

NOTICE OF MEETING

OPEN MEETING

A meeting of the Board Members of
Nelson Marlborough District Health Board
held on Tuesday 27 September 2011 at
1.00pm

DHB Seminar Centre Room 1
Braemar Campus
Nelson



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

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

Our VALUES are:

Respect

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

Innovation

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

Teamwork

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

Integrity

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



BOARD MEETING AGENDA - OPEN

Nelson Marlborough District Health Board
 DHB Seminar Centre Room 1, Braemar Campus, Nelson
 Tuesday, 27 September 2011 commencing 1.00 pm

	Indicative time	Page #
Public Forum	1.00 pm	
SECTION 1	Welcome, Karakia & Apologies	2
SECTION 2	Registration of Interest	3
SECTION 3	Confirmation of Minutes of the previous meeting	9
	• Matters Arising	14
	• Correspondence Received	16
SECTION 4	Chairperson's Report Jenny Black, Chairperson	17
	Chief Executive's Report John Peters, Chief Executive	18
	• <i>Presentations</i>	1.40 pm
	<i>Heather McPherson, CMO – Quality & Safety Governance</i>	
	<i>Carey Virtue, Marlborough Service Director – Clinical Pathways</i>	
	• Items For Decision	18
	• Updates/Standard reporting items:	
	• Quality and Safety	18
	• Financial	18
	• Rutherford Initiative	19
	• Strategy and Planning	22
	• Community Based Services	23
	• Clinical Support Services	25
	• Medical Surgical Services	26
	• Maori Health/Iwi Relationship	28
	• Organisational Development	29
	• Corporate Services	31
	• Intersectoral & Other DHB Linkages	31
	• Strategic Issues	32
	Committee Reports	2.10 pm
	Iwi Health Board, Joe Puketapu – Chairperson	
	CPHAC/DiSAC, Gerald Hope – Chairperson	
	HAC, Judy Crowe – Chairperson	
	Appendices	
	Appendix 1 Tablet Business Case	35
	Appendix 2 Quality & Safety Governance Framework	42
	Appendix 3 Financials August 2011	53
	Appendix 4 MECA & Collective Agreement Update	60
SECTION 5	For Information	61
SECTION 6	Members' Issues	61
Glossary of Commonly Used Acronyms, Abbreviations & Maori Translation		62

PUBLIC EXCLUDED MEETING
Resolution to exclude public

2.15 pm

RECOMMENDATION

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

- **Minutes of a meeting of Board Members held on 23 August 2011 (Clause 32(a) Third Schedule NZ Public Health & Disability Act 2000)**
- **DHB Chair's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)**
- **DHB Chief Executive's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)**

SECTION 1: WELCOME, KARAKIA AND APOLOGIES

SECTION 2: REGISTRATIONS OF INTEREST – BOARD MEMBERS

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

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

As at 1 September 2011

SECTION 2: REGISTRATIONS OF INTEREST – EXECUTIVE LEADERSHIP TEAM MEMBERS

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

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

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

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
		Charitable Trust ▪ Trustee Churchill Trust		& provision of private health services at Wairau Hospital ▪ MIS Ltd previously provided consultant services to other DHBs	
	Keith Rusholme	▪ Wife provides first aid training and complimentary help services		▪ Provision of services to DHB staff or contracted providers	▪ Sister works for IDSS.
	Mike Cummins	▪ Wife works for medical practice			

As at 1 September 2011

SECTION 3: MINUTES

MINUTES OF A PUBLIC MEETING OF BOARD MEMBERS OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD HELD AT THE SUPPORT SERVICES MEETING ROOM 1, WAIRAU HOSPITAL, BLENHEIM ON TUESDAY 23 AUGUST 2011 AT 1.00 PM

Present:

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

Apologies

Roma Hippolite

In Attendance:

John Peters (CE), Nick Lanigan, Mike Cummins, Sharon Kletchko, Katherine Rock, Robyn Henderson, Keith Rusholme, Mike Wiles, Donald Hudson, Peter Burton, Jennifer M Black (Community Representative) and Mabel Grennell (Kaumatua)

Karakia:

Mabel Grennell

SECTION 1: APOLOGIES

Moved: John Moore

Seconded: Patrick Smith

RECOMMENDATION:

THAT THE APOLOGIES BE ACCEPTED.

AGREED

SECTION 2: REGISTRATIONS OF INTEREST

Moved: Gerald Hope

Seconded: Ian MacLennan

RECOMMENDATION:

THAT THE REGISTRATIONS OF INTEREST BE NOTED.

AGREED

SECTION 3: MINUTES OF PREVIOUS MEETING

3.1 Minutes of the Board Meeting 26 July 2011

Moved: Judy Crowe
Seconded: John Inder

RECOMMENDATION:
THAT THE MINUTES OF THE MEETING 26 JULY 2011 BE ADOPTED AS A TRUE AND CORRECT RECORD.

AGREED

3.2 Matters Arising

Quality framework will be presented at the September meeting.

3.3 Correspondence

Moved: John Inder
Seconded: Russell Wilson

RECOMMENDATION:
THAT THE CORRESPONDENCE BE RECEIVED.

AGREED

SECTION 4: REPORTS

4.1 Chair's Report

Taken as read. Meeting dates for 2012 were noted. Proposed that no Advisory Committee be held before the December Board meeting. Frequency to be reviewed in December 2011.

Moved: Jenny Black
Seconded: Gerald Hope

RECOMMENDATION:
THAT THE CHAIRPERSON'S REPORT BE RECEIVED.

AGREED

4.2 Chief Executive's Report

(I) GENERAL

Taken as read.

(II) FOR DECISIONa) Bequest for the Benefit of Wairau Public Hospital

[Judy Crowe noted her conflict of interest.]

Board noted the bequest and agreed that in accordance with the usual procedure the funds be transferred to NMHCT.

Moved: Ian MacLennan

Seconded: Gordon Currie

RECOMMENDATION:

THAT THE BEQUEST OF \$200,000 FROM THE ESTATE OF FLORENCE ETHEL LITCHFIELD BE TRANSFERRED TO THE NELSON MARLBOROUGH HOSPITALS' CHARITABLE TRUST FOR THE GENERAL PURPOSES OF WAIRAU HOSPITAL.

AGREED

(III) QUALITY AND SAFETY

Noted clinical leadership is flowing down to the operational areas at the Service Manager level. Members to be briefed on the resolution rate of complaints as part of the presentation in September.

(IV) FINANCIAL

Noted July results were favourable. Revenue for the displaced ARC clients from Christchurch has not been booked. Audit of 2010/11 results continuing.

Summarised Results

For the Month Ended July 2011

	Prior YTD	Year to Date			July 2011
	<i>Actual</i> \$000	<i>Actual</i> \$000	<i>Budget</i> \$000	<i>Variance</i> \$000	<i>Variance</i> \$000
Funder	(217)	(338)	(166)	(172)	(172)
Governance	72	55	(3)	58	58
Provider	(255)	1,068	467	602	602
Net Result	(399)	785	297	488	488

(V) RUTHERFORD

Noted.

(VI) STRATEGY AND PLANNING

Noted.

(VII) COMMUNITY BASED SERVICESGolden Bay

Members discussed the recent decision by the Joan Whiting Memorial Trust Trustees to withdraw from IMG for the new Integrated Family Health Centre. Their concerns were over the size of the rooms and each room having its own en-suite.

The Board reinforced the approach being taken by the IMG, the property trust and management.

Members were briefed on the current facilities at Joan Whiting, the financial position of the Joan Whiting Memorial Trust, and the Australian Facilities Guidelines. The consultation process with staff from both Joan Whiting Memorial Trust and the hospital has commenced.

Licence to Occupy

Noted the comments from Peter Bruce in the public forum. Other DHBs also following up on the issue in their districts. Under the contract we are unable to withhold payments to providers. Advice is being sought on the next steps.

Details on those rest homes already refunding the portion to be provided at the next meeting.

(VIII) MEDICAL SURGICAL SERVICES

Noted.

(IX) MAORI HEALTH/IWI RELATIONSHIP

Noted.

(X) ORGANISATIONAL DEVELOPMENT

Noted that a new programme Well4Life is being trialled within the DHB before roll out to other employers in the district.

(XI) CORPORATE SERVICES

Members noted the requirements to address the abatement notice for the discharge from the Nelson Boilers. This is limited to the increased use of LFG.

(XII) INTERSECTORAL AND OTHER DHB LINKAGES

Noted.

(XIII) STRATEGIC ISSUESHealth Targets

Noted changes to the formula are proposed for the diabetes/cardiovascular indicators.

Rugby World Cup

Planning noted.

Moved: Jenny Black
Seconded: Russell Wilson

RECOMMENDATION:

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

AGREED

4.3 COMMITTEE REPORTS

- (i) Hospital Advisory Committee
Taken as read.

Moved: Judy Crowe
Seconded: Ian MacLennan

RECOMMENDATIONS:

THAT THE HAC COMMITTEE CHAIRPERSON'S REPORT BE RECEIVED.

AGREED

SECTION 5: FOR INFORMATION

Nil

SECTION 6: MEMBER'S ISSUES

Fraud

Members were briefed on the systems in place to prevent or detect fraud.

Public Excluded

Moved: Judy Crowe
Seconded: Russell Wilson

RECOMMENDATION

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

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

- ***Minutes of a meeting of Board Members held on 26 July 2011 (Clause 32(a) Third Schedule NZ Public Health & Disability Act 2000)***

- **DHB Chair's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)**
- **DHB Chief Executive's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)**
 - **Dalton House Building - To protect information that is subject to negotiation (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)**
 - **NMDHB / CHFA Treasury Collaboration Project Report – To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)**

AGREED

Actions Arising from the Meeting

Action	Responsible	Time Frame	Completed
Number of people receiving ostomy supplies	Peter Burton	27 September	
Presentation on Quality Framework and complaints resolution	Heather McPherson	27 September	
Details on rest homes refunding the LTO position	Peter Burton	27 September	

Meeting closed at 3.13 pm

Members of Public

Penny Wardle and Ian Allen (Marlborough Express), Peter Bruce, John Brett and Jean Wilson.

Jean Wilson thanked the Board for the health shuttle services now in place.

John Brett asked for details on the number of people receiving ostomy supplies.

Peter Bruce noted the actions by the Board on reimbursements where a licence to occupy is in place. He asked if funding could be withheld to force providers into resolving the issue. Also expressed concern with the quantum that some ARC providers have suggested.

3.1 MATTERS ARISING

Ostomy Supplies

NMDHB supplies Stoma products to 221 people through home delivery of products in Nelson/Tasman. There are 120 people in Marlborough and are in the process of moving to home delivery.

