



**Nelson Marlborough
District Health Board**

NOTICE OF MEETING

OPEN MEETING

**A meeting of the
Community and Public Health Advisory Committee
of the Nelson Marlborough District Health Board
will be held on 22 June 2010 at 9.30 a.m. in the
DHB Seminar Centre Room 1
Braemar Campus, Waimea Road
Nelson**

Note: should you wish to join the meeting by videoconference from Blenheim, please contact the Secretary (03) 5461235 on or before 21 June 2010.

AGENDA**PUBLIC FORUM – 9:30 a.m.****OPEN SECTION – 9:40 a.m.**

- 9:40 a.m. Karakia (Jenny Black) and welcome (Chair)
- SECTION 1: **Apologies**
- SECTION 2: **Registrations of Interest**
- 9:50 a.m. SECTION 3: **Minutes**
- From previous meeting
 - Matters Arising
- SECTION 4: **Correspondence**
- 10:00 a.m. SECTION 5: **Monitoring Reports**
- Chair
 - Te Roopu Tupu Tahī
 - Director of Māori Health
 - GM Planning and Funding
 - GM Primary and Community
 - Members' Reports
 - Members' Issues
- 10:55 a.m. SECTION 6: **Government Priorities**
- 11:00 a.m. SECTION 7: **For Discussion:**
 "Transformed Care Through
 Integration Across Settings of Care"
- 12:25 p.m. Closing Karakia (Jenny Black)

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1 APOLOGIES

- Lorraine MacMath
- Liz Richards

2 REGISTRATIONS OF INTEREST

1) Committee Members

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
John Moore	<ul style="list-style-type: none"> ▪ Nil 	<ul style="list-style-type: none"> ▪ Member Nelson Regional Land Transport Committee ▪ Trustee Top of the South Athletics Charitable Trust. 		
Liz Richards	<ul style="list-style-type: none"> ▪ Member of Nelson Community Health Links Group ▪ Chair of the Upper South A Regional Ethics Committee 	<ul style="list-style-type: none"> ▪ Deputy Chair Canterbury Community Trust ▪ Member of Nelson Labour Electorate Committee. ▪ Appointed as Trustee Tasman Bay Heritage Trust. 	<ul style="list-style-type: none"> ▪ Advocacy and Health Issues ▪ Health Research ▪ Donations to community health groups. 	
Jenny Black	<ul style="list-style-type: none"> ▪ Life member of Diabetes NZ. 			
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. 	
Judith Holmes	<ul style="list-style-type: none"> ▪ Partner works for Child and Adolescent Mental Health Services (CAMHS). ▪ NMDHB representative on the Mapua, Ruby Bay and Moutere District Health Centre Inc Board 			
Lorraine McMath	<ul style="list-style-type: none"> ▪ Director of Wellbeing Works Ltd. 	<ul style="list-style-type: none"> ▪ NMDHB representative on Marlborough Regional Land Transport Committee 		<ul style="list-style-type: none"> ▪ Husband is Director of Construction Coatings and has been contracted for work with Wairau Hospital redevelopment.
Sonny Alesana	<ul style="list-style-type: none"> ▪ Nil 			

<p>Suzanne Win (ex- officio)</p>	<ul style="list-style-type: none"> ▪ Director of Split Ridge Associates Ltd that provides consultancy services to health & disability organisations ▪ Trustee of Gracelands Group ▪ Member of DHBNZ Chairs Executive with lead responsibility for workforce and participant on Tripartite Forum ▪ Partner is a part-time employee of NMDHB Provider Division. 	<ul style="list-style-type: none"> ▪ Trustee of Donald Beasley Institute ▪ Career Force Board Member (Currently on leave). 	<ul style="list-style-type: none"> ▪ Provision of consultancy services to health and disability organisations for DHBs or Ministry of Health. 	<p>Partner is</p> <ul style="list-style-type: none"> ▪ Member on PHO Alliance Executive ▪ Chair of West Coast PHO ▪ contracted to MOH to coordinate the implementation of the Cardiac Network ▪ Chair of the Board of Access Home Health Ltd ▪ Director on Management Board of Jack Inglis Friendship Hospital.
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As at 15 June 2010

2) Strategic Leadership Team Members

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Andre Nel	<ul style="list-style-type: none"> ▪ Member RACMA NZ ▪ Member of National Service & Technology Review Sub-committee (NSTR) ▪ Wife works for DHB. 		<ul style="list-style-type: none"> ▪ Certification/accreditation, appointment of medical administrator candidates. 	
Denise Hutchins	<ul style="list-style-type: none"> ▪ Member DHBNZ Workforce Group ▪ Surveyor/Team Leader Quality Health NZ. 		<ul style="list-style-type: none"> ▪ Certification/Accreditation. 	
John Peters	<ul style="list-style-type: none"> ▪ Director of SISSAL ▪ Trustee of Nelson Marlborough Hospitals' Charitable Trust ▪ Trustee Churchill Trust. 	<ul style="list-style-type: none"> ▪ Director of Management and Industrial Services Ltd. 	<ul style="list-style-type: none"> ▪ Shared services provision, administration of trust funds for health purposes & provision of private health services at Wairau Hospital ▪ MIS Ltd previously provided consultant services to other DHBs. 	
Keith Rusholme	<ul style="list-style-type: none"> ▪ Wife provides first aid training and confidential 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			
Nick Lanigan	Nil			
Nigel Trainor				<ul style="list-style-type: none"> ▪ Wife works for NMDHB Oral Health Services.
Peter Burton	Nil	<ul style="list-style-type: none"> ▪ NMDHB Representative on Tasman Council's Regional Land Transport Committee. 		

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Sharon Kletchko	<ul style="list-style-type: none"> ▪ Member Exceptional Circumstances Panel – PHARMAC ▪ Member St John Northern Region South Island 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. 	<ul style="list-style-type: none"> ▪ Deputy Chair of the New Zealand Standards Council. 		
Robyn Henderson	Nil			
Harold Wereta	<ul style="list-style-type: none"> ▪ Ngati Toarangatira Connections 		<ul style="list-style-type: none"> ▪ Tribal Interest 	

As at 15 June 2010

3 MINUTES

MINUTES OF THE OPEN MEETING OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD			
Date	27 April 2010	Time	12.30
Where	DHB Seminar Centre, Nelson connected to Support Services Room 3, Wairau Hospital, Blenheim by videoconference	Previous meeting date	23 February 2010
Present	John Moore (Chair), Judy Crowe, Sonny Alesana, Liz Richards, Jenny Black, Judith Holmes, Suzanne Win (ex officio)		
In attendance	John Peters, Peter Burton, Harold Wereta, Bruce Moorhead, Mark Garisch, Jean Wilson, John Brett, Naomi Arnold, Dave Dixon, Margaret Gibbs, Jane Kinsey, Andrew Swanson-Dobbs, Rennie Dix, Christine Smith, Rennie Dix, Joe Puketapu, Penny Wardle, Jasmin Brandt (minutes)		
Apologies	Nil		
Mihi/Intro	Judy Crowe		

Item	Discussion	Action
Public Forum	<p>John Brett and Jean Wilson, GreyPower</p> <p>Question 1 from John Brett re: Ostomy Services <u>Why is the budget for Ostomy overspent by \$36K?</u> NMDHB's Board Chair advised that she will respond to this query, as this information was originally requested at a Board meeting.</p> <p>Question 2 from John Brett re: DHB Elections <u>When will calls go out for community representatives for DHB elections?</u> CPHAC Chair explained that community representatives will be appointed once Board election held. That process will be publicly notified in due course. <u>Will there be a public talk to the community in regards to the progress made by the DHB over the last three years?</u></p>	Board Chair

Item	Discussion	Action
	<p>NMDHB’s Board Chair advised that the annual report fulfils the DHB’s requirement to report on the year gone by, and is the most appropriate tool to do so. A public talk might be seen as ‘politicking’.</p> <p>Question 3 from John Brett re: Changes to Wairau Hospital <u>John Brett noted that demolition of the nurses home had commenced and wondered if there was a way to be informed of the changes going on?</u> NMDHB’s Board Chair noted that this information is available on NMDHB’s website, and that John Brett will be added to the recipient list of the regular newsletter providing updates of the changes going on.</p>	<p>Board Chair</p>
Apologies	<p>Nil</p>	
Registrations of Interest		<p>Moved: Liz Richards Seconded: Judy Crowe THAT THE REGISTRATIONS OF INTEREST BE NOTED. AGREED</p>
Minutes	<p>Matters Arising</p> <p>Acute Care Review. Chair noted that regular updates would be appreciated, as discussed previously. It was noted that these might possibly come to CPHAC as part of Alliance updates in future.</p>	<p>Moved: Jenny Black Seconded: Judith Holmes THAT THE MINUTES OF THE MEETING ON 23 FEBRUARY 2010 BE ADOPTED AS A TRUE AND CORRECT RECORD. AGREED</p>
Correspondence	<p>Correspondence was noted</p>	
Reports	<p>Committee Chair Verbal report given</p> <p>Chair noted that the Interagency Sustainability Forum is having a strategy session on 28 April, which the Chair will attend and report on next time where appropriate.</p>	

