NELSON MARLBOROUGH DISTRICT HEALTH BOARD

Annual Plan

Incorporating Statement of Intent and Statement of Performance Expectations

2015-16

Our Vision

"Towards Healthy Families"

Our Mission

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

Our Values

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

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

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

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

Nelson Marlborough District Health Board (NMDHB) Annual Plan & Statement of Intent

Produced June 2015
Pursuant to Section 38 of the New Zealand Public Health and Disability Act 2000; Section 139 of the Crown Entities Act 2004; Section 49 of the Crown Entities Amendment Act 2013; New CE Act s149C.

Nelson Marlborough District Health Board, Private Bag 18, Nelson

Office of Hon Dr Jonathan Coleman
Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

16 OCT 2015

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

Dear Mrs Black

Nelson Marlborough District Health Board 2015/16 Annual Plan

This letter is to advise you I have approved and signed Nelson Marlborough District Health Board's (DHB's) 2015/16 Annual Plan for three years.

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

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2015, Vote Health received an additional $1.7 billion in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, a refresh of the New Zealand Health Strategy is currently under way. The Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for the next three to five years for delivery of health services to New Zealanders. Thank you for your involvement to date and your continued input into the refresh.

Living Within our Means
The Government is determined to reach surplus in 2015/16. To assist with this, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning a surplus for 2015/16 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2015/16.

Health Shared Services Programme
DHBs have committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to include cost and benefit impacts for the Finance Procurement and Supply Chain Initiative in Annual Plans where these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

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

With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

National Health Targets

Your Annual Plan provides a good range of actions that I am confident will support strong health target performance when implemented in 2015/16. However, your recent results show a need for improvement in relation to the Faster Cancer Treatment and Increased Immunisation health targets. Please ensure all health target actions identified in your Annual Plan are fully implemented to help you to continue to deliver better outcomes for your population.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator became the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. I am concerned that the pace of progress needs to improve if the 85 percent target is to be achieved by July 2016. Please ensure delivery of this target remains a key priority for your teams.

System Integration

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2015/16. Shifting services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Nelson Marlborough DHB intends to maintain primary care access to radiology, and to strengthen integration in 2015/16 by:

- shifting spirometry services through the development of a clinical pathway for Chronic Obstructive Pulmonary Disease with St John and primary care by quarter three
- developing and implementing a community pain programme by quarter three
- investigating the option of shifting B4 School Checks with a decision by the end of quarter one
- making a decision about developing a Rapid Response Service by quarter two
- rolling out the Options for Care Programme starting at the end of quarter one to reduce acute demand.

I look forward to being advised of your progress with this throughout the year. Where these services trigger the service change protocols you will need to follow the normal service change process.

Better Public Services (BPS): Results for New Zealanders

Of the ten whole-of-government key result areas, the health service is leading the following areas:

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

It is important that DHBs continue to work closely with other social sector organisations, including non-governmental organisations, to achieve our sector goals in relation to these and other initiatives, such as Whānau Ora, Children's Action Plan and Youth Mental Health.

Tackling Obesity

I am pleased to note that your Annual Plan includes a focus on obesity, and identified a range of activities and initiatives to help tackle obesity. I have asked Ministry officials to look at what actions can be undertaken to help address childhood obesity, including, advice on a possible obesity target that will be meaningful and evidence based. I will be writing to all DHBs in coming months to outline proposed next steps.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. Please ensure that

you advise the National Health Board as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2015/16 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

SIGNATORY PAGE

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

This Annual Plan has been prepared to meet the requirements of both governing Acts and the relevant sections of the *Public Finance Act*. This Plan sets out Nelson Marlborough DHB's goals and objectives and describes what the DHB intends to achieve in 2015/16 in terms of improving the health, wellbeing, and independence of our population and in delivering on the expectations of the Minister of Health. This Annual Plan also contains service and financial forecast information for the 2015/16 year and the three subsequent years.

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

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

In line with this collaborative approach, the actions in this Annual Plan represent a joint commitment by Nelson Marlborough DHB, Nelson Bays Primary Health organisation, and Kimi Hauora Primary Health Organisation to working together to provide the best health services and achieve the best health outcomes for the Nelson Marlborough population, and to deliver on the expectations of the Minister.

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

The Nelson Marlborough DHB Annual Plan should be read in conjunction with the Maori Health Plan and the Public Health Service Plan. These documents set out further actions to improve population health and reduce inequalities, and are available on our website: www.nmdhb.govt.nz

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

Jenny Black
Chair
NMDHB

Russell Wilson
Deputy Chair
NMDHB

Chris Fleming
Chief Executive
NMDHB

Hon Jonathan Coleman
Minister of Health

Primary Care Letters of Support
From Kimi Hauora Marlborough PHO

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

Kimi Hauora Wairau
Marlborough Primary Health Organisation
SEEKING WELLBEING IN MARLBOROUGH

15th June 2015

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

Dear Chris

Nelson Marlborough District Health Board Annual Plan 2015/16

I am pleased to advise the board of Kimi Hauora Wairau Marlborough Primary Health Organisation (KHWMPHO) endorses the 2015/16 Nelson Marlborough District Annual Plan. The collegial development of the plan between KHWMPHO, Nelson Bays Primary Health and the NMDHB can only continue to advance a seamless integrated approach to care across the district.

Yours sincerely

David Taylor
Chair
Kimi Hauora Wairau MPHO

Primary Care Letters of Support

From Nelson Bays PHO

281 Queen Street, Richmond, Nelson 7020
PO Box 1776, Nelson 7040
Tel: 03 539 1170 Free: 0800 731 317 Fax: 03 539 4958
Website: www.nbph.org.nz

16 June 2015

Andrew Lesperance
General Manager, Strategy & Planning
NMDHB
Private Bag 18
Nelson 7042

Dear Andrew,

Thank you for presenting the NMDHB Annual Plan to the Nelson Bays Primary Health Board at its meeting of 4 June 2015. This letter serves to confirm the plan was endorsed by the board.

Regards,

John Hunter
Chair: Nelson Bays Primary Health

CONTENTS

EXECUTIVE SUMMARY

FORWARD FROM CHAIR, DEPUTY CHAIR, AND CHIEF EXECUTIVE

The Nelson Marlborough District Health Board (NMDHB) is committed to providing excellence in healthcare and achieving the best health outcomes for our community, while living within our means.

To do this we are continuously challenging and transforming the health system for the Nelson Marlborough community and for the broader South Island region. The healthcare environment is rapidly changing and Nelson Marlborough DHB, along with every other DHB in New Zealand, has some significant challenges to address. Tweaking the existing healthcare system will not be sufficient to tackle the challenges we are facing, so we are on a fast-paced journey to deliver a new model of healthcare service delivery for our region.

We will achieve this through continued integration and partnership of healthcare services. The traditional community, primary and secondary services are becoming better linked, with patients and their families beginning to experience a single system of healthcare in settings as close to home as possible. We will keep investing in initiatives that provide the opportunity to enhance the integration of community, primary and secondary services under the umbrella of the Top of the South Health Alliance / Te Tau Ihu o Te Waka a Maui Health Alliance (ToSHA).

The Nelson Marlborough DHB Mission is to work with the people of our community to promote, encourage and enable their health, wellbeing and independence. This collaborative and person-centred approach to health care requires our community to share responsibility for managing their own health and wellbeing, and the health and wellbeing of their families. We plan to increase support for families to prevent chronic disease and obesity, and to better manage long-term conditions by improving health literacy and other related initiatives.

Providing integrated and efficient services that are people-centred requires our highly skilled workforce to operate at the 'top of their scope'. To make this happen, we are developing innovative new models of care and new ways of working. Specifically, there are emerging opportunities for our nursing workforce to take on more specialised care roles to support our aim to provide better, sooner, more convenient care.

We are proud of the healthcare we provide to our community. We acknowledge that some members of our community struggle to access healthcare, specifically Maori, Pasifika, immigrants, disabled people and those with mental health issues. This is not good enough for our consumers or our wider community, and we are committed to the equal treatment of individuals and groups in the same circumstances, and are working towards equitable health outcomes.

The health sector plays an important role in supporting the rights of Maori to achieve equitable outcomes in health and social wellbeing. Our relationship with the Tangata Whenua of our district is expressed through the partnership with the Iwi Health Board and joint agreement titled 'He Kawenata.' We are strategically advised on the planning and delivery of all service, including Maori health services, by our Iwi Health Board, who has guided the development of the Maori Health Plan and this Nelson Marlborough DHB Annual Plan. The Maori Health Plan specifies how national initiatives to achieve better health outcomes for Maori will be implemented locally, as well as addressing the needs of Maori in the Nelson Marlborough region through local initiatives. These collaborative initiatives are reflected in this annual plan to ensure alignment and coordination in delivery. There is a shared role in implementing health strategies for Maori, and addressing health inequities for local Maori is a key focus for Te Piki Oranga, our Maori health provider coalition.

We are continuing to integrate mental health, addiction, disability support and physical health care services to provide better person-centred care and support. We are working collaboratively with our two PHOs and other partners on specific actions to increase access to screening and health monitoring programmes.

Fundamentally, our health services must be safe. We'll keep strengthening our approach to Clinical Leadership and Clinical Governance to ensure a common framework is applied at all levels of the organisation and across the Nelson Marlborough health system. Strong clinical leadership will support improvements in quality and patient safety, and aid the transformation of our health system. We'll continue to invest in initiatives that will strengthen commitment to our 'One Service, Two Sites' approach for medical and surgical services in Nelson and Wairau Hospitals. We are also investing in key initiatives through the Information Systems Alliance under the South Island Alliance umbrella which will significantly enhance the integration of clinical information both across our district and regionally.

Financially, our prudent, comprehensive approach to identifying and eliminating waste and cutting costs has paid off. Nelson Marlborough DHB is now achieving a financial surplus, and we will keep living within our means while maintaining, and where possible enhancing, access to services across the system and across the district. Our continued favorable financial position allows us to support initiatives that will deliver the new model of healthcare for our region. Some examples include, but are not limited to, closer working relationships and efficiencies achieved by co-locating the public health services with the PHOs, and up-skilling GPs to provide post-operative follow-up appointments for cancer patients.

This is an exciting time for the Nelson Marlborough health system, as the DHB leads the transformation that will provide the best healthcare and health outcomes for our community.

INTRODUCING THE NELSON MARLBOROUGH DHB

1.1 WHAT WE DO

1.1.1 National Context

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

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

1.1.2 Regional Context

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

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

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

1.1.3 Our DHB – Structure and Funding

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

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

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

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

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

1.1.4 Nature and Scope of Functions

The Nelson Marlborough DHB receives funding from Government to purchase and provide health and disability services for the local population. In accordance with legislation, we use the funding to:

- **Plan** the strategic direction of the Nelson Marlborough Health System in partnership with clinical leaders, alliance partners, key stakeholders at a local, regional and national level, and most importantly our community;
- **Fund** the majority of the health and support care service provided in Nelson Marlborough through our partnerships, alliances and key relationships with service providers. Our focus is on 'best for patient, best for system' and achieving more health gain for dollar invested (value for money) by ensuring services are high quality, safe, responsive, coordinated, efficient and meet the expectation of the patient's experience of the care provided;
- **Promote, protect, and improve** our population's health and wellbeing through an evidence-based 'whole of system' approach that includes health impact assessments, health promotion, and public health protection interventions.
- **Provide** hospital specialist and community services for our population. We have a 'One Service, Two Sites' approach for hospital specialist services, and also provide an Intellectual and Physical Disability Support Service;
- **Integrate** health service activity in our region with an appropriate level of management and administrative support required for an organisation of the size of Nelson Marlborough DHB.

1.2.1 Our Health Profile

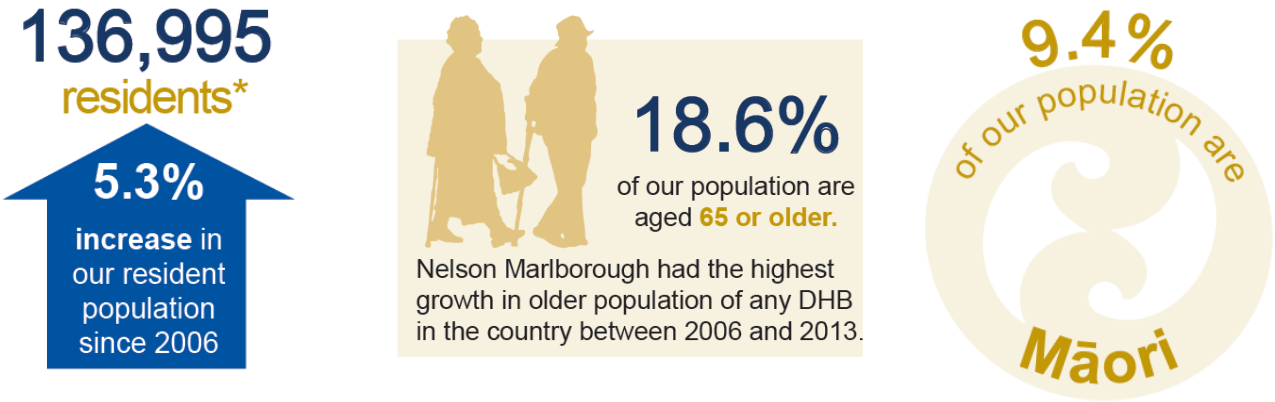
Analysing the demographics and health profile of our population helps us to predict the demand for services and influences the choices we make when prioritising and allocating resources across our health system. This information also helps us to understand the factors affecting our performance.

Nelson Marlborough DHB has a population of 136,995 at the last (2013) census[1], a 5.3% increase in our resident population since 2006 and the highest growth of any DHB in the South Island. There has been an increase in migration from Christchurch since 2006, with almost all of this additional migration from Christchurch to the Tasman District and Nelson, rather than the Marlborough District. We are continuing to see our older residents making up a greater proportion of our population. 18.6% of our population are now aged 65 years or older, which has increased from 14.7% in 2006. Nelson Marlborough has experienced the highest growth in older population of any DHB in the country.

There has been an increase in ethnic diversity in Nelson Marlborough since 2006. 9.4% of our population now identify as Maori, up from 8.7% in 2006. Our Maori population are much younger than our general population, with 45.9% of our Maori population under the age of 20. This is considerably higher than our non-Maori population (22.8%). Our Maori population live in areas of higher deprivation than our non-Maori population. However, our Maori population are less deprived than Maori nationally. There are also increased proportions of our population identifying as Asian and Pacific ethnicities than in 2006. 3.1% of our population now identify as an Asian ethnicity and 1.7% of our population now identify as a Pacific ethnicity.

Our population is distributed over large rural topographic and geographic boundaries, creating challenges around trauma response and access to services for our rural population.

Consideration of these changes is crucial to the planning of future health services in Nelson Marlborough.



[1] The Nelson Marlborough population figure of 136,995 according to the 2013 Census data, is less than the projected population figure of 146,270 produced by Statistics NZ and used for population funding purposes by the Ministry of Health.

1.2.2 Our Challenges and Opportunities

The health and care environment is rapidly changing, and Nelson Marlborough DHB needs to respond and adjust to the following challenges when planning services:

- Population changes with an ageing population, increasing diversity, rural decline and changing family structures – we need to understand how these changes will influence the mix and provision of services and invest in staff, IT and infrastructure to ensure more efficient, effective and sustainable service delivery.
- Increases in chronic disease and long-term conditions, which means the costs of health and care will continue to rise, particularly for the growing number of older people in Nelson Marlborough who have more complex needs – we need to focus on better management of long term conditions and improving the health of older people.
- The Nelson Marlborough workforce is also ageing – we need to proactively plan for their exit from the workforce so we can transfer institutional knowledge, and also develop new models of care to respond to workforce shortages. We need to "Think nationally, and Act regionally" to benefit from emerging opportunities for our nursing workforce to take on more specialised care roles to support our aim to provide better, sooner, more convenient care.
- Funding rate increases do not keep pace with healthcare innovations available which the community increasingly expect to be publicly funded - we need to work in partnership with our community to make tough decisions about services, and work with our alliance partners to develop more sustainable solutions.
- Persistent inequalities in access to health services and health outcomes for some members of our community, specifically Maori, disabled people and those with mental health issues – we need to understand and address the barriers to healthcare access, and monitor health indicators for specific population groups.
- We are rebalancing our approach to focus more on promoting health and wellness and the prevention of obesity and disease – we need to think much more long-term about population health benefits which may not be so easy to see in the shorter term.
- Increased IT demands as new models of care require new technologies, and advances in technology are driving opportunities for new models of care – we are currently constrained by a legacy patient administration system which will be replaced in 2016, allowing increased access to relevant information at the point of care and greater use of information systems to enhance care delivery.
- Significant strengthening of earthquake prone buildings and structures is required – we need to prioritise repairs and replace core hospital infrastructure that has reached the end of its useful life, in line with the broader strategic facilities master plan for the Nelson Marlborough health system.
- Integration of services is an ongoing challenge - we need to develop new ways of working with all health providers, local and government agencies and consumer groups to develop efficient, effective and sustainable services.

OUR STRATEGIC DIRECTION

WHAT ARE WE TRYING TO ACHIEVE?

1.3 OUR STRATEGIC CONTEXT

Although they differ in size, structure and approach, DHBs have a common goal: to improve the health and wellbeing of their populations by delivering high quality and accessible health care. Increasing demand for services, workforce shortages, rising costs and tighter financial constraints make this increasingly challenging.

In 2010, the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHBs in their service planning.

International direction emphasises that a 'whole of system' approach is required to improve health outcomes and ensure the sustainability of high quality health services. This approach entails four major service shifts:

- Early intervention, targeted prevention, self-management and more home-based care
- A connected system, integrated services and more services provided in community settings
- Regional collaboration, clusters and clinical networks, and more regional service provision
- Managed specialisation, with a shift to consolidate the number of tertiary centres/hubs.

Hospitals continue to be a key support and a setting for highly specialised care, with the importance of timely access to care being paramount. However, the increased prevalence of long-term conditions and the ageing of our population means we need to move away from the traditional health model in order to support our population to maintain good health for longer.

Rather than wait for people to become acutely unwell or require institutionalised care, the whole of the health system needs to works in partnership to deliver accessible and effective services that support people to stay well and in their own homes for as long as it is possible and financially viable.

1.4 NATIONAL DIRECTION

At the highest level, DHBs are guided by the New Zealand Health Strategy, Disability Strategy, and Māori Health Strategy (He Korowai Oranga) and the New Zealand Public Health and Disability Act.

The ultimate high-level health system outcomes are that all New Zealanders lead longer, healthier and more independent lives and the health system is cost-effective and supports a productive economy.

DHBs are expected to contribute to meeting these system outcomes and the commitments of Government to provide '*better public services*' and '*better, sooner, more convenient health services*' by: increasing access to services; improving quality and patient safety; supporting the health of children, older people and those with mental illness; making the best use of information technology; and strengthening our health workforce.[2]

Alongside these longer-term goals and commitments, the Minister of Health's annual 'Letter of Expectations' signals annual priorities for the health sector. The 2015/16 focus is on: clinical leadership; integration between primary and secondary care; tackling the key drivers of morbidity; delivery of national health targets; fiscal discipline and performance management.

Nelson Marlborough DHB is committed to playing its part in the delivery of longer-term health system outcomes and progress against national goals. Activity planned and prioritised in the coming year is in line with the priorities expressed by the Minister of Health and is highlighted in Section 2 of our Annual Plan.

[2] *For further detail refer to the Ministry of Health's Statement of Intent 2014-2018 available on their website – www.health.govt.nz.*

1.5 REGIONAL DIRECTION

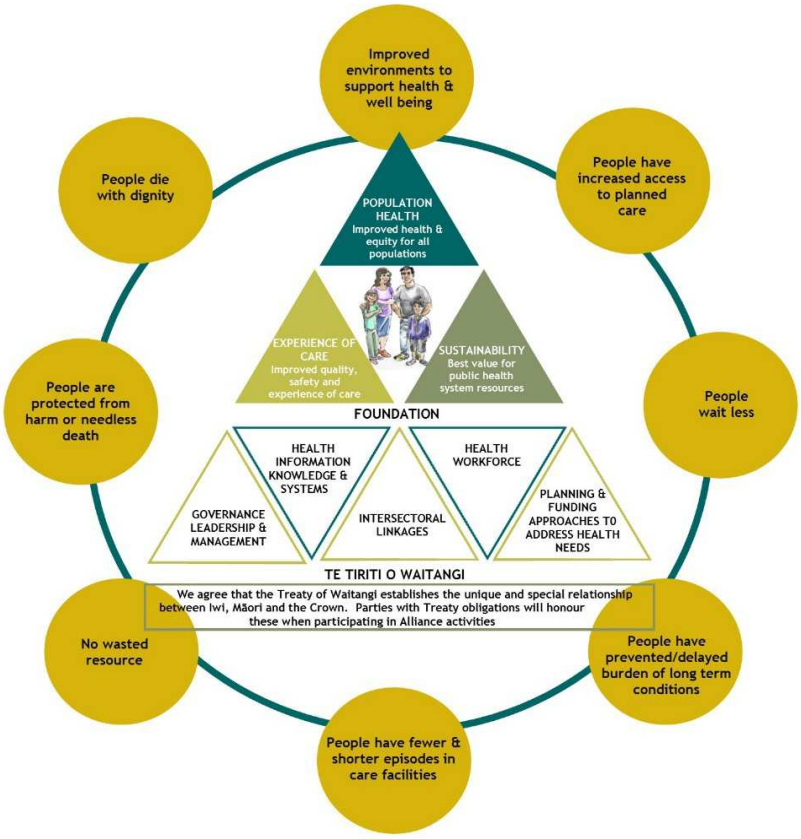
In delivering its commitment to better public services and better, sooner, more convenient health services the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for 1,081,953 people or 23.5% of the total NZ population.[3]

While each DHB is individually responsible for the provision of services to its own population, we recognise that working regionally enables us to better address our shared challenges. Together we are committed to delivering a sustainable South Island health system, focused on keeping people well, and providing equitable and timely access to safe, effective, high-quality services – as close to people's homes as possible.

The success of the Alliance relies on improving patient flow and the coordination of services across the South Island by: agreeing and aligning patient pathways, introducing more flexible workforce models and improving patient information systems to better connect services and the clinical teams involved in a patient's care

Figure 1. South Island Best for People, Best for System Framework.



Closely aligned to the national direction, and operating under a 'Best for People, Best for System' framework, the shared outcomes goals of the South Island Alliance are:

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

A set of high level outcomes sits alongside the 'Best for People, Best for System' framework and enable evaluation of regional activity at a population level. These are highlighted in the outer circles in Figure 1.

The South Island Health Services Plan highlights the agreed regional activity to be implemented through our service level alliances and work streams in seven priority service areas: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

Regional activity in the coming year will also focus on: cardiac services, elective surgery, palliative care, public health, stroke and major trauma services. Workforce planning, through the South Island Regional Training Hub and regional asset planning, will contribute to improved delivery in all service areas.

Nelson Marlborough's commitment in terms of the regional direction is outlined in the Regional Health Services Plan, and key deliverables are also highlighted in Section 2 of our Annual Plan.[4]

[3] *2015/16 Population Based Funding Projection provided to the Ministry of Health by Stats NZ, based off the 2013 Census.*
[4] *For further detail refer to the Regional Health Services Plan available on the South Island Alliance website: www.sialliance.health.nz.*

1.6 NELSON MARLBOROUGH DHB LOCAL DIRECTION

Our DHB Vision

"Towards Healthy Families"

Our DHB Mission

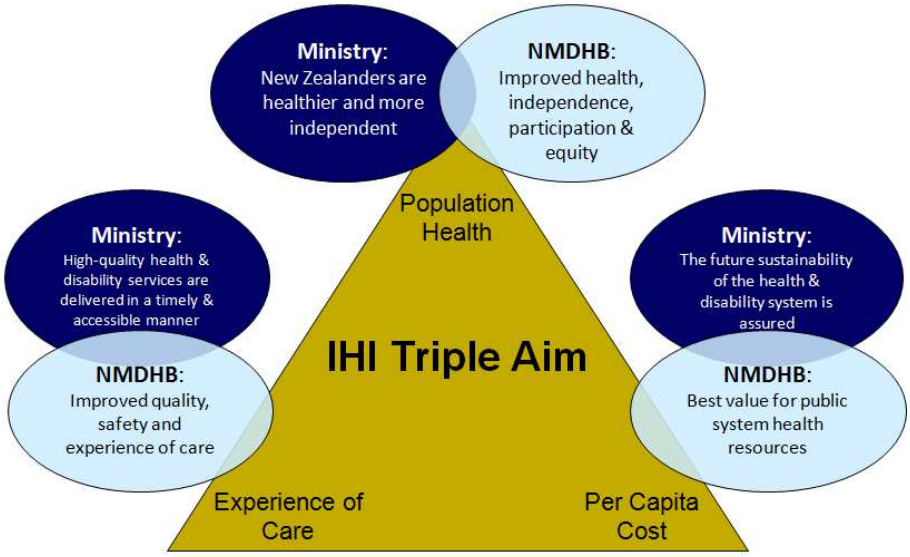
Working with the people of our community to promote, encourage and enable their health, wellbeing and independence.

Our Local Direction

Health for Tomorrow (formerly known as Health 2030) is the Nelson Marlborough health system's strategic commitment to deliver our vision of healthy families. Health for Tomorrow sets out the approach we will take to plan and deliver the health and care services we must have to meet the health needs of our communities, now and in the future. Health for Tomorrow is currently being updated to include a wider system perspective, and to more clearly articulate the principles that drive future work. The updated document better articulates the ambition for an integrated system that responds to changing personal and population needs over an individual's life.

