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- Barbara Cameron (Deputy Chair)
- Adrian Broad
- Ann Chapman
- Nadarajah Manoharan
- Oriana Paewai
- Phil Sunderland (ex officio)
- Donald Campbell
- Andrew Ivory

Board Members
- Lindsay Burnell
- Kate Joblin
- Karen Naylor
- Barbara Robson

Management Team
- Kathryn Cook, CEO
- Craig Johnston, General Manager, Strategy, Planning & Performance
- Mike Grant, General Manager, Clinical Services & Transformation
- Neil Wanden, General Manager, Finance & Corporate Support
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Next Meeting Date 15 March 2016
Deadline for Agenda Items 1 March 2016

MidCentral District Health Board

A g e n d a

Community & Public Health Advisory Committee

Part 1

Date: 2 February 2016

Time: 1.00pm

Place: Board Room
Board Office
Heretaunga Street
Palmerston North

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Tuesday, 2 February 2016

Part 1

Order

1. APOLOGIES

2. NOTIFICATION OF LATE ITEMS

3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1 Amendment to the Register of Interests

3.2 Declaration of Conflicts in Relation to Today's Business

4. MINUTES

4.1 Minutes

Pages:	1-9
Documentation:	minutes of 24 November 2015
Recommendation:	that the minutes of the previous meeting held on 24 November 2015 be confirmed as a true and correct record.

4.2 Recommendations to the Board

To note that all recommendations contained in the minutes were approved by the Board.

4.3 Matters Arising from the Minutes

To consider any matters arising from the minutes of the meeting held on 24 November 2015 for which specific items do not appear on the agenda or in management reports.

5. GOVERNANCE

5.1 2015/16 Work Programme

Pages:	10-15
Documentation:	report from Chief Executive Officer dated 26 January 2016
Recommendation:	that the updated work programme for 2015/16 be noted

5.2 CPHAC Terms of Reference

Pages:	16-28
Documentation:	report from Chairman, dated 22 December 2015
Recommendation:	that this report be received, and member's views on future committee structures and roles be provided to the Board Chair

6. STRATEGIC

6.1 Regional Services Plan 2016/17 – Draft 1

Pages:	29-34
Documentation:	report from Manager, DHB Planning and Accountability dated 20 January 2016
Recommendation:	that this report be received

6.2 New Zealand Health Strategy Submission

Pages:	35-41
Documentation:	report from General Manager, Strategy, Planning and Performance dated 19 January 2016
Recommendation:	that this report be received

7. OPERATIONAL REPORTS

7.1 Strategy, Planning & Performance Operating Report (Results for November & December)

Pages:	42-48
Documentation:	report from General Manager, Strategy, Planning and Performance dated 6 January 2016
Recommendation:	that this report be received

7.2 Finance Report – Result for November & December 2015

Pages:	49-51
Documentation:	report from Finance Manager, Funding and Planning dated 15 January 2016
Recommendation:	that the report be received

8. LATE ITEMS

To discuss any such items as identified under item 2

9. DATE OF NEXT MEETING

15 March 2016

10. EXCLUSION OF PUBLIC

Recommendation: that the public be excluded from Part 2 of this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	Reason	Reference
"In Committee" Minutes of the previous meeting	For reasons stated in the previous agenda	
2016/17 Funding Envelope	Subject to negotiation	9(2)(j)
Contracts – Update 2	Subject to negotiation	9(2)(j)

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Minutes of meeting held on Tuesday, 24 November 2015 at 1pm at MidCentral District Health Board Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North

PRESENT:

Barbara Cameron (Deputy Chair)
Adrian Broad
Ann Chapman
Nadarajah Manoharan
Phil Sunderland (ex officio)
Donald Campbell
Andrew Ivory
Oriana Paewai

IN ATTENDANCE:

Kathryn Cook, Chief Executive Officer
Craig Johnston, Acting General Manager, Funding & Planning
Rebecca Bensemann, Committee Secretary
Barb Bradnock, Senior Portfolio Manager, Child, Youth & Intersectoral Partnerships
Jo Smith, Senior Portfolio Manager, Health of Older Persons
Claudine Nepia-Tule, Portfolio Manager, Mental Health & Addictions
Ian Ironside, Portfolio Manager, Secondary Care
Vivienne Ayres, Manager, DHB Planning & Accountability
Maha Patel, Intern Portfolio Manager
Brad Grimmer, Project Manager
Cheryl Benn, Midwifery Advisor
Janine Stevens, Public Health Medicine Registrar
Kelly Johnson, Contractor
Stephanie Turner, Director, Maori Health & Disability
Wayne Blissett, Manager, Maori Health, Strategy & Support
Doug Edwards, Manager Maori Workforce Development
Jordan Dempster, Communications Officer
Chiquita Hansen, Director of Nursing PHC/CEO Central PHO
Simon Allan, Director, Palliative Care, Arohanui Hospice
Bruce Stewart, Chair, Central PHO
Syed Zaman, Deputy Clinical Director, Medical Services
Syed Ahmer, Clinical Director, Mental Health Services
Barry Keane, Acting Nurse Director, Mental Health Services
Michele King, Clinical Nurse Specialist Lead Older Adult
Barbara Robson, Board Member
David Ayling, Chairman, Central PHO Clinical Board
Megan Pybus, Paediatrician

OTHER:

Public: (3)
Media: (0)

1. APOLOGIES

An apology for absence was received from Diane Anderson.

2. NOTIFICATION OF LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendment to the Register of Interests

There were no amendments to the Register of Interests.

3.2 Declaration of Conflicts in Relation to Today's Business

Ann Chapman declared a conflict in relation to Item 15.1 Sexual and Reproductive Health Services (within Part 2 of the agenda).

Barbara Cameron declared an ongoing conflict in relation to the Feilding Integrated Family Health Centre (IFHC) and noted that she is a Councillor for Manawatu District Council.

4. MASTERCLASS 2015

4.1 2015 MasterClass Report

Dr Bruce Stewart introduced this report and together with various participants from MasterClass 2015 presented a powerpoint overview to the Committee. Questions were welcomed at the conclusion of the presentation.

Mr Adrian Broad noted the importance of strengthening connections between health care and academia. With specific reference to the area of diabetes, Mr Broad questioned what had been learnt about meeting future demands due to the impact of an increasing and ageing population. Dr Bruce Stewart recognised the importance of reaching out to other sectors within the community to influence change across a range of social determinants.

Dr Donald Campbell inquired what information was communicated in terms of MidCentral District Health Board (DHB) progress. Ms Chiquita Hansen responded the main message imparted was the supported and continued investment in primary care, including the establishment of Integrated Family Health Centres (IFHC), together with strong clinical networks to involve everyone in the decision making process. Dr Simon Allan added that interaction with people across MasterClass was extremely beneficial. Learning from and engaging with a range of people creates passion in taking ideas forward and building on them into the future in a way that is not obtained by reading publications and visiting websites.

Dr Nadarajah Manoharan noted that participants had visited big hospitals with different population bases to that of MidCentral DHB. He commented that some initiatives may be applicable but implementation may prove difficult. Dr Syed Zaman expressed optimism that change can be effected, particularly as a direct result of those initiatives gleaned from the MasterClass experience.

Mr Phil Sunderland asked whether an overarching agenda exists to maintain a similar line of focus across previous and future classes. Dr Bruce Stewart responded the same four themes had underpinned all the MasterClasses to date. The themes for any future MasterClass will be determined in the development and planning phase. Mr Sunderland noted this and expressed his continued support of MasterClass in future.

It was recommended:

that this report be received.

At this point the Deputy Chair asked the Committee to move forward in the agenda to Item 8.1 Central PHO Clinical Board 2014/15 Annual Report.

8.1 Central PHO Clinical Board 2014/15 Annual Report

Dr David Ayling, Chairman, Central PHO Clinical Board summarised this report and provided general commentary around key areas being:

- The PHO's success in engaging practices to enhance their capabilities in order to reach their Integrated Performance and Incentive Framework (IPIF) targets.
- All but three practices are fully engaging in meeting the Cornerstone accreditation target by 1 July 2016. These three have chosen to go with the lesser Foundation standard.
- Completion of the Comprehensive Health Assessment project with significant reduction in Ambulatory Sensitive Hospitalisation (ASH) rates.
- Successful Primary Options Acute Care (POAC) roll out as a methodology, with initial positive data being received.
- Implementation of Shared Care Health Record resulting in a significant improvement in population coverage and commencement of work on patient portal access.

Mr Adrian Broad noted there are approximately 900 Maori living in MidCentral who are not enrolled with a Central PHO practice. Dr Ayling clarified this is an estimate based on Census data. Within MidCentral there is one DHB and one PHO but the defining boundaries are not solid. Some MidCentral residents are enrolled in PHOs outside the district, and vice versa. Dr Ayling agreed there is still some way to go in terms of Maori enrolment with a Central PHO practice but it is difficult to quantity the data.

Dr Bruce Stewart acknowledged the significant work achieved by Dr Ayling in his role as Clinical Chair. The Chief Executive also thanked Chiquita Hansen, David Ayling and Bruce Stewart for all the work done in improving performance around healthcare indicators.

It was recommended:

that this report be received.

The Deputy Chair asked the Committee to refer to Item 5. Minutes within the agenda.

5. MINUTES

5.1 Minutes

It was recommended:

that the minutes of the previous meeting held on 13 October 2015 be confirmed as a true and correct record.

5.2 Recommendations to the Board

It was noted that all recommendations contained in the minutes were approved by the Board.

5.3 Matters Arising from the Minutes

There were no matters arising from the minutes.

The Deputy Chair asked the Committee to move forward in the agenda to Item 8.2 DHB Position Statement on Water Fluoridation.

8.2 DHB Position Statement on Water Fluoridation

Dr Megan Pybus introduced this report and proposed that MidCentral DHB adopt a position statement in favour of water fluoridation. Dr Pybus emphasised that water fluoridation is a safe, effective option to improve the oral health of our communities.

Ms Ann Chapman agreed and noted her complete support of this recommendation, adding that such a statement would have been useful to her own Council on this issue.

Mr Adrian Broad clarified the Horowhenua and Tararua regions did not have water fluoridation and asked whether an opportunity existed to engage with relevant local councils in support of this. Dr Pybus responded it was more appropriate to adopt a DHB position statement before pursuing further discussions with local authorities.

Dr Donald Campbell expressed support but noted fluoridation is only beneficial for community water supplies that are over a specified volume. In other areas it may be worthwhile to promote further fluoridation options, such as toothpaste, to create a wider impact.
The Deputy Chair commented, in her role as a District Councillor, that it would be valuable to make a submission in support of fluoridation at the appropriate time.

Mr Phil Sunderland expressed his full support of the proposed position statement and reminded the Committee that the recommendation needed to be approved before proceeding to the Board for endorsement. The Chief Executive suggested the recommendation wording be changed accordingly. It was also suggested that Dr Megan Pybus be available to attend the relevant Board meeting to address any queries that may arise.

It was recommended:

> *that the Community and Public Health Advisory Committee recommend to the Board the position statement be adopted in that MidCentral District Health Board supports water fluoridation as a safe, effective and affordable way to prevent tooth decay across the whole population.*

The Deputy Chair asked the Committee to refer to Item 6. Governance within the agenda.

6. GOVERNANCE

6.1 2015/16 Work Programme

Generally reporting is occurring in line with the work programme.

The Chief Executive advised planning assumptions for 2016/17 were to be deferred until after the current strategic planning framework has progressed further and once greater clarity was achieved around the intended direction of focus from the Ministry of Health.

It was recommended:

> *that the updated work programme for 2015/16 be noted.*

7. STRATEGIC/SPECIAL ISSUES

7.1 Mental Health Report

Mr Phil Sunderland updated the Committee in that this report was presented to the Hospital Advisory Committee (HAC) earlier today with the Committee gratified with progress made to date. Discussion focused on what will occur at stage two of the process along with identification of processes to be undertaken. This was followed up by significant discussions at the mental health workshop.

Mr Adrian Broad remarked it is pleasing the leadership team is looking to strengthen collaboration across agencies in order support delivery of mental health services.

It was recommended:

that this report be received.

7.2 2015/16 Annual Maori Health Plan Progress Report – Update 1

The Director, Maori Health & Disability summarised the highlights of this report, being improved immunisation coverage, increasing Maori enrolment numbers in the PHO, improved ASH rates and continued advice given to Maori around smoking cessation. It is also encouraging that the Board is adding to Maori Health leadership within the DHB as a Maori-based focus across all aspects of service delivery is of importance.

