

NOTICE OF MEETING

OPEN MEETING

**A meeting of the Board Members of
Nelson Marlborough District Health Board
held on Tuesday 19 April 2011 at
1.00pm**

**DHB Seminar Centre Room 1
Braemar Campus
Waimea Road
Nelson**

**BOARD MEETING AGENDA**

Nelson Marlborough District Health Board
 DHB Seminar Centre Room 1, Braemar Campus, Waimea Road, Nelson
 Tuesday, 19 April 2011 commencing 1.00 pm

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PUBLIC EXCLUDED MEETING
Resolution to exclude public

3.15 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 8 March 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)***
 - ***Golden Bay Integrated Health Service – To protect information that is subject to negotiation (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***

SECTION 1: WELCOME, KARAKIA AND APOLOGIES

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

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Jennifer Black	<ul style="list-style-type: none"> ▪ Life member of Diabetes NZ. 			
Ian MacLennan	<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 Grey Power 		<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	Nil	<ul style="list-style-type: none"> ▪ Own HR practice. 	<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"> ▪ Broker, The Research Broker 	<ul style="list-style-type: none"> ▪ Contracts for services to NMDHB ▪ Provided marketing research brokering services to Public Health in 2008 	

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 April 2011

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

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
MEDICAL SURGICAL SERVICES DIRECTORATE					
	Dr Bruce King	To be advised			
	Dr Elizabeth Wood	<ul style="list-style-type: none"> ▪ Self employed contractor at the Mapua Health Centre as a GP ▪ Work at NRAHDD and a shareholder 			
	Dr Peter Bramley	To be advised			
MENTAL HEALTH SERVICES DIRECTORATE					
	Dr Heather McPherson	Nil			
	Dr Jocy Wood	<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 Nichol	<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	To be advised			
	Dr Ros Gellatley	To be advised			
	Carey Virtue		<ul style="list-style-type: none"> ▪ Partner works in the Ministry of Health 		
CORPORATE SUPPORT					
	Nick Lanigan	Nil			
	Denise Hutchins	Nil		<ul style="list-style-type: none"> ▪ Certification/ Accreditation 	

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
	Dr Sharon Kletchko	<ul style="list-style-type: none"> ▪ Member Exceptional Circumstances Panel – PHARMAC ▪ Treasurer, International Society for Health Care Priorities ▪ Member St John South Island Region Trust Board ▪ Member RACP NZ Policy and Advocacy Committee ▪ South Island Representative on RACP NZ Joint Executive. ▪ Member of the Medicine’s Review Committee (Medicine’s Act) MEDSAFE ▪ Member DHBRF Governance 	<ul style="list-style-type: none"> ▪ Deputy Chair of the New Zealand Standards Council ▪ 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 (Acting CMO)	Nil			
DMH & Whanau Ora	Harold Wereta	<ul style="list-style-type: none"> ▪ Ngati Toarangatira Connections 		<ul style="list-style-type: none"> ▪ Tribal Interest 	
CHIEF EXECUTIVE’S OFFICE					
	John Peters	<ul style="list-style-type: none"> ▪ Director of SISSAL ▪ Trustee of Nelson Marlborough Hospitals’ Charitable Trust ▪ Trustee Churchill Trust 	<ul style="list-style-type: none"> ▪ Director of Management and Industrial Services Ltd 	<ul style="list-style-type: none"> ▪ Shared services provision, administration of trust funds for health purposes & provision of private health services at Wairau Hospital ▪ MIS Ltd previously provided consultant services to other DHBs 	

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
	Keith Rusholme	<ul style="list-style-type: none"> ▪ Wife provides first aid training and complimentary help services 		<ul style="list-style-type: none"> ▪ Provision of services to DHB staff or contracted providers 	<ul style="list-style-type: none"> ▪ Sister works for IDSS
	Mike Cummins	Nil			

As at 1 April 2011

SECTION 3: MINUTES

MINUTES OF A PUBLIC MEETING OF BOARD MEMBERS OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD HELD AT THE SEMINAR CENTRE BRAEMAR CAMPUS NELSON ON TUESDAY 8 MARCH 2011 AT 12:30 PM**Present:**

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

Apologies:

Nil

In Attendance:

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

Karakia:

Tahi Takao

SECTION 1: APOLOGIES

Nil

SECTION 2: REGISTRATIONS OF INTEREST

Roma Hippolite noted that he has been appointed Ngati Koata representative on the IHB.

Moved: Judy Crowe

Seconded: Ian MacLennan

RECOMMENDATION:

THAT THE REGISTRATIONS OF INTEREST AS AMENDED BE NOTED.

AGREED

SECTION 3: MINUTES OF PREVIOUS MEETING**3.1 Minutes of the Board Meeting 1 FEBRUARY 2011**

Moved: John Moore

Seconded: Gordon Currie

RECOMMENDATION:

THAT SUBJECT TO THE FOLLOWING AMDENDMENT:

Added 'to Churchill Trust' to item (xv) page II 'the scope of the Wairau Hospital Redevelopment project to leasing land to Churchill Trust rather...'

THAT THE MINUTES OF THE MEETING 1 FEBRUARY 2011 BE ADOPTED AS A TRUE AND CORRECT RECORD.

AGREED

3.2 Matters Arising

A letter has been sent to the three councils regarding a joint governance meeting.

3.3 Correspondence

Moved: Roma Hippolite

Seconded: Patrick Smith

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

AGREED

SECTION 4: REPORTS

4.1 Chair's Report

The report was taken as read. A letter is to be sent to staff involved, assisting or deployed as part of NMDHB's response to the Christchurch Earthquake 22 February 2011.

Moved: Jenny Black

Seconded: Judy Crowe

**RECOMMENDATION:
THAT A LETTER BE SENT TO ALL STAFF FOR THEIR EFFORTS IN ASSISTING IN THE RESPONSE TO THE CHRISTCHURCH EARTHQUAKE.**

AGREED

It was noted that following the earthquake, some aspects of regionalisation are likely to be accelerated.

South Island Health Alliance

Members discussed the obligations to follow the regional direction set by the Health Alliance. It was noted that participation is a requirement following a change to the Act that strategic planning is now undertaken on a regional basis.

Also discussed was the role of the Chair and CE as South Island delegates. This remains to represent and report back so that the Board can make a decision.

Members noted that there is no formal agreement in place with CCDHB for them to provide services to Nelson Marlborough residents. NMDHB does

participate in the service planning for these CCDHB services to which patients are referred.

A concern was raised that improved collaboration in the district is also required. The principle of single service multiple sites remains the strategic direction for service.

Meeting Papers and Agendas

Members noted that the papers are to support governance. The Terms of Reference for the advisory committees are to be revised to include how these Committees have input into strategic issues.

Moved: Gerald Hope

Seconded: Ian MacLennan

RECOMMENDATIONS:

1. THAT THE BOARD RECEIVES AND ENDORSES THE DIRECTION OF THE SOUTH ISLAND HEALTH ALLIANCE PLAN FOR COLLABORATION.
2. THAT THE BOARD REAFFIRMS THAT THE CHAIRPERSON AND CHIEF EXECUTIVE REPRESENT THE BOARD IN THE SOUTH ISLAND WORK AND THE FUTURE ALLIANCE.
3. THAT THE BOARD RECEIVES THE BOARD AND COMMITTEE STRUCTURE AND MEETINGS – 2011.
4. THAT THE CHAIRPERSON'S REPORT BE RECEIVED.

AGREED

4.1 Chief Executive's Report

(I) GENERAL

The report was taken as read. The impact of the Christchurch Earthquake on services both in the community and hospital environments was discussed.

Noted that elective surgery requiring an inpatient stay was postponed for four days. Day surgery continued.

Members were briefed that the impacts on CDHB will continue for a considerable period, likely to be at least 12 months.

The impact of displaced persons leaving Christchurch was discussed. It is assessed that current activity in the district is similar to the height of summer. Services for Canterbury resident's are to be provided without prior consideration to the cost, which are not to inhibit the response. It was noted costs are being recorded separately. Focus will remain in achieving targets for the year for our own population.

Members noted that the NMDHB was rated number 1 for patient satisfaction in the latest quarterly results (December 2010).

Rutherford

Members noted the process had been modified for clinical areas to help with the flow. The Corporate Services restructure is on track.

(II) FINANCIAL

	Year to Date			January 2011
	Budget \$000	Actual \$000	Variance \$000	Variance \$000
Funder	(2,033)	(533)	1,500	180
Governance	(6)	(419)	(413)	49
Provider	(1,453)	(189)	(1,642)	(30)
Net Result	(3,479)	(75)	3,555	198

Results remain better than budget (\$3,555K favourable YTD). The gain on the sale of land remains a risk to achieving budget. The forecast does not include any impact from the recent court discussion regarding sleepovers.

The forecasts in the papers were completed before the 22 February earthquake. The impacts are being assessed and forecasts revised. Budget Controls will remain tight for the rest of the financial year. This needs to be balanced with providing better services and utilisation is being regularly monitored.

(III) STRATEGY AND PLANNING

Noted.

(IV) COMMUNITY BASED SERVICES

Members noted the efforts of staff to improve performance under smoking cessation targets.

(V) MEDICAL SURGICAL SERVICES

Noted.

(VI) CLINICAL SERVICES SUPPORT

Noted.

(VII) MENTAL HEALTH

Noted.

(VIII) MAORI HEALTH/IWI RELATIONSHIP

Noted.

(IX) ORGANISATIONAL DEVELOPMENT

Noted that the high number of complaints at Wairau in January was related to the higher temperatures in the new Inpatient Unit.

(X) QUALITY AND SAFETY

Noted.

(XI) CORPORATE SERVICES

Noted.

(XII) INTERSECTORIAL AND OTHER DHB LINKAGES

An update was given on a meeting of the Golden Bay IMG. Martin Ridgeway has been appointed Project Manager by the Ministry and Sue Morris has been appointed Change Manager. Both were part of the Wairau Hospital Redevelopment Team. A final business case is expected for the next meeting.

Moved: John Moore

Seconded: Gordon Currie

RECOMMENDATION:

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

AGREED

4.3 COMMITTEE REPORTS**(i) Iwi Health Board**

Moved: Roma Hippolite

Seconded: Patrick Smith

RECOMMENDATION:

THAT THE IHB CHAIRPERSON'S REPORT BE RECEIVED.

(ii) Community and Public Health/Disability Support Committee

No meeting.

(iii) Hospital Advisory Committee

A verbal report was given from the meeting in the morning.

Moved: Jenny Black

Seconded: Ian MacLennan

RECOMMENDATION:

1. THAT THE BOARD RATIFIES THE RECOMMENDATIONS FROM HAC.
2. (a) THAT JUDY CROWE BE APPOINTED CHAIR.
(b) THAT RUSSELL WILSON BE APPOINTED DEPUTY CHAIR.

AGREED

SECTION 5: GENERAL

Members noted the result for the second quarter Annual Plan in the Balanced Scorecard. Work is under way to meet the Ministry timetable.

SECTION 6: MEMBER'S ISSUES

Members were briefed on the process used to assess staff views in the staff survey.

Public Excluded

Moved: Gerald Hope
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:

- ***Minutes of a meeting of Board Members held on 14 December 2010 (Clause 32(a) Third Schedule NZ Public Health & Disability Act 2000)***
- ***DHB Chair's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***
- ***DHB Chief Executive's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***

AGREEDActions Arising from the Meeting

Action	Responsible	Time Frame
Papers on how committees will address strategic issues.	Mike Cummins	19 April 2011
Golden Bay Business Case.	Peter Burton	19 April 2011
Update on after hours business case.	Peter Burton	19 April 2011

Meeting closed at 4.10pm

Members of Public

Sarah Young (Nelson Mail) attended.

3.1 MATTERS ARISING

3.2 CORRESPONDENCE RECEIVED

Date Received	Received From	Title
11/02/11	Churchill Hospital Trust	Request for garden area to be retained on Wairau site
04/03/11	Ministry of Health	Health Targets
14/03/11	Canterbury DHB	Recognition of staff assistance – Christchurch earthquake
16/03/11	National Health Board	Quarter Two 2010/11 Performance
16/03/11	Minister of Health	Quarter Two Reporting
16/03/11	Health Quality & Safety Commission New Zealand	Surgical site infection surveillance programme cost benefit analysis
17/03/11	Human Rights Commission	Equal Employment Opportunities
21/03/11	Dental Council of NZ	Consultation feedback on the proposed changes to the dental hygiene, orthodontic auxiliary and dental therapy scopes of practice
23/03/11	Ministry of Health	Quality assurance processes in home-based support services for older people
28/03/11	Dental Council of NZ	Consultation on proposed changes to the scope of adult care in dental therapy practice
01/04/11	MOH/Cancer Control NZ	Improvements to the NZ Cancer Registry
04/04/11	NZ Red Cross	Thank you for staff member time – Christchurch earthquake

SECTION 4: REPORTS

4.1 Chair's Report

A verbal update will be provided at the meeting.

