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Contact Details Committee Secretary
Telephone 06-3508626
Facsimile 06-3508926

Next Meeting Date 3 May 2011
Deadline for Agenda Items 20 April 2011

MidCentral District Health Board

A g e n d a

Community & Public Health Advisory Committee

Part 1

Date: 5 April 2011

Time: 1.00 pm

Place: Board Room
Board Office
Gate 2
Heretaunga Street
Palmerston North

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Tuesday 5 April 2011

Part 1

Order

1. **APOLOGIES:** Diane Anderson

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:	4.1 – 4.6
Documentation:	minutes of 1 March 2011
Recommendation:	that the minutes of the previous meeting held on 1 March 2011 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 1 March 2011 for which specific items do not appear on the agenda or in management reports.

5. **OPERATIONAL REPORTS**

5.1 **Cardiology Landscape Review**

Pages:	5.1 - 5.3 PLUS Cardiology Landscape Review document
Documentation:	General Manager, Funding's report dated 23 March 2011
Recommendation:	that this report be received.

5.2 Funding Division Operating Report – March 2011

Pages: 5.4 - 5.14
Documentation: Funding General Manager Manager's report dated 23 March 2011
Recommendation: that this report be received.

5.3 Finance Report

Pages: 5.15 - 5.20
Documentation: Finance Manager's report dated 11 March 2011
Recommendation: that this report be received.

6. GOVERNANCE

6.1 Committee's Work Programme 2010/11

Pages: 6.1 – 6.4
Documentation: Chief Executive Officer's report dated 28 March 2011
Recommendation: that the updated work programme for 2010/11 be noted.

7. LATE ITEMS

8. DATE OF NEXT MEETING

3 May 2011

9. 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 folloowing items for the reasons stated:

Item	Reason	Reference
"In Committee" Minutes of the Previous Meeting	For reasons stated in the previous agenda	
2011/12 District Annual Plan	Under negotiation	9(2)(j)
Funding Division Operating Report: Well Child Framework Contract	Subject of negotiation	9(2)(j)

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Minutes of meeting held on Tuesday, 1 March 2011 at 1.00 pm in the Boardroom of Board Office, Gate 2 Heretaunga Street, Palmerston North

PRESENT:

Diane Anderson (Chair)
Ann Chapman (Deputy Chair)
Linda Gray
Pat Kelly
Mavis Mullins
Karen Naylor
Phil Sunderland
Charmaine Hamilton
Oriana Paewai

IN ATTENDANCE:

Murray Georgel, Chief Executive Officer
Mike Grant, General Manager, Funding Division
Carole Chisholm, Committee Secretary
Lindsay Burnell (part)

OTHER:

Staff: (7)
Public: (1)
Media: (0)

Following the Chair's request for an update concerning the Christchurch earthquake, the Chief Executive Officer advised that because of the need to channel all information from one place, the National Health Coordination Centre was coordinating all communications and requests, outgoing correspondence and other such matters and disseminating the information across the country. Following the event other DHBs closer to Canterbury had immediately responded by ceasing surgery, so as to free up as many beds as possible. It was understood that some non infectious patients, such as those on renal dialysis, were transferred to Auckland. Approximately 300 elderly people were requiring relocation around the country. MidCentral DHB's response had been to get back as many patients as possible from Capital & Coast DHB including neonates. Some staff were sent to Christchurch at their request but overall the Board was taking its guidance from the National Health Coordination Centre.

1. APOLOGIES

Mavis Mullins (late).

2. NOTIFICATION OF LATE ITEMS

There were no late items.

4.2

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendment to the Register of Interests

There were no amendments.

3.2 Declaration of Conflicts in Relation to Today's Business

Linda "Gray declared a conflict in relation to the 'Primary Health Care DAP 10/11 Update' page 5.5 para 4.1.2 'Feilding Integrated Health Centre'.

4. MINUTES

4.1 Minutes

It was recommended:

> *that the minutes of the previous meeting held on 1 February 2011 be confirmed as a true and correct received.*

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 the February Board meeting at which the recommendations of the 1 February draft minutes of this committee were approved. A member of the public had referred to page 4.3, Item 2.7.1 'Poverty Affecting Health of Children in our Region' and expressed concern over the statement: 'The DHB needed to be aware that more people, particularly children, were being admitted to hospital with respiratory illnesses and infections due to the recessionary times'. The Board had subsequently commented that although 'due to' was not causative, the recording was accurate and the minutes were a true and correct record.

5. STRATEGIC/SPECIAL ISSUES

5.1 Primary Health Care (DAP 2010/11) – Update 2

Linda Gray's conflict of interest in relation to the Feilding Integrated Health Centre was noted.

The development of integrated family health centres aimed to enable the better management of patients in primary health care rather than through the Emergency Department. Following an enquiry as to whether at this early stage any progress had been made, management advised there had been a considerable flattening out in terms of the admissions of internal medicine patients at MidCentral Health. A great deal of work was being undertaken in primary care and that was possibly causing a change in patterns. It was also noted that a further enhancement would be clinic space for specialists and GPs to work together.

Following an enquiry around Chronic Care Teams, management noted that these were still very active within the PHO environment. However the transition to a broad scope of practice predicted that over the next 12 – 18 months chronic care nurses would be managing diabetes and cardiology patients.

It was recommended:

that this report be received

5.2 centralAlliance – Implementation of Funding Workstream

Management referred to Para 4.2 'General Practice Capacity Waiting Lists' and advised that this subject had been a feature of discussion earlier in the day at the Hospital Advisory Committee meeting. In the Horowhenua, a Waiting List Practice was picking up the people who had not been able to get access to first level service. The Waiting List Practice was essentially nurse practitioner driven with oversight by the Medical Practitioner/Clinical Director for Primary Health Care in the Horowhenua. Access to other practitioner support was also available. The service commenced in February and had quickly got up to speed.

Mavis Mullins entered the meeting.

A Committee Member referred to the 800 people who had not responded to the invitation to enrol and questioned the existence of a process to identify those people. A further query was made around any risk factor involved in the non enrolment of a section of the community.

Management advised there had been a number of attempts to contact those not enrolled. As people needed to access health care they would come forward and be plugged into the Waiting List Practice. It was considered that no risk existed.

Management referred to 'GP Consult Rates by Age Band and Ethnicity' and noted that the commentary for Table 2 on page 5.9 contained an error which made for confusion. The commentary should have read: "Table 2 also shows that the European ethnic group had the highest overall consultation rates". The paragraph then went on to explain that while on the face of it this appeared to suggest high needs people received the least services, this was not the case. A more detailed analysis showed that High Needs patients, defined as Maori, Pacific and people living in decile 9 and 10, had higher service utilisation rates.

A Committee Member drew attention to Financial and Risk Considerations on page 5.16 and noted the very important part NGOs played in the community. However, one of the difficulties these organisations experienced was their short term contracts.

Management advised that short term contracts were difficult for both providers and funders. The funder bore transaction costs while the provider had reduced financial certainty and sustainability. At present the Board was trying, where possible, to achieve a three year agreement with providers. It was also noted that in general provider contracts tenure were related to performance risk.

The question was also raised around the responsibility for informing NGOs in Primary Health of what was taking place in the community. Management confirmed that various organisations were responsible for different components. The Regional Services Plan was the DHB's responsibility. The Better Sooner More Convenient project rested with the Ministry of Health and Central PHO. Local Priorities were generally part of the DHB's annual plan, and providers received that document. All the information received by the Board and Committees as well as that provided to the Ministry was available on the website. Following discussion management considered the overall responsibility lay with the DHB.

A Committee Member referred to No 3.4 of the Schedule of Primary Health Care Initiatives 'Improved Access and Utilisation of Health Services Amongst Whanau' and enquired of any progress. Management advised that many of the issues were related to the Better Sooner More Convenient Project. More information would be provided in the next Primary Care update.

