

NOTICE OF MEETING

OPEN MEETING

**A meeting of the Board Members of
Nelson Marlborough District Health Board
held on Tuesday 9 November 2010 at
9.45 am**

**Support Services Meeting Room 1
Wairau Hospital
Blenheim**

**BOARD MEETING AGENDA**

Nelson Marlborough District Health Board
 Support Services Meeting Room 1, Wairau Hospital, Blenheim
 Tuesday, 9 November 2010 commencing 9.45 am

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Lunch		12.30 pm – 1.00 pm	
Visit Stage 3 of Wairau Hospital		1.00 – 1.30 pm	
PUBLIC EXCLUDED MEETING		1.30 pm	
Resolution to exclude public			

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 28 September 2010 (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)**
 - **Golden Bay Provision of Health Services - To protect information that is subject to negotiation (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)**

SECTION 1: WELCOME, KARAKIA AND APOLOGIES

SECTION 2: REGISTRATIONS OF INTEREST**Board Members**

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
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. 	
Liz Richards	<ul style="list-style-type: none"> ▪ Chair of the Upper South A Regional Ethics Committee 	<ul style="list-style-type: none"> ▪ Member of Nelson Labour Electorate Committee. ▪ Appointed as Trustee Tasman Bay Heritage Trust. 	<ul style="list-style-type: none"> ▪ Health Research. 	
Lynette Jones	<ul style="list-style-type: none"> ▪ Convenor of "Friends of Marlborough Hospice" ▪ Patron of Marlborough Red Cross. 			
Sharon Brinsdon	<ul style="list-style-type: none"> ▪ Financial interest in husband's GP practice ▪ Husband is employed one-tenth at Nelson Hospital (Eye Department) ▪ Financial interest through husband's shareholding in Nelson Medical Limited (1/6 share) which owns the Health @132 medical centre ▪ Financial interest through husband's shareholding in different companies undertaking medical developments in Collingwood St, Nelson (1/60 share) and Queen Street, Richmond (1/10 share). 		<ul style="list-style-type: none"> ▪ The provision of health and disability services in the Nelson-Marlborough District. 	<ul style="list-style-type: none"> ▪ Husband is a member of executive of Southlink Health (IPA) ▪ Sister is staff nurse at Wairau Hospital. (A&E OPD).

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Suzanne Win	<ul style="list-style-type: none"> ▪ Director of Split Ridge Associates Ltd that provides consultancy services to health & disability organisations ▪ Trustee of Gracelands Group ▪ Member of DHBNZ Chairs Executive with lead responsibility for workforce and participant on Tripartite Forum ▪ Partner is a part-time employee of NMDHB Provider Division. 		<ul style="list-style-type: none"> ▪ Provision of consultancy services to health and disability organisations for DHBs or Ministry of Health. 	Partner is <ul style="list-style-type: none"> ▪ Member on PHO Alliance Executive ▪ Chair of West Coast PHO ▪ Contracted to MOH to coordinate the implementation of the Cardiac Network ▪ Chair of the Board of Access Home Health Ltd ▪ Director on Management Board of Jack Inglis Friendship Hospital.
Ian MacLennan	<ul style="list-style-type: none"> ▪ Treasurer of Nelson Centre of the Cancer Society of NZ. 			<ul style="list-style-type: none"> ▪ Accommodation for the Cancer Society.
Jennifer Black	<ul style="list-style-type: none"> ▪ Life member of Diabetes NZ. 			
Graeme Faulkner	<ul style="list-style-type: none"> ▪ Provision of rental premises to DHB clinic ▪ Employee of medical practice. 		<ul style="list-style-type: none"> ▪ District Nurse clinics ▪ Picton Medical Centre a contracted GP service. 	<ul style="list-style-type: none"> ▪ Negotiating DHB contracts for practice.
Judi Billens	<ul style="list-style-type: none"> ▪ Board Member Age Concern ▪ Member Barnardos Advocacy for Children & Young People ▪ NZ Pelim Practitioners Nelson (Kaumatua) ▪ NM Iwi Health Board ▪ Healthcare New Zealand Advisory Committee Member ▪ Committee Member of St John Nelson Bays Area ▪ CYFS Care and Protection Group. 	<ul style="list-style-type: none"> ▪ Member Ngāti Tama Iwi Trust Board ▪ Board of Governance Te Rito Family Violence ▪ Shareholder and owner in Wakatu Inc. 		
Joe Puketapu	<ul style="list-style-type: none"> ▪ Member IHB Executive Committee ▪ Chair IHB ▪ Chairperson Waikawa Marae Committee ▪ Employee, Te Hauora O Ngati Rarua Ltd ▪ Chair of Kimi Hauora Wairau PHO Board. 	<ul style="list-style-type: none"> ▪ Trustee Te Atiawa Manawhenua Trust ▪ Former Director Tainui Taranaki Ki Te Tau Ihu. 	<ul style="list-style-type: none"> ▪ Health Services 	

1 November 2010

REGISTRATIONS OF INTEREST – NMDHB EXECUTIVE LEADERSHIP TEAM (ELT) MEMBERS

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
MEDICAL SURGICAL SERVICES DIRECTORATE					
	Dr Bruce King	<ul style="list-style-type: none"> Private practice and interactions. 			
	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	To be advised.			
MENTAL HEALTH SERVICES DIRECTORATE					
	Dr Heather McPherson	Nil			
	Dr Jocy Wood	To be advised.			
	Robyn Byers	Nil			
COMMUNITY BASED SERVICES DIRECTORATE					
	Dr Nick Baker	To be advised.			
	Dr Bev Nichol	To be advised.			
	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	To be advised.			
	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 Jeremy Stevens	To be advised.			
	Dr Ros Gellatley	To be advised.			
	Carey Virtue	To be advised.			
CORPORATE SUPPORT					
	Nick Lanigan	Nil			
	Denise Hutchins	Nil		<ul style="list-style-type: none"> Certification/Accreditation. 	

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
	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. 		
SERVICE DELIVERY					
DONM	Robyn Henderson	Nil			
CMO	Heather McPherson (Acting CMO)	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 ▪ Trustee Churchill 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 health services at Wairau Hospital ▪ MIS Ltd previously provided consultant services to other DHBs. 	
	Keith Rusholme	<ul style="list-style-type: none"> ▪ Wife provides first aid training and complimentary health 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	Nil			

As at 1 November 2010

SECTION 3: MINUTES

MINUTES OF A PUBLIC MEETING OF BOARD MEMBERS OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD HELD AT THE DHB SEMINAR CENTRE ROOM 1, BRAEMAR CAMPUS, NELSON ON TUESDAY 28 SEPTEMBER 2010 AT 11.00AM

Present:

Suzanne Win (Chair), Judi Billens, Lynette Jones, Graeme Faulkner, Ian MacLennan, Jenny Black, John Moore, Liz Richards, Sharon Brinsdon and Judy Crowe

Apologies:

Joe Puketapu

In Attendance:

John Peters (CE), Mike Cummins, Harold Wereta, Sharon Kletchko and Katherine Rock

Karakia:

Harold Wereta

SECTION 1: APOLOGIES

Joe Puketapu

Moved: Sharon Brinsdon

Seconded: Liz Richards

RECOMMENDATION:

THAT THE APOLOGIES BE ACCEPTED.

AGREED

SECTION 2: REGISTRATIONS OF INTEREST

Moved: Judy Crowe

Seconded: Lynette Jones

RECOMMENDATION:

THAT THE REGISTRATIONS OF INTEREST BE NOTED.

AGREED

SECTION 3: MINUTES OF PREVIOUS MEETING**Minutes of Board Meeting 17 August 2010**

Moved: John Moore
Seconded: Jenny Black

RECOMMENDATION:
THE MINUTES OF MEETING 17 AUGUST 2010 BE ADOPTED AS A TRUE AND CORRECT RECORD.

AGREED

Matters Arising

- The changes to the balanced scorecard/strategy map were outlined. Members noted this will be used to monitor progress of performance. Revised measures to be provided for next meeting.

Correspondence

Moved: Jenny Black
Seconded: Sharon Brinsdon

RECOMMENDATION:
THAT THE CORRESPONDENCE BE RECEIVED.

AGREED

SECTION 4: REPORTS**4.1 Chair's Report**

The Chair noted the response by NMDHB staff assisting following the Christchurch earthquake. Members were briefed on current industrial relations, DHB elections, Advisory Committee appointments, Wairau Project Steering Group representative and the strengthening relationships with IHB.

Moved: Suzanne Win
Seconded: Ian MacLennan

RECOMMENDATION:
THAT THE BOARD CHAIR'S REPORT BE RECEIVED.

AGREED

4.2 Chief Executive's Report

(i) GENERAL

The report was taken as read.

Updates were given on the continuing strikes by MRT staff, discussions with RMOs and Golden Bay. This included the recent agreement with the Minister of Health over keeping open the Joan Whiting Memorial Trust rest home at Collingwood while the IFHC is put in place. It was noted that the DHB had been working with the Golden Bay community since 2005. Members thanked staff involved and asked that a letter of thanks be sent to the Minister.

Members were briefed on a recent meeting of primary and secondary clinicians as part of the Nelson Marlborough Health Alliance (NMHA). This is centred around clinical pathways and plans to use the tools developed in the Canterbury Initiative for local solutions.

(ii) FOR DECISION

(a) Welsh Charity Trust

(Judy Crowe noted her conflict of interest as Chair of NMHCT)

Moved: Liz Richards

Seconded: Sharon Brinsdon

RECOMMENDATION:

THAT THE SHARE OF THE RESIDUE OF THE WELSH CHARITY TRUST BE TRANSFERRED TO THE NELSON MARLBOROUGH HOSPITALS' CHARITABLE TRUST FOR THE PURPOSES OF WAIRAU HOSPITAL.

AGREED

(iii) FINANCIAL

Noted. Year to date results are \$1,395k favourable to budget.

Summarised Results

For the Month Ended August 2010

	Year to Date			August 2010
	Budget \$000	Actual \$000	Variance \$000	Variance \$000
Funder	(615)	(256)	359	223
Governance	3	134	131	54
Provider	(792)	114	906	444
Net Result	(1,404)	(8)	1,395	721

Members were advised that the variance in HBSS is due to the phasing with the move to the new model being completed earlier than planned. A forecast for the year to be provided for the next meeting.

(iv) RUTHERFORD INITIATIVE

Noted. Progress in clinical areas with the timeframe extended to February 2011.

(v) PLANNING AND FUNDING

Noted.

(vi) PRIMARY AND COMMUNITY

Noted. Members supported the message from the Nelson Marlborough Health Alliance.

(vii) HOSPITAL PROVIDER SERVICES

Noted. Members questioned the variance to plan for acute cardiology. They noted that more was being provided on a capacity model rather than a contract model.

(viii) MAORI HEALTH/IWI RELATIONSHIP

Noted. The IHB to consider the welcome for the new Board. Director of Maori Health is working through a due diligence process around Whanau Ora.

(ix) **HR, AND ORGANISATIONAL DEVELOPMENT**
Noted.

(x) **QUALITY**
Noted.

(xi) **INFORMATION SERVICES**
Noted.

(xii) **STRATEGIC ISSUES**
Noted. A letter has been drafted to the Minister seeking approval to dispose of surplus properties.

Moved: Graeme Faulkner
Seconded: Lynette Jones

RECOMMENDATIONS:

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

AGREED

4.3 Committee Reports

(i) Iwi Health Board
No report.

(ii) Disability Support Advisory Committee
A report on the meeting of 21 September 2010 was tabled.

Moved: Sharon Brinsdon
Seconded: Graeme Faulkner

RECOMMENDATION:
THAT THE CHAIRPERSON'S REPORT BE RECEIVED.

Discussion

Members noted that the Department of Social Welfare has the role of keeping a register of vulnerable people in the event of an emergency.

AGREED

- (iii) Community and Public Health Advisory Committee
Taken as read.

Moved: John Moore
Seconded: Liz Richards

RECOMMENDATION:
THAT THE CHAIRPERSON'S REPORT BE RECEIVED.

AGREED

- (iii) Hospital Advisory Committee
Noted the presentation on Echo Technician Led Services, the donation to the Paediatric courtyard by the Marlborough Hospital Equipment Trust and the work of John Ealand in fund raising.

The Chair noted that a new Board representative will be required for the Wairau Project and the Community Group. Next meeting moved to Wairau on 26 October.

Moved: Lynette Jones
Seconded: Ian MacLennan

RECOMMENDATIONS:

- 1. THAT THE HOSPITAL ADVISORY COMMITTEE RECOMMENDS THAT THE BOARD ENDORSES THE CAPITAL PROGRAMME FOR THE 10/11 FINANCIAL YEAR**
- 2. THAT THE CHAIRPERSON'S REPORT BE RECEIVED.**

AGREED

SECTION 5: GENERAL
Nil

SECTION 6: MEMBERS' ISSUES

- Members not returning were reminded of the process to dispose of confidential papers.
- Next meeting to consider the change in frequency of Advisory Committee meetings.
- Memorial for Glenys Baldick, Brian Kennedy and Alex Grooby. Previous resolution to be checked. Alternative is to have a plaque where the Board meets.

Public Excluded

Moved: Judy Crowe

Seconded: Jenny Black

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 17 August 2010 (Clause 32(a) Third Schedule NZ Public Health & Disability Act 2000)**
- **DHB Chair's/Committee 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)**
 - **Letter of Representation and Annual 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)**
 - **Health Targets- To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)**
 - **After Hours Business case - To protect information that is subject to negotiation (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000).**

Actions Arising from the Meeting

Action	Responsible	Time Frame
Letter to Minister regarding Joan Whiting Memorial Trust	Suzanne Win	10 October 2010
Consider change in meeting frequency for Advisory Committees	Board	9 October 2010
Memorial at Wairau	Mike Cummins	9 October 2010

Meeting closed at 4.15pm

Members of Public

Naomi Arnold (The Nelson Mail) attended.

3.1 MATTERS ARISING

Memorial Garden – Wairau Hospital

At the 11 August 2009 meeting the Board considered a paper from the Steering Group (attached) on the advice of the Community Liaison Group. The background to this was that the Board in April 2006 had discussed possible options for a memorial to Alex Grooby. The suggested solution was for a memorial garden to be established at Wairau as part of the redevelopment project. The garden was seen as a centre point and will be available to acknowledge others who have made a contribution, e.g. Brian Kerridge and Glenys Baldick.

The minutes from the August 2009 meeting note:

a) Memorial Garden, Wairau Hospital

Moved: Sharon Brinsdon

Seconded: Lynette Jones

RECOMMENDATION:

THAT THE BOARD APPROVES AN INCLUSIVE ACKNOWLEDGEMENT TO ALL STAFF AND BOARD MEMBERS.

Discussion:

Members discussed the recommendation from the Community Liaison and Maori and Pacific Island Reference Groups.

It was agreed that further discussion be held on alternate ways of acknowledging specific people, for example trees, seats or a memorial book or plaque.

AGREED

Paper for Wairau Hospital Site Redevelopment Steering Group July 2009 Wairau Hospital Memorial Garden

Title

Wairau Hospital Memorial Garden.

Background

NMDHB CEO John Peters has requested that the Redevelopment Project Community Liaison Group work in conjunction with the Maori and Pacific Island Reference Group to develop a Memorial Garden on the grounds of Wairau Hospital.

Role and Function

The Memorial Garden's purpose is to

- Provide a focus point for the remembrance of staff and board members of Wairau Hospital who have passed away.

Recommendation for Memorial Garden Location

The Redevelopment Project Community Liaison Group and the Maori and Pacific Island Reference Group propose that the Memorial Garden is positioned in the treed area adjacent to the existing staff car park accessible from Gate 3.

The proposed location is:

- Not otherwise utilised
- Maintains a green 'buffer' zone between the hospital and the roadside
- Secluded and conducive to contemplation
- Suitable for a waiting area for visitors to the hospital
- Close to car parking
- Has ready shade and coolness in summer months.

