CPHAC/DISAC COMMITTEE AGENDA

NOTICE OF MEETING

OPEN

19 April 2011

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE AGENDA

Nelson Marlborough District Health Board
DHB Seminar Centre Room 1
Braemar Campus, Waimea Road
NELSON
Tuesday, 19 April 2011 commencing at 9.30 am

Public Forum		9.30am	
SECTION 1	Welcome, Karakia and Apologies	9.40am	4
SECTION 2	Registration of Interest	9.45am	5
SECTION 3	Confirmation of Minutes from the previous meeting	9.55am	10
	Matters arising	10.05am	25
	Correspondence	10.10am	26
SECTION 4	Reports	10.15am	27
	Chairperson's Report		27
	Management Reports		28
	Updates/Standard Reporting Items		
	General		28
	Decision		28
	Quality		31
	Utilisation/Activity		31
	Performance to KPIs		33
	Financial Results and Forecasts		35
	Emerging Issues		49
	Project Reports or Status		50
	Health Alliance/Collaboration		52
	Progress Against Service Improvement Plans		53
	Directorate Profiles		53
SECTION 5	For Information	11.50am	55
SECTION 6	Members Issues	11.55am	56
SECTION 7	Glossary of Commonly Used Acronyms, Abbreviations And Maori Translation		57
SECTION 8	Appendices		63
	Appendix 1 Earthquake Briefing		63
	Appendix 2 Clinical Services Support Presentation		72

Appendix 3 Community Based Services Presentation 75
Appendix 4 Mental Health Services Presentation 77

Resolution to Exclude Public 12.00pm

PUBLIC EXCLUDED MEETING
RECOMMENDATION
THAT the Committee 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 CPHAC Committee held on 26 October 2010 Clause 34(a) Schedule 4 of New Zealand Public Health & Disability Act 2000).***

SECTION 1: WELCOME, KARAKIA AND APOLOGIES

SECTION 2: REGISTRATIONS OF INTEREST – CHPAC/DISAC MEMBERS

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Gerald Hope (CHAIR)	▪ Chairman Marlborough Hospice Trust	▪ Executive Officer Marlborough Research Centre ▪ Director Maryport Investments Ltd	▪ Landlord to Cawthron Laboratory Services Blenheim	
Fleur Hansby	▪ Son is 6th year medical student ▪ Disability Funding from ACC		▪ Family member ▪ Self	
Gordon Currie	▪ President Nelson GreyPower		▪ Residents over 50 years	
Jenny Black	▪ Life member of Diabetes NZ			
Jennifer M Black*	▪ Nil			
John Moore	▪ Nil	▪ Member Nelson Regional Land Transport Committee ▪ Trustee Top of the South Athletics Charitable Trust		
Jos Van der Pol*	▪ Nil			
Judith Holmes*	▪ Partner works for Child and Adolescent Mental Health Services (CAMHS). ▪ NMDHB representative on the Mapua, Ruby Bay and Moutere District Health Centre Inc Board			
Patrick Smith	▪ Nil	▪ Own HR practice	▪ Consultancy services	
Sonny Alesana	▪ Nil			
Mabel Grennell	▪ Provides Chaplaincy Services at Wairau Hospital			
Glenys MacLellan**	▪ Cancer Society – Bookkeeping			▪ Get Sorted (business) – May have contracts with government agencies which may include health and disability agencies ▪ Active at a national level with the Green Party of Aotearoa NZ and

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
				spokesperson
George Truman**	▪ Has an adult son with intellectual disability in residential care ▪ Wife is committee member of Nelson Branch Alzheimer Society NZ ▪ Member of Rescare, National Association of Parents for the Intellectually Disabled (ID)	▪ Active member of Grey Power (Nelson) ▪ Townhouse resident at Ernest Rutherford Retirement Village		

**Community Representative - CPHAC*
*** Community Representative - DiSAC*
As at 1 April 2011

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	To be advised			
	Dr Elizabeth Wood	▪ 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	▪ Partner of Nelson East Family Medical Centre. Group GP practice ▪ Shareholder – Nelson Regional After Hours			
	Robyn Byers	Nil			
COMMUNITY BASED SERVICES DIRECTORATE					
	Dr Nick Baker	▪ Sr Clinical Lecturer, Community Child Health, University of Otago Wellington School of Medicine ▪ Member Steering Group NZ Child and Youth Epidemiology Service (previously Chair of and co-founder of the service) ▪ Chair NZ Child and Youth Mortality Review Committee ▪ Member Child and Youth Network Advisory Group – MOH/PSNZ/NHB ▪ Member NZ Paediatric and Child Health Committee Royal Australasian College of Physicians ▪ Instructor for Advanced Paediatric Life Support NZ	▪ Wife is a graphic artist who does some health related work		

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
	Dr Bev Nichol	▪ Board of NRADD and Shareholder ▪ Nelson Bays PHO Clinical Governance Group ▪ GP and recipient of Nelson Bays PHO funds ▪ Member of IT Development, National IT Board ▪ Member National Information Clinical Leadership Group	▪ Wife and close friend GPs.		
	Peter Burton	Nil	▪ NMDHB Representative on Tasman Council's Regional Land Transport Committee		
CLINICAL SERVICES SUPPORT DIRECTORATE					
	Dr Stephen Busby	▪ Shareholder Director, Nelson Radiology Limited			
	Dr Neil Whittaker	▪ General Practice owner ▪ Contracted to RNZCGP Medical Educator		▪ Clinical Director Community	
	Hilary Exton	Nil			
	James Bowyer		▪ 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		▪ Partner works in the Ministry of Health		
CORPORATE SUPPORT					
	Nick Lanigan	Nil			
	Denise Hutchins	Nil		▪ Certification/Accreditation	

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
	Dr Sharon Kletchko	▪ 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	▪ Deputy Chair of the New Zealand Standards Council ▪ Member of the Board – EVIDEM Collaboration	▪ EVIDEM is a Not-for-Profit international research collaboration whose purpose is "To promote public health through transparent and efficient healthcare decision making via systematic assessment and dissemination of the evidence for and value of healthcare interventions."	
DONM	Robyn Henderson	Nil			
CMO	Heather McPherson (Acting CMO)	Nil			
DMH & Whanau Ora	Harold Wereta	▪ Ngati Toarangatira Connections		▪ Tribal Interest	
CHIEF EXECUTIVE'S OFFICE					
	John Peters	▪ Director of SISSAL ▪ Trustee of Nelson Marlborough Hospitals' Charitable Trust ▪ Trustee Churchill Trust	▪ Director of Management and Industrial Services Ltd	▪ 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	▪ Wife provides first aid training and complimentary help services		▪ Provision of services to DHB staff or contracted providers	▪ Sister works for IDSS
	Mike Cummins	Nil			

As at 1 April 2011

SECTION 3: CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) – 26 OCTOBER 2010

MINUTES OF THE OPEN MEETING OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD			
Date	26 October 2010	**Time**	12.30
Where	DHB Seminar Centre, Nelson connected by videoconference to Support Services Room 3, Wairau Hospital, Blenheim	**Previous meeting date**	31 August 2010
Present	John Moore (Chair), Judy Crowe, Liz Richards, Jenny Black, Judith Holmes		
In attendance	John Peters, Gordon Currie, Peter Burton, Brigitte Ruesseler, Naomi Arnold, Bruce Moorhead, Christine Smith, Mark Garisch, Jasmin Brandt (Secretary)		
Apologies	Lorraine McMath, Suzanne Win, Sonny Alesana		
Mihi/Intro	Judith Holmes		

Item	Discussion	Action
Apologies	Apologies received from • Suzanne Win • Lorraine McMath • Sonny Alesana	**Moved: Judy Crowe** **Seconded: Judith Holmes** **THAT THE APOLOGY RECEIVED BE ACKNOWLEDGED.** **AGREED**
Registrations of Interest		**Moved: Judy Crowe** **Seconded: Jenny Black** **THAT THE REGISTRATIONS OF INTEREST BE NOTED.** **AGREED**
Minutes	**Matters Arising** Nil.	**Moved: Liz Richards** **Seconded: Judith Holmes** **THAT THE MINUTES OF THE MEETING ON 31 AUGUST**

Item	Discussion	Action
		2010 BE ADOPTED AS A TRUE AND CORRECT RECORD. **AGREED**
Correspondence		**Moved: Liz Richards** **Seconded: Jenny Black** **THAT THE CORRESPONDENCE BE RECEIVED.** **AGREED**
Reports	**Committee Chair** Taken as read The committee thanked John Moore for his leadership and long-time standing commitment to the role of Chair.	**Moved: John Moore** **Seconded: Judy Crowe** **THAT CHAIR' S REPORT BE RECEIVED.** **AGREED**
	Te Roopu Tupu Tahi CPHAC thanks Naomi Arnold and the Nelson Mail for their series of articles which were helpful in promoting healthy lifestyles and nutrition in our district.	**Moved: Jenny Black** **Seconded: Liz Richards** • **THAT REPORT FROM TE ROOPU TUPU TAHI BE RECEIVED.** • **THAT THE COMMITTEE EXPRESSES ITS THANKS TO FACILITATOR CAROL GOWAN FOR HER EXCELLENT REPORTS TO CPHAC IN THIS CURRENT 3-YEAR PERIOD.** **AGREED**
	GM Planning and Funding Taken as read. Chair noted that it is remarkable and commendable to see how close to budget we are. Question raised whether there	**Moved: Judith Holmes** **Seconded: Judy Crowe** • **THAT THE REPORT FROM THE GENERAL MANAGER PLANNING AND FUNDING BE RECEIVED.**

Item	Discussion	Action
	are any areas where difficulties could arise in this regard? Possibly in Aged Residential Care and demand driven pharmaceuticals. Noted that pharmaceutical expenditure investigation is still being carried out by Acting Chief Medical Advisor to address hospital expenditure.	• **THAT THE FINANCIAL REPORT BE ADOPTED.** **AGREED**
	Director of Maori Health Report taken as read.	**Moved: Jenny Black** **Seconded: Judith Holmes** **THAT THE REPORT FROM THE DIRECTOR OF MAORI HEALTH BE RECEIVED.** **AGREED**
	GM Primary and Community **Golden Bay** Noted that developments are coming together step by step.	**Moved: Liz Richards** **Seconded: Judith Holmes** **THAT THE REPORT FROM THE GENERAL MANAGER PRIMARY AND COMMUNITY BE RECEIVED.** **AGREED**
Discussions	**Meeting frequency 2011** Chair noted that some guidance around this may be helpful for the new Board members. Discussion by members showed members being in strong favour of returning to the six-weekly meeting cycle because the eight-week cycle that had been used this year had created a lack of synchronisation between committees and board resulting in disjointed communication. A member suggested amendment of the reporting structure to reduce the preparation time needed from management.	**Moved: Liz Richards** **Seconded: Judy Crowe** **THAT CPHAC MEMBERS ADVISE THE BOARD THAT THEY FEEL ADVISORY COMMITTEES ARE BETTER AT 6-WEEKLY INTERVAL AND THAT THIS BE FURTHER CONSIDERED BY THE BOARD AT THEIR NEXT MEETING WITH NEW BOARD MEMBERS TO ENABLE PASSING ON FEEDBACK FROM OLD TO NEW MEMBERS.** **AGREED**

Item	Discussion	Action
Presentation 1	**Nelson Marlborough Health Needs Assessment 2010** *Meeting joined by Jim Hurring, Jane Large, Claire McKenzie, Lorraine Eade, Jane Large* Presentation given by Sarah Simmonds, Public Health Analyst, NMDHB, who had carried out an update of the Health Needs Assessment from 2008 with new available data. **Intentional self harm** Significant number of death by suicide in age groups spanning 15 to 44 years noted as single highest cause of death. NMDHB is second only to Wairarapa with intentional self harm. Portfolio manager Mental Health remarked that NMDHB may have got the pilot for Suicide Coordinator because of the high numbers, which NMDHB has had since approximately 2005. **Premature deaths** Concern noted that 65% of Maori under 65 die prematurely. Most die between 54 and 70 years in Nelson Marlborough. **Cancer** Malignant melanoma is higher than rest of NZ – probably due to higher sunshine hours. **Hospitalisations** Medical abortions was the leading cause for admissions for age groups 15 to 44 years. **Obesity** NMDHB compared okay with the rest of NZ in NPA baseline survey. Noted that we have more overweight than obese	

Item	Discussion	Action
	people. According to OECD the health care data 2009 report we are the third country after USA and Mexico. In 13 years, NZ went from 13% to 26% obesity. Noted that national initiatives may be needed to make the right choices easier (e.g. ban on advertisements for unhealthy foods similar to ban on advertising alcohol). **Points from the discussion that followed:** • Chair recommended to have this data presented to the Iwi Health Board and ask for their advice around Maori Health. • Suggestion made to use numbers rather than percentages to make comparisons, especially where it is small numbers. • Abortion numbers – may be useful to ask questions around emergency morning after pill – access issues? Noted that NMDHB needs to ensure that early intervention options are available to those who need it. • Suicide, abortions, dental issues (lack of fluoridation) are areas that appear preventable and further investigation may reveal areas where the DHB can make a difference. • Alcohol abuse noted as vicious cycle which may lead to poor nutrition, unwanted pregnancy numbers, increase in violence. • GM Primary and Community noted that the data presented confirms patterns we have been aware of, e.g. tobacco consumption, obesity etc as causes of heart disease. Chair noted that the report had been useful in highlighting the challenges for this DHB. Noted that none of the problems were totally new. The committee thanked Sarah	

Item	Discussion	Action
	for a very useful report and the work put into preparing it.	
Presentation 2	**Board and Committee Financial Reporting** Presentation by John Peters (NMDHB CE) and Mike Cummins (Board Secretary) NMDHB CE noted that the challenge around reporting is that the new ELT structure has an integrated approach which is not shared by the existing advisory committee structure. In terms of reporting, the two key people for CPHAC will be the community based services directorate and the Strategy and Planning component. CE noted that he will be looking towards the appropriate lead service directorate and the Chair to work through some of these issues. Chair asked if joint-meetings of committees may be useful? CE noted that other DHBs are holding joint meetings, with some having permanently combined DiSAC and CPHAC and others holding HAC on the same day with some time overlapping between committees. NMDHB will let that evolve. **Board and Committee Financial reporting** The Board Secretary gave an overview of the 'must have' reporting, i.e. statutory, governance and management and common reporting standards, as set out in the relevant legislation. Complexity of reporting matrix noted. What about PBF for Marlborough, and allocation thereof? CE noted that Marlborough currently takes more than its	

Item	Discussion	Action
	PBF which is noted; this will be addressed as part of district wide thinking. **Operational reporting** 260+ departments which report to the directorates. They in turn will report to the appropriate committee. Chair thanked the CE and the Board Secretary for coming to the meeting.	
	The meeting went into closed session at 3.05pm	

RECOMMENDATION:
THAT THE MINUTES OF THE CPHAC MEETING 26 OCTOBER 2010 BE ADOPTED AS A TRUE AND CORRECT RECORD.