Lindsay Burnell entered the meeting.

4.4

In response to an enquiry around Initiative 3.5 'Improved Models of Care for Older People, including Case Management for People with High and Complex Needs' and the spread of establishment dates, management confirmed that this was partly related to project management resource. The project had started in Tararua and was ongoing.

In noting that Primary Health Care Services were a Centre of Excellence for the DHB, and had led the way over recent years, the Chair conveyed the Committees congratulations and thanks to the staff involved in this achievement.

It was recommended:

that this report be received.

5.3 Improved Local and Regional Coordination of Services Update

It was recommended:

that this report be received.

5.4 Improved Hospital Productivity

The Chief Executive Officer noted that the report included a number of aspects being looked at, together with improvements and efficiencies. These were not just confined to Health Targets but included shared clinical services and primary care.

In response to the Chair's enquiry around para 5.3.8 'Theatre Productivity' and whether there was any national agreement as to what constituted a late start or early finish, management confirmed that there was a definition and it was very fine.

It was recommended:

that this report be received.

6. OPERATIONAL REPORTS

6.1 Non Financial Performance Indicators

It was recommended:

that this report be received.

6.2 Funding Division Operating Report – February 2011

Item 2.4.1 GP Registrars Update
Management confirmed that the Board had five GP Registrars under the Pilot Scheme and one outside. All applicants had been interviewed by a panel including two General Practitioners and a hospital consultant who was involved with registrar training. The five Registrars were all of high calibre and it was hoped that they would make a significant contribution to the district.

The five GP Registrars were employed on packages based on the DHB's internal Multi Employer Collective Agreement (MECA). However, it was pointed out that hospital registrars received a great deal of overtime whereas at the present time GP Registrars did not. Some fine tuning of arrangements may be required to make the GP training programme attractive.

It was understood that a number of the Registrars would not have undertaken GP training at this stage if it had not been for the Pilot Scheme. This was an indication that it was fulfilling its intended function of making GP training more attractive.

A critical factor in attracting doctors to the GP training programme in this district appeared to be prior familiarity with the general practice teams. In the last year the DHB had funded junior doctor rotations through general practices. Some of the GP Registrars had been on this rotation. Other DHBs had taken this a step further by having the GP training programme overseen by a GP who was working in the main hospital. An example was given as the GP Liaison officer. This enabled a more personal and direct approach to junior doctors working in the hospital. The Funding Division was currently talking with MidCentral Health about whether this role could be included within the scope of the GP Liaison role.

The future of the GP Registrar Pilot Scheme was being reviewed by the Health Workforce Council at a national level. MidCentral DHB had put its views forward already and would continue to do so. The Board would like to see the scheme continue so that the five individuals currently doing Year 1 can be retained and supplemented with another intake of students. At the same time, it was hoped that some of the difficulties with the current scheme would be ironed out.

Item 2.7.2 Safe and Efficient Disposal of Unused Medicines (SEDUM)
Management provided an update on the work of the Manawatu Community Pharmacy Group. The Committee endorsed the collaborative work between the Group, Primary Health Care and the Funding Division.

It was recommended:

that this report be received.

6.3 Finance Report – February 2011

It was recommended:

that this report be received.

GOVERNANCE ISSUES

7.1 Work Plan

It was recommended:

that the updated work programme for 2010/11 be noted.

8. LATE ITEMS

There were no late items under 2 above.

9. DATE OF NEXT MEETING

Tuesday, 5 April 2011. Diane Anderson noted her apologies for this meeting.

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 reason stated.

4.6

Item	*Reason*	*Ref*
"In Committee" Minutes of the Previous Meeting	For reasons stated in the previous Agenda	
2011/12 District Annual Plan	Under negotiation	9(2)(j)

The meeting closed at 2.10pm.

Confirmed this 5th day of April 2011

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Chairperson

TO Community and Public Health Advisory Committee
Hospital Advisory Committee

FROM Mike Grant
General Manager, Funding

DATE 23 March 2011

SUBJECT **Cardiology Landscape Report**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

Purpose

The purpose of the Cardiology Landscape project was to complete an assessment of cardiology service provision across MDHB and deliver a report for internal planning, funding and investing purposes.

Summary

The landscape project identified that the issues for cardiology services are significant and lie across the continuum. The major finding was that improvement in cardiology outcomes is less than that being achieved nationally – MDHB is an outlier.

Resources alone will not improve outcomes and new ways of working will be crucial. It is important that the proposed investment is made within a framework of clinical governance to ensure an integrated practice model of care, that the service providers work together to ensure that resources are targeted appropriately and that the effectiveness of service provision is evaluated.

Recommendation

It is recommended:

that this report be received.

COPY TO:

Corporate Services
Heretaunga Street
P O Box 2056
Palmerston North
Phone +64(6) 350 8912
Fax +64(6) 355 0616

The purpose of the Cardiology Landscape review was to complete an assessment in response to concerns raised internally and also regionally and nationally that the level of cardiology service provision at MidCentral Health might be inadequate. Intervention rates for cardiology procedures and cardiac surgery are monitored nationally and it was pointed out that these had been low over time and needed to be raised.

Improving cardiovascular health has been given a high priority regionally and nationally recognising that cardiovascular disease is responsible for the most deaths / highest health burden nationally. There are also significant health disparities in health outcomes. The Central Region Cardiac Network was formed in 2007 and the National Cardiac Surgery Network in 2009 to lead service improvements in these areas.

Recognising that interventions occur at the end of the patient pathway, MDHB commissioned a continuum wide assessment of cardiology service provision and related health outcomes across the district. The assessment used approaches developed nationally (MoH led Diabetes and Cardiovascular Quality Improvement Plan) and regionally (Key Performance Indicators published by the Central Region Cardiac Network). This was supplemented with the views of service providers and stakeholders.

The project was undertaken between October 2010 and January 2011. The Project Sponsor was Mike Grant, GM Funding and Corporate Services and oversight was provided by a steering group made up of primary and secondary service clinicians and managers. Dr Mark Beale, Clinical Leader Internal Medicine chaired the group. Dr Mark Simmonds, Head of the Cardiology Department at Capital & Coast DHB and regional Clinical Director of Cardiology received all project information.

About 50 stakeholders across the district were interviewed during the project and many others provided information, most notably other DHBs and the Ministry of Health. Examination of data and analysis was a significant part of the project involving multiple data sources and organisations.

The draft report was received by the steering group early February 2011 and circulated to a group of stakeholders on 16 February with a two week feedback period comment. One response was received. The response emphasised the importance of timeframes for action, regional service provision and ensuring services are functioning better before considering the introduction of PCI.

Solutions require significant investment into planning, people and infrastructure. The MidCentral Health cardiology service in particular has not been developed and the size of the department and the facilities are less than adequate for service provision. This affects the ability to attract specialist staff and achieve the critical mass necessary to provide services at an appropriate level. This was also a finding in previous reviews.

Providing services regionally, particularly for the Whanganui population is strongly promoted by the regional Cardiac Network. This will be possible once the capacity at MidCentral Health is increased. As well as providing benefits for Whanganui such as better support for physicians and providing services closer to home, this will also improve cath lab utilisation and cost effectiveness.

5.3

At a high level, MidCentral will need to invest $1.2m per annum to upgrade the Cardiology Service in line with the recommendations. Management has provided for this increase in the 2011/12 financial year effective from the fourth quarter. The full impact of the investment will occur in the 2012/13 financial year. Management has not included the inter district flow (IDF) revenue/expense in the financial modelling. In the short to medium term the IDF situation should improve the financial situation. This will be achieved by an increase in revenue from Whanganui and a reduction in outflows to Capital and Coast. Once the new service is bedded in, management will update the Committee on the opportunities to improve the financial viability through the IDF changes.

