

# Statement of Intent 2009-2012



12 October 2009

# CONTENTS

<b>1</b>	<b>EXECUTIVE SUMMARY</b>	<b>3</b>
<b>2</b>	<b>STRATEGIC OVERVIEW</b>	<b>4</b>
2.1	NMDHB VISION	4
2.2	NELSON MARLBOROUGH DISTRICT HEALTH BOARD PRIORITIES	4
2.3	STATUTORY FUNCTIONS	7
<b>3</b>	<b>OPERATING ENVIRONMENT</b>	<b>8</b>
3.1	EXTERNAL ENVIRONMENT	8
3.2	ACHIEVING POPULATION HEALTH IMPACTS AND OUTCOMES	9
3.3	INTERNAL ENVIRONMENT	10
<b>4</b>	<b>NMDHB OUTPUTS CLASSES AND STATEMENTS OF FORECAST SERVICE PERFORMANCE</b>	<b>11</b>
4.1	DHB SPECIFIC MEASURES (NON-FINANCIAL MEASURES)	11
<b>5</b>	<b>NMDHB SERVICES AND ENABLERS</b>	<b>21</b>
5.1	PLANNING FOR THE FUTURE	21
5.2	MEASURING PERFORMANCE AGAINST STRATEGY	21
5.3	LIVING WITHIN OUR MEANS – OUR RUTHERFORD INITIATIVE	22
5.4	FUNDING PHARMACEUTICALS AND COMMUNITY PHARMACIST SERVICES	22
5.5	FUNDING AND PROVIDING SERVICES TO MEET THE NEEDS OF SPECIAL POPULATIONS	23
5.6	DEVELOPING BETTER SETTINGS OF CARE THROUGH OUR PRIMARY AND COMMUNITY DIVISION	24
5.7	ENSURING BETTER SPECIALIST SERVICES THROUGH OUR PROVIDER DIVISION	25
5.8	ORGANISATIONAL CAPABILITY	27
5.9	INFORMATION SYSTEMS TO SUPPORT CLINICIANS IN PATIENT CARE	28
5.10	DEVELOPING FACILITIES THAT SUPPORT BETTER CARE	28
5.11	ENABLING NATIONAL AND REGIONAL COLLABORATION AND CROSS SECTORAL COLLABORATION	29
<b>6</b>	<b>NMDHB FINANCIAL INFORMATION</b>	<b>30</b>
<b>7</b>	<b>APPENDICES</b>	<b>46</b>
7.1	Appendix 1: Price Volume Schedule (as of July 2009)	46
7.2	Appendix 2: NMDHB Balanced Scorecard (as of February 2009)	56
7.3	Appendix 3: NMDHB Accounting Policies	57
7.4	Appendix 4: Schedule of the Existing Range of Services Funded per SOI Output Class	66
7.5	Appendix 5: DHB Provider Arm 2009/10 Internal MoH Revenue Funding by Output Class	69
7.6	Glossary and Abbreviations	74

## 1 Executive Summary

This Statement of Intent (SOI) outlines to Parliament and the general public the performance that Nelson Marlborough District Health Board (NMDHB) will deliver during 2009/10 and contains non-financial and financial forecast information for 2010/11 and 2011/12<sup>1</sup>. This document sets out our strategic goals and provides an overview of some of the services we deliver along with the performance targets we have set for ourselves for the period ahead.


NMDHB has organised itself around its vision “Leading towards Health Conscious Families” using a conceptual model we refer to as JUMBO (see page 4). The full spectrum of healthcare and disability support services is included in this framework and for the past three years in particular NMDHB has been focusing on improving public health services, primary and community services and support services outputs. This year we are focusing on improving models of care, quality and safety of our hospital services outputs whilst maintaining hospital based services at agreed levels. Due to the range of services delivered by our DHB, we have selected key priority areas to discuss in detail in our SOI. The rationale for selecting and including these priority areas is detailed further in sections 2 and 3.

The external environment is challenging with an expansion of high health needs due to the ageing population and higher than usual birth rates. These two population groups constitute a high and growing cost for this DHB. We are also experiencing higher levels of chronic disease with associated increased acute hospital admission rates. For the term of this SOI we, along with our clinical leaders, are aligning our district services to support the collective South Island Health Services Plan, a significant part of which is the Elective Services Plan. We are also working in partnership with Nelson Marlborough Primary Health Organisations (PHOs) and other health providers to devolve appropriate services currently delivered through hospitals and to reconfigure existing community services around ‘Integrated Primary Health Centres’. This involves expanding the current roles, capacity and capabilities of existing community and hospital clinicians to deliver higher quality and better outcomes for the people of Nelson Marlborough.


In this SOI we outline our intentions to utilise the additional revenue provided by Government to address a range of commitments as well as address the Minister of Health’s expectations to provide better, faster and more convenient care through increasing elective discharges, reduced cancer waiting times and reduced emergency department waiting time. These are outlined in more detail in this SOI. We intend to build on our clinical leadership and engagement processes to ensure higher quality, safer and more productive services delivery into the future.

We include our Statement of Forecast Services Performance that should reassure Parliament with regard to what services and programmes we will deliver for the people of Nelson Marlborough and other New Zealanders who need our services. The NMDHB ‘Balanced Scorecard’ is highlighted to demonstrate our commitment to measure our performance.

We also outline what we will be doing internally to achieve the transformational change required over the term of this SOI. In particular, we are introducing ‘Project Rutherford’, our approach to ensure ‘value for money’.



Signature  
(Board Member)



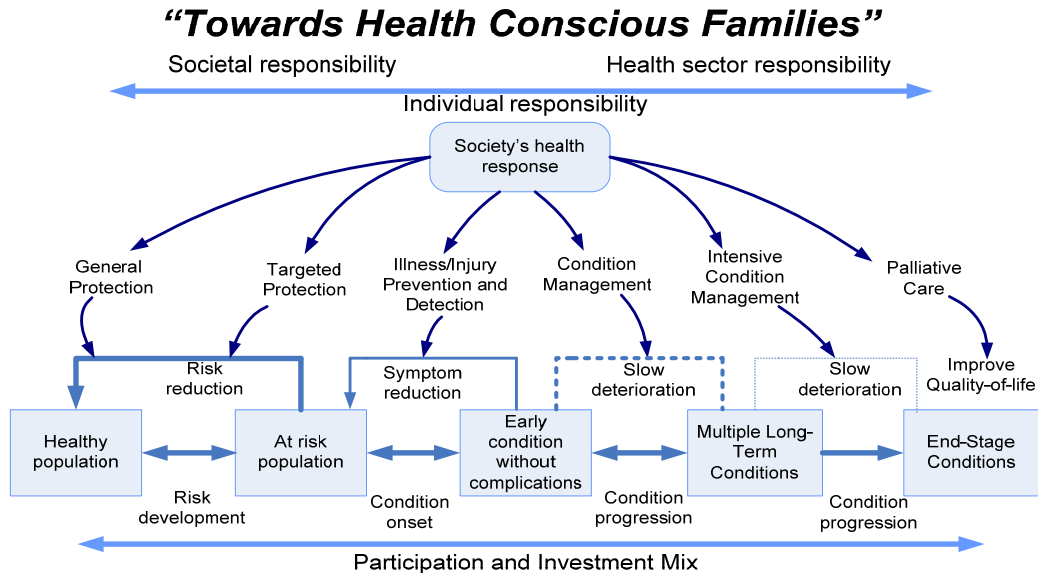
Signature  
(Board Member)

<sup>1</sup> To meet the requirements of section (s) 39 of the New Zealand Public Health and Disability Act 2000 and s 139 (1) of the Crown Entities Act 2004.

## 2 STRATEGIC OVERVIEW

### 2.1 NMDHB VISION

Our Nelson Marlborough DHB Board has a vision of “Leading towards Health Conscious Families”, and the following diagram illustrates how NMDHB will work to achieve this vision:

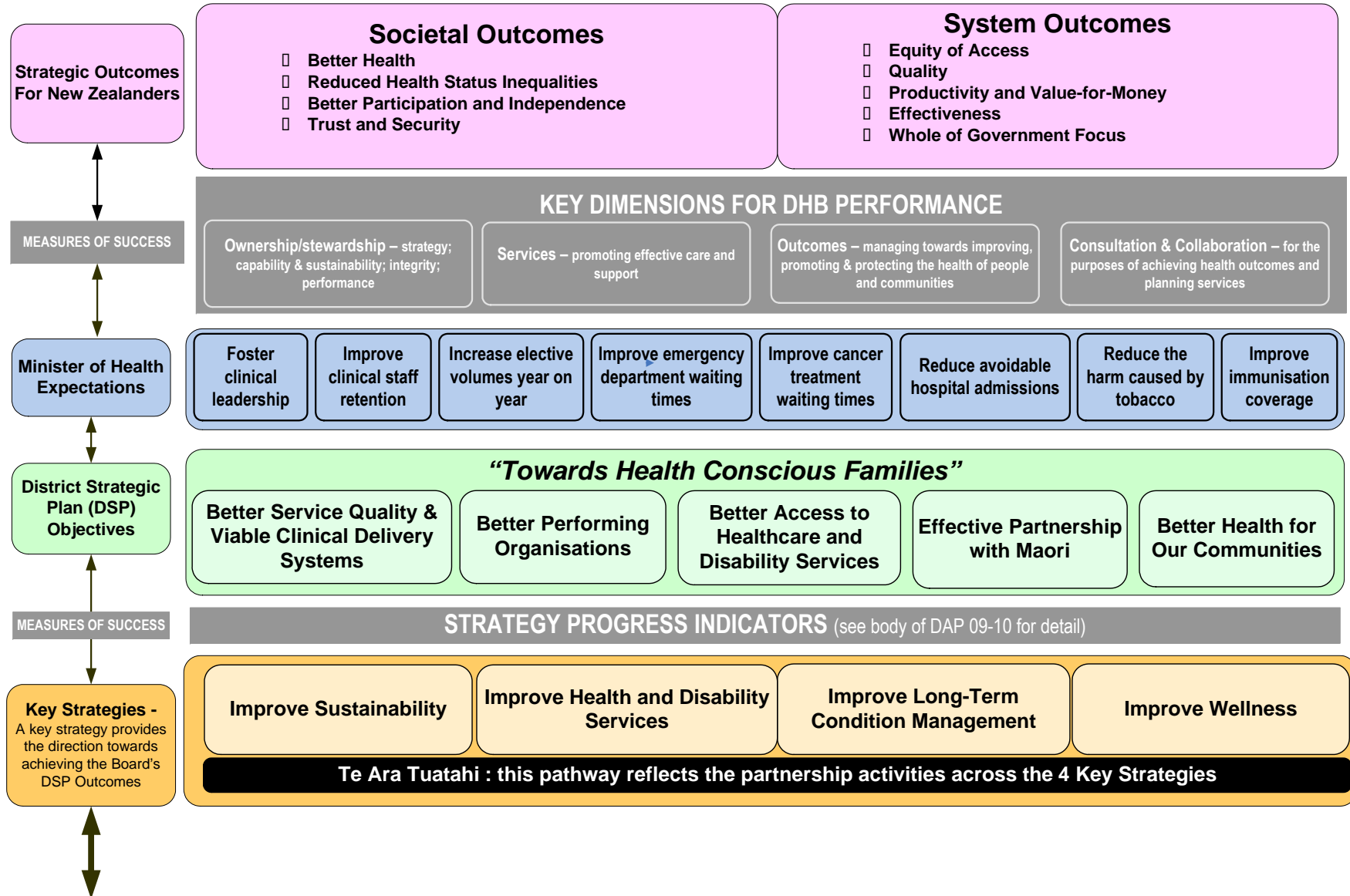


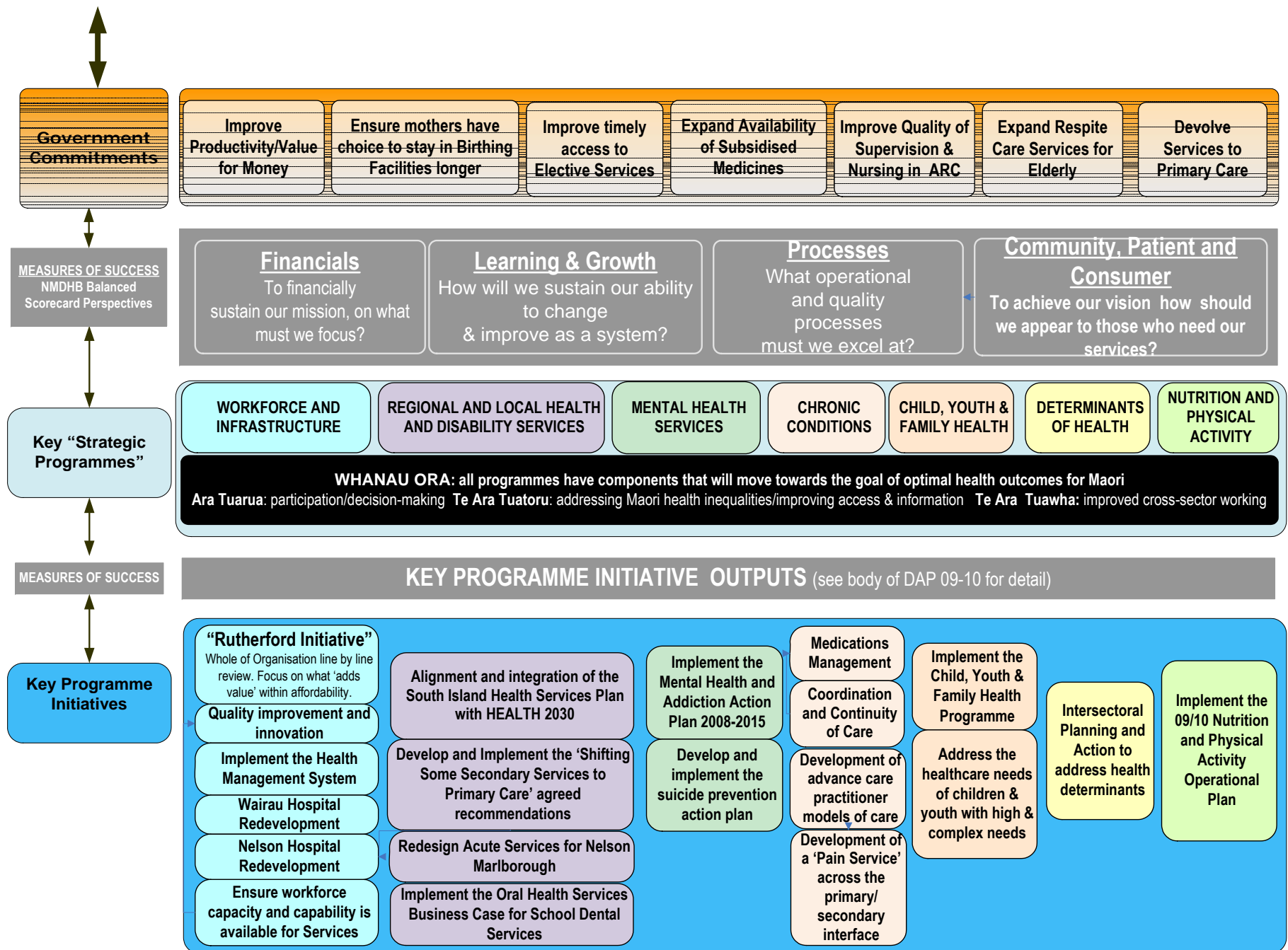
### 2.2 NELSON MARLBOROUGH DISTRICT HEALTH BOARD PRIORITIES

Our decisions, resources and actions necessary to achieve this outcome are detailed in the NMDHB Outcomes Framework illustrated on the following page. The Outcomes Framework shows the link between the overarching outcomes we are trying to achieve with other Government Sectors for New Zealanders, the Minister of Health's Expectations, our Board's Strategic Goals and Strategies, specific Government commitments, and our key Programme Initiatives and what 'DHB Enablers' we intend to deliver for the 2009/2010 year. 'DHB enablers' support what we must achieve in order to deliver more services (outputs). The products and services we produce for others, our outputs, are outlined in more detail under the Statements of Forecast Service Performance aligned to each of our four Output Classes.

Our Outcomes Framework which follows on the next page has been developed utilising a number of different health planning documents. All of these documents are based on local strategic priorities and government directions as identified in our current District Strategic Plan. It reflects identified community health need, as outlined in the next section.

## 2.2.1 NMDHB Outcomes Framework





## 2.3 STATUTORY FUNCTIONS

Nelson Marlborough District Health Board is one of twenty-one DHBs in New Zealand established on 1 January 2001 in accordance with Section 19 of the NZPHD Act. The objectives of DHBs are covered by the NZPHD Act (2000), as follows:

### 2.2 Objectives of DHBs

(1) Every DHB has the following objectives:

- (a) to improve, promote, and protect the health of people and communities:
- (b) to promote the integration of health services, especially primary and secondary health services:
- (c) to promote effective care or support for those in need of personal health services or disability support services:
- (d) to promote the inclusion and participation in society and independence of people with disabilities:
- (e) to reduce health disparities by improving health outcomes for Maori and other population groups:
- (f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:
- (g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:
- (h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:
- (i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:
- (j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:
- (k) to be a good employer in accordance with section [118](#) of the [Crown Entities Act 2004](#).

(2) Each DHB must pursue its objectives in accordance with its district strategic plan, its annual plan, its statement of intent, and any directions or requirements given to it by the Minister under section [33](#) of this Act or section [103](#) of the [Crown Entities Act 2004](#), or under section [107](#) of the [Crown Entities Act 2004](#).

Nelson Marlborough DHB receives population-based funding from the Government, that is, funding is allocated on the basis of the number of people living in our district, their historic utilisation of health services, their ethnicity and socio-economic status as measured using the New Zealand Deprivation Score (2006 census), their rurality and an adjuster for 'unmet need'.

## 3 OPERATING ENVIRONMENT

### 3.1 EXTERNAL ENVIRONMENT

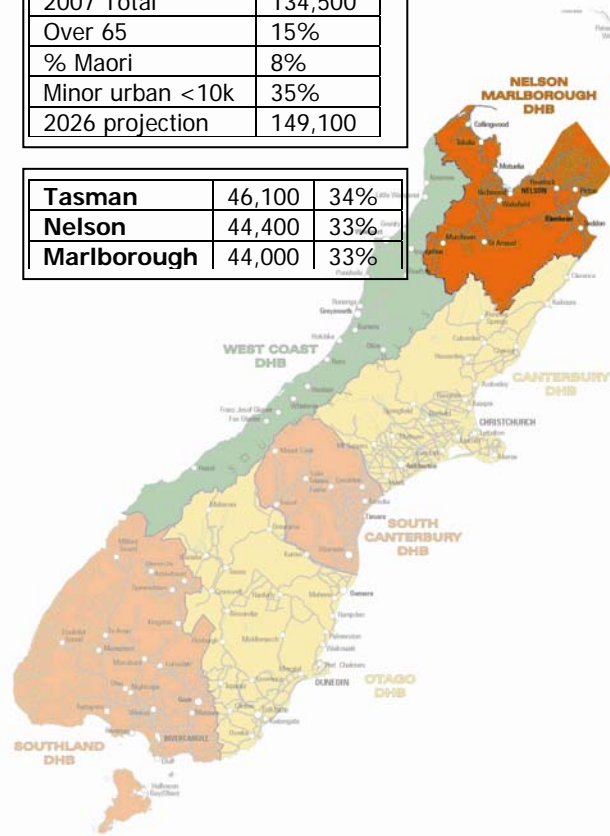
#### 3.1.1 Population

This section describes the NMDHB geographic population. Our external environment includes our geographical location and our population profile. The summarised information below is drawn from the comprehensive NMDHB Health Needs Assessment 2008, which is available on the NMDHB website.

Our District covers the top of the South Island and incorporates the three local authority areas of Marlborough District in the east and Nelson City and Tasman District in the west.

Our District	
2007 Total	134,500
Over 65	15%
% Maori	8%
Minor urban <10k	35%
2026 projection	149,100

Tasman	46,100	34%
Nelson	44,400	33%
Marlborough	44,000	33%



Our population has an older age-structure compared with New Zealand: 14.7% of the population are aged 65 or more compared with 12.3% for New Zealand as a whole. Our district has a significant number of people living in rural areas, with 35% living in minor urban (population 1,000 - 10,000), rural centres (population 300 - 999) or the remote countryside. While generally the population is in the middle of the socio-economic scale, there are significant pockets of deprivation. While population projections show that the overall population of NMDHB is expected to increase by nearly 10% between 2006 and 2026 a reduction in the population is expected for people aged less than 50 years with all the growth expected to occur for people aged over 50.

#### *Ethnicity*

Currently Māori comprise 8% of the NMDHB population which is less than the New Zealand average of 15%. There is a small population of Pacific people resident in the Nelson Marlborough district (about 1% of the total population), with an expected increase of about 3% per annum in the next decade. Because of local industries this population swells significantly during the late summer/early Autumn when seasonal workers arrive to harvest apples, grapes and other crops.

### 3.1.2 Health Profile of Nelson Marlborough

Based on NMDHB health needs assessments we know that the following are some of the health issues of particular importance for the Nelson Marlborough communities:

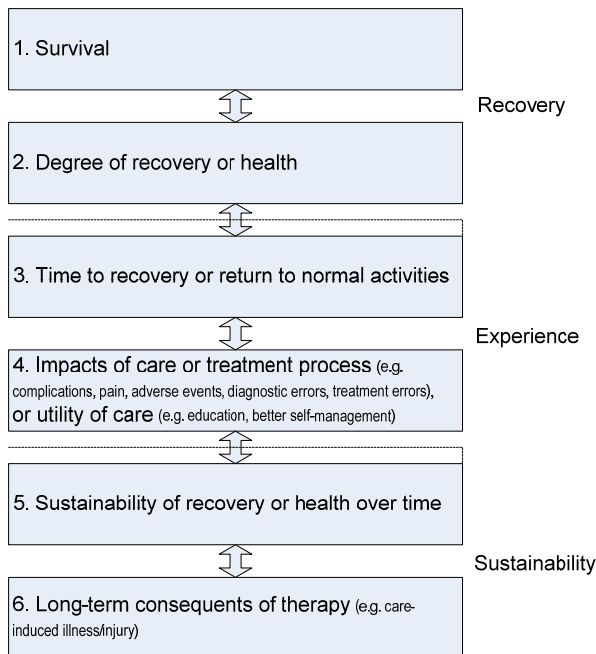
- Due to our older population, we need to invest in keeping people well, supporting them at home and minimising the need for residential services
- Due to poor overall oral health, especially for children, we need to put emphasis on fluoridation of our water supplies and improved access to child and adolescent oral health services
- While we still have a high number of smokers i.e. 18,500 or one in every five people; our rate is 19.3% of the population which is just below the average for New Zealand but less than ideal
- We have poor air quality due to 'horticultural spray drift', winter wood burners etc. and poor water quality including access to potable water in some parts of the district, both in urban and rural settings. All contribute to higher than NZ average respiratory, communicable and other diseases
- Our population has better overall health status than the NZ average; we eat more fruit and vegetables and are more physically active overall, which creates a higher than average injury rate.

### 3.2 ACHIEVING POPULATION HEALTH IMPACTS AND OUTCOMES

As required under the Act, our goal is 'better health' for the people of Nelson Marlborough. We contend that the best opportunity for achieving 'better health' is through improving quality and efficiency and reducing inequalities in health status. This requires us to:

- Pursue value/benefit-creating solutions for patients and whanau
- Organise teams from the patient perspective around health conditions for the full cycle of care
- Measure outcomes to drive learning and to communicate our accountability to New Zealanders for use of public funds
- Demonstrate value to ensure ongoing support for DHB provided and/or funded health and disability services

We propose to measure outcomes (impacts/results) for each condition using the following model:



Copyright 2008 © Michael E. Porter and Elizabeth Olmsted Teisberg

This year 2009/10 we will be developing succinct measures for the full range of 'Health and Disability Conditions' as outlined through the International classification of diseases and disability. In order to do this, we will be actively engaging with clinical teams at primary and secondary levels to provide us with information as to:

- What indicates improved health and disability outcomes?
- When is the team successful?
- What the problems/concerns are?
- Where insight is needed?
- What can be measured now?

