



**Nelson Marlborough
District Health Board**

NOTICE OF MEETING

OPEN MEETING

**The following agenda will be considered at a meeting of the
Disability Support Advisory Committee
of the
Nelson Marlborough District Health Board
to be held on
16 March 2010 at 11.00 a.m.
in DHB Seminar Centre Room 1
Braemar Campus, Waimea Road
Nelson**

Should videoconferencing from Wairau Hospital (Blenheim) be required
please ring (03) 5461235 on or before 15 March 2010

AGENDA

PUBLIC FORUM – 11:00 a.m.

OPEN SECTION – 11:15 a.m.

11:15 a.m.

Karakia

SECTION 1:

Apologies

SECTION 2:

Registrations of Interest

11:20 a.m.

SECTION 3:

Minutes

- From previous meeting
- Matters Arising

SECTION 4:

Correspondence

11:35 a.m.

SECTION 5:

Monitoring Reports

- Chair
- GM P&F
 - Health of Older People
 - SupportWorks
- GM Finance & Commercial
 - IDSS

12.30 p.m. – 1.00 p.m. LUNCH BREAK

1:00 p.m.

Reports continued

- Members' Reports
- Members' Issues

1:30 p.m.

Closing Karakia

1 APOLOGIES

Nil received

2 REGISTRATIONS OF INTEREST

1) Committee Members

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Sharon Brinsdon	<ul style="list-style-type: none"> ▪ Financial interest in husband's GP practice ▪ Husband is employed one-tenth at Nelson Hospital (Eye Department) ▪ Financial interest through husband's shareholding in Nelson Medical Limited (1/6 share) which owns the Health@132 medical centre ▪ Financial interest through husband's shareholding in different companies undertaking medical developments in Collingwood St, Nelson (1/60 share) and Queen Street, Richmond (1/10 share). 		<ul style="list-style-type: none"> ▪ The provision of health and disability services in the Nelson-Marlborough District. 	<ul style="list-style-type: none"> ▪ Husband is a member of executive of Southlink Health (IPA) ▪ Sister is staff nurse at Wairau Hospital.
Graeme Faulkner	<ul style="list-style-type: none"> ▪ Provision of rental premises to DHB clinic ▪ Employee of medical practice. 		<ul style="list-style-type: none"> ▪ District Nurse clinics ▪ Picton Medical Centre a contracted GP service. 	<ul style="list-style-type: none"> ▪ Negotiating DHB contracts for practice.
Judi Billens	<ul style="list-style-type: none"> ▪ Board Member Age Concern ▪ Member Barnardos Advocacy for Children & Young People ▪ NZ Pelim Practitioners Nelson (Kaumatua) ▪ NM Iwi Health Board ▪ Healthcare New Zealand Advisory Committee Member ▪ Committee Member of St John Nelson Bays Area ▪ CYFS Care and Protection Group. 	<ul style="list-style-type: none"> ▪ Member Ngāti Tama Iwi Trust Board ▪ Board of Governance Te Rito Family Violence ▪ Shareholder and owner in Wakatu Inc. 		

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
George Truman	<ul style="list-style-type: none"> ▪ Has an adult son with intellectual disability in residential care ▪ Wife is committee member of Nelson Branch Alzheimer Society NZ ▪ Member of Rescare, National Association of Parents for the Intellectually Disabled (ID). ▪ As of 26/02/10 will be residing in a townhouse at Ernest Rutherford Retirement Village 	<ul style="list-style-type: none"> ▪ Active member of Grey Power (Nelson). 		
Glenys MacLellan	<ul style="list-style-type: none"> ▪ Cancer Society – Bookkeeping 			<ul style="list-style-type: none"> ▪ Get Sorted (business) – May have contracts with government agencies which may include health and disability agencies ▪ Active at a national level with the Green Party of Aotearoa NZ and spokesperson.
Tahi Takao	<ul style="list-style-type: none"> ▪ Kaumatua – NMDHB ▪ Kaumatua – Te Amo Health ▪ Kaumatua – Te Awhina Marae Health ▪ IHB Member ▪ Adult daughter with intellectual and physical disability ▪ Respite care bed with NZ Care 	<ul style="list-style-type: none"> ▪ Member – National Maori Men’s Coalition ▪ Member – Te Rau Matatini; Kaumatua Reference Group 		
Suzanne Win (ex-officio)	<ul style="list-style-type: none"> ▪ Director of Split Ridge Associates Ltd that provides consultancy services to health & disability organisations ▪ Deputy Chair of Gracelands Group ▪ Member of DHBNZ Chairs Executive with lead responsibility for workforce and participant on Tripartite Forum ▪ Chair of Career Force ▪ 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. 	<ul style="list-style-type: none"> ▪ Partner is Chair of West Coast PHO ▪ Partner is an independent director of Access Home Health ▪ Contracted to MOH to coordinate the implementation of the Cardiac Network ▪ Member on PHO Alliance Executive ▪ Partner appointed Chair of the Board of Access Home Health Ltd.

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Fleur Hansby	▪ Nil			

March 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	Nil			<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 – DHBRF Governance Group with the Health Research Council ▪ Member St John Trust Board Northern Region (SI). 	<ul style="list-style-type: none"> ▪ Deputy Chair of Standards New Zealand Council. 		
Robyn Henderson				
Harold Wereta	<ul style="list-style-type: none"> ▪ Ngati Toarangatira Connections 		<ul style="list-style-type: none"> ▪ Tribal Interest 	

March 2010

3 MINUTES

MINUTES OF THE OPEN MEETING OF THE DISABILITY SUPPORT ADVISORY COMMITTEE (DiSAC) OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD			
Date	17 November 2009	Time	11.00
Where	Nelson DHB Seminar Centre	Previous meeting date	6 October 2009
Present	Sharon Brinsdon (Chair), Graeme Faulkner, Judi Billens, Glenys MacLellan, Tahi Takao, Fleur Hansby, George Truman, Suzanne Win		
Apologies	Nil		
In attendance	John Peters, Sharon Kletchko, Carole Kerr, Jane Large, Jasmin Brandt (minute taker), Nigel Trainor for his report		
Karakia	Tahi Takao		

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
1.	Public Section	No members of the public present			
2.	Apologies	Nil received			
3.	Registrations of Interest	Amendments to Registrations of Interest: <ul style="list-style-type: none"> Tahi Takao: delete all 'existing others' for Tahi Takao Judi Billens: add 'Board member of Age Concern' Suzanne Win: taking six months' leave from position as Chair of Career Force 	Moved: Suzanne Win Seconded: Glenys McLellan THAT THE REGISTRATIONS OF INTEREST BE NOTED. AGREED		
4.	Minutes	Matters Arising	Moved: George Truman		

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		Nil	<p>Seconded: Tahi Takao</p> <p>THAT THE MINUTES OF THE MEETING ON 6 OCTOBER 2009 BE ADOPTED AS A TRUE AND CORRECT RECORD.</p> <p>AGREED</p>		
	Correspondence	Additional outgoing: Chair sent email to William Robinson to explore hearing aid recycle options	<p>Moved: Judi Billens Seconded: Glenys MacLellan</p> <p>THAT THE CORRESPONDENCE BE RECEIVED.</p> <p>AGREED</p>		7
5.	Reports				
5.1	Chairperson's Report	<p>Taken as read.</p> <p>Meeting Frequency for 2010 The committee members discussed option 3 of the paper in appendix A that had been referred to DiSAC for discussion from the Board. General consensus was that option 3 makes good sense and should be adopted.</p>			
5.2	GM Planning and Funding's Report	<p>Taken as read.</p> <p>Query from GreyPower received re their concern that</p>			

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		<p>the level of funding has been cut for home based support</p> <p>It was noted that the committee and the Board had done a review of the packages of care and found that a number of clients who had little or no disability were receiving home help. When costed, this would equate to over \$700K. The Board decided to reinvest this amount as part of the Rutherford savings. The packages of care were then reviewed and realigned accordingly with providers of the service. Currently, negotiations with the providers are taking place to adjust their contracts accordingly.</p> <p>Board Chair noted that the packages were carefully developed based on science with the use of the InterRAI tool and that the money in question had never actually been spent in 2008/09, and was therefore an adjustment to the budget for the 2009/10 financial year.</p> <p>Page 20: Psycho-geriatric Care Reduction noted. Reasons may be the positive impact of the expert clinically-led service development undertaken by Dr Robert Clafferty who has since left to return to Scotland. Older persons' functional independence is encouraged through these restorative health developments which can lead to a reduction in annual cost..</p> <p>Mental Health NASC Question raised whether this NASC is a duplication that could be consolidated with other NASC? GM P&F noted</p>			7