Mike Grant
General Manager, Funding

TO Community and Public Health Advisory Committee

FROM General Manager
Funding Division

DATE 23 March 2011

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Memorandum

SUBJECT **FUNDING DIVISION OPERATING REPORT – MARCH 2011**

1. RESPONSES TO COMMITTEE AND BOARD REQUESTS

Reference	Matter	Achieved	Comment
CPHAC Mtg 1 March 2011	Further information was sought on Improved Access and Utilisation of Health Services Amongst Whanau	Y	This information is provided at paragraph 2.4.3 of this report.

2. LOCAL MATTERS

2.1 Health of Older Person

2.1.1 Funding Long Term Supports for People with Chronic Health Conditions (LTS – CHC)

Responsibility for this initiative is expected to transfer to MidCentral at 1 July 2011.

In 2007 a government decision was made that District Health Boards would take over responsibility for managing funding and long term support services for people under 65 years who have chronic health conditions to DHBs. Historically this funding and service programme was known as the Interim Funding Pool and led by the Ministry of Health.

Much planning and discussion has been necessary in subsequent years after DHBs expressed concerns that they may be accepting responsibility for a large client group with insufficient funds to meet demand. They were also concerned that the eligible client group is not clearly defined.

In 2010 Minister Ryall confirmed that devolution would go ahead and directed that DHBs adopt a regional approach. Consequently, Northern, Midland, Central and South Island regions have proposed a regional model for managing their respective budget allocations with a lead DHB in each region assuming this responsibility.

The preferred arrangement for the transition to full PBFF is for funding to be based on actual expenditure for 2011/12 and 2012/13, (with unspent funding allocated by PBFF), then move to full PBFF from 2013/14 onwards. The Ministry is also looking at alternative ways for calculating the PBFF weightings for this client group which is not evenly distributed throughout the respective DHB regions. Some smaller DHBs are likely to incur disproportionate liabilities under the standard PBFF.

The current funding work-ups indicate approximately $500, 000 deficit for Central Region.

In MidCentral, the forecast expenditure 2010/11 is $798,707. In out years this will rise to $1,119,111 if funding is allocated on a PBFF basis. The estimated financial effect on MidCentral in 2011/12 and 2012/13 is $271,739 (4.12%)

Work is also underway on developing an agreed process for Dispute Resolution. A draft for this has been prepared by MOH and further papers will follow, including a paper describing the MOH DSS 'status quo' position and an updated definition of 'close in interest' in a bid to establish common interpretations.

The role of the National Reviewer (1 FTE nationally) is under review in terms of whether this should remain in the short or long term for assistance with national consistency and/or disputes resolution.

Minimum access criteria to services will be held initially and if this is to be changed in the first 2 years following devolution, agreement will be required at a national level; after this period decisions will be made at a regional level.

2.1.2 Christchurch Earthquake sequel

MidCentral DHB has notified the National Health Coordination Centre that beds are available across the district should transfers here be necessary. So far about 6 families have made independent arrangements to move their elders up this way. Supportlinks are managing those. There have been no formal transfers under the state of emergency requirements yet.

Overall more than 500 rest home residents have been relocated since the February 22 quake. This includes 300 who have been transferred out of the region and 200 who are temporarily relocated to other facilities in and around Christchurch.

The decision to move residents from their 'home' has been a sensitive issue for families even though not a decision taken lightly. The circumstances and speed required to ensure the safety of residents meant many families couldn't be contacted prior to their loved one being moved.

Rest home beds in Christchurch remain at a premium. There are 600 fewer rest home beds today than there were before the quake. In the early days post quake many of the facilities were operating without power, running water or sewerage. Other rest homes have suffered serious structural damage and have closed some sections of their facility.

Residents who are stable have been transferred to rest homes out of Christchurch so that they will receive good quality care. Canterbury DHB is retaining some capacity locally to ensure older people being discharged from hospital, or those whose condition has deteriorated since the quake are able to be safely looked after.

Some temporary measures are not sustainable given the extent of damage to buildings and in some rest homes residents have been sharing single-size bedrooms.

In other cases storage rooms have been converted to temporary bedrooms, while others have beds in open corridor areas and set up ward-like arrangements in lounge areas.

This is not sustainable long-term and it is expected that more rest home residents will have to be moved over the coming weeks and months.

So far seven rest homes have been totally evacuated and two have been partially evacuated. Of the remaining aged residential care facilities, ten have serious infrastructure problems and seven have been totally evacuated and two partially evacuated.

2.2 Māori Health

2.2.1 Māori Health Planning

The Ministry of Health organised a planning and discussion day for Central Region Māori General Managers and Directors of Māori Health regarding the changes in Maori Health

Planning activity.

Highlighted in the Ministry of Health's Operational Performance Framework (2011) outlines the requirement for all DHBs to have a Māori health plan. The Ministry of Health is working with Bay Of Plenty DHB and Lakes DHB over 2011-2012 to refine this new approach. The key elements of the action plan are a description of activities that each DHB will perform during 2011-12 to improve Māori health outcomes. The activities described in MidCentrals plan link to the national, regional, and local Māori health indicators.

At the end of the month the GM of Funding and the members from the team will make a presentation to Manawhenua Hauora on the progress of the Māori Health Action Plan development for the Annual Plan 2011/12

2.2.2 Māori Workforce Development

Maori health workforce development is progressing well with the development of an action framework and branding. The framework will be published in poster format in April/May and the branding that has been chosen is "Kaimahi ora" – which signifies a vision of a workforce that is thriving.

A workforce development update will be provided to the board in May.

2.2.3 Māori Provider Development Scheme

Te Puna O Te Ora Māori Managers represent seven of our local iwi/Māori service providers. The funding team has worked with Maori health provider managers toward a more strategic approach to MPDS funding and provider development. The providers are currently undertaking joint training in governance and leadership to access economies of scale and facilitate enhanced collaboration.

Furthermore, of all the providers who applied for MPDS Funding in the 2010/11 calendar year only one provider has an outstanding report.

2.2.4 Māori Health Regional and National Update:

Māori Health Planning Regional

The regional Māori Health Action plan has been developed and is named Tu Ora. The aim of the plan is to facilitate synergies through the DHBs and leverage across our work programmes to achieve grater gains in Maori health outcomes. In the period the Central Regions Maori Relationship Board forum met in Hastings and received a presentation by Dr Kevin Snee Chief Executive of the Hawke's Bay District Health Board on the Regional Services Plan *RSP*. The plan was endorsed by the Central Regions Māori Relationship Board.

2.2.5 Whānau Ora Update

Twenty five providers/collectives are involved in the Whānau Ora implementation process. Most have signed a preliminary contract to fund them for the development of their programme of action and business case to achieve the service and organisational transformation needed to get the service organisation ready to undertake whānau centred work. It is noted that where Whānau Ora providers have general practice services, the first contact funding cannot be included in contract integration discussions. This work is due by 30 June 2011 and needs to be congruent with respective Ministry and Minister Expectations and BSMC processes where applicable.

Interim information indicates that devolution of funding is not planned at this stage. Ministry Social Development is facilitating the local funder/provider discussions about common reporting and outcomes sought and contract integration. Also there is no

expectation that all contracts will be integrated, and where it occurs the integration is likely to be phased in an achievable and pragmatic way. The MOH has indicated that it will be linking directly with GMs Planning & Funding on these matters.

2.2.6 Tumu Whakarae Māori Managers Meeting

At the end of the month the National Tumu Whakarae meeting for DHB Māori Health Managers will be occurring in Whangarei. It is being hosted by Northland DHB on the 31st of March. Key items up for discussion are:

- Whānau Ora - update
- Roll out of National Maori Health Template
- Working collaboratively with the NHB
- Learnings from Christchurch Earthquake (National Maori Response)
- Tumu Whakarae Nation Project updates
- Tumu Whakarae joint work program with MOH SCI directorate
- Update for CEOs

Further update will be provided in April.