Jenny Black
Chairperson

Status

This report contains:

- For decision
- Update
- Regular report
- For information

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

4.2 Chief Executive’s Report

<p>Status This report contains: <input checked="" type="checkbox"/> For decision <input checked="" type="checkbox"/> Update <input checked="" type="checkbox"/> Regular report <input type="checkbox"/> For information</p>

(I) ITEMS FOR DECISION

(a) Golden Bay Service Delivery

<p>1 Purpose of this Paper</p> <p>The purpose of this paper to:</p> <p>Update the Board on the progress in the last 12 months towards integrating health services in Golden Bay.</p>
<p>2 Recommendation</p> <p>THAT THE BOARD ENDORSES THE DIRECTION FOR THE GOLDEN BAY INTEGRATED HEALTH SERVICES:</p> <ul style="list-style-type: none"> i. TRANSFER SERVICES PROVIDED IN GOLDEN BAY BY NMDHB, THROUGH THE GOLDEN BAY COMMUNITY HOSPITAL AND DISTRICT AND PUBLIC HEALTH NURSING SERVICES, TO NBPH AT THE END OF SEPTEMBER 2011; ii. COMMENCE THE CONSULTATION PROCESS WITH STAFF FROM THE GOLDEN BAY COMMUNITY HOSPITAL AND DISTRICT AND PUBLIC HEALTH NURSING SERVICES, AND THEIR REPRESENTATIVES, TO TRANSITION THEIR EMPLOYMENT TO NBPH BY THE END OF SEPTEMBER 2011; iii. ENTER INTO A REVENUE AGREEMENT BASED ON THE DRAFT AGREEMENT FOR THE PROVISION OF THOSE SERVICES; AND iv. MEET THE COSTS OF THE PRELIMINARY DESIGN WORK UNTIL THE PROPERTY OWNING ENTITY IS IN PLACE AND HAS SECURED FUNDING FOR THE CONSTRUCTION PROJECT UP TO \$100,000.
<p>3 Background and Discussion</p> <p>Attached as Appendix 1.</p>

(b) Licence to Occupy

1 Purpose of this Paper
To provide information to the Board on the requirements of Clause A14 for a decision on the Licence to Occupy client refunds.
2 Recommendation
THAT THE BOARD ENDORSES THE REQUIREMENT FOR ALL ARRC PROVIDERS IN NELSON MARLBOROUGH TO COMPLY WITH THE REQUIREMENTS OF CLAUSE A14 FOR CLIENTS IN LICENCE TO OCCUPY RECEIVING RESTHOME LEVEL CARE AND THAT THE REFUND BE MADE TO THE CLIENT.
3 Background
<p>Background</p> <p>As serviced apartments and units become more popular an issue that is arising more often is that of the facilities component payment when rest home services are being provided to a client while they remain in their unit.</p> <p>Most arrangements are through a Licence to Occupy (LTO) under which the client pays the provider a fee for the licence which gives them the right to occupy the unit and an obligation on the provider to buy back the licence when the unit is vacated at an agreed rate (less any refurbishment charges). The rate is similar to depreciating the unit over the agreed period. On vacation by the client the provider has the right to resell the unit.</p> <p>The Retirement Commission has developed a view on the likely return to clients (or their estates) for retirement units. The example in Appendix 2 shows how a unit purchased for \$300,000 might after two years result in \$263,000 being returned to the client/estate (a cost of \$18,500 per annum) or after five years \$222,000 (a cost of \$15,600 per annum). As an occupier of a serviced unit the client will receive a level of services as agreed and be charged extra for these. Usually these relate to supported living. As the client's needs grow they may meet the criteria for home based services or rest home level services depending on their need.</p> <p>Under the licence the provider has sole right of provision of services to the client. NMDHB has a contract for Restorative Home Based Support Services however the LTO providers will not permit these to be delivered within their complexes. However they will allow rest home level care to be provided. Under the Social Security Act clients are assessed against a set of financial thresholds including assets (currently \$200,000 rising to \$350,000 by June 2026) and income to determine their eligibility for a subsidy. Those ineligible for a full subsidy will be required to fund their services up to a maximum contribution of \$804 – 828 per week (the variance is based on local costs). The average weekly cost of rest home care is \$850 per week which means the DHB pays a small subsidy (the difference between the average weekly cost and the maximum contribution). Those eligible for a full subsidy ie the payment of the average weekly cost are entitled to receive \$56 per week from their benefit plus a small annual income from assets retained. Under the criteria used to determine the value of assets the licence to occupy is usually included. As the value of their licence diminishes the level of subsidy may increase.</p>

4 Discussion**The Issue**

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

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

Current Actions

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

NMDHB supports any resident towards his or her entitlements under the Social Security Act while ensuring that the ARRC contract is complied with to address equity issues and ensure fairness for residents. It has an expectation that providers will work through the process with existing residents.

Until a national position is determined NMDHB will be introducing a process for all ARRC providers in the district from April 2011 onwards. The process has three linked considerations:

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

Impacts

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

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

- Where the client is making a significant contribution towards their care there

is no concern with the client retaining the refund; and

- For clients for whom the subsidy is at or near to the maximum are they entitled to retain the refund? Under the financial threshold set by the Social Security Act they are currently entitled to retain assets to the value of \$200,000. As the LTO is part of that sum then as time passes and their eligibility decreases they will be penalised (\$15 – 18,000 per annum). Using the local daily rate the annual cost would be \$9,855 which would only partially compensate the client.

Conclusions

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

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

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

(II) QUALITY AND SAFETY

(a) Medical Surgical Services

(i) Quality Framework

A structure has been proposed that provides a framework to connect quality activity across the organisation. The next step is to review the various quality committees. Focus at present is on establishing a Reportable Events process that supports learning and improved health outcomes.

(ii) Theatre Productivity

Focus on “first case starts” to help drive efficient use of theatre resources. Other key metrics of interest are turnover time of cases, theatre lists that go long, and the number of sessions that are cancelled. Revised theatre schedules are being worked on to reduce the impact of acute surgery on elective surgery cancellations.

(iii) Scoping Review

Consideration of a single waiting list is to be considered. Focus will be on improving access, reducing waiting times, and consistent prioritisation.

(iv) Surgical Pre-Admission Redesign

Various initiatives are underway to improve the patient pathway both in terms of improving the quality of surgical work-up, and making it more efficient for patients. This will be addressed in line with the Rutherford Capacity Planning initiative.

(v) Cardiology

Work has begun providing improved access for Wairau patients. Other areas of service improvement include improvements to patient flow by providing a five day a week PCI service and increasing nurse led cardiology initiatives.

(b) Clinical Service Support

(i) Pharmacy

Work is continuing on the roll out of Medicines Reconciliation in both Nelson and Wairau Hospitals, after working with the National Quality implementation team. Due to resignation of a key team member, implementation in Nelson will be delayed. The replacement process has commenced.

Work is continuing on the project plan for the introduction of the new National Adult Medication Charts to be used by all DHBs. The charts are to be introduced by December 2011 at the latest, however NMDHB plans to start implementation from May 2011.

(c) Organisational Development

(i) Certification Audit 2011

NMDHB was notified by its contracted Designated Audit Agency (DAA) Telarc Quality Health in late February that it was exiting health auditing as of 1st April 2011 and transferring its business to the DAA Group Ltd. As NMDHB's certification audit is due to take place commencing 11th April, we have agreed to the DAA Group undertaking the Audit. Telarc Quality Health also notified us that the organisation's accreditation status is for four years and as such we do not require an Accreditation Survey this year. Planning is in hand for the certification audit.

(d) Corporate Services

The project to develop a plan for other health service providers for the provision of emergency power in key areas has been delayed while the response to the 22nd February Christchurch earthquake is underway. Local awareness has been heightened as to their vulnerability to the loss of power. The Emergency Management Planning Group (EMPG) will be overseeing the response to this, along with plans for the Rugby World Cup and SI Masters Games, which are being held in Nelson from 15-23 October 2011.

(III) FINANCIAL**(a) Overview**

The March 2011 net result for the year to date is a loss of \$73k, which is \$2,675k favourable to budget.

Summarised Results

For the Month Ended March 2011

	Year to Date			March 2011
	<i>Budget</i> \$000	<i>Actual</i> \$000	<i>Variance</i> \$000	<i>Variance</i> \$000
Funder	(2,107)	(962)	1,145	(442)
Governance	(46)	412	459	(74)
Provider	(595)	477	1,072	(51)
Net Result	(2,748)	(73)	2,675	(567)

The consolidated finance report is attached as **Appendix 3**.

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

Fund

The Fund year to date result is a deficit of \$962k, this being \$1,145k favourable to budget.

Revenue has a positive variance of \$2.0m, \$618k from prior year adjustments, additional revenue for Hospice \$297k, and funding for PBF adjustments and new programmes (offset by additional expenditure) \$968k. An overspend of \$660k YTD in Disability Support expenditure includes \$276k for support of Christchurch ARC evacuees and is partly offset by increased revenue. Interest Received favourable to budget by \$202k.

Total Provider

The NMDHB Provider year to date financial result is a surplus of \$477k against a budget deficit of \$595k.

The positive variance in personnel costs of \$1,616k is partly an underspend in Medical personnel, which is offset by an overspend in Outsourced Medical (covering vacancies, sick leave, maternity leave, and Wairau absences due to credentialing). Positive variances have also occurred as a result of average cost and staff mix differences to budget, along with vacancies in the Allied Health area.

Clinical Supplies are overspent \$1,926k due to over budget expenditure December through March, mainly for surgical consumables. Orthopaedic

caseweights, which utilise high cost implants and prostheses, remain ahead of budget (21%) YTD. The Ministry have indicated that they will fund over-delivery of surgical discharge volumes in the last quarter of the year.

Forecast

The consolidated forecast is a deficit of \$155k, including the anticipated full year effect of the Christchurch earthquake.

The Fund is forecasting to be better than budget by \$738k. This is driven from the favourable variances to date being maintained during the rest of the year which has some risk given that some of the favourable variances are in demand driven expenditure lines. The forecast does not assume at this stage that the extra Aged Residential Care costs for displaced Christchurch clients will be covered by increased revenue.

The provider is forecasting a deficit of \$193k against budget, locking in YTD positive variances in revenue and personnel costs (offset by outsourced overspend), and anticipating that budgeted savings in Clinical Supplies and Infrastructure costs will not be fully achieved.

Interest received is forecast to be \$489k over budget, interest paid \$456k better than budget and capital charge over budget due to the better than planned result as 30 June 11.

(b) Risks for 2010/11 Financial Year Result

We are closely reviewing all contingency accruals and provisions to ensure that we have retained the most accurate and relevant provisions. Significant provisions exist for Alexandra Hospital & Management Restructuring.

(i) Gain on Sale

Gain on property sales of \$3m has been budgeted in June, and remains in the forecast. However, process delays have held back the sale process for the Wairau land and completing that sale by June is now uncertain.

Four properties in Nelson have been cleared for sale and a marketing programme is being developed. The subdividing of the clinic building from the rest of the Tapawera property is well underway and a consent from TDC is expected shortly.

Discussions are underway with the Ministry on getting the surplus land at Wairau cleared for disposal. The delay is due to Health Legal seeking clarification on why the "held in trust for hospital purposes" was placed on the title in 1927. As these records are held by the Land Transfer Office in Christchurch there has been delay in getting access (or whether they still existing following the 22 February earthquake).

The CFHA is exploring the options available to NMDHB to enable a sale of the Wairau land in particular to proceed before 30 June. This is

required if NMDHB is to achieve the gain on sale of assets planned in the DAP. The Board will be kept informed of progress.

(ii) **Christchurch Earthquake**

The situation is far from static making forecasting difficult, however work is continuing to be done in an attempt to quantify the risk. Extra costs in the region of \$1m in the Fund for Aged Residential Care have been identified for patients transferred from Christchurch.

The transfer of IDSS patients has resulted in net revenue for NMDHB (currently forecast at approximately \$150k) as the extra clients are filling vacant places in the service for minimal extra cost.

Additional costs of \$44k have been incurred, covering GP visits, EOC and staff deployment to Canterbury costs.

(iii) **IDSS Sleepover ruling**

NMDHB disclosed a contingent liability in its 2009/10 annual accounts in the range of \$4.7m to \$7.9m. The Court of Appeal made its ruling in February ([2011] NZCA14), for the defendant. NMDHB's possible exposure under this ruling has been conservatively recalculated at \$6.2m, however there remains no provision in the balance sheet.

(iv) **Volumes**

The extent of the Clinical Supplies overspend now poses a considerable risk to the year end result, particularly as the pressure to keep waiting lists under 6 months continues. However, extra Electives funding has been indicated by the Ministry, to cover over-delivery of surgical discharge volumes for the last three months of the financial year only.

(IV) RUTHERFORD INITIATIVE

(a) Ophthalmology

As the consultation feedback is ready to be discussed with stakeholders, a series of meetings with staff has been organised to discuss the feedback. This will ensure that final recommendations for the service can be developed.

After the concerns raised by the Ophthalmology consultation document, the Rutherford Team has met with ASMS to revise the pathway for the Rutherford process to follow. This process is designed to ensure good consultation prior to recommendations being finalised and good checking of data and assumptions.

Since the initial agreement NZNO and the PSA have been included in the process.

ASMS, PSA and NZNO have nominated representatives to walk alongside the review process.

(b) Alexandra Hospital

The service development group has been meeting regularly to progress the recommendations accepted from the review. This group is almost ready to recommend the model of care and bed numbers to the Steering Group.

The RFP process for the community beds will be reported to the Steering Group at its next meeting.

(c) Scheduled and Unscheduled Travel

The consultation documents were released in the week commencing 11th April.

(d) Obstetrics and Gynaecology

The background information and the associated assumptions are due to be released to key staff for checking and feedback. Once this is completed the consultation document, with recommendations, will be developed and released.

(e) IDSS

The report to the CE is expected to be completed by 18th April.

(f) Capacity Planning

This review encompasses patient flows, bed management and booking systems. Due to its extensive subject matter, it covers multiple areas of the organisation. It is due for completion by the end of April. The team is experiencing good engagement from staff, and union representatives are being very helpful.

(g) Orthopaedic

This review is due to commence shortly. Planned meetings with staff will introduce the Rutherford Team and the process to be used.

(h) General

Rutherford Initiative has been in place since August 2009.

As previously noted the focus has moved to the clinical areas.

This report looks at the progress of the recommendations from completed reviews.

The first set of reviews looked at the support areas of Information Technology, Payroll, Organisational Development, Staff Travel, Courses and Conferences. These were followed by infrastructural areas of Maintenance, Property, Hotel Services, Procurement, plus duplicated services or contracts in Mental Health, Primary and Community.

Once the recommendations have been reviewed by the CE and the relevant Leadership Team member the implementation process commences. A number of recommendations have not proceeded for a variety of reasons. Others have been modified or substituted as Annual Planning proceeds. Some are not

readily measurable on a monthly basis eg sick leave usage which requires a longer view to determine the effectiveness of the changes made or planned.

In the period from August 2009 and June 2010 savings of \$2.6 million were achieved. For 2010/11 our progress against the planning savings (2010/11 DAP page 75) is reported to the Ministry. The following is the report for March.

Initiatives	Total Planned Savings \$'000	Year-to-date			
		Achieved	Planned	Variance	
		\$'000	\$'000	\$'000	%
Achieve Financial Security	4,768	3,546	3,521	25	0.7
Improve Productivity & Quality	2,629	972	864	108	12.5
Enhance Regional Cooperation	240	174	169	5	3.0
TOTAL	7,637	4,692	4,554	138	3.0

The report uses 2009/10 as a baseline and includes the implemented Rutherford savings plus additional gains from items such as higher interest received and lower interest paid (the drawdown of the loan for Wairau has been spread rather than early in the financial year).

(V) STRATEGY AND PLANNING

(a) Annual Planning

We submitted the draft Annual Plan to the Ministry of Health and Audit NZ on 25th March. Initial feedback from the NHB and Audit NZ is expected mid April.

