



**Nelson Marlborough
District Health Board**

**District Strategic Plan
2005 to 2015**

**LEADING THE WAY TO
HEALTH-CONSCIOUS
FAMILIES**

Final December 2005

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1 FOREWORD From the Board Chair and Chief Executive

We are pleased to present our District Strategic Plan 2005-15. This plan updates our first strategic plan, developed in 2002, which identified four main themes. These were improving health status by emphasising prevention, reducing health inequalities, developing an integrated and co-operative approach to health care and ensuring a high quality of service delivery. The DHB has pursued this strategy over the last three years and we are particularly proud of our achievements in the rebuilding of Nelson Hospital, the establishment of two Primary Health Organisations and the resettlement of people from Braemar into the community. This new Plan aims to provide continuity and uses community feedback to build on the progress already made in improving the health of our community and the independence of people with disabilities.

Health and wellbeing are dependent on a balance of factors: physical aspects of health (te taha tinana); spiritual health (te taha wairua); emotional and psychological well-being (te taha hinengaro) and the social environment in which individuals live (te taha whanau). We are firm believers in prevention and health promotion and we will be giving emphasis to this as a good investment for the future health of our community. For this reason, we have called our Plan “Leading the Way to Health-Conscious Families”. We will continue to work with people and organisations in Nelson Marlborough to address issues such as education, employment and housing which determine the health of the community. We hope to make it easier for families to make healthy choices in their daily lives.

Primary health care is particularly important, as it is the first level of care that people access from the health system. It brings health care as close as possible to where people live and work and covers a broad range of services (not all of them government funded), including general medical practices, Māori health providers, community health services, family planning, pharmacy, laboratory and dentistry. In this regard, we consider the Primary Health Organisations will play a major role, and we will work closely with them, and other providers to ensure that people can easily get to these services when they need them.

To support primary care we will ensure that there is good access to locally provided specialist services and to services in other centres when care is unable to be provided in Nelson or Marlborough. We will continue with our efforts to develop and improve the services people need for the treatment of illnesses and injuries, and support for disabilities

There will never be enough money to meet all health and disability needs and it is our responsibility to make sure that the money the government gives to the Nelson Marlborough community is spent wisely, fairly and covers as many needs as possible. We will sometimes need to take hard decisions and to target services to particular groups. There are some key groups to whom NMDHB will give priority when deciding which services to fund:

- children and youth, because achieving good health for young people is vital for later adult health. Working with the education sector is particularly important in improving the health of children and youth.
- people with high health needs, because there is evidence that some populations in the community do not enjoy the same good health as others. We support the need to reduce these inequalities for example for Māori and people from lower socio-economic groups.

This Ten Year Plan seeks to continue progress in “Leading the Way to Health-Conscious Families” by:

- Improving the health of the community
- Improving access to services
- Enhancing quality services and improving organisational effectiveness
- Developing an effective partnership with Māori

Finally, we would like to thank the community and staff members who contributed to this plan. This has allowed the Board to fulfil its commitment to consult and listen to input on the organisation's strategic direction. We look forward to continuing to work together to achieve good health, wellbeing and independence for the people of Nelson Marlborough.

Liz Richards
Acting Chair

John Peters
Chief Executive

2 ABOUT THIS STRATEGIC PLAN

This strategic plan is a public document which:

- outlines how, within the available funding, NMDHB will work towards achieving government priorities over the next 5-10 years, and will be reviewed at least every three years.
- presents the strategic outcomes the Board is wanting to achieve and the major strategies which will be followed to achieve these outcomes.
- sets the context for the Board's annual plans which will outline actions relating to each strategy and the outcome which will be achieved.
- is consistent with the NZ Health Strategy, the NZ Disability Strategy and other government strategies.
- uses the recently completed health needs assessment.¹
- describes the environment in which NMDHB operates and outlines the challenges that could affect our ability to meet our responsibilities.
- explains the opportunities we see to meet these challenges and how we will perform our functions as owner, planner, funder and provider of health and disability services.

¹The NMDHB Health Needs Assessment has been published and is available on the Board's web site (www.nmdhb.govt.nz) or through the Board Office (Private Bag 18, Nelson)

3 OUR CONTRIBUTION TO THE NELSON MARLBOROUGH COMMUNITY

3.1 What we do

The Nelson Marlborough District Health Board² (NMDHB) is the organisation given responsibility by government for the majority of publicly funded health services across the top of the South Island. In a range of strategy documents, the government has set out what it wants to do to improve the health and independence of New Zealanders, especially those who have the poorest health. With this knowledge, we plan for and fund the services to be provided to those people with the highest need in our own community. Sometimes, especially for the complicated or specialist services, our organisation also has a role as a provider of services.

Our mission is to:

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

We believe that:

- most people want to be healthy and independent
- access to health services should be fair and based on people’s need
- our decisions must be based on good information and evidence
- we should invest in promoting health, and preventing illness and injury
- the community should be involved in our decision-making
- people’s rights should be the focus of all services
- service rationing should be based on identified need and best outcome
- open decision making will contribute to community confidence
- improved co-ordination and integration of health providers and services will improve outcomes and achieve efficiency
- the community has a right to a high performing health service.

We want to:

- work with iwi to improve Māori health
- work with other government and social agencies to change those things that contribute to illness and injury
- ensure the community can have confidence in the availability and quality of health services
- work collaboratively and co-operatively.

To fulfil our mission and meet our statutory objectives (see Appendix 1), NMDHB has two main functions:

- Planning and funding of services for the district
- Providing health and disability services, usually specialist services.

² NMDHB was established on 1 January 2001 under the New Zealand Public Health and Disability Act 2000 (The Act).

3.2 How we operate

NMDHB is an organisation of over 2000 people. We are governed by a Board which is partly elected by the community and partly appointed by the Minister of Health. The Board is responsible for ensuring government health objectives are achieved within the available funding.

The Board appoints a Chief Executive to manage the operational functions of the organisation.

We are committed to being a high-performing organisation that is:

- innovative and bold in approaching our challenges
- effective in all aspects of our work, especially managing our risks
- achieving good value for money
- principled in our decision-making and recognised by others as having integrity
- contributing to the advancement of the health services within our district, regionally and nationally.

This plan signals our continuing desire for a more co-operative and integrated approach to health and disability issues involving not just the health sector but all the other community and social services.

Co-operation and integration are particularly important because every dollar of government money is precious. The community understands that there will never be enough dollars to meet all health needs. It is our responsibility to make sure that the money the government gives to the Nelson Marlborough community is spent wisely, fairly and covers as many needs as possible.

There will be times when we will only be able to put money into a particular service by taking it from somewhere else. To make these difficult decisions we must have an understanding of the needs within our community and what the community feels should take priority. We will encourage and support people to do what they can to improve and maintain their own health.

3.3 Who we work with

The Community

We are committed to involving the community in our activities. The health needs assessment process, completed in April 2005³, a range of other initiatives and formal consultation have enabled community and health provider input into the planning leading to this document.

To enable the community to let us know their views and so that we can keep them in touch with our activities, we have developed some processes for involving the community, including the consultation on this strategic plan.⁴

We are keen to continue the process of working with our communities to ensure improved health and wellbeing. We believe that the future health of our community will be determined by our ability to work together as a community to influence the social determinants of health, using all the population health approaches proposed in the Ottawa Charter.⁵

³ A summary Health Needs Assessment document is available on the website www.nmdhb.govt.nz

⁴ The Board's community involvement framework, including the policies and processes are available on the Board's website or through the Board Office.

⁵ The Ottawa Charter was adopted at the International Conference on Health Promotion, Nov 1986, Ottawa, Canada.

Iwi and other Māori

NMDHB acknowledges the special relationship between Māori and the Crown in response to the Treaty of Waitangi and is committed to fulfilling its responsibilities as an agent of the Crown, within the context of the NZPHD Act 2000 and in accordance with the principles of partnership, protection and participation (see also page 27).

In 2001 the Board entered into a Memorandum of Agreement with Iwi⁶. As a result of the MOA, an Iwi Health Board was established and a number of management and service positions created in the DHB, specifically to focus on Māori health. We will continue to work in close co-operation with the Iwi Health Board and the Māori community to improve the health of the Māori people living in Te Tau Ihu.

Other Social Agencies

Whilst we know that the provision of good health and disability services is essential to our community, we are very aware that wider social issues, such as our economic situation, employment, education, and housing, have an important effect on our health and wellbeing. We want to continue to develop programmes that explicitly address the root causes of ill health, health inequalities and the needs of those affected by social disadvantage.

As an important example of our work with other agencies the NMDHB will continue its focus on child health. A good start in life means supporting mothers and young children: the health impact of early development and education lasts a lifetime. We will make every effort to ensure the hearing and vision-screening pathways provide the best opportunities for children to be able to learn. We will continue to strengthen our Health Promoting Schools activity in conjunction with the Ministry of Education and local schools. We will continue to participate in community capacity building, including support for healthy housing projects. We will continue with Action for Healthy Children, a collaborative effort with other agencies, including the Ministry of Social Development and the three Territorial Authorities. We will promote the use of Health Impact Assessment as a tool in predicting the potential effects of a policy on child health, particularly with non-health, non-government agencies in the Nelson Marlborough region.

Service Providers

There are currently a large number of health and social service providers (state sector, private, non-governmental and voluntary agencies) offering a wide range of services in our community. We have contracts with the majority of the health and disability support service providers to provide services across the continuums. We fund promotion, prevention, treatment and palliative care health services at primary and secondary levels.

The Ottawa Charter five strategies are:

- *Building healthy public policy*
- *Creating supportive environments*
- *Strengthening community action*
- *Developing personal skills*
- *Re-orienting health services*

⁶ *Manawhenua o Te Tau Ihu o Te Waka a Maui:*

- *Ngati Apa ki te Waipounamu*
- *Ngati Koata no Rangitoto ki te Tonga Trust*
- *Te Runanga o Ngati Kuia Charitable Trust*
- *Ngati Rarua Iwi Trust*
- *Ngati Tama Manawhenua ki te Tau Ihu Trust*
- *Te Atiawa Manawhenua ki te Tau Ihu Trust*
- *Te Runanga o Rangitane o Wairau*
- *Ngati Toa Rangatira Manawhenua ki te Tau Ihu Trust.*

The Memorandum of Agreement is available on the Board's web site (www.nmdhb.govt.nz) or through the Board Office (Private Bag18, Nelson)

We support the health of older people through funding assessment, treatment, rehabilitation and support services both community-based and residential. We also fund a number of small agencies to help the community's understanding of service availability and to provide support to individuals and families to manage their illness or disability.

To encourage Māori people to access health services, we fund a range of kaupapa Māori services provided by Māori health providers to complement the mainstream health and disability services.

We are gradually increasing the relationships and contract arrangements that we have with providers outside the traditional health services. Organisations such as Sport Tasman are able to provide many of the healthy life style programmes that we want to develop.

Through our hospitals in Nelson Marlborough and the rural areas we are the largest service provider. Our provider division is responsible for the provision of the majority of publicly funded specialist, or secondary level services. We fund this division through an Internal Service Level Agreement, the equivalent of a contract with the non-DHB providers. Over time we would like to reduce the percentage of total funding which is spent on secondary level services in favour of health promotion and primary services. This has to be carefully balanced however due to the burden of illness that exists. Particularly, older people need to be confident that the treatment services will be accessible when they need them. The Board acknowledges that the results of its increasing investment in health promotion and prevention will not enable a reduction in expenditure on curative services for some years.

Primary Health Organisations

The government's Primary Health Care Strategy 2001 signalled the establishment of Primary Health Organisations (PHOs) to facilitate the implementation of the Strategy. Two PHOs have been established in Nelson Marlborough, Nelson Bays and Marlborough PHOs. Together they provide coverage for the entire district with the exception of the Murchison area.

With this exception, all the publicly-funded general practice services (first level) and a range of prevention and treatment programmes are contracted for from general practice, through the PHOs. We will be continuing to work with the PHOs to further develop the important role they have in the provision of the full range of primary level services.

As the PHOs develop they are increasing their contribution to the planning activities and decisions of the DHB.

Other District Health Boards

As a provincial District Health Board, there is a wide range of services that we cannot provide locally. Instead, we must have effective relationships and processes in place to ensure that Nelson Marlborough people can access the appropriate regional or national service. To help achieve this, the organisation actively participates in national and regional networks such as for mental health. The planning undertaken in such networks is reflected in this plan.

Through District Health Boards New Zealand (DHBNZ) we work co-operatively with all the other DHBs to prevent duplication of effort, share experiences and learnings and ensuring the ongoing development of the sector.

We have a special relationship with the other South Island DHBs, working closely on governance, management and clinical issues of mutual interest. The South Island

Shared Services Agency (SISSAL) owned by the South Island DHBs supports these co-operative relationships.

Other Policy and Funding Agencies

We work closely with the Public Health and Disabilities Issues Directorates of the Ministry of Health, which have responsibility for funding the services not yet devolved to District Health Boards. Both the Ministry and the Board are keen to ensure that we have a common understanding of our community and are working together towards the same goals. The Board is party to a shared decision-making framework with other DHBs and the Public Health Directorate to enable synergy in planning and funding of services at national, regional and local level.

We are developing our relationship with the other funding agencies outside the health sector, including ACC and the Ministry of Social Development. We are keen to work with other funding agencies to develop integrated contracts where we are contracting with the same provider.

3.4 Where we have come from

The five strategic outcomes upon which this plan is based were first developed, and expressed as the Strategic Goals, by the NMDHB Establishment Board in 2001. The current Board reviewed these goals and decided that they are still consistent with government priorities and reflective of what they wish to achieve for the Nelson Marlborough community.

In the intervening four years, the organisation has successfully moved from a hospital provider to one that has made significant progress towards realising the government's vision for DHBs. NMDHB has made good progress in implementing government strategies, particularly the Māori Health Strategy, the Reducing Inequalities Framework, the Primary Health Care Strategy and the Health of Older People Strategy.

We have worked actively with the community, encouraging input into our planning and decision making. We are improving our knowledge and understanding of our community and have introduced a wide range of initiatives to improve the health and independence of the people of Nelson Marlborough. In developing our initiatives we have drawn heavily on the "toolkits" developed by the MoH to support DHBs.

We have strongly adhered to the belief that we need to invest in the health of the future generation through promoting increased physical activity and improved nutrition and reducing the effects of tobacco. Whilst our desire has been to invest in health promotion and illness prevention programmes, we have not done this at the expense of the treatment services needed by those people in our community living with illness, chronic disease or disability. We have tried to be particularly mindful of the needs of those groups in our population who are currently carrying the greatest burden of disease, especially those people from lower socio-economic groups and Māori.

We have taken many opportunities to work with other social agencies to develop the awareness of community leaders and decision-makers on the social determinants of health and the effect that social policy can have on the ability of individuals to make healthy lifestyle choices.

Each year since our establishment, our proposed District Annual Plan has been accepted and agreed to by the Minister of Health with very little change. Each year we have generally been successful in delivering against our plan.