2.3 Mental Health and Addictions

2.3.1 New Service Specifications for Mental Health and Addiction providers

Currently all mental health and addiction providers are orientating to the new service specifications from the Ministry of Health. For providers this entails an extensive review of current contracts and alignment to the new service specifications and codes.

These changes to the service specifications will bring providers up to date and make them more connected with the strategic directions outlined within national documents. The Funding Division is undertaking this one on one negotiation with providers over the next three months and aims to have this completed by the end of May 2011.

2.4 Primary Health

2.4.1 Regional Fees Review Committee

The DHB has a role in approving proposed fee increases by general practice teams. Any increase that is higher than a certain defined level (referred to as the Annual Statement) must be referred to the Regional Fees Review Committee for consideration. By and large the increases that are submitted by practices are within the Annual Statement and are therefore automatically approved. In the last few months, however, we have referred a couple of increases to the Fees Review Committee. We have received the results for the first increase; it was approved.

2.4.2 Primary-Secondary Integration – Workshop for Doctors

On 14 March Dr Ant Gear, Chief of Medical Staff, hosted a very successful meeting of primary and specialist medical staff. The meeting was held in the Hall at the Education Centre and was very well attended by a good cross representation of both specialists and GPs. Presentations were made by Dr Dave Ayling (history and development of primary care), Craig Johnston (role and function of the Funding Division) and Dr Bruce Stewart (an update on the Better, Sooner, More Convenient Business Case). There followed discussion around the following four key themes:

1. Direct communications, referrals, clinic letters
2. Shared electronic records
3. Education

4. Networks, Clinical Pathways, Guidelines

This was a very positive meeting. It highlighted that on some issues primary and specialist clinicians have different perspectives/priorities but that all were in agreement on the need for communication and collaboration between primary and specialist services.

2.4.3 Maori Enrolment and Service Utilisation

At the March meeting a Committee Member asked about progress on 'Improved Access and Utilisation of Health Services Amongst Whanau' – one of the DAP initiatives. Management advised that this initiative corresponded with the Better, Sooner, More Convenient Business Case – in particular the Whanau Ora workstream. Central PHO has provided the following update on the work of this group:

The Whānau Ora programme of activity comprises a suite of initiatives proposed in the MidCentral Business Case:

- ***Development and implementation of a Whānau Ora assessment tool.*** This tool has been named "Te ara Whānau Ora". It has been developed based upon te whare tapa wha, six whānau outcome goals as identified by the Whānau-centred Taskforce. Tool development has involved a small group of Māori / Iwi practitioners, with sign-off gained through the Whānau Ora Leadership Group. A small pilot involving Iwi/Māori providers delivering Te ara Whānau Ora will begin in mid-April 2011. It will be evaluated prior to a general roll-out in July / August 2011.

- ***Development of Whānau Ora Navigators to facilitate the enrolment process***
  The scoping of the Whānau Ora Navigator role is underway. The primary function of the role is to facilitate the enrolment process for Māori whānau, and to support the implementation of Te ara Whānau Ora.

- ***Cultural training for general practice and primary care workforce***
  A Māori Cultural Responsiveness training module has been developed and is part of the Interdisciplinary Knowledge and Skills Framework. Alongside this, a small number of Māori primary care practitioners have been trained in delivering the Māori Cultural Responsiveness module. In addition, one-on-one training and knowledge sharing continues to be provided to general practices undertaking Cornerstone Accreditation which have specifically sought advice, support and training from the PHO.

- ***Establishment of the Whānau Ora Leadership Group***
  This group is now well established. It is meeting regularly and is working through its work programme.

Given most of the Whānau Ora work to date has focussed on development, impacts on increased enrolment of Māori in PHO are not yet evident. Review of Māori enrolment figures between data as at 1 July 2010 and data as at 1 Jan 2011 shows a slight increase (see table below). With the imminent pilot of Te ara Whānau Ora in April 2011, and continued effort in other areas of the Whānau Ora work programme and other Business Case activity, we would expect that in at least 9-12 months comparative data will show significant increases in the number of Māori enrolled in PHOs. In addition, with a strong self-management focus it is envisaged that in the long term the Whānau Ora initiative will contribute to a reduction in emergency/acute admissions through improved and timely access to general practice and hospital services.

5.9

Table: Enrolment Coverage of Māori in MidCentral DHB

Quarter Start	Funded Māori in MidCentral PHO's	Projected Māori in MidCentral From 2006 Census	% Enrolment Coverage
Jul-07	22147	29480	75.1%
Oct-07	22000	29615	74.3%
Jan-08	22229	29750	74.7%
Apr-08	22364	29885	74.8%
Jul-08	22564	30020	75.2%
Oct-08	22959	30140	76.2%
Jan-09	23440	30260	77.5%
Apr-09	23765	30380	78.2%
Jul-09	24005	30500	78.7%
Oct-09	24058	30618	78.6%
Jan-10	24169	30735	78.6%
Apr-10	24405	30853	79.1%
Jul-10	24483	30970	79.1%
Oct-10	24651	31105	79.3%
Jan-11	24834	31240	79.5%

2.5 Health Care Development

HCD continues to work towards its vision *"Interdisciplinary health care teams achieving Quality Living: Healthy Lives"*. This report provides an update on the work occurring towards promoting and improving primary health care in the MDHB region.

2.5.1 MDHB Child Health Nurse Led Eczema Service

Key Action - A primary based nurse led service be implemented into the MDHB region.

This service is to be provided by the Community Child Health Clinical Nurse Specialists (CNSs) with clinics to be created across the district. Initial establishment will occur in Horowhenua and Palmerston North and once fully operational thought will be given to extending the service to Tararua, following completion of an evaluation process. The development of an Eczema clinic is in line with the DHB's Child Health Strategy (2005) in terms of increased access for children /tamariki to specific services with the priority being community based health.

Atopic dermatitis should not be regarded as a minor skin disorder but as a condition that involves considerable personal, social and financial consequences both for the family and for the community. While hospital admission rates are not high, the costs when the child is admitted are relatively significant with extended bed stay, IV antibiotic usage, painful skin treatments, loss of schooling, and time off work for parents.
Nurse Led Services for eczema and dermatitis are already available in a number of other DHBs.

Research has shown that 18 months after the nurse led eczema service was established, there was >30% reduction in severity of eczema symptoms, reduced irritability of the child, 50% reduction in antibiotic usage, reduced hospitalisations, and reduction in pain. These services are relatively simple to set up, cost little to run, require few resources but make a significant difference to children and families.

Clinic space has been found at Central PHO premises in Levin and Palmerston North. Clinic days (two per week in each location) have been designed to coincide with the availability of MDHB paediatricians so that if medical input is required by specific patients this can be obtained when needed. The CNSs have received training in the primary care patient management IT system (MedTech) and the first clinic day is expected to be mid April 2011 in Horowhenua. Acknowledgement is made of the support and assistance provided by the nursing staff of Eczema services in other DHBs which were visited by our Community Child Health Clinical Nurse Specialists, notably CCDHB and Whangarei.

Along with the already established nurse-led nocturnal enuresis service, the nurse led eczema clinic once operational it is hoped this will be followed by a series of other nurse-led projects, based on identified need, such as:

- Respiratory/asthma
- Obesity (in conjunction with paediatrician input)
- Continence/day time wetting/constipation

Other work also being undertaken by the two Community Child Health Clinical Nurse Specialists (totalling 1 FTE) includes the development of collaborative clinical pathways for the better primary and secondary care management of children with selected conditions. To date work has commenced on the creation of pathways for constipation and gastroenteritis with a further eight conditions yet to be targeted. The CNS role also requires the provision of education to primary care providers who work with children. To date a programme for new graduate primary care nurses has been developed and is available on line.