For example from top to down for the model: *Measuring Breast Cancer Outcomes* will involve the following: 1. survival rates, 2. remission rates, 3. time to remission; 4. frequency of hospital acquired infections, nausea/vomiting; 5. cancer recurrence; 6. incidence of secondary cancers, etc.

### **3.3 INTERNAL ENVIRONMENT**

#### **3.3.1 Significant Fiscal Pressure**

With the outlook nationally for minimal economic growth and limited funding increases, an even stronger focus on value for money in the health and disability sector is required. NMDHB is committed to ensuring that our available resources are productively applied. We will continue to achieve improvements in services provision through reconfiguration resulting in better, sooner, more convenient and fairer access<sup>2</sup> for the people of Nelson Marlborough within the revenue provided by the Crown.

#### **3.3.2 NMDHB's Fiscal Position**

We are now an 'over-funded DHB' that is receiving more funding than our entitlement under the population-based funding formula (PBFF) calculates we should receive. This has been caused by the population growth in the District being less than that used in the forecasts by the Ministry of Health and a reworking of the formula that has seen greater weighting given to communities with a higher socioeconomic deprivation than ours. This has created a situation where we receive no additional funding for demographic change in 2009/10. While we do receive our proportion of funding through the Future Funding Track (FFT) percentage, this is below the cost of delivering many services, in particular hospital-based services as outlined in the agreed national prices. This puts significant pressure on our ability to afford a broad range of community, primary care and hospital-based services.

As NMDHB has built up a surplus by 'receiving our population funding in advance', our medium-term intention is to utilise this surplus to enable a transition from current models of services delivery to new models such as integrated primary health care centres, and more productive hospital-based services. We also intend using this surplus to invest in infrastructure upgrades such as new information management systems, quality of care processes, and facilities redevelopment for Wairau (in progress) and Nelson Hospitals and in our rural communities.

#### **3.3.3 Reporting to the Minister of Health**

As a Crown Entity we are responsible to the Minister of Health and our accountability is monitored through a series of regular reports and on an as required basis:

Regular reports include:

- monthly and quarterly reporting of indicators of DHB performance (IDPs), including against the agreed
- Minister's Health Targets, as detailed in our DAP 2009/10
- various Ministry of Health service contract and Crown Funding Agreement (CFA) reporting requirements.
- quarterly reporting of Operational Policy Framework (OPF) information requirements
- quarterly Hospital Benchmarking reporting
- monthly Ministry of Health DHB Funding and Performance Directorate Financial Reporting.

In addition to this we will also be reporting six monthly on our Marlborough hospital redevelopment project.

##### ***3.3.3.4 Minister's Expectations and the Health Targets***

The Minister expects NMDHB to deliver on his six Health Targets. NMDHB's agreed level of delivery of these Health Targets, including: shorter stays in Emergency Departments, improved access to elective surgery, shorter waits for cancer treatment, immunisation, better help for smokers to quit, better diabetes and cardiovascular services is detailed in our District Annual Plan 2009/10 (pages 80-81).

---

<sup>2</sup> Fair access in this context refers to provision of services that address people's need for care based on 'ability' to significantly benefit from that care

## 4 NMDHB OUTPUTS CLASSES and STATEMENTS OF FORECAST SERVICE PERFORMANCE

### 4.1 DHB SPECIFIC MEASURES (NON-FINANCIAL MEASURES)

#### 4.1.1 Outputs Classes and aligned Statements of Forecast Service Performance for Nelson Marlborough DHB

One of the functions of this SOI, and in particular this section, the Outputs Classes and Statement of Forecast Service Performance, is to show how NMDHB will evaluate and assess what services and programmes (outputs) we deliver to the people of Nelson Marlborough and those New Zealanders who require our services in 2009/10. There are four nationally consistent output classes:

- public health services
- primary and community services
- hospital services
- support services.

For each output class the health sector is working towards agreed national performance measures and targets of the desired outcomes and objectives<sup>3</sup>. These measures and targets will be subject to annual external audit. The performance measures chosen are not a comprehensive list and do not cover all of the activity of our DHB, but they do reflect a picture of our activity against local and national strategies and priorities. Where possible, we have included past performance (baseline data) along with each performance target to give more context as to what we are trying to achieve and to better evaluate our performance.

As we are just beginning as a sector, the development of national measures aligned to these output classes, there will not be universal alignment amongst DHBs. We aim over the next few months to address this issue and be able to present to Parliament agreed measures so that DHB performance can be compared.

NMDHB Output Classes and Statements of Forecast Service Performance section is organised as follows:

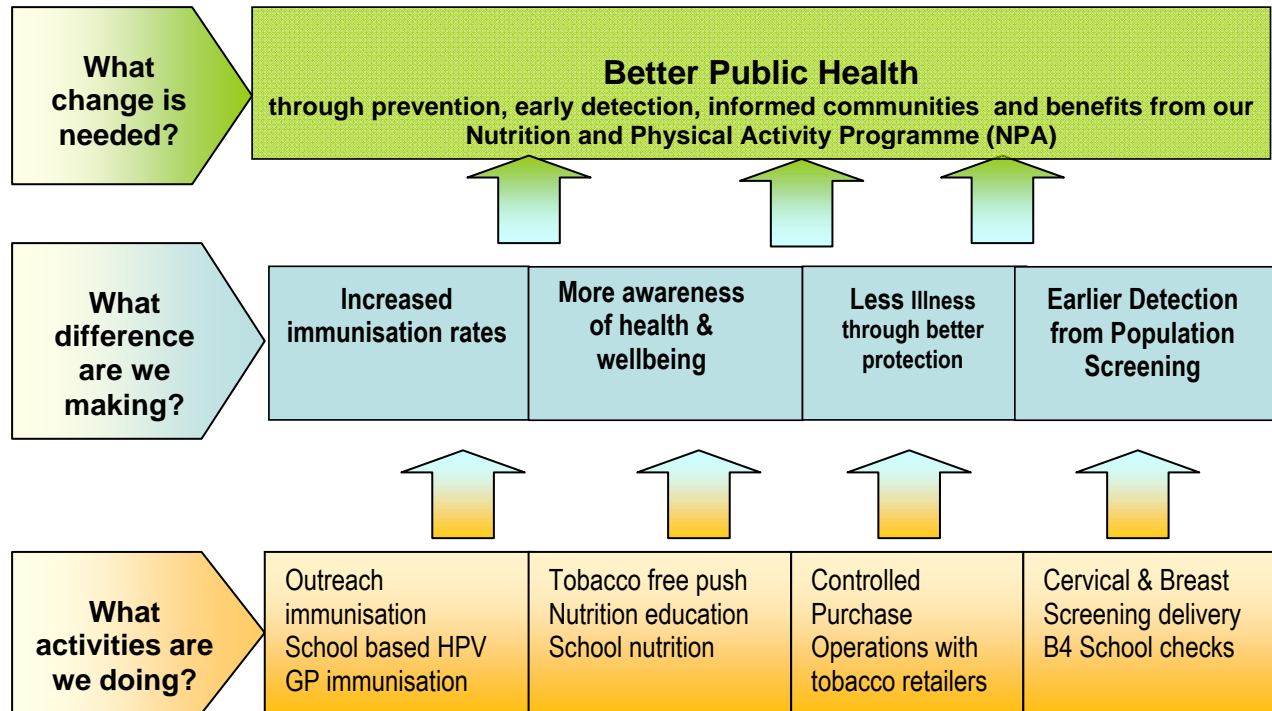
1. our price volume schedule that sets our contracted level of service to be delivered by a Hospital provider. Delivery against these volumes is reported regularly using the NMDHB Balanced Scorecard (Appendix 2) monthly report to our Strategic Leadership Team and to our Board
2. the four output classes 'logic models': Public Health Services, Primary and Community Services, Hospital Services and Support Services. These output classes logic models include the relevant Government Commitments and Minister of Health's expectations as well as any agreed national health targets.
3. tables outlining our Statements of Forecast Service Performance for each Output Class. These include the 'key sub-output classes' and the outputs for the 08/09 baseline year, the 09/10, 10/11 and 11/12 years according to the *Crown Funding Agreement (CFA) and CFA Variations*
4. a description of our 'DHB Enablers', how we are 'internally organising' the way we intend to deliver services in order to meet future needs and deliver clinician led, high quality, safe, and efficient services and programmes into the future within the funding provided by Government.
5. the output measures are the first set of measures by output class that we have set. Over the next two years we will refine these measures further. For example, we will examine how we can include further quality measures on acceptability of the treatment provided to people receiving our services, and measures of effectiveness, safety and access. We also intend on developing 'patient reported outcomes measures' in

<sup>3</sup> As stated in the Crown Entities Act 2004 (s 142 (1))

order to better reflect the impact of healthcare interventions on health outcomes for patients/consumers. These measures and indicators will complement the existing activity and volume output measures.

#### 4.1.1.1 Output Class 1: Public Health Services

The Public Health Services Output Class includes services that contribute to achieving 'JUMBO' objectives of Improving Wellness, Improving Long Term Condition management and Improving Sustainability.



#### 4.1.1.2 Public Health Services Statement of Forecast Service Performance

The following table outlines the Public Health services we intend to deliver to our population. These outputs are aggregated into the following sub-classes Health Protection services; Health Promotion services; Population Screening services; Immunisation services.

This section outlines the Public Health services we intend to deliver to our population under these subcategories: Health Protection services; Health Promotion services; Population Screening services; Immunisation services.					
Outputs	Measures	Base-line	09-10	10-11	11-12
Health Protection Services	1. Number of Controlled Purchase Operations carried out with Tobacco retailers	Two	Three	Four	Five
	2. Proportion of Environmental Health complaints that are investigated, out of those notified and that require investigation	100%	100%	100%	100%
	3. Number of Communicable Disease investigations completed (24 hour service) per annum	Approx. 450	450	450	450

This section outlines the Public Health services we intend to deliver to our population under these subcategories: Health Protection services; Health Promotion services; Population Screening services; Immunisation services.

Outputs	Measures	Base-line	09-10	10-11	11-12
Health Promotion Services	<ol style="list-style-type: none"> <li>Number of Controlled Purchase Operations carried out with alcohol retailers</li> <li>Implementing school/ECC nutrition food &amp; beverage classification system</li> <li>Provision of Public Health Policy Advice</li> <li>Provision of Public health training to health professions on nutrition policy and practice</li> </ol>	<p>Three</p> <p>10% of schools</p> <p>Input into 4 Council plans</p> <p>10% of Practice / PHC Nurses trained</p>	<p>Four</p> <p>20% of schools</p> <p>Input into 4</p> <p>20% of Practice / PHC Nurses trained</p>	<p>Four</p> <p>40% of schools</p> <p>Input into 6</p> <p>40% of Practice / PHC Nurses trained</p>	<p>Four</p> <p>60% of schools</p> <p>Input into 6</p> <p>60% of Practice / PHC Nurses trained</p>
Population Screening Services	<ol style="list-style-type: none"> <li>percentage of eligible women 'registered' on the National Cervical Screening Programme (NCSP), 20-69 years</li> <li>percentage of enrolled women completing free breast screening, in line with programme criteria)</li> <li>B4 School Checks carried out</li> </ol>	<p>75%</p> <p>70%</p> <p>300</p>	<p>75%</p> <p>75%</p> <p>837</p>	<p>80%</p> <p>75%</p> <p>837</p>	<p>80%</p> <p>75%</p> <p>837</p>
Immunisation Services (these are subject to Ministry of Health funded levels)	<ol style="list-style-type: none"> <li>The percentage of age-appropriate immunisation for 2-year olds, as per the National Immunisation Register (NIR)</li> <li>The percentage of children completing the year 7 vaccination, of those eligible and who have consented</li> <li>The rate of immunisation for year 8 girls for the HPV vaccine</li> </ol>	<p>79%</p> <p>90%</p> <p>85%</p>	<p>81%</p> <p>90%</p> <p>85%</p>	<p>81%</p> <p>90%</p> <p>90%</p>	<p>81%</p> <p>90%</p> <p>90%</p>

### 4.1.1.3 How we are Organising Ourselves to Achieve these Results

The key public health initiatives (our enablers) that we are taking in 2009/10 are:

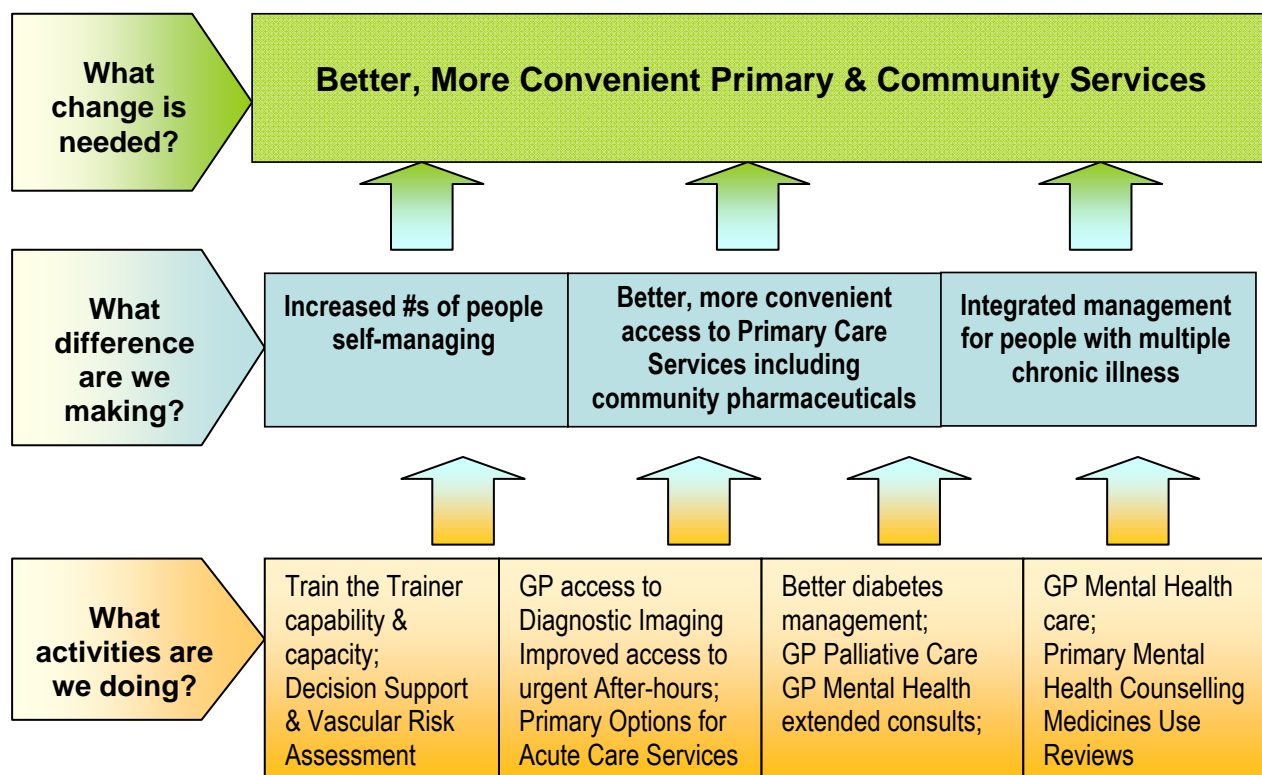
- implementing new services as part of our Nutrition and Physical Activity Programme. This is a core component of our strategy to improve wellness and encourage our community to take individual responsibility for their health. This will reduce the demand for acute services and enable us to put further investment into primary care services for our communities
- working closely with other agencies that have a major impact on the major determinants of health for improved community well-being. Examples include disability-friendly, healthy and accessible housing; and impact assessment on Local Authority policies and Council plans
- strengthening:
  - preventing and reducing family violence and improving the mental wellbeing of communities
  - using Impact Assessment (IA) in the development of key policies such as:

- ✓ increasing the uptake of fluoridation of public water supplies for improved oral health
- ✓ addressing with Local Authorities: air and water quality, tobacco smoking in open places, cycle and walking pathways, contaminated sites restoration, housing insulation/solar heating/sustainable energy sources; sale of alcohol issues; urban design; safe environments.

#### 4.1.2 Output Class 2: Primary and Community Services

Primary Health and Community Services Output Class services are focused on achieving all four 'JUMBO' objectives: Improving Wellness, Improving Long Term Condition Management, Improving Health & Disability Services and Improving Sustainability.

Some of these services are provided by the Hospital division of the DHB while others are funded by the DHB, through a range of contracts and provided by PHOs and other NGOs. These outputs are aggregated into the following sub-classes: personal health services, mental health services, Maori and Pacific health services and disability services.



#### 4.1.2.1 Primary and Community Services Statement of Forecast Service Performance

The table on the following page outlines the Primary and Community Services we intend to deliver to our population. These outputs are aggregated into: Supported Self-Management, Provision of Primary Care Services for Enrolled People (Access and First Point of Contact Services), and Provision of Services for people with Long-Term (chronic) Conditions.

<b>Primary and Community Services Statement of Forecast Service Performance</b>					
This section outlines the Primary and Community Services we intend to deliver to our population.					
<b>Outputs</b>	<b>Measures</b>	<b>Base-line</b>	<b>09-10</b>	<b>10-11</b>	<b>11-12</b>
<b>Supported Self-Management</b>	# of Primary Care practitioners trained to deliver Self-Management	0	10	30	50
<b>Provision of primary care services for Enrolled People</b>	<b>Access</b>				
	• Enrolment of the resident and eligible population	92%	94 %	95%	96%
	• very low cost access (note Murchison included in this)	3 services	4 services	5 services	6 services
	• urgent after-hours Primary Care Services	5 services	5 services	5 services	5 services
	<b>First point of contact services</b> (reducing Triage 4&5 attendance levels to Nelson Marlborough EDs)	2008/09 ED triage 4 &5 levels	10 % reduction on base	12% reduction on base	15 % reduction on base
Number of patients completing vascular risk assessment (VRA)	1500	7139	≥ 7139	≥ 7139	
<b>Provision of services for people with Long Term (chronic) conditions care</b>	Proportion people on the diabetes register who have good diabetes management (HBA1c ≤ 8.0%)	Maori 68%; PI 62%; Other 79%	Maori >70%; PI >65%; Other <75%	Maori >70%; PI >70%; Other >75%	Maori >75%; PI >75%; Other >75%
	<b>GP Diagnostics Imaging Access</b> (No of Diagnostic Images)	500	500	500	500
	Number of patients received GP supported palliative care	14	18	20	24
	Primary mental health services:				
	• GP extended consultations	795	834	850	870
• Packages of care	573	834	850	870	
• Primary mental health brief intervention clinical service	100 (partial year)	1500	2000	2500	
• Counselling sessions provided					

#### **4.1.2.2 How we are Organising Ourselves to Achieve these Results**

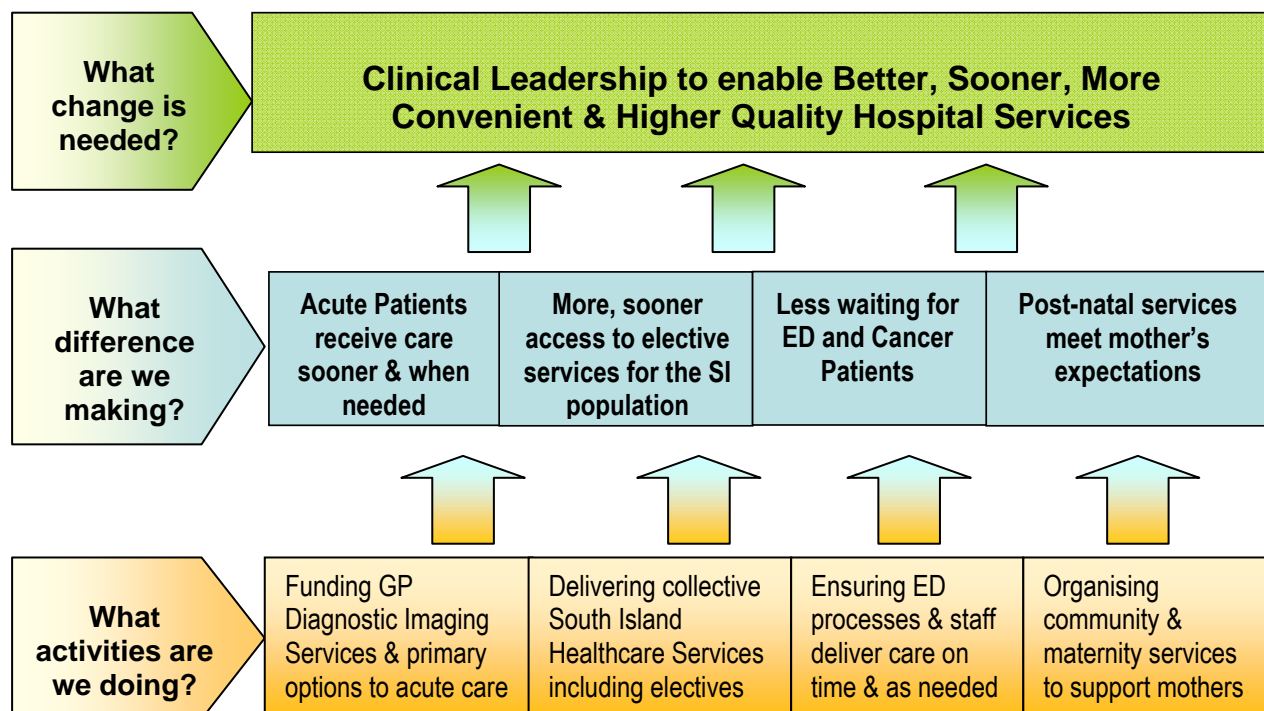
The key Primary and Community initiatives (our enablers) that we are taking in 2009/10 are:

- scoping the development and implementation for 'Integrated Primary Health Care Centres' to incorporate a full range of service providers and services
- expansion of Primary Care capability and capacity to include management of acute patients who would normally be referred and managed by secondary services through realignment of existing service lines and contracts (within current resource investment)
- Extending 'Optimising the Patient Journey' to cover the full continuum of care
- Implementing the devolution of hospital provided service, DHB owned community services and community contracted services to Primary Care according to the plan agreed between the PHOs and NMDHB (within current resource investment and at no charge to patients)
- supporting PHOs to implement the remaining 4 community hubs under the Urgent After Hours Primary Health Care Strategy (within current resource investment)
- Improving access to Primary Care Mental Health Services to enable more people to be managed proactively by their Primary Care Practice Team.

### 4.1.3 Output Class 3: Hospital Services

Hospital Services are focused on achieving three of 'JUMBO' strategic objectives: Improving Long Term Condition Management, Improving Health & Disability Support Services and Improving Sustainability. This section outlines the hospital-based services we intend to deliver.

It also outlines those hospital services we intend to fund others to provide for our population. Hospital services include all personal health services, mental health services, Maori health services and services for older people provided through our hospital provider and through other DHBs via interdistrict flows (IDFs).



#### 4.1.3.1 Hospital Services Statement of Forecast Service Performance

For the purposes of this SOI these outputs are aggregated into: Acute (those services that are unplanned) and Elective (those services that are planned) inpatient caseweights<sup>4</sup>; and, 'Non-admitted patient caseweights, Emergency Department Attendances<sup>5</sup>, Assessment, Treatment and Rehabilitation Episodes and Maternity Patients. In the future we will be recording these as 'discharges' to better reflect the output as an individual receipt of service.

The table on the following page outlines some of the outputs and measures we will be delivering over the next three years.

<sup>4</sup> New Zealand Caseweights or Weighted Inpatient Stays (WIESNZ09) is a standard classification method for all inpatient activity in NZ hospitals. Caseweights define complexity of care and are different from inpatient discharges (numbers of people treated) which will also be reported against

<sup>5</sup> For more detail, please refer to Appendix 1, our 2009/2010 Price-Volume Schedule (PVS).