Our planning for the provision of health and disability services has been underpinned by population health and rehabilitation concepts. We have worked with communities and service providers to review and re-develop services so they can be better aligned with these concepts and the identified health and support needs of our community.

We have effectively contracted with service providers across the region to ensure fair and reasonable access to services for our population. We have achieved this within the funding provided by government, generally maintaining excellent relationships with the provider agencies. We have endeavoured to understand the issues faced by our providers and be responsive, particularly when provider groups have raised staffing or price issues. Our provider relationships have allowed us to recognise early indications of unsatisfactory service provision. In many cases we have successfully supported providers to improve their performance to re-gain the level of service quality that we expect them to deliver to the community.

As a provider of specialist and rural hospital (and community based) services we have achieved certification and continued to comply with the wide range of legislative requirements applying to these environments. The quality of our services has been recognised through our achievement of accreditation by Quality Health NZ and our high ranking in the DHB consumer satisfaction surveys. We have continued to enjoy the support of our communities through wide and varied voluntary contribution to our hospitals, facilities and equipment.

We have operated services that have been very responsive to the emergency and urgent health and support needs of the community. We have made some improvements in our responsiveness to non-urgent needs but want to significantly improve this over the early years of this plan.

Like other DHBs we are pleased to have been a participant in successful major public health campaigns, such as MeNZ B and the extension of the smokefree environment, especially the implementation of smokefree hospitals.

4 OUR POPULATION AND ENVIRONMENT

4.1 The Population Of Nelson Marlborough

NMDHB has responsibility for the population within the areas covered by the three local authorities: Marlborough District, Nelson City and Tasman District. All have increasing populations, as shown in Table 1. NMDHB has about 3.28% of the national population.

Table 1: Population of Nelson Marlborough DHB

Territorial local authority	Estimated pop. June 2001	Estimated pop. June 2003	Estimated pop. June 2004	Forecast pop. June 2011	Forecast pop. June 2021
Marlborough District	40,700	41,700	42,300	44,200	45,700
Nelson City	42,900	44,400	45,300	47,300	50,400
Tasman District	42,400	44,700	45,800	47,900	50,400
NMDHB TOTAL	126,000	132,803	135,404	139,400	146,500

Source: Statistics NZ, Census 2001 and Population Estimates Nov 2004; and Population Projections Medium Series, Nov 2002 (based on 2001 population estimate)

In Nelson Marlborough 14% of the population is aged over 65 years compared with the New Zealand average of 12%, although the Māori population has a higher proportion of young people. The elderly population, particularly people aged over 80, is expected to grow significantly both in number and as a percentage of the total population over the next 10 years.

The district has a smaller percentage of Māori (8%) than the New Zealand average (15%), but Nelson Marlborough's Māori population is expected to increase proportionately more than the national average over the next 10 years. It is well recognised nationally that Māori people have measurably poorer health outcomes than non-Māori.

There is a small but growing number of Pacific people and other ethnic groups resident in the district. Some of these people will have relatively poor health and high need for services.

There is a significant visitor population (tourists and seasonal workers, both national and international) attracted by the natural features (coastline, national parks and the climate) and the industries of the area (fishing and fish processing, viticulture, arts and crafts, horticulture).

A large percentage (34.5%) of our population lives in minor urban areas or rural centres⁷, and further significant number live (some very remotely) in the countryside served by these rural centres. Some of these populations are isolated by distance, terrain and weather, which creates difficulties in access to health services.

⁷ The Statistics NZ Urban Rural classification system classes areas as follows:

- Main urban – centres with populations of 30,000 or more. (Nelson)
- Secondary urban- centres with populations between 10,000 & 29,999 (Blenheim, Richmond)
- Minor urban- centres with populations of 1,000 or more (eg Motueka, Picton, Takaka, Wakefield)
- Rural centres - centres with populations of 300 to 999 in a reasonably compact area. (eg Seddon Murchison, Tapawera, Havelock,)

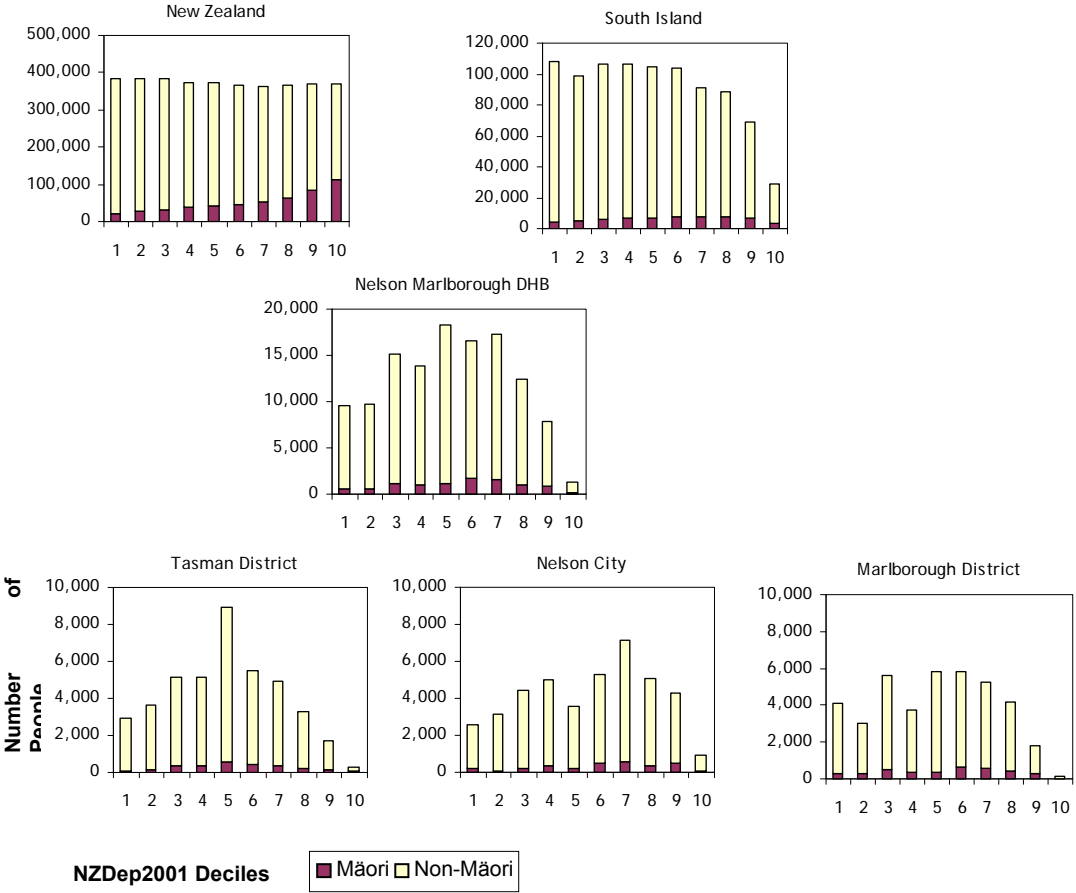
Compared to the New Zealand average we have mixed socio-economic indicators: income is lower, employment is higher, and educational achievement is variable. There is relatively high economic growth and generally people have 'average' to 'higher than average' socio-economic and health status. However there are pockets of need and relative deprivation, and we know there is a strong link between lower socio-economic circumstances and lower health status and early death⁸.

Some of our key health issues, are related to lifestyle. We have significant and increasing levels of diseases, such as diabetes, cardiovascular diseases and dental decay, caused by poor nutrition and lack of physical activity. We need to use the opportunities that exist within this district to encourage the community to be fit and healthy. With its favourable climate, natural environment and relatively prosperous economy, Nelson Marlborough can provide access to locally grown fruit and vegetables and active recreation opportunities and we need to ensure these opportunities are maximised..

Environmental, social, cultural and economic conditions all contribute to the overall health of the community. Nelson Marlborough has a strong sense of community and a wide range of organisations, groups and individuals actively involved in promoting the wellbeing of the community in its broadest sense. This provides the opportunity to work together to achieve maximum benefit for those in most need.

⁸ A good source of evidence is *The Social Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health*, National Health Committee, June 1998.

Figure 1 Deprivation Profiles for New Zealand, the South Island, Nelson Marlborough DHB and Local Authorities (NZDep2001 Index)



Source: Statistics New Zealand from Census 2001 and sourced from Public Health Consultancy, Public Health Directorate and the Ministry of Health, September 2004.

4.2 The Health Of The Community

The health of people in Nelson Marlborough is generally very similar to that of people in the rest of New Zealand.

In our district two main groups are identified as having higher health needs;

- Māori
- relatively low socio-economic groups.

While there is some overlap between these two groups, a focus on one alone would miss a large number of people with high health needs. For example, most people in the low socio-economic group are not Māori and Māori in higher socio-economic groups still have relatively poor health status compared to non-Māori from the same socio-economic group.

Regarding the 13 priority population health objectives in the *New Zealand Health Strategy, 2000 (NZHS)*, see Appendix 2 (page 48), (and noting the lack of data for some categories), the health of the people of Nelson Marlborough appears better than New Zealand overall. All age groups in Nelson Marlborough show higher levels of participation in physical activity than the New Zealand average.

However, from the health needs assessment⁹, we know that the health issues of particular importance for the Nelson Marlborough community are:

- chronic illnesses
- oral health, especially for children
- the number of smokers.

Avoidable hospitalisations¹⁰ have been shown to be higher from more socio-economically deprived areas. In Nelson Marlborough, the top 5 causes of these were: dental conditions; heart disease; respiratory infections; gastro-enteritis and asthma. It is acknowledged that there will always be some avoidable hospitalisations but these should be kept to a minimum.

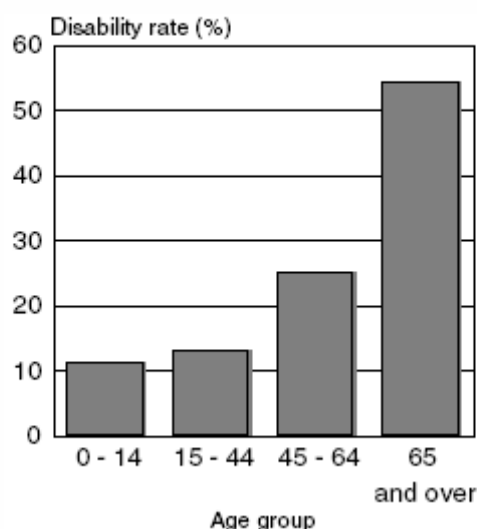
The standard of some rural water supplies is one of the major environmental issues of concern. Air quality is of concern in the Nelson City and Richmond areas.

Of note is the limited amount of information on primary health care and mental health and also the difficulties in accurately capturing ethnicity data in the health services.

There is also a lack of information on the prevalence of disability in our community. As we have not got local information on the number of people in our community who have a disability, NZ information is shown in the following graph.

Disability is closely associated with age. In 2001¹¹, 11 percent of children (0 to 14 years) had a disability, compared with 13 percent of adults aged 15 to 44 years and 25 percent of adults aged between 45 and 64 years. More than half (54 percent) of people aged 65 years and over reported having a disability. The disability rates for each age group were similar to those observed in 1996–1997.

Disability Rates by Age Group



⁹ The NMDHB Health Needs Assessment has been published and is available on the Board's web site or through the Board Office.

¹⁰ "Avoidable hospitalisations" are those which could be avoided by either preventing the illness or accident that led to the admission through the provision of health promotion or disease prevention programmes (e.g. preventing lung cancer through smoking education) or by better management of the patients in the community.

¹¹ This information is from Disability Counts 2001 (Statistics NZ website) – in the survey, a disability was defined as any limitation in activity resulting from a long-term condition or health problem. The focus was, therefore, not on identifying the nature of the disorder or disabling condition, but rather the limitation resulting from it.

Disability was determined by responses to a series of questions that assessed difficulties performing certain day-to-day activities. Answers reflected respondents' own perception of their situation and were, therefore, subjective.

5 STRATEGIC OUTCOMES

In keeping with the DHB statutory functions and objectives we will work with the local community, including service providers and other social service agencies, to achieve the five strategic outcomes detailed below.

The outcomes we want to achieve are high level, take account of government priorities, our community's state of health, service provision challenges, community expectations and the trends and forecasts generally accepted by the health sector.

Each year NMDHB's strategic outcomes inform the annual planning process. The annual plan will outline the year's objectives and the actions that will be taken that year towards achieving the strategic outcomes. The annual plan will also give an account of the expected achievement and how progress will be measured.

STRATEGIC OUTCOME	STRATEGIES
<p>OUTCOME 1: THE HEALTH AND WELLBEING OF THE PEOPLE OF NELSON MARLBOROUGH IS IMPROVED AND, IN PARTICULAR, HEALTH INEQUALITIES FOR MĀORI, AND OTHER POPULATION GROUPS ARE REDUCED</p>	<ul style="list-style-type: none"> • Reduce health inequalities • Improve nutrition and physical activity • Reduce smoking and the harm from second-hand smoke • Improve oral health • Reduce the incidence and impact of diabetes • Reduce cardiovascular disease • Reduce the incidence and impact of cancer • Improve the health of children and youth • Improve the health of older people • Improve Māori health • Increase independence for people with life-long disability • Improve mental health
<p>OUTCOME 2: MANAWHENUA IWI WORK IN PARTNERSHIP WITH THE BOARD AND MĀORI PARTICIPATE IN DECISIONS AFFECTING THEIR HEALTH, WELLBEING AND INDEPENDENCE</p>	<ul style="list-style-type: none"> • Work in partnership and encourage participation of Māori
<p>OUTCOME 3: THE COMMUNITY HAS FAIR ACCESS TO A RANGE AND LEVEL OF WELL-INTEGRATED SERVICES APPROPRIATE FOR ITS SIZE, LOCATION AND COMPOSITION.</p>	<ul style="list-style-type: none"> • Prioritising access to services • Improving integration of services • Access to primary care • Access to specialist services • Access for rural communities
<p>OUTCOME 4: THE EFFECTIVENESS OF SERVICES ACROSS THE SECTOR ARE ENHANCED THROUGH A STRONG QUALITY IMPROVEMENT CULTURE AND MANAGEMENT OF CLINICAL RISK</p>	<ul style="list-style-type: none"> • Improve the use of quality-enhancing systems • Value, retain and develop staff • Maintain facilities • Ensure safety and currency of equipment
<p>OUTCOME 5: FINANCIAL AND BUSINESS RISKS ARE MANAGED AND DECISIONS MADE BASED ON GOOD INFORMATION AND ROBUST BUSINESS PRACTICE</p>	<ul style="list-style-type: none"> • Develop information management and technology • Manage our finances • sound business processes and risk management

6 WHAT WE WANT TO ACHIEVE: Improving the Health of the Community

To improve the health and wellbeing of the whole community it is essential to promote health and prevent illness and injury. We believe that a population health approach must be taken across the whole health and disability sector. The foundation for a population health approach is the Ottawa Charter⁴. This will involve changing current thinking and practice to include promotion of health as an everyday activity of all service providers. Using this approach, and by using strategies that will particularly reach our children and young people, we will achieve the best outcomes.