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		<p>that a single Health Needs Assessment could be the way to go; as currently we have several different needs assessment coordination services. Expected that this will be looked at through the Rutherford Initiative.</p> <p>ACC Falls Prevention Programme Withdrawal ACC is funding the programme till December 2009. GM P&F advised that wider discussions with PHOs are taking place and that injury prevention is part of this. Currently, injury prevention lies with ACC as per their Act. Chair raised the question that if there was a strong cost-benefit behind this falls prevention programme, would it not fall into the DHB/ PHO? Board Chair noted that this will have to go into the pot with everything else as part of the DAP prioritisation discussions for 2010/11 that will be had by the Board mid-December.</p> <p>Respite Beds for long term disability RFP went out about a year ago. There is a preferred provider but they haven't reached agreement on a contract. Despite having considered various options, there has been no resolution. It depends on what the Ministry wishes to do. The beds are still needed. Have had two crisis situations with Child, Youth and Family where beds were needed urgently. Noted that we have a small number of very complex children out there. Do not want to advocate 'out of home placement' for these children. The frustration is that in other parts of the country they have spare beds but none to be had in this district.</p> <p>DiSAC agreed to help by writing to MoH asking for a</p>	<p>Write letter to MoH</p>	<p>DM/ Chair</p>	<p>7 15</p>

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		resolution for the RFP. Letter to come from Chair.			
5.3	GM Finance and Commercial's Report	<p>The GM Finance and Commercial spoke to his report.</p> <p>Taken as read.</p> <p>Page 25: Budget Error It is hoped such an error will not be repeated next year.</p> <p>Page 27: Work and Income As explained in the last report, there has been a historical issue where a housing supplement was received which shouldn't have been received.</p> <p>\$39 of the benefit received are for own personal wishes per client; remainder of benefit is used as contribution to IDSS for care provided. The latter is used for rent, electricity and food from a joint account, similar to a flat account. Nationally, we are only one of two providers who do it this way. This money hasn't been historically counted as revenue, which is being changed at present. Requirement on us is to recognise the money as revenue and capture the expenses. Meeting set up for next week to work through this issue. It was noted that some houses build up balances to save for trips or pieces of furniture. If it was seen as DHB money, then this could potentially change. Issues around accounting and ownership noted.</p> <p>The issue has arisen from the fact that all those clients were seen as residential clients. It is different to supported independent living where the client has more input to what their benefit is spent on.</p>	<p>Moved: Glenys McLellan Seconded: Judi Billens</p> <ul style="list-style-type: none"> • THAT THE GM REPORT PLANNING AND FUNDING including SUPPORT WORKS BE RECEIVED • THAT THE REPORT FROM GENERAL MANAGER FINANCE AND COMMERCIAL BE RECEIVED. <p>AGREED</p>		

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		<p>required. This decision was tested for legality by the Ministry. The requirement for DHBs was always to make allowance for access to other dental clinics for people with disabilities.</p> <p>The CE expressed his concern at this and has until now declined to sign the business case. However, he is now required to sign. He noted his disappointment in the process.</p> <p>What options will people with disabilities have? There will be fixed clinics in Motueka and Richmond, but children with disability living in Picton, Golden Bay and Murchison may be required to travel to get this service, or it will be attempted to secure contracts with local dentists where possible.</p> <p><u>Amputation Support Group</u></p> <p>Amy Hindley, phone (03) 5441547</p> <p>The above details can be made available for circulation to people who are going to have limbs amputated and would like support from someone else who has had this happen.</p> <p>Member’s Issue - Fleur Hansby</p> <p>Re: Presentation on ‘Health Needs Assessment for People with a Disability’ given by Jane Large in Motueka (14/07/09)</p>			

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		<p>Fleur wanted to belatedly comment on the recommendation made in July that people in the public sector should be better educated on the needs of disabled people. She noted that disabled people can and do say if they can't do certain things, and she feels it is not a good use of money to put it into education. It was noted that it was not planned to spend money but rather to circulate the DVDs viewed by the committee around providers in this district to raise awareness.</p> <p>Member's Issue - Tahi Takao</p> <p>New Director of Māori Health will be welcomed on two occasions: mihi whakatau at DHB Office; as well as powhiri a week later at Whakatū marae. Noted that it was not necessary to attend both; and that strictly speaking a powhiri should be held on the actual day work is commenced.</p>			
6.	Presentation	<p>InterRAI – Jen Lockwood</p> <p>InterRAI in the international context: Nelson Marlborough, along with over 20 countries are taking part in a study on InterRAI.</p> <p>The InterRAI tool provides a scoring system which then matches up which packages of care, if any, are needed. The outcomes scale is very detailed giving different breakdowns of the needs that may be identified from the answers provided. Information provided relates to the last 24 hours, and 1-3 days; so very immediate to give good detail. Rigorousness of the tool noted.</p>			

	Section	Discussion	Action	Who/ When	Health & Disability Strategy
		<p>Care and Support in the Community – Carole Kerr</p> <p>Regular meetings have been held with service providers such as home based service providers, Allied Health, Support Works and Planning and Funding since implementation of InterRAI began. A special review meeting was held a year after implementation which led to the discussion of possible changes (benchmarking results available).</p> <p>The benchmarking exercise led to the five new packages of service under the restorative model of care; groups were defined using InterRAI criteria, and timeframes reviewed.</p> <p>Key aims of the new packages are to support client-driven outcomes, reinforce a restorative approach, define measurable outcomes, monitor expenditure and ensure sustainability.</p> <p>Noted that three years ago a lot of the people on the high level care would have been put into hospital. The average length of time for hospital beds is three months to time of death. On the restorative model, however, people have been at home for over a year. This means we are prolonging life by using the new model.</p> <p>It is hoped that the upcoming meeting with providers will bring a resolution and enable us to move forward.</p>			

MATTERS ARISING

- Reduced frequency of advisory committee meetings as agreed by DiSAC at the last meeting adopted by the board.
- Progress regarding access to the Railway Reserve for IDSS day services. George to update.
- Respite beds for long term disability. Letter to MoH no longer required, as the situation has been resolved as outlined on page 32 of this agenda.

4 CORRESPONDENCE

Nil

5 MONITORING REPORTS

5.1 CHAIR'S REPORT

Welcome to the first DiSAC meeting of the year. This meeting, I hope, will set the scene and lay out the challenges facing us.

It is important to note that while it is the first of the calendar year, it is half way through the financial year, and many of the challenges we face are financial. The Minister has directed NMDHB to address its worsening deficit. On 5 February the CEO and Board Chair presented him with the Board's Recovery Plan.

The plan and the Rutherford Initiative, which we have been working on for some time, require a DHB- wide effort. DiSAC will continue to advise on and oversee those parts that come within disability and the health of older people. More than ever we will need to carefully consider what is most important and how we can provide the best and most equitable services for our population within the available funding. No one is expecting this to be easy. DiSAC members also need to communicate effectively with the public; particularly, in the context of alarmist media reports. The public need to know that the DHB is continuing to meet the needs of the people of Nelson Marlborough, as it addresses our deficit.

On a lighter note, Tahi, Judi and I attended the council-initiated Accessibility Workshop on 4 March 2010. A brief verbal report from those that attended will be given.

5.2 REPORT FROM GENERAL MANAGER PLANNING, FUNDING AND PERFORMANCE

5.2.1 Financial Report

Statement of Expenditure

NMDHB Fund Division – Health of Older People

At the end of the seventh month of the 2009/10 financial year, the Health of Older People Fund was over budget by seven hundred and eighty seven thousand dollars.

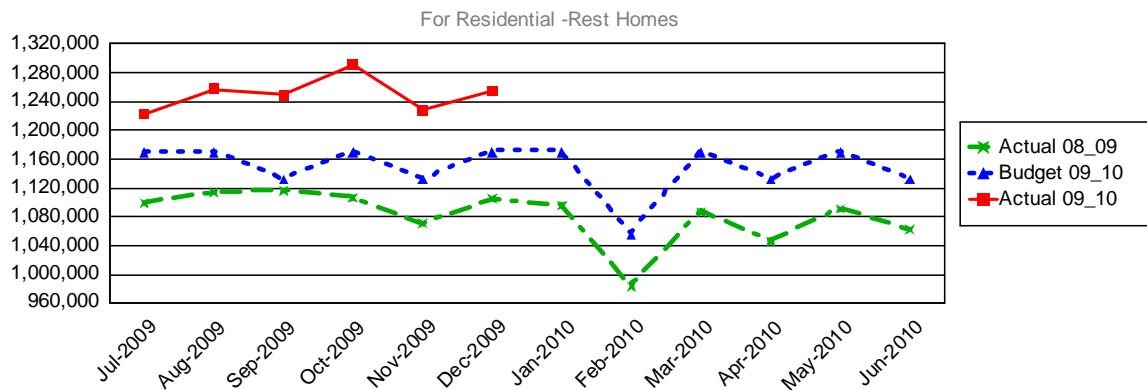
Statement of Expenditure for the month ending 31 January 2010						
\$000's	Budget YTD	Actual YTD	Variance YTD	Annual	Year End	Projected
	Jan-10	Jan-10	Jan-10	Budget	Projection	Variance
Expenditure						
AT&R	5,667	5,667	(0)	9,714	9,714	-
Information & Advisory	30	39	(10)	51	65	(14)
Service Co-ordination	797	797	0	1,367	1,367	-
Home Based Support	5,451	5,725	(274)	9,254	9,254	-
Residential -Rest Homes	8,112	8,929	(817)	13,771	15,184	(1,413)
Residential Care Loans	(324)	(253)	(71)	(555)	(441)	(115)
Residential -Hospitals	8,984	8,546	438	15,253	14,704	549
Equipment	269	269	0	461	461	-
Day Programmes	247	265	(19)	423	451	(28)
Respite Care	282	365	(83)	484	618	(134)
IDF Payments	1,136	1,087	49	1,948	1,948	-
TOTAL EXPENSES	30,651	31,438	(787)	52,170	53,324	(1,154)

