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

Management Team
- Kathryn Cook, CEO
- Craig Johnston, General Manager, Strategy, Planning & Performance
- Mike Grant, General Manager, Clinical Services & Transformation
- Neil Wanden, General Manager, Finance & Corporate Support
- Janine Hearn, General Manager, Clinical Services
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- Peter Jane, Account Manager

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Contact Details Committee Secretary
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Next Meeting Date 22 November 2016
Deadline for Agenda Items 4 November 2016

MidCentral District Health Board

A g e n d a

Healthy Communities Advisory Committee

Part 1

Date: 11 October 2016

Time: 1.00pm

Place: Board Room
Board Office
Heretaunga Street
Palmerston North

MidCentral District Health Board

Healthy Communities Advisory Committee Meeting

Tuesday, 11 October 2016

Part 1

Order

1. APOLOGIES

Kathryn Cook, CEO

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 – Healthy Communities Advisory Committee

Pages:	5-17
Documentation:	minutes of 30 August 2016 and 19 July 2016
Recommendation:	that the minutes of the previous meeting held on 30 August 2016 and 19 July 2016 be confirmed as a true and correct record.

4.2 Minutes – Disability Support Advisory Committee

Pages:	18-23
Documentation:	minutes of 7 June 2016
Recommendation:	that the minutes of the previous meeting held on 7 June 2016 be confirmed as a true and correct record.

4.3 Recommendations to the Board

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

4.4 Matters Arising from the Minutes

To consider any matters arising from the minutes of the meeting held on 30 August 2016 for which specific items do not appear on the agenda or in management reports.

5. GOVERNANCE

5.1 2016/17 Work Programme

Pages: 24-26
Documentation: report from Chief Executive Officer dated 4 October 2016
Recommendation: that progress against the 2016/17 work programme be noted

6. PERFORMANCE MONITORING

6.1 Equity Snapshot and Dashboard Development Approach

Pages: 27-29
Documentation: report from General Manager, Maori & Pacific Health dated 27 September 2016
Recommendation: that this report be received

7. DISABILITY MATTERS

7.1 Disability Strategy and Aged Care in MidCentral

Pages: 30-40
Documentation: report from Senior Portfolio Manager, Health of Older Persons dated 3 October 2016
Recommendation: that this report be received

8. OPERATIONAL REPORTS

8.1 Immunisation Stakeholder Group Work Plan 2016/17

Pages: 41-51
Documentation: report from Senior Portfolio Manager Children, Youth & Intersectoral Partnerships dated 3 October 2016
Recommendation: that this report be received

8.2 Health Shuttles Arrangements MidCentral DHB

Pages: 52-62
Documentation: report from Intern Portfolio Manager dated 3 October 2016
Recommendation: that this report be received

8.3 Consumer Council

Pages: 63-66
Documentation: report from General Manager, Strategy, Planning & Performance dated 29 September 2016
Recommendation: that this report be received

8.4 Strategy, Planning & Performance Operating Report

Pages: 67-74
Documentation: report from General Manager, Strategy, Planning and Performance dated 28 September 2016
Recommendation: that this report be received

9. LATE ITEMS

To discuss any such items as identified under item 2

10. DATE OF NEXT MEETING

22 November 2016 (Shared matters of interest)

MidCentral District Health Board

Healthy Communities Advisory Committee

Minutes of meeting held on Tuesday, 30 August 2016 at 9am at MidCentral District Health Board Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North

The shared matters of interest section of the meeting commenced at 9.00am.

PRESENT

HCAC Members
- Diane Anderson
- Adrian Broad
- Ann Chapman
- Nadarajah Manoharan
- Oriana Paewai
- Phil Sunderland (ex officio)
- Vicki Beagley
- Donald Campbell
- Jonathan Godfrey
- Tawhiti Kunaiti

QEAC Members
- Barbara Robson (Chair)
- Lindsay Burnell (Deputy Chair)
- Kate Joblin
- Karen Naylor
- Phil Sunderland (ex officio)
- Duncan Scott
- Cynric Temple-Camp

IN ATTENDANCE

Kathryn Cook, Chief Executive
Craig Johnston, General Manager, Strategy, Planning & Performance
Mike Grant, General Manager, Clinical Services & Transformation
Megan Doran, Committee Secretary
Neil Wanden, General Manager, Finance & Corporate Services
Stephanie Turner, General Manager, Maori & Pacific
Gabrielle Scott, Executive Director, Allied Health
Michele Coghlan, Acting Executive Director, Nursing & Midwifery
Ken Clark, Chief Medical Officer
Vivienne Ayres, Manager, DHB Planning and Accountability
Jill Matthews, PAO

Barb Bradnock, Senior Portfolio Manager, Children, Youth & Intersectoral Partnerships
Jo Smith, Senior Portfolio Manager, Health of Older Persons
Claudine Nepia-Tule, Portfolio Manager, Mental Health & Addictions
Mahashewta Patel, Intern Portfolio Manager
Ian Ironside, Portfolio Manager, Secondary Care
Lyn Horgan, Operations Director, Hospital Services
Nicholas Glubb, Operations Director, Specialist Regional & Community
Chris Nolan, Service Director, Mental Health Services
Barry Keane, Nurse Director, Mental Health Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Kelly Isles, Project Manager
Dennis Geddis, Communications Team Leader

OTHER

Public: (3)
Media: (1)

1. APOLOGIES

There were apologies from Healthy Communities Advisory Committee (HCAC) member Barbara Cameron, and, Quality & Excellence Advisory Committee members Dennis Emery and Lindsay Burnell (for lateness).

2. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

2.1 Amendment to the Register of Interests

Barbara Robson advised she had been appointed to the Ministry of Health's Oral Health Electronic Record Programme Advisory Group as a consumer representative.

2.2 Declaration of Conflicts in Relation to Today's Business

No HCAC members identified any conflicts in relation to the day's business.

Lindsay Burnell entered the meeting.

3. INTEGRATED SERVICES PLANNING

3.1 Mental Health Report

There was full discussion of the report. There was general support for the good progress made to date but mindfulness of the areas still requiring development. With regard to Dr Gloria Johnson's report from her follow-up visit on 1 July, it was noted that she had since met with Mr and Mrs Hume and that her letter to the Service Director regarding this visit would be formally tabled at the next meeting.

From the discussion, the Chair of the Healthy Communities Committee summarised the following key points from that committee's perspective:

- The importance of ensuring further integration with the primary and community sectors. This was beginning to build and was critical for the future. The aim was to achieve 'one team'. Of particular importance was the linkage with general practice to ensure there are no gaps in services.
- The importance of ensuring primary care had the capacity and capability to support people with a mental illness in the community.