Item	Discussion	Action
	<p>Te Roopu Tupu Tahī Report taken as read</p>	<p>Moved: Judy Crowe Seconded: Liz Richards THAT REPORT FROM TE ROOPU TUPU TAHI BE RECEIVED. AGREED</p>
	<p>Director of Maori Health Spoke to his report.</p> <p>Whanau Ora The Director of Maori Health noted that at this point in time the impacts from the Whanau Ora taskforce report on the health sector are not known and that substantial changes are expected over the next two to three years. In the meantime, NMDHB continues with its programme as planned. Noted that</p> <p>The IHB Chair advised that discussions around roll-out of Whanau Ora have commenced, that IHB will report back once matters of funding become clearer. Liz Richards noted that once the budget is released we will know where funds will be coming from.</p> <p>Pacific Health The CEO of Kimi Hauora Wairau advised that a Pacific Health coordinator had been appointed yesterday. The role entails 20 hours per week and is Blenheim-based.</p> <p>Regional Seasonal Employers Scheme Noted that some 300 workers expected under RSE this year. Harold noted he was looking into visiting contractors as part of the relationship building.</p>	<p>Moved: Judith Holmes Seconded: Sonny Alesana THAT THE REPORT FROM THE DIRECTOR OF MAORI HEALTH BE RECEIVED. AGREED</p>
	<p>GM Planning and Funding The Acting GM Planning & Funding Mark Garisch spoke to the report.</p>	<p>Moved: Liz Richards Seconded: Jenny Black • THAT THE REPORT FROM THE GENERAL MANAGER PLANNING AND FUNDING BE RECEIVED.</p>

Item	Discussion	Action
		<ul style="list-style-type: none"> • THAT THE FINANCIAL REPORT BE ADOPTED. <p>AGREED</p>
	<p>GM Primary and Community Taken as read</p> <p>Financial report. Noted that there is no detail attached, in consistency with previous reports.</p> <p>Fee Schedule for Nelson Region After Hours and Duty Doctor (appendix C) GM P&C noted that we need to remember that this service is what it is, i.e. a service provided outside office hours, hence higher costs. Noted that fees are in line with what is seen around the country. However, the fee structure is being reviewed at present in an attempt to further remove barriers to access. GP Liaison for Nelson noted that it is essential to continue to work with the Emergency Department to improve the public's access to GP After Hours services instead of public hospital ED services. Noted that ED services are encouraging those people who are suited to seek out a primary care provider, while not turning them away as such. Noted that bringing down the fees for After Hours services was likely to increase access, but that currently at weekends the service was already at full capacity.</p> <p>Question was raised whether on casual weekdays, if the regular GP is not available and people go to the After Hours clinic instead, do the fees apply to locals? Yes the fees apply because there is no capitation attached. It was noted that the cheaper rate through the GP people are enrolled with is meant to encourage people to stay with their own GPs.</p> <p>A CPHAC member noted that she would like to see the removal of barriers for children of all ages. Noted that this should be addressed as part of the acute services review.</p>	<p>Moved: Jenny Black Seconded: Judy Crowe THAT THE REPORT FROM THE GENERAL MANAGER PRIMARY AND COMMUNITY BE RECEIVED.</p> <p>AGREED</p>

Item	Discussion	Action
	<p>CPHAC Chair asked if there are any GPs who consider providing GP services from 5-8pm, as has been done in the past? GP Liaison for Nelson noted that this was unlikely, and that this time would be considered After Hours and would mean costs go up.</p> <p>NBPH Report on VLCA Dr Outreach Clinics (appendix D) It was noted that the service was targeted at specific people, i.e. those with the highest need, and has been hugely successful, with nearly 500 people regularly accessing these VLCA services.</p>	
<p>Government Priorities</p>	<p>The Alliance Concept</p> <p>NMDHB's Chief Executive noted that this district is particularly well placed for the Alliance; that the 'natural' next step for the existing relationships with PHOs is working in partnership. Noted that the Alliance concept fits well with the Minister's expectations around providing 'Better Sooner More Convenient' care. Expected to have Alliance agreement in place as of 1 July 2010.</p> <p>Noted that the three management teams involved are excited about this new concept and are looking forward to next steps. Noted that final accountability to the Ministry lies with NMDHB although the level of engagement will be a much more collaborative approach. The foci will lie on doing things differently in order for the Alliance to achieve increased efficiencies, increased ability to measure outputs, and elimination of duplication of processes.</p> <p>Question raised if the Iwi Health Board's Executive will be engaged for input? NMDHB's CE noted that Alliance contracting could be applicable for all areas, ultimately.</p> <p>CPHAC Chair asked what the new structure would need from CPHAC from a governance point of view? NMDHB's CE noted that while the Alliance is a different way of contracting, this applies more at the implementation level, not governance level, and that the interaction of the three organisations is</p>	

Item	Discussion	Action
	<p>outlined in their respective Memorandum of Understanding. Strategic directions of the organisations are not anticipated to change. CPHAC can expect to receive more outcome orientated reports (versus activity orientated).</p> <p>NMDHB's Board Chair added that while this concept is relatively new to us, Canterbury DHB strongly promotes this approach and have successfully used it. Noted that governance will remain governance. Noted that Alliance will not be another layer but seen as an enabler. Allows for clinical engagement where it was not always possible in the past.</p> <p>Are transactional costs expected to reduce through Alliance contracting? Unknown at this point; however, NMDHB's CE noted that he is not expecting an increase.</p>	
Presentation	<p>How to Embed Population Health Gains – PHO and DHB joint activity</p> <p>Presenters: NMDHB's GM Primary and Community (P&C) Peter Burton, Nelson Bays Primary Health (NBPH) CEO Andrew Swanson-Dobbs and Kimi Hauora Wairau (KHW) CEO Christine Smith</p> <p>NMDHB's GM P&C noted that an understanding of our unique place in the health care continuum is needed to enable the transformational approach to population health. Change in language reflects and supports the transformation, for example the use of words such as: partnering, mutual innovation, shared learning, etc.</p> <p>The CEOs of NBPH and KHW spoke to a number of examples which demonstrate joint efforts undertaken by PHOs and DHB to embed population health gains, such as</p> <ul style="list-style-type: none"> • Golden Bay Integrated Health Services. • Community Nutrition Service – Marlborough 	

Item	Discussion	Action
	<ul style="list-style-type: none"> • Rural Marlborough • Pharmacy Facilitation • Immunisation facilitation • Tobacco Control. <p>Noted that all of the above are Alliance based relationships.</p> <p>NBPH CEO added that PHOs are data rich in areas where the DHB is not, that information sharing will be essential in identifying duplications and barriers from meeting targets (e.g. immunisation).</p> <p>Discussion <u>From experience, how can we do better in regards to our relationship with local territorial authorities to achieve/ embed health outcomes?</u></p> <p>KHW noted that they already have a really good relationship with their Council, Seddon and RSE are such an example. KHW CEO meets regularly with the mayor to address issues.</p> <p>NMDHB's GM P&C noted that the list of projects reflecting collaboration with TLA is significant, e.g. Golden Bay, seasonal workers.</p> <p><u>How will we meet the immunisation target?</u> Noted that there were ways to identify and target specific population groups in order to raise their awareness, also in regards to consequences of non-immunisation.</p>	
Presentation	<p>Walking and Cycling Model Communities</p> <p>Presenters: NMDHB's Richard Butler and Nelson City Council's Andrew James</p> <p>Noted that Nelson is competing with a handful of other cities for the funding that is available for this pilot scheme (\$2M for 2010/11 and \$5M for 2011/12).</p>	

Item	Discussion	Action
	<p>Prior work already in place in Nelson that complements the Walking and Cycling Model:</p> <ul style="list-style-type: none"> - Regional Land Transport Strategy - Sustainability Policy - Cycling and Pedestrian Strategies - Land Development Manual - Heart of Nelson - Residential Subdivision Policy. <p>Noted that lots of plans are under way. Winning the pilot scheme will enable Nelson to make plans reality faster and better. Andrew James spoke to slides outlining ideas for improvements/ visions for improved walking/ cycling.</p> <p>Longer term focus on creating dedicated radial routes:</p> <ul style="list-style-type: none"> - Greenways - Green highway - Cycle boulevard - Pedestrian boulevard - Shared space <p>Removing barriers</p> <ul style="list-style-type: none"> - Connecting up routes - Links through CBD <p>NMDHB has contributed to this through Way2Go:</p> <ul style="list-style-type: none"> - Pedometer Programme - Spring Strut Stride - Walking Groups - Guided Walks - Sunday Cyclovia - Bike Trailer - Cycling Education Programme - Upcycle. 	

Item	Discussion	Action
	<p><u>What can the DHB do to assist with the competition?</u></p> <ul style="list-style-type: none"> • It was noted that a lot of work has been done already, e.g. letter of support. What would be useful would be ideas on how to evaluate potential health benefits and promotion by talking about it, getting people behind the Walking and Cycling Model. • NMDHB's Chief Executive noted that he is familiar with New Plymouth walkway, which has garages containing free-loan mobility scooters at each end of the walkway. Might be useful for Nelson to incorporate a focus not just on health but also disability access. Suggestion made to contact CCS, Foundation for the Blind, IHC, Ed Kiddle (Wellness Cluster) for suggestions and feedback, e.g. braille markers. • Pathways to local conference facilities could also be a useful addition. 	
General Business	Liz Richards noted apologies for the next meeting in June	
The meeting closed at 3.25 p.m.		

RECOMMENDATION

THAT THE MINUTES OF THE MEETING HELD ON 27 APRIL 2010 BE ADOPTED AS A TRUE AND CORRECT RECORD OF THE MEETING

MATTERS ARISING

- Nil

4 CORRESPONDENCE

Nil.

