

HAC COMMITTEE

NOTICE OF MEETING

OPEN

24 May 2011

HOSPITAL ADVISORY COMMITTEE AGENDA

Nelson Marlborough District Health Board
DHB Seminar Centre Room 1
Braemar Campus, Waimea Road
NELSON
Tuesday, 24 May 2011 commencing at 9.30 am

Public Forum		9.30am	
SECTION 1	Welcome, Karakia and Apologies	9.40am	4
SECTION 2	Registration of Interest	9.45am	5
SECTION 3	Confirmation of Minutes from the previous meeting	9.55am	11
	Matters arising	10.05am	16
SECTION 4	Reports	10.10am	17
	Chairperson's Report		17
	Management Reports		18
	<i>Updates/Standard Reporting Items</i>		
	General		18
	Decision		18
	Quality		18
	Utilisation/Activity		19
	Performance to KPIs		25
	Financial Results and Forecasts		28
	Emerging Issues		33
	Project Reports or Status		33
	Health Alliance/Collaboration		33
	Progress Against Service Improvement Plans		33
	Directorate Profiles		33
SECTION 5	For Information	11.50am	34
SECTION 6	Members Issues	11.55am	35
SECTION 7	Glossary of Commonly Used Acronyms, Abbreviations And Maori Translation		36
SECTION 8	Appendices		42
	Appendix 1 – TOR and Standard Operating Procedures For Advisory Committees		42

Resolution to Exclude Public

12.00pm

**PUBLIC EXCLUDED MEETING
RECOMMENDATION**

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

- ***Minutes of a meeting of HAC Committee held on 8 March 2011 Clause 34(a) Schedule 4 of New Zealand Public Health & Disability Act 2000).***

SECTION 1: WELCOME, KARAKIA AND APOLOGIES

SECTION 2: REGISTRATIONS OF INTEREST – HAC MEMBERS

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Judy Crowe (CHAIR)	<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 	
Francis Gargiulo	<ul style="list-style-type: none"> Nil 			<ul style="list-style-type: none"> Sister-in-law is an employee at Alexandra Hospital An executor of the Gladys Amelia Pascoe Estate Nelson GPs Number of roles in investment companies
Ian MacLennan	<ul style="list-style-type: none"> Honorary Treasurer of Nelson Centre of the Cancer Society of NZ 		<ul style="list-style-type: none"> Tenancy and IT hosting 	<ul style="list-style-type: none"> Accommodation for the Cancer Society
Jane Anderson-Bay	<ul style="list-style-type: none"> To be advised. 			
Jenny Black	<ul style="list-style-type: none"> Life member of Diabetes NZ 			
John Inder	<ul style="list-style-type: none"> Board Member St Mark's Society 		<ul style="list-style-type: none"> Alcohol and other drug residential treatment. NGO part funded by NMDHB 	
Roma Hippolite	<ul style="list-style-type: none"> Chair, Te Rau Matatini Ltd Member of Ngati Koata 	<ul style="list-style-type: none"> Broker, The Research Broker 	<ul style="list-style-type: none"> Contracts for services to NMDHB Provided marketing research brokering services to Public Health in 2008. 	

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

As at 13 May 2011

REGISTRATIONS OF INTEREST – NMDHB EXECUTIVE LEADERSHIP TEAM (ELT)

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

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
		Physicians ▪ Instructor for Advanced Paediatric Life Support NZ			
	Dr Bev Nicholls	▪ Board of NRADD and Shareholder ▪ Nelson Bays PHO Clinical Governance Group ▪ GP and recipient of Nelson Bays PHO funds ▪ Member of IT Development, National IT Board ▪ Member National Information Clinical Leadership Group	▪ Wife and close friend GPs.		
	Peter Burton	Nil	▪ NMDHB Representative on Tasman Council's Regional Land Transport Committee		
CLINICAL SERVICES SUPPORT DIRECTORATE					
	Dr Stephen Busby	▪ Shareholder Director, Nelson Radiology Limited			
	Dr Neil Whittaker	▪ General Practice owner ▪ Contracted to RNZCGP Medical Educator		▪ Clinical Director Community	
	Hilary Exton	Nil			
	James Bowyer		▪ Wife a nurse on Paediatric Ward Nelson Hospital		
MARLBOROUGH SERVICES DIRECTORATE					
	Dr Jeremy Stevens	To be advised			
	Dr Ros Gellatley	To be advised			
	Carey Virtue		▪ Partner works in the Ministry of Health		
CORPORATE SUPPORT					
	Nick Lanigan		▪ Wife consultant for 2 Degrees		
	Denise Hutchins	Nil		▪ Certification/Accreditation	

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
	Dr Sharon Kletchko	<ul style="list-style-type: none"> ▪ Member Exceptional Circumstances Panel – PHARMAC ▪ Treasurer, International Society for Health Care Priorities ▪ Member St John South Island Region Trust Board ▪ Member RACP NZ Policy and Advocacy Committee. ▪ South Island Representative on RACP NZ Joint Executive. ▪ Member of the Medicine’s Review Committee (Medicine’s Act) MEDSAFE ▪ Member DHBRF Governance 	<ul style="list-style-type: none"> ▪ Deputy Chair of the New Zealand Standards Council ▪ Member of the Board – EVIDEM Collaboration. 	<ul style="list-style-type: none"> ▪ EVIDEM is a Not-for-Profit international research collaboration whose purpose is “To promote public health through transparent and efficient healthcare decision making via systematic assessment and dissemination of the evidence for and value of healthcare interventions.” 	
DONM	Robyn Henderson	Nil			
CMO	Heather McPherson	Nil			
DMH & Whanau Ora	Harold Wereta	<ul style="list-style-type: none"> ▪ Ngati Toarangatira Connections 		<ul style="list-style-type: none"> ▪ Tribal Interest 	
CHIEF EXECUTIVE’S OFFICE					
	John Peters	<ul style="list-style-type: none"> ▪ Director of SISSAL ▪ Trustee of Nelson Marlborough Hospitals’ Charitable Trust ▪ Trustee Churchill Trust 	<ul style="list-style-type: none"> ▪ Director of Management and Industrial Services Ltd. 	<ul style="list-style-type: none"> ▪ Shared services provision, administration of trust funds for health purposes & provision of private health services at Wairau Hospital ▪ MIS Ltd previously provided consultant services to other DHBs 	
	Keith Rusholme	<ul style="list-style-type: none"> ▪ Wife provides first aid training and complimentary help services 		<ul style="list-style-type: none"> ▪ Provision of services to DHB staff or contracted providers 	<ul style="list-style-type: none"> ▪ Sister works for IDSS

Service Delivery	Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
	Mike Cummins	<ul style="list-style-type: none">▪ Wife works for medical practice			

As at 13 May 2011

SECTION 3: CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING

MINUTES OF A MEETING OF HOSPITAL ADVISORY COMMITTEE OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD HELD AT THE SEMINAR CENTRE MEETING ROOM 1, NELSON HOSPITAL, NELSON ON TUESDAY 8 MARCH 2011 AT 9.30 AM

Present:

Judy Crowe (Interim Chair), Russell Wilson, John Inder, Ian McLennan, Francis Gargiulo, Roma Hippolite, Jane Anderson-Bay, Jenny Black and Tahi Takao

Apologies:

Nil

In Attendance:

Peter Bramley (Service Director Medical/Surgical Services Directorate), James Bowyer (Service Director Clinical Services Support Directorate), John Peters (CE), Nick Lanigan (GM Corporate Services), Sharon Kletchko (GM Strategy and Planning) and Mike Cummins (Board Secretary)

Welcome:

Judy Crowe provided a reading and members introduced themselves.

SECTION 1: APOLOGIES

Nil

SECTION 2: REGISTRATIONS OF INTEREST

Francis Gargiulo noted that he has a number of roles in investment companies.

Peter Bramley noted that he has no interests to declare.

Moved: Ian MacLennan

Seconded: Russell Wilson

RECOMMENDATION:

THAT THE REGISTRATIONS OF INTEREST AS AMENDED BE NOTED.

AGREED

SECTION 3: MINUTES OF PREVIOUS MEETING

Minutes of the Committee Meeting 28 October 2010.

Moved: Ian MacLennan

Seconded: Jenny Black

RECOMMENDATION:

THAT THE MINUTES OF THE MEETING 28 OCTOBER 2010 BE NOTED.