  Management advised that consultation and liaison support to primary care was a key element, and was being built. Contacts and relationships were key. The primary mental health services were being reviewed and would be relaunched to strengthen the 'one team' approach.
- Equity was a key issue across communities and across ethnic groups and its visibility needed to be increased in future reports. The Strategic Plan provided a good framework for developing a mental health service plan with a strong emphasis on equity.
- The need to further strengthen mental health services in rural communities, with Tararua and Horowhenua cited as examples. It was noted these were being built up around Integrated Family Health Centres. It was also noted there needed to be consistency in the naming of the proposed Locality Plans.

From the discussion, the Chair of Quality & Excellence Advisory Committee summarised the following key points from that committee's perspective:

- The issue of the unsatisfactory physical environment in Ward 21 needed to be addressed, and a timeframe for this was critical. Management advised a lot of planning work had occurred and an options paper (indicative business case) would be presented at the Committee's next meeting.
- The need for Service Improvement Audits to be further developed and embedded across the MHAS.
- The need to determine the budget and resource requirements for the Mental Health Service is a priority. This work needed to take into account the expected increase in mental health needs in future. Management advised this was occurring from a "bottom up" approach.
- The 'Integrated Service Model' (cluster) approach was supported in principle but the Committee required more information on how this would be structured and would work. The Chief Executive advised a paper would be brought to the next Board Meeting, and that the cluster model development supported joined up decision making, particularly between the provider arm and funder.
- The reporting framework and dashboard would need to evolve to include a fuller picture of the entirety of mental health services. This includes bringing forward information contained in other reports – for example, the measures to be found in the Non-Financial Monitoring Framework & Performance Measures Report. It was also important to include ethnicity data for all services.
- Family/Whanau input to service development was very important and should be made more visible. It needs to be included in all areas, including service and locality plans and service design.

- There needed to be more visibility in future reports on the matters of 'caution and concerns' as raised by Dr Gloria Johnson. Management advised these would be brought forward into the work programme.
- A workshop on Community Mental Health Teams was required to support the Committee to develop a more complete understanding of mental health services in the district.
- It was agreed that Dr Gloria Johnson should attend a Board meeting to speak to her report on her follow-up visit of 1 July.
- Follow up after discharge is notable in the KPIs (KPI 19) as an area requiring further work, along with better discharge planning to other services.

The importance of workforce was discussed. Management advised that recently there has been success in recruiting across a range of professional groups, for example psychologists. It was noted that the service was nearing a full complement of psychiatrists and that the New Entry to Practice programme had had a very positive effect in terms of nursing.

The Mental Health Awareness week was discussed. Management advised that this is a national initiative but at the local level it involves activities across the entire mental health network.

The Chairs of both Committees thanked the clinical leadership and management team for their efforts and congratulated them on progress to date. There is still a lot to do, but this does not detract from the excellent progress to date.

It was recommended:

that this report be received

4. DHB PLANNING

4.1 2016/17 Annual Plan – Priorities, Accountabilities and the Production Plan

It was recommended:

that this report be received

4.2 Proposed Annual Planning Approach – 2017/18

The Chair noted this paper was for information only purposes.

It was recommended:

that this report be received.

5. DHB and Regional Reporting

5.1 Regional Services Plan Implementation – Report for Quarter 4, 2015/16

It was recommended:

that this report be received.

5.2 Non-Financial Monitoring Framework and Performance Measures – Report for Quarter 4, 2015/16

Vivienne Ayres, Manager, DHB Planning and Accountability introduced this paper and advised that although this report and the Regional Services Plan Implementation Report for Quarter 4 2015/16 had the same topics this was an entirely different report as it is based solely on MidCentral DHB results.

It was recommended:

that this report be received.

6. DATE OF NEXT MEETING

11 October 2016
22 November 2016 (Shared matters of interest)

The meeting closed at 10.55am.

Confirmed this 11th day of October 2016

.....
Chairperson

MidCentral District Health Board

Healthy Communities Advisory Committee Meeting

Minutes of meeting held on Tuesday, 19 July 2016 at 1pm at MidCentral District Health Board Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North

PRESENT:

Diane Anderson (Chair)
Barbara Cameron (Deputy Chair)
Adrian Broad
Ann Chapman
Nadarajah Manoharan
Phil Sunderland (ex officio)
Vicki Beagley
Jonathan Godfrey

IN ATTENDANCE:

Kathryn Cook, Chief Executive
Craig Johnston, General Manager, Strategy, Planning & Performance
Megan Doran, Committee Secretary
Neil Wanden, General Manager, Finance & Corporate Services
Janine Hearn, General Manager, People & Culture
Stephanie Turner, General Manager, Maori & Pacific
Barbara Robson
Jo Smith, Senior Portfolio Manager, Health of Older Persons
Claudine Nepia-Tule, Portfolio Manager, Mental Health & Addictions
Mahashewta Patel, Intern Portfolio Manager
Lydia Kirker, Communications Officer
Sharon Bevins, Contractor

OTHER:

Public: (1)
Media: (0)

1. APOLOGIES

There were three apologies from Donald Campbell, Oriana Paewai & Tawhiti Kunaiti

2. NOTIFICATION OF LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendment to the Register of Interests

There were no amendments to the Register of Interests.

3.2 Declaration of Conflicts in Relation to Today's Business

Jonathan Godfrey advised that he was the program developer for the Renal Cue program, which is mentioned in the Renal Report. This was not considered to constitute a conflict within the context of today's business.

4. MINUTES

4.1 Minutes

The Chair referred to item 6.2 2015/16 Annual Plan Implementation: Update 2, paragraph four, part of the text was missing and should have read: Other aspects of the sexual and reproductive service review have been put on hold.

Item 6.4 Mental Health update. It was noted that the last paragraph was incorrect. The Memorandum of Understanding with Massey University is complete, while the MOUs with the Universal College of Learning (UCOL) and the International Pacific University New Zealand were in progress.

It was recommended:

> *that the minutes of the previous meeting held on 7 June 2016 be confirmed as a true and correct record.*

4.2 Recommendations to the Board

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

4.3 Matters Arising from the Minutes

There were no matters arising from the previous minutes.

5. GOVERNANCE

5.1 2015/16 Work Programme

The Chief Executive introduced this paper. This is currently a work in progress due to the Committee's new Terms of Reference. A work programme will be developed after the Board workshop on 9 August 2016.

It was recommended:

> *that the report from the Acting Chief Executive Officer for 2015/16 be noted.*

5.2 Terms of Reference

A committee member queried whether the formal terms of reference for the Committee were clearly enough linked to the NZ Public Health and Disability Act 2000. Essentially the Committee is fulfilling objectives stated in the Act and perhaps the Terms of Reference should be worded in that way. The Board Chair, Mr Sunderland, agreed to look further at this matter.

