabilities	**66,471**	**70,795**	**79,597**	**72,219**	**70,821**	**63,721**
Total liabilities	**134,537**	**138,168**	**137,730**	**135,112**	**132,974**	**130,134**
Total equity & liabilities	**232,188**	**236,824**	**239,839**	**241,174**	**244,489**	**248,602**

4.9.4 Statement of Prospective Cash Flows

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Cash flows from operating activities						
Receipts from Ministry of Health & patients	440,792	457,229	470,520	478,973	487,443	496,081
Interest received	2,689	2,157	2,250	2,250	2,250	2,250
Payments to employees	-158,571	-169,767	-165,196	-183,409	-180,483	-189,064
Payments to suppliers	-260,574	-266,552	-279,947	-272,052	-283,284	-280,471
Capital charge paid	-7,252	-7,801	-7,937	-8,017	-8,217	-8,537
Interest paid	-3,225	-3,005	-2,986	-2,988	-2,991	-2,993
Net GST paid	-534	0	0	0	0	0
Net cash inflow from operating activities	**13,325**	**12,261**	**16,704**	**14,757**	**14,718**	**17,266**
Cash flows from investing activities						
Sale of property, plant & equipment	183	262	150	150	150	150
Cash inflow on maturity of investments	0	0	0	0	0	0
Acquisition of property, plant & equipment	-11,696	-8,671	-5,600	-6,000	-11,000	-36,000
Acquisition of intangible assets	-2,474	-2,951	-4,250	-4,250	-4,250	-4,250
Acquisition of investments	0	0	0	0	0	0
Net cash inflow / (outflow) from investing activities	**-13,987**	**-11,360**	**-9,700**	**-10,100**	**-15,100**	**-40,100**
Cash flows from financing activities						
Loans raised	0	0	0	0	0	0
Finance leases raised	0	0	0	0	0	0
Equity injections	0	0	0	0	0	0
Equity repaid	-547	-547	-547	-547	-547	-547
Repayment of borrowings	0	0	0	0	0	0
Repayment of finance lease liabilities	-529	-283	-776	-20	-240	-240
Net cash outflow from financing activities	**-1,076**	**-830**	**-1,323**	**-567**	**-787**	**-787**
Net increase/(decrease) in cash & cash equivalents	**-1,738**	**71**	**5,681**	**4,090**	**-1,169**	**-23,621**
Cash & cash equivalents at 1 July	45,450	43,712	43,783	49,464	53,554	52,385
Cash & cash equivalents at 30 June	**43,712**	**43,783**	**49,464**	**53,554**	**52,385**	**28,764**

4.9.5 Summary of Prospective Revenue and Expenses by Dimension

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Revenue						
Funds	401,448	419,631	428,289	436,398	444,522	452,659
Governance & funding administration	6,857	5,147	4,281	4,281	4,281	4,281
Provider	250,282	264,862	266,133	271,402	276,779	282,273
Eliminations	-215,334	-228,068	-228,029	-232,953	-237,984	-243,127
Total revenue	**443,253**	**461,572**	**470,674**	**479,128**	**487,598**	**496,086**
Expenses						
Funds	402,115	423,041	425,114	434,174	442,419	450,774
Governance & funding administration	4,136	4,061	4,437	4,469	4,501	4,533
Provider	250,619	260,986	265,152	268,938	272,662	276,406
Eliminations	-215,334	-228,068	-228,029	-232,953	-237,984	-243,127
Total expenses	**441,536**	**460,020**	**466,674**	**474,628**	**481,598**	**488,586**
Net contribution						
Funds	-667	-3,410	3,175	2,224	2,103	1,885
Governance & funding administration	2,721	1,086	-156	-188	-220	-252
Provider	-337	3,876	981	2,464	4,117	5,867
Net surplus / (deficit)	**1,717**	**1,552**	**4,000**	**4,500**	**6,000**	**7,500**

4.9.6 Statement of Prospective Revenue and Expenses by Output Class

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Revenue						
Prevention services	7,877	8,160	8,364	8,515	8,665	8,816
Early detection & management services	115,006	119,133	122,121	124,314	126,512	128,714
Intensive assessment & treatment services	228,877	239,502	243,035	247,400	251,774	256,156
Support services	91,494	94,777	97,154	98,899	100,647	102,400
Total revenue	**443,254**	**461,572**	**470,674**	**479,128**	**487,598**	**496,086**
Expenses						
Prevention services	6,948	7,193	7,366	7,491	7,604	7,719
Early detection & management services	110,894	115,322	117,158	119,427	121,281	123,139
Intensive assessment & treatment services	232,465	242,715	245,761	249,514	253,016	256,525
Support services	91,230	94,790	96,389	98,196	99,697	101,203
Total expenses	**441,537**	**460,020**	**466,674**	**474,628**	**481,598**	**488,586**
Net contribution						
Prevention services	929	967	998	1,024	1,061	1,097
Early detection & management services	4,112	3,811	4,963	4,887	5,231	5,575
Intensive assessment & treatment services	-3,588	-3,213	-2,726	-2,114	-1,242	-369
Support services	264	-13	765	703	950	1,197
Net surplus / (deficit)	**1,717**	**1,552**	**4,000**	**4,500**	**6,000**	**7,500**

4.9.7 Statement of Prospective Financial Performance – Prevention Services

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Income	**7,877**	**8,160**	**8,364**	**8,515**	**8,665**	**8,816**
Operating Expenditure						
Workforce costs	3,679	3,794	3,933	3,996	4,060	4,126
Other operating costs	985	1,018	1,023	1,034	1,044	1,054
External providers & inter district flows	2,284	2,381	2,410	2,461	2,500	2,539
Total expenditure	**6,948**	**7,193**	**7,366**	**7,491**	**7,604**	**7,719**
Net surplus / (deficit)	**929**	**967**	**998**	**1,024**	**1,061**	**1,097**

4.9.8 Statement of Prospective Financial Performance – Early Detection and Management Services

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Income	**115,006**	**119,133**	**122,121**	**124,314**	**126,512**	**128,714**
Operating Expenditure						
Workforce costs	19,870	20,489	21,242	21,583	21,930	22,282
Other operating costs	7,991	8,259	8,302	8,391	8,470	8,547
External providers & inter district flows	83,033	86,574	87,614	89,453	90,881	92,310
Total expenditure	**110,894**	**115,322**	**117,158**	**119,427**	**121,281**	**123,139**
Net surplus / (deficit)	**4,112**	**3,811**	**4,963**	**4,887**	**5,231**	**5,575**