AGREED

SECTION 4: MATTERS ARISING

KPIS/Variance Reports

Member's feedback was requested on what information should be reported to reflect a future focus comparison with previous years as well as performance to date.

ELECTION OF CHAIRPERSON

John Peters, CE, assumed the role of Chairperson. The process set out in the Terms of Reference is to be reviewed. It is noted that the Board nominated Judy Crowe. The Committee agreed to endorse Judy Crowe as Chair. It is also noted that the Committee has the right to review every twelve months.

ELECTION OF DEPUTY CHAIRPERSON

Roma Hippolite and Jane Anderson-Bay nominated John Inder. Judy Crowe and Jenny Black nominated Russell Wilson.

[The candidates left the room]

On a show of hands, Russell Wilson was elected Deputy Chair.

SECTION 5: REPORTS

5.1 Chair's Report

The report was tabled. Members noted that the other hospitals (rural and psychogeriatric) will be monitored by CPHAC/DiSAC.

The role of the Committee in the ToR is to be expanded to include the strategic issues relating to the regional provision of hospital services across the South Island.

The Chair noted the actions by staff in assistance with the response to the Canterbury Earthquake.

Moved: Judy Crowe
Seconded: Russell Wilson

RECOMMENDATION:
THAT THE COMMITTEE CHAIR'S REPORT BE RECEIVED.

AGREED

5.2 Medical Surgical Directorate Report

The structure of the directorate was explained.

Noted the efforts of staff coordinating the response to the Canterbury Earthquake and the increased pressure on services across the district. It is expected that this will continue for some time with significant ongoing impacts.

Members were given an update on the impacts on the CDHB and the expected recovery period. A reconfiguration of services is also expected.

NMDHB will be providing ongoing support which will have an impact on service delivery and increased costs. Currently it is unclear if there is an ability to recover these costs. It was also noted that the effect of the transfer of ARC clients will have an impact of \$3 – 4 million in costs for a full year.

Day surgery has continued at both hospitals. Inpatient elective surgery was ceased for four days and it is anticipated that this will be recovered by the end of the financial year. A small number of non-deferrable surgical procedures have been performed by CDHB staff for Canterbury patients.

The cancellation of the 2011 census could have an impact on future funding.

Regional service planning will need to take into account the reconfiguration of services from Christchurch Hospital.

Concerns were discussed regarding not meeting two national health targets; smoking cessation and diabetes / cardiovascular. Additional focus has been placed on these areas to improve future results.

Members noted that the overall status for ESPIs is being maintained.

5.2.1 Quality Improvement

Members were briefed on the DHB-wide initiative to revise the quality framework integrating the existing activities and applying learning as part of ongoing improvements.

5.2.2 Alliance Pathway Groups

Plans are being finalised to move minor surgical procedures for skin lesions into a community setting. This will release theatre capacity for more complex surgery. Members noted that changes to public perception where the surgery should be carried out will be required. Also noted are the funding issues arising from the change, i.e. remains free to the patient.

5.2.3 Activity

Directorate remains on track to meet CWD delivery targets. Noted increased acute presentations in orthopaedics, which is impacting on elective procedures. Gynaecology remains a concern.

5.2.4 Structural Directorate

A final decision on the structure is expected late March following feedback from staff.

5.2.5 Financial

The positive variance of \$1.7 million in the year to date results was noted (a surplus of \$15.3 million against a budget of \$13.6 million). The risk of the timing of planned savings was also noted. Ongoing vacancies in medical personnel have resulted in higher outsourced costs.

5.3 Clinical Support Directorate

(i) Financial Results

As a result of increased demand, the deficit is \$0.5 million higher than planned (deficit of \$15.9 million against a budgeted deficit of \$15.4 million). Results have been impacted by the MRT strike from August to November 2010 and a rising demand for higher cost pharmaceuticals.

(ii) Laboratory Services

It was noted that the premises of Medlab South have been damaged in the Christchurch earthquake. Services are continuing to be provided from CHL premises. The planned restructure locally has been deferred temporarily.

Moved: Ian MacLennan

Seconded: Russell Wilson

RECOMMENDATIONS:

**THAT THE REPORTS FROM THE SERVICE DIRECTORS
MEDICAL/SURGICAL AND CLINICAL SUPPORT BE RECEIVED.**

AGREED.

SECTION 6: GENERAL

A post-project review for Wairau is to commence before the team disperses. Members noted that patient satisfaction for NMDHB was again number 1 for all DHBs.

SECTION 7: MEMBER ISSUES

Members issues to be forwarded to the Chair and Board Secretary two weeks before the meeting.

PUBLIC EXCLUDED

Moved: Roma Hippolite
Seconded: Jane Anderson-Bay

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

Meeting Closed at: 11:55 am

Members of Public

Nil

ACTIONS ARISING FROM THE MEETING

Action	Responsible	Time Frame
Feedback Comments on KPIs and reporting	All Committee	22 March
Terms of Reference Revised	Board Secretary	31 March
Post project review for Wairau to commence	Board Secretary	31 March

SECTION 3.1: MATTERS ARISING

Wairau Post Project Review

Work is underway on the post project review of the Wairau site redevelopment project.

SECTION 4: REPORTS

4.1 CHAIRPERSON'S REPORT

GENERAL

- i. Verbal report
A verbal report will be provided at the meeting.
- ii. Terms of Reference
The revised HAC Terms of Reference following the combined Chairs meeting is attached as **Appendix 1** for review and endorsement.

Status

This report contains:

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

Judy Crowe
Chairperson

RECOMMENDATIONS:

1. THAT THE HAC TOR BE ENDORSED
2. THAT THE CHAIRPERSON'S REPORT BE RECEIVED.

4.2 DIRECTORATE REPORT

Status

This report contains:

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

4.2.1 General

The Medical Surgical Directorate is on target Caseweights and Discharges. The DHB remains ESPI compliant overall.

The services are meeting the six Ministry of Health targets with the exception of Better Help for Smokers to Quit and Better Diabetes and Cardiovascular Services, however significant progress has been made with regard to the Better Help for Smokers to Quit target.

In terms of financials the Directorate is showing a YTD surplus of \$ 37.2M compared to a budgeted surplus of \$ 35.6M giving a positive variance of \$1.6M.

4.2.2 For Decision

Nil

4.2.3 Quality

l) Medical / Surgical Service Directorate

Following is an update for key quality initiatives for the Medical Surgical (M/S) Directorate:

- a. Quality Framework.** A draft quality framework is being developed, and a new Quality and Safety Governance Committee is to be convened. Work is being done currently to improve our process around reportable and sentinel events, with a focus to feedback to the reporter and capturing the learnings and recommendations for improvement.
- b. Theatre Productivity.** New reports around key theatre metrics are being developed. Being reported are: measuring percentage of first case starts; percentage of theatre lists finishing late; turnover time and percentage utilisation of theatre session by speciality and surgeon; and cancellation data. Reporting to theatre teams and engagement with clinical teams to encourage service improvement is the next step.
- c. Scoping Review.** The scoping team has met to identify areas for service improvement. Analysis of capacity and demand needs to be completed and reporting established to show how well the service is meeting the demand for endoscopy.
- d. Surgical Pre-Admission Redesign.** A team has met to pull together a variety of initiatives that will improve the pre-admission journey. We are wanting to improve both the quality of the pre-admission work-up, to minimise the waiting time and the number of visits a patient needs to make.

The team is currently process mapping the pre-admission pathway and gathering some patient experiences to highlight the issues for improvement.

- e. **Minor Surgical Skin Lesions.** A clinical working group from both primary and secondary care is meeting to clarify which particular procedures can be better delivered for our patients in a primary care setting. This will not only provide a more convenient and timelier service for patients, but also free up capacity in our hospital setting for more complex surgical procedures.
- f. **Cardiology.** This service regularly meets to improve the quality and efficiency of the service provided.

II) Clinical Services Support Directorate

a. **National Medication Chart**

New Adult Medication chart went live in both Nelson and Wairau Hospitals on May 2. Good work by implementation team on its introduction, minor teething problems but overall going well. The roll out of the National Adult Medication Charts is required to be implemented by all DHBs by 31 December 2011.

b. **Medicines Reconciliation Project**

A workgroup involving clinical staff has been set up to implement this project for both Nelson and Wairau. Wairau has now started in March with Nelson commencing late April now Pharmacy is fully staffed.