In recognition of the importance of the socio-economic determinants of health, we will work with the other sectors to achieve a measurable improvement in the health and wellbeing of our community.

We will be working to address all 13 of the priority population health objectives identified in the NZ Health Strategy (refer Appendix 2). However we are choosing to place particular emphasis on those which are priorities for this district and in which we believe we can make a significant difference in a relatively short time:

- Nutrition and physical activity
- Smoking
- Oral health
- Diabetes
- Cardiovascular disease
- Cancer.

We have identified several priority groups within our population to whose needs we will give particular attention. These population groups are a priority either because investment now will reduce the burden of disease in years to come or because they currently carry the greatest burden of disease and loss of independence. The priority population groups are:

- Children and youth
- Older people
- Māori
- People with life-long disability
- People with mental illness.

Our physical health, mental health and disability health gain priorities have been chosen on the basis of the:

- Health needs assessment and other information received from providers and the community
- Opportunity to benefit Māori and other groups with high health needs
- National and international trends
- Opportunity for “flow-on” effects towards achieving the other priority population health objectives
- Feedback received during DSP consultation.

OUTCOME 1:

THE HEALTH AND WELLBEING OF THE PEOPLE OF NELSON MARLBOROUGH IS IMPROVED AND, IN PARTICULAR, HEALTH INEQUALITIES FOR MĀORI, AND OTHER POPULATION GROUPS ARE REDUCED.

6.1 Reducing Inequalities

There is strong evidence¹² that Māori, regardless of their socio-economic status, and people from lower socio-economic groups, do not enjoy equal health status with other New Zealanders. It is a government and Board priority to address these differences.

STRATEGIES TO REDUCE THE HEALTH INEQUALITIES

- a. Work to increase understanding of and address the wider determinants¹³ of health across sectors and the community.
- b. Improve access to primary care for Māori and people from lower socio-economic groups.

We will have been successful if:

- There is an increase in the number of Maori enrolled in the PHOs
- Maori and people from lower socio-economic groups in PHOs use primary care at the same rate as the general population

6.2 Nutrition and Physical Activity

In New Zealand more than half of the adult population are already overweight or obese. The problem is increasing rapidly, both in adults and in children. Adults from the most deprived areas have higher levels of obesity than those in the less deprived areas.

The health problems resulting from poor eating, lack of physical activity and obesity include diabetes, cardiovascular diseases and cancer.

Physical inactivity is estimated to account for 2,600 premature deaths each year in New Zealand. A 10% increase in physical activity could result in 600 fewer premature deaths per year. Although our community is relatively more active than many regions in New Zealand, we still have a significant number of people who are obese (about 18% of the adult population) and are not active enough (25% of the adult population). The number of people with diabetes is also increasing rapidly.

Delay in addressing these issues will lead to further demand for health services in the future. The government has developed a Healthy Eating, Healthy Action Strategy to tackle these growing problems.

Issues and challenges

- Programmes that promote good nutrition and physical activity have the potential to increase health inequalities, so need to be assessed using the Health Equalities Assessment Tool (HEAT)¹⁴.
- There are a range of agencies and groups with a role to play in improving nutrition and physical activity and a range of funding sources. Initiatives need to be co-ordinated to achieve maximum benefit.

STRATEGIES TO IMPROVE NUTRITION AND PHYSICAL ACTIVITY

- a. Lead a bold, 'whole of district' project that co-ordinates existing activity and implements a balanced mix of strategies to promote healthy nutrition and physical activity.

¹² A variety of information sources have been drawn on in compiling this and later sections of the plan – further details can be obtained from the Health Needs Assessment Summary 2005 on the website www.nmdhb.govt.nz

¹³ Determinants of health are things that are recognised as having a significant influence on our health, such as our income, employment, education, social support and housing.

¹⁴ This is a set of questions developed to assist in considering how particular inequalities in health have come about, and where the effective intervention points are to tackle them.

- b. Promote the Ministry of Health's Food and Nutrition Guidelines, encouraging people to change their eating patterns and supporting community initiatives that are consistent with the guidelines
- c. Work with parents, children and teachers to develop healthy eating patterns and active lifestyle habits amongst pre-school and school aged children, including encouraging education settings to be supportive of the development of healthy eating and physical activity.
- d. Ensure that maternity and child health services promote and support breastfeeding.
- e. Support local councils, PHOs, Sport Tasman, other agencies and communities to develop environments and initiatives that encourage better nutrition and increased physical activity, particularly for those with sedentary lifestyles.
- f. Continue developing and implementing the Action for Healthy Children and Food with Attitude projects

We will have been successful if:

- There is increased awareness of the importance of healthy eating and more people are eating the recommended 5+ fruit and vegetables per day.
- The percentage of breast fed babies is increasing.
- There are fewer obese people in our community.
- More people are taking the opportunity to be regularly physically active.

6.3 Limiting the effects of smoking

Smoking causes a lot of illness and premature death. Each year approximately 4,500 deaths in New Zealand are attributable to tobacco, including 390 deaths caused by second-hand smoke. Each year in Nelson Marlborough 2200 people over the age of 35 are admitted to hospital and 257 people die as a result of tobacco smoking. The cost of these hospital admissions is more than 6 million dollars.

Smokers suffer from a range of conditions, including heart disease, stroke, various cancers and chronic lung disease.

There is also strong evidence of the negative effects of second-hand smoke. For children this is a particularly important as it causes increased rates of sudden infant death syndrome (SIDS), chest infections, glue ear and hearing loss.

The overall smoking rate for adults in Nelson–Marlborough in 1996 was 23%. Smoking rates for Māori are much higher with 50% of Māori women and 43% of Māori men being current smokers.

Although tobacco use has generally declined in the last 20 years, and many current smokers want to quit or reduce consumption, there has been an increase in smoking among youth. An estimated 19,000 young New Zealanders start smoking each year.

The Quitline offers free and confidential telephone support to 35,000 callers per year throughout New Zealand. An evaluation indicated a quit rate of 18%¹⁵; 20% of callers identified themselves as Māori and 67% as New Zealand European. The lower percentage of Māori may be explained by Māori preference to use the Aukati Kai Paipa programme, which is a Ministry of Health funded kaupapa Māori service, and which indicates higher quit rates (29% in 2000).

¹⁵ *Evaluation of Subsidised NRT Exchange Card Scheme and the Quitline Subsidised NRT Exchange Card Programme, BRC Marketing & Social Research, 2003*

To lead by example, NMDHB has implemented smokefree policies for grounds, buildings and vehicles, and have offered access to cessation services for staff and patients.

Issues and challenges

- Reducing the number of young people, particularly young women, who start smoking.
- Reducing the number of Māori who smoke.
- Enhancing the ability of general practice to support the estimated 5,000 smokers who are thinking about quitting.
- Extending DHB smokefree services, and tailoring approaches to particular services, including mental health and maternity services.

STRATEGIES TO REDUCE SMOKING AND THE HARM FROM SECOND-HAND SMOKE

- a. Work with children and youth, and with pregnant women and Māori to ensure they are aware of the benefits and are supported to remain smokefree.
- b. Ensure that appropriate cessation services are readily accessible for all.
- c. Support all health and disability service providers to adopt comprehensive smokefree practises.
- d. Continue to support the implementation of the Smokefree Environments Amendments Act.

We will have been successful if:

- Statistics show a reduction in the rate of smoking locally, particularly for young people and Māori.
- There is a measurable reduction in the number of NMDHB staff who smoke.

6.4 Improving oral health

Nelson Marlborough children have higher rates of dental decay than in many other parts of New Zealand where there is supplementary fluoride added to the water supply and similar rates to other areas where there is no supplementation of fluoride.

In Nelson Marlborough in 2004, 35% of Māori five-year-olds have no tooth decay compared to 56% of European/other children. There are also differences in oral health status linked to socio-economic factors.

Issues and challenges

- Water fluoridation is known to reduce dental decay by up to 50% and has been shown to be particularly effective in reducing socio-economic and ethnic differences in oral health. However, public water supplies in Nelson Marlborough do not have fluoride added. The local authorities and the community have to help us decide how to address the inequalities in oral health and relatively low oral health status, including continuing the discussion on the merits of fluoridation. In making this decision it should be noted that the added costs of treating a higher incidence of dental disease means that we have less to spend on other areas of health.
- Achieving sustainable services for school children and adolescents. Most school dental clinics do not meet modern standards and there are some difficulties with recruitment and retention of staff. There has been an improvement in the number of children transferring from school services to the adolescent dental services, but further efforts need to be made to improve the rate of attendance for treatment and the rates of completion of treatment. This district has experienced difficulties,

particularly in Marlborough, in attracting enough dentists for the adolescent dental service.

STRATEGIES TO IMPROVE ORAL HEALTH

- a. Encourage children and youth to adopt eating and drinking habits that prevent tooth decay.
- b. Promote the uptake of fluoride, including improving the availability of fluoride tablets to families and stimulating an informed discussion within the community about water fluoridation.
- c. Improve access of low-income adults to oral health services.
- d. Maintain high enrolment of adolescents and find ways of increasing their attendance for treatment, especially for young Māori, including working with dentists to achieve a sustainable adolescent service throughout the district.
- e. Work with the Ministry of Health to implement the vision and policy for the School Dental Service.

We will have been successful if:

- The community makes an informed decision on whether or not to supplement the fluoride levels of its water supplies.
- Ninety percent (90%) of adolescents transfer from the School Dental Service to the Adolescent services each year
- There is an increase in the proportion of adolescents who complete treatment.
- There is an increase in the percentage of 5-year-olds who are caries-free.

6.5 Diabetes

Currently about 4% of the population have diabetes, although for Māori and Pacific Peoples the occurrence is three times higher than for other New Zealanders. The incidence of both Type 1 and Type 2 diabetes is increasing. The reason for the increase in Type 1 is not clear, but Type 2 is a lifestyle disease related to increasing levels of overweight/obesity and inactivity. Of particular concern is the increasing number of young people with Type 2 diabetes. It is expected that each year there will be about 100 more people diagnosed with diabetes (of any type) in Nelson Marlborough.

People with diabetes have an increased risk of serious health complications (e.g. blindness, heart disease, kidney failure and lower limb amputations), particularly if the diabetes remains undiagnosed or is not well managed.

Currently, about 65% of all people (but only one third of Māori) with diabetes attend a free annual check in general practice. Of those attending for annual checks, 75% have their diabetes well managed (63% of Māori), and 72% have eye checks two-yearly as recommended (74% of Māori).

Issues and challenges

- Even if we are able to slow the rate of increase in the incidence of Type 2 diabetes, there are still likely to be more people with diabetes due to the growing population, the ageing of the population and an increase in the number of Māori people in the population.
- A range of services need to be co-ordinated and integrated to reduce the incidence of diabetes and to support people with diabetes to manage the disease.

STRATEGIES TO REDUCE THE INCIDENCE AND IMPACT OF DIABETES

- a. Extend nutrition and physical activity initiatives as prevention strategies aimed at preventing non-insulin dependent (Type 2) diabetes for which life-style issues are significant risk factors.

- b. Promote early detection of diabetes including targeted screening particularly for Māori and Pacific peoples.
- c. Strengthen the ability of primary care to support people to better manage their diabetes.
- d. Work with primary, Māori and secondary service providers to improve the planning and co-ordination of diabetes services, ensuring that appropriate services are in place, services work well together and that they are used effectively.

We will have been successful if:

- There is an increase in the number and proportion of people with diabetes who are accessing free annual checks.
- An increasing number of people with diabetes are diagnosed as a result of screening, and are well supported by education and treatment services.
- There are fewer diabetes-related hospital admissions, complications and deaths.

6.6 Cardiovascular diseases

Although death rates from cardiovascular diseases (CVDs) have been decreasing over the last 30 years, this is still the leading cause of death in New Zealand for all ethnic groups. In 1999 41% of all deaths in New Zealand were due to CVDs such as stroke or heart attack. More men die of CVDs than women, and the less well-off people are, the more likely they are to die from a CVD. Māori people have the highest rates of death from all types of CVD. The people of our district are affected by CVDs at much the same rate as the New Zealand average.

The older a person gets, the more likely they are to suffer from a CVD and to die from it. This will have a considerable impact on the health services as the population ages. However, although older people are more likely to be affected by CVDs, these illnesses are also a significant cause of premature death, accounting for one-third of the life years lost between ages 45 and 64 years.

When considering CVDs it is very important to remember that many of the major risk factors are able to be modified (eg, tobacco smoking, alcohol use, high blood pressure, high cholesterol, obesity, physical inactivity and (pre)diabetes).

Issues and challenges

- Making people aware of their risk of CVD and supporting them to reduce this risk is one of the big challenges faced by the health services.
- Addressing the socio-economic differences that underpin the CVD inequalities for Māori and people who are less well-off.

STRATEGIES TO REDUCE CARDIOVASCULAR DISEASES

- a. Work with the PHO and general practices to introduce a CVD risk factor assessment and early treatment for high-risk people.
- b. Continue health promotion work via the public health units, Māori health providers and PHOs to reduce smoking, increase physical activity and promote healthy eating.
- c. Increase the rehabilitation focus of the specialist and other services.
- d. Integration of planning and service delivery across the sector.
- e. Work with other agencies to reduce socio-economic disadvantage in our community.

We will have been successful if:

- An increasing proportion of people have had their CVD risk factors assessed each year.
- The proportion of the population who are affected by a stroke or a heart attack is reducing.

6.7 Cancer

There are increasing numbers of people being treated for cancer and more people of all ages entering palliative care programmes. These increases are likely to continue as the number of older people increases. Many people are touched by this disease either through being diagnosed themselves or through having a family member or friend diagnosed. In Nelson Marlborough 540 people died from a cancer in 2000 to 2001.

Because cancer is the second highest cause of death in New Zealand it is easy to forget that many cancers can be prevented and many can be successfully treated. The government has recently released a *Cancer Control Strategy* and an *Action Plan*, which will guide the planning, funding and provision of cancer services over the next five years.

Issues and challenges

- The widespread lack of public recognition of the impact that healthy lifestyles can have on cancer prevention.
- The wide range of services that need to be co-ordinated and integrated to achieve successful curative and/or palliative service.
- The public expectations for access to expensive treatments regardless of a poor probability of cure.
- The difficulties of the boundary between the curative and palliative care services.
- A growing older rural population leads to an increased need for both clinical and support services and difficulty providing palliative care services to these areas.
- The financial viability of hospice services is problematic due to the small population, particularly in Marlborough.

STRATEGIES TO REDUCE THE INCIDENCE AND IMPACT OF CANCER

- a. Promote a range of activities that will prevent cancer (see Nutrition and Physical Activity page 15).
- b. Where appropriate tests exist, encourage people with a high risk to be tested to check whether they have cancer.
- c. Ensure that people are able to access treatment very soon after they are diagnosed.
- d. Ensure that people receive support appropriate to their needs.
- e. Improve the co-ordination of the cancer services.
- f. Implement effective case management and improved psychological support for children suffering from cancer, and their families.
- g. Provide appropriate support services so that people who are no longer able to be treated are able to be cared for and die in their own home, with the back-up of a hospice service.
- h. Ensure individuals and their families are supported through the grief process.
- i. Strengthen the links between palliative care services and primary care.