## Hospital Services Outputs Class Statement of Forecast Service Performance

This section outlines the Hospital Services we intend to deliver to our population.

Outputs	Measures	Base-line 2007/8	2009/10	2010/11	2011/12
<b>Acute Inpatient Caseweights</b>	Caseweights: Acute Inpatients	12,950	13,300	13,300	13,300
<b>Elective Inpatient Caseweights</b>	Caseweights: Elective Inpatients Procedures: Elective Inpatients Cancer Waiting Times (weeks to treatment)	8,130 125 6	7,635 145 6	7,635 167 6	7,635 191 6
<b>Mental Health Acute Inpatient outputs</b>	Number of acute inpatient bed nights occupied on a per annum basis. Number of service users with a 50% improvement change in HONOS from admission to discharge.	8,541 New measure	8,711 70% of admissions	8,885 75% of admissions	9,062 85% of admissions
<b>Mental Health Follow up Face to Face contacts (excludes addictions)</b>	Monthly number of direct client contacts to support achievement of service user/tangata whaiora recovery plans <sup>[1]</sup> Number of service users with a 10% improvement change in HONOS from admission to discharge.	3,834	3,836 70% of service users	3,838 75% of service users	3,839 85% of service users
<b>Number of people supported within the Mental Health</b>	Number of people accessing mental health services on a monthly basis <sup>[2]</sup> (excludes addictions)	1,013	1,015	1,017	1,019
<b>Non-admitted Patient Caseweights</b>	First Specialist Attendances Follow Ups Procedures	18,247 38,475 13,802	18,475 38,875 13,952	18,700 39,250 14,102	18,900 39,750 14,260
<b>Emergency Department Attendances</b>	Number of attendances Percentage of people waiting more than 6 hours for treatment	25,295	24,295 <5%	23,295 <5%	22,295 <5%
<b>Assessment, Rehabilitation &amp; Treatment Episodes</b>	Bed Days: Inpatient Services Attendances/Visits: Outpatients	10,571 11,570	10,873 11,920	11,167 12,312	11,500 12,702
<b>Maternity Services</b>	Deliveries in facility Post Natal Stays	1,610 1,512	1,625 1,650	1,657 1,720	1,700 1,800 <sup>[3]</sup>

<sup>[1]</sup> (Calculated by July, September, October, November, December 08 Follow up Face to Face contacts 19,172 divided by 5 months to average it out.)

<sup>[2]</sup> (Calculated by July, September, October, November and December 08 data divided by 5 to get an average).

<sup>[3]</sup> calculations for post natal stays – at 15% of current patients may elect up to 5 days extra may mean approx 1000 extra stays: this will be confirmed in final version

<sup>9</sup> includes new assessment, reassessments and reviews

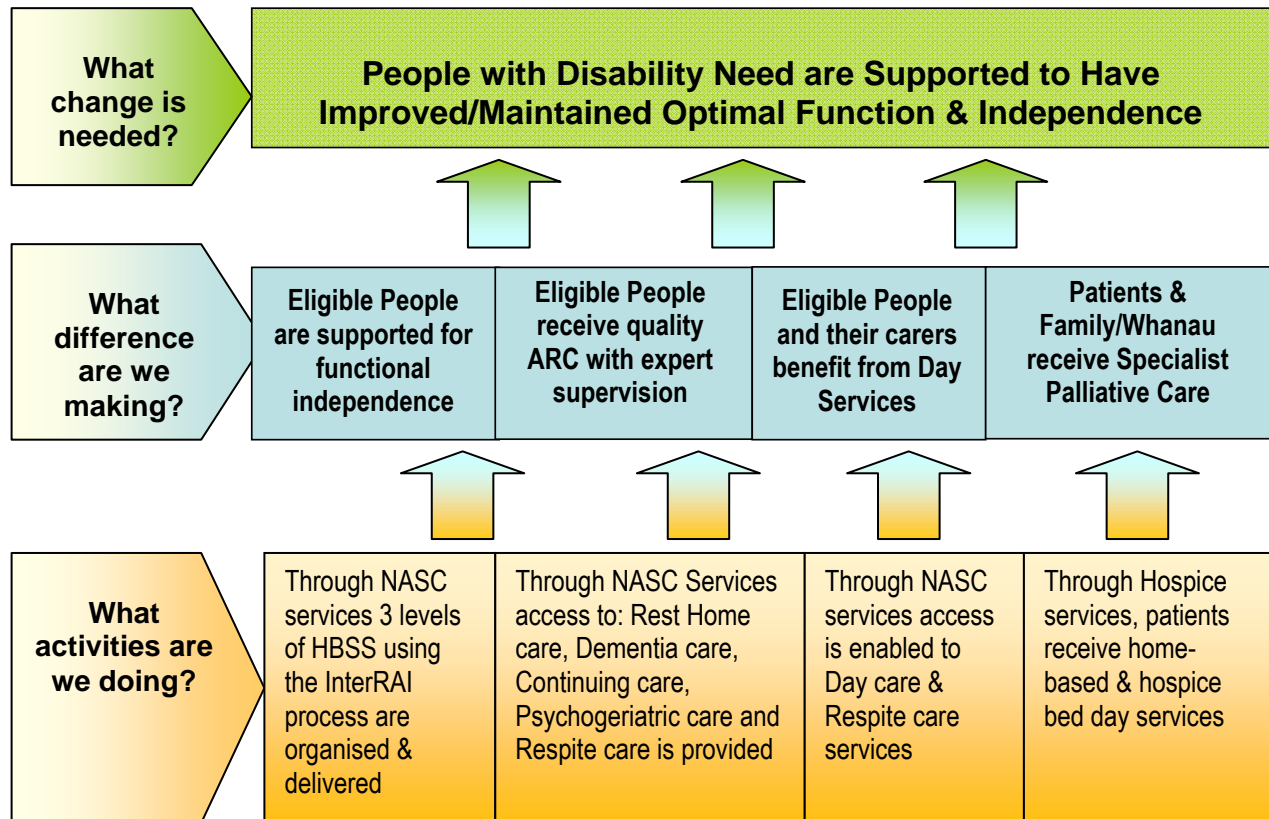
### 4.1.3.2 How we are Organising Ourselves to Achieve these Results

The key Hospital Services Initiatives (our enablers) that we are taking in 2009/10 are:

- enhanced clinical leadership to continue to engage our clinicians in all levels of planning through a participatory approach as outlined in the 'In Good Hands' Ministerial Task Group Report 2009
- continuing the devolution to Primary Care settings of relevant hospital services as illustrated by our 'GP Access to Diagnostic Imaging Pilot' initiated in the 2008/2009 year
- providing certainty for better more convenient access to elective services through a collective South Island Elective Services Planning (SI ESP) approach
- reviewing current services provision across the District to live within funding
- establishing single waitlists
- improving urgent after hours cover
- re-configuring primary care services, acute Emergency Department (ED) and acute inpatient services using information from the Acute Care Review (April 2009)
- working collaboratively with South Island DHBs to plan and implement regional solutions to more, better, higher quality, more robust hospital care delivery through the South Island Health Services Plan (SI HSP).

### 4.1.4 Output Class 4: Support Services

Support Services are those services that assist people with maintaining functional independence and/or support for daily living as well as palliative care support. Support services activities are focused on achieving three NMDHB strategic objectives: Improving Long Term Condition Management, Improving Health & Disability Support Services and Improving Sustainability. This section outlines the Support services we intend to deliver to our population. Each aggregate includes people with long-term disabilities; people with mental health problems and people who have age-related disabilities.



#### 4.1.4.1 Support Services Statement of Forecast Service Performance

For the purposes of this SOI these outputs are aggregated into: Home-based support services; Residential Care support services; Day Services; Palliative Care services. The table below outlines some of the outputs and measures we will be delivering over the next three years.

<b>Support Services Output Class Statement of Forecast Service Performance</b>					
These are the Support Services outputs we intend to provide over the period of this SOI					
<b>Outputs</b>	<b>Measures</b>	<b>Base-line</b>	<b>09-10</b>	<b>10-11</b>	<b>11-12</b>
<b>Assessments</b>	Community Based Assessments - HOP	1,850	1,905	1,962	2,021
	Residential Based Assessments- - HOP	585	602	620	639
<b>Life Long Disability ASC</b>	Number of Individual Contacts <sup>9</sup>	1,777	1,830	1,885	1,941
	Number of Coordination Services	2,035	2,096	2,159	2,224
<b>Home-Based Support Services</b> (per month)	Number of Non Complex Packages Units utilised pm	7,193	7,711	7,942	7,181
	Number of Intermediate Package Units utilised pm	0	5,839	6,014	6,195
	Number of Complex Packages Units utilised pm	21,787	17,518	18,043	18,585
<b>Residential Care Support Services</b>	Rest Home Bed Days	152,610	152,763	152,916	152,985
	Dementia Care Bed Days	43,145	43,999	45,102	46,234
	Continuing Care Bed Days	118,891	122,183	126,234	130,456
	Psychogeriatric Bed Days	7,784	5,862	6,235	6,756
	Respite Care Bed Days	2,760	2,790	2,812	2,843
<b>Day Services</b>	Day Care Days	10,382	10,691	11,054	11,400
	Respite Care Days	2,760	2,790	2,812	2,843
<b>Palliative Care Services</b>	Palliative Care Bed Days	401	410	440	460
	Home Based Support Packages	431	451	461	471

#### 4.1.4.2 How we are Organising Ourselves to Achieve these Results

The key Support Services Initiatives (our enablers) that we are taking in 2009/10 are:

- ensuring improvement in the supervision of quality and nursing provision with the Aged Residential Care sector and contributing to the completion of the national review of Aged Residential Care services through the existing national shared DHB processes
- having already developed a local dedicated respite bed service with a number of contracted providers we will ensure that our approach is aligned with agreed national approach and service specifications
- ensuring funding for Home-Based Support Services (HBSS) is invested in those who are most in need and could achieve most benefit
- implementing the criteria for access to the 'interim funding pool' to enable this client group with disabling chronic health conditions to have appropriate access to restorative support services that meet their needs
- working collaboratively with SI DHBs to implement the InterRAI tool for the purposes of needs-assessment, coordination of care plans and delivery, improvements in quality of care and better understanding of the costs of care
- working with our two palliative care providers (hospices) to continue to implement the new specialist palliative care service specification across Nelson Marlborough.

## 5 NMDHB SERVICES AND ENABLERS

### 5.1 PLANNING FOR THE FUTURE

Our HEALTH2030 Framework outlines how we intend to develop health care services over the next two decades so that we can continue to deliver on our strategic vision and meet our statutory accountabilities under the New Zealand Health & Disability Act 2000.

Our process used a participatory approach actively involving clinicians from community, primary care and hospital services as well as community members. The key elements of the framework are designed around *people with need for healthcare services and activities across a continuum from: being well, to reducing risk of disease, to managing illness, to dying well.*

A different services delivery model has been identified around a system that uses:

- expanded, networked providers (some for example include non-government organisations [NGOs], GPs, Maori Providers, Pharmacists) through primary care led teams
- integrated family health centres utilising technology that provides better, more convenient, sooner access to a full range of services
- expert health practitioners to provide high quality, more responsive hospital-based services and publicly funded services that work with our communities to create environments that support wellness and resilience
- a cooperative, coordinated and collaborative systems model that enables all available health resources to provide co-delivered services.

Our intention is to consult on our HEALTH2030 framework for the 2009/10 year aligned to our review of our District Strategic Plan. Our framework is being used as an input into the development of the collective South Island Health Services Plan and aligns to the national Long Term Systems Framework.

### 5.2 MEASURING PERFORMANCE AGAINST STRATEGY

Our Balanced Scorecard is directly linked to NMDHB's strategy as illustrated in Appendix 2. Every month Management (SLT) receives a reporting package comprising:

1. The Strategy Map
2. Snapshot & Trends Report; and
3. Exception Reporting: those Measures and Initiatives that are Red or Amber as outlined in the NMDHB outcomes framework and the District Annual Plan.

At the SLT meetings where the Balanced Scorecard (BSC) Reports are discussed the focus is on decision-making around strategic and operational issues as opposed to tactical issues, implications, and reviewing past performance. We focus on variation from strategy and how to keep on track. Non-strategic issues have been moved as much as possible outside of the BSC discussion because the purpose of reporting with the Balanced Scorecard is to:

- create an environment where management can actively and systematically manage strategy
- discuss the DHB's performance around executing the strategy and making strategic decisions
- help identify gaps in the strategy or areas that are poor performing and that require attention.

To get the most out of the BSC NMDHB has:

- developed a reliable and repeatable process
- identified clear roles and responsibilities
- selected a reporting system
- conducted thorough meeting preparation
- focuses meeting discussion on strategic objectives; and
- has a disciplined review of objectives, measures, and initiatives.

The BSC is formally reviewed and updated in accordance with NMDHB's District Strategic Plan (DSP) and Outcomes Framework. This happens every three years for the Strategy Map, Objectives and Measures in line with the DSP; and medium term for the Initiatives as per SOI; and annually in line with the District Annual Plan (DAP).



The **Strategy Map** (illustrated in Appendix 2 as of Quarter 2 2008-2009 reporting) has current Measures (M) and Initiatives (I) in colour coded tags next to the objectives. The colour of these tags indicates performance against measures and initiatives (green, amber and red).

### 5.3 LIVING WITHIN OUR MEANS – OUR RUTHERFORD INITIATIVE

Under the Rutherford Initiative, which is based on the scientist's famous quote *"We've no more money so now we've got to think"*, the Chief Executive will review all contracts with all of our providers (community and DHB) and levels of service provision as well as all DHB costs.

The Rutherford initiative will involve multi-disciplinary teams including clinicians, analysts and service experts working with managers to review expenditure to improve the quality and performance of the public health system in this district. The teams will be examining line by line current expenditure to ensure each is a priority and gives good quality health services for this district. This advice could lead to the reconfiguring of some services contracts and the exiting of others that are not considered to add value. Our aim is for a break-even forecast budget within the planning timeframe (2009-2012).

Together with the outcomes from the Ministerial Group (led by Murray Horne) advising on improving the quality and performance of the public health sector and our Health 2030 framework, these teams should enable NMDHB to achieve a transformational change to the provision of health services in this district.

### 5.4 FUNDING PHARMACEUTICALS AND COMMUNITY PHARMACIST SERVICES

Government has committed increased funding for community pharmaceuticals as well as for Pharmaceutical Cancer Treatments (PCTs) and twelve months Herceptin treatment for those who qualify. NMDHB is working collectively with other DHBs to provide support to PHARMAC with regard to the increased investment in community pharmaceuticals. We are working with our hospital clinical leaders and Pharmacists as to the best approach regarding effective; equitable; safe and quality use of medicines is addressed for patients being managed within the hospital services. This initiative also includes access to PCTs and to Herceptin as well as other treatments such as the biologics (e.g. adalimumab).

Community Pharmacist Services are being considered for reconfiguration to ensure value for money services are available into the future particularly for people requiring complex, long-term medicines regimens. It is anticipated that the new contracting framework encompassing these new services will be agreed for provision in 2010.

## **5.5 FUNDING AND PROVIDING SERVICES TO MEET THE NEEDS OF SPECIAL POPULATIONS**

### **5.5.1 Mental Health Services**

NMDHB has invested \$1.8M more funding into Mental Health than is required under the Ring Fence rules. As we are addressing a deficit in the fund, we have signalled our intentions to reduce Mental Health Funding by this amount over the next three years. For the 2008/09 year we are no longer investing in 'unfunded' Blue Print Services. This has resulted in a need to reduce Mental Health services investments by \$1.3M for 2009/10 through to 2011/12.

During 2009/10 and 2010/11 Mental health services will focus on:

- reviewing all our service lines to determine which meet Value for Money criteria and/or address Government Commitments
- implementing action to reduce overall investment by \$1.3 M
- reviewing all Alcohol and Other Drug services
- continuing support for the Ministry of Social Development/NMDHB Community/Voluntary Agency
- reviewing Crisis Support
- enhancing rural mental health
- meeting Pacific Islands and Asian mental health service needs.

### **5.5.2 Māori Health Services**

The Māori Health & Wellness Strategic Framework is NMDHB's guide to improving Māori health outcomes. It is a long term strategy, focused on using partnerships, collaboration and alliances to improve the care Māori receive. Three priority areas have been identified:

1. Improving access for Māori to Primary Care services
2. Improving responsiveness of mainstream organisations to Māori people
3. Improving access to services for Māori people with chronic conditions.

The framework informs all DHB strategy and Initiative planning, service development and improvement to ensure that services are responsive to Māori needs and also those specific services are in place. Key directions and initiatives to achieve our objectives for Māori include the continued extension of He Taura Tieke (a quality measuring tool to determine how effective a service is for Māori) into PHOs and other NGOs meets the intent of one of the key priorities.

### **5.5.3 Pacific Health Services**

Although Nelson Marlborough has a very small population of Pacific people, we recognise that their health status is likely to be lower than for the population overall. Our DHB has established a Nelson Marlborough Pacific People's Reference Group (NMPPRG). This group will provide support to senior DHB management in all parts of the organisation around Pacific People's health issues. The group will also advise the DHB on the implementation of the Pacific Health Action plan.

#### **5.5.4 Disability Support Services for Older People**

The early implementation of the NDHB Home Based Support strategy during 2008/09 has been evaluated to ensure the initial approach and support packages are appropriately being re-designed to align to best value for money. This evaluation will be assisted by information from the use of the DHB's International Resident Assessment Instrument (InterRAI) needs assessment programme. In addition to this focus on ensuring value for money from existing services the DHB will also focus on the infrastructure required for a redesigned Specialist Health Services for Older People (SHOP) service.

During 2009/10 the NASC service will continue:

- the provision of service co-ordination for people with short term need for support post-acute personal health problems, carer support for families of children with chronic medical illness and home based support packages for people with palliative care needs
- implementation of the InterRAI standardised assessment tool to improve the identification of need levels and improve care coordination
- expansion of services for people with chronic conditions under the NMDHB Chronic Conditions Framework, and is collaborating with other NASC services within our district to better integrate services for the population
- provision of NASC services funded by the Ministry of Health for people with life-long disabilities.

### ***5.6 DEVELOPING BETTER SETTINGS OF CARE THROUGH OUR PRIMARY AND COMMUNITY DIVISION***

Our Primary and Community (P&C) Division provides the foundation and tools for progressing 'JUMBO' services to achieve wellness, sustainable primary and community health services, and our environment. Our work extends from community agency development, to intersectoral planning, through to supporting the implementation of the primary health care strategy initiatives. Our P&C Division is responsible, in collaboration with Nelson Bays Primary Health, and Kimi Hauora Wairau PHO, for the ongoing implementation of the Primary Health Care Strategy and Implementation Plan. We also ensure engagement of, and relationship building between, public health, secondary, and primary health sectors to enable the efficient implementation of new services and where efficient and effective to do so the devolution of existing services. We also collaborate with Nelson Marlborough PHOs on improving access to timely and appropriate care, developing better linking and co-ordinating of hospital services with the primary health care sector, and all community providers with each other.

We aim to improve health outcomes by providing opportunities and motivating people to eat better, be more active, and make healthier choices. We do this through promoting community gardens and active transport, through the processes of community development and through intersectoral involvement. We engage schools, early childhood centres, sports trusts, councils, and community groups in a wide variety of projects designed to empower healthy living. We focus on promoting and protecting the health of the local community and addressing the needs of vulnerable and at risk groups therefore providing a broad and responsive range of primary health and personal health programmes and services that seek to improve health outcomes. We also provide public health leadership in our interface with key community groups and providers, ensuring that positive public health messages are actively promoted.

#### **5.6.1 Primary Healthcare**

A strong primary health care system (as outlined in the Primary Health Care Strategy) is central to improving New Zealanders' overall health, and to reducing health inequalities between different groups. A major project addressing 'Shifting Some Secondary Services to Primary Care' has been started. The key improvements in primary care to better meet the health needs of the Nelson Marlborough community include:

- improving access to services particularly sustainable after hours care, rural communities and affordable and appropriate services for higher need communities
- the development of primary health care capabilities and services to improve the prevention and management of long term chronic conditions, and reduce hospitalisations through improved coordination of services and better integration of service provision to address the diverse needs of people at risk
  - Ensuring the appropriate and timely use of the NMDHB Long Term Chronic conditions vascular risk assessment tool
  - Implementation of new models of primary health care nursing including a specialist long term chronic conditions nursing service
- strengthening the role of our PHOs to lead the implementation of changes in primary health care health services
  - ensuring both governance and operational partnerships continue to be progressed
  - progressively aligning primary health care provider networks (some for example include: pharmacists, podiatrists, dentists, residential and home-based care providers) within the PHO umbrella of networked providers to facilitate multidisciplinary teams work, and optimal integration with secondary care services provision.

## ***5.7 ENSURING BETTER SPECIALIST SERVICES THROUGH OUR PROVIDER DIVISION***

### **5.7.1 Public Health Services**

In 2009/10 the key areas of focus will include:

- strengthening the effectiveness of service delivery by improving the interface between the different programmes delivered within the Public Health Services and within the DHB, strengthening intersectoral activities and relationships, ensuring our programmes are well focused and underpinned by strong programme logic
- ensuring the successful delivery of key government priorities including Before School Checks and the HPV immunisation programme
- working with the Ministry of Health and other south Island DHBs on the development and successful implementation of Healthy South
- improving contractual performance
- implementing the Oral Health school dental project.

### **5.7.2 Needs Assessment and Coordination Service (NASC-Support Works)**

The services provided by the NASC are for the purposes of functional support for people with age-related disabilities and for people with life-long disabilities. NMDHB has recently added services for people with long-term chronic conditions. The NASC uses the InterRAI tool to enable a restorative approach for people with age-related disabilities. NMDHB is working collaboratively with Canterbury DHB to further develop the utility of this approach particularly for people needing supportive community care. In 2009/10 the focus will be on further refining 'packages of care' using the InterRAI process.

### **5.7.3 Intellectual and Physical Disability Services**

The services provided for people with disabilities are designed around the New Zealand Disability Strategy 2002. Key directions and initiatives to achieve our objectives for people with disabilities include: continuing to provide a range of community-based support services for people with mainly intellectual and physical disabilities

## 5.7.4 Hospital and Specialist Services

This SOI sees a critical focus on our Hospital Services to address our current high intervention rate of some services such as cardiology, vascular and elective. These are significantly above the New Zealand average.

Our review this year intends to implement alternative models of care, establish single waiting lists, ensure appropriate emergency service provision and do this through clinical leadership and engagement across the district. We aim to live within the revenue we receive for delivering our services and we expect services to become more efficient as a consequence of this approach.

In the future we plan to move services from Hospital to Community settings of care where this is feasible appropriate and cost-effective. Our intention is to provide sooner, better and more convenient hospital-based services provision to our population. Planning for this service shift has commenced and some services have been devolved to Primary Care Providers e.g. GP access to specialist diagnostic tests to reduce wait times to first specialist assessment.

Also NMDHB's Hospital Services Provider will introduce a number of quality initiatives to improve patient flow and reduce waste. These include *'optimising the patient journey'* and *'Medicines Management'* Programmes.

The following services are the focus for the term of this SOI:

### 1. *Emergency Department (ED) Services*

Consequent to the project to improve the patient journey in the ED which was completed in 2008, the ED intend to "stream" patients to improve wait times within the Minister of Health's expectations. We regularly review ED attendance data for inappropriate attendance and hospital admission and are working with Nelson Marlborough PHOs to identify "frequent flyers" to ED and put strategies in place to reduce inappropriate attendance. We have also worked with PHOs to establish low cost access primary care clinics close to EDs to encourage people to use primary care facilities if they are not experiencing an emergency. We aim to hold ED wait times to the national target of 6 hours from attendance to treatment.