Appropriate way finding signage will guide visitors from the Main Entrance of the hospital and from the roadside, via a new pathway from the Main Entrance and the existing pathway from Hospital Road.

A strip of NMDHB land beside Taylor Pass Road has been identified by the Property department for possible resale. The proposed Memorial Garden may encroach on this strip of land; however a survey is yet to take place.

Scope of Garden

The Memorial Garden will be harmonious with the overall landscaping plan for the redevelopment. A circular theme will provide a contrast to the sharp angles of the hospital courtyards and buildings. The Memorial Garden will reflect Wairau Hospital's cultural diversity and be conducive to contemplation.

Functionality

- The Memorial Garden will be easily accessible by the general public and wheelchairs/scooters
- The Memorial Garden will be easily accessible for servicing and maintenance, and include adequate irrigation.

Proposed Garden Features

- The Memorial Garden could feature one inclusive memorial plaque; individuals not being named on the plaque or elsewhere in the Memorial Garden
- The central focus of the garden could be a large boulder upon which the memorial plaque will be attached.
- The boulder may be bordered by an area of crushed shell ground cover
- Paving of a permanent material to meander through the Memorial Garden and lead to the boulder. It is proposed that the paving would be linked to the existing paving. The existing paving will require surveying for safety

- Seating to be positioned throughout the Memorial Garden. One option is to build the seating in a circular fashion around the tree trunks which would complement the circular theme of the garden and be secure to prevent theft
- Trees for spotlighting to be identified
- The memorial plaque to be spotlit
- The pathway from the Main Entrance could include a pergola/arch to create a formal entrance to the Memorial Garden
- A climbing plant over the pergola/archway
- Bins to be positioned on the pathway close to the hospital to encourage appropriate disposal of waste
- Suitable signage stating the purpose of the Memorial Garden to be positioned beside the pergola/archway.

Planting

- Pine trees in the Memorial Garden area to be identified for removal in order to create a natural forest clearing/amphitheatre
- The garden design to include Camellias, deciduous Azaleas, Hellebores, Rhododendrons, Daffodils and native species
- Plants which co-exist with existing foliage to be selected
- Plants which encourage the return of native bird species to be considered
- Identify positions for possible planting of exotic specimen trees representing the nationalities that make up the Marlborough region.

Suggested Wording for Main Memorial Plaque

This garden is in memory of all staff and Board members who have contributed to the services provided at Wairau Hospital since its establishment in 1878.

Opened by [name, position] on [date]

Existing Memorial Plants and Trees

The existing memorial plants and trees will remain in their current positions on recommendation from Wairau Hospital's groundsperson, who considers that the memorial plants and trees may not survive further relocation.

External Parties

Jo Saunders, a landscape architect based in Blenheim who undertook the Stage One landscape design to be commissioned to complete the final design of the Memorial Garden.

Suggestions for Funding

- Funding for the Memorial Garden is to be provided by the Redevelopment Project Community Liaison Group trust fund, other hospital trust funds for the beautification of the grounds, and from the donations of materials, time and services from the Marlborough Community
- A silent auction could be held for the firewood from the trees that have been identified for removal from the Memorial Garden area. The resulting funds would be used to purchase plants. Lions Club could be approached to organise the auction. The tree felling and subsequent auction could be an opportunity for positive press coverage.

Supplementary Material

- Overall landscaping concept for the redevelopment
- Photos and map identifying the proposed Memorial Garden area.

Memorandum

Date: 2 December 2008
To: Sue Morris
From: Sara Antonievich
File/ref number:
Subject: Landscape Concept - Wairau Hospital Site Redevelopment

ISSUES TO BE ADDRESSED IN LANDSCAPE CONCEPT

- Hospital site to be considered as a whole
 - landscape concept to address the overall Hospital site
 - the landscape concept to reflect the unique nature of the Wairau valley
 - demolition of buildings and structures within the whole site to be determined
 - a plan to be marked up - this includes identifying immediate demolition work for the construction and redevelopment of the Hospital and also identifying future demolition work to 'tidy up' the site as a whole i.e. demolition of boarded up swimming pool
 - plan to identify areas of land proposed to be sold
- Integration of all exterior requirements with the overall landscape plan
 - car parking requirements to be integrated with the overall landscape plan
 - exterior lighting concept, hard surfaces – roads and paving, water features, signage and way finding signage etc to be integrated into the overall landscape concept
- Site damage from the construction process
 - scaring and other damage to the natural features of the site from the construction process to be addressed as an immediate issue
 - assessment of damage and methodology for rapid remedial landscape work required
 - addressing immediate areas around the new building works
- Detail of smaller individual areas in the Hospital redevelopment
 - courtyards – individual design for each courtyard according to their location, use, size and access – private spaces
 - design concept to acknowledge the difference between viewing a courtyard from within the Hospital, viewing a courtyard itself and views of the surrounding Hospital from within a courtyard
 - entry points to the Hospital – the Main entry and Emergency Department entry points – the relationship of natural landscape features / hard paving surfaces / pedestrian and vehicular access / the canopies above to be addressed as a holistic whole within the overall landscape concept

S. Antonievich

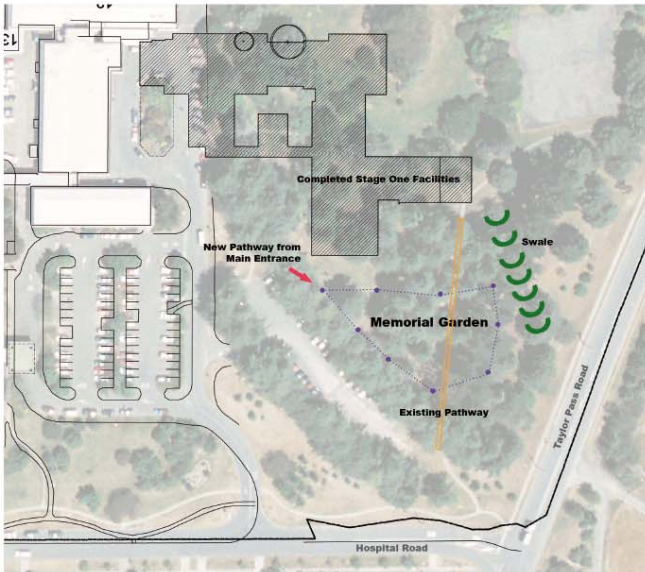
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View of Proposed Location from East



View of Proposed Location From West



Aerial View of Proposed Location

Paper for Wairau Site Redevelopment Steering Group July 2009
Wairau Hospital Memorial Garden

3.2 CORRESPONDENCE RECEIVED

Date Received	Received From	Title
21/09/10	Ministry of Health	Expectations regarding the integration of primary and secondary care
21/09/10	Centre for Housing Research	Newsletter
28/09/10	Associate Minister of Health	Key performance indicator framework for New Zealand mental health and addictions services
30/09/10	Minister of Health	Spending on supplier and services: where to focus first
04/10/10	Ministry of Justice	Charging guidelines for Official Information Act 1982 requests
04/10/10	Ministry of Health	Revised guidelines for tuberculosis control in New Zealand
15/10/10	Auditor-General	Auditor-General's Client Satisfaction Survey
21/10/10	National Health Board	Director of DHB performance/Deputy National Director
21/10/10	State Services Commission	Changes to central agency reporting on performance issues and risks in selected crown entities
26/10/10	Dental Council of New Zealand	Consultation on proposed changes to the dental hygiene, orthodontic auxiliaries and dental therapy scope of practice

SECTION 4: REPORTS

4.1 Chair's Report

(i) GENERAL

As this is my last Board meeting I want to make some comments about the past almost five years in the role and also look forward to the future and continued development of the work of the Board and staff.

I do not intend to use this occasion to grandstand or provide gratuitous advice but do want to provide some of my own thoughts of Board performance and views of the future challenges ahead.

When I was appointed to this role commencing on 1 January 2006 it was to me a great honour. I had started employment in the Mental Health area at Nelson as a hospital aide in June 1968 with a view to commencing training as a psychiatric nurse later that year and have worked as an employee of the Board for 23 years in a number of roles the last being as one of four general managers. To be asked to be the Chair of the Board was a satisfying completion for me of a long journey and while I have sometimes found the public face difficult, particularly when decisions need to be made that affect people, it has been a rewarding and humbling role.

I have been supported well by my Board colleagues who have challenged and debated in a professional way the decisions that Boards inevitably make in their work and through this have kept me honest. We have been all supported by John an outstanding Chief Executive with competent and effective managers who have informed, analysed, translated and implemented Government and Board strategies and managed any fall out. Special mention must be made of Mike Cummins who has guided us through the Board processes, some of which have been challenging in terms of complicated resolutions etc. Sharon Kletchko has learned to slow down enough for us to catch up with her quick mind and large ideas. Denise has given us assurance about the human resources area, Nick has provided IT 101 for us, Nigel until his recent departure has informed us, entertained us and we could always rely on a left field observation. Robyn a relatively new member of the ELT has demonstrated her experience and Keith his long time hard work and effective provider outcomes. It was great to see Harold return to us to take on the Maori Health portfolio and continue the journey initiated by Nicola. Peter has continued in his quiet and effective way to bridge the primary care environment. Not least of all is Gaylene who has looked after the administration and my comings and goings not an easy job at any time.

Status

This report contains:

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

Andre Nel led some great initiatives in the setting up of the Clinical governance group. And of course behind all these people there are an efficient and effective group of people providing administrative and planning and implementation support.

Our Provider Division has and will continue to serve the people of Nelson, Marlborough and Tasman well and the new ELT structure have the potential to strengthen the clinical input, develop more cohesive and effective links across community and hospital services and enable true clinical leadership and governance. Clinical staff and the support provided to them by the administration have been at the sharp end and again this is work that the Board appreciates. Evidence over the five years I have been in this role shows us that the Board continues to meet the majority of Government targets and that we have a responsive and willing workforce. This is in great part due to Keith and his team.

Community members of Board committees are a valuable touchstone and have made a great contribution to development of policy and processes. Te Roopu Tupu Tahi has also informed us of the work of mental health across the district as well as advising on any service development that is warranted. My thanks to you all for the time taken to read the material and attend meetings to give your perspectives.

As a DHB we have a number of partners. The Iwi Health Board has taken on the approach of collegial and cooperative work amongst Maori providers, has guided the DHB in its quest to better meet the needs of Tangatawhenua and Manawhenua across Te Tau Ihu. The inclusion of Pacific peoples in the Iwi Health Board is a milestone in embracing other cultural needs. While we are making progress in terms of access for Maori and Pacific Peoples until their health status is the same as Pakeha we have not met our obligations to the partnership in my view. Cultural advice, safety and support of the Kaumatua have been invaluable to me personally and to the Board.

Work with Kimi Haoura Wairau and Nelson Bays PHO has now led to a more outcome based approach through an alliance arrangement. Our MoU with both organisations have guided the relationships and it will be important to ensure that this is adapted as necessary to manage new ways of working. The initiatives under the Nelson Marlborough Health Alliance offer particularly exciting potential in this area.

The Board has a contracting and planning function which works closely with NGOs and private providers' to meet the wider health and disability needs of the Nelson, Marlborough and Tasman Districts. The work of NGOs and private providers is critical to meeting the needs of people in Nelson/Marlborough and I personally have appreciated my contact with organisations that have made time to discuss issues with us.

The Board and management have worked hard to bring a district wide approach to the DHB services and it is important that any new Board appreciates the considerable work that has already gone into this approach

as well as supporting the CE and the organisation in future developments. Government policy is about clarity of purpose and close collaboration and I am reminded that this is just as important within the Board as it is across other DHBs. I remind Board members of a comment from the Minister of Health in his press release relating to newly elected Board members.

“DHBs must continue to improve key frontline services in emergency departments, cancer treatment, cardiac and elective surgery. They will also need to work together more on a regional basis to secure and protect vulnerable services.”

We need to ensure that we have our own house in order so that we can then present as a united organisation. The point of elections at large is to ensure that Board members are responsible for services across the district. The need for protection of, or representing a particular geographical area or interest group does not make the best use of Board collegiality and can be divisive. Resources have to be stretched to make sure that there is the best coverage for all across the district.

Board members will be challenged on an ongoing basis to demonstrate they are making decisions that are in line with Government policy, they can meet targets and are responsive to their community. It's a big ask but can be done if the Board works as a team with the CE and his team.

I also want to thank the people of Nelson Marlborough who have and continue to volunteer time, resources and advice to us. It has been estimated that the value of volunteers in New Zealand is \$2B a year and I am sure that the health and disability sector receives a considerable part of that resource.

I would like to finish with a précis of what I see as team achievements. Inevitably when one makes a list something gets left off so I apologise if some areas are not covered. No single one of us can lay claim to this as a personal achievement but we can all be proud of the progress made:

- Wairau redevelopment
- Golden Bay and the exciting move towards an integrated service
- Finalising Murchison systems to provide certainty to the community
- Transfer of services to the Jack Inglis Friendship Hospital in Motueka
- Upgraded facilities for mental health
- Considerable progress in areas such as immunisation, diabetes services, access, enrolments with PHOs and primary care services
- Obtaining Breastfeeding accreditation
- PCI
- Successful joint venture to provide MRI services
- Achieving # 1 and #2 in patient satisfaction for the entire period
- Meeting (and exceeding) electives year on year
- Joint processes for Maori Health strategic planning
- Strengthening relationships with the IHB and PHOs
- Greater involvement and responsiveness to Maori in the Provider Division

- The beginning of alliance contracting across the district with PHOs
- Successful introduction of improved IT and accounting systems
- Strengthening ED and after hours provision
- Outsourcing laboratory contract, with significant savings, in the region of \$8 million to date
- Murchison Hospital redevelopment
- Improvements in staff development, especially nursing PDRP.

And while this development work carries on so does the day to day work. It is also noted that from time to time errors occur and regrettably that can impact on individuals. The wider transparency that comes from releasing sentinel events data has been in my opinion a good thing. The Board has appreciated the responsiveness to errors and the willingness to in the words of LV Martin “put things right”.

Finally I want to pay tribute to my Board colleagues those who are standing down, some after nine years and to wish the best to those who are remaining to continue the good work. We have had some great debates, some tough decisions to make and satisfaction in making changes that have brought about better services and use of resources. Despite some of those tough debates we always retained our professionalism and team approach; this also includes the current and past Executive members. I also wish the new and existing members well in the work of the Board and for the future wellbeing of the health and disability sector.

I will miss the rough and tumble of health and disability and its politics but know that the Board will continue to be responsive to the people across the District. I wish you well.

(ii) FOR DECISION

(a) Meeting Timetable

Introduction

The frequency of Advisory Committee meetings has been raised following the move to two-monthly meetings for 2010.

The Ministerial Review Group in its report 2009 commented about the number of Board and Committees, this together with the fiscal constraint led to the move from six weekly meetings. The Board noted the following impacts from the move to two-monthly meetings were expected:

- The number of meetings would be reduced to five excluding workshops. It was assumed each Committee would have one workshop making the total number of meetings six, four fewer than previously
- The financial impact, based on seven members for each Committee, was a saving of \$1,812.50 per meeting or \$21,750 if all committees only met six times per year.

A number of indirect savings in staff time were identified as arising from the reduced number of agendas and meetings.

- Agenda preparation:
 - Meeting with Committee chairs to develop the topics (1 – 2 hours)
 - Development of the working papers (can involve range of staff – say 20 hours)
 - Review by the management teams of the working papers (2 – 4 hours)
 - Formatting (4 hours)
 - Printing and binding (4 hours).

- Actual Meeting:
 - Staff attendance (up to 4 hours for 1 – 4 people)
 - Minute taking and preparation (4 – 6 hours).

It was estimated that savings of 50 hours per meeting were possible.

Meetings in 2010

During 2010 the Committees met as follows:

DiSAC regular meeting	CPHAC regular meeting	HAC regular meeting
21 September	31 August	24 August
20 July	22 June	22 June
18 May	27 April	20 April
16 March	23 February	16 February

None of the Committees held a workshop on a separate day. Each Committee will be meeting one more time during 2010. The first meeting of the Committees in 2011 will be in March to enable the appointment of community representatives to be completed.