4.9.9 Statement of Prospective Financial Performance – Intensive Assessment and Treatment Services

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Income	**228,877**	**239,502**	**243,035**	**247,400**	**251,774**	**256,156**
Operating Expenditure						
Workforce costs	115,071	125,120	127,140	129,180	131,254	133,360
Other operating costs	76,369	74,592	75,332	76,137	76,859	77,556
External providers & inter district flows	41,025	43,003	43,289	44,197	44,903	45,609
Total expenditure	**232,465**	**242,715**	**245,761**	**249,514**	**253,016**	**256,525**
Net surplus / (deficit)	**-3,588**	**-3,213**	**-2,726**	**-2,114**	**-1,242**	**-369**

4.9.10 Statement of Prospective Financial Performance – Rehabilitation and Support Services

	2014/15 Actual $000	2015/16 Forecast $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000	2019/20 Projection $000
Income	**91,494**	**94,777**	**97,154**	**98,899**	**100,647**	**102,400**
Operating Expenditure						
Workforce costs	20,809	21,457	22,246	22,603	22,966	23,335
Other operating costs	9,983	10,318	10,371	10,482	10,581	10,678
External providers & inter district flows	60,438	63,015	63,772	65,111	66,150	67,190
Total expenditure	**91,230**	**94,790**	**96,389**	**98,196**	**99,697**	**101,203**
Net surplus / (deficit)	**264**	**-13**	**765**	**703**	**950**	**1,197**

STEWARDSHIP

Good stewardship is about managing our business so it operates efficiently and makes the best use of the funds allocated to us so we can provide the best healthcare and achieve the best health outcomes for our community.

Our transition from good to great requires strong governance and leadership, integrated public health actions to make positive health choices the easy choices, a capable and engaged workforce, effective partnerships and alliances, and information systems and infrastructure that enable and enhance integrated service delivery.

5.1 GOVERNANCE & LEADERSHIP

Nelson Marlborough Health is guided by a skilled and committed Board. The Board's core responsibility is to set the strategic direction and policy that is consistent with Government objectives, improves health outcomes and ensures sustainable service provision. The Board also ensures compliance with legal and accountability requirements. 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.' We are strategically advised on the planning and delivery of Maori health services by our Iwi Health Board.

As identified in the *Health Needs & Service Profile*, the Nelson Marlborough health system performs at or above the New Zealand average for many indicators. Nelson Marlborough Health'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. This objective, reflected in the HSP, 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.

Operational and management matters have been delegated by the Board to the Chief Executive, who is supported by the Executive Leadership Team (ELT). The DHB has a clinical governance group supported by the Clinical Governance Support team with input from both PHO clinical governance groups, and two consumer representatives. Over time we aspire to have the three clinical governance groups for Nelson Marlborough Health, Nelson Bays Primary Health, and Kimi Hauora PHO converge into a single committee for the Nelson Marlborough Health System.

The extent of strong clinical leadership at Nelson Marlborough Health can be seen in the health target and service plans in Section 2: Delivering on Priorities and Targets. The majority of the plans have both a managerial and clinical lead as the owner / champion of the plan.

5.3 IMPROVING THE QUALITY AND SAFETY OF CARE

Patients are at the heart of our services and the desire to create a better service for patients drives our quality and safety improvements. Nelson Marlborough health professionals are committed to delivering the best service possible within the resourcing available.

At a national level, we will engage with the Ministry of the work programmes of the former National Health Committee once the programme is confirmed, and we will continue our commitment to all of the Health Promotion Agency initiatives.

The Nelson Marlborough Health chief executive Chris Fleming and board chair Jenny Black officially pledged their support for the *Open for Better Care* patient safety campaign in June 2013. The national campaign, coordinated by the Health Quality & Safety Commission (HQ&SC) and implemented regionally by DHBs and other health providers, focuses on four key areas where evidence shows it is possible to reduce patient harm. The four areas of focus are: Falls, Healthcare Associated Infections, Perioperative (Surgery) Harm and Medication Safety.

Locally, the high profile clinician-led campaign has included establishing champions in hospital and community settings, information booths and visual displays for staff and patients, learning opportunities - guest speakers, eLearning modules and webinars – and local and national media coverage.

Each area of focus has a Quality Safety Marker (QSM) which is a related indicator that helps us determine whether the desired changes in practice and reductions in harm and cost have occurred. The QSM targets have been incorporated into business as usual, and we will continue to refine and improve our integrated approach across the DHB that has seen us achieve continued improvement in the QSMs. Nelson Marlborough Health is committed to achieving, sustaining and improving on all QSM targets (refer to the Improving Quality & Clinical Governance plan). For each specific area of focus, we will:

- **Falls**: Achieve and sustain the QSM targets that 90% of older patients are given a falls risk assessment, and 98% of older patients assessed as at risk of falling receive an individualised care plan addressing those risks; Build on the work of the Falls Prevention working group (a group of primary and secondary clinicians and managers led by the Director of Allied Health) to ensure an integrated approach to reducing harm from falls, by examining our results and taking action to improve quality and safety, using falls-related data.
- **Hand Hygiene**: Achieve and sustain the QSM target of 80% compliance with good hand hygiene practice by continuing to use our trained hand hygiene auditors to promote good hand hygiene practice messages to staff, patients and visitors; and examine our results to identify and implement actions to improve quality and safety.
- **Perioperative (Surgery)**: Refocus the use of the checklist as a teamwork and communication tool (rather than an audit tool); Work with the HQ&SC to implement the new perioperative harm QSM; and introduce briefing and debriefing for each theatre list.
- **Surgical Site Infection**: Achieve and sustain the QSM targets that 95% of hip and knee replacement patients receive cefazolin ≥2g or cefuroxime ≥1.5g as surgical prophylaxis; 100% of hip and knee replacement patients have recommended skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine; 100% of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision; continue to develop infection management systems; and examine our results to identify and implement actions to improve quality and safety.
- **Medication Safety**: Continue to conduct prioritised paper-based medicine reconciliations until the implementation of the electronic medicine reconciliation platform is completed for Nelson Marlborough Health.

We plan further work to reduce harm from opioids in our hospitals, and to build capability within our DHB in medication safety and quality improvement, will continue during the coming year. This will include supporting the use of MediMap to facilitate safer transitions of patients to aged residential care (ARC) facilities. We eagerly anticipate the introduction of eMR to increase the volume of medicine reconciliations we are able to complete through improved process efficiency.

Nelson Marlborough Health has produced a Quality Account for three years, and will produce another Quality Account in 2016 in accordance with HQ&SC guidance. The Quality Account is an annual report about the quality of the services provided within Nelson Marlborough Health, the consumer experience and health outcomes. As the target audience for the Quality Account is our local community, we appointed two consumer advisors and accepted their guidance on content and layout. The language used is clear and simple to understand, and we avoided complicated graphs and tables. We were also mindful of cost. The Account is not a full report on every quality initiative at Nelson Marlborough Health, but a selection of projects that show what we are doing to improve the quality and safety of care.

