MidCentral District Health Board

A g e n d a

Community & Public Health Advisory Committee

Part 1

Date: 1 February 2011

Time: 1.00 pm

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

Distribution

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

Board Members
- Lindsay Burnell
- Jack Drummond
- Kate Joblin
- Richard Orzecki
- Barbara Robson

Management Team
- Murray Georgel, CEO
- General Manager, Corporate Services
- Mike Grant, General Manager, Funding
- Jill Matthews, PAO
- Carole Chisholm, Committee Secretary
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Next Meeting Date 1 March 2011
Deadline for Agenda Items 18 February 2011

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Tuesday 1 February 2011

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:	4.1 – 4.6
Documentation:	minutes of 2 November 2010
Recommendation:	that the minutes of the previous meeting held on 2 November 2010 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 2 November 2010 for which specific items do not appear on the agenda or in management reports.

5. OPERATIONAL REPORTS

5.1 Hospital Benchmarking Information – Comparative Results Report Status Update

Pages:	5.1– 5.2
Documentation:	Manager, Planning & Performance Unit's report dated 14 January 2011
Recommendation:	that this report be received

that the reporting item for the HBI be removed from the reporting framework for the work programmes of the Hospital Advisory Committee and the Community and Public Health Advisory Committee.

5.2 Funding Division Operating Report – December 2010 & January 2011

Pages: 5.3 - 5.17
Documentation: General Manager's report dated 21 January 2011
Recommendation: that this report be received.

5.2 Finance Report – January 2011

Pages: 5.18 – 5.23
Documentation: Finance Manager's report dated 17 January 2011
Recommendation: that this report be received.

6. GOVERNANCE ISSUES

6.1 2010/11 Work Plan

Pages: 6.1 – 6.5
Documentation: Chief Executive Officer's report dated 25 January 2011
Recommendation: that the updated work programme for 2010/11 be noted.

7. LATE ITEMS

8. DATE OF NEXT MEETING

1 March 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 following items for the reasons stated:

Item	Reason	Reference
"In Committee" Minutes of the Previous Meeting	For reasons stated in the previous agenda	
Contracts Update	Commercially sensitive information	9(2)(j)
GM Operating Report – Sale and Purchase of General Practice	Commercially sensitive information	9(2)(j)

MidCentral District Health Board

4.1

Community & Public Health Advisory Committee Meeting

Minutes of meeting held on Tuesday, 2 November 2010 at 1.00 pm in the Boardroom of Board Office , Gate 2B Heretaunga Street, Palmerston North

PRESENT:

Diane Anderson (Chair)
Dennis Emery (Deputy Chair)
Graeme Campbell
Ann Chapman (ex officio)
Linda Gray
Charmaine Hamilton

IN ATTENDANCE:

Mike Grant, General Manager, Funding Division
Carole Chisholm, Committee Secretary
Lindsay Burnell, Board Member (part)
Karen Naylor, Board Member Designate

OTHER:

Staff: (4)
Public: (1)
Media: (0)

The Chair conveyed her thanks to two members of the Community & Public Health Community who were attending their last meeting. Dennis Emery, Deputy Chair of the committee, had been a strong contributor at the monthly meetings and his presence would be missed in the future. Dennis' input had been very much appreciated. It had also been a pleasure to have Graeme Campbell as a member of this Committee over the last term and his contributions had been gratefully received.

1. APOLOGIES

Oriana Paewai; Phil Sunderland; and Murray Georgel

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.

4.2

3.2 Declaration of Conflicts in Relation to Today's Business

Linda Gray referred to page 5.13, para 4.1.2 'Integrated Family Health Centres' and declared a conflict.

Dennis Emery declared a conflict in relation to page 5.15 para 4.1.5 'Whanau Ora'.

Following a prior request, Mr John Bent, a member of the public, was invited to speak to Item 1.3.1 'Mental Health and Addiction NGO Sector', which appeared on page 6.8 of the Funding Division's Operating Report.

Mr Bent questioned the term 'severe mental health'. He believed it was either severe mental illness or serious mental illness. If the former, a definition would be required. There were slight variations on the meaning of 'severe mental illness' but the three constants that appeared in such literature as the British Journal of Psychiatry, named the first constant as schizophrenia with or without other psychotic areas. The second constant was bipolar disorder, and the third was the major depression area.

In the case of the term 'serious mental illness', this was defined in various Ministry of Health and MidCentral DHB documents.

The Chair thanked Mr Bent and advised the matter would be discussed later in the meeting.

4. MINUTES

4.1 Minutes

It was recommended:

that the minutes of the previous meeting held on 5 October 2010 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

There were no matters arising.

5. STRATEGIC/SPECIAL ISSUES

5.1 Price and Volume Schedule 2010/11

Management noted that this paper was an annual report to the committee which set out the context for the funding of MidCentral Health by the funder and that context arose out of both a national and local process. Although there was a lot of specific language used in the report, the glossary in Appendix A was helpful in terms of clarification. In summary the report confirmed that the funding pressures for 2011/12 would continue to exist but that there would be trade-offs between volume and price. Even though the total funding and total expenditure were in synchronization for the first three or four months of the year, there was variation in the mix of volume and price.

A committee member referred to 'Funding Considerations in Setting Volumes and Funding Levels', page 5.7, number 11 'Priorities' and requested that Elder Health and Maori Health be

rated high amongst those priorities. Reference was also made to No 8 'Inter District Flows' and the need to keep population based funding under observation.

It was recommended:

that this report be received.

5.2 Primary Health Care (DAP 2010/11) – Update 1

Management reported on the progression of primary health care activities from 2004, when the DHB put its Primary Health Strategy together, to the present time, together with the associated achievements. The next evaluation of the process was by Better, Sooner, More Convenient aspirational targets which formed part of the accountability between the PHO and Ministry of Health. MidCentral as the DHB was heavily involved.

In response to a question from the Chair, management confirmed that aspirational targets, which were based over a two to three year period, were reported to the Ministry of Health. However, due to the DHB's involvement the reports would come back to the Board and that information reported through to this committee.

Linda Gray's conflict with para 4.1.2 'Integrated Family Health Centres' was noted.

Following a Committee member's enquiry, management advised that the Palmerston North Integrated Health Centre project was not due to start until 2012/13.

Weekly meetings at Horowhenua were led by the PHO with Doctors from MidCentral Health and other service providers.

With the advent of nurse led clinics, the question of fees was raised. As in any emerging service there would be the ability to set a price for the service but the nurse practitioner could draw on capitation reimbursement for funding as enabled through the PHO agreement. A committee member noted there was a risk of confusion around the identity of practice nurses and nurse practitioners, and identification of nurses' roles in the community.

It was agreed that the committee would keep a watching brief on this issue.

Dennis Emery's conflict in relation to 'Whanau Ora' was noted.

The member concerned expressed disappointment that no providers had been selected in this area in the first wave. Following an enquiry on their design, management advised that information was currently being received and an update would be provided to the next meeting.

In response to the committee's interest in InterRAI, management undertook to include an update in next month's 'Health of Older Persons' section of the Operating Report.

The Chair congratulated the author on a very good and informative report.

It was recommended:

that this report be received.

5.3 PIA 1: Improved Hospital Productivity – Update

This report had been discussed at the Hospital Advisory Committee (HAC) meeting earlier in the day and its inclusion in this agenda was for information purposes.

Management referred to Appendix 2 relating to the percentage of Emergency Department patients discharged or transferred within six hours by service. The charts revealed that the

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waiting times depended on where the patient was in the system or whether they were awaiting transfer. Most services were trending in the right direction but it was noted that if the Emergency Department was to lift their performance, a whole system approach would be required.

A Committee member who had been present at the HAC meeting spoke of considerable discussion around 'smoking cessation' and a debate concerning what constituted a late start in the operating theatre. Although five minutes would appear to be of no consequence, an hour late was significant. The question was then raised as to whether the figures quoted on page 5.39 included the five minute period or whether it was more. Concern was expressed that if detailed information was not captured then an incorrect picture was presented.

