

NOTICE OF MEETING

OPEN MEETING

A meeting of the Board Members of
Nelson Marlborough District Health Board
held on Tuesday 20 December 2011 at
9.30am

Slip Inn
Function Centre
Havelock



Our VISION is: *“leading the way to health conscious families”*

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

Our VALUES are:

Respect

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

Innovation

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

Teamwork

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

Integrity

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



BOARD MEETING AGENDA - OPEN

Nelson Marlborough District Health Board

Slip Inn, Function Centre, Havelock

Tuesday, 20 December 2011 commencing 9.30 am

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	<i>Nick Lanigan, GM Corporate Services</i>	
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PUBLIC EXCLUDED MEETING
Resolution to exclude public

11.50 am

RECOMMENDATION

THAT the Board resolve itself into a Committee of the whole and that in terms of the NZ Public Health & Disability Act 2000, the public be excluded while the following items are considered:

- ***Minutes of a meeting of Board Members held on 22 November 2011 (Clause 32(a) Third Schedule NZ Public Health & Disability Act 2000)***
- ***DHB Chair's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***
- ***DHB Chief Executive's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***

SECTION 1: WELCOME, KARAKIA AND APOLOGIES

Nothing reported.

SECTION 2: REGISTRATIONS OF INTEREST – BOARD MEMBERS

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Jenny Black (Chair)	<ul style="list-style-type: none"> ▪ Life member of Diabetes NZ. 			
Ian MacLennan (Deputy Chair)	<ul style="list-style-type: none"> ▪ Honorary Treasurer of Nelson Centre of the Cancer Society of NZ 		<ul style="list-style-type: none"> ▪ Tenancy and IT hosting 	<ul style="list-style-type: none"> ▪ Accommodation for the Cancer Society
Fleur Hansby	<ul style="list-style-type: none"> ▪ Son is 6th year medical student ▪ Disability Funding from ACC 		<ul style="list-style-type: none"> ▪ Family member ▪ Self 	
Gerald Hope	<ul style="list-style-type: none"> ▪ Chairman Marlborough Hospice Trust 	<ul style="list-style-type: none"> ▪ Executive Officer Marlborough Research Centre ▪ Director Maryport Investments Ltd 	<ul style="list-style-type: none"> ▪ Landlord to Cawthron Laboratory Services Blenheim 	
Gordon Currie	<ul style="list-style-type: none"> ▪ President Nelson GreyPower 	<ul style="list-style-type: none"> ▪ Wife is Health Representative for Nelson Greypower 	<ul style="list-style-type: none"> ▪ Residents over 50 years 	
John Inder	<ul style="list-style-type: none"> ▪ Board Member St Mark's Society 		<ul style="list-style-type: none"> ▪ Alcohol and other drug residential treatment. NGO part funded by NMDHB 	
John Moore	Nil.	<ul style="list-style-type: none"> ▪ Member Nelson Regional Land Transport Committee ▪ Trustee Top of the South Athletics Charitable Trust 		
Judy Crowe	<ul style="list-style-type: none"> ▪ Chairperson of Nelson Marlborough Hospitals' Charitable Trust 	<ul style="list-style-type: none"> ▪ Member of the Gladys Amelia Pascoe Trust 	<ul style="list-style-type: none"> ▪ Provision of trust funds towards equipment, training and patient support 	
Patrick Smith	<ul style="list-style-type: none"> ▪ Member of IHB 	<ul style="list-style-type: none"> ▪ Managing Director, Patrick Smith HR Ltd ▪ Member on Board of Nelson Tasman Chamber of Commerce ▪ Shareholder in Kimi Human Resources 	<ul style="list-style-type: none"> ▪ Consultancy services. ▪ HR business with a focus in primary industries and Maori Services 	
Roma Hippolite	<ul style="list-style-type: none"> ▪ Chair, Te Rau Matatini Ltd ▪ Board Member of Ngati Koata Trust 		<ul style="list-style-type: none"> ▪ Contracts for services to NMDHB 	

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Russell Wilson	<ul style="list-style-type: none">▪ Sister in law is an employee of NMDHB	<ul style="list-style-type: none">▪ Member of NZ National Party (Regional Office holder)▪ Managing Director of Carat Investments;▪ Principal Consultant at Wilson Consultants (HR and Business Management consultancy)	<ul style="list-style-type: none">▪ NMDHB Board Office;▪ NZ National Party▪ Carat Investments▪ Wilson Consultants	

As at 1 December 2011

SECTION 2: REGISTRATIONS OF INTEREST – EXECUTIVE LEADERSHIP TEAM MEMBERS

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
MEDICAL SURGICAL SERVICES DIRECTORATE					
	Dr Bruce King	Nil			
	Dr Elizabeth Wood	<ul style="list-style-type: none"> ▪ Self employed contractor at the Mapua Health Centre as a GP ▪ Work at NRAHDD and a shareholder 			
	Dr Peter Bramley	Nil			
MENTAL HEALTH SERVICES DIRECTORATE					
	Dr Heather McPherson	Nil			
	Dr Jocy Wood	<ul style="list-style-type: none"> ▪ Partner of Nelson East Family Medical Centre. Group GP practice ▪ Shareholder – Nelson Regional After Hours 			
	Robyn Byers	Nil			
COMMUNITY BASED SERVICES DIRECTORATE					
	Dr Nick Baker	<ul style="list-style-type: none"> ▪ Sr Clinical Lecturer, Community Child Health, University of Otago Wellington School of Medicine ▪ Member Steering Group NZ Child and Youth Epidemiology Service (previously Chair of and co-founder of the service) ▪ Chair NZ Child and Youth Mortality Review Committee ▪ Member Child and Youth Network Advisory Group – MOH/PSNZ/NHB ▪ Member NZ Paediatric and Child Health Committee Royal Australasian College of Physicians ▪ Instructor for Advanced Paediatric Life Support NZ 	<ul style="list-style-type: none"> ▪ Wife is a graphic artist who does some health related work 		

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
	Dr Bev Nicholls	<ul style="list-style-type: none"> ▪ Board of NRADD and Shareholder ▪ Nelson Bays PHO Clinical Governance Group ▪ GP and recipient of Nelson Bays PHO funds ▪ Member of IT Development, National IT Board ▪ Member National Information Clinical Leadership Group 	<ul style="list-style-type: none"> ▪ Wife and close friend GPs. 		
	Peter Burton	Nil	<ul style="list-style-type: none"> ▪ NMDHB Representative on Tasman Council's Regional Land Transport Committee 		
CLINICAL SERVICES SUPPORT DIRECTORATE					
	Dr Stephen Busby	<ul style="list-style-type: none"> ▪ Shareholder Director, Nelson Radiology Limited 			
	Dr Neil Whittaker	<ul style="list-style-type: none"> ▪ General Practice owner ▪ Contracted to RNZCGP Medical Educator 		<ul style="list-style-type: none"> ▪ Clinical Director Community 	
	Hilary Exton	Nil			
	James Bowyer		<ul style="list-style-type: none"> ▪ Wife a nurse on Paediatric Ward Nelson Hospital 		
MARLBOROUGH SERVICES DIRECTORATE					
	Dr Ros Gellatly	<ul style="list-style-type: none"> ▪ Practice Partner Scott St Health ▪ GP Liaison NMDHB ▪ Executive Clinical Director Marlborough Services NMDHB ▪ Clinical Advisor Electives, NHB, MOH ▪ Kimi Hauora Wairau Marlborough PHO Clinical Governance Committee Chair ▪ Representative, National Health IT Board Clinical 			

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
		<ul style="list-style-type: none"> ▪ Leadership Group RNZCGP ▪ Advisory Group Member, Royal NZ College GPs ▪ Professional Practice Expert Advisory Group 			
	Carey Virtue		<ul style="list-style-type: none"> ▪ Partner works in the Ministry of Health 		
CORPORATE SUPPORT					
	Nick Lanigan		<ul style="list-style-type: none"> ▪ Wife consultant for 2 Degrees 		
	Denise Hutchins	Nil			
	Dr Sharon Kletchko	<ul style="list-style-type: none"> ▪ Member Exceptional Circumstances Panel – PHARMAC ▪ Treasurer, International Society for Health Care Priorities ▪ Member St John South Island Region Trust Board ▪ Member RACP NZ Policy and Advocacy Committee. ▪ South Island Representative on RACP NZ Joint Executive. ▪ Member of the Medicine’s Review Committee (Medicine’s Act) MEDSAFE ▪ Member DHBRF Governance 	<ul style="list-style-type: none"> ▪ Deputy Chair of the New Zealand Standards Council ▪ Member of the Board – EVIDEM Collaboration. 	<ul style="list-style-type: none"> ▪ EVIDEM is a Not-for-Profit international research collaboration whose purpose is “To promote public health through transparent and efficient healthcare decision making via systematic assessment and dissemination of the evidence for and value of healthcare interventions.” 	
DONM	Robyn Henderson	Nil			
CMO	Heather McPherson	Nil			
DMH & Whanau Ora	Harold Wereta	<ul style="list-style-type: none"> ▪ Ngati Toarangatira Connections 		<ul style="list-style-type: none"> ▪ Tribal Interest 	
CHIEF EXECUTIVE’S OFFICE					
	John Peters	<ul style="list-style-type: none"> ▪ Director of SISSAL ▪ Trustee of Nelson Marlborough Hospitals’ Charitable Trust 	<ul style="list-style-type: none"> ▪ Director of Management and Industrial Services Ltd. 	<ul style="list-style-type: none"> ▪ Shared services provision, administration of trust funds for health purposes & provision of private 	

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
		<ul style="list-style-type: none"> ▪ Trustee Churchill Trust 		health services at Wairau Hospital <ul style="list-style-type: none"> ▪ MIS Ltd previously provided consultant services to other DHBs 	
	Keith Rusholme	<ul style="list-style-type: none"> ▪ Wife provides first aid training and complimentary help services 		<ul style="list-style-type: none"> ▪ Provision of services to DHB staff or contracted providers 	<ul style="list-style-type: none"> ▪ Sister works for IDSS.
	Mike Cummins	<ul style="list-style-type: none"> • Wife works for medical practice 			

As at 1 December 2011

SECTION 3: MINUTES

MINUTES OF A PUBLIC MEETING OF BOARD MEMBERS OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD HELD AT THE SUPPORT SERVICES MEETING ROOM 1, WAIRAU HOSPITAL, BLENHEIM ON TUESDAY 22 NOVEMBER 2011 AT 1.00 PM

Present:

Jenny Black (Chair), Gerald Hope, Judy Crowe, Gordon Currie, Roma Hippolite, John Moore, Fleur Hansby, Russell Wilson, John Inder and Ian MacLennan (Deputy Chair)

Apologies

Patrick Smith

In Attendance:

John Peters (CE), Nick Lanigan, Mike Cummins, Sharon Kletchko and Katherine Rock

Karakia:

Roma Hippolite

SECTION 1: APOLOGIES AND REGISTRATIONS OF INTEREST

Roma Hippolite noted he is now a member of the Ngati Koata Board.

Moved: Judy Crowe

Seconded: Russell Wilson

RECOMMENDATIONS:

**THAT THE APOLOGIES BE ACCEPTED; AND
THAT THE REGISTRATIONS OF INTEREST AS AMENDED BE NOTED.**

AGREED

SECTION 2: MINUTES OF PREVIOUS MEETING

2.1 Minutes of the Board Meeting 25 October 2011

Moved: Gerald Hope

Seconded: John Moore

RECOMMENDATION:

**THAT THE MINUTES OF THE MEETING 25 OCTOBER 2011 BE ADOPTED
AS A TRUE AND CORRECT RECORD.**

AGREED

2.2 Matters Arising

It was suggested that the media should take up the issue of immunisation of children.

2.3 Correspondence

Moved: Russell Wilson

Seconded: Fleur Hansby

**RECOMMENDATION:
THAT THE CORRESPONDENCE BE RECEIVED.**

AGREED

SECTION 3: REPORTS**3.1 Chair's Report**

The Chair gave a verbal report on the meeting of the Chairs Group the previous day. An update was also given on the Board to Board meeting with the IHB at Onetahua Marae and the visit to Golden Bay Community Hospital. Acknowledgements to be sent to those involved. Members suggested a Board meeting be scheduled for Murchison in 2012.

3.2 Chief Executive's Report**(I) FOR DECISION**

Nil

(II) QUALITY AND SAFETY

Noted. The report on compliments to be expanded to include emails and other sources.