### 2. *Acute Services*

The following actions will be conducted to reduce acute inpatient admissions:

- Medicines Use Review Services performed by Community Pharmacists with targeted medicines management programmes will be introduced in the 2009/10 year
- Establishment of a Primary Care led community Cellulitis Service (Primary Options to Acute Care)
- Introduction of Self Management Programmes in Primary Care Settings for those with long term conditions.

### 3. *Elective Services*

We intend to organise elective services performance to meet the elective services discharges (and caseweights) target as required by the Minister of Health. We are working collaboratively through the South Island Elective Services Planning process to deliver services needed by our local patients and where appropriate by patients in other South Island Districts. This South Island Regional Initiative intends to improve both public and private utilisation of funding, facilities and human resources and provide more elective services to the population of the South Island while ensuring more equity of access to services for the people of the whole region.

### 4. *Community Services*

We will continue the development of a new integrated community health centre in Golden Bay along with our partners including Nelson Bays Primary Health (PHO) and the aged residential care sector. We also intend to explore aligning the Murchison Community and Services to Nelson Bays Primary Health to ensure that community benefits into the future in our investment in new primary health care services.

## 5. *Cancer Services*

One of the Government commitments is to reduce waiting times for people with cancer to effective, high quality and safe cancer treatment services. NMDHB is working through the South Island Cancer Network to address any 'bottlenecks' to timely access to services for patients as well as access to timely surgical and radiotherapy oncology services through the South Island Health Services Plan. We are also negotiating access to services through our interdistrict flows relationship with Hutt DHB.

## 5.8 *ORGANISATIONAL CAPABILITY*

### 5.8.1 **Workforce Development and Organisational Health**

Workforce development and strong organisational health are central to our DHB to ensure that we provide effective, timely, efficient and safe services and meet the continued challenges of the health needs of our patients. As a 'good employer' we have a number of policies and processes that promote equity, fairness and a safe and healthy work environment. These policies include:

- fair and transparent recruitment to ensure we have the right skills, knowledge and attributes to meet current and future workforce needs with a focus on retaining key people
- our zero tolerance to all forms of harassment and bullying
- training and development opportunities for staff aimed at the development of the individual while meeting the goals of the organisation
- active management of, and encouragement to disclose adverse events and near misses, to ensure a safe working environment
- Provision of onsite physical activity opportunities for staff to maintain their own physical health.

Our DHB is committed to engaging our clinicians through participative approaches to further develop clinical leadership and clinical networks. Better understanding of the needs of our workforce will enable us to deliver more responsive services now and into the future. We continue to be committed to promoting clinical leadership opportunities and enhancing a positive culture for the people who work with us in our organisation. Our DHB works collaboratively with other DHBs on regional and national workforce initiatives and is actively engaged with them under the auspices of the 21 DHBs Future Workforce programme.

### 5.8.2 **Quality, Innovation and Safety**

Quality, innovation and safety is fundamental to all activity within our organisation and those providers with whom we contract for services. Our organisation's quality improvement structure was revised in 2008. In addition to the overarching Clinical Quality Improvement Committee a Corporate Quality Improvement Committee is mandated to oversee all non clinical organisational processes. Both Committees report to the Chief Executive and his Strategic Leadership Team which includes the Chief Medical Adviser, Director of Nursing and the Director of Maori Health. Quality and Safety forms a key part of contracts with all providers and regular audit of this area is maintained.

We have an active Clinical Advisory Council (CAC) chaired by the Chief Medical Advisor (CMA) that provides advice to Management on services' development and associated clinical issues. CAC has primary care, PHO and Maori membership to ensure that a participatory input across settings of care for patients is addressed. Risk management systems and processes are in place and regularly reviewed by the Board and management at all levels.

Our organisation's comprehensive patient complaint service and systems to manage sentinel and reportable events are in line with national developments in this area. We also maintain our certification and accreditation processes currently on a three year cycle.

We are participating in the National Quality Improvement Programme and have been a pilot site for the ward based 'Optimising the Patient Journey (OPJ)'. OPJ has been extended throughout clinical areas in the organisation with the intention that it will be implemented in all clinical and non clinical areas over time.

## ***5.9 INFORMATION SYSTEMS TO SUPPORT CLINICIANS IN PATIENT CARE***

Prior to 2005, NMDHB invested relatively small amounts into information technology, resulting in many manual, inefficient processes and systems. There was little integration with primary care, and information transfers between providers were very manual. Following the creation and acceptance of an information strategic plan based up on three planks, significant investment in information technology has been occurring at NMDHB. The three planks are:

- Clinical Intranet
- Reporting
- Patient Management System.

The Clinical Intranet has been deployed within NMDHB to provide seamless access to laboratory, radiology, encounter and discharge information. NMDHB is now sending significant volumes of discharges summaries to general practice electronically. NMDHB is currently planning the implementation of the next set of functionality including e-ordering, e-signoff and hospital bound referrals from general practice. These initiatives will significantly reduce the size of the paper clinical records currently in use at NMDHB and in general practice, and provide clinicians access to information as soon as it is created.

NMDHB has created a new data warehouse which forms the basis of reporting. The DHB now has a single source of information, ensuring more consistent and accurate reports. Ongoing development will provide end users with direct access to the warehouse.

NMDHB and South Canterbury DHB (SCDHB) embarked on a replacement patient management system project in collaboration. Both DHBs had a desire to leap frog the existing norm in New Zealand, and implement a patient centric system, allowing appropriate access for all clinicians caring for an individual, regardless of the provider relationships. Since starting the process, another five DHBs have joined the collaborative work, leading to the formation of the Health Management System Collaborative. Three more DHBs are currently observing progress and may join the process at a later time. The collaborative has attracted significant local, national and international interest and is seen as a vehicle for the next generation health system for New Zealand. Underpinning these applications is a solid infrastructure connecting NMDHB's various sites in the district, including a disaster recovery site at Wairau Hospital.

## ***5.10 DEVELOPING FACILITIES THAT SUPPORT BETTER CARE***

NMDHB has a redevelopment of Wairau Hospital Blenheim underway. This will see an extensive rebuild programme covering over 12,000 m<sup>2</sup> of new and refurbished areas. The aim being to create a contemporary, collaboratively operated Hospital and Health Care facility that will provide optimised services for the Marlborough community in settings designed and resources to achieve that end, and of which all can be proud. The redevelopment is expected to be completed by December 2010.

NMDHB has a number of projects underway at the wider Nelson Hospital campus. These include refurbishing existing buildings for use by Public Health Services and Mental Health Outpatient Services and the upgrade of the electrical reticulation network including replacement of the existing emergency power generators. The strategic part of a business case for the stage two of the redevelopment of Nelson Hospital has been submitted to the National Capital Committee for consideration as part of the Health Capital Budget for 2009/10. This stage will address pressures on inpatient areas especially surgical and some medical as well as learning and education facilities. If the project is approved it is expected construction would commence late 2010.

## **5.11 ENABLING NATIONAL AND REGIONAL COLLABORATION AND CROSS SECTORAL COLLABORATION**

Working collaboratively, both across the sector and with other health and social service providers is integral to the success of Nelson Marlborough District Health Board (NMDHB) in achieving the goals set out in our DSP. We are committed to sharing resources, knowledge and experience with regional DHBs and providers as well as with the Ministry of Health, DHBNZ<sup>10</sup>, NGOs<sup>11</sup> and other service providers in order to achieve these goals.

### **5.11.1 National Collective Decision-making**

Our Board is part of the national DHB collective decision-making facilitated by District Health Boards New Zealand (DHBNZ). The collective activity of 21 District Health Boards will be maintained during 2009/10. Based on the trend in collective District Health Board activity, Nelson Marlborough DHB will continue to contribute its share to DHBNZ costs in 2009/10. We are working collaboratively on specific issues such as new services, technology and review, improvement in existing national services, disability aids, public awareness campaigns and aspects of the national quality improvement projects.

### **5.11.2 South Island Regional Collective Decision-making**

During 2008/09 the six South Island DHBs have progressed agreed collaborative work to develop strategic level regional approaches to health service planning. The purpose of this collaborative and cooperative relationship is to provide a regional overview of health care provision, to challenge the current service configuration and together improve access, outcomes and sustainability of these services within the funding available. It allows the S.I. District Health Boards to forward plan and align their resources to meet the needs of their population and the wider combined region of the South Island. This planning involves active participatory engagement of clinical leaders with this being the core principle of the planning process.

Regional service planning encompasses clinical and corporate support functions within the following parameters:

- major capital projects that have a potential regional service impact
- working with partner DHB's to "leapfrog" service development issues by "borrowing" learning from those DHB's that have already developed or trialled service strategies
- new service configurations that have a regional impact
- new health interventions and technology that have a regional impact
- standards and guidelines development
- development of systems and processes or products to address health needs.

NMDHB is also linked with the Central Region as patient referral patterns require close clinical engagement and a close working relationship with Central Region DHBs.

### **5.11.3 Other Collaboration**

Our DHB is a shareholder in the South Island Shared Services Agency Limited (SISSAL), which supports the activities of the South Island DHBs by providing services as determined by the participating DHBs, such as planning and funding information, analysis, project management and audit support. SISSAL provides a shared vehicle through which all components of our respective DHBs can be brought together around areas of mutual interest.

---

<sup>10</sup> DHBNZ (District Health Boards New Zealand) has the overall purpose of assisting DHBs in meeting their objectives and accountabilities to the Crown.

<sup>11</sup> NGOs (Non-Governmental Organisations) for more information on NGOs go to <http://www.moh.govt.nz/ngo>

West Coast DHB and ourselves are continuing to work together to identify approaches to improve the clinical and financial sustainability of specialist and associated support services at both DHBs. Both are facing increasing challenges regarding sub-specialisation of services.

Additionally, Canterbury DHB, West Coast DHB and us are working towards shared tiered services delivery that meet the healthcare needs of patients.

## 6 NMDHB FINANCIAL INFORMATION

Nelson Marlborough District Health Board has prepared these financial forecasts in line with the accounting policies adopted by the Board, these accounting policies are included in the Statement of Intent 2009-12.

Nelson Marlborough District Health Board (NMDHB) has three separate divisions for which statements of financial performance are completed. These divisions are:

- Funding Health Services
- Provision of Health and Disability Services
- Administration and Governance of the DHB.

Since the 2004/05 Financial Year NMDHB has funded and delivered health and disability services to the population of the district within the funding made available. Overall the DHB has enjoyed the following financial results over the last four financial years:

2004/05	\$2,144K
2005/06	\$8,895K
2006/07	\$11,131K
2007/08	\$7,789K

These surpluses have been retained as equity. Specific contracts have been put in place to utilise these accumulated surpluses over the next three years for services as well as planned capital investment.

This equity is finite and was not planned to be used on an ongoing basis for services. The Rutherford Initiative will establish the way forward to bring the DHB back to a break even position and maintains this over the medium term.

### Financial Performance - NMDHB Consolidated

(000's)	2007/08	2008/09	2009/10	2010/11	2011/12
<b>Revenue</b>					
Government & Crown Agency	338,726	356,639	367,840	379,910	394,334
Other Revenue	13,548	11,828	10,888	11,061	11,033
<b>Total Revenue</b>	<b>352,274</b>	<b>368,467</b>	<b>378,728</b>	<b>390,971</b>	<b>405,367</b>
<b>Expenses</b>					
Personnel Costs	124,277	134,770	142,632	146,323	149,684
Outsourced Services	12,647	14,932	11,646	11,490	11,755
Clinical Supplies	26,291	27,147	28,024	28,333	28,395
Infrastructure & Non-Clinical Supplies	23,701	24,451	22,700	23,131	23,768
Interest	2,496	2,318	2,669	2,684	2,971
Depreciation	9,752	10,185	11,521	12,887	13,008
Capital Charge	7,117	6,894	6,342	6,356	6,500
Payments to Providers	138,203	150,075	159,202	163,546	170,471
<b>Total Expenditure</b>	<b>344,484</b>	<b>370,772</b>	<b>384,736</b>	<b>394,749</b>	<b>406,552</b>
<b>Operating Surplus/ (Deficit)</b>	<b>7,790</b>	<b>(2,305)</b>	<b>(6,008)</b>	<b>(3,778)</b>	<b>(1,185)</b>
Gain on Disposal of Assets	-	-	126	3,025	123
<b>Net Surplus/ (Deficit)</b>	<b>7,790</b>	<b>(2,305)</b>	<b>(5,882)</b>	<b>(753)</b>	<b>(1,062)</b>

These forecasts are based on the Funding Envelope from the Government, which includes the population based funding as well as funding signalled by the MoH for IDSS, elective surgical services, care plus and public health oral health business case.

By maintaining a break even position NMDHB will be in the position to reinvest in frontline services and facilities such as the next stage in the redevelopment of Nelson Hospital.

### Financial Performance - NMDHB Fund

\$000s	2007/08	2008/09	2009/10	2010/11	2011/12
<b>Revenue</b>					
Gov't & Crown Revenue	311,068	329,955	342,776	354,040	367,689
Other Revenue	3,034	1,947	1,502	1,353	1,033
<b>Total Revenue</b>	<b>314,102</b>	<b>331,902</b>	<b>344,278</b>	<b>355,393</b>	<b>368,722</b>
<b>Expenditure</b>					
Personal Health	190,842	209,727	221,394	227,204	235,157
Personal Health IDF	26,783	28,013	28,854	29,777	30,849
Mental Health	31,081	32,581	33,945	34,231	35,464
Mental Health IDF	2,440	2,405	2,672	2,758	2,857
Maori	2,729	3,017	2,766	2,855	2,957
Disability Support	43,749	47,422	50,222	51,329	52,777
Disability Support IDF	1,735	1,831	1,948	2,010	2,083
Government Priority Target			1,780	1,837	1,903
Governance & Administration	6,976	7,127	5,661	5,635	5,614
<b>Total Expenses</b>	<b>306,335</b>	<b>332,123</b>	<b>349,242</b>	<b>357,635</b>	<b>369,660</b>
<b>Surplus/(Deficit)</b>	<b>7,767</b>	<b>(221)</b>	<b>(4,964)</b>	<b>(2,242)</b>	<b>(938)</b>

These forecasts for the Fund reflect existing time based contracts that are in place to utilise accumulated surpluses through to 30 June 2012. In addition, all service contracts will be challenged through the Rutherford initiative to ensure value for money.

In order to remove one-line adjusters – some of which funded specific Māori Health positions within the Hospital Provider Arm – NMDHB agreed that these adjusters were included in the national price. This has led to the Māori specific expenditure appearing to be reduced in 2009/10. This is not the case in reality.

NMDHB has maintained records to ensure any surplus within mental health was retained for use in mental health. The Provider Division is subject to a wash-up and any funds from undelivered mental health services have been returned to the Fund for use on services in out years. NMDHB has been funding Mental Health services at a rate higher than that expected by the MoH to ensure the services are developed and remain financially sustainable. Following the decision to allow DHBs with allocation above the ring-fence for mental health to plan for delivering existing services levels at ring-fence levels NMDHB will be discussing with the Mental Health Group options to reduce expenditure to the mental health ring-fence level.

NMDHB Provider services have been funded using the national prices for services excluding mental health. The national price has further been discounted 1.53% or \$2,021K in personal health delivered by NMDHB. The Provider division is not only a hospital service, but also provides a significant number of community services. As the local community providers increase their capacity, opportunities to review how community services continue to be delivered will be explored.

Provision has been made to enable non-government organisations to receive price increases this ranges from 1.5% to full future funding track, some growth in volumes has also been assumed in demand driven services such as pharmaceuticals, PHO, palliative care, immunisation, elderly disability services.

NMDHB is now an over-funded DHB i.e. is receiving more funding than the population-based funding formula indicates. This is a result of actual population growth in the district being less than forecasted growth used by the Ministry of Health to calculate the population based funding. NMDHB received minimal additional funding for demographic change in 2008/09, as a corrective action. The DHB planned to invest these funds in the 2008/09 year into services to improve the management of chronic conditions and home based support services for the elderly as well as to address quality and innovation both locally and nationally through our collective decision-making processes. This investment is seen as critical to ensure the health services can continue to be sustainable over the long term. As the PHOs evolve and funding changes are made by the Government, NMDHB forecasts will change.

The outcomes of how the services are delivered in both Golden Bay have not been confirmed. The Golden Bay Integrated Services Project will result in a possible change to both the operational and capital costs in Golden Bay. In terms of capital, it may result in further capital development at the existing community hospital or the possible sale of the existing hospital and a new green fields hospital/ community services base being built. Therefore the financial impact of the projects is not included in these forecasts.

The changes in Motueka have commenced with the sale of the old community hospital to the Friends of Motueka Trust (FOMHT). During 2009/10 the FOMHT will open a new aged residential care hospital that will also cater for a small number of medical beds.

NMDHB has made a commitment to fund nutrition and physical activity programme until June 2012 – this investment is aimed at reducing the future impact of chronic disease on our population. This amount is to cover a number of community projects, but is accounted for in the Provider Division.

Over the next three years, in consultation with the MoH, work will be carried out in analysing in more detail the future population based funding projections for this district. NMDHB has one of the highest intervention rates in the New Zealand health sector and this will need to be critically analysed as part of the projected PBF work. As NMDHB is transition funded decisions will need to be made on the intervention rate and these range from holding the current rate while the PBF catches up to possibly having to reduce the intervention rate.

A business case for the redesign of the school oral health service has been approved by the MoH. Additional funds for both capital and operational costs have been approved by the MoH. The financial implication of this business case is included in these financial forecasts.

#### **Assumptions:**

- Mental Health spending in 2008/09 will utilise past surpluses and will be revised to fit to ring-fence levels
- Future Funding track as advised by MoH
- Volumes to be purchased from NMDHB Provider division remain the same as 2008/09, except some small changes.
- The case weights for 2009/10 have been converted to WIESNZ09
- Mental Health uses local prices
- Other local prices have been increased by a range from 0 to full FFT
- NGO prices have been increased by a range from 0 to full FFT
- Historical adjusters in the PVS have been removed
- Funding for NPA as follows 2008/09 \$2.0M, 2009/10 \$1.66M, 2010/11 \$1.45M, 2011/12 \$0.95M. This assumption is contingent on HEHA funding continuing
- Growth in volumes for demand driven services such as pharmaceuticals, PHO capitation, immunisation, elderly disability services. Palliative care
- No additional Blueprint funding from 2009/10
- Government priority funding utilised per advice with a residual amount maintained as a reserve for priorities yet to be announced.

**Risks:**

- Implications of national employee agreements on health workers' pay rates throughout all health providers in the district
- The ageing population and how this may affect services including primary, home support, residential and secondary services
- The level of health intervention is higher than the fund can afford on a sustainable basis
- Assumed price increases are set too low creating sustainability issues for the district health sector
- It is important the Board remains conservative in the use of this Fund equity. A number of one-off projects will need to be considered to ensure that the service mix remains sustainable within the population based funding in the future. The above expenditure of mental health ring fence surplus will mean that there is only \$52K of mental health surplus left in 2010/11.

<b>Financial Performance - NMDHB Governance &amp; Admin</b>					
<b>\$000s</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	<b>2011/12</b>
<b>Revenue</b>					
Internal revenue from Fund	6,976	7,127	5,661	5,635	5,614
Other Revenue	107		140		
<b>Total revenue</b>	<b>7,083</b>	<b>7,127</b>	<b>5,801</b>	<b>5,635</b>	<b>5,614</b>
<b>Expenditure</b>					
Personnel costs	1,978	2,128	1,931	1,903	1,953
Outsourced Services	417	478	503	516	530
Clinical Supplies					
Capital Charge	2,596	2,345	1,875	1,695	1,620
Projects		481	50	50	
Infrastructure & Non-Clinical Supplies	1,361	1,084	708	717	736
<b>Total Expenditure</b>	<b>6,352</b>	<b>6,516</b>	<b>5,067</b>	<b>4,881</b>	<b>4,840</b>
Internal Allocations	726	712	734	754	774
<b>Surplus/ (Deficit)</b>	<b>5</b>	<b>-101</b>	<b>0</b>	<b>0</b>	<b>0</b>

This small division covers the costs of the Board, Iwi Health Board, Advisory Committees, consultation and management / planning of the Fund. The Planning and Funding team is complemented by the South Island Shared Service Agency (SISSAL) and the senior leadership team at NMDHB.

Generally, the division will be maintained at break-even. A percentage increase to cover inflation has been included and this budget will need to be carefully managed. The majority of the strategic projects outlined in this DAP will be delivered by the Planning and Funding division.

The financial forecast at a high level for Governance and Administration division is:

**Financial Forecast – Provider Division**

NMDHB Provider Division has a break-even forecast for 2009/10 and beyond. This will be achieved by a number of strategies. Revenue will increase from government funding. All prices and revenue systems will continue to be reviewed to ensure services paid for by other entities are identified and collected. All expenditure will be challenged through the Rutherford Initiative.

The Mental Health service within the Provider Division has a loss forecasted in 2009/10; work will be completed during 2009/10 to identify the underlying cause of the loss.

Provider Division staff costs are to be held by the following:

- Inflation on settlements will be held as close as possible to the future funding track received in the funding envelope from the Government
- Staff numbers, particularly in clinical areas, are budgeted to increase to meet compliance requirements; these will continue to be challenged as part of the approval process
- Any new positions will require full justification and demonstrated funding streams.

Supply costs will continue to be tightly managed to a minimum. A project to reduce the cost of supply via standardisation, utilisation, number of suppliers and price will continue.

A review of all management and administration positions will be undertaken to ensure that the NMDHB has the most efficient configuration in order to deliver the health services. We anticipate making significant savings from this process that will enable us to reinvest into 'front-line services'.

### Financial Performance – NMDHB Provider

(000's)	2007/08	2008/09	2009/10	2010/11	2011/12
<b>Revenue</b>					
Government & Crown Agency	188,814	201,605	209,442	214,325	220,221
Other Revenue	10,407	9,881	9,246	9,708	10,000
<b>Total Revenue</b>	<b>199,221</b>	<b>211,486</b>	<b>218,688</b>	<b>224,033</b>	<b>230,221</b>
<b>Expenditure</b>					
Personnel	122,299	132,642	140,701	144,420	147,731
Outsourced Services	12,230	14,454	11,143	10,973	11,225
Clinical Supplies	26,291	27,147	28,024	28,333	28,395
Infrastructure & Non-Clinical Supplies	22,340	22,886	21,942	22,364	23,032
Interest	2,496	2,318	2,669	2,684	2,971
Depreciation	9,752	10,185	11,521	12,887	13,008
Capital Charge	4,521	4,549	4,467	4,661	4,880
<b>Total Expenditure</b>	<b>199,929</b>	<b>214,181</b>	<b>220,467</b>	<b>226,323</b>	<b>231,242</b>
Internal Allocations	(726)	(712)	(734)	(754)	(774)
<b>Operating Surplus/ (Deficit)</b>	<b>18</b>	<b>(1,983)</b>	<b>(1,044)</b>	<b>(1,536)</b>	<b>(247)</b>
Gain On Sale		-	126	3,025	123
<b>Surplus/ (Deficit)</b>	<b>18</b>	<b>(1,983)</b>	<b>(918)</b>	<b>1,489</b>	<b>(124)</b>

## **Assumptions**

The Provider Division has been forecast using a number of assumptions. These include:

### *Revenue*

- Internal revenue from the Fund has been calculated by using the 2009/10 national prices. Mental Health services will receive local prices, which are lower than the national mental health prices.
- Price adjusters have been removed as it is assumed these are covered by the new prices paid
- Price increases for other lines range from 2% to 5%
- No other adjusters are made from the fund to the provider.

### *Personnel Costs*

- Employment agreements that have been settled have been included at the rates agreed
- The inflation on employee costs in the out-years are set at the indicated future funding track (inclusive of step movements in the various agreements). If the agreements are settled at rates higher than this then other strategies will be required to match any funding gap
- No additional pay jolts have been included in these forecasts
- Additional FTEs have been included to cover some compliance issues and others as contingencies for possible changes to the staff mix, this includes a reduction in the reliance on locum staff
- Some FTEs have been reduced to reflect changes that will be worked through in some services and facilities, it is anticipated that the back office review will reduce the number of Management and Administrative FTEs.