DISABILITY SUPPORT ADVISORY COMMITTEE – 16 NOVEMBER 2010

MINUTES OF THE OPEN MEETING OF THE DISABILITY SUPPORT ADVISORY COMMITTEE (DiSAC) OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD			
Date	16 November 2010	**Time**	11.00
Where	Nelson DHB Seminar Centre	**Previous meeting date**	21 September 2010
Present	Sharon Brinsdon (Chair), Tahi Takao, Liz Richards, George Truman, Suzanne Win, Glenys MacLellan, Judi Billens, Liz Richards, Fleur Hansby		
Apologies	Nil received; absent: Graeme Faulkner		
In attendance	John Peters, Jasmin Brandt (Secretary), Gordon Currie, Sharon Kletchko, Jane Large, Carole Kerr		
Karakia	Sharon Brinsdon		

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
1.	Apologies	No apologies were received. Graeme Faulkner's absence was noted.			
2.	Registrations of Interest	Amendments to Registrations of Interest: • Nil	**Moved: George Truman** **Seconded: Glenys MacLellan** **THAT THE REGISTRATIONS OF INTEREST BE NOTED.** **AGREED**		
4.	Minutes	**Matters Arising** **Relay NZ.** George Truman noted that an article in the AA Directions magazine suggests that the service is ready to be launched. **Disabled access** to Rabbit Island? Noted that Tasman District Council had advised that they have accessible toilets.	**Moved: Glenys MacLellan** **Seconded: Judi Billens** **THAT THE MINUTES OF THE MEETING ON 21 SEPTEMBER 2010 BE ADOPTED AS A TRUE AND CORRECT RECORD.**		2

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		Suggestion was made to write to all councils regarding a 'barrier free' audit on public facilities. Points from the discussion: • Recreational areas, such as Rabbit Island are important for the whole of population • it's about creating 'universal access' • Basins inside disabled toilets are the preferred option by wheelchair users.	**AGREED** Write to CEOs of Councils to see if they have ever assessed their facilities for accessibility? If there was a 'barrier free' audit, DiSAC would be interested to learn the outcome? For Marlborough copy in Jenny Andrews.	Chair	2
	Correspondence	No correspondence received. Chair noted that letters to the local councils had gone out to follow up on correspondence from earlier in the year around beach access mats for wheelchair users as seen in Canterbury.			7
5.	Reports				
5.1	Chairperson's Report	Taken as read.	**Moved: Sharon Brinsdon** **Seconded: Suzanne Win** **THAT THE CHAIR'S REPORT BE RECEIVED.** **AGREED**		
5.2	Report from General Manager Strategy & Planning	Taken as read. **Health of Older People** Naomi Courts is going to change their services to exclusively provide dementia care.			**7**

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		Page 17: Financials show that we are within budget which is positive and we are hopeful that this will be maintained. Page 20: figures 5 and 6: Why is the 'current information' at August only? Why not more recent? **Health of Older People Network** The HOP Network is a regional approach to services that meet the need of older people within the South Island. DiSAC members noted that a quarterly report on developments would be appreciated. **SupportWorks Report** GM S&P noted that Support Works reports to James Bowyer as of 1 November. **Ministry of Health Clients** Support Works noted that residential budget for MoH clients is currently at capacity. Need to stay within 1% of allocated budget at year end which requires careful managing of current and new clients. Stressed that this is not a demand driven service with an open ended budget. The budget is based on last year's actuals, the PBF and our forecast. We got more funding this year because we could demonstrate that we had a higher need for young people. However, as DM Support Works explained, it is about juggling the planned group and unplanned emergency situations where young people require placements urgently. **Home Based Support Services** Number of HBSS recipients is slowly increasing while the entry into residential care is going down. Support Works is	Provide quarterly reports to DiSAC on SI HOP network	Portfolio Manager	**7** **7; 8**

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		reviewing numbers weekly to allow accurate forecast for 2011/12. Noted that it has been three years since the Board approved the changes to HBSS packages. Question raised around qualitative analysis of the implemented changes. DM noted that work is under way to evaluate InterRAI and new models. GM noted that EQ-5D information is being entered currently and will soon be available as data.			
5.3	IDSS Report	Taken as read. **Financials** Inconsistencies around order (actual/ budget/ variance) in different financial reports noted. Noted this was due to different analysts preparing the different reports. Queries around Day Service locations – which one is in Trafalgar Street? John P to follow up for clarification. Over night court ruling is 'in reserve' so won't hear the outcome until next year probably.	**Moved: Sharon Brinsdon** **Seconded: Glenys MacLellan** • **THAT THE GM REPORT STRATEGY AND PLANNING INCLUDING SUPPORT WORKS BE RECEIVED** • **THAT THE IDSS REPORT BE RECEIVED.** **AGREED**		8
5.4	Members' Issues	**UN Convention on the Rights of Persons with Disabilities** http://haveyoursay.odi.govt.nz/ It was noted that submissions on the draft report on the implementation of the United Nations Convention on the Rights of Persons with Disabilities close on 17 December. The committee discussed options regarding a submission on	Refer request to respond to submission to appropriate groups within the DHB	GM S&P and Chair	2

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		behalf of the DHB and agreed that a staff response would be appropriate. It was noted that this did not preclude any personal submissions members may wish to make.			
6.	Presentation 1	*Marieke Jansen, Janet Bentley, Claire McKenzie, Maggie Cambra joined the meeting* **'CYF workers in hospitals'** **Presentation by Marieke Jansen, Child Youth & Family, on this newly established position** Janet Bentley introduced herself as the recently appointed CYF worker in hospitals Hon Paula Bennett's 'Vulnerable Infant Programme' includes the 'Never Shake a Baby' media campaign as well as the creation of 'CYF Hospital Liaison Social Worker' positions in all DHBs. Two key functions of CYF Social worker in hospital role are: 1. To ensure that police, CYF and Health work together 2. Early identification of at risk children. Noted that it will be an advantage to have one person who is first contact and helps make necessary connections between DHB staff and CYF. Will be able to provide advice and assist with sharing of information and communication. CYF is keen to learn from each other. The CYF social worker will be involved in training opportunities both for CYF and DHB staff. **General Discussion** Question was raised about coverage across the DHB – will			

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		the Nelson worker be available for Tasman and Marlborough? Noted that Tasman may be covered by Nelson's 20 hours but a solution for Marlborough needs to be looked at. CYF wondered if there are better ways to deal with young offenders who are mentally disabled? District Manager SupportWorks noted that no testing takes place in education to assess IQ levels in order to prevent children from being labelled as disabled. However, when they can't cope at school, problems arise. Support Works has done work in Nelson and Marlborough to support affected families but it is challenging with families being transient. Noted the key may be to connect the families with the services that are available. Often they are not made aware of what services are out there. The District Manager also noted that it would be beneficial for all if the education sector could do some testing and not leave it to the disability sector to do all the testing. Disability should be the service people are referred to after testing. The committee thanked CYF for their presentation. *Marieke Jansen, Janet Bentley, Claire McKenzie, Maggie Cambra exited the meeting*			
	Presentation 2	**Emergency Planner Pete Kara spoke on "Disaster Preparedness for People with Disabilities"** Pete Kara tabled a document entitled "Disaster Preparedness for People with Disabilities" which was developed by the Disabilities Resource Centre Trust in 2009.			

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		The committee sees the publication as a very useful self help guide which could be amended for our purposes. Question raised how to include the very elderly people at home? How would we trace them? Noted that as a response to the Canterbury earthquake in September 2010, MSD had stepped in and used their superannuation contact list to call people by phone. It was agreed that in Nelson Marlborough we commence capturing some of the questions from the checklists provided in the document and make them part of the assessments Support Works carries out. Board Chair commended work being done by Pete Kara, and his excellent reputation regionally and nationally.	Develop standard generic form (checklist) and make part of Support Works assessment	Pete Kara/ Carole Kerr	
7.	For Discussion	**Meeting frequency 2011** Discussion points made were: • Frequency should depend on what work is expected of DiSAC. For instance, if it's purely about monitoring, 8-weekly might be sufficient. • If DiSAC's workload shifts, the meeting frequency may be amended again later in the year. • Board Chair noted that the reason for the shift to 8-weekly meetings had been about saving staff time. Noted that 40 support staff FTE have been removed. Noted that in future there will be less leeway locally in regards to strategy, so unlikely to need more frequent meetings in 2011.	**Moved: Suzanne Win** **Seconded: Judi Billens** **THAT WE GIVE ADVICE TO THE BOARD THAT THE [MEETING FREQUENCY] STATUS QUO IS RETAINED.** **AGREED**		

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		Farewell to existing DiSAC members Board Chair Suzanne Win thanked all committee members on behalf of the Board for all the work that has been carried out, also behind the scenes. Suzanne Win thanked Sharon for her consistent battling and advocating, highlighted the achievement around restrictive covenants, and thanked her for enriching the lives of the people in Nelson, Tasman and Marlborough. George Truman, Liz Richards, Tahi Takao and Judi Billens also took the opportunity to speak and thanked Sharon for her leadership and wished newly elected Board members well. John Peters thanked Sharon on behalf of the staff and as Chief Executive of NMDHB.			

Meeting closed at 2.10pm

Members of the public
Matt Wilson attended the meeting until the lunch break at 12.45pm

RECOMMENDATION:
THAT THE MINUTES OF THE DISAC MEETING 16 NOVEMBER 2010 BE ADOPTED AS A TRUE AND CORRECT RECORD.

SECTION 3.1: MATTERS ARISING

Nil

SECTION 3.2: CORRESPONDENCE

Organisation	From	To	Date	Subject
NMDHB	Sharon Brinsdon, Chair DiSAC	Andrew Besley CEO Marlborough District Council	2/12/10	Access to facilities managed by councils in the district
NMDHB	Sharon Brinsdon, Chair DiSAC	Keith Marshall CEO Nelson City Council	2/12/10	Access to facilities managed by councils in the district
NMDHB	Sharon Brinsdon, Chair DiSAC	Paul Wylie CEO Tasman District Council	2/12/10	Access to facilities managed by councils in the district
Nelson City Council	Keith Marshall CEO	Sharon Brinsdon Chair DiSAC	15/12/10	Response to letter regarding access to facilities for disabled people
Marlborough District Council	Rosie Bartlett Reserves and Amenities Manager	Sharon Brinsdon Chair DiSAC	18/1/11	Response to letter regarding access to facilities for disabled people
Tasman District Council	Pamela White EA to CEO and Mayor	Jasmin Brandt DiSAC Secretary	8/3/11	Receipt of letter regarding access to facilities

SECTION 4: REPORTS

4.1 CHAIRPERSON'S REPORT

Status
This report contains:
☐ For decision
☐ Update
☐ Regular report
☐ For information

GENERAL

A verbal report will be provided at the meeting.

Gerald Hope
Chairperson

RECOMMENDATION:
THAT THE CHAIRPERSON'S REPORT BE RECEIVED.

4.2 DIRECTORATE REPORT

Status
This report contains:
✓ For decision
✓ Update
✓ Regular report
✓ For information

4.2.1 General

i. Earthquake 22 February 2011
Attached for information is a paper on the implications for NMDHB from the earthquake in Christchurch on 22 February 2011. Attached as **Appendix 1.**

ii. IDSS Service

a. IDSS Sleepover payments
IHC is now seeking leave to appeal the appeal court ruling in the Supreme Court. The Supreme Court will decide shortly whether it will accept the appeal.

b. Christchurch Clients
IDSS is supporting 11 people evacuated from Christchurch due to being displaced by the earthquake. They have settled in well.

c. Development of Physical Disability Residential Facility
A property has been identified in Blenheim for the development of a six bed physical disability residential support facility. This is the culmination of a long search for a suitable property by Housing New Zealand who will purchase and redevelop the property to meet the service needs. They will lease the property to NMDHB.

4.2.2 For Decision

1 Purpose of this Paper
Brief the Committee on changes relating to clients receiving resthome services in a licence to occupy unit.
2 Recommendation
THAT THE BOARD ENDORSES THE REQUIREMENT FOR ARRC PROVIDERS TO COMPLY WITH THE REQUIREMENTS OF CLAUSE A14 FOR CLIENTS IN LTOS RECEIVING RESTHOME LEVEL CARE AND THAT THE REFUND BE MADE TO THE CLIENT.
3 Background
As serviced apartments and units become more popular locally an issue that is arising more often is that of the facilities component payment when rest home services are being provided to a client while they remain in their unit. Most arrangements are through a licence to occupy (LTO) under which the client pays the provider a fee for the licence which gives them the right to occupy the unit and an obligation on the provider to buy back the licence (less any refurbishment

charges) when the unit is vacated at an agreed rate. The rate is similar to depreciating the unit over the agreed period. On vacation the provider has the right to resell the unit.

The Retirement Commission has developed a view on the likely return to clients (or their estates) for retirement units. The example used shows how a unit purchased for $300,000 might after two years result in $263,000 being returned to the client/estate (a cost of $18,500 per annum) or after five years $222,000 (a cost of $15,600 per annum).(see Get Sorted).As an occupier of a serviced unit the client will receive a level of services as agreed and be charged extra for these. Usually these relate to supported living. As the client's needs grow they may meet the criteria for home based services or rest home level services depending on their need.

Under the licence the provider has sole right of provision of services to the client. NMDHB has a contract for Restorative Home Based Support Services however the LTO providers will not permit these to be delivered within their complexes. However they will allow rest home level care to be provided. Under the Social Security Act clients are assessed against a set of financial thresholds including assets (currently $200,000 rising to $350,000 by June 2026) and income to determine their eligibility for a subsidy. Those ineligible for a full subsidy will be required to fund their services up to a maximum contribution of $804 – 828 per week (The variance is based on local costs). The average weekly cost of rest home care is $850 per week which generates a small subsidy. Those eligible for a full subsidy are entitled to retain $56 per week from their benefit plus a small annual income from assets retained. Under the criteria used to determine the value of assets the licence to occupy is usually included. As the value of their licence diminishes the level of subsidy may increase.

4 Discussion

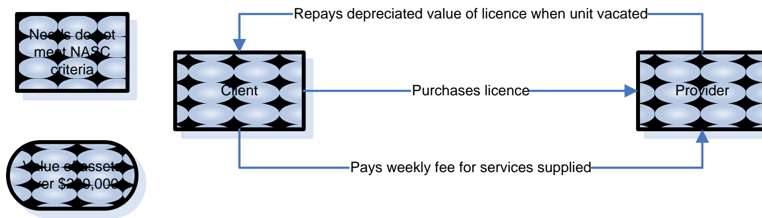
The issue

When a client in their facilities is assessed as needing home based support this is provided by the provider with no contract for this from the DHB. When a client in their facilities is assessed as needing resthome care the services are determined through the Age Related Residential Care Contract with NMDHB. These contracts include a financial component that relates to the provision of a facility. For clients remaining in their own units this results in two facility payments ie under the rest home contract and under the licence to occupy. They are, in effect, paying twice.