4.2.4 Utilisation/Activity

I) Medical / Surgical Service Directorate

The Medical Surgical Service delivered 1789 Caseweights (116% of plan) for April and has delivered 16811 Caseweights (104% of plan) YTD (see tables following).

Acute activity was 116% of plan for the month with a high number of acutes, in particular in Cardiology, General Surgery and Orthopaedics.

Elective activity was 116% of budget for the month. The General Surgery, ENT and Orthopaedic Services in particular had high elective delivery (136%, 133% and 134% of budget) with the DHB increasing throughput to address long wait patients, which is supported by additional elective funding by the Ministry of Health in the last quarter of 2011.

Elective discharges for April were 468 (106% of plan), and YTD 4486 elective discharges have occurred (97% of plan).

Elective caseweight delivery for April was 617 CWDs (117% of plan) compared to budget 528 caseweights. YTD caseweights are 5814 compared to budget of 5575 (104% of plan).

The DHB remains green overall in terms of ESPI compliance. The Ministry of Health requires by 1 October that no patient is waiting longer than six months for an FSA or elective procedure.

Only two services remain non compliant for ESPI 2 (patients waiting longer than 6 months for an FSA), they are General Surgery and Rheumatology although there are still 127 patients waiting > 6 months.

ESPI 5 – Patients waiting for surgical treatment > 6 months is now complaint although there are still 99 patients waiting > 6 months, of which 36 are in Orthopaedics. Additional theatre sessions are being undertaken in May and June to address long wait patients.

Bed Management

The month of April was a high acuity month which at times caused significant pressures on beds and thus limiting elective capacity.

Nelson Hospital

Average daily occupancy for April was 86%, this is 4% above the average year to date. Bed Management related cancellations of surgery equated to 3.8% of booked in patient cases.

Wairau Hospital

The occupancy at Wairau is showing an upward trend with an average occupancy in April of 87%, this is 9% above the average year to date. Three out of 57 elective cases were cancelled due to lack of beds.

Medical & Surgical Acute/ Elective

Caseweights

NMDHB

April 2011

DM Area	Unit Code	Description	Type	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan
Med	M00001	General Internal Medical Services - Inpatient Serv	Acute	5161	3895	3606	-289	93%
			Elective	139	105	104	-1	99%
		General Internal Medical Services - Inpatient Serv	Total	5300	4000	3710	-290	93%
	M10001	Cardiology - Non PCI Inpatient Services (DRGs)	Acute	253	191	443	252	232%
			Elective	207	156	200	44	128%
		Cardiology - Non PCI Inpatient Services (DRGs)	Total	460	347	643	296	185%
M10001P	Cardiology - PCI Inpatient Services (DRGs)	Acute	305	230	167	-62	73%	
		Elective	102	77	50	-27	65%	
	Cardiology - PCI Inpatient Services (DRGs)	Total	406	306	217	-89	71%	
Med Total				6166	4654	4571	-83	98%
Surg	S00001	General Surgery - Inpatient Services (DRGs)	Acute	2281	1722	1827	105	106%
			Elective	1918	1448	1467	19	101%
		General Surgery - Inpatient Services (DRGs)	Total	4200	3169	3294	125	104%
	S05001	Anaesthesia Services - Inpatient Services (DRGs)	Acute	29	22	12	-9	57%
			Elective	61	46	22	-24	48%
		Anaesthesia Services - Inpatient Services (DRGs)	Total	90	68	34	-33	51%
	S25001	Ear, Nose and Throat - Inpatient Services (DRGs)	Acute	112	85	77	-8	91%
			Elective	455	343	372	29	108%
		Ear, Nose and Throat - Inpatient Services (DRGs)	Total	567	428	450	21	105%
	S40001	Ophthalmology - Inpatient Services (DRGs)	Acute	35	27	25	-2	93%
			Elective	425	321	259	-61	81%
		Ophthalmology - Inpatient Services (DRGs)	Total	460	347	284	-63	82%
	S45001	Orthopaedics - Inpatient Services (DRGs)	Acute	1673	1263	1551	288	123%
			Elective	1893	1428	1703	274	119%
		Orthopaedics - Inpatient Services (DRGs)	Total	3566	2691	3253	562	121%
	S70001	Urology - Inpatient Services (DRGs)	Acute	218	164	149	-16	90%
			Elective	532	402	357	-44	89%
		Urology - Inpatient Services (DRGs)	Total	750	566	506	-60	89%
Surg Total				9632	7270	7821	552	108%
W, C & OH	D01001	Inpatient Dental treatment	Acute	23	17	16	-2	90%
			Elective	213	161	115	-46	71%
		Inpatient Dental treatment	Total	237	179	130	-48	73%
	M55001	Paediatric Medical Service (Inpatient)	Acute	689	520	456	-64	88%
			Elective	41	31	25	-7	79%
		Paediatric Medical Service (Inpatient)	Total	730	551	480	-71	87%
	S30001	Gynaecology - Inpatient Services (DRGs)	Acute	183	138	170	32	123%
			Elective	702	530	524	-6	99%
		Gynaecology - Inpatient Services (DRGs)	Total	885	668	694	26	104%
	W06003	Neonatal Inpatient (DRGs)	Acute	416	314	309	-5	98%
Neonatal Inpatient (DRGs)		Total	416	314	309	-5	98%	
W10001	Maternity Inpatient (DRGs)	Acute	1345	1015	1017	1	100%	
	Maternity Inpatient (DRGs)	Total	1345	1015	1017	1	100%	
W, C & OH Total				3613	2727	2630	-97	96%
Grand Total				19412	14650	15022	372	103%

Elective Discharges

NB. These volumes are set by the Funder, but have NO funding impact (ie funding remains with the cwd's)

These discharges are the same cases that are shown as the Elective Caseweights in the table above

DM Area	Unit Code	Description	Type	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan
Surg	S00001	General Surgery - Inpatient Services (DRGs)	Elec Disch	1816	1371	1220	-151	89%
	S05001	Anaesthesia Services - Inpatient Services (DRGs)	Elec Disch	234	177	89	-88	50%
	S25001	Ear, Nose and Throat - Inpatient Services (DRGs)	Elec Disch	760	574	596	22	104%
	S40001	Ophthalmology - Inpatient Services (DRGs)	Elec Disch	688	519	486	-33	94%
	S45001	Orthopaedics - Inpatient Services (DRGs)	Elec Disch	886	669	734	65	110%
	S70001	Urology - Inpatient Services (DRGs)	Elec Disch	443	334	338	4	101%
	Surg Total				4827	3643	3463	-180
W, C & OH	S30001	Gynaecology - Inpatient Services (DRGs)	Elec Disch	728	549	555	6	101%
W, C & OH Total				728	549	555	6	101%
Grand Total				5555	4192	4018	-174	96%

Outpatient Attendances

First Attendances

NMDHB

April 2011

DM Area	Unit Code	Description	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Act % Complete vs YTD Plan
Med	M00002	General Medicine - 1st attendance	1450	1094	1190	96	109%
	M10002	Cardiology - 1st attendance	1500	1132	1289	157	114%
	M15002	Dermatology - 1st attendance	400	302	307	5	102%
	M20004	Diabetes - 1st attendance	280	211	257	46	122%
	M25002	Gastroenterology - 1st attendance	920	694	732	38	105%
	M45002	Neurology - 1st attendance	632	477	537	60	113%
	M50002	Oncology - 1st attendance	574	433	373	-60	86%
	M60002	Renal Medicine - 1st attendance	60	45	28	-17	62%
	M65002	Respiratory - 1st attendance	100	75	111	36	147%
	M70002	Rheumatology (incl immunology) - 1st attendance	290	219	223	4	102%
Med Total			6206	4684	5047	363	108%
Surg	S00002	General Surgery - 1st attendance	3454	2607	2410	-197	92%
	S25002	Ear Nose and Throat - 1st attendance	1500	1132	950	-182	84%
	S40002	Ophthalmology - 1st attendance	1445	1091	1084	-7	99%
	S45002	Orthopaedics - 1st attendance	3800	2868	2607	-261	91%
	S70002	Urology - 1st attendance	1100	830	807	-23	97%
	PC0001	Pain Clinic - 1st attendance	110	83	61	-22	73%
Surg Total			11409	8610	7919	-691	92%
W, C & OH	M55002	Paediatric Medical Outpatient - 1st attendance	1045	789	739	-50	94%
	S30002	Gynaecology - 1st attendance	1200	906	1065	159	118%
	W03002	First obstetric consults	830	626	582	-44	93%
W, C & OH Total			3075	2321	2386	65	103%
Grand Total			20690	15615	15352	-263	98%