(b) Health Needs Analysis

Work is continuing on updating the Health Needs Analysis. This includes a section on “emergent knowledge from international and New Zealand practice” which, in the first instance, will include information from the Alberta Provincial Stroke Strategy which had impressive results including:

- 23% drop in emergency department and inpatient hospital visits for stroke between 2004/05 and 2008/09;
- 27% reduction in in-hospital deaths for ischemic stroke.

This information may assist actions in Nelson Marlborough where 501 (9.6%) of our 5,239 deaths between 2003 and 2007 were due to cerebrovascular diseases. It is noted that 14% of the 284 discharges for cerebrovascular diseases in the fiscal year 2009/10 died.

(c) Age Residential Care

There has been a number of transfers to Nelson/Marlborough due to the Christchurch earthquake, and there is still capacity available at all levels. The

Omaio Village rest home has been certified for provision of 10 Continuing Care beds and 22 rest home beds.

(d) Fund Results

For your information attached as **Appendix 4** are the fund results which sets out the YTD results for Strategy and Planning.

(VI) COMMUNITY BASED SERVICES

(a) Christchurch Earthquake

As an ongoing arrangement post earthquake, all South Island public health services will continue to assist Canterbury Public Health. In particular, the in Nelson Marlborough Medical Officer of Health cover will include the West Coast and Kaikoura districts. South Island Public Health planning processes are changing as a result of the earthquake. The three public health services will approach the South Island as a whole. For planning purposes, over the next several years Christchurch will be identified as a high needs area, and be fitted into the generic South Island plan for public health.

(b) Health Impact Assessment

The Public Health Service has submitted both a Health Impact Assessment (HIA) and a commentary on the Nelson City Council 'Nelson Arterial Traffic Study'. The initial HIA has generated positive feedback and a request has been received to present it in a community forum. The Council has indicated that the recommendation set out in the commentary will be incorporated in their Annual Plan.

(c) Smokefree Schools Project Plan

The Smokefree Schools Project Plan has been drafted ready for piloting. A school will implement the ABC framework into school policy and have selected students and staff trained in the ABC method to become quit card providers in their schools with the support of their teachers.

(VII) MEDICAL SURGICAL SERVICES

(a) Activity

The DHB received a letter from the NHB advising that DHBs need to focus on reducing the number of patients waiting greater than six months for assessment or treatment. We are currently preparing an action plan identifying how the DHB will reduce the backlog and maintain this to ensure all patients are treated within six months of acceptance.

We delivered 1562 Caseweights (110% of plan) for February and have delivered 13101 Caseweights (101% of plan) YTD.

Acute activity was 109% of plan for the month with a high number of acutes, in particular in Cardiology and Orthopaedics.

Elective Caseweight activity was 112% of budget for the month. The Orthopaedic Service in particular had high elective delivery (140% of budget) with a third Orthopaedic Surgeon being available to undertake more complex procedures in Blenheim and additional surgery being undertaken in Nelson in order to address long waits.

Elective discharges for February were 407 (100% of plan), and YTD 3507 elective discharges have occurred (95% of plan).

Elective Caseweight delivery for February was 551 CWDs (112% of plan) compared to budget 488 Caseweights. YTD elective Caseweights are 4518 compared to budget of 4461 (101% of plan).

Cancellation rate for elective cases was 9% compared to 7% the previous month. The increase is mainly due to cancelled elective surgery cases to free up surgical bed capacity following the Christchurch earthquake.

Nelson Marlborough has been offering assistance to Canterbury DHB following the earthquakes. This has therefore meant a certain number of patients have had to have their elective surgery postponed in order to maintain sufficient bed capacity should Canterbury require it. As at 3rd March the following number of NMDHB patients have been cancelled:

Nelson had 39 patients cancelled:

- 14 General Surgery
- 5 Gynaecology
- 6 Orthopaedics
- 11 Ophthalmology
- 3 ENT

Wairau had 36 patients cancelled:

- 10 General Surgery
- 4 Gynaecology
- 18 Orthopaedics
- 4 Ophthalmology

The DHB remains green overall in terms of ESPI compliance.

Those services that are non compliant for ESPI 2 (patients waiting longer than 6 months for a FSA) are Gynaecology, Pain, Rheumatology and Urology.

Only orthopaedics is non complaint for ESPI 5 (patients waiting longer than 6 months for a surgical procedure).

Gynaecology – Additional outpatient clinics are being undertaken, referrals are being assessed as to suitability of patients being treated via non contract FSA, and theatre sessions are being swapped for outpatient clinics due to low surgical volumes.

A Wellington Hospital specialist is visiting mid March to see some of our long wait patients and our own local pain specialist is undertaking additional clinics every fortnight.

Urology – additional clinics being held in Wairau to reduce long wait patients.

(b) Bed Management

(i) Nelson Hospital

Bed occupancy for Nelson hospital exceeded 85% on 11 days during February.

Earthquake support for CDHB resulted in the cancellation of all electives requiring over night stay from 23-25 February.

(ii) Wairau Hospital

For Wairau Hospital February averaged 63.5% occupancy. The Canterbury earthquake did have an effect on elective services while acute demand remains consistent.

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

Acute / Elective Caseweights - KPI View

March 2011

Type	DM Area	Unit Code	Description	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan	
Acute	Med	M00001	General Internal Medical Services - Inpatient Serv	5161	3895	3606	-289	93%	
		M10001	Cardiology - Non PCI Inpatient Services (DRGs)	253	191	443	252	232%	
		M10001P	Cardiology - PCI Inpatient Services (DRGs)	305	230	167	-62	73%	
	Med Total				5719	4316	4217	-99	98%
	Surg	S00001	General Surgery - Inpatient Services (DRGs)	2281	1722	1827	105	106%	
		S05001	Anaesthesia Services - Inpatient Services (DRGs)	29	22	12	-9	57%	
		S25001	Ear, Nose and Throat - Inpatient Services (DRGs)	112	85	77	-8	91%	
		S40001	Ophthalmology - Inpatient Services (DRGs)	35	27	25	-2	93%	
		S45001	Orthopaedics - Inpatient Services (DRGs)	1673	1263	1551	288	123%	
		S70001	Urology - Inpatient Services (DRGs)	218	164	149	-16	90%	
	Surg Total				4348	3282	3640	358	111%
	W, C & OH	D01001	Inpatient Dental treatment	23	17	16	-2	90%	
		M55001	Paediatric Medical Service (Inpatient)	689	520	456	-64	88%	
		S30001	Gynaecology - Inpatient Services (DRGs)	183	138	170	32	123%	
		W06003	Neonatal Inpatient (DRGs)	416	314	309	-5	98%	
		W10001	Maternity Inpatient (DRGs)	1345	1015	1017	1	100%	
	W, C & OH Total				2657	2005	1967	-38	98%
	Acute Total				12724	9603	9825	222	102%
	Elective	Med	M00001	General Internal Medical Services - Inpatient Serv	139	105	104	-1	99%
M10001			Cardiology - Non PCI Inpatient Services (DRGs)	207	156	200	44	128%	
M10001P			Cardiology - PCI Inpatient Services (DRGs)	102	77	50	-27	65%	
Med Total				447	338	354	16	105%	
Surg		S00001	General Surgery - Inpatient Services (DRGs)	1918	1448	1467	19	101%	
		S05001	Anaesthesia Services - Inpatient Services (DRGs)	61	46	22	-24	48%	
		S25001	Ear, Nose and Throat - Inpatient Services (DRGs)	455	343	372	29	108%	
		S40001	Ophthalmology - Inpatient Services (DRGs)	425	321	259	-61	81%	
		S45001	Orthopaedics - Inpatient Services (DRGs)	1893	1428	1703	274	119%	
		S70001	Urology - Inpatient Services (DRGs)	532	402	357	-44	89%	
Surg Total				5284	3988	4181	193	105%	
W, C & OH		D01001	Inpatient Dental treatment	213	161	115	-46	71%	
		M55001	Paediatric Medical Service (Inpatient)	41	31	25	-7	79%	
		S30001	Gynaecology - Inpatient Services (DRGs)	702	530	524	-6	99%	
W, C & OH Total				956	722	663	-59	92%	
Elective Total				6688	5047	5197	150	103%	
Grand Total				19412	14650	15022	372	103%	

March 2010

Type	DM Area	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan
Acute	Med	5547	4145	3903	-242	94%
	Surg	4412	3297	3509	213	106%
	W, C & OH	2735	2044	1925	-119	94%
Acute Total		12694	9486	9337	-149	98%
Elective	Med	275	206	343	137	167%
	Surg	5010	3744	4403	659	118%
	W, C & OH	866	647	736	89	114%
Elective Total		6151	4597	5483	886	119%
Grand Total		18846	14082	14819	737	105%

(VIII) CLINICAL SERVICES SUPPORT**(a) Chaplain**

The new Chaplain in Nelson was welcomed on 4th April 2011.

(IX) MAORI HEALTH/IWI RELATIONSHIP**(a) IHB Meetings**

The IHB was to host the Board to Board meeting on 24th March 2011. Unfortunately, due to a tangi at Waikawa Marae, this meeting was postponed.

At this hui discussions were to be held on Whanau Ora as members from the Whanau Ora Regional Leadership Team were invited. Another invitation will be extended to this group when the meeting is re-scheduled.

(b) Maori Health Provider Coalition

The meeting planned for March 2011 was cancelled in favour that NGO Managers coordinate meetings with their Boards to progress the discussion on the Memorandum of Agreement for the Coalition.

The DHB has been engaging with each Provider Board. On 14th March Te Rapuora held a workshop where the DHB gave information on why change was needed and presented data to support this view. The DHB also provided similar information, on 21st March, to Te Kahui Hauora O Ngati Koata Board representatives, a member from Ngati Koata Trust and a manager from Whakatu Marae Health and Social Services.

The DHB has advised that for the Coalition to become a credible option, the MOA needs to be signed off by June 2011. The original date for sign off on the MOA was 31st March 2011, however this was altered once discussions were held with Provider representatives.

The DHB has also indicated that should Provider Boards decide not to pursue the Coalition, the DHB will consider its options.

The next steps include:

22 nd April	Coalition MOA templates completed by Provider Boards
27 th May	DHB consolidate templates into a single MOA document
23 rd June	Memorandum of Agreement signed by Coalition Provider Board Chairs.

(c) Maori Health Provider Collective

Similar to the discussions held with the Maori Health Providers Coalition (Te Hauora o Ngati Rarua, Te Rapuora o Te Waiharakeke, Te Awhina Marae, Whakatu Marae Health & Social Services), the Maori Health Directorate met

with the Maori Health Provider Collective (Whakatu Te Korowai Trust, Te Amo Health and Maata Waka O Te Tau Ihu Trust) on 23 February, 2011. The focus was on building a working relationship and seeking a district wide approach to service planning and delivery, similar to the Maori Health Providers Coalition. The Maori Health Directorate will continue to meet with this group.

(X) ORGANISATIONAL DEVELOPMENT

(a) FTE Report – March 2011

FTE has fallen back into line YTD March, with the reversal of the February accrual for unpaid days – actual hours worked at the end of February was less than was accrued.

FTE Report March 2011

FTE	Budget CM	Actual CM	Variance	Budget YTD	Actual YTD	Variance
SMO	97	90	7	93	91	2
MOSS	20	17	3	19	17	2
Registrars	11	13	(2)	11	11	0
House Officers	42	44	(2)	41	46	(5)
Probationers & Interns	-	0	(0)	-	0	(0)
Nursing	613	599	14	628	637	(8)
Allied Health	553	531	22	556	544	11
Support	89	93	(5)	89	96	(7)
Management/Admin	344	348	(4)	353	349	4
Total	1,769	1,737	32	1,791	1,791	(0)

(b) Complaints

There were 23 complaints for the month of February compared to 20 in January. Of these, nine complaints were for Nelson and 14 complaints for Wairau. Three complainants identified themselves as Maori. 100% of complaints were responded to within 20 working days. Wairau complaints are higher than Nelson due to parking issues during the redevelopment which is being monitored and air flow/air conditioning in the Outpatients Department.

(c) Human Resources

The HR Team is currently 2.0 FTE under strength, and is supporting all change processes within the organisation. This placing considerable strain on the remaining team and advertising has commenced for replacements for an HR Advisor and HR Administrator.

(d) Occupational Health & Safety

Twenty-nine staff related reportable events were lodged in February. From those 29, 12 injuries were reported. One 'serious harm' injury was reported to the Department of Labour during the period which took the form of a Ruptured Achilles Tendon.

In conjunction with the Public Health Unit and NPA the Occupational Health Team is planning a mobile 'healthy staff initiative' commencing in April. A mobile staff testing station will visit work areas and offer staff simple screening tests. If unusual results are found the staff member will be provided with one free voucher to attend their own GP for more indepth examination. Health information will also be provided from the station. The initiative will be spread over a number of months as it progressively visits NMDHB facilities.

(e) Employee Relations

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

(f) Hospital Workforce

Key vacancies impacting both service delivery and cost exist in Anaesthetics (Wairau) and ED (Nelson and Wairau). Advertising is underway.

An ENT Specialist is urgently required in Nelson to cover maternity leave commencing in May 2011.

FACEM for ED Wairau required to cover maternity leave approximately June 2011.

Issues around provision of the acute paediatric roster in Nelson have prompted the need to complete a review of duties in the service and job sizing of each role.

(g) 3rd Tier Structure

Recruitment is underway for the 3rd tier management structures in each of the Directorates, Strategy & Planning and Corporate Services following completion of the consultation process. We expect to have the full team in place in June.

(XI) CORPORATE SERVICES

(a) Regional Patient Management System

NMDHB participated in a meeting of the South Island IT leads, together with the Central Region project and NMDHB, to understand their project structure and direction. A paper will be submitted to the South Island CEs outlining a proposed plan for the South Island.

(XII) INTERSECTORAL AND OTHER DHB LINKAGES

- (a) Intersectoral and other DHB linkages for the period:
- Golden Bay Interim Management Group
 - National CEOs
 - DHBNZ Management Board
 - SI CEOs
 - Nelson Grey Power
 - Marlborough Grey Power
 - Joint 20 DHBs Monthly Oversight Group
 - MP for Blenheim/Kaikoura
 - Australasian Health Round Table AGM
 - Safe Staffing Health Workforce Unit
 - Treasury and Crown Health Funding Agency.

(XIII) STRATEGIC ISSUES

(a) Health Targets

(i) Shorter Stays in Emergency Departments

This target is being met. Project work has commenced on lowering the length of stay in the Emergency Departments, particularly in Wairau, with a view to improving targets further.

There has been a notable increase in Emergency Department admissions following the Christchurch earthquake.