It was noted that item 3 Delegated Authority, should refer to the Healthy Communities Advisory Committee, not the Community and Public Health Advisory Committee.

A member enquired if the Board Meeting Workshop in Horowhenua on 9 August 2016 was open to all committee members or just Board Members. The Chief Executive Officer advised that the invitation to attend the Board Worksop would be extended to all committee members.

Committee members were invited to consider the Terms of Reference and what they would like to see at future meetings.

It was recommended:

> *that the Committee's terms of reference be noted, including the scheduled 12 month review of these. Clarification will be provided to the committee at the next meeting.*

6. STRATEGIC

6.1 Renal Services Plan 2016

The General Manager, Strategy, Planning & Performance introduced the Renal Plan by outlining the reasons it was initiated and its key findings. Demand for Renal Replacement Therapy has grown steadily over recent years and is expected to continue to do so in future. Renal dialysis services have come under pressure because of significant growth in the number of people on in-centre dialysis. The Plan seeks to address the situation by emphasising early detection and management of deteriorating renal function and by the promotion of home-based dialysis.

There was discussion about the need for better detection and management of people in the community, and the interrelationship between renal, diabetes and cardiovascular disease. The DHB already funds an extensive range of long term condition services in the community, and renal needs to have a higher profile within these services.

It was noted by a Committee member that declining renal function and managing this decline is a complex business, which is reflected in the Renal Cue. There was also mention of the need for Renal Specialists to have a greater role in primary care, supporting general practice teams and the like.

It was noted that the district needs to be doing more home-based peritoneal dialysis. This modality has advantages for the both the patient and the service, including rapid work up and training. Increasing rates of home based peritoneal dialysis will require a lot of work selling the concept to patients and the community.

There was also discussion about the very significant ethnic disparities, particularly the rapid growth in Maori, Pacific and Asian Renal Replacement Therapy patients. Targeted approaches are required in community settings. Services need to be sensitive to the needs of

the people they are caring for and work with a whanau ora philosophy. This has been well worked out in the district and there are specialist providers of whanau ora who can be involved in care where appropriate.

It was noted that MidCentral rates for renal transplant are at about the national level, but that this is still well below international comparators. Overall there is about a 10% lifetime chance of receiving renal transplant. Transplants are more likely in younger, newly diagnosed patients without cardiovascular and diabetes complications. This again highlights the importance of early detection and active management in primary care.

A member inquired as to whether it was possible to have dialysis services in IFHCs, for example Feilding. It was explained that satellite services are likely to have the effect of pulling people away from home-based dialysis. In future, with 60% of patient on home-based dialysis, the service will be able to consider the services required to meet patient need. At present, Horowhenua Health Centre makes sense because of the number of suitable patients in that community, the ease of setting up the service, and the high level of community support.

A member inquired about children with kidney problems. It was clarified that this was outside the scope of this particular piece of work. The current Renal Replacement Therapy programme is an adult service.

It was noted that this Renal Plan has ramifications for the DHB in terms of priority activities, expenditure and capital. The 2016/17 Annual Plan includes initiatives for Renal (both primary and specialist services) but these were prepared before the Renal Plan was finalised. There was no provision in the Capital Plan for changes to renal services. In the medium term, capital investment will be picked up by the Master Health Services Plan, but these timeframes are too long. The implementation plan will identify what is required by way of service activity and capital investment.

The Committee gave its approval to move to the next step.

It was recommended:

that this report be received

that the Renal Plan is agreed in principle and that an implementation plan now be prepared to achieve the recommended changes.

6.2 2016/17 Funding Arrangements Document

This paper was for information only; no decision is required as it had already been approved by the Board.

This is a very useful document that is referred back to regularly for any external inquiries received as it lists services and providers.

The Chair sought clarification under Youth Crises Respite Services and the 6 beds. It was confirmed that it is six beds in total covering Horowhenua, Otaki & Tararua regions.

It was recommended:

that this report be received.

7. OPERATIONAL REPORTS

7.1 Strategy, Planning & Performance Operating Report

Item 4.2 Master Health Services Plan (Site Redevelopment)
Separe are currently refreshing the background material underpinning the Master Health Services plan, and a further update would be made to this Committee in due course.

Item 4.3 Annual Plan
The Ministry of Health has advised that the Annual Plan is now essentially complete and will likely be one of the first to go to the Minister for sign off. Once this occurs it will be available to the public and committee members vie the website. Hard copies will be made available to those who request them.

Item 5.1.1 Home Based Support Services
The Chair asked for clarification around the implementation of the national price for Home Based Support Services and if the increase would be passed directly to the carers. Management advised that the funding goes to the provider, but that the DHB has no control over whether it is passed through to Home Based Support Workers.

Item 5.1.2 Palliative Care Services
Arohanui Hospice was congratulated on their successful funding. At this stage there is no information on which Aged Residential Care facilities will be involved in the pilots. It was noted that Palliative Care in the MidCentral district is very well set up with excellent linkages between Arohanui-based specialist services, the Hospital team and general practice.

Item 5.3.2 St John Ambulance Charges
The increase in patient charges was noted with concern. It was noted that one option open to people is to join the St John Supporters Scheme. In return for a small annual fee, all patient charges are waived in the event a family member has to call an ambulance.

Item 5.3.3 New PHARMAC Investments
A member enquired about the new PHARMAC investments and if there was any information available yet on how it will work on our district. Management advised that information was coming through slowly. PHARMAC recognised that some of the new medicines would have an impact on health services, but the detail is yet to be worked through.

Item 7 Staff Changes
The Committee thanked Andrew Orange, Portfolio Manager Clinical Services, for his work and sent him their best wishes for his new endeavour. A letter of appreciation from the Committee would be sent to Andrew.

It was recommended:

that this report be received.

7.2 Finance Report – Result for May 2016

The General Manager, Strategy, Planning & Performance noted that the report was for the month of May.

The Year End result is still being provided but at this stage it looks like the Funder will be better than budget by about $700,000.

It was recommended:

that this report be received.

8. LATE ITEMS

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

9. DATE OF NEXT MEETING

Tuesday, 30 August 2016

11. EXCLUSION OF PUBLIC

It was recommended:

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

Item	Reason	Reference
"In Committee" Minutes of the previous meeting	For reasons stated in the previous agenda	

Confirmed this 30th day of August 2016

.....