5 MONITORING REPORTS

5.1 CHAIR'S REPORT

Verbal report

5.2 REPORT FROM TE ROOPU TUPU TAHI

Again there are two meetings of Te Roopu Tupu Tahi to report on this time. We met on 20 April at Wairau Hospital and on 1 June in Nelson.

These are some of the items we covered at the April meeting:

Sharing Resources for Workforce Development: Following on from our Workforce Development Workshop at the last meeting, we spent some time adding details to the training plans which had been developed. We now have a list of training opportunities for this year – local, regional and national, on-line and face-to face, which NGOs can tap into. This has been an extremely useful exercise for NGOs as many of them have very limited resources for providing training in-house and for accessing external workshops and courses. Lorraine Eade has taken over the production of the monthly workforce calendar, co-ordinating both training requests and training programmes offered. By collating NGOs' individual Workforce Development Plans she co-ordinates requirements to get the best use of resources to meet their objectives.

NGO Activities: Some of the activities of individual groups have included: **Health Action Trust** was present at the opening of the new Saxton Field Stadium with the mental health message: "raising your mood for 12 hours takes 20 minutes of exercise". **SF Nelson** Carers Writing Group has produced a "Roar Power" calendar for 2010 taking the theme of The Year of the Tiger. **Kimi Houora** Wairau PHO have an anxiety management clinic starting in May which is contracted to Relationship Services. This includes a course of therapy for 6 sessions for those with mild to moderate conditions. And **Nelson Bays PHO** is providing a Brief Intervention service from new premises, offering up to 4 sessions for those with mild to moderate conditions. This service is also available in Motueka and they are looking at providing a similar service in Tapawera. **SF Marlborough** have extended their service to Picton and have offered their premises to other mental health providers at an attractive rental.

Mental Health Promotion: Members of Te Tau Ihu Mental Health Promotion Network gave a presentation on achievements to date and plans for the future. The Network was formed in 2008 from a meeting looking at services to reduce stigma and discrimination in relation to mental illness. Their focus has been on identifying gaps in services and how to fill them, how to provide consumer representation, and how to provide assistance to outreach areas. The group has also developed strategies for how to work collectively and purposefully together, how to approach professional development, and how to strengthen health promotion principles and services. Mental Health

Awareness Week in October last year provided an opportunity to look at the various issues of mental wellbeing in the workplace, and this has led to quite a bit of activity in larger workplaces in the Nelson region. A significant reduction in staffing in health promotion has curtailed some of this work, and the group is now exploring where to go from here and who else should be included. Their priorities will include alcohol and other drugs, family violence and mental health in schools.

At the June meeting our agenda included two presentations:

Nelson Bays Primary Health Organisation: Jane Kinsey, the Programme Development Manager, gave an overview of the Nelson Bays Primary Health Organisation and explained its structure and funding streams. Jane works in the area of health promotion and improving access and has responsibility for the PHO's relationships with health organisations outside of general practice supporting the delivery of good quality health care. This involves working with the community to get them to be self-empowered to improve their own health. Her role is to make sure the providers' information is known to GPs, to wrap multi-disciplinary support services around them so that the system works. They invest resources in education and workforce development for health workers. For their work in reducing health inequalities they ensure every programme has targeted outcomes, and some money is ring-fenced for special groups and projects. Promoting community leadership is another aspect of their work, which is assisted by the fortnightly publication of a newsletter for the community (see www.bewell.org.nz). They also publish a Directory of Health Services which has a printed and online version. They have a range of relationships, agreements, contracts, memoranda of understanding, partnerships, and a relationship manager is appointed for each one setting out how they work together and what help the PHO can provide. At the meeting Jane offered NGO access to some PHO workforce development funding and further discussion will take place on this.

Addictions and Co-existing Disorders: Eileen Varley and Debbie Christie from the Alcohol and Other Drug Service gave a presentation on the development of the part of their service which assists people who have both addiction (substance use disorder) and mental health problems. This is now termed Co-existing Disorders. This service has been staffed by one FTE nurse since 2008. It is a very specialist area requiring a close liaison with the Mental Health Service in particular the MCT. It is estimated that 40% of people with a substance use disorder also have an anxiety disorder. It is not always easy to determine why this is, as addiction can cause mental illness and mental illness can cause addiction. There are also underlying risk factors as about 50% of people are vulnerable through their genetic make-up. The treatment of both the substance use and the mental illness concurrently is important because of factors such as an increased risk to violence, homelessness, poor treatment compliance, the reduced effect of medication

that the substance use can cause, and a slower recovery from illness. The service has found that it is best to ask simple questions to get to the root of their problems. They assess the person's readiness for change and involve significant others in their treatment. Debbie gave some useful advice for NGOs who have clients with co-existing disorders. For instance: to stay positive and helpful, to ensure the responsibility for the condition rests with the client, to get them to recognise the need for change, to use one's peers for support and advice, and to get specialist help when appropriate. She said that in the management of co-existing disorders a team approach is often necessary, and both the mental illness and the substance use disorder should be treated in parallel with a focus on what's driving the substance use. Treatment options are pharmacological, psychological, AA/NA or Rational Recovery, detoxification, and rehabilitation.

Rutherford Initiative: There was discussion about recent media articles on the report on Mental Health Services by the Rutherford Initiative Group. Disappointment was expressed that an article in the Marlborough Express led some workers at Care Marlborough to believe that they were going to lose their jobs. However, some members of the network believe that media attention to the Rutherford decisions is helpful as it gets the message out into the community that services are going to be affected. But statements around an anticipated increase in crime and suicide rates is disappointing as it undermines the amount of good work already done by mental health providers. TRTT network has agreed to have a standard agenda item at our meetings on collaboration and consolidation (to further implementation of Rutherford decisions) and members indicated that they are keen to get the process of collaboration going and are approaching this in a positive way. A special meeting was to be held between NGOs and the Planning and Funding Portfolio Manager (Lorraine Eade) after Te Roopu Tupu Tahī meeting.

Other Items: Disappointment was expressed that the Ministry of Health is no longer going to fund the **Mental Health Advisory Coalition**. The NGOs are concerned that there will no longer be a forum for feedback from the regions to the Ministry. **Workforce development programmes** are being well supported by NGOs and the new regime developed at the April meeting is working well.

Te Roopu Tupu Tahī Terms of Reference: The network has finalised and approved the Terms of Reference and these are included as Appendix A for your information and comment.

Carol Gowan
Facilitator
Te Roopu Tupu Tahī

RECOMMENDATION
THAT THE REPORT FROM TE ROOPU TUPU TAHI BE RECEIVED.

5.3 REPORT FROM DIRECTOR OF MĀORI HEALTH

5.3.1 Whanau Ora Programme

Operational Programme

The Maori Health Directorate supported by IHB hosted a meeting with Maori Health Provider Board Chairs and managers. This followed the full IHB Board meeting held on 10 June 2010. Nicola Ehau of Te Rau Matatini facilitated this two-hour workshop. The focus of the work was to:

- Agree what the collaborative intention is
- What does this look like when it is in place (knowing we have arrived)
- Governance and management accord
- Timeline for implementation and completion.

There were challenges raised from the session:

- Why the need for a coalition? Providers are pretty happy with the way things are going.
- What would be the incentive from their (Maori health providers) end that would ensure their service is looked after?
- How will the DHB ensure that their individual interests are looked after?
- They don't want a repeat of Ko Te Poumanawa Oranga? How will their ownership interest be managed in this arrangement?
- What things will the DHB expect us (Maori health providers) to share?

We were able to get Board Chairs to agree that their managers be tasked with continuing the work towards achieving a Maori Health Provider Coalition.

The DHB is now planning a one- or two-day workshop to delve into more detail about the structural arrangements that the coalition might take in the near future.

Whanau Ora: Report of the Taskforce on Whanau-Centred Initiative

Te Puni Kokiri has now released the Whanau Ora Expression of Interest (EOI) report. The EOI criteria seeks information on:

- Best Whanau Outcomes – Explain how you would work with Whanau and encourage them to identify their goals.
- Whanau Opportunity – Describe how you would identify the collective strengths within Whanau and build them towards solutions.
- Whanau Integrity – Explain how you will work with whanau to ensure their aspirations are realised and their whanau self-determination achieved.
- Nga Kaupapa Tuku Iho – Explain how you would strengthen whanau connection with and participate in Te Ao Maori.

- Coherent Service Deliver – Discuss how you will intend providing customised services and will work across sectors to meet the diverse needs of whanau in your community.
- Competent and Innovative Service Provision – Identify your priorities for innovation and capacity and capability building to achieve best outcomes for Whanau (includes workforce and practitioner training).
- Effective resourcing – Outline the change you propose to make to your current service delivery model, organisational structure and resource allocation to implement Whanau Ora.

Applicants will need to have evidence or attestations from funding agencies of which the DHB will be part of this process. The DHB will review applications based on:

- What the national requirements are for Whanau Ora (as set out above); and
- How the application will support regional developments for Whanau Ora.

Applications open on 10 June 2010 and close 7 July 2010.

5.3.2 Pacific Health

Two key developments have taken place since the last report to this committee. In summary:

- Nelson Bays Primary Health and the Nelson Bays Pacific Community Trust celebrated the signing of the Memorandum of Understanding on 15 May 2010. This marks an important achievement for the Pacific community in that it has now forged a stronger connection that will support health outcomes for their people.
- Kimi Hauora Wairau PHO and the Marlborough Pacific Community Trust signed their Memorandum of Understanding on 29 May 2010. Marlborough has a diverse Pacific population. A high percentage of the population are seasonal workers. This celebration acknowledges the importance of the relationship with the Pacific community.
- Pacific Pandemic packs have been ordered for the community. Four have arrived and two will be co-located in the Marlborough and Nelson Bays Pacific Community Trusts. The other two packs will be held by the respective PHOs.