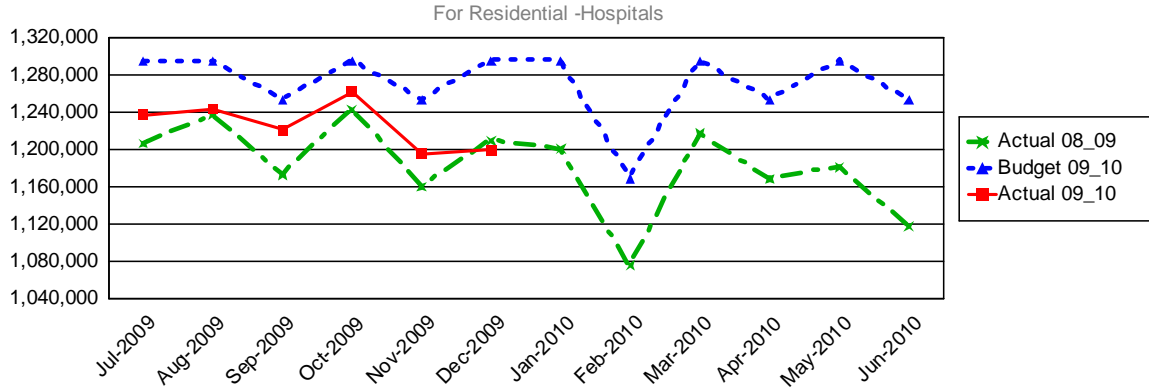
The main areas currently showing variance from budget are:
Residential Rest Homes and Hospitals

Residential Rest Home level care is over budget by \$817K. The reason for this is the recent increase in the number of available dementia beds. 19 beds come into service at Ernest Rutherford Village Rest Home in June 2009, with a further ten beds becoming available at the Jack Inglis Friendship Hospital in August 2009. This is a demand driven service and investigation indicates there were a number of people meeting the needs criteria for these facilities in the community and waiting for the beds to open. Planning, Funding & Performance have worked with the new Psycho-geriatrician and Geriatricians to ensure that all patients have their needs assessed through the Support Works InterRAI process.

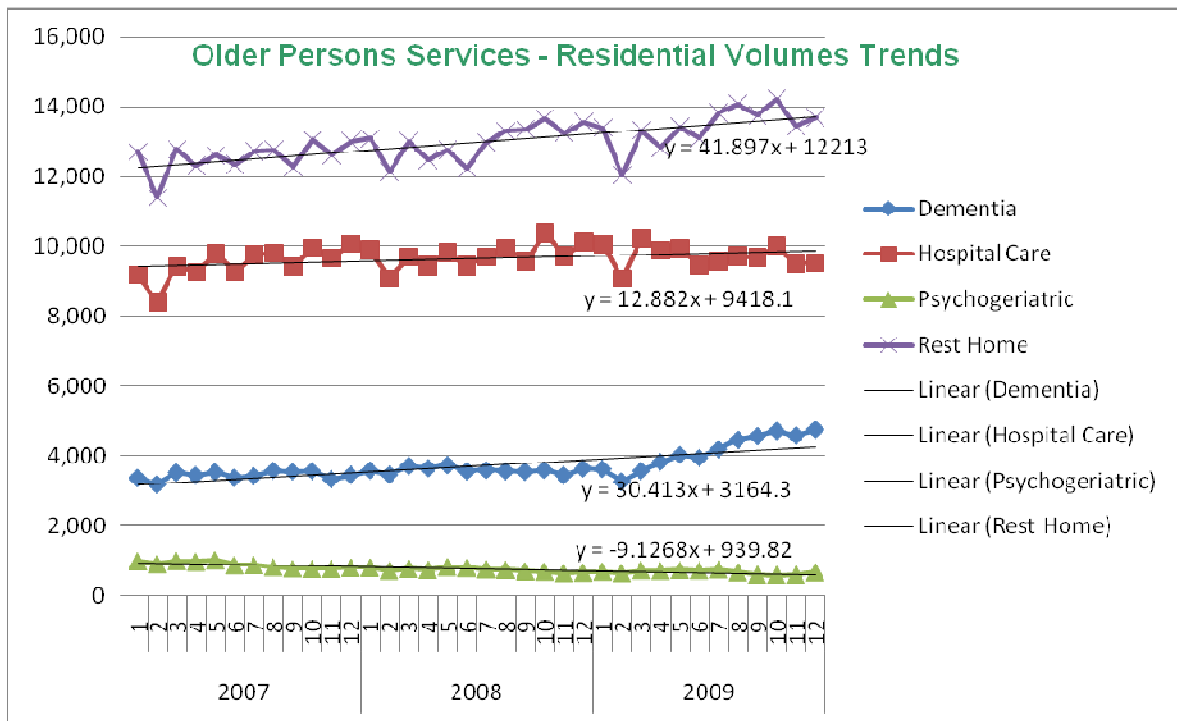
Residential hospitals, on the other hand, are below budget by 438K and have been tracking below budget for the entire financial year to date. We believe this could be an effect of the goal based model of home support.

The graphs below show the actual cost of services delivered by month. Because these graphs show actual payments, data are only present up to November 2009.





The graph below shows the trend in utilisation of aged residential services since January 2007. Over the entire period, rest home, hospital and dementia care have had an upward trend. The increase in dementia care volumes since mid 2009 is very apparent and rest home volumes also continue to increase. Increases in hospital care appear to have slowed since mid 2009. Psychogeriatric care usage has been reducing.



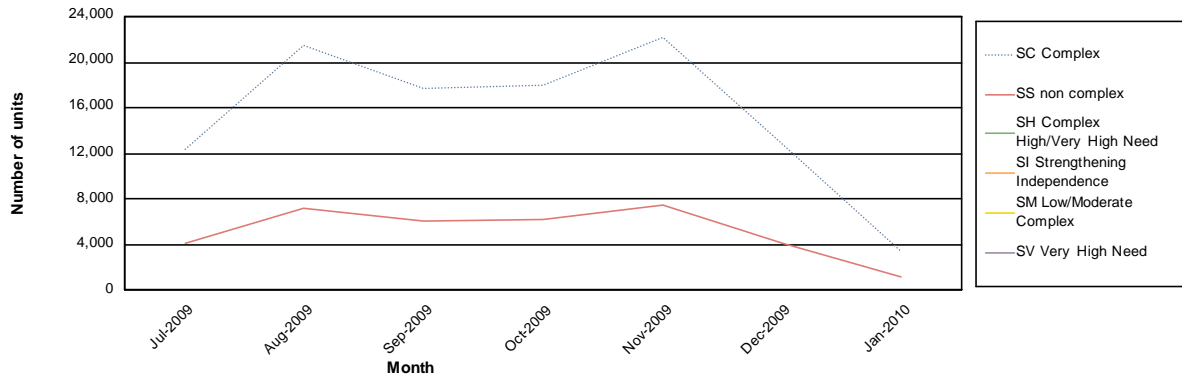
Home Based Support

Home Based Support Services are currently overspent by \$274K. The move from the old model of care to the new goal based model of care has occurred for the majority of individuals but some changes to the threshold for the packages of care delivered under the plan have occurred since the budget was set. Individuals receiving household management support alone will not transfer over to the new model. Additional levels of care packages have been

introduced to better target client need. While the expenditure is currently over budget, costs are expected to return towards budget as the year progresses.