2.6 Child & Youth Health

2.6.1 School Based Service Activities

Roll out of phase one of the School Based Health Service contract commenced in February 2011 with the two largest colleges in Horowhenua, Waiopehu and Manawatu College. The Nurses are settling into the environments well and are currently reporting an average of 15 students per day seeking their professional services. Work continues around refining the many systems and processes that are required to enhance their work environment and this will be ongoing for some time.

Implementation of the second phase of the programme is due to roll out in April/May. This involves working with Alternative Education providers to deliver health services to their students.

Positive negotiations are underway with a local provider specialised in working with this age group to provide health services to the three Alternative Education schools in Palmerston North. Once negotiations are completed work will be expecting to start at the beginning of term two.

Establishment of Standing orders for the Nurses involved in the programme is progressing well. A local GP with a youth focus is working with the Nurses and the project manager to ensure the established pathways are clinically safe and that best practice models are adhered to.

Local service providers and General Practices have been kept well informed around the project. This has involved a number receiving individual visits to discuss the implications of the programme on their service, how they might refer etc.

This is an exciting project that is already making a difference to the young people that have already utilised the services. As time progresses we will keep the board informed of progress

and some outcome based data as it evolves.

2.6.2 ASD Developmental Coordination Function Contract

MidCentral District Health Board and Whanganui District Health Board have been successful in a proposal to the Ministry of Health to provide a regional Autism Spectrum Disorder (ASD) Developmental Coordination function for the families of children with ASD. We have taken some time to agree to a proposed model of service delivery but with that now completed and once the contract is signed the Project Manager for the Whanganui and MidCentral DHB's Children's Health – Managed Clinical Network will work with MidCentral and Whanganui clinicians and management to develop this service quickly and efficiently.

The service is intended to support, and be supported by, the existing resources and services available to children and young people within the DHB's as providers of this service. The core objectives of the service are that:

a) All referrals for children and young people identified as having developmental concerns that require professional assessment are coordinated to multidisciplinary, multiagency diagnosis and assessment pathway in an effective and timely manner.

b) Post diagnosis referrals into services for children and young people who receive a diagnosis that includes ASD are managed in a coordinated manner to meet the identified needs of the individuals with ASD. This will include linkage or integration and coordination with multiple services.

There is no doubt that the opportunity for children to have a comprehensive work up and collation of necessary documentation pre Clinician assessment will be hugely advantageous. We will keep the Board up dated on this service development as it develops.

2.7 Pharmacy

2.7.1 Better, Sooner, More Convenient Business Case Medicine Management

The Central PHO Business Case to transform primary health care services includes a section on medicines management, a major outcome of which is the development of a group to advise and oversee district-wide medicines management. This group will be clinically-led and supported by the PHO. It will identify patterns of pharmaceutical use and potential interventions to improve medicines utilisation in the district and provide direction to the Clinical Advisory Pharmacists and other providers.

Group membership is currently being determined and will include representation of the major stakeholders in medicines management (e.g. prescribers, dispensers, and those that administer or advise on medicines use) from both MidCentral Health and primary care.

2.8 Population Health

2.8.1 Nutrition and Physical Activity Projects

iWorkWell Programme

iWorkWell is a programme run by Sport Manawatu to help improve the health and wellbeing of employees in the workplace. Studies have shown a healthy work place has:

- Reduced absenteeism
- Reduced accidents and injuries

- Improved physical and mental health
- Increased job satisfaction
- Higher staff morale
- Reduced health care costs
- Increased productivity

There are seven priority areas to iWorkWell. An organisation who signs up on the programme will work on one or two of these priorities at a time where changes are made at the strategic level through changing or implementing business policies. The seven priority areas are:

1. Sport and active recreation
   Having workers involved in sport and active recreation options to improve health, increase fitness and to maintain an active lifestyle.

2. Healthy eating
   Ensuring employees understand the benefits of healthy eating and supporting them to make the right food choices to fuel their day and maintain a healthy body weight.

3. Mental health
   Improving the mental health of an individual and an organisation reduces stress, anxiety and depression while increasing staff moral and job satisfaction.

4. Quit smoking
   The iWorkWell programme advocates for a smokefree work force and helps those who want to kick the habit.

5. Alcohol and other drugs
   Alcohol and other drugs can have detrimental effects on individuals, families and workplaces. iWorkWell helps employees choose safe drinking levels and to be drug free.

6. Disease and immunisation
   Healthy and active employees are less likely to suffer from illness. However, due to close working proximity of employees, diseases and other infections can spread. Organisations who manage infection control and immunisation strategies have far less chance of being affected.

7. Breastfeeding
   iWorkWell promotes breastfeeding and encouraging an environment where breastfeeding is accepted as the norm.

Workplaces:
The following organisations have indicated their intention to be involved in the iWorkWell programme:

- Fonterra Longburn
- Fonterra Pahiatua
- Fonterra Research Centre
- Vautier Pharmacy
- Youth Start
- Horizons Regional Council

We also have other organisations that are in the contemplation stage of committing to the programme. It is expected another five organisations will be signed up to iWorkWell in the coming few weeks obtaining the target of 10-15 workplaces.

Health Agencies
Key to the iWorkWell programme is developing relationships with health agencies, community groups and sporting clubs and facilities. This allows the workplace to have linkages with these professionals and develop their own long term sustainability strategies.

"Te Kawei Whakaheke– he patukinga tahi" (One Heart Many Lives)

The aim of the programme is to deliver four Tane Ora initiatives congruent with the National One Heart Many Lives Programme. Initiatives target local Maori and Pacific men within the MidCentral District, implementing a heart warrant of fitness (WOF) and referred onto appropriate services as needed. Champions will be identified to influence and promote this project within their communities. The Project expiry date has been extended from 31 October 2010 to 30 June 2011.

HP² (Health Promoting Health Providers)

In 2010 an advisory group of key health providers was established to implement the concept of HP2. A framework was developed in August 2010. An action from this group initiated an HP2 clause in all provider contracts for 2011.

2.8.2 Tobacco Control

ABC initiatives in Secondary Care

The MidCentral DHB ABCD health target further improved this quarter. The target proportion of hospitalised smokers offered advice and help to quit has now increased to 77% for the second quarter and an 81% result for February. This is a big improvement on the 14% that was reported for the first quarter of last year. The ABCD Smoking Cessation Taskforce continue to provide initiatives that have started making a difference across secondary care, especially in areas that were previously under performing. Further opportunities are being identified and followed through by Taskforce members. Patients are also encouraged to request smoking cessation support from hospital staff.ABC screening form in clinical notes:

Service managers continue to reinforce the need for all staff to complete the new green screening forms for every patient. Audits and "walk a rounds" have made significant improvement to staff documentation and overall performance

MDHB Executive/Clinical Champion Campaign

Phase twp of the ABCD Campaign is focused on recruiting clinical staff for surveys and interviews aimed at the short-term impact of the posters. Interviews with staff will commence in April/May 2011. Next steps for the evaluation will include the development of brochures identifying and utilising champions from the STEPS programme, Maori and Pacific staff as well as nurses in various wards.

Smoking Cessation Request for Proposals

The smoking cessation services Request for Proposals, entitled 'Challenge 2018 – Quit Smoking Services for Whānau/Family' was issued on 16 March.

A key goal for the service established as a result of this RFP process will be to reduce Māori smoking prevalence in our district (currently 45%) to the same or less than the smoking prevalence for European/Other by 2018 (European/Other prevalence is currently 20%, but predicted to fall at least as far as 15% by 2018).

Responses to the RFP are due on 27 April. It is expected that discussions/negotiations with the preferred service provider(s) will be concluded by the end of May.

Rangatahi Cessation Pilot

Best Care Whakapai Hauora have commenced the planning component of Stage One which consists of:

- Conducting a scoping exercise to identify specific needs from the Target Population Group in regards to smoking cessation; and
- Consulting with the Target Population utilising focus groups and other qualitative methods.