We also obtain input from consumers using the national patient experience survey. The patient experience survey provides excellent feedback from inpatients about what they think about their most recent stay in hospital. The survey has 20 questions covering issues such as whether patients understood the advice they were given by their doctor, whether they were involved in decisions about their care and treatment, and whether they were treated with respect and dignity by hospital staff. We will continue to expand the use of this data to drive improvement via the local “You said – We did”, campaign.

To continue to improve the quality and safety of care we provide we will participate in Mortality & Morbidity Reviews. Our Clinical Governance Committee will review and act on the findings of Mortality & Morbidity Reviews to improve services and reduce harm.

Nelson Marlborough Health performs comparably with other DHB’s, and we have committed to a regular review of patient experience survey results and development of an action plan (refer to the Improving Quality & Clinical Governance plan) so we can continue to improve the patient experience.

5.4 PUBLIC HEALTH ACTIONS

During 2016/17 we will work with our local councils on key health promotion / prevention activities such as the removal of sugar-sweetened beverages and artificially-sweetened beverages, addressing the issue of fluoridation in our water, and reducing alcohol related harm.

We will continue to lead the campaign to reduce the impact sugar is having on our health. Following the removal of sugar-sweetened beverages (SSBs) in March 2014, we have strengthened our policy and will remove artificially-sweetened beverages (ASBs), juices, flavoured waters and pre-packaged 'smoothie' drinks from our hospitals.

Nelson Marlborough Health has endorsed community water fluoridation as an important public health measure to maintain good oral health, the prevention of tooth decay and the reduction of health inequalities. A project manager is working alongside community groups and agencies, local authorities, media and health professionals to promote community water fluoridation in the Nelson Marlborough region.

We acknowledge the wide range of alcohol-related harm that is experienced by people within the Nelson Marlborough district and that the burden of this harm is carried disproportionately by some population groups. Alcohol use is a major risk factor for numerous health conditions, injuries and social problems. Additionally, alcohol-related harm costs the health sector significant money, time and resources. We will continue to reduce the alcohol-related harm experienced by people within the Nelson Marlborough district by finalising and implementing an Alcohol Harm Reduction Strategy.

5.5 STRENGTHENING OUR WORKFORCE

A capable and engaged workforce is essential to support the transformation of the health system for the Nelson Marlborough community. We need our people to develop competencies that enable them to work differently – 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 through regional systems, and contributing to the innovative redesign of services.

A workforce strategy has been developed to address the specific workforce issues facing the Nelson Marlborough health system, which 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 aging 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 Nelson Marlborough Health workforce strategy will be integrated with the workforce plan for the South Island region. We need to "Think nationally, and Act regionally" to benefit from emerging opportunities for our nursing workforce to take on more specialised care roles to support our aim to provide better, sooner, more convenient care.

Although a local workforce plan is not required by the Ministry, we thought it was important to include the key actions for the year ahead to develop a capable and engaged workforce in this Annual Plan. The actions are captured in the 'Workforce' plan in Section 2: Delivering on Priorities and Targets.

5.6 SAFE AND COMPETENT WORKFORCE

To deliver safe, quality care the Nelson Marlborough Health needs to provide a safe environment for staff and patients, and build a competent workforce through training and development.

Our programme over the last 12 months has included the following activities:

- Employee Engagement Survey – A union-DHB partnership alliance has been established to put into action initiatives to improve employee engagement and is working on a plan and developing initiatives as part of Nelson Marlborough Health's wider Workforce Action Plan. The Workforce Action Plan contains over 35 projects to align our workforce with our population and health strategy.

- Policies and Procedures – A full review of all of the Human Resources policies and procedures is ongoing – of 36 policies, 26 are operational and 10 have expired and are under review.
- Police Checks - Police checks are completed for all new employees. The police check results must be received prior to employment commencing for all children's workers.
- Online Learning - e-learning packages that support the Nelson Marlborough Health Cultural Competency Framework have been introduced, including an e-Learning course in Foundations of Cultural Competency in conjunction with the Ministry of Health e-Learning website. Workforce Action initiatives are aimed at providing better pathways for Maori and other targeted groups to be employed in Nelson Marlborough Health/local health sector

Nelson Marlborough Health has a range of policies designed to protect children which are reviewed three-yearly. We are continually updating and implementing changes around these in response to our environment and in keeping with the directions of the Children's Action Plan. Key policies are in place for Family Violence, Child Abuse and Neglect and Partner Abuse which all underpin children's protection. Shortly there will also be an Elder Abuse Policy. Training is offered around these key areas (Elder Abuse training is in development). All new staff employed in designated areas (paediatric, mental illness etc) are automatically enrolled on the next training course.

5.6.2 Children's Worker Safety Checking

Nelson Marlborough Health is committed to identifying, supporting and protecting vulnerable children. The prevention of abuse and enhancing the wellbeing of children and their families aims to keep vulnerable children safe before they come to harm so they can thrive, achieve and belong.

On 1 July 2014 the Vulnerable Children Act and other associated legislation passed into law. The Act forms a significant part of comprehensive measures to protect and improve the wellbeing of vulnerable children and strengthen New Zealand's child protection system. The Act introduced safety checking requirements for Children's Workers and is designed to protect children from the threats posed by a small number of high-risk individuals, while at the same time ensuring that safe and competent individuals are not discouraged from entering the workforce.

The safety checking process includes verification of an individual's identity, a police vet and places more rigour around the recruitment process (e.g. CV, practicing licence verification, qualification verification, reference checking and interview process). The safety checking requirements are being phased in to give organisations time to have all of their children's workforce checked:

- From 1 July 2015 new core children's workers starting a job or contract must be safety checked before they start work
- From 1 July 2016 new non-core children's workers starting a job or contract must be safety checked before they start work
- By 1 July 2018 existing children's core workers (i.e., those currently employed, or engaged as a contractor) must have been safety checked
- By 1 July 2019 all existing non-core children's workers must have been be safety checked.

In addition to the above all children's workers are required to be safety checked on a three yearly cycle.

To date Nelson Marlborough Health has:

- Included specific children's worker questions in interview templates and reference check templates
- Included a statement regarding child well-being and protection in the 'Employee Responsibilities' section of position descriptions
- Included a statement regarding safety checking in all offer letters
- Communicated information about the Vulnerable Children Act 2015 and safety checking to Nelson Marlborough Health management (including information being available via the Intranet).

Work in progress includes:

- Project plan in development in order to achieve safety check compliance of all existing children's core workers by 1 July 2018 and of all existing non-core children's workers by 1 July 2019
- Development of our Child Protection Policy
- Screens being added to our Payroll system to a) identify children's worker roles and b) record safety check information including required renewal date
- Process mapping for safety checking, police vetting and receipt of adverse results
- Considering updating the approval to recruit form, online application form and recruitment advertising to reference child protection and legislative requirements

- Considering development of a child protection intranet sub-site
- Considering reference to child protection on Nelson Marlborough Health website.