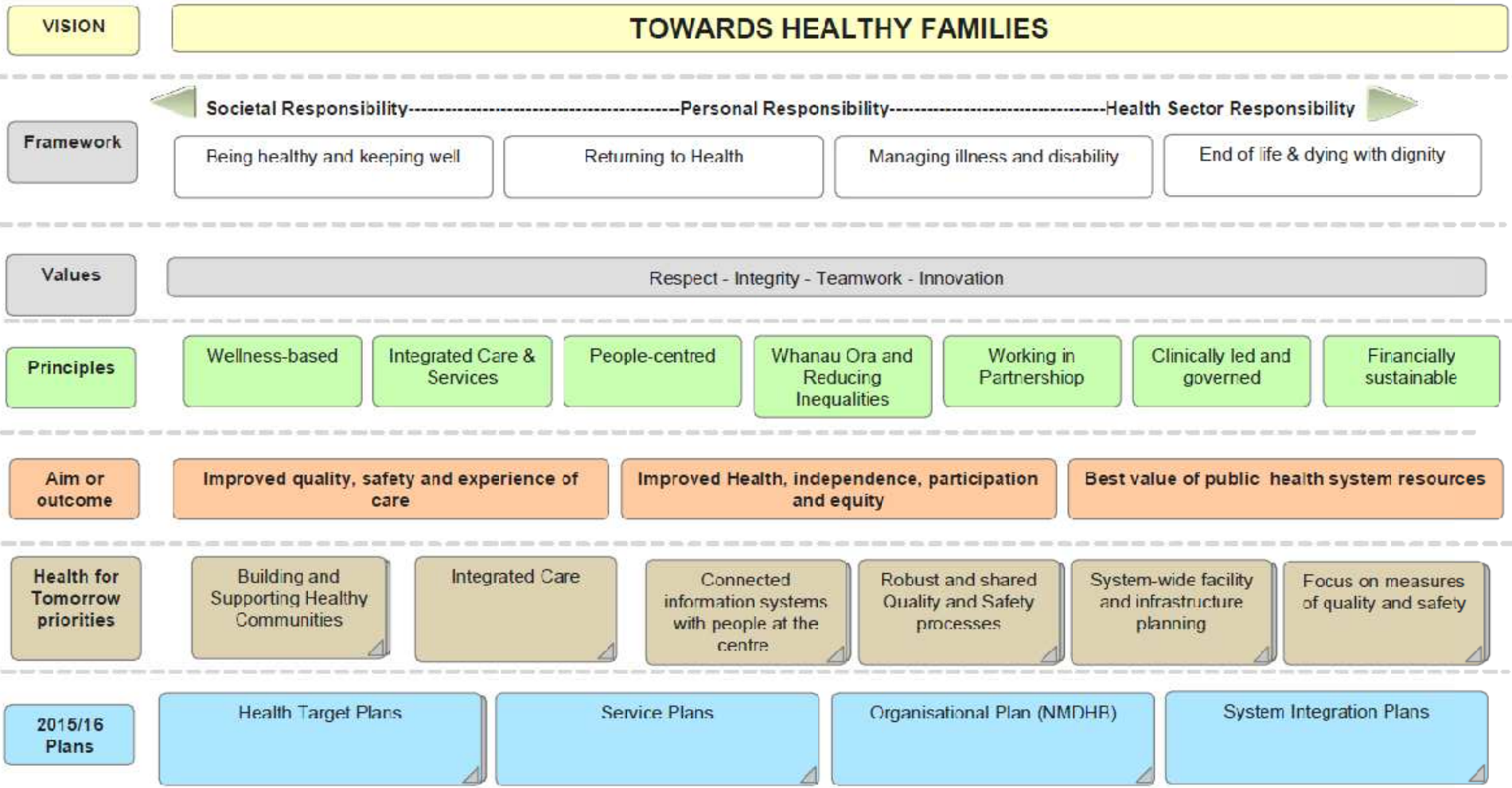
The diagram below shows how the Nelson Marlborough health system's three over-arching goals align with the Ministry's high level outcomes and the Institute of Healthcare Improvement's Triple Aim (see the diagram below).

Figure 2. Triple Aim Linkages: Nelson Marlborough DHB and Ministry of Health Alignment



The first goal of 'Improved health, independence, participation and equity' reflects our ambition to ensure we build good health through supporting the people of our community to take ownership and responsibility for their health, and supporting individual choices and behaviour change. The next goal of 'Improved quality, safety and experience of care' reflects our focus on providing coordinated, safe, quality care that delivers the right balance of hospital and community services using an integrated, multi-agency approach. We must do this while living within our means, which is reflected in the final goal of 'Best value for public system health resources'. We need to work in partnership with our community to make tough decisions about services, and work with our alliance partners to invest and develop more sustainable solutions.

Health for Tomorrow incorporates the values of the Nelson Marlborough DHB, the principles that guide how we plan and deliver health and care services, and the priorities for the Nelson Marlborough health system. How we will achieve each of the priorities is reflected in more detail in this Annual Plan.


VISION
TOWARDS HEALTHY FAMILIES
Framework
Societal Responsibility----------Personal Responsibility----------Health Sector Responsibility
Being healthy and keeping well
Returning to Health
Managing illness and disability
End of life & dying with dignity
Values
Respect - Integrity - Teamwork - Innovation
Principles
Wellness-based
Integrated Care & Services
People-centred
Whanau Ora and Reducing Inequalities
Working in Partnershiop
Clinically led and governed
Financially sustainable
Aim or outcome
Improved quality, safety and experience of care
Improved Health, independence, participation and equity
Best value of public health system resources
Health for Tomorrow priorities
Building and Supporting Healthy Communities
Integrated Care
Connected information systems with people at the centre
Robust and shared Quality and Safety processes
System-wide facility and infrastructure planning
Focus on measures of quality and safety
2015/16 Plans
Health Target Plans
Service Plans
Organisational Plan (NMDHB)
System Integration Plans

IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

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

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

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

In developing our strategic framework, the South Island DHBs identified three shared high-level outcome goals where collectively we can influence change and deliver on the expectations of Government, our communities and our patients by making a positive change in the health of our populations.[5]

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

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

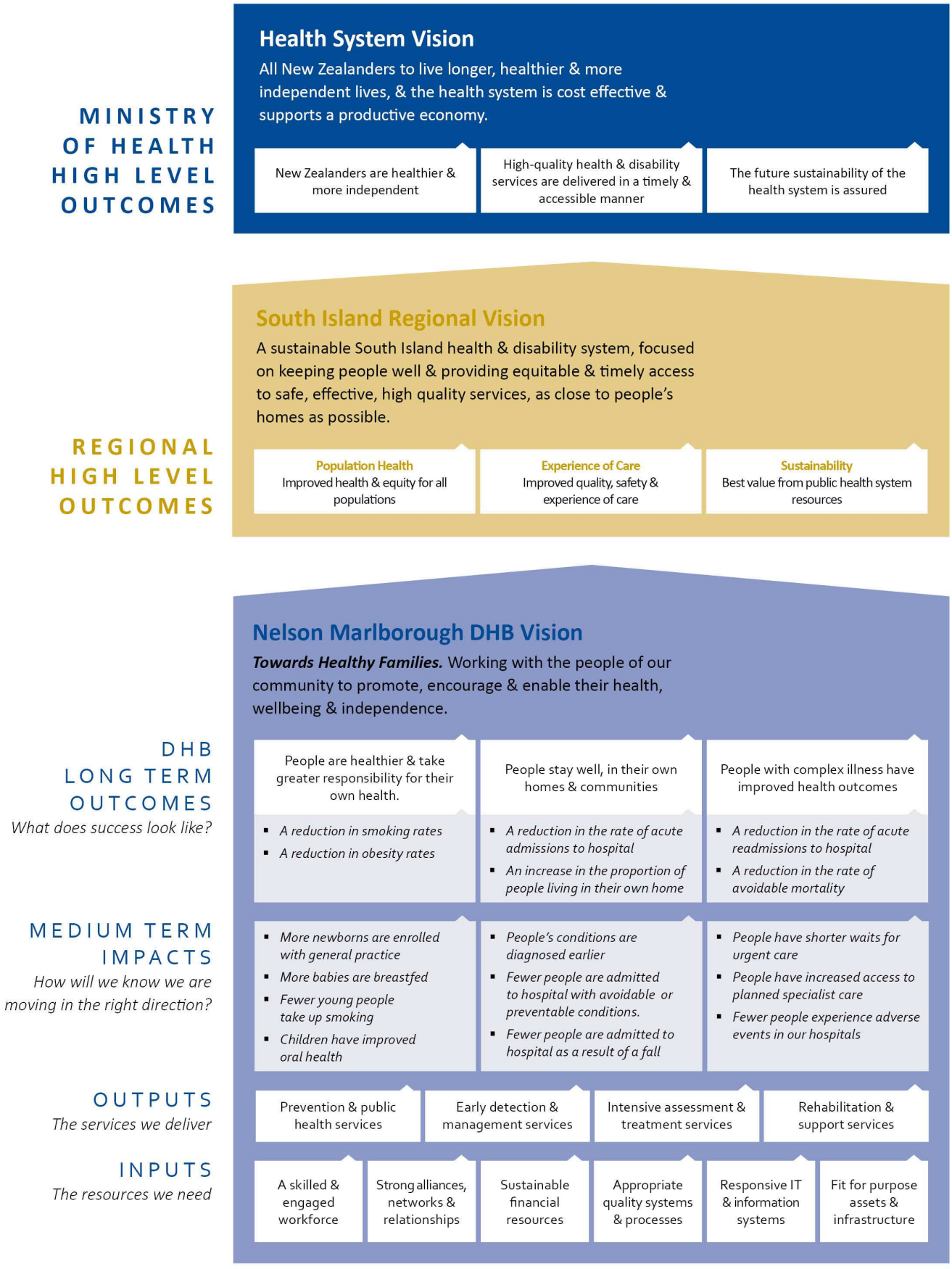
The South Island DHBs have also identified a core set of associated medium-term indicators. Because change will be evident over a shorter period of time, these indicators have been identified as the headline or main measures of performance. Each DHB has set local targets in order to evaluate their performance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

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

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

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

[5] *A more comprehensive regional Outcome Framework is currently under development. When complete this will sit alongside the South Island's regional planning and enable evaluation of regional activity.*


MINISTRY OF HEALTH HIGH LEVEL OUTCOMES
Health System Vision
All New Zealanders to live longer, healthier & more independent lives, & the health system is cost effective & supports a productive economy.
New Zealanders are healthier & more independent
High-quality health & disability services are delivered in a timely & accessible manner
The future sustainability of the health system is assured
REGIONAL HIGH LEVEL OUTCOMES
South Island Regional Vision
A sustainable South Island health & disability system, focused on keeping people well & providing equitable & timely access to safe, effective, high quality services, as close to people's homes as possible.
Population Health
Improved health & equity for all populations
Experience of Care
Improved quality, safety & experience of care
Sustainability
Best value from public health system resources
Nelson Marlborough DHB Vision
Towards Healthy Families. Working with the people of our community to promote, encourage & enable their health, wellbeing & independence.
DHB LONG TERM OUTCOMES
What does success look like?
People are healthier & take greater responsibility for their own health.
A reduction in smoking rates
A reduction in obesity rates
People stay well, in their own homes & communities
A reduction in the rate of acute admissions to hospital
An increase in the proportion of people living in their own home
People with complex illness have improved health outcomes
A reduction in the rate of acute readmissions to hospital
A reduction in the rate of avoidable mortality
MEDIUM TERM IMPACTS
How will we know we are moving in the right direction?
More newborns are enrolled with general practice
More babies are breastfed
Fewer young people take up smoking
Children have improved oral health
People's conditions are diagnosed earlier
Fewer people are admitted to hospital with avoidable or preventable conditions.
Fewer people are admitted to hospital as a result of a fall
People have shorter waits for urgent care
People have increased access to planned specialist care
Fewer people experience adverse events in our hospitals
OUTPUTS
The services we deliver
Prevention & public health services
Early detection & management services
Intensive assessment & treatment services
Rehabilitation & support services
INPUTS
The resources we need
A skilled & engaged workforce
Strong alliances, networks & relationships
Sustainable financial resources
Appropriate quality systems & processes
Responsive IT & information systems
Fit for purpose assets & infrastructure

1.4.1 STRATEGIC OUTCOME GOAL 1

People are healthier and take greater responsibility for their own health

Why is this outcome a priority?

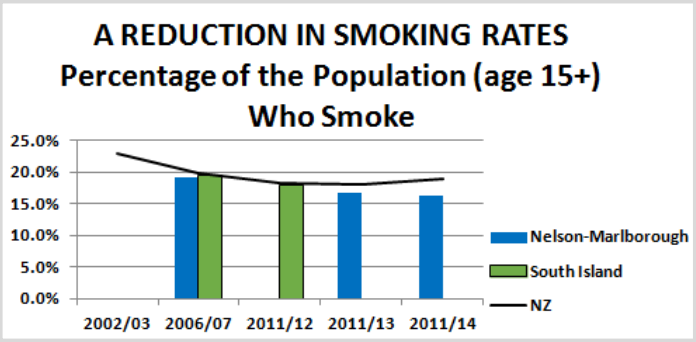
New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and hospital and specialist services. The likelihood of developing long-term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

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

Overarching Outcome Indicators

SMOKING

Percentage of the population (15+) who smoke



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

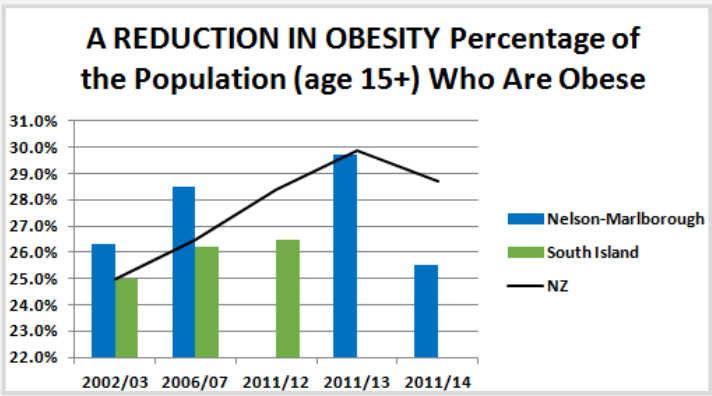
In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

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

Data Source: National Health Survey[6]

OBESITY

Percentage of the population (15+) who are obese



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

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

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

Data Source: National Health Survey[7]

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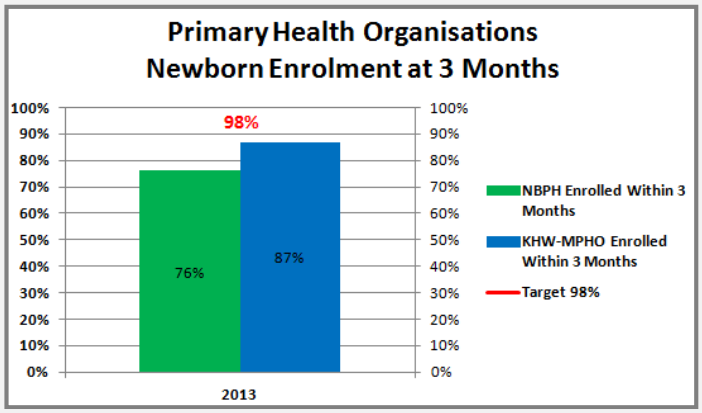
[6] *The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2012/13. However the 2011/12 and 2012/13 surveys were combined in order to provide results for smaller DHBs – hence the different time periods presented. Results are unavailable by ethnicity. The 2013 Census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

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

Intermediate Impact Indicators – Main Measures of Performance

NEWBORN ENROLLMENT -

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



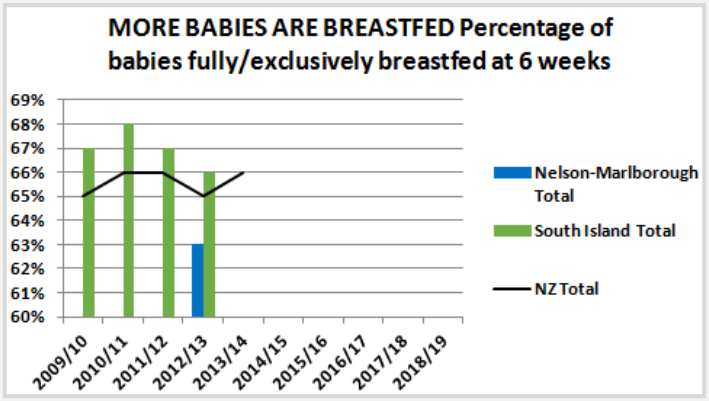
2013/14	2015/16	2016/17	2017/18	2018/19
	Target: 98%	98%	98%	98%

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

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

BREASTFEEDING

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



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 66%	Target: 75%	75%	75%	75%

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

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

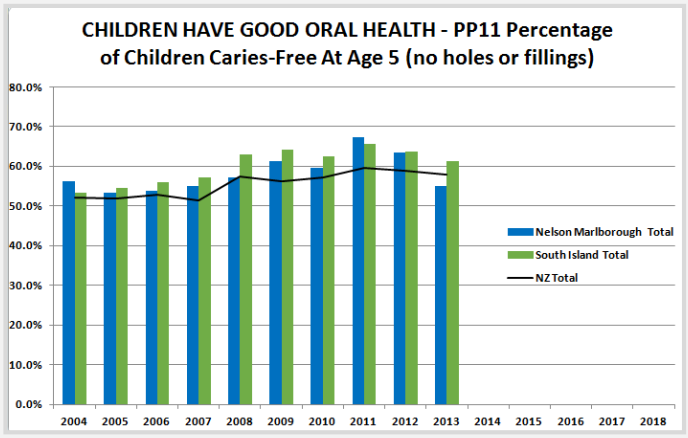
An increase in breastfeeding rates is seen as a proxy indictor of the success of health promotion and engagement activity, appropriate access to support services and a change in both social and environmental factors influencing behaviour and support healthier lifestyle choices.

Data Source: Plunket via the Ministry of Health[8]

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

ORAL HEALTH

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



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 55.1%	Target: 65%	65%	65%	65%

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

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

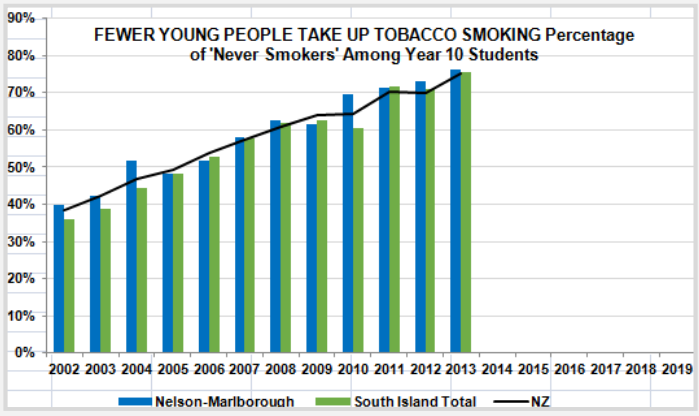
Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy indicator of equity of access and the effectiveness of services in targeting those most at risk.

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

Data Source: Ministry of Health Oral Health Team

SMOKING

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



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 76%	Target: 78%	78%	78%	78%

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

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

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

Data Source: National Year 10 ASH Snapshot Survey[9]

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

1.4.2 STRATEGIC OUTCOME GOAL 2

People stay well in their own homes and communities

Why is this outcome a priority?

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

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

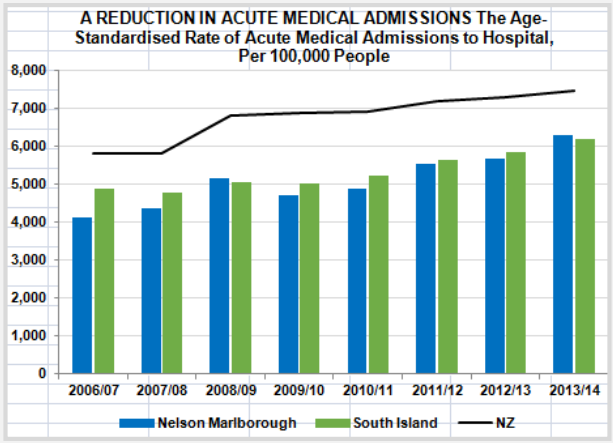
Health services also play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, allied and personal health providers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

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

Overarching Outcome Indicators

ACUTE HOSPTIAL ADMISSIONS

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



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

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

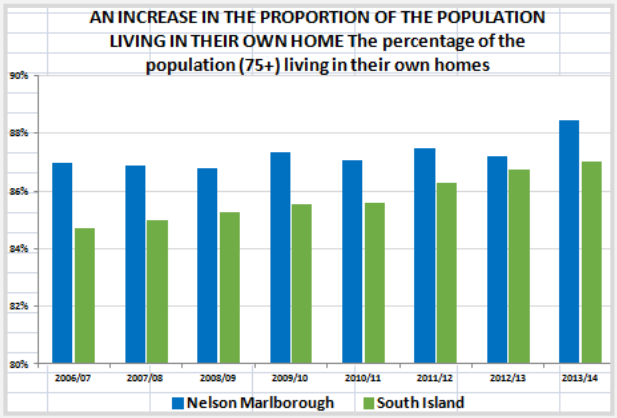
Lower acute admission rates can be used as a proxy indicator of improved conditions management they can also be used to indicate the accessibility of timely and effective care and treatment in the community.

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

Data Source: National Minimum Data Set

PEOPLE LIVING AT HOME

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



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

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

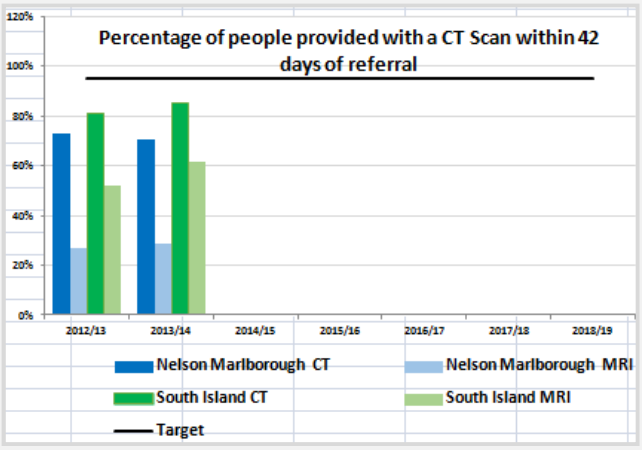
An increase in the proportion of older people supported in their own homes can be used as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

Data Source: SIAPO Client Claims Payment System

Intermediate Impact Indicators – Main Measures of Performance

EARLIER DIAGNOSIS

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



2013/14	2015/16	2016/17	2017/18	2018/19
CT Actual: 70%	Target: 95%	95%	95%	95%
MRI Actual: 28%	Target: 85%	85%	85%	85%

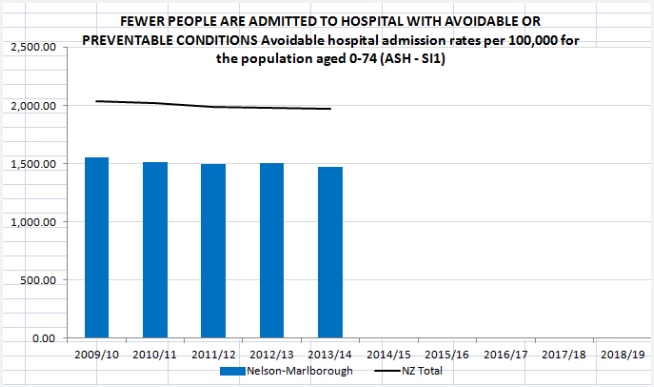
Diagnostics are an important part of the healthcare system and timely access, by improving clinical decision making, enables early and appropriate intervention, improving quality of care and outcomes for our population.

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

Data Source: Individual DHB Patient Management Systems

AVOIDABLE HOSPITAL ADMISSIONS

Ratio of actual vs. expected avoidable hospital admissions for the population aged under 75 (per 100,000)



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 1,469	Target: N/A	N/A	N/A	N/A

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

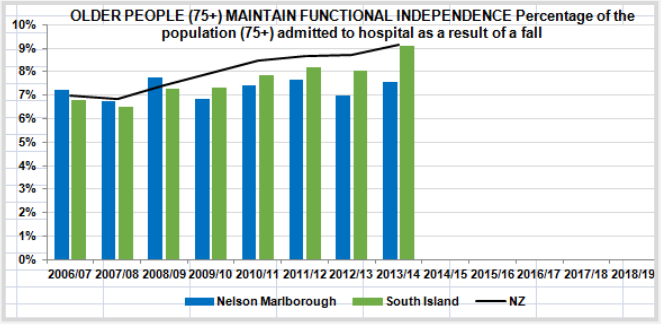
Keeping people well and supported to better manage their long-term conditions by providing appropriate and coordinated primary care should result in fewer hospital admissions - not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

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

Data Source: Ministry of Health Performance Reporting SI1[10]

FALLS PREVENTION

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



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 7.6%	Target: N/A	N/A	N/A	N/A

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

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

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

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

Data Source: National Minimum Data Set

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

1.4.3 STRATEGIC OUTCOME GOAL 3

People with complex illness have improved health outcomes

Why is this outcome a priority?

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

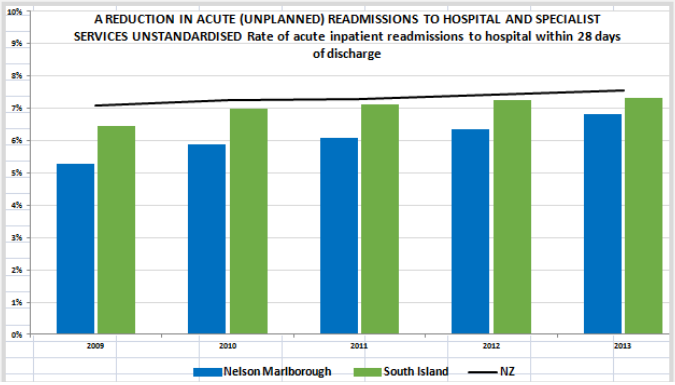
As providers of hospital and specialist services, DHBs are operating under growing demand and workforce pressures. At the same time, Government is concerned that patients wait too long for specialist assessments, cancer treatment and elective surgery. Shorter waiting lists and wait times are seen as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

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

Overarching Outcome Indicators

ACUTE READMISSIONS

Rate of acute readmissions to hospital within 28 days of discharge



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

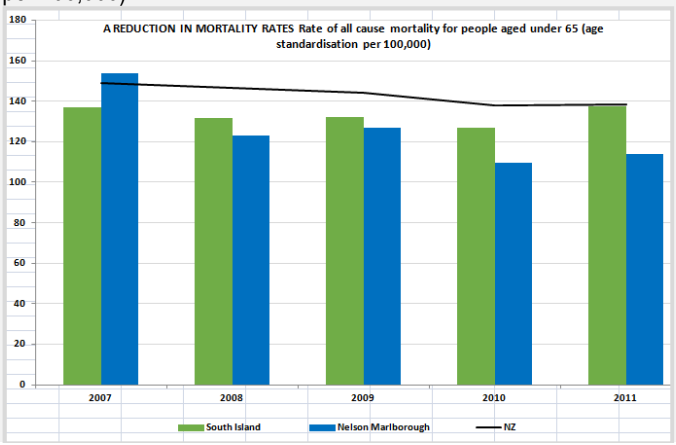
As well as reducing public confidence and driving unnecessary costs - patients are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

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

Data Source: Ministry of Health Performance Data OS8[11]

AVOIDABLE MORTALITY

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



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

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

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

Data Source: National Mortality Collection - 2010 Update.[12]

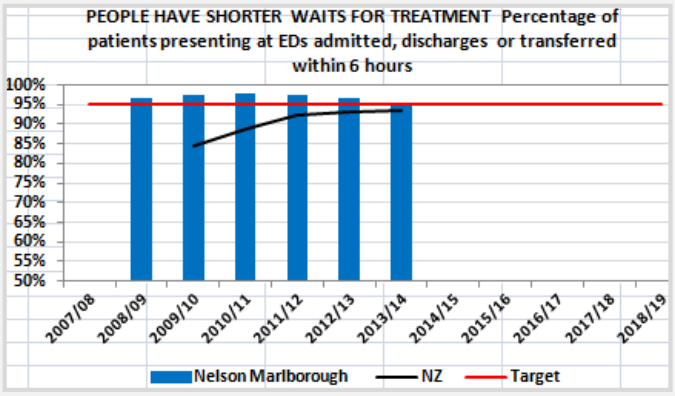
[11] *This indicator is based on the national performance indicator OS8. The DHB has identified a number of data inconsistencies with the when comparing local data, particularly where patients transferring between hospitals are coded as readmissions. The DHB continues to work with the Ministry to resolve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

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

Intermediate Impact Indicators – Main Measures of Performance

WAITS FOR URGENT CARE

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



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 95.5%	Target: 95%	95%	95%	95%

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

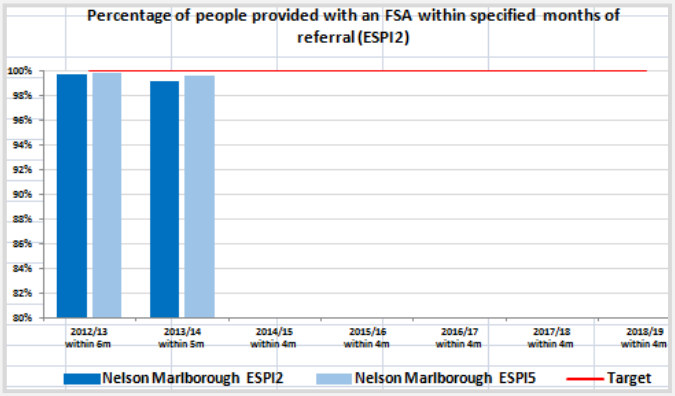
Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Enhanced performance will not only improve patient outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.

