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- Kathryn Cook, CEO
- Craig Johnston, General Manager, Strategy, Planning & Performance
- Mike Grant, General Manager, Clinical Services & Transformation
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Next Meeting Date 7 June 2016
Deadline for Agenda Items 24 May 2016

MidCentral District Health Board

A g e n d a

Community & Public Health Advisory Committee

Part 1

Date: 26 April 2016

Time: 1.00pm

Place: Board Room
Board Office
Heretaunga Street
Palmerston North

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Tuesday, 26 April 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: 1-6
Documentation: minutes of 15 March 2016
Recommendation: that the minutes of the previous meeting held on 15 March 2016 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 15 March 2016 for which specific items do not appear on the agenda or in management reports.

5. GOVERNANCE

5.1 2015/16 Work Programme

Pages: 7-12
Documentation: report from Acting Chief Executive Officer dated 18 April 2016
Recommendation: that the updated work programme for 2015/16 be noted

6. STRATEGIC

6.1 Renal Plan for MidCentral DHB

Pages: 13-15
Documentation: report from General Manager, Strategy, Planning & Support and General Manager, Clinical Services & Transformation dated 11 April 2016
Recommendation: that this report be received

7. OPERATIONAL REPORTS

7.1 Funding & Planning Operating Report (Results for March)

Pages: 16-25
Documentation: report from General Manager, Strategy, Planning and Performance dated 11 April 2016
Recommendation: that this report be received

7.2 Finance Report – Result for March 2016

Pages: 26-28
Documentation: report from Finance Manager, Funding and Planning dated 12 April 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

7 June 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 Draft Regional Service Plan (Version 2)	Subject of negotiation	9(2)(j)
2016/17 Annual Plan Update	Under negotiation	9(2)(j)
2016/17 Draft Funding Arrangements Document	Annual Planning – under negotiation	9(2)(j)

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Minutes of meeting held on Tuesday, 15 March 2016 at 1pm at MidCentral District Health Board Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North

PRESENT:

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

IN ATTENDANCE:

Kathryn Cook, Chief Executive Officer
Craig Johnston, General Manager, Strategy, Planning & Performance
Megan Doran, Committee Secretary
Neil Wanden, General Manager, Finance & Corporate Services
Jo Smith, Senior Portfolio Manager, Health of Older Persons
Claudine Nepia-Tule, Portfolio Manager, Mental Health & Addictions
Maha Patel, Intern Portfolio Manager
Stephanie Turner, Director, Maori Health & Disability
Jordan Dempster, Communications Officer
Barbara Robson, Board Member
Andrew Orange, Portfolio Manager, Clinical Services

OTHER:

Public: (2)
Media: (0)

1. APOLOGIES

There were no apologies.

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

Ms Oriana Paewai declared a conflict with regards to Mana o te Tangata, Royal New Zealand Plunket Society, Rangitane o Tamakai nuia Rua, Tararua Hauora Services and Te Wakahuia Trust on item 14.1, General Approach to Contract Review and renewal for 2016/17 (within Part 2 of the agenda).

4. MINUTES

4.1 Minutes

It was recommended:

that the minutes of the previous meeting held on 2 February 2016 be confirmed as a true and correct record.

4.2 Recommendations to the Board

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

4.3 Matters Arising from the Minutes

The Chair referred to Item 7.1 Strategy, Planning & Performance Operating Report specifically the Feilding IFHC Official Opening, as the previous minutes had the official opening as 6 February 2016, when it was in fact 5 March 2016.

Mr Adrian Broad clarified that in Item 2.2.1 Maori Directorate, the event the Directorate attended was the Massey Maori Science Academy event.

5. GOVERNANCE

5.1 2015/16 Work Programme

The Chair noted the absence of the Price Volume Schedule. The General Manager, Strategy, Planning & Performance advised that historically the report on the Price Volume Schedule marked the beginning of negotiations between the Funder and MidCentral Health. The revised approach this year sees the Price Volume Schedule being developed as an integral part of the Annual Plan and budgeting process, and that accordingly it will not be reported on separately.

It was confirmed that the Board workshop to be held on 17 May 2016 will occur in Feilding.

It was recommended:

that this report be received.

6. STRATEGIC

6.1 Regional Services Plan Implementation Update – Quarter 2, 2015/16

A member inquired as to whether the major trauma network included a preventative component. It was clarified that the network is entirely concerned with the management of major trauma after it has occurred.

The Chair noted the temporary closure of dedicated stroke beds and questioned what impact this had on the dedicated stroke service and patients. Vivienne Ayres advised that the service is provided by the clinical team, and although there are dedicated beds, the organised stroke service is provided to eligible patients regardless of bed location. Management confirmed that the bed situation was being closely monitored by the clinical team. There was no further detail at the time, but there was an undertaking to provide an update at the next meeting.

It was recommended:

that this report be received.

6.2 Regional Services Plan 2016/17 – Development of Draft 1

Vivienne Ayres, Manager, DHB Planning & Accountability, introduced this paper and advised that the draft 2016/17 Regional Service Plan (RSP) was not yet ready to be submitted to the Committees. Central TAS was updating the current draft to incorporate feedback from the Central Regional Chief Executives / programme sponsors and further input from the regional networks. There is confidence that the plan will be ready in time to go to the Ministry by the due date, but DHBs will not see it in advance. The draft RSP will include a caveat that it has not yet been approved by DHBs when submitted to the MoH.

It was recommended:

that this report be received.

6.3 Non Financial Monitoring Framework & Performance measures – Report for Quarter 2, 2015/16

Vivienne Ayres, Manager, DHB Planning & Accountability, introduced this paper and noted that this was a good quarter for the DHB against the 53 measures being reported. The DHB is performing relatively well in many areas, however more work was needed in some areas.

The Chair questioned the difference between "non-urgent" and "urgent" with regards to the Mental Health Service as it would seem that some patients were waiting between 3-8weeks before having a specialist appointment. Non-urgent was the same as routine and applied where a patient was not at immediate risk to themselves or others or assessed at point of referral as requiring an urgent intervention. In these circumstances the 3-8 week timeframe would not be detrimental to patients, particularly as there is always the opportunity to reefer if a person's needs increase. The measure excludes contacts with the mental health crisis team. The measure intends that almost all (95%) people referred are seen within 8 weeks and 80% within 3 weeks.

It was also noted that these were new patient referrals (or those who had not been seen in the last 12 months) and is focused on the 0 – 19 year old population. It includes Alcohol and Drug services provided by NGOs, including the Youth One Stop Shop, whose wait times have improved considerably over the last six months.

It was noted that although there was a slight improvement for Cervical Screening rates, there is still room for improvement with Maori/Pacific and Asian women population groups. These

should continue to be monitored. Concern was expressed that proposed national changes to the programme could be detrimental and could result in less women being screened. Consistent monitoring and reporting was considered vital.

Breastfeeding rates were discussed and an observation was made that by the time some patients are seen by the Well Child Providers it was too late to assist with any breastfeeding issues that some women may be experiencing, if breastfeeding is not established. In the postnatal period, after 4 to 6 weeks, there are transfers of care occurring between Lead Midwifery Carers and general practice teams and well child providers. Ensuring attention to breast feeding during this transition period is critical, and it depends on relationships. There is a lot of focus on improving transitions, but there is no easy fix.

A member noted another area of concern was the B4 School Checks and the Childhood Obesity Health Target. Some parents might refuse to engage with or be referred for assessment and intervention if their child/children is/are in the high BMI range. They could also refuse a B4 School Check in the first place. Some parents might not understand that there are serious health issues associated with obesity. As with other service areas, the key here is effective communication between health providers/clinicians and parents. Over time it is expected that this will improve and that the approach will deliver benefits for children. At present, a B4 School Check might identify a child as in the obese range but there are limited opportunities currently for support.

It was recommended:

that this report be received.

6.4 Mental Health Report

Kathryn Cook, Chief Executive Officer gave an overview of this paper. She advised it had been considered in detail at the Hospital Advisory Committee Meeting.

Key points were that while there has been some progress implementing the recommendations there continued to be issues/concerns around reporting. There are also some workforce challenges that were currently being worked through, however this was work in progress.