Chairperson

MidCentral District Health Board

Healthy Communities Advisory Committee Meeting

Minutes of meeting held on Tuesday, 19 July 2016 at 1pm at MidCentral District Health Board Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North

"In Committee"

PRESENT:

Diane Anderson (Chair)
Barbara Cameron (Deputy Chair)
Adrian Broad
Ann Chapman
Nadarajah Manoharan
Phil Sunderland (ex officio)
Vicki Beagley
Jonathan Godfrey

IN ATTENDANCE:

Kathryn Cook, Chief Executive
Craig Johnston, General Manager, Strategy, Planning & Performance
Megan Doran, Committee Secretary
Neil Wanden, General Manager, Finance & Corporate Services
Janine Hearn, General Manager, People & Culture
Stephanie Turner, General Manager, Maori & Pacific
Barbara Robson, Board Member
Jo Smith, Senior Portfolio Manager, Health of Older Persons
Claudine Nepia-Tule, Portfolio Manager, Mental Health & Addictions
Mahashewta Patel, Intern Portfolio Manager
Lydia Kirker, Communications Officer
Sharon Bevins, Contractor

11. APOLOGIES

There were three apologies from Donald Campbell, Oriana Paewai & Tawhiti Kunaiti

12. MINUTES OF THE PREVIOUS MEETING "IN COMMITTEE" SECTION

12.1 Minutes

It was recommended:

> *that the minutes of the previous meeting held on 7 June 2016 be confirmed as a true and correct record.*

12.2 Recommendations to the Board

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

12.3 Matters Arising from the Minutes

There were no matters arising from the minutes.

13. LATE ITEMS

There were no late items.

14. AVAILABILITY OF "IN COMMITTEE" MINUTES

It was recommended:

that the items discussed today "in committee" remain unavailable to the public.

The meeting closed at 3.05pm.

Confirmed this 30th day of August 2016

.....
Chairperson

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Disability Support Advisory Committee held on Tuesday, 7 June 2016 at 3.30pm in the Board Room, Board Office, Gate 2, Heretaunga Street, Palmerston North Hospital

PRESENT

Lindsay Burnell (Chair)
Adrian Broad (Deputy Chair)
Barbara Cameron
Nadarajah Manoharan
Phil Sunderland (ex officio)
Vicki Beagley
Tawhiti Kunaiti

IN ATTENDANCE

Kathryn Cook, Chief Executive Officer
Diane Anderson, Board Member
Raewyn Cameron, Manager Community Disability Support Services
Di Traynor, Committee Secretary
Janine Hearn, General Manager People and Culture
Jo Smith, Senior Portfolio Manager, Health of Older People & Palliative Care
Karen Upston, Project Co-ordinator Patient Safety and Clinical Effectiveness
Jeff Small, Group Manager, Commercial Support Services
Neil Wanden, General Manager, Finance & Corporate Support
Craig Johnson, Acting General Manager, Funding & Planning
Jill Matthews, Manager Administration and Communications
Lydia Kirker, Communications Officer

In opening the meeting, Chair congratulated Nadarajah Manoharan on behalf of the Committee for his recognition in the Queen's Birthday honours list.

1. APOLOGY

Jonathan Godfrey
Scott Ambridge, General Manager, Enable New Zealand
Muriel Hancock, Director Patient Safety and Clinical Effectiveness

2. LATE ITEMS

No late items.

3. CONFLICTS OF INTEREST

3.1 Amendments to the Register of Interest

There were no Amendments to the Register of Interest.

3.2 Declaration of Conflicts in Relation to Today's Business

There were no declared conflicts in relation to today's business.

4. MINUTES OF THE PREVIOUS MEETING

4.1 Minutes

That the minutes of the previous meeting held on 15 March 2016 be confirmed as a true and correct record.

4.2 Recommendations to Board

The Committee noted that all recommendations contained in the minutes had been approved by the Board.

4.3 Matters Arising

The Chief Executive brought Committee members up to date regarding Enable New Zealand's contracts with the Ministry of Health and ACC.

5. WORK PROGRAMME

The Committee's updated Work Programme dated 30 May 2016, was taken as read.

The Chief Executive acknowledged the contribution of Enable New Zealand in the successful completion of the 2015/16 Work Programme.

It was recommended:

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

6. STRATEGIC ISSUES

6.1 Disability Sector Update

On behalf of the General Manager, Enable New Zealand, the Chief Executive noted the Disability Sector Update as read.

A highlight of the report had been the volume of visitors to the EASIE Living Centre since opening. Raewyn Cameron, Manager Community Disability Support Services, noted that the large number of presentations made to a wide range of community, disability and aged groups had contributed to the success of the first quarter of operation. Presentations are ongoing, and word of mouth about the Centre is spreading.

It was noted that the Central Regional CEO / Chair meeting is due to be held in Palmerston North on 14 June and a visit to the EASIE Living Centre would feature as part of that visit, providing an opportunity for Enable New Zealand to promote the Centre alongside the range of other services Enable New Zealand is able to provide to District Health Boards.

The meeting acknowledged and congratulated the EASIE Living Centre for being awarded 'Centre of the Year' by the Federation of Disability Information Centres.

The Manager, Community Disability Support Services, brought the committee up to date on the status of the DIAS / NASC review by the Ministry of Health.

Discussion ensued around a variety of topics including rural access to NASC (Needs Assessment and Service Co-ordination) services, and NASC interaction with community housing trusts.

It was recommended:

that this report be received.

6.2 Accessibility Self Audit Update

The Project Co-ordinator Patient Safety and Clinical Effectiveness, spoke to the report dated 7 June 2016 on behalf of the Director Patient Safety and Clinical Effectiveness.

Three self audits have been completed, with a fourth planned to be completed in June 2016.

The Committee discussed the key findings that indicated low staff awareness of health passports and low take up by staff of customer service training, and also discussed the question set. The Project Co-ordinator noted that once the fourth self-audit was complete, a review of questions would be undertaken.

It was recommended:

that this report be received.

7. OPERATIONAL REPORTS

7.1 Annual Update – Stocktake of Employment Practices and Education & Development

The General Manager People and Culture, Janine Hearn, introduced herself and spoke to the report on behalf of the Manager, Human Resources and Organisational Development, dated 15 May 2016.

MidCentral District Health Board has achieved 100 per cent compliance in the Human Rights Commission review and analysis of the good employer reporting obligations of Crown Entities in their annual reports. The Committee acknowledged the benefits for MidCentral District Health Board of having Enable New Zealand as part of its structure, given its reputation and expertise in the disability sector.

It was recommended:

that this report be received.

7.2 Annual Update – Disability Facility Stocktake

The Group Manager, Commercial Support Services, spoke to his report dated 27 May 2016 which provided a stocktake of work undertaken on Disability Facility buildings including signage, maintenance and housekeeping requirements, physical building upgrades and new building compliance.

It was recommended:

that this report be received.

Deputy Chair Adrian Broad left the meeting at 4.10 pm.

7.3 Annual Update – New Zealand Disability Strategy Contracts

The Senior Portfolio Manager, Health of Older People and Palliative Care, spoke to her report dated 23 May 2016.