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

Data Source: Individual DHB Patient Management Systems[13]

ACCESS TO PLANNED CARE

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



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: >99%	Target: 100%	100%	100%	100%

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

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

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

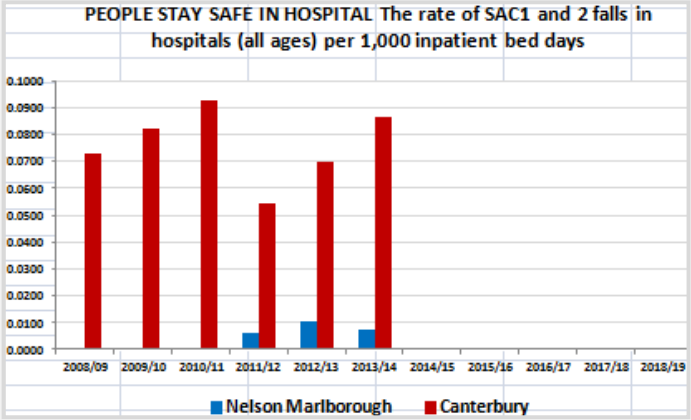
Data Source: Ministry of Health Quickplace Data Warehouse[14]

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

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

ADVERSE EVENTS

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



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 0.0076%	Target: N/A	N/A	N/A	N/A

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

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

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

Data Source: Individual DHB Quality Systems[15]

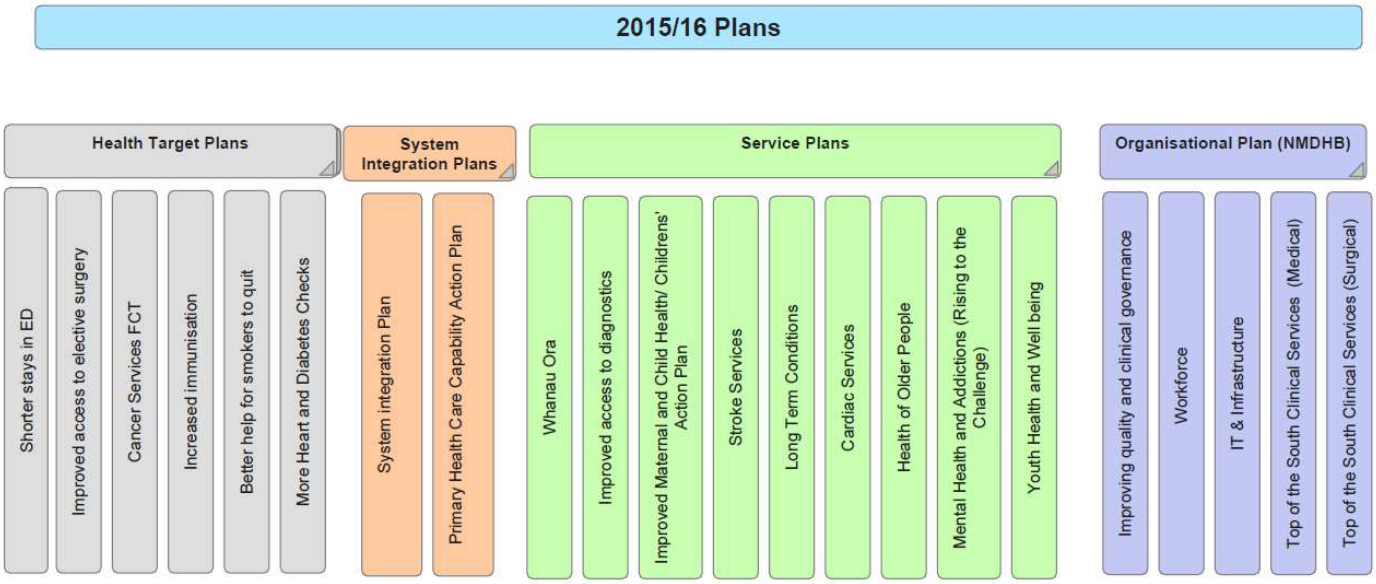
[15] *The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest consequence and likelihood.*

DELIVERING ON PRIORITIES AND TARGETS

2.1 PRIORITIES AND TARGETS

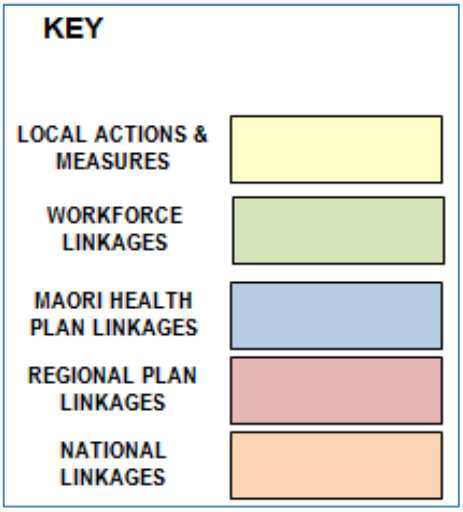
The key strategic outcomes our health system is working towards are clustered into the themes of Health Target Plans, Service Plans, Organisational Plans (Nelson Marlborough DHB), and System Integration Plans as follows:

The Nelson Marlborough Health System Key Strategic Outcomes



The following section pulls the national, regional, and local priorities together. Each plan sets out the key actions needed beyond business as usual to achieve the higher-level results that Nelson Marlborough DHB expects to achieve, and identifies measures that provide evidence of progress towards achievement. The actions in the plans are colour coded to clearly identify the linkages between the specific plans to deliver a single integrated and aligned plan for the Nelson Marlborough health system. The key is shown below:

We aim to provide the best healthcare and achieve the best health outcomes for our community. We have an over-arching strategy called 'Health for Tomorrow' which outlines what we will do in the long-term. The actions required to deliver this long-term strategy and meet the priorities outlined by the Minister for the coming year are documented in the health target and service plans provided in this Annual Plan – Section 2: Delivering on Priorities and Targets. Please note that these one page plans do not include the 'Business As Usual' activities required to run the organization and deliver day-to-day services. They contain activities aimed at transforming the health and care system in Nelson Marlborough.



2.1.1 HEALTH TARGET PLANS

Health Targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities. The impact they make can be measured to see how they are improving health for all New Zealanders.

Within the Nelson Marlborough health system, the health targets provide a focus for action and also help us to maintain and build the confidence of the public. We report on our progress against the health targets four times a year, so the people of our community can see how we doing, and the level of care they receive compared with New Zealanders in other regions.

We are proud of the gains we have made to achieve certain health targets, and our plans for the year ahead will build on our previous successes, while lifting our performance for the targets where we must do better.

Please refer to the specific health target actions plans below:

Health Target		Page Number
	95 percent of patients will be admitted, discharged, or transferred from an emergency department within six hours.	• Page 39
	This plan outlines how we will improve access to elective services, maintain reduced waiting times for elective First Specialist Assessment (FSA) and treatment, and improve equity of access to services, so patients receive similar access regardless of where they live. We will also deliver our agreed volume schedule to deliver the Electives Health Target.	• Page 40
	85 percent of patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.	• Page 41
	95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	• Page 42
	95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking. Within the target a specialised identified group will include progress towards 90 percent of pregnant women (who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer) are offered advice and support to quit. In the year ahead we will be incentivising pregnant Maori women to quit smoking.	• Page 43
	The plan outlines how we will support people living with diabetes so they can be leading partners in their own care within systems that ensure they can manage their own condition effectively and with appropriate support. 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.	• Page 44

2.1.2 SERVICE PLANS

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

Service Plan		Page Number
Whanau Ora	The service plan outlines how we will strengthen our relationship with our local Whanau Ora provider collectives; identify opportunities to collaborate with Whanau Ora Commissioning Agencies; participate in processes by the Ministry to obtain a broader health sector view on Whanau Ora implementation, and deliver improved contracting process through a greater focus on outcomes for whanau.	• Page 45
Improved Access to Diagnostics	The service plan aims to achieve waiting time targets by more efficient use of existing resources, support deliverables under the National Radiology Service Improvement Initiative, and improve GP access to diagnostics to support GPs to make informed management or referral decisions.	• Page 46
Improved Maternal & Child Health and Children's Action Plan	The plan outlines how the service will work with their wider sector, including Primary Care providers, Lead Maternity Carers, Well Child Tamariki Ora, and Community Oral Health services to achieve improved Maternal & Child Health and ensure we are meeting the requirements of the Vulnerable Children's Act.	• Page 47
Stroke Services	The service plan outlines how we will improve stroke prevention, stroke event survival, and reduce subsequent stroke events; and improve access to organised acute and rehabilitation stroke services.	• Page 48
Long-Term Conditions	The service plan outlines how we will support people in our community with long-term conditions to live longer, healthier and more independent lives.	• Page 49
Cardiac Services	The service plan outlines how we will ensure emergency chest pain care is equitable and timely irrespective of patient's time or place of presentation; continue access and delivery of expected intervention rates for coronary angiography; continue access and delivery of expected intervention rates for cardiac surgery and percutaneous intervention (PCI).	• Page 50
Health of Older People	The service plan aims to ensure older people and their whanau are valued partners in an integrated health and social support system that supports wellbeing and control over their circumstances.	• Page 51 & 52
Mental Health and Addictions (Rising to the Challenge)	The service plan outlines actions and measures to deliver on Mental Health as a regional priority, including Children of Parents with a Mental Illness or Addiction (COPMIA). We will also make better use of resources, improve integration between primary and specialist services, cement and build on gains in resilience and recovery, and deliver increased access for all age groups.	• Page 53 & 54
Youth Health & Wellbeing (and Prime Minister's Youth Mental Health Project)	The service plan outlines a continuum of services that is acceptable, accessible and responsive to young people, including school based services, mental health and addiction services, and primary care services.	• Page 55

Other Service Plans – Regional Collaboration

We are working with other DHBs in the South Island region to reduce the incidence of Rheumatic Fever, deliver a Spinal Cord Impairment action plan, implement a formal regional Major Trauma system to ensure more patients survive major trauma and recover with a good quality of life, and explore the options and benefits of a sub-regional diagnostic laboratory agreement.

For Rheumatic Fever, we will continue to provide a progress report about our regional prevention plan, and will include quarterly reporting of the Case Review (actions taken and lessons learned) of each new case of Rheumatic Fever.

Canterbury DHB is our regional provider of spinal services and regional management and transport protocols are in place to safely ready patients for transfer from our acute services when acute spinal cord injuries present. Canterbury DHB is working alongside Counties Manukau DHB, the Ministry of Health, ACC and the St John Ambulance Service to implement the national Spinal Cord Impairment Action Plan. The approach aims to improve the coordination of services that support people with spinal cord impairment, enhance health outcomes and maximise the quality of people's lives. In line with the New Zealand Spinal Cord Impairment Action Plan 2014-2019, Nelson Marlborough DHB will work in partnership with its regional provider during 2015/16 to implement agreed nationally directed destination and referral processes for acute spinal cord injuries.

For Major Trauma, we are taking the opportunity to work with the South Island Alliance DHBs to develop a nationally consistent data set using data held in the new Patient Information Care System (PICS). PICS will be implemented at Nelson Marlborough DHB in 2016. The data will help to tell us on a national level how well our major trauma services are serving the population and offer further quality improvement opportunities.

We have agreed to develop a sub-regional laboratory strategy for the purpose of establishing the service needs for community and hospital diagnostic laboratory provision and to inform future contracting options. Southern, South Canterbury and Nelson Marlborough DHBs agreed to explore the options and benefits of a sub-regional diagnostic laboratory agreement, due to the alignment of each of our contracts expiring in similar months in 2016. The objectives of the laboratory strategy are to:

- Inform DHB Boards about future direction of laboratory services.
- Identify and recommend options to deliver on the triple aim associated with taking a sub-regional approach to the provision of laboratory services.
- Maintain and or where indicated improve the quality medical laboratory diagnostic services.

Actions to Support Delivery of Regional Priorities

Nelson Marlborough DHB has made a strong commitment to a 'whole of system' approach to planning and service delivery, and this includes regional alliances as well as local alliances.

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

The key actions the DHB will deliver as part of its commitment to the regional alliance are highlighted throughout the plans (see the pink colour-coded regional actions).

2.1.3 ORGANISATIONAL PLANS (NELSON MARLBOROUGH DHB)

Our organisational plans outline how we will support and enable the health workforce to deliver the best healthcare and achieve the best health outcomes for our community. To do this requires support functions at an appropriate level for an organisation the size of Nelson Marlborough DHB.

Delivering on our health promises requires improved quality and strong clinical governance, a capable and engaged workforce, and information systems and infrastructure that enable and enhance integrated service delivery.

The Nelson Marlborough region is one of the few in New Zealand to have two secondary hospitals – Nelson and Wairau (Blenheim). The potential benefits of two secondary hospitals include the ability to deliver services as close to home as possible, and increased capacity to respond to health needs. However, having two secondary hospitals does create challenges for the optimal utilisation of Nelson Marlborough DHB resources, and standardisation of service across the region. Following on from the Top of the South Clinical Services Review in 2014, we are progressing our 'One Service, Two Sites' approach for medical and surgical services in Nelson and Blenheim.

National Entity Priority Initiatives

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

Our IT & Infrastructure plan includes our commitment to implement the national linen and laundry contract, and to transfer local infrastructure to one of two National Infrastructure Platforms (NIP) in Auckland or Christchurch. We will continue to implement Health Connect South (our regional Clinical Workstation), the National Patient Flow requirements from the Ministry of Health, the South Island Patient Information Care System (PICS) to replace our legacy Patient Administration System, and continue to work towards implementation of eMedicines Reconciliation (eMR) and eDischarge Summary. During the coming year we will work towards providing patients with access to a patient portal for core functions.

Our Workforce plan outlines local activities to develop an appropriately trained, motivated, supported and flexible NMDHB workforce. We are also working as a South Island region to increase the number of sonographers; expand the role of nurse practitioners, clinical nurse specialist and palliative care nurses; create new nurse specialist palliative care educator and support roles expand the role of specialist nurses to perform colonoscopies; increase the number of medical physicists; and increase the number of medical community based training place and provide access to primary care / community settings for prevocational trainers.

Organisational Plan (Nelson Marlborough DHB)		Page
Improving Quality and Clinical Governance	This plan outlines how we will drive quality improvement, including supporting the national Open for Better Care patient safety campaign, Quality Safety Markers, and developing an annual Quality Account for our community. The plan also outlines the actions needed to create a no-blame culture based on organisational values and personal responsibility to create an environment in which excellence in clinical care will flourish.	• Page 56
Workforce	This plan outlines how we will develop a capable and engaged workforce to support the transformation of the Nelson Marlborough health system. Building on the Nelson Marlborough DHB Workforce Strategy developed during 2014-15, we will integrate the strategy with the workforce plan for the South Island region.	• Page 57
IT & Infrastructure	This plan outlines how we will continue to invest in improving our clinical IT systems to enhance care delivery, and provide patients in Nelson Marlborough with secure access to their personal health information. The plan also outlines how we will manage and develop our infrastructure assets to support health system transformation, sustainability, safety and security.	• Page 58
Top of the South Clinical Services Plans	These plans outline how we will act on the Top of the South Clinical Services Review and progress our 'One Service, Two Sites' approach for medical & surgical services in Nelson and Blenheim.	• Pages 59 & 60

2.1.4 SYSTEM INTEGRATION PLANS

At NMDHB, we are integrating services across the traditional boundaries of community, primary and secondary settings to enable patients and their families to experience a single system of healthcare in settings as close to home as possible.

Outlining the actions we will take to achieve Health Targets and deliver Health Services does not provide the full picture of what we plan to do in the year ahead, and how we will continue working with organisations outside the Nelson Marlborough DHB to transform the full health system in our region.

Our ability to move towards a single, integrated health service for our community has been supported with increased co-location of hospital and primary care based services [refer to the IT and Infrastructure plan]. In the Nelson area, the NMDHB's public health service staff and the Nelson Bays PHO's staff now operate from a single shared facility in Richmond. This provides us with the opportunity to create a community-facing service, and also supports greater collaboration on common objectives such as improving immunisation coverage and helping people to quit smoking.

Prime Minister John Key officially opened the Marlborough Health Hub in May 2015. The Marlborough Health Hub accommodates PHO staff and NMDHB's public health service, child and adolescent mental health services and child development services. There is some space available for other health organisations within the facility, and we are excited about developing a community health hub in the town centre.

All our clinical pathways have been localised for the Nelson Marlborough region, and are being reviewed to ensure services are provided as close to home as possible for patients, and to identify opportunities for service improvement.

We have made considerable progress towards our goal of delivering more of our services closer to home for patients. More skin lesion removals are now being done in primary care rather than in hospital, along with IV treatments for conditions such as cellulitis which prevent a visit unnecessarily to a hospital. We have developed a Rheumatology service that is multidisciplinary using specialist, nursing and GP resources but based in the community. We also provide some post-surgery follow-up appointments in the community rather than in a hospital, including breast and prostate cancer surgery follow-up appointments.

In the year ahead we will continue to build on our successes to deliver more of our services closer to home for patients.

We will deliver improvements in managing acute demand by reviewing Emergency Department presentations at Wairau Hospital to identify why ED presentations are greater than what is expected for the size and demographics of the Marlborough community. This will be done using a robust project methodology, with a project manager recruited and a general approach agreed in the first quarter. By engaging with stakeholders to identify possible solutions (second quarter), we will develop and deliver a work plan (end second quarter) to reduce the level of ED presentations at Wairau hospital (with implementation during the third and fourth quarter) to ensure we are providing sustainable access to healthcare for patients in the 'right' settings of care.

An Acute Demand Management Steering Group has been established to oversee a number of initiatives that will support care closer to home and ensure only appropriate presentations to the Emergency Department in Nelson. Options for Care, which is similar in approach to the POAC initiatives implemented elsewhere in New Zealand, will be a key focus for this group during 2015. A working group has therefore been established to agree the principles, scope of services and associated claiming mechanisms by July 2015. A staggered roll-out across Nelson Marlborough will then be implemented during the remainder of 2015. An implementation team and associated project plan is also being established (first quarter 2015) to drive the re-development of the COPD pathway. Two key initiatives over Winter 2015 (second and third quarter) are the management of acute exacerbations in conjunction with St. John and Primary Care, and a spirometry roll-out across Marlborough. A GP survey to better understand workforce, facility and available acute appointments has also been initiated with results analysed during the first quarter 2015. In addition a GP patient follow-up pilot is underway in Marlborough to better understand why patients have presented to the Emergency Department (first and second quarter 2015). The research findings from both these projects will be used to inform both the Wairau ED and future acute demand initiatives.

We will also further develop and implement a multidisciplinary community pain programme, beginning with a stocktake of available community services (first quarter 2015), service development (second quarter), and full implementation (by the

third quarter) to support people living with chronic pain, and equip them with self-management strategies and coping skills to better manage their pain at home or in the work place.

As outlined in the Improved Maternal, Child & Whanau Health & Children's Action Plan [refer to page 43] we will investigate the option of moving B4 School Checks into primary care during the first quarter of 2015, while maintaining our achievement of above 90% B4 School Check rate. If the decision is made to progress, we will establish appropriate infrastructure and training of staff (during the second quarter and initiate services (during the third quarter). This will improve access to B4 School Checks and support the establishment of functional, effective linkages to support families with no gaps in service provision.

The Primary Care plan was developed by the Chief Executives of Nelson Bays PHO and Kimi Hauora Marlborough PHO, with the DHB's General Manager of Strategy, Planning and Alliance Support. The plan confirms our continued support for a Rural Service Level Alliance team, and we will develop and implement a plan for distribution of Rural Primary Care Funding according to the agreed process in the PHO services agreement.

Other Annual Plans for our Health System

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

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

System Integration Plans		Page Number
Primary Health Care Capability Action Plan	This plan outlines how the two PHOs in the Nelson Marlborough region will work together to improve primary care capability and capacity, ensure Rural Health services are sustainable and integrated, and Improve Population Health Outcomes by tackling key drivers of morbidity locally, regionally and nationally.	• Page 61
Nelson Marlborough Health System Integration Plan	This plan captures strategic priorities from our Top of the South Health Alliance, Public Health, Maori Health, regional and national initiatives.	• Page 62 & 63

Shorter Stays in Emergency Departments (ED)

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

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

OUTCOME MEASURE: 95 percent of patients are admitted, discharged, or transferred from Wairau and Nelson Hospital Emergency Departments within six hours

ACTION THEME 1: Using Information to Inform Process Improvement

ACTION: Diagnostic/Analysis: ED at a Glance (EDaaG) patient flow reports used to better understand the factors impacting on LoS and quality

MEASURE: Regular analysis of patient flow reports and implementation of associated improvement initiatives

ACTION: Development of process improvement methodology

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

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

MEASURE: After hours transport pathway developed by 31/03/16

ACTION THEME 2: ED Quality Framework

ACTION: Continued measurement and analysis via ED at a Glance (EDaaG) of mandatory framework measures

MEASURE: Implementation of prioritised service improvement activity by June 2016

ACTION: Continued and expanded measurement of non-mandatory measures, as prioritised and recommended by the Clinical Governance group

MEASURES:

- Finalise EDaaG IT requirements matrix including non-mandatory measures: By July 2015
- Complete EDaaG prioritised enhancements: By October 2015
- Finalise revised measures report: By December 2015
- Learn from findings and implement improvements: Ongoing

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

ACTION THEME 3: Acute Demand in ED

ACTION: Assess need for an Acute Admissions Unit

MEASURE: Business Case developed by 31/12/15

ACTION: Implement ED Frequent Presenters resourcing proposal

MEASURE: Establishment of additional nursing coordination resource by 31/12/15

ACTION: Evaluation of Workforce to respond to demand

MEASURE: Development of nursing roles and models of care to strengthen delivery

ACTION: Support implementation of project to ensure appropriate presentations to ED in Marlborough

MEASURE: Project implemented and reduction in presentations achieved

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

Improved Access to Elective Services

OWNER / CHAMPION: Service Manager Surgical Services

OUTCOME GOAL 1: Standardised systems and processes

OUTCOME MEASURE 1: Delivery against agreed volume schedule, including a minimum of 7,445 elective surgical discharges in 2015/16 towards the Electives Health Target

ACTION THEME 1: Delivery and Quality of Care

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

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

ACTION: Embed direct access for patients requiring endoscopy with a high suspicion of cancer

MEASURE: FCT waiting time target of 62 days met

ACTION: Electives referral pathway improvement opportunities identified and referral pathways updated regularly

MEASURES:
50% of elective surgery health pathways reviewed & updated per annum
Elective services pathway and process patient brochure published by June 2016

ACTION: Continue to contribute to South Island elective cancer initiatives including bowel surgery and the endoscopy/colonoscopy programme

MEASURE: Participation in South Island initiatives

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

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

ACTION THEME 2: Future Demand Analysis

ACTION: Using results of Health Needs Analysis and current SIRs to determine future elective surgery demand and associated service implications

MEASURES:
Finalised future growth needs projection for Elective Surgery completed by June 2016
Capacity and service gap analysis completed by June 2016

ACTION: Continue to implement new/updated national CPAC tools

MEASURE: Increased uptake of national CPAC tools to improve consistency in prioritisation decisions

SEE ALSO: Cancer Services

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

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

ACTION THEME 3: Timely Patient Access

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

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

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

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

ACTION: Continue to implement / contribute to the South Island PICS roll out resulting in further standardisation of elective processes

MEASURE: PICS implemented in 2016

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

Cancer Services – Faster Cancer Treatment

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

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

OUTCOME MEASURE: Health Target: 85% of patients referred urgently with a high suspicion of cancer and a need to be seen within 2 weeks, wait 62 days or less to receive their first treatment (or other management) - by July 16
OUTCOME MEASURE: PP 30: 31 day indicator – improvement in the proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management)
OUTCOME MEASURE: Improved quality of data & data collection including FCT records submitted & number of records declined (<10%)

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

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

ACTION THEME 1: Workforce

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

MEASURE: CNC attends regular FCT forums and participates in cross functional service development processes

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

MEASURE: Workload measures fall within nationally accepted benchmarks

ACTION: Implement a dedicated clinical lead and recognised Service Management responsibility for Cancer Services

MEASURE: Position appointed and established by 30/12/15

ACTION: Implement psychosocial support for secondary cancer services through SI regional initiative

MEASURE: Psychosocial position appointed by 30/11/15

CONTEXT: Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Radiotherapy and chemotherapy have been proven to be effective in reducing the impact of a range of cancers and improving treatment outcomes. The national indicators will therefore be used to measure the timeliness of cancer treatment across the whole patient journey, and are representative indicators of specialist treatment efficiency and patient health outcomes. NMDHB's success in achieving previous shorter wait for cancer treatment targets is due to the combined work of local cancer coordinators, oncology services, and the tertiary cancer referral centres

ACTION THEME 2: Faster Cancer Treatment

ACTION: Develop improved information processes and systems that support tracking and prioritisation of patients and provide relevant timely information to clinical decision-makers

MEASURE: Quarterly attendance by FCT admin staff at relevant tumour stream forums

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

MEASURE: MOSAIQ Business Case developed & agreed by 30/06/16

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

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

ACTION: Lead approved round two National Service Improvement Initiatives in conjunction with other S.I. DHBs

MEASURE: Local initiatives implemented in accordance with agreed timeframes

ACTION: Continue to monitor CDHB / CCDHB radiotherapy and NMDHB chemotherapy wait times

MEASURE: Radiotherapy and chemotherapy wait time measures met

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

ACTION THEME 3: Cancer Pathway Improvement

ACTION: Local revision of 2 not previously reviewed national tumour standards
ACTION: Implement tumour standard review findings from 2013/14 and 2014/15

MEASURE: 2 Tumour standards reviewed / implemented, in alignment with the Southern Cancer Network, by 30/06/16
MEASURE: Implementation of prioritised findings

ACTION: Explore need and options for an appropriate Cancer facility by participating in facilities planning

MEASURE: Facility options identified by 30/06/16

ACTION: Implement regionally agreed Multidisciplinary Meetings (MDM) priorities

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

ACTION: Implement national guidance on the use of active surveillance treatment for prostate cancer care

MEASURE: Care pathways & MDM proformas updated to include guidance on use of active surveillance treatment for prostate cancer by June 2016

ACTION: Using the Equity of Health Care for Maori Framework resource and the results of the Maori Cancer Pathway 2014/15 audit findings, implement agreed improvements

MEASURE: Actions prioritised and implemented within agreed timeframes

ACTION: Implement relevant local initiatives associated with the Cancer Health Information Strategy

MEASURE: Local information initiatives implemented as required to facilitate the Cancer Health Information Strategy

Increased Immunisation

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

- Reduction in death and health consequences in vulnerable populations
- Reduced incidence of vaccine-preventable disease

➢ 95% of 8 month olds & 2 year olds & 90% of four-year-olds are fully immunised by age 5 by June 2016.