The Committee noted that a community organisation Hui is to be held on 28 April 2016. A Hui Organisation Group has been established to lead this work. An independent facilitator was being secured.

It was recommended:

that this report be received.

7. OPERATIONAL REPORTS

7.1 Strategy, Planning & Performance Operating Report (Results for January & February)

The General Manager, Strategy, Planning and Performance provided a page by page overview of this report.

Item 2.1.1 Innovations in aged care
Jo Smith, Senior Portfolio Manager, Health of Older Persons gave an over view of two new projects, technology (telehealth in the home) and “Accelerate 25”.

It was noted that the "Accelerate 25" project was a pilot focused on the Horowhenua. Members inquired as to the involvement of other communities and other local authorities. It was clarified that the location of the pilot was not a DHB decision.

Item 2.2.1 Pae Ora – Maori Health Directorate
It was pleasing to see the engagement with Manawhenua Hauora with regards to a workshop that was held on 7 March strengthening the relationship between Manawhenua Hauora and the Maori Health Directorate Pae Ora team. It was hoped this would form the path going forward and the commitment that all parties have towards aligning the Annual Plan with the Maori Health Plan.

Item 2.3.1 Provider Surveillance Audits (Ministry of Health)
2.3.1.1 MASH Trust
The Chair was pleased to see the inclusion of the provider audits but did question whether there was enough detail for the committee. The General Manager, Strategy, Planning & Performance advised that the FRAC committee receives a more in depth Audit report on providers, and would certainly be involved if there were concerns. The purpose of the report to the CPHAC committee was to provide a brief overview and to highlight the great work in the two providers.

Item 2.4.1 Feilding Integrated Family Health Centre (IFHC)
The Chair along with the General Manager, Strategy, Planning & Performance congratulated the General Practitioners of the Feilding Integrated Family Health Care Centre on a successful opening. A lot of work and commitment by many had ensured this IFHC got up and running. The Dawn Ceremony was also recognised and applauded.

Item 2.4.2 Future Pharmacist Services Workshop
The Chair applauded the recent workshop on Community Pharmacy Services. There was also commendation for the participation of local leaders at the national workshop – particularly Tom Ward and John Hannifin.

There was a discussion about how the vision of a clinically oriented service fits with the current Community Pharmacy Services Agreement. Andrew Orange, Portfolio Manager, Clinical Services, advised that despite the best intentions, the current contracting approach has not succeeded in focusing attention on clinical services to any significant extent. It was hope that the workshop process would help clarify the future vision which the next round of contract development would then focus on.

Item 2.5.1 Smokefree Turbos Contract:
The Committee was pleased to see that all though the funding of the Smokefree Turbos Contract had reduced the relationship was continuing. The General Manager, Strategy, Planning and Performance confirmed that the Turbos have been a standout performer for the DHB and it is excellent to have them involved for another year.

Item 3.1 Children's Team Tamariki te Tuatahi:
Clarification was sought regarding management's statement that "the role is temporary for eighteen months at which time the funding will be exhausted" and what this meant for the service. Management advised that the role was created with one-off establishment funding allocated by the Ministry of Health and this team decided the best way forward was to have one key social worker/health broker assess cases and decide which way to move forward, rather than have a number of teams looking at who would assist the child/family and end up with delays.

It is possible that future funding may be available to continue this role once the eighteen months was up.

Item 3.2 Primary Birthing Unit
The Chief Executive Office and General Manager, Strategy Planning & Performance advised they were to meet with the CEO of the Primary Birthing Unit and a further update would be provided at the next committee meeting.

It was recommended:

that this report be received.

7.2 Finance Report – Result for January 2016

The General Manager, Strategy Planning & Performance introduced this report and advised the Division was currently tracking towards budget.

The Chair questioned the mismatches in IDFs and was advised that these continued to be worked through all the time.

It was recommended:
that this report be received.

8. LATE ITEMS

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

9. DATE OF NEXT MEETING

Tuesday, 26 April 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 Draft Annual Plan	Subject to negotiation	9(2)(j)
2016/17 Draft Maori Health Plan	Subject to negotiation	9(2)(j)
General Approach to Contract Review & Renewal for 2016/17	Negotiation Strategy	9(2)(j)

Confirmed this 26th day of April 2016

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Chairperson

TO Community & Public Health Advisory Committee

FROM Acting Chief Executive Officer

DATE 18 April 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 Committee's work programme is attached. Generally reporting is progressing in accordance with this, with one exception:

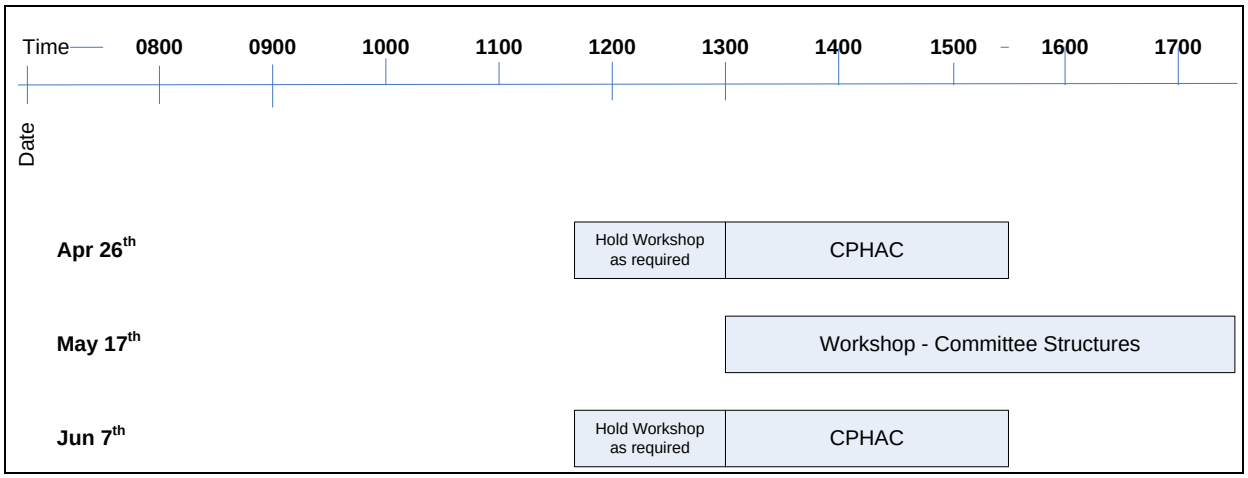
- 2016/17 Price : Volume Schedule
  This is still being developed as part of the annual plan and budget and will be presented to the Committee next month.

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	• Draft 2016/17 annual plan • Draft 2016/17 Maori health plan	• Regional Service Plan 2016/17 – Draft 1 • Draft 2016/17 Funding Arrangements document	• 2016/17 price:volume schedule
Monitoring Annual (AP) & Regional (RSP) Plan Implementation	• 2015/16 RSP implementation: update • Mental health service reconfiguration: update 3 • Feasibility of primary birthing unit, Palmerston North	• Renal plan for MDHB	• 2015/16 RSP implementation: update 4 • 2015/16 AP implementation: update re primary care initiatives • 2015/16 Maori Health Plan: update • Mental health service update
Sub-regional work - centralAlliance			• centralAlliance laboratory contract: proposed approach • centralAlliance strategic plan update
Quality	Non-financial performance measures for quarter ended December 2015		• Non-financial performance measures for quarter ended March 2016

Operational Matters	• January/February financial results • General Manager's report • Proposed negotiating strategy 2016/17	• General Manager's report • February results	• General Manager's report • March results • Contracts update
Reporting	• Work programme update	• Work programme update	• Work programme update
Workshops	• Women's health workshop		

Committee commitments through until June 2016 are set out below.