Ms Ann Chapman referred to Indicator 12, the 'Rheumatic Fever target' and queried whether the MidCentral district population profile was better than other parts of the country. The Senior Portfolio Manager, Child, Youth & Intersectoral Partnerships acknowledged the statistics are correct with MidCentral having lower rates of hospitalisation compared to other DHBs.

Mr Adrian Broad remarked that to get young Maori into work will help to overcome health issues in to the future and he acknowledged the support given by MidCentral DHB to employment initiatives within the city.

The Chief Executive asked for the newly appointed Manager, Maori Health, Strategy and Support to be introduced. Mr Wayne Blissett was introduced to the Committee by the Director, Maori Health & Disability and welcomed to the meeting.

that this report be received.

7.3 2015/16 Annual Plan Implementation: Update 1

The Acting General Manager, Funding & Planning advised that this paper, along with the next two items on the agenda, contained the same information presented in different context. The Deputy Chair agreed to combine these three papers for discussion.

It was recommended:

that this report be received.

7.4 Non Financial Monitoring Framework and Performance Measures – Report for Quarter 1, 2015/16

It was recommended:

that this report be received.

7.5 Regional Services Plan Implementation Update – Quarter 1, 2015/16

Dr Donald Campbell referred to the table outlining ratings given by the region and by the Ministry for each programme and sought clarification around the key difference between 'self-rating' and 'MoH rating'. The Manager, DHB Planning & Accountability advised Central Region's Technical Advisory Services (TAS) has modified its criteria to align with Ministry of Health criteria, although there is an element of timing applicable with the Central TAS self-rating being a little more realistic.

It was recommended:

that this report be received.

7.6 Development of the 2016/17 Regional Service Plan – Approach and Timeline

The Acting General Manager, Funding & Planning provided a summary overview in that priorities remain similar to last year, with change occurring in the area of capital planning. Treasury will run this process with DHBs to submit long-term investment plans. The NZ Health Strategy update will need to be taken on board at some stage.

It was recommended:

that this report be received.

7.7 Update to the New Zealand Health Strategy – Consultation Draft

The Acting General Manager, Funding & Planning confirmed MidCentral DHB will make a submission on the draft update to the NZ Health Strategy. It is similar to the previous strategy, essentially maintaining key principles from the previous strategy and adding an eighth principle of working in partnership with other agencies. The focus will look more outside of health to provide a patient-centered health service by engaging with community and educating and working together with whanau.

The NZ Health Strategy is a readily available document and Committee Members are welcome to send any comments or reflections to management to include in the submission. It was agreed that a copy of the intended draft response be forwarded to the Chief Executive and MidCentral DHB Chair in advance, with a copy also to be circulated to Committee Members.

Mr Adrian Broad reiterated the importance of active partnerships working across sectors at all levels within communities and agreed it is important to keep momentum building.

The Director, Maori Health & Disability confirmed her intention to also tender a submission which focused on increasing visibility of collaboration work across sectors, the importance of developing a culturally competent workforce, together with other areas of significance.

It was recommended:

that Committee members provide feedback to management on the update to the New Zealand Health Strategy if they wish by Tuesday 24 November to be included in the DHB's feedback submission to the Ministry of Health.

8. OPERATIONAL REPORTS

8.3 Proposed Primary Birth Unit

This report is provided in response to a request arising from the Board meeting held in Otaki on 3 November 2015.

The Acting General Manager, Funding & Planning confirmed that a private provider has announced its intention to set up a primary birthing unit in Palmerston North. MidCentral DHB would like to support this facility if possible because it fits well within the previous review which found positive benefits of a primary birth unit for low-risk mothers and babies, especially through linkages with Women's Health.

The Midwifery Advisor added that Lead Maternity Carers (LMCs) would like to be included in consultation around developing this purpose-built facility in order to use it safely and effectively. It needs to be a well-supported process from the beginning. To date, engagement with midwives has been less than optimal. The provider is understood to be visiting in early December, however there are concerns this does not leave enough time to organise midwives' attendance.

The service provided will be a free service for mothers. The Acting General Manager, Funding & Planning advised no formal approach has been made to MidCentral DHB for funding and that the developer has advised the facility will proceed whether or not support is given by the DHB. The expectation is that MidCentral DHB will work through this process and land on a facility delivering a service that is it fitting and appropriate for our community.

Dr Donald Campbell sought clarification that the primary birthing unit will be licensed by the Ministry of Health. It was advised that accreditation and licensing need to be in place before the facility is functional.

It was recommended:

that this report be received.

8.4 General Criteria Used by the Regional Fees Review Committee for GP Fee Increases

This update is provided in response to a request for further information from the Committee.

Mr Adrian Broad queried whether there is an appeal process in place. The Acting General Manager, Funding & Planning affirmed this is the case. It was also advised this particular Regional Fees Review Committee can only makes decisions on general practice fees, not fees set by other health care providers.

It was recommended:

that this report be received.

8.5 Funding & Planning Operating Report (Results for September & October)

The Acting General Manager, Funding & Planning, provided an overview of this report.

Item 3.2.2 CEO visits to Iwi/Maori Providers
Mr Adrian Broad suggested it may be worthwhile visiting Te Aroha Noa Community Services in future. The Acting General Manager, Funding & Planning commented Te Aroha Noa is not a contracted provider as such but acknowledged the excellent work achieved by this service in the community.

Item 3.5.1 Childhood Obesity Plan
Two points of interest are that this is good information on the government's direction on childhood obesity, and, secondly, that it provides an example of what the Ministry is wanting to see in Annual Plans and the like. Rather than the big service developments of the past, the emphasis is on a well-connected series of service components, many of which already exist, which collectively cover the full continuum of care and bring together all the different agencies into a coherent whole.

Ms Oriana Paewai referred to the new childhood obesity health target to be included as part of Before School Check (B4SC) referrals. She expressed concern that this is another lifestyle factor in which families may feel unduly criticised or blamed. The Senior Portfolio Manager, Child, Youth & Intersectoral Partnerships commented the intention is not to stigmatise families further but to ensure that where a child is identified as obese the appropriate services and supports are put in place.

AOD Residential Review Project – Service Model Report
Ann Chapman noted that 'AOD' should be spelt in full on the title page of this report.

Item 3.3.2 Query September CPHAC: Clarification re AOD providers and relationships
Dr Donald Campbell mentioned MidCentral Health was not listed as a provider of current AOD related services and that MidCentral Health should be added to the table for completeness.
It was recommended:

that this report be received.

8.6 Finance Report - Result of October 2015

The Acting General Manager, Funding & Planning confirmed the Funder's October 2015 YTD result is a positive variance to budget. The Funder has accrued elective income as per the elective initiatives budget and this will be adjusted in subsequent months based on actual activity.

It was recommended:

that the report be received.

9. LATE ITEMS

There were no late items for this section of the meeting.

10. DATE OF NEXT MEETING

Tuesday, 2 February 2016

11. EXCLUSION OF PUBLIC

It was recommended:

that the public be excluded from Part 2 of this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reason stated:

Item	*Reason*	*Reference*
"In Committee" Minutes of the Previous Meeting	*For reasons stated in the previous agenda*	
2016/17 Annual Plan Development: Update and Assumptions	*Subject to negotiation*	*9(2)(j)*
Sexual and Reproductive Health Services	*Subject to negotiation*	*9(2)(j)*

Confirmed this 2nd day of February 2016

.....
Chairperson

TO Community & Public Health Advisory Committee

FROM Chief Executive Officer

DATE 26 January 2016

SUBJECT **2015/16 Work Programme**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

This report updates progress against the Committee's 2015/16 work programme. It is provided for the Committee's information and discussion.

2. SUMMARY

The draft price:volume schedule for 2016/17 and the planning assumptions for that year are still under development as part of the planning and budgeting process. These will be discussed at the planning workshop on 23 February 2016. This workshop is for board and committee members. Meantime, a report on the funding envelope is provided.

The draft Regional Service Plan is in development and will be submitted to the Committee as soon as it is available. Meantime, an update is provided.

A business case for Turbo Kidz was scheduled but as noted in the General Manager's operational report this has been deferred in light of our current financial position and will be considered as part of the 2016/17 annual plan.

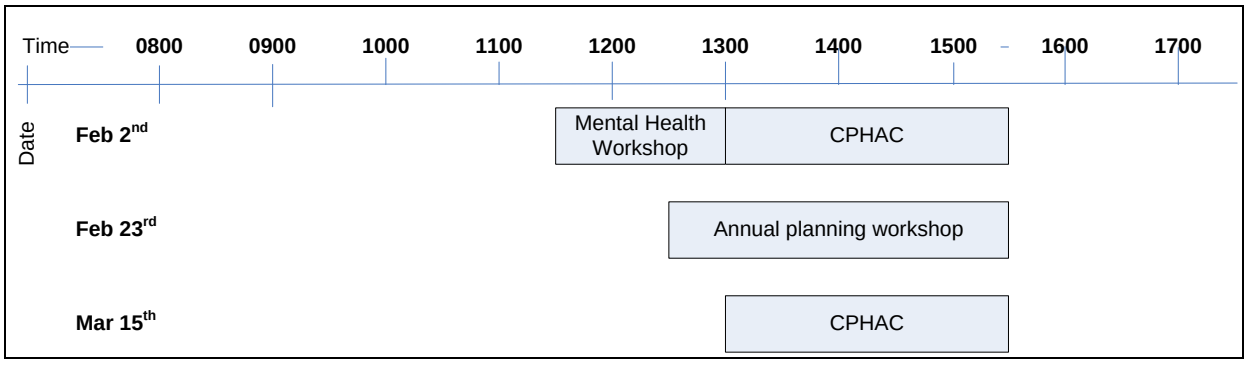
There are no new developments with the centralAlliance Strategic Plan with the focus being on the local annual and strategic planning process. The centralAlliance planning work will recommence in early February, covering both the long term strategic planning and more detailed plans for specific service areas.

Set out below is a schedule of the reports provided to the Community & Public Health Advisory Committee. This includes reports provided to the Committee at its last meeting, its current meeting, and those scheduled for its next meeting.

Reporting Category	Last Meeting	Current Meeting	Next Meeting
2016/17 Annual Plan Development	• 2016/17 Regional Service Plan – approach & timeline • 2016/17 planning assumptions – funding related	• Regional Service Plan update • Funding envelope 2016/17	• Regional Service Plan 2016/17 – Draft 1 • Draft 2016/17 annual plan • Draft 2016/17 Maori health plan • Draft 2016/17 Funding Arrangements document
Monitoring Annual (AP) & Regional (RSP) Plan	• 2015/16 RSP implementation – update 2	• Profile of a 2015/16 AP service/initiative	• 2015/16 RSP implementation – update 3

Implementation	• 2015/16 AP – update 1 re implementation of primary care initiatives • Mental health service update 2 • 2015/16 Maori Health Plan – update 1 re implementation • Fluoride policy • Sexual and reproductive health		• Mental health service reconfiguration – update 3 • Feasibility of primary birthing unit, Palmerston North
Sub-regional work - centralAlliance	•		• centralAlliance update
Other strategic matters	• NZ Health Strategy submission • Private primary birthing centre, Palmerston North	• MDHB's submission on NZ Health Strategy	
Quality	• Non-financial performance measures for quarter ended September 2015 • Annual report from the Central PHO Clinical Board • Master Health Class presentation		• Non-financial performance measures for quarter ended December 2015
Operational Matters	• September/October results • General criteria for general practice fee increases	• Contracts update • November/December results	• January/February results
Governance		• CPHAC terms of reference	
Reporting	• Work programme update	• Work programme update	• Work programme update
Workshops	• Mental health workshop • Masterclass presentation (as part of meeting)	• Mental health strategic planning workshop • Annual planning workshop (23 Feb)	

Committee commitments through until the end of March 2016 are set out below.