Subsequent Attendances

NMDHB

April 2011

DM Area	Unit Code	Description	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan
Med	M00003	General Medicine - Subsequent attendance	2500	1887	1957	70	104%
	M10003	Cardiology - Subsequent attendance	2394	1807	2078	271	115%
	M15003	Dermatology - Subsequent attendance	420	317	288	-29	91%
	M20005	Diabetes - Subsequent attendance	550	415	411	-4	99%
	M25003	Gastroenterology - Subsequent attendance	991	748	338	-410	45%
	M45003	Neurology - Subsequent attendance	476	359	404	45	112%
	M50003	Oncology - Subsequent attendance	3800	2868	2601	-267	91%
	M60003	Renal Medicine - Subsequent attendance	550	415	374	-41	90%
	M65003	Respiratory - Subsequent attendance	70	53	24	-29	45%
	M70003	Rheumatology (incl immunology) - Subsequent at	1110	838	666	-172	80%
Med Total			12861	9706	9141	-565	94%
Surg	S00003	General Surgery - Subsequent attendance	4617	3484	3074	-410	88%
	S25003	Ear Nose and Throat - Subsequent attendance	1800	1358	1495	137	110%
	S40003	Ophthalmology - Subsequent attendance	6000	4528	4507	-21	100%
	S45003	Orthopaedics - Subsequent attendance	6600	4981	4417	-564	89%
	S70003	Urology - Subsequent attendance	2000	1509	1470	-39	97%
	PC0003	Pain Clinic - Subsequent attendance	200	151	168	17	111%
Surg Total			21217	16013	15131	-882	94%
W, C & OH	M55003	Paediatric Medical Outpatient - Subsequent atter	2600	1962	1869	-93	95%
	S30003	Gynaecology - Subsequent attendance	1250	943	991	48	105%
	W03003	Subsequent obstetric consults	728	549	388	-161	71%
W, C & OH Total			4578	3455	3248	-207	94%
Grand Total			38656	29174	27520	-1654	94%

Medical & Surgical Procedures

NMDHB

April 2011

DM Area	Unit Code	Description	Annual Plan	Budget YTD	Actual YTD	Vol Variance	Actual % Complete vs YTD Plan
Med	M00006	General Medicine - Blood Transfusions	660	498	553	55	111%
	M10004	Cardiac Education and Management	900	679	737	58	109%
	M15004	Dermatology - UV Treatment	350	264	478	214	181%
	M20006	Diabetes Education and Management	990	990	858	-132	87%
	M25005	Gastroenterology - Colonoscopy	440	332	282	-50	85%
	M25006	Gastroenterology - Gastroscopy	600	453	448	-5	99%
	M45004	Neurology - Botulinum toxin therapy	50	38	55	17	146%
	M60008	Renal Medicine - Incentre dialysis	1980	1494	1084	-410	73%
	M65005	Respiratory - Bronchoscopy	60	45	19	-26	42%
	M65006	Sleep apnoea - assessment	170	128	174	46	136%
	M65007	Sleep apnoea - long term treatment	170	128	215	87	168%
MS02009	IV Chemotherapy - cancer - Any health speciality	1780	1343	1580	237	118%	
Med Total			8150	6394	6483	89	101%
Surg	M20007	Diabetes - Fundus Screening	1500	1132	1401	269	124%
	S00004	General Surgery - Colonoscopy	943	712	860	148	121%
	S00005	General Surgery - Gastroscopy	323	244	254	10	104%
	S00008	Minor operations (Gen Surgery)	800	604	434	-170	72%
	S25006	ENT Minor procedure	950	717	789	72	110%
	S40004	Minor Eye Procedures	650	491	615	124	125%
	S40005	Eye - Argon Laser	180	136	164	28	121%
	S70005	Urology - Cystoscopy	400	302	390	88	129%
	S70006	Urology - Lithotripsy	30	23	20	-3	88%
	S70007	Urology - Urodynamics	60	45	27	-18	60%
Surg Total			5836	4404	4954	550	112%
W, C & OH	S30006	Termination of Pregnancy	450	340	309	-31	91%
	S30008	Gynaecology - High cost Minor Procedures	90	68	61	-7	90%
	W03005	Amniocentesis	50	38	11	-27	29%
W, C & OH Total			590	445	381	-64	86%
Grand Total			14576	11243	11818	575	105%

MoH Elective Services Online

Summary of Patient Flow Indicator (ESPI) results for each DHB

DHB Name: Nelson Marlborough

	2010			2010			2010			2010			2010			2010			2010			2010			2011			2011			2011			Target			
	Apr			May			Jun			Jul			Aug			Sep			Oct			Nov			Dec			Jan			Feb				Mar		
	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.				
1. DHB services that appropriately acknowledge and process all patient referrals within ten working days.	21 of 21	100%	0	21 of 21	100%	0	21 of 21	100%	0	21 of 21	100%	0	21 of 21	100%	0	21 of 21	100%	0	21 of 21	100%	0	21 of 21	100%	0	21 of 21	100%	0	21 of 21	100%	0	21 of 21	100%	0	> 90%			
2. Patients waiting longer than six months for their first specialist assessment (FSA).	336	1.8%	0	379	2.0%	0	373	2.0%	0	265	1.4%	0	169	0.9%	0	226	1.2%	0	145	0.8%	0	171	0.9%	0	186	1.0%	0	250	1.4%	0	236	1.3%	0	216	1.2%	0	< 1.5%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (ATT).	95	1.7%	0	91	1.6%	0	72	1.3%	0	74	1.3%	0	75	1.3%	0	61	1.1%	0	54	1.0%	0	58	1.1%	0	39	0.7%	0	43	0.8%	0	48	0.9%	0	45	0.8%	0	< 5%
4. Clarity of treatment status.	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	< 5%
5. Patients given a commitment to treatment but not treated within six months.	212	3.5%	0	214	3.6%	0	175	3.0%	0	133	2.2%	0	126	2.1%	0	110	1.8%	0	111	1.9%	0	128	2.2%	0	142	2.4%	0	160	2.7%	0	140	2.4%	0	135	2.3%	0	< 4%
6. Patients in active review who have not received a clinical assessment within the last six months.	58	9.3%	0	52	8.6%	0	32	5.6%	0	24	4.5%	0	18	3.5%	0	50	8.9%	0	19	4.0%	0	22	4.6%	0	38	8.4%	0	31	7.0%	0	25	5.7%	0	23	5.2%	0	< 15%
7. Patients who have not been managed according to their assigned status and who should have received treatment.	167	2.9%	0	175	3.1%	0	141	2.5%	0	102	1.8%	0	96	1.7%	0	90	1.6%	0	93	1.7%	0	116	2.1%	0	100	1.6%	0	121	2.2%	0	104	1.9%	0	113	2.0%	0	< 5%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	493	100%	0%	470	100%	0%	506	100%	0%	479	100%	0%	491	100%	0%	477	100%	0%	430	100%	0%	478	100%	0%	465	100%	0%	526	100%	0%	413	100%	0%	519	100%	0%	> 90%

This report displays overall ESPI results for a DHB over a 12 month period. The ESPI results do not include non-electives or elective patients awaiting planned, staged or surveillance procedures. ESPIs 3, 7 and 8 assess surgical specialties where patients are prioritised using nationally recognised tools. Medical specialties are currently included in ESPI 1 and 2 results but excluded from other ESPI results. In August 2010 the ESPI 2 threshold was reduced from 2% to 1.5%, and the ESPI 5 threshold was reduced from 5% to 4%. Please contact the Ministry of Health's Electives Team if you have any queries about ESPIs. (elective_services@moh.govt.nz).

Data Warehouse Refresh Date: 30/Apr/2011
Report Run Date: 02/May/2011

II) Clinical Services Support Directorate

a. **Nelson Hospital Shop**

Nelson Volunteers shop donated \$20,000 for Hospital Equipment.

b. **Clerical and Admin**

Customer Service training - implementation being worked on for all Clerical and Admin staff.