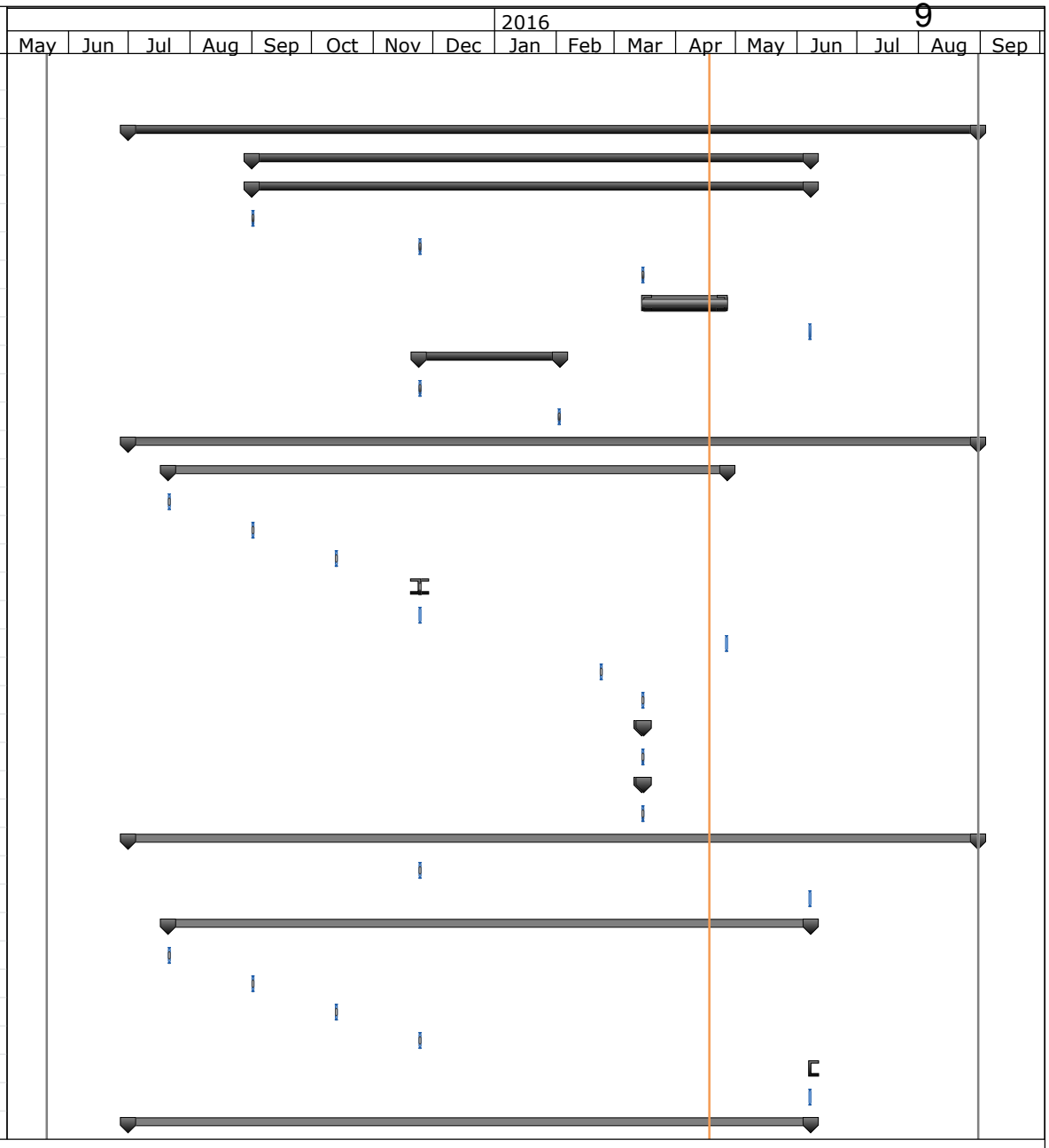
3. RECOMMENDATION

It is recommended:

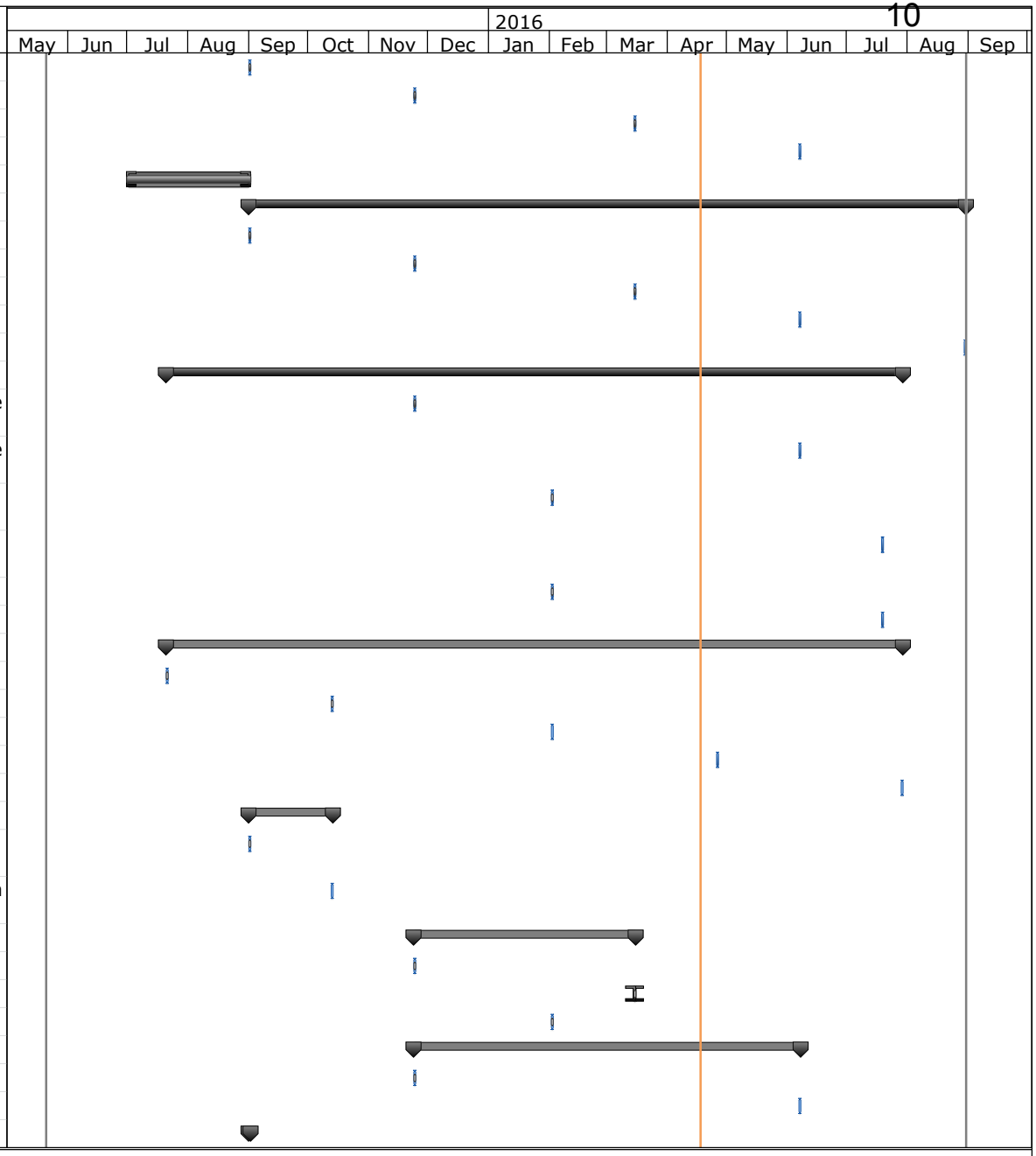
that the updated work programme for 2015/16 be noted.