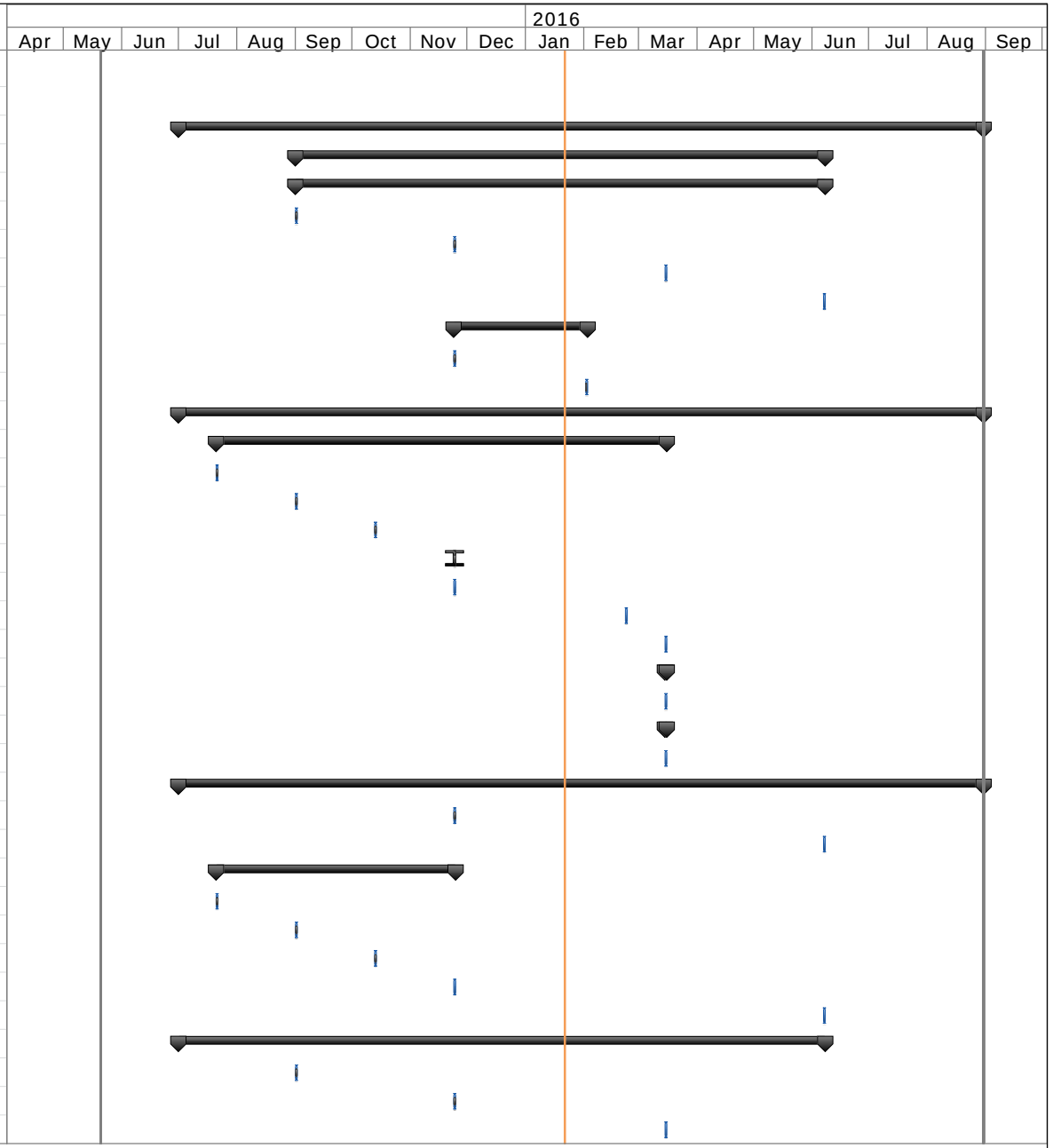
3. RECOMMENDATION

It is recommended:

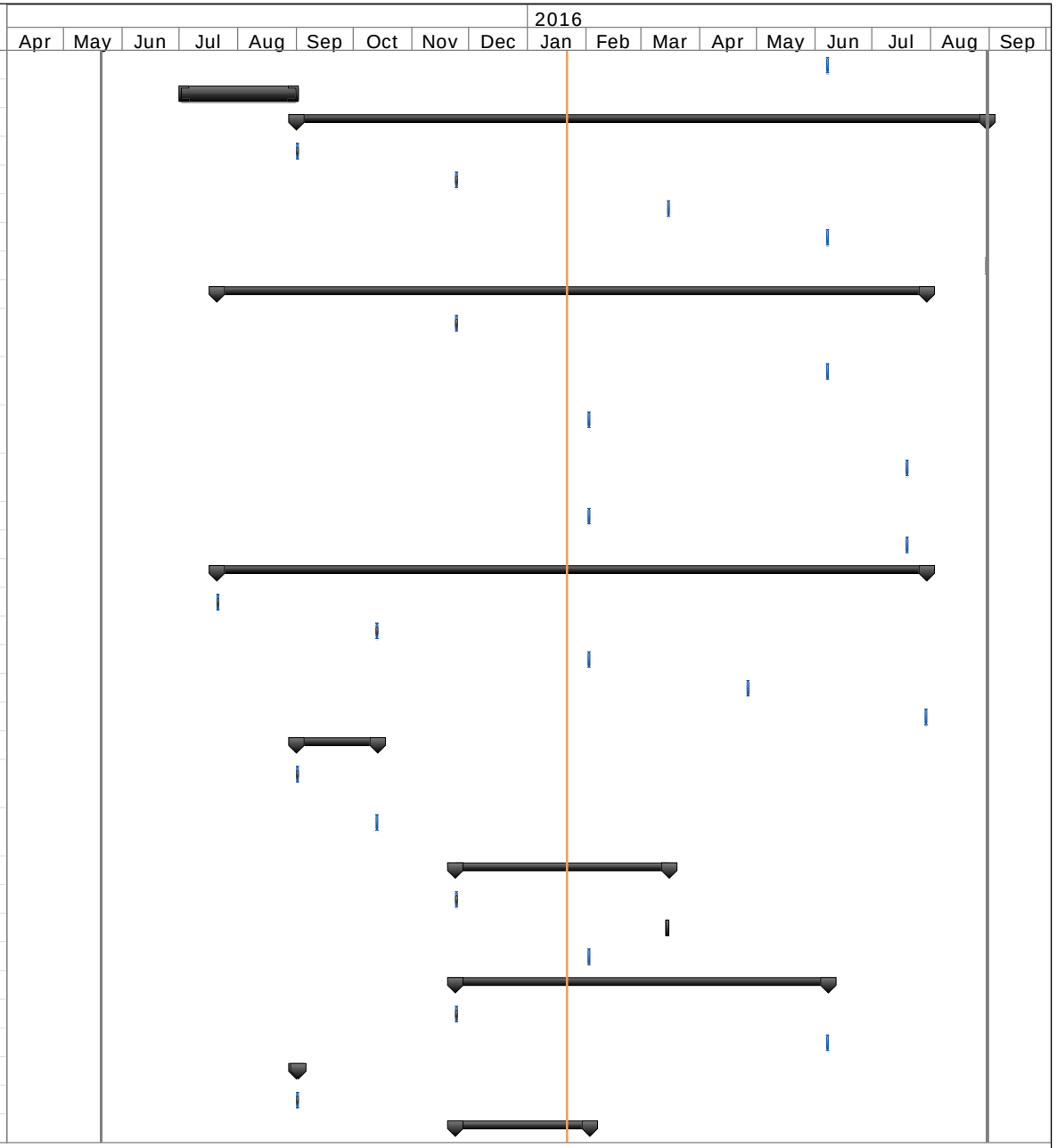
that the updated work programme for 2015/16 be noted.

Kathryn Cook
Chief Executive Officer

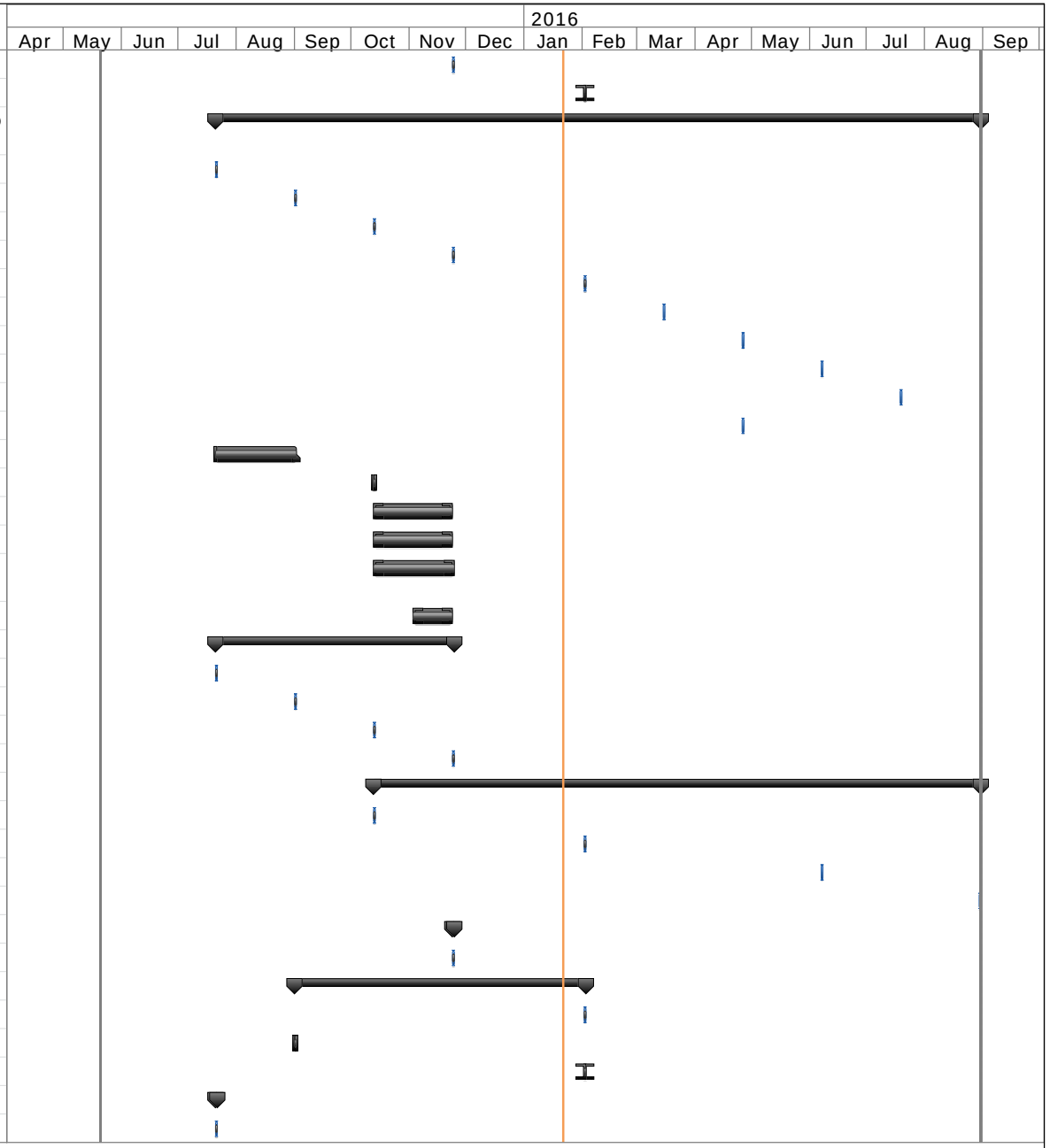
ID	Task Name
1	**CPHAC, 2015/16 Work Programme**
2	
3	**STRATEGIC ISSUES**
4	**Regional Services Plan**
5	**2015/16 Implementation**
6	Update 1
7	Update 2
8	Update 3
9	Update 4
10	**2016/17 RSP Development**
11	Approach & timeline
12	Draft 1
13	**Annual Plan**
14	**2016/17 AP Development**
15	Needs assessment
16	Annual review of prioritisation framework
17	Assumptions - funding related
18	Assumptions - funding related
19	Price volume schedule (draft)
20	Planning workshop
21	Draft AP
22	**2016/17 Maori Health Plan Development**
23	Draft 1
24	**2016/17 Funding Arrangements Document**
25	Draft 1
26	**2015/16 AP Implementation**
27	Primary care initiatives: update 1
28	Primary care initiatives: update 2
29	**centralAlliance Strategic Plan**
30	Update 1
31	Update 2
32	Update 3
33	Update 4
34	centralAlliance - laboratory contract
35	**Mental Health Service Reconfiguration**
36	Update 1
37	Update 2
38	Update 3