Quality Framework Presentation

Presentation provided by Heather McPherson, CMO. See CE report.

Rest homes refunding the LTO position

Verbal update.

3.2 CORRESPONDENCE RECEIVED

Date Received	From	Title
16/08/11	Perinatal and Maternal Mortality Review Committee	Latest report of the Perinatal and Maternal Review Committee
22/08/11	Crown Health Funding Agency	Letter outlining the process for the disestablishment of the CHFA
22/08/11	NZ Medical Association	Request for information on NMDHB's emergency plan including access points with GPs
25/08/11	National Health Board	Improving patient flow: a toolkit for DHBs
25/08/11	Minister of Health	Repeat presentations to Emergency Departments
29/08/11	Minister of Health	2011/12 South Island Regional Health Services Plan
29/08/11	Medical Council	Changes to fees for the assessment of international medical graduates
06/09/11	Health Research Council	Publication: Celebrating 20 years of health research in New Zealand
06/09/11	Ministry of Health	Publication: "Health Indicators for New Zealanders with Intellectual Disability" Report
06/09/11	Ministry of Health	Shorter stays in Emergency Departments Health Target: Update on Activities
12/09/11	National Health Board	Publication: Mortality and Demographic Data 2008

SECTION 4: REPORTS

4.1 Chair's Report

Status

This report contains:

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

(i) GENERAL

Safe at the Top, a programme adopted by the Talking Heads Group, has been launched in Nelson Tasman. This programme involves many groups - ACC, NMDHB, Nelson City and Tasman District Council, Police, Ministry of Social Development – and takes “safety” in a broad context. Our thanks to Les Milligan from Health Promotion, for his work on this initiative.

We have been advised that the Hon. Tony Ryall will be in Nelson on September 30th. He will visit the hospital in the morning and Grey Power in the afternoon. More information will be given as we receive it.

The business paper for the use of tablet technology by the Board and its Advisory Committee's is attached. I look forward to the discussion.

(ii) FOR DECISION

(a) Tablets for Board Members and Community Representatives – Business Case

1 Purpose of this Paper
To obtain approval from the Board to purchase tablets for Board members and Advisory Committee Community Representatives to view agenda papers electronically.
2 Recommendation
THAT THE BUSINESS CASE TO PURCHASE TABLETS FOR BOARD MEMBERS AND COMMUNITY REPRESENTATIVES BE ACCEPTED AND PROGRESSED.
3 Discussion
The GM Corporate Services raised the option of providing Board members and Community Representatives with tablet devices to access Board/Committee agendas, rather than the current printed versions of these documents. The current process of assembling agendas is time consuming and resource intensive.
Other DHBs have made the transition to electronic agenda management successfully and NMDHB has decided to explore this option.
Business Case is attached as Appendix 1 .

Jenny Black
Chairperson

RECOMMENDATIONS:

1. THAT THE BUSINESS CASE TO PURCHASE TABLETS FOR BOARD MEMBERS AND COMMUNITY REPRESENTATIVES BE ACCEPTED AND PROGRESSED
2. THAT THE CHAIRPERSON'S REPORT BE RECEIVED.

Status

This report contains:

- For decision
 Update
 Regular report
 For information

4.2 Chief Executive's Report**(I) ITEMS FOR DECISION**

Nil

(II) QUALITY AND SAFETY**(a) Clinical Pathways**

A presentation will be given at the Board Meeting.

(b) Medical Surgical Services**(i) Quality and Safety Governance Framework**

A draft quality framework has been developed, and a new Quality and Safety Governance Committee has met. Work is underway to improve processes around reportable and sentinel events, terms of reference for the various committees, the management of policies in the organisation, and risk management.

A presentation will be given at the Board Meeting. The Quality and Safety Governance Framework overview is attached as **Appendix 2**.

(c) Clinical Services Support**(i) IANZ Accreditation**

The Mortuary has obtained accreditation as a requirement of Department of Justice contract for Coroners examinations.

(iii) FINANCIAL

The August 2011 net result YTD is a surplus of \$557k, which is \$646k favourable to budget.

Summarised Results

For the Month Ended August 2011

	Prior YTD	Year to Date			August 2011
	Actual \$000	Actual \$000	Budget \$000	Variance \$000	Variance \$000
Funder	(256)	(547)	(179)	(368)	(196)
Governance	134	95	(14)	109	50
Provider	114	1,009	104	906	304
Net Result	(8)	557	(89)	646	158

The detailed finance report is attached as **Appendix3**.

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

Fund

The Fund result YTD is a deficit of \$547k, being \$368k unfavourable to budget.

Revenue has a positive variance of \$499k including interest received. This is due to \$259k of new/additional funding – particularly \$166k for Long Term Support, and \$160k washup/brought forward funding relating to 2010/11. Disability Support expenditure is \$518k unfavourable to budget. Christchurch evacuees account for \$354k of this variance for which there is no matching revenue accrual at this point as no process has yet been agreed. The remaining variance is largely due to demand driven Disability Support services. Personal and Public Health expenditure is \$401k unfavourable to budget including the costs of Pharmaceutical Cancer Treatment drugs of \$187k variance (paid to the Provider) and a one-off payment to Pharmac of \$204k to top up the discretionary fund.

Provider

The NMDHB Provider result YTD is a surplus of \$1,009k, \$906k favourable to budget.

Revenue is favourable to budget by \$329k including interest received. Expenditure in total is \$574k favourable to budget. Personnel costs are \$917k favourable to budget, largely in Medical Personnel. The one-off effects of the annual capping exercise for CME leave and corrections to annual leave recording have contributed to this variance. Clinical Supplies costs are \$359k unfavourable to budget mostly due to the costs of Immunosuppressive and Cytotoxic drugs, which are demand-driven. Costs driven by orthopaedic and cardiology procedures are also unfavourable to budget, reflecting over-delivery of caseweights in these areas.

(IV) RUTHERFORD INITIATIVE

As Rutherford moves into the clinical areas the process has been modified to reflect the obligations the DHB has in these areas. The emphasis of the project remains with Service Directorates taking on the role of oversight and direct participation, including:

- Recommending priorities
- Resourcing with appropriate staff , including clinical engagement
- Advising on the selection and use of external clinical input
- Liaising with the Rutherford team and facilitating access and data collection
- Reporting on progress on initiatives to ELT
- Service Directorates are the implementers and managers of the changes arising, to the timeframes agreed in the Rutherford outputs.

The Rutherford Team will continue to focus investigations and analysis including:

- Working with each Directorate on the topics and agreed priorities as established by ELT
- The Business Development Manager, as part of the Rutherford Team, will co-ordinate for consolidated reporting
- Establishing a work plan with realistic timeframes, and report progress against this
- Working to the newly established format with regard to union and staff engagement
- Continuing to maintain the probing and enquiry that generate previously unidentified opportunities. Where appropriate these will be put to ELT for prioritisation
- Providing advice, critique and suggestions.

Its objective remains to establish ongoing mechanisms that look at every dollar spent in NMDHB and ensure we are maximising the value gained from that expenditure. Once priority areas are addressed the Rutherford Initiative Team will identify and progress areas that they consider meet the objectives of the Rutherford process. This will be done with the support of the relevant Directorate.

Over the last few months the Rutherford Initiative Team has been analysing a range of areas that include theatre utilisation, referrals, preadmissions, revenue opportunities, procurement, mental health admissions unit, pharmacy and Maori Health. As the analysis is completed it is discussed with the directorates and other stakeholders to ensure its validity and to develop the options or other opportunities for further development.

As planning for 2012/13 commences it is important that Rutherford continues to have a positive impact on the pressures that the DHB faces.

Rutherford Initiative – Status Report

Report	Report Status	Consultation	Implementation Status
CIO	Summary released	Complete	Complete
Business Support	Summary released		Underway
Payroll	Summary released	Continuing	Underway
DONM	Negotiations not complete	Planning	Still to commence
NGO Mental Health	Agreed	Complete	Completed
NGO Child, Youth and Family and Smokefree	Agreed	Underway where required	Underway
OD Courses and Conferences	Summary released	Not required	Underway
Maintenance	Summary released	Complete	Underway
Property	Summary released	Complete	Underway
Primary & Community	Negotiations not	Planning	Still to

Report	Report Status	Consultation	Implementation Status
	complete		commence
Procurement	Summary released	Complete	Underway
Transportation	Summary released	Complete	Underway
Hotel Services, Orderlies and Transportation	Summary released	Complete	Underway
Finance	Summary released	Complete	Underway
P&F Planning	Work to commence		
Whole DHB Personnel (entitlements)	Rutherford review commenced as part of Capacity Planning theatre costing review		
DMH and Maori Health	Rutherford review commenced		
Psychogeriatric services	Summary released	Complete	Underway
Murchison Hospital	Summary released	Complete	Complete
Unscheduled Patient Transfer and Retrieval	Negotiations not complete	Planning	Still to commence
Scheduled Patient Transfer and Retrieval, Staff Air Travel and Site to Site SMO Travel	Negotiations not complete	Planning	Still to commence
Ophthalmology/Orthoptist	Negotiations not complete	Planning	Still to commence
Obstetric and Gynaecology	Negotiations not complete	Planning	Still to commence
Capacity Planning (Theatre utilisation and costing review and preparation of , performance metrics and reporting, pre-admissions, referral management, discharge processes)	Rutherford review well underway and report is currently being drafted.		
IDSS	Summary Released	Underway	Still to commence
After Hours Cover	Covered within each service area.		
Orthopaedics/Orthotics	Work to commence		
Anaesthesia	Initial Rutherford review work has commenced as part of the Capacity Planning review process		
Churchill Trust	Initial Rutherford review		

Report	Report Status	Consultation	Implementation Status
Agreement	work has commenced as part of the Capacity Planning theatre review process		
Pharmacy	Initial stages - Commenced		
Urology	Work to commence		
General Surgery	Work to commence		
ENT and Audiology	Work to commence		
Radiology and Laboratory	Work to commence		
Allied Health, AT&R and Support Works	Work to commence		
General Medicine including Cardiology	Work to commence		
Mental Health	Rutherford review of MHAU and Tipahi Street has commenced		
District Nursing	Rutherford review commenced		
Paediatrics	Work to commence		
Clinical Records, Photography and Clerical	Work to commence		
Clinical Trials	Work to commence		
Oral Health	Work to commence		
Emergency Department/ICU	Work to commence		
Golden Bay	Work to commence		

(V) STRATEGY AND PLANNING

(a) Better Sooner More Convenient

The Ministry of Health is working on an evolution in the policy to make it wider than the current primary care approach and more inclusive of the multi-disciplinary team environment. The suggestion is that all health professionals will work up to their respective scopes of practice and more collaboratively around the patient, with more clarity on the care cycle.