Mike Grant
Acting Chief Executive Officer

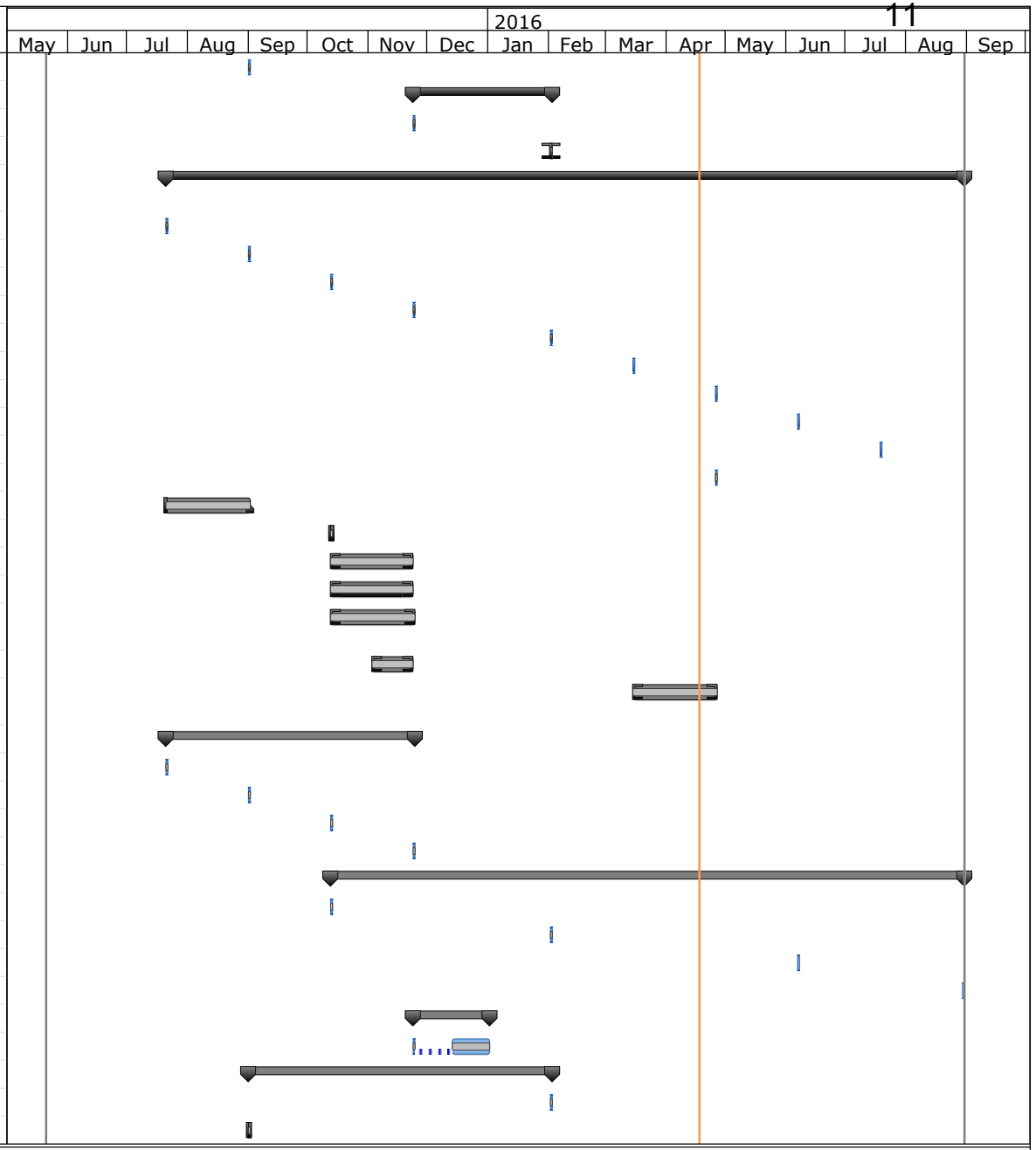
ID	Task Name
1	**CPHAC, 2015/16 Work Programme**
2	
3	**STRATEGIC ISSUES**
4	**Regional Services Plan**
5	**2015/16 Implementation**
6	Update 1
7	Update 2
8	Update 3
9	Update re organised stroke service
10	Update 4
11	**2016/17 RSP Development**
12	Approach & timeline
13	Draft 1
14	**Annual Plan**
15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



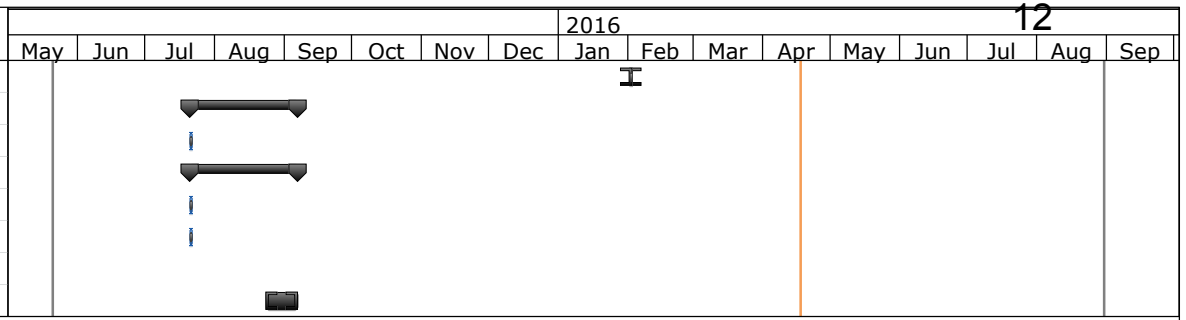
ID	Task Name
39	Update 1
40	Update 2
41	Update 3
42	Update 4
43	Possibility of a mental health workshop
44	**Non-financial Performance Indicators**
45	2014/15, Quarter 4
46	2015/16, Quarter 1
47	2015/16, Quarter 2
48	2015/16, Quarter 3
49	2015/16, Quarter 4
50	**Information Only**
51	Secondary care initiatives, inc centralAlliance: update 1
52	Secondary care initiatives, inc centralAlliance: update 2
53	Quality (inc customer satisfaction & clinical governance indicators): update 1
54	Quality (inc customer satisfaction & clinical governance indicators): update 2
55	Workforce: update 1
56	Workforce: update 2
57	*PNH Site Reconfiguration*
58	Update 1
59	Update 2
60	Update 3
61	Update 4
62	Update 5
63	*Major Projects 14/15 Annual Plan*
64	Regional Women's Health Service Update 1 (including cancer sub-specialty workstreams)
65	RHWS future reporting arrangements (post evaluation - Hospital Audit) NOW JUNE 2016
66	**Business Cases**
67	Feasability of primary birthing unit, PNth
68	Feasability of primary birthing unit, PNth
69	Turbo Kidz
70	**2015/16 Maori Health Plan Implementation**
71	Update 1
72	Update 2
73	**2014/15 Maori Health Plan Implementation**



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



ID		Task Name
111	✓	Mental Health workshop
112		**CARRIED FORWARD FROM 2014/15**
113	✓	Home management services: options for reassessment
114		***Information Only***
115	✓	2014/15 Quality update 2
116	✓	2014/15 Workforce update 2
117		
118		



TO Hospital Advisory Committee
Community & Public Health Advisory Committee

FROM General Manager - Strategy, Planning and Performance
General Manager – Clinical Services & Transformation

DATE 11 April 2016

SUBJECT **Renal Plan for MidCentral DHB**

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

The purpose of this report is to update the committees on the Renal Plan. No decision is required.

2. EXECUTIVE SUMMARY

A project to develop a plan for MidCentral DHBs renal service has commenced. Capacity has recently been reached for facility based haemodialysis provided at the renal unit and the self-care facility on Ruahine Street. Spare capacity is needed in order to treat new patients, acute presentations or transfers from home dialysis. Patient sessions are being juggled in order to maintain an appropriate level of service. This needs a solution, however it is important that this solution reflects current and future service requirements.

3. BACKGROUND

Most people with kidney disease are managed by general practice teams. Specialist services for those with severe deterioration in kidney function, including dialysis are provided by MidCentral Health for the MidCentral and Whanganui populations. Capital & Coast DHB is the principle tertiary provider and performs kidney transplant operations.

The demand for renal services has been steadily growing over the past two decades. More people are receiving dialysis or transplant for end stage kidney disease. The prevalence of dialysis in New Zealand has increased significantly from 436 people per million in 2004 to 606 per million in 2013. MidCentral Health has experienced a similar increase in demand for its dialysis services. There are currently 147 people receiving dialysis, 41% at home and 59% at MidCentral Health facilities.