With respect to overall efficiency, management noted that the engine room of any hospital was the theatre and theatre productivity. According to the table on page 5.39 there was a long way to go in lifting productivity within the hospital environment.

At the HAC meeting it was agreed to benchmark with other DHBs and investigate what some of the issues were and why the metrics were looking the way they did.

Following a recommendation from a committee member, the matter of theatre productivity would be entered on a risk profile.

It was recommended:

that this report be received.

5.4 Regional Service Coordination and Regional Clinical Services Plan - Update

This report had also been discussed at HAC earlier in the day and was included in this agenda for information purposes.

Management confirmed that the DHB was working towards the development of a regional urology service. It was understood that the third urologist would provide surgery at Whanganui as well Palmerston North. It was also noted that there had been a significant turnaround in urology performance within MidCentral Health and this had been largely due to senior clinical nurse specialists working in that department.

It was recommended:

that this report be received.

6. OPERATIONAL REPORTS

6.1 Falls Prevention in the Older Person

It was recommended:

that this report be received.

6.2 Funding Division Operating Report – October 2010

Item 1.3.1 Mental Health and Addiction NGO Sector
The committee referred to Mr John Bent's submission seeking a definition of severe mental illness. The Chair noted that the area of severe mental health essentially lay in the domain of the Mental Health Service.

In response to a request for clarification around people with less severe mental illness, management advised that programmes existed within primary care and these were funded by the Ministry of Health. Services for people with severe mental illness were provided by MidCentral Health or by NGOs under contract to the Funder.

Item 1.3.2 Mental Health Line
Following an enquiry relating to the provision of a Mental Health line, management noted that a period of 12 – 15 months had elapsed since the programme was brought to CPHAC. Management would therefore provide a paper in order to refresh the committee.

Item 1.4.1 GP Registrars
More applicants had come forward and the Board would be in a position to update the committee on placements very shortly. The contract with the Clinical Training Agency allowed for up to six trainees.

Item 1.4.2 General Practice Fees
Management confirmed the steps involved when a GP practitioner applied for a fee increase and noted that generally GPs were happy with the annual adjustment.

Following comments made around practice nurse charging, which had also been discussed during consideration of the Price and Volume Schedule, it was noted that the Board was looking at a number of ways to support nurses and nurse practitioners which would change the nature of the general practice. The changes would require some publicity, particularly for a section of the community and this issue would be included in the strategic planning process in due course.

It was recommended:

that this report be received.

6.3 Finance Report – October 2010

Management advised that on a consolidated basis the DHB was doing reasonably well and this was a marked turnaround from the situation twelve months ago. Under 1.2 '2009-10 Wash-up and 2010-11 IDSF Inflow' some benefits had been signalled but those benefits had been offset by the lower IDF revenue primarily from Whanganui. This would be kept under surveillance as the year progressed.

It was recommended:

that this report be received.

7. GOVERNANCE ISSUES

7.1 Work Plan

Management noted that committee members could attend the Board meeting on 14 December but had no decision rights.

In response to a Committee member's enquiry it was confirmed that if attendance was not possible on 14 December, any reports relating to the Community & Public Health Advisory Committee could be made available in advance.

It was recommended:

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

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8. LATE ITEMS

There were no late items under 2 above.

9. DATE OF NEXT MEETING

Tuesday, 1 February 2011.

Dennis Emery noted it was his final CPHAC meeting after nine years with the DHB. He wished to convey his thanks and appreciation to Diane Anderson, the Committee Chair; Committee members; past Board Chairman, Ian Wilson; and Ian's successor, Phil Sunderland. Dennis advised that he had greatly enjoyed the experience and was full of admiration for the management leadership.

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 item for the reason stated.

Item	*Reason*	*Ref*
"In Committee" Minutes of the Previous Meeting	For reasons stated in the previous Agenda	
Contracts Update	Commercially Sensitive Information	9(2)(j)

The meeting closed at 2.15pm.

Confirmed this 1st day of February 2011

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Chairperson

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MEMORANDUM

TO Hospital Advisory Committee
Community and Public Health Advisory Committee

FROM Vivienne Ayres
Manager, Planning & Performance Unit (Health Information)

DATE 14 January 2011

SUBJECT **HOSPITAL BENCHMARKING INFORMATION – COMPARATIVE RESULTS REPORTS STATUS UPDATE**

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1. PURPOSE

To confirm with the Committees that the Ministry of Health's Hospital Benchmarking Information (HBI) comparative results reporting framework no longer exists and therefore request that this item be removed from the Committees' work programmes.

2. STATUS UPDATE

Over the last few years, the Hospital Advisory Committee has been provided with a summarised analysis and extract of the Ministry of Health's Hospital Benchmarking Information report each quarter. The last report provided to the Committee was in August 2010 for the January to March 2010 quarter. A comparative results report has not been, nor will be, provided or published by the Ministry of Health for the final quarter of the 2009/10 year.

As advised in the last report, reporting and publication of the HBI comparative results was to cease at the conclusion of the 2009/10 year. Certain measures that were part of the HBI suite of indicators were transferred to the current quarterly non financial monitoring framework and performance measures (most of which have modified definitions). These performance measures include:

- Acute inpatient average length of stay
- Elective and arranged inpatient average length of stay
- Elective and arranged day surgery
- Elective and arranged day of surgery admissions
- Unplanned acute readmissions to hospital within 28 days
- Patient satisfaction
- Staff turnover

The modified HBI measures are now included as part of the "ownership" dimension of DHB performance and are reported to the Ministry of Health each quarter together with other performance measures. Instead of a focus on using comparative results to inform the Provider arm's performance, the new non financial monitoring framework and performance measures take more of an accountability approach in response to the DHB's functions as owners, funders and providers of health and disability services and are more focused on government priorities, including the national Health Targets.

All measures within the non financial monitoring framework are incorporated into the DHB's District Annual Plan and include targets that are usually based on achieving results that are around the national average as a minimum expectation.

A copy of the full non financial performance report for each quarter, together with a summary of the results, is provided to the Hospital Advisory Committee and the Community and Public Health Advisory Committee following assessment of the DHB's reported performance by the Ministry of Health. The report is usually provided to the Committees six to eight weeks following the end of the quarter (subject to the Ministry of Health's timeframes). The report for the first quarter of 2010/11 was provided in November 2010.

3. RECOMMENDATION

It is recommended:

that this report be received

that the reporting item for the HBI be removed from the reporting framework for the work programmes of the Hospital Advisory Committee and the Community and Public Health Advisory Committee

Vivienne Ayres
Manager, Planning and Performance Unit
(Health Information)

TO Community and Public Health Advisory Committee

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

FROM General Manager
Funding Division

DATE 21 January 2011

Memorandum

SUBJECT **FUNDING DIVISION OPERATING REPORT – DECEMBER 2010 & JANUARY 2011**

1. WORK PROGRAMME

Reference	Matter	Achieved	Comment
35	Update re cardiac landscape review & outsourcing	Y	Provided at paragraph 2.4 of this report

2. LOCAL MATTERS

2.1 Health of Older Person

This has been a quiet reporting period hence some emphasis is given to the following issue:

2.1.1 Aged Residential Care Extra Charges

There is renewed national debate about the issue of extra charges for premium facilities in Aged Residential Care facilities, now compounded by the additional issue of providers who want to provide 'premium only' facilities.

Definitions:

- **Premium Only Facilities** – This refers to a facility that only has premium facilities, and residents are required to pay additional charges (over and above the subsidised level) to be a resident within the facility
- **Additional Charge Facilities** – This refers to facilities which have both premium facilities and standard facilities. Residents have the option of receiving standard or premium facilities within the facility.