Best Care Whakapai Hauora will develop and deliver a range of smoking cessation services for rangatahi/youth, utilising conventional cessation practices alongside innovations to respond to the smoking cessation needs of rangatahi/youth (the Pilot Programme). The Pilot Programme will be based on recommendations from the Rangatahi Cessation Scoping report developed by MidCentral District Health Board, dated March 2009 and the Scoping Project to be undertaken in this service specification.

Recommendations and final evaluation for the ongoing provision of smoking cessation services for Rangatahi will be submitted to MDHB by 30 June 2012.

ABC Primary Health Care

Training continues to be implemented and well supported in the Primary Health Care Sector. Meetings were held and attended by Primary Health Organisations and Iwi/Maori Health providers to discuss strategies to achieve the training targets.

MidCentral's District Annual Plan outlines the following commitment for ABC training:

> 100% of contracted Māori health care providers undertake ABC training by 30.06.2011.

An ABC Training circular will be developed for Iwi/Maori health providers.

3. RECOMMENDATION

It is recommended:

that this report be received.

Mike Grant
General Manager, Funding Division

5.15

TO Community and Public Health Advisory Committee

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

FROM Finance Manager
Funding Division

DATE 11 March 2011

Memorandum

SUBJECT FINANCE REPORT – MARCH 2011

1. KEY EVENTS

1.1 Forecasted Result for 2010-11

The Funder's YTD result to Feb 11 was $116k surplus to budget and the forecasted 10-11 result is $500k surplus to budget (breaking even on actual income and expenditure). The main reason for the decrease in YTD surplus is the washup with MCH on its over-performance.

1.2 2010-11 IDF

The YTD IDF inflow unfavourable variance is estimated to be $1.9m (about $1m due to drop of inflow from Whanganui DHB). The revised full year net IDF unfavourable washup is currently estimated to be $0.9m ($2.1m inflow unfavourable washup and $1.2m favourable outflow washup). Therefore the current IDF inflow washup provision is considered to be sufficient at this stage.

The final IDF washup will depend largely on Capital and Coast DHB's performance on MidCentral's IDF outflow (currently it is under-delivered by $1.2m in elective). The Funder will continue to monitor the position closely in the coming months.

1.3 Demand Driven Pharmacy Expenditure

There is no change in the projected Pharmacy expenditure.

1.4 MidCentral Health Washup

This month MCH has a favourable turn around of $1.2m. The total year to date (YTD) washup position is $690k over-delivery by MCH.

1.5 Electives Initiatives (EI)

The Funder has accrued $5.3m for YTD EI income which is $0.6m below budget.

2. FUNDER FINANCIAL PERFORMANCE

The Funder had a cumulative surplus to budget of $116k up to the end of Feb 2011.

MidCentral DHB - Funder Income and Expenditure - By Ring Fenced Area For the period ending 28 February 2011	Note	YTD Actual	YTD Budget	YTD Variance	Annual Forecast	Annual Budget	Annual Variance
		$000	$000	$000	$000	$000	$000
Personal Health Income	(a) (b) (c	240,416	236,228	4,188	362,056	354,511	7,545
Personal Health Expenditure	(d)	237,539	234,680	-2,859	357,997	354,511	-3,486
Personal Health Surplus/(Deficit)	(e)	2,877	1,548	1,330	4,059	0	4,058
Mental Health Income		26,158	26,351	-193	39,364	39,526	-162
Mental Health Expenditure		25,578	26,286	708	39,676	39,526	-150
Mental Health Surplus/(Deficit)	(f)	580	64	516	-312	-0	-312
Disability Support Income	(g)	42,608	42,307	301	63,757	63,460	296
Disability Support Expenditure	(h)	45,068	42,591	-2,477	67,950	63,960	-3,989
Disability Support Surplus/(Deficit)		-2,460	-284	-2,176	-4,193	-500	-3,693
Maori Health Income		1,367	1,288	79	2,011	1,932	79
Maori Health Expenditure	(i)	921	1,288	367	1,565	1,932	367
Maori Health Surplus/(Deficit)		446	0	446	446	0	446
Governance Income		1,589	1,589	-0	2,384	2,384	0
Governance Expenditure		1,589	1,589	0	2,384	2,384	0
Governance Surplus/(Deficit)		0	0	0	0	0	0
Total Funder Surplus/(Deficit)		**1,444**	**1,328**	**116**	**-0**	**-500**	**500**

Note on Variance

(a) Extra project funding with corresponding extra expenditure (major projects - Herceptin $2.2m; CYFS $0.4m; VLCA $0.4m; Care Plus $1.7m; After hours $0.4m; NRT $0.3m; Hospice $0.3m; PHO performance $0.5m; Oral Health Business Case $0.5m; Service income from PHO $0.6m) and anticipated reduction of $0.6m Elective income.

(b) The income included $1.2m extra income or saving from 09-10. ($0.3m EI, $0.3m IDF washup and $0.6m extra Pharmac rebate.)

(c) The income also included $1.45m extra 10-11 IDF inflow washup provision

(d) Mainly due to IDF Service change for CYC, Herceptin and spotless adjustment, extra Pharm expenditure and underspend of PHO funding

(e) The surplus is mainly due to underspend in PHO and Primary/ secondary projects

(f) Mainly caused by $0.7m Mental Health washup with MCH

(g) Extra 09-10 MoH funding for AT& R beds

(h) Mainly due to higher than budgeted HBSS and Age Residential Services expenditure

(i) Mainly due to favourable variance from project underspend

5.17

MidCentral DHB - Funder and Funding Administration
Statement of Financial Position as at 28 February 2011

	Year-Ended Jun-10	Actual Current Position Feb-11	Change
	$000	$000	$000
ASSETS EMPLOYED			
Current Assets	**25,536**	**28,859**	**3,323**
Bank	21,309	23,852	2,543
Intercompany Advance Account	0	0	0
Debtors and Prepayments	4,226	5,007	780
Inventories	0	0	0
Properties Intended for Sale	0	0	0
Current Liabilities	**27,107**	**28,530**	**1,423**
Bank Overdraft	0	0	0
Intercompany Current Account	4,768	5,780	1,012
Trade Creditors and Accruals	18,660	18,451	(210)
GST	2,689	2,918	229
Income in Advance	876	1,268	392
Provisions (Payroll)	113	113	0
Current Portion of Term Loans	0	0	0
Net Working Capital	**(1,571)**	**329**	**1,900**
Net Assets Employed	**(1,571)**	**329**	**1,900**
SHAREHOLDERS EQUITY			
	0	0	0
Retained Earnings	39,513	41,413	1,900
Transfer to Co 41	(41,084)	(41,084)	0
	(1,571)	**329**	1,900
Other Reserves	0	0	0
Total Shareholders Equity	**(1,571)**	**329**	**1,900**

3. MIDCENTRAL HEALTH PROVIDER DIVISION RESULT

3.1 Statement of Financial Performance to Budget

MidCentral Health - Provider Division YTD to: February-11
Statement of Financial Performance to Budget
$000

	Month		Year to date		Annual
	Actual	**Variance**	**Actual**	**Variance**	**Budget**
Revenue					
Govt. & Crown Agency Sourced	22,132	1,073	177,735	316	268,338
Patient/Consumer Sourced	51	(13)	703	189	771
Other Income	1,031	621	3,967	687	4,921
Total Revenue	**23,214**	**1,681**	**182,405**	**1,192**	**274,030**
Expenditure					
Personnel	12,008	284	101,501	3,532	158,108
Outsourced Personnel	227	(102)	2,655	(1,658)	1,598
Sub-Total Personnel	12,234	182	104,156	1,874	159,705
Other Outsourced Services	1,053	141	8,947	604	14,326
Clinical Supplies	3,753	83	29,124	1,287	45,834
Infrastructure & Non-Clinical	3,838	189	31,828	194	48,125
Total Expenditure	**20,878**	**596**	**174,056**	**3,959**	**267,991**
Operating Surplus/(Deficit)	**2,336**	**2,277**	**8,349**	**5,151**	**6,039**
Corporate Services	722	0	5,757	17	8,660
Surplus/(Deficit)	**1,614**	**2,277**	**2,593**	**5,167**	**(2,621)**

3.2 Commentary

The month's result was $1614k favourable to budget. Both revenue $1681k and expenditure $596 were favourable to budget.