(ii) Improved Access to Elective Surgery

Focus is on reducing long waits for patients particularly in gynaecology and orthopaedics. Work with the Alliance Group is underway to shift minor skin lesions surgery from hospital to the community to increase theatre capacity – especially in ENT. The MOH is requiring that NMDHB has no patients waiting longer than six months for an FSA or elective procedure. To achieve this new target will require considerable investment in terms of the workforce and dollars.

Currently 189 FSA patients and 141 surgical patients waiting greater than six months at end of February are as follows. Please note the information is received from MOH which is two months behind:

- Ambulatory FSA at end January had delivery of 11,846 FSAs against a plan of 9,545 (124.1%).
- Ambulatory Procedures at end January had a delivery of 848 procedures against plan of 648 (129%).
- Electives Initiative. NMDHB is required to deliver 6029 discharges every year. YTD (January 2011) we were required to deliver 3,323 discharges and have actually delivered 3,384 (101.8%).

- Case Weights (CWDs). Planned case weight delivery (January 2011) was 4,165 with actual case weight delivery 4,679 (112.3%).
- (iii) Shorter Waits for Cancer Treatment
Treatment times are within MOH guidelines.
- (iv) Increased Immunisation
NMDHB Immunisation Targets for 90% of all 2 year olds and 85% of Maori and Pacific Island children to be fully immunised have not been achieved this quarter (Q3). The total number immunised has decreased from last quarter of 90% to 89%, and Pacific from 100% to 82%, however the percentage of Maori has increased from 89% to 91%. We have continued collaboration with the Immunisation Co-ordinators from both Nelson Bays Primary Health (NBPH) and Kimi Hauora Wairau Marlborough Primary Health Organisation (KHWMPHO), including continued sharing of data to increase immunisation statistics across the region. Continued work in collaboration with NBPH to address Outstanding reports with GP Practices for completion. The Immunisation Special Interest Group meetings continue to be held monthly to focus on ways to improve immunisation rates and the sharing of best practice throughout the region.
- (v) Better Help for Smokers to Quit
The average for Q3 is 65%, up from 46% for Q2. Significant effort into the recovery plan for this Health Target has resulted in a further increase in our numbers with the March total of 86% - 332 of patients hospitalised and identified as smokers, 287 were offered advice and support to quit. The plan has brought us on track to achieving the National Target of 90%.
- (vi) Better Diabetes and Cardiovascular Services
For the data reported in Quarter two, NMDHB achieved 69% overall. There are three components to this target, on two of which NMDHB is not achieving as well as expected. The proportion of people who have had a CVD risk assessment in the past 5 years – we are checking the laboratory data on which this is based to ensure that all relevant data is included. For the proportion of people accessing a Diabetes Annual Review (DAR) we have three strategies in place: confirming the denominator (diabetes prevalence) with the Ministry; ensuring we are capturing all the information on people who are accessing services for support with diabetes management (including those in specialist services); and initiatives lead by PHOs, working with practices and NGOs, to actively trace eligible people who have not had a DAR and encourage their participation. On the third component of diabetes management (measured by HBA1c results) Nelson Marlborough achieves well compared to other DHBs and no specific action is required at this time.

The Quarter Three result will available at the meeting.

(b) Wairau Redevelopment

A post implementation report and feedback on benefits realisation is planned for the May meeting.

(c) Christchurch Earthquake

A large part of the period since 22nd February has been directed at managing the local response in the Christchurch earthquake. This has involved coordinating the EOC and providing staff assistance to meet ongoing requests from CDHB. A debrief was held on 18th March and a separate report and action plan is being developed for the EMPG to consider. See CPHAC/DiSAC agenda papers.

(d) Nelson Marlborough Health Alliance

(i) Minor Surgical Skin Lesions

Focus is on moving some of the minor surgical procedures from the hospital into a community setting. The goal is to ensure patients are treated earlier, and in a more convenient setting. This will enable more major surgical procedures to be done in theatres. Clinical meetings in both Nelson and Blenheim will discuss key issues and access criteria. Outcome of these meetings is to have a draft pathway which will include:

- Criteria for triaging to secondary and back to primary
- Clarity around providers of different levels of service, how assessed, trained etc
- Criteria and process for funding
- Recommendations around referral process
- Training requirements.

(e) Regional Services

South Island CEs continue to progress the alliance work streams in the six focus areas of:

- Child health
- Mental health
- Cancer
- Health of older persons
- Procurement
- IT.

Discussions around the final form for the delivery of South Island shared services have been held with HBL. Work is progressing in this regard and will be presented to the South Island Chairs in early May.

John Peters
CHIEF EXECUTIVE
13 April 2011

RECOMMENDATIONS ARISING FROM THIS REPORT:

1. THAT THE BOARD ENDORSES THE DIRECTION FOR THE GOLDEN BAY INTEGRATED HEALTH SERVICES:
 - i. TRANSFER SERVICES PROVIDED IN GOLDEN BAY BY NMDHB, THROUGH THE GOLDEN BAY COMMUNITY HOSPITAL AND DISTRICT AND PUBLIC HEALTH NURSING SERVICES, TO NBPH AT THE END OF SEPTEMBER 2011;
 - ii. COMMENCE THE CONSULTATION PROCESS WITH STAFF FROM THE GOLDEN BAY COMMUNITY HOSPITAL AND DISTRICT AND PUBLIC HEALTH NURSING SERVICES, AND THEIR REPRESENTATIVES, TO TRANSITION THEIR EMPLOYMENT TO NBPH BY THE END OF SEPTEMBER 2011;
 - iii. ENTER INTO A REVENUE AGREEMENT BASED ON THE DRAFT AGREEMENT FOR THE PROVISION OF THOSE SERVICES; AND MEET THE COSTS OF THE PRELIMINARY DESIGN WORK UNTIL THE PROPERTY OWNING ENTITY IS IN PLACE AND HAS SECURED FUNDING FOR THE CONSTRUCTION PROJECT UP TO \$100,000.
2. THAT THE BOARD ENDORSES THE REQUIREMENT FOR ALL ARRC PROVIDERS IN NELSON MARLBOROUGH TO COMPLY WITH THE REQUIREMENTS OF CLAUSE A14 FOR CLIENTS IN LICENCE TO OCCUPY RECEIVING RESTHOME LEVEL CARE AND THAT THE REFUND BE MADE TO THE CLIENT
3. THAT THE CHIEF EXECUTIVE'S REPORT BE RECEIVED
4. THAT THE FINANCIAL REPORT BE ADOPTED.

4.2 Committee Reports

Iwi Health Board

No meeting held. No report.

Joe Puketapu
Chair

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

Status

This report contains:

- For decision
- Update
- Regular report
- For information

**COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE AND
DISABILITY SUPPORT ADVISORY COMMITTEE**

A verbal update will be provided from the meeting held in the morning.

Gerald Hope
Chairman

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

Status

This report contains:

- For decision**
- Update**
- Regular report**
- For information**

HOSPITAL ADVISORY COMMITTEE

8 March 2011

With the restructuring of the Executive Leadership Team (ELT) there are now three directorates involved in HAC with the lead being taken by Service Director Medical Surgical and supported by Service Director Clinical Support Services and GM Corporate Services.

Status**This report contains:**

- For decision
- Update
- Regular report
- For information

The current status of the Christchurch earthquake aftermath has put demands on NMDHB services. Canterbury will still be in serious recovery mode for at least 12 months and NMDHB will be meeting extra demands on its services in support of CDHB. This will have ongoing impact and risks particularly financial for NMDHB. The government directive is that in no way must costs be the driver or inhibitor of the provision of services. The costs are to be borne by the health sector as a whole. However NMDHB will prudently identify and isolate data around this.

It was noted that NMDHB topped the inpatient and outpatient satisfaction surveys for the September to December 2010 quarter.

NMDHB is on target with its ESPI and overall tracking well financially but there is a risk that these savings could be eroded in the later part of the financial year. Outsourced Services and Clinical Supplies are areas over budget but causes identified.

A lack of "closing the loop" in relation to quality improvement has existed whereby the lessons learnt are not rolled through to practice change. The Medical Surgical Directorate will be working towards reversing this situation.

An Audit and Risk review process is underway for the completed Wairau development.

It was noted that the cancellation of the 2011 census will have an impact for all DHBs as it provides the core of information for planning and funding.

Judy Crowe
Chairperson

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

APPENDIX 1 – GOLDEN BAY INTEGRATED HEALTH SERVICES

Purpose

The purpose of this paper to:

- a. Update the Board on the progress in the last 12 months towards integrating health services in Golden Bay;
- b. Seek the Board's endorsement of the proposal to:
 - i. Transfer services provided in Golden Bay by NMDHB, through the Golden Bay Community Hospital and District and Public Health Nursing Services, to NBPH at the end of September 2011;
 - ii. Commence the consultation process with staff from the Golden Bay Community Hospital and District and Public Health Nursing Services, and their representatives, to transition their employment to NBPH by the end of September 2011;
 - iii. Enter into a revenue agreement based on the draft agreement for the provision of those services; and
 - iv. Meet the costs of the preliminary design work until the property owning entity is in place and has secured funding for the construction project.

Background

In April 2010, the NBPH Board endorsed:

- a. A business case for the merger of the health services in Golden Bay
 - i. Primary care services by NBPH through the Golden Bay Medical Centre,
 - ii. Community Hospital services at Takaka plus District and Public Health Nursing Services through NMDHB, and
 - iii. Rest home operated by the Joan Whiting Memorial Trust Board at Collingwood;
- b. A proposal to work with NMDHB and JWMT to transfer both staff and responsibility for service provision to NBPH. These transfers were subject to consultation with staff and their representatives; and
- c. A proposal to transfer the existing community hospital to a charitable community trust who would extend and upgrade the existing facility to enable it to be used for the provision of services.

This proposal sought to address a number of concerns including:

- a. Fragmentation between the three providers resulting in a lack of coordination which has created gaps in terms of service coverage, physical facilities and governance responsibility;
- b. Difficulty to recruit & retain health professionals – principally doctors and nurses;
- c. The need to upgrade the GB Medical Centre to accommodate the greater range of services now available; and
- d. The longer term viability of the Joan Whiting Rest Home, which will close if the services are not integrated.

In endorsing this proposal the NMDHB Board noted that it needed to be affordable within existing funding levels and any DHB contribution would be subject to Ministerial approval.

In April 2010 the NMDHB Board resolved:

THAT SUBJECT TO APPROPRIATE PROCESSES FOR WINDING UP THE TRUST AND THE DISTRIBUTION OF SURPLUS FUNDS HELD BY THE TRUST, THE BOARD:

1. SEEKS MINISTERIAL APPROVAL

- a. **UNDER SECTION 28 OF THE NZPH&D ACT 2000 TO APPOINT A TRUSTEE TO THE CHARITABLE TRUST TO BE ESTABLISHED FOR THE PURPOSE OF PROVIDING THE PROPERTY AND EQUIPMENT NEEDED TO PROVIDE HEALTH SERVICES IN GOLDEN BAY IN ACCORDANCE WITH SECTION 8.4 OF THE TRUST DEED**
- b. **UNDER CLAUSE 43 OF THE THIRD SCHEDULE OF THE NZPH&D ACT 2000 TO TRANSFER THE COMMUNITY HOSPITAL LAND, BUILDINGS AND FURNITURE AND EQUIPMENT TO THE CHARITABLE TRUST ESTABLISHED UNDER (A) SUCH TRANSFER TO TAKE PLACE ONCE FUNDING RAISED**
- c. **TO WRITE OFF THE VALUE OF THE ASSETS TRANSFERRED AGAINST THE FINANCIAL RESULTS**
- d. **TO CHANGE THE SERVICE PROVIDER TO NELSON BAYS PRIMARY HEALTH.**

AGREED

In July 2010 the Minister was advised of the concept being explored for Golden Bay. The letter outlined the approvals that the DHB understood would be required under the NZPHD Act 2000 as per the April resolutions and sought the Minister's advice on whether the project was eligible for any assistance under the Integrated Family Health Centre (IHFC) scheme.

Following the project being identified as suitable for funding under the Integrated Family Health Centre (IHFC) scheme discussions commenced with the Ministry of Health. In November 2010 the Ministry established a Consortia of advisors to provide health planning, health architecture, project planning and change management support. The Ministry also indicated that the Golden Bay project was seen as a pilot for similar centres in rural areas elsewhere in New Zealand.

In September 2010 the Minister agreed to provide funding towards the costs of the Joan Whiting Rest Home Trust while the Integrated Health Centre was constructed. The support was to enable the Trust to continue in the 18 months it was expected to complete the Centre so that the continuity of rest home care in Golden Bay was ensured.

At the 9 November 2010 meeting the Board approved in principle a letter of undertaking to NBPH for the future provision of care. The letter of undertaking underpinned the PHO as an anchor tenant in the planned centre for Golden Bay. This was aimed at giving an assurance to lenders to enable them to consider funding the development. The undertaking is subject to any changes in government policy or direction.

Project Progress

With the assistance of the Consortia the project has now progressed to the extent that:

- A detailed Project (Gantt Chart) Plan has been finalised and agreed to by all parties;
- A community trust has been established for the purpose of undertaking fundraising to upgrade and extend the DHB's property to enable expanded service delivery;
- A firm proposal has been received from a commercial lender which will enable approximately \$4.0 M to be borrowed;
- Enhanced Models of Care have been developed by a Golden Bay Clinical Leadership Group which describe how the services will operate when integrated. This group is largely comprised of clinical leaders from the 3 services;
- An Improvement Pathway Document indicating potential longer term adjustments to the above Service Delivery Models of Care Document has been developed by the Clinical Leadership Group;
- A design brief and concept plans are being finalised for an upgraded and extended community hospital based on the updated models of care, and significant work undertaken on the various elements required to secure a resource consent. The cost of upgrading and extending the Community Hospital to provide integrated services has been estimated by a local Quantity Surveyor at approximately \$6m;
- A revenue agreement has been drafted between NMDHB and NBPH for the provision of rural hospital, maternity, nursing and aged care services;
- St John have agreed to co locate their services with the other integrated health services which will require additional land;
- A proposed staff transition process developed; and
- Work is progressing with the Ministry of Health to obtain the necessary Ministerial approvals for the transfer of NMDHB assets to a property owning entity.

Key changes to the April 2010 business case are that:

- The Ministry requires the land be retained in NMDHB ownership and to be leased to the entity by way of a 35 year lease;
- The impact on the Crown of the options relating to the transfer of the assets is quantified;
- The property owning entity is expected to have a level expertise that will put in place a commercial approach and suitable asset management plans for the overall facility; and
- Additional land will be required to accommodate all the parties now proposing to be part of the Centre. The plan is for NMDHB to purchase the adjoining land and sell a leasehold interest in the same to the Property entity.