The prevalence of additional charges for services has been contentious for DHBs and providers for some time. On the one hand providers seek to maximise revenue and return on investment by creating service options which attract extra charges. On the other hand DHBs express concerns about future availability of standard rooms and affordability for residents. Questions also remain unanswered about what happens to elderly residents who have been paying for a premium room if their money runs out.

The New Zealand Aged Care Association (NZACA) position is that if a facility provides a premium component in every room, then they have the ability to charge prospective residents for that premium component. Where a prospective resident does not want to pay the extra charge they have the option of going back to the market and selecting another facility which offers the room they want.

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At the heart of the debate is how to define premium or standard facilities. Neither party wants to become prescriptive on what 'standard care' means (i.e. defining room sizes etc) rather standard care will remain as being whatever is required to meet the assessed needs of the resident.

In some contemporary facilities a room with it's own en-suite is considered **premium** and able to attract extra charges. The **standard** room alternative typically involves a shared bathroom/toilet between two rooms, or in older facilities, a common bathroom/toilet along the corridor. This latter configuration is likely to diminish in future as older stock is either re-furbished or taken out of the market.

It can be assumed that most new facilities being built to meet future growth in the older population will market themselves as of premium quality and seek to maximise options for extra charges. The Grant Thornton Aged Residential Care Review (2010) assessed a fair rate of return for an efficient and effective provider in the sector as between 11.3% and 12.9% after tax. On that basis the operating profits being achieved by many industry participants are below those required to justify investment in new capacity at current costs.

With such a squeeze on profitability there is uncertainty as to whether newly built facilities will also offer standard rooms. However, what is really needed are tidy standard rooms (with an en-suite) which provide choice for prospective residents to avoid the premium charges. By today's standards one could argue that individual en-suites should be the norm and no longer warrant an extra charge.

Speaking at the NZACA conference in 2010 the Minister of Health was clear that additional charging is allowed and that he is also supportive of the concept of allowing 'premium only' facilities but he does not wish to see residents being required to leave a facility because they can no longer afford to pay for the services.

To this end he has requested that DHBs and provider representatives identify viable options which allow premium and additional charging environments but also protect the residents' rights and ensure that there are mechanisms available to continue subsidised care for potential residents who do not wish to pay for additional services.

The ARC Agreement

Clause A13 sets out the contractual obligations regarding "Charges To Subsidised Residents".

It states:

A13.1 You may not charge any Subsidised Resident or any other Person for any Services in respect of which you receive payments under this Agreement, except for the amount a Subsidised Resident is liable to pay under clause C3.1 and the Social Security Act.

A13.2 Clause A13.1 does not prevent you from providing or charging any Subsidised Resident for any services that are not covered by this Agreement, provided that:

a. You do not require, as a condition of admission to or residence in your Facility, that a Subsidised Resident or a potential Subsidised Resident agree to receive and pay for any such additional service; and

b. The Subsidised Resident has a choice whether or not to receive any individual additional service; and

c. The Subsidised Resident is able, at any time, to decide to receive or cease to receive any additional service; and

d. Full details of the Subsidised Resident's rights to receive or not receive additional services, and of each additional service and the charge for each additional service, are set out in the Admission Agreement referred to in clause D13; and

e. You do not charge the Subsidised Resident or any other Person any more than the agreed charges specified in the Admission Agreement.

Social Security (Long Term Care) Amendment Act 2006

The Social Security Act provides various rules including the obligation for the Funder to fund the difference between the "cost of contracted care services" and either the maximum contribution, or the amount assessed.

The definition of "cost of contracted care services" is:

"...in relation to a resident assessed as requiring care, the amount that

a) Is the cost of the contracted care services provided by a contracted care provider to meet the resident's assessed long-term residential care needs; and

b) Is specified in the service agreement or section 88 notice that applies to the contracted care provider as the price payable for those services, whether or not the services provided to the resident are wholly or partly funded under that agreement or notice"

Premium Only Facilities

District Health Boards contend that the ARC contract prohibits a provider from declining admission to a prospective resident if there is a bed available, simply on the grounds that the room is considered by the provider to be of a superior standard attracting an additional charge and the resident does not wish to pay the additional charge.

Providers contend that the clause relates to the Facility, not every bed in the Facility, and as such if the Facility has a limited number of "standard" rooms that meet the residents' assessed long-term residential care needs, and they are all full, they have the right to decline admission to these "premium" rooms. Further, providers contend that this is not a breach of the contract as it is not a requirement regarding entry to the Facility, but rather a part of the facility.

There are two fundamental issues at stake:

1. **Residents Being Able To Fund Ongoing Occupancy**

   If Premium Only facilities are permitted, and the prevalence of Additional Charging facilities increase, how do we safeguard everyone when a resident who has been in one of these facilities for an extended period of time, considers it their home, but runs out of funding and can not afford to remain. While this is unfortunate, generally on admission residents and their families do not know how long their life expectancy is, and as such it becomes difficult to ascertain how much the ongoing cost will be.

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2. **Ensuring Supply of Facilities Across All Levels of Socio Economic Wellbeing**

Concern is expressed by some District Health Boards that allowing Premium Only facilities will impact on the market significantly even in mixed (premium/standard) facilities, and that adequate supply of standard facilities may not be present to meet future need.

Further that this will simply ratchet the expectations up on residents to contribute to their services above the maximum contribution rates prescribed. Provider representatives advocate that this is not correct as the market will adjust to meet demands, and that DHBs have the ability to influence this by ensuring sustainable pricing for subsidised residential care is funded.

The Minister has given a signal that he is comfortable with the concept of Premium Only and Additional Charging facilities, but at the same time does not want to see residents evicted unnecessarily from facilities. Further, he expects DHBs to be accountable for ensuring adequate supply to meet the care needs of the older person regardless of socio economic status (i.e. adequate supply of premium, additional charging, and fully subsidised residents).

These issues will require more work but all point toward a future environment where residents may need to determine the level of risk they are prepared to take, ranging from an absolute mitigation of their financial risk to being prepared to accept responsibility for their own financial risk.

Summary of Key Points:

1. Additional charging is allowable

2. Additional charging must be for any services that are included in the definition of "contracted care services" and **not** covered by the ARC Agreement (i.e. costs that are not associated with meeting the resident's assessed long-term residential care needs.

Points where DHBs and providers differ:

1. The exact nature of what are contracted care services. The ARC agreement keeps it open in terms of whatever is required to meet the long-term residential care needs of an individual.

2. Requiring a resident or a prospective resident to accept additional services and as such require them to pay additional charges.

3. Where a resident has chosen to receive additional services and agreed to pay additional charges, subsequently chooses to cease receiving / paying for them, what might be an appropriate notice period for ceasing service receipt and payment?

Currently the lead CEO is canvassing the views of all DHBs on these issues. There are also three options being promulgated based upon the Australian experience where user contributions are common practice. It is intended to report further as the debate progresses over ensuing months.

2.2 Māori Health

2.2.1 Hauora Māori Scholarships

As reported earlier the Hauora Maori Scholarships are now administered through Health Workforce New Zealand. This the third year of operation of the Hauora Māori scholarship which provides financial assistance to eligible students or trainees. The course of study must be an NZQA accredited course in health and disability studies at a level 4 Certificate of Higher Education, level 5 Diploma of Higher Education and level 6 Undergraduate Certificate.

In December 2010 15 scholarship applications were received from eligible individuals for the 2011 academic year. The applications were then discussed with the Health Workforce New Zealand (HWNZ) representative and the DHB scholarship papers submitted. Discussions with the HWNZ representative have confirmed the 2011 MidCentral DHB funding allocation and the breakdown of scholarship funding as follows:

1. 143,920.00 for fees, travel assistance, mentoring and support
2. 10, 140.00 for a DHB Programme Coordination.

This translates to approximately $9,000 per applicant and a total contract for the 2011 training year of $ 154,060.

We expect to receive the funding contract early this year and the payment schedule will begin in March with monthly reporting requirements in place.