➢ 75% of those 65 and over are immunised for influenza

➢ 65% of eligible girls receive dose 3 of the HPV (Human papillomavirus) vaccination

Work with Te Piki Oranga (TPO) and PHO Liaison Services to develop immunisation clinics, focusing on influenza, on Marae

➢ Marae based immunisations occur by 30/06/16

Work with General Practice to embed systems to ensure engagement with whanau of newborns

➢ 98% of newborns enrolled by 3 months by 1/10/15
➢ Method of measuring engagement developed by 30/6/16

Establish a process for health care professionals to document reasons for declining and ensure that systems for working with decliners are in place

➢ Number of active decliners in 15-16 are less than in 14-15

Develop a DHB policy on occupational & work with healthcare providers to ensure they have policies in place

➢ DHB occupational pre-employment vaccination policy in place by 31/12/15
➢ 51% of frontline DHB high risk clinical staff are vaccinated according to policy by 30/6/16
➢ All GP Practices have a staff immunisation policy by 31/12/15

Work across agencies to promote immunisation week

➢ Narrative report details immunisation week activities by 28/2/16

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

➢ 10 editorials in community newspapers addressing vaccine preventable diseases (VPDs) across the district by 30/06/16
➢ Annual communications plan developed by 31/7/15

Establish and promote pathways for referrals to Te Piki Oranga (TPO), Kaiatawhai Service and Pacific Health Service to improve immunisation uptake

➢ 95% of Maori, Pacific and high needs population are immunised on time, reported quarterly

Engage with midwives and other antenatal providers to develop interventions to promote vaccinations during pregnancy and provide education regarding the National Immunisation Schedule

➢ DIFs attend at least 1 midwifery forum to promote immunisation and educate on VPDs by 30/06/15

Understand influenza vaccination uptake in pregnancy to develop options to improve vaccination rates

➢ Influenza vaccination in pregnancy options developed by 31/6/16

Investigate possibility of pharmacists as vaccinators

➢ Investigation complete by 31/12/15

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

➢ Annual training offered including use of the delaying or declining pamphlet and on difficult conversations by 30/06/16

Increase HPV immunisation rates by promotional activity, expanding the range of organisations promoting immunisations, and workforce development

➢ Te Piki Oranga promotes HPV immunisations by 31/10/15
➢ HPV Communications strategy developed by 31/7/15
➢ Online learning tools are promoted by 31/8/15

Children presenting at ED and inpatients are assessed for immunisation status and immunisation offered and undertaken before discharge, and explore the viability of each outpatient service assessing and undertaking opportunistic vaccinations

➢ A process for reliably determining immunisation status in ED, inpatients & selected outpatient services developed by 31/12/15
➢ Unvaccinated children in ED, inpatients and selected outpatient services are able to receive opportunistic vaccinations by 31/1/16

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

➢ Governance Group meets at least quarterly

CONTEXT: Immunisation can prevent a number of diseases. It not only provides individual protection but also population-side protection by reducing the incidence of infectious diseases and preventing the spread to vulnerable people. Although vaccination rates have been improving, prior to this time immunisation rates have enabled breakthrough of diseases like measles and whooping cough. Our district-wide Immunisation Facilitation Plan has four key strategic areas for action to improve immunisation coverage: collaborative leadership; community engagement; access and equity; and engagement of health professionals. A key focus is to understand why people decline immunisations and to work to provide people with clear, consistent information about immunisations.

SEE ALSO: Improved Maternal & Child Health module; Maori Health, Public Health and District Immunisation Facilitation Plans (available – NMDHB Strategy Planning & Alliance Support Team);

Better Help for Smokers to Quit

OWNER / CHAMPION:
Service Manager, Public Health

- **OUTCOME**: By 2025, less than 5 percent of the DHB's population will be a current smoker.

OUTCOME: Reduction in the harm to people caused by smoking

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

ACTION: Further staff training to support quality ABC interactions
- Training programme for primary care is completed by 30/6/16

ACTION: Link cessation services with Green script and other services
- General Practice programmes have smoking cessation integrated by 30/6/16

ACTION: Work with Maori & Pacific leadership to role model smokefree behaviours, undertake engagement and health promotion activity at hui, sporting events and marae
- Promotion & engagement activities undertaken each quarter

ACTION: Programmes initiated that focus on youth smoking
- Little lungs programme initiated by 30/7/15
- Childhood organisations have smokefree policies by 30/6/16
- ASH survey undertaken by more secondary schools by 31/12/15

ACTION: Provide information to General Practice of ABC outpatient activity in secondary care
- Information provided by 31/12/15

ACTION: Expand the quit card service to pharmacy
- Selected Pharmacies offer quit card service by 31/12/15

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

ACTION: Provide staff training on the ABC approach at orientation and increase utilisation of e-learning
- 100% of new clinical staff attending orientation receive training
- e-learning incorporated by all hospital areas by 31/8/15

ACTION: Promote referral pathways and embed ABC conversations in outpatients
- Measurement and baseline established for referrals from outpatients by 30/10/15

ACTION: Move to a quality focus of the ABC approach with emphasis on ensuring offering of cessation services
- Internal quality audits show an increase in high quality 'gold' results by 31/12/15

ACTION: Roll out e-learning to Mental Health Managers, Case Managers and NGO mental health providers
- Group cessation activities occurring by 30/06/16

ACTION: Ensure quality and consistency of information recording in the hospital
- Audits undertaken 6 monthly

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

ACTION: Provide education tailored to midwives to support their conversations, in particular with Maori women and whanau.
- Education sessions with midwives held by 30/6/16
- Patient story video available by 31/12/15

ACTION: Implement a smokefree pregnancy incentives pilot
- Pilot implemented by 31/10/15
- Smokefree pregnancy pathway developed by 31/10/15
- Prevalence of pregnant Maori women smoking decreases by 30/6/16

ACTION: Further develop smokefree leadership in the midwifery service with monitoring and feedback
- Feedback reports provided to midwives by 31/08/15
- Midwives represented in the Smokefree Coalition by 31/08/15

ACTION: Improve information flow between GPs, LMC's and smoking cessation services
- Standardised discharge letter to GPs that includes brief intervention information by 31/3/16
- Increase in referrals to cessation providers by 30/6/16

ACTION: Improve the resources available to pregnant women
- Redesigned pregnancy packs distributed by 31/8/15

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

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

More Heart & Diabetes Checks & Diabetes Care Improvement

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

OUTCOME: All people with CVD, high CVD risk, diabetes & prediabetes receive optimal care

- **MEASURE**: 90% of the eligible population will have had their Cardiovascular Disease (CVD) risk assessed within the last 5 years

- **MEASURE**: The proportion of patients with Hba1c above 64, 80 and 100 mmol/mol decreases in 2015-16

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

- Maori Health Providers receive training and expert clinical nurse specialist and/or specialty clinical nurse support for diabetes and cardiac care by 31/12/15
- Expert clinical nurse specialist and/or specialty clinical nurses are linked to General Practices and provide education and support for diabetes and cardiac care by 31/12/15
- Insulin initiations undertaken by 50% more General Practices by 31/12/15
- Access to specialty support/advice is formalised in pathways by 31/12/15

ACTION: IT systems support the workforce in managing diabetes and CVD

- Virtual Diabetes Register data match to Practice Management Systems undertaken by 31/12/15
- Point of Care testing strategy developed by 30/06/16
- Appropriate decision support software tool for vascular risk assessments installed in all general practices by 31/12/15
- Shared care IT solution implemented by 30/06/2016
- Utilise the existing real time reporting functionality to track and guide activity

ACTION: Systems are in place to ensure early identification and treatment of diabetes and cardiac related complications

- Roll-out of MDT foot clinics completed by 30/06/16
- The diabetic retinal screening, grading and management guidelines are implemented when issued
- Measures developed, and feedback provided to practices, of appropriate management of CVD risk
- 90% of those who have had a cardiac event are offered cardiac rehabilitation

ACTION: National guidelines are implemented to ensure quality services are being delivered

- National guidelines for the screening, diagnosis and management of gestational diabetes implemented by 30/06/16
- Work programme to implement the 20 quality standards for diabetes care is in place by 30/08/15

ACTION: Those with pre-diabetes and at high risk of CVD are identified and supported with healthy lifestyle support

- Over 500 people with prediabetes, diabetes or high CVD risk receive nutrition advice through the dietetics service in 15-16.
- Business case for offering lifestyle support for more people at higher risk of a cardiac event completed by 31/7/15
- Referral pathways for healthy lifestyle support are in place.

ACTION: Review the delivery of retinal screening and the interface of the service with primary care

- Implementation plan for retinal screening delivery agreed by 30/6/16
- 2 yearly screens achieved from 30/6/16

ACTION: Reduce health outcome and access inequities for those with, or at risk of, cardiovascular disease and diabetes

- 90% of Maori men in the 35-44 age group have had a risk assessment in the last 5 years
- Maori Health Providers are undertaking CVD risk assessments and linking with General Practice by 31/12/15

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

- Patient surveys show an increase in confidence and ability for those with diabetes to self manage during 2015-16
- Additional nurse led clinics are held according to plan in 15-16

ACTION: Ensure consumers are directly involved in service design

- focus groups and surveys of people with diabetes are undertaken during 15-16 to aid service redesign

CONTEXT: Cardiovascular disease (CVD) is substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. Diabetes is a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of our health service. The number of people with diagnosed diabetes across our district is estimated at around 5,800 and there are an estimated 46,000 people who are considered eligible for a CVD risk assessment. Our Top of the South Health Alliance (ToSHA) CVD and Diabetes Working Group has developed a framework enabling more coordinated care for people with CVD and diabetes; this includes enabling more coordinated care for people with CVD and/or diabetes, improving access to services, increasing engagement, supporting the health workforce, improving the information available and enhancing self-management.

SEE ALSO: Cardiovascular Disease and Diabetes Framework (available from the Strategy Planning & Alliance Support Team; Maori Health Plan; Improved Access to Diagnostics module; Long term conditions module; improved maternal & child health module; Maori Health Plan.

Whānau Ora Action Plan (also refer to the separate Maori Health Plan)

OWNER / CHAMPION: GM Maori Health & Whanau Ora

OUTCOME GOAL 1: Improved health outcomes for Maori in Te Tau Ihu o te Waka-Ā-Māui	OUTCOME GOAL 2: District planning that integrates the Maori workforce and supports long term capacity and capability	OUTCOME GOAL 3: Quality, integrated services that are responsive and person/whanau-centred
OUTCOME MEASURE 1: Improvements for Maori on key indicators of health	OUTCOME MEASURE 2: Joint annual and workforce plans across DHB, PHOs and Te Piki Oranga	OUTCOME MEASURE 3: Positive feedback from Maori about experience of care

ACTION THEME 1: Being focused on outcomes	**ACTION THEME 2:** Building Capacity and Capability	**ACTION THEME 3:** Supporting strategic change
ACTION: Review and re-develop contracted Results Based Accountability (RBA) measures with Te Piki Oranga ➢ **MEASURE:** Review complete and contract updated by December 2015	**ACTION**: Implement the DHB Workforce Development Plan and Maori Health Workforce Action Plan to contribute to increasing the Maori workforce & increasing skills in delivering services responsive to Maori ➢ **MEASURE**: Workforce plan milestones for 15/16 fully implemented	**ACTION**: Review the Nelson Marlborough Maori Health & Wellness Strategic Framework including engagement with Maori communities and cross-sector agencies ➢ **MEASURE**: Strategic framework updated by 30/06/16
ACTION: Complete feasibility studies with both PHOs and with DHB hospital settings on implementing RBA to give greater focus to the impact and outcomes of services ➢ **MEASURE:** Agreements with both local PHOs on feasibility report findings & implementation by 31/03/16 ➢ Agreements with specialist hospital services on feasibility report findings & implementation by 30/06/16	**ACTION:** Work with Te Piki Oranga to ensure that the allocation of non-frontline funding contributes to key workforce development and other health priorities ➢ **MEASURE:** Priorities and Investment plan agreed to by Sept 2015	**ACTION**: Maori Health Monitoring Framework to assess and monitor progress on Maori Health outcomes is agreed by DHB Board and Iwi Health Board ➢ **MEASURE**: Monitoring framework implemented and reviewed at 6-month intervals during 2015/16
ACTION: Engage with Te Piki Oranga & PHOs to develop a joint Maori Health Plan to improve Maori health outcomes ➢ **MEASURE:** Joint plan agreed with TPO & PHOs by 30/6/16	**ACTION**: Design Maori cultural competency e-learning packages for NMDHB and explore broadening access to the e-learning for other parts of the health sector ➢ **MEASURE**: Three additional e-learning packages are implemented during 2015/16	**ACTION:** Joint workplan addressing key strategic priorities developed between DHB Board & IHB Board and PHO Boards ➢ **MEASURE**: Joint work plan agreed to by 30/11/15
ACTION: Develop and implement a health promotion project to improve oral health care for Maori children ➢ **MEASURE:** Project implemented by 30/06/16	**ACTION**: NMDHB will participate in processes led by the Ministry to implement Whanau Ora nationally, including policy / operational discussions that support the roll-out to providers using the Whanau Ora Information System ➢ **MEASURE**: Engagement with the Ministry about the implementation of Whanau Ora Information System	**ACTION:** Work with Te Putahitanga to develop a strategic collaboration for the benefit of whanau ➢ **MEASURE:** Formal arrangement, e.g. Memorandum of Agreement, is signed by 30/04/16

CONTEXT: The Nelson Marlborough Whanau Ora model is unique to this district & is delivered by Te Piki Oranga. Maori community health nurses, community health workers (navigators) & health social workers work across the district as a multi-disciplinary team. Our model is based on the Waka & introduces six hoe – Culturally Secure, Nurturing, Economically Secure, Knowledgeable, Healthy & Leaders. The tikanga which support these hoe are Tapu, Mana, Aroha, Tika & Pono. Health priorities were defined by the local community: diabetes, heart disease, cancers, & respiratory illness. There is a focus on Maori mental health and Tamariki Ora. These domains cover the Maori population (Pepe, Tamariki, Pakeke & Kaumatua) focusing on prevention (breaking the intergenerational challenge) & intervention (managing pre- and diagnosed conditions). NMDHB will form strategic relationships with the Whanau Ora Commissioning Agency, Te Putahitanga, to ensure the aspirations of Whanau Ora locally are aligned to future regional developments. We expect, through local Iwi who are partners to Te Putahitanga, that our own Iwi Health Board will be advised about strategic priorities. For NMDHB this will be achieved through Te Herenga Hauora and working with providers to support national implementation of Whanau Ora.

Improved Access to Diagnostics

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

OUTCOME GOAL 1: More effective and efficient service delivery
OUTCOME GOAL 2: Improved patient tracking and flow

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

ACTION THEME 1: Radiology Access and Improvement

ACTION: Implement National Radiology Service Improvement Initiative agreed actions

MEASURE: Agreed initiatives associated with demand analysis / management, standard scans, capacity, patient flow and production planning implemented by 31/05/16

MEASURE: Communications plan and process developed and implemented for key internal and external stakeholders

ACTION: Participate in sub-regional laboratory strategy development & possibly supplier selection

MEASURE: Sub-regional strategy finalised by February 2016, with potential RFP process initiated May 2016

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

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

ACTION: Progress implementation of improved primary care access to radiology

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

CONTEXT: Good quality and timely diagnostics – primarily imaging and diagnostic laboratory testing, but also hearing and vision assessments – with best practice reporting and clinical analysis, enable better diagnoses and faster identification of disease or injury impact, which ultimately lead to better health outcomes/prognoses for consumers. In 2015-16 we are participating in the National Radiology Service Improvement Initiative.

SEE ALSO: Elective Services, Cardiac Services, Workforce Planning

OUTCOME GOAL 3: Improved performance relative to service targets

OUTCOME MEASURE: 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days
OUTCOME MEASURE: 65% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 120 days
OUTCOME MEASURE: Surveillance colonoscopy – 65% of people waiting for surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days

ACTION THEME 2: Colonoscopy / Endoscopy

ACTION: Review local demand and determine associated capacity / resource over next 5 years

MEASURE: Resourcing Action Plan agreed by May 2016

ACTION: Assess need for an additional scope room as part of the overall facility planning

MEASURE: Requirements and options agreed by June 2016

ACTION: Review and agree action plan for NQUIP recommendations

MEASURE: NQUIP recommendations implemented by December 2015

ACTION: Explore the option of training a Nurse Endoscopist once the national NZ workforce training programme has been agreed

MEASURE: Nurse Endoscopist option reviewed post national agreement

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

ACTION THEME 3: Coronary Angiography

ACTION: Review forward planning and scheduling for angiography

MEASURE: Access to elective angiography is improved

Improved Maternal, Child & Whanau Health & Children's Action Plan

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

OUTCOME: Women, babies, children and their families have access to high quality maternal and child health services and improved health outcomes

MEASURES: 80% of infants are exclusively or fully breastfed at 2 weeks (including Maori) by 30/06/16; 75% are exclusively or fully breastfed at 6 weeks; 60% are exclusively or fully breastfed at 3 months; 65% of infants are fed breast milk at 6 months

MEASURES: 80% of women register with an LMC by week 12 of their pregnancy; 98% of newborns are enrolled with general practice and an oral health service by 3 months; 95% of pregnant women receive continuity of care through a community or DHB LMC

ACTION: Support the implementation of the Children's Action Plan and develop systems to reduce assaults on children

MEASURES:
- Consider, in partnership with key stakeholders, extension of E-Prosafe & National Child Protection Alert System (NCPAS) to primary care by 30/06/16
- Violence Intervention Programme (VIP) training completed within audiology, dietetics, oral health & PHOs by 31/12/15
- Exceptions & remedial actions reported for all audit scores less than 80/100 for the child & partner abuse components of the VIP
- 30% of existing staff & 100% of new staff who have contact with children will have safety checks undertaken by 01/7/15

ACTION: Implement the regional Children's Team in Marlborough

MEASURES:
- Lead Health Professionals identified by 30/08/15
- A pool of trained team members is developed by 30/08/15
- Referral pathways implemented

ACTION: Infants are enrolled and engaged in primary health care services (GP, WellChild/Tamariki Ora 'WCTO', NIR, Community Oral Health COHS, Newborn Universal Hearing screening)

MEASURES:
- 98% of 3 month olds, including Maori, enrolled with a GP & WCTO by 1/9/15
- 95% of preschoolers, including Maori, are enrolled in the community oral health service by 30/6/16

ACTION: Implement actions to improve engagement, quality, safety, experience and continuity of maternity care

MEASURES:
- An annual maternity report is produced by 1/10/15 and a workplan for recommendations developed
- A maternal mental health pathway is embedded by 30/06/16
- Redesigned pregnancy packs distributed by 31/8/15
- Single point of entry for early LMC engagement is made available by 30/6/16
- Vulnerable pregnant women pathway in place/reviewed by 1/7/16
- Electronic Health system (Manage my Health) pilot starts 1/1/16
- Family friendly accreditation developed by 30/06/16
- Consumer engagement is continued
- Work continues with practices to ensure continued and improved rates of newborn enrolment
- Model of care for post operative care for maternity clients is embedded district wide by 31/12/15
- Evaluate patient controlled epidural analgesia by 31/12/15
- Increased advertising of pregnancy & parenting education in 15-16
- Maternity services and Te Piki Oranga meet 6 monthly to place education delivery options with clusters of high need whanau.

ACTION: Implement WCTO Quality Framework local plan.

MEASURES:
- Local plan implementation begins by 30/08/15
- Improved performance on prioritised WCTO Quality Indicators
- B4 School Checks provision in a primary care setting by 1/12/15

ACTION: Support healthy lifestyles in pregnant women & whanau

MEASURES:
- Smokefree pregnancy incentives pilot implemented by 31/10/15
- Work programme for agreed sugar sweetened beverage priorities initiated by 1/7/15
- National guidelines for the screening, diagnosis & management of gestational diabetes implemented by 30/6/16
- Support the healthy start education & skills programme implementation
- 30% of Maori, Pacific & teen pregnant women complete pregnancy and parenting education

ACTION: Move B4 School Checks into primary care, while maintaining our achievement of above 90% B4 School Check rate

MEASURE: 90% of children receive a B4 School Check, including 90% of children living in high deprivation areas and Maori

ACTION: Improve access to breastfeeding support services for Maori women

MEASURES:
- Breastfeeding week promotion
- 'Supporting Maori wahine and breastfeeding' study day 2015
- Te Piki Oranga employee attains Lactation Consultant (LC) qualification
- Hapu Ora programme feasibility determined by 30/06/16
- Feeding support services are reviewed, with a focus on improving access, by 27/2/16
- Increased LC clinic hours

CONTEXT: To have healthy adults we need to ensure we have healthy children; healthy children also need health caregivers and whanau. The Maternity Quality and Safety Plan details much of what NMDHB is doing to ensure coverage of high quality maternity and child health services and improving access and support to vulnerable families. We are working across sectors (such as education, social welfare and justice) to establish functional, effective linkages to support families with no gaps in service provision. ToSHA's Integrated Maternal and Child Health Integration Project is crucial to ensuring the level of collaboration required in the future.

SEE ALSO: Better help for smokers to quit; Immunisation; Stewardship section (safe & competent workforce); Maori Health Plan; Public Health Plan; Maternity Quality & Safety Plan; Mental Health & Addictions (COPMIA)

Stroke Services

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

OUTCOME GOAL 1: To improve outcomes for patients following a stroke event	OUTCOME GOAL 2: To improve access to organised stroke services	OUTCOME GOAL 3: All eligible stroke patients receive appropriate rehabilitation services
OUTCOME MEASURE 1: 6% of stroke patient's Thrombolysed	OUTCOME MEASURE 2: 80% of stroke patients admitted to organised stroke services with demonstrated stroke pathway	OUTCOME MEASURE 3: proportion of patients with acute stroke who are transferred to in-patient rehabilitation service

ACTION THEME 1: Thrombolysis

- **ACTION**: Thrombolysis delivered within NMDHB Stroke Guidelines
- **MEASURE**: 100% of eligible stroke patients receive Thrombolysis within stroke guidelines - 12 monthly Thrombolysis audits

- **ACTION**: Through Alliance and Community Partners promote FAST
- **MEASURE:** FAST campaigns completed in Nelson, Tasman and Marlborough.

- **ACTION**: Develop stroke Thrombolysis quality assurance procedures
- **MEASURE**: 100% of 12 monthly Thrombolysis audits completed as per the national registry data collection; Stroke journey audit (imaging, catheterisation, LOS, Allied Health therapies, AT&R referral, etc)

- **ACTION**: Participate in the national thrombolysis register
- **MEASURE**: National thrombolysis register involvement.

ACTION THEME 2: Organised Stroke Services

- **ACTION**: Embed a dedicated Stroke Nurse, to support patients through stroke continuum
- **MEASURE**: Dedicated Stroke Nurse in Nelson and Wairau Hospital implemented

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

- **ACTION**: Implement and support MDT stroke training opportunities

MEASURES
- MDT Stroke Training Days implemented, e-learning module for dysphagia completed June 16
- Stock take of Stroke Training needs completed Dec 2015

- **ACTION**: Maintain local MDT Stroke Steering Group
- **MEASURE:** Team will comprise Allied Health, Nursing and physician professional and Stroke association members who are involved in the care of stroke patients

ACTION THEME 3: Rehabilitation

- **ACTION**: Stroke patients are referred to Allied Health services for appropriate intervention
- **MEASURE**: 100% of eligible people with stroke admitted to hospital are assessed by Allied Health for their rehabilitation needs

- **ACTION**: All stroke patients receive early active rehabilitation by a multidisciplinary team within 72 hours of admission.

MEASURES
- 60% of appropriate acute stroke patients are transferred to in-patient rehabilitation service within 10 days of admission, reported by Nelson and Wairau.
- All Stroke patients receive a MDT assessment in AT&R within 72 hours

- **ACTION**: Implement a Community Rehab Team in Marlborough.

MEASURES
- 100% of patients appropriate for rehab are referred for community rehab
- Community rehabilitation to commence within 5 working days of discharge from hospital

- **ACTION**: Develop a consistent outcome measure across community and inpatient settings for stroke patients
- **MEASURE**: Consistent Functional Independent Measure developed for community and inpatient settings by Dec 2015.

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

SEE ALSO: Workforce, Cardiac Services

Long Term Conditions

OWNER / CHAMPION: Alliance Support Managers: Health of Older People & Personal Care

OUTCOME GOAL 1: Intersectoral Collaboration to Promote Healthy Lifestyles across Nelson, Tasman and Marlborough Districts.

OUTCOME MEASURE 1: Health Promotion Plan implemented and completed reported 6 monthly.

ACTION THEME 1: Prevention

- **ACTION**: Ensure referral to Green Prescriptions for people who can benefit.
- **MEASURE**: 100% of people who meet the criteria receive Green Prescription.

- **ACTION**: Reduce the number of smokers in the Nelson and Marlborough districts.
- **MEASURE:** 95% of hospitalised smokers are given advice to quit and 90% of smokers in primary care are given advice to quit.

- **ACTION**: Development of an Alcohol Harm Reduction Strategy in line with the NMDHB Position Statement on Alcohol
- **MEASURE**: Alcohol Harm Reduction Strategy approved by the NMDHB by June 2016

OUTCOME GOAL 2: Pro-active recall and management of at risk populations

OUTCOME MEASURE 2: NMDHB ASH rates are lower than national bench mark of 100

ACTION THEME 2: Identification of patients at risk of long term conditions

- **ACTION**: CVD Risk Assessments are undertaken in the community, with a particular focus on Maori men in the 35-44 age group
- **MEASURE**: 90% of Maori men in the 35-44 age group have had a risk assessment in the last 5 years

ACTION THEME 4: Enablers

- **ACTION**: Development of an overarching Long Term Conditions framework across Primary & Secondary services
- **MEASURE**: Long Term Conditions framework across Primary & Secondary services developed by March 2016

- **ACTION**: Develop a local business case to implement and link Health One with Health Connect South (CWS) as a single electronic record for hospital and community based clinicians (e.g. GPs, pharmacists, and St John).
- **MEASURE**: Business case developed by 31/12/2015

- **ACTION**: Sector wide professional development
- **MEASURE**: Education sessions for general practice (including medical, nursing and pharmacy) held by 31/12/15

OUTCOME GOAL 3: Provide co-ordination of access and case management for people with Long Term Conditions

OUTCOME MEASURE 3: 100% of patients requiring co-ordination of Access wait less than 5 days for intake meetings, Nelson and Wairau

ACTION THEME 3: Management - Enhancing Resilience

- **ACTION**: Enable patients with long term conditions to self manage their condition.