Guidance from the Ministry of Health IFHC Consortia identified the benefit of breaking the project into 3 inter-related business cases covering:

- Services to be delivered by NBPH;
- Subsequent building of a facility to support the service provision agreed; and
- Impacts on NMDHB and the Crown.

The first of these business cases, together with the draft revenue agreement between NMDHB and NBPH, was approved by the Board of NBPH at its meeting in March 2011.

Agreement has also reached with the Ministry of Health on the steps that need to be followed to, with the assistance of the IHFC Consortia to develop the other two business cases (property entity and impacts on DHB and Crown). Appendix B sets out advice from the Consortia on issues to be addressed in these business cases particularly as it relates to the Crown.

The business cases will be completed in time to enable NMDHB Board consider them on 25 May 2011 and if appropriate agree to:

- Purchase extra land;
- Sell leasehold interest in the land to the Trust (and St John);
- Transfer other DHB assets to the trust; and
- Appoint a trustee to the trust.

We are advised by the Ministry that we could expect Ministerial approval shortly thereafter

The Updated Services Business Case

The Board of NBPH has considered the business case around the services proposed in the models of care or service description. The forecast results for the service based on the combined income of the 3 organisations, the organisation design that was derived from the models of care and the current costs of the 3 organisations is shown in **Appendix A**. It differs from the forecast in the previous business case in that:

- The mix and number of staff has changed resulting in higher initial staff cost follows and it is now assumed that any efficiencies from the introduction of a more flexible team based approach to nursing to work within a broader primary care nursing context will take longer to realise; and
- Rest home bed occupancy has been reduced by 6% in line with recent experience.

However it also continues to demonstrate that an integrated service can meet the key objectives of:

- Achieving efficiency gains from integration to ensure the sustainability of service provision; and
- Providing a more co-ordinated range of primary and community care services in Golden Bay which are patient-centric and accessible.

Draft Revenue Agreement

While the revenue agreement is still in draft form and requires further work particularly in the area of the ongoing support to be provided by NMDHB in the provision of services the key points of the agreement as drafted include:

- a. The term of the agreement which is for an initial period of ten years. A long term agreement is critical to provide sufficient confidence to NBPH to enter into a long term lease arrangement for the integrated health facility. This long term lease arrangement, in turn, is necessary to secure commercial funding arrangements;
- b. An outline the services to be provided by NBPH. They include:
 - i. Five inpatient beds to supply primary care inpatient services;
 - ii. Support for mobile surgical services in accordance with the Memorandum of Understanding between NMDHB and Mobile Surgical Services Limited;
 - iii. Provision of access to a maternity facility and sufficient qualified staff in order to provide primary maternity services in accordance with the Primary Maternity Services Notice 2007, issued Pursuant to section 88 of the New Zealand Public Health and Disability Act 2000;
 - iv. District and Public Health Nursing Services, Occupational Therapy and Physiotherapy Services, and Meals on Wheels;
 - v. All services are to be provided in accordance with the relevant service specification in the National Service Framework or contract with the Ministry of Health as outlined in the draft revenue agreement; and
 - vi. Provision of 7 certified continuing care (hospital) residential aged care beds for which a claim can be made for a residential care subsidy for residents who are eligible for all or some of the cost of the aged residential care services provided to them.
- c. An outline of the services that will continue to be provided by NMDHB in the provision of these services. Such support includes but is not limited to:
 - i. Vision and hearing technician to support in the delivery of the public health nursing services;
 - ii. The ongoing provision of continence and stoma supplies to Golden Bay residents where appropriate; and
 - iii. The provision of professional nursing support in the ongoing development of nursing capability in Golden Bay.
- d. The price to be paid for the provision of services. This has been based on:
 - i. The prices currently paid for the provision of community hospital services in Golden Bay (\$1.736 million);
 - ii. An amount of \$97,000 for the provision of Public Health Nursing Services;
 - iii. A provider adjustment of \$274,000. This adjustment was identified in the previous business case as being needed to offset the shortfall between the costs of providing community hospital and district nursing services (after the inclusion of internal charges for property and IT) and the prices paid for those services principally via the one line funding; and
 - iv. An agreement to pass on any contribution to costs that it receives from the Ministry of Health in future years that relates to the service provided.

Design Work

The Ministry have given a commitment to meet the costs of preparing the business cases, revenue agreement, models of care and concept design to the point where capital funding sources have been agreed. The commitment does not cover implementation costs (resource consent fees, loan placement fees or professional fees beyond concept design).

The design team from the Consortia have already indicated that it will be difficult to achieve the target date in the Minister's support agreement for Joan Whiting Trust (April 2012). To minimise further delays to the design work it is proposed that NMDHB should meet the costs of preliminary design (architectural, engineering and quantity surveying) up to a limit of \$100,000. These costs are to be recovered from the property entity once funding is in place.

Next Steps

The next steps that follow will include:

- Progressing the consultation process with staff from the Golden Bay Community Hospital and District and Public Health Nursing Services, and their representatives, with a view of completing the transition of their employment to NBPH by the end of September 2011;
- Completing the business cases for the building of a facility to support service provision and impacts on NMDHB for consideration at the May Board meeting and to enable the requisite Ministerial approvals to be obtained;
- Finalise the revenue agreement with NBPH for the provision of extended range of primary health and aged care services. It is intended that this will be done with assistance from Sector Services;
- Confirming the funding arrangements for the community trust,
- Secure the needed adjoining property;
- Developing a satisfactory back to back long term lease agreements with Golden Bay Community Health-Te Hauora o Mohua and St John; and
- Continue the design work for the Centre to enable a target completion date to be finalised.

The Board will need to revise the current resolutions against the recommendations in the final business cases.

**Appendix A
Ten Year Financial Analysis**

Revenue (\$000)	1	2	3	4	5	6	7	8	9	10
One line funding	2017	2052	2087	2123	2160	2197	2235	2273	2312	2352
ACC	128	130	132	135	137	139	142	144	147	149
Maternity	95	97	98	100	102	103	105	107	109	111
Respite Care	6	6	6	6	6	7	7	7	7	7
Meals on Wheels	20	20	21	21	21	22	22	23	23	23
Continuing Care Beds	373	379	386	393	399	406	413	420	428	435
Rest Home Beds	625	635	646	657	669	680	692	704	716	728
Capitation Patient Co payments	670	682	693	705	717	730	742	755	768	781
Rural Retention/bonus	510	519	528	537	546	555	565	575	585	595
Other Medical Centre Income	210	214	217	221	225	229	233	237	241	245
Rents Received	118	120	122	124	126	129	131	133	135	138
	3	3	3	3	3	3	3	3	3	3
Total Revenue	4775	4857	4939	5025	5111	5200	5290	5381	5474	5567

Expenditure (\$000)	1	2	3	4	5	6	7	8	9	10
Staff Costs	3577	3623	3651	3701	3764	3829	3895	3962	4030	4099
Outsourced	4	4	4	4	4	4	4	5	5	5
Clinical Supplies	109	112	115	116	118	121	123	125	127	129
Equipment Depreciation	15	15	16	16	16	17	17	17	17	18
Hotel Services, Laundry, Cleaning	181	186	190	193	197	200	204	207	211	214
Utilities & Insurance	80	82	84	85	87	88	90	92	93	95
Transport	43	44	45	46	47	48	48	49	50	51
Telecommunications	82	84	86	88	89	91	92	94	95	97
Other	122	125	128	130	133	135	137	140	142	144
Rent	557	571	585	599	614	629	644	660	676	693
Total Expenditure	4770	4846	4904	4978	5069	5162	5254	5351	5446	5545

Surplus	5	11	35	47	42	38	36	30	28	22
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Appendix B

To: Nelson Marlborough District Health Board Members
From: Mike Stanton and David Clarke (Cranleigh Health)
Date: 11 April 2011
Subject: Golden Bay IFHC Structure Options Introductory Paper

Background

As previously advised it has been proposed that the Golden Bay IFHC should be structured with a new charitable trust owning the buildings gifted by the DHB and NBPHT (PHO) being the tenant. The land would be leased to the Trust for 35 years. It is envisaged that this structure would be supported by a range of contractual arrangements that would allow for an appropriate level of DHB oversight. The key documents are the Trust rules, ground lease, head lease and DHB funding agreement. This would allow the DHB to flexibly support the ongoing provision of primary healthcare services.

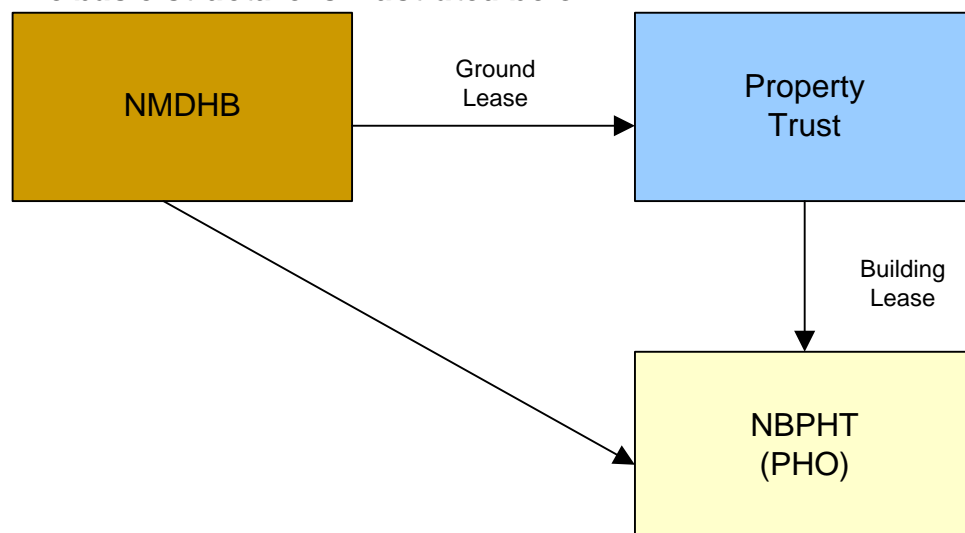
Following discussions with the MoH it is clear that the Ministry wishes to ensure that these arrangements are robust and will allow the DHB sufficient certainty to ensure the effective use of the land and buildings transferred to the Trust by way of lease and or gift and the continuation of health services. In other such arrangements associated with the Crown “gifting” assets in the past it has been found that the DHBs may need this capability over the long term when the current trustees may no longer be involved. In addition, any structure while needing to provide the best governance for all parties, should also optimise the tax position, cost of bank funds, donations and other mechanisms such as control and appropriate decision making. These can be incorporated in a number of documents, not just the Trust rules or Constitution, but also in the ground lease, building lease and DHB funding agreements.

The Ministry has agreed to fund the hiring of advisers (Cranleigh Health) to assist in the review to these arrangements to ensure that the structural and governance arrangements are optimal for all parties. The purpose of this introductory paper is to describe the basis of this review.

Previously advised structure

To date the preferred structure has envisaged the Board leasing the land for 35 years and gifting the existing buildings to a newly formed, charitable property trust who will undertake the development of the new buildings. The property trust will then lease the buildings to NBPHT PHO. NBPHT will benefit from a long term services contract from the Board to fund the delivery of primary health care services in Golden Bay.

The basic structure is illustrated below.



Factors Influencing Structure

The following factors and structural options will be considered when determining the optimum structure.

Structural Factor	Comments
Governance Appointment possesses Decision making Major transactions Ordinary and Special decisions Term and rotation of appointments Reporting and auditing DHB representative – DHB liability.	MoH wishes to ensure that the parties have sufficient influence to ensure the prudent and effective use of resources e.g. it may be attractive to appoint a DHB representative to the board of the property owning entity, this will give the DHB at least a moral liability for that Board’s decisions.
Investment Decisions Major Transactions Use of financial surpluses Investment of surplus cash Related party conflicts of interest.	E.g. in the medium term it is likely that the property entity will start to accumulate cash surpluses once debt is reduced. Ensuring that these funds are prudently invested or spent on effective health initiatives will be important.
Assets and Facility Management Asset Management Planning Commercial separation of owner/tenant roles.	E.g. strong asset management planning will be required to ensure that the property is well maintained and growth provide for.
Banking and Funding Ability to raise funds Assets, debt on DHB balance sheet? Lowest cost of Funds? Term of debt	E.g. the structure adopted needs to be acceptable to banks so as to maximise the amount of debt that may be raised within prudent limits while maintaining financial viability. At the same time banking covenants should be reasonable and the costs

Structural Factor	Comments
Bank security for debt Loan covenants Tax implications Financial/ commercial viability.	manageable.
Insolvency Risk	E.g. it will be important to ensure that the assets and health service provision can be protected in the event of the insolvency of the property entity. A first right of refusal to buy the assets in this circumstance has already been negotiated by the DHB.
Partner Risk	E.g. protections may be required to allow the DHB to act should the property entity or tenants not be able to effectively carry out their roles. Some of these protections will be covered by the terms of the DHB funding agreement.
Other Service planning, transfer and continuity Community consultation and involvement Partner buy in.	E.g. community consultation and partner buy in will be required for the final structure. The chosen structure must be as simple as possible and flexible.
Regulatory Gifting of Crown assets Public Works Act Office of Treaty Settlements Meets DHB objectives under S22 Cost of DHB director/trustee covered Analysis of risks and mitigating factors provided Explanation of why the proposed structure is best Community consultation required MoH land disposal guidelines met.	A transfer of DHB property to the property entity either as a gift or long term lease needs ministerial approval. These matters must be addressed to ensure approval.

Possible Solutions

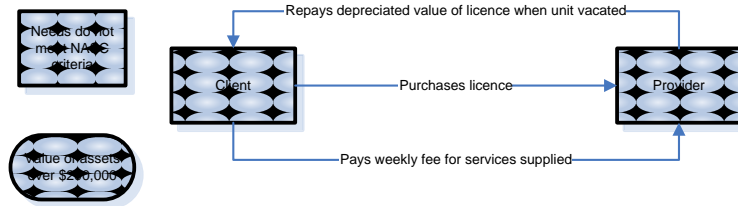
There are a range of possible solutions which could be considered including trusts, a company, a combination of both or other entities. It is possible to have a charitable company as well as the normal charitable trust vehicle. Some of the objectives may also be met within the DHB's funding agreement or the terms or the ground lease or lease of the buildings. It may be possible to simply amend the rules of the charitable trust already formed by the community to meet the above requirements.