2.2.2 Māori Workforce Development hui at Aorangi Marae

In early December MidCentral Funding Division and Whakatutuki Moemoea held a Workforce engagement hui at Aorangi marae. Over sixty people from a range of health providers, health education, and many rangatahi (young people) attended the hui.

The purpose of the hui was to provide an update on Maori workforce activities and a platform for workforce development action over the next 18 months. Professor Sir Mason Durie was the keynote speaker for the hui which was facilitated by Tipi Wehipeihana both showing inspiring leadership on the day.

The update consisted of key Maori health workforce activities since 2006. These have included:

- a stock take of Māori and generic service providers about their Māori Workforce
- improved access to workforce information on MidCentral DHB website
- a facilitated network hui amongst service providers to enhance existing forums to discuss Māori workforce issues and solutions
- closer relationships with tertiary institutes
- the launch of the cultural competency framework in general practice
- the commencement of the Hauora Māori Scholarships
- Kia ora Hauora

The attendees received the update positively and participated in workshops toward designing Maori health workforce actions including a Maori health workforce network. The hui participants provided valuable input and feedback to drive workforce development forward. Many of the attendees signalled their interest in being part of a Maori health workforce network and and some were interested in being mentors or mentees. The feedback from the hui is being analysed and a further update will be provided in March.

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2.3 Mental Health and Addiction

2.3.1 National Services Framework NSF

All NGO mental health and addiction providers have now commenced the NSF project which changes all mental health contracts to align to the new service specifications and purchase units.

This project is a national directive by the Ministry of Health and the framework is based on a three tiered system that categorises the services of adult mental health; child and adolescent; consumer leadership; kaupapa Māori; addiction; pacific; refugee; forensics; peri natal mental health and older people. Essentially the development of new service specifications allows flexibility and supports the continuum of care approach for mental health and addiction services.

2.3.2 Te Pou National Workforce Centre

Te Pou National Workforce Centre has undertaken the roll out of the Lets Get Real Skills workshops for mental health practitioners in all NGO mental health and addiction providers at no cost.

This initiative has developed despite nil funding contracts between the DHB and Te Pou Workforce Centre. Te Pou National Workforce Centre have agreed to provide catering and resources for the half day workshops. Feedback from the sector has been extremely positive and well received. The next step is undertaking the training workshop with the Central PHO.

2.3.3 Regional Mental Health and Addiction Strategy 2011-2014

For the last three months the central region has been developing the Central Region Mental Health and Addiction Action Plan 2011-2014. A primary focus will be on regional detoxification services, in which there has been sporadic service provision by MidCentral Health's sub-regional detoxification medical beds (Ward 26); focus is also on the Regional Rehabilitation and Extended Care model, through which MidCentral Health buys two beds from Capital Coast DHB.

Further work will be undertaken in 2011 alongside MidCentral Health to develop improved services and systems for mental health services in secondary services.

2.4 Cardiology Landscape Project Update

This project was commissioned to provide an assessment of cardiology service provision and related health outcomes across MDHB. Objectives include assessing the steps required to better meet the needs of the population over the next three to five years, in particular the capability and capacity of the cardiology department at MDHB to meet these needs. The report will provide a basis for internal planning, funding and investing purposes.

The project sponsor is Mike Grant, GM Funding Division and the steering group is chaired by Mark Beale, Clinical Leader Internal Medicine. Steering group membership comprises; Dr Laura Davidson, Cardiology Head of Department; Dr Delamy Keall, General Practitioner; Jan Dewar, Nurse Director Medicine; Amanda Driffill, Medical Services Manager and Lyn Horgan, Operations Director Hospital Services. Dr Mark Simmonds, Head of the Cardiology Department at Capital & Coast DHB and regional Clinical Director of Cardiology is closely connected to the project and has been receiving all project information.

Over 50 stakeholders across the continuum have been interviewed, including representatives from the community cardiology service, general practice, PHOs, secondary service cardiology department staff and other services that interact with cardiology (e.g. general medicine,

paediatrics, emergency department, medical imaging, anaesthetics, intensive care unit and palliative care). Those contacted external to MDHB include other DHBs, TAS and the Ministry of Health. As well as review of relevant local and national documents and selected international articles, the project has a large analytical component which has required the contribution of many analysts across MDHB, Compass Health and the Ministry of Health. Reports and data available nationally are also being used such as Health Targets and PHO Performance Management System.

The draft report will be received by the steering group on Thursday 3 February 2011 and will be circulated to stakeholders week 7 February.

2.5 Health Care Development

HCD continues to work towards its vision "Interdisciplinary team achieving Quality Living: Healthy Lives". This report provides an update on some of the work underway which continues to gain momentum within the district.

Nursing Entry to Practice Expansion Programme (NETPEP)
HCD continues to successfully organise and coordinate this CTA funded year long programme which was first introduced for primary health care nurses in 2006. Since this time:

- 76 newly registered nurses have enrolled
- 45 have graduated
- 7 currently completing requirements.

Moving out of the region or over to Australia are the main reasons for non-completion of the programme although parental leave has also had an impact. Thirty two of the 45 graduates from nine cohorts have remained working within the region and six have gone on to commence post graduate study.

NETPEP is a demanding programme which supports both the nurse, their preceptor and employer throughout the course of the year. It provides the new nurse with 10 study days, clinical supervision and personalised mentoring by a HCD nurse educator. The preceptor is also supported and attends two study days, one of which is the work-based assessor course. Many registered nurses working in primary health care do so in highly autonomous roles (aged residential care, mobile nursing, tamariki ora positions etc) and so new graduates can find themselves having to function in challenging environments with varying levels of support. They and their preceptor appreciate and make use of the assistance and extra study that the programme provides.

The ninth cohort (which commenced February 2010) comprises 12 new graduates working across the region in a variety of settings such as Maori and Iwi providers, aged residential care, general practice and youth health. Seven participants have completed programme requirements with another five close to finishing. The 10th cohort started NETPEP in August 2010 with two participants, both of whom work in elder care. Planning is underway for the February 2011 intake and four nurses have enrolled. Other primary health care employers have expressed interest but currently have no capacity to take on new employees.

Other achievements for the 2010 year are the successful reaccreditation of the Programme by the Nursing Council. Positive feedback was received from the auditors with another review not required for three years. Additionally, the Programme is now available on-line, so participants and preceptors can access their Knowledge and Skills programme, timetable, study day agendas, pre-quizzes, discussion boards and all other aspects in their own time. This also enables HCD nurse educators to view participants progress remotely. A project has commenced to improve the functionality of this facility in conjunction with the MCH nurse educator to make the same electronic ability available to hospital based new graduates.

5.10

2.5.1 Professional Development and Recognition Programme (PDRP)

To prove ability nurses in the MDHB region have the opportunity to complete a PDRP (or 'portfolio') to a competent, proficient or expert standard, depending on their work requirements. This programme is available to both primary and secondary care nurses and as part of NETPEP participants must provide a level 2 (competent) portfolio before they can graduate.

To encourage other primary health care nurses to undertake the PDRP programme a number of workshops have been held in Palmerston North over the course of 2010. 25 community based registered nurses working in a variety of fields have completed the workshops and about 20 have gone on to commence development of their portfolios. Many of these nurses are enrolled in a HCD Nursing Knowledge and Skills Programme (see below) so cross referencing of evidence will mean completing a PDRP portfolio will not be an onerous exercise for these people. Six other nurses are currently completing level 4 (expert) PDRPs. Workshops for enrolled nurses are being planned for and will be rolled out in 2011.

2.5.2 Nursing Knowledge and Skills Programme

This programme, set at Level 2 (Competent), identifies the minimum knowledge and skills that Registered Nurses require to care for people in our district. When completed, the evidence can be cross referenced to the Nursing Council of New Zealand's domains for the registered nurse scope of practice. To retain registration nurses have to complete 60 hours education within a three year time frame and confirm that they are competent to practice. The Knowledge and Skills Programme enables participants to show that they have met these criteria.

