

1. Has the Ministry, crown entity, government department or government agency’s mission statement or vision statement been changed in the financial year under review; if so, what are the details of these changes?

Response

There has not been any change in NMDHB’s mission or vision statement for 2009/10. Progress towards our mission to “work with the people of our community to promote, encourage and enable their health, wellbeing and independence” continues. Our vision of “leading the way to health-conscious families” reflects the Board’s commitment to being a community leader with an emphasis on improving health status through prevention, health promotion and reducing health inequalities in this district.

The DHB did increase the profile of its underpinning values:

**NMDHB VALUES**  
*To work with people of our community to promote, encourage and enable their health, well-being and independence.*

VALUES <i>What we value</i>	ATTRIBUTES <i>What you would see us 'being'</i>	BEHAVIOURS <i>What you would see us 'doing'</i>
<p><b>Respect</b> We care about and will be responsive to the needs of our diverse people, communities and staff.</p>	<ul style="list-style-type: none"> <li>• caring for others</li> <li>• understanding</li> <li>• patient</li> <li>• committed</li> <li>• courteous</li> <li>• compassionate</li> <li>• enabling</li> <li>• culturally sensitive</li> </ul>	<ul style="list-style-type: none"> <li>• taking the time</li> <li>• engaging-working together</li> <li>• listening and acting</li> <li>• advocating</li> <li>• acknowledge the individuals situation</li> <li>• putting aside personal preferences or ways of doing</li> <li>• heeding verbal and non verbal messages</li> <li>• valuing diversity</li> </ul>
<p><b>Innovation</b> We will provide an environment where people can challenge current processes and generate new ways of working and learning.</p>	<ul style="list-style-type: none"> <li>• challenging the status quo</li> <li>• enquiring</li> <li>• seeking out new information</li> <li>• researching</li> <li>• having a can do attitude</li> <li>• embracing change</li> <li>• an enabling environment</li> <li>• reflective</li> <li>• seeking constant improvement</li> </ul>	<ul style="list-style-type: none"> <li>• generating and supporting new ways of working and learning</li> <li>• evaluating and learning from our actions</li> <li>• external evidence and local learning guide our direction</li> <li>• utilising the best from wherever and making it work for us</li> <li>• benchmarking to improve</li> </ul>
<p><b>Teamwork</b> We create an environment where teams flourish and connect across the organisation for the best possible outcome.</p>	<ul style="list-style-type: none"> <li>• cooperative</li> <li>• problem solving</li> <li>• creative</li> <li>• energetic</li> <li>• enthusiastic</li> <li>• clear of purpose – team and individual</li> <li>• supportive</li> </ul>	<ul style="list-style-type: none"> <li>• communicating effectively</li> <li>• sharing resources and knowledge</li> <li>• utilising strengths of individual team members</li> <li>• providing seamless service from consumers perspective</li> <li>• all staff actively contributing to decision making</li> <li>• achieving effective outcomes</li> <li>• acknowledging and valuing diverse skills and contributions</li> </ul>
<p><b>Integrity</b> We support an environment which expects openness and honesty in all our dealings and maintains the highest integrity at all times.</p>	<ul style="list-style-type: none"> <li>• accountable</li> <li>• personally and collectively responsible</li> <li>• culturally responsive</li> <li>• being true to oneself</li> <li>• open, fair and reasonable</li> </ul>	<ul style="list-style-type: none"> <li>• taking personal responsibility for actions and outcomes</li> <li>• telling the truth</li> <li>• challenge, question and address appropriately</li> <li>• honouring commitments</li> <li>• walking the talk</li> <li>• striving to be open, fair and reasonable</li> </ul>

2. What new services, functions or outputs have been introduced in the 2009/10 financial year? Describe these and provide details of all associated costs.

Response

Description	Details	Contract price (Excl GST)
Maori health: Whanau Ora Palliative Care	Service started from August 2009 and expires on 30 December 2011. The service seeks to provide education, whanau support, facilitation and links with other services for whanau with palliative care requirements. The service is lead by Whakatu Marae Health & Social Services and is supported by Te Hauora O Ngati Rarua and Te Amo Health. This is a district wide service.	\$262,500
Whanau Ora Hauora Tane	Service started from July 2009 and expires on 30 December 2011. The service seeks to increase awareness of issues for men and provide environments for discussion/debate and health checks. The service is lead by Te Hauora O Ngati Rarua supported by Te Rapuora O Te Wai Harakeke and Whakatu Marae Health & Social Services. This is a district wide service.	\$240,000
Whanau Ora Pathfinder service	This service has been approved in July 2009. Te Amo Health was appointed as the lead provider and withdrew from this role because of Whanau Ora in August 2010. Funding has not been reallocated. However, discussions are pending with Maori health providers in Te Tau Ihu. This service was to support whanau who have had experience with cancer and required community support.	\$75,000
Primary Mental Health	Brief Intervention Clinical Teams (per annum value)	\$458,136
	Extended General Practice Consultations (per annum value but also includes the purchase of some one off volumes)	\$175,425
	Packages of Care (per annum value and also includes the purchase of some one off volumes)	\$322,850
	Workforce Development (per annum value also includes one offs)	\$48,210
Addictions	Effective Intervention Alcohol and Drug Residential Beds (per annum value)	\$70,686
Nutrition and physical Activity Programme	New initiatives funded through Small grants to 60 plus schools, Early Childhood Education (ECE) services and community organisations supported to establish nutrition and/or physical activity initiatives; - 8 school edible gardens; 14 Open Orchards; - Breastfeeding Coordinator positions within two Primary Health Organisations; Peer Counselling Administrator roles in Nelson/Tasman and Marlborough; - Maori Leadership programme within local marae; - 'Trolley Tips' – web-based meal planning resource; - 'Seasonal Challenge' social marketing programme - nutrition, and physical activity for children and parents; - 'Active8' programme in Kimi Hauora Wairau PHO.	\$110,000 \$41,000 \$67,000 \$40,000 \$3,000 \$60,000 \$10,400
Vascular Risk Assessment (VRA) delivered by Community Providers	NMDHB contracted with Kimi Hauora Wairau PHO in March 2009 for a three year contract to deliver the NMDHB VRA programme. In September 2010 NMDHB varied the VRA contract with Kimi Hauora Wairau to include Maori Health providers in Marlborough. This was a formal agreement which engages Maori Health providers to assist Kimi Hauora Wairau to target at risk Maori groups.	\$589,347 (for all VRA interventions over 3 years)
InterRAI	Introduction of interRAI assessments into the AT&R unit at Nelson Hospital. This is supported by input from the NASC service.	No additional cost. Internal improvement process
HBSS enhancements	Introduction of a single referral form for hospital based services delivered into the community such as District Nursing, Allied Health Services, NASC services. This development will facilitate service integration, reduce duplication of assessment	No addition cost Internal improvement process

Description	Details	Contract price (Excl GST)
	and promote patient centred service delivery through coordinated service delivery.	
Targeted Youth Health Service	Providing youth health co-ordination as well as clinical assessments for young people in Alternative Education and Youth Transition Services. The service is funded by CFA Variation and is contracted to Nelson Bays Primary Health who have subcontracted the clinical role to Te Rapuora O Te Wai Harakeke. The contract runs from 1 January 2010 – 30 June 2012. The service is district wide.	\$270,000
Implementation of Smoking Cessation ABC in Primary Care	This is an 'enabler' service designed to support the development and implementation of systems in general practice to give smokers better advice and support to quit. March 09 – June 2011	\$145,167

3. *Are there any plans to introduce services, functions or outputs in the current financial year that were not provided in the 2009/10 financial year? Describe these and provide details of all associated costs.*

#### Response

Besides actions outlined below, we are also taking actions in 2010/11 that will result in new services in future years. We are implementing new mobile and fixed community oral health clinics. The additional capital cost in 2010/11 is \$962,000 and \$1,050,000 in operating costs in 2010/11 and 2011/12.

Following community consultation and agreed business case, we are progressing the development of an Integrated Family Health Centre in Golden Bay in 2011/12 in conjunction with the Ministry of Health. This integrates services currently provided by the Golden Bay Community Hospital, the Joan Whiting Memorial Trust Rest Home and the GP practice run by Nelson Bays Primary Health in a community owned facility. A key objective of this development is to provide the Golden Bay community with confidence in the future provision of sustainable, appropriate health services. It is envisaged that the extension to and upgrade of the existing community hospital will be funded through a combination of commercial lending, donations from philanthropic sources and community contributions.

**ASD** Co-ordination – providing co-ordination of diagnosis service for children with developmental delay where ASD is suspected and where a diagnosis of ASD is made, then co-ordination of a development plan and access to services. The service is commencing January 2011, provided by the NMDHB Child Development Services and Autism NZ Nelson Marlborough branch. This is an ongoing service funded through CFA variation as part of the roll-out of services following the adoption of the ASD Guidelines. Value is \$75,000 per annum.

Health and Education Assessments – Pilot for 6 months Jan-Jun11 to establish the Health and Education Assessments for children and young people entering state care. This is an enabler (rather than outputs) at this stage but is designed to establish the systems, with a view to these assessments becoming an ongoing service. Value is \$32,000 one-off.

Sexual Abuse Assessment and Treatment – A contract with ACC taken up and a new process for delivery has been introduced from 1 October 2010. This has enabled improved quality and accessibility of the service. This service is funded by ACC (although NMDHB funded Paediatric Services to support the service delivery to children) and is ongoing.

Chronic pain pathway through the Nelson Marlborough Health Alliance (patient pathways programme similar to the Canterbury Initiative) - through the NM Health Alliance NMDHB has developed a chronic pain management pathway to support people in a community setting. This is a multi-disciplinary service model focused on pain self management.

Primary Care Management of Morbid Obesity Nelson Marlborough Health Alliance – also through the NM Health Alliance NMDHB has developed a primary care management of morbid obesity pathway to support people in the community. Completion of the programme will be a precondition for access to bariatric surgery.

Regional Bariatric Surgery programme - Additional money from the Health Minister for a defined number of procedures for morbid obesity patients at the complex end is currently being rolled out under regional service delivery.

The Murchison integrated model of care has been affirmed by the Rutherford process resulting in the appointment of a nurse practitioner to complement the 3 days per week hospital based GP. The enhanced model is being partly funded through co-payments from Murchison eligible people (previously this was a “special area”).

Mental Health will be receiving an additional \$130k in 2010/11 for a Youth AOD position,

4. *What services, functions or outputs have been cut, amended or curtailed in the 2009/10 financial year and at what cost or saving?*

Response:

In 2009/10 NMDHB put in place the Rutherford Initiative to avoid on going deficits and return it to a viable path to break even. As part of that Initiative a number of changes to services or functions were identified. These included introducing a new home based support services model, revising mental health services to the ring fenced funding and consolidating a number of community based programmes where duplication or low volumes were involved:

Services, functions or outputs that have been cut, amended or curtailed in the 2009/2010 financial year		Cost savings
Provider Division Services	Home Based Support	\$48,465.00
	Adult Planned Respite	\$13,197.00
	Adult Crisis Respite	\$64,646.00
	Other Residential Support	\$2,402.00
	Child and Youth Respite	\$20,623.00
	Child and Youth services	\$229,374.00
	Alcohol and Drug Counsellors	\$108,782.00
	Older Persons Mental Health	\$341,254.00
Total mental health savings (as identified in District Annual Plan)		<b>\$828,743.00</b>

Service, Function or Output	Provider	Savings in 2009/10	Further saving in 2010/11
Green Prescription	Tasman Regional Sports Trust	\$17,050	\$34,099
Active Steps Physical Activity	Tasman Regional Sports Trust	\$11,935	\$23,869
Healthy Activities	Nelson Bays Primary Health	\$75,000	-
Chronic Conditions co-ordinator	Nelson Bays Primary Health	Implemented for 10/11 year only	\$100,000
Healthier Homes	Energy Smart and Energy Options	\$150,000	-
Smokefree Mental Health	NMDHB		\$48,000
Cardiothoracic inpatients	Heart Centre at St George's Hospital	\$975,000	
HPV Maori & Pacific	NMDHB	-	\$12,500

5. *Are there any plans in this financial year to cut, amend or curtail services, functions or outputs that were provided in the 2009/10 financial year? If so, provide details and an explanation of the reasons for any changes.*

Response:

As noted in question 4 under the Rutherford Initiative a number of changes were identified so as to return NMDHB to on going viability. Changes have

been made where duplication or low volumes was identified and follow discussions with affected providers. These have included consolidating some small providers, where services are duplicated, so that NMDHB can deliver affordable and effective services to our district.