ID	Task Name
39	Update 4
40	Possibility of a mental health workshop
41	**Non-financial Performance Indicators**
42	2014/15, Quarter 4
43	2015/16, Quarter 1
44	2015/16, Quarter 2
45	2015/16, Quarter 3
46	2015/16, Quarter 4
47	**Information Only**
48	Secondary care initiatives, inc centralAlliance: update 1
49	Secondary care initiatives, inc centralAlliance: update 2
50	Quality (inc customer satisfaction & clinical governance indicators): update 1
51	Quality (inc customer satisfaction & clinical governance indicators): update 2
52	Workforce: update 1
53	Workforce: update 2
54	*PNH Site Reconfiguration*
55	Update 1
56	Update 2
57	Update 3
58	Update 4
59	Update 5
60	*Major Projects 14/15 Annual Plan*
61	Regional Women's Health Service Update 1 (including cancer sub-specialty workstreams)
62	RHWS future reporting arrangements (post evaluation - Hospital Audit) NOW JUNE 2016
63	**Business Cases**
64	Feasability of primary birthing unit, PNth
65	Feasability of primary birthing unit, PNth
66	Turbo Kidz
67	**2015/16 Maori Health Plan Implementation**
68	Update 1
69	Update 2
70	**2014/15 Maori Health Plan Implementation**
71	Update 2
72	**NZ Health Strategy**



ID	Task Name
73	Draft submission
74	Copy of MDHB's submission on NZ Health Strategy
75	**General Manager's Report (inc health targets & portfolio updates)**
76	Report 1 (results for May/June)
77	Report 2 (results for July)
78	Report 3 (results for August)
79	Report 4 (results for Sep/Oct)
80	Report 5 (results for Nov/Dec)
81	Report 6 (results for Jan/Feb)
82	Report 7 (results for March)
83	Report 8 (results for April)
84	Report 9 (results for May/June)
85	Proposed negotiating approach 2016/17
86	Consolidated financial reporting reinstated
87	HMSS full briefing
88	Clarification re AOD providers and relationships
89	Copy of review of regional AOD services
90	General criteris used by regional fees review committee for GP fee increases
91	Primary birthing centre, PNth - private development
92	**Annual Plan - Profile of Initiatives**
93	Profile 1
94	Profile 2
95	Profile 3
96	Profile 4
97	**Contract Updates (>$250k)**
98	Update 1
99	Update 2
100	Update 3
101	Update 4
102	**Quality**
103	Annual report from PHO Clinical Board
104	**GOVERNANCE**
105	CPHAC terms of reference review
106	Mental Health Workshop
107	Mental Health workshop
108	**CARRIED FORWARD FROM 2014/15**
109	Home management services: options for reassessment



ID	Task Name	2016
		Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep
110	***Information Only***	
111	2014/15 Quality update 2	
112	2014/15 Workforce update 2	

TO Hospital Advisory Committee
Community & Public Health Advisory Committee
Disability Support Advisory Committee

FROM Chairman

DATE 22 December 2015

SUBJECT **Terms of Reference Review, and Committee Structure**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

This report is provided for the Committee's consideration and discussion. No decision is sought.

2. SUMMARY

The Committees' terms of reference are due for their regular review. At the same time, I am giving consideration to our committee structure, including the configuration of each committee, its key focus, and membership, to ensure it is aligned to our strategic direction.

In October 2015, the DHB commenced the establishment of a strategic framework for the organisation. This framework will establish our vision, purpose, values and strategic imperatives for the next five to 10 years.

MidCentral DHB's last formal strategic plan covered the period 2005 to 2015. It involved investment in 10 priority areas and was successfully delivered. MidCentral achieved a lot over this period and now has a strong foundation, however it is time to look forward again. Recent changes within the DHB have highlighted the need to re-evaluate and renew the organisation's strategic direction.

At a management and operational level, the CEO is leading review of leadership structures within the DHB to ensure they are aligned to our future direction.

I believe it is important that as governors we also look at our structures to ensure we are well positioned to support the achievement of our strategic framework. I envisage that any change will be in place for the new financial year, ie 1 July 2016 so that we have plenty of time to fully debate this matter.

One change to the structure has already been made, being the amalgamation of three audit committees into a single Finance, Risk and Audit Committee (FRAC). This change will come into effect on 1 January 2016. Membership initially will be those who previously served on the Group Audit Committee, with two new committee members to be recruited, being an independent chair with financial expertise and a member with clinical risk management experience. (Refer Appendix A for a copy of the *draft* terms of reference.)

Looking at the configuration of our statutory committees, HAC, CPHAC and DSAC, I see these playing an important part in the achievement of our strategic goals. My early thinking is HAC should increase its focus on quality and clinical governance, and that CPHAC's focus on strategy development and implementation should increase. I also suggest that to improve the effectiveness of DSAC and to ensure a disability perspective is incorporated into all our strategies, this committee should merge with CPHAC.

These are suggestions only and I would like to hear the Committees' views. These would then be pulled together for a workshop at which we can give more in-depth consideration to this matter, including the terms of reference for each Committee. Meantime, it is suggested that the current terms of reference remain in place.

In respect of membership, the three statutory committees benefit from external membership. It is proposed that this membership continue through until the end of the current term (30 June 2017). This will ensure continuity of experience and knowledge, including through the 2016 DHB election process.

3. RECOMMENDATION

It is recommended:

> *that the report be received, and members' views on future committee structures and roles be provided to the Board Chair.*

4. DISCUSSION

4.1 Legislative Requirements

Under the NZ Health & Disability Act 2000, DHBs must establish:

- a committee to advise on health improvement measures, called the community and public health advisory committee, and must provide for Maori representation on the committee;

- a committee to advise on disability issues, called the disability support advisory committee, and must provide for Maori representation on the community; and

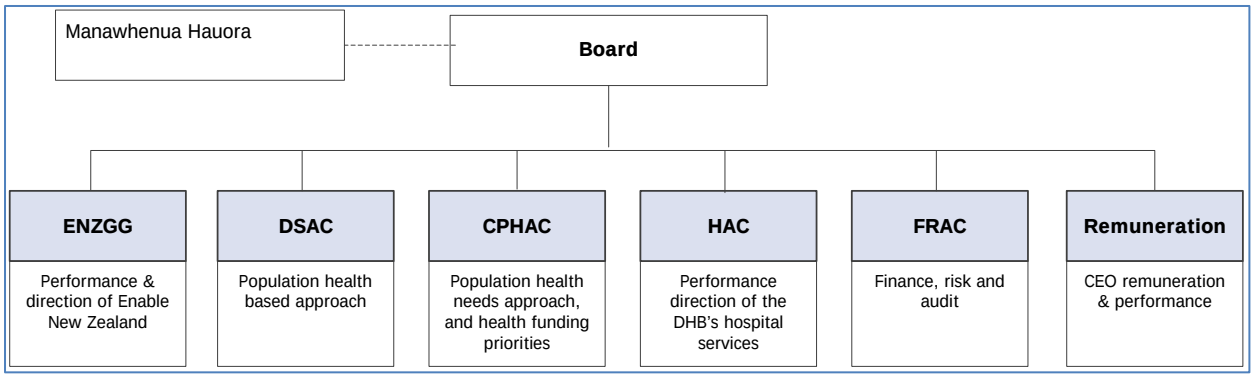
- a committee to advise on matters relating to hospitals, called the hospital advisory committee, and must provide for Maori representation on the committee.

The legislation sets out the functions of each committee and these are reflected in the current terms of reference which MidCentral DHB has in place for HAC, CPHAC and

DSAC. A copy of the terms of reference for each Committee is attached (refer Appendices B-D).

4.2 Current Arrangements

The Board's current committee structure is as follows and includes a partnership relationship with Manawhenua Hauora:



The structure has served us well but over recent times we have seen duplication of reports being considered by HAC and CPHAC.

MidCentral DHB has enjoyed a good working relationship with Manawhenua Hauora but there is potential for this to be increased and Oriana Paewai, Chair, Manawhenua Hauora and I will be giving further consideration to how this can be progressed in the new year.

A growing integrated approach is being taken by MidCentral DHB, but this is not reflected at governance level, other than with Manawhenua Hauora.

4.3 Strategic Framework

The establishment of a strategic framework for the next five to 10 years is underway and it is expected that this will be completed by the end of February 2016, with further work to be done on developing a roadmap for each of the strategic imperatives. The roadmap will include the work to be done, together with key milestones and measures.

Engagement with staff on the framework is occurring and this will continue to shape its final form.

Engagement with the community will occur at the next stage, being the roadmap for implementation of each of the strategic imperatives. We want to learn the community's view on what we should address and/or do as a priority and how they would measure success.

A copy of the draft Strategic Framework is set out on the following page. You will see that the proposed strategic imperatives are:

- Achieve quality and excellence by design
- Partner with people and whanau to support health and wellbeing
- Connect and transform primary, community and specialist care
- Achieve equity of outcomes across communities

Strategic Framework

We are committed to

Quality Living – Healthy Lives – Well Communities

We are about

Better health outcomes, better health care for all

Better health outcomes is about achieving the best possible health for individuals, whanau and communities. It's about wellness and wellbeing. Health care is across the life stages from the best possible beginnings, healthy adulthood and independence through to old age. It's about the continuum from health promotion and the determinants of health all the way through to palliative care. Health and health care are about people and Whanau owning and managing their own health and wellbeing.

We will be

Compassionate | **Respectful** | **Courageous** | **Accountable**

Individually and together we will

Achieve quality and excellence by design

Partner with people and whanau to support health and wellbeing

Connect and transform primary, community and specialist care

Achieve equity of outcomes across communities

We will achieve success through our:

4.4 Governance Arrangements Looking Forward

I have been thinking about our structure moving forward and have a few ideas which I put forward for discussion. The views of all members are sought and I am happy to receive these both at the committee meeting and following this once members have had more time to consider this.

a. Increase strength of relationship between MidCentral DHB and Manawhenua Hauora, particularly around strategies moving forward. This to be progressed by the Chairs of both entities. No change required to structure or terms of reference, rather the means of engagement.

b. Establish a consumer alliance at governance level to provide consumer input into our decision-making and enable co-design. A consumer and co-design council was established by management to help shape the Health Charter. I believe this group could grow into an advisory council at governance level. In addition to seeking members' feedback, the CEO and I will meet with the consumer council's Chair in February 2016 to seek his input.

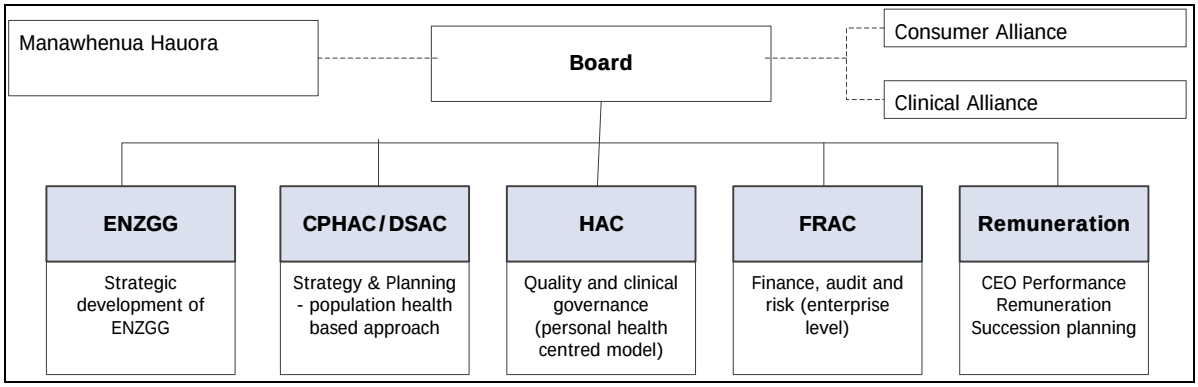
c. Establish a clinical advisory council at governance level to provide clinical input into our decision-making. This group would be representative of clinicians across the continuum, and covering primary, secondary and tertiary care.

d. Merge CPHAC and DSAC to strengthen the disability perspective of our decision-making, particularly regarding strategy development.

e. Strengthen the terms of reference for CPHAC/DSAC to focus on a population health-based approach and the development and implementation of strategies to achieve all our strategic imperative, and particularly our desire to achieve equity of health outcomes.