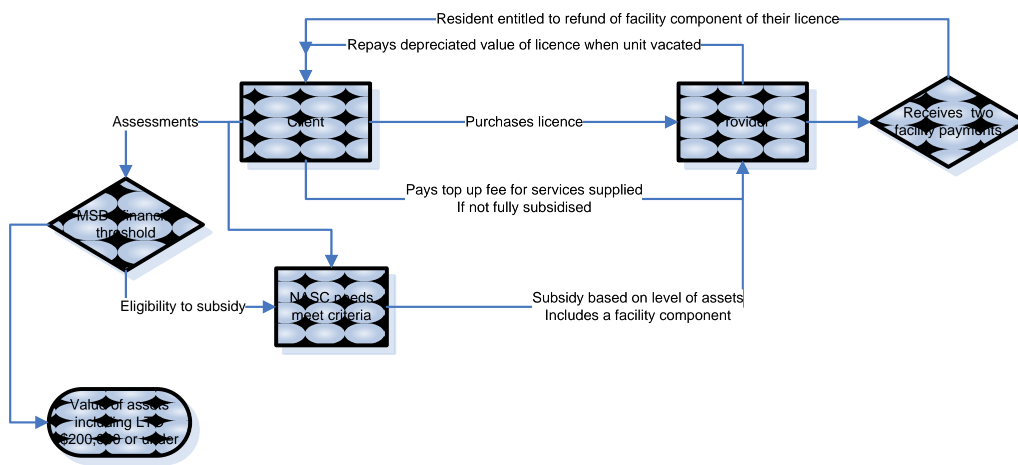
Nationally there is no consistency of approach to address this issue however the ARRC contract has a clause which prohibits double payment (A14). Some providers have recognised the issue and refund to the client a daily rate based on a formula (the rate being refunded locally is $27 per day). Other providers have either not made a refund or following approaches by clients or their families have agreed a refund which reflects a smaller amount e.g. $10 per day.. There is no consistency in the practice.

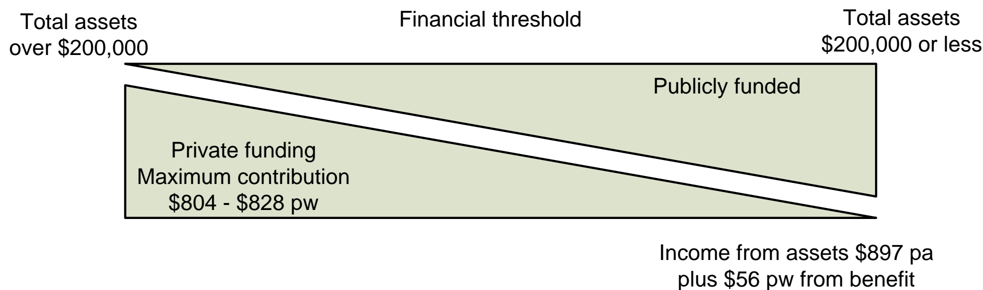
The following flowchart sets out the position:

Client agrees to purchase unit/apartment and has residential services provided from the facility at own cost



Client purchases unit/apartment and has rest home services provided while remaining in the unit or apartment subsidised





Income from assets $897 pa
plus $56 pw from benefit

Clients who live in flats or houses on hospital or rest home grounds and clients living in retirement villages usually purchase a licence to occupy rather than purchase the premises.

Where a client purchases the licence to occupy, it would normally be refundable and should be included as an asset in the means assessment of assets.

Not all LTO comply with Certification for delivery of Rest Home services…. So Village dwellings e.g. flats or houses will not meet certification (e.g. safe night care cannot be assured) there fore this issue will not arise.

Current Actions

The question of the provision of Resthome care in a 'Licence to Occupy' Apartment or LTO is part of the national ARRCC (Age Related Residential Care Contract) negotiation process. That agreement determines the national approach for all DHBs and ARRCC providers. It is possible that the current round of negotiations will not resolve this issue.

NMDHB supports any resident towards his or her entitlements under the Social

Security Act while ensuring that the ARRC contract is complied with to address equity issues and ensure fairness for residents. It has an expectation that providers will work through the process with existing residents.

Until a national position is determined NMDHB will be introducing a process for the district. The process has three linked considerations:

1. NMDHB requires the provision of Rest home care in serviced apartments to comply with the Health and Disability Services (Safety) Act 2001; and that
2. The provision of services complies with the provisions of the Age Residential Care Contract 2010; and that
3. The provider demonstrates their processes and procedures for addressing Clause A14 in a fair manner.

Impacts

There are an increasing number of people now receiving rest home services while in their own unit.

The question remains who should benefit from the refund of the facility component of the LTO – the client or the DHB?

- Where the client is making a significant contribution towards their care there is no concern with the client retaining the refund; and
- For clients for whom the subsidy is at or near to the maximum are they entitled to retain the refund? Under the financial threshold set by the Social Security Act they are currently entitled to retain assets to the value of $200,000. As the LTO is part of that sum then as time passes and their eligibility decreases they will be penalised ($15 – 18,000 per annum). Using the local daily rate the annual cost would be $9,855 which would only partially compensate the client.

Conclusion

The issue only arises where rest home services are being provided in the clients own facility. NMDHB expects a consistent approach by ARRC providers in this district to them meeting the requirements of clause A14.

Who receives the refund remains a policy decision at a national level. As the period in which the services will continue to be provided is uncertain inequities in compensation to the client can arise. If the subsidy was to exclude the facility component then those people whose assets are at or near the threshold levels for assets would be penalised.

NMDHB also expects that ARRC providers in this district will work with existing clients to address this issue.

4.2.3 Quality

All services are preparing for audit and certification.

i. Mental Health Services Directorate
Mental Health Directorate has developed a Mental Health Information Site available to Mental Health staff showing reporting trends against service activity and reportable events etc.

4.2.4 Utilisation/Activity

i. Mental Health Services Directorate

	Feb11	Jan11	YTD Monthly Average
Inpatient Acute Admissions		33	30
Inpatient Acute LOS	9.5 days	10.2days	10.4 days
Inpatient Seclusion Use	428.5 hours	979 hours	874
Community Crisis Contacts	103	102	1307 (total YTD)
Community After Hours Calls	76	73	48
Community Caseload Numbers	2897	2825	3038

Activity – Total clients seen by NGO Service 2010/11 FY

Service	Q1	Q2	Q3	Q4
Richmond NZ	51	Not provided		
Gateway Housing Trust	194	180		
MHSS	38	36		
Te Whare Mahana	77	83		
Te Rapuora	149	Not provided		
Te Ara Mahi	119	99		
Health Action Trust (Kotuku)	38	44		
Ngati Koata	Not provided	Not provided		
Te Awhina Marae	Not provided	89		
Horizon Trust	Not provided	44		
Care Marlborough	Not provided	Not provided		
Care Solutions	Not provided	Not provided		
SF Nelson	Not provided	Not provided		
SF Blenheim	Not provided	Not provided		
St Marks	16	41		

4.2.5 Performance to KPIs

i. Community Based Support Services Directorate

Better CVD/Diabetes services Quarter 2 results:

	National Health Target (%)	Achieved at Q2 (Oct-Dec, 2010) (%)
Diabetes Annual Check		
Maori	52	52.8
Pacific	n/a	n/a
Other	76	**57.6**
Total	72	**57**
Diabetes Management		
Maori	72	**69**
Pacific	n/a	53
Other	82	83
Total	79	81
CVD Risk Assessment		
Maori	55	59.5
Pacific	n/a	53.6
Other	76	**69.4**
Total	72	**68.6**

a. Better help for smokers to quit
Quarter 2 results: Total 46%, (Total target 90%); January: 52%. February result for 'Better Help for Smokers to Quit' was 56%, up from 46% for Quarter 2. Considerable work has been undertaken aimed at improving our performance including a 17 step recovery plan; a steady improvement is now evident.

b. Increased immunisation
Quarter 2 Results: Total 90% (target 90%); Maori 89% (target 85%); Pacific 100% (target 85%). February result: Total at 88% has dropped below the target of 90%, it is expected that this minor drop will be improved on by the end of Quarter 3; 'Maori' and 'Pacific' targets continue to be achieved.

ii. Maori Health Service Directorate
Directorate supports the accomplishment of CVD, Smokers, and Immunisation targets with a key focus will towards the reporting of health outcomes for Maori for these targets. The Directorate will work with Community Based Services and Medical/Surgical Directorate to improve data quality for Maori Health. The Maori Health Plan 2011/ 2012 will place a greater focus on Maori Health targets.

iii. Mental Health Service Directorate
Results for Quarter 2 for Access Rates and Relapse Prevention are all above target (except for Relapse Prevention for Adult Addictions - 94% against a target of 95%).

PP6 – Mental Health Service Access Rates (last reported Q2 2010/11)

Population Group		Target	Actual Q2
Age 0-19	Māori	3.2%	3.54%
	Other	3.61%	3.8%
	Total	3.53%	3.76%
Age 20-64	Māori	6.36%	6.99%
	Other	3.89%	4.3%
	Total	3.93%	4.53%
Age 65+	Total	0.73%	0.88%

PP7 – Relapse prevention planning (last reported Q2 2010/11)

Group		Target	Actual Q2
Adults (excluding Addictions)	Māori	95%	96%
	Pacific	95%	100%
	Total	95%	97%
Adults (Addictions only)	Māori	95%	94%
	Pacific	95%	100%
	Total	95%	94%
Child & Youth	Māori	95%	100%
	Pacific	95%	100%
	Total	95%	96%
Total	**Māori**	95%	95.8%
	Pacific	95%	100%
	Total	95%	95.7%

PP8 – Alcohol and Drug Service wait times (last reported Q2 2010/11) – no targets set

Group		Longest wait time (6 month average)	Number on waiting list (6 month average)
Specialist Prescribing	Māori	2 weeks	0
	Other	2 weeks	12
Structured Counselling	Māori	34 days	0
	Other	59 days	0

National KPI Project results 2009/10

KPI	NMDHB 2010/11	2008/9 test average
KPI 1 – Acute Inpatient HoNOS effect size large	39%	N/A
KPI 2 – 28 day acute inpatient readmission rate	22%	12%
KPI 8 – Average length of acute inpatient stay	13 days	22 days
KPI 10 – Weekly community treatment das per clinical FTE	13	12
KPI 12 – Community treatment days per service user	10	8.5
KPI 16 – NGO services investment	27%	27%
KPI 18 – Pre-admission community care	70%	56%
KPI 19 – Post-discharge community care	63%	66%
KPI28 – Total staff turnover	9%	12%
KPI 29 – Sick leave usage	3.3%	3.3%

4.2.6 Financial Report for the Month Ended 28 February 2011

March results will be tabled at the meeting.

FUND BY DIRECTORATE

Fund Arm Statement of Financial Performance

$000	February 2011			Prior Year	Year to Date			Full Year	
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*
Revenue									
MoH Devolved Funding	28,787	28,867	80	225,066	231,219	232,500	1,281	347,292	349,347
IDF Revenue	591	629	38	4,333	4,728	4,995	266	7,093	7,534
Other Revenue	0	0	0	79	0	56	56	0	55
Total Revenue	**29,378**	**29,495**	**117**	**229,477**	**235,948**	**237,551**	**1,603**	**354,384**	**356,936**
Expenditure									
Personal Health Expenditure	20,822	20,838	(15)	164,589	170,159	170,190	(31)	255,715	256,924
Mental Health Expenditure	3,043	3,073	(30)	24,520	24,346	24,380	(34)	36,520	36,675
Public Health Expenditure	237	260	(23)	2,121	1,896	1,883	14	2,845	2,876
Disability Support Expenditure	4,351	4,318	33	35,736	36,273	36,421	(147)	54,567	54,681
Hauora Maori Services Expenditure	228	228	0	1,788	1,821	1,817	4	2,732	2,731
Governance Expenditure	458	458	(0)	3,774	3,667	3,668	(0)	5,501	5,501
Total Expenditure	**29,140**	**29,175**	**(35)**	**232,529**	**238,164**	**238,359**	**(194)**	**357,879**	**359,388**
Net Surplus/(Loss) before Interest & Capital Charge	**238**	**320**	**83**	**(3,051)**	**(2,216)**	**(808)**	**1,409**	**(3,494)**	**(2,452)**
Interest Received	55	59	5	530	476	655	178	715	868
Net Surplus/(Loss)	**292**	**380**	**87**	**(2,521)**	**(1,740)**	**(153)**	**1,587**	**(2,779)**	**(1,584)**

Community Based Services

$000	February 2011			Prior Year	Year to Date			Full Year	
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*
Revenue									
IDF and NGO Allocation	6,167	6,167	0	0	50,721	50,721	0	76,783	76,783
Total Revenue	**6,167**	**6,167**	**0**	**0**	**50,721**	**50,721**	**0**	**76,783**	**76,783**
Expenditure									
Personal Health Expenditure	2,705	2,552	153	0	21,650	20,968	682	33,023	33,242
Public Health Expenditure	4	23	(19)	0	34	28	6	51	74
Disability Support Expenditure	3,239	3,231	8	0	27,282	27,658	(376)	41,078	41,483
Hauora Maori Services Expenditure	219	219	0	0	1,755	1,751	4	2,632	2,631
Total Expenditure	**6,167**	**6,026**	**142**	**0**	**50,721**	**50,406**	**316**	**76,783**	**77,431**
Net Surplus/(Loss)	0	142	142	0	0	316	316	0	(648)

Clinical Services

$000	February 2011			Prior Year	Year to Date			Full Year	
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*
Revenue									
IDF and NGO Allocation	3,285	3,285	0	0	29,499	29,499	0	43,896	43,896
Total Revenue	**3,285**	**3,285**	**0**	**0**	**29,499**	**29,499**	**0**	**43,896**	**43,896**
Expenditure									
Personal Health Expenditure	3,274	3,344	(71)	0	29,411	29,931	(521)	43,763	44,070
Disability Support Expenditure	11	11	(0)	0	89	89	(0)	133	133
Total Expenditure	**3,285**	**3,355**	**(71)**	**0**	**29,499**	**30,020**	**(521)**	**43,896**	**44,203**
Net Surplus/(Loss)	0	(71)	(71)	0	0	(521)	(521)	0	(307)

Medical and Surgical Services

$000	February 2011			Prior Year	Year to Date			Full Year	
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*
Revenue									
IDF and NGO Allocation	2,511	2,511	0	0	20,091	20,091	0	30,137	30,137
Total Revenue	**2,511**	**2,511**	**0**	**0**	**20,091**	**20,091**	**0**	**30,137**	**30,137**
Expenditure									
Personal Health Expenditure	2,509	2,542	(32)	0	20,074	19,906	168	30,111	30,371
Disability Support Expenditure	2	2	(0)	0	17	(47)	65	26	(39)
Total Expenditure	**2,511**	**2,544**	**(32)**	**0**	**20,091**	**19,859**	**233**	**30,137**	**30,333**

Mental Health Services

$000	February 2011			Prior Year	Year to Date			Full Year	
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*
Revenue									
IDF and NGO Allocation	1,048	1,048	0	0	8,386	8,386	0	12,579	12,579
Total Revenue	**1,048**	**1,048**	**0**	**0**	**8,386**	**8,386**	**0**	**12,579**	**12,579**
Expenditure									
Personal Health Expenditure	81	95	(14)	0	644	775	(131)	967	1,163
Mental Health Expenditure	968	998	(30)	0	7,742	7,744	(2)	11,613	11,681
Disability Support Expenditure	0	2	(2)	0	0	5	(5)	0	0
Total Expenditure	**1,048**	**1,095**	**(47)**	**0**	**8,386**	**8,524**	**(138)**	**12,579**	**12,844**
Net Surplus/(Loss)	0	(47)	(47)	0	0	(138)	(138)	0	(265)