RECOMMENDATION

THAT THE REPORT FROM THE DIRECTOR OF MĀORI HEALTH BE RECEIVED.

5.4 REPORT FROM GM PLANNING AND FUNDING

5.4.1 Update on the NM Patient Care Alliance

Nelson Marlborough District Health Board (NMDHB) and the Iwi Health Board (IHB) recognise the value and significance of establishing a 'Partnering Alliance' with Kimi Hauora Wairau Marlborough PHO (KHW) and Nelson Bays Primary Health PHO (NBPH) and NMDHB's Health Services providers in the first instance. We believe that this alliance will further local ability to deliver on Government policy for 'Better Sooner More Convenient' (BSMC) Primary Health Care through ensuring coordination and management of care particularly for Nelson Marlborough people who have multiple and/ or complex long term conditions and those who have poorer health status. To do this successfully according to the definition of an 'alliance' requires us to work together as a team, 'share' in both the gain and the pain, and, to connect our currently 'fragmented' service providers around the needs of our patients.

The key purpose of coming together as an Alliance i.e. our mission, is *"to develop health services around the patient as an integrated 'programme of care' unconstrained by organisational boundaries"*¹. We have agreed to adapt the model outlined in the paper entitled *'Constellation Collaboration – A model for multi-organisational partnership'* authored by Tony Surman of the Canadian Centre for Social Innovation and published in June 2006.

The strategic group is currently drafting the "Patient Care Alliance Charter" for Governance of all partners. The purpose of the draft 'partnering charter' is to affirm and emphasise the collaborative culture required for any future 'relationship contracting' (agreement/s) we will enter into. This Partnering charter includes the 'strategic mission', the principles to manage our relationships to give effect to any such agreement/s, each partner's moral commitment such as trust, equity, co-operation, commitment, good faith and the development of, and commitment to, mutual goals and objectives. The partners expect the charter to overcome any inherent adversarial nature of future agreement/s and, as such, sits outside any future agreement/s but requires any current agreement/s to be modified to support the partnering arrangement. There is provision in the charter for accepting new partners as well as exiting some onto the 'stewardship/partnership group' and for addressing any conflicts/issues that arise over time.

The partnering charter will inform the formal 'alliance agreement' and the operational /'constellation groups'². Also in the work scheme are the

¹ The NHS Plan DOH July 2000 -

http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/documents/digitalasset/dh_4055783.pdf

² Constellations are "self-organising action teams" that operate in cooperation with a broader strategic vision. The structures and initiatives of the collaboration take the form of "constellations" - clusters of activity in which a subset of the partners

necessary inclusion of the 'BPMC Policy settings, including alliance-based agreements (these are underpinned by the new PHO agreement version 19); a flexible funding pool³ and a monitoring framework⁴.

5.4.2 Dental National Agreement

The GM Planning and Funding is expecting 100% of NM's current dental providers to sign the national agreement for 2010/11. We are continuing to work nationally to address some concerns by Dentists regarding some of the payments for procedures/ diagnostics.

5.4.3 Patient Reported Outcomes Measures (PROMs) Pilot

The joint MoH/ NMDHB PROMs pilot programme is progressing. The pilot's required numbers of patients receiving cataract surgery have almost been completed and follow-up post-operative review and reassessment using the EQ-5D tool is currently being set up. The numbers of patients in the study undergoing major joint surgery is slightly behind that planned for this stage of the pilot. This delay is due to the need to align internal surgical services procedures around initial patient assessment and entry to the surgical waiting list. This alignment has now been achieved. Post-operative review and reassessment using the EQ-5D tool for these patients is also being organised.

5.4.4 Mental Health and Addictions

Suicide Prevention Action Position

Notification has been received from the Ministry of Health that the Suicide Prevention Action Position is to continue for an additional two-year period. Agreement has been reached with Nelson Bays Primary Health to host the position as of the 1 July 2010.

Information on the Rationale and Process Regarding the Cuts in Mental Health Funding

Please refer to Appendix B for a full response to the Member's Issue received concerning information on the rationale and process regarding the cuts in mental health funding.

voluntarily participates. Constellations can be formal projects, occasional and opportunistic initiatives, or committees that guide particular aspects of the work of the partnership.

³ Flexibility to enable local prioritisation and specification and to improve innovation and responsiveness to clinically-led service development – the focus of which is to achieve smooth transitions and deliver agreed changes. The 'NM Patient Care Alliance' will jointly determine how the 'pooled resources' are used to deliver services and achieve outcomes for patients that are of highest local priority.

⁴ The monitoring framework is designed to focus the alliance on achievement of shared system-level outcomes; provide the Governance and Stewardship groups with information to assess the impact of SBMC and to assess progress on the agreed actions.

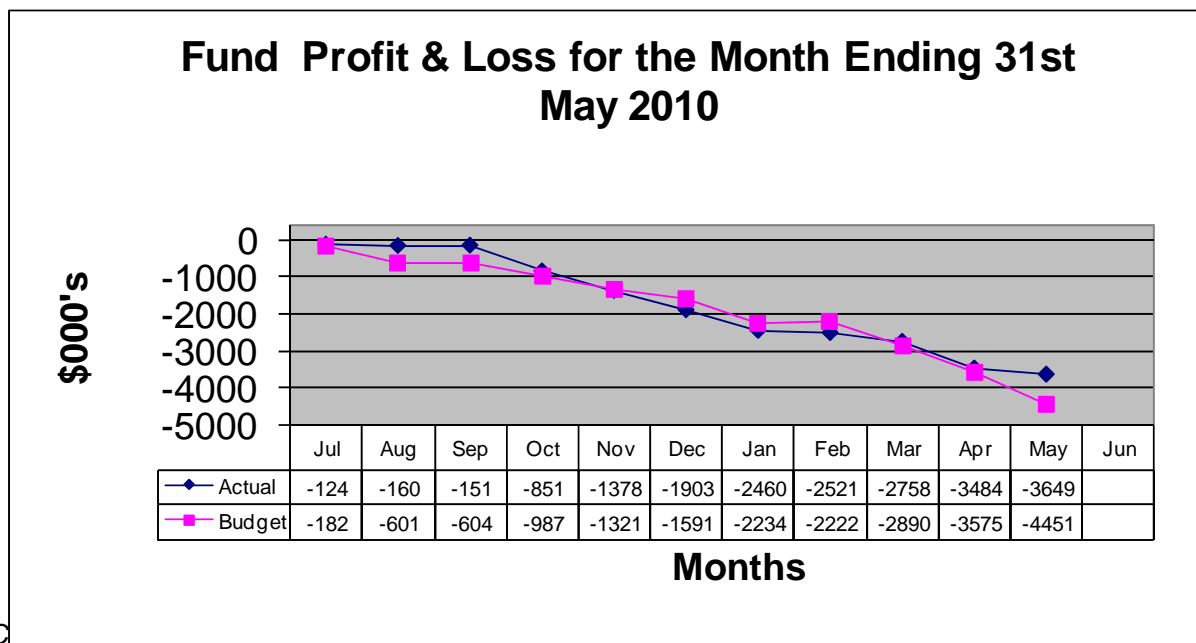
5.4.5 Financial Report

Operating Result NMDHB Fund Division

Statement of Financial Performance for the 11 Months to 31st May 2010

\$000's	YTD	YTD	Variance		Annual	Year End	Forecast
	Budget	May-10	YTD		Budget	Forecast	Variance
REVENUE							
PBF Vote Health - Mental Health Ringfence	32,490	32,568	78		35,444	35,534	90
PBF Vote Health - Funding (excluding Mental H	263,920	263,920	(0)		287,913	287,913	(0)
PBF Adjustments	-	(215)	(215)	1	-	(222)	(222)
MOH - Funding Subcontracts	11,819	13,902	2,083	2	12,893	16,099	3,206
IDFs - Mental Health Services	606	714	108	3	661	779	118
IDFs - All Other (excluding Mental Health)	5,375	5,373	(2)		5,864	5,846	(17)
Other DHB Revenue	-	-	-		-	-	-
Interest	1,385	763	(622)	4	1,502	839	(663)
REVENUE TOTAL	315,595	317,027	1,432		344,276	346,788	2,512
EXPENSES							
Governance & Admin	5,189	5,189	(0)		5,661	5,661	-
Personal Health	230,894	230,197	697		252,026	252,034	(8)
Mental Health	33,562	33,703	(141)		36,618	36,783	(165)
Maori Health	2,536	2,471	65		2,766	2,766	(0)
Disability Support	47,866	49,115	(1,249)		52,170	53,533	(1,363)
EXPENSES TOTAL	320,046	320,675	(629)		349,242	350,777	(1,536)
Net Result Mental Health Ringfence	(466)	(420)	45		(513)	(470)	43.20
Net Result - All other services	(3,986)	(3,228)	757		(4,452)	(3,519)	933
Net Result - All Services	(4,451)	(3,649)	803		(4,965)	(3,989)	976

The Fund has a deficit of \$3.649M against a budget deficit of \$4.451M at the end of May 2010. This is an overall positive variance of \$803K.



Revenue: The total Fund revenue is above budget by \$1.432M at the end of May.