4.2.5 Performance to MOH Health Targets KPIs

I) Medical / Surgical Service Directorate

a. **Shorter Stays in Emergency Departments**

NMDHB is exceeding the Ministry of Health target.

b. **Shorter Waits for Cancer Treatment Radiotherapy**

Current treatment times are within Ministry of Health guidelines. Patients are receiving treatment at both Canterbury District Health Board and Capital and Coast District Health Board.

c. **Improved Access to Elective Surgery**

Ambulatory FSA, at end March 2011, has delivered 15,518 FSAs against plan of 12,313 (126%). Of this total, surgical FSAs are 9,300 actual delivery against plan of 8,057 (115.4%).

Ambulatory Procedures at end March 2011, has delivered 1,145 procedures against plan of 851 (135%). Ambulatory Procedure includes Colonoscopy procedures across both Medical and Surgical specialities.

d. **Electives Initiative:**

- Health Target. NMDHB is required to deliver 6029 discharges every year. As of March, YTD we were required to deliver 4,368 discharges and have actually delivered 4,404 discharges (100.8%); and
- Case Weights (CWDs). Planned case weight delivery (March 2011) was 5,432 with actual case weight delivery 6,121.2 (112.7%).

e. **Increased Immunisation (Q3 result, January–March 2011)**

	Achieved (%)	Target (%)
Total	89	90
Maori	91	85
Pacific	82	85

We are continuing to collaborate with the Immunisation Co-ordinators from both Nelson Bays Primary Health and Kimi Hauora Wairau Marlborough Primary Health Organisation. This includes sharing of data to increase immunisation statistics across the region; addressing outstanding reports with GP Practices for completion; and the Immunisation Special Interest Group meetings continue to be held monthly to focus on ways to improve immunisation rates and the sharing of best practice throughout the region.

f. **Better Diabetes and Cardiovascular Services**
(Q3 result, January –March 2011)

	National Health Target (%)	Achieved Q2 (Oct-Dec, 2010) (%)	Achieved Q3 (Jan-Mar, 2011) (%)
<i>1. Diabetes Annual Check</i>			57
Maori	52	52.8	
Pacific	n/a	n/a	56
Other	76	57.6	61
Total	72	57	61
<i>2. Diabetes Management</i>			65
Maori	72	69	
Pacific	n/a	53	61
Other	82	83	80
Total	79	81	79
<i>3. CVD Risk Assessment</i>			Awaiting final figures from MoH
Maori	55	59.5	
Pacific	n/a	53.6	
Other	76	69.4	
Total	72	68.6	70

There are three components to this target; two of which NMDHB is not achieving as well as expected - for these two components a recovery plan is in place.

Due to the data being lagged by three months, this indicator will take time to show improvement as a result of any initiatives put in place – we are unlikely to meet the National Target for Q4 (as that measures data for the 12 months to the end of March).

The proportion of people who have had a **CVD Risk Assessment** in the past five years – the laboratory data on which this is based is being checked to ensure that all relevant data is included.

For the proportion of people accessing a **Diabetes Annual Review (DAR)** NMDHB has three strategies in place: confirming the denominator (diabetes prevalence) with the Ministry; ensuring we are capturing all the information on people who are accessing services for support with diabetes management (including those in specialist services); and initiatives lead by PHOs, working with practices and NGOs to actively trace eligible people who have not had a DAR and encourage their participation.

On the third component of **Diabetes Management** (measured by HBA1c results) Nelson Marlborough achieves well compared to other DHBs and no specific action is required at this time.

g. Better Help for Smokers to Quit



Significant progress has been made over the last quarter by the Smokefree Team and staff. The March result was 86%, and April 87%. This progress indicates we are on the right track to meeting the Q4 Health Target of 90% by the end of June 2011.

II) Clinical Support Services Directorate

a. Laboratory

Laboratory Contract renewal negotiations on hold (not cancelled) until May due to CHC EQ impact on Medlab South (their building is red stickered). They are working out of Canterbury Health Laboratories at this time which is working well.

4.2.6 Financial Report for the Month Ended 30 April 2011

I) Medical / Surgical Services Directorate

Medical Surgical Services Directorate Statement of Financial Performance

\$000	April 2011			Year to Date			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	DAP	Variance
Revenue									
MoH Revenue	136	101	34	1,234	1,309	(75)	1,497	1,610	(113)
Other Govt Revenue	255	271	(15)	2,741	2,683	59	3,307	3,222	85
Other Income	283	254	29	2,760	2,511	249	3,236	3,019	218
Internal Revenue									
PVS	10,853	10,863	(10)	108,411	108,656	(245)	130,107	130,391	(283)
NGO & IDF	2,511	2,511	-	25,114	25,114	-	30,137	30,137	0
Internal Charge	-	-	-	0	-	0	0	-	0
Total Revenue	14,038	14,000	38	140,261	140,273	(12)	168,285	168,378	(93)
Expenditure									
Personnel Costs	5,536	6,089	553	55,768	58,325	2,557	67,300	70,120	2,820
Outsourced services	321	176	(145)	2,479	1,800	(679)	2,996	2,165	(831)
Clinical Supplies	1,305	1,114	(191)	12,653	11,800	(854)	15,280	14,261	(1,019)
Infrastructure and Non Clinical	450	452	2	4,341	4,574	233	5,241	5,491	251
Provider Payments									
IDF & NGO									
Personal Health	2,510	2,509	(1)	24,926	25,093	166	29,947	30,111	164
Disability Support	2	2	(0)	(43)	22	65	(39)	26	65
Internal (PVS)									
Internal Expenses	328	321	(7)	2,927	3,037	109	3,561	3,670	109
Total Expenditure	10,452	10,663	211	103,052	104,650	1,598	124,285	125,844	1,559
Net Surplus/(Loss)	3,586	3,337	249	37,209	35,623	1,586	44,000	42,534	1,465

FTE's - Medical Surgical Services Directorate

Staff Type	April 2011			Year to Date			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance		DAP	Variance
Medical Personnel	136.3	140.6	4.3	139.6	139.4	(0.1)		140.4	0.0
Nursing Personnel	454.0	451.7	(2.3)	430.5	432.7	2.3		432.7	0.0
Allied Health	41.5	43.3	1.8	39.9	43.1	3.2		43.2	0.0
Hotel Services	26.4	32.0	5.6	28.7	30.8	2.1		30.8	0.0
Management/Administration	11.1	14.5	3.4	12.9	14.9	2.0		14.9	0.0
Total FTEs	669.3	682.1	12.8	651.5	660.9	9.4		661.9	0.0

REVENUE:

MOH Revenue is \$75k unfavourable YTD. The main driver of this variance is Public Health screening revenue which is \$117k unfavourable caused by lower screening volumes. Alexandra Hospital has a favourable variance of \$42k due to a new direct funding contract.

Other Income is \$249k favourable. Donations for assets of \$231K and a \$45K annual supplier rebate in Surgical Services are the main positive features. This is partially offset by lower patient co-payments in relation to continuing care volumes.

Internal Revenue (PVS) is \$245k unfavourable YTD. Health of Older People is \$287k unfavourable as Alexandra Hospital has experienced lower continuing care volumes - currently running at 96% of YTD contract. Partly offsetting this are Dental Healthpac claims which have brought in \$5k more than budgeted.

EXPENDITURE:

Personnel costs are \$2.6M favourable (9.4 FTE favourable).

Medical Personnel \$1.2M favourable (0.1 FTE unfavourable)

The positive \$ variance is caused by the mix of Senior versus junior doctors being different to budget.

Nursing Personnel \$801k under (2.3 FTE under) with positive variances in most services. Notable variances are:

- Surgical \$526k favourable (4.3 FTE favourable)
- Medical \$155k over budget (5.0 FTE over) mostly in Medical Unit NN and Emergency Department
- HOP \$198k favourable (2.2 FTE favourable)
- Women Children and Oral Health \$146k favourable (0.7 FTE unfavourable).

Allied Health \$289K favourable (3.3 FTE favourable)

- Surgical Services \$186k favourable (2.6 FTE favourable) in Theatre Technicians and Sterile Services
- Medical Services \$79k (0.3 FTE favourable) in ECG/Physiology Departments.