MEASURES:

- Patient surveys show an increase in confidence and ability for those with diabetes to self manage during 2015-16
- Development of a community-based respiratory service.

- **ACTION**: Increase awareness and use of Advance Care Planning
- **MEASURE**: Participation in Conversations that Count Campaign 2016.
- **ACTION**: Update Health Pathway for musculoskeletal pain management, non surgical interventions.
- **MEASURE**: Health pathway updated by December 2015.
- **ACTION**: Development of the High & Complex Needs business case, implementing a care coordination role.
- **MEASURE**: Patients with high & complex needs are more effectively managed
- **ACTION**: Continue to develop partnerships with Maori Health Providers
- **MEASURE**: Maori Health Providers are undertaking CVD risk assessments and linking with General Practice by 31/12/15

CONTEXT: Long term conditions include diabetes, cardiovascular disease (including Stroke and Heart Failure), cancer, asthma, chronic pulmonary disease, arthritis and musculoskeletal disease, dementia and mental health problems and disorders. This group represent a major health burden on New Zealanders currently and into the foreseeable future because as the population ages and lifestyles change, these conditions are likely to increase significantly. This group disproportionally affects Maori, Pacific and South Asian peoples. There is strong evidence that integrated care improves patient experience and health outcomes for people with multiple health needs.

SEE ALSO: More Heart & Diabetes Checks, Primary Care, Cancer Services, Mental Health, Home and Community Services, Better Help for Smokers to Quit, IT and infrastructure, Public Health Plan and Workforce development, Cardiac Services (Heart Failure Nurse) and System Integration plans.

Cardiac Services

OWNER / CHAMPION: Service Manager Medicine / Regional Specialist Physician Cardiology.

OUTCOME GOAL 1: Continuing access and delivery of expected intervention rates for cardiac surgery and percutaneous intervention (PCI)

OUTCOME MEASURE: SIR of 6.5 per 10,000 of population for cardiac surgery, and SIR of 12.5 per 10,000 population for PCI, are achieved
OUTCOME MEASURE: 110 elective & acute cardiac surgical discharges

ACTION THEME 1: Access to Secondary Services

ACTION: Ensure appropriate access to cardiac diagnostics and intervention to facilitate appropriate treatment referrals, including angiography, echocardiograms, exercise tolerance tests and FSA

MEASURES
(I): 95% of people will receive elective coronary angiograms within 90 days
(II): Elective Patients wait no longer than four months for first specialist assessment (FSA) or treatment
(III): SIR of 12.5 per 10,000 of population for percutaneous revascularisation

ACTION: Implement agreed clinic reconfiguration so that patients are seen by the most appropriate clinician for their presenting complaint

MEASURE: Independent nursing and other clinician clinics undertaken by 30/6/16

ACTION: Review the ACPP and Community Referred Chest Pain pathways for Maori patients

MEASURE: Care pathway reviews completed by 31/03/16

ACTION: Undertake an equity assessment audit for both chest pain pathways

MEASURE: Equity assessment completed by 31/03/16

SEE ALSO: Maori Health plan; Primary Care (CV screening & nurse led clinics)

OUTCOME GOAL 2: Emergency chest pain care is equitable and timely irrespective of patient's time or place of presentation

OUTCOME MEASURE: 70% of STEMI patients receive primary PCI or are relocated to a PCI centre within 120 min

ACTION THEME 2: Emergency & Acute Chest Pain / ACS

- **ACTION**: Continued use of Accelerated Chest Pain Pathway (ACPP) and establishment of ED based STEMI coordinator
- **MEASURE**: 90% of appropriate patients are treated in accordance with the ACCP

ACTION: Progress introduction of a district wide STEMI Pathway

MEASURE: Following establishment of the STEMI Pathway, 70% of STEMI patients receive primary PCI or are relocated to a PCI centre within 120 min

ACTION: Ensure appropriate access to acute angiography and intervention to facilitate appropriate treatment referrals

MEASURE: 70% of high risk Acute Coronary Syndrome (ACS) patients receive an angiogram within 3 days of admission

ACTION: Using established risk stratification tools contribute data to the Cardiac ANZACS-QI and Cardiac Surgical registers to enable ACS risk stratification and time to appropriate intervention reporting / measurement

MEASURE: >95% of ACS coronary angiography patients have ANZACS-QI ACS & Cath/PCI registry data collected within 30 days

ACTION: Development of appropriate processes, protocols and systems to enable local risk stratification and transfer of appropriate ACS patients

MEASURE: 95% of ACS patients have available risk stratification data

OUTCOME GOAL 3: Continuing access and delivery of expected intervention rates for coronary angiography

OUTCOME MEASURE: SIR of 34.7 per 10,000 of population for coronary angiograph

ACTION THEME 3: Heart Failure

ACTION: Development of a Nelson Marlborough heart failure service (including Te Piki Oranga) with appointment of a specialist heart failure nurse

MEASURE: **(I)** 50% of primary care facilities visited by nurse
(II) 50% of primary care to have conference capability with nurse

ACTION: Continued involvement in regional and national Cardiac Network TCs & forums including clinical lead role in establishing regional care pathways cardiology and non metropolitan representative for the cardiac society (Cardiology HoD)

MEASURE: NMDHB cardiologist attends 90% of cardiac network TCs

CONTEXT: The acute coronary syndromes ('heart attack') represent a spectrum of presentations of a sudden reduction in blood supply to the heart, usually caused by a blood clot within a coronary artery at the site of rupture of a plaque. Coronary heart disease and ACS are important causes of health loss and death in New Zealand, and health inequity; much of this burden is avoidable through a combination of prevention and treatment interventions including those around key risk factors of poor physical activity, diabetes, substance abuse, smoking, and hypertension. In terms of treatment, one of the best opportunities for improving survival for an ACS is reducing the delay from symptom onset to first medical contact, and then the initiation of targeted treatment.

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

OWNER / CHAMPION: Alliance Support Manager: HOP

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

OUTCOME MEASURE 1: Electronic referral for Dementia Support Services from general practice established by Dec 2015.

OUTCOME GOAL 2: Safe independent Living

OUTCOME MEASURES 2
- Increase in people receiving HBSS support versus admitted to ARRC from 1.9% to 2.5%
- Number/%age of people who have received long-term home & community support services that have had an InterRAI assessment & care plan

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

OUTCOME MEASURES 3
- Number/percentage of people who have received long-term support services (home or ARRC) that have had an InterRAI assessment
- Percentage of older people in ARRC who have a second InterRAI LTCF assessment completed 230 days after admission

- **ACTION**: Develop an overarching Health of Older People Strategy and start to pilot initiatives that improve service coordination and care delivery for older people
- **MEASURE**: Health of Older People Strategy developed by December 2015

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

- **ACTION**: Improve community awareness and understanding of Dementia
- **MEASURE**: Review of supports and specialist services for early onset dementia completed by Mar 2016.

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

- **ACTION**: Deliver Walking in Another's Shoes Dementia Training
- **MEASURE**: Two WIAS programmes completed by June 2016

- **ACTION**: Undertaken audit of prescribing for patients in dementia care
- **MEASURE**: Audit results analysed and results feedback to Aged Care Facilities by Dec 2015

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

- **ACTION**: Implement with Home Based Support Providers allocation of specific funding for in-between travel
- **MEASURE**: Implementation completed within specified timeframes.

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

- **ACTION**: Annual on-line InterRAI test undertaken by all InterRAI assessors.
- **MEASURE:** 100% of InterRAI assessors pass the on-line InterRAI evaluations.

- **ACTION**: Ensure referral to Green Prescriptions for people who can benefit.
- **MEASURE**: 100% of people over 65yrs who meet the criteria receive Green Prescription.

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

- **ACTION**: InterRAI Lead Practitioner/Systems Clinician supports provides quarterly InterRAI forums
- **MEASURE**: 100% of ARRC facilities trained and utilising InterRAI by 30/06/15

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

- **ACTION:** InterRAI Lead Practitioner/Systems Clinician undertakes bi-annual audits of assessments and care plans.
- **MEASURE**:100% assessors competency in bi-annual InterRAI audits

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

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

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

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

OUTCOME GOAL 4: Reduce acute demand through rapid response and discharge management.	OUTCOME GOAL 5: Increase in eligible patients receiving relevant osteoporosis care.	OUTCOME GOAL 6: Health of Older people integrated workforce
OUTCOME MEASURE 4: Readmission rates for 65+/75+ population is lower than the national average.	OUTCOME MEASURE 5: 5% Increase in prescribing of biphosphonates.	OUTCOME MEASURE 6: NMDHB maintains HOP specialist FTE
ACTION THEME 4: Implementation of discharge planning and rapid response review findings	**ACTION THEME 5**: Implementation of Fracture Liaison Service	**ACTION THEME 6**: Utilise NMDHB HOP specialists to advise and educate in primary care and ARRC
➢ **ACTION**: Co-ordinated Access (CARES) implemented across NMDHB for physical and mental health. ➢ **MEASURE**: 100% of Co-ordinated Access referrals triaged for over 65yrs.	➢ **ACTION**: People with Fragility Fractures identified and referred to General Practitioner. ➢ **MEASURE**: Number of people per quarter referred to General Practitioner for follow-up after fragility fracture.	➢ **ACTION**: Health of Older People Nurse Educators provide clinical coaching to ARRC and HBSS providers ➢ **MEASURE**: 100% of ARRC facilities receive clinical coaching session by Nurse Educators per year.
➢ **ACTION**: Development & implementation of a district wide discharge care protocol. ➢ **MEASURE:** Protocol developed by December 2015.	➢ **ACTION**: Increase number of people receiving falls prevention intervention. ➢ **MEASURE**: Number of people attending falls prevention programmes in Nelson and Wairau (incl Allied Health Services).	➢ **ACTION**: HOP Specialists provide advice and training to primary care and ARRC facilities. ➢ **MEASURE**: One session per quarter to ARRC and/or primary care.
➢ **ACTION**: Acute demand management proposal developed by September 2015 for >65 in Marlborough ➢ **MEASURE**: Proposal approved by Top of the South Health Alliance	➢ **ACTION**: Increase Vitamin D prescription ➢ **MEASURE**: 100% of ARRC facilities meeting Vitamin D target of 70%.	➢ **ACTION**: Older Person's Mental Health Liaison Nurse provides advice, education and expertise to Aged Residential care. ➢ **MEASURE**: Maintain Older Person's Mental Health Liaison Nurse FTE at 1.8 FTE
➢ **ACTION**: Review pre-admission questionnaire to ensure it reflects the needs of older people. ➢ **MEASURE**: Pre-admission questionnaire updated by Sept 2015.	➢ **ACTION**: Community Pharmacy Facilitators complete poly-pharmacy reviews in Aged Residential Care. ➢ **MEASURE**: 12 reviews completed by June 2016.	➢ **ACTION**: Improve end of life planning in Aged Residential Care (ARRC) ➢ **MEASURE**: 100% of ARRC facilities receive Palliative Care training from Hospice Nurse Educators.

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

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

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

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

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

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

- **ACTION**: Develop pathways for stable clozapine clients to transition to general practice care, while still attending the nurse-led clinic. (also contributes to Theme 4)
- **MEASURE**: Increase in % of clozapine patients receiving primary care-led services.

- **ACTION**: Improve the liaison between GPs & psychiatrists to facilitate consultation to support GP management of care. (also contributes to Theme 4)
- **MEASURE**: No. of clients discharged to primary care

- **ACTION**: Progress development of a single shared care plan across Mental Health & Addiction specialist and NGO services.
- **MEASURE**: Shared care plan process established by 30/06/16

ACTION THEME 2: Build on Resilience Gains and Recovery

- **ACTION**: Ensure flexible packages of care that address key needs to support recovery (e.g. dental care, vocational support, physical health and access to appropriate accommodation)
- **MEASURE**: No. of individual packages of care

- **ACTION**: Strengthen participation & leadership of service users by supporting the development of Peer-led services
- **MEASURE**:
- Peer facilitated recovery groups piloted by 30/06/16; Business Case for Peer-led crisis alternative to admission developed by 30/06/16

- **ACTION**: Implement agreed actions from the Residential Review
- **MEASURE**: All agreed actions are implemented by 30/06/16

- **ACTION**: Progress work to reduce seclusion with Te Pou's Six Core Strategies
- **MEASURE:** No. of sensory modulation sessions/hours

- **ACTION**: Extend liaison with General Practice Teams to ensure consumers physical health needs are addressed and they are referred to lifestyle support services as required
- **MEASURE**: Pathway for health checks at Nikau House and Kawai Clinic reviewed to include sharing information with GPs. CME session provided for GPs

ACTION THEME 3: Increasing Access

- **ACTION**: Implement locally agreed stages of the Ministry's COPMIA guidelines
- **MEASURE**: Two local actions are implemented by 30/06/16

- **ACTION**: Increase opportunities to access support services 'after hours' (e.g. medication support)
- **MEASURE**: After hours community support work established by 31/12/15

- **ACTION**: Review use of Community Treatment Orders (CTOs) for Maori.
- **MEASURE:** Implement any agreed alternative pathways by 31/12/15.

Contribution to Rising to the Challenge 2012-2017 (The Mental Health & Addiction Service Development Plan) continued…

ACTION THEME 4: Improve Primary and Specialist Integration

- **ACTION**: Review the client caseload of specialist services to ensure appropriate transition to primary care-led management, where indicated
- **MEASURE**: Client cases reviewed with appropriate discharge to primary care by 30/06/16

- **ACTION**: Explore implementation of a decision support tool for depression and anxiety across primary and specialist services to support best practice treatment.
- **MEASURE**: Decision support tool implemented or alternatives identified by 31/12/15

- **ACTION:** Implement the Transition Planning Guidelines for young people transitioning from child and youth Mental Health and Addiction services.
- **MEASURE**: Transition planning policies and protocols are reviewed to incorporate the guidelines by 30/06/16

ACTION THEME 5: Workforce Development

- **ACTION**: Provide Directorate-wide training in Co-Existing Problems to increase service capability.
- **MEASURE**: Two training sessions provided for Mental Health workforce

- **ACTION**: Provide training in sensory modulation for personnel in Older Persons Mental Health services.
- **MEASURE**: Two training sessions provided for Older Persons Mental Health workforce

- **ACTION:** Education and training is provided to strengthen the community support work workforce.
- **MEASURE**: Gap analysis and training needs analysis completed by 30/06/16

- **ACTION**: Develop and expand the peer support workforce (also links to Action 6)
- **MEASURE**: Two training sessions provided for peer support workforce

ACTION THEME 6: Suicide Prevention

- **ACTION**: Finalise the District suicide prevention and postvention plan
- **MEASURE**: District suicide prevention and postvention plan submitted by 20/07/2015

- **ACTION**: Explore opportunities for workplace suicide prevention initiatives, with a focus on primary industries.
- **MEASURE**: Sector workshop on workplace suicide prevention takes place by 30/06/16.

- **ACTION**: Continue to offer workforce development opportunities for the sector and community
- **MEASURE**: Two workshops or training sessions in suicide prevention provided

- **ACTION**: Implement a 'pilot' youth resilience/entrepreneurial skills initiative with rangatahi and a local marae if resources allow.
- **MEASURE:** Pilot implemented and evaluation by 30/06/16

- **ACTION**: Review and redevelop pathways for postvention services
- **MEASURE**: Pathways for postvention confirmed by 30/09/15

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

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

Youth Health & Wellbeing

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

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

ACTION THEME 1: School Based Health Services

- **ACTION**: Using "Youth Health Care in Secondary Schools: A framework for continuous quality improvement", work with one further education setting to implement the quality improvement framework
- **MEASURE**: Quality Improvement framework applied in one additional setting implemented by 30/06/16

- **ACTION**: Maintain existing school based health services & improve the efficiency of referrals to services when issues are identified
- **MEASURE**: Develop health pathways for 2 key youth health issues

- **ACTION**: Support a 'Teen Health Fest' in at least 4 schools
- **MEASURE**: Teen Health Fest held in Youth Week 2016

ACTION THEME 4: Improving the follow-up care for those discharged from CAMHS & AOD Youth services

- **ACTION**: Operationalise the Ministry of Health Transition Planning Guidelines for young people transitioning from child and youth Mental Health and Addiction services.
- **MEASURE**: Transition planning policies and protocols are consistent with the guidelines by 30/06/16

ACTION THEME 2: Youth Primary Mental Health & Addiction services

- **ACTION**: Maintain a specific allocation of funding to ensure access for young people to the primary mental health services
- **MEASURE**: 15% of all PMHI contacts are for youth aged 12-24 yrs.

- **ACTION**: Participate in intersectoral activities that support the promotion of youth mental health and early intervention.
- **MEASURE**: Three activities implemented by 30/06/16

- **ACTION**: Explore the feasibility of expanding Coordinated Access (CARES) to all youth referrals across DHB & Primary Care
- **MEASURE**: Study completed and feasibility determined by 30/06/16

ACTION THEME 5: Improve Access to CAMHS & Youth AOD services through wait time & integrated case management

- **ACTION**: Continued focussing on meeting waiting time targets

MEASURE: 80% of children & youth access specialist services within 3 weeks of referral by 30/06/16; 95% within 8 weeks by 30/06/16

- **ACTION:** Work collaboratively across MH & Addictions to develop integrated care plans for young people with MH and AOD issues.
- **MEASURE**: Evidence of integrated care plans

ACTION THEME 3: Improving the responsiveness of primary care to youth

- **ACTION**: Establish & utilise the Youth Health alliance group to ensure implementation of Annual Plan actions & to plan & oversee future improvements in youth health service delivery & access
- **MEASURE**: Agreed initiatives are implemented by 30/06/16

- **ACTION**: Continue a youth focus for workforce development, including providing HEEADSSS assessment training to targeted groups of clinicians
- **MEASURE**: HEEADSSS training provided to trainee doctors and in two rural areas by 30/06/16

- **ACTION**: Support workforce development to increase capability in working with Maori youth
- **MEASURE**: Workforce plan actions implemented

- **ACTION**: Support a network for youth health clinicians to further increase collaborative clinical practice.
- **MEASURE**: Local clinical network meets 3 times in 2015/16

- **ACTION**: Employ mechanisms for engaging youth in service planning & design & in evaluating services gaps and effectiveness
- **MEASURE**: Evidence of youth involvement in service planning, design and evaluation by 30/06/16

SEE ALSO: Maori Health Plan; Mental Health & Addictions; Maternal, Child & Whanau Health & Children's Action Plan Plan; Better Help for Smokers to Quit

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

Improving Quality & Clinical Governance

General Manager Clinical Governance Support and Chief Medical Officer

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

OUTCOME MEASURE 1: **40% response rate for the Patient Experience Survey**
OUTCOME MEASURE 2: **80% of patients have confidence and trust in the staff treating them** (overall question in Patient Experience Survey)
OUTCOME MEASURE 3: **All Quality Safety Marker (QSM) targets achieved and improved upon**

Culture & Vision

- **ACTION:** Promote and implement the NMDHB clinical governance framework
- **MEASURE**: NMDHB clinical governance framework developed by July 2015

- **ACTION**: Development of a self-audit tool for creating an environment for clinical excellence to flourish
- **MEASURE**: Clinical excellence self-audit tool developed by September 2015

- **ACTION**: Strengthen clinical advice to the Board and increase clinical participation at Board level
- **MEASURE**: 80% of clinical papers to the Board are presented by the appropriate clinician

Information & Reporting

- **ACTION**: Regular review of patient experience survey results and development of an action plan
- **MEASURE:** Quarterly patient experience reviews completed from July 2015 onwards and appropriate actions taken

- **ACTION**: Demonstrate a commitment to QSM targets and regularly review data to sustain and improve on achievements
- **MEASURE:** Quarterly patient QSM reviews completed from July 2015 onwards and appropriate actions taken

- **ACTION**: Quality Safety Markers (QSMs) performance update included in the 2015 Quality Account
- **MEASURE**: 2015 Quality Account published by end of November 2015

- **ACTION**: Local mortality review teams contribute to national mortality and morbidity reviews
- **MEASURE**: Participation in national mortality and morbidity reviews

Capacity & Capability

- **ACTION**: Develop a clinical governance and quality improvement calendar of training
- **MEASURE**: Clinical governance and quality training calendar developed by December 2015

- **ACTION**: Develop a consumer engagement strategy, with an emphasis on Health Literacy
- **MEASURE**: Consumer engagement strategy developed by September 2015

- **ACTION**: Develop a programme to create a Just Culture based on organisational values & personal accountability
- **MEASURE**: Culture programme developed by November 2015

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

SEE ALSO: IT & Infrastructure Plan (e Medicines Reconciliation linkages); Top of the South Clinical Services Development: Surgical; Workforce Development plan, and Stewardship section.

Workforce Development

General Manager Human Resources; Director of Nursing & Midwifery; Director of Allied Health; Chief Medical Officer

OUTCOME GOAL: Optimised workforce capacity	OUTCOME GOAL: Productive workplace culture	OUTCOME GOAL: Advanced workforce capability
OUTCOME MEASURE: Increased capacity	OUTCOME MEASURE: Increased staff engagement	OUTCOME MEASURE: Increased capability

Implement the prioritised actions of the NMDHB Workforce Strategy

CAPACITY	CULTURE	CAPABILITY
➢ **ACTION**: Establish system-wide recruitment targets for Maori, Pasifika and migrant populations to match our community demographics	➢ **ACTION**: Conduct a staff engagement survey to identify areas for improvement and develop an engagement plan	➢ **ACTION**: Implement Leadership & Management Domains framework
➢ **MEASURE**: Targets developed by December 2015	➢ **MEASURE**: Staff engagement survey action plan developed by July 2015	➢ **MEASURE**: Action plan to implement Leadership & Management Domains framework developed by December 2015
➢ **ACTION**: Implement the national Workforce Intelligence & Planning framework	➢ **ACTION**: Develop a recognition scheme to celebrate achievement and years of service	➢ **ACTION**: Develop a local leadership & management capability framework based on existing national resources
➢ **MEASURE**: Workforce Intelligence & Planning framework implemented by June 2016	➢ **MEASURE**: Recognition scheme developed by September 2015	➢ **MEASURE**: Local leadership & management capability framework developed by June 2016
➢ **ACTION**: Support the national 'Grow Our Own' project by implementing a local talent development solution	➢ **ACTION**: Develop a programme to create a Just Culture based on organisational values & personal accountability	➢ **ACTION:** Make decisions on Models of Care and emerging roles for nursing, midwifery, Allied Health, kaiawhina and medical
➢ **MEASURE**: Local talent development solution developed by December 2015	➢ **MEASURE**: Culture programme developed by November 2015	➢ **MEASURES:** By June 2016: ➢ Integrated Models of Care developed & agreed ➢ Clear direction for senior nursing roles developed & agreed

CONTEXT: An appropriately trained, motivated, supported and flexible workforce is essential for NMDHB to provide high quality, safe and sustainable health services to our population. However, we are facing significant workforce challenges including an ageing workforce, growing demand for health and care workers, and national skill shortages for specific roles. We are working towards a workforce that reflects our local community demographics, and to support staff to reach their full potential to ensure we have the capacity, capability and flexibility that will be required in the future.

SEE ALSO: Maori Health Plan; Improving Quality & Clinical Governance Plan; and Stewardship (Strengthening our Workforce; and Safe & Competent Workforce).

IT and Infrastructure

OWNER / CHAMPION: General Manager IT & Infrastructure and CDC Community Based Services

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

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

SUSTAINABLE HEALTH SYSTEM INFRASTRUCTURE

- Define functional requirements for site redevelopment as part of the strategic facility master plan for the Nelson Marlborough health system
- Functional requirements developed by December 2015
- Treasury business case for site redevelopment commenced early 2016

- Implement the Health Benefits Limited (HBL) Linen contract
- Implement regional contract by 30/06/2016

- Systematically reduce the average age of our motor fleet
- Average motor vehicle age to be under 6 years by 2018

- Complete co-location of DHB and PHO services
- Nelson - Phase II completed by 30/06/2015; Marlborough – Phase I completed mid 2015

- Conduct security review and develop a prioritised investment plan to increase security and safety
- Initial security improvements implemented by mid 2016

DIGITAL HOSPITAL

- Refresh existing desktop stock to increase timely access to electronic information and support implementation of new regional systems
- Majority of desktop infrastructure is less than 5 years old by June 2016

- Begin transferring local infrastructure to one of two National Infrastructure Platforms (NIP) in Auckland or Christchurch
- 100% of all agreed local infrastructure transferred to NIP by 30/6/2018

- Implement PAS stability programme until implementation of regional PICS in late 2016
- PAS stability programme implemented by 30/06/2015

- Establish proof of concept for use of tablets at the bedside at Wairau Hospital
- Initial proof of concept completed by 30/06/2016

- Introduce e-Triage to receive and manage all referrals electronically
- Implementation plan agreed by 30/06/2016

SINGLE ELECTRONIC RECORD

- Develop a business case & implement Health One; subject to business case at NMDHB
- Work with the region to develop a plan for PICS and HCS integration

- Business case developed by 31/12/2015

- Provide patients with access to a patient portal for core functions

- Initial proof of concept for a patient portal underway at NMDHB

NOTES:

- A 'Paper Lite' strategy is under development for the Nelson Marlborough DHB which underpins a broader vision of digital hospitals & a digital health system.
- Dispensation sought for progressing to next phase of **NPF** as it will require significant investment in a system that is being phased out:.
- Health One needs to be a joint project between NMDHB, Nelson Bays PHO and Kimi Hauora Marlborough PHO

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

SEE ALSO: Primary Care Plan (infrastructure linkages, Health One linkages).

Top of the South Clinical Services Development Surgical

Service Manager Surgical Services and Clinical Director Surgical Systems

Delivery of a safe, one service, two site, model of secondary service delivery

OUTCOME MEASURES:

District wide consistent access to services; Improved patient safety and quality; Increased theatre efficiency and sustainability; A sustainable regional workforce

Patient Safety & Quality

- **ACTION**: Develop action plan to achieve QSM surgical site infection reduction targets
- **MEASURES:**
  - Action plan developed by 1 July 2015
  - QSM surgical sites infection reduction targets achieved by July 2016

- **ACTION**: Develop action plan to achieve QSM surgical safety checklist target
- **MEASURES:**
  - Action plan developed by December 2015
  - All three parts of the surgical safety checklist are used in 100% of operations by July 2016

Theatre Efficiency & Sustainability

- **ACTION**: Develop action plan to achieve improved theatre efficiency
- **MEASURES**
  - Action plan developed by 1 July 2015 with specific targets to achieve by July 2016:
    - Increased number of lists that start on time
    - Reduced turnaround time between cases

Workforce & Culture

- **ACTION**: Develop NMDHB protocol for Multi Disciplinary Team Meeting
- **MEASURE** : NMDHB Multi Disciplinary Team Meeting protocol developed by 1 July 2015

- **ACTION**: Develop succession plans for surgeons at Wairau Hospital
- **MEASURE**: Succession plans developed for 80% of surgeons by 2016

- **ACTION**: Review services & procedures to identify tasks suitable for emerging nursing roles; Develop b-case for suitable roles
- **MEASURE**: Business case for emerging nursing roles developed by June 2016

- **ACTION**: Develop regional workforce plan and identify staff impacts (e.g. travel, accommodation, rostering)
- **MEASURE**: Regional workforce plan developed by June 2016

CONTEXT: The review of clinical services across Nelson & Wairau hospitals was undertaken to: ensure sustainability of our services for the population of the district; improve quality of services and implement continuous quality improvement; ensure the district's population benefit from equity of access to services; optimise our 24/7 acute and elective coverage; and ultimately improve care for patients and consumers (reducing serious & sentinel events). During 2015/15 the recommendations of the review lead by Bryan Thorn (Chair), an Orthopaedic Surgeon from the Bay of Plenty DHB, will continue to be implemented.