The key issue that arose during the year was the fit to the financial reporting cycle and ensuring that Committee reports to the Board reflected the most up to date information. This resulted in the HAC moving to the second month in the cycle.

With Committees meeting two-monthly and the Board six-weekly, several Committee meetings were rescheduled. The reports presented to the Board were (the months indicate the YTD financial results considered at the Committee meeting):

Date	CPHAC	DiSAC	HAC	IHB
26-Jan	No meeting	No meeting	No meeting	No meeting
2-Mar	Written- Jan 10	No meeting	Verbal – Dec 09	verbal
13-Apr	No meeting	Written - Jan 10	No meeting	Tabled
25-May	Written	Verbal	Written – Mar 10	Written
6-Jul	Written - May 10	Written – Apr 10	Written – May 10	Tabled
17-Aug	No meeting	Written – Jun 10	No meeting	Written
28-Sep	Written – Jul 10	Tabled – Aug 10	Written – Jul 10	No report

Decision Making

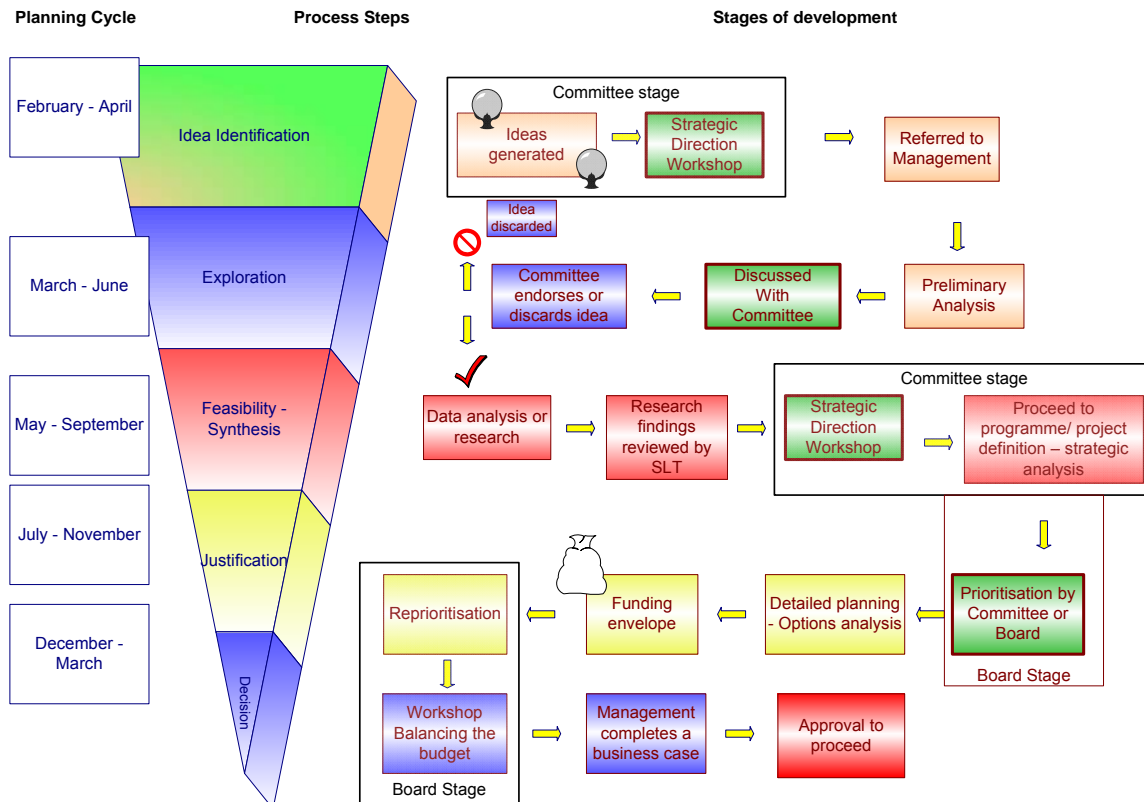
For 2011 to fit with the planning cycle for the District Annual Plan (DAP) and the appointment of community representatives, the Board is meeting on 1 February and again 8 March to review the analysis of the DAP projects and strategies. Both of the meetings will be in the form of a workshop with key stakeholders, e.g. IHB, PHOs, senior staff etc.

The change to two-monthly meetings has resulted in a small number of reports being presented either verbally or tabled as shown above. If such a report contains a recommendation by the Committee there is limited opportunity for members to research the issue before being asked to make a decision.

Planning Cycle

The current planning cycle has each of the Committees feeding into the ideas, projects, programmes or initiatives that should be part of the overall DAP through workshops midyear. The Board as a whole then considers all of the ideas etc from the Committees about September for a decision on those which management are to complete their analysis. For 2010/11 the cycle was varied due to the pending legislative changes and the focus on achieving a break even position by 2011/12.

The various stages of the planning cycle are:



This planning process is likely to change as the move towards regional planning is integrated into the overall cycle.

Financial Impact

Under the current payment arrangements for Advisory Committees, members are entitled to payments of \$250 for each meeting attended with a maximum of 10. The Chair of the Committee is entitled to a higher fee.

As noted in 2010, the cost of each meeting (assuming 7 members) is \$1,812.50 excluding any travel costs.

Options

The options for Committee meetings in 2011 are:

- Remain with a two-monthly cycle
- Return to a six-weekly cycle.

At a recent meeting of CPHAC the existing Committee members indicated a desire to return to six weekly meetings. A HAC Committee meeting concluded that remaining with a two monthly cycle would be reasonable provided the meeting was held as late as possible in the month. It was also suggested that an interim performance report would be issued in the months that HAC did not meet.

The strengths and weakness of each option are:

Option	Strengths	Weaknesses
Two-monthly	<ul style="list-style-type: none"> ➤ Reduced staff time in servicing the meeting ➤ Lower total meeting fees. 	<ul style="list-style-type: none"> ➤ Gaps to reporting to the Board, the time between reports can be up to three months. This can be partially addressed with interim offline reporting ➤ Information to the Committee is not timely especially if it meets before the 20th.
Six-weekly	<ul style="list-style-type: none"> ➤ Fits with the Board reporting cycle ➤ Number of meetings (8) enables the Committee to still have two workshops ➤ Enables maintaining Tuesdays as DHB meeting day. 	<ul style="list-style-type: none"> ➤ Increase in staff time to service the meeting ➤ Higher meeting costs ➤ Information to the Committee is not timely especially if it meets before the 20th.
Mixed	<ul style="list-style-type: none"> ➤ Fits with the desire of each Committee. 	<ul style="list-style-type: none"> ➤ Additional work for staff to service meetings at different times ➤ Possible overlaps (which could be used to meet jointly).

Legislative Changes

With national and regional plans being central to delivery of health and disability services and the basis for collaboration, the focus of the committees will be on the annual plan. There will be no strategic plan.

The annual plan will set out the operational focus for the coming financial year and describes how the DHB will be held accountable for the delivery of explicit actions (national, regional and local).

A new requirement will be for DHBs to consult where the Minister of Health considers the DHB is making changes to service eligibility, access or the way services are provided that will have a significant impact on recipients of services, their caregivers or providers. The impact of these changes on the role of the committees is still to be determined.

Conclusions

With the changes in the Board membership there is a need to ensure the new members are fully briefed on health issues in Nelson Marlborough. This change in experience may also be replicated in the advisory committees. Therefore to enable members to seek information orientation workshops will be scheduled for both Board and Committee members.

To enable the new Board to consider the frequency of Committee meetings it is proposed that they continue to meet two monthly until April 2011.

Suzanne Win
Chairman

RECOMMENDATIONS:

- 1. THAT THE NEW BOARD CONSIDERS THE FREQUENCY OF COMMITTEE MEETINGS AT ITS FIRST MEETING AND IN THE MEANTIME ADVISORY COMMITTEES CONTINUE MEETING TWO-MONTHLY UNTIL APRIL 2011**
- 2. THAT THE CHAIRMAN'S REPORT BE RECEIVED.**

4.2 Chief Executive's Report

(i) GENERAL

I would like to congratulate Jenny Black, Judy Crowe and John Moore on their re-election, and also congratulate and welcome Gerald Hope, Fleur Hansby, John Inder and Gordon Currie as new Board members.

At the time of writing we are waiting to hear about the Minister's appointments and the Chair and Deputy Chair positions.

I would also like to take the opportunity to sincerely thank the outgoing Board members. I have genuinely enjoyed, as well as greatly appreciated, working with you over the last Board term. A number go back to before my appointment, and collectively and individually have made huge contributions to this organisation and the health services in our district.

I, and the management team, have always appreciated the open and frank relationship with the Board, and the support we have received from you all.

In particular I would like to thank Suzanne. The relationship between the Chair and the Chief Executive is an important one that, as history in other places has shown, can seriously impact on the entire organisation if this is not healthy, respectful and robust. Thank you Suzanne.

I would also like to specifically mention Liz, who has constantly and consistently supported both myself and the organisation in her role as Deputy Chair.

The new Executive Leadership Team (ELT – another new acronym) commenced on 1st November, and is working through the early requirements of the settling in process and establishing a new way of working, which is very different to the old. I want to recognise and thank the members of the previous Strategic Leadership Team. SLT has provided effective leadership in getting NMDHB to its current point as a sound organisation and a nationally respected service provider.

However, the current requirements of health leadership strongly support a "service delivery" focus instead of the previous "corporate management" approach, and this is what ELT brings, with its strong clinical participation and patient-centric focus. Together with the Nelson Marlborough Health Alliance in partnership with our PHOs, it offers an exciting opportunity to transform the way we do things.

The industrial relations landscape involving those workforces that are represented by CNS Ltd continue to be disruptive, with little sign of resolution in sight. Our contract with an external laboratory provider is insulating us to some degree from the issues affecting other DHBs' laboratory services. However, the MRT strikes are continuing with increasing levels of intensity and impact on

Status

This report contains:

For decision

Update

Regular report

For information

both patients and non-striking staff, with patients increasingly being put at risk, notwithstanding the availability of Life Preserving Services.

This strike is approaching its thirteenth week, and is a national issue with a national group seeking resolution. To date, the union has not been able to provide a compelling case why this workforce is deserving of a higher level of settlement than has been accepted by 90% of the remainder of the workforce.

The impact on elective services is being closely monitored, with a number of operations being disrupted.

The negotiations with RMOs, also represented by CNS Ltd, are also underway on a national basis.

The financial and service performance for the first quarter of the year are largely satisfactory, with the budget being positive. The new leadership structure has required a new financial reporting format, which will be presented to the Board for information later this meeting.

(ii) FOR DECISION

Nil

(iii) FINANCIAL

The September 2010 net result for the year to date is a surplus of \$344k, which is \$1,988k favourable to budget.

Summarised Results

For the Month Ended September 2010

	Year to Date			September 2010
	<i>Budget</i> \$000	<i>Actual</i> \$000	<i>Variance</i> \$000	<i>Variance</i> \$000
Funder	(607)	(111)	496	137
Governance	7	188	181	50
Provider	(1,045)	267	1,311	406
Net Result	(1,645)	344	1,988	593

These results are subject to audit. The detailed finance report is attached as **Appendix 1**.

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

Fund

The Fund year to date result is a deficit of \$256k, this being \$359k favourable to budget. This result is due to additional revenue being received together with expenditure overall being lower than budgeted:

- Additional funding for MoH programmes (\$42k), IDF revenue (\$82k) and a PBF adjustment (\$132k) make up the bulk of the higher revenue
- Higher than budget expenditure in IDF outflow expenditure (\$146k) and home based support (\$122k) is offset by lower than budget spending in Aged residential care (\$130k), mental health support (\$21k) and respite care (\$22k).

Total Provider

The Provider Division has a year to date surplus of \$114k against a budget deficit of \$946k. This is an overall favourable variance of \$1,060k;

- Revenue is higher than budget (\$240k) in increased billing of patient aids and other income such as rebates
- Personnel costs include favourable variances in Medical (\$423k), Nursing (\$48k) and Allied Health (\$152k). These are partial offset by higher expenditure in outsourced services (\$114k)
- Expenditure in clinical supplies and infrastructure are close to planned levels
- Interest received is higher reflecting effective cashflow management, while interest paid is lower due to the timing of the uplifting of the loan for the Wairau project.

Governance

Governance and Administration has a surplus of \$134K which reflects additional revenue for staff secondment and lower personnel costs.

Forecast

An initial forecast for the 2010/11 year has been completed on the basis of the YTD results to 30 September. This forecast indicates an improvement as follows:

Consolidated Statement of Financial Performance

\$000	September 2010			Year to Date			Full Year	
	Budget	Actual	Variance	Budget	Actual	Variance	DAP	Forecast
Revenue	32,550	32,885	335	97,010	97,837	828	390,604	392,058
Expenditure								
Personnel Costs	12,096	11,991	105	36,593	35,787	806	146,184	144,939
Outsourced Services	891	885	6	2,704	2,804	(99)	10,811	10,766
Clinical Supplies	2,767	2,837	(70)	8,233	8,269	(36)	30,234	31,605
Infrastructural and Non Clinical Supplies	2,617	2,559	58	7,905	7,819	86	31,255	31,262
Personal Health Expenditure	9,065	9,107	(43)	27,000	27,102	(101)	107,863	106,406
Mental Health Expenditure	968	952	15	2,903	2,864	39	11,613	11,558
Public Health Expenditure	4	0	4	13	5	8	51	51
Disability Support Expenditure	3,374	3,350	24	10,263	10,254	9	41,237	41,361
Hauora Maori Services Expenditure	228	210	18	683	665	18	2,732	2,732
Interdivisional Eliminations	0	0	0	0	0	0	0	0
Internal Revenue/Expenses	(0)	0	0	(0)	0	0	(0)	0
Total Expenditure	32,011	31,893	118	96,297	95,568	729	381,980	380,680
Net Surplus/(Loss) before Interest & Capital Charge	539	992	453	712	2,269	1,557	8,624	11,378
Interest Received	66	126	60	202	376	174	802	(1,282)
Interest Paid	(272)	(183)	89	(833)	(571)	262	(3,306)	(3,282)
Capital Charge	(574)	(583)	(9)	(1,726)	(1,731)	(4)	(6,819)	(6,822)
Net Surplus/(Loss)	(241)	352	593	(1,645)	344	1,988	(699)	(8)
Made up of Divisional Surplus/(Loss):								
Funder	8	145	137	(607)	(111)	496	(2,779)	(1,382)
Governance	4	54	50	7	188	181	0	0
Provider	(253)	153	406	(1,045)	267	1,311	2,080	1,374
Total	(241)	352	593	(1,645)	344	1,988	(699)	(8)

With only three months actual data this forecast assumes that the planned savings for the rest of the year will be achieved and the gains on the sale of land realised.

Credit Rating

CHFA has recently undertaken an annual review of credit worthiness of all DHBs. This included credit worthiness, credit rating and financial sustainability.

NMDHB has been rated at "B" with an overall comment that:

"Return to break even is challenging but appears achievable. Cash resources may be required to fund capex, leaving minimal scope to absorb P&L deterioration".

The comment by CHFA regarding cash resources is based on an assumption that the Nelson Surgical Ward project is approved. Since then the decision has been to undertake an interim solution.

CHFA also notes that if cost increases are aligned to the overall sector average over the last four years (2005 – 2009) of 8.8% then DAP budgets are at risk.

Overall CHFA sees the following risks for NMDHB to achieving the 2010/11 projections:

- Planned FTE reductions
- Planned cost reductions in infrastructure, clinical supplies and community health services
- Nil increases in primary care cost lines
- Pressure on cash resources from capital expenditure. The scale of these long term plans need to be consistent with likely revenue growth and trends to community based delivery.

For DHBs overall CHFA has concluded that for Personnel costs

- Projected low growth in both FTE numbers and per FTE costs over the next three years appears challenging especially in light of the expected demand growth in the same period
- Is the most significant single cost group accounting for 66% of internal costs and a 1% growth in demand would increase overall sector costs by \$285m for 2010 – 2013.