We will be successful if:

- More people are eating a healthy diet, having regular physical activity and protecting themselves from the harmful effects of tobacco and the sun.
- Waiting times, for access to treatment for cancer, reduce.
- Rates of enrolment in proven early detection programmes increase.
- Families whose loved ones are dying feel adequately supported.

6.8 Children and Youth

Achieving good child health is vital for later adult health; and while health services are important, the social and economic circumstances in which children live have a major influence.

Māori and Pacific children and youth often do not have the same health status as European young people. Some examples of this are breastfeeding rates, presence of hearing problems, dental health and rates of smoking.

We have about 2500 hospital admissions of children each year. The main causes are dental conditions, respiratory infections, ear/nose/throat infections and gastro-enteritis. The main causes of death are related to the development of babies and births, with injuries being the next highest.

We have about 1870 hospital admissions of youth (aged 15–24 years) each year. The main causes are pregnancy-related, injury, and infections. The main causes of death are road accidents and suicide.

The main health issues for youth, which are of concern, are teenage pregnancy, suicide, access to counselling, access to primary health care services, and the impact of risky behaviours (e.g. rates of road vehicle crashes, sexually transmitted infections and alcohol/drug abuse).

Family violence is common in all populations and the effects are significant and long lasting. Follow-up of children who have been physically abused, neglected or have failed to thrive has shown that more than half have long-term developmental, educational and emotional consequences.

Issues and challenges

- Getting good information about the health of children and youth.
- Addressing social and economic issues that have a big impact on child and youth health.
- Having services work well together and be easy for children and families to use.

STRATEGIES TO IMPROVE THE HEALTH OF CHILDREN AND YOUTH

- a. Have a child and youth focus when we think about which services to fund and how services are provided.
- b. Continue to develop good information about child and youth health.
- c. Strengthen promotion/prevention, early intervention and primary health care services to support good health outcomes for children/youth, working with the education sector in particular.
- d. Work with other organisations to ensure that services are available, easy to use, and that they support children and families to achieve good health or manage their disability better.
- e. Work to reduce teenage pregnancy and the number of young people with sexually transmitted disease.
- f. Other strategies as identified in the priority health areas.

We will have been successful if:

- The differences in health outcomes between ethnic groups are reduced.
- The incidence and impact of family violence are reduced.
- Avoidable hospital admissions and deaths of children and youth are reduced.
- There is a reduced incidence of teenage pregnancy and sexually transmitted infections.

6.9 Older people

There is an increasing number of people aged over 65 years, which means that even if the rates of chronic illness remain the same, there will still be a significant increase in the number of people needing general practice, hospital and support services.

In 2001 there were 8,125 people aged 75 and over. In this age group nearly half need support to remain independent, and a small minority needs residential care in the last years of their life.

Issues and challenges

- Moving from a 'doing for' dependency approach to a 'working with' restorative approach.
- Meeting the needs of an increasing population of older people.
- A need for better sharing of information between services to improve co-ordination.
- Support services currently are not fully meeting the needs of older people, particularly because of a lack of focus on rehabilitation.
- A generally poorly paid, casualised, unskilled workforce in support services.

STRATEGIES TO IMPROVE THE HEALTH OF OLDER PEOPLE

- a. Integration of planning and service provision between PHO, specialist services for older people, NASC¹⁶, allied health, support services, secondary services and community/voluntary services.
- b. Develop a stronger rehabilitation focus in all services across the sector, including clients and families.
- c. Implement a standardised assessment process for older people.
- d. Strengthen service co-ordination.
- e. Improve dementia care support primary care to keep patients out of acute hospitals.
- f. Ensure there are sufficient and responsive support services.
- g. Further develop the specialist Health Services for Older People (Geriatric and Psycho-geriatric).
- h. Encourage secondary services to streamline the patient journey into, through and out of hospital, give more priority to surgery that keeps people independent, and implement case co-ordination.
- i. Promote workforce development across the sector.
- j. Other activities as outlined in the priority health sections.

We will have been successful if:

- The average age at which the population needs to access formal support is increasing.
- A greater proportion of those needing support receive it in their own homes.
- A greater range of residential and community support services are available.
- Improved retention and optimal numbers of staff with appropriate qualifications working in the sector.
- The community is satisfied with the level of rehabilitation an older person can access.

¹⁶ Needs Assessment Service Co-ordination – the local agency is Support Works.

6.10 Māori health

Māori experience lower health status than non-Māori in New Zealand. The reasons for this health inequality are complex and include socio-economic status, unequal access to health services, lifestyle choices, cultural and genetic factors. There are more Māori people living in the poorer areas and fewer living in the better-off areas compared to non-Māori.

The health profile for the Nelson Marlborough Māori population gives a snapshot of Māori health status in 2005. Inequalities in health status are clearly identified in *smoking, diabetes, oral health, hearing, cancer, and cardiovascular disease*. Lack of specific Nelson Marlborough information on some issues requires us to use national data. There is an assumption that inequalities also exist in the other government priority areas. These are immunisation, disability support services, injury prevention, rangatahi health, hearing, sexual and reproductive health, asthma, alcohol and drug use, smoking, mental health, diabetes, cancer, oral health, cardiovascular diseases.

Issues and challenges

- A need to improve information on the ethnicity of service users and a process for assessing Māori health, in order to better plan for Māori health improvements.
- Working with other agencies to reduce poverty and improve educational status for Māori.

STRATEGIES TO IMPROVE MĀORI HEALTH

- a. Work with iwi and the Māori communities to identify health needs, including improvement in the collection of ethnic-specific health information.
- b. Focus on reducing Māori health inequalities.
- c. Focus on health promotion and prevention of illness and injury.
- d. Enhance the work with Māori health providers on physical activity and healthy eating.
- e. Increase Māori capacity and capability to provide appropriate and effective services for Māori
- f. Improve mainstream service delivery to Māori, particularly in primary care.
- g. Other activities as outlined in the priority health sections.

We will have been successful if:

- We have in place a current profile of Māori health for Te Tau Ihu.
- All contracted providers are reporting the ethnicity of service users.
- Increased numbers of Māori are accessing services.
- There is an increased number of Māori working in the health services.
- Māori report positively on the responsiveness of mainstream services.
- The difference in life expectancy between Māori and non-Māori is significantly reduced.

6.11 People with a life-long disability

There is a lack of information on the prevalence of disability in our community. Applying the New Zealand data to Nelson Marlborough, we could expect there to be around 25,000 people in the district with some level of disability, with about 15% of these severely limited by the disability.

We want to contribute to developing a community in which everyone feels they belong. We want to support all residents to be as independent as possible and able to participate in the community activities of their choice.

NMDHB would be supportive of having disability support funding devolved, so that we can take a comprehensive and integrated approach to the health and wellbeing of the community.

In the meantime, led by our Disability Support Advisory Committee¹⁷, we will do what is possible to promote the objectives of the NZ Disability Strategy, with particular reference to:

- Creating long-term support systems centred on the individual's particular need.
- Supporting quality living in the community for people with disabilities.

Issues and challenges

- There is a need to increase the community's understanding of the issues for people with disabilities and how the community itself can be disabling or enabling.
- In order to improve the opportunities for full participation in community life and meet the personal health needs of people with disabilities, health services must take more account of the special needs of people with disabilities (eg, access to GPs, dentists, physiotherapy, occupational therapy, hospital treatment).

STRATEGIES TO INCREASE INDEPENDENCE FOR PEOPLE WITH LIFE-LONG DISABILITY

- a. Obtain comprehensive information on the level of the disability of the community.
- b. Support the integration of assessment services and entitlement to support based on need rather than underlying diagnosis or cause.
- c. Continue to work with the community to implement the New Zealand Disability Strategy, particularly through advocating to improve the inclusion and participation in society of people with a disability, and supporting all providers to improve access to their service for people with a disability.
- d. Work with other agencies and organisations to develop and implement better systems to support families who have children with a high level of need.
- e. Work with the Ministry of Health to reassess the needs of people who are under the age of 65 and currently living in aged care facilities.
- f. Address issues of unsuitable housing, and move towards more supported living situations/options.

we will have been successful if:

- People with a life-long disability are able to actively participate in all aspects of society.
- Effective case management is in place for children who have a significant disability.
- There are improved residential options available in our district for people who have a life-long disability.

6.12 People with mental illness

It is estimated that at least one in five New Zealanders will suffer from a mental illness at some time in their life. About 3% of adult New Zealanders have severe mental health disorders and access specialist mental health and community support services. Another 5% of adults have moderate to severe mental health disorders and are largely cared for in the primary care sector, and a further 12% have mild to moderate mental health disorders and are cared for by a combination of social networks and primary health care services.

¹⁷ The Disability Support Advisory Committee has a formal work plan which is available through the Board Office.

In 2003, hospital-based services provided care to approximately 4050 clients. The majority (48%) of these clients were seen by community mental health, with alcohol and other drug services seeing another 22%, and child and adolescent mental health service a further 21%. We contract with 18 NGOs to provide community support services.

Mental health funding is targeted towards those with the highest need caused by severe mental illness. We recognise, however, that there is also a high number of people in the community whose lives are significantly affected by less severe mental health issues. We are also aware of the increasing number of people who have both a mental illness and an alcohol or other drug problem. We recognise the interrelationship between mental and physical health and we will work with individuals, families and the community to approach these issues holistically.

To address this, we will be working toward improving the state of mental health and reducing substance abuse across the community, especially adopting health promotion strategies. Recognising the potential that communities have to influence their health and wellbeing, we will support a community development approach.

Issues and challenges

- Implementing “*Te Tahuu Improving Mental Health 2005–2015*” within existing resources.
- Meeting the needs of people with a dual-diagnosis, e.g. mental illness and a drug dependency.
- Ensuring the recovery approach is embedded in all mental health services.
- Supporting providers to improve service delivery to Māori tangata whaiora.
- Recruitment and retention of sufficient mental health workers to enable maintenance of existing services and the establishment of new services.
- Ensuring adequate housing is provided for people with mental illness.

STRATEGIES TO IMPROVE MENTAL HEALTH

- a. Obtain comprehensive information on the mental health of the community and improve outcomes measurement across services.
- b. Support the development and implementation of community action to improve mental health and reduce stigma and discrimination.
- c. Implement the National Mental Health Plan and Blueprint and the Regional Mental Health Plan to ensure access to quality services for the community.
- d. Support communities to reduce the level of alcohol and other drug abuse, particularly amongst young people.
- e. Develop specialist dual-diagnosis expertise at a district level.
- f. Embed the “recovery” approach in all services.
- g. Support PHOs to develop mental health plans to address the interface between primary and secondary based care
- h. Continue building capacity within the whānau/family and consumer/tangata whaiora advisory/advocacy sector.
- i. Support mental health providers improve their services to Māori tangata whaiora and their whanau.
- j. Work with other agencies to ensure good quality, affordable housing is available.

We will have been successful if:

- Service users are respected, and have the same opportunities to fully participate in the everyday life of their communities and whānau.
- Mental health services have a strong and demonstrated focus on service users leading their own recovery.

- Mental health services are available that meet the needs of service users and their families.
- Access improves and is co-ordinated with other key agencies.
- There are fewer people accessing secondary services in crisis.

7 WHAT WE WANT TO ACHIEVE - Effective Partnership with Māori

OUTCOME 2:

MANAWHENUA IWI WORK IN PARTNERSHIP WITH THE BOARD AND MĀORI PARTICIPATE IN DECISIONS AFFECTING THEIR HEALTH, WELLBEING AND INDEPENDENCE.

As an agent of the Crown, the Board has a responsibility to assist the Crown to fulfill its obligations under the Treaty of Waitangi. The Board makes a commitment to implementing government policy in relation to Māori health as specified within the framework of the New Zealand Public Health and Disability Act 2000 and He Korowai Oranga, (the government's Māori Health Strategy). Our primary relationship is with the eight manawhenua iwi of this rohe and this has been formalised through a Memorandum of Agreement with them. Under this agreement an Iwi Health Board has been established to provide advice on all aspects of Māori health. Also in the context of the Agreement, iwi have made a commitment to ensure the participation of all Māori in the district.

The Memorandum of Agreement and NMDHB's Māori Health Strategy form the foundation of our work towards improving Māori health. We also recognise the benefits that will be achieved in working collaboratively with other agencies to achieve improved social outcomes for Māori.

Issues and challenges

- Due to the relatively small size of the Māori population, the capacity of iwi and the Māori community to meet the growing needs of consultation and representation across the sector will be an ongoing issue.
- The establishment of effective linkages between maata waka and the Iwi Health Board.
- Increasing the level of understanding of tikanga Māori within the non-Māori community

STRATEGIES TO WORK IN PARTNERSHIP AND ENCOURAGE PARTICIPATION OF MĀORI

- a. Support the effective functioning of the Memorandum of Agreement.
- b. Ensure that all providers are committed to safeguarding the cultural concepts, values and practices of Māori.
- c. Encourage the development of services that have a Māori kaupapa.
- d. Actively participate in the Regional Iwi/Crown Agency forum (RIF).
- e. Foster understanding of and support for the implementation of He Korowai Oranga.
- f. Facilitate the provision of bi-cultural education to the community.

We will have been successful if:

- Advice from Māori is evident in Board decisions affecting Māori.
- Māori report positively on the responsiveness of mainstream services.
- There is a network of effective sustainable Māori Health providers.
- The health services are making a measurable contribution to the social and economic development of Māori across the district.
- NMDHB's Māori Health Strategy has currency and there is evidence of its ongoing implementation.

8 WHAT WE WANT TO ACHIEVE: Improved Access to Services

OUTCOME 3:

THE COMMUNITY HAS FAIR ACCESS TO A RANGE AND LEVEL OF WELL-INTEGRATED SERVICES APPROPRIATE FOR ITS SIZE, LOCATION AND COMPOSITION.

The government is concerned to ensure that all New Zealanders have fair and reasonable access to a similar level of health and disability support services, so most of the decisions on which services will be publicly funded are made at a national level. A high priority is to support all New Zealanders to make lifestyle decisions that will improve the health of their whole family. The government also wants to ensure that all people, regardless of where they live, have reasonable access to:

- Population health services (public health) – to ensure that people live in a safe environment, where they have information and are supported to make healthy lifestyle choices.
- Primary health care – to ensure that people can see a nurse, a general practitioner (GP), a Māori health worker or other primary health care worker to help their family stay well or to get help at the earliest stages of illness or injury.
- Specialist level services for serious accidents or medical emergencies or health problems that cannot be handled by the primary services – to ensure that people can access specialist care as soon as possible to prevent further deterioration of their condition and to increase their chances of full recovery.

We recognise how essential it is to understand the community in order to meet its needs. The first step in this process is maintaining a comprehensive understanding of the health needs of the community and planning services to effectively meet these needs.