Revenue
The month's favourable position to budget is mainly due to increased surgical case weight volumes in both acute and electives $844k and additional Ministry of Health funding relating to the IT capital expenditure to meet the health targets shorter cancer treatment times $553k and to fast track the new linear accelerator's business case $169k. The additional Ministry of Health's funding would account for the majority of the year to date variance as well.

Total Personnel (including Outsourced Personnel) Costs
The total personal costs being within budget is a result of the focus on FTE and locum management and the impact of the financial service reviews.

Other Costs
These are within the budget for the month and year to date. The favourable cost variance is mainly due to lower acute volumes and favourable outcomes from cost saving initiatives.

5.19

4. MIDCENTRAL DHB RESULT

Feb-11 *Year to date*	DHB RESULT ('000's)	Funding Division ('000's)	Provider Division ('000's)	Governance ('000's)
Net Result				
YTD - Actual	**5,015**	1,442	2,896	677
YTD - Budget	**(1,688)**	1,328	(2,479)	**(537)**
Variance	**6,703**	114	5,375	1,214

After eight months, the DHB result is a favourable variance to budget of $6,703k.

5. CONSOLIDATED FINANCIAL POSITION

MidCentral District Health Board
Statement of Financial Position (summary)

	Jun 2009 $000	Jun 2010 $000	Feb 2011 $000	Change $000
Assets Employed				
Current Assets	44,727	41,941	53,645	11,704
Current Liabilities	(54,841)	(55,944)	(59,805)	(3,861)
Fixed Assets and Investments	164,748	160,010	157,524	(2,486)
	154,634	**146,007**	**151,364**	**5,357**
Funds Employed				
Equity	98,521	89,425	94,771	5,346
Bank Loans	54,867	55,301	55,312	11
Long Term Liabilities	1,246	1,281	1,281	0
	154,634	**146,007**	**151,364**	**5,357**

6. COVENANTS

Feb-11	Actual	Limit / Covenant
YTD - Variance to Budget	$6.7	< ($2.0m)
Bank Loans (net debt)	$17.9	$71.7m
Equity	$94.8	> $30m
Debt & Equity	$112.7	
Debt Ratio	15.9%	< 55.0%
YTD Interest Cover	6.72	> 3.00

7. DEBT POSITION

MidCentral District Health Board	Jun-09 $m	Jun-10 $m	Feb-11 $m
Available Bank Facility	71.7	71.9	71.9
Net Debt (CHFA & Banks)	29.0	29.8	17.9
Debt Facility Surplus / (Shortfall)	42.7	42.1	54.0
Reserved Funds	18.7	18.7	20.2
Debt Facility Available	24.0	23.4	33.8

8. CASH POSITION

A summary of the cash position by division is shown below.

Cash / Investment Summary as at 28 February 2011

	$m
Treasury Division	17.3
Funding Division	16.4
MidCentral Health	2.0
Trust Funds – Short Term	0.3
Enable	1.4
Total	37.4

9. RECOMMENDATION

It is recommended:

that this report be received

Gordon Ngai
Finance Manager
Funding Division

TO Community & Public Health Advisory Committee

FROM Chief Executive Officer

DATE 28 March 2011

SUBJECT **Committee's Work Programme, 2010/11**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. Purpose

This report updates progress against the Committee's 2010/11 work programme. It is provided for the Committee's information and discussion.

2. Summary

Reporting is occurring in accordance with the timeline.

A schedule of all reports scheduled for consideration at the Committee's next meeting are set out below. If there are any new items which members require, or any issues they would like canvassed in future reports, please advise.

- General Manager's Operating Report
- Contracts Update
- 2010/11 District Annual Plan: Quality Update (information only)
- Workshop on Primary/Secondary Integration (with Hospital Advisory Committee)

3. Recommendation

It is recommended:

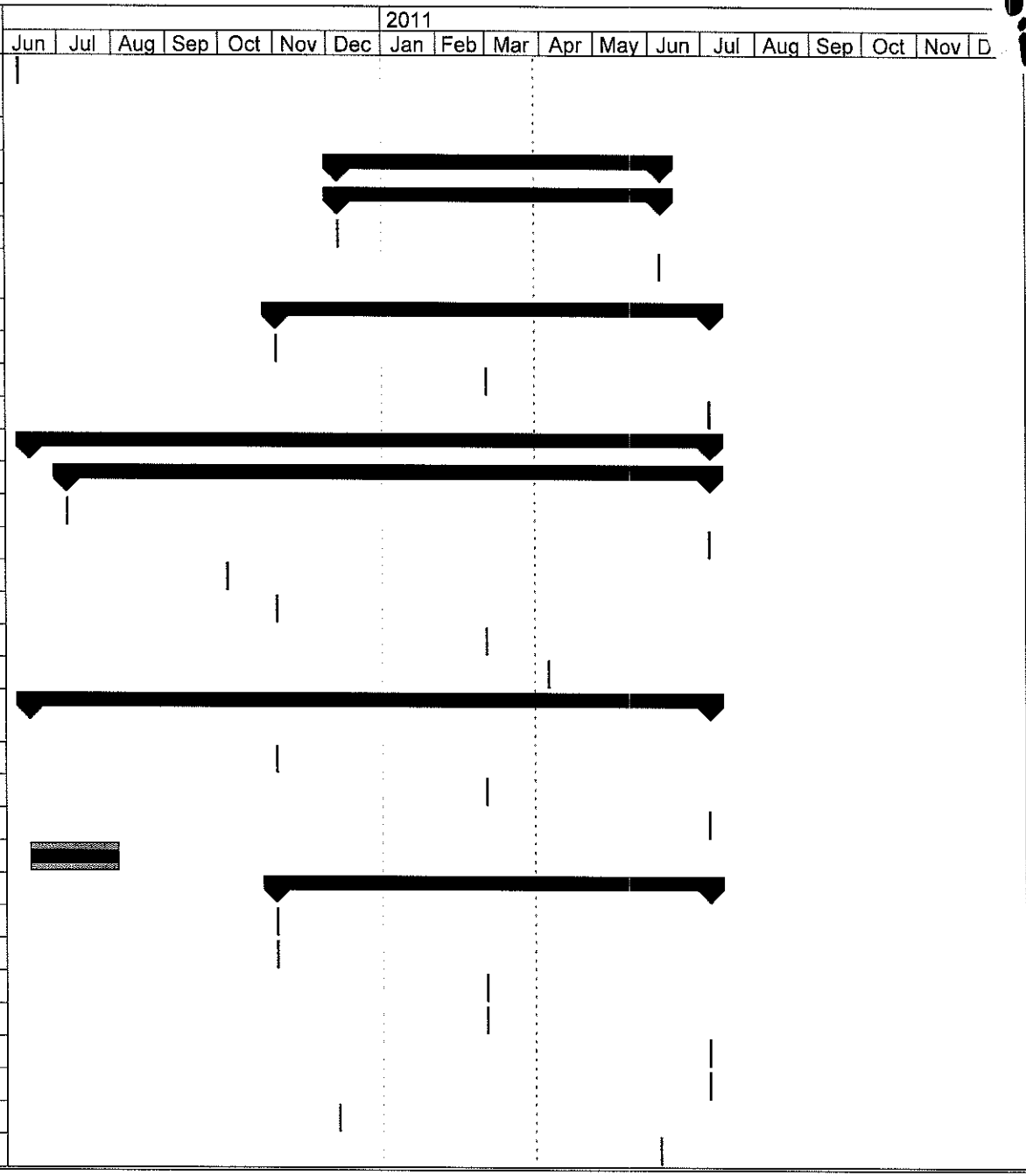
that the updated work programme for 2010/11 be noted.