### *Outsourced Services*

- This area of expenditure has increased significantly in 2008/09 with the inclusion of the new Lab contract, off-set partly with the introduction of the in-house MRI service, in addition outsourced medical and nursing staff was over budget. The 2009/10 budget has been reduced for outsourced medical and nursing, this may be exceeded if permanent FTE's are not fully employed, but will be off set by personnel costs being under budget.

### *Clinical Supply Costs*

- Clinical supplies include an inflation factor close to the future funding track received, however this has then been discounted to represent savings that may be available through better procurement practises.
- Travel and accommodation for IDFs will be funded direct (via Sector Services) by the fund
- In the 2009/11 years the Procurement project will deliver savings on the cost of clinical supplies, these savings have been factored into the district annual plan.

### *Infrastructure*

- Continue to utilise finance leases for the purchase of IT hardware, and radiology equipment
- Depreciation per the Capex programme. However the full effects of increased depreciation from the new health information system have not been fully recognised as they will materialise in 2012/13, but may be off set by efficiencies gained
- Interest rates reflect the current term loan rates with a reduction to 4% for any loans where the term is due to mature during 2009/10
- Inflation on supplies to be held to the future funding track level
- The effects of future revaluations are not included in these forecasts. The last revaluation of land and buildings was performed in June 2006. The next revaluation is scheduled to occur in June 2009.

The following projects have commenced, but the financial effects have not been included, these are:

### *Nelson Hospital Redevelopment –Stage 2*

A business case for the stage two of the Nelson Hospital redevelopment has commenced for consideration as part of the 2009/10 Health Capital Expenditure Budget. This project has been signalled in the NMDHB District Strategic plan. The redevelopment will replace the very old surgical wards that were not changed as part of the stage one development. Nelson hospital currently has no training and development facilities, this project will also include this. A full analysis of bed numbers is being completed to ensure that the Nelson hospital is right sized, this will include a

review of the models of care and also link in with neighbouring DHBs to ensure a regional view is taken into account. The capital and on-going operational costs of this project have not been included in these financials as the project has not yet received approval from the National Capital Committee.

### *Motueka Community Hospital*

The lease of land and sale of improvements to the Friends of Motueka Community Hospital Trust. Staff, revenue and associated costs have been removed from the Statement of Financial Performance as the transfer is expected to be completed around the end of the 2008/09 financial year.

### *Golden Bay Community Hospital*

A community led review/project to achieve full integration of health services in Golden Bay has commenced. This may have an impact on both the Balance Sheet and Statement of Financial Performance of NMDHB.

### *Secondary Services*

Service review – it is intended to complete a full service review within the Health service plans over the next three years to ensure the models of care are appropriate for each service value stream<sup>13</sup> and to confirm the efficiency level of the Provider. This is being led by the Planning and Funding Division with significant input from the providers in both secondary and primary services.

### *Oral Health-School Dental Services Business Case Implementation Project*

Service review – the approved business case for school oral health is included. This will result in changes in these services for which Government funding will be drawn for both the operational costs and capital expenditure in this plan.

### *Sensitivity*

The key risks the NMDHB Provider Division faces are the cost of personnel given this comprises 64% of operating costs and the volatile exchange rates for imported goods. Therefore the sensitivity of these forecasts is related to these costs.

The inflation on employee costs has been included at future funding track rates for 20010/11 and 2011/12 as advised by MoH. Historically inflation has been closer to an average of 5% (excluding any pay jolts). If personnel inflation was to be at the historical levels in these years this would add a minimum of \$3.1M to the costs, then the operating result would be a significant deficit:

Other costs have also been included in the plan at less than the future funding track as projects are planned to reduce these costs over time. For every 1% increase over this, the costs would increase by \$588K.

### *Risks*

- Personnel inflation in the out years has been included at a level below the historical average paid by the organisation in the past. If settlements are above the future funding track, then the risk of a deficit will be high or it will place pressure on the mix of services and/or capital expenditure
- Changes in the intervention rates leading to reduced volumes to be delivered by the Provider division, the reductions required to the resource structure over two sites may result in costs savings that are less than the revenue lost
- The costs of running small services and the cost of compliance continues to increase, this may result in further deterioration of the financial position
- The growth in ED volumes continues

---

<sup>13</sup> A value stream is all the actions (both value added and non-value added) currently required to achieve better patient/client outcomes, better quality, better productivity and satisfied customers and staff, by focusing on the flow of patients/clients through the system of care.

- Ageing workforce – NMDHB has a workforce in the higher age bracket. This has two significant risks:
- This may lead to a shortage of skilled labour in the future. Although this is mitigated somewhat by the Nelson Marlborough district being an attractive place to live and by workforce planning
- The expenditure on employee costs is well above the average in total costs. This is due to a large number of staff being on the higher steps in their respective employment contracts
- % increase in Other Revenue – either users of services do not accept increase or do not continue to purchase services
- Mental health – ability to right size services within the PBFF share
- Change in the mix of IDF, in that fewer people either present or are referred to another facility, which puts pressure on the services within the district
- Capex – If the Provider runs a deficit, then the planned Capex spend will need to be reduced. This creates high risks that equipment may fail before it is scheduled for replacement, and that the Board will have to continue to replace in response to breakdowns rather than in a planned way. Ultimately, either additional debt and/or equity may be required to maintain operations
- NMDHB does not continue to receive revenue in advance. This would add an additional \$1.8M to the interest expense, again creating a deficit
- Clinical Supplies - changes in funded drugs, shift of services from tertiary setting to local setting. Increased technology will lower volumes, creating higher costs of procedures. Patient travel and accommodation assistance is exceeding available funds.

#### *Capital Expenditure (Capex)*

The capital expenditure plan is in line with the Strategic Plan 2005-2015. All capital expenditure proposals over \$100K require a business case. NMDHB has always made the Capex programme subject to a break-even position in the Provider Division. Effectively this is to ensure sufficient cash to cover the operational costs, and avoids the need to seek equity at an 8% charge.

NMDHB will seek to strike the balance of keeping the asset base at an optimal level. This means that the business cases for capital expenditure projects are justified by either a direct business gain/efficiency or deliver a gain in health outcomes. This ensures that the ongoing operational and capital costs are fully acknowledged and covered by either efficiencies or funded by the DHB.

The capital plan below is aggressive and significant additional investment will be made in the information services. This is an area where the DHB has under-invested in the past. This investment is critical for the success of a number of the strategies in the Nelson Marlborough District Strategic Plan and this District Annual Plan. The capital funds available and expenditure lines are as follows:

<b>Capital Expenditure \$000s</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	<b>2011/12</b>	
<b>Funding Source:</b>						
Net Surplus/(Deficit)	7,790	(2,305)	(5,882)	(753)	(1,062)	
Depreciation	9,758	10,191	11,521	12,887	13,009	
Asset Sales	795		4,085	3,751	374	
Loans (CHFA)**				12,500		
Finance Leases	2,967	3,730	3,140	1,715	1,625	
Cash/Overdraft or (excess cash)	(8,527)	19,633	20,748	(4,854)	(2,133)	
<b>Total Funds Available</b>	<b>12,783</b>	<b>31,249</b>	<b>33,613</b>	<b>25,246</b>	<b>10,188</b>	
<b>Capex</b>						<b>Status</b>
General Equipment	3,852	4,129	4,183	3,584	2,873	Various
IT/IS	2,969	4,665	4,715	3,075	3,075	Various
Vehicles	926	685	1,542	2,541	1,446	Various
Wairau Site Development*	1,206	15,460	15,608	12,908		Approved
Nelson Site Business case			400			
Cardio Angio	1,466					Complete
Dalton House – Public Health building			1,700			Approved
PCI*	181					Complete
Nelson Mental Health Outpatient Building, MCT & Admin	1,242	1,000	800			In progress
Psychogeriatric Services		600				In progress
School Dental Buildings				2,438	1,194	Approved
Other Buildings	941	910	865	200	200	Various
Mental Health - IPC		1,000			400	In progress
Primary Care After Hours Building			500			Concept stage
Fluoroscopy Nelson (Equipment & Building Alterations)		1,100				Complete
Emergency Power Upgrade		1,200	600			Approved
Wairau Site FF & E*		500	1,500	500		Various
Boiler					1,000	Concept
Boiler Emission Filters			1,200			Concept
<b>Total Capex</b>	<b>12,783</b>	<b>31,249</b>	<b>33,613</b>	<b>25,246</b>	<b>10,188</b>	

\* Denotes strategic capital expenditure

\*\* \$12M loans are signalled to assist funding the Wairau Site Redevelopment project.

### *Unapproved Capital Requirements*

A business case will commence for the replacement of the Nelson Hospital surgical wards and education centre. This case will need to follow the national capital process as the estimated capital cost will be between \$33m and \$42m. This amount may require additional debt and/or equity, therefore has not been included in the above forecast.

### *Asset Sales*

The asset sales include:

- |         |   |
|---------|---|
| 2009/12 | 113 & 115 Kawai Street: Mental Health services relocated  |
|         | Nelson community house real estate: sale to either Housing NZ or RHMU with current tenants and services continuing to be provided from these homes. |
|         | Sub-divide the Tapawera property with NMDHB retaining the Community Clinic and the house and section being sold.                                    |
|         | Wairau – both the west and east surplus blocks with funds being used for the Wairau redevelopment.  |

It is the intention of the Board to investigate leasing of buildings as an option; this may include investors building purpose-built facilities for the DHB to lease. This would enable capital funds to be freed up to purchase clinical equipment or speed up the investment the DHB needs to make in information systems.

A review of the strategic plan for the Nelson sites is being completed. This will be the base for placement of facilities for services covering mental health, surgical services, public health, education centre, primary care after hours and Alexandra Hospital. The business case for any new facility on the Nelson campus will be completed in line with this strategic plan.

Provision has been made for a primary care after-hours facility on the Nelson campus. This will be subject to a District wide after-hours service plan and business case.

Vehicles are historically leased under an operating lease. We are changing this to finance leases which mean the vehicle is included as an asset and a corresponding liability on the Balance Sheet. Depreciation and interest have been included instead of lease payments in the Operating Statement.

<b>Consolidated Statement of Cash Flows</b>					
<b>\$000s</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	<b>2011/12</b>
<b>Cash Inflow from Operating</b>					
Government & Crown Agencies	335,000	357,571	367,979	379,909	394,334
Other Revenue	7,750	6,886	7,447	7,909	8,200
<b>Total Cash Inflow from Operating</b>	<b>342,750</b>	<b>364,457</b>	<b>375,426</b>	<b>387,818</b>	<b>402,534</b>
<b>Cash Outflow from Operating</b>					
Personnel	119,823	133,552	141,499	145,151	148,486
Creditors	60,279	67,259	62,369	62,953	63,918
Interest Paid	2,347	2,713	2,669	2,684	2,971
Capital Charge	7,815	7,652	6,364	6,402	6,506
GST	(719)	1,146	72	167	216
Payments to other Providers	138,204	152,049	158,493	163,214	169,970
<b>Total Cash Outflow from Operating</b>	<b>327,749</b>	<b>364,371</b>	<b>371,466</b>	<b>380,571</b>	<b>392,067</b>
<b>Net Inflow/(Outflow) from Operations</b>	<b>15,001</b>	<b>86</b>	<b>3,960</b>	<b>7,247</b>	<b>10,467</b>
<b>Investing Activities</b>					
Interest receipts	5,695	4,379	3,302	3,153	2,833
Sale of Assets	795	0	4,085	3,751	374
Purchase of Assets	12,782	29,238	33,397	28,210	12,582
<b>Net Inflow/(Outflow) from Investing</b>	<b>(6,292)</b>	<b>(24,859)</b>	<b>(26,010)</b>	<b>(21,306)</b>	<b>(9,375)</b>
<b>Financing Activities</b>					
Equity	-563	-530	-530	15	1,908
Loans Raised	17,967	3,730	3,140	14,215	1,625
Trust Funds	0	0	0	0	0
Loans Repaid	16,425	628	1,341	2,013	2,352
<b>Net Inflow/(Outflow) from Financing</b>	<b>979</b>	<b>2,572</b>	<b>1,269</b>	<b>12,217</b>	<b>1,181</b>
<b>Net cash inflow/(outflow)</b>	<b>9,688</b>	<b>(22,201)</b>	<b>(20,780)</b>	<b>(1,842)</b>	<b>2,273</b>
Opening balance	49,944	59,632	37,431	16,650	14,808
<b>Closing Balance</b>	<b>59,632</b>	<b>37,431</b>	<b>16,650</b>	<b>14,808</b>	<b>17,081</b>

### *Operating Cashflow*

The operating cashflow assumes that the mix of current assets and liabilities will remain relatively constant during this planning period. This forecasts a net cashflow from operations which provides a cashflow contribution to the capital expenditure programme. The investing cashflow reflects the planned sale and investment in assets. This is financed from a mix of cash generated from operations, loans and existing funds in the bank plus an operating overdraft. The financing cashflow reflects the finance leases drawn plus the loans from the Crown Health Financing Agency.

### *Risks*

The overall operating performance of the Provider Division is the largest risk to the cashflow.

This may be off-set by the capital expenditure timeframes with the DHB having a history of delays in major capital programmes. Sale of surplus assets – if the Board decides not to sell any property, then the capital program will need to be reviewed.

*Balance Sheet*

<b>Consolidated Statement of Financial Position</b>					
<b>\$000s</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	<b>2011/12</b>
<b>Current Assets</b>					
Bank	59,632	37,431	16,650	14,808	17,081
Debtors	13,097	12,930	13,117	13,287	13,416
Stock	2,379	2,378	2,378	2,378	2,378
Prepayments	276	418	418	418	418
Bonds Held	18	18	18	18	18
Provision Doubtful Debts	(402)	(402)	(402)	(402)	(402)
<b>Total Current Assets</b>	<b>75,000</b>	<b>52,773</b>	<b>32,179</b>	<b>30,507</b>	<b>32,909</b>
<b>Current Liabilities</b>					
Creditors/Accruals/provisions	24,136	19,914	20,738	21,078	21,641
Capital Creditors	0	2,262	2,472	2,152	802
Income in Advance	379	379	379	379	379
Capital Charge	1,966	1,133	1,111	1,065	1,059
Payroll Accrual & Clearing	9,028	9,189	9,190	9,191	9,192
Employee Entitlement	16,919	16,972	17,083	17,194	17,308
Finance Lease	1,467	2,202	2,670	2,593	2,404
<b>Total Current Liabilities</b>	<b>53,895</b>	<b>52,052</b>	<b>53,643</b>	<b>53,652</b>	<b>52,785</b>
<b>Net Working Capital</b>	<b>21,105</b>	<b>721</b>	<b>(21,464)</b>	<b>(23,145)</b>	<b>(19,876)</b>
<b>Long Term Assets</b>					
Long Term Assets	113,995	135,052	153,186	167,468	165,591
Prepayments non-current	142				
Investments in Assoc	7	7	7	7	7
<b>Long Term Debt</b>					
Long Term Debt	35,000	35,000	35,000	47,500	47,500
Finance Leases	3,927	6,268	7,599	7,379	6,841
Other Term Liabilities	8,718	9,743	10,772	11,832	12,916
<b>Total Net Assets</b>	<b>87,604</b>	<b>84,769</b>	<b>78,358</b>	<b>77,619</b>	<b>78,465</b>
<b>Crown Equity</b>					
Ordinary Shares	28,354	27,824	27,294	27,309	29,217
Revaluation reserve	33,661	33,661	33,661	33,661	33,661
Provider Retained earnings	(3,026)	(5,110)	(6,028)	(4,539)	(4,663)
Fund Equity	28,615	28,394	23,430	21,188	20,250
<b>Total Equity</b>	<b>87,604</b>	<b>84,769</b>	<b>78,358</b>	<b>77,619</b>	<b>78,465</b>

This balance sheet is a result of the operating statements and capital programme. The risk to the balance sheet is the mix of assets and liabilities. A review of the debt/equity mix will be required to ensure a robust debt/equity plan can be put in place.

### *Movement in Equity*

<b>\$000</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	<b>2011/12</b>
Equity at beginning of year	80,361	87,604	84,769	78,358	77,619
Net Surplus/(Deficit) for the Year	7,790	(2,305)	(5,882)	(753)	(1,062)
Revaluation of Property					
Total recognised income & expense for the year	7,790	(2,305)	(5,882)	(753)	(1,062)
Equity injections	-	-	-	545	2,438
Equity repayments	(547)	(530)	(530)	(530)	(530)
<b>Total Equity at the end of the year</b>	<b>87,604</b>	<b>84,769</b>	<b>78,358</b>	<b>77,619</b>	<b>78,465</b>

## **Debt and Equity**

### *Debt*

This plan includes increased long term borrowing from the Crown Health Financing Agency (CHFA). In 2010/11 \$12.5M will be borrowed from the CHFA for the Wairau redevelopment. A business case will also be submitted to the National Capital Committee (NCC) for the rebuild of the surgical wards in Nelson. The cost of the rebuild of the Nelson surgical wards is estimated as between \$33M and \$42M.

All NMDHB term debt is borrowed from the Crown Health Financing Agency. NMDHB will investigate (once the hospital rebuilds have been completed) converting some equity to debt to move the debt to equity ratio to 65:35. This would reduce the weighted average cost of capital closer to the sector average.

NMDHB will carry additional working capital debt with the overdraft facility to be increased to \$15.0M. NMDHB will be utilising its overdraft facility within the requirements of the Operational Policy Framework.

The term borrowing forecasts include finance leases for information technology, and radiology equipment. Analysis will be completed at the time of purchasing and the best option will be selected for financing the purchase.

NMDHB has the following facilities approved:

- Crown Health Financing Agency total term loan approved \$55M, these are drawn to \$35M. Of this \$12M is to cover the redevelopment of Wairau Hospital and the remaining facility is to cover any change to the funding in advance status
- Westpac Banking Corp overdraft limit currently at \$15M and committed lease facility \$4.0M
- Lease Companies limits per individual item leased.

### *Equity*

Equity is held the same as current levels in this plan; however, NMDHB will be discussing converting some equity into debt. This will need to also take into account the requirements of the Wairau site redevelopment.

### *Key Ratios to Meet Loan Requirements*

These ratios are required by our bankers for which the DHB has working capital facilities. All term debt is borrowed from the Crown Health Financing Agency and there are no covenant ratios, but the DHB is subject to annual review.

The debt to debt plus equity ratio is required to be no greater than 55%.

2007/08	32. %
2008/09	34. %
2009/10	36 %
2010/11	42 %
2011/12	41 %

Interest cover is to be greater than 2.5 times:

2007/08	7.67
2008/09	3.93
2009/10	3.68
2010/11	6.04
2011/12	5.45

See Appendix 3 for NMDHB Accounting Policies

## 7 APPENDICES

### 7.1 APPENDIX 1: PRICE VOLUME SCHEDULE (AS OF JULY 2009)

#### NMDHB Price Volume Schedules 2009/10

09/10 Volumes include Additional Elective Volumes

<i>PU Code for template</i>	<i>Unit of Measure</i>	<i>Description</i>	<i>Vols 08/09</i>	<i>Price 08/09</i>	<i>Total Amount 08/09</i>	<i>Vols 09/10</i>	<i>09/10 Price</i>	<i>Total Amount 09/10</i>
TR0201	Service	Patient transport - non emergency and inpatient tr	714	2,706	1,932,375	777	2,791	2,168,351
ADJ111	Adjuster	ACC non resident funding	1	60,456	60,456	1	62,754	62,754
MS01001	Attendances	General Surgery - Nurse Clinic	40	139	5,544	40	141	5,649
MS01001	Attendances	ENT Nurse Clinic	2,300	139	318,800	2,500	141	353,056
MS01001	Attendances	Ophthalmology Nurse clinics	325	139	45,048	325	141	45,897
MS01001	Attendances	Orthopaedics - Nurse Clinic	120	139	16,633	120	141	16,947
MS01001	Attendances	Urology - nurse Clinic	375	139	51,978	425	141	60,020
PC0010	Attendances	Pain Psycho-social assessment		250		60	250	15,000
MS01001	Attendances	Pain Clinic nurse clinic		139		60	141	8,473
PC0001	Attendances	Pain Clinic - 1st attendance	110	428	47,038	110	554	60,922
PC0003	Attendances	Pain Clinic - Subsequent attendance	200	318	63,510	200	358	71,533
S00001	Cost weighted discharges	General Surgery - Inpatient Services (DRGs)	4,264	3,985	16,995,093	4,002	4,315	17,269,815
S05001	Cost weighted discharges	Anaesthesia Services - Inpatient Services (DRGs)		3,985		90	4,315	387,019
S00002	Attendances	General Surgery - 1st attendance	3,320	266	884,159	3,445	239	822,560
S00003	Attendances	General Surgery - Subsequent attendance	4,585	221	1,011,304	4,608	239	1,100,248
S00008	Procedures	Minor operations (Gen Surgery)	800	232	185,933	800	312	249,762
S25001	Cost weighted discharges	Ear, Nose and Throat - Inpatient Services (DRGs)	565	3,985	2,253,554	577	4,315	2,491,767
S25002	Attendances	Ear Nose and Throat - 1st attendance	1,500	244	366,218	1,519	262	398,002
S25003	Attendances	Ear Nose and Throat - Subsequent attendance	1,540	189	290,475	1,819	215	390,489
S25006	Procedures	ENT Minor procedure	950	158	150,005	950	213	201,919

<b>PU Code for template</b>	<b>Unit of Measure</b>	<b>Description</b>	<b>Vols 08/09</b>	<b>Price 08/09</b>	<b>Total Amount 08/09</b>	<b>Vols 09/10</b>	<b>09/10 Price</b>	<b>Total Amount 09/10</b>
S40001	Cost weighted discharges	Ophthalmology - Inpatient Services (DRGs)	378	3,985	1,507,673	612.	4,315	2,643,059
S40002	Attendances	Ophthalmology - 1st attendance	1,250	161	201,795	1,445	206	298,190
S40003	Attendances	Ophthalmology - Subsequent attendance	5,450	135	738,286	5,645	156	877,965
S40004	Procedures	Minor Eye Procedures	50	164	8,222	50	209	10,458
S40005	Procedures	Eye - Argon Laser	180	210	37,824	180	215	38,716
S45001	Cost weighted discharges	Orthopaedics - Inpatient Services (DRGs)	3,208	3,985	12,783,162	3,387	4,315	14,614,776
S45002	Attendances	Orthopaedics - 1st attendance	3,390	281	952,860	3,489	285	994,865
S45003	Attendances	Orthopaedics - Subsequent attendance	6,775	231	1,563,304	6,874	233	1,600,442
S70001	Cost weighted discharges	Urology - Inpatient Services (DRGs)	698	3,985	2,782,487	754	4,315	3,253,695
S70002	Attendances	Urology - 1st attendance	900	280	252,255	1,010	326	328,829
S70003	Attendances	Urology - Subsequent attendance	1,725	185	319,127	1,791	240	429,259
S70004	Attendances	Urology - Chemotherapy	200	282	56,448	0	293	0
S70005	Procedures	Urology - Cystoscopy	400	361	144,561	400	556	222,444
S70006	Procedures	Urology - Lithotripsy	30	5,466	163,983	30	5,569	167,075
S70007	Procedures	Urology - Urodynamics	50	289	14,469	60	340	20,397
M20007	Procedures	Diabetes - Fundus Screening	1,500	81	121,682	1,500	99	148,858
S00004	Procedures	General Surgery - Colonoscopy	600	957	574,358	673	1,038	698,467
S00005	Procedures	General Surgery - Gastroscopy	250	814	203,607	323	814	263,076
MEOU0009		CQI	1	28,557	28,557	1	29,447	29,447
AH01001	Contacts	Dietetics	4,050	152	615,786	4,050	140	566,833
AH01003	Contacts	Occupational Therapy	3,200	105	336,177	3,200	133	426,944
AH01005	Contacts	Physiotherapy	13,200	55	729,093	13,200	74	973,174
AH01007	Contacts	Social Work	1,700	106	179,950	1,700	127	215,428
AH01007	Contacts	Social Work (Paediatrics)	158	106	16,725	158	127	20,022
AH01008	Contacts	Speech Therapy	714	139	99,441	714	155	110,373
CS01001	Relative Value Unit	Community Radiology	23,295	82	1,912,714	41,444	64	2,664,033
CS04003	Tests	Community referred tests - audiology	3,000	124	372,122	3,000	131	392,657
DOM101	Clients	Community Services - professional services	35,917	64	2,316,526	35,917	89	3,195,495
DOM101	visits	Community nurse clinics	428	64	27,605	428	89	38,079
DOM102	Clients	Community Services - home oxygen	220	551	121,290	220	562	123,578
DOM103	Clients	Community Services - stomal service	400	1,738	695,084	400	2,155	862,135
DOM104	Clients	Community Services - continence service	800	796	636,650	800	551	440,735
DOM106	Meals	Community Services - meals on wheels	92,000	4	374,611	92,000	4	381,671
M30018	Service	Intragram	1	326,465	326,465	1	338,871	338,871
OT01001	Service	Private Blood	1	60,628	60,628	1	62,517	62,517