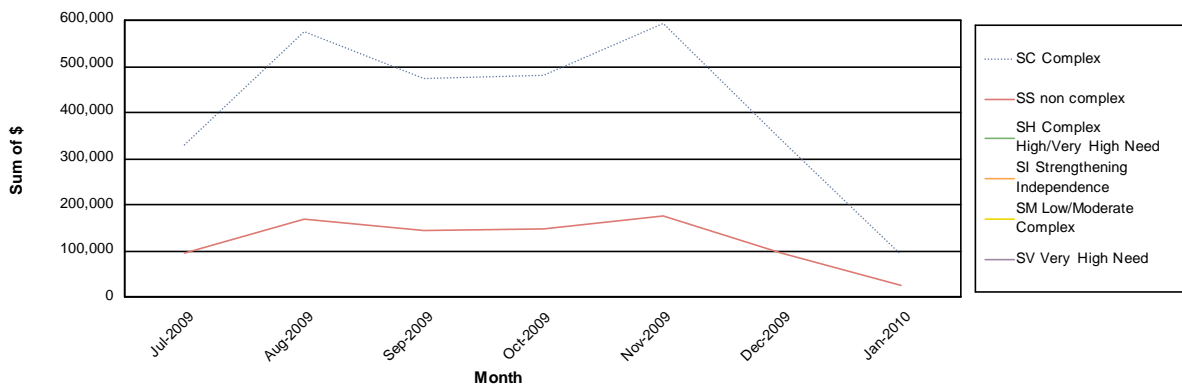
The graphs that follow show the volumes invoiced to the end of January 2010.

HBSS Volumes invoiced by Month

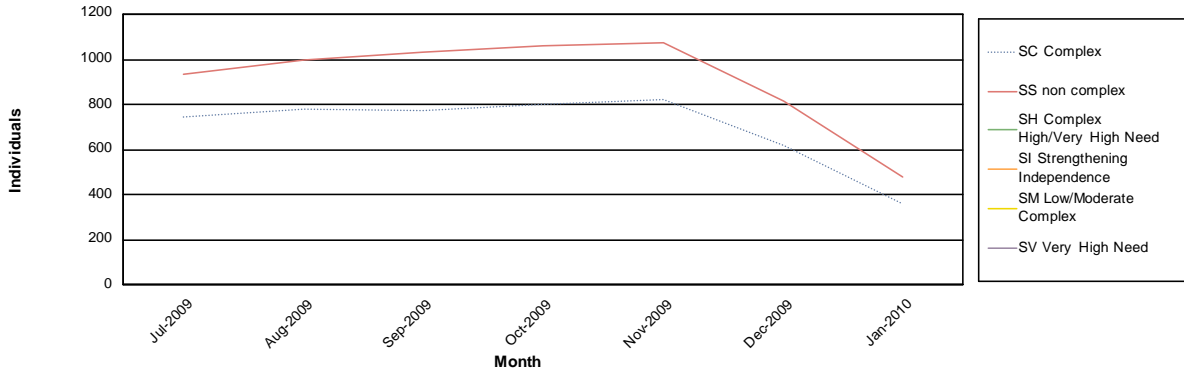


Some of the reduction shown since November will be due to delay in invoicing, however, part of the reduction may be due to the introduction of the new levels of care (numbers not yet sufficiently large to show up on the graph) as well as the move back towards providing housework only (not shown in the graph) to those that would not benefit from the goal based model of home support.

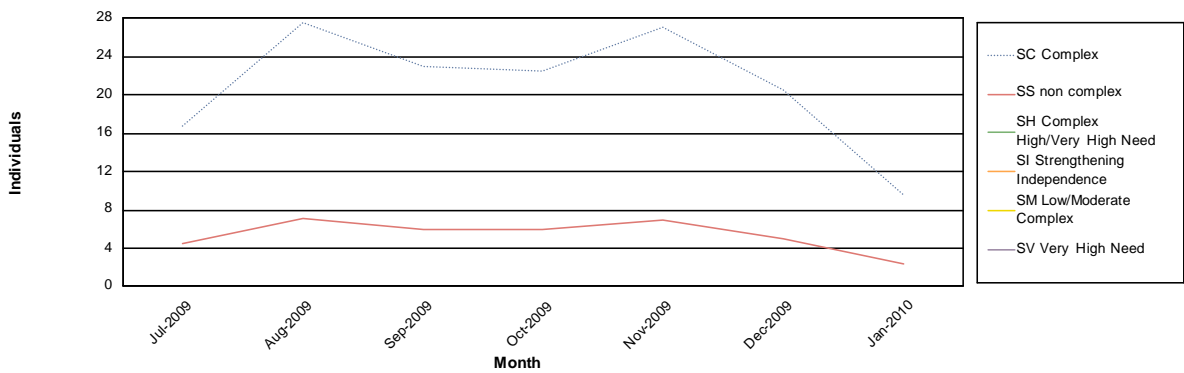
HBSS \$ invoiced



Number of Individuals for whom HBSS services were invoiced by month

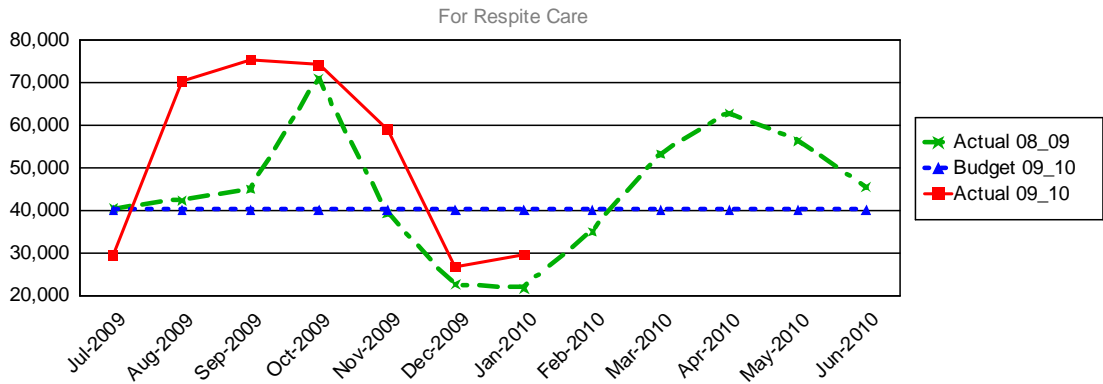


Mean number of units per individual per month by service type



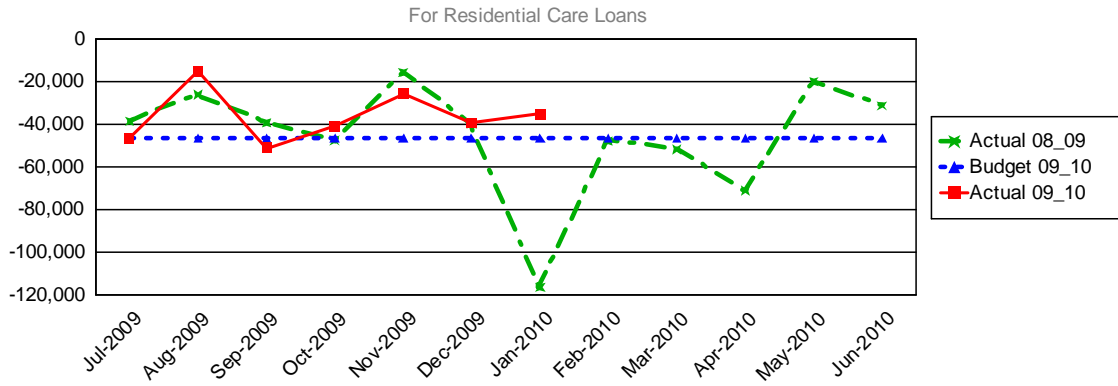
Respite Care

This service is currently \$83K over budget. It should be borne in mind that this is a demand driven service.



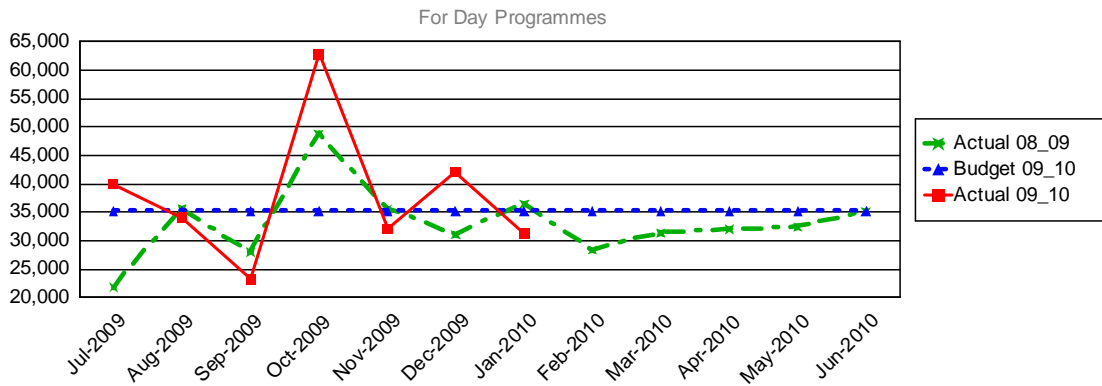
Residential Care Loans

This line has currently been repaid \$71K less than budgeted. It is budgeted with only history to guide. We have no control over what repayments are made to us and when.