Murray Georgel
Chief Executive Officer

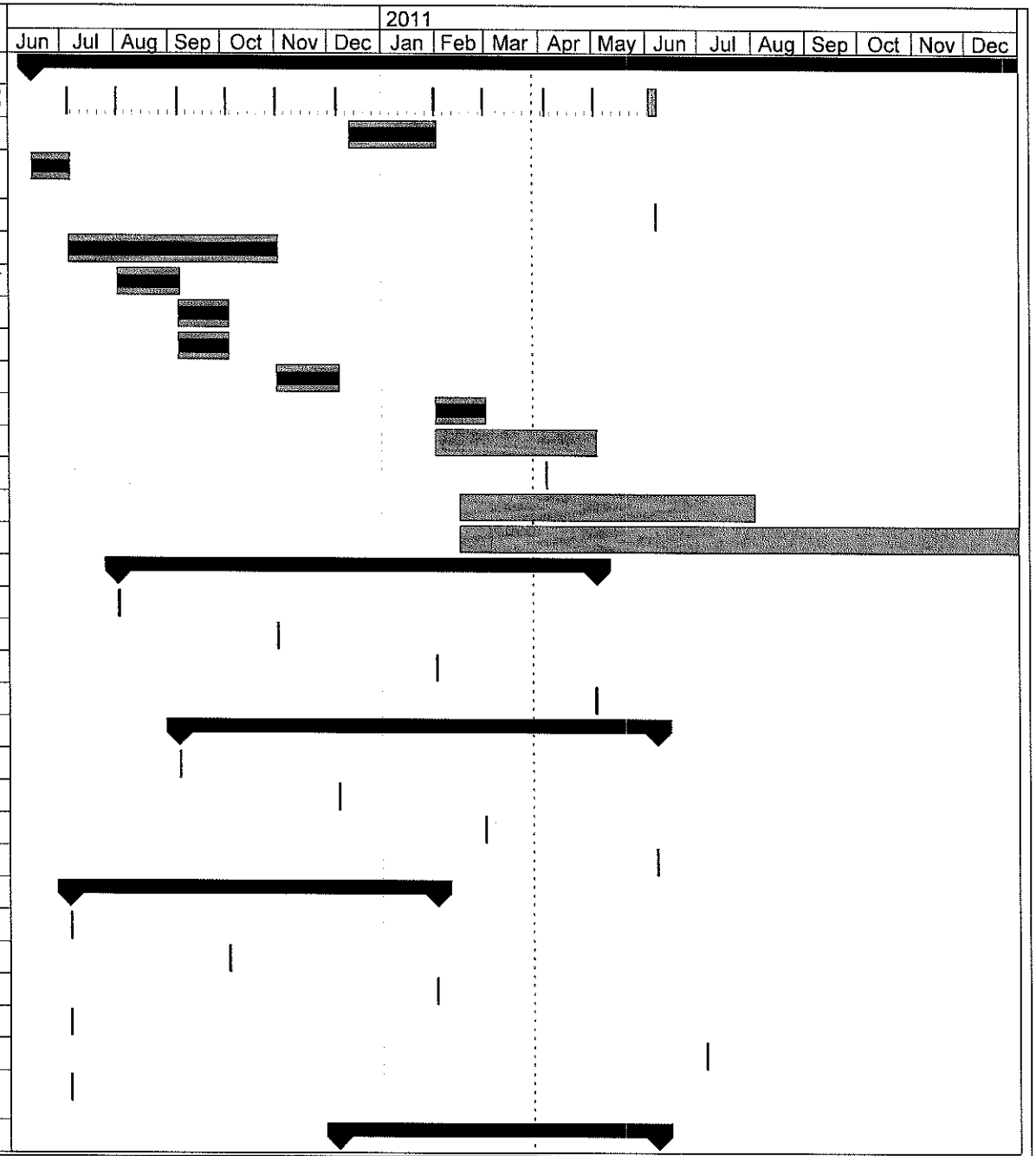
COPY TO:

CEO's Department
MidCentral DHB
Heretaunga Street
PO Box 2056
Palmerston North
Phone +64 (6) 350 8910
Fax +64 (6) 355 0616

ID		Task Name
1		**COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE: 2010/11 WORK PROGRAMME**
2		
3		**STRATEGIC PLANNING**
4		**Chronic Disease Plans**
5	✓	Update 1 re progress against long term measures
6		Update 2 re progress against long term measures. To include more infor re links to health outcomes
7		**REGIONAL PLANNING**
8	✓	Implementation of RCSP: update 1 (copy for info)
9	✓	Implementation of RCSP: update 2 (copy for info)
10		Implementation of RCSP: update 3 (copy for info)
11		**ANNUAL PLANNING**
12		**2011/12 Plan(s) - Development**
13	✓	Annual review of Health Needs Assessment
14		Annual review of Health Needs Assessment:
15	✓	Annual review of Prioritisation Framework
16	✓	Price:Volume Schedule (draft)
17	✓	2011/12 Plan: Draft 1
18	✓	2011/12 Plan: Draft 2
19		**2010/11 Plan - Implementation (inc update re implementation & identified outcomes)**
20	✓	PIA 2: Primary Care - update 1
21	✓	PIA 2: Primary Care - update 2
22		PIA 2: Primary Care - update 3
23	✓	Workshop re BSMC Bus Case & central PHO
24		***Information Only:***
25	✓	PIA 1: Hospital Productivity - update 1
26	✓	PIA 3: Regional Services - update 1
27	✓	PIA 1: Hospital Productivity - update 2
28	✓	PIA 3: Regional Services - update 2
29		PIA 1: Hospital Productivity - update 3
30		PIA 3: Regional Services - update 3
31	✓	PIA 4: Quality - update 1
32		PIA 4: Quality - update 2



ID		Task Name
33		**OPERATIONAL REPORTS**
34		General Manager, Funding Division (inc portfolio updates)
35	✓	Update re cardiac landscape review & outsourcing
36	✓	Breast reconstruction - Govt funding of $8m & central region share
37		Proposed contract negotiating strategy & approach
38	✓	Vitamin D: proposal for extension to community
39	✓	QIPPs: clarification re who provided/funded establishmer
40	✓	Update on Better, Sooner, More Convenient bus. Case
41	✓	Update on Integrated Health Care Project
42	✓	InterRAI (update to be inc. in ops report)
43	✓	No of GP registrars accepted for training
44		Details of FD's staffing mix
45	✓	Cardiology Landscape Review
46		Horo Nurse-led General Practice: update 1
47		Horo Nurse-led General Practice: update 2
48		**Contracts (Funding)**
49	✓	Update 1
50	✓	Update 2
51	✓	Update 3
52		Update 4
53		**Non-financial performance indicators**
54	✓	Update 1
55	✓	Update 2
56	✓	Update 3
57		Update 4
58	✓	**Hospital Benchmark Information**
59	✓	Update 1 (copy only)
60	✓	Update 2 (copy only)
61	✓	Update 3 (copy only)
62	✓	PHO Combined Clinical Council: annual report
63		PHO Combined Clinical Council: annual report
64	✓	Financial Recovery Programme: update re FD component
65		**Workforce**



ID		Task Name
66	✓	Update 1
67		Update 2
68		**CENTRALALLILANCE**
69		**Implementation of Funding Workstream**
70	✓	Update 1 (joint rpt WDHB)
71	✓	Update 2 (joint rpt WDHB)
72		Update 3 (joint rpt WDHB)
73	✓	**CARRIED FORWARD FROM 2009/10**
74	✓	Acute demand: follow-up paper
75	✓	Breast reconstruction: response from HVDHB re issues
76	✓	Potential liability re third party carers
77	✓	MCAP Evaluation Results