Support Staff is \$72k favourable

- HOP is \$64k favourable (1.9 FTE favourable) with lower staffing in Alexandra Hospital.

Management and Administration \$191k favourable budget (2.0FTE favourable)

- Vacancy in Dental accounts for \$80k
- Balance is largely in Directorate Management where Executive Staff budget is positive, partly as new Director costs are now in Corporate.

Outsourced Services are \$679k unfavourable.

Outsourced Medical is \$882k unfavourable with additional locum cover for long-term sick leave, maternity leave and staff vacancies. This has impacted most in Obstetrics/Gynae and Paediatrics.

Outsourced Nursing is now \$97k under budget, showing continued controls over this cost and greater use of Internal Bureau Nursing.

Outsourced Clinical Services are \$106k favourable to budget. Most Services are below budget as some of these costs are now likely to be charged to Clinical Support outsourced radiology examinations. Extra costs (\$38k) have been incurred in Ward 9 Nelson for Rest-Home stays of non-weight-bearing patients on the basis that this will free up Hospital beds to better accommodate surgical throughput.

Clinical Supplies are \$854k unfavourable.

Surgical is overspent by \$753k. Of this, \$591k is in Implants and Prostheses. The extra costs are reflected in Orthopaedics with Wairau being 18% over contract volume YTD and Nelson 23% over. Also of note is the higher cost of grafts this financial year (\$167k over). Much of this is related to the employment of a vascular surgeon and the use of high cost endovascular grafts.

Medical Services are \$84k unfavourable to budget. \$35k is due to additional use of specialised pressure mattresses. A work stream is under way to introduce revised clinical guidelines in conjunction with potential to own rather than lease some of this equipment. Emergency Departments are unfavourable to budget by \$69k across a range of codes.

Infrastructure is \$233k favourable with positive variances in most areas.

Hotel and Laundry costs are \$95k favourable to budget with Laundry \$115k positive.

Transport is \$76k favourable to budget, with Staff Travel and vehicle costs showing savings.

Professional Fees are \$32k under budget, mostly in Consultants fees (Hospital Management Department).

Other Operating costs are \$60k favourable to budget with equipment purchases and repairs accounting for \$27k of this and depreciation \$46k. There is an unfavourable variance in stationery, which is over budget by \$42k ranging across a number of areas.

Partly offsetting these is an adverse variance on IT and telecommunications with depreciation being above budget by \$48k.

Personal Health expenditure is \$165k favourable

The favourable variance year to date is due to the 09-10 washup for inpatient Diagnostic Related Group (DRG) outflows.

Disability Support expenditure is \$65k favourable due to a favourable washup for 09-10 (Assessment Treatment and Rehabilitation (ATR) inpatient volumes.

Internal Allocations are \$109k favourable

The positive variance is caused mostly by Pharmacy (\$96K under budget).

II) Clinical Services Support Directorate

Clinical Services Support Directorate Statement of Financial Performance

\$000	April 2011			Year to Date			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	DAP	Variance
Revenue									
MoH Revenue	85	146	(62)	817	1,464	(647)	971	1,756	(785)
Other Govt Revenue	223	98	125	1,235	978	257	1,431	1,174	257
Other Income	129	182	(53)	1,645	1,807	(162)	1,976	2,174	(198)
Internal Revenue									
PVS	1,102	1,009	93	10,516	10,089	427	12,707	12,107	600
NGO & IDF	3,624	3,560	64	37,643	36,668	975	45,000	43,896	1,104
Internal Charge	569	518	51	5,057	4,859	198	6,077	5,879	198
Total Revenue	5,731	5,513	218	56,913	55,865	1,048	68,163	66,987	1,176
Expenditure									
Personnel Costs	1,476	1,514	38	14,666	14,960	294	17,630	17,995	365
Outsourced services	491	459	(32)	4,737	4,603	(135)	5,668	5,526	(141)
Clinical Supplies	1,163	1,128	(35)	11,799	11,142	(657)	14,166	13,448	(718)
Infrastructure and Non Clinical	179	180	1	1,816	1,811	(5)	2,160	2,174	14
Provider Payments									
IDF & NGO									
Personal Health	3,595	3,549	(46)	36,867	36,557	(310)	44,233	43,763	(470)
Disability Support	11	11	(0)	111	111	(0)	133	133	(0)
Internal (PVS)									
Internal Expenses	278	237	(42)	2,570	2,233	(337)	3,037	2,700	(337)
Total Expenditure	7,192	7,077	(116)	72,567	71,417	(1,150)	87,027	85,739	(1,288)
Net Surplus/(Loss)	(1,461)	(1,564)	103	(15,654)	(15,553)	(101)	(18,864)	(18,753)	(111)

FTE's - Clinical Services Support Directorate

Staff Type	April 2011			Year to Date			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance		DAP	Variance
Medical Personnel	5.7	5.3	(0.3)	5.4	5.4	0.0		5.4	0.0
Nursing Personnel	8.1	7.6	(0.5)	7.9	7.6	(0.3)		7.6	0.0
Allied Health	130.2	129.8	(0.4)	126.6	129.8	3.2		130.4	0.0
Hotel Services	2.7	2.4	(0.3)	2.6	2.4	(0.2)		2.4	0.0
Management/Administration	147.6	141.1	(6.5)	143.5	140.5	(2.9)		140.9	0.0
Total FTEs	294.3	286.3	(8.1)	286.0	285.7	(0.3)		286.8	0.0

Fund - Service View

Service	April	April	April	YTD	YTD	YTD	Full Year		
	Actual	Budget	Var	Actual	Budget	Var	Forecast	DAP	Variance
PFM2 - Primary & Referred Portfolio	(18)	0	18	(665)	0	665	(634)	0	634
	(18)	0	18	(665)	0	665	(634)	0	634

Provider - Service View

Service	April	April	April	YTD	YTD	YTD	Full Year		
	Actual	Budget	Var	Actual	Budget	Var	Forecast	DAP	Variance
ADM - Administration	461	436	(25)	4,609	4,418	(190)	5,522	5,340	(182)
CLS - Clinical Support	1,058	1,121	63	11,977	11,058	(918)	14,247	13,310	(936)
FAC - Support Works	(55)	(9)	46	(423)	(87)	336	(461)	(92)	368
MAR - Maori Health	16	16	0	157	163	6	190	195	5
	1,479	1,564	84	16,319	15,553	(767)	19,498	18,753	(745)

Summary of Significant Variances

Financial Variances:

REVENUE:

MOH revenue is \$647k adverse with \$568k due to Herceptin revenue overstatement of budget expectation for the year.

Other Govt is \$257k favourable with higher Pharmac subsidy receipts and Audiology Enable revenue budgeted in Other Income category.

Internal PVS Revenue is \$427k favourable with \$318k in Pharmacy Herceptin claims and \$109k in Support Works to fund Inter-RAI operating costs received post budget being set.

Internal Revenue NGO/IDF is \$975k favourable. Pharmac Risk Pool accounts for \$333k and \$642k is in additional funding for Herceptin IDF costs. These were only notified by the Ministry after the budget was set and are also reflected in the \$310k Personal Health variance in Provider Payments expenditure.

EXPENDITURE:

Personnel costs are \$294k favourable with \$456k in Allied Health offset by \$166k in additional Medical costs.

Outsourced costs are \$135k unfavourable with additional radiologist fees incurred to cope with increased volumes.

Clinical Supplies are \$657k unfavourable with:

- Treatment Disposables (\$297k unfavourable) - blood products (\$208k) of which \$93K is recoverable in revenue; increased radiology costs (\$85k)
- Patient Appliances - \$206k over with \$95k in Audiology departments offset by revenue and \$110k in Orthotics
- Pharmaceuticals (\$168k unfavourable) driven mostly by Immunosuppressive/cytotoxic drugs including Herceptin. Revenue for this is reflected in both Internal PVS revenue and Internal Charge.

Provider Payments \$310k unfavourable variance includes \$642k unfavourable for Herceptin(see revenue offset above) but is reduced by \$106k favourable in Pharmacy Services with some services not implemented and \$217k favourable in Community Pharmaceuticals through increased forecast subsidies.

4.2.7 Emerging Issues

Nil

4.2.8 Project Reports or Status

Nil

4.2.9 Health Alliance / Collaboration

The Health Alliance Pathway support group is now meeting, and currently has a focus to the minor surgical skin lesions pathway. The group has also worked on assessing a website service to support the clinical pathways across primary and secondary care.