Discussion ensued on various aspects of the report including Individualised Funding support, the 'Accelerate 25' innovation project, and dementia friendly environments.

Barbara Cameron asked about friendly environments for visual and hearing impaired people, and noted the opportunity for MidCentral DHB to work with a range of organisations in this space.

It was recommended:

that this report be received.

7.4 Annual Communications Update

The Manager, Administration and Communications, spoke to her report dated 26 May 2016.

The Chair noted and commended the range of initiatives undertaken in 2015/16 on communications and accessibility of DHB information to people with a disability.

It was recommended:

that this report be received.

8. DATE OF NEXT MEETING

Tuesday, 22 November 2016.

Venue: MidCentral DHB Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North.

9. EXCLUSION OF PUBLIC

Recommendation:

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

Item	***Reason***	***Ref***
"In Committee" minutes of the previous meeting	For reasons stated in the previous agenda	

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Disability Support Advisory Committee held on Tuesday, 7 June 2016 at 3.30pm in the Board Room, Board Office, Gate 2, Heretaunga Street, Palmerston North Hospital

In Committee

PRESENT

Lindsay Burnell (Chair)
Barbara Cameron
Nadarajah Manoharan
Phil Sunderland (ex officio)
Vicki Beagley
Tawhiti Kunaiti

IN ATTENDANCE

Kathryn Cook, Chief Executive Officer
Diane Anderson, Board Member
Raewyn Cameron, Manager Community Disability Support Services
Di Traynor, Committee Secretary
Janine Hearn, General Manager People and Culture
Neil Wanden, General Manager, Finance & Corporate Support
Craig Johnson, Acting General Manager, Funding & Planning
Jill Matthews, Manager Administration and Communications
Lydia Kirker, Communications Officer

APOLOGIES
Jonathan Godfrey
Scott Ambridge, General Manager, Enable New Zealand
Muriel Hancock, Director Patient Safety and Clinical Effectiveness
Adrian Broad (Deputy Chair) – Left meeting early

9. MINUTES OF THE PREVIOUS MEETING IN COMMITTEE SECTION

9.1 Minutes

That the minutes of the previous In Committee meeting held on 15 March 2016 be confirmed as a true and correct record.

9.2 Recommendations to Board

The Committee noted that all recommendations contained in the minutes had been approved by the Board.

9.3 Matters Arising

There were no matters arising.

10. LATE ITEMS

There were no late items.

11. RESOLUTION RE AVAILABILITY OF "IN COMMITTEE" MATTERS

None.

The meeting closed at 4.30 pm.

TO Healthy Communities Advisory Committee

FROM Chief Executive Officer

DATE 4 October 2016

SUBJECT **2016/17 Work Programme**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

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1. PURPOSE

This report updates progress against the Committee's 2016/17 work programme. It is provided for the Committee's information and discussion.

2. SUMMARY

The Committee's 2016/17 work programme has been developed in line with the Governance Reporting Framework approved by the Board at its last meeting.

The work programme is based on five key reporting areas being:

- strategic and operational planning
- performance reporting
- consumer and disability
- integration
- meetings

At this stage, reporting is occurring in accordance with the work programme.

3. RECOMMENDATION

It is recommended:

that progress against the 2016/17 work programme be noted.

Kathryn Cook
Chief Executive Officer

HCAC Meeting Work Plan 2016/17				
Strategic & Operational Planning	**Performance Reporting**	**Consumer & Disability**	**Integration**	**Meetings**
October 2016				
• Equity snapshot & dashboard development approach • Health shuttle arrangements • Immunisation stakeholder group workplan 2016/17 • Disability & aged care	• Operational report (inc financials)	• Consumer council NB: refer also "strategic/operational planning" re disability priorities		• Minutes • Matters arising • Work programme
November 2016				
• Planning priorities & financial assumptions 2017/18* • Ward 21 indicative business case*	• Health target results* • 2016/17 RSP update* • centralAlliance update* • 2016/17 Maori Health Plan update* • 2016/17 Annual plan update maternal, child & youth*		• Integrated service arrangements (clusters) workshop* • Renal health implementation plan* • Mental health review (& G Johnson)* • Portfolio updates:* o Maternal/maternity o Child & youth	• Minutes • Matters arising • Work programme
February 2017				
• Health service plan/priorities for Central Region • Health needs assessment • Funding envelope & CFA variations • Locality plans (approach & timeline) • Iwi plans (approach & timeline) • Maori health priorities 2017/18 • Disability priorities 2017/17	• Operational report (inc financials) • Health equity dashboard results • Whanau ora collectives update	• Establishment and role of Consumer Council • Disability self-audit update • Disability consumer feedback NB: refer also "strategic/operational planning" re disability priorities		• Minutes • Matters arising • Work programme
March 2017				
• Draft 2017/18 Annual Plan* • Planning workshop* • Statement of intent & performance expectations*	• Health target results* • 2016/17 RSP update* • centralAlliance update* • 2016/17 Annual Plan update health of older people, mental health & addictions*		• Mental health review* • Meeting with Pharmac* • Portfolio updates:* o Health of older people	• Minutes • Matters arising • Work programme

May 2017				
• 2017/18 Regional Service Plan • 2017/18 Funding Arrangements • 2017/18 Annual Plan • 2017/18 Maori Health Plan • Contracting/commissioning plan 2017/18 •	• Operational report (inc financials) • Health equity dashboard results	• Consumer Council report and meeting • Disability requirements/parameters for IFHCs, providers, etc	Meeting with Health Promotion Agency	• Minutes • Matters arising • Work programme
June 2017				
	• Health target results* • 2016/17 RSP update* • centralAlliance update* • 2016/17 Maori Health Plan update* • 2016/17 Annual Plan update general & specialist*	• Clinical Council report • Clinical governance (quality) report	• Mental health review* • Portfolio updates* o General & specialist assessment & treatment o Cancer services & palliative care • Meeting with Central PHO* • Workshop re community mental health*	• Minutes • Matters arising • Work programme

*area of shared interest with Quality & Excellence Advisory Committee

To	Healthy Communities Advisory Committee
From	Stephanie Turner General Manager Maori and Pacific Health
Date	27th September 2016
Subject	Equity Snapshot and Dashboard Development Approach

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

To inform and update the Committee on the development approach being taken to produce an Equity Snapshot for the MidCentral DHB population.

2. SUMMARY

This report summarises key achievements and progress towards the development of an Equity Snapshot for the MidCentral DHB population. Our local approach builds on similar work undertaken by Hawke's Bay DHB in the development of their district wide equity report.

This component of work is an action determined through the 'Achieve Equity of Outcomes Across Communities' strategic imperative.

The overall aim is to generate a meaningful reference and baseline snapshot of our population health and wellbeing that informs our actions and measures our progress to achieve equity of health outcomes across our communities.