(b) National Planning

An invitation has been accepted by the GM S&P from the National Health Board (NHB) to be part of a Sector Reference Group (SRG) to work with the NHB on the development of planning guidance for the 2012/13 Planning Package. Last year the Joint Oversight Group sponsored a reference group to support the development of the 2011/12 Annual Plan Guidance. The group proved invaluable and this collaborative approach received positive feedback.

It is proposed that the SRG be re-established to inform the 2012/13 Planning Package. The focus of the group is being expanded to consider Regional Service Plans and other relevant components of the Planning Package (Operational Policy Framework and Service Coverage Schedule for example) in order to achieve more effective integration of regional planning and individual DHB annual planning. This will involve the revision and further development of Annual Plan Guidelines including better representation of regional work programmes within the Annual Plan. It also covers review of other DHB accountability documents such as the Operational Policy Framework, Service Coverage Schedule and Reporting Requirements.

(VI) COMMUNITY BASED SERVICES

(a) Newborn Screening

There has been an overall reduction in the percentage of babies missed for screening over the last 18 months: from 5% missed in June 2010, the number for June 2011 is down to 1.5%. The Screening Team has set itself a target of 100% of having all newborns screened by December 2011. Screening tests include antenatal HIV, newborn hearing and newborn metabolic testing.

(b) Rest Home Services in "Licence to Occupy" Dwellings

The LTO process is still being discussed at a national level facilitated by 20 DHBs. A letter is being sent to NZACA requesting that their position is determined and informed to the 20 DHBs by 30th September.

Two further families have raised their concerns about providers addressing the 'double dipping' issue.

Currently there are 11 rest homes in Nelson Marlborough that are able to provide rest home services to residents of 'Licence to Occupy' apartments, of which six are currently providing this service. In total there are 19 rest home residents in 'Licence to Occupy' apartments in these six rest homes in the Nelson Marlborough district.

On 2nd May 2011 we wrote to all 11 rest homes asking them to provide information on how they were addressing clause A14 of the Aged Residential Care Contract, to assure us that they were not receiving additional "payment, benefit or value" by receiving the residential care subsidy for rest home residents in 'Licence to Occupy' apartments. We received replies from seven of these rest homes, five agreeing that some level of refund was appropriate. Two stated that they did not consider they were receiving additional benefit from the residential care subsidy, over and above the additional costs they incurred managing the 'Licence to Occupy' apartments and for the additional value of a 'Licence to Occupy' apartment over a standard rest home room.

Of the five rest homes that agreed a refund was appropriate, only two currently have rest home residents in 'Licence to Occupy' apartments. One of these rest homes credits an agreed sum fortnightly against the residents village fee; the

other implements a deferred payment scheme where an agreed sum, calculated on a weekly basis, is credited to the resident's final payout once they vacate the 'Licence to Occupy' apartment.

We have written again to the remaining four rest homes that have not replied to our 2nd May letter, and to the two rest homes that do not agree a refund is appropriate, to arrange meetings within a month to discuss the matter further.

(c) Golden Bay Integrated Family Health Centre

The project programme has been re-baselined and updated, and now indicates completion of the facilities in November 2012. The formal consultation process with NMDHB and Joan Whiting rest home staff to transfer their employment to Nelson Bays Primary Health before the end of the year commenced on 10 August 2011, although Joan Whiting Trust has signalled its withdrawal from providing formal input into the project following concerns relating to changes to the facilities design.

Discussions are continuing with the Ministry of Health as to the final approvals required to get the concept underway. A meeting with Health Legal is planned for Friday 23 September and an update will be given at the meeting.

While the approvals are awaited an application to subdivide the land to be purchased is to be lodged with the TDC. This is a notified application due to the zoning of the land being Rural 1 (the same as the under lying zoning of the hospital).

Other discussions have occurred with TDC on the fees that may be levied on the facility. It is proposed the design team share the latest plans to enable suggestions as to possible savings in fees.

The overall business case is being updated to reflect the final options for governance, the operational forecasts and the impacts on the DHB. This will be considered by the sub-committee before the next meeting.

(d) Nelson Extended Primary Care and After Hours Facility

Ministerial approval has been received for the lease/build of the new facility. There are two riders to the approval:

- That the DHB Board decides the final location
- That the DHB works with Ministry officials to ensure the appropriate paperwork is in place.

(e) Child Development Service

A pilot for a group-based therapy programme for sensory conditions is under development. This aims to reduce waiting times and cater for children who do not have complex conditions. This service is also now fully utilising NMDHB's e-documentation process under the pilot programme.

(f) 'Safe at the Top' Safe Community Designation

Nelson Tasman was officially designated as an 'International Safe Community' at a ceremony on 30th August at Saxton Field. International Safe Communities

is a World Health Organisation concept that recognises safety as 'a universal concern and a responsibility for all'. This approach encourages greater cooperation and collaboration between non-government organisations, the business sector, local and government agencies; it has the support of over 80 community organisations and is led by NMDHB, NZ Police, Accident Compensation Corporation, Nelson City Council, Tasman District Council, the Ministry of Social Development and Fulton Hogan. Safe at the Top has been aiming for this goal since 2008; however, achieving the International Safe Community status is not an end, but a milestone on a continuing journey. The Director of the Safer Communities Foundation commended NMDHB's Public Health Service and Emergency Department for improving capacity to provide an effective evidence base for injury prevention action. The future direction will be to address the identified key community safety issues, and to begin the accreditation process in Marlborough.

(g) Community Oral Health Service

Five Community Oral Health Clinics are now operational in the Nelson Marlborough area. Feedback from patients and staff has been positive, and whilst there have been some teething issues, the process has been successful. The first mobile unit is being commissioned and is expected to begin operation in late October; once the landing pads at the schools in Tasman have been completed. Tendering for the transporting of the mobile unit is underway. The second mobile unit is due to arrive in April 2012; work on the landing pads for the Marlborough mobile unit is being scoped and discussions with schools have begun.

There is some surplus equipment that requires disposal and that process will be completed by the end of December. New positions in the Community Oral Health Service are being advertised; interviews have been completed and appointments have been made for some positions. The scholarships for the new graduates will be advertised shortly at Otago and Auckland Universities.

(VII) CLINICAL SERVICES SUPPORT

(a) Blenheim Nelson Shuttle

The patient shuttle service from Wairau to Nelson started on 5th September. There were four passengers who used it in the first week.

Monitoring and promotion are continuing.

(b) Pharmaceutical Services

All but one Community Pharmaceutical provider (operating two separate community pharmacies) have signed the Pharmacy Service Agreement variation for a further eight month period. This is to allow NMDHB time to consult with local community pharmacies to restructure the Pharmacy Service Agreement to fund Long Term Conditions using a different mechanism drove the unit dispensing fee now utilised (funded more around patient health outcomes). It will also allow NMDHB to introduce changes to the current Close Control mechanism to establish more rigorous criteria for prescriber access.

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

The Medical Surgical service delivered 3518 caseweights (104% of plan) YTD.

Acute activity was 108% of plan for the month.

Elective activity is 104% of budget YTD. The General Surgery and Orthopaedic services, in particular, had high elective delivery with the DHB increasing throughput to address long wait patients.

The DHB remains green overall in terms of ESPI compliance.

There are still a number of patients waiting > 6 months for FSA and Surgical treatment, however numbers are continuing to decrease each month. As at 5th September 65 patients are waiting > 6 months for FSA and 107 surgical patients waiting > 6 months for surgery. The Ministry of Health has announced that for 2012/13 the expectation is that no patients will be waiting longer than 6 months – with new reporting to be put in place, and new financial penalties for DHBs that do not comply.

(b) The following is a breakdown of volumes for August.

Acute / Elective Caseweights - KPI View									
August 2011									
Type	Service	Unit Code	Description	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan	
Acute	Med	M00001	General Medical Inpatient DRG's	4797	842	931	89	111%	
		M10001	Cardiology Inpatient DRG's	623	109	203	94	186%	
	Med Total				5420	951	1134	182	119%
	Specialist	D01001	Dental Inpatient DRG's	27	5	3	-2	67%	
		M55001	Paediatric Medical Inpatient DRG's	697	122	118	-5	96%	
		S25001	Ear, Nose and Throat Inpatient DRG's	112	20	13	-6	67%	
		S30001	Gynaecology Inpatient DRG's	203	36	35	0	99%	
		S40001	Ophthalmology Inpatient DRG's	30	5	3	-2	61%	
		W06003	Neonates Inpatient DRG's	416	73	87	14	119%	
		W10001	Maternity Inpatient DRG's	1345	236	271	35	115%	
	Specialist Total				2831	497	530	33	107%
	Surg	S00001	General Surgery Inpatient DRG's	2273	399	337	-62	84%	
		S05001	Anaesthesia Services Inpatient DRG's	20	4	0	-3	4%	
		S45001	Orthopaedics Inpatient DRG's	1766	310	329	19	106%	
		S70001	Urology Inpatient DRG's	156	27	33	6	120%	
		S75001	Vascular Inpatient DRG's	8	1	7	5	472%	
		Surg Total				4224	741	706	-36
Acute Total				12474	2190	2370	180	108%	
Elective	Med	M00001	General Medical Inpatient DRG's	114	20	14	-6	69%	
		M10001	Cardiology Inpatient DRG's	338	59	52	-8	87%	
	Med Total				452	79	66	-14	83%
	Specialist	D01001	Dental Inpatient DRG's	196	34	27	-7	79%	
		M55001	Paediatric Medical Inpatient DRG's	28	5	4	-1	75%	
		S25001	Ear, Nose and Throat Inpatient DRG's	479	84	39	-45	46%	
		S30001	Gynaecology Inpatient DRG's	758	133	127	-6	95%	
		S40001	Ophthalmology Inpatient DRG's	420	74	69	-5	93%	
	Specialist Total				1880	330	265	-65	80%
	Surg	S00001	General Surgery Inpatient DRG's	1710	300	311	11	104%	
		S05001	Anaesthesia Services Inpatient DRG's	30	5	8	3	152%	
		S45001	Orthopaedics Inpatient DRG's	2040	358	415	57	116%	
		S70001	Urology Inpatient DRG's	571	100	82	-18	82%	
		S75001	Vascular Inpatient DRG's	172	30	1	-29	3%	
	Surg Total				4523	794	818	24	103%
	Elective Total				6855	1203	1148	-55	95%
	Grand Total				19329	3393	3518	125	104%
August 2010									
Type	DM Area		Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan		
Acute	Med Surg W, C & OH		5719	1004	939	-65	94%		
			4348	763	786	23	103%		
			2657	466	468	1	100%		
Acute Total			12724	2234	2193	-40	98%		
Elective	Med Surg W, C & OH		447	79	84	5	107%		
			5284	928	1027	99	111%		
			956	168	135	-33	80%		
Elective Total			6688	1174	1245	71	106%		
Grand Total			19412	3408	3438	31	101%		

(c) Theatre Productivity

New reports around key theatre metrics are ready for distribution. The Theatre schedule is being changed to spread elective cases and improve theatre utilisation. Dedicated acute lists have been added to reduce cancellations of elective cases. Electronic display of theatre bookings is being implemented.