Previous MidCentral DHB planning exercises have developed strategies to cope with this – a self-management facility for haemodialysis was opened opposite the hospital in 2007 and there have been a number of initiatives in primary care to improve the detection and management of chronic kidney disease. ‘Kidney Health in Horowhenua’ improved general practice systems and processes for kidney disease and clinical collaborative pathways for chronic kidney disease and renal impairment have been introduced.

The most recent review in 2013 found that current facilities for haemodialysis would be adequate until the year 2022. However, since this time (particularly in the last year) there has been a significant rise in the number of people requiring haemodialysis and capacity has been reached much earlier than expected – this shows how difficult it is to accurately estimate the demand for dialysis services.

Renal service costs have been escalating, MidCentral DHB's investment has increased from $6 million to over $8 million in the last five years.

Project goal and approach
The goal of the project is to provide a plan to guide future decision making for renal service delivery, workforce and facilities and make improvements to service sustainability.

New options for services will be considered including where and how they are delivered and the resources required, in particular, the facilities required for MidCentral DHB. The project will look at the whole of the patient journey recognising that dialysis in the hospital is part of a journey that begins in primary care. The future model of care will consider what needs to occur in general practice to better manage chronic kidney disease, home dialysis and what is needed to support this and the best location for haemodialysis including consideration of non-hospital locations.

A transition plan will outline the actions required to resolve the immediate service and capacity issues.

Input will be obtained from a range of people including clinicians and managers from primary and specialist services. Patients will be informed of the project via letter and will also have opportunity to provide input.

The process will include interviews, analysis of service information and looking at the situation elsewhere, including other DHBs.

Project resources and governance
Project management has been outsourced – Sharon Bevins is undertaking this work.

General managers Mike Grant and Craig Johnston are project co-sponsors and have formed a steering group. Members are:

- Valerie Barnes and Tony Davis – Consumers
- Dr Bruce Stewart – Medical Director Primary Care
- Dr Norman Panlilio – HOD Renal Services
- Gillian Treloar – Nurse Manager Renal
- Amanda Driffill – Service Manager Medical Services
- Dr Mark Beale – Clinical Director Medical Services
- Lyn Horgan – Operations Director
- Jan Dewar – Nurse Director

Progress
Information gathering is well underway with stakeholder discussions and benchmarking work nearing completion. The focus over the next month will be analysis of service information, short term capacity planning and initial work on future options. The report is expected to be submitted to CPHAC's July 2016 meeting.

4. RECOMMENDATION

It is recommended:

that the report be received

Craig Johnston
General Manager
Strategy, Planning and Performance

Mike Grant
General Manager
Clinical Services & Transformation

TO Community and Public Health Advisory Committee

FROM General Manager
Strategy, Planning & Performance

DATE 11 April 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 on strategic work currently underway, and provides an update on the current focus on falls prevention activities in aged residential care.

Current activity of Pae Ora – Māori Health Directorate is summarised, while the Mental Health and Addictions portfolio provides an overview of the Ministry of Health's Commissioning Framework.

The Primary Care portfolio updates the Committee on work being done on an IFHC for south-western Palmerston North, the impact of zero fees for under 13's, the Whānau Triathlon, and the current consultation with community pharmacies on margins paid by DHBs on pharmaceuticals.

An overview is provided from the Child and Youth Health portfolio on the Well Child Tamariki Ora Quality Improvement project.

Annual Plan initiatives reported on are the Community Probation Services and Alcohol and Drug Services initiative, and the Primary Birthing Unit.

1.3 Recommendation

It is recommended:

that this report be received

Craig Johnston
General Manager, Strategy, Planning, & Performance

2 RESPONSES TO COMMITTEE AND BOARD REQUESTS

2.1 Committee Update – Provision of Organised Stroke Services in relation to the temporary closure of beds at Palmerston North Hospital

At the Committee's last meeting, a member questioned whether the temporary closure of beds at Palmerston North Hospital over the summer months had any impact on the provision of organised stroke services, in particular relating to the four dedicated beds for stroke patients. The Committee was advised that the clinical team was maintaining a close eye on the potential for disruption to the service for acute patients who had had a stroke throughout the period of bed closures, and management undertook to provide the Committee with an update.

The national target is that 80 percent (or more) of patients who are admitted with an acute stroke (primary discharge diagnosis of ischaemic, haemorrhagic or undetermined stroke) are admitted to a stroke unit or organised stroke service with demonstrated stroke pathway. This is one of the two key indicators pertaining to the provision of stroke services, in line with recommendations of the New Zealand Clinical Guidelines for Stroke Management (the other indicator relates to thrombolysis).

The DHB has been reporting this indicator as part of the non financial performance monitoring framework and performance measures for some time. It has also submitted its quarterly data as part of Central Region's Regional Service Plan Stroke programme, with results included in the quarterly implementation progress reports, which are also provided to the Ministry of Health.

The following data shows that MidCentral Health has been relatively consistent in at least meeting, if not exceeding, the national target since October 2014, as shown below.

(Baseline 71.2 percent for the 12 months to December 2012)

	2014		2015				2016
	July - September	October - December	January - March	April - June	July - September	October - December	January - March *
Number of acute stroke patients	57	58	55	39	51	62	54
Number admitted to Acute Stroke Unit	38	49	46	33	42	53	42
Percentage admitted to Acute Stroke Unit	67%	84%	84%	85%	82%	85%	78% *

* Note: provisional results for 01 January to 31 March 2016 only – coding of all discharged records not yet complete – the final result is expected to be at least 80 percent.

The majority of acute stroke patients who were not admitted to the Acute Stroke Unit (ASU) in any quarter were 'ineligible' because of other clinical priorities for principal condition of concern requiring treatment and care elsewhere, such as coronary care unit, orthopaedic, other surgical, oncology, palliative care, enteric isolation or dementia. A number of patients admitted to Medical Assessment and Planning Unit (MAPU) with a transient ischaemic attack (TIA) also received acute stroke care services and then were discharged home without the need for admission to Ward 26 (or the ASU) for a longer inpatient stay.

The Clinical Nurse Specialist for the Acute Stroke Service advises that of those patients referred to the service who were eligible for admission to the ASU, the majority were admitted to the dedicated beds, or to Ward 26 but not one of the four beds (ASU beds are co-located in one room at the end of Ward 26) during the four months to end March 2016. The rationale for bed allocation also considers the continuity of nursing care across shifts, which may mean that on occasion a patient remains on Ward 26 rather than move to a "dedicated

stroke bed". Regardless of location, the specialist stroke service physicians, therapy and nursing team continued to assess all stroke patients referred and guide their treatment pathway accordingly. They did not consider that the temporary reduction in beds had a direct impact on the provision of the organised stroke service to patients over this period.

3 LOCAL MATTERS

3.1 Health of Older Person

3.1.1 Aged Residential Care Falls Programme

The annual plan each year includes an initiative around falls and falls education on the basis that this is a worthy investment where inroads are relatively easily attained. The challenge is to keep the project fresh with new and innovative ideas in order that providers, their staff, and resident's families continue to prioritise this as good practice.

All 36 aged residential care facilities have had targeted visits by DHB staff providing support on resources, messaging, frameworks and innovations to assist with falls prevention. Feedback via aged residential care audits continues to demonstrate that work is occurring in this area. A provider recently audited received no corrective actions and attained two positive continuous improvements specifically around falls and pressure areas. The falls feedback is illustrated here:

> "*...Through proactive falls prevention goals, including vitamin D plan for 90 per cent of residents, compulsory in-service education on manual handling, colour coding system on resident files to identify the high falls risk residents, walkie-talkies purchased to communicate between care staff not having to leave the resident unattended, care staff knowing the mobilising routine of the high risk residents, utilising a system of elimination for reason of falls, i.e. delirium, nurse manager takes lunch/morning tea later or earlier before care staff go on breaks to ensure assistance is always available, ensuring correct equipment is available and maintaining a safe environment, appropriate InterRAI assessments to identify falls as primary instead of secondary.*
>
> *Progress toward the achievement of these goals was communicated at resident and staff meetings and updates placed on site notice boards. Corrective action plans were reviewed monthly at staff meetings and the monthly indicator data was analysed and discussed. The service has successfully reduced all falls over a period from August 2014 to December 2015. Falls without injury statistics for August 2014 were at 6.82 and in December 2015 were at 4.76. Falls with injury for August 2014 were at 3.32 and in December 2015 were at 1.83. This was a positive result for the service and continues as a remaining goal for 2016.*"

3.2 Maori Health

The Pae Ora – Maori Health Directorate recently welcomed Dr Janine Stevens to the role of Public Health Physician – Maori Health Practice Leader. New members of the Pae Ora team have been orientating to their new roles and functions. This has included meeting and introducing the Pae Ora – Maori Directorate to the Maori Provider network across the district.