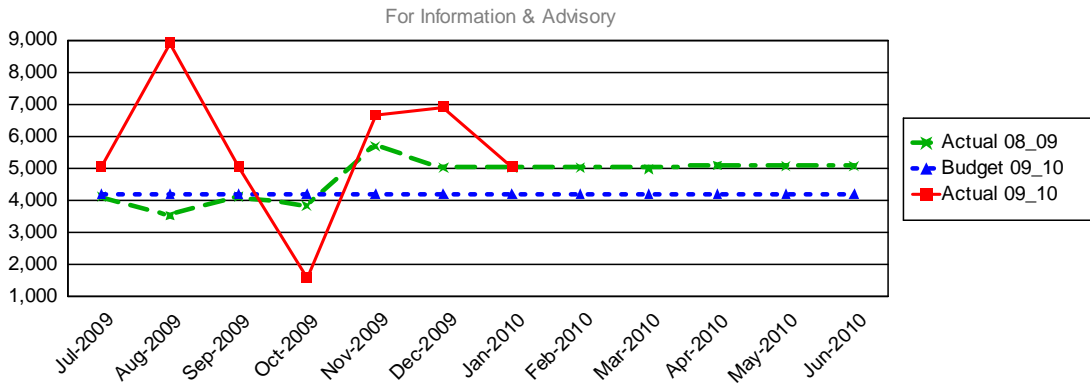
Day Programmes

This service is currently over budget by \$19K. This is a demand driven service and closely aligned to respite care.



Information and Advisory

This service is currently over budget by \$10K. One contract (\$11K for the year) was unbudgeted and the Specialist Health of older people financial review was paid for (\$4K).



In summary, at the end of the seventh month of the year, the Planning, Funding and Performance Health of Older People (HOP) Services budget is over budget by \$787K. Currently we predict the HOP expenditure will be over budget by one million one hundred and fifty four thousand dollars at the end of the year.

5.2.2 Health of Older People (HOP)

Report on Redesign of NMDHB's Specialist Health Services for Older People (SHSOP)

Prepared by

Mark Garisch: Team Leader Funding and Contracts

Jane Large: Manager HOP Service Development

The report on the Redesign of Specialist Health Services for Older People (SHSOP) was completed in June 2009. There was considerable clinical, service and general stakeholder engagement in the generation of the report over many months extended period of time and 'buy in' from clinicians with respect to the main recommendations of the report is good.

Following review by NMDHB's Strategic Leadership Team, the Report on the Redesign of SHSOP was referred to the Rutherford Initiative Group in October 2009.

The report describes the future vision, direction and structure of a redesigned Specialist Health Service for Older People. A robust financial analysis of options for service redesign is also included. In summarising the report, the following main priorities for a redesigned service are identified:

- The development of a Psycho-geriatrician led Specialist Service and the possible transfer of Psycho-geriatric Continuing Care Services at Alexandra Hospital to a Community Service Provider.
- Integrated service provision across the continuum of care for older people.
- The development of strong SHSOP Community Teams across the Nelson Marlborough District. These will provide clinical services in the community setting and clinical oversight, advice and support to community providers in order to maintain older people in the community. This will minimise hospital admissions and reduce/delay entry to age related residential care and contain costs of care.
- The establishment of a Single Point of Referral/Entry to SHSOP and HOP services. This will reduce duplication of assessment of older people, reduce duplication of service provision and enhance the integration of health and support service provision to older people.
- The continued roll out of the interRAI Comprehensive Geriatric Assessment Tool. Targeting services to need is critically dependant on

reliable, comprehensive, and reproducible assessment across the continuum of care

These broad directions will facilitate

- an integrated SHSOP/HOP service continuum across primary care, community services and secondary services.
- the implementation of clinical pathways or processes to promote easy access to secondary care and other services when these are required
- improved interface between community based services (primary care) and hospital based services through offering timely liaison and referral and through providing educational opportunities to community providers
- increasing the range of community based services to include long term supported accommodation, community assessment and treatment, step down beds and packages of care to support in home respite care.
- building and developing the capacity of the workforce (Community and Inpatient SHSOP teams and Community Providers)
- supporting the 'Ageing in Place' strategy, supporting those older people living in the community with long term conditions and co-morbidities, promoting wellness and reducing/delaying entry to Aged Residential Care.

Dedicated Respite Beds

On 31 December 2009 the NMDHB budget for Older People's Respite Care was \$83K overspent year to date for 2009/10. At present NMDHB contracts with all Age Related Residential Care Providers in the district for the provision of Respite Care beds on an as required basis. In addition the Board is spending \$130k per year on three dedicated respite beds at three Age Related Residential Care facilities across the Nelson Marlborough district. These beds were funded as a result of complaints to the Board regarding a lack of Respite Care Service Provision for Older People in the Nelson Marlborough district.

However, analysis shows the occupancy of the three dedicated Respite Care beds averaged 60% for the 2009 calendar year. Thus 40% of NMDHB expenditure on these dedicated beds was associated with no service provision – equating to \$52K expended for no service. In a time of resource constraint this investment does not represent good value for money. At the same time the availability of Age Related Residential Respite Beds on an 'as required' basis appears adequate across the Nelson Marlborough district.

If the contracts for the three dedicated Respite Care Beds were terminated, there would be a saving of \$52K to offset the \$83K general overspend in Respite Care services.

The Planning, Funding and Performance Division at NMDHB intends to monitor the availability of Age Related Residential Respite Care Beds with a view to terminating the contracts for the three dedicated Respite Care Beds should the investment in these beds continue to represent poor value for money in the face of adequate capacity to provide Respite Care on an 'as and when required' basis.

Plans for Building Additional Age Related Residential Care Beds in the Nelson Marlborough District

NMDHB is aware that Ernest Rutherford Retirement Village (owned by Rhymans Ltd) has made an application Nelson District Council (NDC) for consent to build additional Age Related Residential Care Beds. This application is in progress and the NDC has made no decision yet on the application. It is understood the NDC has requested further information from Rhymans Ltd about the application.

Dementia Care Beds

During 2009, an additional 29 Dementia Level Age Related Residential Care (ARRC) Beds were built, commissioned and occupied within the district. This represents additional unbudgeted HOP expenditure of between \$750K and \$1.4 million per annum depending on the level of subsidy paid by NMDHB in respect of each resident (i.e. depending on the outcome of income and asset testing).

Providers are no longer obliged to obtain agreement from the NMDHB to build additional ARRC beds. There are other providers planning to increase ARRC bed supply in the district and this will place additional pressure on the HOP budget.

Further increasing NMDHB's financial risk relating to ARRC is the increasing incidence of early onset dementia due to adverse effects of long term prescribing of certain medications (e.g. psychotropic drugs) and alcohol and drug abuse.

Home Based Support Service (HBSS) Client Categories and Monitoring HBSS expenditure.

Table 1 below shows the 5 groupings into which HBSS clients were split using aggregated information gained from the implementation of interRAI comprehensive geriatric assessment. The groupings are based on assessed levels of disability support need. Service provision will be monitored weekly (see graphs in Support Works' Report) and corrective action taken as required to monitor performance against budget. Quarterly meetings with providers will also monitor service provision and quality and deal with arising issues around implementation of the restorative model of HBSS provision.