(d) Scoping Review

Discussion on the Endoscopy waiting list is being held district wide and preliminary work has begun on creating a wait list in Concerto that consultants will be able to enter online. There is a need to match demand with capacity, and better manage those waiting for a colonoscopy.

- (e) Surgical Pre-Admission Redesign
The team has process mapped the pre-admission pathway and highlighted the key bottlenecks. Currently designing an improved criteria based nurse supported preadmission pathway.
- (f) Strengthening Clinical Leadership
Advertising for the roles of Head of Department for the various specialty groups will be underway shortly. To enhance service improvement and build capacity in secondary care we need a strong partnership between clinicians and management, and hence will need to invest in clinical leadership.

(IX) MAORI HEALTH/IWI RELATIONSHIP

- (a) IHB Meetings
The IHB meeting planned for August 2011 was cancelled due a number of illnesses of members. The next meeting is planned for 29 September 2011.
- (b) Maori Health Provider Coalition
At the meeting held on 18 August 2011, the following key points were discussed:
- Good discussion on a name for the Coalition. A number of recommendations were made. It was agreed to delay a final decision until the September meeting.
 - There was discussion on the appointment of the Project Manager. A public tender process was agreed to. The DHB was asked to draft up the documentation for the meeting in September. One important decision was that the position would report to the Coalition Management Group Chairperson.
 - The group talked about future reporting. There was agreement that reporting needed to be simple and speak only to the matters on hand in the work plan. A set of templates will be drafted for the September meeting.
 - Results based accountability was discussed. The DHB lead this discussion to gather information on what this might mean and how it could be applied under the Coalition.

The results in the table below give a progress report on milestone achievement. Until the Coalition appoints the Project Manager, the DHB will continue to provide support.

By When	Milestone	Status Report
27 July 11	Memorandum of Agreement signed by 'Coalition Provider' Board Chairs or their nominated representatives	Completed – MOA was signed on 27 July 2011
30 Oct 11	Recruitment process developed for Project Manager	Under action – tender documents have been drawn up and will be approved on 22 September 2011

By When	Milestone	Status Report
	Governance & mgmt group terms of reference approved	Under action - TOR for both groups has been reviewed by the Management Group and will be submitted to the Coalition Board in October 2011 for approval.
30 Oct 11	New legal entity established for Coalition	Not yet started and CMG will discuss in September 2011
23 Dec 11	Shared services workstream	The project has been scoped and will be discussed at the Management Group meeting on 22 September 2011.
23 Dec 11	Whanau Ora Model of Care workstream	The project has been scoped and will be discussed at the Management Group meeting on 22 September 2011.

(X) ORGANISATIONAL DEVELOPMENT(a) FTE Report – August 2011

**FTE Report
August 2011**

FTE	Actual CM	Budget CM	Variance	Actual YTD	Budget YTD	Variance
SMO	85	98	13	89	95	6
MOSS	17	20	3	17	19	3
Registrars	12	12	(1)	14	11	(2)
House Officers	42	48	6	43	47	4
Nursing	621	628	7	643	629	(15)
Allied Health	538	586	48	562	579	16
Support	93	98	4	96	97	2
Management/Admin	327	334	6	332	333	1
Total	1,735	1,823	87	1,795	1,810	15

(b) Complaints

There were 39 complaints for August compared to 16 in July. Of these, 27 were for Nelson and 12 Wairau. Five complainants identified themselves as Maori. 100% of complaints were responded to within 20 working days.

(c) Employee Relations

The National Multi Employer Collective Agreement (MECA) and NMDHB Collective Agreement updates are attached as **Appendix 4**.

(d) Human Resources Activity

The HR Administration Team has had an extraordinarily busy period as they coped with planned staff leave and an upsurge in applications (the highest number received in any one month) and subsequent appointments.

Vacancies:	51 Nelson, 29 Wairau
Applications:	572 received district wide
Terminations:	13 Nelson, 4 Wairau
Appointments:	62 Nelson, 24 Wairau

SMO recruitment activity continues to be busy mainly in the locum area. Year to date 86 locums, 11 fixed term and nine permanent positions have been processed.

The recruitment team is encouraging the use of Skype as part of the selection process. The technology, which is now dedicated to HR, has been used in a number of interview processes recently which has resulted in considerable saving to the organisation in terms of travel costs.

(e) Occupational Health & Safety

The Well4Life Initiative was launched at Alexandra Hospital in early September with approximately two thirds of the staff availing themselves of the service. It received a very positive response, with staff taking the initiative and following up with their GP on the information gained.

(f) Learning & Development

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

- Core Level 4-7 Resuscitation Training was provided to 35 staff across the district
- MS Office Upskill training in Wairau, 54 booked 49 attended
- IT orientation, clinics and up-skilling training held in both Nelson and Wairau, 47 attendees across the district
- Orientation attendees – Nelson 18, Wairau 15. Three students also attended orientation
- Nursing conducted three study days with 38 staff attending
- Midwifery conducted 10 training days with 80 staff attending.

Acting Team Leader has been working with the Service Directors to develop and deliver leadership development programme to the new Service Manager Team. The first day was held on 14th September. Two operational 'how we do things around here' half days will be held in early October based on OD

and Finance. A second leadership development session will be held at the end of October.

Support to the Oral Health Project continues with team building sessions and IT support still occurring.

The IT trainer has been assisting Emergency Management and the Ministry of Health to introduce and train key NMDHB staff on the Esponder software. Emergency Management have released resources to backfill some of the trainers hours.

L&D facilitated the Administration Services Customer Service Champion Training for the six selected Champions.

(g) Health Innovation and Quality Awards

Entries for the Awards closed on the 19th August. Fifteen entries from across the district were received covering a wide variety of projects and initiatives. The judging process has commenced and will be finalised in mid October. The Awards presentation will take place on 1st November 2011.

(XI) CORPORATE SERVICES

(a) Corporate Services Staffing

A number of changes have occurred recently, including:

- The Property Team Leader has been recruited, and has started
- Interviews are now underway for the Finance Manager role.

(b) Alternative Energy Options

These will be explored as the projects around the Nelson Site are developed as part of the business cases.

(XII) INTERSECTORAL AND OTHER DHB LINKAGES

(a) Intersectoral and other DHB linkages for the period:

- Golden Bay Interim Management Group
- National CEOs
- SI CEOs
- MP for Blenheim/Kaikoura
- Churchill Trust
- Mayor and CEO Tasman District Council
- Regular meetings with PHO CEOs.

(XIII) STRATEGIC ISSUES**(a) Health Targets****(i) Shorter Stays in Emergency Departments**

There is no new data available for this report.

(ii) Improved Access to Elective Surgery

There is no new data available for this report.

(iii) Shorter Waits for Cancer Treatment

There is no new data available for this report.

(iv) Increased Immunisation

There is no new data available for this report.

(v) Better Help for Smokers to Quit

The figure for July 2010 is 87%, and for August 92%. The new target for hospitals to be met by June 2012 is 95%.

Discussion has been held with Nelson Bays Primary Health regarding the Smokefree ABC facilitation contract and new Smoking Cessation Services Specifications. General practices in their area are achieving 76.5% and 76.7% on 'smoking status ever recorded' for the total population and the high needs population respectively. This is one of the key markers in the PHO Performance programme on the way to achieving the primary care Health Target. To be determined is the extent to which we wish NBPH to extend the ABC facilitation role into working with NGOs. They will adapt their GP-based smoking cessation programme to align with the new service specifications over the course of this financial year. Similar discussion has been held with Kimi Hauora Wairau, for whom the general practice picture is quite different. The 'smoking status ever recorded' for the total population and the high needs population in Marlborough is 28.71% and 29.75% respectively. This will make their achievement of the Health Target very difficult. Strategies to improve this were discussed, however the general issues for general practice in Marlborough impact on this as well. KHW will work with SouthLink Health to align the GP-based smoking cessation programme with the new service specifications over the course of this financial year.

(vi) Better Diabetes and Cardiovascular Services

There is no new data for this report. Indications are that this measure will be changed for the 2012/13 year.

(b) Nelson Marlborough Health Alliance

(i) Minor Surgical Skin Lesions

The drivers for this initiative are making the pathway for removal of minor skin lesions more accessible and convenient for patients, and increasing the capacity of secondary care for more complex surgical cases. A proposal is being put forward for MoH workforce and productivity funding to help transform the service in Wairau. It is proposed a “see and assess” service is offered with dermoscopy to then identify the best pathway for patients, i.e. surgical intervention, non surgical intervention or discharge to primary care.

(c) Rugby World Cup Planning

Work is continuing. A verbal update will be provided at the meeting.

John Peters

CHIEF EXECUTIVE

21 September 2011

RECOMMENDATIONS ARISING FROM THIS REPORT:

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

4.3 Committee Reports

Nil

Status

This report contains:

- For decision
- Update
- Regular report
- For information

APPENDIX 1 – BUSINESS CASE – TABLETS FOR BOARD MEMBERS AND COMMUNITY REPRESENTATIVES



Tablets for Board Members and Community Representatives Business Case

Final v1.0

*Nelson Marlborough DHB
Business Case*

Contents

1 APPROVALS	1
2 VERSION HISTORY	1
3 SUMMARY	2
4 BUSINESS DRIVERS	2
5 PROJECT ORGANISATION	2
6 SCOPE	2
6.1 IN SCOPE	2
6.2 OUT OF SCOPE.....	2
7 TIME FRAMES	2
8 BENEFITS	2
8.1 TANGIBLE BENEFITS	3
8.2 INTANGIBLE BENEFITS	3
9 COSTS	3
9.1 TANGIBLE COSTS	3
9.2 INTANGIBLE COSTS	3
10 RISKS	3
11 ASSUMPTIONS	3
APPENDIX A FINANCIAL ANALYSIS - SUMMARY	5

*Nelson Marlborough DHB
Business Case*

1 Approvals

Name	Position	Signature
John Peters	Chief Executive	

2 Version History

Version	Description	Author
0.1	Initial Draft	Nick Lanigan
1.0	Final	Nick Lanigan. Updates around data usage following review by I MacLennan.

3 Summary

The GM Corporate Services raised the option of providing Board members and community representatives with tablet devices to access Board/Committee agendas, rather than the current printed versions of these documents.