5.7 PARTNERSHIPS & ALLIANCES

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. By using our combined resources to jointly solve problems we are better positioned to respond to changes in the technology and demographics that will have a significant impact on the health sector in the coming years. So the actions in this Annual Plan also reflect key commitments to the regional alliance.

Locally, the 'Top of the South Health Alliance' (ToSHA) is our key vehicle for effecting transformational health system change. We will keep investing 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.

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

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

5.8 INFORMATION SYSTEMS

In 2015 Nelson Marlborough Health agreed a technology strategy with its stakeholders that focuses on making our hospitals paper-lite within 5 years as a critical enabler for progressively moving our hospitals and local health system to digital over a 10 year period.

The implementation of the regional Health Connect South Clinical Portal in June 2016 - July 2017 will be a key enabler for our first suite of technology implementations designed to move us towards being paper-lite. These are electronic laboratory and radiology sign-off and electronic referral triaging. In 206-17, subject to availability of capital, we also plan to implement 'Patientrack', which will enable us to capture observations and other data currently captured on paper electronically, and to systematically engineer paper medical charts out of our hospitals over the next 2-4 years. Subject to the availability of capital, we also plan to implement electronic pharmacy and medicines capabilities.

The implementation of a new regional Patient Administration System, PICS, currently scheduled for implementation in 2016-17 will also be a key enabler. PICS is supplied by the same product vendor as Health Connect South. Once implemented we will be able to work with our product vendor to systematically integrate the key tools we need to achieve our paper-lite outcomes, including Health Connect South, Patientrack and PICS. Integration of these tools will enable workflow to be managed electronically, and information to be stored in a single location but used by multiple systems in the overall patient journey.

5.9 INFRASTRUCTURE

A key focus for our facilities team has been the earthquake resilience of our main structures. When the Wairau Hospital was re-developed in 2005 most of the campus was brought up to an acceptable standard. However, the main structure which houses the Emergency Department on the ground floor and office space and administration on the 1st floor is a building called Arthur Wicks that was constructed in 1973. The Arthur Wicks building was found to have a relatively low earthquake rating under the latest building standards and a successful business case was made in 2015 to strengthen the building and to re-fit the 1st floor. This work is now underway and is anticipated to be completed by October 2016.

Another focus has been the consolidation of our property portfolio. We have sold several DHB houses in the community which are now surplus to our needs, and we are in the process of sub-dividing a number of houses that are on the Wairau DHB campus so that separate decisions can be made on them in respect of retaining or selling them. We also intend to sell of a large block of bare land on the Wairau campus once it has been subdivided onto its own title.

Work is underway to develop conceptual plans for a Learning & Development Centre. Subject to a successful proposal, work on developing the centre is anticipated to get underway in 2016-17.

The re-development of the Nelson Hospital site is our largest pending piece of work. The re-development would modernise the facility to meet existing needs and to cope with anticipated growth in demand in the future. The size of the investment is significant at between $120m and $150m and requires us to follow a full Ministry of Health and Treasury Better Business Case process. The business case work will get underway in 2016-17 and is expected to take 2 years to complete. Once the business case has been complete we will explore what initial pieces of work can be commissioned prior to getting underway with the main re-development in 5 years time. As well as addressing our future needs the re-development will comprehensively address earthquake limitations with our current structures. We believe our current structures would protect life but be unusable after a major event.

5.10 SUBSIDIARIES, OTHER INTERESTS OR COOPERATIVE ARRANGEMENTS

The Minister of Health has under sections 24 and 28 of the NZPHD Act 2000 approved the following arrangements:

- NZ Health Partnerships Limited
- Nelson Marlborough Hospitals' Charitable Trust; holds trust funds for the benefit of public hospitals
- Marlborough Hospital Equipment Trust; provides equipment, other items from public donations raised by Trust
- Churchill Private Hospital Trust; provides private medical and surgical services in Marlborough
- Agreement with Pacific Radiology; joint MRI service from the Nelson & Wairau Hospital sites
- Agreement with Christchurch Radiology Group; visiting Radiology service at Wairau Hospital site
- Agreement with Top of the South Cardiology Ltd; covers private cardiology services from Nelson Hospital
- 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
- Appointment of Trustee to the Board of the Golden Bay Community Health Trust – Te Hauora O Mohua Trust
- South Island Alliance Project Office (SIAPO); supports the activities of the South Island DHBs by providing services (planning and funding audit, analysis and advice and contract management).

Nelson Marlborough Health does not hold any controlling interests in a subsidiary company.

5.10 STEWARDSHIP ROLE AS OWNER OF CROWN ASSETS

DESCRIPTION	PHYSICAL ASSETS
Nelson Marlborough Health is a Crown Entity with ownership of	***Buildings and Equipment***
Nelson Hospital delivering the full range of New Zealand Role Delineation Model level 4 secondary services: emergency, surgical and medical specialist (acute and elective), primary and secondary maternity, neonatal, paediatric, specialist health services for older people and support services, diagnostic imaging.	Waimea Rd, Nelson
Wairau Hospital delivering the full range of New Zealand Role Delineation Model level 3 secondary services: emergency, surgical and medical specialist (acute and elective), primary and secondary maternity, neonatal, paediatric, specialist health services for older people, support services including diagnostic imaging, and mental health services.	Hospital Rd, Blenheim
Mental Health and Addiction services with acute inpatient facilities and community facilities in Nelson and Wairau.	Tipahi St & Braemar Campus Nelson; Hospital Rd Blenheim
Alexandra Hospital in Richmond delivering psycho-geriatric services for older people and aged residential care services for people with dementia.	Gilbert St, Richmond
Murchison Hospital and Health Centre delivering the full range of primary care services: 'Primary Response for Medical Emergencies' [PRIME], district nursing service, aged residential care rest home, and hospital services for Murchison residents.	Fairfax St Murchison
District Nursing Services located in Motueka.	Courtney St, Motueka
Disability Support Services (DSS) – Nelson community based residential and day activities for people with intellectual and physical disabilities.	Tahunanui Drive, Nelson, plus 65 individual community homes
Needs Assessment and Coordination Services (Support Works) for people with life-long, long-term conditions and age-related disabilities.	Harley St, Nelson and Blenheim Hospital Campus
Public Health Unit providing a range of health promotion, health protection and Medical Officer of Health services for Nelson and Wairau.	Richmond (Tasman) and Blenheim (Marlborough)
Specialist Dental, School Dental and Adolescent Health Services based in Nelson and Wairau Hospitals and in our communities.	Various locations
Corporate Offices in Nelson for the Chief Executive and some members of Executive Leadership Team: GM Strategy, Planning & Alliance Support; GM Finance & Performance; GM Clinical Governance Support; GM IT & Infrastructure; GM Human Resources; General Manager Maori Health & Whanau Ora; Chief Medical Officer; Director of Nursing & Midwifery.	Braemar Campus, Waimea Road, Nelson
South Island DHB Alliance Project Office (SIAPO) – ownership shared with Canterbury DHB, South Canterbury DHB, Otago DHB, Southland DHB and West Coast DHB.	Christchurch
20 District Health Boards Shared Services, a national arm of TAS, to ensure organisation and collective delivery of national strategies and the organisation of national service interests.	TAS Building, L7, 186 Willis St, Wellington
NZ Health Partnerships Limited	Auckland

SERVICE CONFIGURATION

6.1 SERVICE COVERAGE

There are no identified significant service coverage exceptions identified for 2016/17.