We are committed to funding and delivering services in a collaborative way, based on a firm belief that co-operation and good relationships between funders, providers and individuals and families is a key step toward good health and wellbeing.

8.1 Prioritising Access to Services

We know that the need and demand for services will always exceed the level of funding that we have. Population and social changes will result in the need for more services and technological developments will increase the range of treatment options that are available. Further the large geographical area covered by Nelson Marlborough, encompassing a city, a secondary urban area, a number of minor urban areas and rural centres, several of which are relatively remote and isolated provides additional access challenges.

These challenges mean that NMDHB and the community will need to make choices about which services will be achievable within the funding available. Services will be rationed and provided to those people who have the greatest need and ability to benefit. We have developed a prioritisation process that helps us to ration the services decided by government, and which services to fund with our discretionary funding. We base these decisions on the principles of effectiveness, value for money, equity and whānau ora¹⁸.

¹⁸ The principle of whānau ora gives priority to services which deliver relatively large gains in whānau ora (physical, spiritual, mental and emotional health; longer life and better quality of life; participation in te ao Maori (the Maori world) and wider New Zealand society).

STRATEGIES TO SUPPORT FAIR PRIORITISING AND ACCESS TO SERVICES

- a. Continuing to develop a comprehensive understanding of the community's health and support needs.
- b. Consistently challenge all processes, funded services and budgets to ensure effective and efficient service provision, funding only those services that have evidence to support their effectiveness and being prepared to stop funding services if the cost well exceeds the value of having such a service.
- c. Ration services fairly based on agreed principles and using a transparent and clearly defined framework for decision making.
- d. Take a long-term view on service investment and therefore give preference to funding prevention programmes particularly in the priority "health gain" areas for children.
- e. Provide services as close to the population as possible and minimise the overhead costs of provision through use of primary and community based service providers.
- f. Engage each rural community in the process of determining the mix and level of service suitable for their population and how these will be provided.¹⁹
- g. Prioritise our investment in technology and treatments to ensure the range of specialist services offered is maintained and developed appropriately.

We will have been successful if:

- There is evidence of an up to date profile of the community's health priorities.
- All significant prioritisation decisions are transparent to the community.
- The community understands the need for and supports the prioritisation decisions.
- The community recognises the need to make long-term investments in health promotion, and supports reducing the proportion of the DHB's funding invested in specialist services in favour of primary and community-based services.
- The urban/rural access to service is in balance and is fair and reasonable.

8.2 Integrated services

Integrated services work well together so that they are easy for people to use and to move from one to another when required. We are committed to funding and delivering services in a collaborative way, based on a firm belief that co-operation and good relationships between funders, providers, individuals and families is a key step toward good health and wellbeing.

STRATEGIES TO ACHIEVE IMPROVED INTEGRATION OF SERVICES

- a. Maintain high levels of communication and co-operation between all service providers.
- b. Within the DHB provided secondary services improve the co-ordination of care and extend initiatives such as increased use of day and outpatient treatment to facilitate the achievement of the government's elective service targets.
- c. Work with the rural communities to ensure health professional can maximise the contribution they can make to the community's health and achieve optimal use of rural health and social service facilities.

¹⁹ *The mix and level of services will need to take into account several factors, including:*

- the size and needs of the population of the area. Resources will be allocated to those services which will reduce inequalities in health (i.e. improve the health of those with the poorest health status)
- the appropriate level of funding for services for that population.
- the distance people can reasonably be expected to travel to services.
- the most cost-effective provision of services.
- long term sustainability of funding the services.

- d. Encourage the development of innovative approaches to integrated services, for example:
- public/primary – joint contribution to agreed programmes using population health approaches
 - primary/secondary – the “hospital at home” concept
 - disability/personal health – remove boundaries between treatment and support services
 - publicly owned/private – co-location of services and sharing of capital investment.

We will have been successful if:

- Health providers across the continuum are active participants in a range of health promotion programmes.
- Population health approaches are in evidence in primary and secondary services.
- There is demonstrable links between primary and secondary services to improve patient flow across the services.
- Integrated models of primary care are operating in the minor urban and rural areas.

8.3 Accessing Primary Care

Primary health care is care that we get from a GP, practice nurse or other community health providers. In recent years the government has made significant increases in the funding of general practice. They want to ensure that people can get support to stay well, and if they are unwell to be able to access low-cost primary care as early as possible to prevent them becoming so unwell that they need hospital care. This funding is available to people if they are enrolled in a PHO, as described in the government’s Primary Health Care Strategy.

In our district there are two PHOs. The boards of both the Nelson Bays and Marlborough (Kimi Hauora Wairau) PHOs are made up of GPs, practice nurses, and community and Māori representatives. All the general practices in the district are part of one or other of the PHOs (apart from the DHB-operated Murchison service).

The establishment of PHOs is aimed at helping people with the highest health need to access primary care. People with chronic diseases can now see their GP/practice nurse more regularly at a reduced cost to better manage their health and can be supported through prevention programmes such as Green Prescription and smoking cessation.

Issues and challenges

- The cost of going to the GP is still an issue for some people.
- The uptake of new programmes in general practice is limited by a shortage of practice nurses and space in some surgeries.
- There is an anticipated shortage of general practitioners and possibly also primary care nurses.
- GPs are concerned about the cost and burden of providing after-hours care.
- Some people, particularly the elderly, find it difficult to manage their multiple medications correctly.
- At this stage general practices are the only providers contracted to the PHOs.
- Not all primary care providers have worked collaboratively or had effective lines of communication with each other previously.

STRATEGIES TO SUPPORT PEOPLE GETTING CARE EARLY

- a. Work with the primary care sector to ensure a strong primary health care system and develop initiatives to implement the government’s Primary Health Care strategy. Specifically we will work with:

- PHOs and GPs to ensure that further funding increases result in an appropriate reduction in fees for patients.
- PHOs and GPs to reduce the other identified barriers to primary care particularly for Māori and other ethnic minorities, such as through the introduction of Services to Improve Access.
- PHOs to maximise the effectiveness of new programmes such as Care Plus.
- PHOs on workforce development across the occupational groups working in primary care.
- PHOs and GPs to develop solutions to manage the consequences of the declining number of general practitioners and locums.
- PHOs and GPs to develop a sustainable district-wide plan for after-hours services.
- Pharmacists and general practices to implement effective medicine management programmes.
- GPs and practice nurses to ensure there is improved access for their patients to other services such as dietitians, health educators and diagnostic support services.
- Primary care nurses to further enhance their contribution to effective primary care.
- All primary care providers to encourage their co-operation and participation in the PHO.
- All primary care providers to improve lines of communication, collaboration and relationships among primary care providers to foster teamwork.

We will have been successful if:

- There is an increase in the number of Māori enrolled in the PHOs.
- Fewer people report reluctance to go to the GP because of cost and other barriers.
- A high number of eligible people are enrolled in new programmes.
- Demand on secondary, specialist services is reducing relative to population growth, e.g. avoidable admissions to hospital are decreasing as a proportion of total admissions to hospital.
- Models of care are developed to deal with workforce shortages.
- Models of care reflect optimal teamwork with effective communication and collaboration between providers.
- More providers are within the PHO.

8.4 Accessing the specialist services

A wide range of specialist services is provided from Nelson and Wairau hospitals. We have Emergency Departments in both centres and transfer patients who need highly specialised care mainly to Wellington and Christchurch hospitals.

We provide well for emergency and urgent health needs however we do not manage to see and treat all people referred with non-urgent needs as quickly as we would like.

Issues and challenges

- Technology is constantly developing. However it can be very expensive and may be beyond the reach of smaller DHBs, meaning that people may have to travel to larger centres for an increasing number of procedures.
- Treatments are improving all the time, which allows people a better quality of life or to live longer, particularly with cancer. However many of these treatments are very expensive putting pressure on funding.
- As doctors become even more specialised this will impact on our ability to maintain the right number of staff.
- As the population ages there will be an increasing number of people in the district with chronic disease, putting further pressure on our costs.

STRATEGIES TO IMPROVE ACCESS TO SPECIALIST SERVICES

- a. Ensure a good spread of specialist services across the district and develop models of care which provide best use of specialist staff.
- b. Increase the amount of outpatient activity and day case surgery.
- c. Continue to work with the primary health providers to improve access for people with non-urgent health needs.
- d. Maintain levels of access to elective volumes and review and address areas of comparative under-provision.
- e. Ensure our commitment to patients does not exceed our capacity to provide treatment.
- f. Work with the primary health providers to improve the co-ordination of care for people with chronic illness and to enhance rehabilitation and self-management.
- g. Continue to work with providers to ensure referrals are appropriate.

We will be successful if:

- People with the greatest need and ability to benefit are offered treatment first.
- Local specialist services are well integrated with primary and specialist tertiary services.
- People indicate that the services we provide are of a high standard.
- We complete all the work we are contracted to provide.
- We live within our funding.
- The government targets for elective services are being achieved.
- We maintain specialist services appropriate to our population and location.

8.5 Rural Communities Access to Health Services

Our population is spread over a wide geographical area with many people living in minor urban areas such as Motueka, or rural centres such as Seddon and Tapawera. Providing services to these small, sometimes isolated communities continues to be a challenge.

The small number of people living in the rural areas makes it very difficult for services to be provided at the same cost as in an urban area. The relative isolation and the perception of poor profitability means that it is often difficult to get providers to set up business in these areas. We accept the financial implications of the low numbers of people and pay significant price premiums for a range of rural services.

STRATEGIES TO IMPROVE ACCESS FOR RURAL COMMUNITIES

- a. Maximise the level of primary care services provided in the minor urban and rural areas.
- b. With the community, regularly review the cost and benefit of local provision of services in rural areas and be prepared to stop funding services if the cost well exceeds the value of having such a service in a particular rural area.
- c. Minimise the inconvenience for rural people of travelling to the more specialist services by improving the co-ordination of their appointments with different services.
- d. Encourage quality providers into rural areas by continuing to pay price premiums for the provision of some services. We will work with the communities to explore options for providing health services, within the available funding, that support the ongoing clinical and financial viability of the providers.

We will have been successful if:

- Minor urban and rural communities recognise and accept the need to prioritise the locally available services.
- Integrated models of primary and community care are operating in the minor urban and rural areas.
- Specialist services provided to rural people are well organised and co-ordinated to minimise the inconvenience experienced by the person.

9 WHAT WE WANT TO ACHIEVE: Enhanced Quality Of Services and an Effective Organisation

OUTCOME 4:

THE EFFECTIVENESS OF SERVICES ACROSS THE SECTOR ARE ENHANCED THROUGH A STRONG QUALITY IMPROVEMENT CULTURE AND MANAGEMENT OF CLINICAL RISK

9.1 Quality Improvement

We expect all providers to be able to demonstrate ongoing quality improvement and we are increasing our focus on the assessment of outcomes for all services.

The delivery of health services requires an extensive range of resources, skilled clinical and management staff, up to date equipment and safe appropriate facilities. The ability for the staff to use the resources for the provision of good quality services will be enhanced by effective quality systems.

STRATEGIES TO IMPROVE THE USE OF QUALITY-ENHANCING SYSTEMS BY ALL PROVIDERS

- a. As a service funder, our requirements of all providers are that they:
 - comply with all relevant legislation and standards and any directives from the Minister of Health
 - have an active quality improvement programme.
- b. As a service provider, we will retain our long-standing commitment to the Quality Health NZ accreditation programme.
- c. Achieve optimal outcomes for patients/clients through “evidence-based practice”, which will include proper use of measurement and statistics.
- d. Develop an environment that encourages consumer feedback, learns from mistakes and builds on successes.

We will have been successful if:

- Relevant certification and/or accreditation outcomes are achieved.

9.2 Our Staff - Having well-trained people to provide the services

Our range of responsibilities and activities requires us to be a large organisation with a need for over 2000 staff. To a large extent it is our staff who determine the effectiveness and quality of our services.

To have the best staff we need to be effective at attracting appropriately qualified people and to be an organisation that values and develops each and every staff member.

We are committed to being a good employer and we are an equal opportunities employer. We will endeavour to model best practice to other employers in the district.

We have a relatively stable, although ageing, health workforce in relation to other health districts in New Zealand. This is due to a number of factors, especially the geography and climate of the district and the lifestyle able to be enjoyed here.

Workforce pressures do exist in both the primary and secondary services, however. These are not unique, with all current shortages being experienced elsewhere in New Zealand and/or internationally.

The training for the majority of health professions is done outside of the district and involves national and sometimes international educational requirements. To ensure our requirements are considered in national decision-making we need to have input at a national and regional level.

Issues and challenges

- The health workforce is ageing and it is more marked in some health professions (e.g. the nursing workforce in this district is older than the New Zealand average).
- The home support workforce is crucial to effective care in the community and we compete with a number of other sectors for these workers. The challenge will be to ensure that caring in the community is seen as a viable career option.
- Attracting our fair share of the national health workforce resource will be a continuing challenge. While the district does not have the major shortages and high turnover of staff of other parts of the country, it does have shortages and we must continue to make the health environment in the district vibrant to attract both people originally from the district and new practitioners.
- Ensuring that the health workforce reflects the population it serves.
- The DHB needs to take a leadership role on behalf of all Nelson Marlborough health services so we can develop a more consistent and unified approach to attracting health professionals to the district.

STRATEGIES TO VALUE, RETAIN AND DEVELOP STAFF

- a. Foster a culture of co-operation and collaboration with all staff having a commitment to the organisation's strategic goals.
- b. Effective communication with staff and providing opportunities for their involvement in planning and developing services.
- c. Maintain current, effective and comprehensive staff management policies and processes.
- d. Provide leadership within the district to ensure a workforce with the right skills at the right time.
- e. Maintain a fiscally responsible employee relations strategy
- f. Work effectively, and in "good faith" with employee organisations and representatives.
- g. Work with clinical staff in the primary and secondary services to encourage a flexible approach to health-care delivery that reflects the changing needs of the community
- h. Create a supportive, safe environment and a positive culture for health workers
- i. Create work environments that promote health service careers as a viable option for school-leavers
- j. Participate in national workforce development activities
- k. Work collaboratively with the education sector as the supplier of the future workforce.

We will have been successful if:

- Nelson Marlborough is seen as the district of choice by health workers.
- The workforce reflects the community it serves and adjusts to community need through implementing different delivery models.
- Our contribution to regional and national workforce development initiatives is evident.

9.3 Our Facilities

In our role as a provider of health services, we need appropriate facilities. Because of the specialised nature of some of the buildings that we require, generally we own and maintain the majority of land and buildings from which we provide services. The buildings are mixed in terms of age and condition, with some being not suitable for purpose.

Over the last 10 years we have consolidated services into facilities owned by NMDHB, using existing buildings where possible. This has seen some services being located in premises that are not purpose-built. During this period there has been investment in new facilities including theatres at both Nelson & Wairau Hospitals, a new hospital in Golden Bay, a new acute mental health unit and refurbished facilities at Motueka and Alexandra Hospital.