SEE ALSO: Health Target: Cancer Services / Faster Cancer Treatment; Health Target: Electives & Improved Access to Elective Surgery: Improved Quality & Clinical Governance; and Workforce Development

Top of the South Clinical Services Development Medical

Service Manager Medical Services and Clinical Director Medical / Surgical Services

OUTCOME GOAL 1: Equitable Service Delivery

OUTCOME MEASURE 1: Services are delivered equitably

ACTION THEME 1: Value patient's and clinician's time to deliver services closer to home

- **ACTION**: Ensure equity of access by creating single Nelson Marlborough wait lists for selected services.

- **MEASURE**:
- Single Nelson Marlborough waitlist created for selected services by July 2016
- Equitable waiting times for patients in Nelson and Marlborough.

- **ACTION**: Implement consistent care pathways across the Nelson Marlborough district.

- **MEASURES**:
- Review of selected care pathways completed by July 2016 with a focus on increased shared care with Primary care.

OUTCOME GOAL 2: Staff Support and Retention

OUTCOME MEASURE 2: Improved engagement as measured by the Staff Survey

ACTION THEME 2: Staff work well when they are supported at the top of their licence

- **ACTION:** Develop common district wide understanding of models of care and services provided by different workforce groups.

- **MEASURE**:
- All SMO and Senior Nurse roles have a district wide focus, including Acting roles, by July 2017
- Inclusion of engagement in annual appraisals achieved with identified work addressed.

OUTCOME GOAL 3: Maintenance of Acute General Services

OUTCOME MEASURE 3: Reduced cost of Locums

ACTION THEME 3: Consistent Service Provision

- **ACTION:** Reduction in overdue follow up appointments.

- **MEASURE**:
- Reduction in overdue follow up appointments across all services by July 2016
- Development of alternative ways of managing workload demands.

- **ACTION:** Continue to establish sustainable service for Nelson medical registrar night cover.

- **MEASURE**: Sustainable Nelson medical registrar night cover service with appropriate funding agreed by July 2016.

CONTEXT: The review of clinical services across Nelson & Wairau hospitals was undertaken to: ensure sustainability of our services for the population of the district; improve quality of services and implement continuous quality improvement; ensure the district's population benefit from equity of access to services; optimise our 24/7 acute and elective coverage; and ultimately improve care for patients and consumers (reducing serious & sentinel events). During 2015/15 the recommendations of the review lead by Bryan Thorn (Chair), an Orthopaedic Surgeon from the Bay of Plenty DHB, will continue to be implemented.

SEE ALSO: Workforce Development; Top of the South Clinical Services Development Surgical

Primary Health Care Capability Action Plan

OWNER / CHAMPION:
CE Kimi Hauora Marlborough PHO and CE Nelson Bays Primary Health

OUTCOME GOAL 1: Improve Population Health Outcomes by tackling key drivers of morbidity locally, regionally and nationally

OUTCOME MEASURE 1: Primary care is supported to strategically develop improved access to care, preventative care strategies, responsiveness to acute demand and long term condition management

ACTION THEME 1: Primary care is well placed to respond to care and support for patients and whanau across the continuum

ACTION: Improved access to care

MEASURE:
- Free access available for all under 13yr olds in Primary care
- New-borns are enrolled with a PHO within four weeks of birth
- Patient portals are implemented across 20% of the network
- e-Enrolment implemented within General Practice by June 2016
- Emergency Contraception pill district wide by 09/2015

ACTION: Preventative care

MEASURE:
- IPIF indicators are achieved and capability met
- Childhood obesity interventions & smoking prevention are undertaken across the district

ACTION: Acute Demand- reduction in ED presentations

MEASURE:
- Direct access to plain film after hours for 90% of GPs
- Rapid response capability decision made by December 2015
- ED project manager recruited Q1 2015; Work plan delivered Q2 2015; Reduction of non-appropriate ED presentations at Wairau hospital 30/06/16

ACTION: Long Term Condition management

MEASURE:
- Implement a sustainable community pain programme for people with early onset musculoskeletal pain, orthopaedic issues by 30 June 2016
- Develop community-based services for diabetes and COPD services, implement pathways and develop self-management and supportive management district wide

OUTCOME GOAL 2: Primary care capability and capacity is improved

OUTCOME MEASURE 2 & 3:
- Workforce development plan agreed and in place.
- Clinical leadership and governance structures are robust.
- Consumer input strategies are implemented

ACTION THEME 2: Enhance clinical and consumer leadership and workforce development strategies to be implemented to support integration and coordination capability across the Health and Social System

ACTION:
1. Ready Nursing workforce for primary care prescribing module
2. Support Marlborough PHO with registrar and GP recruitment processes
3. Further support GPs to work at their Top of scope through GPSI type model

MEASURE:
- 5% of Nursing workforce is working toward obtaining Nurse Prescribing status
- Dedicated registrar places are agreed for implementation from 11/16
- Development of Options for Care training for General Practitioners

ACTION: Clinical and consumer leadership and governance supposed across the district Stock take of Clinician's leadership role vacancies to be undertaken by 09/15

MEASURE:
- Well supported clinical governance structures in place across the system, with clinicians sitting on more than one of the three governance committees.
- All clinical leadership role vacancies filled by 03/16
- Consumer involvement plan is developed and in placed by 12/15

ACTION:
- 1. COPD pilot completed and evaluated by Q2 2015
- 2. Increased co-location of hospital and primary care based services in to both PHOs across the district
- 3. GP capacity survey results analysed during Q1 2015

MEASURE:
- Spirometry services established at 8 GP practices in the district.
- Acute exacerbation pathway and services for COPD implemented
- Co-location – Diabetes, Cardiac and Respiratory (Wairau) nurses will have a greater presence in the community setting.

OUTCOME GOAL 3: Rural Health services are sustainable and integrated

OUTCOME MEASURE 4:
- Integrated models of care are in place across our rural regions

ACTION THEME 3: Rural health services are enhanced and sustainable

ACTION: The ToSHA SLAT will work to operationalise the rural funding and rural flexible funding contracts; and review the equity of PRIME services across NMDHB

MEASURE:
- Rural funding distribution and rural flexible funding agreed by the SLAT,
- SLAT review of the PRIME model of service delivery by 03/16

ACTION: Integrated Models of care

MEASURE:
- Models of care are well recognised and understood across the region
- Business case investigated for rural private provision of Allied Health services

ACTION: Technology advances

MEASURE:
- Remote / virtual technologies are trialled in rural areas with willing practices by April 2016

ACTION: Equity of Access

MEASURE:
- Services are flexible and adaptable to meet the needs of rural communities and utilise local resources when possible

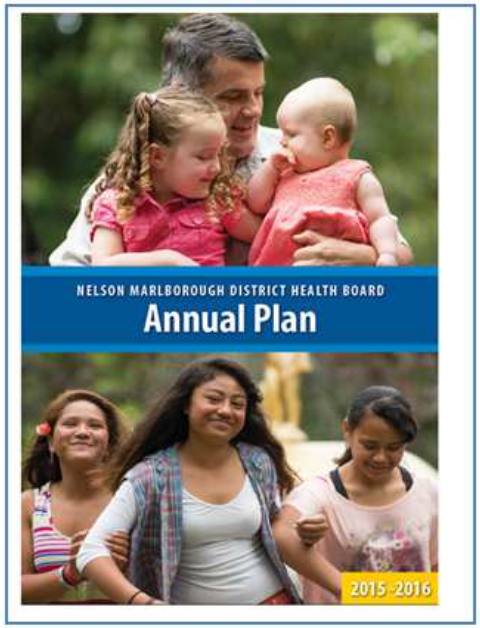
SEE ALSO: Long term conditions, Immunisation, Maternal & Child Health, Access to Diagnostics, Mental health & Addictions, Workforce development, Secondary services and IT& Infrastructure.

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

Nelson Marlborough Health System Integration Plan

Key Public Health Plan Themes / Initiatives

- **Reduce Obesogenic Environments**
- **Sugar-Sweetened Beverages Action Plan**
- **Fluoridation Policy Statement**
- **Alcohol Harm Reduction Strategy**



Key Maori Health Plan Themes / Initiatives

- **Access to Care** – ASH, PHO enrolment
- **Data Quality** – ethnicity reporting, PHO enrolment registers
- **Cancer Screening** – cervical, breast
- **Cardiovascular Disease** – screening coverage & subsequent treatment
- **Child Health / Oral Health** – breast feeding, enrolment with Oral Health Services
- **Immunisation** – childhood; influenza 65+
- **Mental Health** – S29 CTOs for Maori
- **Smoking Cessation** – pregnant women

- **Promoting Health** – Nutrition & Physical Activity initiative in education settings; Referral Pathways; Coordinated Planning; Alcohol Harm Reduction
- **Workforce** – Recruitment targets for Maori, Pasifika & migrant populations
- **Improved Access for At Risk Communities** – Pilot initiative
- **Child & Maternal Health** – WCTO quality improvement; Access to B4 School Checks

Context: The Nelson Marlborough DHB Annual Plan needs to be reviewed together with the Public Health Plan, Maori Health Plan and South Island Regional Services Plan to provide an accurate reflection of overarching transformation of the Nelson Marlborough region's health system. The DHB and its PHO partners are currently undertaking a refresh of the Health Needs Assessment which will form the foundation of discussions for Health Services Plans to be developed in the 15/16 year

System Integration Plan (Strategic Priorities not necessarily included in other DHB Action Plans)

Key Top of the South Health Alliance (ToSHA) Initiatives

Primary Care Strategy –development of a Primary Care framework that informs a common understanding of what can be provided in primary care across the district, with due consideration of access, workforce and sustainability

Medicine Management Group– support pharmacy facilitators in the community to collaborate with GP practice and ARC services to optimise patient medication management. Collaboration of pharmacy committees across the community will also enable a more integrated view of the pharmacy system in the district and better support the optimal use of medicines in NMDHB

Primary and Community Nursing – development of a long term conditions framework for the Nelson Marlborough region. This will in turn inform workforce development opportunities for primary and community care.

Health of Older People – development of a strategic plan including a series of collaborative, innovative initiatives that will facilitate keeping people well in their preferred locality for longer

Acute Demand Management - reduce unplanned presentations to secondary care through: better understanding GP capacity, improve patient understanding about where to present, lead and establish the provision of additional GP acute services, and develop an integrated COPD self management pathway

Long Term Conditions – established work streams will continue to work on CVD & diabetes target achievement, shifting diabetes care from secondary to primary care for select patient groups, and implementation of the newly released diabetes quality standards.

Rural Services - Work stream is currently working to agree service models, rural and flexible funding contract operationalisation and undertake a review of PRIME services

Access to Diagnostics –implement primary care direct access to plain film X-rays; once established, to consider access to more complex radiology investigations

Primary and Public Health – working group established to realise the gains associated with colocation, including collaboration in health promotion space and better use of workforce resources

Child & Maternal Health – working to ensure all whanau across the Nelson Marlborough region experience a safe, positive journey through maternity, child health, and social services. A Healthy start will better enable them to lead fulfilling lives.

CONTEXT: Nelson Marlborough DHB is working collaboratively with its two local PHOs, and Iwi provider, through the Top of the South Health Alliance (ToSHA). Together with Nursing, Allied Health, and Pharmacy service representatives, ToSHA is strategically positioning itself to consider the major area where it can demonstrate significant impact and transformational change through collaboration across the system. There are a variety of work streams under development and in progress. The above reflects the agreed work plan for each of the work streams at the time of writing. A variety of integration enablers exist to support these initiatives including Health pathways, ERMS, CARES, and Access to Diagnostics. While the enablers are not necessarily described in detail above, they are foundational building blocks to better service delivery. Once informed by the HNA and HSP (noted on the previous page), it is expected that selected health pathways will be reviewed (through the established multi-disciplinary team) and further customised for the NMDHB health system.

STATEMENT OF PERFORMANCE EXPECTATIONS

We aim to provide the best healthcare and achieve the best health outcomes for our community. We have an over-arching strategy called 'Health for Tomorrow' which outlines what we will do long-term. The actions required to deliver this long-term strategy and meet the priorities outlined by the Minister for the coming year are documented in the health target and service plans provided in this Annual Plan – Section 2: Delivering on Priorities and Targets.

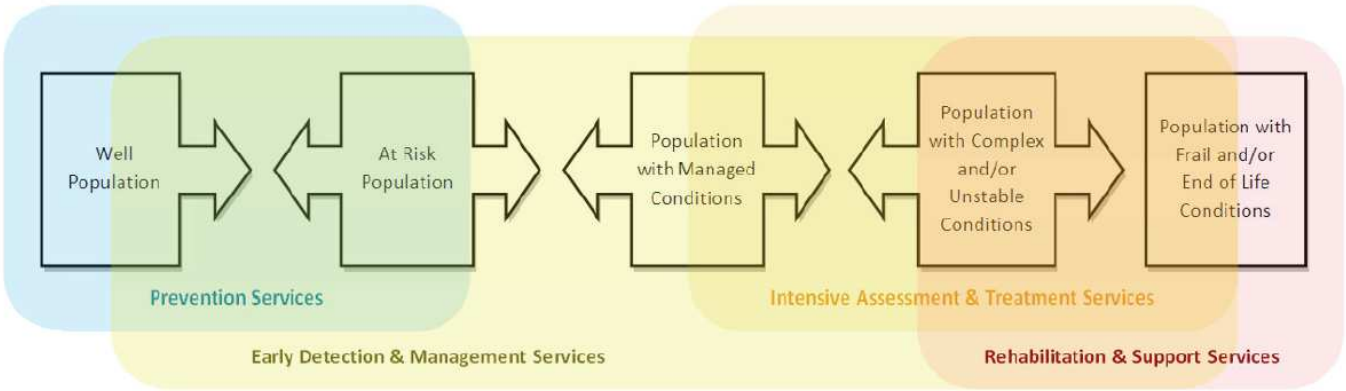
We need to monitor our performance to evaluate the effectiveness of the decisions we make on behalf of our population, and ensure we are achieving the outcomes required for our community.

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

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

Figure 3. Scope of DHB Operations – Output Classes against the Continuum of Care.

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



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

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

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

3.1 Prevention Services

Output Class Description

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

Significance for the DHB

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

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

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

Outputs: Short Term Performance Measures 2015-16

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2013/14	Target 2014/15	Target 2015/16
Percentage of enrolled women (20-69) who had a cervical smear in the last 3 years	V	88	80	85
Percentage of enrolled high-needs women (20-69) who had a cervical smear in the last 3 years	V	90	90	90
Percentage of enrolled high-needs women (45-65) having mammography within 2 years	V	70	70	70
Percentage of newborn hearing screening completed within 1/12 birth	V	62	95	95
Percentage of two year old children fully vaccinated	C	88	95	95
Percentage of over 65 year olds vaccinated for seasonal influenza	V	64.45	75	75
Percentage of eligible children receiving Before (B4) School Checks	V	90	90	90
Reduction in Alcohol related harm measure – Development of an Alcohol Related Harm Reduction Strategy by 30th June 2016	Q	N/A	New	New

3.2 Early Detection and Management Services

Output Class Description

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

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

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

Significance for the DHB

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

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

Outputs: Short Term Performance Measures 2015-16

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2013/14	Target 2014/15	Target 2015/16
Percentage of people in the district enrolled with PHO – Nelson	C	99%	99%	99%
Percentage of people in the district enrolled with PHO – Marlborough	C	98%	96%	99%
Ambulatory Sensitive Hospitalisation (ASH) rates for children age 0 – 4 years	Q	91%	93%	95%
Percentage of children <5 years enrolled in DHB funded dental services	C	6,103	7,242	7,242
Number of patients contacts receiving asthma / COPD services – Nelson	V	362	443	443
Number of patients contacts receiving asthma / COPD services – Marlborough	V	87	156	156
Percentage of secondary care patients whose medicines are reconciled on admission	C,Q	27.1%	40%	>22%
Percentage of Medical Imaging reports meeting 14-day-availability to referrer	T	100%	100%	100%
Percentage of patients seen within waiting time target for Medical Imaging procedures – urgent (within 24 hours)	T	100%	98%	98%
Percentage of PMHI Extended GP consults and Packages of care used by youth	Q	n/a	15%	15%

3.3 Intensive Assessment & Treatment Services

Output Class Description

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

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

Significance for the DHB

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

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

Outputs: Short Term Performance Measures 2015-16

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2013/14	Target 2014/15	Target 2015/16
Acute inpatient average length of stay (days)	Q	3.50	3.47	3.47
Percentage of elective and arranged surgery undertaken on a day case basis	Q	67.1%	60.5%	60.5%
Percentage of people receiving their elective & arranged surgery on day of admission	Q	96.6%	97%	97%
Women registering with an LMC by week 12 of their pregnancy	T	New	New	80%
Percentage of total deliveries in primary birthing units	Q	7%	70%	70%
Average post natal length of stay (days)	V	2.1 Nelson 2.4 Wairau	<2	<2
Average post natal length of stay (days) - caesarean	V	4	<4	<4
Percentage of AT&R patients (65+) discharged back to their original setting	Q	64%	64%	64%

3.4 Rehabilitation and Support Services

Output Class Description

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

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

Significance for the DHB

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

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

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

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

Outputs: Short Term Performance Measures 2015-16

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2013/14	Target 2014/15	Target 2015/16
Percentage of NASC response time to assessment within 20 working days	T	90.37%	>80%	>90%
Percentage of audited InterRAI Care Plans meet the assessed needs of the client	Q	n/a	95%	95%
Percentage of older people living in ARRC	C	6.8%	7.3%	7.3%
Improving Mental Health services using transition (discharge) planning and employment		New		

FINANCIAL PERFORMANCE

4.1 FISCAL SUSTAINABILITY

Over the past ten years an increasing share of national expenditure has been allocated into the health budget. Whilst health continues to receive a significant share of the national funding, the Government has given clear signals that the health sector needs to rethink how it will meet the needs of the constituent populations with a more moderate growth platform now and into the future.

In setting the expectations for 2015/16, the Minister expects DHBs to operate within existing resources and approved financial budgets and to work collaboratively to meet fiscal challenges and ensure services and service delivery models are clinically and financially sustainable. The following section provides a summary of the NMDHB's financial assumptions and projections over the next four years, in order to achieve the objectives and goals outlined in this Annual Plan.

4.2 MEETING OUR FINANCIAL CHALLENGES

NMDHB faces the same fiscal pressures as other DHBs: demographically and technologically driven demand, increasing expectations, increasing cost growth, wage and salary expectations and an increasing ageing population. The DHB acknowledges however that it must ensure that it operates within a constrained financial environment.

Additionally it is vital that we appropriately and prudently position ourselves for significant future capital investment, particularly an expected redevelopment of the Nelson hospital site over the next 10 years. This includes growing a surplus that will allow us to incur the additional interest, depreciation and capital charges that will accrue following an investment of this magnitude and not fall into the trap experienced by other district health boards of struggling to find efficiency programmes with the quantum of realisable and achievable efficiencies and benefits to afford the increase in capital costs.

This Plan recognises and builds on the basis of the reported deficits in the 2011/12 and 2012/13 years and turned those results round to report a surplus of $4.4M in 2013/14. At the time of writing this Plan we are forecasting a surplus of $1.5M for the 2014/15 year in line with the expectations set in the 2014/15 Annual Plan and increasing surpluses into the four years covered by this Plan. Critically, to ensure the health system is financially sustainable, we are focussed on making the whole of system work properly and achieving the best possible outcomes for our investment. This is work that NMDHB has been focussing on, and investing in, over the last two years to meet the challenges faced across the health system.

4.2.1 FORECAST FINANCIAL PERFORMANCE

For the 2015/16 year we are forecasting a surplus of $3.856M which is made up of:

- A base surplus of $3.0M; and
- The NMDHB share of the additional $25M announced by the Government in Budget 2015, totalling $0.856M.

The following three years project surpluses with the base surplus rising by $1.5M each year and the share of the additional funding from the Government constant at $0.856M for each of the years. This projects surpluses as follows:

Financial Year ($M)	2015/16	2016/17	2017/18	2018/19
Base Surplus	$3.000	$4.500	$6.000	$7.500
Share of additional Government funding	$0.856	$0.856	$0.856	$0.856
Total Surplus	**$3.856**	**$5.356**	**$6.856**	**$8.356**

4.2.2 CONSTRAINING OUR COST GROWTH

Constraining cost growth is critical to our success in delivering a surplus in the 2015/16 year and the projected surpluses in the years covered by this Plan. If the pressure that an increasing share of our funding continues to be directed into meeting the growing cost of providing services, our ability to maintain current levels of service delivery will be at risk whilst placing restrictions in our ability to invest in new equipment, technology and new initiatives that allow us to meet future demand levels.

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

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

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

4.3 ASSUMPTIONS

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

1. NMDHB's funding allocations will increase as per funding advice from the Ministry of Health.
2. Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives.
3. No additional compliance costs have been budgeted, as it is assumed these will be cost neutral or fully funded. It is also assumed that the impact of any legislative changes, sector reorganisation or service devolvement (during the term of this Plan) will be cost neutral or fully funded.
4. Any revaluation of land and buildings will not materially impact the carrying value or the associated depreciation costs.
5. IDF volumes and prices are at the levels identified by the Ministry of Health and advised within the Funding Envelope.
6. Employee cost increases are based on terms agreed in current wage agreements. Expired wage agreements are assumed to be settled on affordable and sustainable terms.
7. Staff vacancies (existing and as they occur in future) will be reassessed to ensure the positions are still required, affordable and alternatives explored before vacancies are filled. Improved employee management can be achieved with emphasis in areas such as sick leave, discretionary leave, staff training and staff recruitment/turnover.
8. External provider increases will be made within available funding levels, after allowance for committed and demand-driven funding.
9. Price increases agreed collaboratively by DHBs for national contracts and any regional collaborative initiatives will be within available funding levels and will be sustainable.
10. Any increase in treatment related expenditure and supplies is maintained at affordable and sustainable levels and the introduction of new drugs or technology will be funded by efficiencies within the service.
11. All other expense increases including volume growth will be managed within uncommitted funds available or deferred.
12. The DHB will meet the mental health ring fence expectations.

4.4 ASSET PLANNING AND SUSTAINABLE INVESTMENT

4.4.1 ASSET MANAGEMENT PLANNING

NMDHB is committed to advancing and maturing its asset management planning with a view to a more strategic approach to asset maintenance, replacement and investment. A revised Asset Management Plan (AMP) is currently being developed. This revision of the AMP includes a detailed review of the asset management practices and will provide a robust platform on which to base capital investment decisions in the future. The AMP reflects the joint approach taken by all DHBs and current best practice.

4.4.2 CAPITAL EXPENDITURE

NMDHB has significant capital expenditure committed in 2014/15 and the next four financial years covered by this Plan.

Based on NMDHB's fiscal position, we estimate that we will fund a total of $7.75M of general capital expenditure across the four years within this Plan. In addition significant investment has been allowed for major or strategic projects across the 2014/15 year and the four years covered by this Plan.

With this level of capital investment, the remaining capital expenditure funding available will be very tight. To manage this level of capital expenditure will require discipline and focus on the DHB's key priorities. The following table summarises the capital expenditure plan. Of note is the beginning of the Nelson Hospital redevelopment with preliminary costs commencing in the 2017/18 year and further costs in 2018/19.

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Baseline capital expenditure						
Land	0	0	0	0	0	0
Buildings & plant	826	2,011	2,000	2,000	2,000	2,000
Clinical equipment	1,809	3,322	2,200	2,200	2,200	2,200
Other equipment	558	500	500	500	500	500
Information technology	518	1,083	1,750	1,750	1,750	1,750
Intangible assets (software)	245	1,209	500	500	500	500
Motor vehicles	1,899	923	800	800	800	800
Total baseline capital expenditure	**5,855**	**9,048**	**7,750**	**7,750**	**7,750**	**7,750**
Major & strategic capital expenditure						
Buildings & plant	0	6,977	5,500	2,000	5,000	30,000
Clinical equipment	1,000	1,000	0	0	0	0
Clinical information systems	0	8,032	1,255	500	0	0
HBL - Finance, procurement & supply chain programme	546	803	0	0	0	0
Total major & strategic capital expenditure	**1,546**	**16,009**	**6,755**	**2,500**	**5,000**	**30,000**
Total capital expenditure	**7,401**	**25,057**	**14,505**	**10,250**	**12,750**	**37,750**

Details of major/strategic capital planning	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Facilities related					
Seismic work		500			
Alexandra hospital refurbishment	800				
Wairau remediation	557				
Arthur Wicks refurbishment	5,400				
Learning & development centre		5,000	2,000		
Murchison	220				
Nelson hospital redevelopment preliminary phase				5,000	30,000
Total facilties	**6,977**	**5,500**	**2,000**	**5,000**	**30,000**
Clinical information systems related					
PICS BUS	400				
PICS	6,032	955			
HCS	1,600				
ePharmacy		300			
eSCRV			500		
Total clinical information systems	**8,032**	**1,255**	**500**	**0**	**0**

4.4.3 BUSINESS CASES

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

- Learning & Development Centre
- Master site plan leading to the redevelopment of Nelson Hospital and other interim and transition moves that will likely be required.

4.4.4 ASSET VALUATION

NMDHB completed a full revaluation of its property and building assets at 30 June 2012 in line with generally accepted accounting practice requirements. The next revaluation is underway at the time of writing and will be effective as at 30 June 2015. This Plan assumes that there will be no material difference between the carrying value and the revaluation occurring at that time.

4.5 DEBT AND EQUITY

4.5.1 CORE DEBT

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

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

4.5.2 OTHER DEBT FACILITIES

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

NMDHB has a finance lease arrangement relating to the Golden Bay Community Health Centre (GBCHC). This relates to the 35-year lease arrangement entered into by NMDHB to lease the GBCHC from the Golden Bay Community Health Trust. We have in turn sub-leased the GBCHC to the Nelson Bays Primary Health Trust. Further disclosures on this arrangement are made in our 2013/14 Annual Report.