3. RECOMMENDATION

It is recommended:

That this report be received.

4. BACKGROUND

MidCentral DHB has worked over the last 12 months to develop and refine an inclusive health strategy that actively supports MidCentral DHB and our partners to achieve Quality Living, Healthy Lives and Well Communities across the district. One of the key imperatives of this strategy is to 'Achieve Equity of Outcomes Across Communities'.

The Equity of Outcomes Task Force Group has developed a number of objectives and practical approaches to support MidCentral DHB to achieve this strategic imperative. Understanding the current inequities across our district is key to ensuring that we focus our actions effectively to challenge these inequities in a deliberate and purposeful way. A wealth of local and national data is available to MidCentral DHB that describes the health and wellbeing of our population and the variation in outcomes experienced by different groups in our communities. The next step is to make sense of this information to inform our actions and target our resources to the right places in order to support positive and equitable health gains for people living in our district.

4.1 Summary of progress to date

The Equity of Outcomes Task Force Group reviewed the "Health Equity in Hawke's Bay" report published by Hawke's Bay DHB in 2014 (and updated in 2016) and found that it provides a useful translation of data to identify key areas of inequity that exist in the Hawke's Bay region. Following the direction of the Equity of Outcomes Task Force group, Pae Ora – Maori Health Directorate has tasked Dr Janine Stevens (Maori Public Health Physician – Pae Ora), to lead the development of a similar Equity Snapshot for the MidCentral DHB population in partnership with Strategy and Support.

Dr Stevens has accessed the Hawke's Bay technical data profile that sits behind the Hawke's Bay equity report. This substantive technical document provides a useful foundation upon which to base our approach to data collection, analysis and interpretation for the purposes of generating the MidCentral DHB Equity Snapshot. Dr Stevens has shared this technical report with the MidCentral DHB Data Quality and Health Information Manager and early discussions have taken place to determine how the development of the Equity Snapshot can be supported by the data analytics team.

To further support our local approach to the data, Dr George Gray (Maori Public Health Physician, Bay of Plenty), who has worked in partnership with Tumu Whakarae – National Network of DHB Maori General Managers to develop Trendly (a data interpretation tool focused on the Annual Maori Health indicators), is scheduled to meet with the MidCentral Data Analytics Team in November to explore how Trendly can complement the equity measurement approach being developed here.

It is envisaged that the Equity Snapshot will actively inform locality planning, supporting communities to acknowledge, understand and focus on important inequities within their local area. It will also facilitate active monitoring of progress towards achieving equity of outcomes across our communities through the

identification and development of key equity measures that are able to be regularly updated and reviewed.

It is intended that the Equity Snapshot will enhance our local understanding of population health and wellbeing data in practical and measurable ways, demystifying assumptions and identifying root causes of health inequities, rather than just presenting the symptoms of inequity that are commonly depicted in data profiles in the form of significant health disparities.

4.2 Key deliverables

The key deliverable for this piece of work is a comprehensive written report with clear data visualisation and meaningful interpretation that is relevant across our communities. A locally relevant framework for measuring our progress towards achieving equity across communities for a variety of key equity indicators will also be developed as part of this work.

4.3 Indicative timeline

It is anticipated that the Equity Snapshot will be completed by 31st March 2017.

5. CONCLUSION

This is a significant piece of work that will provide a solid foundation for understanding and measuring our progress towards achieving equity of outcomes across communities. MidCentral DHB is committed to investing in this development to actively support informed and purposeful actions that challenge the current inequities in health outcomes experienced by different groups in our population.

Stephanie Turner
General Manager – Maori and Pacific Health

TO Healthy Communities Advisory Committee

FROM Senior Portfolio Manager
Health of Older People

DATE 3 October 2016

Memorandum

SUBJECT **DISABILITY STRATEGY AND AGED CARE IN MIDCENTRAL**

1. PURPOSE

This report provides an overview of the current revision of the New Zealand Disability Strategy and its application to MidCentral's district, with a particular focus on the health of older people. It is for information and discussion; no decision is required.

2. SUMMARY

The New Zealand Disability Strategy of 2001 is currently undergoing a revision by the Office for Disability Issues. It is expected that the new Strategy will be launched in November/December 2016. The new Strategy will provide a whole of Government approach to responding to the growing population affected by disability, enable New Zealand to better support disabled people to achieve their potential and improve the lives of disabled New Zealanders and their families. It is intended to show how we implement the United Nations Convention on the Rights of Persons with Disabilities in a New Zealand context, taking into account the Treaty of Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples.

There are seven themes in the proposed Strategy so far, all related to accessibility: accessibility to health and social services; inclusive education; meaningful and appropriate employment; accessibility of information through accessible formats; accessibility of built environments including facilities and buildings; accessibility to transport in communities and better attitudes towards disabled people.

Locally, there are many examples of current and planned work that reflect the intentions of the proposed revised Disability Strategy. It is intended that future integrated service planning will build on this as we develop specific actions for services to give effect to the four strategic imperatives of our Strategy. This will cover the population health continuum from prevention and early detection through to rehabilitation and support.

We anticipate that the strategies and key activities for people with disabilities will build on current work and an assessment of gaps once the revised New Zealand Disability Strategy is launched, together with advice from the Clinical Council and the yet to be developed Consumer Council. This will ensure MidCentral's contribution is consistent with and supported by the revised New Zealand Disability Strategy as well.

Evidence that can now be gleaned from an analysis of data from the interRAI assessment tool will be used to inform future planning for age-related disability issues in our district. A snapshot of data from older person's services is provided in this report to illustrate the link between data, analysis and action for service improvement.

Further reports will be provided to update the Committee and focus on a topic to illustrate progress against the national and local direction.

3. RECOMMENDATION

It is recommended:

that this report be received

Jo Smith
Senior Portfolio Manager
Health of Older People & Palliative Care
Strategy, Planning & Performance

4 INTRODUCTION

In 2013, 24 percent of the New Zealand population were identified as disabled, a total of 1.1 million people. The increase from previous census data relates to the ageing population. People over 65 are much more likely to be disabled (59 percent) than adults under 65 (21 percent) or children under 15 (11 percent). Maori and Pacific people had higher than average disability rates after adjusting for difference in ethnic population age profiles[1].

For adults, physical limitations were the most common type of impairment. For children, learning difficulties were the most common type. Six percent of children and, 52 percent of disabled children had difficulty learning. The most common cause of disability for adults was disease or illness (42 percent). For children, the most common cause was a condition that existed at birth (49 percent).

Disability rates across the country differ, Auckland (19 percent), Bay of Plenty and Manawatu-Whanganui (both 27 percent), Northland (29 percent) and Taranaki (30 percent). These areas experience above average disability rates. Responding to disability and the implications disability has on everyday New Zealanders requires a whole of government approach.