<b>PU Code for template</b>	<b>Unit of Measure</b>	<b>Description</b>	<b>Volts 08/09</b>	<b>Price 08/09</b>	<b>Total Amount 08/09</b>	<b>Volts 09/10</b>	<b>09/10 Price</b>	<b>Total Amount 09/10</b>
COPH0005	Claims	Pharms claims	1	330,000	330,000	1	342,540	342,540
COOC0070	Service	Family Violence Project Coordination	1	166,243	166,243	1	100,000	100,000
ED09001	Service	Major incident health co-ordinating responsibility	1	58,159	58,159	1	59,972	59,972
COOC0074	Service	Psych-Oncology services	1	53,133	53,133	1	54,788	54,788
CS04001	Tests	Community referred tests - cardiology	6,000	204	1,223,874	6,000	206	1,237,070
CS04004	Tests	Community referred tests - gastroenterology	24	40	965	24	441	10,589
CS04005	Tests	Community referred tests - endocrinology	164	55	8,957	164	139	22,822
CS04008	Tests	Community referred tests - respiratory	900	111	100,216	900	236	212,563
ED04001	Attendances	Emergency Dept - Level 4	25,125	280	7,032,071	25,575	283	7,225,110
M00001	Cost weighted discharges	General Internal Medical Services - Inpatient Serv	4,851	3,985	19,333,676	4,873	4,315	21,030,161
M00002	Attendances	General Medicine - 1st attendance	1,130	312	352,087	1,130	357	403,560
M00003	Attendances	General Medicine - Subsequent attendance	2,500	223	557,947	2,500	252	629,381
M00006	Attendances	General Medicine - Blood Transfusions	660	384	253,720	660	584	385,221
M10001	Cost weighted discharges	(Non PCI) Cardiology - Inpatient Services (DRGs)	0	3,985	0	654	4,315	2,824,224
M10001	Cost weighted discharges	(PCI) Cardiology - Inpatient Services (DRGs)	312	3,985	1,245,098	295	4,315	1,272,793
M10002	Attendances	Cardiology - 1st attendance	950	331	314,294	1,094	360	393,543
M10003	Attendances	Cardiology - Subsequent attendance	2,150	251	540,002	2,294	266	609,337
M10004	Clients	Cardiac Education and Management	900	215	193,555	900	219	197,205
M15002	Attendances	Dermatology - 1st attendance	500	202	100,812	500	239	119,644
M15003	Attendances	Dermatology - Subsequent attendance	420	161	67,412	420	198	83,142
M15004	Treatment	Dermatology - UV Treatment	500	85	42,553	500	87	43,356
M20004	Attendances	Diabetes - 1st attendance	230	358	82,384	230	343	78,780
M20005	Attendances	Diabetes - Subsequent attendance	585	259	151,613	585	271	158,299
M20006	Service	Diabetes Nurse Educator	1	177	177	1	257	257
M20006	Clients	Diabetes Education and Management	990	177	175,422	990	257	254,245
M20020	Service	Diabetes Coordination	1	23,574	23,574	1	24,309	24,309
M25002	Attendances	Gastroenterology - 1st attendance	660	262	172,737	660	267	175,995
M25003	Attendances	Gastroenterology - Subsequent attendance	1,200	235	281,439	1,200	239	286,746
M25005	Procedures	Gastroenterology - Colonoscopy	440	866	381,170	440	1,038	456,650
M25006	Procedures	Gastroenterology - Gastroscopy	570	703	400,724	570	814	464,251
M45002	Attendances	Neurology - 1st attendance	714	485	346,493	714	564	402,663
M45003	Attendances	Neurology - Subsequent attendance	700	280	196,005	700	338	236,637
M45004	Completed treatment	Neurology - Botulinum toxin therapy	90	897	80,700	90	914	82,221

<b>PU Code for template</b>	<b>Unit of Measure</b>	<b>Description</b>	<b>VoIs 08/09</b>	<b>Price 08/09</b>	<b>Total Amount 08/09</b>	<b>VoIs 09/10</b>	<b>09/10 Price</b>	<b>Total Amount 09/10</b>
M50002	Attendances	Oncology - 1st attendance	500	579	289,462	500	651	325,506
M50003	Attendances	Oncology - Subsequent attendance	2,500	346	865,939	2,502	443	1,108,232
MS02009	Attendances	IV Chemotherapy - cancer - Any health specialty	2,050	511	1,047,598	2,050	521	1,067,353
M60002	Attendances	Renal Medicine - 1st attendance	65	458	29,740	65	466	30,301
M60003	Attendances	Renal Medicine - Subsequent attendance	508	249	126,375	508	253	128,758
M60008	Number of Patients	Renal Medicine - Incentre dialysis	1,640	402	659,269	1,640	410	671,702
M65002	Attendances	Respiratory - 1st attendance	75	424	31,810	75	494	37,036
M65003	Attendances	Respiratory - Subsequent attendance	80	383	30,625	80	338	27,040
M65004	Clients	Respiratory Education and Management	80	240	19,214	80	245	19,576
M65005	Procedures	Respiratory - Bronchoscopy	15	1,305	19,581	15	1,260	18,895
M65006	Clients	Sleep apnoea - assessment	250	2,319	579,771	170	1,584	269,321
M65007	Clients	Sleep apnoea - long term treatment	100	504	50,441	100	445	44,460
M70002	Attendances	Rheumatology (incl immunology) - 1st attendance	400	495	197,814	400	535	213,961
M70003	Attendances	Rheumatology (incl immunology) - Subsequent attendance	1,110	287	318,750	1,110	285	315,974
ADJ111	Service	Project Office	1	200,000	200,000	0	0	0
PH1015	Service	Disposal of Pharmaceuticals	1	3,965	3,965	1	4,088	4,088
ADJ111	Service	Murchison	1	386,945	386,945	0	0	0
ED09001	Service	Emergency Management	1	165,381	165,381	1	170,534	170,534
D01001	Cost Weighted Discharges	Inpatient Dental treatment	250	3,985	995,386	237	4,315	1,020,734
D01002	Attendances	Outpatient Dental treatment	4,900	217	1,063,266	4,900	238	1,166,670
D01003	Clients	School dental services	22,000	98	2,159,765	24,889	104	2,578,219
COCH0021	Programme	Child Abuse Co-ordination	1	165,438	165,438	1	170,593	170,593
M55001	Cost Weighted Discharges	Paediatric Medical Service (Inpatient)	717	3,985	2,856,885	718	4,315	3,097,696
M55002	Attendances	Paediatric Medical Outpatient - 1st attendance	950	343	326,066	950	438	416,039
M55003	Attendances	Paediatric Medical Outpatient - Subsequent attend	2,499	249	622,875	2,499	283	708,037
M55005	Service	Paediatric community programme	8	42,666	348,154	8	43,995	359,002
S30001	Cost weighted discharges	Gynaecology - Inpatient Services (DRGs)	969	3,985	3,860,722	885	4,315	3,817,786
S30002	Attendances	Gynaecology - 1st attendance	1,100	383	421,296	1,200	378	453,259
S30003	Attendances	Gynaecology - Subsequent attendance	1,050	264	276,979	1,050	272	285,170
S30006	Procedures	Termination of Pregnancy	500	1,193	596,259	500	995	497,300
S30008	Procedures	Gynaecology - High cost Minor Procedures	90	526	47,360	90	465	41,841
W01002	Courses	Pregnancy and Parenting Education	36	1,497	53,429	36	1,579	56,378

<b>PU Code for template</b>	<b>Unit of Measure</b>	<b>Description</b>	<b>Vols 08/09</b>	<b>Price 08/09</b>	<b>Total Amount 08/09</b>	<b>Vols 09/10</b>	<b>09/10 Price</b>	<b>Total Amount 09/10</b>
W02002	Deliveries in facility	Maternity Facility -Fee for labour and delivery WR	510	1,037	528,941	0	1,077	0
W02003	Deliveries in facility	Maternity Facility -Fee for labour and delivery NN	1,100	772	849,082	0	801	0
W02005	Postnatal stays	Maternity Facility - Fee per postnatal WR	500	1,566	782,443	0	1,625	0
W02006	Postnatal stays	Maternity Facility -Fee per postnatal NN	1,012	1,158	1,171,727	0	1,202	0
W03001	Deliveries in catchment area	Secondary Maternity	1,750	1,093	1,913,554	0	1,135	0
W07006	Maternity adjustment	Maternity S88 adjuster	1	577,538	577,538	0	595,534	0
W03002	Attendances	First obstetric consults				1,012	383	387,452
W03003	Attendances	Subsequent obstetric consults				728	374	272,319
W03005	Attendances	Amniocentesis				86	1,231	105,833
W10001	Cost Weighted Discharges	Maternity inpatient (DRGs)		3,985		1,345	4,315	5,806,151
W08001	Programme	Lactation clinic	2	14,477	28,954	2	14,928	29,857
W06002	Service	Neonatal home care	1,307	60	78,315	1,307	62	80,755
W06003	Cost Weighted Discharges	Neonatal Inpatient (DRGs)	413	3,985	1,644,690	416	4,315	1,797,379
M20015	Items	High risk Type 1 Diabetes Support for up to 18 year olds	12	3,218	38,618	12	3,279	39,346
SH01004	Service	Medical Management of Sexual Abuse	1	58,542	58,542	1	60,366	60,366
M40004	Service	Antenatal HIV screening & co-ordination	1	39,956	39,956	1	73,223	73,223
D01017	Claims	Dental claims	1	94,633	94,633	1	97,582	97,582
RU103	Service	Murchison health services	1	1,120,665	1,120,665	1	1,163,250	1,163,250
RU105	Service	Motueka Health Services	1	1,570,545	1,570,545	1	889,472	889,472
RU109	Service	Golden Bay Health Services	1	1,499,523	1,499,523	1	1,556,505	1,556,505
RU111	Service	Gbay Doctors	1	40,893	40,893	1	42,167	42,167
WM1001	Service	Primary maternity - Rural	1	83,905	83,905	1	86,520	86,520
WM1001	Service	Primary maternity - ultrasound	1	163,328	163,328	1	168,418	168,418
WM1001	Service	Primary maternity NN/WR	1	1,132,973	1,132,973	1	1,168,276	1,168,276
PH1016	Service	Supply of sharp disposal containers to diabetics	1	12,618	12,618	1	13,011	13,011
PCT001	Service	PCT Drugs (New PU framework)	1	2,116,000	2,116,000	1	2,181,935	2,181,935
MHCR09.1	Programme	Home Based Support Services	1	235,874	235,874	1	194,579	194,579
MHCS01A	FTE	Community Alcohol & Drug Services (Other Clinical FTEs)	12	100,460	1,205,515	11	108,782	1,196,604
MHCS01B	FTE	Community Alcohol & Drug Services (Senior Medical Clinical FTEs)	2	197,746	316,394	2	214,128	342,605
MHCS03	FTE	Detoxification - Home/Community	1	108,948	54,474	1	117,973	58,987
MHCS06A	FTE	Community Mental Health Service (Other Clinical)	50	105,049	5,241,930	50	113,751	5,676,196

<b>PU Code for template</b>	<b>Unit of Measure</b>	<b>Description</b>	<b>Volts 08/09</b>	<b>Price 08/09</b>	<b>Total Amount 08/09</b>	<b>Volts 09/10</b>	<b>09/10 Price</b>	<b>Total Amount 09/10</b>
MHCS06A	FTE	Community Mental Health Service (Other Clinical)	2	105,049	199,593	2	113,751	216,128
MHCS06A	FTE	Community Mental Health Service (Maori)	4	105,049	420,195	4	113,751	455,006
MHCS06A	FTE	Community Mental Health Service (Other Clinical)	3	105,049	315,146	3	113,751	341,254
MHCS06A	FTE	Community Home based treatment	4	105,049	367,670	4	113,751	398,130
MHCS06B	FTE	Community Mental Health Service (Senior Medical FTEs)	8	240,113	1,896,895	8	260,005	2,054,043
MHCS08A	FTE	Children & Young People Community Services (Other Clinical FTEs)	22	105,913	2,338,646	20	114,687	2,303,017
MHCS08B	FTE	Children & Young People Community Services (Senior Medical FTEs)	2	240,113	408,193	2	260,005	442,009
MHCS11	FTE	Community Forensic Service	2	126,463	252,925	2	136,939	273,879
MHCS12	FTE	Prison/Court Liaison	1	126,463	139,109	1	136,939	136,939
MHCS16C	FTE	Activity-Based Rehabilitation Service/Day Activity and Living Skills	5	83,000	439,902	5	89,877	476,346
MHCS21	FTE	Advocacy/Peer Support – Consumers	1	76,417	76,417	1	82,747	82,747
MHCS22	FTE	Advocacy/Peer Support - Families/Whanau	1	76,734	76,734	1	83,091	83,091
MHCS29.1	Case	Methadone Treatment – General Practitioner	57	2,525	143,951	57	2,735	155,877
MHCS29.2	Case	Methadone Treatment – Specialist	160	3,154	504,720	160	3,416	546,533
MHCS38	FTE	Children and Youth Day Activity Service	1	82,502	82,502	1	89,337	89,337
MHIS01	Available bed day	Acute Inpatient Beds	7,300	538	3,927,197	7,300	583	4,252,545
MHIS09	Available bed day	Intensive Psychiatric Care Beds	1,460	702	1,025,092	1,460	760	1,110,015
MHIS03	Available bed day	Clinical Rehabilitation/Sub-Acute/Extended Care Inpatient Beds	4,745	369	1,750,575	4,745	399	1,895,601
MHIS07	Available bed day	Child and Youth Inpatient Beds	730	720	525,498	730	779	569,032
MHRE01	Programme	Adult Planned Respite	730	88	63,989	584	90	52,786
MHRE02	Programme	Adult Crisis Respite	1,125	280	315,402	900	289	260,184
MHQI01	Programme	Mental health Quality Improvement	1	105,049	105,049	1	91,696	91,696
MHCR09	Programme	Other Residential Support	1	11,648	11,648	1	9,608	9,608
MHCS01A	FTE	Opioid treatment service	1	100,460	147,207	1	108,782	159,403
MHCS08A	FTE	Children & Young People Community Services (Early Intervention)	1	105,913	105,913	1	114,687	114,687
MHCS08A	FTE	Children & Young People Community Services Home based treatment)	1	105,913	105,913	1	114,687	114,687
MHCS06A	FTE	Community Mental Health Service (home based treatment)	1	105,049	105,049	1	113,751	113,751
MHCS06A	FTE	Community Mental Health Service (Kawai St clinic)	1	105,049	52,524	1	113,751	56,876

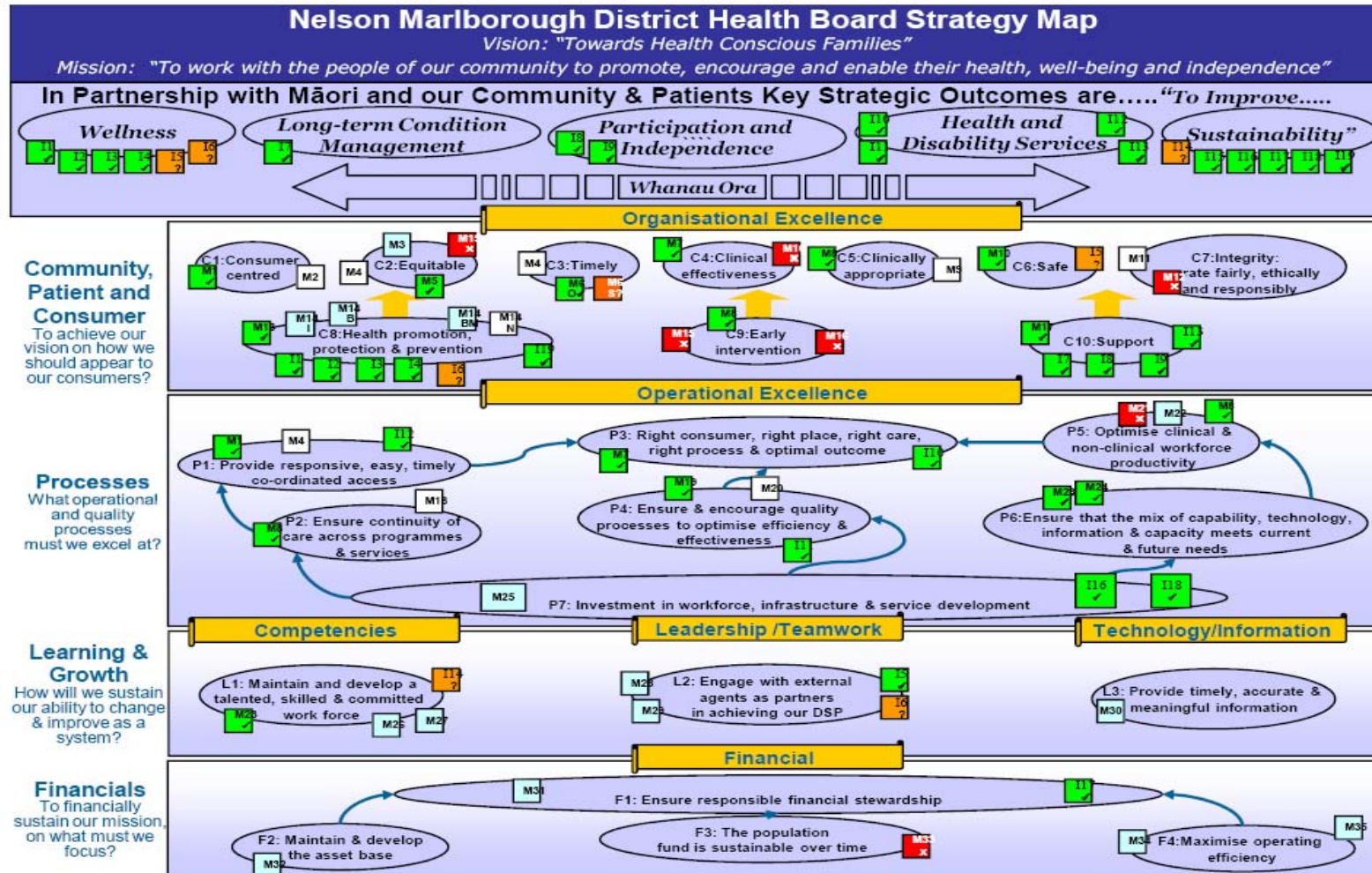
<b>PU Code for template</b>	<b>Unit of Measure</b>	<b>Description</b>	<b>Volts 08/09</b>	<b>Price 08/09</b>	<b>Total Amount 08/09</b>	<b>Volts 09/10</b>	<b>09/10 Price</b>	<b>Total Amount 09/10</b>
MHCS08A	FTE	Children & Young People Community Services (NASC)	1	105,913	105,913	1	114,687	114,687
MHCS31B	FTE	Dual Diagnosis MH/ID	0	240,113	72,034	0	260,005	0
MHCS18	FTE	Community Service - Older People	3	105,049	315,146	0	113,751	0
ADJ106	Service	Maori Health workers	4	77,500	310,000	4	0	0
ADJ106	Service	Maori Health Initiatives (Kaumatua)	1	10,000	10,000	1	0	0
ADJ106	Service	Maori Health Initiatives	1	60,000	60,000	1	0	0
ADJ106	Service	Maori Health Initiatives (ethnicity training)	1	30,000	30,000	1	0	0
MHCR04	Service	IDSS/MH IFA	1	36,500	36,500	1	37,637	37,637
COOC0001	Service	IDSS/MH IFA	1	36,500	36,500	1	37,637	37,637
HOP217	Visits	ATR Outpatient – domiciliary assessments & education sessions	2,100	179	376,284	2,100	185	388,401
HOP235	Bed days	ATR Inpatient – Mental Health Services for Elderly	2,555	595	1,521,469	2,555	746	1,906,285
HOP215	Attendances	ATR Outpatient – Clinics	10	179	1,795	10	185	1,853
HOP217	Visits	ATR Outpatient – domiciliary assessments & education sessions	647	179	115,931	847	185	156,655
HOP214	Bed days	ATR Inpatient	5,067	595	3,017,333	5,067	717	3,633,803
HOP215	Attendances	ATR Outpatient – Clinics	1,700	179	305,100	1,700	185	314,925
HOP217	Visits	ATR Outpatient – domiciliary assessments & education sessions	3,905	179	699,709	3,705	185	685,251
HOP214	Bed days	ATR Inpatient	2,839	595	1,690,588	2,839	717	2,035,991
HOP215	Attendances	ATR Outpatient – Clinics	860	179	154,345	860	185	159,315
HOP217	Visits	ATR Outpatient – domiciliary assessments & education sessions	2,334	179	418,213	2,334	185	431,680
HOP1020	Project	Initiatives - Psychgeriatrician	1	262,870	262,870	1	0	0
HOP218	Programme	Orthotics	1,350	131	176,573	1,350	135	182,075
HOPR260	Assessments	Accredited Equipment Assessment	1,600	169	270,461	1,600	174	278,889
HOP2005	Service	Service Coordination	1	1,244,585	1,244,585	1	1,366,879	1,366,879
M00008	Service	Service Coordination (Chronic conditions)	1	184,700	184,700	1	190,455	190,455
HOP1035	Bed days	Alexandra Hospital	1	1,084,715	1,084,715	1	1,118,515	1,118,515
HOP1006	Bed days	Murchison Hospital and Health Centre	1	203,576	203,576	1	209,919	209,919
HOP1006	Bed days	Golden Bay Community Hospital	1	266,373	266,373	1	274,673	274,673
HOP1006	Bed days	Motueka Community Hospital	1	437,707	437,707	0	451,346	0
HOP213	Bed days	Respite/Carer relief	1	8,000	8,000	1	8,249	8,249
HOP1020		ATR OT&Physio	1	180,000	180,000	1	0	0
COOC0053	Service	Primary Secondary Liaison Services (New Graduates)	4	43,276	190,414	4	44,624	196,348
COOC0053	Service	Primary Secondary Liaison Services (Nurse Consultant)	1	99,229	99,229	1	102,321	102,321
COOC0021	Service	Primary Healthcare Nurse education	1	102,298	102,298	1	105,486	105,486