Within the programme, there are five Dimensions which all participants complete - Core, Health and Wellbeing, Clinical Specific, Information and Knowledge, and Clinical Leadership. The core component includes:

- Health Care Teams
- Communication
- Ethical Health Care
- Cultural Responsiveness
- Health, Safety and Risk Management
- Service Improvement
- Quality Improvement
- Personal Development

The clinical specific aspects vary depending on the field in which the nurse works. In this way the programme can be made to suit all primary health care nurses regardless of their work setting. For marketing purposes nurses enrol in either Knowledge and Skills Programme Older Persons, Knowledge and Skills Programme Child Health , Knowledge and Skills Programme Youth Health or Knowledge or Skills Programme General Practice- depending on their interest and work setting. As can be seen this is a very comprehensive programme which can be tailored and made relevant to each individual nurse.

In November 2010 a graduation ceremony was held for 16 aged residential care and four general practice nurses who had successfully completed their programmes. Another cohort of around 40 nurses (most being from residential care) are due to complete early next year. Twenty five aged residential care facilities are enrolled with all registered nurse employees participating in the Older Person programme.

2.6 Primary Health

2.6.1 Diabetes Management Target

Over recent years MidCentral DHB has accorded a high priority to the management of diabetes. In 2005 a Diabetes Service Plan was published. It guided an investment programme that has seen the creation of many new services and clinical positions in primary health care. These have included specialist nursing, podiatry, retinal screening and lifestyle change services (smoking, exercise and diet).

At the national level, DHB performance in the diabetes area is measured by two main indicators. The first is the number of people each year who have a Diabetes Annual Review through the Diabetes Get Checked Programme. This is calculated as a percentage over the number of people in the district estimated to have diabetes (ie, diabetes prevalence as calculated by the Ministry of Health).

The second indicator is the proportion of people who have had Diabetes Annual Review who have an HbA1c level of 8 or less. HbA1c is a measure of blood glucose. A score of 8 or less is widely accepted as an indicator of good diabetes management. Rates of more than 8% are associated with complications and poor health outcomes.

While Diabetes Annual Review rates in our district are consistently good, there has been room for improvement on the Diabetes Management indicator. In November we wrote to Central PHO requesting that a higher priority be applied to improving the Diabetes Management indicator. The PHO has responded by developing an Action Plan with the following key initiatives:

- Immediate communication with general practice teams about the need to lift performance, identifying each individual practice's performance, providing clinical guidelines and reminding practices of the resources that are available within the district. Thereafter regular provision of information on the practice's performance and identification of patients who are "outside the zone".
- Working with the six practices in the district with the largest number of patients with HbA1c of 8 or more. This includes assigning PHO resources to work with patients with HbA1c of between 8% and 9% - which is the largest group considered to have the most potential to move.
- Developing a system for tracking HbA1c improvement in patients because its based on the Diabetes Annual Review (which is an annual event) the Diabetes Management indicator is not very good at measuring improvement.
- Improving general practice capability around identified gaps – eg, initiating insulin therapy.
- Develop a formal collaborative clinical pathway for adult Type 2 diabetes that runs across general practice teams, PHO services, the Manawatu/Horowhenua/Tararua Diabetes Trust, and the Diabetes Lifestyle Centre.

The PHO's recovery plan includes a good mixture of short term and medium term measures. It goes beyond a knee-jerk response and seeks to improve the way services are functioning and, perhaps more importantly, the way the various services and agencies are working together.

Because Diabetes Management is taken from a patient's Diabetes Annual Review, which is an annual event, this indicator is likely to be slow to show improvement. For example, if at their

Diabetes Annual Review a patient is found to have an HbA1c of 9%, this result stands until the next Annual Review is done, even if the general practice team gets the patient's HbA1c to 7% within two months. There is no mechanism to update the indicator if the patient's health improves.

Our intention is that improvement in the Diabetes Management indicator be achieved without reducing performance on the Diabetes Annual Review indicator. This is an area we will continue to monitor.

2.6.2 After Hours

The Better, Sooner, More Convenient Business Case included a number of initiatives relating to after hours. Two of these have recently got underway:

Single Point of Access
On 1 December the national HealthLine service became the Single Point of Access for all after hours calls to general practice (with the exception of Feilding). Under the arrangement, general practice team phones automatically switch to HealthLine at the end of their normal clinic hours. HealthLine receives calls, triages patients, and then refers patients on to the services they need. HealthLine carries a list of the after hours arrangements in place within the district and can thus advise patients as to exactly which services are available. If required, HealthLine performs a "warm handover" which means they connect the patient to the service they need.

The HealthLine service was rolled out first in Horowhenua and then across the whole district. Feilding GPs have elected not to use the service at this stage. Feilding GPs already use a service which can book appointments with whichever GP is on duty. At the time of writing no significant issues had been identified.

Extended Care Paramedics
On 1 December St Johns began providing Extended Care Paramedic services in the Horowhenua. Under this service, specially trained paramedics triage and treat patients rather than triage and transport as has traditionally been the case. Within the first week St Johns reported success in managing patients who would previously been taken to the Emergency Department.

2.6.3 Horowhenua Waiting List Practice

Central PHO is in the process of establishing a nurse-led Waiting List Practice which will enrol all the patients currently held on the general practice waiting list. This is in response to a steady rise in the waiting list over the last 12 or 18 months. By late-December, about 400 people had signed up to the new practice with a further 400 confirming that they were no longer wanting to enrol with a GP (eg, left the district, found a GP). Over the Christmas period the PHO has been appointing nursing staff for the new service. It is due to commence on 1 February.

Central PHO has purchased the GP Practice of Dr Robin Stephen. MidCentral DHB provided assistance to support this purchase to occur.

2.6.4 Medlab Éclair and Electronic Ordering

Medlab Central has advised the Laboratory Clinical Council that its Éclair Orders system has now been rolled out to general practices. This is regarded as quite a milestone. Éclair Orders is significant because it provides GPs with online access to all lab results and also has the capacity to guide lab ordering through diagnostic rules.

At this stage some practices report problems with Éclair because of broadband issues.

Medlab is waiting for the application to gain wider coverage before instituting the Diagnostic Rules feature.

2.7 Child & Youth Health

2.7.1 Poverty Affecting Health of Children in our Region

The recent release of the 2010 New Zealand Children's Social Health Monitor Report mirrors what paediatricians are seeing in the Manawatu, Horowhenua and Tararua regions. The report written by researchers at the Child and Youth Epidemiology Service based at Otago University confirms that children's health is suffering because of the recession. Throughout the country there are more children being admitted to hospital for respiratory illnesses and infections related to poor housing and economic hardship.

Over the last few years, the local paediatricians have seen more children being admitted to hospital with skin infections and presenting later with severe lung infections.
Dr Jeff Brown Clinical Director Child Health reiterated in a local media release that "It is now routine to have children on the ward receiving intravenous antibiotics for nasty skin infections". He went on to say that "at the start of the year there were a number of children with very serious lung infections, some of whom required surgery to drain lung abscesses". Part of the problem appeared to be due to children not getting antibiotics until too late due to families not being able to afford GP visits after hours.

There are initiatives under way in MidCentral DHB to try and address the problems related to children and families not being able to access medical care. An example of this is the move to Integrated Family Health Centres across the region. This will enable paediatricians and other hospital specialists to work along side GPs, nurses and other health professionals in order to provide care closer to home. However, the ongoing issue of cost to families for after hours care for children remains fore front. The Children's Commissioner and leading paediatricians throughout the country are calling for health care to be free 24 hours per day for children under 6 years. This is a matter of government policy and MidCentral DHB will continue to initiate actions to improve child health within the current policy arrangements.

2.7.2 Immunisation

The Improving Immunisation Coverage Project Group continues to work innovatively to improve the coverage rates of two year olds in our district. Coverage rates currently stand @ 90%. The current Outreach Immunisation Service list has become a challenge over the last two months as General Practice works hard to forward children overdue for immunisation onto OIS in a timelier manner. In response to this the OIS service is receiving increased funding in the short term to meet the need.