(i) Medical Surgical Services

Members were briefed on the presentation to the Hospital Advisory Committee on theatre utilisation and surgical preadmissions redesign.

(ii) Organisational Development

The Health Quality & Innovation Awards were judged by four former Board members.

(III) FINANCIAL

Noted the results YTD were unfavourable by \$704k. The initial forecast to June 2012 indicates a deficit of \$2m against a break even budget. Work is underway to address using a similar process to the 2010 Recovery Plan. This involves all ELT who will focus on controllable costs, impacts of displaced people, high acute activity, focus on lowering waiting lists and phasing.

The Board Sub Committee (Chair, Deputy Chair and Chair of Audit & Risk) to be reconvened to monitor progress.

Summarised Results

For the Month Ended October 2011

	Prior YTD	Year to Date			October 2011
	Actual \$000	Actual \$000	Budget \$000	Variance \$000	Variance \$000
Funder	(111)	(183)	(228)	45	433
Governance	265	52	(19)	71	41
Provider	417	52	872	(820)	(903)
Net Result	571	(79)	625	(704)	(430)

(IV) RUTHERFORD

Noted. Focus is on the clinical areas. The aim is to make the process business as usual across the organisation.

(V) STRATEGY AND PLANNING

No report.

(VI) COMMUNITY BASED SERVICES

NMDHB has participated in a mayoral taskforce on a sustainability strategy for Nelson City. Noted the Minister has approved the Golden Bay IFHC proceeding to the next stage. Members noted the contributions of Harry Holmwood to health in Golden Bay over the years (Harry died during the previous weekend). It was also noted that applications for the required resource consents have been lodged and the trustees of the Golden Bay Community Health Te Hauora o Mohua Trust have reached the developed design stage in the project. Members noted that once the facility is complete the resthome at Collingwood will be sold.

The Minister approved NMDHB appointing a trustee to the Trust.

Moved: John Moore

Seconded: Judy Crowe

RECOMMENDATION:

THAT MIKE CUMMINS, BOARD SECRETARY, BE APPOINTED A TRUSTEE TO THE GOLDEN BAY COMMUNITY HEALTH TE HAUORA O MOHUA TRUST.

AGREED

(VII) CLINICAL SERVICES SUPPORT

Noted a report on the first three months will be presented to the next meeting.

(VIII) MEDICAL SURGICAL SERVICES

Noted. Members questioned if the cancellation rate for elective cases was normal.

(IX) MAORI HEALTH/IWI RELATIONSHIP

Noted.

(X) ORGANISATIONAL DEVELOPMENT

Noted. Members noted the work on Care Capacity Demand Planning (CCDP).

(XI) CORPORATE SERVICES

Noted relocations from Dalton House are well underway and work continues with Historic Places Trust on options for Dalton House.

Noted work on the grounds at Wairau Hospital is well underway which has received good feedback from the public already.

(XII) INTERSECTORAL AND OTHER DHB LINKAGES

Noted.

(XIII) STRATEGIC ISSUES

Noted. Members were briefed on the work around Emergency Planning. Focus is moving to working with Primary / Community based providers and business continuity planning.

Letter of acknowledgement to Pete Kara, Emergency Planning Officer.

Moved: Ian MacLennan

Seconded: Roma Hippolite

RECOMMENDATION:

- 1. THAT THE FINANCIAL REPORT BE ADOPTED**
- 2. THAT THE CHIEF EXECUTIVE'S REPORT BE RECEIVED**
- 3. THAT THE RECOVERY PLAN SUB COMMITTEE BE RECONVENED.**

AGREED

3.3 COMMITTEE REPORTS

Nil

SECTION 4: FOR INFORMATION

Nil

SECTION 5: MEMBER'S ISSUES

Strategic Workshop 6 December 2011

Members discussed whether Rodney Tolley (Transport Planning Advisor) speak to the workshop. Members agreed that a separate session prior to the workshop would be arranged if possible.

Licence to Occupy

Members discuss the presentation by Peter Bruce. Management to identify a timetable in which it is proposed the matter to be resolved. Response to be sent to Mr Bruce.

Public Excluded

Moved: Jenny Black
Seconded: Gordon Currie

RECOMMENDATION

THAT the Board resolve itself into a Committee of the whole and that in terms of the NZ Public Health & Disability Act 2000, the public be excluded while the following items are considered:

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- ***DHB Chair's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***
- ***DHB Chief Executive's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***

AGREED

Actions Arising from the Meeting

Action	Responsible	Time Frame
Circulate minutes of Chairs Group	Sharon Kletchko	9 December
Letters of thanks to Onetahua Marae, Chris Hill and Alexia Russell	Jenny Black	9 December
Report on Health Shuttle	James Bowyer	9 December
Response to Peter Bruce	Peter Burton	9 December

Meeting closed at 4.00 pm

Members of Public

Jean Wilson (Greypower), Peter Bruce and Ian Allen (Marlborough Express).

Peter Bruce spoke to the Board about the double dipping by ARC providers where a client is receiving services in a facility under a licence to occupy (LTO). He raised concerns with what he says as delays in getting providers to comply.

Jean Wilson noted that the shuttle service had been well advertised. She asked that clinicians be encouraged to remind patients of the availability of the service.

3.1 MATTERS ARISING

Wairau Patient Shuttle Review

Information provided under section - Clinical Services Support VII (a).

3.2 CORRESPONDENCE RECEIVED

Date Received	From	Title
18/11/11	Ministry of Transport	Yearly report 2011 Motor Vehicle Crashes in NZ 2010 (Publication)
28/11/11	National Health Board	Release of the 2012/13 DHB Planning Package
05/12/11	Ministry of Health	Quarter One 2011/12 Health Target Results
06/12/11	National Health Board	Changes to National Health Information Collections (NCAMP2012)
07/12/11	Archives NZ	Request for feedback – Digitisation Standard Review

SECTION 4: REPORTS

4.1 Chair's Report

Status

This report contains:

- For decision
- ✓ Update
- ✓ Regular report
- For information

As a Board, we have come to the end of our first year in office. It has been a busy 12 months with significant decisions about Nelson After Hours healthcare, Golden Bay health services, and the future of Disability Services. In June, a new hospital was opened in Wairau, 5 Oral Health Community Centres were completed plus a mobile clinic to service the rural communities was commissioned. In house, under the watchful eye of the Chief Executive, a new senior executive structure has been bedded in and there has been a strong emphasis placed on Quality and Safety with new committee's overseeing these important tasks. There has been clinical engagement at management level, an enormous effort put into regional service alliances and there is progress in the shifting of services from secondary to primary care. All of this happens on top of business as usual. Nelson Marlborough is meeting its targets in most areas and is still on top of the charts of patient satisfaction. Great results for a very hard working workforce.

2012 will be challenging as we continue to meet the health needs of our population. The strategic planning which we have been doing over the last three months will help guide the activities for next year and beyond. Many thanks to all the Board members who willingly gave their time to this process, we did try something different and I believe we had a robust process. It did take time and involved more people – staff and our partners – but I hope we have the makings of a better plan, as a result. The draft annual plan will be presented at the workshop on our Board day on January 24th.

We are very grateful to all the staff for the work they do in helping Nelson Marlborough DHB be the organisation that it is, and thank them very sincerely. As with any 24/7 business, some will be working during this festive season and we hope that they will get some family time in due course. To everyone in the Nelson Marlborough DHB team, Merry Christmas and have a happy and safe summertime.

Jenny Black
Chairman

**RECOMMENDATION:
THAT THE CHAIRMAN'S REPORT BE RECEIVED.**

4.2 Chief Executive's Report

(I) ITEMS FOR DECISION

Nil

(II) QUALITY AND SAFETY

(a) Medical Surgical Services

(i) Shifting Services

A number of initiatives are being trialled to shift services from a hospital setting to a community setting, with the focus on delivering a service that is better, sooner and more convenient for the patient. Services include delivery of IV antibiotics, skins lesion removal in community practice, follow-up appointments with General Practitioners with special interests, and IV treatment for migraines.

(ii) Theatre Productivity

The theatre schedule is to be changed to spread elective cases and improve theatre utilisation. Dedicated acute lists have been added to reduce cancellations of elective cases. Electronic display of theatre bookings is being implemented. Ministry of Health has approved funding for NMDHB to participate in The Productive Operating Theatre programme of change.

(iii) Scoping Review

Discussion on a shared Endoscopy waiting list is being held district wide. There is a need to match demand with capacity, and better manage those waiting for a colonoscopy. The Ministry of Health is considering a proposal to support improvements to the endoscopy service.

(iv) Surgical Pre-Admission Redesign

The team has process mapped the pre-admission pathway and highlighted the key bottlenecks. Currently designing an improved criteria-based, nurse-supported preadmission pathway. The Ministry of Health has approved funding to support the redesign of NMDHB's pre-admission pathway.

(b) Organisational Development

(i) NMDHB Prevention of Workplace Bullying & Harassment Policy

The revised NMDHB Prevention of Workplace Bullying & Harassment Policy was launched on 1st December. A joint NMDHB, New Zealand Nurses Organisation and Public Service Association initiative, the Policy provides for significantly improved reporting and investigation mechanisms. Information has been distributed throughout the organisation regarding the building of a healthy workplace environment.

Status

This report contains:

For decision

✓ Update

✓ Regular report

✓ For information

The staff education package is also being reviewed and a revised programme will be available to the organisation in the first quarter of 2012.

(iii) FINANCIAL

The November 2011 net result YTD is a deficit of \$418k, which is \$677k unfavourable to budget.

Summarised Results

For the Month Ended November 2011

	Prior YTD	Year to Date			November 2011
	Actual \$000	Actual \$000	Budget \$000	Variance \$000	Variance \$000
Funder	(69)	203	(197)	400	354
Governance	268	65	(21)	86	15
Provider	341	(686)	477	(1,163)	(342)
Net Result	540	(418)	259	(677)	27

The detailed finance report is attached as **Appendix 1**.

High level commentary and action planned on the financial result follows:

Fund

The Fund result YTD is a surplus of \$203k, being \$400k favourable to budget.

Revenue is ahead by \$1,132k. This reflects the continuing income from Canterbury DHB for aged residential care of Christchurch residents, now \$543k above budget. This recovery is expected to be about 80% of costs. The favourable revenue surplus also includes \$137k favourable variance for Interest received.

Personal Health expenditure is \$216k unfavourable to budget including the one-off payment to Pharmac of \$204k to top up the discretionary fund, the \$314k expense over budget for PCT drugs and the extra travel costs of \$187k for sending patients to Wellington rather than Christchurch, and \$138k aged residential care expenditure for Christchurch evacuees. These were offset by \$229k in payments for the PHO performance management programme, \$159k Inter District Flows and a \$100k combination of savings in other areas.

Provider

The NMDHB Provider result YTD is a deficit of \$686k, which is \$1,163k unfavourable to budget.

Revenue is \$647k ahead of budget due to additional PCT receipts of \$240k, extra recharges of energy costs to other onsite users of \$149k, and the \$178k

YTD gain on the sale of Wakatu House and three Kawai Street properties. An additional \$70k of ACC levy has been provided for in November.

Expenditure on Medical personnel is \$1,077k below budget for the first 5 months. This is offset by \$306k over budget in outsourced medical staff.

Nursing staff are over budget by \$473k YTD.

Clinical supplies expenditure continues to exceed budget by \$617k in the month, \$1620k (12%) year to date. Immunosuppressive drugs are \$276k (25%) over YTD, and knee prostheses \$202k (39%) over YTD.

Interest received remains above budget as rates earned are better than budgeted and more is being invested. Interest paid is at a lower rate on the newest Crown loan than was budgeted.

Recovery Plan

The Recovery Plan process has been fully implemented and is underway to bring the financial result into line with budget. The Board Sub-Committee has been engaged.

(IV) RUTHERFORD INITIATIVE

Analysis work on the pharmaceutical and theatre capacity projects has been completed and a series of recommendations made. These recommendations are being reviewed by the Service Directorates to enable final decisions to be made as to those to be implemented or investigated for further development. Due to the complexity of both areas the work of collecting data, analysing it, options evaluation and discussions with subject experts, staff and other stakeholders has taken significantly more time than originally planned.

Work has also been completed on analysing the relationship with Churchill Trust. Once the options have been developed final recommendations will be made.