4.6 ADDITIONAL INFORMATION AND EXPLANATIONS

4.6.1 DISPOSAL OF LAND AND OTHER ASSETS

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

4.6.2 ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

4.6.3 ACQUISITION OF SHARES

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

The investment in the Finance, Procurement and Supply Chain (FPSC) programme lead by the now defunct Health Benefits Ltd (HBL) included the acquisition of "B" Class shares in HBL. The Minister of Health announced late in 2014 that HBL would be wound up and a new vehicle allowing district health boards' to drive the implementation of the national business cases prepared by HBL would need to be established. HBL will be replaced by NZ Health Partnerships Limited, and district health boards will be put in charge of the major programme to find $620 million of savings in the public health sector. Whilst the arrangements for the "B" Class shares is correct at the time of writing, it is expected that an alternative shareholding arrangement will be required once NZ Health Partnerships Limited is fully established. If new share capital is required it is assumed that ministerial approval will be obtained.

4.7 ACCOUNTING POLICIES

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

4.8 PROSPECTIVE FINANCIAL STATEMENTS

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

4.8.1 STATEMENT OF PROSPECTIVE FINANCIAL PERFORMANCE

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Income	**434,176**	**443,379**	**457,125**	**473,318**	**489,538**	**505,786**
Operating Expenditure						
Workforce costs	159,804	164,021	170,064	172,791	175,562	178,377
Other operating costs	68,115	69,434	71,568	79,577	86,941	94,080
External providers	142,723	144,429	149,107	151,937	155,279	158,694
Inter-district flows	37,841	40,846	40,966	41,867	42,789	43,730
Interest	3,131	3,281	3,187	3,191	3,194	3,197
Depreciation & amortisation	11,196	11,746	11,067	11,067	11,067	11,067
Capital charge	6,974	7,186	7,310	7,532	7,850	8,285
Total expenditure	**429,784**	**440,943**	**453,269**	**467,962**	**482,682**	**497,430**
Operating surplus / (deficit)	**4,392**	**2,436**	**3,856**	**5,356**	**6,856**	**8,356**
Write-down of loans provided to Golden Bay Community Health Centre Trust	**0**	**(936)**	**0**	**0**	**0**	**0**
Net surplus / (deficit)	**4,392**	**1,500**	**3,856**	**5,356**	**6,856**	**8,356**

4.8.2 STATEMENT OF PROSPECTIVE COMPREHENSIVE INCOME

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Net surplus / (deficit)	**4,392**	**1,500**	**3,856**	**5,356**	**6,856**	**8,356**
Other comprehensive income						
(Impairment)/revaluation of property, plant & equipment	(449)	0	0	0	0	0
Total comprehensive income	**3,943**	**1,500**	**3,856**	**5,356**	**6,856**	**8,356**

4.8.3 STATEMENT OF PROSPECTIVE MOVEMENTS IN EQUITY

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Equity at beginning of the year	**86,846**	**90,242**	**91,195**	**94,504**	**99,313**	**105,622**
Comprehensive income						
Net surplus/(deficit)	4,392	1,500	3,856	5,356	6,856	8,356
Other comprehensive income	(449)	0	0	0	0	0
Total comprehensive income	**3,943**	**1,500**	**3,856**	**5,356**	**6,856**	**8,356**
Owner transactions						
Equity injections	0	0	0	0	0	0
Equity repayments	(547)	(547)	(547)	(547)	(547)	(547)
Total owner transactions	**(547)**	**(547)**	**(547)**	**(547)**	**(547)**	**(547)**
Equity at end of the year	**90,242**	**91,195**	**94,504**	**99,313**	**105,622**	**113,431**

4.8.4 STATEMENT OF PROSPECTIVE FINANCIAL POSITION

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Non current assets						
Property, plant & equipment	159,635	166,118	174,215	171,307	172,505	199,450
Intangible assets	1,982	7,110	9,201	11,292	13,382	15,473
Prepayments	182	182	182	182	182	182
Other financial assets	3,794	3,660	3,660	3,660	3,660	3,660
Total non current assets	**165,593**	**177,070**	**187,258**	**186,441**	**189,729**	**218,765**
Current assets						
Cash & cash equivalents	45,450	39,103	26,055	32,186	34,968	13,500
Debtors & other receivables	11,055	11,055	11,055	11,056	11,055	11,056
Inventories	2,171	2,171	2,171	2,171	2,171	2,171
Prepayments	328	328	328	328	328	328
Assets held for sale	751	751	751	0	0	0
Total current assets	**59,755**	**53,408**	**40,360**	**45,741**	**48,522**	**27,055**
Total assets	**225,348**	**230,478**	**227,618**	**232,182**	**238,251**	**245,820**
Equity						
Crown equity	29,156	28,609	28,062	27,515	26,968	26,421
Revaluation reserve	46,974	46,974	46,974	46,974	46,974	46,974
Retained earnings	14,112	15,612	19,468	24,824	31,680	40,036
Total equity	**90,242**	**91,195**	**94,504**	**99,313**	**105,622**	**113,431**
Non current liabilities						
Interest bearing loans & borrowings	55,645	57,214	62,968	47,729	52,489	51,749
Employee entitlements	10,907	10,907	10,907	10,907	10,907	10,907
Total non current liabilities	**66,552**	**68,121**	**73,875**	**58,636**	**63,396**	**62,656**
Current liabilities						
Creditors & other payables	26,975	31,680	26,180	26,179	26,179	26,179
Employee benefits	31,586	31,586	31,586	31,586	31,586	31,586
Interest bearing loans & borrowings	8,765	6,668	245	15,240	10,240	10,740
Provisions	1,228	1,228	1,228	1,228	1,228	1,228
Total current liabilities	**68,554**	**71,162**	**59,239**	**74,233**	**69,233**	**69,733**
Total liabilities	**135,106**	**139,283**	**133,114**	**132,869**	**132,629**	**132,389**
Total equity & liabilities	**225,348**	**230,478**	**227,618**	**232,182**	**238,251**	**245,820**

4.8.5 STATEMENT OF PROSPECTIVE CASH FLOWS

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Cash flows from operating activities						
Receipts from Ministry of Health & patients	431,621	440,476	454,870	471,063	487,284	503,532
Interest received	2,180	2,830	2,250	2,250	2,250	2,250
Payments to employees	(155,704)	(155,920)	(173,784)	(170,993)	(173,746)	(176,543)
Payments to suppliers	(247,476)	(258,905)	(263,422)	(275,180)	(286,075)	(298,339)
Capital charge paid	(6,974)	(7,186)	(7,310)	(7,532)	(7,850)	(8,284)
Interest paid	(3,131)	(3,281)	(3,187)	(3,190)	(3,194)	(3,197)
Net GST paid	(184)	0	0	0	0	0
Net cash inflow from operating activities	**20,332**	**18,014**	**9,417**	**16,418**	**18,669**	**19,419**
Cash flows from investing activities						
Sale of property, plant & equipment	2,065	126	0	755	150	150
Cash inflow on maturity of investments	0	0	0	0	0	0
Acquisition of property, plant & equipment	(3,955)	(17,453)	(18,250)	(7,250)	(12,250)	(37,250)
Acquisition of intangible assets	(1,899)	(5,959)	(3,000)	(3,000)	(3,000)	(3,000)
Acquisition of investments	0	0	0	0	0	0
Net cash inflow / (outflow) from investing activities	**(3,789)**	**(23,286)**	**(21,250)**	**(9,495)**	**(15,100)**	**(40,100)**
Cash flows from financing activities						
Loans raised	0	0	0	0	0	0
Finance leases raised	0	0	0	0	0	0
Equity injections	0	0	0	0	0	0
Equity repaid	(547)	(547)	(547)	(547)	(547)	(547)
Repayment of borrowings	0	0	0	0	0	0
Repayment of finance lease liabilities	(991)	(528)	(668)	(245)	(240)	(240)
Net cash outflow from financing activities	**(1,538)**	**(1,075)**	**(1,215)**	**(792)**	**(787)**	**(787)**
Net increase/(decrease) in cash & cash equivalents	**15,005**	**(6,347)**	**(13,048)**	**6,131**	**2,782**	**(21,468)**
Cash & cash equivalents at 1 July	30,445	45,450	39,103	26,055	32,186	34,968
Cash & cash equivalents at 30 June	**45,450**	**39,103**	**26,055**	**32,186**	**34,968**	**13,500**

4.8.6 SUMMARY OF PROSPECTIVE REVENUE AND EXPENSES BY DIMENSION

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Revenue						
Funds	393,229	401,335	416,867	432,733	448,624	464,539
Governance & funding administration	7,382	6,853	5,159	5,159	5,159	5,159
Provider	240,870	250,542	261,688	274,355	286,312	298,203
Eliminations	(207,305)	(215,351)	(226,589)	(238,929)	(250,556)	(262,114)
Total revenue	**434,176**	**443,379**	**457,125**	**473,318**	**489,539**	**505,787**
Expenses						
Funds	387,868	400,625	416,661	432,733	448,624	464,539
Governance & funding administration	6,436	4,808	5,075	5,159	5,159	5,159
Provider	242,785	251,797	258,121	268,999	279,456	289,847
Eliminations	(207,305)	(215,351)	(226,589)	(238,929)	(250,556)	(262,114)
Total expenses	**429,784**	**441,879**	**453,268**	**467,962**	**482,683**	**497,431**
Net contribution						
Funds	5,361	710	206	0	0	0
Governance & funding administration	946	2,045	84	0	0	0
Provider	(1,915)	(1,255)	3,567	5,356	6,856	8,356
Net surplus / (deficit)	**4,392**	**1,500**	**3,857**	**5,356**	**6,856**	**8,356**

4.8.7 STATEMENT OF PROSPECTIVE REVENUE AND EXPENSES BY OUTPUT CLASS

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Revenue						
Prevention services	7,448	7,548	7,697	7,837	7,976	8,136
Early detection & management services	111,870	114,505	116,761	118,877	120,993	123,413
Intensive assessment & treatment services	222,735	230,665	240,220	252,481	264,771	276,523
Support services	92,123	90,661	92,447	94,123	95,798	97,714
Total revenue	**434,176**	**443,379**	**457,125**	**473,318**	**489,538**	**505,786**
Expenses						
Prevention services	6,740	6,858	6,977	7,095	7,214	7,342
Early detection & management services	111,016	113,003	115,144	116,997	118,858	120,751
Intensive assessment & treatment services	221,953	230,730	238,291	249,586	260,927	272,109
Support services	90,075	91,288	92,857	94,284	95,683	97,228
Total expenses	**429,784**	**441,879**	**453,269**	**467,962**	**482,682**	**497,430**
Net contribution						
Prevention services	708	690	720	742	762	794
Early detection & management services	854	1,502	1,617	1,880	2,135	2,662
Intensive assessment & treatment services	782	(65)	1,929	2,895	3,844	4,414
Support services	2,048	(627)	(410)	(161)	115	486
Net surplus / (deficit)	**4,392**	**1,500**	**3,856**	**5,356**	**6,856**	**8,356**

4.8.8 STATEMENT OF PROSPECTIVE FINANCIAL PEFORMANCE – PREVENTION SERVICES

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Income	**7,448**	**7,548**	**7,697**	**7,837**	**7,976**	**8,136**
Operating Expenditure						
Workforce costs	3,419	4,036	4,097	4,158	4,220	4,304
Other operating costs	1,001	962	981	1,007	1,032	1,047
External providers & inter district flows	2,320	1,860	1,899	1,930	1,962	1,991
Total expenditure	**6,740**	**6,858**	**6,977**	**7,095**	**7,214**	**7,342**
Net surplus / (deficit)	**708**	**690**	**720**	**742**	**762**	**794**

4.8.9 STATEMENT OF PROSPECTIVE FINANCIAL PEFORMANCE – EARLY DETECTION AND MANAGEMENT SERVICES

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Income	**111,870**	**114,505**	**116,761**	**118,877**	**120,993**	**123,413**
Operating Expenditure						
Workforce costs	20,444	21,084	21,400	21,721	22,047	22,488
Other operating costs	9,105	9,027	9,133	9,247	9,366	9,506
External providers & inter district flows	81,467	82,892	84,611	86,029	87,445	88,757
Total expenditure	**111,016**	**113,003**	**115,144**	**116,997**	**118,858**	**120,751**
Net surplus / (deficit)	**854**	**1,502**	**1,617**	**1,880**	**2,135**	**2,662**

4.8.10 STATEMENT OF PROSPECTIVE FINANCIAL PEFORMANCE – INTENSIVE ASSESSMENT AND TREATMENT SERVICES

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Income	**222,735**	**230,665**	**240,220**	**252,481**	**264,771**	**276,523**
Operating Expenditure						
Workforce costs	111,386	115,312	123,263	125,288	127,347	129,198
Other operating costs	72,570	74,891	72,321	80,329	87,813	95,072
External providers & inter district flows	37,997	40,527	42,707	43,969	45,767	47,839
Total expenditure	**221,953**	**230,730**	**238,291**	**249,586**	**260,927**	**272,109**
Net surplus / (deficit)	**782**	**(65)**	**1,929**	**2,895**	**3,844**	**4,414**

4.8.11 STATEMENT OF PROSPECTIVE FINANCIAL PEFORMANCE – REHABILITATION AND SUPPORT SERVICES

	2013/14 Actual $000	2014/15 Forecast $000	2015/16 Projection $000	2016/17 Projection $000	2017/18 Projection $000	2018/19 Projection $000
Income	**92,123**	**90,661**	**92,447**	**94,123**	**95,798**	**97,714**
Operating Expenditure						
Workforce costs	20,856	20,989	21,304	21,624	21,948	22,387
Other operating costs	10,439	10,679	10,697	10,784	10,841	11,004
External providers & inter district flows	58,780	59,620	60,856	61,876	62,894	63,837
Total expenditure	**90,075**	**91,288**	**92,857**	**94,284**	**95,683**	**97,228**
Net surplus / (deficit)	**2,048**	**(627)**	**(410)**	**(161)**	**115**	**486**

STEWARDSHIP

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

Our transformation of the health system for the Nelson Marlborough community requires cultural change - different ways of working – as well as organisation change – strong governance and leadership, clear public health policy statements that reflect what the DHB stands for, a capable and engaged workforce, effective partnerships and alliances, and information systems and infrastructure that enable and enhance integrated service delivery.

5.1 GOVERNANCE & LEADERSHIP

Nelson Marlborough DHB is guided by a skilled and committed Board. The Board's core responsibility is to set the strategic direction and policy that is consistent with Government objectives, improves health outcomes and ensures sustainable service provision. The Board also ensures compliance with legal and accountability requirements. Our relationship with the Tangata Whenua of our district is expressed through the partnership with the Iwi Health Board and joint agreement titled 'He Kawenata.' We are strategically advised on the planning and delivery of Maori health services by our Iwi Health Board.

Operational and management matters have been delegated by the Board to the Chief Executive, who is supported by the Executive Leadership Team (ELT). Our ELT has been reformed to lead the transformation of the Nelson Marlborough health system. Although the overall number of ELT members has been reduced, the importance of strong clinical leadership is reflected in the recent creation of a General Manager Clinical Governance Support role whose key responsibility is to create an environment in which excellence in clinical care will flourish.

The DHB has a clinical governance group supported by the General Manager Clinical Governance Support with input from both PHO clinical governance groups. Notably, the chair of the clinical governance group is the Clinical Director Primary, who is a local GP as well as a NMDHB staff member. The role holder of the recently created position of Chief Primary Care Medical Advisor is also a member of the clinical governance group, and ensures there is strategic input from primary care to the District Health Board. These roles, and the appointment of Clinical Directors representing specialist areas, reflect the progress made towards strong clinical leadership and a truly integrated health system for our region. Over time, we would like the three clinical governance groups for Nelson Marlborough DHB, Nelson Bays Primary Health, and Kimi Hauora PHO to converge into a single committee for the Nelson Marlborough Health System.

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

We continue to invest significant effort and energies to strengthen our approach to Clinical Leadership and Clinical Governance. The clinical governance group agreed the priority action themes as: culture, vision for clinical governance, information and reporting, capability and learning, patient and family centred care, and communication. The key actions for the year ahead, to create an environment in which excellence in clinical care will flourish and reflecting the priority themes above, are captured in the 'Improving Quality & Clinical Governance' plan in Section 2: Delivering on Priorities and Targets. The action to create a just culture based on organisational values and personal responsibility will involve working closely with the General Manager Human Resources and team.

5.2 NATIONAL ENTITY PRIORITY INITIATIVES

As well as transforming the health system for the Nelson Marlborough community and for the broader South Island region, we are also supporting national health system change.

National initiatives relevant to IT (e.g. eMedicines Reconciliation, Regional Clinical Workstation), Infrastructure (e.g. linen and laundry), and the workforce (e.g. increasing the number of sonographers, expanding the role of nurse practitioners) can be found in section 2.1.3 Organisational Plans.

In addition, we are also supporting national initiatives for Shared Services, Health Promotion, PHARMAC and the National Health Committee.

For Shared Services, we are committed to implementing Finance, Procurement and Supply Chain initiatives. By implementing the national Supply Chain Service, process improvements and supply chain strategies, we aim to release clinician time back to front line care and achieve savings for the DHBs.

For Health Promotion, we will continue to support the health targets campaign, and will support promotion of the campaign to reduce consumption of alcohol during pregnancy, which fits with our local aim to reduce alcohol related harm.

For PHARMAC, we support PHARMAC's role in managing hospital medical devices to create national consistency in access to treatment, improve transparency of decision-making and improve the cost-effectiveness of public spending to generate savings.

The National Health Committee is developing the Pull model to be proactive instead of reactive when it comes to decisions on what health technologies to use or phase out. Nelson Marlborough DHB is supportive of both the proactive and reactive work programmes of the National Health Committee, and will work with the National Health Committee to develop recommendations, strategies, budgets and stakeholder engagement.

5.3 IMPROVING THE QUALITY AND SAFETY OF CARE

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

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

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

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

- **Falls**: Achieve and sustain the QSM targets that 90% of older patients are given a falls risk assessment, and 98% of older patients assessed as at risk of falling receive an individualised care plan addressing those risks; Build on the work of the Falls Prevention working group (a group of primary and secondary clinicians and managers led by the Director of Allied Health) to ensure an integrated approach to reducing harm from falls, by examining our results and taking action to improve quality and safety, using falls-related data.
- **Hand Hygiene**: Achieve and sustain the QSM target of 80% compliance with good hand hygiene practice by continuing to use our trained hand hygiene auditors to promote good hand hygiene practice messages to staff, patients and visitors; and examine our results to identify and implement actions to improve quality and safety.
- **Perioperative (Surgery)**: Achieve and sustain the current QSM target that all three parts of the WHO surgical safety checklist is used in 90% of operations; Refocus the use of the checklist as a teamwork and communication tool (rather than an audit tool); Work with the HQ&SC to implement the new perioperative harm QSM; and introduce briefing and debriefing for each theatre list.
- **Surgical Site Infection**: Achieve and sustain the QSM targets that 95% of hip and knee replacement patients receive cefazolin ≥2g as surgical prophylaxis; 100% of hip and knee replacement patients have recommended skin antisepsis in

surgery using alcohol/chlorhexidine or alcohol/povidone iodine; 100% of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision; and examine our results to identify and implement actions to improve quality and safety.

- **Medication Safety**: Continue to conduct prioritised paper-based medicine reconciliations until the implementation of the electronic medicine reconciliation platform is completed for Nelson Marlborough DHB.

The most recent focus of the *Open for Better Care* campaign was reducing harm from high-risk medicines. Further work to reduce harm from opioids in our hospitals, and to build capability within our DHB in medication safety and quality improvement, will continue during the coming year. We will also support the development of a new medication safety QSM. Electronic medicines reconciliation (eMR) is currently carried out at Counties Manukau, Waitemata, Taranaki and Northland District Health Boards, and will be rolled out to more DHBs during the coming year. We eagerly anticipate the introduction of eMR to increase the volume of medicine reconciliations we are able to complete through improved process efficiency.

Nelson Marlborough DHB has produced a Quality Account in 2013 and 2014, and will produce another Quality Account in 2015 in accordance with HQ&SC guidance. The Quality Account is an annual report about the quality of the services provided within Nelson Marlborough DHB, the consumer experience and health outcomes. As the target audience for the Quality Account is our local community, we appointed two consumer advisors and accepted their guidance on content and layout. The language used is clear and simple to understand, and we avoided complicated graphs and tables. We were also mindful of cost. The Account is not a full report on every quality initiative at NMDHB, but a selection of projects that show what we are doing to improve the quality and safety of care.

We also obtain input from consumers using the national patient experience survey. The patient experience survey provides excellent feedback from inpatients about what they think about their most recent stay in hospital. The survey has 20 questions covering issues such as whether patients understood the advice they were given by their doctor, whether they were involved in decisions about their care and treatment, and whether they were treated with respect and dignity by hospital staff.

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

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

5.4 PUBLIC HEALTH POLICY STATEMENTS

The Public Health Service Annual Plan outlines how they aim to improve the health of communities and reduce inequalities in health status. A key intention in the Public Health Service Annual Plan 2015-2016 is to tackle obesogenic environments. This intention is aligned with the objectives of the Nelson Marlborough DHB.

At a high level, tackling obesogenic environments will be supported by clear policy statements on issues that contribute to obesity, such as sugar-sweetened beverages. Policy statements provide a clear signal of the Public Health Service position on specific issues, and the research can be used to engage and influence stakeholders. The content of policy statements can also be used for submissions related to the specific issue.

The Nelson Marlborough DHB withdrew sugar-sweetened beverages from Nelson and Wairau hospitals, and led a successful campaign which resulted in Nelson City Council agreeing to stop the sale or supply of sugar-sweetened beverages at Council venues or Council-sponsored events. Marlborough District Council is considering a similar move, which has the backing of councillors.

The Public Health Service and Nelson Marlborough DHB plan to work together to achieve a similar level of success for the issues of Fluoridation and Alcohol Related Harm.

As well as the Public Health Service and Nelson Marlborough DHB working collaboratively to develop a sugar-sweetened beverages action plan, we will also develop a policy statement on the issue of Fluoridation, and an Alcohol Harm Reduction Strategy by early 2016.

5.5 STRENGTHENING OUR WORKFORCE

A capable and engaged workforce is essential to support the transformation of the health system for the Nelson Marlborough community. We need our people to develop competencies that enable them to work differently – to work at the top of their professional scope, as a member of a multi-disciplinary team across settings of care, accessing shared care information through regional systems, and contributing to the innovative redesign of services.

A workforce strategy has been developed to address the specific workforce issues facing the Nelson Marlborough health system, which include: a high average age of the health workers and the risk of knowledge loss as staff retire; high retention and the associated difficulty of introducing new people into the workforce to support, learn from, and eventually replace aging staff; barriers to accessing the learning and development opportunities which are necessary to support staff to develop the required competencies to work differently; and a homogenous workforce that does not reflect the diversity of the local community population.

The Nelson Marlborough DHB workforce strategy will be integrated with the workforce plan for the South Island region. We need to "Think nationally, and Act regionally" to benefit from emerging opportunities for our nursing workforce to take on more specialised care roles to support our aim to provide better, sooner, more convenient care.

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

5.6 SAFE AND COMPETENT WORKFORCE

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

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

- Employee Engagement Survey – This has been carried out to assess engagement levels of our staff and to identify any issues. Results are being benchmarked against other DHBs and the top 3 issues identified will be addressed over the next 12 months.
- Policies and Procedures – A full review of all of the Human Resources policies and procedures is ongoing – of 34 policies, 23 have been agreed by NMDHB and the unions, and are now operational; 3 are close to finalisation and 8 are still in the stage of updating/gaining union agreement.
- Police Checks - Police checks are completed prior to employment commencing for all joiners and for all existing staff who are taking part in the Children's Team (see below).
- Online Learning - e-learning packages that support the NMDHB Cultural Competency Framework have been introduced, including an e-Learning course in Foundations of Cultural Competency in conjunction with the Ministry of Health e-Learning website.

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

5.6.2 Children's Worker Safety Checking

The Vulnerable Children Bill was enacted in June 2014. The Bill is designed to protect children from the threats posed by a small number of high-risk individuals, while at the same time ensuring that safe and competent individuals are not discouraged from entering the workforce. NMDHB was identified with several other DHBs nationally to work as a pilot site for implementation of the

Bill. A Children's Team was established and together we have been working on gaining a consistent approach around the guidelines and implementation of the Bill. Over the last 12 months, we have:

a) Ensured that we have suitable policies in place to underpin children's protection and safety.
b) Identified all roles in the workforce that have high child contact and started a safety checking process on each person, complying with the requirements for safety checking for core-workers (and non core workers as appropriate) as prescribed in the Act.
c) Developed a safety checking process which includes verification of identity, police checking, and a risk assessment.
d) Amended relevant contracts to ensure providers comply with all requirements, including police checks for workers and the adoption of a child protection policy.

Over the next 12 months we will be completing further safety checking of staff in compliance with the legislation and implementing a system to identify staff needing police checking on a 3 yearly cycle. We will also publish a specific child protection policy on our website.

5.7 PARTNERSHIPS & ALLIANCES

Nelson Marlborough DHB is a member of the South Island Alliance which enables the region's five DHBs to work collaboratively to develop more innovative and efficient health services than could be achieved independently. By using our combined resources to jointly solve problems we are better positioned to respond to changes in the technology and demographics that will have a significant impact on the health sector in the coming years. So the actions in this Annual Plan also reflect key commitments to the regional alliance.

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

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

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

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

We are still embedding Te Piki Oranga, the new Maori health entity, into our local health system and developing services to be delivered under the new Whanau Ora framework for the Nelson Marlborough districts.

5.8 INFORMATION SYSTEMS

Nelson Marlborough DHB is investing in information systems that enable and enhance integrated service delivery, and ensure sustainability. The most significant information system investment for the year ahead is the implementation of the regional Patient Information Care System (PICS) at Nelson Marlborough DHB in early 2016. PICS will replace the existing patient administration system, which is volatile and has necessitated the implementation of a stability programme until the regional PICS solution is in place. PICS will allow increased access to relevant information at the point of care and greater use of information systems to enhance care delivery.

Nelson Marlborough DHB is also supporting national initiatives. An example is the transfer of local infrastructure to one of two National Infrastructure Platforms (NIP) in Auckland or Christchurch. During 2014-15 we also rolled out a 'zero client, virtual desktop infrastructure' solution, which enables us to progressively migrate all users onto a standard set of hardware and to manage our desktop users' computing requirements centrally.

An exciting new initiative for the year ahead will provide patients with access to a patient portal by general practices. Patient portals give patients online access to their health information and enable them to manage aspects of their own health care, and can help patients to become more proactive with their care. This project will require close working with our PHOs to support the implementation of patient portals by general practices, and to address potential issues about keeping health information secure.

Although a local IT plan is not required by the Ministry, we thought it was important to include the key actions for the year ahead in this Annual Plan. The actions are captured in the 'IT & Infrastructure' plan (page 56) in Section 2: Delivering on Priorities and Targets.

5.9 INFRASTRUCTURE

We have a long term plan to manage the significant strengthening of earthquake prone buildings and structures required, and to replace core hospital infrastructure that has reached the end of its useful life. A broader strategic facilities master plan for the Nelson Marlborough health system has been developed which will support the planned redevelopment of Nelson Hospital as well as providing guidance for facility investment in primary and community settings.

During 2015 the Nelson Marlborough DHB public health service will be co-located with the PHOs in both Nelson and Marlborough. We will also complete the re-fit of the first floor of the Arthur Wicks building at Wairau hospital. The first floor needed to be stripped and 'made good' during earthquake strengthening work, so we have taken the opportunity to provide our management and administration staff with a modern, light, open plan facility. The first floor of the Arthur Wicks building will also be the 'satellite' site for the Learning & Development Centre on the Nelson Hospital site.