Plans in this financial year to cut, amend or curtail services, functions or outputs that were provided in the 2009/2010 financial year.		Cost savings
Rutherford Initiative Mental Health	Kaupapa Maori Adult Planned Respite	\$12,499.00
	Addiction Support House	\$9,603.00
	Addictions Respite	\$22,403.00
	Alcohol and Drug Counsellor	\$15,403.00
	* Alcohol and Drug Counsellor	\$19,125.00
	* Community Support Worker	\$12,000.00
	* AddictionsWananga	\$63,400.00
	Community Support Workers	\$190,200.00
	Day Activity Programme	\$199,997.00
	Work Rehabilitation, Employment and Education	\$64,000.00
	Work Rehabilitation, Employment and Education	\$28,000.00
	Consumer Advocacy and Peer Support	\$17,500.00
	Workforce Development	\$6,500.00
	Workforce Development	\$10,907.00
	Workforce Development	\$7,898.00
<b>Total mental health savings (as per OPF notification)</b>		<b>\$679,435.00</b>

6. *What user charges were collected by the department/ministry in the 2009/10 financial year? Do these differ from those collected in the previous financial year; if so, why? Are there any plans to introduce any new charges in the current financial year; if so, what charges and why?*

Response:

Existing revenue (no new user charges):

Revenue Description \$(000)	2008/09	2009/10
Charges to Non-Residents	495	325
Patient Co-Pays – Pharmaceutical	122	108
Patient Co-Pays – Dental	160	148
Patient Co-Pays – Cont Care	848	573
Patient Co-Pays – Audiology	194	200
Patient Co-Pays – Meals On Wheels	389	330
Disability-related Day Services	0	63

Misc Sales/hires of equipment and parts	36	26
<b>TOTAL</b>	<b>2,245</b>	<b>1,773</b>

7. How much funding was allocated to capital works in the last Budget? How does this figure compare with that allocated and spent in the previous financial year? What is this figure broken down for each capital works project? (If the Ministry, crown entity, government department or government agency operates on a regional/area/district basis also itemise the total amount spent by each region/area or district).

Response:

The Capital Plan since 2008/09 is:

000's	2008/09	2009/10	2010/11	2011/12	2010/13
Buildings & Plant	\$20,470	\$17,838	\$19,106	\$ 634	----
Clinical Equipment	\$ 4,929	\$ 3,383	\$ 3,316	\$ 5,196	\$ 2,923
Other Equipment	\$ 500	\$ 1,500	\$ 500		
IT / IS	\$ 4,666	\$ 3,015	\$ 3,128	\$ 4,790	\$ 3,515
Motor Vehicles	\$ 685	\$ 1,542	\$ 540	\$ 733	\$ 1,775
	<b>\$31,250</b>	<b>\$27,278</b>	<b>\$26,590</b>	<b>\$11,353</b>	<b>\$ 8,213</b>
This includes:					
Wairau Site	\$15,460	\$15,608	\$12,908		
Nelson Site Bus. Case		\$ 200	\$ 200		
Dalton House - refurbish			\$ 1,700		
Mental Health (Braemar)	\$ 1,000	\$ 800			
School Oral Health - buildings			\$ 2,663	\$ 34	
School Oral Health – Mobile Clinics			\$ 239	\$ 558	
School Oral Health – Clinical Equipment			\$ 532	\$ 723	
General Site Works	\$ 910	\$ 480	\$ 585	\$ 300	
Mental Health Acute Unit	\$ 1,000		\$ 100		
After Hours (Primary)		\$ 150	\$ 350		
Staff Accommodation			\$ 600	\$ 300	
Emergency Power	\$ 1,200	\$ 600			
Other Buildings	\$ 300				
Clinical Equipment	\$ 4,929	\$ 383	\$ 2,034	\$ 2,873	\$ 2,923
CT Scanners				\$ 1,600	
Ultrasounds			\$ 750		
IT / IS	\$ 4,666	\$ 3,015			
Clinical Intranet			\$ 500	\$ 500	\$ 500
Patient Management System			\$ 500	\$ 3,000	
Reporting			\$ 250	\$ 250	
PACs					\$ 1,000
ED			\$ 700		
Other IT / IS			\$ 1,178	\$ 1,040	\$ 2,015
Vehicles	\$ 685	\$ 1,542	\$ 301	\$ 125	\$ 1,775
<b>Total</b>	<b>\$31,250</b>	<b>\$27,278</b>	<b>\$26,590</b>	<b>\$11,353</b>	<b>\$ 8,213</b>

8. *What polls, surveys or market research have been undertaken in the 2009/10 financial year, and at what cost for each project? Provide copies of all reports prepared as a result of any poll, survey or market research conducted.*

Response:

NMDHB undertook the following surveys:

Date	Type	Cost
January 2010	Nutrition and Physical Activity focus groups – costs of attendees	\$9,820
January 2010	Survey and telephone interviews with Primary School principals on school nutrition and physical activity - internal staff	No cost
August 2009	Older adults physical and nutrition situation report	\$20,000

Because of the value (under \$100,000) and the specialised nature of the August 2009 report the work was not tendered.

The following reports are attached:



Social Marketing



OPAN-Current

Overall Report FINAL Situation report (word)

9. *What polls, surveys or market research were budgeted for in the 2010 Budget, and at what estimated cost for each project?*

Response:

The following surveys are planned for 2010/11:

Date	Type	Cost
April – May 2011	Repeat of Nutrition and Physical activity baseline health survey	\$100,000
November 2010	Interviews with NPA stakeholders which contributed to the NPA evaluation	\$60,000

July 2010	Repeated survey and telephone interviews with Primary School principals on school nutrition and physical activity - internal staff	No cost
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10. *What were the major projects commenced or completed in the 2009/10 financial year? When were they commenced; when were they or are they due to be completed; and what was the cost or estimated cost?*

Response:

No new projects were commenced during the 2009/10 financial year.

NMDHB continued work on the redevelopment of Wairau Hospital commenced in 2007. Completion is scheduled for 16 February 2011.

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#### WAIRAU HOSPITAL REDEVELOPMENT

The completion of the construction of the second stage of the Wairau Hospital Redevelopment Project in February 2010 was another significant milestone achievement. The first department to occupy the new stage two facilities was Medical Records, closely followed by Laboratory, Support Services, Emergency Department, Acute Assessment Unit/High Dependency Unit and finally the Radiology Department. The completion of the construction of the new operating theatre in June 2010 was also a significant milestone for the NMDHB.

Twelve months have now passed since the occupation of the new wards and allied health facilities which were completed in stage one of the development. Positive feedback continues to flow from staff and patients, as the new systems and facilities become utilised, with particular praise falling on the new Emergency Department.

The pressure has continued throughout the year with the construction progress and to remain within budget. Cooperation from the public and patients has enabled an efficient construction work programme minimising any significant impact or disruptions being incurred by hospital services.

We look forward to the completion of the whole redevelopment of the hospital campus in 2011 when all services will be located in their new premises and the community of Marlborough will continue to enjoy the highest level of care in newly constructed and contemporary healthcare facilities.

*11. What key policy changes were worked on and/or implemented by the Ministry, crown entity, government department or government agency in the 2009/10 financial year and what were the total and specific fiscal costs of these policy changes?*

Response:

The key policy changes worked on/and implemented in 2009/10 related to the development of the Nelson Marlborough Health Alliance as a partnership with the two PHOs in Nelson Marlborough.

Whanau Ora was launched as a national initiative to improve health outcomes for families. Nelson Marlborough has three local Maori Health providers involved.

Regional PET scanning was introduced following additional public funding investment for cancer conditions coordinated through Canterbury DHB.

The priorities implemented in the 2010-13 NMDHB Statement of Intent and 2010/11 District Annual Plan reflect the Government's priorities on clinical and financial sustainability and achieving the health targets and priority areas.

*12. What key policy changes will be implemented as a result of the 2010 Budget and what are the estimated fiscal costs of these policy changes?*

Response:

NMDHB is progressing aligned Clinical Pathways through the Nelson Marlborough Health Alliance. NMDHB is progressing a formal Alliance Contract agreement with an associated monitoring framework and a flexible funding pool as per Government Policy.

Other priorities for 2010/11 are detailed in NMDHB's accountability documents.

NMDHB is progressing development of a Maori provider coalition with links to Whanau Ora.

*13. What are the major projects or policy development areas to be given priority in the current financial year and why?*

Response:

The Maori Health Provider Coalition is a key project now underway. The project seeks to bring together eight NGO Maori health providers into a

collective. The project seeks to improve service delivery to Maori living in Te Tau Ihu and improve coordination. There is an expectation that the project will consider a shared service arrangement between the NGO providers.

The formation seeks to strengthen NGO Maori Health Provider workforce developments in the region and place Whanau at the focus of ongoing service delivery. The project aims to respond to the key policies 'Better, Sooner, More Convenient' and Whanau Ora nationally.

Psycho-Geriatric Services are being reconfigured with continuing DHB ownership of the acute specialist service and outsourcing of the continuing care residential care service.

Continuing the community oral health model and Golden Bay Integration Project are being progressed. (See question 3)

In 2009/10 NMDHB put in place the Rutherford Initiative to avoid on going deficits and return it to a viable path to break even. The Initiative is reviewing all aspects of expenditure by NMDHB and identifying possible opportunities to improve the delivery of affordable and efficient services for our population.

The original focus of the Initiative was on support services and a number of benefits identified and implemented. The focus has now moved to clinical areas including psychogeriatrics, ophthalmology, maternity and capacity planning. Consultation is underway on the first two services and has created considerable interest and views from a range of people and groups.

The work on capacity planning is laying a platform for examining other clinical services. While it will create debate there is a need to continue to identify a wide range of options to be explored in how NMDHB might reconfigure service delivery in the future. This approach is consistent with overall health and disability services policy so that we get the best benefit for the health dollars available.

There is a need to ensure that gains are captured and sustainable changes made.

*14. Provide a copy of the Ministry, crown entity, government department or government agency's work programme and a brief explanation of each project or policy area to be addressed during 2010/11. Provide details of timelines and milestones for each project or policy area.*

Response:

Refer to Appendix A (page 30) being an extract from the NMDHB 2010-13 Statement of Intent for the 2010/11 work programme.

15. *What restructuring has taken place in the Ministry, crown entity, government department or government agency in the 2009/10 financial year; why, and at what cost?*

Response:

There were 29 redundancies or buyouts of terms and conditions arising from:

- the transfer of services at Motueka Community Hospital
- reconfiguration of mental health services, health promotion services and maintenance services.