(V) STRATEGY AND PLANNING

(a) 2012/13 Annual Plan

The third workshop to prepare for the 2012/13 Annual Plan was held on 6th December with the Board/partners. Useful and positive conversations were held about the challenges in delivering on Government priorities and advancing health care in the Nelson Marlborough district within available resources.

The outcomes will be used to develop the content of the 2012/13 draft Annual Plan. An initial draft will be discussed by the Board on 24th January 2012.

(b) Quarter One 2011/12 Health Target Results

The Quarter One 2011/12 health target results have been finalised.

Nationally the results show:

- Excellent performance for the shorter waits for cancer treatment target, where all DHBs achieved their 100 percent target
- Excellent performance for the improved access to elective surgery national target that was also achieved this quarter with 1275 (3 percent) more discharges delivered than planned
- Good progress has been made in the better help for smokers to quit target with a 3.4 percent improvement compared with last quarter
- There has been positive improvement in the increased immunisation target, up 0.4 percent
- The shorter stays in ED target performance has decreased slightly due to winter seasonal factors although shows good improvement when compared with the same winter quarter last year
- The national composite results for the better diabetes and cardiovascular services health target reduced slightly this quarter from 72 percent last quarter to 70 percent in quarter one.

At a local level the summarised results for NMDHB are attached as **Appendix 2**. We still have improvements to make in immunisations and Diabetes (covered in the Community Based Services section).

(VI) COMMUNITY BASED SERVICES

(a) Primary Care and Orthopaedics Building, Nelson Site

The project is now in the detailed planning stage against the revised objectives. These are:

- To develop a purpose built facility to accommodate the short term needs of an extended primary care and after hours service until the location for the service is available
- Meet the long term needs of the Orthopaedic Department on the Nelson Hospital site by June 2012
- Keep within a budget of \$1m.

(b) Golden Bay Integrated Family Health Centre

Members of the IMG are aware of the formation of the Rototai Trust and have been working to get a meeting with its members to identify any areas of common ground. Recent highlights for the project include:

- The appointment of a sixth GP for Golden Bay
- Lodging a resource consent application for construction of the new facility
- Agreement by NMDHB and NBPH to join with the Golden Bay Community Health Te Hauora O Mohua Trust to establish a formal alliance to support the project – reflecting the degree of cooperation that has evolved through the development of this project

- Further progress integrating hospital staff with those of the medical centre in preparation of becoming one team once the new facility is open. The DHB staff will be transferred to the PHO in early February
- Successful Community Open Day on 12 December 2011.

(c) Health Targets

(i) Increased Immunisation

	Target	Actual
Maori	95%	94%
Pacific	95%	91%
Asian	95%	85%
Total	95%	86%

(ii) Better Help for Smokers to Quit

The first quarter result showed a trend upwards, which has been continued this month as indicated below:

- July: 87% (Nelson 94%, Wairau 75%)
- September: 90% (Nelson 91%, Wairau 88%, Golden Bay 100%)
- October: 96% (Nelson 95%, Wairau 99%, Murchison 100)
- November: 98% (Nelson 98%, Wairau 100%, Golden Bay 100%).

The Target for June 2012 is 95% which the DHB is on track to achieve.

The Smoking Cessation ABC Implementation contract with Nelson Bays Primary Health is in process and will be agreed with Kimi Hauora Wairau PHO in the new year.

(iii) Better Diabetes and Cardiovascular Services

No updated data is available this month. The Quarter One (July to September) Results for DHBs, reported by the Ministry of Health, indicate that the Nelson Marlborough result reflects incomplete data due to the system change in laboratory reporting. This result masks the level of activity that is taking place in the Nelson Marlborough community. For example, Kimi Hauora Wairau Marlborough PHO has, since February 2011, contracted Te Hauora O Ngati Rarua to deliver a Vascular Risk Assessment Maori programme. While it is early days, there is already evidence of success for this programme. An extract from the Nelson Bays Primary Health Quarterly Report, outlining their Diabetes Annual Review activity for July to September 2011, is attached as **Appendix 3**.

(VII) CLINICAL SERVICES SUPPORT

(a) Blenheim Nelson Shuttle

The Blenheim to Nelson Health Shuttle pilot is due to end on 29th February 2012.

It has been estimated that during a twelve month period the number of patients that could access the shuttle in Blenheim, and along the route, could be 2,461 patients based on 2010/11 numbers, out of a total of 3590 who travel from Marlborough to Nelson.

Since the shuttle has been launched the utilisation has increased. Cumulative use at the end of September was 9.8%, in October 13.5%, and November 16.6%. A total of 201 passengers have been carried of which 90% hold a Community Services Card.

A survey was conducted by contacting over 62 of 114 patients who could have used the shuttle in a period from 10 October to 31 October 2011. Of these patients:

- 53% did not want to use the shuttle as they wanted to use their own transport due to the convenience of not being restricted to shuttle departure times and wanting to do other things while in Nelson
- 27% did not know about the shuttle
- 12% had used the shuttle
- 8% had other reasons.

A health shuttle service card outlining its availability, time and cost is sent out with every outpatient appointment to encourage patients to use the service.

Overall comment on the shuttle service has been very positive, with a number of feedback forms being received. These have commented on the excellent customer service from the driver, good comfort of the vehicle, and the convenient service. Very few comments have been received on the lack of current wheelchair access.

The health shuttle will run through the Christmas and New Year.

A more detailed report will be provided at the end of the trial.

(b) Relocation of Nelson Hospital Therapy Equipment Store

The Nelson Hospital Therapy Equipment Store moved on 5th December to temporary premises on the Braemar Campus. All returns of Nelson Hospital therapy equipment, loaned to patients rehabilitating in the community, will be dropped off at the new Store, with the entrance by Taylors Laundry off Motueka Street.

The Allied Health Store is responsible for maintaining, cleaning and receiving Occupational Therapy equipment and Physiotherapy equipment e.g. shower stools, toilet frames and wheelchairs.

(VIII) MEDICAL SURGICAL SERVICES**(a) Activity**

The Medical Surgical Service delivered 2,377 caseweights (139% of plan) for November and has delivered 9,260 caseweights (109% of plan) YTD.

Acute activity was 115% of plan for the month, and 110% YTD. Elective activity was 183% of budget for the month, and 106% YTD.

Orthopaedics had a busy November with an additional 30 Acute caseweights and 25 Elective caseweights being undertaken over and above October volumes. The elective workload was to address the number of long wait patients. This has accounted for high consumable, theatre and implant costs.

Elective caseweight delivery for November was 1,110 caseweights (183% of plan) compared to a budget of 605 caseweights. YTD Caseweights were 3,198 compared to a budget of 3,017 (106% of plan). A correction has been made to the WEISS model which has resulted in an increase in the caseweights calculated. The correction was applied to the November result.

Theatre cancellations for November was 7%.

The DHB remains green overall in terms of ESPI compliance.

It would appear that hospital activity has increased significantly since February 2011. This has resulted in a month on month increase when compared to last year in acute activity, hospital admissions and bed occupancy with the flow on effects to staffing costs, ward and theatre activity, and patient consumables.

(b) Health Targets**(i) Shorter Stays in Emergency Departments**

The latest reports continue to indicate excellent performance by our Emergency Department teams with 97% of patients admitted or discharged within six hours of presenting.

(ii) Improved Access to Elective Surgery**Elective Services**

Ambulatory FSA at end October 2011 had a delivery of 7,569 FSAs against plan of 5,652 (133.9%). Of this total, surgical FSAs are 4,167 actual delivery against a plan of 3,674 (113.4%).

Ambulatory Procedures at end October 2011 had a delivery of 479 procedures against plan of 376 (127%). Ambulatory Procedures include Colonoscopy procedures across both Medical and Surgical specialities.

Electives Initiative

NMDHB is required to deliver 6,029 discharges every year. At the end of October 2011 we had delivered 2,085 discharges against a plan of 2,053 (101.6%)

Planned caseweight delivery (October 2011) was 2,603 with actual caseweight delivery of 3,198 (122.9%).

High caseweights are still being delivered in Orthopaedics with the focus to reducing long wait times for a procedure to ensure patients are treated within six months of being given certainty

As at 5th December 37 patients are waiting more than six months for an FSA, and 46 patients are waiting more than six months for a surgical procedure.

(iii) Shorter Waits for Cancer Treatment

The latest reports indicate that patients needing radiation treatment are currently receiving this within the target time.

(c) The following is a breakdown of volumes for November.

Acute / Elective Caseweights - KPI View									
NMDHB									
November 2011									
Type	Service	Unit Code	Description	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan	
Acute	Med	M00001	General Medical Inpatient DRG's	4797	2111	2230	120	106%	
		M10001	Cardiology Inpatient DRG's	623	274	507	233	185%	
	Med Total			5420	2385	2737	352	115%	
	Specialist	D01001	Dental Inpatient DRG's	27	12	7	-5	58%	
		M55001	Paediatric Medical Inpatient DRG's	697	307	285	-21	93%	
		S25001	Ear, Nose and Throat Inpatient DRG's	112	49	40	-9	82%	
		S30001	Gynaecology Inpatient DRG's	203	89	93	3	104%	
		S40001	Ophthalmology Inpatient DRG's	30	13	11	-2	85%	
		S70001	Urology Inpatient DRG's	156	69	98	30	143%	
		W06003	Neonates Inpatient DRG's	416	183	209	26	114%	
	W10001	Maternity Inpatient DRG's	1345	592	654	62	110%		
	Specialist Total			2987	1315	1398	83	106%	
	Surg	S00001	General Surgery Inpatient DRG's	2273	1000	1030	30	103%	
		S05001	Anaesthesia Services Inpatient DRG's	20	9	2	-7	18%	
		S45001	Orthopaedics Inpatient DRG's	1766	777	859	82	110%	
		S75001	Vascular Inpatient DRG's	8	4	36	33	1033%	
	Surg Total			4067	1790	1927	137	108%	
	Acute Total				12474	5489	6062	573	110%
Elective	Med	M00001	General Medical Inpatient DRG's	114	50	37	-13	73%	
		M10001	Cardiology Inpatient DRG's	338	149	131	-18	88%	
	Med Total			452	199	168	-31	84%	
	Specialist	D01001	Dental Inpatient DRG's	196	86	66	-20	77%	
		M55001	Paediatric Medical Inpatient DRG's	28	12	12	0	98%	
		S25001	Ear, Nose and Throat Inpatient DRG's	479	211	143	-68	68%	
		S30001	Gynaecology Inpatient DRG's	758	334	399	65	120%	
		S40001	Ophthalmology Inpatient DRG's	420	185	156	-29	84%	
		S70001	Urology Inpatient DRG's	571	251	256	5	102%	
	Specialist Total			2451	1079	1031	-48	96%	
	Surg	S00001	General Surgery Inpatient DRG's	1710	752	786	34	105%	
		S05001	Anaesthesia Services Inpatient DRG's	30	13	14	1	104%	
		S45001	Orthopaedics Inpatient DRG's	2040	898	1112	215	124%	
		S75001	Vascular Inpatient DRG's	172	76	87	11	115%	
	Surg Total			3952	1739	2000	261	115%	
	Elective Total				6855	3017	3198	182	106%
	Grand Total				19329	8506	9260	754	109%

NMDHB								
November 2010								
Type	DM Area	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan		
Acute	Med	5719	2517	2277	-240	90%		
	Surg	4348	1914	1896	-18	99%		
	W, C & OH	2657	1169	1136	-33	97%		
Acute Total		12724	5599	5309	-290	95%		
Elective	Med	447	197	214	17	109%		
	Surg	5284	2325	2405	80	103%		
	W, C & OH	956	421	377	-43	90%		
Elective Total		6688	2943	2996	53	102%		
Grand Total		19412	8542	8305	-237	97%		

NB. Changes of the Casemix Model and its exclusions between years mean that exact correlations cannot be made (eg exclusion of Skin Lesions in 11/12 FY)

(IX) MAORI HEALTH/IWI RELATIONSHIP**(a) Joint DHB Board / IHB Board Meeting**

The joint Board-to-Board meeting was held on 18th November 2011 at Onetahua Marae in Golden Bay. The marae was open to IHB and NMDHB board members the day before.

The agenda provided time for both Boards to view taonga held by local iwi and to hear the history of the marae.

Discussion was held on working together to encourage teenage mothers to immunise their children, stop teenage children taking up smoking, and how to tackle the obesity problem. It was agreed that rather than tackling many issues, it may be best to work jointly on one specific project, like Child Health.

The conversation held fitted well with a publication that was released known as the 'Spirit Level'.