The current process of assembling agendas is time consuming and resource intensive.

Other DHBs have made the transition to electronic agenda management successfully and NMDHB has decided to explore this option.

4 Business Drivers

This project is expected to provide a reduction in expenditure.

It also seeks to reduce NMDHB's environmental impact.

5 Project Organisation

NMDHB's IT team will test and deliver a solution, with usability input from the Board Secretary.

6 Scope

6.1 In Scope

The following components make up this project:

- Provision of a tablet device to Board members, and to community representatives
- Training of end users
- Sourcing a suitable application for reading the papers, making annotations etc
- Cessation of agenda printing for ELT members, Board members and community representatives
- Development of a policy that ensures NMDHB does not fund any private usage of the tablet devices

6.2 Out of Scope

Provision of devices to ELT members does not form part of this case, as it is assumed ELT members already have access to appropriate technology.

7 Time Frames

Following approval, it is expected a solution is available within 2 months.

8 Benefits

8.1 Tangible Benefits

The following tangible benefits are expected:

- Reduction in resource usage (paper etc)

Details are contained in Appendix A.

8.2 Intangible Benefits

The following intangible benefits are expected:

- Reduction in labour for the printing/assembly of agenda packs
- Reduction in environmental impact, although no net environmental impact has been undertaken

9 Costs

9.1 Tangible Costs

Costs will be incurred in the procurement of tablet devices, and in end user training.

Details are contained in Appendices A.

9.2 Intangible Costs

There will be a learning curve for all users as they adapt to a different way of working.

10 Risks

Risk	Mitigation
Security of information held on device	Appropriate security arrangements put in place
Board members/community reps unable to utilise technology	Pilot group used to prove concept, with a range of skill levels involved in the pilot
Perception of expenditure	Publication of expected benefits
Personal usage funded by DHB	Appropriate policy development and implementation including education

11 Assumptions

It is assumed that the use of tablet devices will produce a net surplus of environmental benefits.

Data traffic related to NMDHB's business is expected to travel over home wifi networks for those Board members and committee members that have wifi installed. Cellular data

traffic is expected to be low for NMDHB's business use and will be covered without extra charge in NMDHB's cellular data package.

Data roaming has been blocked for all NMDHB devices following a policy change. Data roaming is only available through an exception process, requiring managerial approval.

A volume cap on NMDHB Board and Committee business will need to be in place, and the policy covering the tablet devices will need to include clarity around reimbursements for excessive usage unrelated to NMDHB's business.

Current Annual Costs of Printing		
Board	\$7,773	
HAC	\$2,993	
CPHAC/DiSAC	\$3,318	
Audit & Risk	\$1,021	
Total Annual Costs	\$15,105	
Costs if printing for ELT members ceases - 21 Board Member & Community Reps given tablets		
Board	\$1,990	
HAC	\$557	
CPHAC/DiSAC	\$875	
Audit & Risk	\$655	
Tablet Depreciation - Purchase @ \$1120 per unit, 3 year straight line	\$7,840	
Training of 21 Board Members and Community Reps - 1 Day for internal trainer	\$300	
Total Annual Costs	\$12,217	
Total Savings	\$2,889	per annum
Labour Efficiency	\$950	
Total "Hard" Savings	\$1,939	per annum

APPENDIX 2 – QUALITY AND SAFETY GOVERNANCE FRAMEWORK



Nelson Marlborough
District Health Board

FROM: Heather McPherson
TO: The Board Secretary
DATE: 12 September 2011
SUBJECT: **Quality and Safety Governance Framework**

Purpose of this paper

This paper provides an overview for The Board on the new Quality and Safety Governance Framework. The content will also be used to inform the communication strategy for implementation of the framework across the NMDHB.

Appendices include:

1. The diagrammatic representation of the model and committee structures
2. A model representing the flow of metrics and
3. The dimensions of the framework as developed by the work group.

NELSON MARLBOROUGH QUALITY & SAFETY GOVERNANCE FRAMEWORK OVERVIEW

BACKGROUND

Leading to the restructure of the ELT in 2010, it had been identified that there was a need for significant change to reflect a whole systems approach to quality and safety within the organisation. ELT has been structured to respond by focusing services on the patient /client with service provider's working across the continuum and engaging clinical leadership within hospital and community based services.

Various services across the DHB have quality plans within their service plans but there has been no consistent organisational wide quality structure embedded within the services. There is an opportunity with the new directorate structure (supported by clinical leadership from secondary and primary care) to develop a governance framework that will support the quality planning process across services and directorates by clearly defining a structure which supports clinical leadership, accountability, engagement and innovation at all levels.

In the first instance, the framework focuses on services within the DHB, but it is envisaged that the framework will span both primary and secondary care with an increasing focus on a one health system approach

This document outlines the Quality and Safety Governance Framework proposed for the Nelson Marlborough district, following a review of the quality framework by the Executive Leadership Team in 2011.

INTRODUCTION

NMDHB is committed to continuously improving the safety and quality of services provided to patients, consumers and their families and the community. This requires clear and transparent governance of all aspects of our activities.

Quality and Safety Governance provides a framework by which all staff, management and governors, led by clinicians, can be involved in contributing to improving patient safety and service quality.

The inclusion of community-based executive clinical directors within the Executive Leadership Team and its links with the Marlborough and Nelson Bays PHOs leave us ideally poised to adopt a whole of system approach to quality and safety that encompasses primary and secondary health services across our district.

VISION

NMDHB aims to achieve a culture of quality improvement whereby clinicians lead improvements in health care with a patient/community centred strategy within available resources.

APPROACH

The Quality and Safety Governance Framework provides the structure to focus quality improvement activities in a consistent way across the organisation and the district.

The Framework is inclusive of Clinical Governance which builds on a range of factors and quality and risk management approaches to support and drive quality care. Achieving consistently safe and quality care requires a mix of team work, leadership, planning, workforce competence and capability, consumer involvement, and risk management systems.

The Framework includes key principles and practices necessary for effective improvement, monitoring, and management and focuses on:

- Safety and quality of clinical care
- Leadership and accountability for the safety and quality of health care
- Providing a district wide focus for quality activities and reporting, recognising the essential role played by leaders, consumers and all health service staff in quality improvement
- Recognition of the essential cultural requirements of quality and safety improvement.

Leadership from the Board and Executive Leadership Team provide the environment in which quality and safety is promoted, monitored, supported and evaluated.

Key Components or dimensions of the Quality and Safety Governance Framework include:

- **Consumer / Community Value:** Involving our consumers and communities in planning for the districts / organisation's future, improving our performance, in sharing decision making in all aspects of their care, and ensuring there is meaningful and positive participation
- **Effectiveness:** The extent to which our health services maintain and improve the health of consumers, securing the greatest possible health gain from the available resources
- **Safety & Risk:** A whole-of-system approach for patient, consumer and staff safety, in performance improvement, environmental safety and risk management
- **Competence and Capability:** Achieving and maintaining a high level of staff competence and capability at all levels to ensure the safe and effective delivery of health care.

The approach to quality and safety governance is operationalised through:

- Recognising and understanding the effects that human factors and systems errors will have on our services
- Developing and using ways to monitor, measure and analyse the outcome of decisions and care
- Using our understanding and information to provide clinicians, support staff, managers and governors with the ability to contribute to service improvement.
- Multidisciplinary teams working together to deliver comprehensive patient care.

SERVICE IMPROVEMENT

Improving quality in health care is a continuous process. The framework will form the foundation from which we seek to improve health outcomes through organisational and directorate led quality improvement programmes and projects which support implementation of innovative solutions and the continual pursuit of best practice.

A number of models and tools are available and will be used for supporting improvement.

HE TAURA TIEKE

He Taura Tieke is a quality assessment tool in use at NMDHB, based on key attributes that make services effective for Maori. It broadly identifies effective health services and presents a check list that indicates performance outcomes for each attribute. He Taura Tieke is a useful and positive tool for measuring how effective health services are for Maori and is a self-audit and self-measuring tool for quality and effectiveness.

PATIENT SAFETY INCIDENT MANAGEMENT AND OPEN DISCLOSURE

There are expectations of us that accountability for the safe delivery of health services will be openly demonstrated. Important principles of patient safety are:

- Focusing on system issues and change management

- Moving away from a blame culture that focuses on individuals when incidents occur, to one that recognises the impact of systems errors
- Understanding cause and error, including the complex human factors involved in clinical care
- Using and valuing adverse events, errors, incidents and near misses as flags to improve health care systems, and
- Promoting a culture of openness in which errors are acknowledged and openly discussed with patients and their families.

INCIDENT MANAGEMENT

Incident management is key strategy for managing risks of clinical care as well as corporate risks. It is an effective mechanism for systematically identifying and managing problems and failures in the system and supporting learning to prevent them happening again. A component of this environment is that it is one in which open disclosure of an event happens in an open and constructive way.

The incident management and open disclosure policy have been reviewed to reflect the current directorate structure and quality and safety framework. The implementation of this reviewed policy will be supported by training for staff across the organisation.

STRENGTHENING CONSUMER VOICE

Consumer participation involves consumers being actively involved in decision making about health services at every level including governance, planning, policy development, setting priorities, and highlighting quality issues in the delivery of our health services. The quality and safety framework will support the development of a policy and guidelines to improve consumer participation within the organisation.

RISK MANAGEMENT

An integrated organisation-wide risk management policy and system ensures that corporate and clinical risks are identified, minimised and managed. The risk management policy and guidelines are being reviewed to align with the Quality and Safety Framework and to ensure that there is effective integration between the quality improvement systems and risk management across the organisation.

KEY RESPONSIBILITIES AND ACCOUNTABILITIES

Everyone involved in health across the district including those within our organisation, whether it be as a board member, manager, clinician, or a support staff member, has a responsibility to positively contribute to quality and safety. The structure, and the high level responsibilities and accountabilities to support the Quality and Safety Governance approach, is as outlined in the following section.

THE DISTRICT HEALTH BOARD

Members of the District Health Board have responsibility for creating the expectation of safe, good, quality health services and have responsibility for holding the Chief Executive Officer accountable for meeting this expectation.

CHIEF EXECUTIVE, EXECUTIVE LEADERSHIP TEAM, CLINICAL LEADERS AND OTHER MANAGEMENT STAFF

The Chief Executive, Executive Leadership Team (ELT), clinical leaders and managers throughout the organisation, are accountable for ensuring that a culture of patient safety exists within the organisation and that appropriate standards are in place, staff have the resources to deliver to the expected standard, and that systems are in place to ensure adequate monitoring, measurement and risk management.

THE QUALITY & SAFETY GOVERNANCE COMMITTEE

The Quality and Safety Governance Committee is a subcommittee of ELT. It is multidisciplinary and has the role of setting the strategic direction for improving the quality of patient/community care, and promoting a culture of safety, quality and accountability.