   This Committee's terms of reference to also have a strong focus on the partnering approach being taken (strategic imperative no 2), particularly the underlying philosophy that services be provided a close to home as possible.

f. Strengthen the terms of reference for HAC to have a larger focus on quality and clinical governance, ie the personal health centred approach. Also, to oversee the transformation change programme underway within secondary care and how this connects to other parts of the continuum (strategic imperative 4). I see HAC's terms of reference being informed by the current internal audit of clinical governance, the results of which will be reported to us early in 2016.



5. NEXT STEPS

The next steps in the review and development of our governance structure would be:

- committee feedback and amendment to proposed structure in line with their thoughts (February/March);
- development of draft terms of reference for each committee (April);
- workshop of board and committee members (May);
- formal proposal submitted for the Board's consideration (June).

As part of the development of a FRAC, the Board has asked that a mapping exercise be done to provide clarity around the role of that committee and the statutory committees. I would see a similar exercise being done as part of the development of draft terms of reference for all committees so that we can clearly see the interface between committees, and that there is clarity around the role and responsibilities of each Committee. We must also be able to assure ourselves that all key aspects of governance are covered.

Phil Sunderland
Chairman

Appendix A: FRAC Terms of Reference

Purpose:

The purpose of the Finance, Risk and Audit Committee (FRAC) is to advise and assist the MidCentral District Health Board (MDHB) to meet governance responsibilities relating to finance, risk, safety and quality management, audit and compliance.

Functions:

The functions of FRAC are to provide oversight in respect of:

1. Finance:

a) Ensure that appropriate reporting processes are in place to enable the Board and sub-committees to monitor and make decisions on the financial and commercial affairs of MDHB and its divisions;
b) Monitor the overall financial performance of MDHB, including the performance of the Provider Arm;
c) Monitor the capital expenditure and the overall financial position of MDHB.

2. Risk, Safety and Quality Management:

a) Monitor and review the adequacy and performance of MDHB risk management framework, strategies, processes and reporting;
b) Ensure appropriate patient safety and clinical quality measures and reporting are in place, are maintained and managed, and working effectively.

3. Audit:

a) Provide assurance that all audit processes required by statute and the Board are completed;
b) Ensure that effective control environment and assurance programmes are in place;
c) Ensure all issues identified by audits are appropriately addressed.

4. Compliance:

a) Ensure MDHB is complying with all relevant statutory, regulatory and policy obligations and requirements.

5. Planning:

a) Review and advise the Board on those aspects of the Annual Plan and Budget related to finance, risk, safety and quality

Level of Authority:

FRAC has the authority to give advice and make recommendations to the MDHB Board.

FRAC is authorised by the Board to investigate any activity it deems appropriate. It is authorised to seek any information from any officer or employee of the organisation, all of whom are directed to co-operate with any request made by the Committee or on its behalf.

FRAC is authorised to engage any firm of professionals as the Committee sees fit to provide independent counsel and advice to assist in any review or investigation on such matters as the Committee deems appropriate.

Meetings:

The Committee shall meet at least 6 times per year;

In addition to scheduled meetings, the Chair shall call a meeting at any time if requested to do so by any member, Board member, the Chief Executive, the Internal Auditor or the External Auditor;

All meetings shall be held with the public excluded;

Matters may be dealt with between meetings through discussion with the Chair and other relevant members of the Committee.

Workplan:

Each year the committee will adopt a workplan to provide review and oversight of the matters within its scope.

Reporting:

The Chair shall report on Committee business to the Board with such recommendations as the Committee may deem appropriate;

The minutes of the Committee's meetings shall be submitted to the Board for its consideration and approval;

The Committee shall recommend approval of the interim and annual financial statements and other audit obligations along with any other certificates requiring approval to the Board.

Appendix B: CPHAC Terms of Reference

1 Committee of the Board

The Community and Public Health Advisory Committee is a committee of the Board, established in accordance with Section 34 of the New Zealand Public Health and Disability Act 2000 (the Act). These Terms of Reference are supplementary to the provisions of the Act and Schedule 4 of the Act.

2 Functions of the Community and Public Health Advisory Committee

a. To provide advice to the Board on the needs, and any factors that the committee believes may adversely affect the health status of the resident population of the district health board.

b. To provide advice to the Board on priorities for use of the health funding provided.

c. To ensure that the following maximise the overall health gain for the population the committee serves:

   i. All service interventions the district health board has provided or funded or could provide or fund for the care of that population.

   ii.- All policies the district health board has adopted or could adopt for the care of that population.

d. Such advice must not be inconsistent with the New Zealand Health Strategy.

e. To consider annual purchasing plans and recommend same to the Board for approval.

f. To recommend policies relating to the planning and purchasing of health services for the district.

g. To develop an annual workplan for the Board's consideration and approval.

h. To report regularly to the Board on the committee's findings (generally the Minutes of each meeting will be placed on the Agenda of the next Board meeting).

3 Delegated Authority

The Community and Public Health Advisory Committee shall not have any powers except as specifically delegated by the Board from time to time. The following authorities are delegated to the Community and Public Health Advisory Committee:

a. To require the Chief Executive Officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.

b. To interface with any other committee(s) that may be formed from time to time.

4 Membership and Procedure

Membership of the Community and Public Health Advisory Committee shall be as directed by the Board from time to time. All matters of procedure are provided in Schedule 4 of the Act, together with Board and Committee Standing Orders.

5 Meetings

The Community and Public Health Advisory Committee shall hold meetings as frequently as it considers necessary or upon the instruction of the Board. It is anticipated that eight meetings will be held annually.

Note

For the purposes of this document, the definition of 'public health' is incorporated in the Act, which means the health of all of the community in the district health board's region.

Appendix C: DSAC Terms of Reference

1 Committee of the Board

The Disability Support Advisory Committee is a committee of the Board, established in accordance with Section 35 of the New Zealand Public Health and Disability Act 2000 (the Act). These Terms of Reference are supplementary to the provisions of the Act and Schedule 4 of the Act.

2 Functions of the Disability Support Advisory Committee

a. To provide advice to the Board on the disability support needs of the resident population of the district health board.

b. To provide advice to the Board on priorities for use of the disability support funding provided.

c. To ensure that the following promote the inclusion and participation in society, and maximise the independence of people with disabilities within the district health board's resident population:

   i. The kinds of disability support services the district health board has provided or funded or could provide or fund for those people.

   ii. All policies the district health board has adopted or could adopt for those people.

d. Such advice must not be inconsistent with the New Zealand Disability Strategy.

e. To advocate to external parties and organisations on the means by which their practices may be modified so as to assist, on a population basis, those experiencing disability.

f. To consider and recommend the disability support component of the annual purchasing plan and the annual provider business plan.

g. To recommend policies relating to the planning and purchasing of disability support services for the district.

h. To develop an annual workplan for the Board's consideration and approval.

i. To report regularly to the Board on the committee's findings (generally the Minutes of each meeting will be placed on the Agenda of the next Board meeting).

3 Delegated Authority

The Disability Support Advisory Committee shall not have any powers except as specifically delegated by the Board from time to time. The following authorities are delegated to the Disability Support Advisory Committee:

a. To require the Chief Executive Officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.

b. To interface with any other committee(s) that may be formed from time to time.

4 Membership and Procedure

Membership of the Disability Support Advisory Committee shall be as directed by the Board from time to time. All matters of procedure are provided in Schedule 4 of the Act, together with Board and Committee Standing Orders.

5 Meetings

The Disability Support Advisory Committee shall hold meetings as frequently as it considers necessary or upon the instruction of the Board. It is anticipated that at least three to four meetings will be held annually.

Note

For the purposes of this document, the definition of 'disability support services' is as incorporated in the Act, which means disability support for all of the community in the district health board's region.

Appendix D: HAC Terms of Reference

1. Committee of the Board

The Hospital Advisory Committee is a committee of the Board, established in accordance with Section 36 of the New Zealand Public Health and Disability Act 2000 (the Act). These Terms of Reference are supplementary to the provisions of the Act and Schedule 4 of the Act.

2 Functions of the Hospital Advisory Committee

a. To monitor the financial and operational performance of the hospitals (and related services) of the district health board.

b. To assess strategic issues relating to the provision of hospital services by or through the district health board.

c. To give the Board advice and recommendations on that monitoring and that assessment as noted in 2(a) and (b) above.

d. To consider annual business plans and recommend same to the Board for approval.

e. To recommend policies relative to the good governance of hospital services.

f. To develop an annual workplan for the Board's consideration and approval.

g. To report regularly to the Board on the committee's findings (generally the Minutes of each meeting will be placed on the Agenda of the next Board meeting).

3 Delegated Authority

The Hospital Advisory Committee shall not have any powers except as specifically delegated by the Board from time to time.

The following authorities are delegated to the Hospital Advisory Committee:

a. To require the Chief Executive Officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.

b. To interface with any other committee(s) that may be formed from time to time.

4 Membership and Procedure

Membership of the Hospital Advisory Committee shall be as directed by the Board from time to time. All matters of procedure are provided in Schedule 4 of the Act, together with Board and Committee Standing Orders.

5 Meetings

The Hospital Advisory Committee shall hold meetings as frequently as it considers necessary or upon the instruction of the Board. It is anticipated that eight meetings will be held annually.

Note

For the purposes of this document, 'Hospital' means all public health services owned by the Crown and previously known as 'Hospital and Health Services'.

TO Community & Public Health Advisory Committee
Hospital Advisory Committee

FROM Vivienne Ayres
Manager
DHB Planning and Accountability

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

DATE 20 January 2016

SUBJECT **2016/17 REGIONAL SERVICE PLAN DEVELOPMENT**

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1 Purpose

To provide the Committees with an update on the development of the 2016/17 Regional Service Plan.

This update is for information – no decision is required.

2 Summary

Development of the Central Region's Regional Service Plan (RSP) for 2016/17 is underway. The regional planning process continues to be facilitated and coordinated by the Central Region's Technical Advisory Service (TAS) programme management office. At this stage, development of the RSP is not sufficiently advanced to submit to MidCentral District Health Board as a work in progress draft.

The strategic component of the RSP is being further considered through the regional Chief Executives Forum. This is particularly in response to the requested refresh and update to the 2008 Regional Clinical Services Plan and the combined Boards' indications from the regional workshops in the latter part of 2015. The Ministry advises that the RSP, as with DHB Annual Plans, should reflect the strategic intentions and roadmap of the refreshed New Zealand Health Strategy, and that there is a clear "line of sight" evident in each of the planning documents. Consultation on the draft Strategy closed in early December; further information and advice is expected to be received from the Ministry of Health in February.

The implementation planning component of the RSP is currently progressing with the development of action plans for each of the work programmes that reflect regional priorities, Government priorities and the planning guidelines issued by the Ministry of Health. The work in progress for each of the work programmes builds on prior years' work and achievements guided by the relevant regional networks. The working draft work programmes will be subject to a moderation process via the DHBs' planners in the first instance (scheduled for end of January) before being submitted to the regional executive and governance groups for their consideration.

The indicative timeframe issued by the Ministry of Health has the first draft of the RSP being submitted to the Ministry on 31 March 2016 for their review, at the same time as the DHBs' Annual Plans and Maori Health Plans. It is expected that the Committees will receive a copy of the draft RSP for consideration at their meetings in March 2016.

3 Recommendation

It is recommended:

that this report be received

Vivienne Ayres
Manager, DHB Planning and Accountability

4 Update

Implementation planning for each of the regional work programmes for the 2016/17 year is currently underway. The work in progress for each of the work programmes builds on prior years' work and achievements guided by the relevant regional networks. MidCentral DHB has a number of clinical and non-clinical staff involved in the regional networks, so is contributing to the development of the 2016/17 work programmes through those networks.

The regional programmes of work are:

- Elective Services
- Cardiac Services
- Mental Health and Addictions
- Stroke Services
- Health of Older People
- Major Trauma
- Hepatitis C
- Health Informatics
- Workforce

As for this current year, cancer services will be included in the RSP under the umbrella of the Regional Cancer Networks' work programme. This will include implementing priorities of the New Zealand Cancer Plan: Better, Faster cancer care, 2015 – 2018 as the priority for regional planning. The draft plan to date has a focus on improving equity of access to cancer services, timeliness of services across the whole cancer pathway and the quality of cancer services delivered.

Although capital planning will continue to be an integral part of the RSP planning processes, the requirement for a regional Capital Plan has been superseded by the new Investment Management and Asset Performance (IMAP) process as advised by Treasury, which took effect from July 2015. All District Health Boards are required to complete a Long Term Investment Plan, which must be formally refreshed every three years (notwithstanding regular review). As a 'non-intensive investment agency', MidCentral DHB is expected to submit its LTIP by October 2016. The RSP planning processes will need to reflect the intentions from each DHB in this regard.