Again, although a local Infrastructure plan is not required by the Ministry, we thought it was important to include the key actions for the year ahead in this Annual Plan. The actions are captured in the 'IT & Infrastructure' plan (page 56) in Section 2: Delivering on Priorities and Targets.

5.10 SUBSIDIARIES, OTHER INTERESTS OR COOPERATIVE ARRANGEMENTS

The Minister of Health has under sections 24 and 28 of the NZPHD Act 2000 approved the following arrangements:

- Nelson Marlborough Hospitals' Charitable Trust; holds trust funds for the benefit of public hospitals
- Marlborough Hospital Equipment Trust; provides equipment, other items from public donations raised by Trust
- Churchill Private Hospital Trust; provides private medical and surgical services in Marlborough
- Agreement with Pacific Radiology; joint MRI service from the Nelson & Wairau Hospital sites
- Agreement with Christchurch Radiology Group; visiting Radiology service at Wairau Hospital site
- Agreement with Top of the South Cardiology Ltd; covers private cardiology services from Nelson Hospital
- Golden Bay Health Alliance for an Integrated Family Health Centre with Nelson Bays Primary Health Trust and Golden Bay Community Health Trust – Te Hauora O Mohua Trust
- Appointment of Trustee to the Board of the Golden Bay Community Health Trust – Te Hauora O Mohua Trust
- South Island Alliance Project Office (SIAPO); supports the activities of the South Island DHBs by providing services (planning and funding audit, analysis and advice and contract management).

NMDHB does not hold any controlling interests in a subsidiary company.

5.10 STEWARDSHIP ROLE AS OWNER OF CROWN ASSETS

DESCRIPTION	PHYSICAL ASSETS
NMDHB is a Crown Entity with ownership of	***Buildings and Equipment***
Nelson Hospital delivering the full range of New Zealand Role Delineation Model level 4 secondary services: emergency, surgical and medical specialist (acute and elective), primary and secondary maternity, neonatal, paediatric, specialist health services for older people and support services, diagnostic imaging.	Waimea Rd, Nelson
Wairau Hospital delivering the full range of New Zealand Role Delineation Model level 3 secondary services: emergency, surgical and medical specialist (acute and elective), primary and secondary maternity, neonatal, paediatric, specialist health services for older people, support services including diagnostic imaging, and mental health services.	Hospital Rd, Blenheim
Mental Health and Addiction services with acute inpatient facilities and community facilities in Nelson and Wairau.	Tipahi St & Braemar Campus Nelson; Hospital Rd Blenheim
Alexandra Hospital in Richmond delivering psycho-geriatric services for older people and aged residential care services for people with dementia.	Gilbert St, Richmond
Murchison Hospital and Health Centre delivering the full range of primary care services: 'Primary Response for Medical Emergencies' [PRIME], district nursing service, aged residential care rest home, and hospital services for Murchison residents.	Fairfax St Murchison
District Nursing Services located in Motueka.	Courtney St, Motueka
Disability Support Services (DSS) – Nelson community based residential and day activities for people with intellectual and physical disabilities.	Tahunanui Drive, Nelson, plus 65 individual community homes
Needs Assessment and Coordination Services (Support Works) for people with life-long, long-term conditions and age-related disabilities.	Harley St, Nelson and Blenheim Hospital Campus
Public Health Unit providing a range of health promotion, health protection and Medical Officer of Health services for Nelson and Wairau.	Richmond (Tasman) and Blenheim (Marlborough)
Specialist Dental, School Dental and Adolescent Health Services based in Nelson and Wairau Hospitals and in our communities.	Various locations
Corporate Offices in Nelson for the Chief Executive and some members of Executive Leadership Team: GM Strategy, Planning & Alliance Support; GM Finance & Performance; GM Clinical Governance Support; GM IT & Infrastructure; GM Human Resources; General Manager Maori Health & Whanau Ora; Chief Medical Officer; Director of Nursing & Midwifery.	Braemar Campus, Waimea Road, Nelson
South Island DHB Alliance Project Office (SIAPO) – ownership shared with Canterbury DHB, South Canterbury DHB, Otago DHB, Southland DHB and West Coast DHB.	Christchurch
20 District Health Boards Shared Services, a national arm of TAS, to ensure organisation and collective delivery of national strategies and the organisation of national service interests.	TAS Building, L7, 186 Willis St, Wellington

SERVICE CONFIGURATION

6.1 SERVICE COVERAGE

There are no identified significant service coverage exceptions identified for 2015/16.

6.2 SERVICE CHANGE

There are no identified significant service changes identified for 2015/16.

SERVICE	SPAN	FUNDING PATH	APPROVAL PROCESS	BENEFIT

6.3 SERVICE ISSUES

There are no identified significant service issues identified for 2015/16.

PERFORMANCE MEASURES

7.1 MONITORING FRAMEWORK PERFORMANCE MEASURES

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders, and providers of health and disability services.

DIMENSIONS OF DHB PERFORMANCE	DESCRIPTION	CODE
'Policy priorities'	Achieving Government's priority goals/objectives and targets	PP
'System Integration'	Meeting service coverage requirements and supporting sector inter-connectedness	SI
'Outputs'	Purchasing the right mix and level of services within acceptable financial performance	OP
'Ownership'	Providing quality services efficiently	OS
'Developmental'	Establishment of baseline (no target/performance expectation set)	DV

PERFORMANCE MEASURE	2015/16 PERFORMANCE EXPECTATION/TARGET		
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19		Maori 4.2% Total 4.2%
	Age 20-64		Maori 6.5% Total 4.6%
	Age 65+		Maori 0.9% Total 0.9%
PP7: Improving mental health services using transition (discharge) planning and employment	Long term clients		Provide report as specified
	Child and Youth with a Transition (discharge) plan		At least 95 percent of clients discharged will have a transition (discharge) plan.
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm		
	Age	<= 3 weeks	<=8 weeks
	0-19	80%	95%
	Addictions (Provider Arm and NGO)		
	Age	<= 3 weeks	<=8 weeks
	0-19	80%	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1		1.00
	Ratio year 2		0.95
PP11: Children caries-free at five years of age	Ratio year 1		65%
	Ratio year 2		65%
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1		85%
	% year 2		86%
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1		85%
	0-4 years - % year 2		95%
	Children not examined 0-12 years % year 1		10%
	Children not examined 0-12 years % year 2		10%

PP20: improved management for long term conditions (CVD, diabetes and Stroke) Focus area 1:Long term conditions	Report on delivery of the actions and milestones identified in the Annual Plan.	
Focus area 2: Diabetes Management (HbA1c) Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control	Narrative quarterly report on DHB progress towards meeting deliverables for Diabetes Care Improvement Packages (DCIP) as identified in 2015/16 Annual Plan. Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control	
Focus area 3: Acute coronary syndrome services	70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')	
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	
	Over 95 percent of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data within 30 days of discharge	
	Report on delivery of the actions and milestones identified in the Annual Plan, including actions and progress in the quality improvement initiatives to support the improvement of ACS indicators as reported in ANZACS-QI	
Focus area 4: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed	
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	
	Report on delivery of the actions and milestones identified in the Annual Plan	
PP21: Immunisation coverage (previous health target)	Percentage of two year olds fully immunised	95%
	Percentage of five year olds fully immunised	90% (2015-16) 95% (2016-17)
	Percentage of eligible girls fully immunised with three doses of HPV vaccine Reported annually in Quarter 4	65% for dose 3
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP23: Improving Wrap Around Services – Health of Older People	The percentage of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan	
	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP25: Prime Minister's youth mental health project	Initiative 1: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities. 1. quarterly quantitative reports on the implementation of SBHS, as per the template provided. 2. quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS. Initiative 3: Youth Primary Mental Health	

	1. quarterly narrative progress reports with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: • early identification of mental health and/or addiction issues • better access to timely and appropriate treatment and follow up • equitable access for Maori, Pacific and low decile youth populations. Initiative 5: Improve the responsiveness of primary care to youth. 1. quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliancing arrangements. 2. quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme.	
PP26: The Mental Health & Addiction Service Development Plan	Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2015/16 and for any actions which are in progress/ongoing.	
PP27: Delivery of the children's action plan	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP28: Reducing Rheumatic fever	Provide a 'progress report' against DHBs' Rheumatic Fever prevention plan; including quarterly reporting of the Case Review (actions taken and lessons learned) of each new case of Rheumatic Fever.	
	Hospitalisation rates (per 100,000 DHB total population) for acute Rheumatic Fever are 55 percent lower than the average over the last 3 years	0.2 per 100,000
PP29: Improving waiting times for diagnostic services	<u>Coronary angiography</u> 95 percent of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	
	<u>CT and MRI</u> 95 percent of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days)	
	<u>Diagnostic colonoscopy</u> 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days); 100 percent within 30 days 65% of people accepted for a non urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days); 100% within 120 days	
	<u>Surveillance colonoscopy</u> 65 percent of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date; 100 percent within 120 days	
PP30: Faster cancer treatment	<u>Part A</u> *Faster cancer treatment* *31 day indicator*	< 10 percent of the records submitted by the DHB are declined.
	<u>Part B</u> Shorter waits for cancer treatment *Radiotherapy and chemotherapy*	All patients ready for treatment, receive treatment within four weeks of decision to treat.
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region (the report includes local DHB actions that support delivery of regional objectives	
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to	

	service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement	an intervention rate of 21.0 per 10,000 of population
	Cataract procedures	an intervention rate of 27.0 per 10,000
	Cardiac surgery	a target intervention rate of 6.5 per 10,000 of population DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain or improve this rate.
	Percutaneous revascularization	a target rate of at least 12.5 per 10,000 of population
	Coronary angiography services	a target rate of at least 34.7 per 10,000 of population
SI5: Delivery of Whānau Ora	Provision of a qualitative report identifying progress within the year that shows that the DHB has delivered on its planned Whānau Ora activity and what the impact of the activity has been	
SI6: IPIF Healthy Adult - Cervical Screening	80% of eligible women have received cervical screening services within the last 3 years	
OS3: Inpatient Length of Stay	Elective LOS	1.48 days which is the 75th centile of national performance
	Acute LOS	2.37 days
OS8: Reducing Acute Readmissions to Hospital	Total population	Improvement on baseline performance
	75 plus	Improvement on baseline performance
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections Focus area 1:Improving the quality of identity data	New NHI registration in error	Greater than 1 percent and less than or equal to 3 percent
	Recording of non-specific ethnicity	Greater than 0.5 percent and less than or equal to 2 percent
	Update of specific ethnicity value in existing NHI record with a non-specific value	Greater than 0.5 percent and less than or equal to 2 percent
	Invalid NHI data updates causing identity confusion	% TBC
Focus area 2:Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS	Greater than or equal to 97 percent and less than 99.5 percent
	National collections file load success	Greater than or equal to 98 percent and less than 99.5 percent
	Standard vs edited descriptors	Greater than or equal to 75 percent and less than 90 percent
	NNPAC timeliness	Greater than or equal to 95 percent and less than 98 percent
Focus area 3:Improving the quality of the programme for Integration of mental health data (PRIMHD)	PRIMHD data quality	Routine audits undertaken with appropriate actions where required
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient	

	services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan
Developmental measure DV4: Improving patient experience	No performance target set

APPENDIX 8.1 GLOSSARY OF ACRONYMS

ABC	**A**sk about and document every person's smoking status, give **B**rief advice to stop to every person who smokes, and strongly encourage every person who smokes to use **C**essation support (a combination of behavioural support and stop-smoking medicine works best) and offer to help them access it.
ACS	Acute Coronary Syndrome
ACPP	Accelerated Chest Pain Pathway
AMP	Asset Management Plan
ARRC	Aged Related Residential Care
ASH	Ambulatory Sensitive Hospitalisation
AT&R	Assessment, Treatment, & Rehabilitation
B4SC	Before School Checks
BAU	Business As Usual
C	Coverage
CAMHS	Child and Adolescent Mental Health Services
COPD	Chronic Obstructive Pulmonary Disease
COPMIA	Children of Parents with a Mental Illness or Addiction
CVD	Cardiovascular Disease
DHB	District Health Board
DIF	District Immunisation Facilitator
DMFT	Decayed, Missing, Filled Teeth
DSS	Disability Support Services
ED	Emergency Department
EDaaG	Emergency Department at a Glance (IT system for key ED data)
ESPI	Elective Services Patient Flow Indicators
FPSC	Financial, Procurement and Supply Chain
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GAAP	Generally Accepted Accounting Practice
GBCHC	Golden Bay Community Health Centre
GM	General Manager
GP	General Practitioner
HEADSS	**H**ome and Environment; **E**ducation and Employment; **A**ctivities; **D**rugs; **S**exuality; **S**uicide / Depression. HEADSS is a psychosocial interview tool for adolescents.
HBL	Health Benefits Limited
HBSS	Home Based Support Services
HOP	Health of Older People
IDF	Inter District Flow
IPIF	Integrated Performance Incentive Framework
IT	Information Technology
KHW MPHO	Kimi Hauora Wairau Marlborough PHO
LC	Lactation Consultant
LMC	Lead Maternity Carer
LOS	Length of Stay
MDT	Multi Disciplinary Team
MoH	Ministry of Health
MOH	Medical Officer of Health
MRI	Magnetic Resonance Imaging
NASC	Needs Assessment Service Coordination
NBPH	Nelson Bays Primary Health
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHI	National Health Index
NMDHB	Nelson Marlborough District Health Board

NMDS	National Minimum Dataset
NMHCT	Nelson Marlborough Hospitals Charitable Trusts
NPF	National Patient Flow
OIS	Outreach Immunisation Services
PAS	Patient Administration System
PBE	Public Benefit Entity
PHS	Public Health Service
PHO	Primary Health Organisation
PICS	Patient Information Care System
POAC	Primary Options for Acute Care
Q	Quality
QSM	Quality Safety Marker
RFP	Request for Proposal
SAC	Severity Assessment Code
SI	South Island
SIA	South Island Alliance
SIAPO	South Island Alliance Programme Office
SIR	Standardised Intervention Rate
SIRTH	South Island Regional Training Hub
SMO	Senior Medical Officer
SOI	Statement of Intent
SP&AS	Strategy, Planning, and Alliance Support
SPE	Statement of Performance Expectations
SSE	Serious and Sentinel Events
T	Timeliness
Te Piki Oranga	The Nelson Marlborough Maori Health Coalition
ToSHA	Top of the South/ Te Tau Ihu o Te Waka a Maui Health Alliance
V	Volume (quantity)

APPENDIX 8.2 DEFINITIONS

Term	Definition
Activity	What an agency does to convert inputs to outputs.
Alliance	An agreement between two or more participants made in order to advance common goals and secure common interests; it is not an entity as individual participants retain their separate identify and accountabilities; the Alliance approach entails a collaborative, incentive-driven method of contracting where all participants work co-operatively to the same end, sharing the risk and reward, while respecting the principles of good faith and trust. Our local Top of the South Alliance 'ToSHA' comprises the partners Kimi Hauora Wairau Marlborough PHO, Nelson Bays PHO, and NMDHB.
Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve the Government's goals.
Care Pathway	A complex intervention for the mutual decision making and organisation of care processes for a well defined group of patients during a well defined period: an explicit statement of the goals and key elements of care based on evidence, best practice, and patients' expectations and their characteristics; the facilitation of the communication among the team members and with patients and families; the coordination of the care process by coordinating the roles and sequencing the activities of the multidisciplinary care team, patients and their relatives; the documentation, monitoring, and evaluation of variances and outcomes; and, the identification of the appropriate resources. The aim is to enhance the quality of care across the continuum by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimising the use of resources.
Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister. One of the three types of statutory entities (see also Crown entity; autonomous Crown entity and independent Crown entity).
Crown entity	A generic term for a diverse range of entities within one of the five categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
Efficiency	Reducing the cost of inputs relative to the value of outputs
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
Impact	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. For example, the change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations. (Public Finance Act 1989).
Impact measures	Impact measures are attributed to agency (DHB) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can often be measured soon after delivery, promoting timely decisions; and may reveal specific ways in which managers can remedy performance shortfalls.
Input	The resources such as labour, materials, money, people, information technology used by departments to produce outputs, that will achieve the Government's stated outcomes.
Integrated care	Includes both clinical and service integration to bring organisations and clinical professionals together, in order to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home. WHO definition: Bringing together common functions within and between organisations to solve common problems, developing commitment to a shared vision and goals and using common technologies and resources to achieve these goals.
Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes (Refer State Services Commission 'Performance Measurement – Advice and examples on how to develop effective frameworks: www.ssc.govt.nz.
Intermediate outcome	See Outcomes
Living within our means	Providing the expected level of outputs within a break even budget or National Health Board (NHB) agreed deficit step toward break even by a specific time.
Management systems	The supporting systems and policies used by the DHB in conducting its business.
Measure	A measure identifies the focus for measurement: it specifies what is to be measured.

Objectives	The use of this term recognises that not all outputs and activities are intended to achieve "outputs". For example, increasing the take-up of programmes; improving the retention of key staff; improving performance; improving Governance etc. are 'internal to the organisation and enable the achievement of 'outputs'.
Outcome	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).
Output agreement	Output agreement/output plan - See Purchase Agreement. An output agreement is to assist a Minister and a Crown entity (DHB) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs (see s170 (2) Crown Entities Act 2004.
Output classes	An aggregation of outputs, or groups of similar outputs. (Public Finance Act 1989) Outputs can be grouped if they are of a similar nature. The output classes selected in non-financial measures are also reflected in your financial measures (s 142 (2) (b) Crown Entities Act 2004).
Outputs	Final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).
Ownership	The Crown's core interests as 'owner' can be thought of as: Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown; Capability - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future; Performance - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively.
Performance measures	Appropriate measures should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year and show intended results for the two subsequent financial years.
Priorities	Statements of medium term policy priorities.
Productivity	Increasing outputs relative to inputs (i.e.: either more outputs produced with the same inputs, or the same output produced using fewer inputs).
Purchase agreement	A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs. Some departments piloting new accountability and reporting arrangements now prepare an output agreement. An output agreement extends a purchase agreement to include any outputs paid for by third parties where the Minister still has some responsibility for setting fee levels or service specifications. The Review of the Centre has recommended the development of output plans to replace departmental purchase and output agreements.
Regional collaboration	Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist. • Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB • Midland: Bay of Plenty DHB, Lakes DHB, Tairawhiti DHB, Taranaki DHB and Waikato DHB • Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB and Whanganui DHB • Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB.
Results	Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once.
Standards of Service Measures	Measures of the quality of service to clients which focus on aspects such as client satisfaction with the way they are treated; comparison of current standards of service with past standards; and appropriateness of the standard of service to client needs.
Statement of Performance Expectations	Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year. They form the basis of the Annual Report.
Strategy	See Ownership.
Sub regional	Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping, typically

collaboration	in groupings of two or three DHBs and may be formalised with an agreement. For example a Memorandum of Understanding. Examples of sub regional collaboration include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (CentralAlliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.
Targets	Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.
Te Piki Oranga	The Nelson Marlborough Maori Health Coalition.
Values	The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. NMDHB Values: Respect, Innovation, Trust, Integrity.
Value for Money	The assessment of benefits relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.
Wrap around services	Services that 'wrap around' are services that work together seamlessly, communicating effectively, to ensure removal of both gaps and duplication in health service care and delivery. It places the patient/consumer at the centre of our service design, planning, delivery, and monitoring, in order to ensure that what is best for the patient is not subsumed by what is best for the health professional or the health system; resulting in the patient/consumer having a seamless journey throughout their involvement with all services/professionals, with gaps in health care delivery and professional/consumer communications removed. It is supported by incorporating consumers in continuous quality improvement activities.

APPENDIX 8.3 STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY

Nelson Marlborough District Health Board (NMDHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing NMDHB's operations includes the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. NMDHB's ultimate parent is the New Zealand Crown.

NMDHB's primary objective is to provide services to the New Zealand public. NMDHB does not operate to make a financial return.

NMDHB has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for NMDHB are for the year ended 30 June 2015, and were approved by the Board on 24 March 2015.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

STATEMENT OF COMPLIANCE

The financial statements of NMDHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

These financial statements comply with PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards.

PRESENTATION CURRENCY AND ROUNDING

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

STANDARDS ISSUED AND NOT YET EFFECTIVE AND NOT EARLY ADOPTED

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. NMDHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. NMDHB will apply these updated standards in preparing its 30 June 2016 financial statements. NMDHB expects there will be minimal or no change in applying these updated accounting standards.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

REVENUE

The specific accounting policies for significant revenue items are explained below:

Funding from the Crown

NMDHB is primarily funded from the Crown. This funding is restricted in its use for the purpose of NMDHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

NMDHB considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

The fair value of revenue from the Crown has been determined to be equivalent to the amounts due in the funding arrangements.

Grants received

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Donated assets

Where a physical asset is gifted to or acquired by NMDHB for nil consideration or at a subsidised cost, the asset is recognised at fair value and the difference between the consideration provided and fair value of the asset is recognised as revenue. The fair value of donated assets is determined as follows:

- For new assets, fair value is usually determined by reference to the retail price of the same or similar assets at the time the asset was received.
- For used assets, fair value is usually determined by reference to market information for assets of a similar type, condition, and age.

Rental revenue

Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

Provision of services

Certain operations of NMDHB are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by NMDHB due to the difficulty of measuring their fair value with reliability.

Trust and bequest funds

Donations and bequests are made for specific purposes. The use of these funds must comply with the specific terms of the sources from which the funds were derived.

All donations and bequests are assigned to and managed by the Nelson Marlborough Hospitals Charitable Trust (NMHCT) which has an independent Board of Trustees. The funds are held separately by NMHCT and are not included in NMDHB's statement of financial position. The revenue and expenditure in respect of these funds are also excluded from NMDHB's surplus or deficit.

Donations and bequests to NMDHB from the NMHCT are recognised as income when received, or entitlement to money is established. Expenditure subsequently incurred in respect of these funds is recognised as an expense in the surplus or deficit.

CAPITAL CHARGE

The capital charge is recognised as an expense in the financial year to which the charge relates.

BORROWING COSTS

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

GRANT EXPENDITURE

Non-discretionary grants are those grants awarded if the grant application meets the specified criteria and are recognised as expenditure when an application that meets the specified criteria for the grant has been received.

Discretionary grants are those grants where NMDHB has no obligation to award on receipt of the grant application and are recognised as expenditure when approved by the Grants Approval Committee and the approval has been communicated to the applicant. NMDHB's grants awarded have no substantive conditions attached.

FOREIGN CURRENCY TRANSACTIONS

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ$ (the functional currency) using the spot exchange rates at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

LEASES

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases where NMDHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether NMDHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

CASH AND CASH EQUIVALENTS

Cash and cash equivalents includes cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

RECEIVABLES

Short-term receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that NMDHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

INVESTMENTS

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Equity investments

NMDHB designates equity investments at fair value through other comprehensive revenue and expense, which are initially measured at fair value plus transaction costs.

After initial recognition, these investments are measured at their fair value with gains and losses recognised in other comprehensive revenue and expense, except for impairment losses that are recognised in the surplus or deficit.

On de-recognition, the cumulative gain or loss previously recognised in other comprehensive revenue and expense is reclassified to the surplus or deficit.

A significant or prolonged decline in the fair value of the investment below its cost is considered objective evidence of impairment. If impairment evidence exists, the cumulative loss recognised in other comprehensive revenue and expense is reclassified from equity to the surplus or deficit.

Impairment losses recognised in the surplus or deficit are not reversed through the surplus or deficit.

DERIVATIVE FINANCIAL INSTRUMENTS

Derivative financial instruments may be used to manage exposure to foreign exchange risk arising from NMDHB's operational activities. NMDHB does not hold or issue derivative financial instruments for trading purposes. NMDHB has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into and are subsequently re-measured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit.

The full fair value of a forward foreign exchange derivative is classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, foreign exchange derivatives are classified as non-current.

INVENTORIES

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the weighted average cost method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

NON-CURRENT ASSETS HELD FOR SALE

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

PROPERTY, PLANT, AND EQUIPMENT

Property, plant, and equipment consists of the following asset classes: land, buildings and building fit-out, plant and equipment, and motor vehicles.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation.

All other assets classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are re-valued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value and at least every five years.

The carrying values of re-valued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are re-valued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in

the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to NMDHB and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When re-valued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to NMDHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant, and equipment have been estimated as follows:

Buildings and fit-out	10 to 76 years	1.3%-10%
Plant and equipment	2 to 20 years	5%-50%
Motor vehicles	5 to 16 years	6.25%-20%
Leased assets	2 to 7.25 years	13.8%-50%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year end.

INTANGIBLE ASSETS

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with development and maintenance of NMDHB's website are recognised as an expense when incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Software	3 to 10 years	10%-33.3%

IMPAIRMENT OF PROPERTY, PLANT, AND EQUIPMENT AND INTANGIBLE ASSETS

NMDHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount.

The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

PAYABLES

Short-term payables are recorded at their face value.

BORROWINGS

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless NMDHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

EMPLOYEE ENTITLEMENTS

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, annual leave, and vested long service leave are classified as a current liability. Non-vested long service leave and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

SUPERANNUATION SCHEMES

Defined contribution schemes

Obligations for contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

NMDHB does not make employer contributions to defined benefit pension plans.

PROVISIONS

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in "finance costs".

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

Onerous contracts

A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract.

The provision is measured at the present value of the lower of the expected cost of terminating the contract and the expected net cost of continuing with the contract.

ACC Partnership Programme

NMDHB belongs to the ACC Partnership Programme (the "Full Self Cover Plan") whereby NMDHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, NMDHB is liable for all claims costs for a period of four years up to a specified maximum. At the end of the four-year period, NMDHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

EQUITY

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- contributed capital;
- accumulated surplus/(deficit);
- property revaluation reserves; and
- fair value through other comprehensive revenue and expense reserves.

Property revaluation reserve

This reserve relates to the revaluation of property, plant, and equipment to fair value.

Fair value through other comprehensive revenue and expense reserves

This reserve comprises the cumulative net change of financial assets classified as fair value through other comprehensive revenue and expense.

GOODS AND SERVICES TAX

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from, the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

INCOME TAX

NMDHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

BUDGET FIGURES

The budget figures are derived from the statement of performance expectations as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

COST ALLOCATION

NMDHB has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation.

Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output.

Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

In preparing these financial statements, NMDHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Estimating the fair value of land and buildings

The significant assumptions applied in determining the fair value of land and buildings are disclosed in the notes.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant, and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by NMDHB, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the statement of financial position. NMDHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second hand market prices for similar assets; and
- analysis of prior asset sales.

NMDHB has not made significant changes to past assumptions concerning useful lives and residual values.

Retirement and long service leave

The Notes provide an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

Management has exercised the following critical judgements in applying accounting policies:

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to NMDHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

NMDHB has exercised its judgement on the appropriate classification of equipment leases, and has determined a number of lease arrangements are finance leases.

Grants received

NMDHB must exercise judgement when recognising grant revenue to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

‘NMDHB Annual Plan 2015-16 & Statement of Intent 2015-2018’

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

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