The Draft of the Maori Health Plan 16/17 was submitted to the MOH in partnership with the MidCentral DHB Annual Plan 16/17.

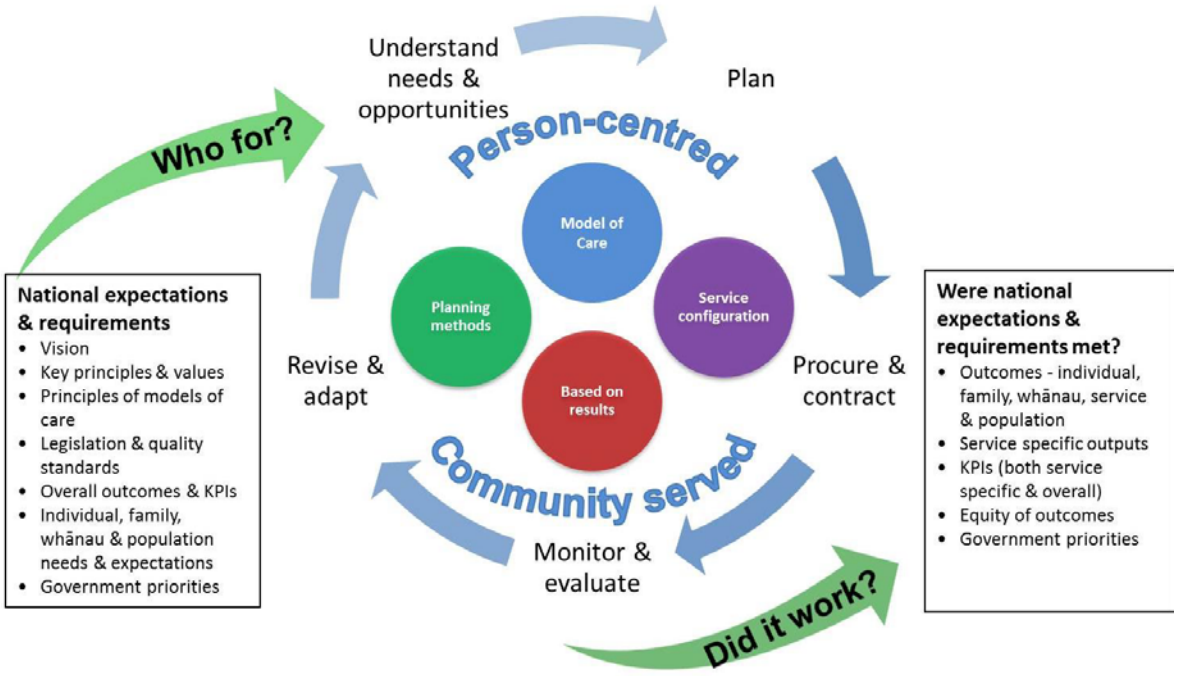
Work has commenced on developing a Maori Quality and Service Improvement Plan that will sit in partnership with MidCentral DHB Quality Plan. Concurrently we are developing a

Maori Workforce Development Plan that seeks to complement national, regional, and local workforce initiatives for both the Maori workforce and the cultural responsiveness and cultural competence of the non-Maori workforce

3.3 Mental Health and Addictions

3.3.1 Commissioning Framework, Ministry of Health

The Ministry has been working with DHBs on development of a new commissioning framework for Mental Health and Addiction Services. This is a specific action arising from *Rising to the Challenge* (2012). The new framework involves an outcomes focused approach and will shift focus from 'how' services are provided to outcomes that make a real difference for people.



The Commissioning Framework is closely connected to the development of the National Population Outcomes Framework and associated measures – including the review and refinement of existing measures. Both of these frameworks are expected to be available for use from July 2016.

The Commissioning Framework provides guidance and direction for those who are responsible for commissioning care to improve outcomes for mental health and addiction. It pulls together relevant information from a range of sources to ensure that an outcome-focused approach is supported by the national infrastructure and contracting systems. It will be applied to publicly funded mental health and addiction care including health promotion, primary, specialist, and NGOs.

The framework:

- identifies the parts of the current system that need to be more flexible and which parts need to be tightened
- addresses the three components of the Triple Aim
- demonstrates the need to continually revise and adapt approaches to ensure responsiveness to changing population need.

Currently work is underway locally with a mental health and addictions NGO to develop an outcomes-based approach which might be used across all contracted DHB service lines.

3.4 Primary Health

3.4.1 An IFHC for South-Western Palmerston North

The health service needs of the community residing in the south-western suburbs of Palmerston North (including Highbury, Takaro, Cloverlea, and West End) have been the subject of interest for the DHB and Central PHO for some time. Specific thought around what health services the community wants and needs, and how better access to health services might be provided, culminated in 2015 in a community profile and needs assessment being undertaken. This work identified that there is a need and also widespread interest amongst the community and health providers, in having better access to more formalised health services that are tailored to Palmerston North's south-western community.

Subsequent to this initial work, Central PHO has been working with two parties that have expressed interest in providing health services to the south-western community. In addition, MidCentral DHB has included in its draft annual plan for 2016/17, provision for work to be continued on developing such services.

We know from experience that the development of IFHC-type services in a community is a lengthy process; to approach this work with a short timeframe in mind is to risk developing services that are not fit for purpose, do not deliver the potential health gains, or which are not underpinned by the strength of relationships required to make these projects sustainable in the medium and long term.

As such, a long term plan for the development of health services to meet the needs of Palmerston North's south-western community is required. MidCentral DHB will work with Central PHO on this plan, which will be brought to the Committee at a later date.

3.4.2 Zero Fees for Under 13s

From 1 July 2015, in line with Government policy announced in Budget 2014, all MidCentral general practices began providing zero-fee visits for children under 13. This was an extension to the existing zero-fee visits for children under six.

The zero-fees for children under 13 scheme is designed to improve access to healthcare for primary and intermediate school children, ensuring they can get the care they need when they need it and avoid possible complications and visits to hospital A&E departments.

Additional funding was provided by the Ministry to facilitate the removal of after hours fees for this age group, thus ensuring improved access. All MidCentral after hours general practice providers opted into this scheme. The level of funding for each provider was based on their historical service volumes, with some allowance for growth based on our experience with the free under sixes arrangement.

In the first six months of the scheme, after hours general practice providers experienced a doubling of after hours and casual consultations for children age 6 to 12 when compared with the same six months in the previous year. Smaller consultation rate increases were also noted in this age group for within hours enrolled patients, and for children aged 0 to 5 years. The level of increase means service volumes are well in excess of the level contracted, which will require adjustment through the wash-up mechanism. This will have a financial impact on the DHB, and is being provided for.

The increase for MidCentral general practices is not unique in that all DHBs have seen increases in primary care utilisation by children aged 6 to 12 years. However, the MidCentral district has seen one of the largest increases for this age group nationally.

Central PHO reports that increases in general practice consultation rates and after hours consultation rates are not confined to the under 13's age group, but are occurring across a range of age groups. There is significant pressure on general practice in general, and more specifically, on after hours providers. This is similar to the pattern being experienced by MidCentral Health through the Emergency Department and in the inpatient wards. There is an increasingly coordinated response to urgent care services, although there is still some way to go. At present there is a joint initiative on 'winter planning' which includes both hospital community services. At a future date we expect to provide a fuller report on urgent care demand over the 2015/16 year.

3.4.3 Whānau Triathlon

This year's whānau triathlon was held in near ideal conditions on Sunday March 20th. A change of finish line location to Ongley park enabled sponsors and stall holders to create a village-like atmosphere for participants on crossing the finish line. Healthy food options were provided, along with lots of preventative health care messaging from organisations such as the Cancer Society, Heart Foundation, Te Tihi, and the Manawatu, Horowhenua, Tararua Diabetes Trust.