<b>PU Code for template</b>	<b>Unit of Measure</b>	<b>Description</b>	<b>Vols 08/09</b>	<b>Price 08/09</b>	<b>Total Amount 08/09</b>	<b>Vols 09/10</b>	<b>09/10 Price</b>	<b>Total Amount 09/10</b>
COOC0020	Service	Nurse consultant Practice development	0	85,930	34,372	0	88,608	35,443
COOC0040	Service(s)	Nurse consultant Mental Health	0	85,930	21,483	0	0	0
COOC0040	Service(s)	Midwifery Advisor	0	85,930	21,483	0	0	0
COOC0040	Service(s)	CNE Medical	0	85,930	17,186	0	0	0
COOC0040	Service(s)	CNE Paeditrics	0	85,930	10,312	0	0	0
COOC0040	Service(s)	CNE AT&R	0	85,930	27,498	0	0	0
COOC0040	Service(s)	CNE OP MHlth	1	85,930	51,558	1	0	0
COOC0040	Service(s)	CNE Mental Health	1	85,930	42,965	1	0	0
COOC0040	Service(s)	Palliative Care Nursing Modules	15	1,705	25,574	15	0	0
M65004	Clients	Asthma Coordination (Marlborough)	1	13,681	13,936	0	245	0
RM00110	Service	Healthy Communities Marlborough	1	45,602	45,602	0	47,023	0
RM00111	Service	Smoke Free Co-ordination (Public Health)	1	136,806	136,806	1	204,000	204,000
D01009	Service	Adolescent oral health co-ordinator	1	76,383	76,383	1	78,763	78,763
M20020	Service	Diabetes Coordination(Community)	1	36,842	36,842	0	37,990	0
RM00107	Service	Physical Activity pilot for staff	1	50,382	50,382	1	0	0
RM00111	Service	Smokefree coord/nrt/training (Staff)	1	101,908	101,908	1	0	0
C01010	Clients (Eligible Children)	Well Child (0-5years)	1	148,014	164,078	1	152,626	169,190
C01010	Clients (Eligible Children)	Well Child - School Aged Services (5-18 years)	1	691,488	766,536	1	713,035	790,421
C01010	Clients (Eligible Children)	Well Child - School Aged Serv	1	37,810	41,914	1	38,988	43,220
SH01001	Contacts	Sexual Health - First Contact	1,203	188	225,764	1,203	191	230,022
SH01002	Contact	Sexual Health - Follow Up	1,235	99	122,148	1,235	156	192,641
C01008	Programme	Children & Young Peoples Death Register/Review	1	51,524	51,524	1	40,000	40,000
COCH0013	Programme	Outreach Immunisation Service	1	84,000	42,000	1	86,617	60,632
ADJ107	Adjuster	Capital Charge	1	51,126	51,126	1	52,719	52,719
ADJ111	Service	Pay jolt adjuster	1	335,719	335,719	1	346,179	346,179
COOC0050	Service	(National Immunisation register system development) NIR administrator	1	49,334	49,334	0	50,871	0
C01013	Service	(Preschool Health Services) B4 School check	1	307,538	307,538	1	317,121	317,121
RM00107	Service	Programme Management	1	240,000	240,000	1	199,200	199,200
RM00107	Service	Action Area 1 - Maori	1	220,000	220,000	1	182,600	182,600
RM00107	Service	Action Area 2 - Vulnerable families/Vulnerable groups	1	270,000	270,000	1	224,100	224,100
RM00107	Service	Action Area 3 - Children and Young people	1	570,000	570,000	1	473,100	473,100
RM00107	Service	Action Area 4 - Urban design/Active Transport	1	50,000	50,000	1	41,500	41,500
RM00107	Service	Action Area 5 - Primary Health Care	1	50,000	50,000	1	41,500	41,500

<b>PU Code for template</b>	<b>Unit of Measure</b>	<b>Description</b>	<b>Vols 08/09</b>	<b>Price 08/09</b>	<b>Total Amount 08/09</b>	<b>Vols 09/10</b>	<b>09/10 Price</b>	<b>Total Amount 09/10</b>
RM00107	Service	Action Area 6 - Food Supply	1	100,000	100,000	1	83,000	83,000
RM00107	Service	Action Area 7 - Communication	1	200,000	200,000	1	166,000	166,000
RM00107	Service	Action Area 8 - Monitoring and evaluation	1	300,000	300,000	1	249,000	249,000
COOC0001	Service	Primary Health Community Development Fund	1	511,490	511,490	1	527,428	527,428
COOC9999	Service	Development Co-ordinator - Primary	1	153,447	153,447	1	158,228	158,228
COOC0072	Service	Manager Community cross sectoral	1	153,447	153,447	1	158,228	158,228
COOC0001	Service	Business and Planning	1	102,298	102,298	1	105,486	105,486
PHOE0002	Service	After Hours Services (July to Dec08)	1	300,000	150,000	1	300,000	300,000
M90002	Service	GP Liaison	1	206,595	206,595	1	213,032	213,032
COGP0020	Service	Elective Services input	1	18,199	18,199	1	18,766	18,766
COOC9999	Service	Maori Leadership - Primary & Community	1	50,000	50,000	1	51,558	51,558
RM00111	Project	To reduce smoking prevalence among People with mental health conditions	1	53,000	53,000	1	48,000	48,000
HOP1020	Project	InterRai	1	256,000	256,000	1	0	0
ADJ111	Project	CQI Initiative	1	800,000	800,000	1	135,772	135,772
ADJ111	Service	SMO additional funding	1	282,231	282,231	0	0	0
ED09001	Service	Funding to advance DHB local & regional emergency planning	1	319,498	112,498	1	329,454	329,454
	Service	Devolution of Breast Screen Aotearoa funding	1	95,545	95,545	0	98,522	0
	Service	Golden Bay Discretionary (W Henderson)	1	2,250	2,250	1	2,320	2,320
	Service	Type I Diabetes - carb counting	12	1,250	15,000	12	1,289	15,467
	Service	Smokefree DHBs	1	85,000	85,000	1	85,000	85,000
MHRE04	Service	Child & Youth Respite	1	100,000	100,000	1	82,493	82,493
MHCR04	Service	IFA David Williams	365	192	70,000	365	192	70,000
AH01010	Attendances	Psychologist Services - Non Mental Health				1	5,833	5,833
COOC0086	Programme	HPV Schools programme	1	192,134	192,134	1	441,986	441,986
COOC0087	Programme	HPV Maori Pacific	1	50,948	50,948	1	111,110	111,110
RM00111	Service	Smokefree clinical leadership				1	25,000	25,000
RM00107	Programme	HEHA Leadership and Cordination	1	701,000	701,000	1	142,460	142,460
RM00107	Programme	HEHA Breastfeeding action plan				1	54,254	54,254
RM00107	Programme	HEHA Communications Maori & Pacific				1	28,835	28,835
RM00107	Programme	HEHA Maori Communities Actions and Projects				1	157,000	157,000
RM00107	Programme	HEHABreast feeding evaluation				1	10,000	10,000
MHIADJ	Adjuster	Mental Health Inpatient Premium/Discount				1	-31,567	-31,567
Electives	Electives	Additional Electives IP	1	2,533,029	2,533,029			
Electives	Electives	Additional Electives GP Access to Diagnostics	1	333,832	333,832			

<b>PU Code for template</b>	<b>Unit of Measure</b>	<b>Description</b>	<b>Vols 08/09</b>	<b>Price 08/09</b>	<b>Total Amount 08/09</b>	<b>Vols 09/10</b>	<b>09/10 Price</b>	<b>Total Amount 09/10</b>
Electives	Electives	Orthopaedic Initiatives	101	15,488	1,564,313			
Electives	Electives	Cataract Initiatives	25	2,584	64,611			
Electives	Electives	Cardiac Funding						
		Total			175,059,908			184,380,702

## 7.2 APPENDIX 2: NMDHB BALANCED SCORECARD (AS OF FEBRUARY 2009)



## 7.3 APPENDIX 3: NMDHB ACCOUNTING POLICIES

### 1. REPORTING ENTITY

Nelson Marlborough District Health Board ("Nelson Marlborough DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Nelson Marlborough DHB is a Crown Entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Nelson Marlborough DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

Nelson Marlborough DHB is a public benefit entity, as defined under NZIAS 1.

Nelson Marlborough DHB's activities involve the delivery of health and disability services and mental health services in a variety of ways to the community.

### 2. BASIS OF PREPARATION

#### (a) Statement of Compliance

The financial statements have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These are Nelson Marlborough DHB's first NZIFRS financial statements and NZIFRS 1 has been applied. On 1 July, the DHB adopted NZ equivalents to IFRS for the first time. This required retrospective application of all NZIFRS to comparative information. An explanation of how the transition to NZIFRS has affected the reported financial position, financial performance and cash flows of the DHB is provided in note 33.

#### (b) Measurement Base

The financial statements are prepared on the historical cost basis modified by the revaluation of certain assets and liabilities as identified in the statement of accounting policies.

#### (c) Functional and presentation currency

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The functional currency of Nelson Marlborough DHB is New Zealand dollars.

#### (d) Management Judgements, Estimates & Assumptions

The preparation of financial statements in conformity with NZIFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Judgements made by management in the application of NZIFRS that have a significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 26.

#### (e) Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

Certain new standards, amendments and interpretations to existing standards have been published that are not effective for the year ended 30 June 2008 and have not been applied in preparing these financial statements. The following standards, amendments and interpretations which are relevant to Nelson Marlborough DHB are:

NZ IAS 1 Presentation of Financial Statements (revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (issued 2004) and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with the Crown in its capacity as "owner". The revised standard gives Nelson Marlborough DHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). Nelson Marlborough DHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.

NZ IAS 23 Borrowing Costs (revised 2007) replaces NZ IAS 23 Borrowing Costs (issued 2004) and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. Nelson Marlborough DHB intends to adopt this standard for the year ending 30 June 2010 and has not yet determined the potential impact of the new standard.

NZ specific amendment to NZ IAS 2 Inventories. In November 2007 the New Zealand Accounting Standards Review Board approved an amendment to NZ IAS 2 Inventories, which requires public benefit entities to measure inventory held for distribution at cost, adjusted when applicable for any loss of service potential. Prior to the amendment, public benefit entities were required to measure inventories held for distribution at the lower of cost and current replacement cost. Application of the amendment is mandatory for reporting periods beginning on or after 1 January 2008. Nelson Marlborough DHB will adopt the amended standard for the year ending 30 June 2009 and expects the impact of adopting the new standard to be minimal.

### **3. ACCOUNTING POLICIES**

The accounting policies set out below have been consistently applied to all periods presented in these financial statements and in preparing an opening NZIFRS Balance Sheet at 1 July 2006 for the purposes of the transition to NZIFRS.

#### *Budget Figures*

The budget figures were approved by the Board at the beginning of the year in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Nelson Marlborough DHB for the preparation of the financial statements.

#### *Borrowing Costs*

Borrowing costs are recognised as an expense in the period in which they are incurred.

#### *Capital Charge*

The capital charge is recognised as an expense in the period to which the charge relates.

#### *Cash and Cash Equivalents*

Cash and cash equivalents means cash on hand, call deposits held with banks, short term deposits that have maturities of three months or less, and bank overdrafts.

#### *Creditors and other payables*

Creditors and other payables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method. Payables of short duration are not discounted.

#### *Debtors and other receivables*

Debtors and other receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Receivables of short duration are not discounted.

Impairment of a receivable is established when there is objective evidence that Nelson Marlborough DHB will not be able to collect amounts due according to the original terms of the receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the estimated recoverable amount. The carrying amount of

the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the Statement of Financial Performance. When the receivable is uncollectible, it is written off and the allowance reversed.

#### *Employee Entitlements*

##### **(a) Defined Contribution Plans**

Obligations for contributions to defined contribution pension plans, such as KiwiSaver and the State Sector Retirement Savings Scheme, are recognised as an expense in the Statement of Financial Performance when they are incurred.

##### **(b) Defined Benefit Plans**

Nelson Marlborough DHB does not make contributions to defined benefit pension plans.

##### **(c) Long Service Leave, Sabbatical Leave, Sick Leave, and Retirement Gratuities**

Nelson Marlborough DHB's net obligation in respect of long service leave, sabbatical leave, sick leave and retirement leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is valued on an actuarial basis.

##### **(d) Annual Leave, Conference Leave and Medical Education leave**

Annual leave, conference and medical education leave are short-term obligations and are calculated on an actual entitlement basis at current rates of pay.

Nelson Marlborough DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

#### *Financial Instruments*

##### **Non-derivative financial instruments**

Non-derivative financial instruments comprise investments in equity securities, debtors and other receivables, cash and cash equivalents, loans and borrowings, and creditors and other payables.

##### **(a) Recognition**

A financial instrument is recognised if Nelson Marlborough DHB becomes a part of the contractual provisions of the instrument.

Non-derivative financial instruments are initially recognised at fair value plus transaction costs unless they are carried at fair value through profit or loss in which case the transaction costs are recognised in the Statement of Financial Performance. Subsequent to initial recognition, non-derivative financial instruments are measured as described below.

Purchases and sales of financial assets are recognised on trade-date, the date on which Nelson Marlborough DHB commits to purchase or sell the asset. Financial assets are derecognised when Nelson Marlborough DHB's rights to receive cash flows from the financial assets have expired or if the DHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of ownership. Financial liabilities are derecognised if Nelson Marlborough DHB's obligations specified in the contract expire or are discharged.

Cash and cash equivalents comprise cash balances and call deposits with maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of Nelson Marlborough DHB's cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flows.

Nelson Marlborough DHB classifies its financial assets into the following categories: available for sale, loans and receivables, fair value through profit and loss, and amortised cost.

##### **(b) Measurement**

###### *Available for sale financial assets*

Nelson Marlborough DHB's investments in equity securities are classified as available-for-sale financial assets. Subsequent to initial recognition, they are measured at fair value and changes therein, other than impairment losses, and foreign exchange gains and losses on available-for-sale monetary items are recognised directly in equity. When an investment is derecognised, the cumulative gain or loss in equity is transferred to profit or loss.

The fair value of financial instruments traded in active markets is based on quoted market prices at balance date. The quoted market price used is the current bid price.

Nelson Marlborough DHB classifies its investment in equity securities as available-for-sale. However, the shares have been recorded at cost as they do not have a quoted price in an active market and their fair value cannot be reliably measured.

#### *Loans and Receivables*

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after balance date, which are included in non-current assets.

After initial recognition they are measured at amortised cost using the effective interest method less impairment. Receivables of short duration are not discounted. Gains and losses when the asset is impaired or derecognised are recognised in the Statement of Financial Performance.

Nelson Marlborough DHB classifies debtors and other receivables, and cash and cash equivalents as Loans and Receivables.

#### *Instruments at fair value through profit or loss*

An instrument is classified at fair value through profit or loss if it is held for trading or is designated as such upon initial recognition. Nelson Marlborough DHB does not have any financial instruments classified as fair value through profit or loss.

#### *Other Financial Instruments*

Financial instruments that are not classified as available for sale, loans and receivables, and fair value through profit or loss are measured at amortised cost using the effective interest method, less any impairment losses.

Nelson Marlborough DHB classifies creditors and other payables, finance leases, and secured loans as Other Financial Instruments.

#### *Derivative financial instruments*

Nelson Marlborough DHB does not have any derivative financial instruments.

#### *Goods and Services Tax*

All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables which are stated inclusive of GST. Where GST is irrecoverable as an input tax, then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the Statement of Financial Position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

#### *Impairment*

##### **(a) Recognition**

Nelson Marlborough DHB considers at each balance date whether there is any indication that its assets other than investment property, inventories and inventories held for distribution may be impaired. If any such indication exists, the asset's recoverable amount is estimated. Given that the future economic benefits of the DHB's assets are not directly related to the ability to generate net cash flows, the value in use of these assets is measured on the basis of depreciated replacement cost.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the Statement of Financial Performance. For assets not carried at a revalued amount, the total impairment loss is recognised in the Statement of Financial Performance.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance date and was estimated at the date of transition.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the Statement of Financial Performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the Statement of Financial Performance is the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in the Statement of Financial Performance.

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on number of days overdue, and taking into account the historical loss experience.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

#### **(b) Recoverable Amount**

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

The estimated recoverable amount of other assets is the greater of their fair value less costs to see and value in use. Given that the future economic benefits of the DHB's assets are not directly related to the ability to generate net cash flows, the value in use of these assets is measured on the basis of depreciated replacement cost.

#### **(c) Reversals of Impairment**

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the Statement of Financial Performance.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in the Statement of Financial Performance, a reversal of the impairment loss is also recognised in the Statement of Financial Performance. For assets not carried at a revalued amount the reversal of an impairment loss is recognised in the Statement of Financial Performance.

#### ***Income Tax***

Nelson Marlborough DHB is a Crown Entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994. Accordingly, no charge of income tax has been provided for.

#### ***Intangible Assets***

##### **(a) Software acquisition and development**

Computer software licenses acquired by Nelson Marlborough DHB capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use by Nelson Marlborough DHB are recognised as an intangible asset. Direct costs include the software development, employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of Nelson Marlborough DHB's website are recognised as an expense when incurred.

**(b) Amortisation**

Amortisation is recognised in the Statement of Financial Performance on a straight line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

*Type of Asset*

Software

*Inventories held for distribution*

Inventories classified as held for distribution are stated at the lower of cost (calculated using the weighted average cost method) and current replacement cost. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Any write-down from cost to current replacement cost is recognised in the Statement of Financial Performance in the period when the write-down occurs.

*Investments*

At each balance date, Nelson Marlborough DHB assesses whether there is any objective evidence that an investment is impaired.

*Leases*

**(a) Finance Leases**

Leases which effectively transfer to Nelson Marlborough DHB substantially all the risks and benefits incident to ownership of the leased asset are classified as finance leases. At the commencement of the lease, Nelson Marlborough DHB recognises finance leases as assets and liabilities in the Statement of Financial Position at the lower of the fair value of the leased asset or the present value of the minimum lease payments.

The finance charge is charged to the Statement of Financial Performance over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over the shorter of its useful life and the lease term.

**(b) Operating Leases**

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as expenses in the periods in which they are incurred.

*Loans and borrowings*

Loans and borrowings are recognised initially at fair value less attributable transactions costs. Subsequent to initial recognition, loans and borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the Statement of Financial Performance over the period of the borrowings on an effective interest basis.

*Non-current assets held for sale*

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use.

Nelson Marlborough DHB does not have any non-current assets that meet the definition of held for sale.

*Property, Plant and Equipment*

**(a) Classes of property, plant and equipment.**

The major classes of property, plant and equipment are as follows:

Freehold Land	Motor Vehicles
Freehold Buildings	Work in Progress
Plant and Equipment	

### **(b) Recognition & Measurement**

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Nelson Marlborough Health Services Limited (a Hospital and Health Service) vested in Nelson Marlborough District Health Board on 1 January 2001. Accordingly, assets were transferred to Nelson Marlborough DHB and their net book values recorded in the books of the Hospital and Health Service. In effecting this transfer, the health board has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested asset have since been revalued and are depreciated over their remaining useful lives.

Except for land and buildings and the assets vested from the Hospital and Health Service (see above), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Cost includes expenditures that are directly attributable to the acquisition of the asset. The cost of self-constructed assets includes the cost of materials and direct labour, any other costs directly attributable to bringing the asset to a working condition for its intended use, and the costs of dismantling and removing the items and restoring the site on which they are located. Purchased software that is integral to the functionality of the related equipment is capitalised as part of that equipment.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

When parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

### **(c) Subsequent Costs**

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Nelson Marlborough DHB and the cost of the item can be reliably measured. All other costs are recognised in the Statement of Financial Performance as an expense as incurred.

### **(c) Revaluation of land and buildings**

Land and buildings are revalued every three years to fair value as determined by an independent registered valuer by reference to the highest and best use. Assets for which no open market evidence exists are revalued on an Optimised Depreciated Replacement Cost basis.

Additions between revaluations are recorded at cost.

The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the Statement of Financial Performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the Statement of Financial Performance.

The carrying values of revalued assets are reviewed annually to ensure that those values are not materially different to fair value.

### **(d) Depreciation**

Depreciation is provided on a straight-line basis on all Property, Plant and Equipment other than freehold land, at rates which will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives.

The estimated useful lives of major classes of assets and resulting rates are as follows:

#### *Type of Asset*

Buildings and Building Fitout	Motor vehicles
Plant and equipment	

The residual values and useful lives of property, plant and equipment are reassessed annually at financial year end.

### **(e) Capital Work in Progress**

Capital work in progress is not depreciated. The total cost of a project is transferred to buildings, building fitout and/or plant and equipment on its completion and then depreciated.

**(f) Leased Assets**

Leases where Nelson Marlborough DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of minimum lease payments.

**(g) Disposal of Property, Plant and Equipment**

When Property, Plant and Equipment is disposed of, any gain or loss is recognised in the Statement of Financial Performance and is calculated as the difference between the net sale price and the carrying value of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

**Provisions**

Nelson Marlborough DHB recognises a provision for future expenditure of uncertain amount or timing when there is a present legal or constructive obligation as result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditures expected to be required to settle the obligation. Provisions are not discounted if the effect of the time value of money is not material.

**(a) Restructuring**

A provision for restructuring is recognised when Nelson Marlborough DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

**(b) ACC Partnership Programme**

Nelson Marlborough DHB belongs to the ACC Partnership Programme under which it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, Nelson Marlborough DHB is liable for all its claims costs for a period of four years up to a specified maximum. At the end of the four year period, Nelson Marlborough DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries.

Expected future payments are discounted at a rate that approximates the average gross yield on Government Bonds of short to medium term durations consistent with the duration of the liabilities.

**Revenue**

Revenue is measured at the fair value of consideration received or receivable.

**(a) Crown Funding**

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

**(b) Goods Sold**

Revenue from goods sold is recognised when Nelson Marlborough DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Nelson Marlborough DHB does not retain either continuing managerial involvement to the degree usually associated with ownership or effective control over the goods sold.

**(c) Provision of Services**

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Nelson Marlborough DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Nelson Marlborough DHB.

**(d) Interest Income**

Interest income is recognised using the effective interest method.

**(e) Donated Assets**

Where a physical asset is gifted to or acquired by Nelson Marlborough DHB for nil or nominal cost, the fair value of the asset received is recognised as income. Such assets are recognised as income when control over the asset is obtained.

*Trust and Bequest Funds*

Donations and bequests to the Nelson Marlborough District Health Board are recognised as income when money is received, or entitlement to receive money is established. Expenditure subsequently incurred in respect of these funds is treated as expenditure in the Statement of Financial Performance.

Trust Funds without restrictions are included within retained earnings.