For other costs for DHBs overall CHFA concluded that the level of savings projected for 2010/11 \$110m is particularly challenging.

(iv) RUTHERFORD INITIATIVE

Work is continuing on the clinical area with draft recommendations made on Ophthalmology and Obstetrics and Gynaecology, plus support areas of hotel services, orderlies and transportation. Analysis is continuing of the current production planning processes with work to move into the options identification stage shortly.

Consultation on the psychogeriatric service is underway. Consultation documents will be released shortly on Ophthalmology. A communication plan for changes to patient travel is being finalised.

The new ELT will be reviewing the outstanding recommendations to ensure that progress can be maintained and targets set for the next seven months achieved.

(v) STRATEGY AND PLANNING

(a) District Annual Plan 2011/12 planning and budgeting cycle

We are entering the 2011/12 planning and budgeting cycle. Once again the timeframe on this is tight. It is expected that the 2011/12 DAP will reflect its Year 1 and Year 2 consistent with Years 2 and 3 as shown in the current 2010/11 DAP.

(b) Diagnostic, Therapeutics and Primary Services

NMDHB has been working with Kimi Hauora Wairau Marlborough PHO (KHW) to resolve access issues regarding the Care Plus Exceptional Circumstances programme. While it is NMDHB intention to roll this programme into a flexible funding stream that funds a range of chronic care conditions, NMDHB has provided access to a designated funding line for this service for KHW until the end of this financial year.

NMDHB continues to monitor pharmaceutical costs and explore strategies to constrain costs. Further data will be obtained from SISSAL to determine whether discussions with senior medical staff prescribers for nervous system medicines have resulted in a decrease in costs (dispensing and/or medicine costs).

(c) Child and Youth

Contract negotiations with Maternity Services Limited for continuation of the services in Motueka were completed prior to expiry on 19 September. Agreement was reached and the contract documentation is in process. The Rutherford Initiative is currently reviewing maternity and related services.

(d) Health of Older People

Roll out of the InterRAI comprehensive geriatric assessment tool continues with completion of training of assessors in the ATR unit in Nelson Hospital.

Naomi Courts Rest Home in Nelson is extending the number of dementia care beds at the facility by converting rest home level beds to dementia care beds. Following the certification audit, NMDHB performed a site inspection to determine the suitability of the facility for increased dementia care client numbers.

The South Island Regional Health of Older People's Forum is performing a stocktake of Career Support and Respite Care Services for older people with a view to improving equity of access to services across the South Island

(vi) **COMMUNITY BASED SERVICES****(a) Health Protection and Health Promotion**

- Conducted two Controlled Purchase Operations (CPOs) to assess compliance with the Smoke Free Environments Act CPO operations (59 premises) with the excellent outcome of 'no sales' to our underage volunteers. Health Promotion did the pre-CPO education/premise audit, followed up by the CPO exercise with Health Protection. When a retailer refuses to sell, the retailer not only complies with their legal obligations under the Smokefree Environments Act, but also contributes to a reduction in youth smoking rates and importantly contributes to preventing the youth starting to smoke
- Drinking Water Assessors and Medical Officer of Health were sent to assist with duties following the Canterbury earthquake: in the Emergency Operations Centre; and, with council inspections teams, looking at food

premises to ensure that hygiene and sanitation were able to be maintained, and doing housing sanitation inspections. A presentation is being prepared for DHB staff

- Nelson Bays Primary Health and Early Child Health Oral Health are mapping oral health services in the Nelson Tasman region. General Practices are being informed in writing of enrolment processes for the School Dental Service and adolescent services, and services available for low income adults.

(b) Nutrition and Physical Activity Programme

- Quality Improvement Programme Planning System (QIPPS) is being trialled with the planning of several projects using this on-line tool, and is being used to develop a joint project with one of the Councils
- There were 5300 attendances at the Nelson and Tasman Way2Go Hubs community programmes.

(c) Primary Health Care

- The Golden Bay Interim Management Group is applying for resource consent to extend the Community Hospital for primary care and rest home facilities that will form the Integrated Family Health Centre. The application should be filed by the end of November. The IMG is developing a project plan to map out the steps required to build the Centre within 18 months. The group's focus over recent months has been gaining various legal approvals and agreements and identifying finance and funding sources. The Government's agreement to provide funding to keep Joan Whiting Rest Home open was based on the commitment to develop the new facility by March 2012.

(vii) HOSPITAL PROVIDER SERVICES

(a) Activity for September

Overall we are 56 cwd behind target, Acute 136 cwd behind expectations and elective 80 cwd ahead of plan.

Elective services are being managed tightly in line with ESPI requirements, however some previous commitments outside of our capacity to complete the procedures within six months are still being worked through.

Nelson

The acute demand year to date inpatients is down 4.8% compared to the same period last year.

Overall occupancy for September was 77.3% compared to 86% for the same period last year.

Wairau

The acute demand year to date for inpatients is down 4.4% in comparison with the same period last year. Overall occupancy for September for inpatients is 72%.

MRT Strike

The MRT strike is having considerable impact on the provision of both acute and elective services.

We have at the time of writing, received 28 notices of industrial actions taken by our MRT staff ranging from withdrawal of services through to working to rule on minimum exam times and withdrawal of labour to theatre.

Our thresholds for life preserving services are under pressure and are having to be reviewed because of the length of strike (which is now in its eleventh week) and its impact on elective services.

This industrial action is having an unacceptable impact on the health of our patients and is causing our front line clinical staff to make sub optimal decisions on patient care. This is very stressful for our staff who are working in good faith with the life preserving services agreement made with the union.

(b) Transport Between Nelson and Wairau

As part of the Rutherford Initiative report on Transport currently being considered, it has been recommended that an investigation be undertaken regarding an arrangement with St John to provide a daily shuttle service between Nelson and Wairau hospitals for patients. NMDHB endeavours to discharge patients at appropriate times to allow for public transport should no family or friends be available to collect them, however if patients are not able to get transport immediately accommodation is available at Altrusa House for \$30 per night.

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

Acute / Elective Caseweights - KPI View									
NB. Note that Additional Electives are now contained within the plan Maternity has been included in casemix funding from July 09									
September 2010									
Type	DM Area	Unit Code	Description	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan	
Acute	Med	M00001	General Internal Medical Services - Inpatient Serv	5161	1359	1133	-226	83%	
		M10001	Cardiology - Non PCI Inpatient Services (DRGs)	253	67	158	91	237%	
		M10001P	Cardiology - PCI Inpatient Services (DRGs)	305	80	48	-32	60%	
	Med Total				5719	1506	1339	-167	89%
	Surg	S00001	General Surgery - Inpatient Services (DRGs)	2281	601	622	22	104%	
		S05001	Anaesthesia Services - Inpatient Services (DRGs)	29	8	4	-4	49%	
		S25001	Ear, Nose and Throat - Inpatient Services (DRGs)	112	30	22	-8	73%	
		S40001	Ophthalmology - Inpatient Services (DRGs)	35	9	9	0	98%	
		S45001	Orthopaedics - Inpatient Services (DRGs)	1673	441	469	28	106%	
		S70001	Urology - Inpatient Services (DRGs)	218	57	44	-13	77%	
		Surg Total				4348	1145	1170	25
	W, C & OH	D01001	Inpatient Dental treatment	23	6	4	-2	64%	
		M55001	Paediatric Medical Service (Inpatient)	689	181	188	7	104%	
		S30001	Gynaecology - Inpatient Services (DRGs)	183	48	68	20	141%	
		W06003	Neonatal Inpatient (DRGs)	416	110	96	-13	88%	
		W10001	Maternity Inpatient (DRGs)	1345	354	350	-5	99%	
	W, C & OH Total				2657	700	706	6	101%
Acute Total				12724	3351	3215	-136	96%	
Elective	Med	M00001	General Internal Medical Services - Inpatient Serv	139	37	40	4	110%	
		M10001	Cardiology - Non PCI Inpatient Services (DRGs)	207	55	71	16	130%	
		M10001P	Cardiology - PCI Inpatient Services (DRGs)	102	27	22	-5	83%	
	Med Total				447	118	133	15	113%
	Surg	S00001	General Surgery - Inpatient Services (DRGs)	1918	505	539	33	107%	
		S05001	Anaesthesia Services - Inpatient Services (DRGs)	61	16	8	-8	48%	
		S25001	Ear, Nose and Throat - Inpatient Services (DRGs)	455	120	141	21	117%	
		S40001	Ophthalmology - Inpatient Services (DRGs)	425	112	90	-22	80%	
		S45001	Orthopaedics - Inpatient Services (DRGs)	1893	499	602	103	121%	
		S70001	Urology - Inpatient Services (DRGs)	532	140	116	-24	83%	
		Surg Total				5284	1392	1495	103
	W, C & OH	D01001	Inpatient Dental treatment	213	56	37	-19	66%	
		M55001	Paediatric Medical Service (Inpatient)	41	11	9	-2	81%	
		S30001	Gynaecology - Inpatient Services (DRGs)	702	185	168	-17	91%	
	W, C & OH Total				956	252	214	-38	85%
	Elective Total				6688	1761	1842	80	105%
	Grand Total				19412	5113	5057	-56	99%
September 2009									
Type	DM Area		Annual Contract	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Contract		
Acute	Med		5547	1434	1503	69	105%		
	Surg		4412	1140	1020	-120	89%		
	W, C & OH		2735	707	748	41	106%		
Acute Total			12694	3281	3271	-10	100%		
Elective	Med		275	71	132	61	186%		
	Surg		5010	1295	1545	250	119%		
	W, C & OH		866	224	281	57	125%		
Elective Total			6151	1590	1958	368	123%		
Grand Total			18846	4872	5229	358	107%		

(viii) MAORI HEALTH/IWI RELATIONSHIP**(a) Iwi Health Board Report**

Both Boards attended the second joint meeting for the year on 14 October 2010, and were hosted at Te Hora Te Pa Marae in Canvastown. The day was a celebration covering the past 3 years and provided an opportunity for both Boards to acknowledge their achievements and to say farewell to each other. Given the challenges ahead, both Boards agreed that they would continue to build on the relationship that has been formed to date.

(b) Maori Health Workforce Action Plan

The Action Plan has been reviewed and an update completed, realigning the document to the proposed pathway. The paper will be submitted to ELT in February 2011.

(c) Te Hoe Nuku Roa

The contract with Massey University has been renewed. Planning has commenced to organise and implement phase two of the research programme including a brochure being prepared to promote the next research phase. A further meeting between the DHB and Massey is planned for early November 2010.

(d) Regional Maori Health Workforce Promotion – Kia Ora Hauora

A final version to the strategy has now been completed. Te Herenga Hauora (SI GM Maori Forum) will consider this strategy at their 5 November meeting.

(e) Manuwhenua ki Mohua

On 21 October a small group including the Chairs of NMDHB and NBPH met with Manuwhenua ki Mohua to discuss the proposal for the IFHC at Golden Bay. The concept was well received and Iwi asked that checks be made on the land owned by NMDHB and JWT plus the area proposed to be purchased as to how they were originally acquired from Maori.

It was also agreed that there would be opportunities for smaller providers to be able to share support service, that the concept design would be referred to Iwi for feedback and that an acknowledgement would be included in the entrance to the new facility.

(ix) ORGANISATIONAL DEVELOPMENT**(a) FTE Report – September 2010****FTE Report
September 2010**

FTE	Budget CM	Actual CM	Variance	Actual YTD	Variance
Medical	168	163	5	158	10
Nursing	634	634	-	630	4
Allied Health	557	550	7	541	16
Support	89	95	(6)	96	(7)
Management/Admin	361	353	8	354	7
Total	1,809	1,795	14	1,779	30

(b) ACC Partnership Programme Audit

The annual ACC Partnership Audit was conducted during 12-14 October. The Auditor completed the audit by visiting three separate service areas, meeting with staff groups in those areas, meeting with a representative group of health and safety representatives and a union organiser and meeting with staff who have been injured at work and rehabilitated back into the workplace. He also met with a representative group of senior managers. We have received the Audit Report that was submitted to ACC for them to decide our Partnership Programme status. The report contains eight recommendations on which action has been taken or is being planned. The Auditor was positive regarding NMDHB retaining its tertiary status but acknowledges this is ACC's decision.

(c) Revised Health & Safety System Implementation

NMDHB has implemented a significant revision of health and safety systems including hazard identification and control plans. Ninety-seven percent (97%) of Health and Safety Representatives attended training on the revised process in September and have commenced rolling these out in their area of responsibility. The revision was aimed at ensuring the district wide nature of the health and safety systems and streamlining processes for representatives and management. The revised process received favourable comment in the ACC Partnership Programme conducted in October.

(d) Complaints

There were 28 complaints received for the month of September 2010, compared to 25 for August. One complainant identified themselves as Maori. Of the 28 complaints received, 15 were for Nelson and 13 for Wairau. 100% of complaints were responded to within 30 days.

(e) Employee Relations

The National Multi Employer Collective Agreement (MECA) and NMDHB Collective Agreement updates are attached as **Appendix 2**.

(x) QUALITY**(a) Qctober**

As indicated in the last Board Report the Clinical Quality Improvement Council designated the month of October as Qctober. Information regarding internal quality activities has been displayed in key places within the organisation and regular thought provoking quality articles have been made available on the Intranet. The Qctober Quality Quiz conducted via the intranet proved to be a challenge for some with those staff with correct entries being placed in the draw for a donated Ipod Shuffle. The month was rounded off by presentations from quality representatives on quality initiatives they have undertaken in their area of responsibility.

(b) Provisional Audit - Wairau Stage Three

The Provisional Audit, required prior to the occupation of stage three in the Wairau Site Redevelopment, which was due to take place on the 6 October, was unavoidably delayed due to auditors not being able to arrive in Blenheim due to inclement weather elsewhere. It was rescheduled for 18 October and was completed that day. With the cooperation of our Designated Audit Agency and the Ministry of Health the provisional certificate has been issued in time for occupation in early November.

(c) Quality Improvement Committees

Clinical: CLQIC met in early October and considered a number of issues including recent guidelines from the Ministry of Health extending the Credentialing process beyond medical practitioners to nursing and allied health. The extension of the process has resource implications for the organisation. It was decided that a committee made up of the Chief Medical Adviser, Director of Nursing & Midwifery and the newly appointed Director of Allied Health, with support from Human Resources, would be established to recommend implementation options for NMDHB. The Committee also considered a number of policies including a revision of the suite of Family Violence policies.

Corporate: COQIC met once during the reporting period where it considered a number of policies including a revision of the organisation's He Oranga Maori Best Practice Policy. The revision has bought a number of separate policies into one document for ease of use and updated some elements of the content. In addition the Committee considered the Access to NMDHB Electronic Information Systems policy. With minor adjustments both policies were approved for forwarding to the Chief Executive for sign off. The Committee also received an update on national procurement activity as it relates to stationery and associated administrative materials.

(xi) INFORMATION SERVICES

Nil to report for this period.

(xii) INTERSECTORAL AND OTHER DHB LINKAGES

Intersectoral and other DHB linkages for the period:

- Golden Bay Interim Management Group
- National CEOs
- CEO Executive Board
- SI CEOs
- Joint Grey Power Meeting
- Joint Oversight Group (JOG).

(xiii) STRATEGIC ISSUES

(a) Wairau Redevelopment

The Project Manager's report is attached as **Appendix 3**.

John Peters

CHIEF EXECUTIVE

3 November 2010

RECOMMENDATIONS ARISING FROM THIS REPORT:

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

4.2 Committee Reports

Iwi Health Board

14 October 2010

To be tabled.

Joe Puketapu
Chairperson

RECOMMENDATION:
THAT THE CHAIRPERSON'S REPORT BE RECEIVED.

Status

This report contains:

- For decision
- Update
- Regular report
- For information

DISABILITY SUPPORT ADVISORY COMMITTEE

No report.