6.2 SERVICE CHANGE

As the needs of our community evolve, our services will need to change to meet those needs. We must also ensure we manage service delivery as effectively as efficiently as possible. Changes to services are always carefully considered, not only for the benefits they bring, but also the impact they might have on other stakeholders.

The table below signals potential services changes during the 2016/17 year.

SERVICE	DESCRIPTION	BENEFITS
Mental Health & Addictions (MH&A)	• Review MH&A service to continually improve and evolve services in line with national policy • Service review and consultation process completed in 2015/16 • Steering Group established • Terms of Reference and implementation plan under development based on review above	• Bolster acute care alternatives to inpaitent care by reallocating resources. • Work with NGOs to move to supported housing and other service developments • Develop local Alcohol & Other Drugs (AOD) service • Increase MH&A clinical support to NGOs and primary care • Increase primary mental health initiatives
Radiology	• Consider and Develop new model for Radiology services that addresses the risks inherent with the current mixed model • Expression of Interest released by end of June 2016 with new model implemented by end of December 2016	• Address risks inherent with the current mixed model (public and private work, and vulnerable workforce) • Increase access, reliability and equity of diagnostics service across the district
Pharmacy	• Businss case for benefit sharing of community pharmaceutical spend to be developed • Implementation of benefit sharing if agreement across the alliance to proceed	• Better management of pharmacy costs (medication and prescribing) • Possibility of benefit sharing
Golden Bay Pharmacy	• Explore a model change for Golden Bay pharmacy services • Provide a consultation process to inform decision • Implementation of new model based on consultation	• Extended range of and access to pharmacy services for the Golden Bay community • Better management of costs
Plastic Surgery	• Provision of some plastic surgery services locally	• Provide services closer to home for patients • Improved patient journey • Reduced IDF costs over time
Home Based Support	• Establish early supported discharge and hospital avoidance planning, working collaboratively with ACC • Implement a Rapid Response team • HBSS contract optimisation via negotiated bulk funding (or similar) arrangement	• Improved patient journey • Strenghtened rehabilitation focus • Improved utilisation of resources • Financial certainty to HBSS providers
Top of the South Roll-Out	• Continue to roll-out 'One Service, Two Sites' approach from the Top of the South Clinical Services Review in 2014	• Single model of care for specific services across the district where reasonable to do so • Improved utilisation of resources

6.3 SERVICE ISSUES

There are no identified significant service issues identified for 2016/17.

PERFORMANCE MEASURES

7.1 MONITORING FRAMEWORK PERFORMANCE MEASURES

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders, and providers of health and disability services.

DIMENSIONS OF DHB PERFORMANCE	DESCRIPTION	CODE
'Policy priorities'	Achieving Government's priority goals/objectives and targets	PP
'System Integration'	Meeting service coverage requirements and supporting sector inter-connectedness	SI
'Outputs'	Purchasing the right mix and level of services within acceptable financial performance	OP
'Ownership'	Providing quality services efficiently	OS
'Developmental'	Establishment of baseline (no target/performance expectation set)	DV

PERFORMANCE MEASURE	2016/17 PERFORMANCE EXPECTATION/TARGET		
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19		Maori 4.2% Total 4.2%
	Age 20-64		Maori 6.5% Total 4.6%
	Age 65+		Maori 0.9% Total 0.9%
PP7: Improving mental health services using transition (discharge) planning	Long term clients		Provide report as specified
	Child and Youth with a Transition (discharge) plan		At least 95 percent of clients discharged will have a transition (discharge) plan.
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm		
	Age	<= 3 weeks	<=8 weeks
	0-19	80%	95%
	Addictions (Provider Arm and NGO)		
	Age	<= 3 weeks	<=8 weeks
	0-19	80%	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1		0.92
	Ratio year 2		0.90
PP11: Children caries-free at five years of age	Ratio year 1		65%
	Ratio year 2		65%
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1		85%
	% year 2		86%
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1		95%
	0-4 years - % year 2		95%
	Children not examined 0-12 years % year 1		10%
	Children not examined 0-12 years % year 2		10%

PP20: improved management for long term conditions (CVD, diabetes and Stroke) Focus area 1:Long term conditions	Report on delivery of the actions and milestones identified in the Annual Plan.	
Focus area 2: Diabetes Services	Reporting on implementation of actions in the Diabetes plan "Living Well with Diabetes" Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c indicator).	
Focus area 3: Cardiovascular (CVD) health	Indicator 1: 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.	
	Indicator 2: 90 percent of 'eligible Maori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years.	
	Report on delivery of the actions and milestones identified in the Annual Plan	
Focus area 4: Acute heart service	70 percent of high-risk patients will receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0') by ethnicity.	
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	
	Over 95 percent of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data within 30 days of discharge.	
	Report on delivery of the actions for acute heart services identified in the annual plan and actions and progress in the quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI	
Focus area 5: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed	
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	
	80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	
	Report on delivery of the actions and milestones identified in the Annual Plan	
PP21: Immunisation coverage (previous health target)	Percentage of two year olds fully immunised	95%
	Percentage of five year olds fully immunised	95% (2016-17) 95% (2017-18)
	Percentage of eligible girls fully immunised – HPV vaccine	70% for dose 3
PP22: Improving system integration	In relation to System Level Measures – a jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will	

	be provided at the end of quarter one 2016/17	
	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan.	
	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan: Provison of data that demonstrates an improvement on current performance	
	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: Provison of data that demonstrates an improvement on current performance	
	The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment: Provison of data that demonstrates an improvement on current performance	
PP25: Prime Minister's youth mental health project	*Initiative 1*: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities. 1. provide quarterly quantitative reports on the implementation of SBHS, as per the template provided. 2. provide quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS. *Initiative 3: Youth Primary Mental Health* 1. provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: • early identification of mental health and/or addiction issues • better access to timely and appropriate treatment and follow up • equitable access for Maori, Pacific and low decile youth populations. *Initiative 5*: Improve the responsiveness of primary care to youth. 1. provide quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliancing arrangements. 2. provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme.	
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for each focus area: • Primary Mental Health • District Suicide Prevention and Postvention • Improving Crisis response services • Improve outcomes for children • Improving employment and physical health needs of people with low prevalence health conditions.	
PP27: Supporting vulnerable children	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP28: Reducing Rheumatic fever	Provide a progress report against DHBs' Rheumatic Fever prevention plan.	
	Hospitalisation rate (per 100,000 DHB total population) for acute Rheumatic Fever	0.2 per 100,000
	Reports on progress in following-up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever.	
PP29: Improving waiting times for diagnostic services	1. Coronary angiography – 95% of accepted referrals for elective coronary	