Total cost \$484,217.32

16. *What restructuring will take place in the Ministry, crown entity, government department or government agency as a result of Budget 2010; why, and at what cost?*

Response:

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In April 2010 the CE commenced a review of the Strategic Leadership Team (SLT). A new structure, to be known as the Executive Leadership Team (ELT), seeks to create a new environment in which joint leadership between clinicians, management and providers across the continuum of care can be engaged to achieve the best care possible within the district's finite resources.

The intent is that this will bring those who are concerned with district-wide delivery of services into the senior team and increases the input of clinicians. It is also intended to achieve greater clarity and accountability across both operational and support functions.

The structure allows that service governance across primary and secondary care will be simplified, clinicians can be involved together with management at all levels of decision making, the 'line of sight' from proposal through to delivery will be clarified and opportunities for integration and efficiencies of both sustainable services and viable financial performance can be improved.

Structural change is, however, only part of the solution. The major ingredients are that the people involved in the leadership positions are competent as leaders, and committed to working collaboratively and for the benefit of the greater objective – the best and most effective services possible to the residents of Nelson, Tasman and Marlborough.

The objectives for the new structure are to:

- Take the work done in the Primary and Community Division to the next level by consolidating the accountability for integration of patient services across the continuum to better achieve health services that support the patient journey;
- Allow greater clinical engagement in leadership;
- Provide structural support for clinical accountability;
- Provide a single point of accountability for service delivery, across the service continuum;
- Clarify roles and responsibilities;
- Provide a single point of accountability for provision of business system support, information and operational analysis;
- Greater focus on quality, safety and risk management;
- Build on the work done on 'Optimising the Patient Journey' and gives greater focus on continuous operational improvement;
- Improvement in the accountability for financial management and delivery of results by budget holders;
- A committed focus on developing the strategic direction and accountability documents, with separation from provider contracting; and
- Allowing the senior managers the time needed to drive improvement and strategic intent versus reacting to operational issues.

In addition as NMDHB works through the Rutherford Initiative a number of changes may be identified. Should these changes affect the delivery of clinical services and impact on staff NMDHB will follow the procedures set out in the operational policy framework including Ministerial agreement and staff consultation.

A provision of \$700,000 has been made for restructuring costs for 2010/11.

*17. How many redundancies were there in the 2009/10 financial year and at what cost? Is the number and cost of redundancies expected to increase or decrease from that figure in the 2010/11 financial year?*

Response:

Refer question 15 for the number and cost of redundancies in 2009/10.

A provision of \$700,000 has been made for 2010/11 for any redundancies arising from service changes. No specific numbers have been identified.

*18. Provide details of staff turnover in 2009/10. Itemise numbers of staff resigning, the section, division or group they worked for, the month they left, and the reasons given for resignation.*

Response:

Staff turnover during 2009/10 was 370 staff in the following occupational groups:

Occupational Group	Number
Medical	40
Nursing	153
Allied Services	87
Support Services	22
Management & Administration	68
	370

The numbers by month were:

Months	Medical	Nursing	Allied Services	Support Services	Management & Administration
July 2009	4	16	10	8	6
August	2	13	10	2	5
September		37	8	2	5
October		5	4	3	4
November	9	10	12	2	8
December	11	10	5	1	5
January 2010	4	8	5		4
February	2	7	6	1	4
March	1	13	7		7
April	1	14	5	2	11
May	5	8	7	1	4
June	1	12	8		5
	<b>40</b>	<b>153</b>	<b>87</b>	<b>22</b>	<b>68</b>

Note – the higher turnover of medical staff in November and December is due to the annual turnover of junior medical staff.

The reasons given for the resignations were:

BECAUSE PARTNER IS MOVING	2
DISSATISFACTION WITH SERVICE	2
FAMILY REASONS	8
GOING OVERSEAS	16
HEALTH REASON	7
NO REASON GIVEN	220
OTHER EMPLOYMENT	38
PERSONAL	9
RESIGNED FROM PARENTAL LEAVE	9
RETIREMENT	16

SHIFTING WITHIN NZ TO STUDY OR FURTHER EDUCATION	9
TRANSFERS FROM PERM TO CASUAL	22
Grand Total	12
	370

19. Are there any concerns in relation to staff turnover; if so, what are these concerns and how are these been addressed?

Response:

NMDHB has the following concerns relating to staff turnover and future workforce shortages:

### **Support Workers**

In Intellectual Disability Support Services NMDHB competes for workers in this area with a number of other industries e.g. hotel and hospitality, seasonal agricultural work. Actions to address the situation include restructuring the employment agreement, provision of good training opportunities and regular local advertising.

### **Mental Health Workers**

As with the majority of DHBs NMDHB has had difficulty recruiting to new mental health positions. The organisation actively participates in regional and national mental health workforce planning initiatives and has developed an NGO workforce development strategy.

### **Recruitment to Wairau Hospital**

NMDHB has experienced particular difficulty in recruiting to health professional positions in Wairau, including senior and junior medical staff, specialised nursing staff and allied health staff. Actions taken include promoting the region to prospective employees, establishing regional positions and active advertising.

With the improvement of the facilities as a result of the new hospital we are seeing encouraging signs of a lift in this area.

### **Ageing Workforce**

As in other regions, NMDHB has an ageing workforce in all areas. It is working with national groups on this matter and currently assessing the size

and impact of the issues to facilitate appropriate future workforce availability.

*20. How many personal grievance claims were laid by staff in the 2009/10 financial year and what was the total cost of all settlements of personal grievance claims?*

Response:

Four claims were officially lodged.

Total cost of settlements was Nil

*21. How many personal grievance claims have been laid by staff in the financial year to date?*

Response:

Fifteen claims have been lodged. Eight of these relate to a matter which those staff consider they are disadvantaged by a service change

*22. Is the Ministry, crown entity, government department or government agency budgeting for more or less personal grievance claims in the current financial year than it did in the previous financial year?*

Response:

No specific provision is made for personal grievance claims.

*23. Provide a breakdown by role and location of the current staff numbers in comparison to each of the last five years. Provide an explanation for any changes in the numbers employed.*

Response:

The following sets out the number of staff employed. It does not include vacancies or positions covered by locums.

	2006	2007	2008	2009	2010
<b>FTE</b>					
Medical	122.13	127.13	133.83	148.07	156.78
Nursing	550.12	557.2	599.79	657.73	618.04

<b>Allied Services</b>	<b>509.46</b>	<b>503.54</b>	<b>534.77</b>	<b>554.51</b>	<b>534.26</b>
Support Services	90.75	92.82	97.4	102.57	94.25
Management & Administration	300.69	318.71	347.2	354.29	346.27
	<b>1573.15</b>	<b>1599.4</b>	<b>1712.99</b>	<b>1817.17</b>	<b>1749.6</b>
<b>Count</b>					
Medical	169	173	181	191	192
Nursing	881	890	954	993	927
Allied Services	745	722	769	769	743
Support Services	152	146	159	157	145
Management & Administration	384	401	440	439	426
	<b>2331</b>	<b>2332</b>	<b>2503</b>	<b>2549</b>	<b>2433</b>

24. *Did the Ministry, crown entity, government department or government agency use any measures in the 2009/10 financial year to ensure staff numbers were maintained at a particular level? If so, what were those measures, and are there any plans to change those measures?*

Response:

The following process was put in place to manage staff numbers and to ensure NMDHB achieved its planned result.

## Overview

CNMs/HODs/Team Leaders are to look at what the consequences of not filling a position might be and how a vacancy may be covered differently - this does not include asking existing staff to work additional hours or overtime or engaging more casual staff. New ways of approach the challenge are encouraged

## Principles

- No service shall employ new or replace existing/arising vacancies (all FTEs) outside of the process documented below
- A prioritisation process will be followed to ensure that FTE is allocated appropriately, as determined by the prioritisation process.
- New MoH programmes with funding attached requiring management or admin staff will need to be resourced within existing capped M&A FTE numbers.
- Clinical growth that requires additional front-line staff to deliver patient care will be applied for using this process.

## Process

### *Application Process*

CNMs/HODs/Team Leaders are to complete the application form for all replacement or new FTEs as well as locums and casual staff. Form to be sent to District Manager who will discuss the request with the General Manager.

**Approval Process**

This application must be agreed to by the District/General Manager and forwarded to the CE for final approval

No recommendations are to be put forward that either exceed the M&A FTE cap or increase the total budgeted FTE for the organisation.

The process remains in place for the 2010/11 year.

*25. How does the Ministry, crown entity, government department or government agency define frontline staff?*

Response:

NMDHB considers front line staff to be those who provide or who perform essential direct support clinical activities. This includes medical and nursing staff, allied support staff eg technicians, imaging and other diagnostic procedures, health care assistants and care workers. Also, clerical staff supporting those clinical activities eg ward, booking, enquiry clerks, clinical typists, coders and medical records filing and administration.

All other staff eg maintenance, finance, payroll and management are classified as not being front-line staff.

*26. What was the proportion of frontline staff as a percentage of the overall staff employed by the Ministry, crown entity, government department or government agency in the 2009/10 financial year? How does that compare to the past five years and how is it expected to change in the current financial year?*

Response:

The percentage of front line staff for the 2009/10 year rose to 85% for those who provide or directly support clinical activities and 15% non clinical support. This mix has changed from 82% in 2003/04 and 84% in 2008/09.

*27. How many staff are currently seconded to work in Ministerial offices and how does this compare with the previous five years?*

Response:

No staff were seconded to work in Ministerial offices during the year.

28. *What was the total amount spent in 2009/10 on the salaries of staff seconded to work in Ministerial offices and how much was spent in each of the previous five years?*

Response:

Nil

29. *How many credit cards does the Ministry, crown entity, government department or government agency have broken down by credit limit on the card?*

Response:

Credit limit	Number of cards
\$10,000	1
\$5,000	1
\$4,000	4
\$2,000	6

The cards are held by the Chief Executive, members of Executive Leadership Team, Librarians and Purchasing Officers.

30. *What was the total amount spent in 2009/10 on the salaries of communications, media or public relations staff and how does that compare to the previous financial year?*

Response:

Total costs for communications staffing 2009/10 was approximately \$120,000.

31. *How many communications, media or public relations staff are currently employed by the Ministry, crown entity, government department or government agency and how does that number compare to the previous financial year?*

Response:

NMDHB had 2 communications staff members (2.0 FTEs) and engages, as required, consultants for specific projects or other public relations. There has been no change to the number of staff. Use of external specialist resource has declined in recent years.

*32. How many vacancies are there for communications, media or public relations staff in the Ministry, crown entity, government department or government agency?*

Response:

No vacancies.

*33. Has the Ministry, crown entity, government department or government agency contracted any consultants or contractors to provide communications, media or public relations advice or services in the 2009/10 financial year; if so, with whom have they contracted, for what specific purpose or project, for what length of time and at what total actual or estimated cost?*

Response:

NMDHB engaged Network PR for advice relating to work undertaken by its Public Health Service in connection with the chemical contamination at Mapua. The time involved was on an as required basis at a cost of \$4,100.