	1.Preventive Maintenance Essential Housework	2. Supportive – strengthening independence	3. Long Term – Low/Moderate Need Complex	4. Long Term – Rehabilitation Complex High Need	5. Long Term – Rehabilitation Complex Very High Need
Vision/ Objectives of Service delivery	To provide a preventive maintenance low level service.	To provide a specific programme of rehabilitation to support the person to regain their previous level of functioning To maintain function and cognitive ability, restore function.	To prevent further decline and restore function.	To prevent or delay long term residential placement.	To prevent or delay long term residential placement.
Client Definition	Typically: Disability impacting on household tasks such as vacuum cleaning, heavy lifting and gardening. Coordination of healthcare is through primary care, chronic conditions managed by GP and self-management.	Typically: Disability impacting on outdoor activity, preventing independence in shopping, leisure and social activities. May have significant potential for recovery and regaining fitness. Person requires oversight, with a flexible approach to restoring confidence with ADLs intermittent and/or minimal assistance with personal cares	Typically: Disability impacts on both extended and basic ADLs, preventing independence in personal care activities, shopping, leisure and social activities. Person requires assistance with or has difficulty with showering, dressing, medication management, cognitive impairment and/or the carer/family is overwhelmed.	Typically: Long-standing disability impacting on both extended and basic ADLs, preventing independence in personal care activities, shopping, leisure and social activities, plus specialist health (SHOP) input. Significant difficulty in most activities of daily living (ADLs), have minimal outdoor mobility, are often socially isolated, have chronic conditions with major symptoms. Significant risk of rest home admission.	May have similar needs as stream 4. This level is likely to have be at risk of admission to Continuing Care.
Goals process	NASC distal Provider detailed. Goal: Maintain independence	NASC Distal Provider detailed	NASC Distal and detailed	NASC Distal and detailed, case managed	NASC Distal and detailed, case managed
Reviews	Provider 12 monthly. NASC 12 and 24 month telephone, 36 month face to face	Provider at 6 months NASC at 12 Months	Provider at 3 & 9 months NASC at 6 & 12 months	SHOP/NASC/HBSS at 3 months case conference NASC 3 – 6 monthly as indicated by need.	SHOP/NASC/HBSS at 3 months case conference NASC 3 – 6 monthly as indicated by need.
			<p>*Transitional To regain ability to live in own home after an acute episode. SHOP team assess potential to benefit. Temporary Short-Term period in ARC whilst receiving Care and Support in the Community. Automatic package completion unless extension criteria met.</p>		

Aged Residential Care (ARC)

Routine visits to ARC providers continue, with one or two visits per provider per year planned. The visits are opportunities for discussion and problem solving. Some of the discussions have resulted in combined service development work with NMDHB's Nursing and Midwifery Service Development Team (NMSDT) and with the PHO. Two recent projects have produced some useful changes involving ARC providers and these are described below.

Project one included the Hospital providers and PHO in Nelson along with ARC. There was a perceived problem of inappropriate presentation of residents from ARC to Emergency Department (ED). Review of data showed a very small number of people being sent to ED who could have been managed elsewhere indicating the perception was incorrect. However the project provided the opportunity to improve aspects of the process. The project found that the documentation sent from providers to the ED with the patient was variable and in many different formats. This made it difficult for the hospital staff to find useful information quickly. The teams worked together to identify the pertinent information and agreed an appropriate format. This was trialled by two ARC providers in Nelson and found to be very useful and prevented some transfers to ED. Discussions are taking place and providers in Nelson and Blenheim have indicated they are keen to adopt this form. How this will be has not yet been agreed.

Project two involved Lisa Turner from NMSDT compiling a resource folder for hospital staff. It contains relevant information about each ARC provider in the district with information on the level of care available and contact details. It also contains information about transport, accessing medication, involving Support Works and other important information and relevant forms needed by hospital staff when transferring a person to/back to ARC. All wards have a copy and the resource folder will be updated each year by NMSDT. Every provider participated in providing their information. The feedback has been positive from ARC, ED and acute wards in Nelson and Blenheim.

Physical Activity and Nutrition (Co-ordinator)

There is no longer any funding available for a Physical Activity and Nutrition co-ordinator for older people.

The local research has been completed and the report includes a number of suggestions about interventions that may be considered for action in the coming years. The agencies involved are considering the realistic and achievable work to include in the short term plan. All agree that any work included will contribute to improving social connectedness and promote an environment that is appropriate for older people.

Professional Workforce Development Health of Older People

In 2007 and 2008 Co-ordinators in Home Based Support Services and Support Works assessors participated in education to equip them to deliver the restorative home based support services. The education was provided by Auckland Uni Services in the form of SMART training. The training centred on a slightly different approach to assessment, goal setting and client reviews which now align very closely with the InterRAI assessment tool. Providers are keen to keep their staff up to-date especially when new staff are appointed and would like to work with the DHB to achieve a common approach for staff development. This involves predominantly nursing staff so work has commenced with the Nursing and Midwifery Service Development Team to agree how this will be delivered. This work has led to the development of a piece of work to define the workforce development plan for nursing staff who work in the Health of Older People (HOP) Continuum. The HOP continuum of services include Support Works, Age Residential Care, Home Based Support Services and Older Persons Assessment Treatment and Rehabilitation services. The draft term of reference for this work can be found in appendix A. This document has been widely circulated to stakeholders and discussed at meetings for feedback by 1 March 2010.

5.2.3 Child and Youth with High and Complex Needs

The report prepared by Planning, Funding and Performance went to the Health and Disability Services Programme Board in November 2009. Requested changes were made and the paper submitted to SLT in February 2010. SLT has referred the report to the Rutherford Initiative for review.

5.2.4 SupportWorks Financial Position

	YTD January 2010			Full Year Budget	Forecast
	Budget	Actual	Variance		
Govt & Crown agency Non Health	588,058	551,821	(36,237)	1,008,099	1,027,399
Internal MoH Income	908,445	908,445	-	1,557,334	1,557,334
Total Revenue	1,496,503	1,460,266	(36,237)	2,565,433	2,584,733
Personnel	1,077,179	998,844	78,335	1,880,947	1,839,226
Outsourced	-	-	-	-	-
Clinical Supplies	94,792	54,437	40,355	162,500	162,500
Infrastructure	199,237	171,382	27,855	341,199	294,546
Internal Charges	48,197	57,198	(9,001)	82,624	91,625
Total Expenditure	1,419,405	1,281,861	137,545	2,467,270	2,387,897
Contribution to Overheads	77,097	178,405	101,308	98,163	196,836
FTEs	31.6	29.8	1.8	31.8	31.0

Revenue: Overall \$36K unfavourable to budget this is related to difference in Discretionary funding that is only accessed as utilised.

Personnel costs: Overall \$78k favourable to budget there have been vacancies that have taken time to fill. Also the Operational Manager position in the Life Long team is vacant.

Expenses:

Clinical Supplies:

\$40k under budget this relates to the utilisation of the discretionary budget for Life Long clients

Infrastructure:

\$28k under budget this due to savings in some expected areas including phone (land line and cellphone) utilisation

Internal Charges:

\$9k over budget due to variation in charging and phasing of some charges.

5.2.5 Life Long Disability Team - Support Works

Support Package Allocation Tool Review

Disability services have been completing a number of streams of work including review of the existing Support Package Allocation (SPA) tool. This change will require the team to assess need and package allocation in line with the new guidelines.

Respite Beds

There has been a resolution to the respite bed request for proposal. The announcement around this should take place shortly.

Autism Spectrum Disorder Project

One team member is representative on the virtual Autism Spectrum Disorder ASD project. This project has a National focus.

NASC

There is planned training for NASC managers around Budget Management for Disability budgets.

Supported Living

The Supported Living Spec has now been reviewed and is being signed off.

Child and Youth with High & Complex Needs

There remains a number of young people with high and complex disability needs that are requiring considerable input for assessors.

Update on the courses being run for people with disabilities through NMIT

In 2010, NMIT is offering the Certificate in Training for Work skills. Student fees are \$50 per paper (the same fee was charged in 2008 and 2009).

The Certificate in Community Integration is no longer offered. Students of this course frequently continued to repeat individual modules they enjoyed the most, for example Cooking Skills. The majority of students did not complete all the modules required to complete the certificate. Over the last ten years some students continued to enrol again and again in the same course.

Currently, there are 120 students enrolled in one or more modules of the Certificate in Training for Work Skills in the Nelson Region. In Marlborough