(X) ORGANISATIONAL DEVELOPMENT**(a) FTE Report – November 2011**

**FTE Report
November 2011**

FTE	Actual CM	Budget CM	Variance	Actual YTD	Budget YTD	Variance
SMO	103	96	(7)	97	95	(2)
MOSS	17	20	3	18	20	2
Registrars	14	12	(2)	14	12	(2)
House Officers	50	47	(3)	48	47	(1)
Nursing	669	635	(34)	648	630	(18)
Allied Health	570	594	24	572	581	9
Support	97	98	1	96	98	2
Management/Admin	336	339	3	336	333	(3)
Total	1,856	1,841	(15)	1,829	1,816	(13)

(b) Complaints

There were 30 complaints for the month of October, with seven of those for Wairau and 23 for Nelson. One complainant identified as being Maori.

Of the overall complaints, there was one for Marlborough which related to the funding of palliative care to which community-based services responded. For the Nelson region, four of the complaints involved mental health services. One DSS complaint has been ongoing, with work in progress to bring that particular complaint to a satisfactory conclusion.

A 100% response rate was recorded as being achieved within 20 working days.

During this period, one complaint was received from Health & Disability. Two complaint decisions were received from Health & Disability, neither of which the DHB was found in breach. Four decisions are currently with the Commissioner.

The chart is attached as **Appendix 4**.

(c) Employee Relations

The National Multi Employer Collective Agreement (MECA) and NMDHB Collective Agreement updates are attached as **Appendix 5**.

(d) Human Resources

Vacancies processed:	52 Nelson, 18 Wairau
Applications received district wide:	451
Appointments:	61 Nelson, 23 Wairau

(e) People Development

Learning activity delivered or facilitated by the L&D Team included:

- Core level 4-7 Resuscitation Training provided to 30 staff across the district and three GPs
- IT orientation, clinics and up-skilling, and MS Office up-skilling training held in both Nelson and Wairau with 93 attendees across the district
- Orientation attendees – Nelson 30, Wairau 14
- Nursing conducted three study days with 53 staff attending
- Midwifery conducted six training days with 56 staff attending
- Newborn life support – first full day course held in Nelson with 11 participants.

(XI) CORPORATE SERVICES

(a) Wairau Subdivision

The property market in Blenheim has moved significantly from when the original decision to subdivide and dispose of the eastern part of the hospital block was made.

We are currently seeking valuations on the various ways of subdividing the block to determine the best way to maximise the DHB's return on the sale. These options include a single large block, or splitting the houses into one or many separate titles.

In parallel, works are being progressed to relocate water mains that supply the hospital and the sewer mains onto land that the DHB will be retaining.

(b) IT Update

A presentation will be given at the meeting updating on IT issues.

(XII) INTERSECTORAL AND OTHER DHB LINKAGES

- (a) Intersectoral and other DHB linkages for the period:
- Golden Bay Interim Management Group
 - National CEOs
 - SI CEOs
 - MP for Blenheim/Kaikoura
 - Churchill Trust
 - Regular meetings with PHO CEOs
 - University of Auckland Researchers
 - Takaka Open Day
 - CCDM Governance Group
 - Meeting with Marlborough Grey Power members.

(XIII) STRATEGIC ISSUES

(a) Emergency Planning

Focus has moved to further developing the work started after the Christchurch earthquakes. This includes placing Civil Defence cabinets in key areas, staff training, exercises and implementation of e-Sponder, the emergency operations centre software being rolled out by Health, Civil Defence and Police.

Work is also underway with non-DHB health providers to help them develop their own response plans. Investigations are continuing on options for either having emergency power generation at selected GP practices or to have a number of practices suitably wired to have portable generators connected in the event of an emergency.

Using the Christchurch experience, a draft Recovery Plan is in development to cover the following activities:

- Minimising the escalation of the consequences of a disaster
- Rehabilitating the emotional, social and physical wellbeing of individuals within the community
- Taking opportunities to adapt to meet the physical, environmental, economic and psychosocial future needs
- Reducing future exposure to hazards and their associated risks.

The Ministry has agreed to fund an existing staff member to work for six months part time to assist with the development of e-Sponder. This work will form the basis of national health reports in the event of an emergency.

The opportunity has arisen where the Emergency Planning Officer at WCDHB has resigned. NMDHB is in discussions with them and CDHB as to whether we should have a greater role in emergency planning on the West Coast.

John Peters
CHIEF EXECUTIVE
14 December 2011

RECOMMENDATIONS ARISING FROM THIS REPORT:

- 1. THAT THE CHIEF EXECUTIVE'S REPORT BE RECEIVED**
- 2. THAT THE FINANCIAL REPORT BE ADOPTED.**

4.3 Committee Reports

Hospital Advisory Committee – 22 November 2011

While the Medical and Surgical Directorate has delivered the required caseweights and remained ESPI compliant, four months into the 2011/2012 financial year there is a negative variation of \$1.05m. The financials are now under the close scrutiny of ELT with a recovery plan in place and this will be overseen at a governance level by the Board Chair, Deputy Chair and Chair of Audit and Risk Committee.

Status

This report contains:

- For decision
- ✓ Update
- ✓ Regular report
- For information

Points raised around the financial situation included:

- Acute activity has been significantly up from July through to October with a need to “seasonise” and phase the budget.
- The 2011/2012 year has seen \$6m in savings to be realised with \$3m of that coming from the Medical and Surgical Directorate. Some of the present over run reflects the reduction of these funds.
- The burgeoning aging population along with increasing chronic conditions have financial implications of having to do more with less. At the same time there is a need for sound bench marking and trend information to ensure resources are being used efficiently.
- While great progress has been made to reduce the waiting lists it has resulted in increasing consumable costs. Patient travel costs also have increased significantly.

Presentations on Theatre Productivity and Surgical Pre-Admission highlighted the work done with expected outcomes to provide improved patient centred services that are financially and operationally efficient. External Ministry one off funding has been granted for these as well as for the Scoping Project.

Judy Crowe
Chairperson

**RECOMMENDATION:
THAT THE CHAIRPERSON'S REPORT BE RECEIVED.**

APPENDIX 1 – FINANCIAL REPORT NOVEMBER 2011

OPERATING RESULTS

Consolidated Statement of Financial Performance								
\$000	November 2011			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	DAP
Revenue	33,792	33,400	392	162,866	169,184	167,579	1,605	402,179
Expenditure								
Personnel Costs	12,826	12,870	44	59,716	61,310	61,558	248	149,506
Outsourced Services	985	883	(102)	4,792	5,089	4,484	(604)	10,646
Clinical Supplies	3,245	2,628	(617)	13,397	14,899	13,280	(1,620)	31,301
Infrastructural and Non Clinical Supplies	2,537	2,665	128	12,983	13,971	13,884	(87)	33,085
Personal Health Expenditure	9,141	9,110	(31)	45,060	45,752	45,701	(51)	109,593
Mental Health Expenditure	986	1,021	34	4,796	4,959	5,103	144	12,154
Public Health Expenditure	2	1	(2)	5	27	4	(23)	10
Disability Support Expenditure	3,472	3,582	109	17,178	18,915	18,225	(690)	43,612
Hauora Maori Services Expenditure	234	234	0	1,135	1,144	1,172	28	2,813
Interdivisional Eliminations	(0)	0	0	0	(0)	0	0	(0)
Internal Revenue/Expenses	0	0	0	(1)	0	0	0	(0)
Total Expenditure	33,431	32,994	(437)	159,061	166,066	163,411	(2,655)	392,720
Net Surplus/(Loss) before Interest & Capital Charge	361	406	(45)	3,805	3,118	4,168	(1,050)	9,459
Interest Received	118	70	48	623	601	348	253	835
Interest Paid	(223)	(242)	20	(987)	(1,163)	(1,260)	98	(3,016)
Capital Charge	(595)	(599)	4	(2,901)	(2,974)	(2,997)	23	(7,170)
Net Surplus/(Loss)	(339)	(366)	27	540	(418)	259	(677)	108
Made up of Divisional Surplus/(Loss):								
Funder	385	31	354	(68)	203	(197)	400	23
Governance	13	(2)	15	268	65	(21)	86	0
Provider	(737)	(395)	(342)	341	(685)	477	(1,162)	85
Total	(339)	(366)	27	540	(418)	259	(677)	108

Revenue: \$1.8m more than budget YTD (including interest received).

Expenses: \$2.5m more than budget YTD (including interest paid and capital charge).

Net Result: \$0.7m worse than budget YTD.

Revenue

Of the \$1.8m variance YTD:

- Income from Canterbury DHB for aged residential care of Christchurch residents is continuing. This has added \$543k to the revenue YTD
- Interest received continues to track better than plan due to careful management and investments made at rates higher than budgeted, giving a \$253k favourable variance to budget YTD

- The YTD gain on sale of Wakatu House and three Kawai Street properties is \$178k
- The PBFF adjustment is now \$695k YTD
- Other miscellaneous income such as rebates from suppliers, reimbursements of energy charges to other onsite users, and rentals are \$180k favourable to budget YTD
- Variances in the Fund include \$137k favourable variance for Interest received, \$143k one off prior year revenue (electives wash up for delayed breast reconstruction, B4 school checks and additional interventions St Marks) and \$87k funding for the Oral health business case (this is a phasing issue).

Expenditure

Payments to providers are reporting close to budget for another month with the exception of Disability Support Residential Care Hospitals and Rest Homes \$81k in October, \$932k YTD unfavourable variance, in connection with the Aged Residential Care for Christchurch residents. Community Pharmaceutical payments through Healthpac are back on track but show a small negative variance of \$75k YTD.

Personnel costs are \$44k (3%) under budget for the month and \$248k under YTD.

- DSS is \$20k under budget for the month and \$319k over YTD which is principally made up of the DSS Sleepover allowance of \$310k
- Clinical Support is \$3k over budget for the month and \$152k over YTD. This is made up of several small unfavourable variances including nursing unbudgeted patient transport, extra Wairau Admin to update records and cover sick leave, and extra Allied Health payments for maternity and sick leave, and a correction to Radiology CME
- Mental Health is over budget \$73k for the month and \$495k under YTD. This is largely in nursing staff.

Outsourced costs show a \$102k (12%) unfavourable variance in the month and \$604k unfavourable YTD.

- This includes the \$107k one-off unbudgeted payment for the InterRAI assessment tool in September
- Medical/Surgical costs are \$410k over budget YTD. This was largely in Wairau because of \$74k locum cover in Obs/Gynae, \$99k in Anaesthetists (offset by saving in Personnel cost in this area) and \$55k on an Orthopaedic locum covering Medical leave.

Clinical Supplies are over budget \$617k (23%) in November, and \$1,620k (12%) YTD.

- Pharmaceuticals are over budget \$492k YTD, of this, Immunosuppressives make up \$276k YTD. Blood products, \$144k unfavourable variance YTD continues to be high reflecting ongoing high activity requiring blood. Air Ambulance for November was \$106k over budget with several high cost flights and showing \$170k over budget YTD. Offsetting these unfavourable variances, Health promotion is under budget YTD by \$173k and Patient appliances is under budget by \$130k YTD
- Medical/Surgical is \$340k (28%) over in the month and \$890k (15%) over YTD. The bulk of this is in Patient consumables and Knee prostheses \$76k (72%) over for the month and \$202k (39%) over YTD. Nelson Theatre costs are \$60k (41%) over for the month and \$105k (14%) over YTD. Private surgery is \$103k over a

budget of \$1k. Health Benefits Ltd is currently reviewing procurement arrangements in an attempt to reduce costs.

Pharmaceuticals Expenditure \$000s	Current Month			Year to Date			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	DAP
Provider	561	459	(102)	2,869	2,377	(492)	5,692
Community Pharmaceuticals	2,831	2,827	(4)	14,255	14,272	17	33,867
Pharmacy Service	-	-	-	204	-	(204)	-
Total NMDHB	3,392	3,286	(106)	17,328	16,649	(679)	39,559

Infrastructure costs are \$33k under budget YTD.

- Corporate training is \$84k below budget YTD
- Interest paid continues with a positive variance related to interest rates obtained late in 2010/11 better than those assumed in the budget for this year
- Utilities are over budget by \$181k (15%) YTD. Coal prices (up 10%) and higher usage than budgeted over the winter have contributed to this variance. These higher costs have been passed on to increase recharges referred to earlier.