While a full analysis is not yet available, event participants totalled 776, nearly a third of who (244) had been through the ten week preparation programme run by Sport Manawatu and funded by MidCentral DHB. A full analysis of objective measures of the impact of the programme (changes in body weight, BMI, and total cholesterol) is yet to come. However, results over the course of the programme for a randomly selected sample of ten programme participants shows an average reduction in body weight of 3.4 kilograms and an average reduction in BMI of 1.2kg/m^2, while on average, no change in total cholesterol was noted.

A full analysis is currently being collated by Sport Manawatu, a summary of which will be reported to the Committee at a later date.

3.4.4 Community Pharmacy Consultation on Drug Margins

At the time of writing, DHBs are consulting with community pharmacies on a proposal to adjust how margins on pharmaceuticals are paid. The margin component of what DHBs pay pharmacies is considered to be a contribution towards the pharmacy's costs of stockholding and stock management.

The current reimbursement model is:

- the subsidised cost plus four percent for medicines with a subsidised cost of less than $150 per pack, and
- the subsidised cost plus five percent for medicines with a subsidised cost of $150 or more per pack.

PHARMAC's success at reducing the subsidised cost of medicines has resulted in the current margin methodology no longer being fit for purpose for both providers and DHBs.

From a provider viewpoint, lower medicines prices results in reduced margins funding for community pharmacies. PHARMAC has been very successful in obtaining very low prices for medicines, which has been highlighted when subsidies for some frequently used medicines reduced considerably once patent protection was removed.

From a DHB perspective, analysis of current margins funding paid to pharmacies nationally has shown that a small number of pharmacies that dispense a relatively large amount of expensive medicines do much better out of margins funding than the majority of pharmacies that dispense mainly low cost medicines. Further, many pharmacies report that

reimbursement for inexpensive medicines dispensed is less than the cost of procuring them because the margin applied by the pharmaceutical wholesaler is in the order of 10 percent.

A national taskforce involving representatives from DHBs, the pharmacy sector, the Ministry of Health, with input from pharmaceutical wholesalers and PHARMAC, has designed a hybrid model involving a percentage margin plus a set fee per pack dispensed, as an interim solution to the current inequitable system. This is modelled to be more equitable by reducing the margin funding paid to the small number of pharmacies that dispense a relatively large amount of expensive medicines, and increasing the margin funding paid to the majority of pharmacies that dispense mainly low cost medicines.

It is also modelled to afford pharmacies some protection against large reductions in medicines prices that PHARMAC may secure in future.

It is the acceptability of this model that is being consulted on at present.

Early indications from limited consultation feedback are that pharmacists consider the solution to the margins problem is simply for DHBs to provide more funding. Besides being of questionable affordability to DHBs, it is unlikely that additional funding will resolve the issue, as it is unlikely to reduce inequitable funding and pharmaceutical wholesalers may well adjust the margins they charge pharmacies in response to any additional funding introduced into the supply chain by DHBs.

At a local level, there is only one MidCentral provider modelled to receive reduced margins funding should the proposal proceed. All other pharmacies in the district for which we have data, are modelled to do the same or better as in recent years, under the proposed methodology and using current modelling.

3.4.5 Fluoridation

On 12 April 2016 Health Minister Jonathan Coleman and Associate Health Minister Peter Dunne announced proposed legislative changes to give DHBs, rather than local authorities, responsibility for deciding on the fluoridation of water supplies within their areas. Under the proposed change, DHBs will:

- assess the oral health of its communities and the water supplies serving its population
- consider the scientific evidence about the benefits and risks of fluoridation of community water supplies to the relevant levels
- decide whether specific water supplies in its community should be fluoridated, and
- if appropriate, direct water suppliers to fluoridate community water supplies.

Local authorities will continue to be responsible for supplying drinking water. A local authority would be required to fluoridate a water supply if it is directed to do so by the DHB. It would also not be able to stop fluoridation unless the DHB directed it to. Local authorities would continue to be responsible for the costs of fluoridating community water supplies.

Although New Zealand's oral health outcomes have improved dramatically over the last 30 to 40 years, we still have high rates of preventable tooth decay. Water fluoridation has been endorsed by the World Health Organization and other international and national health and scientific experts as the most effective public health measure for the prevention of dental decay.

About 2.3 million New Zealanders currently have access to fluoridated water. Those who do not have access to fluoridated water miss out on the significant health benefits provided by fluoridation.

The new decision-making process will provide the opportunity to significantly increase the numbers of New Zealanders who have access to fluoridated water. This would occur if DHBs were to decide there should be an increase in the number of community water suppliers that supply fluoridated water. There are currently 1.45 million New Zealanders who live in places where networked community water supplies are currently not fluoridated.

The findings of a recent report by the Sapere Research Group indicated that for people living in areas with fluoridated drinking-water there is a:

- 40 percent lower lifetime incidence of tooth decay among children and adolescents
- 48 percent reduction in hospital admissions for the treatment of tooth decay among children aged 0 to 4 years
- 21 percent reduction in tooth decay among adults aged 18 to 44 years
- 30 per cent reduction in tooth decay among adults aged 45 years and over.

In addition to the savings in dental costs for both the health system and the public, there will be an overall positive impact on people's general health, fewer days lost at school or work and reduced pain and suffering.

It is anticipated that a Bill will be developed for initial consideration by Parliament by the end of 2016. If passed before the end of the Parliamentary term in 2017 it is likely that legislation would come into force from mid-2018.

3.5 Child & Youth Health

3.5.1 Well Child Tamariki Ora Quality Improvement Update

The Well Child Tamariki Ora (WCTO) Quality Improvement Project evolved out of an identified need by the Ministry of Health's WCTO Expert Advisory Group to support a regional approach to quality improvement. The Ministry of Health has supported DHBs nationally by the appointment of quality improvement project managers. The six Lower North Island DHBs that make up the Central Region agreed that this work should be supported and co-ordinated by a project manager appointed by Central TAS on behalf of the Region. MidCentral DHB's Portfolio Manager was involved in the recruitment process.

The project, which is scheduled to end on 30 June 2017, is expected to support the use of quality improvement tools, build regional relationships and information sharing opportunities to support quality improvement across the wider WCTO sector and deliver quality improvement training where appropriate. Importantly, the programme of work needs to incorporate sustainable benefits that outlive the life of the project.

In developing this regional quality improvement plan, stakeholders have acknowledged and agreed that children are our taonga; investment in the first 1000 days of a child's life is critical in setting them on a path to future health, social, educational and economic success.

The project has a mandate to work with the sector to seek ways to improve the health and social outcomes for all children. However, it is recognised that vulnerable children and their families/whānau have disparate outcomes across a range of health, social and economic indicators.

The Regional Priorities that have been identified are:

Regional Priority 1
Objective: Understand the vulnerability of the population WCTO providers serve using the Vulnerability Assessment Tool to enable WCTO providers and the project

	steering committee to identify high performing WCTO teams in the context of the characteristics of their population and target continuous quality improvement (CQI) initiatives appropriately.
Regional Priority 2	
Objective:	Children and their whānau/family will experience a seamless transition into a WCTO provider within six weeks of birth (or earlier for identified vulnerable families) and from WCTO providers to other services when an identified need arises. Seamless transition is assessed against recommended best practice service coordination guidelines.
Regional Priority 3	
Objective:	WCTO providers will have a model of consistent service provision that considers the model of service delivery, vulnerability of the population and resourcing so that they can provide the best possible service to children, families, and whānau.

In addition to the Regional Priorities above, MidCentral identified three additional areas that required quality improvement:

- Improve the quality of referrals from LMCs to WCTO providers
- Increase newborn enrolment with general practice
- Improve breastfeeding rates at six weeks of age

Each focus area has a work stream that is using quality improvement methodology to work towards the improvements required and these will be reported to the committee regularly.