Director of Maori Health

$000	February 2011			Prior Year	Year to Date			Full Year	
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*
Revenue									
IDF and NGO Allocation	8	8	0	0	67	67	0	100	100
Total Revenue	**8**	**8**	**0**	**0**	**67**	**67**	**0**	**100**	**100**
Expenditure									
Hauora Maori Services Expenditure	8	8	0	0	67	67	0	100	100
Total Expenditure	**8**	**8**	**0**	**0**	**67**	**67**	**0**	**100**	**100**
Net Surplus/(Loss)	0	0	0	0	0	0	0	0	0

Strategy and Planning

$000	February 2011			Prior Year	Year to Date			Full Year	
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*
Revenue									
MoH Devolved Funding	28,787	28,867	80	225,066	231,219	232,500	1,281	347,292	349,347
IDF Revenue	591	629	38	4,333	4,728	4,995	266	7,093	7,534
Other Revenue	0	0	0	79	0	56	56	0	55
IDF and NGO Allocation	(13,020)	(13,020)	0	0	(108,765)	(108,765)	0	(163,496)	(163,496)
Total Revenue	**16,358**	**16,475**	**117**	**229,477**	**127,183**	**128,786**	**1,603**	**190,889**	**193,440**
Expenditure									
Personal Health Expenditure	12,254	12,305	(51)	164,589	98,380	98,609	(229)	147,851	148,078
Mental Health Expenditure	2,076	2,076	(0)	24,520	16,605	16,637	(32)	24,907	24,993
Public Health Expenditure	233	237	(4)	2,121	1,863	1,855	8	2,794	2,801
Disability Support Expenditure	1,099	1,072	27	35,736	8,885	8,716	169	13,330	13,104
Hauora Maori Services Expenditure	0	0	0	1,788	0	0	0	0	0
Governance Expenditure	458	458	(0)	3,774	3,667	3,668	(0)	5,501	5,501
Total Expenditure	**16,120**	**16,147**	**(27)**	**232,529**	**129,399**	**129,483**	**(84)**	**194,383**	**194,477**
Net Surplus/(Loss) before Interest & Capital Charge	**238**	**328**	**90**	**(3,051)**	**(2,216)**	**(697)**	**1,519**	**(3,494)**	**(1,037)**
Interest Received	55	59	5	530	476	655	178	715	868
Net Surplus/(Loss)	**292**	**387**	**95**	**(2,521)**	**(1,740)**	**(43)**	**1,698**	**(2,779)**	**(169)**

i. Clinical Services Support Directorate

Financial Variances:

Clinical Services Support Directorate Statement of Financial Performance

$000	February 2011			Prior Year	Year to Date			Full Year		
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*	
Revenue										
MoH Revenue	146	80	(66)	959	1,171	650	(520)	1,756	977	(779)
IDF Revenue	0	0	0	0	0	0	0	0	0	0
Internal MoH Revenue	1,087	1,030	(57)	11,464	8,111	8,307	196	12,107	12,364	256
IDF and NGO Allocation	3,285	3,285	0	0	29,499	29,499	0	43,896	43,896	0
Other Govt Revenue	98	91	(7)	830	783	925	143	1,174	1,365	191
Other Income	593	654	60	5,066	5,280	5,240	(40)	8,053	7,794	(259)
Total Revenue	**5,209**	**5,138**	**(71)**	**13,253**	**44,844**	**44,622**	**(222)**	**66,987**	**66,396**	**(591)**
Expenditure										
Personnel Costs	1,417	1,348	69	10,900	11,846	11,665	181	17,995	17,887	108
Outsourced services	433	445	(11)	3,615	3,676	3,758	(82)	5,526	5,630	(104)
Clinical Supplies	1,028	1,176	(148)	9,001	8,857	9,198	(341)	13,448	13,633	(185)
Infrastructure and Non Clinical	175	161	13	883	1,447	1,418	29	2,174	2,159	15
Personal Health Expenditure	3,274	3,344	(71)	0	29,411	29,931	(521)	43,763	43,734	29
Disability Support Expenditure	11	11	(0)	0	89	89	(0)	133	133	(0)
Internal Allocations	193	255	(62)	4,975	1,767	1,964	(197)	2,700	2,782	(82)
Total Expenditure	**6,530**	**6,740**	**(210)**	**29,374**	**57,093**	**58,024**	**(931)**	**85,739**	**85,959**	**(219)**
Contribution to Overheads	**(1,321)**	**(1,602)**	**(281)**	**(16,120)**	**(12,249)**	**(13,402)**	**(1,153)**	**(18,753)**	**(19,563)**	**(810)**

Revenue

Ministry of Health revenue is unfavourable by $520k with $454k related to a change in funding for Herceptin. The balance of $66k relates to Support Works discretionary funding. This is offset by lower Client-related costs in Clinical Supplies.

Internal MOH Revenue is $196k favourable, of which $157k relates to higher Pharmac receipts for PCT and other pharmaceuticals.

Other Government revenue is $143k favourable. Pharmac rebates have been higher than budgeted by $176k and Audiology revenue is $173k favourable as there has been a significant referral increase from Enable. This is offset by an unfavourable variance of $227k in ACC revenue, which is down $227K with most of this in Radiology (WR $150k, and NN $44k) because of increased competition from private sector and more stringent claiming rules enforced by ACC.

Expenditure

Personnel costs are $181k favourable (0.6FTE favourable).

Medical personnel is $195k unfavourable driven by gate-keeping costs during the MRT action earlier in the year.

Allied Health personnel are $377k favourable with the most significant variances occurring in:

- Support Works ($120k favourable) having had vacancies in Case Managers;

- Wairau Pharmacy ($33k favourable) having had a vacant Pharmacist position earlier in the year; and
- Radiology and MRI Departments ($182k favourable) partly as a result of the industrial action and have averaged 2.5 FTE under budget for the year.

Clinical Supplies are $341k unfavourable

- Treatment Disposables – Intragram is $71k over YTD. Haemo products are $77k over YTD and Hospital Use Blood Products are $29k over budget. Radiology incurred has $46k on Customised Procedure Packs, although that is slightly offset by a saving in the Disposable Instruments budget. Radiology NN is $15k over budget in other Treatment Disposables, particularly Catheters and Tubes, Drainage and Suction mostly driven by procedures done by a new vascular surgeon;
- Patient Appliances are $223k over with $155k in Audiology departments offset by revenue and $73k in Orthotics; and
- Other Clinical Supplies are $124k favourable with savings of $83k in Client-related costs in Support Works and $40k favourable in Patients Travel and Air Ambulance.

Personal Health expenditure is $521k unfavourable

- Inter District Flows are $513k unfavourable due to the increased cost of Herceptin outflows advised after the budget was set. The Funding for this variance will be transferred across from Strategy and Planning as a wash up in March since the funding has been received from MOH.

Internal Allocations are $197k unfavourable as a result of increased Pharmacy Internal charges which are recover in Internal MOH revenue noted in Revenue section above.

ii. <u>Community Based Support Services Directorate</u>

Financial Variances

Community Based Services Directorate Statement of Financial Performance

$000	February 2011			Prior Year	Year to Date			Full Year		
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*	*Variance*
Revenue										
MoH Revenue	192	214	23	1,760	1,662	1,730	68	2,556	2,574	17
Internal MoH Revenue	1,140	1,308	168	7,389	13,377	13,427	50	20,402	20,439	37
IDF and NGO Allocation	6,167	6,167	0	0	50,721	50,721	0	76,783	76,783	0
Other Govt Revenue	42	49	6	318	337	262	(75)	499	366	(133)
Other Income	42	42	(0)	623	351	462	112	526	717	190
Total Revenue	**7,584**	**7,781**	**197**	**9,467**	**66,448**	**66,603**	**155**	**100,766**	**100,879**	**112**
Expenditure										
Personnel Costs	1,041	893	149	8,575	8,391	7,771	619	12,773	11,923	850
Outsourced services	154	153	1	1,293	1,243	1,144	99	1,870	1,633	237
Clinical Supplies	227	169	58	1,803	1,861	1,773	88	2,798	3,116	(318)
Infrastructure and Non Clinical	83	82	1	630	693	575	118	1,039	929	110
Personal Health Expenditure	2,705	2,552	153	0	21,650	20,968	682	33,023	33,221	(198)
Public Health Expenditure	4	23	(19)	0	34	28	6	51	64	(13)
Disability Support Expenditure	3,239	3,231	8	0	27,282	27,658	(376)	41,078	41,484	(406)
Hauora Maori Services Expenditure	219	219	0	0	1,755	1,751	4	2,632	2,631	1
Internal Allocations	56	51	5	1,548	459	448	11	691	803	(111)
Total Expenditure	**7,729**	**7,374**	**355**	**13,849**	**63,368**	**62,118**	**1,250**	**95,955**	**95,804**	**151**
Contribution to Overheads	**(145)**	**407**	**552**	**(4,382)**	**3,079**	**4,485**	**1,405**	**4,812**	**5,075**	**263**

Revenue

Other Govt Revenue is $75k unfavourable YTD. This has been caused by lower ACC revenue in District Nursing ($50K) and Rural Hospitals ($28k).

Other Income is $112k favourable. This comprises a number of factors, with the most significant being:
- Unbudgeted reimbursements from Marlborough Primary Health Organisation ($33k) for Breast feeding Coordinator and Mum4Mum; and
- Higher Patient Co-payments at Rural Hospitals ($50k) partly due to Rutherford Initiative EFTPOS implemented.

Expenditure

Personnel costs are $619k favourable (FTE favourable). The major variances are in:

Public Health Service ($444k favourable)
- Positions left vacant pending the outcome of Rutherford, ELT restructure and the implementation of the Health Promotion Development Plan - $167k;
- Staff resignations and the winding up of the HPV programme $139k. This was due to budget error where the programme was to cease before the end of the financial year; and
- Other staff vacancies in Smokefree and CX/NIR Coordination ($95k).

District Nursing ($227k unfavourable)
This is due to additional staff being employed to provide cover for staff on leave. This allowance for cover was not factored into the staff rosters for the budget.

Health of Older People ($146k favourable)
- Murchison is $92k favourable in Nursing and Management & Administration costs; and
- Motueka Community Services are $75k favourable having trended under budgeted FTE in Nursing and Allied Health positions.

Outsourced Services are $99k favourable
This is primarily due to:
- Over budgeting in P&C Development ($48k);
- Phasing of expenditure in the Public Health Service and NPA ($68k); and
- This has been partially offset by unbudgeted costs for sleep apnoea studies in Wairau District Nursing ($30k).

Clinical Supplies are $88k favourable
This is primarily due to:
- Phasing of expenditure in the NPA programme ($71k);
- Under spends in HPV and Public Health Service Health Promotion ($21k) due to a combination of over budgeting in the now completed HPV programme ($9k) and phasing of expenditure for Health Promotion ($12k);

- Phasing expenditure for Smokefree DHB ($15k); and
- An under spend in School Dental Nelson ($13k) with Dental Clinics closed for majority of December and January. Dental clinics do not operate during school holidays.

These have been offset by overspends in:
- District Nursing Nelson ($21k) where a $37k overspend in equipment hire and a $11k overspend in dressings and bandages primarily due to vac wound dressings have been offset by a $31k reduction in expenditure on continence products; and
- Motueka Community health ($13k) with over spends in vac dressings ($8k) and equipment hire ($6k) which has been has been partially offset by under spending in other areas.

Infrastructure is $118k favourable with positive variances in most areas.

Personal Health expenditure is $682k favourable
- **Maternity** ($162k favourable) - Budget for postnatal stays (YTD $120k) has not yet been utilised. In addition Motueka Maternity Services has had 12% less volumes (84 post natal plus 36 births) than budget (96 postnatal stays and 41 births);
- **MoH Funded Careplus Programme** ($130k unfavourable) - This is offset by MoH revenue received by Strategy and Planning but not yet transferred to CBSD
- **Primary Health Care Strategy - Other** - ($511k favourable). Payments have not yet been made for the MoH Funded Performance management Programme; and
- **Domiciliary & District Nursing** ($183k favourable). Savings made in home based support services provided to personal health clients (post acute, palliative support and paediatric carer support) with changes made to eligibility criteria to access household.

Disability Support is $376k unfavourable
- **Residential Care: Hospitals** ($271k unfavourable). This is a demand driven service. Hospital level ARC occupancy has increased and has been offset by lower occupancy of rest home beds in the first quarter of the year;
- **Respite Care** ($106k favourable). This is a demand driven service and can vary month by month. Part of the favourable variance is due to the termination of a contract for a dedicated respite bed which was not utilised as expected; and
- **Community Health Services & Support** ($236k unfavourable). The transition to Preventative 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 1300 clients would be supported by the restorative approach whereas currently 1380 clients are receiving this service. The overspend should be reduced by the end of the year as the transition to Preventative 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 to

Preventative Maintenance would take until February 2011 and the budgets have been phased accordingly.

iii. IDSS Service

Statement of Financial Performance

$000	February 2011			Prior Year	Year to Date			Full Year		
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*	*Variance*
Revenue										
MoH Revenue	1,030	1,067	37	8,891	8,939	9,130	191	13,426	13,694	267
Internal MoH Revenue	12	12	0	97	96	96	0	145	145	0
Other Govt Revenue	17	1	(17)	198	141	186	45	212	223	11
Other Income	13	157	144	390	104	678	574	156	1,302	1,146
Total Revenue	**1,072**	**1,237**	**164**	**9,186**	**9,280**	**10,090**	**810**	**13,939**	**15,363**	**1,424**
Expenditure										
Personnel Costs	1,047	981	66	8,228	8,427	8,266	161	12,812	12,587	224
Outsourced services	0	0	0	0	2	0	2	3	1	2
Clinical Supplies	11	72	(62)	80	87	308	(221)	131	623	(492)
Infrastructure and Non Clinical	72	133	(61)	495	572	735	(163)	860	1,348	(488)
Internal Allocations	27	29	(2)	600	216	228	(12)	324	332	(8)
Total Expenditure	**1,157**	**1,216**	**(59)**	**9,403**	**9,304**	**9,536**	**(232)**	**14,129**	**14,891**	**(762)**
Contribution to Overheads	**(85)**	**21**	**105**	**(217)**	**(24)**	**554**	**578**	**(190)**	**472**	**662**
FTE	290.65	288.58	2.07		279.1	274.37	4.74			

<u>Revenue</u>

$810k additional revenue for the YTD period ended 28th February 2011.

Moh Revenue: $191k additional income due to:

- Additional residential volumes for ID Community $240k and reduced volumes for Physical Disability $54k (client left after budgets allocated); and
- Additional Day Services volumes $6k.

Other Govt Revenue: $45k additional income due to:

- Increase in Day Services Ministry of Social Development contract $43k; and
- ACC – reimbursement of expenses $2k.