*34. Has the Ministry, crown entity, government department or government agency contracted any consultants or contractors to provide communications, media or public relations advice or services within a Minister's office in the 2009/10 financial year; if so, with whom have they contracted, for what specific purpose or project, for what length of time and at what total actual or estimated cost?*

Response:

No

*35. For each consultant or contractor that has been engaged in the 2009/10 financial year and paid more than \$5000, or for which more than \$5000 is budgeted to be spent in the current financial year, provide the following details:*

- *Name of consultant or contractor*
- *Type of service generally provided by the consultant or contractor*
- *Details of the specific consultancy or contract*
- *Budgeted and/or actual cost*
- *Maximum hourly and daily rates charged*
- *Date of the contract*
- *Date the work commenced*
- *Completion date*
- *Whether tenders were invited; if so, how many were received*
- *Whether there are proposals for further or following work from the original consultancy; if so what are the details?*
- *A copy of all reports prepared or delivered as a result of the consultancy or contract.*

Response:

Refer to Appendix B (page 65)

36. *How many staff were leased in 2009/10 and 2010/11 to date? Provide the following details for each lease:*

- *Name of person leased and company responsible for the lease arrangement*
- *Type of service generally provided by the person leased*
- *Details of the specific lease (eg reason for the lease, services provided by the leased person, reason for the length of the lease, why permanent staff were unable to be appointed to the leased position)*
- *Actual cost*
- *Maximum hourly and daily rates charged*
- *Date of the contract*

- *Date the work commenced*
- *Completion date*
- *Whether there are proposals for further or following work from the original lease; if so what are the details?*
- *A copy of all reports prepared or delivered as a result of the lease.*

Response:

NMDHB does not lease staff. It does engage temporary staff as locums to meet clinical requirements plus some other staff where there is an immediate demand through illness or where long term commitments cannot be given to staff eg areas subject to a Rutherford review and a staff member has resigned.

37. *What is the average length of service in the Ministry, crown entity, government department or government agency? Has this changed in the last year; if so, is this causing any concerns?*

Response:

The average length of service has not changed significantly over the last five years.

Report Date	Years Service	Months Service
30/06/2006	7	10
30/06/2007	7	6
30/06/2008	7	0
30/06/2009	7	0
30/06/2010	7	7

38. *Provide details of the number of staff in \$10000 salary bands as at 1 July 2008, 1 July 2009 and 1 July 2010. Provide reasons for any significant changes.*

**Response:**

The following table sets out base salary bands for staff. It does not include overtime or any other payments.

	2008	2009	2010
20,000	66	27	13

	2008	2009	2010
30,000	826	833	717
40,000	246	253	284
50,000	773	243	173
60,000	288	865	861
70,000	164	128	154
80,000	62	127	136
90,000	13	23	27
100,000	14	8	15
110,000	7	14	13
120,000	18	7	5
130,000	22	22	20
140,000	15	18	20
150,000	23	18	22
160,000	13	21	18
170,000	17	6	9
180,000	28	24	16
190,000	0	27	43
230,000	1	0	0
240,000	0	1	1
350,000	1	1	1

39. *What was the total amount paid to staff in bonus payments in the 2009/10 financial year and how many staff qualified for such payments? How much has been paid in the financial year to date?*

Response:

A payment of \$500 was made to one staff member in July 2009. No other payments.

40. *What were/are the eligibility criteria for bonus payments? Has there been any changes to the criteria in the 2009/10 financial year from previous years; if so, what specific changes and why?*

Response:

The criteria used will be based on provisions in either a Collective or Individual Employment Agreement which allow the possibility of payments to an employee who has consistently performed above the requirements of the position.

There have been no changes to those criteria.

*41. What was the total amount paid to staff in fringe benefits in the 2009/10 financial year and how many staff qualified for fringe benefits? How much has been paid in the financial year to date? What are the eligibility criteria for fringe benefits?*

Response:

Value of Fringe Benefits 2009/10 was \$59k. A total of 84 employees received these benefits from NMDHB, all in relation to motor vehicles. Of the total 84, 8 employees receive the benefit as part of their employment agreement; the remainder obtained the benefit incidental to the DHB utilising its assets (pool cars) in the most efficient manner.

*42. What was the total amount paid in ACC (or private insurer) levies in the 2009/10 financial year; and how does this compare with the amount estimated to be paid in 2010/11? Explain any significant increases/decreases.*

Response:

NMDHB has managed its own claims under the ACC Partnership Programme (tertiary level) since 2001. Under the programme a reduced levy is paid:

The levy paid in 2009/10 was \$857,012.

The estimated levy for 2010/11 is \$855,416.

*43. What specific instructions, directions or advice have been received in relation to employment contract matters from the State Services Commission or responsible minister in the 2009/10 financial year?*

Response:

The only advice was in relation to the Chief Executive's contract. He decided to take no increase.

*44. How much was spent on overseas travel by officials in 2009/10 and 2010/11 to date? Provide details of each trip (purpose, destination, dates of travel, costs of travel, costs of accommodation, number of staff sent and*

*their positions in the organisation). How much has been allocated to be spent on overseas travel in 2010/11?*

Response:

See appendix C (page 69)

*45. What assets were sold in 2009/10 and why? What is scheduled to be sold in 2010/11 and why?*

Response:

During 2009/10 the following types of assets were sold. This included the sale and lease back of computer hardware and disposal of replaced equipment and vehicles.

<b>Asset Class</b>	
Clinical Equipment	888.89
Computer Hardware	674,082.80
Motor Vehicles	66,222.23
Other Equipment	5,611.92
<b>Grand Total</b>	<b>746,805.84</b>

For 2010/11 the following assets are to be sold:

000s	2010/11	2011/12	2012/13
Whakatu Lodge	\$ 600		
Nelson houses	\$ 2,915		
Kawai Street houses	\$ 1,000		
Wairau surplus land	\$ 2,300		
Wairau houses	\$ 2,080		
Murchison houses	\$ 280		
Vehicles	\$ 110	\$ 38	\$ 525
<b>Total</b>	<b>\$ 9,285</b>	<b>\$ 38</b>	<b>\$ 525</b>

The properties to be sold are surplus to current and forecasted service requirements. The sale of the surplus land at Wairau Hospital is part of the funding for the redevelopment due for completion this month (February 2011).

*46. What internal conferences and seminars have been held in the 2009/10 financial year, what were the total costs, travel costs, and what was the purpose of each conference or seminar? What is estimated to be spent on conferences or seminars in 2010/11?*

Response:

During the year the following costs were incurred for internal courses, conference, seminars and training:

<b>2009/10</b>	<b>Actual</b>	<b>Budget</b>
Medical Personnel	2,072,564	2,057,638
Nursing Personnel	373,492	518,418
Therapies	132,963	206,378
Other Allied Health	21,295	23,885
Hotel Services	1,272	14,365
Management/Administration	312,447	717,455
Outsourced – Medical	0	0
Outsourced Clinical	345	0
Other Clinical	1,316	0
Transport	4,320	0
Other Employment groups	8,835	2,000
	<u>2,928,851</u>	<u>3,540,139</u>

The details of the purpose is not readily retrievable, however processes were put in place to ensure that courses and conferences are appropriate to the operations of NMDHB.

The budget for 2010/11 is \$3,347,447.

47. For each renovation, refurbishment or redecoration project in offices or buildings which cost more than \$5000 in the 2009/10 financial year; provide the following details:

- *Details of the project*
- *Location*
- *Name of provider(s) or manufacturer(s)*
- *Type of product or service generally provided by the provider or manufacturer*
- *Budgeted and actual cost of project*
- *Date work commenced and completed*
- *Whether tenders were invited, if so, how many were received*
- *List separately any single item of furniture worth more than \$5000 and its cost*

Response:

Refer appendix D (page 73)

48. *For each advertising or public relations campaign conducted or commissioned in the 2009/10 financial year provide the following details:*

- *Details of the project*
- *Who is to conduct the project*
- *Type of product or service generally provided by (b)*
- *Budgeted and actual cost of project*
- *Date work commenced and completed*
- *Whether tenders were invited, if so, how many were received*

Response:

NMDHB did a number of small advertising campaigns in community newspapers that included nutrition and physical activity, health promotion, community awareness including influenza and immunisation, use of GPs instead of Emergency Departments, annual planning targets and end of year performance. These were internally prepared and not separately costed.

49. *For each advertising or public relations campaign to be conducted or commissioned in the 2010/11 financial year provide the following details:*

- *Details of the project*
- *Who is to conduct the project*
- *Type of product or service generally provided by (b)*
- *Budgeted cost of project*
- *Date work to be commenced and completed*
- *Whether tenders will be invited*

Response:

These will be internally prepared.

*50. What programmes/projects, if any, have been delayed in the 2009/10 financial year and what is the reason for any delay in delivery or implementation?*

Response:

NMDHB is following the National Community Pharmacy Service Agreement process. Therefore our local approach for a Medicine Use Review Programme has been overtaken by this national process. It is expected that a Medicine Use Review programme will be implemented in accordance with a new national agreement in 2011/12.

*51. Provide details of all monitoring, evaluation and auditing of programmes or initiatives delivered by the Ministry, crown entity, government department or government agency (including details of all performance measures, targets and benchmarks and whether programmes contributed to desired outcomes in an efficient and effective manner).*

Response:

NMDHB conducts monitoring, evaluation and auditing aligned with the DHB requirements under the NZ Public Health and Disability Safety Act 2001. The agents used include the Ministry of Health (certification), the MoH Sector Services (finance audits) and the the South Island Shared Service Agency (aged care, pharmacy, hospice, Mental Health and Maori Health providers).

In addition there is an active internal audit function which reports findings to the Board's Audit and Risk Committee.

NMDHB also has formal ongoing evaluation in respect of its NPA programme conducted by the Auckland University School of Public Health.

A specific evaluation completed in 2009/10 was:

A Maori Health provider had a special audit completed in November 2009. The DHB received a complaint over the provider's Board and the financial performance of that organisation. The DHB engaged the Ministry of Health Sector Services to undertake the audit. They reported their findings in February/ March 2010. The report found no significant breaches in the provider's financial management systems.

We are achieving improvements in services provision through reconfiguration and the implementation of the Rutherford Initiative recommendations. This work results in more efficient and effective service and fairer access for the people of Nelson Marlborough.

NMDHB is also working with the South Island Region to ensure optimisation of capacity and capability regionally.

NMDHB is operating within its funding and according to the intentions outlined in its DAP 2010/11. The Rutherford Initiative, while signalling significant savings, is about achieving best 'value' for the funding provided by Government. NMDHB's aim is to work smarter and ensure the needs of the population are met with services that deliver significant benefit as well as living within our means.

The Rutherford Initiative is continuing in 2010/11 and will then be part of NMDHB's ongoing business practices.

*52. Has the Ministry, crown entity, government department or government agency employed the services of or paid for a purchase advisor within the 2009/10 financial year? If so, what was the total length and cost of the contract?*

Response:

NMDHB participated in the combined purchasing programme provided by DHBNZ. The overall cost was part of the annual fee paid.

*53. What has the Ministry, crown entity, government department or government agency spent on software licensing fees in each of the past five financial years?*

Response:

2005/06	157k
2006/07	213k
2007/08	154k
2008/09	351k
2009/10	467k

## APPENDIX A

### 4 OUTCOME, OUTPUT CLASSES AND STATEMENT OF FORECAST SERVICES PERFORMANCE

#### 4.1 OUTCOME

Crown entities are accountable to Parliament for their use of the public resources and powers that Parliament has conferred on them. Parliament has also legislated that Crown entities operate and account for their performance, in keeping with Parliament's intentions. The Public Health and Disability Support Services Act 2000 provides for the role of DHBs through allocating public funds (Vote Health) that ensure the health of their geographically defined population. In particular, DHBs are required to fund the provision of high quality health and disability services that meet the needs of the people, support the participation and independence of people with disabilities and reduce inequalities in health status particularly for Maori and those in the low socio-economic group.