A clear 'line of sight' between the outcomes and objectives of Government priorities (including the refreshed New Zealand Health Strategy), national entities, the Regional Service Plans and DHB Annual Plans is expected to be shown in each of the documents. This will be demonstrated in MidCentral's Annual Plan and the RSP by clear referencing of the linkages between the respective programme plans. A further update on the refreshed NZ Health Strategy is expected from the Ministry of Health in February.

Draft work plans for each of the regional programmes will be considered by DHB planners and the TAS planning team at the end of January before being submitted as working drafts for consideration by the regional executive and governance groups in February and March.

The strategic component of the RSP is being further considered through the regional Chief Executives Forum. This is particularly in response to the requested refresh and update to the 2008 Regional Clinical Services Plan and the combined Boards' indications from the regional workshops in the latter part of 2015. The Chief Executives will be further discussing this at their meeting in February, focusing on the opportunity for the collective

regional approach to be reframed in order to address emerging challenges as well as build on the regional progress that has been made to date.

5 2016/17 Regional Service Plan – Programme Priorities

The current priorities and regional objectives for which action plans are being developed for the Regional Service Plan are outlined below.

5.1 Regional Clinical Services

Elective Services

- Improve access to elective services
- Maintain reduced waiting times for elective first specialist assessments and treatment
- Improve equity of access to services, so patients receive similar access regardless of where they live

Cardiac Services

- Improve access and timeliness of cardiac services
- Patients with a similar level of need receive comparable access to services, regardless of where they live
- More patients survive acute coronary events and the likelihood of subsequent events is reduced
- Patients with suspected Acute Coronary Syndrome receive seamless, coordinated care across the clinical pathway
- Patients with heart failure are optimally managed at admission, reducing the need for further readmission
- Reviewing and auditing Accelerated Chest Pain Pathways in Emergency Departments

Mental Health and Addictions

- Improve access to the range of eating disorders services
- Improve youth forensic service capacity and responsiveness
- Improve perinatal and maternal mental health acute service options as part of a service continuum
- Improve the physical health of people with low prevalence disorders

Stroke Services

- Improve primary and secondary stroke prevention and reduce stroke related disability and mortality
- Improve access to quality assured organised acute, rehabilitation and community stroke services (including 24/7 thrombolysis services)
- Ensure all stroke patients have access to high-quality stroke services regardless of age, gender, ethnicity or geographic domicile

Health of Older People

- Continue strengthening dementia pathways, dementia awareness, education and support programmes across primary, secondary and community settings and in supporting informal carers
- Proactive use of interRAI data across primary and secondary care to identify equity, population and service trends

Major Trauma

- Implement a regional trauma system that will result in a reduction of preventable levels of mortality, complications and lifelong disability of patients who have sustained a major trauma (as defined by the National Trauma Network). Includes reporting national minimum dataset to regional registries, clinical guidelines and Regional Destination policies for major trauma patients

Hepatitis C

- Implement a single clinical pathway for Hepatitis C care across all regions in order to provide consistent services (including minimum requirements, minimum standards and data collection)
- Implement integrated hepatitis C assessment and treatment services across community, primary and secondary care services in the region (includes HCV testing and care that will include Fibroscan services)

Cancer services

As for this current year, cancer services will be under the umbrella of the Regional Cancer Networks' work programmes and referred as such in the RSP. This will include implementing priorities of the New Zealand Cancer Plan: Better, Faster cancer care, 2015 – 2018 as the priority for regional planning. The plan is expected to focus on improving equity of access to cancer services, timeliness of services across the whole cancer pathway and the quality of cancer services delivered

5.2 Regional Enablers

Workforce

- Facilitate regionally based solutions to address national workforce priorities, enabling
  - implementation of community based attachments for prevocational trainees
  - increasing participation of Maori and Pacific in the health workforce
  - implementation of the Children's Action Plan
  - recruitment of new palliative care specialist nurses and education
  - support for the role of nurse practitioners, clinical nurse specialists and nurses performing endoscopies
  - support for the training of sonographers and medical physicists
- Identify and progress a regional coordinated approach to "new models of care", planning and development
- Demonstrate leadership and commitment that supports the development of the region's health workforce
- Strengthen local and regional health workforce intelligence
- Build on 2015/16 RSPs, demonstrating further progress on actions to meet milestones

Health Informatics

Continue the critical health informatics and technology priorities of the 2015/16 national and regional programmes, building on platforms to create an electronic medical record that supports a new level of digital capability in hospitals)

- The RSP must include the prioritised 3-year plan of all local, regional and national IT initiatives, including the applicable critical IT priorities *(see national priorities below)*, with budget allocation and key deliverable to be achieved in the year. Include actions in Annual Plan on implementation of the National Maternity Information Systems Platform (MISP-NZ)
- The strategies the region has put in place to address the following IT delivery challenges:
  - regional governance, leadership and decision-making
  - regional funding and approval model(s)
  - regional capacity and capability

    - roadmap for development of an EMR environment
  - National priority initiatives:
    - Electronic Prescribing and Administration (ePA), where applicable regionally where not implemented as individual DHBs
    - Regional clinical workstation (Clinical Portal) and clinical data repository
    - Regional PAS (webPAS)
    - Integration with the national electronic health record (design phase)

MidCentral's contribution to the Regional Service Plan from a DHB annual planning or sub-regional perspective will otherwise be coordinated through the Strategy, Planning and Performance group in collaboration with the centralAlliance where appropriate.

TO Community and Public Health Advisory Committee

FROM General Manager,
Strategy, Planning & Performance

DATE 19 January 2016

Memorandum

SUBJECT **NEW ZEALAND HEALTH STRATEGY SUBMISSION**

1. SUMMARY

1.1 Purpose

This report is for the Committee's information only, no decision is required.

1.2 Executive Summary

In late 2015 the Ministry of Health consulted on a refresh of the New Zealand Health Strategy.

MidCentral District Health Board made a submission based on input collected from within the organisation and across the district. This is attached.

The submission noted strong support for the general direction, but suggested further work to align the roadmap with the strategic directions.

3. RECOMMENDATION

It is recommended

that this report be received.

Craig Johnston
General Manager
Strategy, Planning & Performance

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

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4 December 2015

New Zealand Health Strategy Update Consultation
New Zealand Health Strategy Team
Ministry of Health
PO Box 5013
WELLINGTON 6145

Dear New Zealand Health Strategy Team

Ref: New Zealand Health Strategy Update Consultation

Thank you for the opportunity to provide feedback on the update to the New Zealand Health Strategy.

Firstly, we acknowledge the work that has gone in to review, assess and update the New Zealand Health Strategy in order to "outline for all New Zealanders the intended direction and focus for the public health sector over the next ten years". We congratulate the team on successfully meeting the high expectations associated with this exercise and the very tight timeframes under which it has been achieved.

The general direction, Vision, Principles and Strategic Themes are sound. There is a good balance between continuity with the previous strategy and the introduction of new elements in response to contemporary developments.
The Strategic Themes cover the main issues of today; MidCentral DHB has heard similar messages emerging from our community and stakeholders while engaging in a refresh of its own strategic direction.

The areas where we consider the Health Strategy needs to be developed further are in the Roadmap and in the technical aspects of how the Strategy is expressed. We would like to see stronger links between the Directions section and the Road Map. In particular we would like to see intervention logic more clearly expressed throughout the document. This will then result in a Strategy that will serve the health system well over its expected five to ten year timeframe. We appreciate that this is a consultation document and the next phase will involve more detailed planning which will address these issues.

Please find below more detailed feedback, organised under the headings Future Directions and Roadmap of Actions.

MidCentral DHB looks forward to the further development of the Strategy and would be delighted to support the process in any way possible.

Yours sincerely

Craig Johnston
General Manager
Strategy, Planning and Performance

Appendix 1

1 Future Direction

1.1 General direction

Overall, we support the general direction the Strategy proposes for our health system and the guiding principles underpinning the Strategy, including the additional principle pertaining to crossing the traditional boundaries of "health".

We note that the principles are sitting under the title of "culture and values". In our view this is not the right heading. A culture and values section would be a good addition, in which case it should include details of the desired culture and values that a public health (disability and social) system should be demonstrate.

We note that principles 1, 2 and 4 are not followed through in the strategic themes or action plans.

1.2 Vision, outcomes and strategy

The five strategic themes are very good. We have been undertaking a refresh of MidCentral DHB's strategic framework and we have identified similar themes from our community and stakeholders.

We note the deliberate focus on a "high level direction for the health and disability system", rather than a health strategy with goals and objectives to achieve the first part of the vision statement "all New Zealanders live well, stay well and get well"... To turn that around, if we had a health (disability and social) system that was people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system, would that mean that "all New Zealanders live well, stay well and get well"? It is imperative that specific population and other health strategies are indeed updated, as suggested on page 4, to address the desired future state ("...highlights wellness as a goal"), in terms of population (and sub-populations) health outcomes, goals and objectives.

The Strategy would do well to have the health system outcomes "New Zealanders live longer, healthier and independent lives" and "the health system is cost effective and supports a productive economy" statements up front (assuming they remain existent), coupled with explicit links to The NZ Triple Aim (goals) of improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources.

It is difficult to assess the desired change when it is not clear how we will know we've got there and/or what will be different.

It has been suggested that the wording "value and high performance" in the Strategic Themes be reworded as "high performing and delivering value".

There are several position statements to describe the vision of "what great might look like in 10 years" for each of the strategic themes.

The outcomes to be derived from implementing the Strategy are not clear. It is almost as though the strategic themes are being treated as the goals rather than the approach to all that we (the health, disability and social) do; the enabling mechanisms (or tactics used to achieve something). An example is the vision for people-powered health in 10 years' time includes "health and injury services provide a more consistent experience for people". What change will enable that to occur and by when is not evident.

1.3 Challenges and opportunities

Some of the challenges and opportunities are not carried through in the description of the 10-year vision described under the strategic themes or in the subsequent action plans. For example, addressing the roles, functions, capability and capacity, investment in training, of a broad range of regulated and unregulated workforce contributing to the health and disability (and social) system is not strong.

"Improving our health system and wider social services.... a key factor will be our ability to work together". There is very little carry through in objectives and actions that might enable that. For example, enabling policy and legislation and operating models that do not retain the split and separateness of Disability Support Services, Accident Compensation Commission and Public Health Services. Further, what actions could/will be taken to ensure the Ministries of Education, Social Development, Maori Development, Justice and departments, as well as the economic policy promulgated by Treasury are aligned to the Health (disability and social) system? And, what partnerships could/will be established for what purpose?

It is suggested that the role of the Ministry of Health be strengthened in leading/engaging with cross-sector central government departments/ministries/agencies to ensure shared goals on the "health system agenda" are reflected in the plans and actions of those ministries/departments/agencies, and, that enabling legislation and policy is consistent across government.

There needs to be further work on the health and social connection. Also with the current barriers identified on page 7, how do we ensure these are linked with the focused actions? We need to address prevention and access earlier and that means at times a culture change is needed. There is also absence of the equity lens across all areas.

Results of an impact assessment (of opportunities, challenges, risks, strengths and weaknesses) are under developed. Surely this forms the basis for change – the links are not apparent in the proposed Roadmap. We note with interest Treasury's view about the issue of unaffordability. The question might also be around the coherence and connections to economic policies that shape the lives of all New Zealanders.... Treasury has a key role in enabling the health and wellbeing of New Zealanders

What is important is that there is clear connection between the Background, Guiding Principles, Strategic Themes, Roadmap and Action Areas and that certain aspects

labelled as important in the pretext (page 7) of the document don't get lost in the Action Areas.

2 Roadmap of Actions

Critical to the Roadmap of Actions is *Improving where it matters most* and *Driving change.* As the foreword suggests, the purpose of the Roadmap is *to bring the strategic themes to life, proposing an evolution of change to realign our operating model, encourage innovation and ensure sustainability".* As currently drafted, the Roadmap seems very Ministry-focused rather than health (disability and social) system focused. Perhaps that was the intent given one of the purposes of the Strategy is apparently to realign the operating model (for the Ministry of Health).

Turning strategy into action (the Roadmap) then disaggregates the 10 year vision into "what do we want in 5 years?" with twenty actions proposed. Some of the position statements for 5 years' time are status quo, what currently occurs – it is difficult to ascertain what will actually be different. It is at this point that execution seems to be disconnected from the Strategy. The intervention logic seems somewhat blurred.