Financial Performance by Division

Governance & Admin Statement of Financial Performance								
\$000	November 2011			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	DAP
Revenue	522	512	11	2,373	2,662	2,558	103	6,140
Expenditure								
Personnel Costs	80	88	7	632	408	427	19	1,022
Outsourced Services	24	24	0	120	249	121	(129)	289
Infrastructural and Non Clinical Supplies	91	99	8	272	374	506	131	1,228
Internal Allocations	155	154	(1)	310	773	770	(2)	1,849
Total Expenditure	351	365	14	1,334	1,804	1,823	19	4,388
Net Surplus/(Loss) before Interest & Capital Charge	172	147	25	1,039	857	735	122	1,752
Capital Charge	(158)	(149)	(10)	(771)	(792)	(756)	(36)	(1,752)
Net Surplus/(Loss)	13	(2)	15	268	65	(21)	86	0

Fund Statement of Financial Performance

\$000	November 2011			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	DAP
Revenue								
Ministry of Health	30,720	30,519	201	148,374	153,808	152,710	1,099	366,718
Other Revenue	10	8	2	50	75	41	33	99
Total Revenue	30,730	30,527	203	148,423	153,883	152,751	1,132	366,818
Expenditure								
Personal Health Expenditure	21,832	21,776	(56)	106,500	109,246	109,031	(216)	261,615
Mental Health Expenditure	3,110	3,144	34	15,190	15,578	15,722	144	37,639
Public Health Expenditure	147	151	4	1,149	836	756	(80)	1,814
Disability Support Expenditure	4,588	4,723	135	22,641	24,606	23,930	(676)	57,306
Hauora Maori Services Expenditure	234	234	0	1,135	1,144	1,172	28	2,813
Other Expenses	521	508	(12)	2,292	2,613	2,542	(70)	6,102
Total Expenditure	30,432	30,537	105	148,907	154,023	153,153	(870)	367,288
Net Surplus/(Loss) before Interest & Capital Charge	297	(10)	307	(484)	(140)	(402)	262	(470)
Interest Received	88	41	47	415	343	205	137	493
Net Surplus/(Loss)	385	31	354	(68)	203	(197)	400	23

Provider Statement of Financial Performance

\$000	November 2011			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	DAP
Revenue								
Ministry of Health	1,624	1,664	(40)	8,683	8,522	8,631	(110)	20,654
Internal Fund	16,076	16,081	(5)	78,440	80,613	80,406	208	193,004
Other Government	396	390	6	1,960	2,021	2,012	10	4,678
Other Revenue	1,042	816	226	3,718	4,708	4,169	539	9,991
Total Revenue	19,138	18,951	187	92,801	95,864	95,218	647	228,327
Expenditure								
Personnel Costs								
Medical Personnel	3,153	3,541	388	15,398	15,631	16,708	1,077	40,380
Nursing Personnel	4,566	4,289	(277)	20,289	20,849	20,376	(473)	49,674
Allied Health Personnel	2,809	2,883	74	12,977	14,176	13,901	(274)	34,078
Support Personnel	406	382	(23)	1,842	1,907	1,884	(23)	4,620
Management/Administration Personnel	1,813	1,687	(126)	8,578	8,339	8,262	(77)	19,732
Total Personnel	12,746	12,782	36	59,084	60,902	61,131	229	148,484
Outsourced Services	961	859	(102)	4,672	4,839	4,364	(475)	10,357
Clinical Supplies	3,245	2,628	(617)	13,397	14,899	13,280	(1,620)	31,301
Infrastructural and Non Clinical Supplies	2,447	2,566	119	12,711	13,595	13,378	(217)	31,857
Provider Payments	0	0	(0)	(0)	1	0	(1)	0
Total Expenditure	19,401	18,836	(565)	89,864	94,237	92,153	(2,084)	221,999
Internal Allocations	155	154	1	311	773	770	2	1,849
Net Surplus/(Loss) before Interest & Capital Charge	(108)	269	(377)	3,249	2,401	3,835	(1,435)	8,177
Interest Received	30	29	2	208	259	143	116	342
Interest Paid	(223)	(242)	20	(987)	(1,163)	(1,260)	98	(3,016)
Capital Charge	(436)	(450)	14	(2,130)	(2,182)	(2,241)	59	(5,418)
Net Surplus/(Loss)	(737)	(395)	(342)	340	(685)	477	(1,162)	85

Consolidated Financial Position

Consolidated Statement of Financial Position \$000s	June 2011	CM Last Year	CM Actual	CM Budget	Variance	AP
Bank	17,881	22,813	19,826	35,831	(16,005)	40,131
Deposits > 3 months	6,020	-	7,062	-	7,062	-
Debtors & Prepayments	13,027	9,608	11,539	9,055	2,484	8,951
Stock	2,043	2,057	2,085	2,318	(233)	2,318
Assets Held for Sale	2,769	-	1,582	-	1,582	-
Current Assets	41,740	34,478	42,095	47,204	(5,109)	51,400
Creditors	24,094	22,987	24,385	33,158	8,773	34,024
Employee Entitlements	27,994	31,307	27,363	25,925	(1,438)	25,826
Term Debt - Current Portion	13,149	13,354	1,113	1,567	454	1,750
Current Liabilities	65,237	67,648	52,861	60,650	7,789	61,600
Working Capital	(23,497)	(33,170)	(10,767)	(13,446)	2,679	(10,200)
Non Current Assets	162,751	165,186	161,263	163,741	(2,478)	161,498
Net Funds Employed	139,254	132,016	150,496	150,295	201	151,298
Long Service Leave	2,452	2,088	2,452	2,088	(364)	2,088
Retiring Gratuities	7,592	7,754	7,592	7,754	162	7,754
Sabbatical Leave	2,275	1,016	2,275	1,016	(1,259)	1,016
Term Debt	37,130	33,100	48,788	48,587	(201)	49,767
Non Current Liabilities	49,449	43,958	61,107	59,445	(1,662)	60,625
Crown Equity	89,805	88,058	89,389	90,850	(1,461)	90,673
Net Funds Employed	139,254	132,016	150,496	150,295	201	151,298

The variance between the actual June 2011 Consolidated Financial Position and that used for the budget was \$2,427k in Net Funds Employed. The variance against budget for October shows \$201k, therefore \$2,226k of total Net Funds Employed variance is attributable to the current financial year.

Consolidated Cashflow Position

Consolidated Statement of Cash Flows \$000s	Current Month			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	AP
Operating Cash Flow								
Receipts								
Government & Crown Agency Received	34,730	32,597	2,133	158,795	165,893	163,475	2,418	392,344
Other Revenue Received	961	817	144	3,747	4,620	4,169	451	9,990
Total Receipts	35,691	33,414	2,277	162,542	170,512	167,644	2,868	402,334
Payments								
Personnel	14,255	12,870	(1,385)	54,926	62,550	61,558	(992)	149,507
Payments to Suppliers	5,603	5,124	(479)	30,993	30,715	26,245	(4,470)	61,498
Capital Charge	-	-	-	3,510	598	1,735	1,137	5,326
GST	600	(50)	(650)	219	(106)	1,405	1,511	1,519
Payments to Other DHBs	-	3,191	3,191	17,015	-	15,957	15,957	38,203
Payments to Other Providers	13,836	10,831	(3,005)	51,160	70,798	53,932	(16,866)	129,752
Total Payments	34,294	31,966	(2,328)	157,823	164,556	160,832	(3,724)	385,805
Net Cash Inflow/(Outflow) from Operating Activities	1,397	1,448	(51)	4,719	5,957	6,812	(855)	16,529
Cash Flow from Investing Activities								
Receipts								
Interest Received	118	70	48	623	601	348	253	835
Sale of Fixed Assets	507	-	507	91	1,364	43	1,321	129
Total Receipts	625	70	555	714	1,965	391	1,574	964
Payments								
Capital Expenditure	747	477	(270)	12,187	3,394	2,383	(1,011)	7,953
Increase in Investments	4,006	-	(4,006)	-	1,041	-	(1,041)	-
Total Payments	4,753	477	(4,276)	12,187	4,436	2,383	(2,053)	7,953
Net Cash Inflow/(Outflow) from Investing Activities	(4,128)	(407)	(3,721)	(11,473)	(2,471)	(1,992)	(479)	(6,989)
Net Cash Inflow/(Outflow) from Financing Activities	(282)	(244)	(38)	6,647	(1,540)	(1,379)	(161)	(1,799)
Net Increase/(Decrease) in Cash Held	(3,013)	797	(3,810)	(107)	1,945	3,441	(1,496)	7,741
Plus Opening Balance	22,839	35,034	(12,195)	22,920	17,881	32,390	(14,509)	32,390
Closing Balance	19,826	35,831	(16,005)	22,813	19,826	35,831	(16,005)	40,131

- Net Cash Flow from Operating is on budget for the month. The cash flow YTD variance is stable at \$0.9m unfavourable to budget
- Net Cash Flow from investing is unfavourable to budget this month by \$3.7m. This reduces the favourable YTD variance to a \$0.5m unfavourable variance YTD. Short Term investments have been made with money received from MOH and cash was received for the sale of two more Kawai Street property
- Financing activities are reasonably close to budget, \$0.1m unfavourable YTD
- Cash opening balances were \$14.5m unfavourable to budget due to the classification of cash on deposit and also substantial asset sales that were budgeted in the 2010/11 financial year and did not occur.

APPENDIX 2 – QUARTER ONE 2011/12 HEALTH TARGETS



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Wellington
New Zealand
Phone (04) 496 2000
Fax (04) 496 2340

29 November 2011

Ref. No _____

Mr John Peters
Chief Executive Officer
Nelson Marlborough District Health Board
Private Bag 18
NELSON 7042

Dear John

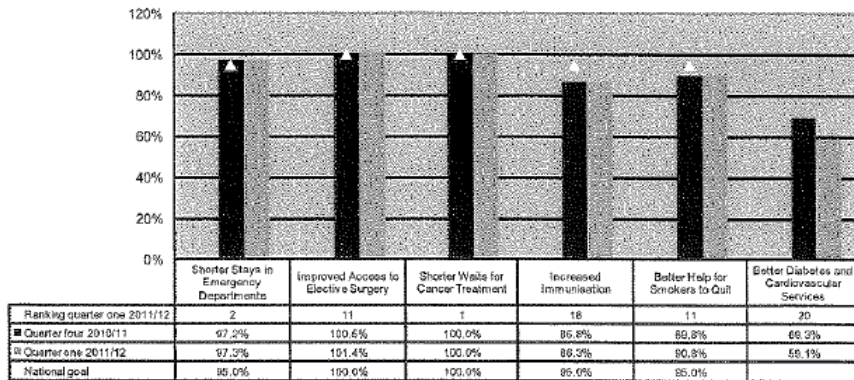
Quarter one 2011/12 health target results are now finalised, and I would like to acknowledge both the good progress, and the considerable energy and effort being made by our sector to deliver on the health targets.

Nationally, the results show:

- excellent performance for the Shorter waits for cancer treatment target, where all District Health Boards (DHBs) achieved their 100 percent target
- excellent performance for the Improved access to elective surgery national target that was also achieved this quarter with 1275 (3 percent) more discharges delivered than planned
- good progress has been made in the Better help for smokers to quit target with a 3.4 percent improvement compared with last quarter
- there has been positive improvement in the Increased immunisation target up 0.4 percent
- the Shorter stays in Emergency Departments (ED) target performance has decreased slightly due to winter seasonal factors although shows good improvement when compared with the same winter quarter last year
- the national composite results for the Better diabetes and cardiovascular services health target reduced slightly this quarter from 72 percent last quarter to 70 percent in quarter one.

Although the quarter one results are good, there remains considerable variability between DHBs and across target areas. Results for your DHB are summarised below.

Nelson Marlborough health targets quarter one 2011/12 results



Quarter one 2011/12 data for the Better diabetes and cardiovascular services target is incomplete due to system change.

The Ministry's Target Champions continue to work closely with the sector to support improved performance. The following feedback is provided by the champions on your results for quarter one.

Mike Ardagh, Target Champion, Shorter stays in Emergency Departments

Nelson Marlborough DHB continues to achieve the Shorter stays in Emergency Departments health target this quarter with a performance of 97 percent. Well done and I look forward to this continuing throughout 2011/12.

Clare Perry, Target Champion, Improved access to elective surgery

Nelson Marlborough DHB has achieved its quarter one health target – Improved access to elective surgery. At the end of quarter one 1594 people have been provided with elective surgery, which is 22 (1 percent) more than planned. This is a good result, well done.