## 7.4 APPENDIX 4: SCHEDULE OF THE EXISTING RANGE OF SERVICES FUNDED PER SOI OUTPUT CLASS

### NGO and Interdistrict Flow (IDF) Agreements (Excludes DHB Provided Services)

Sum of Expenditure (\$000)				
Service Area	Output Class	Service Description	Total	
Health of older People	Support	Carer Support	431	
		Community Health Services & Support	8,755	
		Day Programmes	423	
		Home Support	66	
		Information and Advisory	51	
		Residential Care: Hospitals	12,920	
		Residential Care: Rest Homes	13,493	
		Respite Care	476	
		Residential (Aged - Dementia)	-	
		Aged Continuing Care - Specialist	-	
		Aged residential care	451	
	<b>Support Total</b>			<b>37,067</b>
<b>Health of older People Total</b>			<b>37,067</b>	
Māori	Capability	Māori Service Development	200	
		Māori Workforce Development	278	
	<b>Capability Total</b>			<b>478</b>
	Primary & Community	Māori Service Development	270	
		Whanau Ora Services	1,614	
	<b>Primary &amp; Community Total</b>			<b>1,884</b>
Support	Māori Service Development	404		
<b>Support Total</b>			<b>404</b>	
<b>Māori Total</b>			<b>2,766</b>	
Mental	Capability	Mental Health Workforce Development	45	
	<b>Capability Total</b>			<b>45</b>
	Primary & Community	Alcohol & Other Drugs – Child & Youth Specific	242	
		Alcohol & Other Drugs - General	558	
		Child & Youth Mental Health Services	14	
		Kaupapa Māori Mental Health Services - Community	377	
		Mental Health (to allocate)	25	
		Mental Health Community Services	233	
		Mental Health Workforce Development	11	
	<b>Primary &amp; Community Total</b>			<b>1,459</b>
	Support	Advocacy/Peer Support - Consumer	248	
		Advocacy/Peer Support - Families and Whanau	187	
		Alcohol & Other Drugs - General	623	
		Child & Youth Mental Health Services	630	
Community Residential Beds & Services		4,247		
Crisis Respite		732		
Day Activity & Work Rehab Services		773		
Kaupapa Māori Mental Health Services - Community		40		
Mental Health (to allocate)		34		
Mental Health Community Services	83			

		Mental Health Workforce Development	7
		Other Home Based Residential Support	240
	<b>Support Total</b>		<b>7,844</b>
<b>Mental Total</b>			<b>9,348</b>
Personal	Capability	Chronic Disease Management and Education	44
		Human Papillomavirus	15
		Immunisation	166
		Maternity	45
		Minor Personal Health Expenditure	44
		Palliative Care	400
		Pharmaceuticals	98
		Primary Health Care Strategy - Other	684
		Primary Practice Services – Capitated	967
		Rural Support for Primary Health Providers	419
	<b>Capability Total</b>		<b>2,883</b>
	Enabler	Population Health Analysis	135
	<b>Enabler Total</b>		<b>135</b>
	Hospital	Laboratory	129
		Maternity	180
		Medical Outpatients	949
		Surgical Inpatients	1,586
		Travel & Accommodation	20
	<b>Hospital Total</b>		<b>2,864</b>
	Primary & Community	Adolescent Dental Benefit	1,386
Child (School) Dental Services		198	
Child and Youth		5	
Chronic Disease Management and Education		295	
Community based Allied Health		166	
General Medical Subsidy		309	
Human Papillomavirus		33	
Immunisation		740	
Laboratory		5,187	
Maternity		422	
Minor Personal Health Expenditure		460	
Palliative Care		1,120	
Pharmaceuticals		31,400	
Pharmacy Services		125	
Pregnancy and Parenting Education		20	
Primary Health Care Strategy - CarePlus		1,292	
Primary Health Care Strategy - Health Promotion/SIA		1,260	
Primary Health Care Strategy - Other		1,336	
Primary Practice Services – Capitated		17,294	
Radiology		35	
Sexual Health	255		
Travel & Accommodation	2,108		
GP beds	302		
Meals on Wheels	100		
<b>Primary &amp; Community Total</b>		<b>65,847</b>	
Public health	Tobacco Control	240	
<b>Public health Total</b>		<b>240</b>	

	Support	Domiciliary & District Nursing	526
		Palliative Care	1,982
		Primary Health Care Strategy - Other	288
	<b>Support Total</b>		<b>2,796</b>
<b>Personal Total</b>			<b>74,765</b>
<b>Grand Total</b>			<b>123,946</b>

		Government Priorities to Allocate	1,780
		IDF Personal Health	28,854
		IDF Mental Health	2,672
		IDF Disability Support	1,948
		<b>Grand Total Provider Payments</b>	<b>159,200</b>

## 7.5 APPENDIX 5: DHB PROVIDER ARM 2009/10 INTERNAL MOH REVENUE FUNDING BY OUTPUT CLASS

Output Class	Service Area	Service Description	Total Funding (\$000)
Capability	Mental Health	Quality Improvements	92
	Mental Health Total		92
	Personal Health	Children & Young Peoples Death Register/Review	40
		Clinical Practice Education	105
		Maori Leadership - Primary & Community	52
		Oral Health Regional Co-ordination Services	79
		Practice Development	35
		Primary Health Community Development Fund	158
		Primary Healthcare Nursing Innovations	299
		Primary Secondary Liaison Services	213
		Emergency After Hours - GP visits	300
	Personal Health Total		1,281
Capability Total			1,373
Hospital	Health of Older People	ATR Inpatient	5,670
		ATR Outpatient – Clinics	476
		ATR Outpatient – domiciliary assessments & education sessions	1,662
	Health of Older People Total		7,808
	Mental Health	Acute Inpatient Beds	4,221
		Child and Youth Inpatient Beds	569
		Children & Young People Community Services (Other Clinical FTEs)	2,647
		Children & Young People Community Services (Senior Medical FTEs)	442
		Clinical Rehabilitation/Sub-Acute/Extended Care Inpatient Beds	1,896
		Community Forensic Service	274
		Community Mental Health Service (Senior Medical FTEs)	2,054
		Intensive Care Inpatient Beds	1,110
		Methadone Treatment – Specialist	547
	Mental Health Total		13,759
	Personal Health	Amniocentesis	106
		Anaesthesia Services - Inpatient Services (DRGs)	387
		Blood & Blood Products to Private Hospitals and primary providers	63
		Cardiac Education and Management	197
		Cardiology - Inpatient Services (DRGs)	4,097
		Cardiology - 1st attendance	394
		Cardiology - Subsequent attendance	609
		Dermatology - 1st attendance	120
		Dermatology - Subsequent attendance	83
		Dermatology - UV Treatment	43
		Diabetes - 1st attendance	79
		Diabetes - Fundus Screening	149
		Diabetes - Subsequent attendance	158
		Ear Nose and Throat - 1st attendance	398

Output Class	Service Area	Service Description	Total Funding (\$000)
		Ear Nose and Throat - Subsequent attendance	390
		Ear, Nose and Throat - Inpatient Services (DRGs)	2,492
		Elicitive Quality Initiative	29
		Emergency Dept - Level 4	7,225
		ENT Minor operations	202
		Eye - Argon Laser	39
		First obstetric consults	387
		Gastroenterology - 1st attendance	176
		Gastroenterology - Colonoscopy	457
		Gastroenterology - Gastroscopy	464
		Gastroenterology - Subsequent attendance	287
		General Internal Medical Services - Inpatient Services (DRGs)	21,030
		General Medicine - 1st attendance	404
		General medicine - blood transfusions	385
		General Medicine - Subsequent attendance	629
		General Surgery - Colonoscopy	698
		General Surgery - Gastroscopy	263
		General Surgery - Inpatient Services (DRGs)	17,270
		General Surgery (incl Vascular Surgery) - 1st attendance	823
		General Surgery (incl Vascular Surgery) - Subsequent attendance	1,100
		Gynae Minor Procedure - High Cost	42
		Gynaecology - 1st attendance	453
		Gynaecology - Inpatient Services (DRGs)	3,818
		Gynaecology - Subsequent attendance	285
		High Risk Type I Diabetes Support for up to 18 year olds	39
		HIV/Aids Specialist Community Service	73
		Hospital Pharmacy claims	343
		Inpatient Dental treatment	1,021
		Intragram (referred cost); immunoglobulin treatments; South Canterbury	339
		IV Chemotherapy - cancer - Any health specialty	1,067
		Maternity inpatient (DRGs)	5,806
		Maternity LMC Services	1,423
		Minor Eye Procedures	10
		Minor Operations	250
		Neurology - 1st attendance	403
		Neurology - Botulinum toxin therapy	82
		Neurology - Subsequent attendance	237
		Occupational Therapy	427
		Oncology - 1st attendance	326
		Oncology - Subsequent attendance	1,108
		Ophthalmology - Inpatient Services (DRGs)	2,643
		Ophthalmology - 1st attendance	298
		Ophthalmology - Subsequent attendance	878
		Orthopaedics - Inpatient Services (DRGs)	14,615
		Orthopaedics - 1st attendance	995
		Orthopaedics - Subsequent attendance	1,600

Output Class	Service Area	Service Description	Total Funding (\$000)
		Outpatient Dental treatment	1,167
		Paediatric community programme	359
		Paediatric Medical Outpatient - 1st attendance	416
		Paediatric Medical Outpatient - Subsequent attendance	708
		Paediatric Medical Service (Inpatient)	3,098
		Pain Psycho-social assessment	15
		Pain Specialist Appointment - Follow-up	72
		Pain Specialist assessment	61
		Patient transport - non emergency and inpatient transfers	2,168
		Physiotherapy	973
		Psych-Oncology Services	55
		Renal Medicine - 1st attendance	30
		Renal Medicine - Incentre Haemodialysis	672
		Renal Medicine - Subsequent attendance	129
		Respiratory - 1st attendance	37
		Respiratory - Bronchoscopy	19
		Respiratory - Subsequent attendance	27
		Respiratory Education and Management	20
		Rheumatology (incl immunology) - 1st attendance	214
		Rheumatology (incl immunology) - Subsequent attendance	316
		Sexual Health - Follow Up	193
		Sleep apnoea - assessment	269
		Sleep apnoea - long term treatment	44
		Specialist neonates	1,797
		Subsequent obstetric consults	272
		Termination of Pregnancy - 1st trimester	497
		Type I Diabetes - carb counting	15
		Urodynamics	20
		Urology - Inpatient Services (DRGs)	3,254
		Urology - 1st attendance	329
		Urology - Cystoscopy	222
		Urology - Lithotripsy	167
		Urology - Subsequent attendance	429
	<b>Personal Health Total</b>		<b>118,280</b>
<b>Hospital Total</b>			<b>139,847</b>
Primary & Community	Health of Older People	Accredited Equipment Assessment	279
	Health of Older People Total		279
	Mental Health	Children and Youth Day Activity Service	89
		Methadone Treatment – General Practitioner	156
	Mental Health Total		245
	Personal Health	Community Based Services	38
		Community Radiology	2,664
		Community referred tests - audiology	393
		Community referred tests - cardiology	1,237
		Community referred tests - endocrinology	23
	Community referred tests - gastroenterology	11	

Output Class	Service Area	Service Description	Total Funding (\$000)
		Community referred tests - respiratory	213
		Diabetes Education and Management	255
		Elective Services input	19
		Golden Bay Health Centre Services - A4	1,557
		Golden Bay Health Centre Services - MS2	42
		Lactation clinic	30
		Local Diabetes Teams	24
		Medical Management of Sexual Abuse	60
		Motueka Health Centre Services - A4	889
		Murchison health services	1,163
		Neonatal home care	81
		New Well Child Framework	1,003
		Nurse Led Outpatient Clinics	490
		Outreach Immunisation Services	61
		Pharmaceutical Cancer	
		Treatments	2,182
		Pharmacy Depot Service	4
		Pregnancy and Parenting Education	56
		Preschool Health Services	317
		Primary Health Community Development Fund	633
		Psychologist Services - Non Mental Health	6
		School dental services	2,578
		Service Co-Ordination - chronic conditions	190
		Sexual Health - First Contact	230
		Sharps Containers supplies	13
		Special Dental Services for Children and Adolescents	98
		Speech Therapy	110
	<b>Personal Health Total</b>		<b>16,669</b>
<b>Primary &amp; Community Total</b>			<b>17,193</b>
Public Health	Personal Health	Child Abuse Coordination	171
		Family Violence Project Coordination	100
		HPV Maori Pacific	111
		HPV Schools programme	442
		Intersectoral Community Action for Health (ICAH)	158
		Nutrition & Physical Activity Programme	1,660
		Smokefree DHBs	85
		Tobacco Control	277
		HEHA Leadership and Cordination	142
		HEHA Breastfeeding action plan	54
		HEHA Communications Maori & Pacific	29
		HEHA Maori Communities Actions and Projects	157
		HEHABreast feeding evaluation	10
	<b>Personal Health Total</b>		<b>3,396</b>
<b>Public Health Total</b>			<b>3,396</b>
Support	DHB	Major incident health co-ordinating responsibilities	329
		CQI Initiative	136
	<b>DHB Total</b>		<b>465</b>

Output Class	Service Area	Service Description	Total Funding (\$000)
	Health of Older People	Aged Continuing Care	485
		Alexandra Hospital	1,119
		ATR Inpatient – Mental Health service(s) for Elderly	1,906
		Orthotics	182
		Respite Care	8
		Service Coordination	1,367
	Health of Older People Total		5,067
	Mental Health	Activity-Based Rehabilitation Service/Day Activity and Living Skills (Non-Clinical FTEs)	476
		Adult Crisis Respite	260
		Adult Planned Respite	53
		Advocacy/Peer Support – Consumers	83
		Advocacy/Peer Support - Families/Whanau	83
		Child and Youth Planned Respite	82
		Community Alcohol & Drug Services (Other Clinical FTEs)	1,356
		Community Alcohol & Drug Services (Senior Medical Clinical FTEs)	343
		Community Mental Health Service (Other Clinical FTEs)	
		I	7,257
		Community Residential - Level IV	108
		Detoxification - Home/Community	59
		Other Residential Support	10
		Other Residential Support– Home Based Support Services	195
		Prison/Court Liaison	137
	Mental Health Total		10,501
	Personal Health	ACC non resident funding	63
		Community Services - continence service	441
		Community Services - home oxygen	124
		Community Services - meals on wheels	382
		Community Services - professional nursing services	3,234
		Community Services - stomal services	862
		Dietetics	567
		Golden Bay Discretionary (W Henderson)	2
		Major incident health co-ordinating responsibilities	231
		Public Health Capital Charge	53
		Public Health Pay jolt Adjuster	346
		Social Work	235
	Personal Health Total		6,538
Support Total			22,572
Grand Total			184,381

## 7.6 GLOSSARY AND ABBREVIATIONS

Term	Definition
<b>Accreditation</b>	Achievement against a national system of standards
<b>After Hours Primary Health Care</b>	After hours primary health care is designed to meet those needs which cannot be safely deferred until regular or local general practice services are next available
<b>ALOS</b>	Average Length of Stay
<b>Audit</b>	The verification of performance against predetermined standards or contracts by a process of inspections, interviews and appraisal of documentation
<b>Benefit Realisation</b>	Refers to the efficiencies and savings that will be achieved as a result of a project
<b>Business Case</b>	A document required to gain approval for funding for a project
<b>BS</b>	Board Secretary
<b>Capex</b>	Capital expenditure
<b>CE / CEO</b>	Chief Executive/ Chief Executive Officer
<b>CFA</b>	Crown Funding Agreement
<b>Champion</b>	A senior person taking leadership/sponsorship for a particular project or programme
<b>CIO</b>	Chief Information Officer
<b>CMA</b>	Chief Medical Advisor
<b>CNS</b>	Clinical Nurse Specialist
<b>Community</b>	A collective of people identified by their common values and mutual concern for the development and wellbeing of their group or geographical area
<b>Consultation</b>	The process of seeking the views of individuals or groups. These include providers and users of health & support service.
<b>Continuing Care Bed</b>	A bed for a client who has established complex medical needs, need for registered nursing care, double incontinence, help with feeding, and needs the assistance of two people to transfer and mobilise
<b>COO</b>	Chief Operating Officer
<b>CPHAC</b>	Community and Public Health Advisory Committee
<b>Credentialing</b>	Credentialing in the New Zealand context is defined as 'a process used to assign specific clinical responsibilities to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context. Credentialing is part of a wider organisational quality and risk management system designed primarily to protect the patient.
<b>CWD</b>	Cost Weighted Discharges - a measure of relative patients utilisation of resources
<b>DAP</b>	District Annual Plan
<b>Deliverable</b>	An item that a project has to create as part of the requirements. Also known as a 'product'
<b>DHB</b>	District Health Board
<b>DHBNZ</b>	District Health Boards New Zealand
<b>Disability</b>	Incapacity caused by congenital state, injury or age-related condition expected to last six months or more. A disability may or may not be associated with the need for assistance
<b>DiSAC</b>	Disability Support Advisory Committee
<b>Disparity (or deprivation)</b>	Socio-economic or health inequality or difference relative to the local community or wider society to which an individual, family or group belongs
<b>District Health Boards</b>	District Health Boards are organisations established to protect, promote and improve the health and independence of a geographically defined population. Each District Health Board will fund, provide and ensure the provision of services for its population

<b>Term</b>	<b>Definition</b>
<b>DMH</b>	Director of Māori Health
<b>DoN</b>	Director of Nursing
<b>DSP</b>	District Strategic Plan
<b>DSS</b>	Disability Support Services
<b>ED</b>	Emergency Department
<b>ENT</b>	Services relating to the Ears, Nose and Throat
<b>Equity</b>	Equity means fairness
<b>Evaluation</b>	Assessment against a standard. Evaluations can assess both the process (of establishing a programme to deliver an outcome) and outcomes (ultimate objectives)
<b>FTE</b>	Full Time Equivalent (relates to people)
<b>Funding Agreement</b>	This is the agreement the Crown enters into with any person or entity under which the person or entity agrees to provide or arrange the provision of services in return for payment. For District Health Boards, this will include the District Health Board Annual Plan, funding schedules and the District Health Board Statement of Intent
<b>Gap</b>	A gap occurs when there is no service in place or the disparity between need and availability is so great that the service is effectively unavailable
<b>Gap Analysis</b>	A process for analysing the difference, tools, knowledge etc required to move to another stage in a project or service
<b>GM (F&amp;C, P&amp;C, P&amp;F, OD)</b>	General Manager (Finance & Commercial; Primary & Community; Planning & Funding; Organisational Development)
<b>Goal</b>	A high-level strategic statement of what / where we want to get to
<b>HAC</b>	Hospital Advisory Committee
<b>Hauora Tane</b>	Men's health and wellbeing
<b>HbA1c</b>	The level of 'haemoglobin A1c' reflect the average blood glucose level over past 3 months
<b>Health Needs</b>	What is required by an individual to achieve or maintain health, or an estimation of the programmes required to improve the health of populations
<b>Health Needs Assessment</b>	A process designed to establish the health requirements of a population
<b>Health Outcomes</b>	A change in the health status of an individual, group, or population
<b>Health Policy</b>	A formal statement of procedure within institutions that defines priorities and the parameters for action
<b>Health Status</b>	A description and/or measurement of the health of an individual, group, or population.
<b>HOPS</b>	Health of Older People Strategy
<b>IDFs</b>	Inter-District Flows: relates to the movement of patients between District Health Board areas
<b>IHB</b>	Iwi Health Board
<b>Kaumatua</b>	Elders (male or female) considered of an age to have gained wisdom
<b>Kaupapa Māori</b>	Plan/topic/theme Based in Māori values, culture (sometimes within a mainstream organisation)
<b>KPAs</b>	Key Performance Areas: a description of key areas of focus for the organisation
<b>KPIs</b>	Key Performance Indicators: a detailed description of how a project, programme or activity of work will be measured
<b>Lean</b>	The process of identifying the least wasteful way to provide value to our 'customers'
<b>LOS</b>	Length of Stay
<b>Med</b>	Medical
<b>Medical Credentialing</b>	Refers to the process of permitting an individual physician to practice in a particular hospital, clinic or other medical practice setting

<b>Term</b>	<b>Definition</b>
<b>Model of Care/ MOC</b>	A Model of Care is a description of service delivery. They are patient focused and based on best practice. The Model of Care is a living document and will continue to develop and evolve.
<b>MoH</b>	Ministry of Health
<b>MoU / MU</b>	Memorandum of Understanding
<b>National Health Targets</b>	The New Zealand health sector is implementing Health Targets to focus resources and improve performance in ten key areas. District Health Boards are working with the Ministry of Health to set and achieve them, and in so doing will contribute to overall improvement in the health of New Zealanders and reducing inequalities
<b>NGO</b>	Non-Governmental Organisation
<b>NMDHB</b>	Nelson Marlborough District Health Board
<b>NZDS</b>	New Zealand Disability Strategy
<b>Objective</b>	Objectives state what is to be achieved and can include both desired outcomes and goals
<b>Ophthalmology</b>	Services relating to the Eye
<b>Orthopaedic</b>	Services relating to the skeletal system and associated muscles, joints, and ligaments
<b>Outcome</b>	The term used to describe the totality of what the project is set up to deliver
<b>Pacific Peoples</b>	The population of Pacific Island ethnic origin incorporating people of Pacific Island ethnic origin born in New Zealand as well as overseas
<b>PACs</b>	Picture Archiving and Communication system
<b>Partnership</b>	The relationship of good faith, mutual respect and understanding and shared decision making between the Crown and Māori
<b>Performance Indicator</b>	A measure that shows the degree to which a strategy has been achieved
<b>PHO</b>	Primary Health Organisation
<b>Population Based Funding / PBF</b>	Population based funding involves using a formula to allocate each District Health Boards a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population
<b>Population Health Outcomes</b>	Used to describe a change in the health status of a population
<b>Population Health Status</b>	The level of health experiences by a population at a given time
<b>Poutokomanawa</b>	One of the main poles, central carved post supporting the marae (meeting house)
<b>Primary (Health) Care</b>	Primary Health care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system
<b>Product</b>	See 'Deliverable'
<b>Programme</b>	A portfolio of projects and initiatives selected, planned and managed in a co-ordinated way.
<b>Project</b>	A temporary organisation that is created for the purpose of delivering one or more business products according to a specified Business Case
<b>Project risk</b>	Is an uncertain event or condition that, if it occurs, has a positive or a negative effect on a least one project objective. A risk may have more than one cause and, if it occurs, one or more impacts
<b>Provider</b>	An organisation that provides health services
<b>Psycho-geriatric (PG) Continuing Care</b>	Care of a person who suffers from a psycho-geriatric condition and presents with dementia with high dependency needs and challenging/anti-social behavior. There may be a combination of age related disability and a mental health condition with high dependency needs and challenging behaviour

<b>Term</b>	<b>Definition</b>
<b>Public Health</b>	The act of preventing disease, prolonging life and promoting health and efficiency through organised community effort
<b>Quality Assurance</b>	Formal process of implementing quality assessment in programmes to assure people that professional activities have been performed adequately
<b>Rangatahi</b>	Youth / young people
<b>Residual risk</b>	A risk that remains after implementing a risk response strategy
<b>Rest Home Bed</b>	A bed for a client who needs, for safety reasons, 24 hour care that is not available to this client in the home setting
<b>RMO</b>	Resident Medical Officer
<b>Secondary care</b>	Specialist care that is typically provided in a hospital setting.
<b>Secondary risk</b>	A risk that comes about as a result of implementing a risk response strategy
<b>SISSAL</b>	South Island Shared Services Agency Limited
<b>SLT Champion</b>	In Projects and initiatives and for Health Targets, members of the Strategic Leadership Team are appointed to facilitate, mentor, monitor and support the achievements of the particular project or Health Target
<b>Specialist</b>	Specialist care providers are health professionals trained in a specific area of health and who have completed recognised training programmes for specialist medical or nursing staff
<b>Statement of Intent / SOI</b>	This document is intended to outline for Parliament and the general public what will be delivered by the DHB and contains financial and non-financial information
<b>Strategy</b>	A course of action to achieve targets
<b>Tamariki</b>	Children
<b>Target</b>	A specific and measurable aim relating to an objective
<b>Te Tau Ihu o te waka a maui.</b>	Prow of the canoe of Maui - top of the South Island of New Zealand
<b>Tertiary Care</b>	Very specialised care often only provided in a smaller number of locations nationally.
<b>The Act</b>	The New Zealand Public Health and Disability Act 2000
<b>The Bill</b>	The Health Practitioners' Competence Assurance Bill
<b>The Code</b>	Code of Health and Disability Services Consumer's Rights
<b>The Commission</b>	The Mental Health Commission
<b>The Commissioner</b>	The Health and Disability Commissioner
<b>The Minister</b>	The Minister of Health
<b>The Ministry</b>	The Ministry of Health
<b>The Office</b>	The Office of the Health and Disability Commissioner
<b>The Sector</b>	The New Zealand health and disability sector
<b>TLA</b>	Territorial Local Agencies
<b>Treaty of Waitangi</b>	New Zealand's founding document establishing the relationship between the Crown and Māori as tangata whenua (first peoples) and requires both the Crown and Māori to act reasonably towards each other and with utmost good faith
<b>Triage</b>	An assessment used to rate the urgency with which patients presenting with symptoms need to receive clinical care.
<b>Urology</b>	Services relating to diseases of the urinary tract and urogenital system
<b>Well-child / Tamariki ora</b>	Services relating to the promotion of health and prevention of disease for children, their families, and whanau
<b>Wellness</b>	A dimension of health beyond the absence of disease or infirmity, including social, emotional and spiritual aspects of health.
<b>Whanau</b>	Family
<b>Whanau Ora</b>	Family health and wellbeing
<b>WHO</b>	World Health Organisation