The Quality and Safety Governance Committee has responsibility for co-ordinating and leading quality and risk management activities and providing the formal linkages required to ensure the organisation is taking a co-ordinated approach to quality improvement across the district.

DIRECTORATE QUALITY & SAFETY COMMITTEE (OR APPROPRIATE FORUM)

Directorate multidisciplinary forums which will provide quality and safety leadership within the directorate. The committees will promote and actively encourage all clinicians, staff and managers to participate in a range of quality, safety and risk management activities, designed to continually improve the care and the services provided. The directorate committee will support the development of service level multidisciplinary groups which reflect the components of the Quality and Safety framework.

QUALITY AND SAFETY COMMITTEES

All staff have a role in the operation of the Quality and Safety Framework. A Committee structure which supports the Quality and Safety Governance Committee ensures that there is a formal mechanism for all areas to raise concerns and make suggestions for improving patient safety and service quality.

The Terms of Reference for each committee will follow an agreed format and will include information on membership, key responsibilities and accountabilities, key performance indicators, meeting times and frequency.

The committees report to the Quality and Safety Governance Committee using an agreed format. Reporting includes identification of key performance measures, progress on annual objectives, responsibilities and issues that have arisen and for actions identified by the group.

With the support of the Quality and Safety Governance Committee, and defined terms of reference, the committees, have the authority to establish sub-committees or working groups with a direct reporting line to that committee or professional or service reference group.

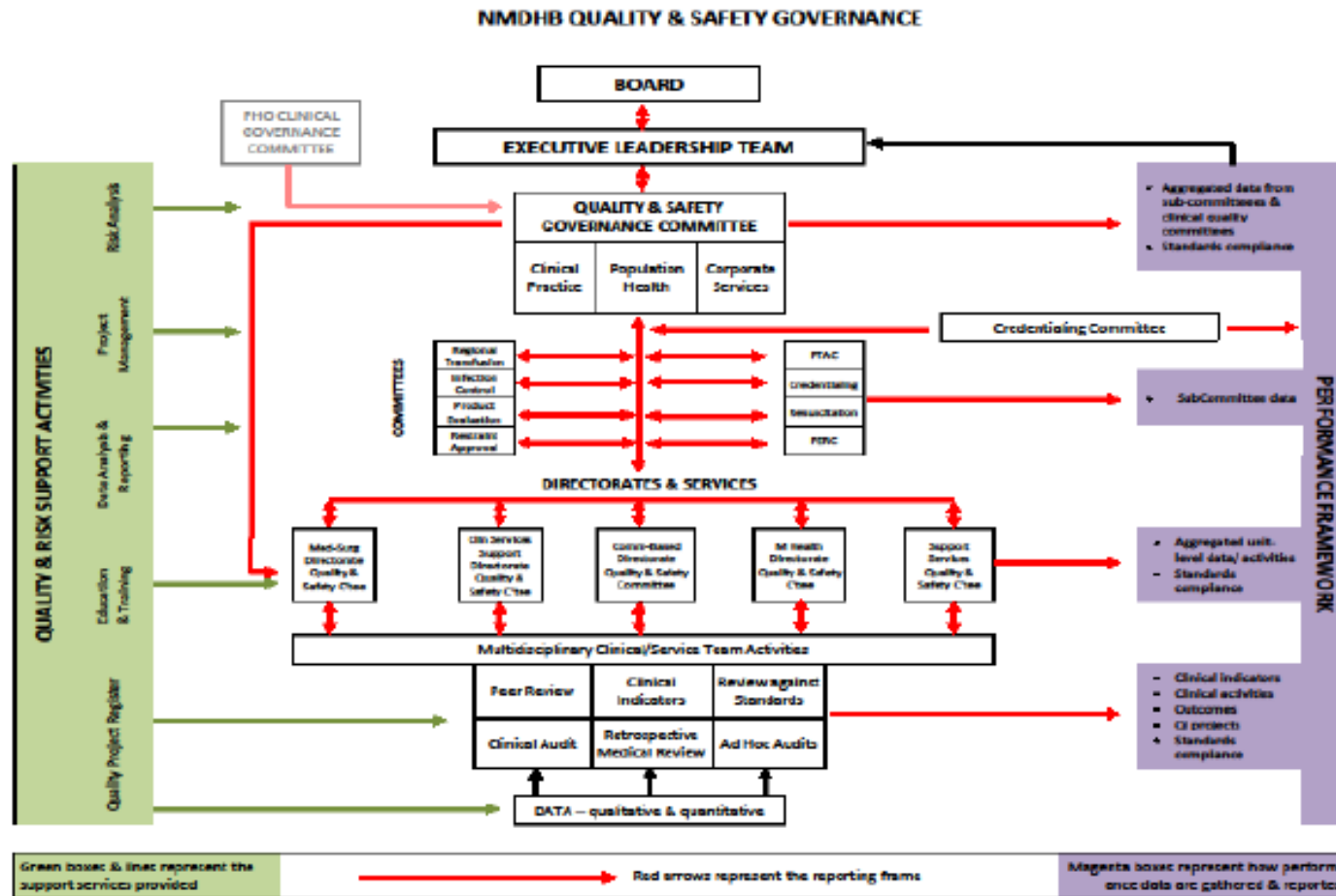
Committees which report to the Quality & Safety Governance Committee include (but are still evolving):

- Directorate/Service Quality & Safety Committees
- Restraint Approval Committee
- Credentialing Committee
- Resuscitation Committee
- Clinical IT Governance Committee
- Infection Control Committee
- Pharmacology & Therapeutics Advisory Committee
- Product Evaluation Committee
- Transfusion Committee.

SYSTEMS AND PROCESSES

Supporting Nelson Marlborough's approach to quality and safety governance is a wide range of systems and processes. The major systems and processes that are integral to our approach are:

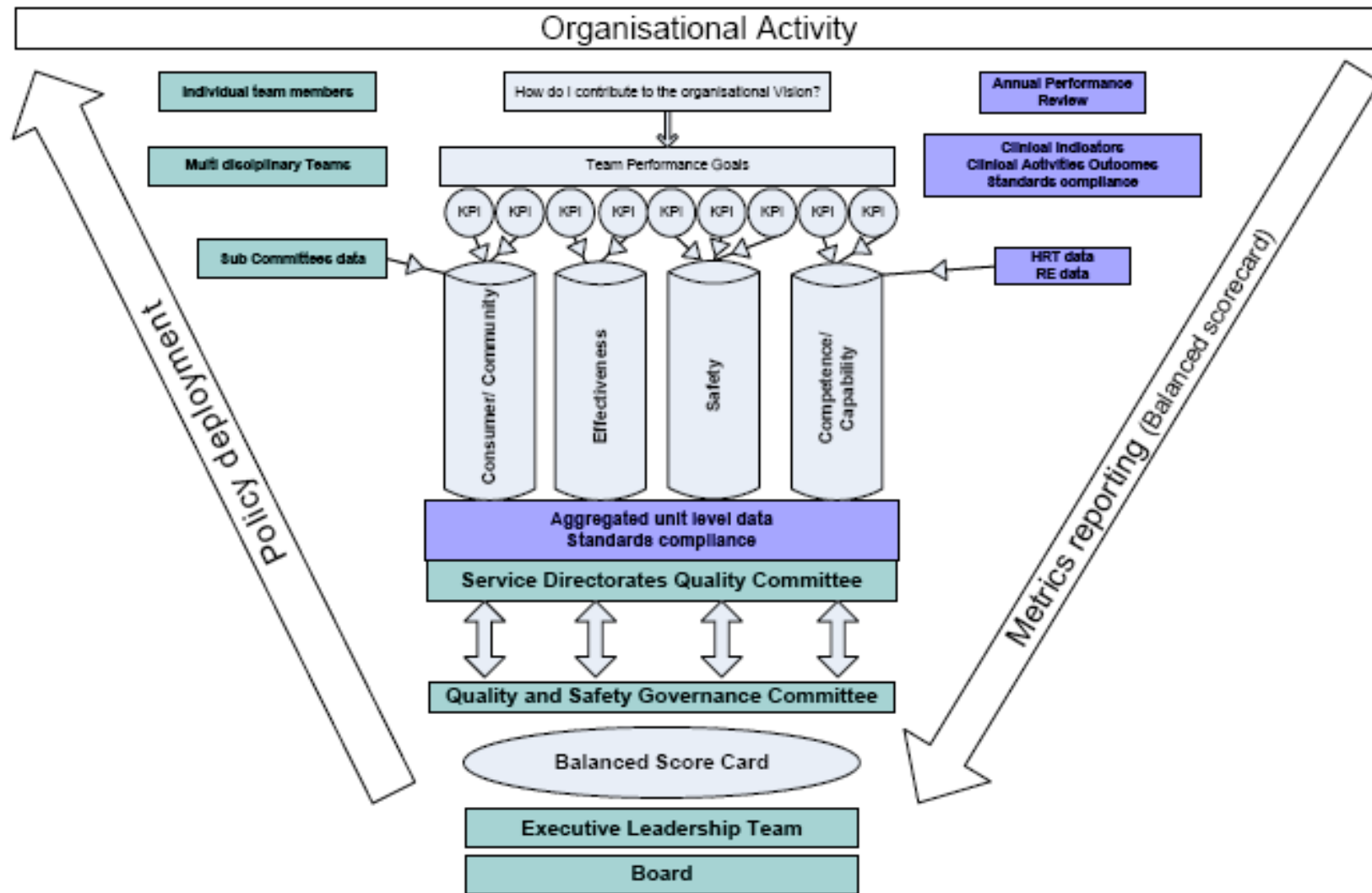
Appendix 1



NMDHB Q&S6 model.doc

Appendix 2

Diagrammatic representation of how the organisational KPIs /metrics flow



Appendix 3

Patient focus	Safety	Effectiveness	Appropriateness	Acceptability	Access	Efficiency	Coordination and Integration
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This Framework for Managing the Safety and Quality of Health Services in the Nelson Marlborough District provides a strategic overview of the key principles and practices necessary for the effective monitoring, management and improvement of health services. The Framework focuses on:

- Safety and quality of clinical care
- Promotion of leadership and accountability for the safety and quality of health care with a systems view
- Principles for managing the safety and quality of health services
- Providing a district wide focus for quality activities and reporting, recognising the essential role played by leaders, consumers and all health service staff in quality improvement
- Recognition of the essential cultural requirements of quality and safety improvement
- Reflecting NMDHB organisational values.