John Childs, Target Champion, Shorter waits for cancer treatment

Nelson Marlborough DHB has achieved the four week Shorter waits for cancer treatment health target in quarter one. This is excellent sustained performance on quarter four 2010/11. The DHB is encouraged to maintain this performance over 2011/12 in close collaboration with your regional oncology centres.

Pat Tuohy, Target Champion, Increased immunisation

In quarter one Nelson Marlborough DHB's total immunisation coverage dropped from 87 percent in quarter four to 86 percent. The DHB will need to improve the timeliness of immunisation referral to outreach to ensure all children who can be immunised are offered a service before they turn two years of age.

The DHB has a combined opt off/decline rate of 10.4 percent which is higher than the national average of 5.1 percent. In addition to auditing the decline population to

confirm that they are true declines, the DHB will need to engage with immunisation providers in the district to ensure they are actively offering information about vaccine preventable disease and immunisation to this group.

I would like to thank Nelson Marlborough DHB for leading the district's implementation of the immunisation health target. Please confirm with your Immunisation Steering Group that there are sustainable systems in place to support achievement of the health target by 1 July 2012 and to maintain this level of coverage once the target is achieved (except where the audited decline rate prevents this).

Karen Evison, Acting Target Champion, Better help for smokers to quit

Quarterly results have increased by 1 percent to 90.8 percent. In previous quarters, Nelson Marlborough DHB have described the clear lines of accountability for achieving the target, and these people will be key in driving up the performance to achieve the target in future quarters. I look forward to seeing these results lift once again during quarter two.

During quarter four 2010/11, there was already a good level of ABC activity in general practice (36 percent), which was above the national average (25.7 percent). Good progress was made during quarter one 2011/12, where performance increased to 48.5 percent (provisional result). I encourage you to share your learning with primary care and look forward to seeing the results continuing to improve over the year.

Brandon Orr-Walker, Target Champion, Better diabetes and cardiovascular services

Nelson Marlborough DHB has reported a significant decline in its overall performance against the Better diabetes and cardiovascular services health target achieving 59 percent in quarter one. This is primarily related to the CVD risk assessment results being incomplete. The effect on the ranking is that the DHB is placed 20th. Your preliminary CVD risk assessment result was 28 percent due to incomplete laboratory data. I am aware the DHB and Medlab are working on a solution to correct this.

Diabetes free annual checks were just below target by 2 percent at 74 percent. This result is 15 percent higher than last quarter in part due to the reduced diabetes prevalence figure following improvement to the virtual diabetes register discussed with your team when we met earlier in the year. Diabetes management, at 76 percent, was 4 percent above target and slightly lower than last quarter.

The Ministry will publish target results in five national newspapers, the New Zealand Herald, Waikato Times, The Dominion Post, The Christchurch Press, and the Otago Daily Times on Tuesday, 29 November 2011. As occurs each quarter, a wider package of supporting information has been sent to DHB General Managers Planning and Funding, and to Communication Managers.

I am confident that we will see further improvements in performance across the full target set as the year progresses.

Yours sincerely

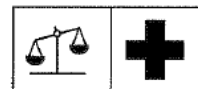


Kevin Woods
Director-General of Health

cc: Jenny Black, Chair, Nelson Marlborough District Health Board

APPENDIX 3 – DISTRICT IMMUNISATION FACILITATION SERVICES

District Immunisation Facilitation Services (DIFS)



Status	Volume	Contract Quality and Risk		
		Budget	Activity	Satisfaction
NEW STAFF 2011	NA	✓	✓	✓

Purpose

To establish and maintain effective and collaborative working relationships with all service providers with an interest in immunisation and Well Child/Tamariki Ora activities, to reduce duplication, enhance effectiveness of services, and achieve the maximum benefit within allocated resources.

Objectives

- To provide up-to-date, accurate information to providers and the public about vaccines;
- To ensure integrity of the cold-chain, through effective monitoring and audit;
- To assist providers to develop their recall systems and immunisation quality plans;
- To collaborate with Well Child/Tamariki Ora providers;
- To assist with National Standard setting and consistency of implementation;
- To support educators and immunisation outreach services;
- To assist in workforce development especially for services that focus on improving access for disadvantaged populations (specifically Māori and Pasifika providers);
- To proactively and reactively deal with the media through an effective communication strategy.

Model

NBPH is the contract lead for this collaborative partnership between Nelson Marlborough District Health Board (NMDHB) Public Health Service (PHS) and Kimi Hauora Wairau Marlborough PHO (KHWMPHO). Immunisation service providers maintain effective and efficient linkages with DHB and primary care services; key to this is face to face contact by immunisation facilitators with medical practitioners and practice nurses. Facilitators also maintain effective linkages with other DHB immunisation services (in particular NIR administrators, NMDHB PHS, Planning & Funding, Medical Officers of Health and Outreach Immunisation Services); regional immunisation advisors (currently employed by the Immunisation Advisory Centre (IMAC) and other agencies or providers as appropriate.

The Immunisation Partnership Group, in conjunction with other providers, has a strategic plan for increasing immunisation coverage in the DHB region as well as sharing of information, training/education, communication, and other areas of common interest where health gains can best be achieved through collaboration or cooperation.

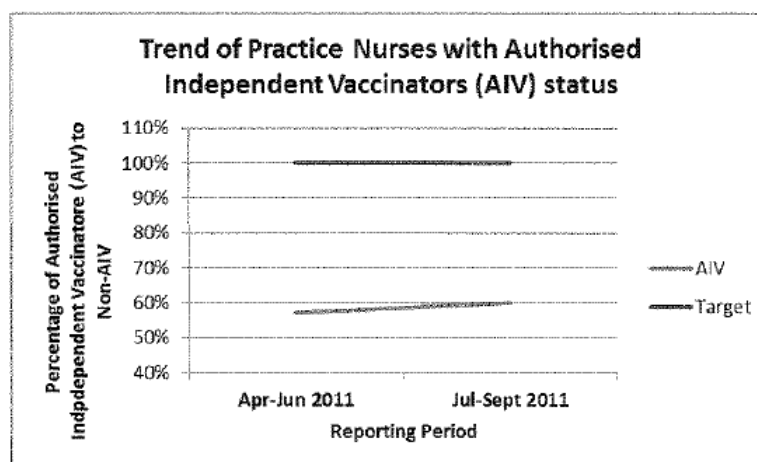
Eligibility Criteria

- The population catchment of Nelson Bays Primary Health – eligible and enrolled.

Activity

- All activities are underpinned by the Annual Immunisation Facilitation Plan and associated Communication and Health Promotion Plans, which have been ratified (February 2011) by the Immunisation Partnership Group made up of representation from Nelson Bays Primary Health, Kimi Hauora Wairau Marlborough PHO and NMDHB Public Health Service.
- Immunisation Partnership Group (IPG) meetings continue to be led by NBPH and are scheduled monthly. The IPG July meeting was cancelled due to the unavailability of key members. All partners were represented at the August meeting.
- A combined IPG and NMDHB Immunisation Leadership Group (ILG) meeting is scheduled in each quarter and held at NBPH. The last combined meeting, held on 8th September 2011, was well attended.

- NBPH has liaised with NMDHB Immunisation contract holders for HPV and NIR to look at improved facilitation of those services and more collaborative activities that reduce replication of practice support services.
- Meetings with NIR representatives are scheduled bi-monthly; the last meeting held on 10 August 2011.
- HPV promotion was supported, in conjunction with an HPV Outreach Immunisation Service event, at the NMIT Health Promotion Day.
- Influenza Technical Advisory Group meetings attended bi-monthly; last meeting was held on 21 September 2011. Promotion of influenza vaccination has been wound down and discussions have commenced around strategies for next year.
- Offers to speak publicly about influenza vaccinations have been taken up by one community based organisation.
- Well Child meetings attended six weekly; following agreement at last Well Child meeting, meetings will now be bi-monthly.
- Engagement with midwives at Midwifery Forum held at NMDHB. Promotion of immunisation via open discussion after presentation by Community Paediatrician on Immunisation.
- The quarterly format for the Immunisation Special Interest Group meetings continues with 20 promoters and providers of immunisation attending the August meeting. Each meeting identifies a focus topic and is accompanied by general discussion about matters relating to immunisation. The Immunisation Facilitator provides support to link vaccinators with Vaccinator Training Courses and Updates, locally and in other parts of NZ. Requests for clinical competency assessments continue.
- Continued updating of information on Authorised Independent Vaccinator (AIV) register. NBPH has set a target of 100% of Practice Nurses with AIV status; this target will be a focus in the next quarter.



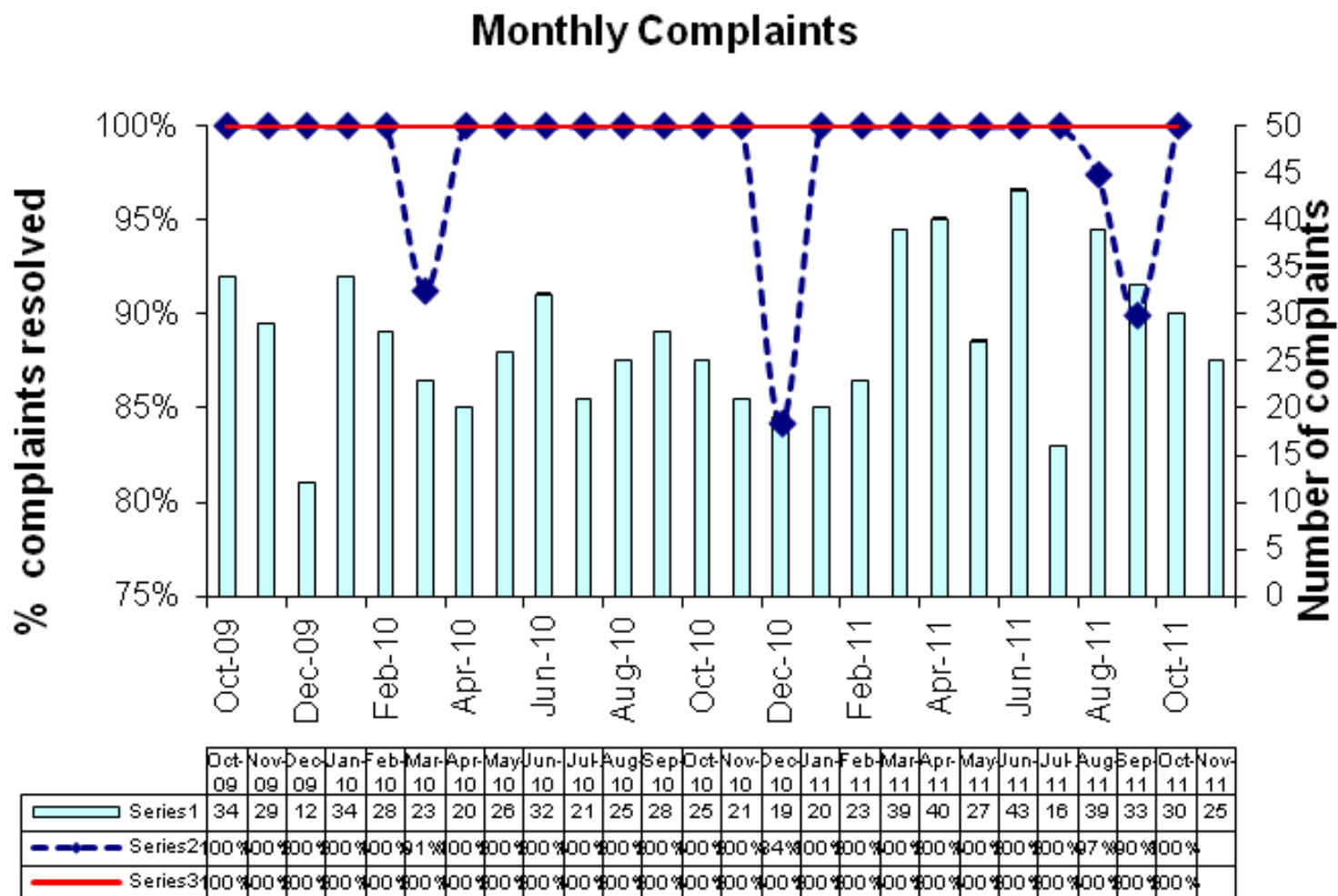
- Cold Chain accreditation continues for practices that are due. Standards have been maintained through 6 monthly temperature logging, education to new practice nurses, support during cold chain failures and reporting of adverse events.
- Visits to practice to discuss Cold Chain Accreditation, Clinical workplace assessments, Recall strategies, OIS referrals of non-responders, NIR support, improving immunisations rates and barriers to immunisation, dissemination of 2011 Handbook, updated "Management of Tetanus prone wounds", pre/post splenectomy guidelines, Hepatitis B pamphlet on risks of Hepatitis B and benefits of immunisation in NZ targeted for migrants from the UK and other countries.
- The Hepatitis B immunisation catch-up programme continues for Burmese refugee people aged between 16-37 years, in the three practices with refugee populations in the Nelson area.
- Review and follow-up of children aged 18-21 months in general practice who are not fully immunised to ascertain reasons why and act on information.
- Strong linkages continue with the Medical Officer of Health to provide clinical overview of immunisation services.