Other Income: $574k additional income due to:

- Income received from client contribution $508k – IDSS are now receiving the client contribution from 1st December 2010 (offset by additional expenses);
- Additional income received $66k - Client recreation/activity funds, Training income, reimbursement of expenses, rental income, Internal transfer from ID residential services to Day Services.

<u>Personnel</u>

Year to date total variance $161k under spent & 4.74 FTE under

Under spending due to:

- New service developments budgeted to commence from July and not opened until the end of September;

- Efficiency gains due to changes in current rosters being worked; and
- Under spending in Physical Disability due to budgeted for staffing NMIT property and the client has now left the service (offset with reduced income).

Offset with:

- Additional client support required in some areas; and
- Additional costs due to budget phasing for sleepover allowances and penal payments being incorrect.

Expenses

Clinical Supplies: $221k over spent due to additional client related costs IDSS are now paying fixed payments to clients as from 01/12/10 (offset with client contribution income).

Infrastructure: $163k over spent due to additional client related costs – power, phone, rents (offset with client contribution income).

Intellectual & Physical Disabilities		**Current Month February 2011**			**YTD February 2011**
Services Provided		**IDSS**	**PDSS**	**Total ID & PD**	**Total ID & PD**
Current Moh Contract	**As per Contracts at month end**	162	7	169	
Beds – Individual contracts	**As per Contracts at month end**	41	2	43	
Beds – Respite contracts	**As per Contracts at month end**	2	1	3	
Beds – Individual contracts P&F	**As per Contracts at month end**	1	1	2	
Beds – Individual contracts with ACC	**As per Contracts at month end**		2	2	
Total number of clients supported	**Residential contracts - Actual at month end**	**206**	**13**	**219**	
		** Vacant Beds reduced due to Christchurch Earthquake			
Vacant Beds	**Actual at month end**	2	1	3	
	Total available beds	**208**	**14**	**222**	
Total number of clients supported	**Residential contracts - Actual at month end**	**206**	**13**	**219**	
	Personal Cares contracts - Actual at month end	**2**		**2**	
		208	**13**	**221**	
	Total available bed days	5,824	392	6,216	54,684
Total Occupied Bed days	**Actual for full month - includes respite**	5,762	350	6,112	52,611
Total Occupied Beds	**Based on actual bed days for full month (includes respite volumes)**	**99%**	**89%**	**98%**	**96%**

iv. Marlborough Services Directorate

$'000	Feb-11 Budget	Feb-11 Actual	Feb-11 Var	Prev Year Actual	Year to Date Budget	Year to Date Actual	Year to Date Var	Full Year (Current) Budget	Full Year (Current) Forecast	Full Year (Current) Var
Revenue:										
Other Income	0	0	0	3	0	8	(8)	0	10	-10
Total Revenue	*0*	*0*	*0*	*3*	*0*	*8*	*-8*	*0*	*10*	*-10*
Expenditure:										
Personnel Costs	13	24	-11	99	106	109	-3	161	161	0
Clinical Supplies	0	0	0	7	1	1	0	2	2	0
Infrastructural and Non Clinical Supplies	3	4	-1	35	23	48	-25	35	72	-37
Internal Allocations	0	1	0	288	4	3	1	6	5	0
Total Expenditure	*16*	*28*	*-12*	*429*	*134*	*161*	*-27*	*203*	*240*	*-37*
Contribution to Overheads	-16	-28	-12	-426	-134	-153	-34	-203	-229.7675	-46.72981

	Budget	Actual	Var	Prev Year Actual	YTD Budget	YTD Actual	YTD Var
FTE	2.13	3.76	-1.63	2.05	2.08	2.21	-0.13

Revenue
Donations received from Nelson Marlborough Hospitals' Charitable Trust.

Expenditure
Infrastructure costs are $25k above budget with Wairau Site Development incurring $19k of unbudgeted expenditure, mostly on cleaning costs. Sundry Wairau Hospital Laundry costs are $5k above budget.

v. Maori Health Services Directorate

Director of Maori Health Statement of Financial Performance

$000	February 2011			Prior Year	Year to Date			Full Year		
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*	*Variance*
Revenue										
IDF and NGO Allocation	8	8	0	0	67	67	0	100	100	0
Other Govt Revenue	0	0	0	(1)	0	25	25	0	25	25
Total Revenue	**8**	**8**	**0**	**(1)**	**67**	**92**	**25**	**100**	**125**	**25**
Expenditure										
Personnel Costs	54	9	45	149	192	88	104	290	125	165
Outsourced services	0	0	0	3	0	0	0	0	0	0
Infrastructure and Non Clinical	12	8	4	57	92	46	47	138	104	35
Hauora Maori Services Expenditure	8	8	0	0	67	67	0	100	100	0
Internal Allocations	7	7	(0)	65	53	54	(1)	79	165	(85)
Total Expenditure	**80**	**32**	**49**	**275**	**403**	**254**	**150**	**608**	**493**	**114**
Contribution to Overheads	**(72)**	**(23)**	**49**	**(275)**	**(337)**	**(162)**	**175**	**(508)**	**(368)**	**140**

Revenue
Other Govt Revenue is $25k favourable with unbudgeted receipts for Hauora Maori CTA contract.

Expenditure
Personnel costs are $104k favourable due to a combination of:

- Realignment of personnel costs for Director of Maori Health under the new DHB structure. This is to be replaced by a higher Internal Charge from Provider Division; and
- Portfolio manager and analyst staff vacancies. The portfolio manager position has now been filled.

Infrastructure is $47k favourable with positive variances in all categories, particularly in Professional Fees and Other Operating expenses. CTA expenses are $19k below budget.

The Forecast full year expenditure includes the increased internal charge for governance and administration functions from the Provider Division.

vi. Medical / Surgical Services Directorate
Medical and Surgical Services shows a surplus of $30.5M compared to a budgeted surplus of $29.0M giving a positive variance of $1.5M.
Monthly details are included on the table following.

Financial Variances:

Medical Surgical Services Directorate Statement of Financial Performance

$000	February 2011			Prior Year	Year to Date			Full Year		
	Budget	*Actual*	*Variance*	*YTD Actual*	*Budget*	*Actual*	*Variance*	*DAP*	*Forecast*	*Variance*
Revenue										
MoH Revenue	101	116	15	1,014	1,008	956	(52)	1,610	1,458	(152)
IDF Revenue	0	(1)	(1)	0	0	0	0	0	1	1
Internal MoH Revenue	11,235	11,151	(84)	86,627	86,922	86,728	(194)	130,391	130,105	(286)
IDF and NGO Allocation	2,511	2,511	0	0	20,091	20,091	0	30,137	30,137	0
Other Govt Revenue	269	245	(24)	2,173	2,141	2,203	62	3,222	3,440	218
Other Income	254	138	(115)	2,003	2,004	2,174	170	3,019	3,204	186
Total Revenue	**14,371**	**14,161**	**(210)**	**89,814**	**112,167**	**112,153**	**(14)**	**168,378**	**168,345**	**(33)**
Expenditure										
Personnel Costs	5,575	5,412	163	44,135	46,129	44,508	1,621	70,120	68,023	2,096
Outsourced services	185	150	36	1,744	1,448	1,857	(409)	2,165	3,013	(848)
Clinical Supplies	1,060	1,142	(82)	9,245	9,405	9,759	(355)	14,261	14,938	(677)
Infrastructure and Non Clinical	438	412	26	2,294	3,658	3,429	229	5,491	5,297	194
Personal Health Expenditure	2,509	2,541	(32)	0	20,074	19,906	168	30,111	30,403	(292)
Disability Support Expenditure	2	2	(0)	0	17	(47)	65	26	(39)	65
Internal Allocations	264	280	(16)	11,285	2,404	2,254	150	3,670	3,560	110
Total Expenditure	**10,034**	**9,938**	**96**	**68,703**	**83,135**	**81,666**	**1,469**	**125,844**	**125,196**	**648**
Contribution to Overheads	**4,337**	**4,223**	**(114)**	**21,110**	**29,032**	**30,487**	**1,456**	**42,534**	**43,149**	**615**

Internal MoH Revenue
Internal MoH Revenue is $194k adverse.

The variance is in Health of Older People $229k under due to reduced continuing care volumes - currently running at 96% of YTD contract.

Personnel
Personnel costs YTD are $1.6M under budget.

For the month of February costs were below budget in all staff groups.

Budget v Actual ($'000)

Staff Group	YTD Actual	YTD Budget	YTD Var
Medical	20,411	21,086	675
Nursing	21,116	21,643	527
Allied	1,431	1,681	250
Support	813	847	34
Mgt & Admin	737	872	135
Total	**44,508**	**46,129**	**1,621**

Budget v Actual FTE

YTD Actual	YTD Budget	YTD Var
140.04	138.65	-1.40
430.83	431.68	0.85
39.81	43.00	3.19
29.31	30.75	1.44
13.28	15.00	1.72
653.27	**659.08**	**5.80**

Medical Personnel
Medical Personnel $675k under budget (1.4 FTE over).
The positive $ variance is caused by the mix of senior versus junior doctors being different to budget.

Nursing Personnel
Nursing personnel is $527k under (0.85 FTE under) with positive variances in most services.

Allied Health
Allied Health $250k under (3.2 FTE under).

Management and Admin
Management and Admin is $135k under budget (1.72 FTE under).

Outsources Services
Outsourced services are $409k over budget.

Outsourced Medical
Outsourced Medical is $584k over budget.

There continues to be major adverse variances in the following areas: Obstetricians Nelson $178k (long-term sick leave) and Wairau $196k (vacancy); Paediatrics Nelson $95k (Maternity leave cover).

Outsourced Nursing
Outsourced nursing is now $76k under budget, showing continued controls over this cost and greater use of Internal Bureau Nursing.

Outsourced Clinical Services
Outsourced Clinical Services are $102k under budget. One relatively new factor is that Ward 9 Nelson are incurring costs ($35k over budget) for Rest-Home stays of non-weight-bearing patients on the basis that this will free up hospital beds to better accommodate surgical throughput.

Clinical Supplies
Clinical supplies are $355k over budget.

The adverse variance for February was $82k – showing further deterioration. Surgical is overspent by $358k. Theatre Wairau is over budget by $321k with much of this being Implants and Prosthesis (Hips, Knees and Screws/Nail/Plates).

Nelson is also $45k over. This is reflected in Orthopaedics Wairau being 16% over contract volume YTD, Nelson 18% over. Additional surgery is being undertaken to address long wait patients, and ensure ESPI compliance with the MOH.

Infrastructure
Infrastructure is $229k under budget with positive variances in most areas.

Hotel and Laundry costs are $113k under budget mostly in laundry and patient meals.

Transport is $65k under budget, with Staff Travel and vehicle costs showing savings.

Internal Allocations
Internal allocations are $150k favourable. The positive variance is caused by Pharmacy ($150k under budget).

vii. Mental Health Services Directorate

Mental Health Directorate - Committee Reporting

	Feb-11			Prev Year	Year to Date			Full Year (Current)		
$'000	Budget	Actual	Var	Actual	Budget	Actual	Var	Budget	Forecast	Var
Revenue:										
MOH	11	6	(6)	89	89	55	(34)	134	88	(46)
Internal Revenue -FUND to FUND	1,048	1,048	0		8,386	8,386	0	12,579	12,579	0
Internal revenue (DHB Fund to DHB Provider)	2,067	2,067	0	16,466	16,540	16,572	32	24,809	24,896	86
Other Govt	5	7	2	10	42	88	46	63	134	71
Other Income	13	7	(6)	47	102	88	(14)	153	133	(20)
Total Revenue	3,145	3,135	(10)	16,612	25,159	25,189	30	37,739	37,830	91
Expenditure:										
Personnel Costs	1,562	1,511	51	12,511	13,104	12,696	409	19,938	19,274	663
Outsourced Services	55	38	18	296	442	323	119	665	561	103
Clinical Supplies	13	11	3	71	107	63	44	160	123	37
Infrastructural and Non Clinical Supplies	118	119	(1)	706	969	807	162	1,451	1,301	150
FUND - Personal Health Expenditure	81	95	(14)		644	775	(131)	967	1,163	(196)
FUND - Mental Health Expenditure	968	998	(30)		7,742	7,744	(2)	11,613	11,681	(69)
FUND - Public Health Expenditure	0	0	0		0	0	0	0	0	0
FUND - Disability Support Expenditure	0	2	(2)		0	5	(5)	0	0	0
FUND - Hauora Maori Services Expenditure	0	0	0		0	0	0	0	0	0
Internal Allocations	40	40	(0)	2,173	335	339	(5)	506	517	(12)
Total Expendtuire	2,837	2,813	24	15,757	23,343	22,752	591	35,298	34,620	678
Contribution to Overheads	307	322	15	855	1,816	2,437	621	2,441	3,210	769
FTE	231.68	234.08	(2.40)	224.19	228.00	222.07	5.93			

Overall Mental Health Directorate Year-to-Date Contribution $621k above budget (Jan $606k) with:

Income
Up by $30k (Jan $39k).
MoH Maori Health CTA funding down $34k (Jan $29k) but with incremental Opioid treatment funding ($32k) and Court Additions assessment reporting contributing positively. Further revenue allocations are awaiting the Funding Management Committee.

Expenditure
Under-spent by $591k (Jan $567k) where:

- **Personnel** costs are lower by $409k (Jan $357k) with 5.93 less FTE than budget mainly in Allied and Management/Admin staff as well as lower Medical costs with lower senior staffing;
- **Outsourced Services** lower by $119k (Jan $102k) with:
  - $26k (Jan $23k) in Medical Outsourcing Fees
  - $51k (Jan $44k) on NASC Outsourced/Respite/Clinical Outsourcing;
- **Clinical Supplies** positive by $ 44k (Jan 41k) mainly in Client related and Psychology costs,

- **Non-Clinical** positive by $158k (Jan158k) under in Infrastructure & Non Clinical in various cost categories; and
- **Funder Personal Health** spend up by $131k (Jan $117k) with spend on a Youth AOD & Suicide Prevention pilot which is funded by MoH but not yet reflected in MoH income above.

Rutherford
From a financial reporting point of view no Rutherford initiatives have yet been incorporated into the Mental Health Directorate's budgets.

Capital Projects
All the 2009/10 carried forward projects have been approved and currently being spent.

Of the 2010/11 projects five projects totalling $40k (Jan $25k) approved with $10k spent, and a number of projects currently being scoped.