Key Components of the Quality and Safety Governance Framework

Strategic Leadership, Planning and Support	Consumer /Community	Effectiveness	Safety	Competence and Capability
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Component	Principles	Actions
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Strategic leadership, planning and support
Leadership from the Board and Executive Leadership Team (ELT) where safety and quality is promoted, monitored, supported and evaluated.

- The Board, Chief Executive and ELT, lead and take accountability for an effective quality and safety improvement programme
- There is a whole of system approach to continuous improvement where responsibility for quality is clearly articulated and enacted at all levels
- Successes are celebrated and all contributions are valued.

The Executive Leadership team will:

- Establish and lead a culture of Improvement
- Empower and resource managers (clinical and non clinical) at all levels
- Develop and promote key strategic quality initiatives for the organisation
- Facilitate staff participation at all levels in a clinical governance framework
- Establish rigorous monitoring, reporting and response systems
- Evaluate and respond to key aspects of organisational performance
- Support culturally responsive healthcare service delivery

Component	Principles	Actions
<p>Consumer /Community</p> <ul style="list-style-type: none"> Involving our communities in improving performance and in planning for the organisation's future Enable consumers to share decision making in all aspects of their care. Meaningful and positive participation of consumers is valued. 	<ul style="list-style-type: none"> The patient/consumer is the primary focus There is a culture of trust and honesty through open disclosure in partnership with consumers and the community Patients/consumer's are enabled and encouraged to participate effectively in their own care Consumer needs and business goals are inseparable. 	<ul style="list-style-type: none"> Recognise disability and diversity of all service users. <p>A responsive health service will be a result of:</p> <ul style="list-style-type: none"> An effective system of complaint and compliment management where feedback and trends influence service change Feedback which is analysed and acted on Engagement with patient/consumer participation in all areas of their health care delivery Effective communication delivered in a form, language and manner that enables the patient/consumer to understand the information provided Enabling a dialogue between users of health services and health planners and providers.
<p>Effectiveness</p> <p>Clinical effectiveness is the extent to which our health services maintain and improve the health of consumers, securing the greatest possible health gain from the available resources. It is described as the right person(s) doing:</p> <ul style="list-style-type: none"> The right thing (evidence-based practice) In the right way (skills and competence) At the right time (providing treatment/services when the patient/consumer needs them) In the right place (location of treatment/services) With the right result 	<ul style="list-style-type: none"> There is a focus on maximising optimal health outcomes Quality of health care is measured systematically with a focus on the minimisation of inappropriate variation in practice and patient outcomes All providers have access to information about the outcomes of the services they provide Quality information is used to drive continuous improvement Whole-of-system thinking and action is integrated into all aspects of planning and delivery across our regions, district, directorates and services Families are supported to achieve their maximum health and well-being in an inclusive approach to providing services; "whanau ora". 	<p>Monitoring and evaluation of evidence based clinical care, is commonplace and expected in every clinical service. Elements of this include:</p> <ul style="list-style-type: none"> Use of clinical indicators to ensure that care delivered is appropriate Use and monitoring of evidence based standards Audit is programmed in every service and results are shared across teams Accreditation is achieved Research and innovation is supported Data and information will be available, accurate, timely Relevant regional collaboration is in place to ensure access to and efficient use of specialist services Benchmarking to improve the quality of healthcare services by consistently measuring and improving performance Peer review to support individual and group learning Protected Quality Assurance Activity is undertaken and reported on to improve clinical service delivery.

Component	Principles	Actions
(maximising health outcome)		
<p>Safety A whole-of-system approach for patient, consumer and staff safety in performance improvement, environmental safety and risk management.</p>	<ul style="list-style-type: none"> • There is a focus on reducing the incidence of patient/consumer/staff harm • Potential risks are identified and controlled and adverse events are examined to better understand their causes and how to prevent these in the future • Safe progress of the patient/consumer through all parts of the system • Lessons learned are shared and actions are followed through. 	<p>A patient/consumer and staff safety culture will include:</p> <ul style="list-style-type: none"> • A Reportable and Serious Events Management system which encourages reporting and supports learning • An effective Risk Management process which is an integral part of the organisational processes and decision making • Open disclosure following adverse events • Legal compliance with all relevant legislation • Current and robust health and safety systems and processes • Certification is achieved • Patient Safety Culture Surveys inform patient care

Competence and Capability

Achieving and maintaining a high level of staff competence and capability at all levels to ensure the safe and effective delivery of health care.

- Workforce competence and capability is both an organisational and personal responsibility
- The system matches workforce and skill sets to workload
- Professional development and education are core elements of continuous quality improvement.

A competent and capable workforce will be supported by:

- Staff satisfaction surveys to inform service and team development
 - Professional development plans
 - Education and training programmes
 - Health and safety plans
 - A performance management system
 - An effective recruitment system
 - A credentialing program
 - Peer review processes
 - Clinical supervision support
 - Succession planning.
-

APPENDIX 3 – FINANCIAL REPORT AUGUST 2011

OPERATING RESULTS

Consolidated Statement of Financial Performance								
\$000	August 2011			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	DAP
Revenue	33,805	33,466	339	64,953	67,700	67,137	563	402,179
Expenditure								
Personnel Costs	11,975	12,751	775	23,795	23,777	24,704	926	149,506
Outsourced Services	1,080	910	(170)	1,918	1,848	1,805	(43)	10,646
Clinical Supplies	3,071	2,654	(417)	5,431	5,726	5,367	(359)	31,301
Infrastructural and Non Clinical Supplies	2,944	2,765	(179)	5,260	5,557	5,639	82	33,085
Personal Health Expenditure	9,137	9,048	(89)	17,994	18,437	18,250	(188)	109,593
Mental Health Expenditure	993	1,021	28	1,912	2,001	2,041	41	12,154
Public Health Expenditure	4	1	(3)	5	4	2	(2)	10
Disability Support Expenditure	3,884	3,687	(197)	6,904	7,925	7,374	(550)	43,612
Hauora Maori Services Expenditure	227	234	7	455	431	469	38	2,813
Interdivisional Eliminations	0	0	0	0	0	0	0	(0)
Internal Revenue/Expenses	0	0	0	0	0	0	0	(0)
Total Expenditure	33,316	33,072	(245)	63,675	65,706	65,651	(56)	392,720
Net Surplus/(Loss) before Interest & Capital Charge	488	394	94	1,277	1,994	1,487	507	9,459
Interest Received	119	70	50	249	241	139	102	835
Interest Paid	(244)	(250)	5	(388)	(489)	(513)	25	(3,016)
Capital Charge	(592)	(601)	9	(1,147)	(1,190)	(1,202)	12	(7,170)
Net Surplus/(Loss)	(228)	(387)	158	(8)	557	(89)	646	108
Made up of Divisional Surplus/(Loss):								
Funder	(209)	(13)	(196)	(256)	(547)	(179)	(368)	23
Governance	40	(11)	50	134	95	(14)	109	0
Provider	(59)	(363)	304	114	1,009	104	906	85
Total	(228)	(387)	158	(8)	557	(89)	646	108

Revenue: \$0.7m more than budget YTD (including interest received)

Expenses: On budget YTD (including interest paid and capital charge)

Net Result: \$0.6m better than budget YTD

Revenue

Of the \$0.7m variance:

- Interest received continues to track better than plan due to careful management, \$102k favourable variance YTD
- Unbudgeted gains on sale of property of \$81k have been recorded
- Other miscellaneous income such as rebates, reimbursements, and rentals are \$148k favourable to budget
- Variances in the Fund include \$166k unbudgeted funding for long term support, \$67k favourable variance for HEHA relating to revenue brought forward from

2010/11, PBFF adjustment for growing and sustaining dementia services \$56k, and additional interventions St Marks \$72k.

Expenditure

Payments to providers are reporting close to budget for the month with the exception of Disability Support (\$550k unfavourable variance) - \$354k has been recorded for Aged Residential Care for Christchurch Evacuees which currently has no corresponding revenue accrual, and \$196k due largely to demand for Community Health and Carer Support. Personal Health has a \$188k unfavourable variance due to the unbudgeted contribution to the Pharmac discretionary fund.

Personnel costs are showing a 4% YTD favourable variance of \$926k.

- A one-off adjustment to CME leave amounting to \$258k was made in August being the annual capping exercise
- A concerted effort to update doctor's annual leave has resulted in favourable \$ and FTE variances, with the annual leave accrual unusually have a debit movement in August, of \$297k
- Nursing costs are overspent \$168k YTD, with Internal Bureau costs overspent \$241k against an underspend in Registered Nurses. Occupancy, admissions, and discharges over July and August are all at or near 12-month peaks.

Outsourced costs show a 2% unfavourable variance of \$43k.

- Medical Outsourcing is unfavourable to budget in anaesthetist and Ob/Gyn
- Outsourced Management costs are directly offset to personnel underspends.

Clinical Supplies are overspent 7%, \$359k.

- Pharmaceuticals are the bulk of this at \$243, with Immunosuppressives at \$159k overspent due to demand and the mix of drugs used, followed by Cardiovascular at \$34k reflecting a 52% YTD over delivery of Cardiology caseweights
- A negative variance of \$204k for Pharmacy Services is relating to a one-off payment to Pharmac as NMDHB's share of topping up their discretionary fund to its minimum balance.

Pharmaceuticals Expenditure \$000s	Current Month			Year to Date			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	DAP
Provider	591	449	(142)	1,193	950	(243)	5,692
Community Pharmaceuticals	2,878	2,766	(112)	5,573	5,666	93	33,867
Pharmacy Service	-	-	-	204	-	(204)	-
Total NMDHB	3,469	3,215	(254)	6,970	6,616	(354)	39,559

- Implants and Prostheses and Orthopaedic Patient Consumables are unfavourable to budget by a total of \$140k or 15%. Orthopaedic caseweights YTD are 12% greater than budgeted overall, 16% in elective procedures.

Infrastructure costs have a positive variance of 2% or \$118k.

- Facilities costs are overspent in maintenance which should smooth out over the upcoming year, and utility charges which reflect seasonal peaks

- Professional fees are overspent relating to the monthly charge from HBL for which extra revenue has been recorded.

Interest paid continues with a positive variance related to interest rates obtained late in 2010/11 better than that assumed in the budget for this year.