- Monthly Newsletter ImmPHO has been re-activated in September and has been distributed to general practices and the wider health community.
- Monthly article for local newspaper promoting immunisation has commenced. The September article on Pertussis featured in the Leader.
- Immunisation Facilitator attended annual IMAC workshop and conference in Rotorua.
- Medtech e-Learning training sought in September with view to running workshops for practice nurses/managers to learn and apply aspects of the Medtech immunisation module in an effort to reduce data entry issues. Still awaiting course access and content (received 6 October 2011).
- A working group (NMDHB and NBPH) continues to look at Triple Enrolment as a mechanism of engaging babies into general practice as early as possible, to meet the NMDHB target of enrolment by 4 weeks and improve timeliness of immunisations.

Māori Health Activities

- Follow up of Māori children enrolled in general practice that are not age appropriately immunised as identified through the PPP.
- Liaison with OIS to follow up on Māori children that are overdue vaccinations.
- Linkage with the Well Child Tamariki Ora, Te Korowai and Te Amo representatives.
- Liaising with Kaiatawhai Whānau Ora Workers to support whānau that are not age appropriately immunised.

APPENDIX 4 – COMPLAINTS REPORT OCTOBER 2011



APPENDIX 5 – MECA & COLLECTIVE AGREEMENT UPDATES**NATIONAL MULTI EMPLOYER COLLECTIVE AGREEMENT (MECA) UPDATE**

MECA & UNION	COVERAGE	UPDATE
Associated Salaried Medical Specialists (ASMS)	132 employees	The parties have agreed a settlement; ASMS Executive and Conference recommended the settlement to members, a postal ratification process is underway, the outcome should be known by 22 December.
Clinical Physiology (APEX)	7 employees	The hearing in the Employment Relations Authority scheduled for the 29 th November on the Unions application for facilitation was deferred by agreement to allow further negotiation around a revised DHB offer. The hearing has been rescheduled for the 17 th January however it is possible a settlement may be reached prior to this date.
Medical Radiation Technologists (MRT) (APEX)	47 employees	The Union initiated bargaining on 4 August. They have initiated to continue a national MRT MECA but have separated Sonographers out for a National MECA. An Interest Based Bargaining approach to these negotiations has been completed and an offer is pending from the DHBs. A separate MECA for Sonographers was agreed by the Chief Executives on the 28 th November and negotiations for this group will commence shortly.
Nurses & Midwives MECA (NZNO)	894 employees	NZNO membership did not ratify the Managed Bargaining offer. Subsequently an Interest Based Bargaining approach was agreed between the parties and is underway.
Public Service Association National MECA	Mental Health & Public Health Nurses (174 employees) Allied Health (270 employees) Clerical (212 employees)	PSA membership did ratify the original Managed Bargaining offer. However given other Unions in Managed Bargaining did not negotiation has continued specifically with the PSA. An offer in line with the original managed bargaining settlement has been agreed between the parties. A postal ballot of PSA members as to whether they will accept the offer has been conducted and the outcome should be known during the week of 12 December.
Midwives (MERAS)	48 employees	MERAS have indicated they wish to await the outcome of DHBs negotiations with NZNO prior to recommencing bargaining.
6 NMDHB Single Employer Collective Agreements	476 employees	These agreements were part of the original Managed Bargaining process. They have accepted an offer in line with the original managed bargaining offer and are currently undertaking a ratification process with their members.

NMDHB & REGIONAL COLLECTIVE AGREEMENT (CEA) UPDATE

CEA & UNION	COVERAGE	UPDATE
Clerical (NUPE)	3 employees	An offer has been made to the Union. We await their response.

SECTION 5: FOR INFORMATION**Guidance for New Zealand emergency departments regarding the interface with primary health care**

June 2011

Overview

This paper is intended as a guide for the providers of New Zealand's hospital emergency department (ED) services for how they should relate to the primary health care sector, with particular reference to the Shorter Stays in ED Health Target.

The paper was developed by the Ministry of Health's Shorter Stays in ED team with input from the Primary Health Care Implementation team. Initial consultation on the paper was sought from the Ministry's ED Services Advisory Group, the Australasian College for Emergency Medicine and the Royal New Zealand College of General Practitioners. This was followed by wider consultation with the sector.

The key guiding principles of the paper are:

- Primary health care is the principal provider of both routine and urgent health care to the New Zealand population, providing continuity and coordination of health care for individuals. EDs provide episodic 'crisis' care for people who perceive the need for acute or urgent care, including hospital admission.
- While there can be overlap in those individuals who might initially present to primary health care or ED, EDs provide emergency medical care and not ongoing primary health care. As such, all attendances to ED should be regarded as a significant health event and all urgent health care should be provided within the framework that the patient will, as much as possible, receive their ongoing care from primary health care.
- Appropriate clinical information on any ED attendance should be provided promptly to patients' usual primary health care provider. This will enable the primary health care provider to follow-up with the patient as required and emphasises that ED care is the management of a 'crisis' in the context of continuing care being provided by primary health care. A strong interface, including electronic links, between EDs and primary health care will facilitate the prompt and reliable sharing of patient information to ensure best patient care is provided.
- The process of triage in ED is designed and validated as an acuity tool. Triage does not accurately determine the appropriateness of a patient's condition for presentation at either the ED or primary health care. Therefore, patients should not be 'triaged away' from the ED. However, further assessment over and above triage, may allow referral to primary health care if best suited to meet the patient's needs.
- Overall the relationship between primary health care and ED should be of two distinct services which refer to each other where and when appropriate. In the same way as primary health care will refer a patient to any other hospital speciality, it will refer to the ED patients who require the expertise of the emergency medicine speciality or the facilities available at the local ED. In return, just as an ED will refer a patient with a perceived cardiac problem to a cardiology service, so will it refer a patient to primary health care if, after adequate assessment, it is clear that the ongoing management of their condition can best be provided by primary health care.

Guidance Statements

1. **Defining the roles and relationship between ED and primary health care**
 - 1.1 Primary health care services are the principal providers of both routine and urgent health care to the New Zealand population.
 - 1.2 Primary health care services offer individuals both continuity and coordination of care with the various other health care providers who might episodically manage their particular health needs.
 - 1.3 Enrolment with a primary health organisation (PHO) through a primary health care provider, and ongoing management of an individual's routine and urgent health needs by that provider, should be encouraged.

- 1.4 There are urgent health care needs that can be attended to in primary health care. However, the capability and capacity to care for urgent needs in primary health care, particularly after-hours, varies from place to place.
 - 1.5 EDs provide episodic 'crisis' care for individuals who perceive the need for acute or urgent care, including hospital admission.
 - 1.6 Although there can be overlap in the individuals who present to each service, primary health care and EDs see different populations of patients and provide different care with a different skill mix and focus.
 - 1.7 District Health Boards (DHBs), EDs and primary health care should work together to ensure that their populations are informed about the differences between primary health care and ED care, the services that are available 24/7 and when to access each service.
- 2. Referring patients from ED to primary health care for ongoing care**
- 2.1 All urgent health care should be provided within the framework that the patient will, as much as possible, receive their ongoing care from their primary health care provider.
 - 2.2 EDs have relationships with other health professionals, which often include processes for the referral of patients. When the ED phase of care is completed and it is evident that the patient would be better served by continuing care under another service, the patient is transferred to that service after communication between ED staff and the staff of the other service. EDs should consider primary health care in a similar way so that the referral to primary health care is undertaken when it is evident that care would be better continued there.
 - 2.3 In referring patients back to primary health care for ongoing care, EDs should be clear what the expectation is of primary health care. Good communication and relationships between ED and primary health care should support this and help to bridge the potential separation in time and distance between ED referral and continuing care in primary health care.
 - 2.4 The extent of ED care prior to referral to primary health care will vary, but the guiding principles should be that sufficient assessment/care is undertaken so that ED staff are satisfied that the patient is clinically:
 - safe (a need for alternative or more urgent care does not appear to be needed);
 - comfortable (distressing symptoms are addressed); and
 - appropriate (sufficient diagnostic work-up has been done so that there is reasonable certainty that primary health care is best suited to continue the patient's management).
- 3. Connecting all patients back to primary health care following an ED attendance**
- 3.1 Regardless of whether there is a direct need for ongoing care following an ED presentation, appropriate clinical information about the event should be provided promptly to the patient's usual primary health care provider (preferably electronically). The primary health care provider can then determine what level of follow-up is required. The intention is to emphasise that the ED care was management of a 'crisis', either real or perceived, in the context of continuing care being provided by primary health care.
 - 3.2 DHBs should consider improving the interface between EDs and primary health care services, particularly through electronic links, to facilitate the prompt and reliable sharing of patient information.
- 4. Identifying and referring patients for whom primary health care is better suited to meet their needs**
- 4.1 Individuals usually present to the ED because they believe that they require hospital-level care.
 - 4.2 Cost, timeliness of access, location and the ability to enrol with a provider, can be barriers to accessing primary health care which can lead individuals to present to ED as an alternative.
 - 4.3 The process of triage in ED, using the Australasian Triage Scale, has been designed and validated as an acuity tool. That is, triage determines the degree of urgency for care; it does not accurately determine the appropriateness of a patient's condition for presentation at either the ED or primary health care. Therefore, patients should not be 'triaged away' from the ED and individuals should not be denied ED care.
 - 4.4 However, referral to primary health care may occur if further clinical assessment determines that primary health care is better suited to meet the patient's needs. This clinical assessment must be over and above the usual triage process and should ensure that the criteria in paragraph 2.4 are met. In addition, referral to primary health care in this context must:
 - be facilitatory and not against the patient's wishes (ED care should not be denied);

- be based on a high level of comfort from the assessing clinician that referral is best for the patient (the assessing clinician must not feel any institutional pressure to 'refer' patients to primary health care and must be protected from any undue risk associated with the referral of patients); and
 - occur in the context of a responsive primary health care service (the patient must be able to be seen in primary health care in an appropriate timeframe for their condition).
- 4.5 For most DHBs it is hospital processes and the ability to admit patients to wards that are the significant contributors to ED overcrowding and increased length of stay, rather than patients who could be served in primary health care. Therefore, implementation of this referral process should be seen as a long-term strategy to reset the expectations and understanding of the public about the respective roles and skills of both ED and primary health care, rather than as a short-term activity to improve performance against the Shorter Stays in ED health target.
- 5. Improving access to acute hospital services**
- 5.1 Emergency medicine adds value to the care of a great many patients. However, there are some patients for whom it does not, for example: patients who are clinically stable, who do not require further urgent treatment or investigations, who have had any distressing symptoms addressed and for whom the need for admission to an in-patient speciality unit has been determined by a primary health care provider (or an ED clinician).
- 5.2 DHBs should endeavour to have systems which allow the timely movement of such patients to the in-patient speciality unit, without the need for undue time or duplication of clinical assessment in the ED. This may include the use of in-patient speciality admissions units, such as Medical Admissions and Planning Units, or direct admission protocols.
- 5.3 The development of alternative pathways through which patients can access acute services, such as access to diagnostics in the community and to 'acute' specialist outpatient clinics, may be an important contributor to managing acute demand.
- 5.4 Opportunities to reduce acute demand are likely to be found in improving the management of long term diseases and the delivery of health care and support services to the elderly.