It is intended to identify the likely solutions and test them for best fit against the requirements. This process will be assisted by Cranleigh and other specialist advisors as needed in consultation with stakeholders including the MoH and PHO. At the end of this process a recommendation will be made on the preferred option.

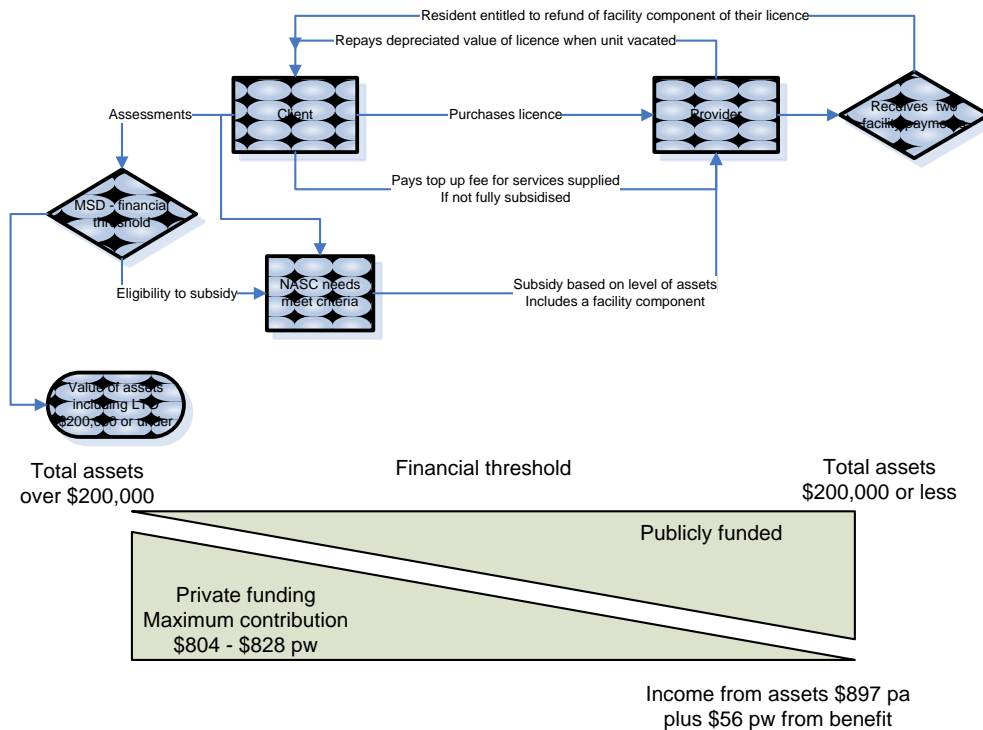
APPENDIX 2 – RESTHOME SUBSIDY IN SERVICE APARTMENTS LICENCE TO OCCUPY (LTO)

The following flowchart sets out the position:

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



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



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

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

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

Appendix A From Get Sorted Website

Knowing the financial consequences

The purchase cost when entering a village is not the only significant cost. In addition, residents may not be entitled to any capital gain when they leave. There are living costs and usually costs when leaving a village. These can include deductions from the original price paid for a unit.

This table shows the net return a resident could get when selling a 'licence to occupy' unit in a retirement village two, five, and 10 years after purchasing a unit for \$300,000. It shows the difference between the resale price and the actual return the resident gets in the hand.

Retirement village unit purchased for \$300,000 today			
	2 years on	5 years on	10 years on
Unit worth	\$330,000	\$385,000	\$490,000
Capital sum deduction	\$24,000	\$60,000	\$60,000
Refurbishment costs	\$4,000	\$7,000	\$12,000
Marketing fees	\$6,000	\$6,000	\$6,000
Service charges for 6 months	\$3,000	\$5,000	\$9,000
Total deductions	\$37,000	\$78,000	\$87,000
Return to former resident	\$263,000	\$222,000	\$213,000
Difference	\$67,000	\$163,000	\$277,000
In today's dollars			
Return to former resident	\$250,000	\$199,000	\$173,000
Difference	\$64,000	\$146,000	\$225,000

As so many things vary between villages, it's not possible to provide a typical example. However, the figures in this table are based on the following circumstances, which are quite common:

- The resident not receiving any share of the capital gain;
- The following deductions from the original purchase price:
 - A capital sum deduction of 4% p.a. for a maximum of five years
 - The costs of refurbishment, marketing fees, and six months of service charges from the time the resident left and the unit was resold
 - Marketing fees of 2% of the original purchase price; and
- Visit Costs for more information about the costs of entering, living in and leaving a village.

The figures in the table

- These figures are based on the value of the units increasing by 5% per annum;
- Property values are rounded to the nearest \$5,000 while all other figures are rounded to the nearest \$1,000;
- An inflation rate of 2% per annum was used to calculate the today's dollars figures; and
- 'Today's dollars' means that any amount you pay or receive in the future will have the same buying power as this many dollars today.

For example, if you could buy something worth \$1000 now, in 10 years time, you would need \$1220 ("nominal dollars") to buy that same thing (assuming 2% inflation). The \$1220 nominal dollars in 10 years time is equivalent to \$1000 today's dollars. This means that the actual dollar amounts that you pay or receive are likely to be more than the figure quoted here, but it will have the same current buying power.

APPENDIX 3 – FINANCIAL REPORT MARCH 2011**OPERATING RESULTS****Consolidated Financial Performance**

\$000	March 2011			Year to Date			Full Year	
	Budget	Actual	Variance	Budget	Actual	Variance	Forecast	DAP
Revenue	32,733	33,293	561	290,741	293,996	3,255	394,768	390,604
Expenditure								
Personnel Costs	12,659	11,888	771	109,362	107,408	1,954	145,030	146,184
Outsourced Services	906	1,112	(206)	8,107	8,666	(559)	11,601	10,811
Clinical Supplies	2,531	3,367	(837)	22,968	24,894	(1,926)	32,503	30,234
Infrastructural and Non Clinical Supplies	2,608	2,829	(221)	23,384	23,552	(168)	31,669	31,255
Personal Health Expenditure	9,197	9,491	(294)	80,976	81,075	(99)	108,533	107,863
Mental Health Expenditure	968	967	1	8,710	8,711	(1)	11,659	11,613
Public Health Expenditure	4	10	(6)	38	38	(0)	64	51
Disability Support Expenditure	3,508	4,053	(545)	30,896	31,758	(862)	42,631	41,237
Hauora Maori Services Expenditure	228	220	8	2,049	2,037	12	2,731	2,732
Interdivisional Eliminations	0	(0)	0	0	(0)	0	0	0
Internal Revenue/Expenses	(0)	0	0	(0)	0	0	3	(0)
Total Expenditure	32,608	33,938	(1,330)	286,490	288,138	(1,648)	386,425	381,980
Net Surplus/(Loss) before Interest & Capital Charge	124	(645)	(769)	4,251	5,857	1,607	8,343	8,623
Interest Received	68	135	67	602	1,135	533	1,291	802
Interest Paid	(280)	(224)	56	(2,481)	(1,869)	612	(2,850)	(3,306)
Capital Charge	(562)	(484)	79	(5,120)	(5,196)	(76)	(6,939)	(6,819)
Net Surplus/(Loss)	(650)	(1,217)	(567)	(2,748)	(73)	2,675	(155)	(699)
Made up of Divisional Surplus/(Loss):								
Funder	(367)	(809)	(442)	(2,107)	(962)	1,145	(2,041)	(2,779)
Governance	4	(69)	(74)	(46)	412	459	0	0
Provider	(287)	(339)	(51)	(595)	477	1,072	1,886	2,079
Total	(650)	(1,217)	(567)	(2,748)	(73)	2,675	(155)	(699)

Revenue: \$3.8m more than budget YTD (including interest received)

Expenses: \$1.1m more than budget YTD

Net Result: \$2.7m better than budget YTD

Revenue

Of the \$3.2m variance:

- One-off prior year adjustments in the Funder Arm of \$618k relating to elective services and IDF washups (\$427k), NRT washup (\$108k), and return of unspent Health Research Council funds to DHBs (\$83k);
- Extra funding of \$297k has been received for Hospice operational requirements;
- Additional revenue in the Fund of \$968k for PBF adjustments (Herceptin and CYF, and Pharmac) is offset by increased costs;
- Funding for new programmes offset by increased expenditure in the Fund (Primary Mental Health, InterRai, Joan Whiting Rest Home temporary funding, PHO Programmes) \$548k;
- \$600k negative variance due to revising down of Oral Health Project operational costs;
- A change to the administration of client income in IDSS as required by the Ministry has resulted in \$653k revenue unbudgeted since Dec. This will be ongoing until Jul 2011 when it will be budgeted, and is offset against increased expenditure in Clinical Supplies and Facilities;
- MoH Disability Support is \$333k ahead of budget for Intellectual Disability due to client volumes;
- Interest Received continues to be better than budget (\$533k) due to good internal processes around the investment of excess funds and better interest rates than budgeted for; and
- The remainder is due to a large number of positive variances related to unbudgeted rebates (particularly Pharmac Hospital Rebate \$181k), secondments, reimbursements, and donations (\$219k), and above budget revenue lines which have offsetting expenditure.

Expenditure

Payments to providers are reporting close to budget with two exceptions:

- Disability Support (\$545k unfavourable variance for the current month). This is partly due to a change in the model of care and 6% more clients being supported than budgeted for Home Based Support. Also, \$276k has been recorded for Residential Care for Christchurch evacuees, and there is increased expenditure offset to increased revenue (Joan Whiting Rest Home, InterRai); and
- Personal Health (\$99k unfavourable YTD) – larger overspends are offset to increased revenues (PHO programmes and Herceptin), and are softened within the expenditure group by underspends relating to Maternity, increase in estimated Pharmac rebate, and expenditure on home support for post acute clients and those with medical chronic conditions. Overspends not covered by increased revenue include Patient Travel and Immunisation.

The \$2.0m saving YTD in consolidated **personnel costs** YTD has had a number of drivers.

- In the current month there has been some benefit from the reversal of the February unpaid days accrual – particularly in respect of FTE. The accrual, which has a methodology based on recent actual hours worked, calculated more hours and expenditure than was actually worked at the end of February. This accrual is in the

- process of being reviewed in detail to improve understanding of the drivers of the swings, and to assess the robustness of the methodology;
- Medical personnel underspend \$549k YTD is offset to Outsourced Medical overspend;
 - Price and volume variance analysis indicates that roughly half of the total underspend is due to price variance (average cost/FTE is lower than budgeted) and half to volume variance (vacancies or hours worked). Influencing both of these measures is staff mix;
 - Allowances are overspent \$360k YTD. This is partly due to Radiologists additional on call allowances during the MRT strike, and other large variances are Wairau ED locum and one off payments, and Wairau Medical – Orthopaedic on call extra allowances;
 - Course Fees are underspent \$293k YTD, relating mainly to DoN. This should be spent by the end of the financial year;
 - Therapies and Allied Health personnel costs are under budget by \$1,471k YTD due to vacancies and staff mix - in particular Mental Health, Health Promotion, Radiology, Physical Disability, and NPA;
 - The overspend of \$275k in Management Admin is mainly due to ELT recruitment costs and unbudgeted ELT allowances;
 - The most significant element of the Nursing overspend is District Nursing (\$226k)
 - Total planned savings YTD that have been achieved overall is \$1.4m; and
 - Some recruitment decisions remain on hold as a result of ELT structural changes and various Rutherford Initiative reports. In some cases roster cover has been provided by less senior staff, or there is an offset in Outsourced costs (particularly Medical, although this relates also to difficulty in recruiting in some specialties). It is taking some time for lower level structural changes and subsequent recruitment decisions to take effect, however there are now signs that this is beginning to happen.

The overspend of \$549k YTD in **Outsourced Services** is driven by locum medical staff in the Medical Surgical Directorate, particularly Ob/Gyn at both sites (covering sick leave and vacancies), and Nelson Paediatrics (for maternity leave). The total overspend for Medical outsourcing is \$695k, which is largely offset by the YTD underspend in Medical Personnel costs. The overspend YTD of \$106k for Management/Admin is vacancy cover in Finance, BST, and Corporate Support. Outsourced Services underspends are predominantly in Nursing and Clinical Support.

Clinical Supplies are overspent by \$837k in the month, leading to a \$1,926k YTD overspend.

- Overall surgical caseweight volumes are now 8% ahead of budget YTD, and total Clinical Supplies costs 8% overspent, including savings and the impact of IDSS;
- Medical and Surgical inpatient caseweights are 222 (26%) ahead of budget overall in the month of March;
- Very high numbers for acute Orthopaedic inpatient services combined with ongoing pressure over the waitlist has resulted in total Orthopaedic caseweights continuing to be hugely above target - 147 (47%) for March, 74 acutes and 73 electives over target. These volumes are driving overspends in Implants and Prostheses (\$788k YTD) in particular, with a knock-on effect to patient consumables, treatment disposables, and pharmaceutical costs, particularly anaesthesia;

- A \$184k overspend in the current month for Air Ambulance is largely due to backdated charges for neo-natal transfers;
- \$659k YTD was budgeted as savings from performance initiatives. Although savings do not appear to have been found in this area at this time, overall organisational savings targets are being met;
- \$292k of the YTD overspend relates to unbudgeted costs since December offsetting increased revenue for IDSS. This overspend will continue through to the end of 2010/11 (it will be budgeted for in 2011/12); and
- The second most significant overspend (\$356k YTD) is in Patient Appliances, particularly Audiology Aids, Orthotics and Surgical Footwear, and Mobility Equipment. The overspends in Audiology Aids and Mobility Equipment are offset by increases in revenue. The YTD Orthotics overspend of \$78k is the result of a change in operating practice that was not able to be built into the budget at the time.

Budgeted savings in consolidated **Infrastructure and Non-Clinical Supplies** of \$1,268k YTD have not been fully found, however if the increased rent and utilities expenditure of \$332k due to the IDSS admin change from November onwards is disregarded, this class of expenditure would be within that savings target.

- These savings YTD have been found particularly against Telecoms (\$177k), Corporate Training (\$188k), Sundry Expenses (\$113k), Staff Travel & Transport (\$292k), Legal Fees (\$80k), Laundry (\$108k), Compliance Costs (\$97k), and Equipment Minor Purchases (\$126k); and
- Some line items are overspent, but predominantly by small amounts. The most significant are Consultants (\$74k), Coal (\$65k), and Stationery (\$41k). Most other line items are underspent.

Interest paid is less than budget by \$612k due to the delayed timing of the \$12.5m drawdown for the Wairau project, and better interest rates than budgeted.