Recent board feedback regarding non identified text messaging has prompted the Portfolio Manager Child and Youth Health to meet with the Immunisation team and remind them of the appropriate processes and protocols around text messaging to families and the need to identify themselves at all times. Whilst this action has been taken, the OIS was not aware of this behaviour. All providers have now been reminded to be vigilant around identifying themselves and their organisation when text messaging.

2.7.3 Child Health Reference Group move to District Group

The Child Health Reference Group (CHRG) met for the last time in December under their current role. Dr Jeff Brown as chair of the group thanked the membership for their commitment, support and the ongoing enthusiasm within the group.

Since 2006 the CHRG has supported the MidCentral District Health Board to progress the Child Health strategy and improve health services offered to children and their families.

While this was a useful process the DHB is now establishing a Clinical Network structure to embed service improvement and development activities.

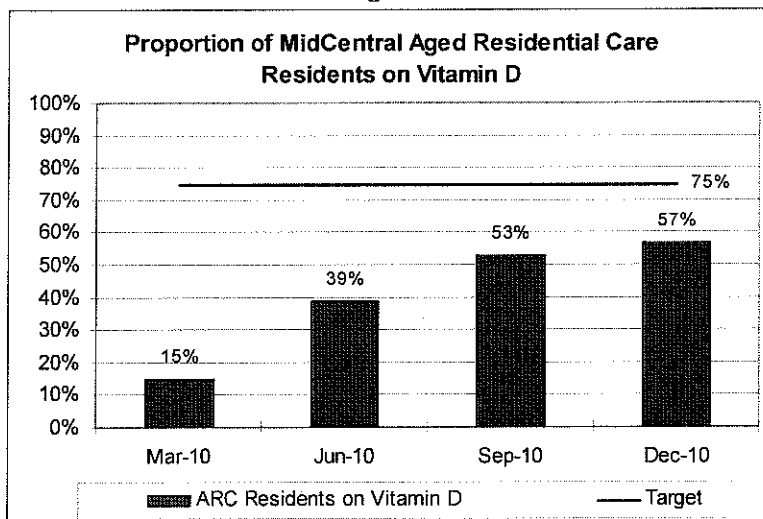
The new Child Health District Group will be formed early in 2011. A letter, background document and nomination process was disseminated widely across the sector mid December. Nominations close 14 February 2011 at which time a robust selection process will be undertaken. All work and progress to date is supported and guided by the Transitional Leadership Group.

2.8 Pharmacy

2.8.1 Vitamin D in Aged Residential Care

In an effort to reduce the incidence and health impact of falls, MidCentral DHB is working with ACC to increase the number of Aged Residential Care (ARC) residents taking vitamin D. Recent data received from ACC in December shows an increase in the rate of vitamin D being utilised by ARC residents. Vitamin D utilisation in MidCentral facilities averages 57% (Figure 1).

Figure 1



When comparing data for December with that for September for the 64 facilities in the district:

- 28 had better and 27 had worse vitamin D utilisation rates, while 9 were unchanged in December;
- the 75% target was met by 18 facilities in December and 17 in September;
- In December, 11 facilities had fewer than 25% of residents taking vitamin D, compared with 15 in September.

The project continues until 2012 and activities in the next quarter will focus on those facilities where vitamin D utilisation is very low, in order to increase their rates. Liaison with facilities that have high utilisation rates will also occur in order to find ways to improve utilisation that may help other facilities.

2.8.2 Appropriate Use of Diabetes Test Strips (AUDiTS)

MidCentral DHB makes a significant investment in the provision of diabetes test strips for use by people with diabetes. At December 2008, the utilisation of diabetes test strips in MidCentral DHB was approximately 140,000 strips per month or 1.68 million strips (33,600 boxes of 50 strips) per year, and growing at about 10% per annum. Expenditure for MidCentral DHB associated with this product was approximately $65,000-$70,000 per month (~$800,000 per year), which is high by national standards.

Recent controlled trial evidence reinforces the view that self monitoring of blood glucose (SMBG) is unlikely to be beneficial in people with Type 2 diabetes who are not being treated with insulin; it may worsen quality of life and is not cost effective. Best practice guidance has been updated to reflect this data.

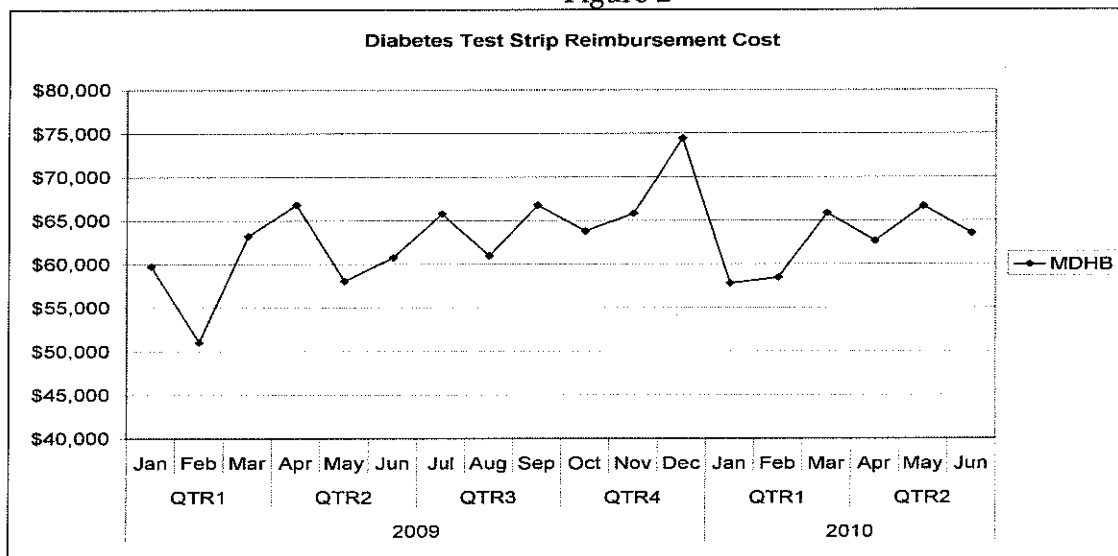
Recent information from the Best Practice Advocacy Centre (BPAC[NZ]) suggests that test strips are being over utilised by people with Type 2 diabetes in the MidCentral district. MidCentral DHB utilisation rates of diabetes test strips appear highest in Horowhenua and Otaki PHOs.

To address this, PHO Clinical Advisory Pharmacists have been utilised to promote best practice use of diabetes test strips in order to optimise test strip utilisation in Horowhenua and Otaki. It was recognised early in this process that there are many significant influences on diabetes test strip utilisation including but not limited to PHARMAC, the pharmaceutical industry, MidCentral Health diabetes services, PHO diabetes services (including the Get Checked and PHO Performance Programmes), general practice team members, community pharmacists, and diabetes consumer groups. These influences are sometimes counter-productive to what PHO Clinical Advisory Pharmacists hope to achieve. The behaviour of only some, not all of these authorities can be influenced.

Nevertheless, Central PHO Clinical Advisory Pharmacists has been working with general practice teams, PHO diabetes services, and the MidCentral Community Pharmacy Group (MCPG) to effect a reduction in the utilisation of diabetes test strips.

The 12 month AUDiTS contract with Central PHO began in March 2010 and will expire at the end of February 2011. Diabetes test strips utilisation data is currently only available for the first four months of this contract (Figure 2).

Figure 2



This data reflects the information gathering phase of the service, with any resulting reduction in test strip utilisation likely to become evident in the last two thirds of the contract term.