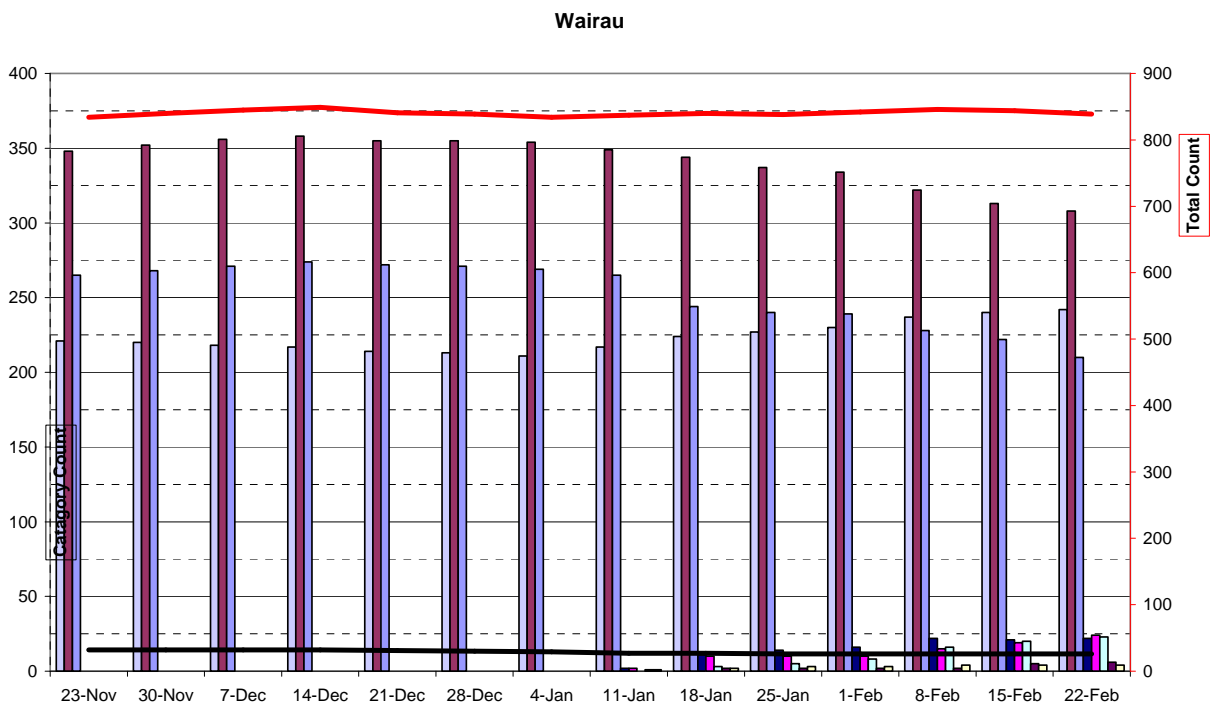
there are seven people enrolled in one or more modules of the Certificate in Training for Work Skills.

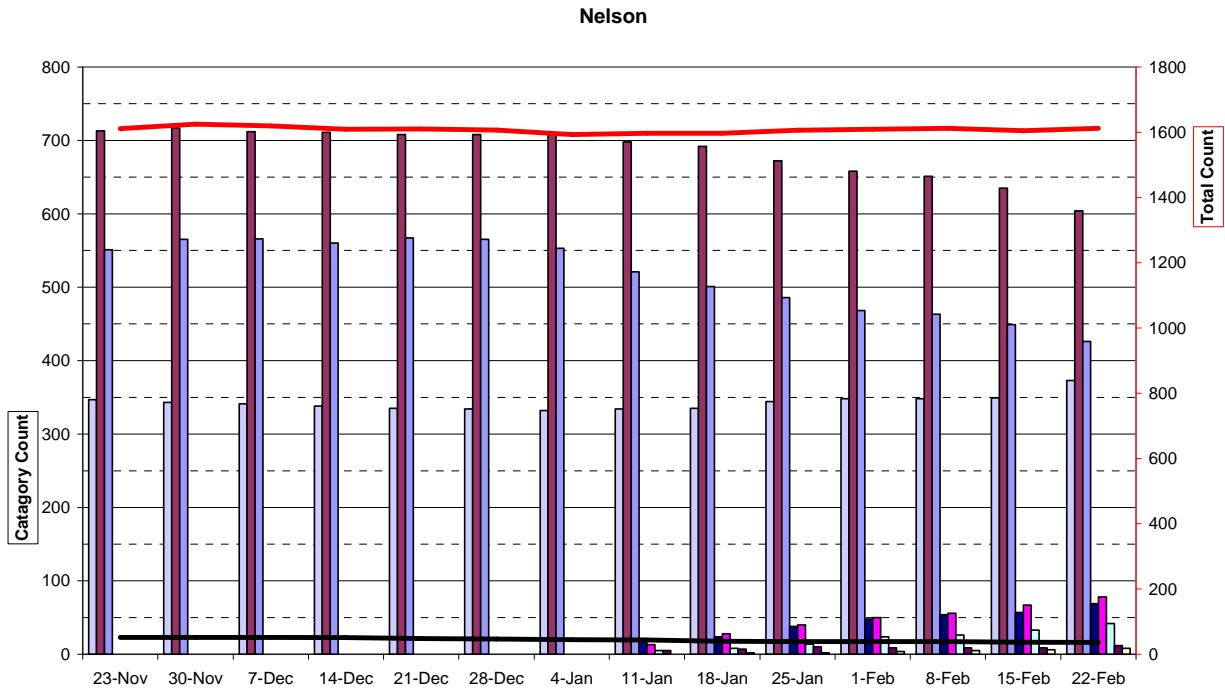
The government has signalled that the Special Education TEC grant (\$67,200 per annum) will not be given to NMIT from 2011.

A community meeting which caregivers, family, Support Works, IDSS and other interested parties are invited to attend will occur in the next few weeks to provide an overview of the current situation for NMIT and what the Supported Training Programme will consist of in the future.

5.2.6 Health of Older People – Support Works

Staff commenced with the changes to the contract for home based support from January. There is weekly monitoring of client numbers into each of the categories of assessed need.





Work is continuing on a national level around InterRAI and we have been asked to participate in some ongoing projects. Nelson Marlborough’s work around home based support is being recognised on a national basis.

Paid Carers Ruling Update

You may have heard that the Human Rights Review Tribunal has made a declaration about the Family Caregivers case, which was heard in September 2008.

The claim was filed on behalf of the parents of disabled adult children who have provided long-term care for their children and two of those adult children. The plaintiffs were seeking a declaration from the Tribunal that the Ministry of Health policy not to fund the employment of parents, spouses and resident family members to provide paid care for disabled family members is discriminatory on the ground of family status, in breach of Part 1A of the Human Rights Act 1993 (HRA).

The Tribunal made a declaration, on Friday 8 January 2010, that the Ministry's policy of not funding the employment of specified family members to provide support services to their disabled family members discriminated on the ground of family status.

What does this mean?

The Tribunal's decision has widespread implications for people who receive and who deliver disability support services, and on wider issues including needs assessments, standards, monitoring and quality control, access to services, employment and fiscal sustainability.

Currently Ministry of Health funded disability support services are provided to a disabled person to complement, not replace, their natural supports (such as those provided by resident family members). It is not possible to fund the employment of those who provide natural support to disabled people within the current disability support services framework. Any redesign of the disability support services framework therefore is a complex task that will take time to complete properly.

What happens now?

The Attorney General makes the decision on whether or not to appeal. The Ministry has 30 days to lodge an appeal (from 8 January 2010). It is likely that an appeal will be made.

Crown Law on behalf of the Ministry of Health has made an application to the High Court to suspend the effect of the declaration for 12 months from the expiry of any appeal period. This means that there will be no immediate change in practice so disability support services would not be significantly disrupted. It also allows time for the appeal process to run or for any work to be done on re-designing the system.

5.3 REPORT FROM GENERAL MANAGER FINANCE AND COMMERCIAL

5.3.1 Financial Report

Intellectual Disability & Physical Disability Services

	January				YTD				Annual		
	Actual	Budget	Variance	% var	Actual	Budget	Variance	% var	Forecast	Budget	Variance
Govt & Crown Agency	1,268,151	1,072,018	196,133	18	8,035,030	7,493,832	541,197	7	13,565,581	12,734,315	831,266
Other Health Related	13,462	7,447	6,015	81	27,978	147,608	(119,630)	(81)	8,254	226,000	(217,746)
Non Health	3,152	7,451	(4,299)	(58)	78,533	52,157	26,376	51	117,132	89,275	27,857
Internal Income	17,048	2,917	14,131	484	234,061	20,417	213,645	1,046	440,369	35,000	405,369
Internal MoH Income	12,106	12,106	0	0	84,743	84,743	0	0	145,274	145,274	0
Total Revenue	1,313,919	1,101,939	211,981	19	8,460,345	7,798,758	661,588	8	14,276,610	13,229,865	1,046,746
											0
Personnel	1,077,680	1,195,507	117,828	10	7,226,477	6,951,774	(274,703)	(4)	12,808,839	12,151,257	(657,582)
Outsourced	0	250	250	100	0	1,750	1,750	100	2,250	3,000	750
Clinical Supplies	13,727	4,411	(9,316)	(211)	69,652	30,939	(38,713)	(125)	107,718	53,055	(54,663)
Infrastructure	56,511	67,918	11,408	17	450,252	489,184	38,931	8	751,226	838,513	87,287
Internal Allocation	59,655	43,533	(16,122)	(37)	524,082	295,336	(228,746)	(77)	978,225	515,646	(462,579)
Total Expenditure	1,207,572	1,311,619	104,047	8	8,270,463	7,768,983	(501,480)	(6)	14,648,258	13,561,471	(1,086,787)
Contribution to Overheads	106,347	(209,681)	316,028		189,882	29,774	160,107		(371,648)	(331,606)	(40,042)
FTE	268.90	285.61	16.71		273.19	260.33	(12.86)				

Revenue: Overall \$662k additional revenue for the year to date to 31st January 2010