The outcome that we work toward is to improve the overall health of people in Nelson Marlborough within the funding provided by Government. We assess progress toward this outcome by measuring the health of our population through the three yearly Population Health Survey conducted by the Ministry of Health (increase in the quality and length of life, and equity in access/health status). The health services delivery work carried out by Nelson Marlborough hospitals and health services as well as the services we fund and the resulting outputs help the people of Nelson Marlborough to improve their overall health, reduce inequities in health and become more independent. Therefore, within each output class, we identify the main measures and targets for the impacts of our outputs as well as with our output performance measures and targets (see appendices 1, 4 and 5). Because information is not yet available in most instances for 2009/10, we have provided forecast achievements for that year.

#### 4.2 FORMATION OF AN OUTPUT-FOCUSED STATEMENT OF FORECAST SERVICE PERFORMANCE

Four **Output Classes** are relevant for DHBs to provide the story regarding the 'impacts' their PBF allocation decisions, Government Priorities and national decision-making have on the 'Health of the DHB Population'. Over time, ensuring the Nationwide Service Framework Library

(NSFL) and associated services' Purchase Unit Codes (PUCs) align to one of the four output classes, it will be possible, through using this framework to demonstrate 'shifts' in resources from one end of the population health continuum of care to another (see DHB Scope of Operations Diagram page 21). For example, by having expert knowledge supporting the care of patients with early diabetes in the community, we can prevent people from needing acute in-hospital services. These 'expert-informed' primary care service outputs will then be located in the Primary and Community Services Outputs Class and not in the Hospital Services Outputs Class.

General Managers Planning and Funding and Chief Financial Officers supported by the Ministry of Health and DHBNZ have worked on the process for 'mapping current Purchase Unit Codes (PUCs) to each of the 'Output Classes' to ensure that they are all mutually exclusive (i.e. there is no service duplicated in the various Outputs Classes).

For each output class (Public Health Services, Primary and Community Services, Hospital Services, Support Services) there are agreed national performance measures and targets of the desired outcomes and objectives<sup>1</sup>. Within these output classes our DHB has prioritised a range of outputs. How these outputs contribute to our intermediate outcomes is detailed below on an output class by output class basis.

One of the functions of this SOI, and in particular the Statement of Forecast Service Performance is to show how our DHB will evaluate and assess what services and products we deliver to others in 2010/11. The performance measures chosen are not a comprehensive list and do not cover all of the activity of the DHB, but they do reflect a picture of our activity against local and national strategies and priorities. Where possible, we have included past performance (baseline data) along with each performance target to give the context of what we are trying to achieve and for us to better evaluate our performance as part of our accountabilities under the Crown Entity Act 2004.

### ***4.3 PUBLIC HEALTH SERVICES – OUTPUT CLASS #1***

Public Health Services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from the curative services which repair/support health and disability dysfunction.

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public Health services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, individual health protections services such as immunisation and screening services.

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<sup>1</sup> As stated in the CE Act 2004 (s 142 (1))

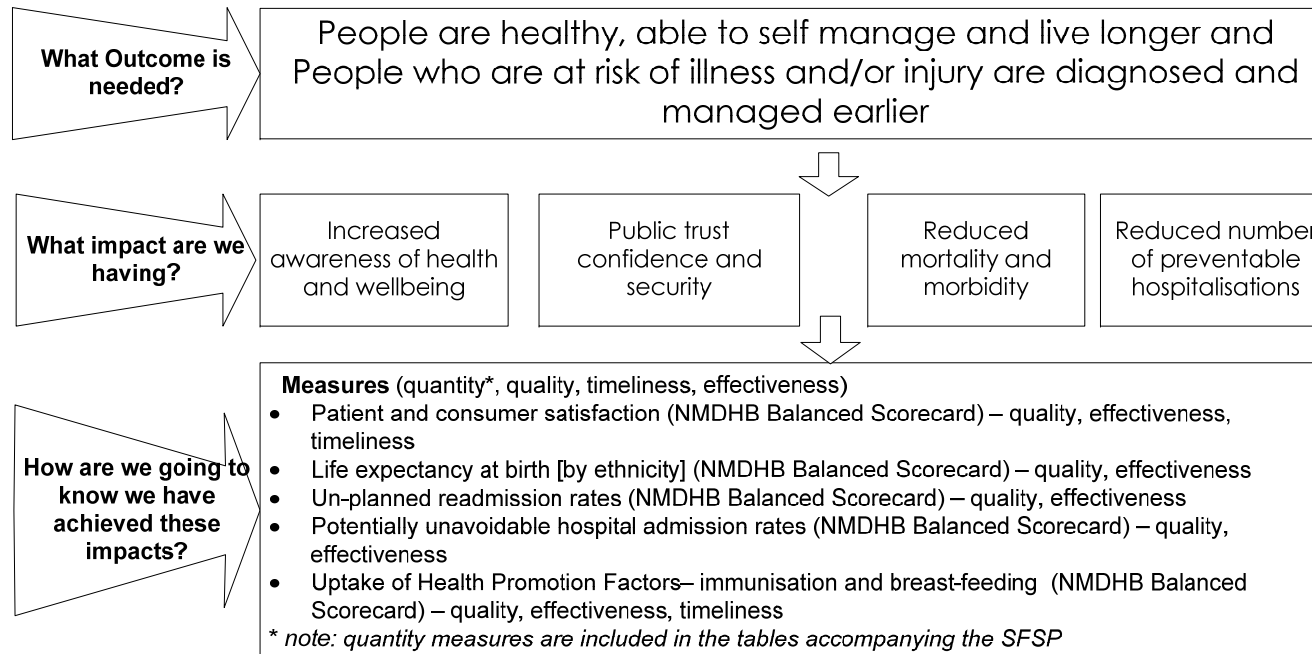
Public health services are the domain of many organisations across our district including:

- Ministry of Health, principally as a funder of public health services, and also as regulator. The Ministry of Health is also a provider of some of these services
- DHBs, both funding and provision to ensure population need was addressed
- Primary Health Organisations (PHOs), mainly in the area of provision of primary health care services, but with some public health functions
- private and non-government organisations (NGOs), including Maori and Pacific providers and Regional Sports Trusts
- local and regional government.

NMDHB owns and operates one of twelve public health units (PHUs) nationally that provide more than half the country's public health services. Public health services delivered by the NMDHB PHU are centrally funded by the Ministry.

Public Health Services include environmental health, communicable disease control, tobacco control and health promotion programmes. Some of these services are provided by Primary care providers including: health improvement and preventive services, such as screening and immunisation.

## Outcomes Logic Model for Public Health Services Output Class



## Statement of Forecast Service Performance

### Public Health Services Output Class #1

This section outlines the Public Health services we intend to deliver to our population. These outputs are aggregated into the following main areas of performance in the Public Health Services Output Class: Health Promotion and Education services; Statutory and Regulatory

Services; Population Based Screening Programmes; Immunisation services

Main areas of performance in Public Health Service output class	Output description	Main area of performance measures (Quantity, quality, measures as appropriate for the Output area of performance) <sup>2 3</sup>	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/ Definitions
<p><b>1. Health Promotion and Education services which include:</b></p> <p><b>Sentinel measure:</b> Smoking cessation programmes</p>	<p>Provision of health promotion services aligned with the Ottawa Charter, that encompass a range of strategies and programmes designed to produce social change for promoting good health, and enabling the community to make the healthier choice the easier choice. Provision of Cessation Support services. Smoking Cessation service in general practice.</p>	<p>Percentage of hospitalised smokers who are provided with advice and help to quit</p> <p>Percentage of patients attending primary care who are provided with advice and help to quit; Quantity:</p>	80%	90%	Aligns to Health Target

<sup>2</sup> Outputs will be delivered to achieve the quality and effectiveness measures in the Public Health Purchasing Handbook published by the Ministry of Health and the National Health Services Framework

<sup>3</sup> Where appropriate we have concentrated on effectiveness measures (percentage of enrolled population) rather than just quantity numbers

Main areas of performance in Public Health Service output class	Output description	Main area of performance measures  (Quantity, quality, measures as appropriate for the Output area of performance) <sup>2 3</sup>	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/ Definitions
<b>2. Statutory and Regulatory Services</b>  <b>Sentinel measure:</b> Border Health	Carry out requirements under Health Act, Biosecurity Act & International Health Regulations 2005.	<b>Border Health (Quantity)</b> Undertake mosquito surveillance weekly (summer) and fortnightly (winter) at Port Nelson (8 sites) and Port Marlborough (5 sites).	500	>500	This is demand driven and most sites have been reviewed
<b>3. Population Based Screening Programmes</b>  <b>Sentinel measure:</b> Cervical screening	Provision of appropriate population screening services	<ul style="list-style-type: none"> <li>Percentage of enrolled women aged 20--69 who have had a cervical screen in the last 3 years Quantity:</li> <li>Percentage of high needs enrolled women aged 20--69 who have had a cervical screen in the last 3 years Quantity:</li> </ul>	76%	78%	total pop NBPH 79.44%; KHW 67.87%. Source PPP 6/09
<b>Sentinel measure:</b> Breast screening		<ul style="list-style-type: none"> <li>Percentage of women aged 50-64 who have received a mammogram Quantity:</li> </ul>	70%	72%	high need NBPH 75.19%; 59.16% Source PPP 6/09
		<ul style="list-style-type: none"> <li>Percentage of women aged 50-64 who have received a mammogram Quantity:</li> </ul>	72%	74%	NPBH 76.44%; KHW 61.52%. Source PPP 6/09
<b>4. Immunisation Services</b>	Provision of appropriate immunisation services (HPV immunisation)	Percentage of enrolled population >65 years receiving 'flu vaccination	67%	70%	total pop NBPH 66.47%; KHW

Main areas of performance in Public Health Service output class	Output description	Main area of performance measures  (Quantity, quality, measures as appropriate for the Output area of performance) <sup>2 3</sup>	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/ Definitions
	programme, Outreach Immunisation Services; District Immunisation Co-ordination; promotion of immunisation	Quantity:			64.27%. source (PPP - 6/09)
	Older people receive annual influenza vaccinations to reduce acute hospitalisations.	Percentage of high needs population >65 years receiving 'flu vaccination Quantity:	65%	68%	high needs NBPH 67.76% KHW 57.32%. (PPP – 6/09)
<b>Immunisation Services (continued)</b>	Girls receive Human Papilloma Virus vaccinations to prevent infections that might contribute to cervical cancers	Percentage of eligible girls vaccinated against Human Papilloma Virus Quantity:	50% eligible population	60% eligible population	53% dose 1 50.9% dose 2 48.4% dose 3
	Children receive vaccinations to reduce the prevalence and incidence of viral and bacterial illnesses that lead to acute hospitalisations	Percentage of children aged 2-3 who have received all vaccinations – total population Quantity:	82%	90%	total pop NBPH 82.52%; KHW 80.8% Source PPP 6/09
	Children who have high health needs receive vaccinations to reduce the prevalence and incidence of viral and	Percentage of children aged 2-3 who have received all vaccinations - high	80%	90%	high needs Source PPP 6/09 NBPH 80.19%; KHW 70.9%

Main areas of performance in Public Health Service output class	Output description	Main area of performance measures  (Quantity, quality, measures as appropriate for the Output area of performance) <sup>2 3</sup>	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/ Definitions
	bacterial illnesses that lead to acute hospitalisations	needs population Quantity:			Mean

### Forecast Public Health Output Class Statement of Financial Performance

000s	2010/11
	<b>Plan</b>
Revenue	\$9,469
Expenditure	
Personnel costs	\$4,670
Outsourced services	\$579

Clinical Supplies	\$881
Infrastructure	\$573
Provider payments	\$1,921
Total Expenditure	\$8,625
<b>Net Surplus/(Loss)</b>	<b>\$844</b>

These output costs include an allocation of overheads based on cost drivers and saving targets of \$48k. The allocation drivers will be further reviewed as the systems mature over the next 12 months.