Issues and challenges

- With the current configuration of existing buildings, patient/client privacy will become increasingly more difficult to attain.
- Increasing demand for air conditioning in existing areas to meet climatic variations and increasing public expectations.
- Existing buildings have constraints that reduce their flexibility and may limit the introduction of new technologies (wireless networks).
- The cost of meeting the standards required under the Health & Disability(Safety) Act 2001 and to achieve accreditation.

STRATEGIES TO MAINTAIN FACILITIES

- a. All new buildings will be energy efficient, based on a thirty-year life cycle (with refits every ten years) and are to be purpose built but have flexibility in construction to allow a change in use.
- b. Services will be concentrated onto the current sites using existing buildings wherever possible and buildings on the fringe of the sites will be used for community-based or support services.
- c. Rationalise the facilities that we own and after the appropriate consultation, continue to dispose of surplus assets not required for the provision of health or disability services.
- d. Complete the Wairau hospital site redevelopment.
- e. Complete the planning and redevelopment of Nelson hospital (including surgical wards, mental health outpatients, administration and a learning and development centre).
- f. Rebuild Murchison community health centre.
- g. Continue working with the Friends of Motueka Hospital Trust who propose to use the current hospital site to develop an aged residential care facility.
- h. Continue working with the community and other providers in Golden Bay to explore how primary, community and aged care could be delivered in a more integrated way.

We will have been successful if:

- Services are provided from facilities which are “environmentally friendly” and fit for purpose.

9.4 Our Equipment

The equipment used for the delivery of services continues to change with the introduction of new technology. The current equipment is of a mixed age, and following

a series of operating deficits, we are now facing a major equipment replacement programme

Issues and challenges

- Maintaining, replacing and acquiring appropriate assets and technology in an environment where funds for investment are significantly limited.

STRATEGIES TO ENSURE THE SAFETY AND CURRENCY OF ALL EQUIPMENT

- a. Assets may be leased or purchased but where technology is changing frequently, we will lease equipment.
- b. The level and standard of maintenance of equipment will ensure that assets remain fit for purpose and meet legislative requirements.
- c. Encourage better utilisation of high cost equipment through avoiding duplication in the public and private sectors.
- d. Ensure funds for equipment are maintained and programmes for replacement are met.

We will have been successful if:

- We have the appropriate assets and they are well managed.

OUTCOME 5:

FINANCIAL AND BUSINESS RISKS ARE MANAGED AND DECISIONS MADE BASED ON GOOD INFORMATION AND ROBUST BUSINESS PRACTICE

9.5 Information and Technology

The main reason for building effective health and disability support information and technology systems is to facilitate improvements in the health and participation of consumers, through the appropriate sharing of information. As simple as it sounds, this has been incredibly difficult to achieve for most of the health systems around the world, regardless of their approach to funding or delivery of services. The challenges experienced by other countries demonstrates that there are features in the delivery of health care that make it more difficult than other industries to achieve the gains possible from the use of information technology.

Currently we have a wide variety of information systems in place, ranging from single-user databases to large DHB-wide systems such as the patient management system. There is little integration between the primary and secondary sectors, resulting in difficulty obtaining a complete picture of a patient's history. A number of our applications are no longer meeting the requirements placed upon them, generally because of their age.

There are four key issues that need to be responded to so that health systems can consistently assist with funding decisions and the delivery of quality health outcomes. These are:

- The impact of adverse medical events and quality of care.
- The growing issues related to security, confidentiality and the evidenced-based standardisation of service delivery.
- The move to population health and integrated care delivery models.
- The management of demand for services through entry and exit criteria.

In 2005 the Ministry of Health released the *Health Information Strategy for New Zealand* (HIS-NZ). This document outlines 12 key action zones for implementation over the next five years. We will play our part in implementing these action zones.

Issues and challenges

- The need to ensure appropriate funding is available for information technology (IT) projects. IT projects compete for the same funds as clinical needs, so their importance will need to be kept visible.
- Effective information management will also be dependent on our ability to attract and retain good staff in an environment of a shortage of people with the suitable skills and knowledge.

STRATEGIES TO DEVELOP OUR INFORMATION MANAGEMENT AND TECHNOLOGY.

- a. Support the development of information systems across the whole health sector, including allocating significant funding to the development of our own information systems.
- b. Implement a system to pull together all of the various patient information components stored in multiple systems (this will effectively form an electronic health record).
- c. Over time, make this system available to primary care, with a view to incorporating their information into the patient's electronic health record.
- d. Enable electronic discharge summaries and referrals to be sent between primary and secondary care.
- e. Develop shared disease management databases (e.g. for diabetes) between primary and secondary care.

We will have been successful when:

- The right information is available to the right people at the right time.
- Patient care is enhanced through the availability of health information across primary and secondary care.
- Efficiencies are achieved through the use of information technology.

9.6 *Managing our finances*

We receive more than 96% of our funding from the government, via the Ministry of Health. Other sources of funding include ACC and part-charges for some services. We also have partnerships at Wairau Hospital with entities that provide private services such as the Churchill Trust.

Funding for each DHB is based on a population-based funding formula (PBF). This is designed by the Ministry of Health to allocate a fair share of the government's health resources to each DHB, so that they have an equal opportunity to meet the health and disability needs of their population. Under this formula, we were under-funded up until the 2005/06 financial year and we were allocated increases gradually to get us up to our full share. From now on, increases in funding will only be at the rate prescribed by the government plus anything we might be entitled to for population growth.

Historically the funding given by government to cover the cost of inflation has been two to three percent, but the cost of hospital services has increased by five to seven percent. The gap between costs and revenue continues to be a challenge in providing sustainable services.

Issues and challenges

- Like all households and businesses, NMDHB has a fixed amount of income to purchase services, supplies, assets and to repay loans. With the demands for health services that exist, it is vital to budget expenditure carefully to ensure that the services which are delivered to the community are those that have the highest priority and best outcomes.

STRATEGIES TO MANAGE OUR FINANCES

- a. Have a sound financial base to fund and provide the health services outlined in our District Annual Plans in a sustainable manner. This involves:
 - staying within the funding available to us each year
 - providing services cost effectively
 - keeping administrative costs to a minimum to ensure the maximum amount is able to be spent on services
 - investing appropriately in buildings and equipment
 - continuing to find better ways to work and enhancing revenue
 - appropriately repaying debt to allow future borrowing.
- b. Adhere to accepted financial standards

We will have been successful if:

- We provide services with a breakeven or surplus financial result.

9.7 Our Business Processes/ Managing Our Risks

Major policy will continue to be set by the Board on recommendations from the Strategic Leadership Team. Appropriate management structures are in place and will be reviewed from time to time to maintain and alignment to the strategic focus and operational demands of the organisation. These are supported by appropriate delegations, position descriptions and review mechanisms. A new performance management process is being implemented.

We have an active risk management programme which complies with ANZ Standard 360:1995 Risk Management and the Crown Funding Agreement. The programme also links closely with our quality and occupational safety and health processes. Our risk management will be supported by the Board's Audit and Risk Committee.

Risk assessments are completed by all our services and are regularly reviewed. A risk reporting structure is set up to escalate high and extreme risk to the Board and to meet the reporting requirement of the Ministry of Health.

Organisational planning is undertaken in line with best practice and we will continue to endeavour to inform service planning with accurate up to date information. All planning and decision-making will be consistent with government policy and priorities and will be in accord with the DHB Accountability Framework.

We recognise our responsibilities for emergency planning and management and maintain our own major incident plans as well as participating with emergency management agencies to contribute to district and regional plans. We will continue to support other health and disability service providers to develop appropriate plans that are integrated with our own.

The principle aims of service contracting will be to achieve effective service for the community and best use of public funding. We will however be cognisant of the need to have quality providers who are financially viable. We are committed to processes which are fair to existing providers but will not discourage the entry of new providers to the market if this is in the best interests of the community. We will maintain regular monitoring and auditing of all providers with whom we establish service contracts

We will have been successful if:

- Regular external audits of our organisation report effective systems are in place to manage our business risks.

10 FINANCIAL SUMMARY

NMDHB has three divisions and following are high level prospective financial statements. Also included are the consolidated prospective financial statements. The three divisions are Funding, Governance and Administration, and the Provider Division.

Assumptions for each division are documented. These assumptions make no provision for a number of items such as new programmes funded by the MOH, impacts of future pay jolts, impacts of future property revaluations. These items also become risks to the DHB in the future years.

10.1 Prospective Statement Of Financial Performance

FUND DIVISION

FINANCIAL PERFORMANCE	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
FUNDER DIVISION	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Revenue										
Own Population	247,114	255,709	263,272	276,243	289,541	303,511	318,188	333,608	349,811	366,838
IRD Revenue/Inflows	3,267	3,353	3,454	3,627	3,808	3,998	4,198	4,408	4,629	4,860
Total Revenue	250,381	259,062	266,726	279,869	293,349	307,510	322,387	338,017	354,440	371,698
Expenditure (Inclusive of IDFs)										
Personal Health										
Primary Care	12,635	12,440	12,815	13,302	13,807	14,332	14,877	15,442	16,029	16,638
Referred Services	31,875	34,084	35,059	36,286	37,556	38,871	40,231	41,639	43,096	44,605
Other	133,230	136,092	140,000	147,319	155,033	163,163	171,734	180,769	190,294	200,336
Total Personal Health	177,740	182,616	187,874	196,907	206,396	216,366	226,842	237,850	249,419	261,579
Total DSS (Health of Older People)	38,422	40,807	41,934	44,007	46,185	48,472	50,876	53,401	56,055	58,843
Total Mental Health	28,105	31,029	31,689	33,280	34,952	36,708	38,554	40,495	42,535	44,679
Total Maori Health	2,098	2,120	2,228	2,314	2,405	2,500	2,599	2,702	2,809	2,920
Total Other	3,036	2,848	2,868	2,928	3,012	3,095	3,177	3,257	3,336	3,415
Total Expenditure	249,401	259,420	266,593	279,436	292,950	307,142	322,049	337,706	354,154	371,435
NET RESULT SURPLUS/(DEFICIT)	980	(358)	132	433	400	368	338	311	286	263

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Assumptions

- Population growth rate - 1.8% to 2.0%
- Future funding track - 3.0% to 3.3%
- Inpatient and day-patient growth - 2.0%
- Capital charge calculated at 8%
- DSS (Health of Older People) growth assumed to be the same as personal health given older people will impact in both service areas.
- No assumption included for the following issues:
- Additional primary sector revenue for PHO enrolled populations,
- Effects of future revaluations,
- Any future pay jolts for employment groups.

The Fund is not allowed to go into deficit, however it is planned to have a deficit in 2005 to 2007 to use equity built up in prior years. This is predominantly in Mental Health services, which is subject to a ring-fenced amount of revenue, this allows past surplus funds held in equity to be spent on health services.

PROVIDER DIVISION

FINANCIAL PERFORMANCE	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
PROVIDER DIVISION	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Revenue										
External (eg: interest/MOH contracts)	29,463	30,109	33,988	32,122	32,925	33,748	34,592	35,457	36,343	37,252
Internal (DHB Fund to DHB Provider)	132,367	134,528	138,158	145,849	153,975	162,560	171,631	181,215	191,342	202,043
Interprovider Revenue (other DHBs)	816	1,184	1,213	1,244	1,275	1,307	1,339	1,373	1,407	1,442
Internal revenue (Gov Admin to Provider)	306	320	335	345	355	366	377	388	400	412
Total Revenue	162,952	166,141	173,694	179,560	188,530	197,981	207,939	218,433	229,493	241,149
Expenditure										
Personnel Costs	104,646	108,713	111,730	117,135	124,508	132,729	141,260	150,346	160,026	170,337
Outsourced Services	5,011	4,656	4,772	4,817	4,962	5,185	5,341	5,501	5,666	5,861
Clinical Supplies	22,756	22,916	23,708	24,653	25,402	26,458	27,107	27,723	28,170	28,745
Infrastructure and Non-clinical Supplies	29,065	29,081	34,085	32,280	32,894	32,581	33,751	34,317	35,141	35,853

Total Expenditure	161,478	165,365	174,295	178,885	187,766	196,953	207,458	217,887	229,003	240,797
NET RESULT (Surplus)/Deficit	1,474	776	(601)	675	764	1,029	482	546	490	352

The Provider Division has a prospective forecast of continued breakeven results. This is achieved while undertaking the planning capital expenditure plan.

Assumptions

- Internal revenue from Fund
 - Demographic Growth - 2%
 - Future funding track - 3.0% to 3.3%
- Other revenue - 2.5%
- Employee Costs, including:
 - inflation and incremental increases - 4.0% to 5.6%
 - FTEs - increases across all employment groups to deliver increased volumes in line with demographic growth.
- Outsourced services - 2.5% to 4.5%
- Clinical supplies - 2.5% to 4.5%
- Capital charge rate - 8%
- Interest Rates - 6.5% to 7%

GOVERNANCE AND ADMINISTRATION

FINANCIAL PERFORMANCE	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Governance and Admin	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Revenue										
Internal (DHB Fund to DHB Provider)	2,884	2,848	2,868	2,928	3,012	3,095	3,177	3,257	3,336	3,415
Total Revenue	2,884	2,848	2,868	2,928	3,012	3,095	3,177	3,257	3,336	3,415
Expenditure										
Expenditure	2,884	2,848	2,868	2,928	3,012	3,095	3,177	3,257	3,336	3,415
Net Result Governance & Admin	0	0	0	0	0	0	0	0	0	0

This small division includes the planning and funding staff, the Board and advisory committee costs. The Corporate functions of NMDHB are included in the provider. It is the intention to move the Corporate functions and cost to the Governance division in the near future.

NMDHB CONSOLIDATED PROSPECTIVE FINANCIAL PERFORMANCE

The consolidated prospective financial statements are the sum of the three divisions above.

FINANCIAL PERFORMANCE	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Consolidated	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Revenue										
Revenue	280,660	290,311	301,928	313,235	327,550	342,565	358,318	374,847	392,191	410,392
Expenditure										
Expenditure	277,523	290,110	302,554	312,271	326,519	341,292	357,612	374,093	391,510	409,865
Net Consolidated Result	3,137	246	(626)	964	1,030	1,273	706	753	680	528

10.2 NMDHB Consolidated Statement of Financial Position

The high level prospective financial position is set out below:

FINANCIAL POSITION	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
DHB CONSOLIDATION	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Current Assets	28,009	16,298	8,299	7,852	10,653	11,204	11,829	13,038	14,521	15,303
Non Current Assets	87,745	101,812	118,517	124,576	118,582	114,118	110,564	106,476	106,455	102,513
Total Assets	115,754	118,110	126,816	132,428	129,235	125,322	122,393	119,514	120,976	117,816
Current Liabilities	(28,540)	(30,131)	(30,920)	(30,484)	(30,121)	(30,734)	(31,331)	(31,861)	(32,730)	(33,050)
Non Current Liabilities	(45,623)	(46,142)	(54,685)	(59,769)	(55,909)	(50,110)	(45,877)	(41,715)	(41,628)	(37,620)
Total Liabilities	(74,163)	(76,273)	(85,605)	(90,253)	(86,030)	(80,844)	(77,208)	(73,576)	(74,358)	(70,670)
Equity	(41,591)	(41,837)	(41,211)	(42,175)	(43,205)	(44,478)	(45,185)	(45,938)	(46,618)	(47,146)
Total Liabilities + Equity	(115,754)	(118,110)	(126,816)	(132,428)	(129,235)	(125,322)	(122,393)	(119,514)	(120,976)	(117,816)

Assumptions

- NMDHB continues to breakeven.
- Capital programme as set out in this strategic plan.
- Additional \$12.5m in loans drawn between 2007/08 and 2008/09. This is related to the Wairau hospital redevelopment.
- Repayment of loans commences in 2009/10
- No additional equity.
- Vehicles continue to be leased. NMDHB will work with the Crown Health Financial Agency to look at alternative financing arrangements, that may include ownership.