Financial Performance by Division

Governance & Admin Statement of Financial Performance								
\$000	August 2011			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	DAP
Revenue	558	512	46	966	1,066	1,023	43	6,140
Expenditure								
Personnel Costs	76	89	13	262	162	171	9	1,022
Outsourced Services	27	24	(3)	48	51	48	(3)	289
Clinical Supplies	0	0	0	0	0	0	0	0
Infrastructural and Non Clinical Supplies	102	103	1	92	131	203	73	1,228
Internal Allocations	155	154	(1)	124	311	308	(3)	1,849
Total Expenditure	359	370	10	526	654	731	76	4,388
Net Surplus/(Loss) before Interest & Capital Charge	198	142	56	440	412	293	119	1,752
Capital Charge	(158)	(152)	(6)	(306)	(317)	(307)	(10)	(1,752)
Net Surplus/(Loss)	40	(11)	50	134	95	(14)	109	0

Fund Statement of Financial Performance

\$000	August 2011			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	DAP
Revenue								
Ministry of Health	30,641	30,519	123	59,044	61,474	61,038	436	366,718
Other Revenue	13	8	4	0	25	17	8	99
Total Revenue	30,654	30,527	127	59,044	61,499	61,054	445	366,818
Expenditure								
Personal Health Expenditure	21,893	21,714	(179)	42,484	43,912	43,582	(331)	261,615
Mental Health Expenditure	3,117	3,144	28	6,063	6,248	6,289	41	37,639
Public Health Expenditure	154	151	(3)	463	372	302	(70)	1,814
Disability Support Expenditure	5,000	4,828	(172)	9,087	10,174	9,657	(518)	57,306
Hauora Maori Services Expenditure	227	234	7	455	431	469	38	2,813
Other Expenses	536	508	(28)	917	1,045	1,017	(28)	6,102
Total Expenditure	30,928	30,581	(347)	59,468	62,182	61,315	(867)	367,288
Net Surplus/(Loss) before Interest & Capital Charge	(274)	(54)	(220)	(424)	(684)	(261)	(423)	(470)
Interest Received	65	41	24	168	137	82	54	493
Net Surplus/(Loss)	(209)	(13)	(196)	(256)	(547)	(179)	(368)	23

Provider Statement of Financial Performance

\$000	August 2011			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	DAP
Revenue								
Ministry of Health	1,723	1,701	22	3,561	3,524	3,539	(15)	20,654
Internal Fund	16,145	16,081	64	31,282	32,340	32,162	178	193,004
Other Government	382	378	4	800	773	866	(94)	4,678
Other Revenue	1,025	856	168	1,498	1,884	1,672	212	9,991
Total Revenue	19,275	19,016	259	37,140	38,520	38,239	281	228,327
Expenditure								
Personnel Costs								
Medical Personnel	2,802	3,585	782	5,992	5,861	6,821	960	40,380
Nursing Personnel	4,134	4,035	(99)	8,133	8,217	8,050	(168)	49,674
Allied Health Personnel	2,863	2,884	21	5,269	5,497	5,560	64	34,078
Support Personnel	382	384	2	734	747	757	10	4,620
Management/Administration Personnel	1,718	1,773	56	3,406	3,294	3,345	51	19,732
Total Personnel	11,900	12,661	762	23,534	23,616	24,533	917	148,484
Outsourced Services	1,053	886	(167)	1,870	1,797	1,757	(40)	10,357
Clinical Supplies	3,071	2,654	(417)	5,431	5,726	5,367	(359)	31,301
Infrastructural and Non Clinical Supplies	2,842	2,663	(180)	5,168	5,426	5,435	9	31,857
Total Expenditure	18,866	18,864	(2)	36,003	36,565	37,092	527	221,999
Internal Allocations	155	154	1	124	311	308	3	1,849
Net Surplus/(Loss) before Interest & Capital Charge	564	306	258	1,261	2,266	1,455	811	8,177
Interest Received	54	29	26	81	105	57	48	342
Interest Paid	(244)	(250)	5	(388)	(489)	(513)	25	(3,016)
Capital Charge	(433)	(448)	15	(841)	(873)	(895)	22	(5,418)
Net Surplus/(Loss)	(59)	(363)	304	114	1,009	104	906	85

Consolidated Financial Position

Consolidated Statement of Financial Position \$000s	June 2011	CM Last Year	CM Actual	CM Budget	Variance	DAP
Bank	17,881	21,187	19,988	31,779	(11,791)	40,131
Deposits > 3 months	6,020	-	3,030	-	3,030	-
Debtors & Prepayments	13,027	10,228	14,081	9,100	4,981	8,951
Stock	2,043	2,084	1,995	2,318	(323)	2,318
Assets Held for Sale	2,769	-	2,361	-	2,361	-
Current Assets	41,740	33,499	41,455	43,197	(4,103)	51,400
Creditors	24,094	26,991	23,351	31,252	7,901	34,024
Employee Entitlements	27,994	30,162	27,373	25,925	(1,448)	25,826
Term Debt - Current Portion	13,149	1,492	13,133	13,500	367	1,750
Current Liabilities	65,237	58,645	63,857	70,677	6,820	61,600
Working Capital	(23,497)	(25,146)	(22,402)	(27,480)	5,078	(10,200)
Non Current Assets	162,751	160,557	162,061	165,518	(3,457)	161,498
Net Funds Employed	139,254	135,411	139,659	138,038	1,621	151,298
Long Service Leave	2,452	2,088	2,452	2,088	(364)	2,088
Retiring Gratuities	7,592	7,754	7,592	7,754	162	7,754
Sabbatical Leave	2,275	1,016	2,275	1,016	(1,259)	1,016
Term Debt	37,130	37,343	36,978	36,746	(232)	49,767
Non Current Liabilities	49,449	48,201	49,297	47,604	(1,693)	60,625
Crown Equity	89,805	87,210	90,362	90,434	(72)	90,673
Net Funds Employed	139,254	135,411	139,659	138,038	1,621	151,298

The variance between the actual June 2011 Consolidated Financial Position and that used for the budget was \$2427k in Net Funds Employed. The variance against budget for July shows \$1,621k, therefore only \$806k of total Net Funds Employed variance is attributable to the current financial year.

The variance lies in equity relating to the better than budget result for the year to date, and the balancing amount is made up of many small variances both favourable and unfavourable, but concentrated around accruals for debtors, salaries and wages and employee entitlements.

Consolidated Cashflow Position

Consolidated Statement of Cash Flows \$000s	Current Month			Prior YTD	Year to Date			Full Year
	Actual	Budget	Variance	Actual	Actual	Budget	Variance	DAP
Operating Cash Flow								
Receipts								
Government & Crown Agency Received	32,068	32,622	(554)	62,533	64,485	65,491	(1,006)	392,344
Other Revenue Received	1,035	857	178	1,498	1,827	1,673	154	9,990
Total Receipts	33,103	33,479	(376)	64,031	66,312	67,164	(852)	402,334
Payments								
Personnel	13,527	12,751	(776)	19,403	25,176	24,704	(472)	149,507
Payments to Suppliers	4,028	5,237	1,209	12,144	11,269	10,611	(658)	61,498
Capital Charge	-	-	-	1,774	598	1,735	1,137	5,326
GST	164	(25)	(189)	386	223	1,511	1,288	1,519
Payments to Other DHBs	3,186	3,191	5	6,280	6,371	6,383	12	38,203
Payments to Other Providers	11,060	10,831	(229)	20,990	22,427	21,438	(989)	129,752
Total Payments	31,965	31,985	20	60,977	66,064	66,382	318	385,805
Net Cash Inflow/(Outflow) from Operating Activities	1,138	1,494	(356)	3,054	248	782	(534)	16,529
Cash Flow from Investing Activities								
Receipts								
Interest Received	119	70	49	249	241	139	102	835
Sale of Fixed Assets	8	21	(13)	42	495	21	474	129
Total Receipts	127	91	36	291	736	160	576	964
Payments								
Capital Expenditure	808	477	(331)	4,406	1,211	953	(258)	7,953
Increase in Investments	(2,002)	-	2,002	-	(2,991)	-	2,991	-
Total Payments	(1,194)	477	1,671	4,406	(1,780)	953	2,733	7,953
Net Cash Inflow/(Outflow) from Investing Activities	1,321	(386)	1,707	(4,115)	2,516	(793)	3,309	(6,989)
Net Cash Inflow/(Outflow) from Financing Activities	(253)	(246)	(7)	(672)	(657)	(600)	(57)	(1,799)
Net Increase/(Decrease) in Cash Held	2,206	862	1,344	(1,733)	2,107	(611)	2,718	7,741
Plus Opening Balance	17,782	30,917	(13,135)	22,920	17,881	32,390	(14,509)	32,390
Closing Balance	19,988	31,779	(11,791)	21,187	19,988	31,779	(11,791)	40,131

- Net cashflow from Operating and Financing activities are both close to budget
- Net cashflow from investing is favourable to budget by \$3.3m due to a decrease in cash on deposit and the unbudgeted sale of assets
- Cash opening balances were \$14.5m unfavourable to budget due to the classification of cash on deposit, and also substantial asset sales that were budgeted in the 2010/11 financial year and did not occur.

APPENDIX 4 – MECA & COLLECTIVE AGREEMENT UPDATES

MECA & UNION	COVERAGE	UPDATE
Associated Salaried Medical Specialists (ASMS)	132 employees	Discussion between the parties will formally resume on 30 September.
Clinical Physiology (APEX)	7 Employees	The document has lapsed and there are no new developments.
Medical Radiation Technologists (MRT) (APEX)	47 Employees	The Union initiated bargaining on 4 August. They have initiated to continue a national MRT MECA but have separated Sonographers out for a National MECA. The parties are discussing the possibility of taking an Interest Based Bargaining approach to these negotiations.
Management Bargaining Including the majority of Collective & Single Employer Agreements with CTU affiliated Unions	5 National MECA Nurses & Midwives (894 employees) Mental Health & Public Health Nurses (174 employees) Allied Health (270 employees) Clerical (212 employees) Midwives (48 Employees) Plus 6 NMDHB SECA (476 employees)	<p>A settlement has been reached with the combined unions, subject to ratification. The ratification process is being undertaken by unions between 19 – 30 September. The outcome is expected to be known on the 4th October.</p> <p>The offer is: A lump sum payment (equivalent to 2% of salary) on expiry of Agreement or 28 October 2011 whichever is the latter. A 2.5% increase on rates from 1 October 2012 or one year after expiry whichever is the latter. The term of the new agreements will be 24 months.</p> <p>Specific conditions for Nurses ie enhanced payment for higher level PDRP and including Allied & Technical professionals, an offer allowing transfer of positive sick leave balances to a maximum of 20 days at T1 between DHBs. There are also a number of agreements to continue collaborative engagement with unions to advance several projects over the term of the agreement.</p>

NMDHB & REGIONAL COLLECTIVE AGREEMENT (CEA) UPDATE

CEA & UNION	COVERAGE	UPDATE
		Nil active at this time.

SECTION 5: FOR INFORMATION

Nil

SECTION 6: MEMBERS' ISSUES

Nil

GLOSSARY OF COMMONLY USED ACRONYMS, ABBREVIATIONS AND MAORI TRANSLATION

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

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

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

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

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

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

September 2011