The New Zealand Disability Strategy is currently being revised through the Office for Disability Issues. The Strategy, which covers the period 2016 through to 2026, is in its second phase of consultation with the final Strategy being released towards the end of this year. The Strategy provides a framework for government agencies to identify and remove barriers that prevent disabled people from participating fully in New Zealand society.

New Zealand has an ageing population which will result over time in an increasing incidence of disability. Disabled people are living longer, and there will be an increasing number of people with age-related disabilities. This is a global trend and one that is drawing greater attention to disability.

This report summarises the current state of New Zealand Disability Strategy and proposed implementation, together with the local response to disability issues and future planning priorities.

One subset of disability relates to aging populations. This report includes a snapshot of data that is becoming more available to inform future planning and outlines our local response to how we are using this information to support improvements in health outcomes for older people.

4. BACKGROUND

The revised Disability Strategy centres on eight broad outcome areas which include education, employment, health and wellbeing, justice, accessibility, attitudes, choice and control and leadership. The existing Disability Action Plan (DAP) will be the primary vehicle for implementation of actions to support the achievement of the Strategy.

The Disability Strategy is required to:

[1] Source: www.odi.govt.nz

- have person-directed participation
- provide a longer-term direction to address the barriers to social and economic participation faced by disabled people
- consider a social investment approach across government to improve economic and social outcomes for disabled people
- align with the obligations and principles of the [2]UNCRPD
- allow for the strategic direction to translate into actions through the DAP.

The recurring themes identified through the first phase of public engagement for the Strategy included the need for action on:

- inclusive education being available at all local early childhood, primary, secondary and tertiary facilities
- meaningful and appropriately paid employment for disabled people
- accessibility of information through accessible formats that enable understanding, including affordable technology
- accessibility of the built environment including facilities, buildings, transport and getting out and about in the community
- better attitudes towards disabled people
- access to disability supports
- allowing flexibility and choice over the supports and/or funding required.

It is proposed that the existing national Disability Action Plan (DAP) will be adapted to become the main mechanism for implementing the Strategy. As the Strategy is New Zealand's approach for implementing the UNCRPD in the New Zealand context, the DAP will also help streamline government responses to international reporting on the UNCRPD.

The DAP approach can be built on by extending its coverage to include high priority, or significant actions that are the responsibility of a single government agency. This change will ensure that the DAP provides a mechanism to identify priorities and measure progress against the Strategy outcomes.

The current Disability Action Plan follows the example of Better Public Services, the Plan focuses on action to achieve four shared results including:

- Increase employment and economic opportunities: for example, confidence to employ disabled people and provide accessible workplaces
- Transform the disability support system: such as effective engagement with disabled people and coordination across sectors and across agencies to focus on outcomes
- Ensure personal safety: for example, promoting systems and practices to protect disabled children and adults in all settings
- Promote access in the community: accessible buildings and spaces, transport, urban design, accessible information justice services and political and civic participation

Progress against this work is reported through the Minister of Disability Issues annual report to Parliament.

[2] UNCRPD – United Nations Convention on the Rights of Persons with Disabilities

Disability services and actions extend across the whole lifespan to the lives of babies and young children, families, those who have had a life changing event (e.g. through an accident), developed an impairment as they have aged or those that have reached retirement and into their latter years who often have multiple impairments. Therefore, a number of organisations are tasked with activity to improve the life of New Zealanders; this can be from the Office for Disability Issues, District Health Boards, other Ministries including Justice and Social Development. Cross Government action is a stronger response to thinking about how the various organisations can contribute to better lives for all New Zealanders.

5. OUR LOCAL RESPONSE TO DISABILITY

Locally, our current key priorities mirror attention on strategies related to accessibility, for example:

- the recent opening of the EASIE Living and Demonstration Centre in Palmerston North by Enable New Zealand
- improving understanding of what is needed to support the delivery of an accessible and inclusive health and disability service through the progressive roll-out of the accessibility self-audit tool
- increasing the range of information and resource kits to support people, their family and whanau living with dementia
- working with non government agencies to support refugee communities to access health and social services
- the psychological support services for people with chronic or life limiting conditions

Additionally, initiatives in the current Annual Plan include:

- developing community-based services for the health of older people with mental health or addiction issues / psychiatric disability
- connecting specialist services in general practice for the frail elderly
- developing the fracture liaison service and working with ACC in establishing a community-based 'strength and balance' exercises in the home programme
- supporting community-based rehabilitation for people who have had a stroke
- improving services for children with learning or behavioural disabilities, complementing the conduct disorder service already available to children and their families through the Special Education Service and the Child and Adolescent Mental Health Services.

Future planning activities will give effect to the strategic imperatives of our Strategy through implementation of the various integrated service plans that are to be progressively developed over the next year or two. We anticipate that the strategies and key activities for people with disabilities will build on current work and an assessment of gaps once the revised New Zealand Disability Strategy is launched, together with advice from the Clinical Council and the yet to be developed Consumer Council. This will ensure MidCentral's contribution is consistent with and supported by the revised New Zealand Disability Strategy as well.

Priorities for 2017/18 are in the early stages of being gathered. The Maori Directorate has identified Elder health as a priority and is narrowing this to specific areas of focus over the coming months. The Older Persons District Group is focused around Dementia, Frailty and Advance Care Planning as responses to the impact of disability. Children with disabilities are a priority group for further service development as well.

6. AN AGING POPULATION

Older people have in general terms been referred to by various commentators as a tsunami of the greying population with various challenges that this will bring to the health and social sector. An aging population is not an apocalyptic concern as often described in emotive terms; it is now seen as an opportunity to work with aging populations particularly in the "prevention and keeping active and well" space and bring about better independence for people in the community.

A progression of initiatives locally is improving services for consumers, and leading to better care and coordination. This paper will touch on some key activities that have occurred, give examples of emerging data and outline a couple of projects aimed at reducing the impact and effects of disability in our district.

7.1 The issue summarised

During the late 1990's activity was undertaken to consider an emerging "population explosion" that would occur with baby boomer's retiring, the impact from an imbalance of working/retiring people in New Zealand and tax revenue to fund government services. This coupled with a healthier aging population and a longer life span for individuals was going to require some significant planning over coming decades.

Nowhere could health services encapsulate the extent of the emerging issues, including clinical information, disease progression, and likely service provision required to support an aging population without data. A government policy saw the introduction of a national electronic assessment tool that could assist with the planning of future services; interRAI.

InterRAI (international resident assessment instruments) assessment tools were introduced in 2008 as a response to a lack of data and a need for better assessment processes for older people. A national rollout occurred across New Zealand with interRAI, and this year data is being made available to help District Health Boards, planners and academics plan appropriate services for communities.