4.2.10 Progress against service improvement plans

The final paper setting out the key recommendations to drive service improvement in Ophthalmology is due for release.

The data underpinning the review of Obstetric and Maternity Services is currently being ratified by clinical teams.

4.2.11 Directorate Profile

To be presented.

**RECOMMENDATION:
THAT THE DIRECTORATE REPORT BE RECEIVED.**

SECTION 5: FOR INFORMATION

SECTION 6: MEMBERS ISSUES

SECTION 7: GLOSSARY OF COMMONLY USED ACRONYMS, ABBREVIATIONS AND MAORI TRANSLATION

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

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

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

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

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

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

May 2011

SECTION 8: APPENDICES

APPENDIX 1 – TERMS OF REFERENCE AND STANDARD OPERATING PROCEDURES FOR ADVISORY COMMITTEES

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
 STANDARD OPERATING PROCEDURES FOR ADVISORY COMMITTEES
 (May 2011)

Standard Operating Procedures for Advisory Committees

Advisory Committees	<p>NMDHB has established the following Advisory Committees to provide advice to the Board in accordance with the statutory functions and aims as set out in the NZ Public Health and Disability Act 2000. The functions, aims, core activities and key relationships for each Committee are set out in the appendices as noted below:</p> <p>Community Public Health Advisory Committee and Disability Support Advisory Committee will meet together – see Appendix A Hospital Advisory Committee – See Appendix B</p>
Membership	<p>Members of the Committee are appointed by the Board. Membership will ordinarily comprise a mix of Board members and community members. There will be Maori representation on the Committee (appointed by the Iwi Health Board). There will be no alternates or proxy voting.</p> <p>Each appointment will be for a specified term of up to three years (although members are eligible for reappointment).</p> <p>Committee members must comply with the provisions of Schedule 4 of the NZPHD Act 2000.</p> <p>The maximum number of Committee members is seven, unless otherwise resolved by the Board.</p> <p>The Board may co-opt additional members to the Committee from time to time, as it deems necessary, to assist the work of the Committee. These co-opted members will have a specified term on the committee and must also comply with the provisions of Schedule 4 of the NZPHD Act 2000.</p> <p>The Board may, by notice in writing stating the reasons for the removal and the dates it takes effect, remove a member of the committee from office after consultation with the member and the committee. (Sch 4, Cl 10).</p> <p>The Board Chair is an ex-officio member of the Committee.</p> <p>Members are entitled to receive copies of all Committee agendas and meeting papers, Board open meeting papers and draft planning documents</p> <p>Community Members are required to complete a declaration of interests in accordance with the Conflicts of Interest Policy and comply with that policy.</p> <p>Any Members and/ or their spouse/ partner who may have a conflict are required to declare it and comply with the terms set out in the Conflicts of Interest Policy.</p> <p>Members are subject to the Code of Conduct as set out in the Governance Handbook for Board and Committee Members.</p>
Chairperson	<p>The Chairperson of the Committee is appointed by the Board for a specified term and must comply with the provisions of Schedule 4 of the NZPHD Act 2000.</p> <p>The Chairperson is a Board member.</p> <p>The Deputy Chairperson is recommended by the Committee and endorsed by the Board.</p>
Relationships	<p>The Committee takes its direction and workload from the Board and is supported in its work by the CE and a lead representative of the Executive Leadership Team (ELT) of the DHB.</p>

**NELSON MARLBOROUGH DISTRICT HEALTH BOARD
STANDARD OPERATING PROCEDURES FOR ADVISORY COMMITTEES
(May 2011)**

	<p>The key relationships with ELT will be through the respective lead Services Directorate/s, as outlined in the section entitled “Key Relationships” in the Terms of Reference, and through Support ELT where appropriate.</p> <p>The CE and Management of the DHB may seek advice on work in progress to test expectations or affordability. Such advice may be sought in the form of public excluded session of a normal committee meeting or by a special workshop.</p> <p>The Committee provides advice by way of recommendations to the Board after considering and debating information provided to it by the Board, CE or Management or CPHAC/ DiSAC). It may refer items to CPHAC/ DiSAC by way of referral.</p> <p>The Committee Chair only, or members at the Chair’s express direction, will act on committee matters only through the Chief Executive (or his/ her delegate) except for matters relating to members.</p> <p>The Chief Executive is accountable solely to the Board. The Chief Executive and delegated officers of the Board may attend and speak at meetings.</p> <p>The Chief Executive is solely responsible for matters relating to individual employees of the DHB and “without interference” from the Board or committees (Sch. 3, cl. 44(4)).</p> <p>Management will service the committee including the provision of secretarial support. Management will prepare agendas, reports and minutes in conjunction with the Chairperson.</p> <p>The Committee is to be cognisant of the work being undertaken by the combined Community and Public Health Advisory Committee and Disability Support Advisory Committee to ensure a cohesive approach to health and disability planning and delivery. The Board may employ cross membership on committees.</p> <p>Committees are to have effective relationships with the community including providers. Individuals and organisations wanting to be heard by a committee are, on a pre-arranged basis, to be given a reasonable opportunity to be heard in person. Each open meeting of the Committee will have a 15 minute public forum where members of the public may raise concerns.</p> <p>The Minister of Health requires DHBs to consult where the Minister considers that DHBs are proposing changes to</p> <ul style="list-style-type: none"> • Service eligibility • Access, or • The way services are provided that will have a significant impact on recipients of services, their caregivers or providers. <p>Where the Minister of Health directs DHBs to make significant changes, the Minister may also require DHBs to consult on how those changes should be made.</p> <p>There will be no media or other statements on Committee matters except via the Board Chair, Committee Chair or Chief Executive.</p>
Parameters	<p>The Committee provides <u>advice</u> to the NMDHB. The Committee has no delegated authority or decision-making power, other than that which may be specifically delegated by the Board.</p> <p>The Committee’s advice should take into account the possible impacts of recommendations on all parts of NMDHB.</p>

**NELSON MARLBOROUGH DISTRICT HEALTH BOARD
STANDARD OPERATING PROCEDURES FOR ADVISORY COMMITTEES
(May 2011)**

	<p>The Committee's advice must be consistent with government strategies and policies, particularly the New Zealand Health Strategy and the South Island Health Services Plan.</p> <p>The Committee must operate in accordance with directions from the Board and with Schedule 4 of the NZPHD Act 2000. A committee may regulate its procedure, at its meetings and otherwise, in any manner not inconsistent with that Act as it thinks fit. The Committee may choose to adopt the same Standing Orders as adopted by the Board.</p>
Accountability	<p>The Committee and its members are accountable to the Nelson Marlborough District Health Board.</p> <p>The Board may, by written notice to a committee, delegate to that committee any of the functions, duties or powers of the Board. (Sch 3, cl 39(4)).</p>
Scope	<p>The Committee's focus will be on the operational performance of the hospital and other health services owned or provided by NMDHB in the provision of acute, elective, continuing care and community health services by hospital and health services owned by NMDHB.</p> <p>The Committee may consider and provide advice on the impact of any proposed changes to the models of service delivery under a South Island Health Services Plan on the operational capability of the hospital and other health services owned or provided by NMDHB.</p>
Process	<p>The Committee meets two-monthly on the fourth Tuesday of the Month or such other day and time as the Board may decide. The Committee may decide in exceptional circumstances that it is necessary to hold additional meetings, with the Board's agreement, up to a maximum of 10 meetings or workshops per year.</p> <p>Meetings will be open to the public and agendas and reports will be made available to the public in accordance with the Act. Where the reasons stated in Clause 34 of Schedule 4 of the Act apply, meetings may be closed to the public.</p> <p>The Committee may from time to time hold workshops that do not constitute a meeting for the purposes of Schedule 4 of the Act (i.e. no decisions or resolutions of the Committee are to be made). In these cases a report or notes from the session/s may be presented in open meeting at the next formal meeting of the Committee.</p> <p>The Committee, with the agreement of the Board, may from time to time form, and operate under its auspices, focus groups, working parties, project teams or similar groups to progress the work of the Committee. These groups will need to have terms of reference, clear expectations and timeframes to work within. The Board may delegate the appointment of members of these groups to the Committee. The groups will be short-term and task oriented.</p>
Reporting Requirements	<p>The Committee will report to the full Board regularly, through a report of its meetings being provided to the Board by the Chairperson of the Committee.</p> <p>The Board may require specific reports from the Committee to inform the Board at particular decision points (e.g. funding allocations, annual plans, regional planning) in a timeframe to meet the requirements of the annual funding cycle with the Ministry of Health.</p> <p>The Committee will develop an annual work plan which aligns to the annual plan. The Committee may be required to submit a summary of the year's activities to contribute to the Board's annual report each year.</p>
Performance	<p>The Committee reviews its performance annually.</p>