The unfavourable variance for Ministry funded programmes not yet invoiced (\$810K) includes revenue budgeted for new programmes not yet implemented, i.e. Emergency Planning, Smoke Free, Oral Health Project and Immunisation Co-ordination. Except for the Oral Health Project, costs have not yet been incurred against these programmes. The New/ Additional Funding streams shown in the table below, except for revenue relating to 2008/09, will be offset by additional expenditure.

1 Population Based Funding (PBF) Adjustment (\$215K Unfavourable)

Funding Stream	Amount (\$000)
NNPAC Funding	51
Child Youth and Family services	(11)
Herceptin treatment	110
Reduction for Herceptin Drug costs	(357)
Removal of AYA funding	(8)
Total PBF Adjustments	(215)

MoH Funding Subcontracts (\$2,083K Favourable)

Unfavourable variances

Funding Stream	Amount (\$000)
Shifting Services claw back	(199)
B4 School Checks	(52)
Other MoH Programmes not yet invoiced	(810)
Interim Funding Pool for disability services	(94)
Pacific Provider Development prior year pay back	(3)
Minor variances from budget	(3)
Total Unfavourable Variances	(1,162)

New/Additional Funding

Funding Stream	Amount (\$000)
PHO Programme funding	395
New Smokefree funding	20
Rural After Hours Premium	415
Additional Primary Mental Health	517
AOHS price increase	174
Additional NRT services	219

Travel Assistance - accommodation allowance	303
Hospice	362
Primary Health Innovations fund	23
Universal Newborn Vision Hearing Screening	73
Population Health Analyst	85
Herceptin refund for 08_09 & 09_10	366
NRT washup 08_09	62
InterRai funding	111
Antenatal HIV screening	8
School based health services	90
Total Additional MoH Subcontract funding	3,223

Subcontract Funding in advance

Funding Stream	Amount (\$000)
HEHA programmes	22
Total MoH Subcontract funding invoiced in advance	22

3 IDF Mental Health: Revenue received from the Regional Forensic contract funded by Canterbury DHB (\$108K)

4 Interest Received

Unfavourable variance (\$622K) continues due to interest rates falling below the rate used at the time the budget was set

Expenditure: Overall year to date Provider payments are \$629K over budget. Overspends are in Mental Health and Disability Support Services

Provider Payments

(on the following page)

\$000's	Budget	Actual	Variance		Annual	Year End	Forecast
	YTD	YTD	YTD		Budget	Forecast	Variance
Personal health							
Child and Youth	1,426	1,453	(27)		1,556	1,589	(33)
Laboratory	4,930	4,844	86		5,379	5,286	92
Maternity	9,740	9,696	44		10,626	10,578	47
Sexual Health	677	673	4		738	735	4
Dental	5,979	5,659	320	5	6,525	6,221	304
Pharmaceuticals	29,333	29,805	(473)	6	31,983	32,544	(562)
Pharmaceutical Cancer Treatment	2,000	1,424	576	7	2,182	1,566	616
GP Services	21,478	21,912	(434)	8	23,430	24,561	(1,130)
Rural Bonus	4,008	4,219	(211)	9	4,373	4,640	(267)
Immunisation	909	833	76	10	967	800	167
Radiology	2,474	2,472	2		2,699	2,699	0
Palliative Care	3,211	3,518	(308)	11	3,502	3,870	(368)
Other Community Based Services	7,507	7,370	137	12	8,190	8,113	77
Chronic Disease Management	1,127	1,133	(6)		1,229	1,247	(18)
Medical/Surgical	91,263	89,839	1,424	13	99,559	98,003	1,557
Emergency Services	7,136	7,136	0		7,785	7,785	0
Miscellaneous Services	3,794	2,182	1,612	14	4,300	2,380	1,921
Price Adjusters	548	567	(19)		597	618	(21)
Patient Travel & Accommodation	3,921	4,375	(454)	15	4,296	4,844	(548)
Pacific Peoples Health	-	-	-		-	-	-
Nutrition and Physical activity	1,882	1,882	0		2,053	2,053	0
Tobacco Control	552	519	33	16	602	602	(0)
HPV Programme	551	522	29	17	601	568	33
Vision hearing Screening	-	101	(101)	18	-	101	(101)
Inter District Flows	26,449	28,061	(1,612)	19	28,854	30,631	(1,778)
TOTAL PAYMENTS - PERSONAL HEALTH	230,894	230,197	697		252,026	252,034	(8)
Maori Health							
Whanau Ora	1,480	1,457	23		1,614	1,638	(24)
Workforce and Service development	1,056	1,014	42		1,152	1,128	24
Other Maori Health	-	-	-		-	-	-
TOTAL PAYMENTS - MAORI HEALTH	2,536	2,471	65		2,766	2,766	(0)
Mental Health							
Acute Mental Conditions	4,887	4,887	(0)		5,331	5,331	(0)
Sub-Acute & Long Term Mental Conditions	1,738	1,738	0		1,896	1,896	0
Respite	958	982	(24)		1,045	1,070	(25)
Alcohol & Drug	3,559	3,574	(15)		3,883	3,912	(29)
Child & Youth Mental Services	4,101	4,084	17		4,474	4,456	18
Forensic Services	251	340	(89)	20	274	372	(98)
Kaupapa Maori Services	382	376	6		416	410	6
Mental Health Team Services	8,825	8,824	1		9,628	9,626	1
Prison/Court Liaison	126	126	0		137	137	0
Mental Health Workforce Development	58	62	(5)		63	67	(4)
Day Activity & Rehab Services	1,146	1,195	(50)		1,250	1,304	(55)
Consumer and Carer/Family Support	550	533	17		600	581	19
Home Based Support	398	380	18		434	422	13
Community Residential Beds & Services	4,000	4,084	(84)		4,364	4,453	(89)
Mental Health – Other	133	84	49	21	151	92	59
Inter District Flows	2,450	2,434	16		2,672	2,654	18
TOTAL PAYMENTS - MENTAL HEALTH	33,562	33,703	(141)		36,618	36,783	(165)
DHB Governance & Administration	5,189	5,189	(0)		5,661	5,661	-

Provider payment year-to-date (YTD) variances from budget (>5% and/or \$100K) are as follows:

Personal Health

Total payments for Personal and Public Health services are \$697K below budget.

Unfavourable

- 6 Pharmaceuticals (473K). Demand for community pharmaceuticals increased in December through to March. Year to date expenditure (net of rebates) to the end of March was 8% higher than the same period last year. The budget for 2009/10 was based on the Pharmac expectation of 6% increase in expenditure. This is being investigated jointly with SISSAL. NMDHB had the second highest percentage growth in the South Island between 2007 and 2009. Initial investigations indicate that the rate of growth for non PHO prescribers is driving this increase
- 8 GP Services (\$434K). Payment for PHO programmes (Careplus, VLCA and Performance Management) and Primary Mental health initiatives have been higher than budget. This is offset by additional revenue from MoH
- 9 Rural Bonus (\$211K). This is due to utilisation of the additional Rural Premium funding received from MoH for Rural After Hours GP services.
- 11 Palliative Care (\$308K). Expenditure on this service is higher than budget due to utilisation of additional funding from MoH for Hospice services plus a one off payment of \$97K relating to long term care services provided in 2008/09
- 15 Patient Travel and accommodation (\$454K) Due to increase in the subsidy for accommodation to a maximum of \$100 per night plus increased patients traveling to Tertiary DHBs for specialist treatment. This is partly offset by additional funding from the Ministry (\$303K)
- 18 Vision Hearing Screening (\$101K). This is a Ministry funded programme
- 19 Inter District Flows (IDFs) (\$1,612K) is due to the accrual of a provision of \$1,600K for over-delivery of Personal Health inpatient IDFs based on volumes to the end of January. The IDF outflows appear to have leveled off in the first quarter of 2010 and the washup may be less than forecast.

Favourable

- 5 Dental (\$320K) – Expenditure on the demand driven Adolescent Oral Health Service is less than budget. In addition the funding for the School Dental project has been deferred due to delays in the implementation of the new services.
- 7 Pharmaceutical cancer Treatments (PCT) (\$576K) – The budget for PCT expenditure was over estimated as it was based on 2008/09 expenditure which included Herceptin costs funded directly by the Ministry of Health. These costs were reimbursed after the budget was set. Expenditure on PCTs (excluding Herceptin) has been less than expected nationally.
- 10 Immunisation (\$76K) – Due to reversal of an over accrual for 2008/09 immunisation expenditure.
- 12 Other Community Based Services (\$137K) – Savings have been made in home based support services provided to personal health clients (post acute, palliative support and paediatric carer support) with changes made to eligibility criteria to access household management services and duration of service provision.
- 13 Medical Surgical (\$1,424K) – Favourable variance relates to budget for unallocated Additional Elective (AE) volumes. These are being delivered as IDF outflows to Tertiary DHBs.
- 14 Miscellaneous Services (\$1,612K) – This is the risk provision for demand driven expenditure.
- 16 Tobacco Control (\$33K) – The contracts for Smokefree Leadership programmes are not spread evenly through the year.
- 17 HPV Programme (\$29K) – Fees for the administration of the HPV vaccine are included in the immunisation expenditure.

Māori Health

Total payments for Māori Health services are \$65K below budget. The under spend has reduced from \$118K at the end of January with the establishment of the Whanau Ora Te Huarahi Mate Pukupuku service.

Mental Health

Total payments to Mental Health providers are over budget by \$141K. Additional services have been put in place to utilise Mental Health funding received for Effective Interventions (Alcohol and Drug Services) and to employ an additional Regional Forensic FTE.