Sharon Brinsdon
Chairperson

Status

This report contains:

- For decision
- Update
- Regular report
- For information

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

26 October 2010

Gordon Currie was welcomed to the meeting, as was Christine Smith.

The Chair's Report was received. He thanked CPHAC members for their work over the last three years. In particular Liz Richards and Suzanne Win as departing members were thanked. Lorraine McMath and Judith Holmes as Community Representatives were acknowledged for their contribution but may be back after a new selection process.

The Report from Te Roopu Tupu Tahi which encompassed two of their meetings, was received. Articles on mental illness by Naomi Arnold for the Nelson Mail and the Marlborough Express were mentioned as being valuable for our communities. CPHAC took advantage of Naomi's presence to express appreciation for her work. Much work on community awareness of mental illness was under way. The Report mentioned the changes to Psychogeriatric services which involve the closure of Alexandra Home. CPHAC thanked the Group and Carol Gowan for the high quality of information and advice it has provided us over the last three years.

The Report from the GM Planning and Funding was received. The Fund has a YTD deficit of \$111K against a budget deficit of \$607K at the end of September. This is a very encouraging outcome. CPHAC congratulated management on this effort and the close control of spending plus the quality of reporting. The usual risks of the uncapped services remain.

The Report of the Director of Maori Health was received. Work continues on the Whanau Ora Policy and collective services.

The Report from the GM Primary and Community was received. Progress continues with the Golden Bay Integrated Family Health Centre on funding and planning processes. The PHS division continues to run substantially under budget (YTD \$146K).

We discussed the paper on Meeting Frequency and resolved to state a unanimous preference to the new Board for 6 weekly Committee meetings to link better with Board meetings.

The CE spoke on Board Committee roles and reporting with the new ELT Directorates. To some extent this will be an evolutionary process as we become accustomed to new processes. At this stage CPHAC will continue its' contacts through Strategy and Planning and Community Based Services. Links will likely need establishing to all Directorates through their Community components. The usefulness of joint Chairs' Meetings to co-ordinate Committee work was mentioned for future consideration. This has worked usefully in the past.

The Board Secretary advised on new Financial Reporting protocols made necessary by the new systems.

The major discussions of the day followed the presentation of an updated Health Needs Assessment paper by Sarah Simmonds, the Board Public Health Analyst. This paper

Status

This report contains:

For decision

Update

Regular report

For information

updated the 2008 version. There were no real surprises with progress shown in most life expectancy measures. Intentional Self Harm remains the leading single cause of death from 15 to 44. Maori health remains a challenge for Maori, the IHB and the Board. Maori have a disproportionate suicide rate plus deaths from medical causes means that 61% of Maori die before the age of 65. For non-Maori the figure is 17%. This is not new information. Obesity at all ages remains a significant health risk in NZ, though not more so in our District.

We discussed the health and mortality risks related to drugs, alcohol, addiction and violence as these seem topical and possibly amenable to determined intervention. Our population is growing slowly, especially the numbers over 65.

The document remains a valuable basis for strategy and service planning. Some of the statistics must be viewed with caution as small numbers can cause large variations. Some of the figures are South Island wide references.

The closed section of the meeting merely confirmed minutes of a previous meeting.

John Moore
Chairman

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

HOSPITAL ADVISORY COMMITTEE

26 October 2010

The last meeting of this Hospital Advisory Committee began with an acknowledgement of attendance and contributions from both governance and management during this term.

The Chairman welcomed Gerald Hope and Gordon Curry both recently elected to the District Health Board. Their observer role (until 6th December) was explained.

REPORTS: Chief Operating Officers – Strike action across both Hospitals continues to have a significant impact on our front line medical and surgical staff.

28 notices (14 for each Hospital) require understanding and support for both staff and patients during these disruptive times.

Life Preserving Services were discussed. All DHBs have an agreement with the unions as to how they operate during the strike. Thresholds are being looked at closely as strike action continues with all services having to be managed carefully.

Wairau Site Development – Earlier the Dawn Blessing of the new facilities for Stage 3 had taken place. Occupation will commence (in stages) from early November onwards. This is a significant milestone for the Wairau Redevelopment Project Team.

HAC noted the reduction from ten to five (work day) delays. This is a helpful improvement. The risks contained in the Project Managers report dated 21 October were noted.

Clearly very close monitoring will be essential as the contingency will provide few opportunities to reduce costs between now and the completion of the final stage.

Outpatient Reports, Key Performance Indicators, Elective Service, Property Management (Motueka/Golden Bay) were discussed in detail.

Financial Report: Hospital services doing better than budget and are showing a surplus. However, given this is for first quarter (only) all expressed concern around expected results for the second half of this year.

Clinical supplies are under pressure plus some non scheduled high cost patient travel is of concern.

Explanations around the planned Rutherford savings were sought.

As savings are achieved they are transferred from one budget to the relevant budget and are captured as early as possible and reflect the savings as achieved so as not to inflate the position.

Due to changes in reporting lines of the new Executive Leadership Team it was agreed that this was something that the new Board may want to discuss.

Status

This report contains:

For decision

✓ Update

✓ Regular report

For information

All members thanked the Chief Operating Officer and wished him well for his new role as Business Development Manager within the office of the Chief Executive.

Glenda Crichton was also thanked for her minute taking, letter writing and other related support to HAC and wished well for the future.

Lynette Jones
Chairman

RECOMMENDATION:
THAT THE CHAIRMAN'S REPORT BE RECEIVED

APPENDIX 1 – FINANCIAL REPORT SEPTEMBER 2010

1. OPERATING RESULTS

1.1. NMDHB Consolidated Profit & Loss of the Three Divisions (Governance & Funding Administration, Provider and the Fund)

The consolidated result for September is a surplus of \$352k against a budgeted deficit of \$241k (a positive variance of \$593k). The YTD results are a surplus of \$344k against a budget deficit of \$1,645k YTD (a positive \$1,988k).

Consolidated Statement of Financial Performance

\$000	September 2010			Year to Date			Full Year
	Budget	Actual	Variance	Budget	Actual	Variance	DAP
Revenue	32,550	32,885	335	97,010	97,837	828	390,604
Expenditure							
Personnel Costs	12,096	11,991	105	36,593	35,787	806	146,184
Outsourced Services	891	885	6	2,704	2,804	(99)	10,811
Clinical Supplies	2,767	2,837	(70)	8,233	8,269	(36)	30,234
Infrastructural and Non Clinical Supplies	2,617	2,559	58	7,905	7,819	86	31,255
Personal Health Expenditure	9,065	9,107	(43)	27,000	27,102	(101)	107,863
Mental Health Expenditure	968	952	15	2,903	2,864	39	11,613
Public Health Expenditure	4	0	4	13	5	8	51
Disability Support Expenditure	3,374	3,350	24	10,263	10,254	9	41,237
Hauora Maori Services Expenditure	228	210	18	683	665	18	2,732
Interdivisional Eliminations	0	0	0	0	0	0	0
Internal Revenue/Expenses	(0)	0	0	(0)	0	0	(0)
Total Expenditure	32,011	31,893	118	96,297	95,568	729	381,980
Net Surplus/(Loss) before Interest & Capital Charge	539	992	453	712	2,269	1,557	8,624
Interest Received	66	126	60	202	376	174	802
Interest Paid	(272)	(183)	89	(833)	(571)	262	(3,306)
Capital Charge	(574)	(583)	(9)	(1,726)	(1,731)	(4)	(6,819)
Net Surplus/(Loss)	(241)	352	593	(1,645)	344	1,988	(699)
Made up of Divisional Surplus/(Loss):							
Funder	8	145	137	(607)	(111)	496	(2,779)
Governance	4	54	50	7	188	181	0
Provider	(253)	153	406	(1,045)	267	1,311	2,080
Total	(241)	352	593	(1,645)	344	1,988	(699)

1.2. Fund Financial Performance

The Fund has a deficit of \$111K against a budget deficit of \$607K. This is an overall positive variance of \$496K.

Fund Statement of Financial Performance							
\$000	September 2010			Year to Date			Full Year
	Budget	Actual	Variance	Budget	Actual	Variance	DAP
Revenue							
Ministry of Health	29,840	29,922	82	88,596	88,967	370	354,384
Total Revenue	29,840	29,922	82	88,596	88,967	370	354,384
Expenditure							
Personal Health Expenditure	21,442	21,502	(61)	63,885	63,986	(101)	255,715
Mental Health Expenditure	3,043	3,028	15	9,130	9,091	39	36,520
Public Health Expenditure	237	229	8	711	692	20	2,845
Disability Support Expenditure	4,483	4,431	52	13,600	13,519	81	54,567
Hauora Maori Services Expenditure	228	210	18	683	665	18	2,732
Other Expenses	458	458	(0)	1,375	1,375	(0)	5,501
Total Expenditure	29,891	29,859	33	89,384	89,327	56	357,879
Net Surplus/(Loss) before Interest & Capital Charge	(51)	64	115	(788)	(361)	427	(3,494)
Interest Received	59	81	22	180	249	69	715
Net Surplus/(Loss)	8	145	137	(607)	(111)	496	(2,779)

1.2.1. Fund Revenue

Year to date revenue is favourable to budget by \$370k at the end of September, excluding interest received.

Favourable Variances

- IDF revenue – Favourable variance of \$82k is mainly due to the estimated inflow revenue relating to the PBF adjustment for Herceptin costs from 1st July
- PBF adjustment – Favourable \$198k net funding for Herceptin costs and \$14k additional funding for Child, Youth, and Family services.

Unfavourable Variances

- IDF Revenue Mental Health – unfavourable variance of 29K for Community Forensic Mental Health Services. There have been ongoing discussions in the last few months around how funding of this service is to flow through to DHBs. At the beginning of October the MoH has finally decided to roll the funding for this service into PBFF. Each DHB will receive a share of the additional national funding based on their PBFF share.

1.2.2. Fund Expenditure

Total Fund expenditure is favourable to budget by \$56k.

- Personal Health expenditure is unfavourable to budget by \$101k
- Mental Health expenditure is favourable to budget by \$39k
- Public Health expenditure is favourable \$20k
- Disability support expenditure is favourable to budget by \$81k
- Maori Health expenditure favourable to budget by 18k
- Other (Governance & Admin) is on budget YTD.

Significant expenditure variances from budget are as follows:

1.2.2.a. Personal Health**Favourable Variances**

- Payments for PHO and GP services are \$183k favourable to budget. Payments for PHO performance Management programmes have not yet been made. Offset by revenue below budget. Invoices are not raised until expenditure has occurred.

Unfavourable Variances

- Immunisation (\$46k) This is a demand driven service. Expenditure on vaccinations was been higher than expected in June and July related to the Ministry of Health widening access to free influenza (including H1N1) vaccination
- Inter District Flows (\$219k) is the estimated outflow expenditure relating to the PBF adjustment for Herceptin costs from 1st July (balanced by additional revenue).

1.2.2.b. Mental Health**Favourable Variances**

- Minor variances across all Mental Health Service lines. Some payments for Home based Residential Support were withheld for non-delivery of service.

1.2.2.c. Maori Health

Expenditure is tracking close to budget.

1.2.2.d. Disability Support**Unfavourable Variances**

- Home Based Support services (\$114k) The transition back to Household maintenance from the new goal based model of care has occurred for the majority of individuals for whom it is indicated. At the time of budgeting we anticipated that the transition back to the Household maintenance would take until February 2011. The budgets have been phased accordingly. This means that the later months of the financial year have larger budgets; as a result we should complete the year well within budget.

Favourable Variances

- Aged residential care services (net of residential care loans) (\$168k) Occupancy of rest home beds for the first 3 months of the year has been less than estimated when the budget was set
- Respite Care is (\$48k) This is a demand driven service and can vary month by month.

1.2.2.e. Governance and Administration

Expenditure is tracking to budget.

1.2.2.f. Interest Received**Previously explained Favourable Variances**

Favourable variance of \$69k. Total cash is close to DAP assumptions but deposits made early in the month that mature before the end of the month have generated significant interest.

1.3. Total Provider

The Provider Division has a year to date surplus of \$267k against a budget deficit of \$1,070k. This is an overall favourable variance of \$1,336k.

Provider Statement of Financial Performance							
\$000	September 2010			Year to Date			Full Year
	Budget	Actual	Variance	Budget	Actual	Variance	DAP
Revenue							
Ministry of Health	1,739	1,675	(63)	5,426	5,236	(190)	21,295
Internal Fund	15,794	15,780	(14)	47,146	47,062	(84)	188,882
Other Government	318	513	195	1,037	1,313	276	4,044
Other Revenue	653	751	98	1,950	2,249	299	10,881
Total Revenue	18,504	18,720	216	55,559	55,860	301	225,101
Expenditure							
Personnel Costs							
Medical Personnel	3,205	3,055	150	9,620	9,047	574	38,148
Nursing Personnel	3,981	4,091	(110)	12,163	12,224	(61)	49,100
Allied Health Personnel	2,696	2,568	128	8,118	7,838	280	33,131
Support Personnel	379	376	3	1,142	1,110	31	4,674
Management/Administration Personnel	1,686	1,769	(83)	5,103	5,174	(71)	19,349
Total Personnel	11,947	11,859	88	36,145	35,393	752	144,401
Outsourced Services	863	861	2	2,620	2,731	(112)	10,473
Clinical Supplies	2,767	2,837	(70)	8,233	8,269	(36)	30,234
Infrastructural and Non Clinical Supplies	2,556	2,508	47	7,720	7,676	43	30,389
Total Expenditure	18,133	18,066	68	54,717	54,069	648	215,497
Internal Allocations	62	62	(0)	187	186	(1)	748
Net Surplus/(Loss) before Interest & Capital Charge	433	716	283	1,029	1,977	948	10,351
Interest Received	7	45	38	22	127	105	87
Interest Paid	(272)	(183)	89	(833)	(571)	262	(3,306)
Capital Charge	(421)	(425)	(4)	(1,263)	(1,266)	(3)	(5,053)
Net Surplus/(Loss)	(253)	153	406	(1,045)	267	1,311	2,080

1.3.1. Provider Revenue

Overall revenue (excluding interest received) was \$216k favourable to budget YTD.

<p>Variances</p> <p>Internal Fund Unfavourable \$84k YTD. Variances are in Pharmacy and Alexandra Home due to utilisation variances.</p> <p>Other Gov't \$195k positive within the month largely due to rebates from Pharmac \$143k.</p> <p>Other Income Other income is favourable \$299k YTD resulting from higher revenue than planned at this stage in the year for supplier rebates (J&J), recharges (offsets expenditure), motor vehicle sales, donations, and addictions assessments.</p>
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1.3.2. Provider Personnel Costs

Personnel costs are favourable to budget by \$752k YTD.

Provider Personnel Costs		
Classification	Sep YTD Var \$k	Sep YTD FTE Var
20 - Medical Personnel	574	4.29
22 - Nursing Personnel	(61)	2.03
24 - Therapies & Allied Health	280	8.85
26 - Hotel Services	31	(7.92)
28 - Management/Admin	(71)	5.23
	752	12.48

Favourable variances in Medical Personnel are directly partly offset to overspends in Outsourced Medical for Obstetrics and General Surgery. As the FTE variance sits in the SMO group, the corresponding underspend is significant. Non-FTE underspends (recruitment and relocation, training, other costs of employment) amount to \$70k of the total underspend in this area.

The favourable variance in Allied Health is mostly driven by under budget FTEs in Mental Health and Disability Support. Strike action by MRT & Sonographers has also contributed to the underspend.

Hotel Services are tracking well to budget.

Management and Admin are overspent reflecting changes currently underway in this group of staff.

Notable favourable YTD variances that are related to areas which have an element of difficulty in predicting phasing, or overall discretion in spend are as follows: recruitment and relocation (\$40k), training (\$75k), and sick leave (\$95k).

1.3.3. Outsourced Services

Outsourced services are \$112k unfavourable to budget YTD. Significant variances are as follows:

Favourable Variances

- Clinical services favourable in total by \$120k, largely in NASC (\$15k), Medical cost centres for both Nelson and Wairau (\$70k in total), and NPA (\$39k), offset by radiology (\$44k) and mortuary (\$12k) overspends
- Nursing favourable \$28k.