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
STANDARD OPERATING PROCEDURES FOR ADVISORY COMMITTEES
(May 2011)

	<p>These terms of reference are in force until amended by the Board. The Board may amend them at its discretion (in so far as they remain consistent with the Act).</p>
Remuneration	<p>In accordance with advice received from the Minister of Health (7 Dec 2000), committee members are remunerated as follows:</p> <ul style="list-style-type: none">• All Committee members (up to a maximum of 10 per committee) receive an annual fee of \$2,500 per person, excepting that the fee for the chair of each committee is 125% (\$3,125) the rate for committee members.• However, if Committee members attend fewer than 10 meetings over the period, the fee to be paid is reduced on a pro-rata basis, as an appropriate proportion of 10.• Reasonable attendance expenses (i.e. <u>reasonable</u> travel-related costs) for board and committee meetings may be paid. This is to be based on a conservative policy established by the Board.• The same fee is payable to board members and non-board members serving on committees. However, any officer or elected representative of an organisation that would expect their officers or elected representatives to attend committee meetings as a normal part of their duties and who is paid by them for that, is not eligible to be paid committee fees. <p>Board Workshops attended by non-Board Committee members are deemed to be meetings for the purposes of remuneration.</p>

**COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
AND DISABILITY SUPPORT ADVISORY COMMITTEE
Terms of Reference (May 2011)**

Appendix A

These Terms of Reference should be read in conjunction with the New Zealand Public Health and Disability Act 2000, particularly Schedule 4, the Amendment Bill 2010 and the Standard Operating Procedures for Advisory Committees this document.

Statutory Functions	<p>As the Community and Public Health Advisory Committee the functions are: To give the Board advice on:</p> <ul style="list-style-type: none"> • The needs, and any factors that the committee believes may adversely affect the health status, of the resident population of the DHB; and • Priorities for use of the health funding provided. <p>(Schedule 4, NZPHD Act, clause 2)</p> <p>As the Disability Support Advisory Committee the functions are: To give the board advice on:</p> <ul style="list-style-type: none"> • The disability support needs of the resident population of the DHB; and • Priorities for use of the disability support funding provided. <p>(Schedule 4, NZPHD Act, clause 3)</p> <p>The Committee is to also give the board advice on:</p> <ul style="list-style-type: none"> • The optimum arrangements for the most effective and efficient delivery of health services in order to meet local, regional, and national needs; and • Ensuring collaboration takes place with relevant organisations to plan and co-ordinate at local, regional and national levels for the most effective and efficient delivery of health services. <p>(NZ Public Health and Disability Amendment Bill 2010)</p>
Statutory Aims	<p>As the Community and Public Health Advisory Committee the aims are: To ensure that the following maximise the overall health gain for the population the committee serves:</p> <ul style="list-style-type: none"> • All service interventions the DHB has provided or funded or could provide or fund for that population; and • All policies the DHB has adopted or could adopt for that population. <p>As the Disability Support Advisory Committee the aims are: To ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB's resident population:</p> <ul style="list-style-type: none"> • The kinds of disability support services the DHB has provided or funded or could provide or fund for those people; and • All policies the DHB has adopted or could adopt for those people. <p>(Schedule 4, NZPHD Act)</p>
Core Activities	<p>The Committee will provide advice to Annual Planning (AP) programmes that relate to community, public health and disability support services in Nelson Marlborough.</p> <p>The Committee will provide strategic advice on regional service planning as part of the redesign of services and service delivery models across the South Island.</p> <p>At times the Committee may be asked to provide advice on matters already considered by the Hospital Advisory Committee (HAC) or on work in progress by the Chief Executive (CE) or management.</p> <p>To monitor the planning and funding of health and disability support services in the Nelson Marlborough district including delivery against the statement of forecasted service performance.</p>

**COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
AND DISABILITY SUPPORT ADVISORY COMMITTEE
Terms of Reference (May 2011)**

	<p>The Committee shall focus on the following:</p> <ul style="list-style-type: none"> • Performance at directorate level against national or best practice benchmarks; • Comparative reporting; • Maximising the overall health gain for people of our district: <ul style="list-style-type: none"> ○ Being aware of their health and disability needs ○ Identifying areas for improvement to address gaps in services being purchased or provided; • Input to operational and regional strategic planning; • Consultation outcomes; • Promoting the inclusion and participation in society, and maximising the independence, of people with disabilities in our district; • Input to the South Island strategic direction for integration of providers and refocusing service delivery models to ensure the optimal use of health resources; • Ensuring there is clinical input and leadership to regional or national priority work streams through multidisciplinary teams that encompass primary as well as hospital and specialist services; and • Monitor service provision for people with disabilities and the progress of key initiatives such as the older persons network implementation plan.
<p>Key Relationships</p>	<p>The Committee takes its direction and workload from the Board and is supported in its work by the CE and</p> <ul style="list-style-type: none"> • Community Based Services Directorate as lead; • Strategy and Planning Directorate; • Mental Health Services Directorate; and • Marlborough Services Directorate. <p>Business Development (IDSS services) will report to this Committee.</p> <p>Other support may be provided by the Directors of Nursing and Midwifery, Maori Health and Chief Medical Officer as required.</p>

**NELSON MARLBOROUGH DISTRICT HEALTH BOARD
HOSPITAL ADVISORY COMMITTEE
Terms of Reference (May 2011)**

Appendix B

These Terms of Reference should be read in conjunction with the New Zealand Public Health and Disability Act 2000, particularly Schedule 4, the Amendment Bill 2010 and the Standard Operating Procedures for Advisory Committees this document.

Statutory Functions	<p>To:</p> <ul style="list-style-type: none"> • Monitor the financial and operational performance of the hospitals (and related services) of the DHB; • Assess strategic issues relating to the provision of hospital services by or through the DHB; and • Give the board advice and recommendations on that monitoring and that assessment. <p>(Schedule 4, NZPHD Act, clause 4)</p> <ul style="list-style-type: none"> • Seek optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs; and • Ensure collaboration takes place with relevant organisations to plan and co-ordinate at local, regional and national levels for the most effective and efficient delivery of health services. <p>(NZ Public Health and Disability Amendment Bill 2010)</p>
Statutory Aims	<p>To ensure that the hospitals and related services of NMDHB operate efficiently and effectively.</p>
Core Activities	<p>To provide advice to Annual Planning (AP) programmes that relate to the provision of hospital and health services in Nelson Marlborough.</p> <p>To provide strategic advice on regional service planning as part of the redesign of services and service delivery models across the South Island.</p> <p>To on request provide advice on matters already considered by the Combined Community, Public Health and Disability Support Advisory Committee (CPHAC / DiSAC) or on work in progress by the Chief Executive (CE) or management.</p> <p>To monitor key major Capex projects, particularly redevelopments pertaining to hospital and health services provided by NMDHB and delivery against the relevant statement of forecasted service performance targets.</p> <p>To focus on the following:</p> <ul style="list-style-type: none"> • Efficient and effective performance of DHB own providers against contracted service delivery; • Comparative reporting to best practice benchmarks; • Quality improvement; • Areas for improvement, accreditation, credentialing; • Input to operational and capital planning; • Consultation outcomes; • Input to the South Island strategic direction for integration of providers and refocusing service delivery models to ensure the optimal use of health resources; and • Ensuring there is clinical input and leadership to regional or national priority work streams through multidisciplinary teams that encompass primary as well as hospital and specialist services.
Key Relationships	<p>The Committee takes its direction and workload from the Board and is supported in its work by the CE and</p> <ul style="list-style-type: none"> • The Medical / Surgical Services Directorate (lead); • The Clinical Support Services Directorate; and • The Marlborough Services Directorate. <p>Other support may be provided by the Directors of Nursing and Midwifery, Maori Health and Chief Medical Officer as required.</p>