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2.9 Population Health

2.9.1 Tobacco Control

ABC Health Target

The ABC health target result over the November and December period has now increased to 71% . This result can be compared to the prior three months' results of 62%. Key improvement areas in secondary care have been the Emergency Department and Women's Health. The ABC taskforce anticipate improved performance across all other areas within the next quarter.

ABC initiatives in Secondary Care

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. This will ensure data is captured right from pre admission notes. Improvements to the form will occur as required to ensure information is detailed and clear for documentation.

An audit was performed in December 2010 for three wards. The results showed that 14 out of 15 files checked had green forms. Audits will be ongoing to ensure screening forms are included into all patient notes.

STEPS ABC Train the Trainer programme:

The STEPS National Smokefree ABC Train the Trainer programme (in both primary and secondary care) will commence in June 2011 and delivered by the Ministry of Health (MoH). Smoking cessation specialists such as Quitline staff, Aukati Kai Paipa kaimahi and health care providers who have been trained as smoking cessation treatment providers are a key component of the ABC approach.

The workshops are not designed to replace specialist smoking cessation treatment, rather to support and strengthen the delivery of the current ABC training as well as the smokefree training workforce within our district. This initiative will ensure consistent messages are delivered and effective, brief ABC training is provided within DHBs and PHOs .

MDHB Executive/Clinical Champion Campaign

The RFP evaluation for the ABC executive/clinical poster campaign has now been finalised and distributed for tender. The posters were distributed to each ward in November 2010, therefore the project timing will commence in February with a final report and presentation in May 2011. The overall aim of the campaign is to assess the short-term impact of the posters, specifically understanding whether or not the presence of the posters:

- was noticed by employees (as well as awareness, MidCentral is interested in learning about whether or not the posters were liked, memorable and well received)
- served as a reminder to employees to undertake ABC service delivery
- made employees think about the reasons why ABC is important to do (beyond meeting health targets).

ABC executive/clinical champions along with administrative and nursing staff will participate in three or four focus groups.

ABC Training in Secondary Care

December month was very quiet, with only five ABC training sessions booked. The taskforce are confident that existing ABC initiatives will increase the uptake of staff who have not yet received training.

Referrals: In December 2010, 80 Maori were identified as smokers. Of these 80 people, 55 were given brief advice and referred to the Public health unit (PHU) smoking cessation services. We will continue to monitor progress to ensure that Maori are approached and offered the chance to quit.

ABC Training in Primary Health Care

Staff continue to be trained in primary care. There is a strong focus to target all staff in all community health settings. The ABC super trainer programme looks to support and increase the momentum of the ABC strategy.

ABC Smoking Cessation and Mental Health Services

Further workshops for the "Lets Get Real' ABC training will be delivered to Whaioro Trust; Whakapai Hauora and Central Health PHO's in February 2011.

2.9.2 Healthy Eating Healthy Action (HEHA)

A group of providers among the Aged Care sector have recognised the need to develop prevention programmes that will help maintain the health of clients as they age. A pilot health promotion project is currently being developed by Sport Manawatu and MetLife Care. There is potential to develop exercise and cooking classes, expand links with local sporting and recreation clubs to encourage membership, and provide train the trainer education to residents who express an interest. There has been interest in this project from other providers and, once developed, the pilot has the potential to be expanded across the district.

Nationally the Green Prescription programme is under review. Aimed at allowing GP's to prescribe physical activity and nutrition programmes to patients as a health improvement measure, the programme has also been reconsidered at a local level. New management within the provider, Sport Manawatu, has meant the provider has considered possible expansion of the programme into key settings, such as mental health. Options to increase referral numbers and expanded the curriculum of the programme are also under consideration.

3. RECOMMENDATION

It is recommended:

that this report be received

pp **Mike Grant**
General Manager, Funding Division

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TO Community and Public Health Advisory Committee

FROM Finance Manager
Funding Division

DATE 17 January 2011

Memorandum

SUBJECT **FINANCE REPORT – DECEMBER 2010 AND JANUARY 2011**

1. KEY EVENTS

1.1 Forecasted Result for 2010-11

The Funder's YTD result to Dec 10 was $585k surplus to budget and the forecasted 10-11 result is equal to budget. The main reason for the surplus is the washup with MCH on its under-delivery.

1.2 2010-11 IDF

The Funder has reviewed the IDF position this month and considered that the YTD provision is adequate.

1.3 Demand Driven Pharmacy Expenditure

In line with the current month trend, the projected expenditure is reduced to $45m based on the revised YTD expenditure.

1.4 MidCentral Health Washup

The total year to date (YTD) washup position is $523k under-delivery by MCH.

1.5 Electives Initiatives (EI)

The Funder has accrued $4.2m for YTD EI income which is $0.4m below budget.

2. FUNDER FINANCIAL PERFORMANCE

The Funder had a cumulative surplus to budget of $585k up to the end of Dec 2010.

MidCentral DHB - Funder
Income and Expenditure - By Ring Fenced Area
For the period ending 31 December 2010

	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)	179,951	177,365	2,586	359,790	354,511	5,279
Personal Health Expenditure	(d)	179,919	178,405	-1,514	356,354	354,511	-1,843
Personal Health Surplus/(Deficit)	(e)	32	-1,039	1,072	3,436	0	3,435
Mental Health Income		19,598	19,763	-165	39,151	39,526	-375
Mental Health Expenditure		18,938	19,881	942	38,909	39,526	618
Mental Health Surplus/(Deficit)	(f)	660	-117	777	243	-0	243
Disability Support Income	(g)	31,983	31,730	253	63,706	63,460	246
Disability Support Expenditure	(h)	34,074	32,268	-1,805	67,885	63,960	-3,925
Disability Support Surplus/(Deficit)		-2,091	-538	-1,553	-4,179	-500	-3,679
Maori Health Income		1,045	966	79	1,932	1,932	0
Maori Health Expenditure	(i)	756	966	210	1,932	1,932	0
Maori Health Surplus/(Deficit)		289	0	289	0	0	0
Governance Income		1,192	1,192	-0	2,384	2,384	0
Governance Expenditure		1,192	1,192	0	2,384	2,384	0
Governance Surplus/(Deficit)		0	0	0	0	0	0
Total Funder Surplus/(Deficit)		**-1,110**	**-1,695**	**585**	**-500**	**-500**	**-0**

Note on YTD Variance

(a) Extra project funding with corresponding extra expenditure (major projects - Herceptin $1.8m; CYFS $0.4m; VLCA $0.3m; 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 $0.4m Elective income.

(b) The YTD 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 YTD income also included $1.2m 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 $0.8m 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

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MidCentral DHB - Funder and Funding Administration
Statement of Financial Position as at 31 December 2010

	Actual		
	Year-Ended Jun-10	Current Position Dec-10	Change
	$000	$000	$000
ASSETS EMPLOYED			
Current Assets	**25,536**	**47,833**	**22,298**
Bank	21,309	43,972	22,663
Intercompany Advance Account	0	0	0
Debtors and Prepayments	4,226	3,861	(365)
Inventories	0	0	0
Properties Intended for Sale	0	0	0
Current Liabilities	**27,107**	**50,206**	**23,100**
Bank Overdraft	0	0	0
Intercompany Current Account	4,768	5,027	260
Trade Creditors and Accruals	18,660	981	(17,679)
GST	2,689	3,030	341
Income in Advance	876	41,054	40,178
Provisions (Payroll)	113	113	0
Current Portion of Term Loans	0	0	0
Net Working Capital	**(1,571)**	**(2,373)**	**(802)**
Net Assets Employed	**(1,571)**	**(2,373)**	**(802)**
SHAREHOLDERS EQUITY			
	0	0	0
Retained Earnings	39,513	38,711	(802)
Transfer to Co 41	(41,084)	(41,084)	0
	(1,571)	(2,373)	(802)
Other Reserves	0	0	0
Total Shareholders Equity	**(1,571)**	**(2,373)**	**(802)**