	angiography will receive their procedure within 3 months (90 days)	
	2. CT and MRI - 95 % of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days)	
	3. Diagnostic colonoscopy a. 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive); 100% within 30 days b. 70% of people accepted for a non urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days); 100% within 90 days Surveillance colonoscopy c. 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.	
PP30: Faster cancer treatment	Part A *Faster cancer treatment 31 day indicator*	85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat
	Part B Shorter waits for cancer treatment - radiotherapy and chemotherapy	All patients ready-for-treatment, receive treatment within four weeks from decision-to-treat.
PP31: Better help for smokers to quit in public hospitals	95 percent of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	
S11: Ambulatory sensitive (avoidable) hospital admissions	Age group 0-4 years [a System Level measure]: Target to be agreed by the Alliance as part of the System Level Measure Improvement Plan	
	Age group 45-64 years: Improvement (decrease) on the baseline population rate of 2,614	
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region	
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry)	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement	an intervention rate of 21.0 per 10,000 of population
	Cataract procedures	an intervention rate of 27.0 per 10,000
	Cardiac surgery	a target intervention rate of 6.5 per 10,000 of population DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain or improve this rate.
	Percutaneous revascularization	a target rate of at least 12.5 per 10,000 of population
	Coronary angiography services	a target rate of at least 34.7 per 10,000 of population
SI5: Delivery of Whānau Ora	Performance expectations are met across all the measures associated with the five priority areas: • Mental health	

	• Asthma • Oral health • Obesity • Tobacco And narrative reports cover all areas indicated.	
S17: SLM total acute hospital bed days per capita	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
S18: SLM patient experience of care	Hospital	Provide a report each quarter as specified in the measure definition. A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.
	Primary Care	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.
S19: SLM amenable mortality	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
OS3: Inpatient Length of Stay	Elective LOS	1.48 days
	Acute LOS	2.28 days (or an improvement on this)
OS8: Reducing Acute Readmissions to Hospital	Tba – under review	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections Focus area 1:Improving the quality of identity data	New NHI registration in error	A. Greater than 2% and less than or equal to 4%
		B. Greater than 1% and less than or equal to 3%
		C. Greater than 1.5% and less than or equal to 6%
	Recording of non-specific ethnicity	Greater than 0.5% and less than or equal to 2%
	Update of specific ethnicity value in existing NHI record with a non-specific value	Greater than 0.5% and less than or equal to 2%
	Invalid NHI data updates (no confirmed target)	% TBC
Focus area 2:Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS	Greater than or equal to 97% and less than 99.5%
	National collections file load success	Greater than or equal to 98% and less than 99.5%
	Assessment of data reported to the NMDS	Greater than or equal to 75%
	NNPAC timeliness	Greater than or equal to 95% and less than 98%
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE,	

	b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan
Developmental measure DV6: SLM youth access to and utilisation of youth appropriate health services	No performance target / expectation set
Developmental measure DV7: SLM number of babies who live in a smoke-free household at six weeks post natal	No performance target / expectation set

APPENDIX 8.1 GLOSSARY OF ACRONYMS

ABC	**A**sk about and document every person's smoking status, give **B**rief advice to stop to every person who smokes, and strongly encourage every person who smokes to use **C**essation support (a combination of behavioural support and stop-smoking medicine works best) and offer to help them access it.
ACC	Accident Compensation Corporation
ACS	Acute Coronary Syndrome
ACPP	Accelerated Chest Pain Pathway
AMP	Asset Management Plan
AOD	Alcohol and Other Drugs
ARC	Aged Residential Care
ARRC	Aged Related Residential Care
ASBs	Artificially Sweetened Beverages
ASH	Ambulatory Sensitive Hospitalisation
AT&R	Assessment, Treatment, & Rehabilitation
B4SC	Before School Checks
BAU	Business As Usual
BMI	Body Mass Index
C	Coverage
CAMHS	Child and Adolescent Mental Health Services
CNC	Cancer Nurse Coordinator
COHS	Community Oral Health Service
COPD	Chronic Obstructive Pulmonary Disease
COPMIA	Children of Parents with a Mental Illness or Addiction
CTO	Community Treatment Order
CVD	Cardiovascular Disease
DHB	District Health Board
DIF	District Immunisation Facilitator
DMFT	Decayed, Missing, Filled Teeth
DSS	Disability Support Services
ECP	Emergency Contraceptive Pill
ED	Emergency Department
EDaaG	Emergency Department at a Glance (IT system for key ED data)
EHR	Electronic Health Record
ELT	Executive Leadership Team
ePA	Electronic Prescribing and Administration
ESPI	Elective Services Patient Flow Indicators
FCT	Faster Cancer Treatment
FLS	Fracture Liaison Service
FPSC	Financial, Procurement and Supply Chain
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GAAP	Generally Accepted Accounting Practice
GBCHC	Golden Bay Community Health Centre
GM	General Manager
GP	General Practitioner
HEADSS	**H**ome and Environment; **E**ducation and Employment; **A**ctivities; **D**rugs; **S**exuality; **S**uicide / Depression. HEADSS is a psychosocial interview tool for adolescents.
HBL	Health Benefits Limited
HBSS	Home Based Support Services
HCS	Health Connect South
HOD	Head of Department
HOP	Health of Older People
HPV	Human Papillomavirus