Unfavourable

- 20 Forensic Services (\$89K). Regional initiative funding is being utilised by the Provider Arm.

Favourable

- 21 Mental Health - Other (\$49K). The budget for contract price increases is held in this line and offsets overspends in Mental Health service lines.

Year-end Forecast

The following assumptions have been made:

- Community Pharmaceuticals expenditure for May will be \$90K over budget and will finish at \$562K overspent
- Pharmaceutical cancer treatment expenditure will remain below budget.
- Overspend in Rural Bonus expenditure is due to utilisation of Ministry funding for After Hours services provision by rural GPs
- Additional Electives included in the Medical/ Surgical budget will be used to fund IDF elective volumes above budget
- Over delivery of IDF elective inpatient volumes will result in a washup of \$1.7M at the end of the year
- Overspend in Personal Health IDFs includes outflows to the value of \$78K for services provided to Children and Youths in residential care.
- The budget for risk will offset the overspend in demand driven areas such as aged residential care
- The recovery plan for HBSS is not fully achieved and expenditure for the year will be \$328K over budget.

RECOMMENDATION

THAT THE REPORT FROM THE GENERAL MANAGER PLANNING AND FUNDING BE RECEIVED.

5.5 REPORT FROM GM PRIMARY AND COMMUNITY

May 2010

5.5.1 Health Protection and Health Promotion

Needle Exchange Programme

The local needle exchange scheme (NEX) has enquired about setting up a mobile exchange scheme for the Mapua–Motueka area. As a harm reduction measure NEX is a national scheme that allows drug users to exchange old needles for clean needles. The local premises will be revisited once the service plan under development has been reviewed.

Tasman District Council Draft Annual Plan

A presentation has been made to Tasman District Council Draft Annual Plan on behalf of the NMDHB. An invitation has been received by the Marlborough District Council to present at their Annual Plan Hearing Panel in June.

Health Impact Assessment as part of the Nelson City arterial traffic flow study

Stage 1 and 2 of the study have been released for public comment and targeted public consultation with identified interest stakeholder groups has commenced.

Adolescent Oral Health

The 2009 adolescent utilisation rate for accessing adolescent oral health services for the district is 80%, against a 2009 DAP target of 76%.

Nelson secondary and intermediate school reducing smoking initiation and increasing smoking cessation programme

A proposal has been developed for Nelson secondary schools and Intermediate schools to establish a student driven, staff and NMDHB supported, smokefree programme that focuses on reducing smoking initiation and increasing smoking cessation. The programme is centred on the ABC Smokefree Approach incorporating staff, students, parents and community groups. Staff of schools (especially ex smokers) will train as Quit Card providers and cessation support resource people. A cross section of students (yr 10 to yr 13), ideally previous smokers, will be trained as 'cessation support people'.

5.5.2 Nutrition and Physical Activity Programme

Breastfeeding Action Plan

The review and update of the Nelson Marlborough Breastfeeding Action Plan has commenced with an interactive workshop held involving 19 organisations.

Fruit Tree Plantings

Marlborough District Council continues to promote and encourage feedback from the Marlborough Community, to expand fruit tree plantings in the region. An NPA Agreement commenced with Kaitakawaenga programme to promote and support fruit trees and vegetable gardens within the Maori community.

Nutrition and Physical Activity

NPA chaired the professional development session of 'Nutrition Risk in Older People, Making Meals Matter' seminar attended by over 20 health professionals, on older person's nutritional needs.

5.5.3 Primary Health Care***Outreach Immunisation Service***

There has been a significant improvement in referrals to the OIS service in Marlborough in part due to the OIS nurse working more closely with two general practices and the Marlborough Immunisation facilitator targeting the practice with the highest number of overdue children in Marlborough. During May nineteen children have received their overdue vaccinations.

B4 School Checks

The B4 school team have continued with clinics working towards the quarterly target with the emphasis on reaching high deprivation children. Despite the best efforts of the B4 school team the target for high deprivation will not be achieved this quarter. However, the overall population target is on track to be achieved.

5.5.4 Primary and Community Development***Golden Bay Integrated Care***

The DHB is part way through the Ministerial consent process for transfer of property and other equipment needed to support the provision of a range of integrated health services in Golden Bay. This is a prerequisite to the establishment of a charitable trust for the purposes of raising money. Meanwhile the Crown Health Financing Agency (CHFA) has issued an RFP to 5 investors who look at funding this type of project. A response due by 16 June. The Interim Management Group have also started approaching philanthropic organisations as part of a broader fundraising plan. CHFA are also looking at options for managing the Treaty clearance mechanism for use of the hospital site land.

Clinical Services Planning for Managing Acute Presentations

is focussing on: developing a new pathway for patients with cellulitis - a proposal has been developed for Nelson Bays Primary Health to coordinate

the treatment of soft tissue infections in primary care for all patients presenting to the Emergency Department in Nelson (~500 per year); establishing a capability at 96 Waimea Road for treating simple fractures - including the potential for a minor fractures clinic to be delivered there (20-30 patients per week); and, improving the signage for both ED and 96 Waimea to help patients make the appropriate choice.

Nelson Region After Hours and Duty Doctor (NRAHDD)

Work is underway on reviewing the progress that has been made in establishing an after hours GP service arrangement for the greater Nelson urban area. The current service started in 2007 but is not yet self sustaining. However it has been successful in three areas, by providing:

1. A vehicle that enables GPs to fulfil their after hours obligations to their patients and visitors in a less onerous manner than would have otherwise been the case;
2. A daytime low cost access service within an area that has the highest un-enrolled / high deprivation population in Nelson. The service currently has almost 500 enrolled patients and it has the capacity to grow further. The location of the service is particularly relevant in that the Acute Services Review. Among other things this identified that people living in areas of high economic deprivation are more likely to use ED services and, the greatest users of ED are from geographic areas close to ED.
3. A service that works cooperatively with NMDHB clinicians to deliver improved care to the population and a vehicle for better managing inappropriate ED presentations and shifting some services provided in a secondary setting to primary care. As identified above, it could provide a vehicle for the simple fractures and IV cellulitis treatment currently provided by ED to be dealt with in primary care.

As such, while there is considerable scope to enhance the services provided by NRAHDD. However, the current building is a limiting factor in the ability to significantly extend the volume and range of services offered by NRAHDD particularly over weekends and in the summer months when patient volumes are at their highest. As a result a business case is being drafted to provide expanded accommodation for the service.

Health Promotion Plan

A single health promotion plan for the Primary and Community Division is being drafted for presenting to the Ministry of Health by 1st July. It will integrate the activities of the Public Health Service health promotion and the Nutrition and Physical Activity Programme teams. This new plan will replace the existing individual health promotion components of both teams, and will lay

the foundation for developing a district-wide plan in collaboration with our PHOs.

5.5.5 Financial, Primary and Community Division By Business Line:

\$'000	Year to Date			Year		
	Actual	Budget	Variance	Forecast	Budget	Variance
Revenue						
PHS	5493	5540	(47)	5990	6044	(54)
NPA	1979	1889	90	2157	2061	96
Development	1473	1469	4	1607	1603	4
Total Revenue	8945	8898	47	9754	9708	46
Costs						
PHS	4873	5507	634	5405	6030	625
NPA	1782	1838	56	1882	2007	125
Development	1110	1280	170	1202	1398	196
Total costs	7765	8625	860	8489	9435	946
Surplus (Deficit)						
PHS	620	33	587	585	14	571
NPA	197	51	146	275	54	221
Development	363	189	174	405	205	200
Total Surplus	1180	273	907	1265	273	992

Year-to-date income and expenditure is tracking in line with previous expectations but well ahead of budget.

RECOMMENDATION

THAT THE REPORT FROM THE GENERAL MANAGER PRIMARY AND COMMUNITY BE RECEIVED.

5.6 MEMBERS' REPORTS

Nil received.

5.7 MEMBERS' ISSUES

- **Rationale and Process regarding the funding cuts in mental health** (refer to appendix B for a response, as per the GM Planning and Funding report)
- **Future Meeting Times** – morning or afternoon for the remainder of 2010?

6 GOVERNMENT PRIORITIES

7 FOR DISCUSSION

Time	Topic	Speaker
11:00 -12.30	“Transformed Care Through Integration Across Settings of Care”	
	A. Intro: How do we transform the existing system into an integrated system? Introduce the new structure and actions that will get us there. Define our goal and why we are taking an integrated approach	GM Planning & Funding
	B. Provide examples including lessons learned, e.g. Alexandra Hospital, Golden Bay, collaboration of Maori health providers	GM Primary & Community
	C. Ask for feedback on gaps/ priorities. General discussion.	Everyone

8 APPENDIX A: TERMS OF REFERENCE TE ROOPU TUPU TAHI

1.0 BACKGROUND

Te Roopu Tupu Tahi was established in 2000 as a network for mental health provider and consumer organisations in the Nelson Marlborough district. Two years later it was formally recognised as the mental health advisory forum for the Nelson Marlborough District Health Board, and reports regularly to the Board's Community and Public Health Advisory Committee.

While initially focussing on specialist and community mental health service development, the scope of Te Roopu Tupu Tahi now encompasses a populations of need approach that caters for healthy populations, at risk populations, early onset of conditions without complications, multiple conditions and end stage conditions.

The work of Te Roopu Tupu Tahi is guided by national and regional strategic objectives for mental health, and its network is used as a consultative forum for mental health strategic and action plans for both the District Health Board and the South Island Region.