Govt & Crown Agency: \$542k additional revenue

- Additional residential volumes for ID Community \$227k and PD \$45k
- Ministry increase on residential contracts \$148k
- Additional Day Services income due to NZ Care contract transferred to the Ministry of Health \$56K
- MSD Day Services contract \$78K

Other Health Related: \$120K less income being the offset of the NZ Care contract and MSD as above

Non Health: \$26K additional revenue due to

- Client recreation/activity funds balances carried forward
- Additional rent due to DHB properties not sold

Internal Income: \$214K additional revenue due to

- additional funding agreements \$4k internal transfer from ID residential \$210k to Day Services (offset in expenses)

Personnel: Overall \$275k over spent and 12.86 FTE over

Allied Health: \$272k over spent (12.64 FTE over)

- Additional salary costs for Sick leave, ACC and Super
- Budget error – missed budgeting for staffing of one house \$140k 6.40 FTE.
- Additional support staff employed for new clients (offset by additional revenue)

Management/Admin: \$3k over spent (.24 FTE over) Leave expensed and not taken

Expenses:

Outsourced Services: Services not utilised at this time

Clinical Supplies: Client related costs incurred

Infrastructure: Reduced conference and courses \$13k and consultants fees \$10k and minor under and overspending occurring in all areas

Internal Charges: internal transfer from ID residential services to Day Services (offset in internal income)

Intellectual & Physical Disabilities		Current Month January 2010			YTD January 2010
Services Provided		IDSS	PDSS	Total ID & PD	Total ID & PD
Current Moh Contract	As per Contracts at month end	165	7	172	
Beds – Individual contracts	As per Contracts at month end	33	2	35	
Beds – Respite contracts	As per Contracts at month end	2	2	4	
Beds – Individual contracts P&F	As per Contracts at month end	1	1	2	
Beds – Individual contracts with ACC	As per Contracts at month end		1	1	
Total number of clients supported	Residential contracts - Actual at month end	201	13	214	
Vacant Beds	Actual at month end	5	1	6	
	Total available beds	206	14	220	
Total number of clients supported	Residential contracts - Actual at month end	201	13	214	
	Personal Cares contracts - Actual at month end	2		2	
		203	13	216	
Total Occupied Beds	Based on actual bed days for full month (includes respite volumes)	98%	85%	97%	96%

5.3.2 IDSS

Client Contributions

Developing a new system to operate this fund. Given this is a significant change process, we are working to establish the ideal balance between financial accountability and maintaining independence.

Physical Disability Marlborough

A business case for Physical Disability support services in Marlborough was approved at the December Board meeting. A housing proposal has been sent to Housing NZ.

Service Development

Support for a younger person with high needs over December highlighted difficulty in providing the right environment to provide support at short notice. Furthermore, the incident underlined the challenge NMDHB has with support for people with intellectual impairment who present outside the scope of residential services capacity

NMIT

NMIT notified IDSS of their intention to change the supported training program in November 2009. There was limited opportunity for feedback in their consultation process. The Service Manager Disability Support met with NMIT management and discussed our perspective. This being that we understood the reasons for NMIT making change but time was required to adjust to the changes.

NMIT has provided services that are more in line with what MSD could be contracting vs. Pathways to Inclusion. NMIT has had a relationship with the only MSD contracted community participation provider (IDEA Services); this has led to significant confusion between what is education and what is community participation. This relationship is changing.

This change is impacting significantly on IDSS in two ways.

We have reduced access to IDEA services as they are putting their residential clients into their Day Services ex NMIT and IDSS clients are not able to retain their places.

NMIT will have significantly reduced capacity as from the later half of this year and ongoing.

Our plan is to identify accurately what the real impact is and write to the MSD National Contracts Manager highlighting our concerns.

The perspective of IDSS is that there is a significant lack of opportunities in Nelson in relation to Pathways to Inclusion. We agree with the NMIT stance it has taken.

Strategic Direction

IDSS management presented a paper to SLT on 8 December 2009. In response IDSS have been advised to work with the Rutherford team in March 2010. Rutherford will lead development of a proposal to the board.

Housing Review

A review of IDSS housing has been completed by IDSS management working with the NASC to identify future housing needs to meet the need of ageing clients. The review has been forwarded to Housing NZ.

NMDHB Properties

Update on the exit of NMDHB owned community homes/ facilities: IDSS has exited the following properties:

- Wakatu lodge
- Haines building
- 387 Main Rd, Stoke
- 659 Main Rd, Stoke
- 32 Tipahi St, Nelson
- 32 A Tipahi St, Nelson
- 659 The Ridgeway, Stoke.

We have reduced numbers at 110 Toi Toi st from seven to three people with planned exit once suitable alternatives are found. The closure of these homes is reflected in the reduced vacancy rate for IDSS.

Over this period we have taken tenancies at 5 Packham Cres, 148 Tahunanui Dr, 7 Exeter St, 4 Appaloosa St (both homes for new clients to the service).

The number of clients supported has remained stable through this period. The services are currently working with eight referrals for services. The Chief Executive has approved development of a new service for four people at 31 Daelyn Ave. This home is purpose built through Housing NZ. A new service is being developed at 13 Rata St for one person; the remaining three referrals will move to existing vacancies once agreement is reached.

5.4 MEMBERS' REPORTS

Verbal

5.5 MEMBERS' ISSUES

Verbal

6 APPENDIX A: WORKFORCE DEVELOPMENT WORKING GROUP TERMS OF REFERENCE (DRAFT)

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
Health of Older People
Workforce Development Working Group
Terms of Reference – 28 January 2010 (Draft Document for Discussion)

Aim	<p>To identify the development needed so that the health and disability workforce is equipped to provide integrated services that maximise independence. Service delivery will be client centred and goal oriented, seeking to build on the individual person's strengths aligning with the principles of ageing in place.</p> <p>Services will have staff that:</p> <ul style="list-style-type: none"> - Understand the philosophy of a continuum of care and the restorative model of care - Facilitate the ability of clients and their caregiver/family/whanau to achieve their goals and participate in their community of choice with holistic services that have a restorative focus - Support caregivers/families/whanau to provide for the physical, emotional, spiritual and social needs of clients - Provide holistic outcome-focused services based on the assessed goals, needs and risks of clients and their caregiver/family/whanau - Provide efficient, effective, flexible, integrated and responsive services - Have integrated assessment, support plan and review processes - Ensure that the dignity and safety needs of the client and their caregivers/family/ whanau are met - Work within the funding resources available
Objective	<p>To identify what is needed to develop integrated, inter-disciplinary capability and capacity of the health and disability workforce across the Health of Older People Continuum.</p> <p>To ensure that the approach is Inter-Disciplinary and inclusive recognising that for older people with a co-morbidity it may take several disciplines working in an integrated manner to ensure their maximum independence</p>

	<p>is achieved.</p> <p>To inform development of appropriate education for 2010 for NASC, HBSS (and possibly ATR assessor/care co-ordinators) relating to assessment and care co-ordination in NMDHB.</p> <p>To build on any previous work including “SMART’ Training and InterRAI training and integrate any development with the InterRAI system.</p> <p>To identify the core competencies</p> <p>To explore the use of common assessment tools in the HOP continuum of services to facilitate common language e.g. InterRAI, Barthels and MSQ</p> <p>To identify the evaluation of the workforce development plan.</p> <p>To identify the large pieces of work that might involve several smaller, staged projects.</p>
In Scope	<p>Nursing and Inter-Disciplinary Workforce Development plan</p> <p>Nursing and Allied Health Assessment and care co-ordination relating to Older People</p> <p>HOP Continuum of Services (ATR, NASC, HBSS, ARC)</p> <p>May include District Nursing & Palliative Care (to be determined)</p>
Out of Scope	<p>Medical staff development</p> <p>Specific allied health professional development</p> <p>Acute Care Services (Initially)</p> <p>Primary Care Services (Initially)</p> <p>Support Worker development</p>
Outcome	<p>A Workforce Development plan for the Health of Older People Continuum of Services NMDHB is documented</p>
Membership	<p>Jen Lockwood, Jane Large, Carole Kerr, Angela Taylor, Brenda Bruning (others to be determined)</p>
Key Stakeholders	<p>HOP Reference Group</p> <p>DISAC</p> <p>HOP Continuum providers (ATR, NASC, HBSS, ARC,)</p> <p>?Hospice/District Nurses</p> <p>? DIAS (Alzheimers society, Stroke Foundation, Arthritis foundation, Age Concern etc)</p>

7 GLOSSARY OF TERMS

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
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
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
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
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
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
IPA	Independent Practitioners Association
IPC	Intensive Patient Care
IPC Units	Intensive Psychiatric Care Units
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
PN	Practice Nurse
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
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 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
YTD	Year to Date

March 2010