10.3 NMDHB Consolidated Cashflow

The high level consolidated prospective cashflow is as follows:

<u>CASH FLOWS - INFLOW/(OUTFLOW)</u>	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Cash (Opening)	12,991	20,171	8,316	259	(249)	2,490	2,978	3,539	4,681	6,097
Net Cash flow from Operating	12,396	9,286	7,094	11,738	12,106	12,378	11,895	12,172	12,124	12,004
Net Cash flow from Investing	(6,063)	(21,142)	(23,151)	(16,746)	(4,866)	(5,390)	(6,334)	(6,029)	(9,708)	(6,292)
Net Cash flow from Financing	847		8,000	4,500	(4,500)	(6,500)	(5,000)	(5,000)	(1,000)	(5,000)
<u>Cash (Closing)</u>	20,171	8,316	259	(249)	2,490	2,978	3,539	4,681	6,097	6,810

NMDHB maintains separate bank accounts for the Fund and the Provider. The Funder has built up significant cash reserves due to the timing of the provider payments, receiving revenue in advance and running past surpluses. The Provider has an overdraft limit of \$8.0m, which is usually fully drawn at some point of each month. The bank accounts are under a set-off arrangement.

Work will be completed on a Treasury policy, which will include a policy of maintaining two accounts vs one and rules around the Provider borrowing from the Fund.

10.4 Capital Base

NMDHB has developed an Asset Management Plan in order to maintain the capital base of the DHB in order to deliver quality health outputs and outcomes. The table below demonstrates the movements in the non-current asset base of the DHB.

TOTAL NON CURRENT ASSETS	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Opening Balance	88,877	87,742	101,812	118,517	124,576	118,582	114,118	110,564	106,476	106,455
Asset purchases and investments	9,500	22,221	28,079	15,853	4,000	5,500	6,400	6,000	10,000	6,000
Depreciation	(8,048)	(8,047)	(10,046)	(9,793)	(9,996)	(9,963)	(9,953)	(10,088)	(10,021)	(9,941)
Revaluations										
Sale of assets and investments	(2,587)	(106)	(1,328)	-	-	-	-	-	-	-
Closing Balance	87,742	101,812	118,517	124,576	118,582	114,118	110,564	106,476	106,455	102,513

The non-current assets are based on the following assumptions:

Buildings

- Murchison rebuild 2005/07
- Braemar refit 2005/07
- Mental Health, Nelson 2005/06
- Wairau Redevelopment 2006/09
- PMS 2006/08
- Nelson Surgical Wards 2007/08
- Alexandra Hospital refit 2008/09
- MRI 2008/09
- Boiler Nelson 2010/11
- Nelson refit 2013/14

Clinical Equipment

- Radiology Wairau 2006/07
- Cardio Angiography 2006/07
- Minor equipment \$2.0m annually, increasing to \$3.0m 2008/09
- IT/IS \$2.0m annually, increasing to \$3.0m 2009/10

In 2009/10 the expenditure on capital reduces below depreciation to enable the repayment of loans. This will ensure the DHB has the capacity to borrow funds at a later date for any major capital project.

Assumptions:

- No assumption has been made for:
 - Changes to services with integration of primary and secondary
 - Future pay jolts for employees
 - Revaluation of assets.
- IDSS is assumed to continue to be provided by NMDHB.
- Changes in Golden Bay and possible need to rebuild or change the facilities have not been included.
- Repayment of debt.
- No restructure of equity (repayment) that may be required.

Appendix 1 - District Health Board Objectives

Every DHB has the following statutory objectives.

- (a) to improve, promote, and protect the health of people and communities:
- (b) to promote the integration of health services, especially primary and secondary health services:
- (c) to promote effective care or support for those in need of personal health services or disability support services:
- (d) to promote the inclusion and participation in society and independence of people with disabilities:
- (e) to reduce health disparities by improving health outcomes for Māori and other population groups:
- (f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:
- (g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:
- (h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:
- (i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:
- (j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:
- (k) to be a good employer.

Appendix 2 – Population Health Objectives

The 13 priority population health objectives listed in the NZ Health Strategy are as follows:

1. Reducing smoking.
2. Improving nutrition.
3. Reducing obesity.
4. Increasing the level of physical activity.
5. Reducing the rate of suicides and suicide attempts.
6. Minimising harm caused by alcohol and illicit and other drug use to individuals and the community.
7. Reducing the incidence and impact of cancer.
8. Reducing the incidence and impact of cardiovascular disease.
9. Reducing the incidence and impact of diabetes.
10. Improving oral health.
11. Reducing violence in interpersonal relationships, families, schools and communities.
12. Improving the health status of people with severe mental illness.
13. Ensuring access to appropriate child health care services including well child and family health care and immunisation.

Appendix 3 – Summary Of Proposed Achievements

ST = Short Term, 1-3 years

MT = Medium Term, 3-6 years

LT = Long Term, 6-10+ years

OUTCOME 1: THE HEALTH AND WELLBEING OF THE PEOPLE OF NELSON MARLBOROUGH IS IMPROVED AND, IN PARTICULAR, HEALTH INEQUALITIES FOR MĀORI, AND OTHER POPULATION GROUPS ARE REDUCED			
STRATEGIES	Measures of Success	Current Status	Goal
Reduce health inequalities	<ul style="list-style-type: none"> There is an increase in the number of Maori enrolled in the PHOs Maori and people from lower socio-economic groups in PHOs use primary care at the same rate as the general population 	Baseline information to be confirmed for 2004/05 and 2005/06	Increase in the medium term
Improve nutrition and physical activity	<ul style="list-style-type: none"> There is increased awareness of the importance of healthy eating and more people are eating the recommended 5+ fruit and vegetables per day. 	<p>Nelson Marlborough adults eating 5+ fruit and vegetables per day (age standardised rates from the NZ Health Survey 2002/03):</p> <ul style="list-style-type: none"> Maori = 33.7% Non-Maori = 42.6% Total = 42.0% 	Increase rates in the medium term
	<ul style="list-style-type: none"> The percentage of breast fed babies is increasing. 	<p>NM's breastfeeding rates (either exclusively or fully breastfed) for the period July 2003 to June 2004 (HNA 2004)</p> <p>At 6 weeks:</p> <ul style="list-style-type: none"> Māori 66%, (NZ = 61%) European/Other 71% (NZ = 71%) Total 71% (NZ = 68%). <p>At 3 months:</p> <ul style="list-style-type: none"> Māori 52%, (NZ = 46%) European/Other 62% (NZ = 60%) Total 60% (NZ = 55%). <p>A 6 months:</p> <ul style="list-style-type: none"> Māori 22%, (NZ = 17%) European/Other 32% (NZ = 27%) Total 31% (NZ = 24%). 	<ol style="list-style-type: none"> increase breastfeeding (exclusive/fully) rate at 6 weeks to 75% by 2010 and maintain in the longer term increase breastfeeding (exclusive/fully) rate at 3 months to 65% by 2010 and maintain in the longer term. stabilise breastfeeding (exclusive/fully) at 6 months at 31%.

	<ul style="list-style-type: none"> There are fewer obese people in our community. 	<p>NZ Health Survey reports 17.8% of NM adults are obese compared to 20.1% for NZ overall. Estimated % of children 5-14 years in NM who are obese is 7.1% compared to 9.8% for NZ overall (HNA 2004)</p>	<p>To maintain obesity rates in Nelson Marlborough at lower than the national average. To stabilise obesity rates at 17.8% for adults and 7.1% for children in the long term.</p>
	<ul style="list-style-type: none"> More people are taking the opportunity to be regularly physically active. 	<p>The proportion of people who are “regularly physically active” (that is, having 30 minutes of moderate physical activity on 5 or more days per week) is 51.4% (NZ = 52.5%). (NZ Health Survey 2002/03, NM data)</p>	<p>Be the same as the national average in the short term and improve our position relative to the national average in the long term.</p>
Reduce smoking and the harm from second-hand smoke	<ul style="list-style-type: none"> Statistics show a reduction in the rate of smoking locally, particularly for young people and Māori. 	<p>The percentage of the population who smoke: Total population: average smoking rates for adults was 22.7% (1996 Census:) Maori: average smoking rates 34% (1996 Census) Non-Maori 21.7% (1996 Census) Young people: % of year 10 students smoking 17.65 (ASH survey 2003)</p>	<p>Reduce smoking rates by 2 percentage points for all these groups by 2011 and a further 2 percentage points by 2016.</p>
	<ul style="list-style-type: none"> There is a measurable reduction in the number of NMDHB staff who smoke. 	<p>Establish baseline data.</p>	<p>Continue to offer smoking cessation support for staff.</p>
Improve oral health	<ul style="list-style-type: none"> The community makes an informed decision on whether or not to supplement the fluoride levels of its water supplies. 		<p>Medium term.</p>
	<ul style="list-style-type: none"> Eighty percent (90%) of adolescents transfer from the School Dental Service to the Adolescent services each year. 	<p>Transfer rates of adolescents have improved, since the appointment of adolescent oral health co-ordinators, from 72% in 2001 to over 90% in 2004.</p>	<p>Maintain transfer rates at 80% or higher.</p>
	<ul style="list-style-type: none"> There is an increase in the proportion of adolescents who complete treatment 	<p>The treatment completion rate in 2004 was about 53%.</p>	<p>Increase treatment completion rates in the medium and long term.</p>
	<ul style="list-style-type: none"> There is an increase in the percentage of 5-year-olds who are caries-free. 	<p>The percentage of children “caries free” (that is having no tooth decay) at age five years. (2002: total 50%) (2003: total 52%) (2004: total 56%)</p>	<p>The percentage of children “caries free” at age five years is stabilised at 56% in the short term and increased in the long term.</p>

<p>Reduce the incidence and impact of diabetes</p>	<ul style="list-style-type: none"> There is an increase in the number and proportion of people with diabetes who are accessing free annual checks. 	<p>Diabetes detection and follow-up rates (expressed as a proportion of the expected number of people who have diabetes, as calculated by the Ministry of Health.) achieved are:</p> <ul style="list-style-type: none"> 2002: Maori 31.2%; Pacific 45.3%; total 65.3%) 2003: Maori 36%; Pacific 56%; total 64%) 2004: Maori 29%; Pacific 106%; total 65%) 	<p>To increase detection and follow-up rates for the total population by 2% per annum on the actual rates of the previous year and stabilise at 77% from 2010. To improve Maori rates relative to the total in the medium term.</p>
	<ul style="list-style-type: none"> An increasing number of people with diabetes are diagnosed as a result of screening, and are well supported by education and treatment services. 	<p>No routine CVD risk assessment and reporting as yet. This is planned for 2006. Obesity and smoking rates amongst patients receiving diabetes reviews have not declined over the period 2002-05 and retinal screening rates are lower amongst diabetes patients who reside in rural areas. For 2004:</p> <ul style="list-style-type: none"> HBA1c\leq8 75.3% Obesity = 43% Tobacco smoking = 12% Retinal screening within 2 years: Nelson urban =68%, Nelson rural = 66%; Marlborough urban = 72%, Marl rural = 54% 	<p>Monitor the number of cases of diabetes who are detected through CVD screening.</p> <p>Improved clinical control rates are achieved for patients with diabetes in the medium term:</p> <ul style="list-style-type: none"> HBA1c\leq8 = 80% Obesity = 40% Tobacco smoking = 10% Retinal screening rates improve for rural residents to be equal to rates for the total population of diabetes patients.
	<ul style="list-style-type: none"> There are fewer diabetes-related hospital admissions, complications and deaths. 	<p>For admissions where the primary reason for admission was either diabetes or one of the recognised complications of diabetes:</p> <ul style="list-style-type: none"> 2003-04: 446 admissions involving 341 people and 1756 admission days plus 97 day-stays 2004/05: 445 admissions of 333 people, 2242 admission days plus 102 day-stays. 	<p>Reduce the number of admissions and number of days in hospital in the long term.</p>
<p>Reduce cardiovascular disease</p>	<ul style="list-style-type: none"> An increasing proportion of people have had their CVD risk factors assessed each year. 	<p>No routine CVD risk assessment and reporting as yet.</p>	<p>All general practices have formal CVD risk assessment-recording capabilities by June 2006.</p>