Financial Performance by Division

Governance & Admin Statement of Financial Performance

\$000	March 2011			Year to Date			Full Year	
	Budget	Actual	Variance	Budget	Actual	Variance	Forecast	DAP
Revenue	458	458	0	4,126	4,211	85	5,180	5,501
Expenditure								
Personnel Costs	159	105	54	1,332	993	339	1,369	1,783
Outsourced Services	28	69	(41)	253	262	(9)	337	338
Clinical Supplies	0	0	(0)	0	0	(0)	0	0
Infrastructural and Non Clinical Supplies	62	46	16	681	499	182	693	866
Provider Payments	0	(3)	3	0	0	0	0	0
Internal Allocations	62	171	(109)	561	667	(106)	933	748
Total Expenditure	311	388	(77)	2,827	2,422	405	3,332	3,735
Net Surplus/(Loss) before Interest & Capital Charge	147	70	(77)	1,299	1,789	490	1,848	1,766
Capital Charge	(143)	(140)	3	(1,345)	(1,377)	(32)	(1,848)	(1,766)
Net Surplus/(Loss)	4	(69)	(74)	(46)	412	459	0	0

Fund Statement of Financial Performance

\$000	March 2011			Year to Date			Full Year	
	Budget	Actual	Variance	Budget	Actual	Variance	Forecast	DAP
Revenue								
Ministry of Health	29,840	30,275	434	265,788	267,770	1,982	356,702	354,384
Other Revenue	0	0	0	0	56	56	56	0
Total Revenue	29,840	30,275	434	265,788	267,826	2,037	356,758	354,384
Expenditure								
Personal Health Expenditure	21,680	22,067	(387)	191,839	192,257	(418)	256,612	255,715
Mental Health Expenditure	3,043	3,042	1	27,390	27,423	(33)	36,652	36,520
Public Health Expenditure	237	247	(10)	2,133	2,130	4	2,866	2,845
Disability Support Expenditure	4,622	5,134	(513)	40,895	41,555	(660)	55,734	54,567
Hauora Maori Services Expenditure	228	220	8	2,049	2,037	12	2,731	2,732
Other Expenses	458	458	(0)	4,126	4,126	(0)	5,095	5,501
Total Expenditure	30,268	31,168	(901)	268,432	269,527	(1,095)	359,690	357,879
Net Surplus/(Loss) before Interest & Capital Charge	(428)	(894)	(466)	(2,644)	(1,702)	942	(2,932)	(3,494)
Interest Received	61	85	24	537	739	202	891	715
Net Surplus/(Loss)	(367)	(809)	(442)	(2,107)	(962)	1,145	(2,041)	(2,779)

Provider Statement of Financial Performance

\$000	March 2011			Year to Date			Full Year	
	Budget	Actual	Variance	Budget	Actual	Variance	Forecast	DAP
Revenue								
Ministry of Health	1,889	1,809	(81)	16,026	15,604	(421)	20,846	21,295
Internal Fund	15,905	15,966	61	141,637	141,782	145	188,976	188,882
Other Government	338	322	(15)	3,035	3,349	314	4,630	4,044
Other Revenue	666	888	222	5,892	7,132	1,240	12,448	10,881
Total Revenue	18,797	18,985	188	166,590	167,867	1,278	226,900	225,101
Expenditure								
Personnel Costs								
Medical Personnel	3,439	3,142	297	28,579	28,052	527	37,240	38,148
Nursing Personnel	4,111	3,845	266	36,599	36,490	109	49,122	49,100
Allied Health Personnel	2,879	2,638	241	24,631	23,163	1,468	32,305	33,131
Support Personnel	402	371	31	3,462	3,338	124	4,572	4,674
Management/Administration Personnel	1,669	1,788	(119)	14,759	15,372	(612)	20,422	19,349
Total Personnel	12,500	11,783	716	108,030	106,414	1,616	143,661	144,401
Outsourced Services	878	1,043	(165)	7,854	8,403	(549)	11,263	10,473
Clinical Supplies	2,531	3,367	(837)	22,968	24,894	(1,926)	32,503	30,234
Infrastructural and Non Clinical Supplies	2,546	2,783	(237)	22,702	23,052	(350)	30,976	30,389
Total Expenditure	18,455	18,977	(522)	161,554	162,764	(1,210)	218,404	215,498
Internal Allocations	62	171	109	561	667	106	930	748
Net Surplus/(Loss) before Interest & Capital Charge	405	179	(226)	5,596	5,770	174	9,426	10,351
Interest Received	7	50	43	65	396	331	400	87
Interest Paid	(280)	(224)	56	(2,481)	(1,869)	612	(2,850)	(3,306)
Capital Charge	(419)	(344)	75	(3,775)	(3,819)	(45)	(5,091)	(5,053)
Net Surplus/(Loss)	(287)	(339)	(51)	(595)	477	1,072	1,885	2,079

Consolidated Financial Position

Consolidated Statement of Financial Position \$000s	June 2010	CM Budget	CM Actual	Variance	DAP	Forecast
Bank	22,920	17,046	23,384	6,338	25,540	26,864
Debtors & Prepayments	9,646	22,362	11,602	(10,760)	22,666	8,453
Stock	2,016	2,318	2,004	(314)	2,318	2,318
Current Assets	34,582	41,726	36,990	(4,736)	50,524	37,635
Creditors	28,584	40,892	26,029	14,863	42,486	29,987
Employee Entitlements	25,921	25,601	30,686	(5,085)	23,736	25,925
Term Debt - Current Portion	1,580	2,404	13,262	(10,858)	2,404	2,404
Current Liabilities	56,085	68,897	69,977	(1,080)	68,626	58,316
Working Capital	(21,503)	(27,171)	(32,987)	(5,816)	(18,102)	(20,681)
Non Current Assets	157,119	168,494	166,844	(1,650)	165,702	166,550
Net Funds Employed	135,616	141,323	133,857	(7,466)	147,600	145,869
Long Service Leave	2,088	1,871	2,088	(217)	1,871	2,088
Retiring Gratuities	7,754	8,657	7,754	903	8,657	7,754
Sabbatical Leave	1,016	942	1,016	(74)	942	1,016
Term Debt	37,540	45,285	34,854	10,431	49,503	47,929
Non Current Liabilities	48,398	56,755	45,712	11,043	60,973	58,787
Crown Equity	87,218	84,568	88,145	3,577	86,627	87,082
Net Funds Employed	135,616	141,323	133,857	(7,466)	147,600	145,869

The major driver of variances to budget is the brought forward variance relating to the June 2010 position, particularly in relation to debtors and creditors balances. Taking that into account, material variances are confined to:

- Retained earnings due to \$2.7m better than budget financial performance YTD and \$1m equity injection (Oral Health Project);
- Accrued Salaries & Wages/Employee entitlements appear inflated due to unsettled MECAs and restructuring accruals in hand;
- Current and Non-Current Term Debt variances offset each other; and
- Timing of asset purchases has led to a positive variance of \$2.7m for capital expenditure, offset by a positive variance of \$1.0m in depreciation.

Of capital projects brought forward from 2010 (unbudgeted in 2011) and still incomplete, \$0.8m remains to be spent.

Consolidated Cashflow Position

Consolidated Statement of Cash Flows \$000s	Current Month			Year to Date			Full Year	
	Budget	Actual	Variance	Budget	Actual	Variance	DAP	Forecast
Operating Cash Flow Receipts								
Government & Crown Agency Received	32,773	30,842	(1,931)	285,033	284,745	(288)	379,710	382,130
Other Revenue Received	661	884	223	5,874	7,136	1,262	7,846	9,366
Total Receipts	33,434	31,726	(1,708)	290,907	291,881	974	387,556	391,496
Payments								
Personnel	12,666	12,483	183	109,402	102,969	6,433	146,247	145,126
Payments to Suppliers	4,963	3,690	1,273	45,297	49,127	(3,830)	59,957	63,231
Capital Charge	-	-	-	5,161	5,511	(350)	6,861	6,536
GST	(143)	(151)	8	(131)	(139)	8	(100)	(845)
Payments to Other DHBs	3,069	3,154	(85)	27,623	29,676	(2,053)	36,833	37,462
Payments to Other Providers	9,952	11,587	(1,635)	94,626	93,943	683	126,527	127,276
Total Payments	30,507	30,763	(256)	281,978	281,087	891	376,325	378,786
Net Cash Inflow/(Outflow) from Operating Activities	2,927	963	(1,964)	8,929	10,794	1,865	11,231	12,710
Cash Flow from Investing Activities Receipts								
Interest Received	68	135	67	602	1,135	533	802	1,268
Sale of Fixed Assets	18	2	(16)	54	100	46	9,285	9,285
Total Receipts	86	137	51	656	1,235	579	10,087	10,553
Payments								
Capital Expenditure	2,190	1,854	336	19,946	19,692	254	26,590	27,688
Total Payments	2,190	1,854	336	19,946	19,692	254	26,590	27,688
Net Cash Inflow/(Outflow) from Investing Activities	(2,104)	(1,717)	387	(19,290)	(18,457)	833	(16,503)	(17,135)
Net Cash Inflow/(Outflow) from Financing Activities	(395)	(7,330)	(6,935)	4,577	8,127	3,550	7,982	8,369
Net Increase/(Decrease) in Cash Held	428	(8,084)	(8,512)	(5,784)	464	6,248	2,710	3,944
Plus Opening Balance	16,618	31,468	14,850	22,830	22,920	90	22,830	22,920
Closing Balance	17,046	23,384	6,338	17,046	23,384	6,338	25,540	26,864

Consolidated cash balances are better than budget by \$6.3m. Major reasons for this are:

- Better than budget revenues have increased operating cash received over budget;
- Variances in accrual balances for operating payments, and personnel costs under budget have resulted in \$0.9m less operating payments than budgeted;
- Better than budgeted interest received, along with timing of Fixed Asset purchases have led to a positive \$0.8m variance in Cash from investing activities; and
- Net cash inflows from financing activities showing a \$3.5m positive variance YTD due to the timing of CHFA drawdowns and of \$1m equity injection relating to the Community Oral Health project.

APPENDIX 4 – FUND RESULTS YTD – STRATEGY AND PLANNING

Summarised Results Governance Arm

For the Month ending 31st March 2011

\$000	March 2011			Prior Year	Year to Date			Full
	Budget	Actual	Variance	YTD Actual	Budget	Actual	Variance	DAP
Revenue	458	458	0	4,260	4,126	4,185	59	5,501
Expenditure								
Personnel Costs	115	93	22	995	968	840	128	1,297
Outsourced Services	28	69	(41)	318	253	262	(9)	338
Infrastructural and Non Clinical Supplies	21	13	8	402	185	97	89	247
Provider Payments	0	(3)	3	0	0	0	0	0
Internal Allocations	52	52	0	422	467	463	4	623
Total Expenditure	216	224	(8)	2,137	1,874	1,663	211	2,504
Net Surplus/(Loss) before Interest & Capital Charge	242	234	(8)	2,124	2,252	2,523	271	2,997
Capital Charge	(143)	(140)	3	(1,486)	(1,345)	(1,377)	(32)	(1,766)
Net Surplus/(Loss)	99	94	(5)	637	907	1,146	239	1,231

Areas of concern/variances over \$10,000 or 10% whichever is the highest.

The Governance Arm of Strategy and Planning has a surplus of \$1,146k at the end of March which is \$239k favourable to budget. The favourable variance is mainly due to savings in personnel costs and discretionary expenditure.

- Revenue** – Shows a favourable variance (\$59k). This is revenue received for a secondment to the National Health Board (NHB). The DHB will not receive any more revenue as the employee has left the organisation to take up a full time position at the NHB.
- Human Resources** – Favourable variance of \$128k. Strategy and Planning employed FTEs are 3 less than budget. One Portfolio Manager position is being advertised the other 2 vacancies have been put into the 'Managerial FTE pool' (note this FTE funding is from the FUND Governance and Administration).
- Outsourced Services** – \$9k unfavourable to budget. The cost of the Central Region Technical Advisory Service Cardiology Network has been paid this month. The budget was phased over 12 months.
- Infrastructure and Non Clinical supplies (excluding capital charge)** – Favourable variance of \$89k. Savings continue to be made in staff travel, consultancy costs and legal fees.
- Capital Charge** – Unfavourable variance of \$32k. The Fund is showing a lower deficit than planned resulting in higher than budget Capital Charge.

Summarised Results Fund Arm

Summarised Results

For the Month ending 31st March 2011

\$000	March 2011			Year to Date			Full Year
	Budget	Actual	Variance	Budget	Actual	Variance	DAP
Revenue							
MoH Devolved Funding	29,249	29,646	397	260,469	262,146	1,678	347,292
IDF Revenue	591	629	38	5,320	5,623	304	7,093
Other Revenue	0	0	0	0	56	56	0
IDF and NGO Allocation	(13,905)	(15,417)	(1,512)	(122,670)	(124,182)	(1,512)	(163,496)
Total Revenue	15,936	14,858	(1,078)	143,118	143,644	525	190,889
Expenditure							
Personal Health Expenditure	12,483	12,575	(93)	110,863	111,184	(321)	147,851
Mental Health Expenditure	2,076	2,076	(0)	18,680	18,712	(32)	24,907
Public Health Expenditure	233	237	(4)	2,095	2,091	4	2,794
Disability Support Expenditure	1,114	1,356	(243)	9,999	10,072	(74)	13,330
Hauora Maori Services Expenditure	0	0	0	0	0	0	0
Governance Expenditure	458	458	(0)	4,126	4,126	(0)	5,501
Total Expenditure	16,363	16,703	(339)	145,763	146,186	(423)	194,383
Net Surplus/(Loss) before Interest & Capital Charge	(428)	(1,844)	(1,417)	(2,644)	(2,542)	102	(3,494)
Interest Received	61	85	24	537	739	202	715
Net Surplus/(Loss)	(367)	(1,760)	(1,393)	(2,107)	(1,803)	305	(2,779)

The FUND overseen by Strategy and Planning has a YTD deficit of \$1,803k against a budget deficit of \$2,107k at the end of March 2011. This is an overall positive variance of \$305k.

1. **Revenue** (including interest received) has a favourable variance of \$727k at the end of March. This is made up of \$2,239k variance for revenue received offset by the adjustment in allocation to Service Directorates for NGO and IDF expenditure not included in the DAP (\$1,512k). This is explained in more detail in the following.

Revenue variances not matched to expenditure in Fund Arm of Strategy and Planning

- a) One off prior year adjustments \$330K
 - \$201k – receipt of Additional Elective Services end of year funding for 2009/10;
 - \$90k – 09_10 washups for B4 school checks, Herceptin and NRT;
 - \$83k – Return of unspent Health Research Funds back to DHBs; and
 - (\$44k) - IDF washup 2009/10.