HQSC	Health Quality & Safety Commission
HSP	Health Services Plan
ICU	Intensive Care Unit
IDF	Inter District Flow
IHD	Ischaemic Heart Disease
IPIF	Integrated Performance Incentive Framework
ISIG	Immunisation Special Interest Group
IT	Information Technology
KHW MPHO	Kimi Hauora Wairau Marlborough PHO
LC	Lactation Consultant
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex people
LMC	Lead Maternity Carer
LOS	Length of Stay
MDT	Multi Disciplinary Team
MH	Mental Health
MoH	Ministry of Health
MH&I	Mental Health & Addictions
MOH	Medical Officer of Health
MRI	Magnetic Resonance Imaging
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NBPH	Nelson Bays Primary Health
NCHIS	National Cancer Health Information Strategy
NCPAS	National Child Protection Alert System
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHI	National Health Index
NIP	National Infrastructure Platform
NMDHB	Nelson Marlborough District Health Board (former name of Nelson Marlborough Health)
NMDS	National Minimum Dataset
NMHCT	Nelson Marlborough Hospitals Charitable Trusts
NPF	National Patient Flow
OIS	Outreach Immunisation Services
PAS	Patient Administration System
PBE	Public Benefit Entity
PHS	Public Health Service
PHO	Primary Health Organisation
PICS	Patient Information Care System
POAC	Primary Options for Acute Care
Q	Quality
QIF	Quality Improvement Framework
QSM	Quality Safety Marker
R2C	Rising to the Challenge
RFP	Request for Proposal
SAC	Severity Assessment Code
SBHS	School Based Health Services
SCN	Southern Cancer Network
SI	South Island
SIA	South Island Alliance
SIAPO	South Island Alliance Programme Office
SIL	Supported Independent Living
SIR	Standardised Intervention Rate
SIRTH	South Island Regional Training Hub
SMO	Senior Medical Officer

SOI	Statement of Intent
SP&AS	Strategy, Planning, and Alliance Support
SPE	Statement of Performance Expectations
SSBs	Sugar Sweetened Beverages
SSE	Serious and Sentinel Events
SUDI	Sudden Unexpected Death in Infancy
T	Timeliness
TPO	Te Piki Oranga
ToSHA	Top of the South/ Te Tau Ihu o Te Waka a Maui Health Alliance
V	Volume (quantity)
VIP	Violence Intervention Programme
VPD	Vaccine Preventable Diseases
WCTO	Well Child Tamariki Ora
WHO	World Health Organisation
WIAS	Walking In Another's Shoes (dementia training)

APPENDIX 8.2 DEFINITIONS

Term	Definition
Activity	What an agency does to convert inputs to outputs.
Alliance	An agreement between two or more participants made in order to advance common goals and secure common interests; it is not an entity as individual participants retain their separate identify and accountabilities; the Alliance approach entails a collaborative, incentive-driven method of contracting where all participants work co-operatively to the same end, sharing the risk and reward, while respecting the principles of good faith and trust. Our local Top of the South Alliance 'ToSHA' comprises the partners Kimi Hauora Wairau Marlborough PHO, Nelson Bays PHO, and Nelson Marlborough Health.
Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve the Government's goals.
Care Pathway	A complex intervention for the mutual decision making and organisation of care processes for a well defined group of patients during a well defined period: an explicit statement of the goals and key elements of care based on evidence, best practice, and patients' expectations and their characteristics; the facilitation of the communication among the team members and with patients and families; the coordination of the care process by coordinating the roles and sequencing the activities of the multidisciplinary care team, patients and their relatives; the documentation, monitoring, and evaluation of variances and outcomes; and, the identification of the appropriate resources. The aim is to enhance the quality of care across the continuum by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimising the use of resources.
Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister. One of the three types of statutory entities (see also Crown entity; autonomous Crown entity and independent Crown entity).
Crown entity	A generic term for a diverse range of entities within one of the five categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
Efficiency	Reducing the cost of inputs relative to the value of outputs
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
Impact	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. For example, the change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations. (Public Finance Act 1989).
Impact measures	Impact measures are attributed to agency (DHB) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can often be measured soon after delivery, promoting timely decisions; and may reveal specific ways in which managers can remedy performance shortfalls.
Input	The resources such as labour, materials, money, people, information technology used by departments to produce outputs, that will achieve the Government's stated outcomes.
Integrated care	Includes both clinical and service integration to bring organisations and clinical professionals together, in order to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home. WHO definition: Bringing together common functions within and between organisations to solve common problems, developing commitment to a shared vision and goals and using common technologies and resources to achieve these goals.
Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes (Refer State Services Commission 'Performance Measurement – Advice and examples on how to develop effective frameworks: www.ssc.govt.nz.
Intermediate outcome	See Outcomes
Living within our means	Providing the expected level of outputs within a break even budget or agreed deficit step toward break even by a specific time.
Management systems	The supporting systems and policies used by the DHB in conducting its business.
Measure	A measure identifies the focus for measurement: it specifies what is to be measured.

Objectives	The use of this term recognises that not all outputs and activities are intended to achieve "outputs". For example, increasing the take-up of programmes; improving the retention of key staff; improving performance; improving Governance etc. are 'internal to the organisation and enable the achievement of 'outputs'.
Outcome	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).
Output agreement	Output agreement/output plan - See Purchase Agreement. An output agreement is to assist a Minister and a Crown entity (DHB) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs (see s170 (2) Crown Entities Act 2004.
Output classes	An aggregation of outputs, or groups of similar outputs. (Public Finance Act 1989) Outputs can be grouped if they are of a similar nature. The output classes selected in non-financial measures are also reflected in your financial measures (s 142 (2) (b) Crown Entities Act 2004).
Outputs	Final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).
Ownership	The Crown's core interests as 'owner' can be thought of as: Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown; Capability - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future; Performance - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively.
Performance measures	Appropriate measures should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year and show intended results for the two subsequent financial years.
Priorities	Statements of medium term policy priorities.
Productivity	Increasing outputs relative to inputs (i.e.: either more outputs produced with the same inputs, or the same output produced using fewer inputs).
Purchase agreement	A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs. Some departments piloting new accountability and reporting arrangements now prepare an output agreement. An output agreement extends a purchase agreement to include any outputs paid for by third parties where the Minister still has some responsibility for setting fee levels or service specifications. The Review of the Centre has recommended the development of output plans to replace departmental purchase and output agreements.
Regional collaboration	Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist. • Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB • Midland: Bay of Plenty DHB, Lakes DHB, Tairawhiti DHB, Taranaki DHB and Waikato DHB • Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB and Whanganui DHB • Southern: Canterbury DHB, Nelson Marlborough Health, South Canterbury DHB, Southern DHB and West Coast DHB.
Results	Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once.
Standards of Service Measures	Measures of the quality of service to clients which focus on aspects such as client satisfaction with the way they are treated; comparison of current standards of service with past standards; and appropriateness of the standard of service to client needs.
Statement of Performance Expectations	Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year. They form the basis of the Annual Report.
Strategy	See Ownership.
Sub regional	Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping, typically

collaboration	in groupings of two or three DHBs and may be formalised with an agreement. For example a Memorandum of Understanding. Examples of sub regional collaboration include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (CentralAlliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.
Targets	Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.
Te Piki Oranga	The Nelson Marlborough Maori Health Coalition.
Values	The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. Nelson Marlborough Health Values: Respect, Innovation, Trust, Integrity.
Value for Money	The assessment of benefits relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.
Wrap around services	Services that 'wrap around' are services that work together seamlessly, communicating effectively, to ensure removal of both gaps and duplication in health service care and delivery. It places the patient/consumer at the centre of our service design, planning, delivery, and monitoring, in order to ensure that what is best for the patient is not subsumed by what is best for the health professional or the health system; resulting in the patient/consumer having a seamless journey throughout their involvement with all services/professionals, with gaps in health care delivery and professional/consumer communications removed. It is supported by incorporating consumers in continuous quality improvement activities.