The opportunity to share learning's and resources across the central region and across providers from multi disciplinary settings has been very beneficial across the central region. The willingness to provide quality services by sharing and not duplicating has provided a climate that encourages a "can do attitude" across the sector. This is clearly a very useful Ministry of Health initiative, which has been enhanced by an excellent project manager sitting at TAS.

3.5.2 Primary Birthing Unit

Initiative 18 of the MidCentral DHB Annual Plan for 2015/16 is to increase birthing options for women in Palmerston North. Actions associated with this initiative include exploring the feasibility of a primary birthing unit for Palmerston North.

Subsequent to the publication of the 2015/16 Annual Plan, MidCentral DHB was approached by a private organisation that intended to build a primary birthing unit in Palmerston North. DHB management has kept abreast of the developments of this process.

Recently, the Chief Executive and GM Strategy, Planning, and Performance met with the CEO of the company developing the Palmerston North private birthing unit. Demolition is underway on the site in Ruahine Street, and construction is expected to start soon. The provider is anticipating the new facility will be operational early in 2017.

The importance of linkages with Women's Health was emphasised, as were relationships with independent local LMCs. The provider acknowledged that to date the latter had not occurred, but that they expect to focus on this as building proceeds.

4 ANNUAL PLAN: PROFILE OF INITIATIVE/S

4.1 Community Probation Services and Alcohol and Drug Services initiative

Addressing the Drivers of Crime is a whole of government priority involving justice and social sector agencies working together to reduce offending and victimisation through

innovation, prevention early intervention, and rehabilitation initiatives. The collaborative service consists of four Alcohol and Drug NGO providers that were successful in the tender for services at the end of 2014. The service is very specific and increases access to alcohol and other drug (AOD) treatment for community-based offenders with AOD problems. The service focus is:

- working inter-sectorally across government agencies, especially Corrections Services
- working across the continuum of health service providers: specialist, primary, community
- providing service coverage in both rural and urban localities
- giving particular emphasis to offenders who identify as Māori plus work with their whānau, hapū, and iwi
- working with youth offenders and with their support communities.

The service is a single point of entry access pathway for people with AOD problems who offend and can be triaged and referred to the most appropriate service. The single point of entry consists of four providers: MASH Trust, Te Runanga o Raukawa (Horowhenua) Rangitane Tamaki Nui A Rua (Dannevirke) and Mana o te Tangata Trust which coordinates the three AOD services.

The timing of people who offend gaining access is critical as most will be sentenced to a compulsory community based treatment programme by a Court Judge. Any unreasonable delay or non attendance could be deemed to be a breach of their probation conditions. However, the AOD services collaboration has been operational for two years and has seen referrals actioned much quicker than has historically been the case. A total of 1,041 offenders have been seen by the single point of entry service, Toitu te Ora. The service has seen an unprecedented degree of collaboration between the provider organisations, and with justice, Community Probation Services in the MidCentral district.

5 PALMERSTON NORTH SITE RECONFIGURATION UPDATE

Work on the Master Health Service Plan is about to re-commence. We intend to commission Sapere to refresh the indicative business case. As this work is not yet underway, it is too early to provide a progress report as scheduled.

TO Community and Public Health Advisory Committee

FROM Finance Manager
Funding and Planning

DATE 12 April 2016

Memorandum

SUBJECT **FINANCE REPORT – RESULT OF 31 MARCH 2016**

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 31 March 2016 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 incorporates the additional $1 million of revenue from the Ministry of Health (as notified in July 2015) and the consequential $1 million improvement in the Annual Plan's bottom line result.

4.2 Result for 31 March 2016

The Funder's Year to Date (YTD) result to 31 March 2016 is a surplus of $519k over budget. Substantively this has resulted from a revision of provisions for committed expenditure and our progression through the financial year.

4.3 MidCentral Health washup

The Funder is paying an extra $1,770k to MidCentral Health as an YTD washup for IDF Cancer Patients. The Funder has accrued an extra $1,770k IDF inflow income as this is expected to be reimbursed from other DHB's. This has no financial impact on the Funder's result.

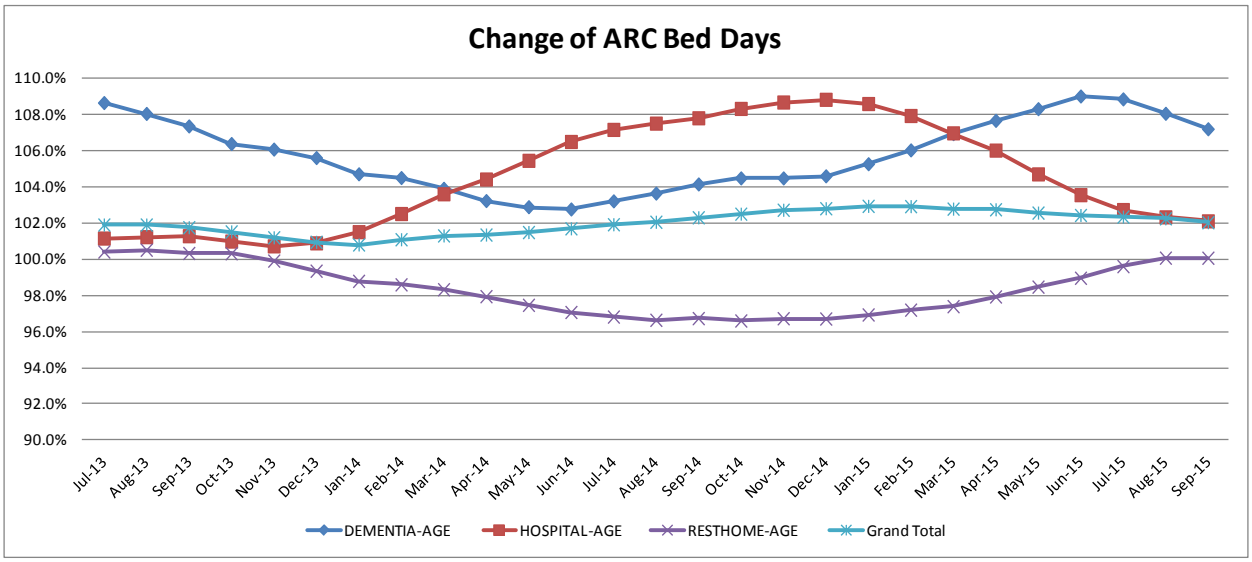
4.4 Elective Income

The Funder has accrued elective income as per the elective initiatives budget and this will be adjusted in subsequent months based on actual activity. We monitoring the progress of this target with Hospital Services directly each month.

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 101 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 whereas the Rest Home bed days dropped by 0.3 percent. Overall bed days grew at 2 percent. We have been successful in recently gaining access to this information and will have an update of this graph in the next report.

5. FUNDER FINANCIAL PERFORMANCE

The Funder's 31 March 2016 YTD result is $519k 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 March 2016		Actual	Budget	Variance	Forecast	Budget	Variance
		$000	$000	$000	$000	$000	$000
Personal Health Income	(a)	305,823	299,479	6,344	403,020	400,317	2,703
Personal Health Expenditure	(b)	304,328	298,388	5,940	401,097	398,305	2,792
Personal Health Surplus/(Deficit)		1,496	1,091	404	1,923	2,012	-89
Mental Health Income	(a)	30,617	30,237	380	40,842	40,316	526
Mental Health Expenditure	(b)	30,470	30,247	223	40,842	40,316	526
Mental Health Surplus/(Deficit)		147	-10	157	0	0	0
Disability Support Income		61,117	61,009	107	81,346	81,346	0
Disability Support Expenditure		61,543	61,035	508	81,707	81,346	361
Disability Support Surplus/(Deficit)		-427	-26	-401	-361	0	-361
Maori Health Income		1,505	1,505	0	2,007	2,007	0
Maori Health Expenditure		946	1,505	-559	1,557	2,007	-450
Maori Health Surplus/(Deficit)		559	0	559	450	0	450
Governance Income		1,842	1,842	0	2,456	2,456	0
Governance Expenditure		2,042	1,842	200	2,456	2,456	0
Governance Surplus/(Deficit)		-200	0	-200	0	0	0
Total Funder Surplus/(Deficit)		1,575	1,056	519	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							