2.0 PURPOSE

Te Roopu Tupu Tahi has three primary aims:

- To foster collaboration among all Nelson Marlborough providers of mental health and addiction services and also key stakeholders, including consumers/tangata whaiora and their families/whanau.
- To provide advice and expertise on mental health issues to the Nelson Marlborough District Health Board, South Island Regional Mental Health Network and the membership of Te Roopu Tupu Tahi.
- To support the implementation of Regional and District Plans, by undertaking specific projects as agreed by the membership of Te Roopu Tupu Tahi.

It will achieve these aims by ensuring that opportunities are provided:

- for networking,
- for the membership to be informed and kept up to date on events, issues and trends; and
- for consultation and collaboration

3.0 NAME

The name Te Roopu Tupu Tahī signifies the Top of the South (*Te Tau Ihu o Te Waka a Maui*) coming together as one.

4.0 MEMBERSHIP

Membership is open to all mental health and addiction providers, consumer/tangata whaiora organisations, family/whanau organisations, primary mental health sector, Primary Health Organisations, public health sector, Kaupapa Maori mental health providers, District Inspectors, and Planning and Funding staff.

5.0 TASKS

Te Roopu Tupu Tahī tasks are as follows:

Task	Achieved by ...
Establish a strong mental health network for the Nelson Marlborough district that takes a collaborative approach to support the improvement of mental health services to tangata whaiora and their families.	<ul style="list-style-type: none"> • Te Roopu Tupu Tahī six weekly meetings, incorporating standing agenda items. • Distributing relevant mental health information through Te Roopu Tupu Tahī email list. • Establishing Te Roopu Tupu Tahī working groups to address specific emergent issues. • Advocating for improved mental health services where appropriate.
Provide advice and expertise on mental health issues to governance and management of NMDHB and other agencies.	<ul style="list-style-type: none"> • Providing advice on mental health goals and projects aligned to NMDHB's Strategic and District Annual Plans and SIRMHN Plans. • Providing advice and expertise on specific emergent issues identified by Planning and Funding. • Assisting with identification of mental health service gaps and with the prioritisation of future mental health service development. • Providing representatives to subsidiary mental health working parties, advisory groups, steering groups as required.

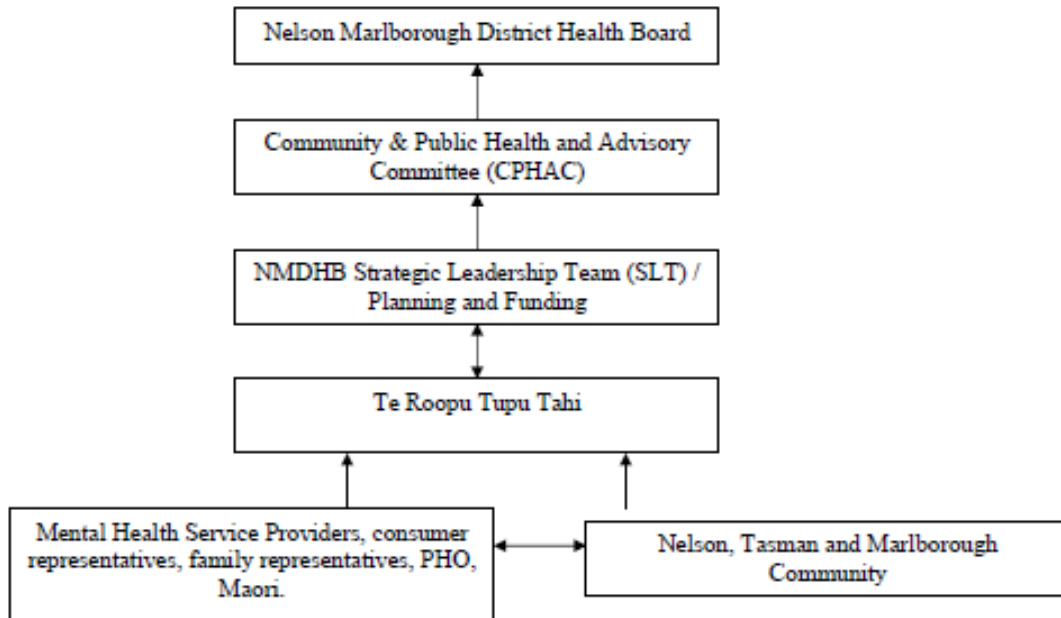
Task	Achieved by ...
Provide opportunities for improving workforce capability and capacity within the mental health sector.	<ul style="list-style-type: none"> • Establishing workforce planning groups from time to time to assist with capacity and capability building. • Providing regular educational sessions on topics relevant to the sector.
Conduct a review among members of the achievements and effectiveness of Te Roopu Tupu Tahī once per year	Review of performance and Terms of Reference completed on an annual basis and supplied to CPHAC.

6.0 PROCESS

The process is as follows:

1. Te Roopu Tupu Tahī hui held six weekly, with approximately two being held in Nelson to one in Blenheim. Hui will also be held in Takaka and Motueka from time to time.
2. Agenda and reports to be sent out for each meeting at least one week prior to the meeting.
3. Minutes will be taken and recorded by a dedicated person, then circulated to all members (identified on a mailing list). Minutes, once approved, to be published on NMDHB website.
4. A report on each meeting will be provided to CPHAC from the Chair. Any items that TRTT members would like to be included in the CPHAC report to be raised at the TRTT meeting or forwarded to the Chair directly.
5. Permanent chair and secretarial service to be provided by the DHB.

7.0 LINES OF ADVICE & COMMUNICATION



9 APPENDIX B: RESPONSE TO MEMBER'S ISSUE

CPHAC Members Issue

Information on the rationale and process regarding the cuts in mental health funding
22 JUNE 2010

This paper is in response to a member's issue for CPHAC regarding information on the rationale and process regarding the cuts in mental health funding as signalled in the 2009/10 DAP.

1.0 Background:

In early 2009, the Ministry of Health informed the NMDHB that we had overspent our mental health ringfence by approximately \$1.8M. This information came at a time when the DHB was signalling a significant deficit with regard to our total budget for 2009/10. As a result we agreed to reduce our expenditure in mental health over the following three years to come within the mental health ringfence.

It is important to note that for the Hospital Mental Health Provider approximately \$0.34M of this 'cost' was never delivered due to Blueprint funding not eventuating and inability to fill some positions. This essentially left \$1.45M of mental health funding to be recovered from both community and Hospital providers out of a total budget of over \$36.6M. Payments to Mental Health providers represent around 10% of the Fund's total revenues and grew by 5.2% from 2007/08 to 2008/09 and 3.8% from 2008/09 to 2009/10. Mental Health services for specialist and community services are purchased on an input based funding model e.g. FTEs, bed nights, programmes, as per the national services framework for Mental Health (mental health services specifications). Payments to Mental Health Providers also represent around 11% of the Fund's total payments to Providers.

The mechanism that NMDHB used was the Chief Executive's Rutherford Initiative (RI). The Rutherford Initiative Group (RIG) prepared a report for the Chief executive in January 2010 consequent to a thorough evaluation of all the NGO mental health service contract lines. The GM Planning and Funding is responsible for the implementation of the recommendations and proceeded by formally notifying providers of relevant recommendations that affected their service agreement in the first week in March 2010.

2.0 Additional Mental Health Services funded during 2009/2010 outside of the Mental Health Ringfence:

NMDHB was one of only five DHBs chosen to pilot the role of Suicide Prevention Coordinator and was also successful in obtaining additional funds for a Primary Mental Health Initiative to address the majority of mental health problems in our population. The funding level is now set at \$1.064 million for the 2010/2011 year. This investment is supporting earlier intervention for those patients with mild to moderate need.

3.0 Process

In April 2009, the GM Planning and Funding and the Mental Health Portfolio Manager met with all Mental Health and Addiction Providers to outline the current economic

environment and to identify the need to save \$1.8 million. The Rutherford Initiative Group Process involved:

- A combined Hospital Provider and Planning & Funding, Mental Health Service Review Team (SRT), constituted according to the RI process, meeting was held on 2 November 2009 and identified a number of opportunities for recovery of funding.
- A subsequent presentation was made to the SRT by Planning & Funding on 23 November 2009 to work through those opportunities in detail.
- An additional SRT meeting was held on 2 December 2009 to consider the merits of encouraging consolidation of NGO Mental Health and Addiction Providers to enable more funding to be spent on front-line services.
- These opportunities were separated into two groups: opportunities that have been identified by P&F to enable service/contract changes and for which the implementation process could commence immediately; and, those that required additional analytical work to quantify and review the impact of any services changes.

4.0 Rationale:

Service changes were underpinned by the following criteria:

- Whether the service is a core Mental Health service (part of the 3%)?
- Whether or not the Provider has demonstrated a health gain for consumers?
- Whether or not, as a result of the service being provided, there is any evidence of an Improved Quality of Life for the consumer?
- Considering the above, whether the service should be changed?
- Whether or not the Provider might have any viability issues as a result of the service change?
- Whether there are any gaps in the services currently being provided?

All NGO Mental Health and Addictions Providers filled out their RIG Line by Line Review (*with the Mental Health Portfolio Manager*) templates. The templates provided information to the RIG SRT and covered service performance; quality; innovation; opportunities; risks; strategic alignment and the consumer population served by the Provider. Eighteen months of input/output data were collected from all NGO Quarterly Reports and presented to the Rutherford Initiative Group Service Review Team. In association with the criteria identified above, the information collected highlighted a range of opportunities for service change.