Unfavourable Variances

Medical fees are unfavourable in total by \$257k, which offsets underspends in personnel costs due to vacancies:

- Obstet/Gynae \$162k
- General and Orthopaedic Surgeons \$127k.

1.3.4. Clinical Supplies Expenditure

Clinical supplies are \$36k unfavourable to budget YTD. Significant demand driven variances are as follows:

Variances

Favourable

- Pharmaceuticals \$140k. Immunosuppressive/cytotoxic expenditure is \$94k down on budget (offset in Revenue), and CNS drugs are currently down \$29k
- Other Clinical and Client Costs \$114k. Air ambulance \$86k and patient travel costs \$23k below budget.

Unfavourable

- Patient Appliances \$123k, particularly mobility aids (\$27k) and Audiology costs (\$36k), both offset by increased revenue, orthotics (\$33k), and anti-embolism stockings (\$21k) due to continued high surgical volume
- Treatment Disposables \$32k. Overspends in blood supplies (particularly Intagram) of \$72k and sutures of \$40k are offset by underspends of \$47k in drapes, \$18k in IV fluids and supplies, \$60k in patient consumables, and \$17k in staples and accessories

- Implants and Prosthetics \$97k. With the exception of hip prostheses and ophthalmic implants, all categories are overspent. Of particular note, there was a sudden increase in costs for pacemakers (now \$7k overspent YTD) due to high cardiology activity, and grafts are \$78k overspent YTD, some 478%. This is due to the recruitment of a vascular surgeon late last financial year, too late for specialist clinical supplies considerations to be included in the budget. The monthly overspend is anticipated to continue.

1.3.5. Infrastructure and Non Clinical Costs

Infrastructure and non-clinical supplies is \$43k favourable to budget (excluding capital charge & interest paid). Expenditure groups are generally showing favourable variances which are altogether offset by planned but unspecified savings of \$315k YTD. Some of the more material variances are as follows:

Variations

Favourable

- Hotel services - \$43k, particularly laundry and uniforms costs
- Facilities \$22k overall, but an overspend of \$45k against electricity (Wairau). This is likely to be a result of the new plant and facilities that are now on line as a result of the restructure, which indicates that this overspend will get steadily larger as the year progresses. An energy audit could be commissioned to confirm this
- IT and Telecommunication \$141k. Savings of \$66k in telecoms call charges and an \$18k in month credit against cell phones are offset by overspends on data/internet (\$10k) and pagers (\$5k)
- Professional Fees \$48k
- Other expenses \$125k, particularly items of discretionary spend: minor equipment purchases \$46k, books & journals \$16k, corporate training \$31k, and sundry expenses \$23k.

1.3.6. Interest & Capital Charge

Interest & Capital charge is \$363k favourable to budget.

Variations

Favourable

- Interest Received \$105k due to effective daily cash management, and slightly higher balances and better interest rates than originally budgeted. This has ensured significant intra-month interest benefits
- Interest Paid \$262k due to \$12.5m capital funding not being drawn in July as planned in the DAP. The first \$4m was drawn down in September, with the next \$4m now scheduled for November. Provided interest rates remain stable, interest savings should continue.

Governance and Funding Administration

Governance and Administration has a surplus of \$188k at the end of September, a YTD positive variance of \$181k.

Governance & Admin Statement of Financial Performance							
\$000	September 2010			Year to Date			Full Year
	<i>Budget</i>	<i>Actual</i>	<i>Variance</i>	<i>Budget</i>	<i>Actual</i>	<i>Variance</i>	<i>DAP</i>
Revenue	458	481	23	1,375	1,447	72	5,501
Expenditure							
Personnel Costs	149	132	16	448	394	54	1,783
Outsourced Services	28	24	4	84	72	12	338
Infrastructural and Non Clinical Supplies	62	51	11	185	143	43	866
Internal Allocations	62	62	0	187	186	1	748
Total Expenditure	301	269	32	905	795	110	3,735
Net Surplus/(Loss) before Interest & Capital Charge	157	212	55	470	653	182	1,766
Capital Charge	(153)	(158)	(5)	(463)	(464)	(1)	(1,766)
Net Surplus/(Loss)	4	54	50	7	188	181	0

Favourable Variances

- Revenue** – Continues to show a favourable variance (\$72k). \$55k relates to revenue received for a secondment to the National Health Board. \$17k relates to Hauora Maori CTA revenue received for the first quarter of the year
- Human Resources** – Favourable variance of \$54k. This is due to portfolio manager vacancies in Maori Health and Planning and Funding plus favourable variance in course and conference expenditure
- Infrastructure and Non Clinical supplies (excluding capital charge)** – Favourable variance of \$43k due to below budget expenditure across several expenditure lines including staff travel, consultancy costs, legal fees, and CTA expenses.

Outsourced Services and Capital Charge are tracking close to budget.

2. CASHFLOW

2.1. NMDHB Consolidated Statement of Cash flows for the 2 months ended 30 September 2010

Consolidated Statement of Cash Flows \$000s	Current Month			Year to Date			Full Year
	Budget	Actual	Variance	Budget	Actual	Variance	DAP
Operating Cash Flow							
Receipts							
Government & Crown Agency Received	31,655	31,562	(93)	94,847	94,095	(752)	379,710
Other Revenue Received	652	744	92	1,950	2,242	292	7,846
Total Receipts	32,307	32,306	(1)	96,797	96,337	(460)	387,556
Payments							
Personnel	12,096	12,527	(431)	36,593	31,930	4,663	146,247
Payments to Suppliers	5,310	6,928	(1,618)	15,879	20,848	(4,969)	59,957
Capital Charge	-	-	-	1,742	-	1,742	6,861
GST	(11)	(74)	63	(98)	311	(409)	(100)
Payments to Other DHBs	3,070	3,140	(70)	9,209	9,420	(211)	36,833
Payments to Other Providers	10,499	10,480	19	31,499	31,470	29	126,527
Total Payments	30,964	33,001	(2,037)	94,824	93,979	845	376,325
Net Cash Inflow/(Outflow) from Operating Activities	1,343	(695)	(2,038)	1,973	2,358	385	11,231
Cash Flow from Investing Activities							
Receipts							
Interest Received	65	126	61	201	376	175	802
Sale of Fixed Assets	-	-	-	-	42	42	9,285
Total Receipts	65	126	61	201	418	217	10,087
Payments							
Capital Expenditure	2,530	2,599	(69)	5,751	7,005	(1,254)	26,590
Total Payments	2,530	2,599	(69)	5,751	7,005	(1,254)	26,590
Net Cash Inflow/(Outflow) from Investing Activities	(2,465)	(2,473)	(8)	(5,550)	(6,587)	(1,037)	(16,503)
Net Cash Inflow/(Outflow) from Financing Activities	3,636	3,709	73	2,856	3,037	181	7,982
Net Increase/(Decrease) in Cash Held	2,514	541	(1,973)	(721)	(1,192)	(471)	2,710
Plus Opening Balance	19,595	21,187	1,592	22,830	22,920	90	22,830
Closing Balance	22,109	21,728	(381)	22,109	21,728	(381)	25,540

2.2. Operating Cash flow

The year to date result shows the net cash inflow from operating activities of \$2,358k against a budget inflow of \$1,973k, an overall favourable variance of \$385k.

Variances

Cash inflow is unfavourable to budget by \$460k

Cash outflow is favourable to budget by \$845k:

- Personnel payments are favourable \$4.7m due to savings in expenditure (\$806k) and accruals \$3.9m more than planned due to a high unpaid days accrual, and accruals for expired collective agreements not yet paid out
- Other operating payments are \$3.8m more than planned, reducing accruals and Accounts Payable balances.

2.3. Investing Cash flow

Net investing Cash outflow is unfavourable to budget by \$1,037k. This is mainly due to the capital expenditure being more than planned (projects carried forward from 2009/10) offset by increased interest received and asset sales occurring in advance of plan.

2.4. Financing Cash flow

Financing cash flow is favourable to budget by \$181k due mainly to interest paid being less than plan because of the delayed timing of the loan drawdown from CHFA.

3. STATEMENT OF FINANCIAL POSITION

3.1. NMDHB Consolidated Statement of Financial Position as at 30 September 2010

Consolidated Statement of Financial Position \$000s	June 2010	CM Budget	CM Actual	Variance	DAP
Bank	22,920	22,109	21,728	(381)	25,540
Debtors & Prepayments	9,646	22,647	11,254	(11,393)	22,666
Stock	2,016	2,318	2,111	(207)	2,318
Current Assets	34,582	47,074	35,093	(11,981)	50,524
Creditors	28,584	40,630	26,454	14,176	42,486
Employee Entitlements	25,921	25,601	29,543	(3,942)	23,736
Term Debt - Current Portion	1,580	2,404	1,451	953	2,404
Current Liabilities	56,085	68,635	57,448	11,187	68,626
Working Capital	(21,503)	(21,561)	(22,355)	(794)	(18,102)
Non Current Assets	157,119	160,587	162,051	1,464	165,702
Net Funds Employed	135,616	139,026	139,696	670	147,600
Long Service Leave	2,088	1,871	2,088	(217)	1,871
Retiring Gratuities	7,754	8,657	7,754	903	8,657
Sabbatical Leave	1,016	942	1,016	(74)	942
Term Debt	37,540	41,912	41,276	636	49,503
Non Current Liabilities	48,398	53,382	52,134	1,248	60,973
Crown Equity	87,218	85,644	87,562	1,918	86,627
Net Funds Employed	135,616	139,026	139,696	670	147,600

3.2. Working Capital

Working Capital is unfavourable to budget (\$794k). The opening position variance (the difference between actual opening balances and those forecast as the starting point of the balance sheet budget) is unfavourable \$711k. The resulting \$83k unfavourable variance YTD is a combination of bank balances \$470k unfavourable, debtors and prepayments \$1.45m favourable, creditors \$2.6m favourable, and accrued personnel/employee entitlements unfavourable \$3.8m (includes \$2.3m restructuring accrual).

3.3. Term Liabilities

The term liabilities are better than budget (\$1,248k). This is as a result of the opening position variance.

3.4. Non Current Assets

Non current assets balances are higher than budget (\$1,464k). The opening position for the year was \$680k lower than forecast. The resulting \$2,144k favourable variance is due to higher work in progress (WIP) resulting from projects carried forward from the 2009/10 capital budget.

3.5. Shareholders Equity

Shareholders equity is over budget (\$1,918k) due to better than budget Financial Performance.

APPENDIX 2 – EMPLOYEE RELATIONS**NATIONAL MULTI EMPLOYER COLLECTIVE AGREEMENT (MECA) UPDATE**

MECA & UNION	COVERAGE	UPDATE
Medical Radiation Technologists (MRTs)	47 employees	Current MECA expired on 30 September 2009. Negotiations have been underway since June 2009. No agreement had been reached and the union is again engaging in industrial action throughout the country. NMDHB has continued to receive regular strike notices throughout the last three months these are generally restrictive in nature impacting on overnight and weekend work. A complete withdrawal of labour did occur for 24 hours on 7 th -8 th September and is due to be repeated on 9-10 November. Life Preserving Agreement(s) are in place. NMDHB contingency plans are working well. However patient care is being impacted and clinical decision making compromised at times. As new employees are recruited they will be offered an individual employment agreement given the expiry of the collective.
Resident Doctors Association (RMOs)	53 employees	RDA initiated on 16 November for three SECA for the three Auckland DHBs and one MECA made up of 18 DHBs. Negotiations have continued regularly throughout 2010 with no settlement reached. The union contends that the DHBs want to claw back previous agreements. The DHBs deny this and had proposed a significant change to the Agreement in order to meet the needs of RMOs and the health service into the 21 st Century. A publicity campaign was launched by the Union in September. The DHBs then provided the union with an alternative option which the union said it would consult with its members on. The parties met again on the 27 th October where the union provided a counter proposal. The national CEOs Group have requested further information be sought from the union prior to a decision being made on the counterproposal. The MECA is due to expire on 31 December 2010.
Associated Salaried Medical Specialists (ASMS)	132 employees	Agreement has been reached for one year with a salary increase of 2% from 30 January 2011 which is in line with the National Terms of Settlement agreed with other CTU affiliated unions. In addition the parties agreed a process to develop a joint Business Case to be forwarded to the Government. The Business Case will address short, medium and long term strategies related to recruitment, retention, remuneration and clinical leadership related to senior medical officers. The DHB Chief Executives will sign the Business Case off prior to it being forwarded to the Government.
Clinical Physiology (APEX)	7 Employees	Negotiations have commenced. The union provided a late claim which is currently being costed by DHBs.

NMDHB & REGIONAL COLLECTIVE AGREEMENT (CEA) UPDATE

CEA & UNION	COVERAGE	UPDATE
IDSS PSA	303 employees	Signed and being implemented
IDSS NUPE	49 Employees	Signed and being implemented
NUPE Clerical	4 employees	CEA expired 30 June 2009, Settled awaiting final signatures prior to implementation

APPENDIX 3: WAIRAU REDEVELOPMENT REPORT

21 October 2010

Tracking - Milestones

Anticipated and actual completion dates, revised Preliminary Design (Option 4a)

Milestone	Original target	Revised target (option 4a)	Contractual Completion Date	Actual	Forecast
Preliminary Design	Aug 2007	June 2008	June 2008	Ph 1 Mar 2008 Ph 2 Jun 2008	Ph 1 Mar 2008 Ph 2 Jun 2008
Developed Design	Oct 2007	July 2008	Aug 2008	Ph 1 Apr 2008 Ph 2 Aug 2008	Ph 1 April 2008 Ph 2 Aug 2008
Commence Construction	Nov 2007	July 2008	Sept 2008	Sept 2008	Sept 2008
<i>Complete Construction</i>					
Stage 1	N/A	March 2009	May 2009	May 2009	May 2009
Stage 2	N/A	Nov 2009	March 2010	March 2010	March 2010
Stage 3	N/A	Aug 2010	Nov 2010		Nov 2010
Stage 4	Sept 2009	Nov 2010	Feb 2011		Feb 2011
Certification & Migration	20 Working Days after construction works completed				

Notes

Major delays, to the original target completion dates contained in the approved business case, are a result of delays by the Ministry of Health for the approval of the initial Preliminary Design proposal.

Revised target dates for completion were set when the revised Preliminary Design (Option 4a) was submitted for approval by the Ministry of Health.

Contractual completion dates are based on the actual contracted completion dates agreed with the project consultants and contractors.

The forecast date for the completion of the final project Stage (Stage 4) ready for occupation is 20 working days after construction completion (current forecast February 2011 plus 20 days).

Stage 1: Inpatients, AT&R, Allied Health, Chapel, CAMHS and Pharmacy.

Stage 1A: Third Theatre – Construction completed 31 May 2010.

Stage 2: ED/HDU/AAU, Imaging, Laboratory, Clerical and Admin.

Stage 3: Maternity, Child & Youth, Day Stay, Outpatients/Oncology, Main Entrance, Café.

Stage 4: AOD/Adult Mental Health, Kitchen.

Churchill Trust wish to build new facilities in the location partly occupied by existing Ward 5 (demolition scheduled to commence at the end of Stage 3) subject to a lease agreement.

A new Dental Clinic is now to be provided under Stage 3 of the redevelopment project.