- b) Ongoing trend Revenue - \$474k
- \$202k interest received;
 - \$297k Hospice Funding;
 - (\$89k) unfavourable variance for Regional Forensic Position (there was confusion from the MoH as to whether this had been topsliced to the Regional provider or not and information since confirmed it must come out of DHB PBF); and
 - \$64k - Public Health Analyst.
- c) Unfavourable Revenue variances not offset by expenditure below budget (\$607k)
- (\$600k) Oral health Project - Estimate for MoH funding for operational costs has been revised down post DAP; and
 - (\$7k) Removal of funding for AYA cancer service specification.
- d) Additional revenue with expenditure in Services Directorates \$1,490k
- \$58k – PHO Performance management payment for 2009/10 higher than estimated at year end (CBSD);
 - \$56k - ACC (Sexual Abuse. A contract is in place to utilize this funding by the end of the year) (CBSD);
 - \$109k temporary funding for Golden Bay rest home (this is being funded from the MoH following an agreement with the Minister of Health – not from PBF so is additional funding) (CBSD);
 - \$40k funding for health services provided to CYFs residents (CBSD);
 - \$118k - Primary Mental Health funding (Suicide Prevention and Youth Addictions) (MHSD);
 - \$578k – Funding for Herceptin IDF outflow costs (CSSD);
 - \$24k – Health Assessments for Children entering residential care (CBSD);
 - \$174k - PHO VLCA and Care plus programmes (CBSD); and
 - \$333k – PHARMAC risk pool (CSSD).

Revenue variances for own DHB services (offset by expenditure in Fund Arm of Strategy and Planning) - \$527k

- \$122k – InterRai implementation;
- \$433k – additional funding for Herceptin drug costs in Pharmaceutical Cancer Treatments; and
- (\$28k) - Budget included in error as a MoH subcontract for National Supplies of Pandemic Antibiotics. This has been rolled into PBF for 2010/11.

Additional Allocation to service Directorates for IDF and NGO expenditure

Service	IDF/NGO	YTD Mar11 (\$000)
Community Services Directorate		
Health Services provided to CYFS residents	IDF	41
Joan Whiting temporary funding	NGO	109
ACC –Support for victims of Sexual Abuse	NGO	47
Health Assessments for Children entering residential care	NGO	16
Smokefree funding	NGO	26
Careplus – expenditure variance from budget	NGO	144
VLCA– expenditure variance from budget	NGO	29
PHO Performance management payment for 09_10	NGO	58
Subtotal Community		470
Mental Health Services Directorate		
Primary Mental Health Youth Addictions	NGO	44
Suicide Prevention Pilot	NGO	75
Suicide Prevention Pilot - Prior year surplus	NGO	12
Subtotal Mental health		130
Clinical services Directorate		
Herceptin - IDF outflows	IDF	578
PHARMAC risk Pool	NGO	333
Subtotal Clinical services		911
Total IDF and NGO allocation		1,512

2. Provider Payments – Year to date Provider Payments are \$423k above budget. This includes the costs of aged residential care for Christchurch evacuees post earthquake of \$278k. The ‘draft’ opinion from MoH is that there will be a washup at the end of the year using the IDF process but this has not yet been confirmed. Payments to our DHB-owned services are above budget by \$145k.

Details of own DHB Provider Payment Variances are shown below:

Personal Health**Unfavourable variances**

- Special dental Benefits - \$43k This is demand driven referrals from the School dental service (this represents good value demand);
- Community Pharmaceuticals - \$63k. This is demand driven (data is being collected and analysis is being done to address the drivers of this demand);
- Pharmaceutical Cancer Drugs - \$177k unfavourable. Herceptin drug costs are above the MoH estimates. (Unfortunately this was predicted as access was widened.) Expenditure now exceeds revenue for Herceptin but is offset by a favourable variance to budget for other PCT drugs. Funding YTD for Provider Arm Herceptin drug costs is \$433k; and
- Price Adjusters - \$36k Payment made to the Provider Arm for on-going operational costs for personal protective equipment stocks were not included in the budget.

Mental Health**Unfavourable variances**

- Alcohol and Other Drug Services - \$32k One off additional funding has been given to the DHB Provider to reduce the waiting list for Methadone treatment for the Blenheim district.

Health of Older People**Favourable**

- Aged Residential Care Services - \$295k. There has been lower bed occupancy particularly in Alexandra Hospital and Golden Bay than was estimated in the budget. This under spend is likely to reduce with the admission of clients evacuated from Christchurch to Alexandra Hospital.

Unfavourable

- Service Co-Ordination - \$93k. Additional funding has been received from the MoH for InterRai implementation (Clinical Support Services Directorate - Support Works budget).

IDF and NGO allocation to Service Directorates

The table below shows the variances in actual expenditure as at the end of March and the impact of adjustment to Internal Revenue on the surplus/(Deficit) by Directorate.

Fund Division Statement of Financial Performance By Services Directorate

\$000	March 2011			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
NGO and IDF Internal revenue						
CBSD - Community Based Services Directorate	6,728	7,198	470	57,449	57,920	470
CSSD - Clinical Services Support Directorate	3,609	4,520	911	33,108	34,019	911
MAORI - Director of Maori Health	8	8	0	75	75	0
MHSD - Mental Health Services Directorate	1,048	1,179	130	9,435	9,565	130
MSSD - Medical Surgical Services Directorate	2,511	2,511	0	22,603	22,603	0
Total Revenue	13,905	15,417	1,512	122,670	124,182	1,512
Provider Payments						
CBSD - Community Based Services Directorate	6,728	7,527	(800)	57,449	57,933	(484)
CSSD - Clinical Services Support Directorate	3,609	3,352	257	33,108	33,372	(264)
MAORI - Director of Maori Health	8	8	0	75	75	0
MHSD - Mental Health Services Directorate	1,048	1,066	(18)	9,435	9,590	(156)
MSSD - Medical Surgical Services Directorate	2,511	2,512	(1)	22,603	22,371	232
Total Provider Payments	13,905	14,466	(561)	122,670	123,341	(672)
Surplus/(Deficit) by Directorate						
CBSD - Community Based Services Directorate	0	(329)	(329)	0	(13)	(13)
CSSD - Clinical Services Support Directorate	0	1,168	1,168	0	647	647
MAORI - Director of Maori Health	0	0	0	0	0	0
MHSD - Mental Health Services Directorate	0	113	113	0	(26)	(26)
MSSD - Medical Surgical Services Directorate	0	(1)	(1)	0	232	232
Total SD Surplus/(Deficit)	0	951	951	0	840	840

The additional funding allocation to the Community Based Services Directorate has resulted in the Directorate showing a position close to breakeven. The expenditure below budget for primary maternity, PHO programmes and personal health home based support services offsets the overspends in Health of Older Persons Services.

Funding allocated to the Clinical Services Directorate has offset the increased expenditure on IDF outflows (Herceptin Drug costs) transferred to DHBs after the DAP was finalised. The YTD

surplus is due mainly to the estimated community pharmaceutical rebate increasing from \$1.9m to \$3.8m in the PHARMAC forecast.

Additional funding has been allocated to the Mental Health Directorate for expenditure above budget for Ministry funded primary mental health services. The YTD deficit of \$26k relates to expenditure on an Individual funding agreement with Capital & Coast DHB offset by expenditure below budget on Home based residential support.

Medical Surgical Services Directorate is showing a surplus caused by a favourable IDF wash-up for the 2009/10 year.

APPENDIX 5 – EMPLOYEE RELATIONS
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NATIONAL MULTI EMPLOYER COLLECTIVE AGREEMENT (MECA) UPDATE

MECA & UNION	COVERAGE	UPDATE
Resident Doctors Association (RMOs)	53 employees	The MECA expired on 31 December 2010. The parties came to an agreement in December 2010 to enter into an Interest Based Bargaining (IBB) process and a salary increase of 2% which mirrors the National Terms of Settlement agreed with other unions earlier in 2010. The IBB process was completed in early March with the parties resuming formal negotiations on 21 March. Agreement has been reached between the parties. The Union is now in discussion with its members prior to a ratification process being undertaken.
Associated Salaried Medical Specialists (ASMS)	132 employees	Discussions with the union resumed on the 15 March. The parties are exploring possible new SMO scales while awaiting the completion of an implementation plan for the draft business case previously developed. Further discussions are to be held with the Union on 31 March.
Clinical Physiology (APEX)	7 Employees	Negotiations reconvened on the 15/16 March. The Mediation Service has been requested to assist with the talks. No firm date for reconvening has been established, likely to be mid April.
Psychologists (APEX)	10 Employees	Previously covered by the PSA the local psychologists have now joined APEX. Negotiations continue with no new developments to report.

NMDHB & REGIONAL COLLECTIVE AGREEMENT (CEA) UPDATE

CEA & UNION	COVERAGE	UPDATE
Clerical South Island Region PSA	212 employees	This Agreement expired on the 31 December 2010. The Union initiated bargaining on the 1 December. The parties met on the 23 March and the Bargaining Process Agreement was signed. The Union presented new salary scale configurations which the DHBs are considering.

SECTION 5: FOR INFORMATION

SECTION 6: MEMBERS' ISSUES

GLOSSARY OF COMMONLY USED ACRONYMS, ABBREVIATIONS AND MAORI TRANSLATION

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

CPIP	Community Pharmacy Intervention Project
CPNE	Continuing Practice Nurse Education
CPO	Controlled Purchase Operations
CPU	Critical Purchase Units
CSR	Contract Status Report
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CTC	Contributions to Cost
CTANAG	Clinical Training Agency Nursing Advisory Group
CTU	Combined Trade Unions
CVD	Cardiovascular Disease
CVDRA	Cardiovascular/Diabetes Risk Assessment
CWD	Case Weighted Discharge
CYAERG	Child Youth Advisory & Expert Reference Group.
CYF	Child, Youth and Family
CYFS	Child, Youth and Family Service
DAP	District Annual Plan
DAR	Diabetes Annual Review
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DHBRF	District Health Boards Research Fund
DiSAC	Disability Support Advisory Committee
DGH	Director General of Health
DMH	Director of Maori Health
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSP	District Strategic Plan
DSS	Disability Support Services
DWCSP	District Wide Clinical Services Plan
EAP	Employee Assistance Programme
EBID	Earnings Before Interest & Depreciation
ECWD	Equivalent Case Weighted Discharge
ED	Emergency Department
EDA	Economic Development Agency
EFI	Energy For Industry
ELT	Executive Leadership Team
EMPG	Emergency Management Planning Group
ENT	Ears, Nose and Throat
EOI	Expression of Interest
ESA	Electronic Special Authority
ESOL	English Speakers of Other Languages
ESPI	Elective Services Patient Flow Indicators
ESR	Environmental Science & Research
ESU	Enrolled Service Unit
EVIDEM	Evidence and Value: Impact on DEcisionMaking
FF&E	Furniture, Fixtures and Equipment
FFT	Future Funding Track
FMIS	Financial Management Information System
FOMHT	Friends of Motueka Hospital Trust
FOUND	Found Directory is an up-to-date listing of community groups and organisations in Nelson/Tasman
FRC	Fee Review Committee
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent

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

LCN	Local Cancer Network
LIS	Laboratory Information Systems
LOS	Length of Stay
LSCS	Lower Segment Caesarean Section
LTC	Long Term Care
LTCCP	Long Term Council Community Plan
LTO	Licence to Occupy
LTS-CHC	Long Term Supports – Chronic Health 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
MHSWF	Maori Health and Wellness Strategic Framework
MOH	Ministry of Health
MOH	Medical Officer of Health
MOA	Memorandum of Agreement
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding
MOW	Meals on Wheels
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Technologist (or Technician)
MSD	Ministry of Social Development
NPA	Nutrition and Physical Activity
NRAHDD	Nelson Region After Hours & Duty Doctor Limited
NRT	Nicotine Replacement Therapy
MRSA	Methicillin Resistant Staphylococcus Aureus
NHBIT	National Health Board IT
NASC	Needs Assessment Service Coordination
NBPH	Nelson Bays Primary Health
NCC	National Capital Committee
NCC	Nelson City Council
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHCC	National Health Coordination Centre
NHI	National Health Index
NIR	National Immunisation Register
NMDHB	Nelson Marlborough District Health Board

NMDS	National Minimum Dataset
NMIT	Nelson Marlborough Institute of Technology
NPA	Nutrition and Physical Activity (Programme)
NPV	Net Present Value
NRAHDD	Nelson Regional After Hours and Duty Doctor Ltd
NSU	National Screening Unit
NTOS	National Terms of Settlement
NZHIS	NZ Health Information Services
NZMA	New Zealand Medical Association
NZNO	NZ Nurses Organisation
NZPH&D Act	NZ Public Health and Disability Act 2000
OAG	Office of the Auditor General
OIA	Official Information Act
OIS	Outreach Immunisation Services
OPD	Outpatient Department
OPF	Operational Policy Framework
OPJ	Optimising the Patient Journey
OSH	Occupational Health and Safety
OT	Occupational Therapy
PACS	Picture Archiving Computer System
P&F	Planning and Funding
PANT	Physical Activity and Nutrition Team
PBF(F)	Population Based Funding (Formula)
PC	Personal Cares
P&C	Primary & Community
PCI	Percutaneous Coronary Intervention
PCO	Primary Care Organisation
PCT	Pharmaceutical Cancer Treatments
PDR	Performance Development Review
PDRP	Professional Development and Recognition Programme
PDSA	Plan, Do, Study, Act
PFG	Performance Framework Group (formerly known as Services Framework Group)
PHS	Public Health Service
PHCS	Primary Health Care Strategy
PHI	Public Health Intelligence
PHO	Primary Health Organisation
PHOA	PHO Alliance
PHONZ	PHO New Zealand
PHS	Public Health Service
PHU	Public Health Unit
PIA	Performance Improvement Actions
PN	Practice Nurse
PPP	PHO Performance Programme
PSAAP	PHO Service Agreement Amendment Protocol
PT	Patient
PTAC	Pharmacology and Therapeutics Committee
PRIMHD	Project for the Integration of Mental Health Data
PVS	Price Volume Schedule
QA	Quality Assurance
QHNZ	Quality Health NZ
QIC	Quality Improvement Council
QIPPS	Quality Improvement Programme Planning System
Rangatiratanga	Autonomy, evidence of greatness (HW Williams Maori Dictionary pg 323)

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

April 2011