We encourage a reconsideration of the linkages between the "what great might look like in 10 years" in each strategic theme and the "what do we want in 5 years" under the Roadmap of Actions for each theme. This would help strengthen the intervention logic, and perhaps more clearly identify what the objectives are – what's required to change. This will be critical to ensure we can track and report progress. We do not want input based reporting, nor solely outputs – outcomes/impacts/results based must be a leading priority.

There seems to be a disconnect between the objectives, their identified actions for each and the "what do we want in 5 years" under each strategic theme.

There are a number actions proposed that appear to have been "retrofitted" so it is difficult to understand how these will make a difference/achieve the desired change.

The Roadmap should be more about summarising the What We Want in 5 Years rather than prejudging the means of getting there. Throughout the following sections the focus seems to be on what it appears the Ministry of Health can/will do rather than the broader health community and gives impressions that many actions have been decided in anticipation of the Strategy rather than flowing from it. This gives a feeling of disconnect between the Strategy and Turning it into Action. A stronger attention to the objectives for the four to five years rather than the actions (actions are best placed in annual planning). (Four years is suggested to align with the requirements for 4 year plans). Further it may be that Government priorities at the time supersede or conflict with the actions outlined in the Strategy.

There is a need to ensure coherence between the actions identified for the "objective" under each and between each strategic theme. Cognisance of dependencies and predecessors, and or the intervention logic in and between the actions is not particularly evident.

As currently written the “One team” and to a lesser extent the “Smart system” strategic themes are fairly well focused on the Ministry of Health and national bodies. There is an opportunity to consider “One team” much more broadly, for example with actions that draw in the cross-sector / social services intention much more (the eighth principle).

Equally applicable, if not more so, is the partnership between the Ministry and DHBs and contracted providers (the principal delivery vehicles to achieve the “vision”).

Holding an annual forum will not “create a one team approach for health in New Zealand.....”. Thinking about the role and responsibilities that contribute to the One Team needs to be much broader than restructuring and reorganising the operating model within the Ministry of Health.

The actions under “Smart system” generally suggest maintenance of the status quo in terms of national bodies (HWNZ, HQSC, NHC, HRC, National Health IT Board) – albeit focused on information systems and technology, yet the “One team” theme considers an action to integrate the health advisory structure to oversee health system changes etc.... There seems to be mixed messaging about functions, roles, responsibilities and accountabilities (for which there is another action proposed but in order to fulfil the Ministry’s stewardship function).

One Team and Smart System would also benefit from a whole of system thinking to a health care continuum approach. That is, from prevention right through to rehabilitation and support. Our “system” does not enable or support this continuum easily. For example the Public Health Services still being “accountable” to the Ministry of Health rather than to the population they serve through DHBs (similarly the National Screening programmes although to a lesser extent), and, having a separate Disability Support Service system and a separate ACC system. Thus navigating the systems is problematic for service users (and arguably for those leading, administering and delivering it).

The step towards online or digital information systems and electronic patient records is an excellent, beneficial focus area that warrants particular attention sooner rather than later. It is currently a rate limiting step. It will, however, involve considerable capital investment within both hospital and community settings. There are issues of cost, commitment, asset ownership, attribution, feasibility and affordability that need to be tested – ideally before being committed to in the Strategy.

Having more information available online will be important, although it’s important to note that we should not place all the emphasis on digital solutions as people do not always read information just because it is available. Education and face to face are still relevant and important mechanisms of communication.

Having stated that there are challenges around the health workforce, the proposed priorities/objectives/actions are relatively silent in addressing this challenge. There are opportunities to think more broadly around workforce development, building capability, functions and utilisation of professional roles and unregulated workforce (there is reference to volunteers too in earlier section, but we suggest this is a diminishing pool) across all of the Strategic themes.

3 Summary

In summary, we are encouraged by the intent of the draft update to the New Zealand Health Strategy. In our view there is considerable work still to be undertaken to clarify and link the purpose of the Strategy and the Roadmap of Actions that signifies a pathway to achieve explicit change that benefits the health of all New Zealanders.

We look forward to receiving the next iteration following the consultation process. We anticipate further clarity will then inform the shape of potential actions that we, as a key player in delivering the intent of the Strategy, to which we can then contribute both in the short and longer term.

TO Community and Public Health Advisory Committee

FROM General Manager
Strategy, Planning & Performance

DATE 06 January 2016

Memorandum

SUBJECT **STRATEGY, PLANNING & PERFORMANCE OPERATING REPORT**

1. SUMMARY

1.1 Purpose

This report is for the CPHAC's information and discussion. Its main purpose is to provide an update on recent activities of the Strategy, Planning and Performance team. No decision is required.

1.2 Executive Summary

The Health of Older Persons' portfolio reports progress with the rollout of an electronic medicines management system in local residential care facilities, while also reporting on recent performance against audit of local aged residential care facilities.

The Primary Care portfolio provides a summary of recent quarterly results against the Integrated Performance and Incentive Framework (IPIF) targets and plans afoot that start shaping a new service delivery model for pharmacist services in the community.

Finally, the Child and Youth Health portfolio overviews changes to the sub-regional Child and Youth Mortality Review Committee, resulting from realigned Ministry funding.

1.3 Recommendation

It is recommended:

that this report be received

Craig Johnston
General Manager, Strategy, Planning & Performance

2 LOCAL MATTERS

2.1 Health of Older Person

2.1.1 InterRAI Assessment Tools

InterRAI electronic assessment tools for older people were introduced into MidCentral DHB in 2010. The tool was developed in Canada in the 1990s to support quality care in residential care nursing homes. Since 2010, MidCentral DHB has collected data across a suite of interRAI instruments. Within the interRAI tool, outcome measures are automatically generated. Use of this data contributes to the design of services and programmes that meet the evolving needs of individuals and populations. We can benchmark our performance with other DHBs in areas of quality and safety for older people.

Regionally, a dashboard will graphically present key metrics enabling clinicians and managers to increase their knowledge and understanding of the characteristics of older people across our district and be comparable regionally. Data has been provided locally to integrated family health centres on their population; the next phase of data analysis will identify opportunities to improve the population's health. This is an exciting process and the Committee will be kept updated as the project evolves.

2.1.2 Medicines Management System

Through 2015 we reported on the progress and roll-out of an electronic medicines management system to aged residential care providers. We have now achieved uptake in 34 of 36 providers, with two Providers electing not to implement the system. It was expected that it would take several years to achieve complete uptake, so this is an outstanding result. Providers have enthusiastically engaged with the system and are reporting significant improvement in the safety of administering medicines to residents. This has benefits to residents, pharmacies and general practice teams. Such is the success of this project and in light of the positive feedback there is consideration of national support more widely.

2.1.3 Audits in Aged Residential Care

From time to time the Portfolio Manager reports on the general state of audits across the district. For several years now, the district has maintained a high standard for aged residential care audits and celebrated a number of Continuous Improvement (CI) findings. Generally the Horowhenua district out performs other areas and this is still the case.

Against this trend, a recent audit of a local provider generated a significant number of corrective actions, almost half of which were rated as 'moderate' risk status. The poor result is attributed to changes in management for the facility and reflect director decisions. The DHB has worked with this provider over the December/January period with some urgency and the key issues are now resolved.

2.1.4 Update on the In between Travel Settlement for Home and Community Based Providers

In 2005/06 the Ministry of Health and District Health Boards increased funding to Home and Community Support providers to reimburse support workers for travel costs (Fair Travel). In general the funding did not recognise the full "mileage" cost to workers or the cost of time taken by them to travel between clients.

In 2014, the Ministry of Health entered negotiations to find a solution that would lead to home support workers getting paid for the time they spend travelling between clients. This is referred to as the In-Between Travel (IBT). Negotiations with unions, employers and

funding agencies have concluded and the necessary legislation is being introduced prior to implementing the new claiming process from 1 March 2016.

The In-Between settlement addresses issues associated with both workers travelling time and the reimbursement of travel cost. The Ministry is calling from feedback from all parties in order to refine any guidance and develop a "real-world experience" of how the new system will work. Our interests will be to ensure the new process is financially sustainable to this DHB.

The next steps include contract variations for the six MidCentral contracted providers, and finalising associated payments under the previous system.

2.2 Maori Health

2.2.1 Maori Directorate

Recent activity with the Maori Directorate includes the formal appointments in November for the positions of Manager Maori Health Strategic and Support and Manager Maori Health Workforce Development. Progress is still underway respect to the Manager Maori Health roles for Quality Improvement, Clinical Manager, Tikanga and Cultural Competency.

2.2.2 Annual Planning and the Maori Health Plan

Work has commenced with the sector on Annual Plan formation for the 2016/17 year. Key to this activity is working alongside Portfolio Managers to develop meaningful and tangible outcomes that sit with the national targets and priorities in Maori Health; this work is on track. In addition, work is underway in developing the Maori Health Plan for the same period. Consultation processes have been agreed with Manawhenua Hauora to ensure that the voice of Manawhenua can be heard clearly throughout the plan as an active contribution to wellbeing of the community.

2.2.3 Joint Initiatives with the Central PHO Maori Health Unit

The Manager Strategy and Support has actively engaged with CPHO Maori Health Unit to undertake two key shared initiatives. Firstly, an equity framework as a useful and practical tool to support those working in health to challenge inequity through their scope of practice and secondly, a shared data collection protocol that will enable ease of access to relevant information and support purposeful of intervention and support. This data protocol will actively contribute for Whanau Ora practices to be consistently applied across organisations

2.2.4 Hauora Workforce NZ

The 2016 workforce funding from the Ministry has been approved. The Maori Directorate is underway with planning on how to best utilise the fund.

The Kaimahi Ora web page on the MidCentral DHB web site has been updated with information on courses, eligibility and information on how to apply. This is readily available to MidCentral DHB Maori staff in pursuit of up-skilling themselves.

2.3 Mental Health and Addictions

2.3.1 Regional Alcohol and Other Drug (AOD) Residential Review

A new service model of care was developed by the regional working group for the AOD Residential Services Review, and presented to the Regional Mental Health and Addictions

Clinical Network (MHAN) in 2015 for consideration. The model proposes to stage levels and settings of care to reduce waste of resource and enhance care pathways for the client accessing alcohol and drug rehabilitation services.

It was then recommended that further feedback on the model be sought from Central Region DHBs through series of presentations in each DHB region and involving all stakeholders of AOD treatment in the Central Region. Work has been underway locally at the end of last year on how the local AOD services would interface with the proposed regional AOD residential services (Salvation Army Wellington, Odyssey House Auckland, Springhill Hawkes Bay and Nova Trust Wellington). A comprehensive report on the local model was provided to CPHAC in October 2015. The Central Regional Portfolio Managers are currently developing a regional business case to present to the Ministry of Health in March 2016. This involves agreement on the regional AOD model, local models of care and Inter District Flows. Further update will be provided.

2.4 Primary Health

2.4.1 Integrated Performance and Incentive Framework

In 2014, the Integrated Performance and Incentive Framework (IPIF) replaced the PHO Performance Programme (PPP) as the incentivised quality improvement programme, focusing initially on primary care services. The goal of IPIF is to support the health sector in addressing equity, safety, and quality of services. IPIF aims to set high-level directions for improved effectiveness and productivity of health care for all New Zealanders. The development of IPIF and its implementation is an evolving process being led by clinicians, sector leaders, and PHOs.

The following IPIF performance measures (with national targets) are currently in place:

- More Heart and Diabetes Checks (90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years)
- Better Help for Smokers to Quit – Primary Care (90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months)
- Increased Immunisation for eight-month-olds (95 percent of eight-month-olds will have their primary course of immunisation at six weeks, three months and five months on time)
- Increased Immunisation for two-year-olds (95 percent of two year-olds are fully immunised)
- Cervical Screening (80 percent of women aged 20 to 69 years have had a cervical screen in the past 3 years)

Progress against achieving the target for each of these measures is reported quarterly, with PHOs incentivised for meeting the target. PHOs receive partial incentive payments for being within 10 percent of a measure's target.

Recently received results for quarter one of 2015/16 saw Central PHO achieve very well against the IPIF measures, meeting the national targets and receiving full incentive payments for all performance measures except "Better Help for Smokers to Quit".