Facilities Progress

During the last reporting period the key activities have been:

- The paving to the vehicle access and drop off zone at the new Main Entrance has been completed. Outpatients/Oncology joinery fittings and decorating are substantially complete. Phase Two of the Day Stay refurbishment is progressing well
- Paediatric Inpatients joinery fittings and decorating are substantially complete. Some second fix services still to be completed
- Maternity flooring and decorating completed to the majority of areas and installation of second fix services and fittings has commenced
- The installation of safety radiators is completed in Stage Three and the installation and commissioning of standard radiators is being implemented on a fast track basis by the Main Contractor to mitigate the late supply of the fittings
- The construction programme for Stage Three is seven days behind the critical path schedule. Two days of the reported delay have been recovered during the reporting period due to rescheduling and extended hours working by the contractors on site. 'Extension of Time' claims have been granted to the Main Contractor for the additional asbestos removal and the inclement weather delays previously reported. It is anticipated that some further time will be recovered from the reported delays; with the overall projection completion expected mid February 2011
- The first fix services and linings to the new Dental clinic are almost complete
- The café building shell has been completed and handed over to the operator for fitting out works
- The design of the kitchen 'shell' has been developed further to enable the construction to be completed within the agreed project timeframes
- The installation of the furniture, fittings and equipment for Stage Three is progressing well
- The certification audit visit for Stage Three Inpatient facilities planned for 6 October 2010 was rescheduled to 18 October 2010 due to travel problems. The auditor's report will be issued to Ministry of Health on 22 October 2010 and it is expected that certification will be issued prior to the occupation of Maternity and Paediatrics on 5 November 2010. The partial and un-attainments of standards noted in the auditors verification report are a result of work which was not due for completion prior to the certification visit, but is scheduled to be complete before the facilities are operational
- A site plan for the proposed new Churchill Trust ward is required to establish the interface with the redeveloped campus buildings, infrastructure and access roads. A

paper is being prepared by Property Management for the proposed lease of land and infrastructure servicing for the Churchill Trust facilities.

Change Management Progress

- Optimising the Patient Journey project activities are progressing with the support of the new Service Improvement Facilitator, whom has now a good understanding of the coordination of Wairau Redevelopment Project activities and OPJ initiatives
- The reported issues with the Nurse Call pager functionality have been investigated, The IT Group has recommended that it is operated on a separate LAN in order to provide a sustainable solution
- The agreed actions from the clinic and theatre scheduling subgroup have resulted in the initiation of a subproject to progress coordinated discharges for inpatients during weekend periods
- An improved phone system has been successfully trialled for the Allied Health clerical hub, which will now be implemented in all the clerical hubs to help support the new workforce model
- Stage Three clerical hub development is focusing on the implementation of new rosters to reflect changes to the activities and rotations to support cross skilling. Areas with potential issues have been identified and one-on-one coaching is occurring as required
- The Inpatients working party has picked up the previously identified issues and resolutions lists from the blue sky events held pre-migration and is progressing with prioritising resolution implementation. The communication and teamwork workshops have been deferred to the 2011 due to other training commitments and coordination with new staff in the area
- The ED/HDU/AAU transition staffing model review is progressing well. Further work has been undertaken on the skills matrix which helps inform the clarification of clinical roles and responsibilities.

Budget

- Prices are being sought for the new Kitchen structure. Any variance between the budget allowance and the tender sum will need to be justified by the Project Quantity Surveyor, together with the identification of cost mitigation measures.

Activity Planned for Next Reporting Period

- Continue with remaining construction activities for Stage Three
- Complete the installation of Stage Three furniture, fittings and equipment
- Relocate the Maternity and Paediatrics services to the new Stage Three facilities on 5 November 2010
- Relocate Outpatients, Oncology and RMO/SMO accommodation to the new Stage Three facilities on 12 November 2010
- Relocate Day Stay and Dental Services to the new Stage Three facilities on 16 November 2010
- Plan Stage Four migration meetings with user representatives
- Monitor the implementation and continuing clerical hub development with Stage Three clerical staff
- Confirm the sub project brief for coordinated discharge planning and time frames
- Continue with the review of the ED/HDU/AAU Model of Care and development of the staffing model

- Complete Stage Four FF&E schedules and submit to the procurement team for final pricing.

Communications

- The Wairau Site Redevelopment web site has been updated with the latest project information and may be viewed using the URL <http://nmdhb.govt.nz/wairau>
- Edition 47 of the project newsletter 'Ex-Site' will be issued on 28 October 2010
- A blessing of the Stage Three new facilities will take place on Tuesday, 26 October 2010
- A community preview of the new Stage Three facilities will be held on Tuesday, 2 November 2010 between 4.00-6.00pm. Departments open for viewing will be Outpatients/Oncology, Paediatrics and Maternity
- An opening ceremony for the children's playground in the new Paediatrics facility will be held just prior to the public preview commencing
- A decommissioning ceremony for the current Paediatrics and Maternity facilities will take place at 4.00pm on Friday, 5 November 2010 prior to refurbishment for Mental Health services
- A decommissioning ceremony for Wards 5/6/7 will take place at 3pm on Tuesday, 16 November 2010 prior to demolition
- Training on Nurse Call, Fire, Security, Electrical, Plumbing and Mechanical services in the new facilities for the maintenance team was led by the sub-contractors for each service on 21 October 2010. Staff training will take place on 22 October 2010
- Orientation sessions for staff working in the Stage Three departments, and those who are required to be familiar with the layout of the new facilities have been scheduled
- General viewing times for all staff of the new facilities have been scheduled
- The Community Liaison Group continues to progress various projects:
 - Artworks continue to be received by the group from local artists. Thirty black and white historic images of Wairau Hospital are currently being framed for installation along the length of the new main corridor
 - The four large glass art panels designed by Rick Edmonds for the main entrance are currently being manufactured with an intention to install on Friday, 29 October 2010. Sowmans Funeral Services and Monumental Masons have sponsored the cost of the panels which each measure 900mm x 1700mm
 - The group has secured 60% of the plants required to complete the main entrance area through donations by local nurseries and have volunteered to complete the planting on Wednesday, 27 October 2010
 - Local service clubs are being approached to assist with completing other areas of landscaping around the campus
 - A washing line has been purchased for AT&R for use with the washing machine that was provided last month
 - The standard-issue tables in the chapel have been replaced with heart Rimun hand crafted tables by the Woodworkers Guild
- Weekly construction impact meetings with staff continue through 2010
- Weekly site visits to the new facilities are taking place for the staff in Stage Three departments.

Key Risks

- HIGH RISK – Capital costs may have been underestimated. The design, cost plan, and Contract Instructions are being reviewed frequently, including the remaining contingency allowance, to provide early cost alerts. Mitigation measures will be implemented as necessary if any cost alerts are raised
- MEDIUM RISK – There is no ‘float’ remaining in the overall project programme, and completion of the construction programme relies upon design and procurement information being issued on time. Progress on programme will continue to be monitored on a weekly basis with ongoing reviews to seek potential mitigation measures where potential delays are identified
- MEDIUM RISK - The revised staffing efficiency benefits for delivering additional ‘throughput’ volumes without increasing staffing may not compare as favourably with the proposed staffing efficiencies in the business case associated with reducing FTEs, and is therefore being kept under review
- MEDIUM RISK – The implementation of new clinic and theatre schedules, together with the introduction of new models of care for the services included in Stage Three of the redevelopment, will have a significant impact on the current SMO work practices and rosters. If there is not sufficient management and clinical leadership support for these changes there is a risk that the proposed efficiency benefits may not be achieved. In order to help minimise these risks, senior management needs to continue to champion the change processes and support the SMO group to implement the required changes
- MEDIUM RISK – The delays to the confirmation of the catering strategy and the peak services demand has resulted in a delay to the proposed kitchen redevelopment programme. Mitigation measures including alternative design, procurement and construction methodologies are being investigated
- MEDIUM RISK – Disestablishment of some Senior Leadership Team and Provider Team management roles may result in distraction and disengagement of some personnel for achieving project objectives. Mitigation measures including regular communications and a transitional period of incumbent personnel with personnel in newly established roles will help mitigate this risk.

Key Issues

- The delays to the issue of the verification report by Telarc to the Ministry of Health (MOH) provide only a ten working day period for the certification of the facilities by the MOH. The MOH have been requested to expedite certification, however there is a risk that the planned move to the new Maternity and Paediatrics facilities will need to be postponed from 5 November 2010 if the MOH are not able to expedite the issue of the certificate.

SECTION 5: FOR INFORMATION

(a) Diabetes Data Matching Project



**Diabetes Data Matching Project
2010**

Report Prepared by:

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For:

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Nelson Marlborough District Health Board
DHBNZ PHO Performance Programme
Ministry of Health



Executive Summary

This report presents the findings of a Diabetes Data Matching project undertaken by Nelson Bays Primary Health (NBPH) in conjunction with the Ministry of Health (MoH) and Nelson Marlborough District Health Board (NMDHB).

NBPH and NMDHB were concerned with the district's continued poor performance reports with respect to diabetes indicators on the PHO Performance Programme (PPP) and the National Health Target of 'Better Diabetes and Cardiovascular Services'. An initial pilot project was undertaken by NBPH to verify the denominator used to calculate performance, which indicated a potential cause of the poor performance. NBPH then requested an opportunity to match those people that the Ministry of Health believe to have a diagnosis of diabetes with those that general practices have coded as having a diagnosis of diabetes.

The aim of the Diabetes Data Matching Project was to ascertain the reasons why NBPH performed poorly on the PHO Performance Programme for the Diabetes Detection indicator, and to correct this performance through a systems approach and education. This would have a significant impact also on the overall DHB performance against the Minister's Health Target as the issue is the same.

NBPH matched 640 patient records for people who have been identified with diabetes by the Ministry of Health but were uncoded in general practice. Of these, we found 54 (8%) patients who were correctly coded at practice but the codes had not been picked up by the Clinical Performance Indicator (CPI) report; 17 (3%) patients who had diabetes but were not coded in practice; 76 (12%) patients who required follow-up to determine their true status with respect to diabetes, and 493 (77%) patients who did not have diabetes.

NBPH also found that there were data anomalies relating to the health service contact of people visiting Nelson Hospital Outpatient Endocrinology clinics for FSA prior to 1 July 2007. NBPH notes that the new PPP Indicator definitions (as at 1 July 2010) have moved to address this anomaly but no allowance has been given to NBPH's denominator. The 2010 upwards revision of the estimated prevalence may compound both performance issues of and financial penalties to NBPH if the original data anomaly is not corrected.

NBPH has made a number of recommendations that include: further education for GPs about monitoring people with pre-diabetic conditions; investigating the CPI report; correcting the Ministry of Health register; adjusting the data definitions for FSA visits to diabetes clinics; adjusting the denominator (estimated prevalence) for the diabetes indicators based on the results of this project.

Background

Nelson Bays Primary Health (NBPH) and Nelson Marlborough District Health Board (NMDHB) were concerned with the district's continued poor performance reports with respect to diabetes indicators on the PHO Performance Programme (PPP) and the national Health Target of "Better Diabetes and Cardiovascular Services". An initial pilot project was undertaken by NBPH to verify the denominator used to calculate performance, which indicated a potential problem. NBPH then requested an opportunity to match those people that the Ministry of Health believe to have a diagnosis of diabetes with those that general practices have coded as having a diagnosis of diabetes.

On 1 July 2008, the PHO Performance Programme, administered by District Health Boards New Zealand (DHBNZ) and supported by the Ministry of Health, introduced new Phase II Chronic Condition indicators. These indicators included two indicators for diabetes: Diabetes Detection and Diabetes Detection and Follow-up. Diabetes Detection describes the process of attributing a Read code to those people with a diagnosis of diabetes within the general practice Practice Management System (PMS). One purpose for attributing a Read code is to create a disease-specific register within practice to allow better monitoring of people with diabetes. By creating a disease-register, patients can be located, offered Diabetes Annual Review and recalls can be implemented. The denominator used to measure performance for the Diabetes Detection indicator is the same for Diabetes Detection and Follow-up – see Appendix 1.

The results received by NBPH for the performance period 1 July, 2008 to 31 December, 2008 showed that NBPH achieved 62.42% of its target for Total Population and 73.07% of its target for the High Needs population (those people who identify as Māori, Pacific or reside in NZDep06 quintile 5) – see Table 1. The target for NBPH, as agreed with NMDHB and approved by DHBNZ, was a 5% threshold target. Although NBPH achieved the target, the main problem identified by the performance report was that over 1000 people were "missing" a Diabetes Read code, and were potentially not identified at practice level. This means they may be missing out on treatment vital to maintaining their health and reducing complications of diabetes. Furthermore, these people would not be offered Diabetes Annual Review, if they could not be identified at practice level.

Table1: Diabetes Detection performance for performance period 1 July 2008 – 31 December 2008

	Enrolled Population with Diabetes Coded at the end of Dec 31 2008	Enrolled Population estimated to have Diabetes using Prevalence Estimate Data	Indicator Value	Agreed Target 1 st 6 months
Total Population	2013	3225	62.42%	5.0%
High Needs	331	453	73.07%	5.0%

Poor performance continued throughout 2009 despite intense education of practice staff on Read coding for diabetes, and the use of DrInfo as a clinical audit tool to locate potential patients with diabetes. That approximately one-third of the estimated target cohort had not

been Read coded prompted NBPH to conduct a pilot investigation to discover why and how this was occurring.

Aim:

The aim of the Diabetes Data Matching Project was to ascertain the reasons why NBPH performed poorly on the PHO Performance Programme for the Diabetes Detection indicator, and to correct this performance through a systems approach and education.

Method

In December 2009, NBPH undertook a small pilot with a limited number of practices to trawl their PMS, to try and locate "missing" patients with diabetes. The trawl included looking at DrInfo reports for diabetes medications and HbA1c results, as well as using MedTech 32 Query builders (all practices in Nelson Bays use MedTech32 as their PMS) for medication, and screening for DIAP codes. We also looked at Inbox documents for laboratory results (fasting glucose and glucose tolerance test results). This was very labour intensive and undertaken by NBPH staff; we are grateful to the practices for giving us permission to perform the audit.

The audit did not reveal serious systemic errors; we did not locate the 1000 patients we hoped to find, and therefore we concluded the numerator was probably correct. Concern was raised over the "accuracy" of the denominator provided by the MoH.

In March 2010, at the request of NBPH, Dr Sandy Dawson at the Ministry agreed to send to NBPH the list of patients that the MoH had attributed a diagnosis of diabetes.

NBPH matched this list of patients to patients with known Read codes as determined by the Clinical Performance Indicator (CPI) report submitted by practices to NBPH quarterly. Where there was agreement, these patients were deemed to be diabetic and no further work was done. Where there was a discrepancy, these patients were assigned to a practice list and two NBPH staff visited every practice to investigate each NHI.

Results

After our analysis, we found:

Table 2: Results of Data Matching

Data Matching	
Total number of people with Diabetes from MoH	3095
Total number with Diabetes from NBPH	2455
Potentially Uncoded with Diabetes	640

The records of 640 patients, located at all 26 general practices within the Nelson Bays region, were thoroughly examined.

Table 3: Results for patients whose clinical records were examined

Patient Clinical Record Examined at Practice	
Patient has diabetes?	
Yes – and coded at practice	54
Yes – and not coded at practice	17
Maybe	76
No	493
TOTAL	640

a. Yes – and coded at practice

The common factor here was that most of these patients were Read coded prior to 1999. There may be an error with the MedTech query that takes data for the CPI report; it may only look at Read codes after 2000, in keeping with other data sets that inform the denominator (estimated prevalence). A request to investigate this has been sent to DHBNZ.

b. Yes – and not coded at practice

NBPH identified patients they believed should be clinically classified as there was evidence within the PMS to support a diagnosis of diabetes. NBPH did not add this classification; a report was left for the appropriate GP with a request to review the evidence and assign a classification if they believed this was appropriate.

A number of GPs did not use the Read code system properly, and while recording within the Classifications template, they used the notes function to record diabetes but kept the Classification as “unclassified”. Education has modified this use of coding.

c. Maybe

This group represented a number of patients who had the potential to have a diagnosis of diabetes but there was insufficient evidence to attribute a Read code of diabetes. For example, people who had an OGTT with a diagnosis of Impaired Glucose Tolerance (IGT) or Impaired Fasting Glycaemia (IFG), had no further follow-up and more than two years had elapsed since their OGTT; people with gestational diabetes and no follow-up; people on oral hypoglycaemic medication with no evidence of a diagnostic OGTT or HbA1c; obese patients managed on metformin; women with Polycystic Ovary Syndrome (PCOS) managed on metformin; people with hospital discharge summaries that stated a diagnosis of diabetes but with no evidence to support this; patients in residential care facilities who have been prescribed medication but without Read codes.