*Please note: The 2010/11 figures are based on our current understanding. It should be noted that as this is a new process our ability to provide data for out years (2011/12 and 2012/13) is beyond the current level of our analysis.*

#### **4.4 PRIMARY AND COMMUNITY SERVICES – OUTPUT CLASS #2**

This Output class comprises services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. It includes general practice, community and Maori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services as well as services provided by a range of non-government organisations [NGOs] (e.g. Asthma Society etc.).

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. A strong primary health care system (as outlined in the Primary Health Care Strategy) is central to improving New Zealanders' overall health, and to reducing health inequalities between different groups but particularly for Maori. New Zealand is experiencing an increasing prevalence rate of long-term conditions including diabetes, respiratory and cardiovascular disease.

The three key goals from the national Primary Health Care Strategy are:

- **transparent national priorities** – DHBs, Primary Health Organisations (PHO) and the Ministry focused on national health priorities and working collaboratively to improve sector performance.
- **collective stewardship and governance** – Communities and PHOs engaged to identify population needs and target responses consistent with national priorities.
- **enhanced delivery** – A continuum of accessible services focused on reducing the incidence and impact of chronic conditions.

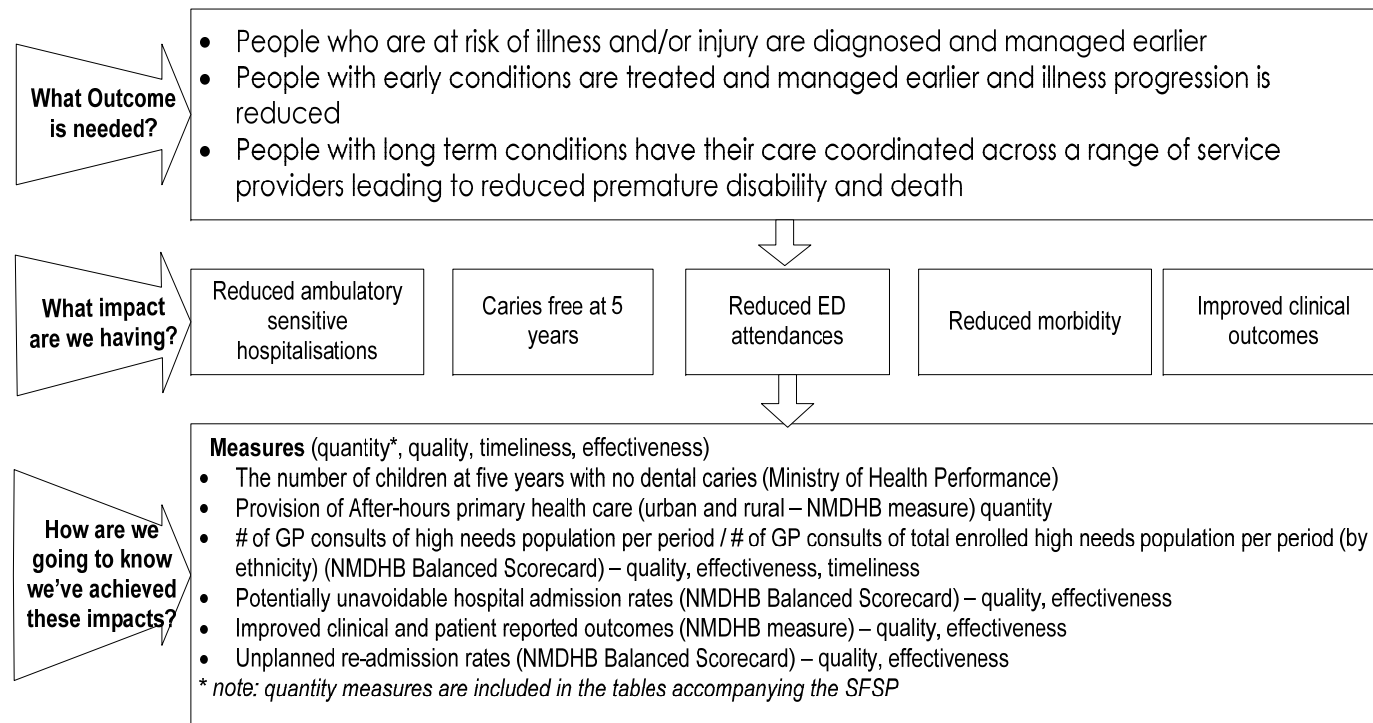
NMDHB works locally with two Primary Health Organisations, one focused on the Nelson-Tasman Population (Nelson Bays Primary Health) and one on the Marlborough population (Kimi Hauora Marlborough). NMDHB and the two PHOs have a Memorandum of Understanding to work together towards improving the health of the people of Nelson Marlborough. We are implementing an 'alliance-based approach' to enable better access to a number of services.

This involves working towards delivering better care for people with long-term conditions and services coordinated through Integrated Family Health Systems under the 'Better, Sooner, More Convenient' policy setting.

Developments in Primary Health Care are supported by NMDHB's Health Services Division and our Maori Health Directorate. The NMDHB  
2010/11 DAP has more detail.



### Outcomes Logic Model for Primary and Community Services Output Class



### Statement of Forecast Service Performance

## Primary and Community Services Output Class #2

This section outlines the Primary and Community services we intend to deliver to our population. Some of these services are provided by us while others are funded by us through a range of contracts and provided by PHOs and other NGOs. These services include personal health services, mental health services, Maori and Pacific health services and disability support services

These outputs are aggregated into the following main areas of performance in the Primary and Community Services; Oral Health Services, Primary and Community Care Programs; Pharmacist Services; Community Referred Test/Diagnostic Services.

Main areas of performance in Primary and Community Service output class	Output Description	Main measures of performance  (Quantity, quality, measures as appropriate for the Output area of performance) <sup>4 5</sup>	Outputs		
			Baseline  (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/Definitions
1. Primary Health Care Services (first contact)	PHO Enrolment for First contact services by General Practitioners or Practice Nurses	Percentage of population enrolled quantity:	90% of NM population	94% of NM population	The Nelson Marlborough region had 134,500 people in 2007 and is expected to be in the range of 135,200 -142,500 by 2011

<sup>4</sup> Outputs will be delivered to achieve the quality and effectiveness measures in the Public Health Purchasing Handbook published by the Ministry of Health and the National Health Services Framework

<sup>5</sup> Where appropriate we have concentrated on effectiveness measures (percentage of enrolled population) rather than just quantity numbers

Main areas of performance in Primary and Community Service output class	Output Description	Main measures of performance  (Quantity, quality, measures as appropriate for the Output area of performance) <sup>4 5</sup>	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/Definitions
2. Oral Health Services	Enrolment of children aged 2.5 to 12/13 years with the School Dental Services for preventative, diagnostic and treatment services	Percentage of pre-school children (2.5 to 5 years of age) enrolled quantity:  Percentage of school children (5 to 12/13 years of age) enrolled quantity  Percentage of Year 8 children examined/treated quantity	88%   96%  96%	90%   98%  98%	The more pre-school, school and year 8 children enrolled in the programme the more children are managed proactively so that they either do not develop caries or have early caries stopped before damage to their teeth occurs.
	Oral Health Care to adolescents (aged 12/13 to 18 years) provided by Private Dentists – Preventative, Diagnostic and oral health treatment services. .	Percentage of adolescents treated quantity	78%	85%	Utilisation rate is approaching 80% of eligible students which means adolescents are having their dental health proactively managed as a group. This group tends not to consult dentists without encouragement
	Hospital Based oral health treatment services to adults with Community Services Card referred by a dentist or	No's low income adults treated quantity	2198	2200	The more high deprivation adults enrolled in the programme the more they are managed proactively so that they either do not develop caries or have early caries stopped before

Main areas of performance in Primary and Community Service output class	Output Description	Main measures of performance  (Quantity, quality, measures as appropriate for the Output area of performance) <sup>4 5</sup>	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/Definitions
	GP				damage to their teeth occurs.
3. Long-Term Conditions Services	Free annual diabetes checks to review and modify (if required) management of patients with diabetes.	Percentage of People with Diabetes receiving a Diabetes Annual Review quantity	52% of Maori and 72% of all people with diabetes attend free annual checks	52% of Maori and 72% of all people with diabetes attend free annual checks	This is part of the national health targets for better diabetes outcomes. Management means a reduction in the significant consequences of poor diabetes care including blindness, lower limb amputation, heart attacks and kidney failure to mention the main ones.
<b>Long-Term Conditions Services (cont'd)</b>	Diabetes Management:	The percentage of people with diabetes who have satisfactory or improved management Quality:	74%	≥79%	MOH target This service provides people with access to support that prevents their condition deteriorating and also prevents acute hospital admissions
4. Pharmacist Services	Pharmaceutical dispensing services	No's of dispensed items Quantity:	1,794,000	>1,794,000	Medicines support people to remain healthy and to better manage their condition as well as prevent acute hospital admissions
	Pharmacy services: Measure for prescribers	Expenditure on Community Pharmaceuticals per enrolled population (by PHO – refer PPP) Quality:	\$239,119	\$240,000	The figure for whole NELSON MARLBOROUGHpop includes costs associated with community pharmaceuticals (PHARMAC operating costs, PHO Pharmacy

Main areas of performance in Primary and Community Service output class	Output Description	Main measures of performance  (Quantity, quality, measures as appropriate for the Output area of performance) <sup>4 5</sup>	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/Definitions
					management, community service development and community claims through the hospital provider).
5. Community Referred Test Diagnostic Services	Medical Laboratory Diagnostic and Therapeutic Monitoring Services	No's of laboratory tests Quantity:	1,507,330	1,540,000	This data reflects both hospital and community volumes.  Laboratory diagnostic tests support people to remain healthy and to better manage their condition as well as prevent acute hospital admissions
	Medical Imaging services for: Diagnosis and Treatment of patients	No's of radiological images provided Quantity:	Procedure: 89,064  RVU: 288,542	Procedure: 90,000  RVU: 290,000	This data reflects both hospital and community data. . Medical Imaging services support people to remain healthy and to better manage their condition as well as prevent acute hospital admissions

### Forecast Primary & Community Output Class Statement of Financial Performance

000s	2010/11
	Plan

Revenue	\$105,856
Expenditure	
Personnel costs	\$20,302
Outsourced services	\$2,358
Clinical Supplies	\$2,079
Infrastructure	\$5,880
Provider payments	\$74,856
Total Expenditure	\$105,476
<b>Net Surplus/(Loss)</b>	<b>\$380</b>

These output costs include an allocation of overheads based on cost drivers, saving targets of \$1,147k and a gain on sale of \$356k. The allocation drivers will be further reviewed as the systems mature over the next 12 months.

Please note: The 2010/11 figures are based on our current understanding. It should be noted that as this is a new process our ability to provide data for out years (2011/12 and 2012/13) is beyond the current level of our analysis.