Central PHO made significant progress against the "Better Help for Smokers to Quit" measure and got within 3 percent, but did not quite meet the national target, achieving 87 percent, which was up from 82 percent for the previous two quarters, and 73 percent in quarter two 2014/15. Continued improvement an achievement of the target is anticipated in the next quarter's results.

2.4.2 Integrating Pharmacist Services in the Community and the next Community Pharmacy Services Agreement

In late November, DHBs held a national stakeholder forum with consumers in attendance, that started a conversation about the future of pharmacy services and what is required to keep pace with the changing environment of healthcare service delivery.

Considerations discussed at the forum include:

- Consumers need to be the focus of service delivery.
- Integration of pharmacist services with wider primary care is critical. We need to consider a range of options on how and where pharmacist services can be best delivered.
- The service model needs to be collectively developed through engaging with a wide range of stakeholders including consumers, pharmacists, general practice, and other primary care providers such as residential care providers.
- A model must fund the right pharmacist services in the community and enable integration into the wider primary care setting.
- Pharmacist services need to be designed to focus on patient-centric service delivery, with an emphasis on clinical (as opposed to medicines supply) services.
- The contract should be a vehicle to deliver on the Ministry of Health's Pharmacy Action Plan (once finalised).

A new service direction will be developed over the coming months, using a collective engagement process with a wide range of stakeholders. It is planned that the new service direction would be introduced within the July 2016 - June 2017 timeframe of the next Community Pharmacy Services Agreement

2.5 Child & Youth Health

2.5.1 Child and Youth Mortality Review Committee (CYMRC):

MidCentral District Health Board (MDHB) received a letter 11 December 2015 from the Health Quality and Safety Commission New Zealand signalling a reduction in funding for the Child and Youth Mortality Review Committee (CYMRC) commencing 1 July 2016. This reduction is in line with a new nationally consistent model to ensure fair and equitable funding to DHBs to support local work.

The CYMRC was established in 2002 with a national role to reduce preventable child and youth deaths. The CYMRC supports local review groups to work with other agencies to review deaths and make changes to reduce preventable deaths and improve quality of services.

Child and youth deaths have decreased nationally by 27 percent to 2014. MDHB three-year rolling average to 2011 was 28 deaths, reducing to 22 to 2014. Whanganui District Health Board (WDHB) three year rolling average to 2011 was 11 deaths and 10 to 2014. This reduction reflects the commitment and efforts by local CYMRC groups to implement initiatives that have led to positive change.

MDHB and WDHB have employed a CYMRC across both DHBs since 2007. This role has worked extremely well for both DHBs. WDHB have been the lead DHB for this contract since inception.

The Portfolio Managers of both DHBs have agreed a way forward to manage the funding reduction, which amounts to $11,094 for MDHB and $4,702 for WDHB. It has been agreed that the shared coordinator role will be reduced by four hours per week (to 16 hours per week) from 1 July 2016 and the coordinator has been informed of this reduction.

Whanganui DHB will manage all costs associated with the role going forward in order to meet the funding reduction. The Portfolio Managers have confidence that the contract can be managed within the reduced hours and that the new goal of 70% of cases will be able to be reviewed with little impact to service delivery.

2.5.2 Turbokidz Update:

The CPHAC committee requested that an update be provided to the Board in February 2016 in respect to progress around the Turbokidz business case. The actual business case has not been progressed due to the current financial position but work is to continue in 2016 around a new model of care for child health.

This approach better aligns to the service and infrastructure plans that will be progressed in line with the DHB's strategic plan. The opportunity to look at a model of care for child health that works across the continuum is one that is well supported by the Child Health Tamariki Ora District Group (CHTODG). This work will be progressed following the first CHTODG meeting of the year.

2.6 Palmerston North Hospital Site Reconfiguration

As previously reported, activities continue within MidCentral Health in support of the future site redevelopment. These include a range of initiatives around decreasing length of stay, improving productivity in theatres, managing increased demand with similar workforces, working with primary and community care to improve the patient journey and extending the range of community based options to support patients.

3. ANNUAL PLAN: PROFILE OF INITIATIVE/S

Initiative 14 of the MidCentral DHB 2016/16 Annual Plan is to implement the Quality Standards for Diabetes Care across the district. This involves:

- Establishing a Diabetes Leadership Group (DLG) to provide oversight of quality standards
- Developing data collection and reporting systems, and
- Providing regular reports about performance against the Quality Standards to clinical governance groups, general practice teams, and other core agencies.

Oversight of this initiative is provided by the Long Term Conditions District Group. Progress against this initiative has been steady and reflects the complicated nature of diabetes management.

The MidCentral DLG was established in March 2015, initially with a large number of interested parties represented that was later reduced to a more manageable number. Current membership of the DLG includes specialist and generalist hospital and community clinicians from the medical, nursing, and dietician professions, consumer and Māori representation, and both PHO and DHB management. The DLG is ably chaired by the MidCentral DHB Director of Nursing and Central PHO provides project management.

Since forming, the DLG has focused on identifying gaps between current practice in the MidCentral district and an ideal practice as outlined in the Quality Standards. This is no small task given the complexity and the number of parties involved in diabetes management – at an individual level, for a practice population, and also at a health systems level. The DLG is realistic in that given resources available resources, any gap analysis it undertakes will not be comprehensive, but will potentially highlight those areas most in need of attention.

To date the DLG's Quality Standards gap analysis process has involved:

- Individual members of the DLG reviewing their practice against the relevant sections of the Quality Standards
- Meetings of small groups of health professionals (e.g. nurses, pharmacists, etc.) being arranged to enable them to review current professional practice against relevant sections of the Quality Standards
- Multiple requests for comment/feedback issued by the DLG to MidCentral health professionals in general
- A Small World Café-style meeting of providers and consumers looking at all of the Quality Standards

Information from each of these forums is currently being collated and is due to be reviewed early in 2016. This will guide further work of the DLG.

In the meantime, both hospital and community providers continue to implement quality improvement initiatives for diabetes management, in line with the Quality Standards. As part of their usual feedback systems, Central PHO provides regular reports about performance against diabetes health targets to all general practice teams in the district and is using various means to encourage consumers to ask about their health dashboard (which includes diabetes indicators) when at their general practice.

TO Community and Public Health Advisory Committee

FROM Finance Manager
Funding and Planning

DATE 15 January 2016

Memorandum

SUBJECT **FINANCE REPORT – RESULT OF 31 DECEMBER 2015**

1. PURPOSE OF REPORT

This report is for the Committee's information and discussion. Its main purpose is to document the financial performance for the Funder. No decision is required.

2. EXECUTIVE SUMMARY

The Funder's budget includes the $1 million improvement in the Annual Plan bottom line result arising from the $1 million of additional revenue from the Ministry of Health.

The Funder's 31 December 2015 YTD result is a positive variance to budget.

3. RECOMMENDATION

It is recommended: *that the report be received*

Steve Tanner
Finance Manager,
Funding & Planning

4. KEY EVENTS

4.1 Revision of 15-16 budget

The Funder's budget has been amended to incorporate the additional $1 million of revenue from the Ministry of Health (as notified in July) and the consequential $1 million improvement in the Annual Plan's bottom line result. Future finance reports will be against the revised Annual Plan financials.

4.2 Result for 31 December 2015

The Funder's Year to Date (YTD) result to 31 December 2015 is a surplus of $113k over budget.

4.3 MidCentral Health washup

The Funder is paying an extra $1,066k to MidCentral Health as a YTD washup for IDF Cancer Patients. The Funder has accrued an extra $1,066k IDF inflow income as this is expected to be reimbursed from other DHB's. This has no financial impact on the Funder's result.

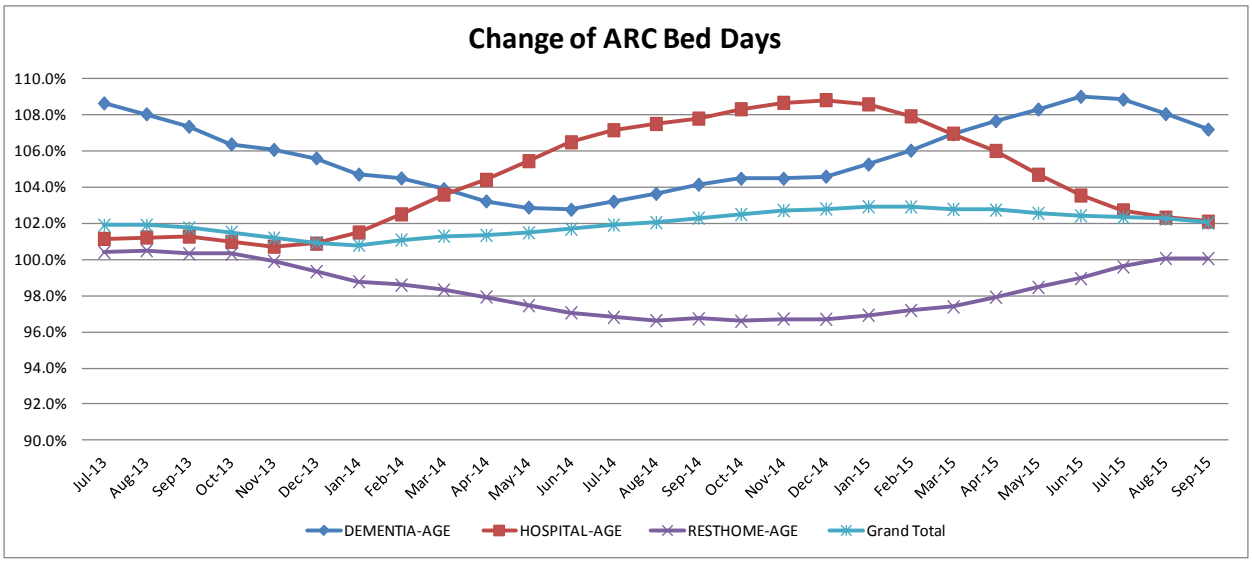
4.4 Elective Income

The Funder has accrued elective income as per the elective initiatives budget and this will be adjusted in subsequent months based on actual activity.

4.5 Inter District Flows - Inflow and Outflow

Reports indicate that the Inter District Flow inpatient inflows to Palmerston North Hospital and inpatient outflows are close to budget, at 108 percent and 102 percent respectively.

4.6 Disability Support Services (DSS)



As at 30 September 2015 the annualised Dementia and Hospital Care bed days continued to grow at 7.9 percent and 2.2 percent respectively, however the growth has reduced from the peak in June 215. The Rest Home bed days dropped by 0.3 percent from the previous month. Overall bed days grew at 2 percent. We are currently reviewing the data for the months since and anticipate being in a position to update this graph in the next report.

5. FUNDER FINANCIAL PERFORMANCE

The Funder's 31 December 2015 YTD result is $113k favourable to budget. The forecast for the year is as per the revised annual plan.

Midcentral DHB - Funder							
Income and Expenditure - By Ring Fenced Area			YTD			Annual	
For the period ending 31 December 2015		Actual	Budget	Variance	Forecast	Budget	Variance
		$000	$000	$000	$000	$000	$000
Personal Health Income	(a)	203,099	199,653	3,446	403,020	400,317	2,703
Personal Health Expenditure	(b)	204,181	200,697	3,484	401,097	398,305	2,792
Personal Health Surplus/(Deficit)		-1,082	-1,044	-38	1,923	2,012	-89
Mental Health Income	(a)	20,411	20,158	253	40,842	40,316	526
Mental Health Expenditure	(b)	20,439	20,179	260	40,842	40,316	526
Mental Health Surplus/(Deficit)		-28	-21	-7	0	0	0
Disability Support Income		40,693	40,673	20	81,346	81,346	0
Disability Support Expenditure		40,777	40,748	29	81,707	81,346	361
Disability Support Surplus/(Deficit)		-84	-75	-9	-361	0	-361
Maori Health Income		1,003	1,003	0	2,007	2,007	0
Maori Health Expenditure		837	1,003	-167	1,557	2,007	-450
Maori Health Surplus/(Deficit)		167	0	167	450	0	450
Governance Income		1,228	1,228	0	2,456	2,456	0
Governance Expenditure		1,228	1,228	-0	2,456	2,456	0
Governance Surplus/(Deficit)		0	0	0	0	0	0
Total Funder Surplus/(Deficit)		-1,027	-1,140	113	2,012	2,012	0
Note on variance							
(a) Due mainly to extra funding from MoH that has corresponding increase in expenditure							
(b) Extra expenditure due to extra funding							