Service Description	Rationale	Changes
Kaupapa Maori Adult Planned Respite	Volume capacity within the service, along with the recent establishment of a service user led pre/post acute crisis service that has agreed to use their spare capacity for planned respite.	140 bed nights
Addiction Services	Service initiated by provider, but supported by NMDHB initially. Service self funded by service users. A 50% utilisation of an addictions respite service. Service changes due to volume capacity issues. Addiction's wananga initially purchased from underspend. Joint venture with Community Corrections.	1 programme 182 bed nights 0.45 FTE 1 wananga

Service Description	Rationale	Changes
Community Support Workers	Low volume of service users to FTE ratio	4.0 FTE
Day Activity Programme	In Nelson and in Blenheim, three Day Activity programmes within close proximity of each other. Service users access a number of these programmes.	2 programmes
Work Rehabilitation, Employment and Education	A core function of the Ministry of Social Development.	1.5 FTE
Consumer Advocacy and Peer Support	Volume less than available capacity and workforce capacity issues.	0.25 FTE
Workforce Development	Maintaining equity across all NGO providers (NMDHB no longer provides NGO workforce development grants)	3 programmes

5.0 Health outcomes/reducing health inequalities:

The RIG template requested NGO's to identify how they contributed to reduced health inequalities. The number of service users on Work and Income benefits ranged between 66% to 95%; and, the number of Maori across services, depending on the service and the provider, ranged between 6% to 95%.

Some of the cost savings were determined by identifying volume and capacity issues. For example, one provider had an average Community Support Worker caseload of five services users per FTE, where the average caseload should be between 10 and 15. Therefore there is capacity to either increase caseloads or reduce capacity to the caseload volume.

6.0 Maori

The three Kaupapa Maori Mental Health and Addiction Providers are all affected by the service changes. The Peer/Support Advocacy position based in a rural area has been a challenge since its inception as the small resource of 0.25 FTE meant recruitment and retention has been an issue. This allocation is because the number of service users is relatively small. Service users still have access to the COMPASS 0800 line (locally funded NMDHB peer support and advocacy service) for support or through the Community Support Worker so removing the 0.25 FTE does not impact on the services for consumers.

The Alcohol and Drug Counselling of 0.45 FTE in total is a small service change to two Providers who both have caseloads that are lower in comparison to other providers. This service change is unlikely to impact on the number of tangata whaiora being seen. One provider altered their model of care to involve more intensive group work to reach more tangata whaiora. Another provider has had a commitment to enhancing their workforce capacity..The staff involved are near completion of their studies, therefore volumes should (over time) increase.

The addictions weekend wananga were initially funded by NMDHB as a one off from our underspend. The increased number of wananga were never considered a longer term investment. The weekend wananga ran two times a year in a joint venture with Community Corrections for up to 20 tangata whaiora at a time. It is acknowledged that tangata whaiora are also able to access the Addictions Counselling service.

7.0 Access to, and quality of services:

- Tangata whaiora who accessed the Kaupapa Maori Peer Support Advocacy Service, will still have access to the COMPASS 0800 line, and/or the rurally based Community Support Worker.

- Service users/Tangata whaiora will still have access to Day Activity services, albeit a slight reduction in choice from three to two day programmes.
- The reduction in the volume of Community Support Workers should have minimal affect on the number of service users supported, given that there is volume capacity by increasing caseloads to an average of 10 to 15 service user caseload.
- Supporting Families in Mental Illness/Wellness workforce development has no direct impact on service users. This service agreement was to support Family/Whanau and Fieldworkers training and conference attendance and was always short-term.
- The Care Marlborough service agreement maintains a Workforce Development Calendar, which will now be picked up by the DHB Planning and Funding Division.
- For the Work Rehabilitation/Education/Employment Support services, the Ministry of Social Development has the core role/responsibility in this sector, and there are synergies with their existing programmes.
- Service users currently accessing the Kaupapa Maori Adult Planned Respite service (*which is delivered by a mainstream provider*), will still have access through their Case Managers to respite services delivered by the Hospital Provider Division service including pre/post acute crisis service.
- The Addictions Service Support House should be self sustainable. There has been less than full capacity in accessing the addictions respite service.

10 GLOSSARY OF TERMS

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
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
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
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
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
EOI	Expression of Interest
ENT	Ears, Nose and Throat
ESA	Electronic Special Authority
ESOL	English Speakers of Other Languages
ESPI	Elective Services Patient Flow Indicators
ESR	Environmental Science & Research
ESU	Enrolled Service Unit
FF&E	Furniture, Fixtures and Equipment
FFT	Future Funding Track
FMIS	Financial Management Information System
FOMHT	Friends of Motueka Hospital Trust
FOUND	Found Directory is an up-to-date listing of community groups and organisations in Nelson/Tasman
FRC	Fee Review Committee
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
FVIP	Family Violence Intervention Programme
GM	General Manager
GMS	General Medical Subsidy
GP	General Practitioner

GRx	Green Prescription
HAC	Hospital Advisory Committee
H&DC / HDC	Health and Disability Commissioner
HBI	Hospital Benchmarking Information
HBSS	Home Based Support Services
HBT	Home Based Treatment
HDSP	Health & Disability Services Plan Programme
HDU	High Dependency Unit
HEeADSSS	Psychosocial tool – Home, Education, eating, Activities, Drugs and Alcohol, Sexuality, Suicidality (mood), Safety
HEHA	Healthy Eating Healthy Action
HEP	Hospital Emergency Plan
HESDJ	Ministries of Health, Education, Social Development, Justice
HFA	Health Funding Authority
HHS	Hospital and Health Services
HIA	Health Impact Assessment
HM	Household Management
HMS	Health Management System
HODs	Heads of Department
HOP	Health of Older People
HPI	Health Practitioner Index
HPV	Human Papilloma Virus
HR	Human Resources
HR & OD	Human Resources and Organisational Development
IANZ	International Accreditation New Zealand
IBA	Information Builders of Australia
IDF	Inter District Flow
IDSS	Intellectual Disability Support Services
IFRS	International Financial Reporting Standards
IHB	Iwi Health Board
IM	Information Management
InterRAI	Inter Residential Assessment Instrument
IPAC	Independent Practitioner Association Council
IPC	Intensive Patient Care
IPC Units	Intensive Psychiatric Care Units
IPG	Immunisation Partnership Group
IPU	In-Patient Unit
IS	Information Systems
ISSP	Information Services Strategic Plan
IT	Information Technology
JAMHWSAP	Joint Action Maori Health & Wellness Strategic Action Plan
KIM	Knowledge and Information Management
KPI	Key Performance Indicator
KHW	Kimi Hauora Wairau (Marlborough PHO)
LA	Local Authority
LCN	Local Cancer Network
LOS	Length of Stay
LSCS	Lower Segment Caesarian Section
LTC	Long Term Care
LTCCP	Long Term Council Community Plan
LTSFSG	Long Term Service Framework Steering Group
MHDSF	Maori Health and Disability Strategy Framework
MHFS	Maori Health Foundation Strategy
MPDS	Maori Provider Development Scheme

MA	Medical Advisor
MCT	Mobile Community Team
MDC	Marlborough District Council
MDO	Maori Development Organisation
MDS	Maori Development Service
MDT	Multi Disciplinary Team
MECA	Multi Employer Collective Agreement
MHAU	Mental Health Admission Unit
MHC	Mental Health Commissioner
MHD	Maori Health Directorate
MHINC	Mental Health Information Network Collection
MHWSF	Maori Health and Wellness Strategic Framework
MOH	Ministry of Health
MOH	Medical Officer of Health
MOA	Memorandum of Agreement
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding
MOW	Meals on Wheels
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Technologist (or Technician)
MSD	Ministry of Social Development
NPA	Nutrition and Physical Activity
NRAHDD	Nelson Region After Hours & Duty Doctor Limited
NRT	Nicotine Replacement Therapy
MRSA	Methicillin Resistant Staphylococcus Aureus
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
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
NZHIS	NZ Health Information Services
NZMA	New Zealand Medical Association
NZNO	NZ Nurses Organisation
NZPH&D Act	NZ Public Health and Disability Act 2000
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
RDA	Resident Doctors Association
RDA	Riding for Disabled
RIF	Rural Innovation Fund
RFI	Request for Information
RFP	Request for Proposal
RICF	Reducing Inequalities Contingency Funding
RM	Registered Midwife
RMO	Resident Medical Officer
RN	Registered Nurse
ROI	Registration of Interest
RSE	Recognised Seasonal Employer
RSL	Research and Sabbatical Leave
SAN	Storage Area Network
SCBU	Special Care Baby Unit
SCN	Southern Cancer Network
SDB	Special Dental Benefit Services
SHSOP	Specialist Health Services for Older People
SICF	South Island Chairs Forum
SICSP	South Island Clinical Services Plan
SI HSP	South Island Health Services Plan
SIRCC	South Island Regional Capital Committee
SISSAL	South Island Shared Service Agency
SLH	SouthLink Health
SLT	Strategic Leadership Team

SMO	Senior Medical Officer
SNA	Special Needs Assessment
SOI	Statement of Intent
SOPD	Surgical Outpatients Department
SOPH	School of Population Health
TDC	Tasman District Council
TLA	Territorial Local Authority
TOW	Treaty of Waitangi
TOR	Terms of Reference
TRTT	Te Roopu Tupu Tahi
UG	User Group
VLCA	Very Low Cost Access
VRA	Vascular Risk Assessment
WAM	Wairau Accident & Medical Trust
WAVE (Project)	Working to Add Value through E-Information
YTD	Year to Date

May 2010