3. MIDCENTRAL HEALTH PROVIDER DIVISION RESULT

3.1 Statement of Financial Performance to Budget

MidCentral Health - Provider Division YTD to: December-10
Statement of Financial Performance to Budget

$000	Month		Year to date		Annual
	Actual	Variance	Actual	Variance	Budget
Revenue					
Govt. & Crown Agency Sourced	21,551	(562)	135,036	(214)	268,338
Patient/Consumer Sourced	72	8	544	158	771
Other Income	757	347	2,630	170	4,921
Total Revenue	**22,381**	**(206)**	**138,210**	**114**	**274,030**
Expenditure					
Personnel	13,467	(79)	76,754	2,541	158,108
Outsourced Personnel	182	(57)	2,237	(1,490)	1,598
Sub-Total Personnel	13,649	(136)	78,991	1,051	159,705
Other Outsourced Services	1,122	72	7,005	158	14,326
Clinical Supplies	3,632	185	22,096	944	45,834
Infrastructure & Non-Clinical	4,097	(102)	24,240	(272)	48,125
Total Expenditure	**22,501**	**19**	**132,331**	**1,882**	**267,991**
Operating Surplus/(Deficit)	**(120)**	**(187)**	**5,879**	**1,995**	**6,039**
Corporate Services	722	0	4,313	17	8,660
Surplus/(Deficit)	**(841)**	**(187)**	**1,566**	**2,012**	**(2,621)**

3.2 Commentary

The month's result was $187k unfavourable to budget, being $206k short in revenue offset by $19k favourable in total expenditure. The year to date result is $2 012k favourable to budget.

Revenue
Revenue is below budget in the month mainly in Surgical $219k and Mental Health $206k where volumes were below target. Approximately $347k of this is internal funding between the Funder and Provider and will remain in the organisation. Indications are that a major portion of the surgical difference is in the timing of recorded volumes and should be pulled back in future months.

Revenue in total is on budget for the year to date.

Total Personnel (including Outsourced Personnel) Costs
Total personal costs were 1% over budget for the month, but are well within the budget for the year to date by $1 051k. Personal costs are $668k lower than those in December 2009, which is a good indication of the success in the management and containment of these costs.

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

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4. MIDCENTRAL DHB RESULT

Dec-10 *Year to date*	**DHB RESULT** ('000's)	**Funding Division** ('000's)	**Provider Division** ('000's)	**Governance** ('000's)
Net Result				
YTD - Actual	**372**	(1,111)	1,671	(188)
YTD - Budget	**(2,586)**	(1,695)	(346)	(545)
Variance	**2,958**	584	2,017	357

After six months, the DHB result is a favourable variance to budget of $2,958k.

5. CONSOLIDATED FINANCIAL POSITION

MidCentral District Health Board
Statement of Financial Position (summary)

	Jun 2009 $000	Jun 2010 $000	Dec 2010 $000	Change $000
Assets Employed				
Current Assets	44,727	41,941	89,453	47,512
Current Liabilities	(54,841)	(55,944)	(100,064)	(44,120)
Fixed Assets and Investments	164,748	160,010	157,374	(2,636)
	154,634	146,007	146,763	756
Funds Employed				
Equity	98,521	89,425	90,128	703
Bank Loans	54,867	55,301	55,354	53
Long Term Liabilities	1,246	1,281	1,281	0
	154,634	146,007	146,763	756

The current assets (investments) and current liabilities (receipts in advance) are unusually high at the end of December, due to the January funding of $39.4m being received from the Ministry of Health on 31 December. This also affects the net debt figures shown in tables 6 and 7, and the cash summary shown in table 8.

6. COVENANTS

Dec-10	Actual	Limit / Covenant
YTD - Variance to Budget	$3.0	< ($2.0m)
Bank Loans (net debt)	($18.2)	$71.7m
Equity	$90.1	> $30m
Debt & Equity	$71.9	
Debt Ratio	-25.3%	< 55.0%
YTD Interest Cover	4.78	> 3.00

7. DEBT POSITION

MidCentral District Health Board	Jun-09 $m	Jun-10 $m	Dec-10 $m
Available Bank Facility	71.7	71.9	71.9
Net Debt (CHFA & Banks)	29.0	29.8	-18.2
Debt Facility Surplus / (Shortfall)	42.7	42.1	90.1
Reserved Funds	18.7	18.7	20.2
Debt Facility Available	24.0	23.4	69.9

8. CASH POSITION

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

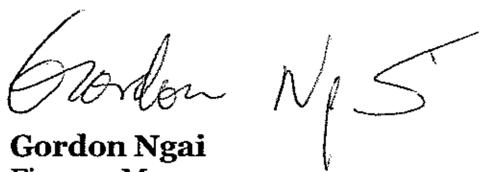
Cash / Investment Summary as at 31 December 2010

	$m
Treasury Division	17.3
Funding Division	53.6
MidCentral Health	0.6
Trust Funds - Short Term	0.4
Enable	1.7
Total	73.6

9. RECOMMENDATION

It is recommended:

that this report be received



Gordon Ngai
Finance Manager
Funding Division

TO Community & Public Health Advisory Committee

MidCentral District Health Board
Te Poe Hauora o Ruahine o Tararua

FROM Chief Executive Officer

DATE 25 January 2011

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

MEMORANDUM

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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.

Next month, the key focus will be on the 2011/12 annual plan and members are reminded of the Board/Committees' annual planning workshop scheduled for **Tuesday, 15 February**. All members are invited to attend. Proposed key initiatives for the year ahead will be considered at the workshop, together with the preliminary financial forecast for 2011/12. As members will be aware, Regional Service Plans are also required for next financial year and our annual plan will be closely aligned to this document. The Regional Service Plan will be part of the workshop.

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
- 2011/12 Draft Annual Plan
- Update re implementation of the Regional Clinical Services Plan
- Updates re implementation of the 2010/11 District Annual Plan:
    - Primary Care
    - Hospital Productivity (information only)
    - Regional Services
- Update re implementation of the centralAlliance's funding/planning workstream
- Non-financial performance measures

COPY TO:

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Palmerston North
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6.2

3. Recommendation

It is recommended:

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

Murray Georgel
Chief Executive Officer

ID	Indicator	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	[calendar]	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	[calendar]	Implementation of RCSP: update 2 (copy for info)
10	[calendar]	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	[calendar]	Annual review of Health Needs Assessment:
15	✓	Annual review of Prioritisation Framework
16	✓	Price:Volume Schedule (draft)
17	[calendar]	2011/12 Plan: Draft 1
18	[calendar]	2011/12 Plan: Draft 2
19		**2010/11 Plan - Implementation (inc update re implementation & identified outcomes)**
20	✓	PIA 2: Primary Care - update 1
21	[calendar]	PIA 2: Primary Care - update 2
22	[calendar]	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	[calendar]	PIA 1: Hospital Productivity - update 2
28	[calendar]	PIA 3: Regional Services - update 2
29	[calendar]	PIA 1: Hospital Productivity - update 3
30	[calendar]	PIA 3: Regional Services - update 3
31	✓	PIA 4: Quality - update 1
32	[calendar]	PIA 4: Quality - update 2

Timeline: Jun Jul Aug Sep Oct Nov Dec | 2011: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

6.4

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		**Contracts (Funding)**
44	✓	Update 1
45	✓	Update 2
46	✓	Update 3
47		Update 4
48		**Non-financial performance indicators**
49	✓	Update 1
50	✓	Update 2
51		Update 3
52		Update 4
53		**Hospital Benchmark Information**
54	✓	Update 1 (copy only)
55	✓	Update 2 (copy only)
56	✓	Update 3 (copy only)
57		Update 4 (copy only)
58	✓	PHO Combined Clinical Council: annual report
59		PHO Combined Clinical Council: annual report
60	✓	Financial Recovery Programme: update re FD component
61		**Workforce**
62	✓	Update 1
63		Update 2
64		**CENTRALALLILANCE**
65		**Implementation of Funding Workstream**

2011: Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

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