#### ***4.5 HOSPITAL SERVICES – OUTPUT CLASS #3***

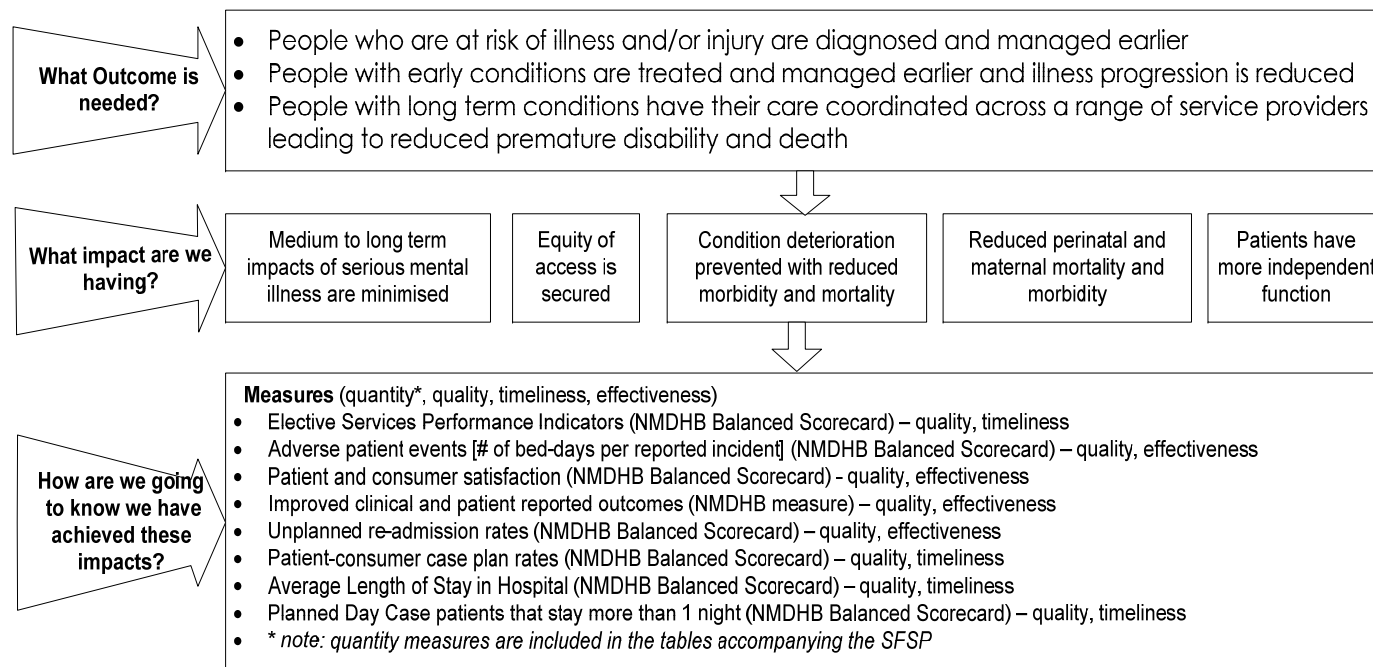
This output class comprises services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialized equipment.

These services are generally complex and provided by health care professionals that work closely together. The intention of these services is to provide timely, appropriate and expert care for those people who need specialist expertise.

They include:

- inpatient and community mental health services for the most serious mental illnesses
- inpatient services (acute and elective streams) including diagnostic, therapeutic, maternity and rehabilitative services
- ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

### Outcomes Logic Model for Hospital Services Output Class



## Statement of Forecast Services Performance

### **Hospital Services Output Class #3**

This section outlines the hospital-based services we intend to deliver to our population. It also outlines those hospital services we intend to fund others to provide for our population. Hospital services include all personal health services, mental health services, Maori health services, services for older people and disability support services provided through NMDHB's hospital provider and through other DHBs via inter district flows (IDFs). These outputs are aggregated into the following main areas of performance in the Hospital service output class: Mental Health Services; Electives Services; Acute Services; Maternity Services; Assessment, Treatment and Rehabilitation Services. For more detail, please refer to our Price-Volume Schedule (PVS). These outputs reflect a whole of population view on Nelson Marlborough utilisation of health services.

Main areas of performance in Hospital Services output class	Output description	Main Measures of Performance (includes quantity, measures of outputs)			Comments/Definitions
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	
1. Mental Health Services	Relapse prevention plans that identify the bio-psychosocial needs and early warning signs for those adult and child and youth service users. .	Percentage of Relapse Prevention Plans up to date Quantity:	95%	95%	National target is 90%. Baseline is 08/09 average. Projections are all 95% (5% above national target).  These services support people with serious mental illness to prevent deterioration
2. Elective Services (inpatient, outpatient)	Provision of 24 hour inpatient and outpatient elective services (treatment after seven days) for surgical, paediatric, and oral health.	No of discharges (CWDs) People discharged Quantity:	8430 6930	>8430 >6930	Extracted from revised 2009/10 forecast and includes budgeted IDF elective volumes. Note NMDHB is delivering significantly greater than NZ average  These services support people with serious health problems to prevent deterioration and potentially cure their

Main areas of performance in Hospital Services output class	Output description	Main Measures of Performance (includes quantity, measures of outputs)			
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/Definitions
					problem.
	People are assessed by a Specialist following referral from their GP	No of First Specialist Assessments - FSAs	12695	>12695	These volumes are for all Surgical and Cardiology elective services only and enable specialists to assess whether a person meets the criteria for intervention.
	People receive an elective intervention through admission and discharge on the day of the intervention	Day Surgery as a percentage of all surgery Effectiveness/ Quality:	54%	>54%	Aligns to Health Target – prevents an inpatient admission to hospital and any adverse events related to hospital-acquired infections, etc.
	People requiring radiotherapy receive it within agreed National Target waiting times.	No within Cancer treatment waiting times within target limits Quality:	Within MoH Target of six weeks	Within MoH Target of six weeks	Aligns to Health Target – ensures people who have cancer get their care quickly so as to prevent spread of the cancer.
3. Acute Services (emergency department, inpatient, outpatient)	Provision of district wide medical services including assessment, diagnosis, treatment, management of medical conditions. This includes provision of emergency services and intensive /cardiac care supporting all other service streams, and the provision of diagnostic testing functions supporting all service streams.	Quality/Effectiveness: Percentage of ED attendances with an ED length of stay less than 6 hours	≥90%	≥95%	Aligns to Health Target

Main areas of performance in Hospital Services output class	Output description	Main Measures of Performance (includes quantity, measures of outputs)			Comments/Definitions
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	
4. Acute Services (emergency department, inpatient, outpatient) continued	Provision of district wide medical services including assessment, diagnosis, treatment, management of medical conditions. This includes provision of emergency services and intensive /cardiac care supporting all other service streams, and the provision of diagnostic testing functions supporting all service streams.	Percentage of patients readmitted: Effectiveness/Quality	< 5%	< 3%	Patients should not require unscheduled acute readmission if their care was appropriate the first time.
	People have efficient and effective care of their acute problem as measured through the 'average length of stay'	Average length of stay (ALOS): Medical/Surgical Effectiveness/Quality:	4.34 days for all DHBs	<4 days	Aligned to Health Target: NMDHB is one of the top performers in the country for ALOS and will seek to maintain this high standard. This is a universal measure of effectiveness and efficiency of healthcare delivery
5. Maternity Services	Maternity services involve pre-natal and post-natal and birthing services as well as specialist obstetric care and neonatal special care bay unit services	Post natal average length of stay (days) Effectiveness/Quality:	2.06	3.0	Enables mothers and babies to be supported who require additional length of stay
	Women receive evidence-based access to Caesarean Section births	Percentage of women having a Caesarean section / total births Quantity/	29%	< 29%	Working towards WHO Best Practice which means that women should only have a C-Section when it is absolutely appropriate in order to preserve maternal and child health.

Main areas of performance in Hospital Services output class	Output description	Main Measures of Performance (includes quantity, measures of outputs)			
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/Definitions
		Quality			
6. Assessment Treatment & Rehabilitation Services	Provision of specialist assessment, treatment & rehabilitation (ATR) services for the older persons in NELSON MARLBOROUGH	No of patients Quantity:	648	667	Population of older people is increasing at about 3% per annum. Older people who become frail (either at home or following an acute illness/injury or following a surgical/medical intervention) require support to recover from their condition from a suitably skilled multidisciplinary team.

## Forecast Hospital Output Class Statement of Financial Performance

<b>000s</b>	<b>2010/11</b>
	<b>Plan</b>
Revenue	\$198,673
Expenditure	
Personnel costs	\$100,796
Outsourced services	\$6,624
Clinical Supplies	\$25,158
Infrastructure	\$30,454
Provider payments	\$35,789
Total Expenditure	\$198,821

<b>Net Surplus/(Loss)</b>	<b>(\$148)</b>
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These output costs include an allocation of overheads based on cost drivers, saving targets of \$5,926k and a gain on sale of \$3,029k. The allocation drivers will be further reviewed as the systems mature over the next 12 months.

*Please note: The 2010/11 figures are based on our current understanding. It should be noted that as this is a new process our ability to provide data for out years (2011/12 and 2012/13) is beyond the current level of our analysis.*

#### **4.6 SUPPORT SERVICES – OUTPUT CLASS #4**

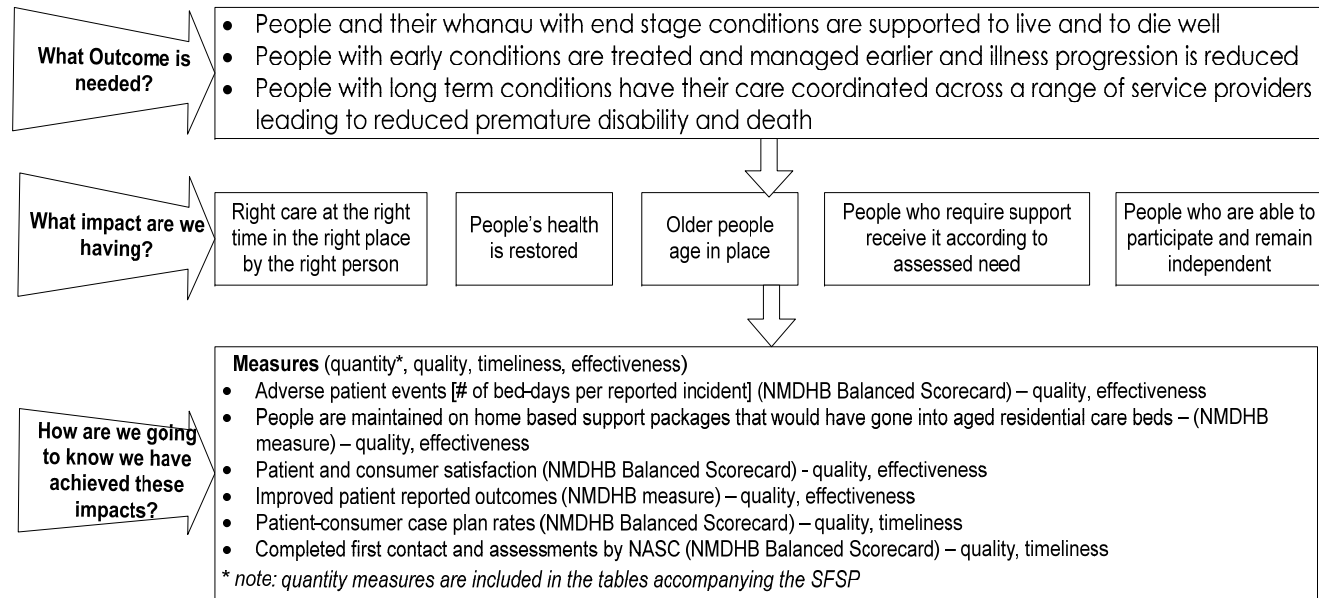
This Output Class comprises services that are delivered following a **'needs assessment' process and 'coordination'** input by NASC Services for a range of services including palliative care services, home-based support services, mental health services and residential care services.