Trends

KPIs/VARIANCE REPORT: MENTAL HEALTH

Performance Areas & KPI'S	Feb 10	Feb 11	YTD	Trend	Forecast EOY	Target	Comment
Access							
Outpatients/Inpatients Seen Within 2 Weeks After Discharge	100%	100%	100%*	–		100%	
AOD New Referrals Seen Within 30 Days	74%	73%	76%*	▼		80%	
CAMHS New Referrals Seen Within 30 Days	83%	79%	78%*	▼		100%	
KSC New Referrals Seen Within 30 Days	74%	74%	81%*	▲		85%	
Witherlea New Referrals Seen Within 30 Days	88%	97%	96%*	–		100%	
Crisis Response - (Witherlea, MCT, CAMHS)	100%	100%	100%*	–		100%	
Staff							
% Contracted FTEs Employed	96%	101%	97%	▼		100%	
Turnover	1.23%	0.8%	Not Avail	–		4%	
Sick Leave	2.9%	3.0%	3.0%	▼		4%	
Service Provision							
Crisis Attendance No's - (Witherlea, MCT, CAMHS)	158	103	1307**	▼		Monthly No's	
Community Caseload No's - (all Community Teams)	2805	2897	3038*	▲		Monthly No's	
Methadone No's	265	272	285**	–		Monthly No's	
AOD Court Assessments	36	31	241**	▲		As required	
Average (Acute) Inpatient Length of Stay	12	9.5	10.4*	▼		14 days	
Finance (Variance from Budget) $000s							
Total Income	(42)	(10)	30	–		Nil Variance	
Total Expenditure	145	71	729	▼		Nil Variance	
Breakdown Expenditure – Personnel	140	51	409	▼		Nil Variance	
Breakdown Expenditure – Other	5	20	320	▲		Nil Variance	
Contribution to Overheads	103	61	759	▲		Cover Overhead Costs	
Quality							
Percentage Discharge Plans	100%	100%	100%*	–		100%	Discharge planning begins at admission
Percentage Relapse Prevention Plans	96%	95.7%	96%*	–		90% - National Target	
Information Management							
PRIMHD Reporting in Timeframe	100%	100%		–		100%	
Reporting Requirements Met (MOH, MHC)	100%	100%		–		100%	

Notes:
Trend – Indicates Change from Last Month.
Trend for Financials Only - (Downwards arrow – variance moving below budget, Upwards arrow variance moving above budget).
NRM = New Reporting Measure
* monthly average YTD
** total YTD

4.2.7 Emerging Issues

i. Community Based Support Services Directorate

a. Long Term Supports – Chronic Health Conditions (LTS-CHC) Programme Funding Devolution

In 2006 the Ministry of Health established new funding to support people, under 65 years, who have a long term chronic condition and ongoing support needs. People with these conditions did not fit the current eligibility and access criteria of services funded by DHBs or Disability Support Services managed by the Ministry of Health. Since establishment the fund has been managed centrally by the Ministry of Health.

An 'in principle' decision has now been made to devolve this responsibility to DHBs.

The preference is that it be managed regionally with the needs assessment being undertaken at a district level. There are issues to be resolved relating to the scope and definition of the client group, the allocation and management of budget, and the grand-parenting of services for existing clients.

While being managed regionally it is proposed that the funding be devolved to DHBs using the Population Based Funding Formula. We are awaiting Ministry confirmation of the funding offer. As the service is likely to grow the challenge will be to manage the growth within the funding devolved. There are also opportunities – if managed well there is potential to reduce need for acute hospital admissions and aged residential care services.

b. South Island Public Health Planning Post Canterbury Quake

The three Public Health Units in the South Island are now looking at the South Island as a whole and, as part of that, are identifying pockets of high need. At the moment – and for the next several years - Christchurch will be identified as a high need area and be fitted into the generic South Island plan for public health.

ii. Maori Health Services Directorate

a. Memorandum of Agreement

By 23 June 2011, the DHB hopes to have the Memorandum of Agreement signed off by the five Maori Health providers who form the Coalition. They include Te Hauora O Ngati Rarua, Whakatu Marae Health and Social Services, Te Kahui Hauora O Ngati Koata, Te Awhina Mara Health and Social Services and Te Rapuora O Te Wai Harakeke. Should the provider boards decide not to go into 'Coalition' the DHB will examine its options and seek NMDHB Board direction.

4.2.8 Project Reports or Status

i. Community Based Support Services Directorate

a. Golden Bay Integrated Health Service

The project has made good progress with the assistance of the Ministry of Health through their Integrated Family Health Centre (IFHC) Consortia. This has included:

- The development of a service delivery business case based on a model for service delivery developed by the Golden Bay Clinical Leadership Group;
- An updated staffing model and organisational structure for service delivery based on the model of service delivery; and
- A draft revenue agreement between NMDHB and NBPH for the additional services to be delivered by NBPH under the arrangements proposed in the Service Delivery Business Case.

This is the 1st of three business cases to be prepared with the assistance of the IHFC Consortia and was approved by the NBPH Board on 24 March, 2011. It is intended that this will go to the NMDHB Board in April. The two other business cases to be developed include a bankable property business case and the impacts on NMDHB. A design brief based on the model for service delivery and proposed concept design plan being unanimously agreed to by IMG.

A building development cost estimate based on the Architects Concept Design has been prepared by a Quantity Surveyor; and Terms for a Commercial Loan from a bank have been provided by the Crown Health Financing Agency.

The next steps are:

- Finalise the amount of land that will be required to be purchased from the land owner to enable the community hospital to be upgraded;
- An agreement will then need to be reached with the landowner to secure the land and put back to back lease arrangements in place with both the Golden Bay Community Health Trust and St John;
- Obtain the requisite Ministerial approvals to enable the community hospital to be transferred to the Golden Bay Community Health Trust (There is some risk that the approach suggested by the Ministry to transfer the DHB property may undermine the community's commitment to the project and potentially impact on the commercial lending proposals received to date. We are working with the Ministry and the IFHC consortia to mitigate this risk);
- Complete the business cases to support the property investment and the impacts on the DHB;
- Progress both the community fundraising; and
- Progress the plan to transition staff to NBPH as the new service provider.

b. The Child and Adolescent Oral Health Project

The Child and Adolescent Oral Health Project is on track for all five sites and the two mobile clinics. Work continues on developing therapist and assistant training programme across all areas. There are some project risks around negotiating team's ability to reach an agreement with PSA over Dental Therapist working hours, the impact of any negotiation on Dental Assistant staff, the training programme and its implementation as the timeline is still under development, and the Titanium IT installation which is dependant on other training timelines. Mitigation actions are in place for these risks.

ii. Maori Health Services Directorate

a. Maori Health Providers

Maori Health Providers have been working intensely on the coalition development since June 2010. The provider managers have agreed to values and principles, strategic intent and resources. The final step is for them to get provider Board sign off. The DHB has asked that they have the MOA approved by 23 June 2011.The DHB is now meeting with provider boards to explain why the change is necessary. Provider managers have been working with their boards for almost twelve months seeking agreement to the Coalition.

b. Hui

The DHB met with Te Amo Health, Maata Waka Ki Te Tau Ihu and Whakatu Te Korowai Trust on 23 Feb 2011. The purpose for this hui was to re-establish relationships and to consider a way forward. The DHB was clear that these providers had to be moving in the same direction to that of the Coalition. The DHB was seeking changes that aligned to population health outcomes for Mäori in Te Tau Ihu. Regular meetings are to be established and a plan of action decided.

c. Cultural Competency Framework

The DHB has engaged Te Rau Matatini to develop a Maori Cultural Competency Framework for the DHB. The funding is not new money, but savings made by TRM from other project work. Its initial focus is towards Maori DHB staff with the view that it be opened up to non-Maori DHB staff. There are a number of policies in place, which speak to Culture or competency. This approach seeks to integrate these policies into a planned pathway.

d. Whanau Ora Taskforce Report

On 10th February, Julie Pattison (CE, Whanganui DHB) hosted a national meeting with TPK, MSD, and MoH representatives to talk about Whanau Ora. Some quick refresher points are:

- DHB will retain current funding;
- MoH will improve the level of communication it has with the sector;
- Providers will have the option of moving onto an integrated contract; and
- Whanau ora is a 'learn as we go' process.

e. Whanau Ora

The government has sent a message that services maybe cut; Whanau ora has been cited as an area where funding maybe reduced.

4.2.9 **Health Alliance / Collaboration**

i. <u>Marlborough Services Directorate</u>

a. Nelson Marlborough Health Alliance

Nelson Marlborough Health Alliance is an agreement between Nelson Marlborough District Health Board and the PHOs, Nelson Bays Primary Health and Kimi Hauora Wairau Marlborough, to work together around clinical process improvement, within the context for the Minister of Health's *Better Sooner More Convenient* health care policy. Within the context of the Alliance, pathway development is a clinically-led service improvement initiative, seeking sustainable change. This involves multi-disciplinary teams from across the district coming together to develop or adapt pathways to meet local challenges.

b. Pathways Support Group Established

The Pathways Support Group (PSG) has been established this month to lead and facilitate the clinical pathway development process. The membership is comprised of primary and secondary clinicians and DHB leadership support (Marlborough and GP liaison, Nelson Tasman GP liaison, Chief Medical Officer, Director of Nursing, PSG leader (Service Director Marlborough) and will be revised be as necessary as the work progresses (also relevant service director/s and Executive Clinical Directors as required). The PSG will lead the pathway development process including: Support pathway development, prioritise encourage and receive ideas; Establish clinical groups, and coordinate and support activity; Facilitate directorate and PHO engagement in pathway development; Link pathway development to systems that can initiate service change; and, Facilitate implementation of pathways by promulgation, training systems and development of resources to support pathways.

Pathways Support Group activities this month:

- Established Pathway Support Group (PSG);
- Worked with stakeholders to clarify terms of reference for the group and a pathways model for Nelson Marlborough;
- Developed draft operating processes and templates to provide a standard framework for pathway development;
- Discussion with various stakeholders and Streamliners about website options; and
- First meeting to review skin lesion proposal and establish process for skin lesion pathway development.

Status update of pathways in progress: Note the first three have been developed prior to the new process. This status information is not complete as yet.

Work stream	Goal	Status	Timeframe
Dementia	To improve Primary Care (especially GP and Practice Nurse) recognition and awareness of dementia and have a consistent pathway for diagnosis and evaluation for Dementia.	Pathway complete. Implementation to come, Waiting for website	TBC
Obesity	To provide a pathway for managing the obese patient (including the criteria for referral for surgical management).	Pathway complete. Implementation to come, Waiting for website.	TBC
Pain pathway	To provide an evidenced based best practice persistent pain service. To shift to a community based MDT service with bio-psychosocial approach.	4 meetings held to design new service. Now meeting with Med/Surg Directorate re funding. Pathways/guidelines to follow?	TBC
Skin Lesion pathway	To identify 'primary care ' capable lesions and treat these in primary care To improve referral information into secondary care for secondary appropriate lesions Greater clarity about what the DHB will fund (+/- financial hardship volume)	Proposal to PSG. Pathway process agreed.	First meetings in Nelson and Marlborough planned March/April

c. **Planned activities for next month**

Determine website option and progress; Further development and agreement around Pathways model for NMDHB and processes; and, Regular meetings to process ideas and support development of clinical work groups

4.2.10 Progress against service improvement plans

i. Community Based Support Services Directorate

- Golden Bay Integrated Health Service: is progressing as detailed above;
- After Hours Primary Care facility: progressing as above;
- Community Oral Health Service: as above; and
- Better, Sooner, More Convenient Strategy: progressing under the Health Alliance framework.

4.2.11 Directorate Profile

i. Clinical Services Support Directorate

Attached as **Appendix 2** is the summary presentation.

ii. Community Based Support Services Directorate

The Community Based Service Directorate will provide a presentation at the meeting. Attached as **Appendix 3** is the summary presentation.

iii. Mental Health Services Directorate
Attached as **Appendix 4** is the summary presentation.

RECOMMENDATIONS:

1. **THAT THE DIRECTORATE REPORTS ARE RECEIVED**
2. **THAT THE BOARD ENDORSES THE REQUIREMENT FOR ARRC PROVIDERS TO COMPLY WITH THE REQUIREMENTS OF CLAUSE A14 FOR CLIENTS IN LTOS RECEIVING RESTHOME LEVEL CARE AND THAT THE REFUND BE MADE TO THE CLIENT.**

SECTION 5: FOR INFORMATION

SECTION 6: MEMBERS ISSUES

SECTION 7: 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 or 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
EVIDEM	Evidence and Value: Impact on DEcisionMaking
FF&E	Furniture, Fixtures and Equipment
FFT	Future Funding Track
FMIS	Financial Management Information System
FOMHT	Friends of Motueka Hospital Trust
FOUND	Found Directory is an up-to-date listing of community groups and organisations in Nelson/Tasman
FRC	Fee Review Committee
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
FVIP	Family Violence Intervention Programme
GM	General Manager

GMS	General Medical Subsidy
GP	General Practitioner
GRx	Green Prescription
HAC	Hospital Advisory Committee
HBI	Hospital Benchmarking Information
HBSS	Home Based Support Services
HBT	Home Based Treatment
H&DC / HDC	Health and Disability Commissioner
HDSP	Health & Disability Services Plan Programme
HDU	High Dependency Unit
HEA	Health Education Assessments
He Kawenata	Covenant, agreement, treaty, testament (PM Ryan Maori Dictionary pg 104)
HEeADSSS	Psychosocial tool – Home, Education, eating, Activities, Drugs and Alcohol, Sexuality, Suicidality (mood), Safety
HEHA	Healthy Eating Healthy Action
HEP	Hospital Emergency Plan
HESDJ	Ministries of Health, Education, Social Development, Justice
HFA	Health Funding Authority
HHS	Hospital and Health Services
HIA	Health Impact Assessment
HM	Household Management
HMS	Health Management System
HODs	Heads of Department
HOP	Health of Older People
HP	Health Promotion
HPI	Health Practitioner Index
HPV	Human Papilloma Virus
HR	Human Resources
HR & OD	Human Resources and Organisational Development
IANZ	International Accreditation New Zealand
IBA	Information Builders of Australia
IDF	Inter District Flow
IDSS	Intellectual Disability Support Services
IFRS	International Financial Reporting Standards
IHB	Iwi Health Board
IM	Information Management
InterRAI	Inter Residential Assessment Instrument
IPAC	Independent Practitioner Association Council
IPC	Intensive Patient Care
IPC Units	Intensive Psychiatric Care Units
IPG	Immunisation Partnership Group
IPU	In-Patient Unit
IS	Information Systems
ISSP	Information Services Strategic Plan
IT	Information Technology
JAMHWSAP	Joint Action Maori Health & Wellness Strategic Action Plan
JOG	Joint Oversight Group
KIM	Knowledge and Information Management
Kotahitanga	Unity, accord, coalition, solidarity (PM Ryan Maori Dictionary pg 127)
KPI	Key Performance Indicator
KHW	Kimi Hauora Wairau (Marlborough PHO)
LA	Local Authority
LCN	Local Cancer Network
LIS	Laboratory Information Systems
LOS	Length of Stay

LSCS Lower Segment Caesarean Section
LTC Long Term Care
LTCCP Long Term Council Community Plan
LTO Licence to Occupy
LTS-CHC Long Term Supports – Chronic Health Conditions
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
SIA	Services to Improve Access
SICF	South Island Chairs Forum
SICSP	South Island Clinical Services Plan
SI HSP	South Island Health Services Plan
SIRCC	South Island Regional Capital Committee
SISSAL	South Island Shared Service Agency
SLH	SouthLink Health
SLT	Strategic Leadership Team
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SOI	Statement of Intent
SOPD	Surgical Outpatients Department
SOPH	School of Population Health
TDC	Tasman District Council
TLA	Territorial Local Authority
TOW	Treaty of Waitangi
TOR	Terms of Reference
TRTT	Te Roopu Tupu Tahi
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

April 2011

SECTION 8: APPENDICES

APPENIDX 1 – IMPLICATIONS FOR NMDHB – CHRISTCHURCH EARTHQUAKE 22 FEBRUARY 2011

Christchurch Earthquake 22 February 2011

Implications for NMDHB – briefing for CPHAC/DiSAC

Following the 6.3 magnitude earthquake on 22 February 2011 in Christchurch there have been a number of impacts on the health sector in Nelson Marlborough.