Further advice

Further advice on the guidance contained in this paper can be obtained by contacting the Ministry of Health's Shorter Stays in ED team: emergencydepartments@moh.govt.nz

SECTION 6: MEMBERS' ISSUES

Nil

GLOSSARY OF COMMONLY USED ACRONYMS, ABBREVIATIONS AND MAORI TRANSLATION

ABC	Ask about their smoking status; brief advice to quit; cessation
A4HC	Action for Healthy Children
A&D / AOD	Alcohol and Drug / Alcohol and Other Drugs
ACC	Accident Compensation Corporation
ACNM -	Associate Charge Nurse Manager
ACU	Ambulatory Care Unit
AE	Alternative Education
AEP	Accredited Employer Programme
AIR	Agreed Information Repository
ALOS	Average Length of Stay
AOD	Alcohol and Drug
AOHS	Adolescent Oral Health Services
AP	Annual Plan with Statement of Intent
ARC	Aged Residential Care
ARF	Audit Risk and Finance
ARCC	Aged Residential Care Contract
ASD	Autism Spectrum Disorder
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment & Rehabilitation
BSCQ	Balanced Score Card Quadrant
BA	Business Analyst
BCTI	Buyer Created Tax Invoice
BFCI	Breast Feeding Community Initiative
BFCI	Baby Friendly Community Initiative
BS	Business Support
BSI	Blood Stream Infection
BSMC	Better, Sooner, More Convenient
CAMHS	Child and Adolescent Mental Health Services
CBAC	Community Based Assessment Centres
CBF	Capitation Based Funding
CE (CEO)	Chief Executive (Chief Executive Officer)
CEA	Collective Employee Agreement
CDHB	Canterbury District Health Board
CCDHB	Capital & Coast District Health Board (also called C & C)
CCDP	Care Capacity Demand Planning
CCF	Chronic Conditions Framework
CCT	Continuing Care Team
CCU	Coronary Care Unit
CDEM	Civil Defence Emergency Management
CDHB	Canterbury District Health Board
CDM	Chronic Disease Management
CEG	Coordinating Executive Group (for emergency management)
CeTas	Central Technical Advisory Support
CFA	Crown Funding Agreement <u>or</u> Crown Funding Agency
CFO	Chief Financial Officer
CHFA	Crown Health Financing Agency
CHS	Community Health Services
CIMS	Coordinated Incident Management System
CIO	Chief Information Officer
CME	Continuing Medical Education
CMI	Chronic Medical Illness
CMS	Contract Management System

CNM	Charge Nurse Manager
Concerto	IT system which provides clinician's interface to systems
COO	Chief Operating Officer
COPMI	Children of Parents with Mental Illness
CPHAC	Community and Public Health Advisory Committee
CPIP	Community Pharmacy Intervention Project
CPNE	Continuing Practice Nurse Education
CPO	Controlled Purchase Operations
CPU	Critical Purchase Units
CRISP	Central Region Information Systems Plan
CSR	Contract Status Report
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CTC	Contributions to Cost
CTANAG	Clinical Training Agency Nursing Advisory Group
CTU	Combined Trade Unions
CVD	Cardiovascular Disease
CVDRA	Cardiovascular/Diabetes Risk Assessment
CWD	Case Weighted Discharge
CYAERG	Child Youth Advisory & Expert Reference Group.
CYF	Child, Youth and Family
CYFS	Child, Youth and Family Service
DAP	District Annual Plan
DAR	Diabetes Annual Review
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DHBRF	District Health Boards Research Fund
DIFS	District Immunisation Facilitation Services
DiSAC	Disability Support Advisory Committee
DGH	Director General of Health
DMH	Director of Maori Health
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSP	District Strategic Plan
DSS	Disability Support Services
DWCSP	District Wide Clinical Services Plan
EAP	Employee Assistance Programme
EBID	Earnings Before Interest & Depreciation
ECWD	Equivalent Case Weighted Discharge
ED	Emergency Department
EDA	Economic Development Agency
EFI	Energy For Industry
ELT	Executive Leadership Team
EMPG	Emergency Management Planning Group
ENT	Ears, Nose and Throat
EOI	Expression of Interest
EQP	Earthquake Prone Building Policy
ESA	Electronic Special Authority
ESOL	English Speakers of Other Languages
ESPI	Elective Services Patient Flow Indicators
ESR	Environmental Science & Research
ESU	Enrolled Service Unit
EVIDEM	Evidence and Value: Impact on Decision Making
FF&E	Furniture, Fixtures and Equipment
FFT	Future Funding Track

FMIS	Financial Management Information System
FOMHT	Friends of Motueka Hospital Trust
FOUND	Found Directory is an up-to-date listing of community groups and organisations in Nelson/Tasman
FRC	Fee Review Committee
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
FVIP	Family Violence Intervention Programme
GM	General Manager
GMS	General Medical Subsidy
GP	General Practitioner
GRx	Green Prescription
HAC	Hospital Advisory Committee
HBI	Hospital Benchmarking Information
HBSS	Home Based Support Services
HBT	Home Based Treatment
H&DC / HDC	Health and Disability Commissioner
HDSP	Health & Disability Services Plan Programme
HDU	High Dependency Unit
HEA	Health Education Assessments
He Kawenata	Covenant, agreement, treaty, testament (PM Ryan Maori Dictionary pg 104)
HEeADSSS	Psychosocial tool – Home, Education, eating, Activities, Drugs and Alcohol, Sexuality, Suicidality (mood), Safety
HEHA	Healthy Eating Healthy Action
HEP	Hospital Emergency Plan
HESDJ	Ministries of Health, Education, Social Development, Justice
HFA	Health Funding Authority
HHS	Hospital and Health Services
HIA	Health Impact Assessment
HM	Household Management
HMS	Health Management System
HODs	Heads of Department
HOP	Health of Older People
HP	Health Promotion
HPI	Health Practitioner Index
HPV	Human Papilloma Virus
HR	Human Resources
HR & OD	Human Resources and Organisational Development
IANZ	International Accreditation New Zealand
IBA	Information Builders of Australia
IDF	Inter District Flow
IDSS	Intellectual Disability Support Services
IFRS	International Financial Reporting Standards
IHB	Iwi Health Board
IM	Information Management
InterRAI	Inter Residential Assessment Instrument
IPAC	Independent Practitioner Association Council
IPC	Intensive Patient Care
IPC Units	Intensive Psychiatric Care Units
IPG	Immunisation Partnership Group
IPU	In-Patient Unit
IS	Information Systems
ISSP	Information Services Strategic Plan

IT	Information Technology
JAMHWSAP	Joint Action Maori Health & Wellness Strategic Action Plan
JOG	Joint Oversight Group
KIM	Knowledge and Information Management
Kotahitanga	Unity, accord, coalition, solidarity (PM Ryan Maori Dictionary pg 127)
KPI	Key Performance Indicator
KHW	Kimi Hauora Wairau (Marlborough PHO)
LA	Local Authority
LCN	Local Cancer Network
LIS	Laboratory Information Systems
LOS	Length of Stay
LSCS	Lower Segment Caesarean Section
LTC	Long Term Care
LTCCP	Long Term Council Community Plan
LTO	Licence to Occupy
LTS-CHC	Long Term Supports – Chronic Health Condition
LTSFSG	Long Term Service Framework Steering Group
Manaakitanga	Goodwill, show respect, or kindness to ((PM Ryan Maori Dictionary pg 172)
Manawhenua	Power, prestige, authority over land (HW Williams Maori Dictionary pg 172)
Manawhenua O Te	Tau Ihu O Te Waka A Maui – Referring to the eight iwi who hold tribal authority over the top of the South Island (no reference)
MHDSF	Maori Health and Disability Strategy Framework
MHFS	Maori Health Foundation Strategy
MPDS	Maori Provider Development Scheme
MA	Medical Advisor
MCT	Mobile Community Team
MDC	Marlborough District Council
MDO	Maori Development Organisation
MDS	Maori Development Service
MDT	Multi Disciplinary Team
MECA	Multi Employer Collective Agreement
MHAU	Mental Health Admission Unit
MHC	Mental Health Commissioner
MHD	Maori Health Directorate
MHINC	Mental Health Information Network Collection
MHWSF	Maori Health and Wellness Strategic Framework
MOH	Ministry of Health
MOH	Medical Officer of Health
MOA	Memorandum of Agreement
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding
MOW	Meals on Wheels
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Technologist (or Technician)
MSD	Ministry of Social Development
NPA	Nutrition and Physical Activity
NRAHDD	Nelson Region After Hours & Duty Doctor Limited
NRT	Nicotine Replacement Therapy
MRSA	Methicillin Resistant Staphylococcus Aureus
NHBIT	National Health Board IT
NASC	Needs Assessment Service Coordination
NBPH	Nelson Bays Primary Health
NCC	National Capital Committee

NCC	Nelson City Council
NCSP	National Cervical Screening Programme
NETP	Nursing Entry to Practice
NGO	Non Government Organisation
NHCC	National Health Coordination Centre
NHI	National Health Index
NIR	National Immunisation Register
NMDHB	Nelson Marlborough District Health Board
NMDS	National Minimum Dataset
NMIT	Nelson Marlborough Institute of Technology
NPA	Nutrition and Physical Activity (Programme)
NPV	Net Present Value
NRAHDD	Nelson Regional After Hours and Duty Doctor Ltd
NSU	National Screening Unit
NTOS	National Terms of Settlement
NZHIS	NZ Health Information Services
NZMA	New Zealand Medical Association
NZNO	NZ Nurses Organisation
NZPH&D Act	NZ Public Health and Disability Act 2000
OAG	Office of the Auditor General
OIA	Official Information Act
OIS	Outreach Immunisation Services
OPD	Outpatient Department
OPF	Operational Policy Framework
OPJ	Optimising the Patient Journey
OSH	Occupational Health and Safety
OT	Occupational Therapy
PACS	Picture Archiving Computer System
PAS	Patient Administration System
P&F	Planning and Funding
PANT	Physical Activity and Nutrition Team
PBF(F)	Population Based Funding (Formula)
PC	Personal Cares
P&C	Primary & Community
PCI	Percutaneous Coronary Intervention
PCO	Primary Care Organisation
PCT	Pharmaceutical Cancer Treatments
PDR	Performance Development Review
PDRP	Professional Development and Recognition Programme
PDSA	Plan, Do, Study, Act
PFG	Performance Framework Group (formerly known as Services Framework Group)
PHS	Public Health Service
PHCS	Primary Health Care Strategy
PHI	Public Health Intelligence
PHO	Primary Health Organisation
PHOA	PHO Alliance
PHONZ	PHO New Zealand
PHS	Public Health Service
PHU	Public Health Unit
PIA	Performance Improvement Actions
PN	Practice Nurse
PPP	PHO Performance Programme
PSAAP	PHO Service Agreement Amendment Protocol
PT	Patient

PTAC	Pharmacology and Therapeutics Committee
PRIMHD	Project for the Integration of Mental Health Data
PVS	Price Volume Schedule
QA	Quality Assurance
QHNZ	Quality Health NZ
QIC	Quality Improvement Council
QIPPS	Quality Improvement Programme Planning System
Rangatiratanga	Autonomy, evidence of greatness (HW Williams Maori Dictionary pg 323)
RDA	Resident Doctors Association
RDA	Riding for Disabled
RIF	Rural Innovation Fund
RFI	Request for Information
RFP	Request for Proposal
RICF	Reducing Inequalities Contingency Funding
RM	Registered Midwife
RMO	Resident Medical Officer
RN	Registered Nurse
ROI	Registration of Interest
RSE	Recognised Seasonal Employer
RSL	Research and Sabbatical Leave
SAN	Storage Area Network
SCBU	Special Care Baby Unit
SCN	Southern Cancer Network
SDB	Special Dental Benefit Services
SHSOP	Specialist Health Services for Older People
SIA	Services to Improve Access
SICF	South Island Chairs Forum
SICSP	South Island Clinical Services Plan
SI HSP	South Island Health Services Plan
SIRCC	South Island Regional Capital Committee
SISSAL	South Island Shared Service Agency
SLH	SouthLink Health
SLT	Strategic Leadership Team
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SOI	Statement of Intent
SOPD	Surgical Outpatients Department
SOPH	School of Population Health
TDC	Tasman District Council
TLA	Territorial Local Authority
TOW	Treaty of Waitangi
TOR	Terms of Reference
TRTT	Te Roopu Tupu Tahī
UG	User Group
VLCA	Very Low Cost Access
VRA	Vascular Risk Assessment
WAM	Wairau Accident & Medical Trust
WAVE (Project)	Working to Add Value through E-Information
WEII	Whanau Engagement, Innovation and Integration
WIP	Work in Progress
YTD	Year to Date
YTS	Youth Transition Service

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