NMDHB's aim is to have a fully inclusive community, where people are supported to live with independence and can participate in their communities. The role of these services is to ensure that these outcomes are met. Our DHB has taken a 'restorative' approach to these services and has introduced the InterRAI (International Resident Assessment Instrument) home-based support tool to ensure people who need support services receive them in a timely way and that they meet the person's assessed need.

Mental Health is based on a 'recovery' approach with community support services being provided to the estimated 3% of the population with serious mental illness. Quality indicators are collected and the client including their caregiver/s is/are actively involved in the process. The collective South Island DHBs are establishing a South Island Health of Older People's network which will focus much of its effort on support services for this growing population group.

It is anticipated that these services will enable more people to live safely and independently in the community with fewer people requiring Aged Residential Care (ARC) support. Home Based Support Services in our DHB are provided by community NGOs delivering a range of packages of care from basic support to major support that enables people to live higher quality lives in their communities.

## Outcomes Logic Model for Support Services Output Class



## Statement of Forecast Service Performance

### Support Services Output Class #4

This section outlines the Support services we intend to deliver to our population. Each aggregate includes people with long-term disabilities; people with mental health problems and people who have age-related disabilities.

These outputs are aggregated into the following main areas of performance in the Support service output class: NASC Services; Palliative Care Services; Rehabilitation Services; Home Based Support Services; Aged Residential Care Bed Services; Life Long Disability Services (may be

specific to some DHBs only); Respite Care Services; Day Services.

Main areas of performance in Support Services output class	Output description	Main measures of performance (include quantity, quality measures of outputs)	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/ Definitions
1. NASC Services	Needs Assessment and Service Co-ordination Services.	No's of assessments completed Quantity:	3404	3506	For 2009/10 754 New Assessments 2650 Re-assessments  Peoples support needs are assessed and appropriately coordinated according to those needs
	Regular review of individual Needs Assessment Service Co-	Time from referral to assessment (national target) Quality:	Urgent referral <7 days; 80% of accepted	Urgent referral <7 days; 80% of accepted	This is the national target set for Needs Assessment to ensure that needs assessment and coordination is delivered

Main areas of performance in Support Services output class	Output description	Main measures of performance (include quantity, quality measures of outputs)	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/ Definitions
	ordination Plans.		referrals assessed <20days:	referrals assessed <20days:	in a timely and appropriate way.
2. Palliative Care Services	Provision of specialist palliative care nursing and medical services	No's of patients assessed and supported (Liverpool Care Pathway) Quantity:	88	88	Palliative care services support people and their whanau who are dying to live and die well.
3. Home Based Support Services	Assessment, Care and Support Services into the Older Person's Home	No's of packages of care Quantity	4213	4339	Number of Older People increasing by around 3% per year so needs increase similarly.
	Home Based Support Services Quality Measure	% of Client Reviews Completed on time by Providers Quality:	70%	>95%	Reviews inform the Care Plan thus improving quality
	Home Based Support Service Quality Measure	% Support Workers Trained to Level 2 on NZQA-quality	30%	.>50%	Training impacts positively on service quality
	Home Based Support Services Quality Measure	% Support Workers Trained to Level 3 on NZQA –quality	10%	>30%	Training impacts positively on service quality

Main areas of performance in Support Services output class	Output description	Main measures of performance (include quantity, quality measures of outputs)	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/ Definitions
4. Aged Residential Care Bed Services	Rest Home, Hospital, Dementia and Psychogeriatric age related residential care services	Quantity: No's of subsidised bed days:	334,883 bed days	340,100 bed days	We have reorganised our HBSS and intend to actively work to either maintain or reduce the current number of bed-days for ARC under a restorative model of care and aim for aging in place.
5. Life Long Disability Services	Disability Support Services provided to patients under 65 years of age	Quantity: No's of individuals supported	1159	1200	The population in the age group serviced is not increasing but health is poorer=more people..
6. Respite Care Services	Provision of crisis and planned respite services.	Quantity: Number of respite days	11992	12350	Number of People >65 yrs increasing at 3% per year
7. Day Services	Provision of Day Activity services to improve their life skills and reduce social isolation.	Quantity: Number of clients	217	223	Number of People >65 yrs increasing at 3% per year
<b>Mental Health</b>					
8. NASC Services	Needs Assessment and Service Co-ordination	Number of assessments			Te Rapuora and Te Whare Mahana for the Mental Health NGO sector. Provider

Main areas of performance in Support Services output class	Output description	Main measures of performance (include quantity, quality measures of outputs)	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/ Definitions
	Services.	completed Quantity: <ul style="list-style-type: none"> <li>• Mental Health NGO</li> <li>• Hospital Provider</li> </ul>	66 527	67 528	Division volumes derived from their NASC database.
	Timeliness of the needs assessment	Percentage of assessments completed within six months Quality:	100%	100%	Mental Health NGO sector reviews six monthly.
9. Rehabilitation Services	Services that address rehabilitation of people with serious mental illness back into the community	No's of patients Quantity:	120	120	This is Te Ara Mahi Employment, Education Rehabilitation, and is the annual number of people supported by the service.
10. Community Support Work/Home Based Support Services	Provision of individual support and rehabilitation services for service users who live independently in the community.	No's of people receiving home based support services hours by client group from Mental Health NGOs Quantity: <ul style="list-style-type: none"> <li>• no's of adults cared for</li> <li>• no's of youth cared for</li> </ul>			Mental health is input based so there are two options for reporting this:  (a) Number of people supported. (b) Number of FTE hours contracted.

Main areas of performance in Support Services output class	Output description	Main measures of performance (include quantity, quality measures of outputs)	Outputs		
			Baseline (delivered 09/10 year)	Forecast (for 10/11 year)	Comments/ Definitions
			200	205	
			44	48	
11. Respite Care Services	Numbers of people for whom respite care is provided	Quantity: No's of respite days provided	2513	>2513	Respite care enables people who have serious mental illness to be supported while their carer has time off which enables carers to be supported.
12. Day Services	Day services provided to enable carers to have some respite from ongoing care	No's of clients receiving day services Quantity:	174	>180	These are the collective number of service users presenting to all NGO Day Activity programmes. These services enable carers to be supported which enables them to be able to care longer for the clients.

## Forecast Support Output Class Statement of Financial Performance

<b>000s</b>	<b>2010/11</b>
	<b>Plan</b>
Revenue	\$77,408
Expenditure	
Personnel costs	\$19,943
Outsourced services	\$1,230
Clinical Supplies	\$1,994
Infrastructure	\$5,087
Provider payments	\$50,929
Total Expenditure	\$79,183

<b>Net Surplus/(Loss)</b>	<b>(\$1,775)</b>
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The above output costs include an allocation of overheads based on cost drivers, saving targets of \$1,924k and a gain on sale of \$178k. The allocation drivers will be further reviewed as the systems mature over the next 12 months.

*Please note: The 2010/11 figures are based on our current understanding. It should be noted that as this is a new process our ability to provide data for out years (2011/12 and 2012/13) is beyond the current level of our analysis.*

## APPENDIX B Question 35

Name	Type of Service generally provided	Specific Consultancy	Budget	Actual	Date of Contract	Date Completed	Tendered	Number tenders	Further work	Report produced
Aon New Zealand	Consultancy	Valuation of long service leave		6,200	On going		No, existing supplier			Actuarial assessment
Marshall Day Acoustics	Engineering	Acoustics testing Murchison		6,238	1/10/2009	30/04/2010	No specialised service			Noise levels of emergency generator
Aon Consulting	Consultancy	Actuarial Assessment		6,300	On going		No, existing supplier			Actuarial assessment
Advanced Management Services	Payroll System	ACTOR implementation and training		7,996	1/07/2009	31/12/2009	No, existing supplier			Train the trainer on rostering system
People Consulting	Consulting	Hazard workshops and ACTOR training		8,370						Training of staff on rostering system
J D Design	Draughting	Design & draughting work for redeveloping Braemar & other facilities on Nelson site.		10,704	On going		No, existing supplier			Construction plans
Bob Campbell Co	Consulting	Security Strategic Plan		12,742						

Name	Type of Service generally provided	Specific Consultancy	Budget	Actual	Date of Contract	Date Completed	Tendered	Number tenders	Further work	Report produced
GBG Audit & Fin	Internal Audit	Internal audit services & Nelson project evaluation		13,342	On going		No, existing supplier			Internal Audit Reports
Tonkin & Taylor	Engineering	Geotechnical services		14,209			No, existing supplier			
Peddle Thorp Architects	Architectural	Input into revised site planning and business case options		15,053			Yes	4	Yes Development of concepts and interim options	Nelson Hospital and value management workshops
Concordia	Consultancy	Team development, staff survey & mediation		17,655			No, existing supplier			Team development, staff survey & mediation
RDT Pacific Ltd	Project Management	Nelson site business case		17,681	2007	30/06/2009	No, existing supplier			Strategic Stage Business Case
KM&T	Consulting	Lean Specialist Coaching		18,132						
Duke & Cooke	Valuers	Valuations for insurance, rental and accounting purposes		18,720	On going		No, existing supplier			Valuations for insurance, rental and accounting purposes
Ncounter Group	Consulting	Peer review of business cases as part of Gateway		18,756	1/04/2009	30/06/2009				Peer review of Nelson site strategic stage

Name	Type of Service generally provided	Specific Consultancy	Budget	Actual	Date of Contract	Date Completed	Tendered	Number tenders	Further work	Report produced
		Review								analysis
Sinclair Taylor	Consulting	Project management Health Promotion Development Project		23,337						
Opus International	Engineering	Building management services		24,875	On going		No, existing supplier			Engineering reports on Seismic status, asset management and preparation of tenders
Sailfish Business Solutions	Consulting	National CBAC Training on behalf Ministry		27,629			No, existing supplier			DVD and handbook distributed nationally to all DHBs
Gorman Consultants	Consultancy	Systems redesign and process evaluation Health Promotion Development Project		29,495	On going		No, existing supplier			Mentoring of project teams
Bishop Fleet Op	Fleet Management	Assessment of vehicle utilisation		30,429	2008	30/06/2009				

Name	Type of Service generally provided	Specific Consultancy	Budget	Actual	Date of Contract	Date Completed	Tendered	Number tenders	Further work	Report produced
Dr Paul Malpass	Consulting	Medical input to business process reengineering		35,170			No, specialised advice			Part of Rutherford Initiative
Duo Media Limit	Video Production	National CBAC Training on behalf Ministry		41,870						DVD and handbook distributed nationally to all DHBs
Energy Management Solutions	Engineering	Audit of energy utilisation and efficiency opportunities		51,600	On going		No specialised service			
DHBNZ	Consultancy	Contribution to national projects		324,676	On going					Various
Alma Consulting	Business process	Analysis and assessment of business processes		748,176	On going		No, specialised advice			Part of Rutherford Initiative and balanced scorecard reporting
				1,529,354						