This paper summarises an initial debriefing held on 18 March and identifies some of the actions that will be followed to improve the preparedness of the health and disability sector in Nelson Marlborough. The actions proposed in this paper will be reviewed by the Emergency Management Project Group (EMPG) at its next meeting (20 April) to enable an implementation timetable to be finalised.

The initial debrief looked at

1. What went well?
2. What didn't go so well?
3. What could we do differently if required to respond in a similar situation?

Background

In accordance with the Crown Funding Agreement (CFA) NMDHB is required to have a Health Emergency Plan and in the event of an emergency to follow

the principles set out in the Coordinated Incident Management System (CIMS) adopted by response agencies New Zealand wide. Under the CFA NMDHB is required to fund 0.1% of its population based funding towards the costs of a response.
There are four phases in CIMS

- Reduction;
- Readiness;
- Response; and
- Recovery.

Under CIMS a generic structure and language is used for all emergencies so that agencies responding are able to readily communicate and there is a clear span of control. The overall response is managed through an Emergency Operations Centre (EOC) lead by a Controller. The Controller is supported by the following key functions; planning and intelligence, operations, logistics, communications and liaison.

EMPG has the overall role of coordinating planning across the health sector in the district, including the training of staff and others under the CIMS framework. Membership of the EMPG has been extended to include representatives from the PHOs.

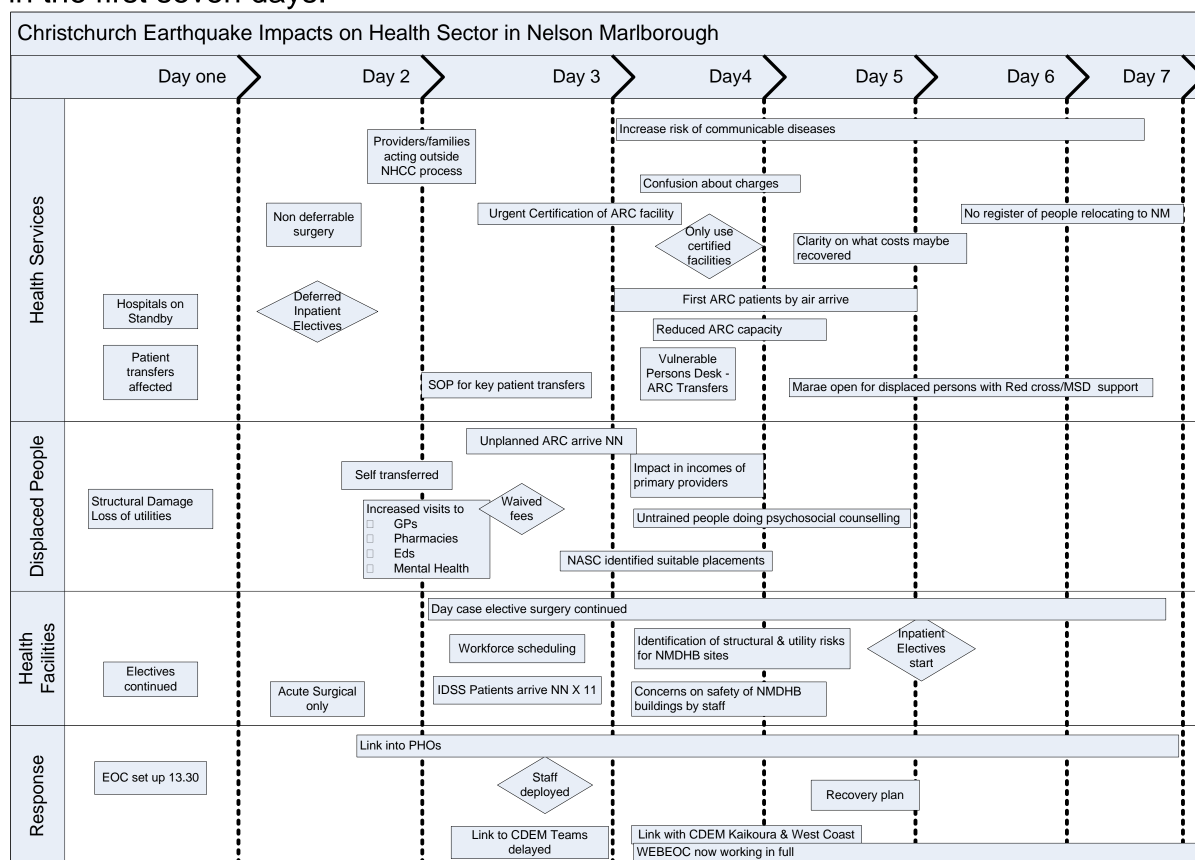
NMDHB has had a major role in developing response plans for the health sector nationally. Our Red E logo has been adopted by the Ministry's Emergency Planning Team as have the templates developed for primary providers to use to develop their own plans. These plans are intended to help providers to reduce their risks in the event of an incident and to have formal plans of how they might respond to that incident. Response plans are aimed at developing a level of readiness by identifying and where possible reducing our risks and having proposed processes on how we might respond in an emergency.

The recovery aspect of any event will depend on the extent of any the impact of the event. As part of the planning departments and other health service providers are expected to identify how they might return to business as usual in the event of say fire, loss of premises, loss of information systems, power outages and loss of key staff. Business continuity is a key part of any planning in the health sector.

Until they are tested by an actual event the plans are seen as a living document to which changes are made as experiences occur. A series of exercises have been held over recent years particularly around a pandemic influenza scenario. A number of staff across the district have been trained in CIMS to provide a pool of staff able to assist in a response.

Timeline

The following chart sets out the timeline of some of the key impacts arising from the Christchurch earthquake on the health sector in Nelson Marlborough in the first seven days.



The Emergency Operations Centre in NMDHB was set up by 1.30pm following news reports of the severity of the quake, deaths and major damage. The EOC staff participated in all of the national teleconferences as organised by the National Health Coordination Committee (NHCC). Hospitals were placed on standby and the elective surgery schedule reviewed to ensure adequate bed numbers were available in the event of a significant number of patient transfers.

The first reported patients were a family of tourists at ED Wairau late Tuesday who travelled from Christchurch after being triaged with injuries suffered in the quake. This was followed by a steady flow over the next few days of people leaving Christchurch and travelling to be with relatives elsewhere in New Zealand. This placed pressure on accommodation particularly in Marlborough with many staying one or two nights at Marae in the area.

There has been an on going impact on EDs at both hospitals, particularly at Wairau where a range of people presented from those part way through chemotherapy treatment to pregnant women. Some 40 pregnant women have relocated to Marlborough.

The first patient transferred from Christchurch was received at Nelson Hospital on the Wednesday morning, which was then followed by a number of

other transfers of patients for post operative recovery. A number of patients from Christchurch have had non deferrable surgery undertaken at Nelson Hospital by CDHB surgeons. There have also been a number of acute transfers from the West Coast and Kaikoura into our hospitals. This followed NMDHB offering to treat these patients to help reduce pressure on Christchurch Hospital.

On Thursday 24 February a busload of relocated aged residential care clients arrived about 5 am after travelling non-stop overnight. This transfer was arranged outside the national process. An intention by a commercial provider to use a closed facility was unable to proceed as a number of actions were required to bring the facility up to a usable state and meet the criteria used by NASC. As a result some of the clients were distributed across vacant beds in other facilities.

Since then approximately 100 additional ARC clients have been relocated into beds across the district. Most of these clients were transferred by Air Force Hercules aircraft.

A number of aged care residents from Christchurch relocated into Nelson Marlborough outside the national process. Requests for respite care by local families caring for those people could not be met as commitments had been made to meet the organised transfers. This created a level of tension for staff and the families. Situations also arose where following the quake residents previously able to care for themselves in their homes became less capable and sought admission into an ARC facility in the district.

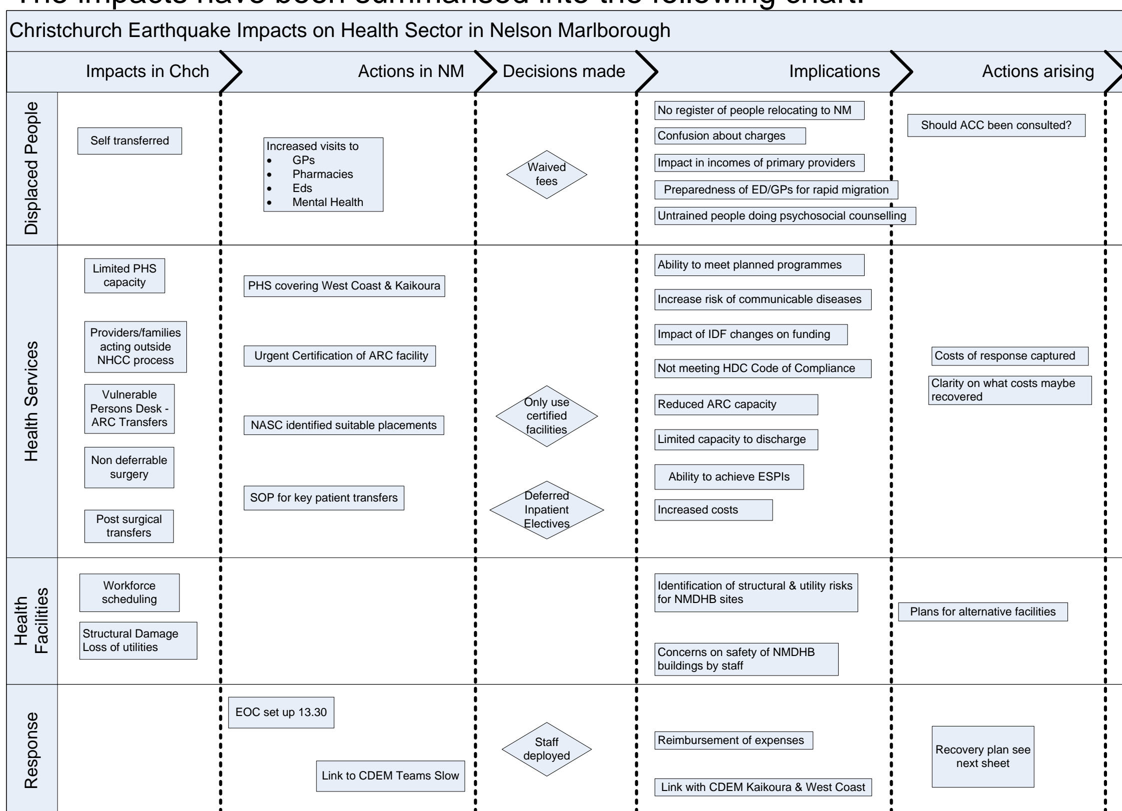
Following a formal request for assistance four staff plus two vans from Intellectual Disability Support Services travelled overnight on Thursday to retrieve 11 intellectually disabled clients and relocate them into existing vacancies in community homes in Nelson.

NMDHB has provided a range of staff to CDHB to assist them in responding to the quake and to give CDHB staff the ability to have time off. These staff have provided some commentary from their observations while working there on possible issues for NMDHB should a similar earthquake hit Nelson or Marlborough.

A number of NMDHB staff were caught in the earthquake. These included management and clinical staff who assisted at triage sites in Christchurch before returning to Nelson or Marlborough in the ensuing days.

Impacts on Health Sector in Nelson Marlborough

The impacts have been summarised into the following chart:



Several key decisions were made as the response evolved.

These included waiving GP and prescription fees for people from Canterbury visiting the district. One of the issues that arose from this decision was that people with injuries were not funded by ACC who have declined to meet costs for any patients for which their process was not followed.

The decision to only use certified facilities was required when a provider proposed to use a facility that had been closed for two years. It did not have any staff onsite or basic furniture and was seen as placing the relocated clients at risk. The provider arranged staff from other centres in order to have the facility certified within 7 days.

The decision to defer inpatient electives was made on day 2 so that adequate bed capacity was available for any acute patient transfers from Christchurch. This position remained in place for four days until it was clear that hospitals in Nelson Marlborough were not required for large numbers of relocated patients. Since the quake occupancy has been higher than the same time in previous years with Nelson Hospital reaching over 85% occupancy 18 days between 22 February and 31 March.

The deployment of staff followed a national process which was managed by the NHCC around requests from CDHB. The key message from CDHB was not to second guess what they might want and to wait from them to ask for the resources they needed. The type of staff deployed included health protection

officers, registered mental health nurses, engineer, emergency planning officer and sonographer. Other staff either travelled to visit family and made themself available to CDHB or volunteered as part of organisations such as Red Cross.

Debrief

Appendix A sets out the notes from the 18 March debrief session. The question of the financial impact was not considered as a national decision is expected on the final treatment of these.

The actions are being separated into the following categories:

- How the EOC operated – notifications, staff training for the role, organisation and scheduling;
- Links with other groups – CDEM, Maraes, professional groups;
- Preparedness – DHB, other health providers, CDEM;
- Communications – internal, providers, affected people and community in general; and
- Recovery – getting back to business as usual.

Appendix B sets out comments from staff who were deployed to Christchurch on behalf of NMDHB.

Seismic Risk of Existing Buildings
A number of requests were received from staff on the seismic risk of NMDHB buildings. Following the 4 September 2010 Canterbury earthquake staff in Dalton House we reassured of the status of that building. All of our major buildings were assessed in April 2006 by SKM against the current seismic standards. Following the Christchurch earthquake it is anticipated that new standards are likely to be issued in the not too distant future which will require a further assessment. Refer to **Appendix B** for comments from a member of the Property Management Team.

The actions arising are:

- Carry out an appraisal of all buildings to identify any major issues of risk and
- Prepare a preliminary report and cost estimates for any remedial work to buildings that may be required.

Risks to Non DHB Buildings
Prior to the 22 February quake NMDHB was in discussion with the PHOs on developing resilience for the primary sector particularly regarding emergency power generation. The scope of an investigation into the options for NMDHB was being drafted and it is proposed that this should form part of any action plan.

Next Steps
The EMPG will be considering this paper and develop an action plan against which it will report to the Chief Executive regularly.

This will include a full review of all response plans, business continuity plans and seismic risks.

Await national decision on how the financial impacts of our response will be managed.