			<p>Progressively work towards achieving the target of 100% of those with risk > 15% have a documented care plan by June 2009.</p> <p>In the medium term, General practices are identifying and reporting the % of their enrolled populations in the target groups who have had CVD risk assessment within 5 years.</p>
	<ul style="list-style-type: none"> The proportion of the population who are affected by a stroke or a heart attack is reducing. 	<p>From HNA: Age-standardised self-reported heart disease prevalence rates, NM 2002-2003 Maori: males – 11.8%; female 6.3% Non-Maori: males 8.7%; females 7.4% Total: males 8.9%; females 7.4%</p> <p>Age-standardised stroke prevalence rates in NM 2002-2003: Maori: numbers too small to calculate Non-Maori: males 1.7%; females 0.9% Total: males 1.7%; females 1.0%</p>	Reduced rates in the long term.
Reduce the incidence and impact of cancer	<ul style="list-style-type: none"> More people are eating a healthy diet, having regular physical activity and protecting themselves from the harmful effects of tobacco and the sun. 	<p>Melanoma registrations in NM per 100,000 population for 2000-2001:</p> <ul style="list-style-type: none"> Male = 41 Female = 46 	<p>Nutrition, physical activity and smoking targets as above.</p> <p>Reduced melanoma registration rates in the long term.</p>
	<ul style="list-style-type: none"> Waiting times, for access to treatment for cancer, reduce. 		Waiting times for treatment are reduced.
	<ul style="list-style-type: none"> Rates of enrolment in proven early detection programmes increase. 	<p>Cervical Screening: Rates of enrolment no longer going to be used but using:</p> <ul style="list-style-type: none"> rates of coverage (women who enrolled on the register and have a smear recorded during the previous 3 years), currently 73.3% at July 2005 rates of participation (enrolled women 20-69 years who have had a 	<p>Cervical Screening: 80% coverage by 2010</p> <p>Participation 90% by 2010</p>

		smear recorded in previous 6 years), currently 84.5% at July 2005	Breast screening: Nelson Marlborough reaches the national target of 70% of target population being enrolled by 2010.
	<ul style="list-style-type: none"> Families whose loved ones are dying feel adequately supported. 		Patient satisfaction survey results to be monitored.
Improve the health of children and youth	<ul style="list-style-type: none"> The differences in health outcomes between ethnic groups are reduced. 	<p>Monitor:</p> <ul style="list-style-type: none"> Low birth weight Breastfeeding rates Hearing failure rates Oral health Sexual health indicators 	Differences between Maori and non-Maori outcomes on key child health measures are reduced in the long term.
	<ul style="list-style-type: none"> The incidence and impact of family violence are reduced. 		<p>Notifications to Child Youth and Family:</p> <ul style="list-style-type: none"> Increase in the short term Stabilise or reduce in the long term.
	<ul style="list-style-type: none"> Avoidable hospital admissions and deaths of children and youth are reduced. 	<p>Mortality From HNA: Total deaths, NM, 0-24 years: 1996/97: Maori 12; non-M = 42 1998/99: Maori 5; non-M = 49 2000/01: Maori 8; non-M = 49 2002/03: Maori 12; non-M = 42</p> <p>From HNA: Death rates per 1000, NM, 0-24 years: 1996/97: Maori 1.12; non-M = 0.64 1998/99: Maori 0.46; non-M = 0.76 2000/01: Maori 0.74; non-M = 0.76 2002/03: Maori 1.12; non-M = 0.64</p>	<p>Baseline data and monitoring processes are confirmed in the short term.</p> <p>Avoidable hospital admissions and deaths of children and youth are reduced in the long term.</p>
	<ul style="list-style-type: none"> There is a reduced incidence of teenage pregnancy and sexually transmitted infections. 	<p>Total number of teenage births NM</p> <p>1999: 72 2000: 80 2001: 74 2002: 96</p> <p>If termination rates in Nelson Marlborough DHB are similar to the New Zealand average however, then for every teenage birth in Nelson Marlborough DHB during 2002 there was also one corresponding therapeutic abortion.</p>	<p>Baseline data and monitoring processes are confirmed in the short term.</p> <p>Reduced incidence of teenage pregnancy and sexually transmitted infections in the long term.</p>

Improve the health of older people	<ul style="list-style-type: none"> The average age at which the population needs to access formal support services is increasing. 		Baseline data and monitoring processes are confirmed in the short term. The average age at which the population needs to access formal support increases in the medium term.
	<ul style="list-style-type: none"> A greater proportion of those needing support receive it in their own homes. 	2004/05 – no. of people 65+ receiving care: Residential (resthme, dementia, hospital, psychoger) – 1154 = 6% Home-based (home support, carer support, day and respite) – 4500 = 23% Home-based = 78.7% of the total number receiving care.	Increase the proportion receiving home-based support services in the short-medium term.
	<ul style="list-style-type: none"> A greater range of residential and community support services are available. 		A greater range of supported living options is available in the short term.
	<ul style="list-style-type: none"> Improved retention and optimal numbers of staff with appropriate qualifications working in the sector. 		Staff turnover reduces and the percentage of staff with no relevant qualifications reduces in the medium to long term.
	<ul style="list-style-type: none"> The community is satisfied with the level of rehabilitation an older person can access. 		Consumer satisfaction survey results demonstrate satisfaction.
Improve Māori health	<ul style="list-style-type: none"> We have in place a current profile of Māori health for Te Tau Ihu. 		Each Health Needs Assessment includes current Maori health information.
	<ul style="list-style-type: none"> All contracted providers are reporting the ethnicity of service users. 		Medium term
	<ul style="list-style-type: none"> Increased numbers of Māori are accessing services. 		Medium term
	<ul style="list-style-type: none"> There is an increased number of Māori working in the health services. 		Medium term
	<ul style="list-style-type: none"> Māori report positively on the responsiveness of mainstream services. 		Consumer satisfaction survey results demonstrate satisfaction.
	<ul style="list-style-type: none"> The difference in life expectancy between Māori and non-Māori is significantly reduced. 	Life Expectancy at birth NM, 2004 Maori: males 73.5; females 78.2 Total population: males 76.1; females 81.3	Reduction in the difference in life expectancy in the long term

Increase independence for people with life-long disability	<ul style="list-style-type: none"> • People with a life-long disability are able to actively participate in all aspects of society. 		Consumer surveys report decreasing barriers to participation in the medium term.
	<ul style="list-style-type: none"> • Effective case management is in place for children who have a significant disability. 		Short term
	<ul style="list-style-type: none"> • There are improved residential options available in our district for people who have a life-long disability. 		Medium term
Improve mental health	<ul style="list-style-type: none"> • Service users are respected, and have the same opportunities to fully participate in the everyday life of their communities and whānau. 		Consumer satisfaction survey results demonstrate satisfaction.
	<ul style="list-style-type: none"> • Mental health services have a strong and demonstrated focus on service users leading their own recovery. 		The recovery model is intrinsic to all aspects of services in the medium term.
	<ul style="list-style-type: none"> • Mental health services are available that meet the needs of service users and their families. 		The range of service options is in line with the national guidelines in the medium to long term.
	<ul style="list-style-type: none"> • Access improves and is co-ordinated with other key agencies. 		There is an increasing % of people with severe mental illness accessing services.
	<ul style="list-style-type: none"> • There are fewer people accessing secondary services in crisis. 		Medium term

OUTCOME 2: MANAWHENUA IWI WORK IN PARTNERSHIP WITH THE BOARD AND MĀORI PARTICIPATE IN DECISIONS AFFECTING THEIR HEALTH, WELLBEING AND INDEPENDENCE			
STRATEGIES	Measures of Success	Current Status	Goal
Work in partnership and encourage participation of Māori	<ul style="list-style-type: none"> • Advice from Māori is evident in Board decisions affecting Māori. 	There is a Memorandum of Agreement with outlines the formal participation.	Participation continues to be in line with the MOA with iwi.
	<ul style="list-style-type: none"> • Māori report positively on the responsiveness of mainstream services. 		As above.
	<ul style="list-style-type: none"> • There is a network of effective sustainable Māori Health providers. 		Maintain appropriate services.
	<ul style="list-style-type: none"> • The health services are making a measurable contribution to the social and economic development of Māori across the district. 		Increasing investment in intersectoral projects affecting Maori.

	<ul style="list-style-type: none"> NMDHB's Māori Health Strategy has currency and there is evidence of its ongoing implementation. 		Ongoing.
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OUTCOME 3: THE COMMUNITY HAS FAIR ACCESS TO A RANGE AND LEVEL OF WELL-INTEGRATED SERVICES APPROPRIATE FOR ITS SIZE, LOCATION AND COMPOSITION.

STRATEGIES	Measures of Success	Current Status	Goal
Prioritising access to services	<ul style="list-style-type: none"> There is evidence of an up to date profile of the community's health priorities. 		Health Needs assessment reviewed 3 yearly.
	<ul style="list-style-type: none"> All significant prioritisation decisions are transparent to the community. 	Prioritisation policy in place.	Decisions made in open Board meetings in line with Board's policy.
	<ul style="list-style-type: none"> The community understands the need for and supports the prioritisation decisions. 		Infrequent adverse publicity relating to service access.
	<ul style="list-style-type: none"> The community recognises the need to make long-term investments in health promotion, and supports reducing the proportion of the DHB's funding invested in specialist services in favour of primary and community-based services. 		The majority of submissions to the DSP support the Board's direction – 3 yearly.
	<ul style="list-style-type: none"> The urban/rural access to service is in balance and is fair and reasonable. 		Infrequent adverse publicity and complaints relating to service access.
Improving integration of services	<ul style="list-style-type: none"> Health providers across the continuum are active participants in a range of health promotion programmes. 		Medium term.
	<ul style="list-style-type: none"> Population health approaches are in evidence in primary and secondary services. 		Medium term.
	<ul style="list-style-type: none"> There is demonstrable links between primary and secondary services to improve patient flow across the services. 		Short term.
	<ul style="list-style-type: none"> Integrated models of primary care are operating in the minor urban and rural areas. 		Medium term.

Access to primary care	<ul style="list-style-type: none"> There is an increase in the number of Māori enrolled in the PHOs. 		Medium term
	<ul style="list-style-type: none"> Fewer people report reluctance to go to the GP because of cost and other barriers. 	<p>NCC Residents Survey 2003: 22% of people had not been to the doctor in the last 12 months; 70% of these gave cost alone as the reason for staying away, or that their symptoms did not justify the cost.</p> <p>MDC Residents Survey 2005: 16% of residents felt that, in the preceding 12 months, there had been a time where a member of the household had wanted to visit a doctor but had not, with 70% of these specifying cost as the reason or that their symptoms did not justify the cost. (NZ 2005 – 21% reported barriers with 61% quoting cost)</p>	Short to medium term.
	<ul style="list-style-type: none"> A high number of eligible people are enrolled in new programmes. 		<p>DAP target: 50% uptake of CarePlus (by eligible people) by June 2006</p> <p>For outyears: 55% by June 2007 60% by June 2008</p>
	<ul style="list-style-type: none"> Demand on secondary, specialist services is reducing relative to population growth, e.g. avoidable admissions to hospital are decreasing as a proportion of total admissions to hospital. 	<p>HNA 2001: For 1997/98, avoidable hospitalisations made up 30% of all hospitalisations in NZ. For NM, between 1996 and 2000 there were 19,024 avoidable hospitalisations, representing 28.9% of the total number of hospitalisations.</p>	<p>Baseline data and monitoring processes are confirmed in the short term.</p> <p>Avoidable hospital admissions are reduced in the long term.</p>
	<ul style="list-style-type: none"> Models of care are developed to deal with workforce shortages. 		Short to medium term.
	<ul style="list-style-type: none"> Models of care reflect optimal teamwork with effective communication and collaboration between providers. 		Short to medium term.
	<ul style="list-style-type: none"> More providers are within the PHO. 		Medium term.

Access to specialist services	<ul style="list-style-type: none"> People with the greatest need and ability to benefit are offered treatment first. 		Ongoing.
	<ul style="list-style-type: none"> Local specialist services are well integrated with primary and specialist tertiary services. 		Ongoing.
	<ul style="list-style-type: none"> People indicate that the services we provide are of a high standard. 	Patient satisfaction rating (Moving Annual Total of patients ranking service good or very good, for y.e. 30 June 2005): Inpatients = 94% Outpatients = 94%	From SOI: Maintain Patient Overall Satisfaction at >90%.
	<ul style="list-style-type: none"> We complete all the work we are contracted to provide. 	Performance to contract: 2003/04 average per qtr 99.8%; 2004/05 ave pr qtr 98.3%	From SOI: Performance to contract is within 5% of 100% per quarter ²⁰
	<ul style="list-style-type: none"> We live within our funding. 	2003/04 NMDHB net result = \$1, 412, 000 deficit; Funding net result = \$1,704,000 surplus 2004/05 NMDHB net result= \$2,144,000 surplus; Funding net result = \$2,144,000 surplus	2005/06 NMDHB net result = \$302,000 deficit 2006/07 NMDHB net result = \$116, 000 surplus 2007/08 NMDHB net result = \$511,000 deficit 2008/09 NMDHB net result = \$1,129,000 surplus
	<ul style="list-style-type: none"> The government targets for elective services are being achieved. 		<p>In the short term achieve government targets of:</p> <ul style="list-style-type: none"> Referrals accepted for specialist assessment are seen within 6 months. 100 percent of people in active review receive a clinical review of their condition and eligibility for publicly funded treatment at least every six months. 100% of those offered publicly funded treatment do not wait longer than 6 months. <p>Maintain government targets in the long term.</p>

²⁰ **Performance to Contract** = Total dollar value of actual outputs for all contract types produced during the quarter ÷ Total dollar value of contracted outputs, during the quarter, expressed as a percentage.

	<ul style="list-style-type: none"> We maintain specialist services appropriate to our population and location. 		Purchasing reflects need – ongoing.
Access for rural communities	<ul style="list-style-type: none"> Minor urban and rural communities recognise and accept the need to prioritise the locally available services. 		Infrequent adverse publicity and complaints relating to service access.
	<ul style="list-style-type: none"> Integrated models of primary and community care are operating in the minor urban and rural areas. 		Medium term.
	<ul style="list-style-type: none"> Specialist services provided to rural people are well organised and co-ordinated to minimise the inconvenience experienced by the person. 		Consumer satisfaction survey results demonstrate satisfaction.

OUTCOME 4: THE EFFECTIVENESS OF SERVICES ACROSS THE SECTOR ARE ENHANCED THROUGH A STRONG QUALITY IMPROVEMENT CULTURE AND MANAGEMENT OF CLINICAL RISK			
STRATEGIES	Measures of Success	Current Status	Goal
Improve the use of quality-enhancing systems	Relevant certification and/or accreditation outcomes are achieved.	NMDHB is a certified provider under Health and Disability Standards. (Ministry of Health). NMDHB has also achieved accreditation through Quality Health and a range of service specific requirements. As a funder, we support all providers to achieve the relevant standards.	Ongoing.
Value, retain and develop staff	<ul style="list-style-type: none"> Nelson Marlborough is seen as the district of choice by health workers 		Timely appointment to vacancies. Acceptable staff turnover.
	<ul style="list-style-type: none"> The workforce reflects the community it serves and adjusts to community need through implementing different delivery models. 		Improving baseline data in the short term In the medium term, there is an appropriate balance of age, ethnicity and gender in the workforce.
	<ul style="list-style-type: none"> Our contribution to regional and national workforce development initiatives is evident. 		Ongoing.
Maintain facilities	<ul style="list-style-type: none"> Services are provided from facilities which are “environmentally friendly” and fit for purpose. 		Ongoing.

Ensure safety and currency of equipment	<ul style="list-style-type: none"> We have the appropriate assets and they are well managed. 		Ongoing.
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OUTCOME 5: FINANCIAL AND BUSINESS RISKS ARE MANAGED AND DECISIONS MADE BASED ON GOOD INFORMATION AND ROBUST BUSINESS PRACTICE

STRATEGIES	Measures of Success	Current Status	Goal
Develop information management and technology	<ul style="list-style-type: none"> The right information is available to the right people at the right time. 		Short term – implementing a range of new information systems. Long term – users report satisfaction.
	<ul style="list-style-type: none"> Patient care is enhanced through the availability of health information across primary and secondary care. 		Short term – systems development. Medium term – integrated information./
	<ul style="list-style-type: none"> Efficiencies are achieved through the use of information technology. 		Increased productivity in the medium term.
Manage our finances	<ul style="list-style-type: none"> We provide services with a breakeven or surplus financial result. 		2005/06 NMDHB net result = \$302,000 deficit 2006/07 NMDHB net result = \$116, 000 surplus 2007/08 NMDHB net result = \$511,000 deficit 2008/09 NMDHB net result = \$1,129,000 surplus
Sound business processes and risk management	<ul style="list-style-type: none"> Regular external audits of our organisation report effective systems are in place to manage our business risks. 		Ongoing.