APPENDIX 8.3 STATEMENT OF ACCOUNTING POLICIES

Reporting entity

Nelson Marlborough District Health Board (NMDHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing NMDHB's operations includes the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. NMDHB's ultimate controlling entity is the New Zealand Crown.

NMDHB's primary objective is to provide health and disability services to the New Zealand public. NMDHB does not operate to make a financial return.

NMDHB has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for NMDHB are for the year ended 30 June 2015, and were approved by the Board on 27 October 2015.

Basis of preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of compliance

The financial statements of NMDHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

These financial statements comply with PBE accounting standards and have been prepared in accordance with the Tier 1 PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no adjustments on transition to the PBE accounting standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

Standards Issues and not yet effective and not early adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. NMDHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. NMDHB will apply these updated standards in preparing its 30 June 2016 financial statements. NMDHB expects there will be minimal or no change in applying these updated accounting standards.

Summary of significant accounting policies

Revenue

The specific accounting policies for significant revenue items are explained below:

MOH population-based revenue

The DHB receives annual funding from the MOH, which is based on population levels within the DHB region. MOH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

MOH contract revenue

The revenue recognition approach for MOH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Inter-district flows

Inter-district patient inflow revenue occurs when a patient treated within the DHB's district is domiciled outside of the district. Inter-district patient inflow revenue is recognised when eligible services are provided.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Grants received

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Donated assets

Where a physical asset is gifted to or acquired by NMDHB for nil consideration or at a subsidised cost, the asset is recognised at fair value and the difference between the consideration provided and fair value of the asset is recognised as revenue unless there is a use or return condition attached to the asset. The fair value of donated assets is determined as follows:

- For new assets, fair value is usually determined by reference to the retail price of the same or similar assets at the time the asset was received.
- For used assets, fair value is usually determined by reference to market information for assets of a similar type, condition, and age.

Rental revenue

Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

Provision of services

Certain operations of NMDHB are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by NMDHB due to the difficulty of measuring their fair value with reliability.

Trust and bequest funds

Donations and bequests are made for specific purposes. The use of these funds must comply with the specific terms of the sources from which the funds were derived.

All donations and bequests are assigned to and managed by the Nelson Marlborough Hospitals Charitable Trust (NMHCT) which has an independent Board of Trustees. The funds are held separately by NMHCT and are not included in NMDHB's statement of financial position. The revenue and expenditure in respect of these funds are also excluded from NMDHB's surplus or deficit.

Donations and bequests to NMDHB from the NMHCT are recognised as income when received, or entitlement to money is established. Expenditure subsequently incurred in respect of these funds is recognised as an expense in the surplus or deficit.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Borrowing costs

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Grant expenditure

Non-discretionary grants are those grants awarded if the grant application meets the specified criteria and are recognised as expenditure when an application that meets the specified criteria for the grant has been received.

Discretionary grants are those grants where NMDHB has no obligation to award on receipt of the grant application and are recognised as expenditure when approved by the Grants Approval Committee and the approval has been communicated to the applicant. NMDHB's grants awarded have no substantive conditions attached.

Foreign currency transactions

Foreign currency transactions are translated into NZ$ (the functional currency) using the spot exchange rates at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Leases

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases where NMDHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether NMDHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

Receivables

Short-term receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that NMDHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Equity investments

NMDHB designates equity investments at fair value through other comprehensive revenue and expense, which are initially measured at fair value plus transaction costs.

After initial recognition, these investments are measured at their fair value with gains and losses recognised in other comprehensive revenue and expense, except for impairment losses that are recognised in the surplus or deficit.

On derecognition, the cumulative gain or loss previously recognised in other comprehensive revenue and expense is reclassified to the surplus or deficit.

A significant or prolonged decline in the fair value of the investment below its cost is considered objective evidence of impairment. If impairment evidence exists, the cumulative loss recognised in other comprehensive revenue and expense is reclassified from equity to the surplus or deficit.

Impairment losses recognised in the surplus or deficit are not reversed through the surplus or deficit.

Inventories

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the weighted average cost method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

Property, plant, and equipment consists of the following asset classes: land, buildings and building fitout, plant and equipment, and motor vehicles.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation.

All other assets classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value and at least every five years.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to NMDHB and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to NMDHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant, and equipment have been estimated as follows:

Buildings and fitout	10 to 76 years	1.3%-10%
Plant and equipment	2 to 20 years	5%-50%
Motor vehicles	5 to 16 years	6.25%-20%
Leased assets	2 to 7.25 years	13.8%-50%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year end.

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with development and maintenance of NMDHB's website are recognised as an expense when incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Software	3 to 10 years	10%-33.3%

Impairment of property, plant, and equipment and intangible assets

NMDHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Payables

Short-term payables are recorded at their face value.

Borrowings

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless NMDHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, sick leave, conference leave and medical education leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, annual leave, and vested long service leave are classified as a current liability. Non-vested long service leave and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

Obligations for contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in "finance costs".

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

Onerous contracts

A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract.

The provision is measured at the present value of the lower of the expected cost of terminating the contract and the expected net cost of continuing with the contract.

ACC Partnership Programme

NMDHB belongs to the ACC Partnership Programme (the "Full Self Cover Plan") whereby NMDHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, NMDHB is liable for all claims costs for a period of four years up to a specified maximum. At the end of the four-year period, NMDHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- contributed capital;
- accumulated surplus/(deficit);
- property revaluation reserves; and
- fair value through other comprehensive revenue and expense reserves.

Property revaluation reserve

This reserve relates to the revaluation of property, plant, and equipment to fair value.

Fair value through other comprehensive revenue and expense reserves

This reserve comprises the cumulative net change of financial assets classified as fair value through other comprehensive revenue and expense.

Goods and services tax

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from, the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

NMDHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

Budget figures

The budget figures are derived from the statement of performance expectations as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Cost allocation

NMDHB has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation.

Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output.

Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements, NMDHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Estimating the fair value of land and buildings

The significant assumptions applied in determining the fair value of land and buildings are disclosed in the notes.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant, and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by NMDHB, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the statement of financial position. NMDHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second hand market prices for similar assets; and
- analysis of prior asset sales.

NMDHB has not made significant changes to past assumptions concerning useful lives and residual values.

Retirement and long service leave

The Notes provide an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to NMDHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

NMDHB has exercised its judgement on the appropriate classification of equipment leases, and has determined a number of lease arrangements are finance leases.

Grants received

NMDHB must exercise judgement when recognising grant revenue to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

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Pursuant to Section 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