Appendix A 18 March 2011 – Initial Debrief Notes

DONE WELL	AREAS FOR IMPROVEMENT
EOC was set up within one hour.	ED / GPs preparedness for self-presenters and general rapid migration from Christchurch.
Process and communications worked very well after a settling in period.	Confusion re funding / fees for GPs and pharmacies.
Communications to Wairau were good.	ED management and flow.
Liaison with PHOs worked well.	Links to Kaikoura and West Coast.
Maori Health liaison was not good at first, but improved.	Problem with communications between NMDHB and Marlborough Civil Defence.
Interactions with Christchurch EOC and NHCC were focussed on responding to their requests.	Internal triggers in DHB for determining emergency priority. Focus on planning and intelligence. Suggested that a mirror of Cascade Levels be created for EOC.
A single point of contact was established in the DHB for patient travel.	Role set-up and role cards. Needs to be flexible because each emergency is different.
Local NASC - ARC response was very good.	Do not second-guess the emergency centre. They will let us know what they need and when.
Didn't go so well	Many teleconferences with many different groups eg national, regional and local.
EOC CIMS roles. It took some time for people to settle into their roles and get organised. Team members need to understand their roles more fully and wear ID jackets.	Improve understanding of HR requirements when deploying staff. Clarification needed on what hours can be claimed, what the employee is entitled to and who is paying.
Communications internally and with Southcom.	Deployment was very confusing between the three coordinating agencies.
Reassess who receives initial alert text.	Inform staff on safety of NMDHB buildings.
Community response on weekend.	Organisation of paperwork in the EOC. Old sitreps on central tables could cause confusion.
CIMS refresher for staff and log detailing the status of employee's CIMS training.	EOC structure information disseminated to staff earlier in the emergency.
Balance 'business as usual' with CIMS role in the EOC for an extended emergency.	Alternative care venues identified with or without ED capabilities.
	Determine if NMDHB contractors have emergency plans (e.g. Medirest).
	A list of counsellors and mental health workers needs to be available across the region.

Appendix B – Comments from Staff Deployed

ED Clinician

- Public address system for ED;
- Quantity of disaster packs (pre-prepared NHI numbers), PPE;
- Single entry triage point for ambulance bay;
- Call tree for ED/trauma staff;
- Alternative locations from which services can be provided; and
- Bedside testing.

Property Management

- Service tunnel at Nelson Hospital under Waimea Road (contains power, steam, telephone, data cabling and medical gases);
- Options for standby steam generation and suitable connection points to the existing reticulation pipe work;
- Seismic inspection of the chimneys at the boilerhouse and domestic type buildings used by NMDHB;
- The reticulation pipe from the emergency water supply tank on the upper Braemar site; and
- The seismic restraints fitted to the roof top water storage tanks in George Manson and Percy Brunette Buildings at Nelson Hospital.

APPENDIX 2 – CLINICAL SERVICES SUPPORT PRESENTATION

Clinical Services Support

James Bowyer
April 2011

Clinical Services Support

Service Director : James Bowyer

Clinical Directors:

Secondary - Stephen Busby (Radiologist)

Primary- Neil Whittaker (GP)

Director of Allied Health-Hilary Exton

Nelson Marlborough District Health Board

Clinical Services Support

Key functions

- Allied Health Services (Physio, Occupational Therapists, Dieticians, Social Workers, Speech Language Therapists)
- Support Works(NASC)
- Orthotics
- Audiology
- Laboratory
- Pharmacy
- Radiology

Clinical Services Support

Key functions -continued

- Infection Control
- Pukenga Hauora
- Family Violence Intervention
- Patient Transfers (Scheduled and Unscheduled)
- Meals on Wheels
- Clerical/Admin staff
- Clinical Records
- Clinical Coders
- Chaplaincy
- Volunteers

Key Issues

- Monitoring and controlling demand for services within Budget
- Laboratory contract with Medlab South
- Medicines Reconciliation(reduction in drug administration and prescribing errors)
- Focus on Clerical staff achieving First Specialist Assessment targets

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Where to?

- Using Clinical Directors to achieve better clinical pathways for all of the patient journey
- Find better ways to control demand, i.e Community Pharmacy Budget exceeds $30 million
- Implement Rutherford Initiatives- i.e Patient Travel both scheduled and unscheduled

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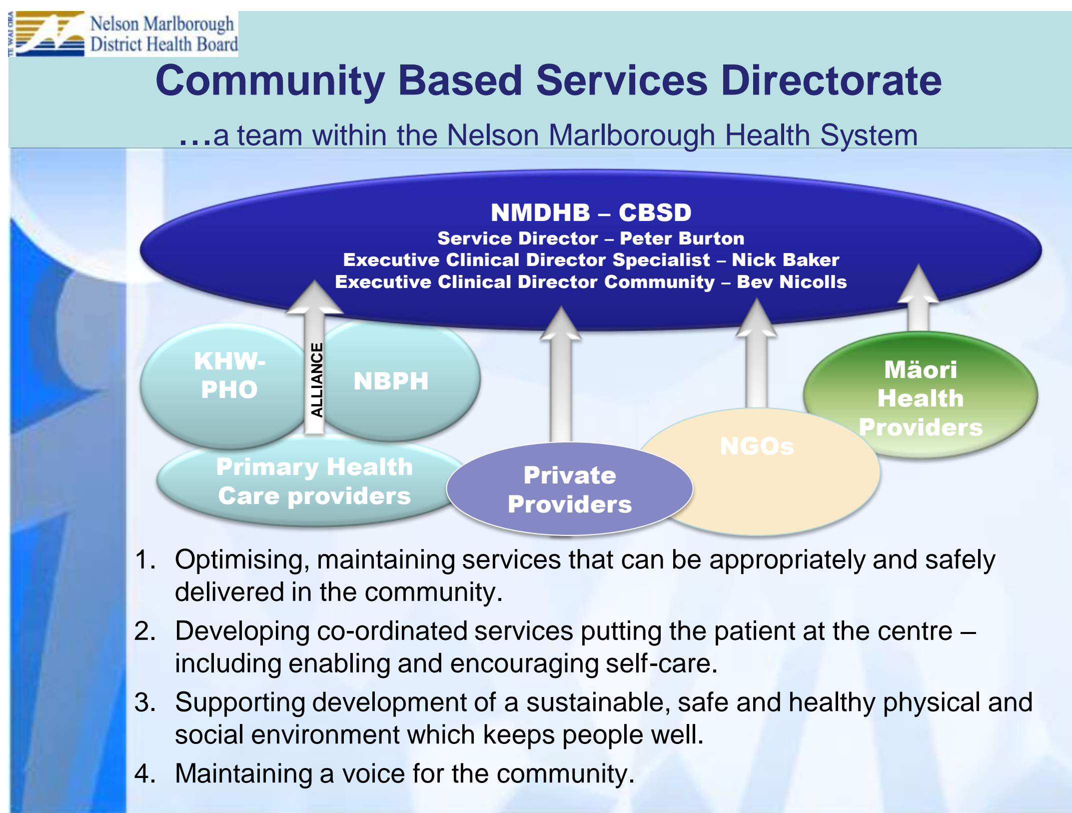
APPENDIX 3 – COMMUNITY BASED SERVICES PRESENTATION



CBSD funds 'Community Based Services'…

Services delivered in the community by staff or through contracted providers worth $97million (25% of DHB's total funding)

$75m community contracts:

- $24m PHO contracts (v18.1)
- $15m Residential rest homes
- $14m Residential care hospitals
- $8.7m Home Based Support Services
- $2.6m 8 Mäori health providers
  Whanau Ora programmes, immunisation, diabetes services, physical activity/nutrition
- $3.6m Hospice long-term and palliative care
- $1.4m Adolescent dental services

$21m direct delivery:

- Smoking cessation
- Immunisation
- Border health protection
- Community Oral Health Clinics
- Screening services
- Well Child
- Child Development/Paediatrics
- Sexual health services
- District Nursing
- Diabetes services
- Rural services

...over the entire Continuum of Care...

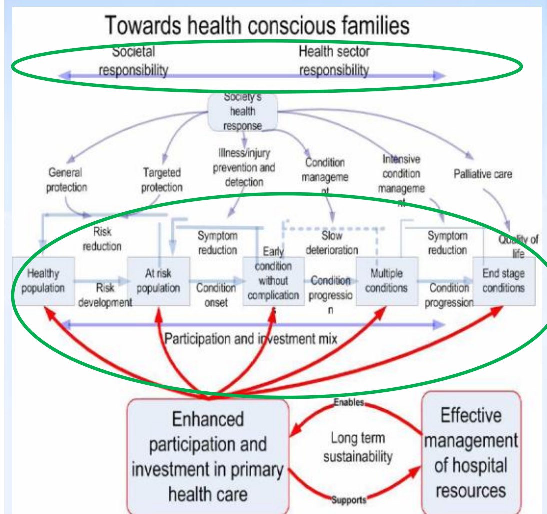
Delivered through:

- 'Programmes of Care'
- Safe and efficient services for older people
- Services provided 'closer to home'
- Prevention, early detection, management
- Better, sooner, more convenient primary care

Directorate structures have been organised around '*programmes of care*' – groups of services likely to be used by a particular group of people; because,

people often use a number of health services at the same time or consecutively – the '*patient journey*'; and,

Greatest gains in the health care system will come from improving the ways health services work together to streamline this journey



CBSD Recent Advances...

South Island Public Health Planning post Canterbury Quake

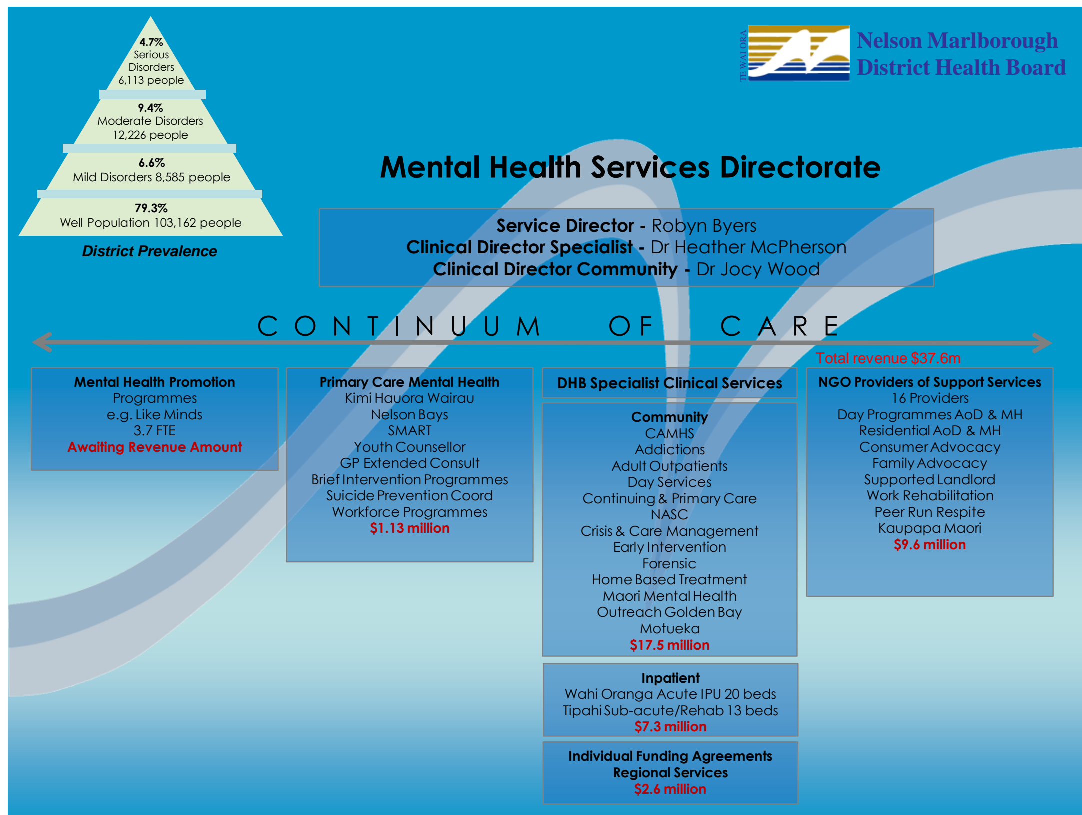
The three Public Health Units in the South Island are now looking at the South Island as a whole and, as part of that, are identifying pockets of high need. At the moment – and for the next several years - Christchurch will be identified as a high need area and be fitted into the generic SI plan for public health.

Community Oral Health Service – community clinics at Stoke, Richmond, Nelson, Motueka, and Blenheim, mobile clinics in Tasman and Marlborough.

Extended Primary Care Facility – on the Nelson Hospital Campus for the After Hours, Duty Doctor, and Low Cost Access services; building expected to be completed by December this year.

Golden Bay Integrated Family Health Centre – commercial funding secured for 2/3 of total project value and necessary steps required to gain Ministers approval agreed. Centre on track to be completed mid 2012.

APPENDIX 4 – MENTAL HEALTH SERVICES PRESENTATION



Nelson Marlborough District Health Board

Whakatauki

He Aha te Mea Nui o te Ao
He Tangata! He Tangata! He Tangata!

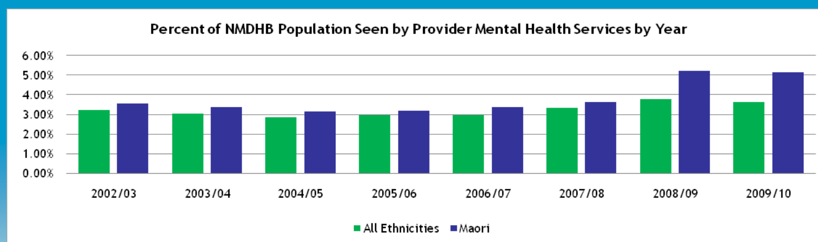
People are our focus – those accessing the service (consumers & families) and those who provide it.

Ministry of Health Performance Monitoring

Provider: **Access Rates 2009/10**

Total District Population Seen - 4th of 21 DHBs (3.63%)

Total District Maori Population Seen - 4th of 21 DHBs (5.16%)



	Maori	Other	Total
0-19	3.26%	3.78%	3.69%
20-64	6.75%	4.12%	4.33%
65+	0.99%	0.86%	0.89%

Relapse Prevention – 1 of 10 DHB Services above national target (child and adult)

Acute Inpatient L.O.S – 12 days (national average = 18)

National Consumer Satisfaction – 87% overall satisfaction (highest DHB)

Primary: Demonstrated positive clinical gain each quarter with minimum 8% decrease in PHQ-9 scores

Key Features of Mental Health Services

- **Consumer Partnership**
  - "With us not without us"
  - Advanced Directives
  - Planning, Delivery, Monitoring, Evaluation
  - Advisors and Advocates
- **Whanau Involvement**
- **Holistic Recovery Model Care**
  - Strength based, not illness
- **Low Tech High Care**
- **National Strategy & Framework**
- **Legislative Requirements**
  - Mental Health Act
  - Alcohol and Drug Act
- **Social Inclusion**
- **Primary Health Integration**
- **Extensive Reporting**
  - MoH, MHC, PRIMHD, National KPIs
- **Multiple Audits**
  - MoH, MHC, District Inspector, Funder
- **Close Sector Collaboration**
  - National Forums (MHAC, National Managers, CAMHS, Addictions)
  - National Projects (MH SMART/PRIMHD, KPIs, Pricing Model, National Framework)
- **Regional/Local Collaboration**
  - South Island MH Network
- **Intersectorial Collaboration**
  - Joint ventures
  - Shared training
- **Funding Model**
  - "The Ringfence"
  - Designated FTEs, bed days & methadone