Reports were left with practices requesting that this group be reviewed with a view to having an OGTT to establish diagnosis, or an HbA1c if more appropriate.

This group of patients caused the largest dilemma for NBPH and represented an area where education would be of benefit. Many GPs debated the frequency of

testing for IGT and IFG; the New Zealand Guidelines Group (NZGG) (NZGG, 2009) are clear that this should be annually. Some GPs believed in the regime of aggressively treating overweight people with metformin but had not considered when they would attribute a diagnosis of diabetes to the patient (based on HbA1c or OGTT) so that the patient could receive treatment they may require e.g. Diabetes Annual Review, Retinal Screening and Podiatry.

d. No

The majority of the patients whose records were examined did not have diabetes. Of the 640 patients whose records were examined, 493 unequivocally did not have diabetes (77%).

We noted several errors with data from the Pharmacy Warehouse. Where a patient had been ascribed 'Pharm Dispensed' (i.e. information from the national Pharmacy Warehouse indicates a person has had a prescription dispensed for either metformin or other hypoglycaemic medicine e.g. insulin, glitazone) from the Ministry of Health, and the patient PMS records did not support the issuing of a script for insulin or oral hypoglycaemic agents, the patient was contacted by the Practice Nurse. One instance was a child of seven; according to Ministry of Health data, he had been prescribed metformin and both the practice and the parents agreed that this was a mistake.

A number of women were taking metformin for PCOS, and were not diagnosed with diabetes but met the criteria for 'Pharm Dispensed'.

A number of patients were seen by other hospital specialists; one clinic summary noted the patient had been diagnosed with type II diabetes because of a high cholesterol result but no evidence of abnormal carbohydrate metabolism was discovered (all glucose results were normal at the practice).

The majority of patients in this group had at some time since 2000 visited Dr Pamela Hale. Dr Hale is not only the Nelson Hospital Diabetes Specialist but also the Endocrine Specialist. Most of the patients had been to see Dr Hale for an endocrine disorder other than diabetes (thyroid disease, pituitary disease, chromosomal disorders, etc).

NBPH then conducted a meeting with Nelson Hospital staff to determine why so many patients with endocrine disorders were identified on the Ministry of Health database as having a diagnosis of diabetes. The hospital data administrators noted that on 1 July 2007, to make way for the new Health Targets, hospital out patient clinic department codes were split from M20 (Endocrinology and Diabetes) to M95 (Endocrinology) and M96 (Diabetes). Hence all data prior to 1 July 2007 has Endocrinology clinic patients coded by the Ministry of Health as having a diagnosis of diabetes, when in fact they are not.

Discussion:

a. Performance

If the Ministry of Health data used to estimate the denominator for the Diabetes Detection indicator was corrected to take into account the incorrect attribution of First Specialist Assessments (FSA) at Endocrinology outpatients clinics, the data for NBPH would be:

Table 4: "Corrected" performance using denominator adjusted for anomalous FSA

	Enrolled Population with Diabetes Coded at the end of Dec 31 2008	Enrolled Population estimated to have Diabetes using Prevalence Estimate Data	"Corrected" Prevalence	"Corrected" Indicator Value
Total Population	2013	3225	2706	74.4%
Total Population (adding in a+b)	2084		2706	77.0%

If the 54 patients in groups a (Yes- and read coded at practice) and the 17 patients in group b (Yes- and not read coded) are added to the numerator, then the "corrected" indicator value would be 77.0%; this is a 15% improvement on the result to the end of December 2008 and would mean that NBPH would be rated higher on MoH released league tables for PHO performance.

The PPP Performance Report to end of December 2009 shows the following:

Table 5: Performance data to the end of December 2009 for Diabetes Detection

	Enrolled Population with Diabetes Coded at the end of Dec 31 2009	Enrolled Population estimated to have Diabetes using Prevalence Estimate Data	Indicator Value	Agreed Target
Total Population	2461	3225	76.31%	65.01%
High Needs	422	453	93.16%	77.33%

NBPH made both the targets for the Diabetes Detection indicators, and was rewarded financially for making this indicator. Over the period of 12 months a further 377 have been coded with diabetes; some of these are as a result of the Vascular Risk Assessment programme. Some are the result of intensive work to locate diet-controlled type II diabetes patients. However, the denominator has still not been adjusted; if it had the result for Total Population would be 90.9%. There is a significant difference between Diabetes Detection for Total Population and High Needs populations; this is highly unusual given that this result is usually the other way round. If the denominator was corrected these would be much closer, reflecting a truer picture of Read coding in practice.

Similarly, the denominator affects the Diabetes Detection and Follow-Up indicator (essentially those people with diabetes who have had an Annual Diabetes Review). NBPH missed the target for Total Population by 12 patients.

Table 6: Performance data to the end of December 2009 for Diabetes Detection and Follow-up

	Enrolled Population with a Diabetes Annual Review at the end of Dec 31 2009	Enrolled Population estimated to have Diabetes using Prevalence Estimate Data	Indicator Value	Agreed Target
Total Population	1444	3225	44.78	45.15
High Needs	232	453	51.21	50.99

If the denominator had been adjusted (because if the patient does not have diabetes, they cannot be expected to have a Diabetes Annual Review), then NBPH would have made the target with a result of 53.4% (denominator 2706).

Performance for these indicators is reported publicly: it is unfair to penalise NBPH and by default NMDHB and bring the organisation and general practices into disrepute by reporting on overestimated prevalence.

b. Revised Estimated Prevalence

In December 2009, NBPH was advised that the estimated prevalence had been revised upwards. This also caused concern. The current data we have that relates to the Progress report until the end of March 2010 shows:

Table 7: Progress data to the end of March 2010 for Diabetes Detection

	Enrolled Population with Diabetes Coded at the end of Dec 31 2009	Enrolled Population estimated to have Diabetes using Prevalence Estimate Data	Indicator Value	Agreed Target
Total Population	2585	3579	72.23%	74.05%
High Needs	445	537	82.87%	81.16%

Table 8: Progress data to the end of March 2010 for Diabetes Detection and Follow-up

	Enrolled Population with a Diabetes Annual Review at the end of Dec 31 2009	Enrolled Population estimated to have Diabetes using Prevalence Estimate Data	Indicator Value	Agreed Target
Total Population	1693	3579	47.30%	43.85%
High Needs	289	537	53.82%	46.70%

NBPH has not made the target for Total Population Diabetes Detection; performance has gone backwards as would be expected with a further increase in the denominator. The denominator (estimated prevalence) still includes the 493 patients who do not have diabetes; if this anomaly was corrected, the denominator would be approximately 3086 and our result would be 83.8%. Similarly, the results for Diabetes Annual Review would show an improvement.

c. Financial

The PPP incentivises general practices to meet targets for the programme. By missing the target for the Diabetes Detection and Follow-up, NBPH missed a payment of \$1126.67 for the performance period up to the end of December 2009. This is not of as great concern as the performance and understanding the data. However, if this anomaly is not corrected, there may be ongoing financial penalties.

Recommendations:

Following this project, NBPH would like to see the following actions taken:

- a. The Ministry of Health should acknowledge the finding of this report and agree that there are issues with the data.
- b. The Ministry of Health should update its database so that people without diabetes identified in this project are removed from their register.
- c. DHBNZ should investigate the MedTech query for the CPI report to ensure all Read codes assigned before 2000 are picked up in the report for Diabetes Detection.
- d. Given that the **definition of people with diabetes (i.e. the denominator)** is defined by the PPP as:
Within the health service contact population defined above: people were defined as having diabetes if they had at least one previous diabetes related hospitalisation (primary and secondary diagnostic codes shown below) or attended diabetes clinics in hospital outpatients, or had received 2 or more diabetes-related pharmaceutical dispensing or had 4 or more Hba1c tests as defined below
(DHBNZ, 2010, p. 60; Appendix 1)

And that the **National Diabetes Prevalence Estimates** are described by the PPP as:

The expected number of people with diagnosed diabetes in a specified population (a DHB or PHO) was calculated by applying the national average prevalences of diagnosed diabetes (as defined above) by age, gender and ethnicity to a specified DHB or PHO population (DHBNZ, 2010, p.61; Appendix 1)

NBPH would like to see the prevalence estimate for the region adjusted in the light of our data analysis.

- e. Further education should be undertaken by general practice about the follow-up and management of people with IGT, IFG and obesity treated with oral hypoglycaemic agents.
- f. The Ministry of Health should consider this project and apply the adjustment to the National Health Target data.

- g. The indicator definition should be changed to address the FSA data prior to 1 July, 2007. (we note that as of 1 July 2010, version 4 of the PPP Indicator definitions has been updated to take this into account).

Conclusion:

Concerns about poor performance with diabetes indicators on the PPP led NBPH to undertake a data matching project with the Ministry of Health. NBPH found that there were data anomalies related to the health service contact of people visiting Endocrinology clinics for FSA prior to 1 July 2007. We note that the new PPP Indicator definitions (as at 1 July 2010) have moved to address this anomaly but no allowance has been given to NBPH's denominator. We also found that there may be an error, which requires further investigation, with the Read codes picked up in practice CPI reports. This work has been initiated. The 2010 upwards revision of the estimated prevalence may compound both performance issues of and financial penalties to NBPH if the original data anomaly is not corrected.

The project itself was extremely well received by general practice as they too were concerned with their individual practice performance. The PPP states:

Analyses of expected versus observed prevalences for smaller populations, such as at the practice level, should be interpreted with considerable caution given the influence of random error in small populations. At the practice level it will be difficult to differentiate between random error and under-diagnosis as the cause of any significant differences between observed and expected prevalences. (DHBNZ, 2010, p. 61; Appendix 1)

However, we would argue that under-diagnosis of diabetes does not relate to those who require medication; these are easily detected by querying the PMS database, which we did and out of 640 patients, we found 17. The number of diet-controlled diabetics is very small and will account for some variation, which we have allowed for in our calculations. Over-estimation of the prevalence of diabetes remains the major concern.

There is a need for further education about the monitoring of people with pre-diabetic conditions. There seems to be no consistent approach in the region despite guidance in the New Zealand Cardiovascular Guidelines 2009. There is a possibility that there will be a delay in the diagnosis for some people, which may affect complications later.

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References:

New Zealand Guidelines Group (NZGG) (2009). *The New Zealand Cardiovascular Guidelines 2009*. Wellington: NZGG.

District Health Boards New Zealand (DHBNZ). (2010). *Indicator Definitions: as at 1 July 2010, Version 4*. Wellington: DHBNZ.

Appendix 1:

8.6 Appendix F– Method for Calculating NZ National Diabetes Prevalence

(DHNBSZ, 2010, pp 59-61)

Inclusion criteria of the study population (i.e. the numerator)

1. New Zealand "health service contact" population refers to people who had any form of health services contact in New Zealand from 1st July 2007 to 30th June 2008 or who were actively enrolled with a PHO, as documented in at least one of the following NHI-linked national datasets:

- a. On a PHO Enrolment Register (GP Consult date or current PHO enrolment – there will be a small number of people who are not resident but are enrolled, but they are greatly out weighted by including people enrolled with no contact in the last 12 months),
- b. NMDS Public Hospital Event (Admission or Discharge date),
- c. NMDS Private Hospital Event (Admission or Discharge date),
- d. National Health Index list (last updated date),
- e. National Mental Health Collection (service start, service end and contact dates),
- f. Laboratory Testing Claims,
- g. Community Pharmaceutical Dispensing.
- h. People with at health system contact in at least one of the four quarters were included unless they were without residency status and then they were excluded (domicile code was not used as criteria for exclusion).

2. Ethnicity recordings were taken from the 2008 2nd quarter of the PHO enrolment database. If an ethnicity recording was unavailable, it will be taken from the latest version of NMDS or NHI. Ethnicity was stratified by Maori (ethnic code 21), Pacific people (30–37), 'South Asian' (43), and 'Other' New Zealanders.

Note that the best map for 'South Asian' ethnicity (as specified in the New Zealand Guidelines Group guidelines) using 2 -digit ethnicity codes was determined to be code 43.

3. Socioeconomic status was measured using the NZDep2001 index of deprivation by quintile at the census area unit (CAU 2001) level for the DHB of domicile extract and at meshblock (MB 2001) level for the PHO extract.

4. In the PHO and practice extracts the definition of the DHB is based on the DHB the PHO is in. The PHO and practice come from the PHO enrolment register 2008 2nd quarter. The DHB extract is based on the CHD of domicile and includes all live and resident NHIs, not just those enrolled with a PHO.

Definition of people with diabetes (i.e. the denominator)

5. Within the health service contact population defined above: people were defined as having diabetes if they had at least one previous diabetes related hospitalisation (primary and secondary diagnostic codes shown below) or attended diabetes clinics in hospital outpatients, or had received 2 or more diabetes-related pharmaceutical dispensing or had 4 or more Hba1c tests as defined below.

- a. ICD codes for hospitalisation from 1998 to 2008 were ICD 10: E10-E14 (diabetes codes), O24.0 to O24.3 (referring to pre-existing diabetes in pregnancy), ICD 9: 250 (diabetes codes); but not ICD 10:O24.4 (diabetes arising from pregnancy).
- b. Hospital outpatients (from 2006 to 2008) were identified by the purchase units within the National Non-admitted Patient Collection (NNPAC), namely M20004 to M2007 and MAOR0106 (Maori Management) covering first and subsequent diabetes attendances to clinics, and clinics for diabetes education and management and retinal screening (no other diabetes specific purchase units were included e.g. High Risk Type I Diabetes Support; High Risk Type I Diabetes Support for up to 18 year olds).
- c. Diabetes related pharmaceutical dispensing (from 2001 to 2008) include all subsidised forms of insulin, and oral hypoglycaemic. However, dispensing of glucose test strips, insulin needles, and glucagon were not included (we did not exclude dispensing in the younger age groups in this extract).
- d. 4 or more Hba1c testing undertaken for an individual between 1 July 2006 and 30 June 2008.

National diabetes prevalence estimates

6. The prevalence of diagnosed diabetes is estimated as the numerator (people with diabetes as defined above) divided by the denominator (the 'health service contact' population as defined above).
7. The expected number of people with diagnosed diabetes in a specified population (a DHB or PHO) was calculated by applying the national average prevalences of diagnosed diabetes (as defined above) by age, gender and ethnicity to a specified DHB or PHO population.
8. The observed prevalence of diagnosed diabetes was simply the number of people with diagnosed diabetes, as defined above, in a specified DHBs, PHO or practice.
9. The observed prevalence for a specified population was then compared with the expected prevalence.
10. Of note, these methods eliminate numerator-denominator bias commonly found in estimates of prevalence or incidence derived from national data sets as both the numerator and denominator are derived from the same 'health contact' datasets.

Method in calculating PHO performance targets for diabetes

11. The expected prevalence for a specified population based on national averages by age, gender, and ethnicity (calculated from step 6) were used to generate a PHO performance target for each PHO based on the demography of the particular enrolled population (i.e. accounting for age structure, gender and ethnicity mix).
12. Analyses of expected versus observed prevalences for smaller populations, such as at the practice level, should be interpreted with considerable caution given the influence of random error in small populations. At the practice level it will be difficult to differentiate between random error and under-diagnosis as the cause of any significant differences between observed and expected prevalences.

SECTION 6: MEMBERS' ISSUES

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
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
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)
CCF	Chronic Conditions Framework
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)
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
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
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
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
EOI	Expression of Interest
ENT	Ears, Nose and Throat
ESA	Electronic Special Authority
ESOL	English Speakers of Other Languages
ESPI	Elective Services Patient Flow Indicators
ESR	Environmental Science & Research
ESU	Enrolled Service Unit
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
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 Caesarian Section
LTC	Long Term Care
LTCCP	Long Term Council Community Plan
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
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
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
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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