There are around 27,000 people over age 65 in the district; the national average for older people age over 65 is 14 percent of its population. Palmerston North city sits around 16 percent and the Horowhenua areas at 24 percent. Understanding our population by locality will help us with planning using a range of data such as interRAI, cognisant that this is just one subset.

A taste of this data is provided in the body of this report which illustrates some of the unique and similar issues planners of services are facing today. A brief profile of newly engaged activity and proposed activity for the 2016/17 year is also included.

7.2 Better community support for older people

A range of disability services exist for older people and include Providers such as Needs Assessment Services, home and community support providers, aged residential care, access to advocacy such as Age Concern and Health and Disability Advocacy services, Caring Caller (St John), Accredited Visiting Services (Age Concern), and various field officer positions across a number of diseases such as Parkinson's and Stroke.

Balancing investment bids for different services alongside other DHB priorities is often challenging for the various parts of the sector pushing forward their own priorities. Notwithstanding this, this district has a suitable range of services that cover many needs for our communities, though we might often suggest there is "never enough".

The Older Persons District Group has new investments in the older person's space to better the community disability side of support. These include:

- Respite Case Coordinator introduced in 2014
- WiAS (walking in another shoes) programme, a dementia values based training programme, 2014
- Investment in Home and Community Providers with additional travel payments, 2016
- Health of Older People teams (emerging district wide), 2015

Emerging as a new service is a partnered approach with primary care whereby ACC are funding two programmes of support. First a strength and balance in the home programme for those at risk of further falls following an initial incident and secondly, community group strength and balance exercise programmes coordinated district wide.

Both these programmes will commence over the next six month period, both adding significant benefit to consumers and health services as a result of falls without fracture and few services to educate and link to better health literacy on this topic.

The latter programme is targeted at a sustainable network of programmes which include activities delivered in gated communities (retirement villages), Zumba type programmes, Tai Chi, exercise groups associated with the various disease memberships such as Parkinson Society, Stroke, and Alzheimer's Society. The essence of this programme is to improve the community's resilience within current resource.

Other areas of improvement and active implementation within current resources include a dementia action group, an interest group of clinicians and non clinicians to advance the awareness of the disabling conditions associated with cognitive memory loss, dementia and Alzheimer's conditions. These types of groups ensure a district wide response to raising awareness, opportunistic networking and sharing of great ideas. These groups exist for community falls, dementia, and pressure injury prevention.

A new contract was issued this period to a Provider who specialises as a third party provider working with families on individual funding and packages of support to aid better personal preferences with services.

7.3 Mobilising the districts resources: a whole of community approach

Annually, MidCentral DHB (MDHB) sponsors the '*Age on the Go Expo*' in partnership with the Horowhenua District Council (HDC). This enormously successful event showcases the areas subject matter experts/providers on items related to aging populations. Attendees this year included groups from the Ministry of Social Development (MSD), Hearing Association, Easie Living Centre, aged residential care, equipment, retirement villages, exercise groups, Age Concern, Grey Power, Alzheimer's Society, Driving Services and others. A total of sixty contributors attended with numerous others turned away due to venue space limitations.

A stand out feature this year was the network of services working together and sharing resources and knowledge of each other's roles and service. This type of leadership/partnership from Council and District Health Board's supports a greater connected up response to growing demands on limited resources and works towards the concept of "age Friendly Communities".

Our focus for next year will be twofold. Firstly for Horowhenua, a bigger venue for increased participation, within this includes a focus towards in-house technology and clinicians for front line engagement with consumers. Secondly, to challenge our districts partners to this concept being district wide.

7. CHARACTERISTCS OF OLDER PEOPLE IN OUR DISTRICT

Getting to know our population and planning appropriately will ensure resources are provided and utilised in the right areas. Data has started emerging which profiles aspects of the population and allows for analysing /planning next steps.

7.1 What does the data say

7.1.1 Data from InterRAI and Discussion

Our understanding of data will inform whether we fit within a regional profile or that of being an 'outlier'. 9,725 assessments were completed on older people across the region in 2015. Of this, 1510 new assessments were completed for our district. Regionally, six percent of people assessed were Maori, 29 percent of Maori who were assessed were aged 80 years or older, 62 percent of all people assessed were aged 80 years or older, and 23 percent of the population is at high risk of being admitted to an aged residential care facility.

As an example of receiving data and using this to inform planning, a snapshot of local interRAI data is reported below followed by our response; the regional data is in brackets.

- 28 percent of people reported feeling lonely (21 %)

The local data is slightly higher than that represented for the region. Several community initiatives exist to support social inclusion such as Caring Caller (St John) and the Accredited Visiting Service (Age Concern). These referrals are made once an older person has been assessed, so it stands to reason an initial assessment would identify the issue, ideally the service coordination aspect following an assessment is the opportunity to reduce the social isolation.

- 19 percent of informal carers express feelings of distress, anger or depression (18%)

Being Needs Assessed is an opportunity to identify the problem area. In the same vein as social isolation, when it is identified carers are distressed, angry or depressed, additional support such as respite care, day programmes, personal care supports and other referrals can alleviate concerns and improve the experience for the carer. Carers are a significant resource to supporting people to remain at home. By ensuring additional suitable supports are in place, carers can often journey on for longer periods before requiring permanent care for their family member.

- 11 percent report that they live with severe or excruciating pain each day (12%)

Unmanaged pain raises a concern. There is reliance on people being prescribed pain medicines along with appropriate adherence regimes in order to live relatively pain free. The data tells us that unmanaged pain does not present as an issue in permanent residential care as care staff prompt around the clock care, specifically for medicines.

Generally, unmanaged pain is correlated with low functional ability around the home, feelings of distress and impacts on people's coping and resilience. The longer people can go pain free, the more they can achieve with independence.

- 40 percent of people have the potential to do more things for themselves like showering, eating and walking (39%)

Often being able to do more and be independent is about how we self manage co-morbidities, being pain free, having the appropriate equipment and support and information at hand. This requires a range of primary care options such as physiotherapist and occupational support, navigators to help with information and case management to revisit and provide guidance.

- 27 percent have cognitive difficulties with everyday decisions such as when to get up, remembering to take their medicines, what clothes to wear, or using a walking frame when leaving the house (19%)

Many people can live at home for long periods of time after they receive a diagnosis of cognitive impairment with the right supports in place. Strategies, local supports, transport, social inclusion activities, active neighbours and aged friendly communities are all aspects that better support people with failing memory.

- 39 percent of people have no enduring power of attorney (45%)

A lack of enduring power of attorney (EPOA) can be problematic towards end of life or when a significant health event occurs for any of us. A Needs Assessment is an opportunistic time to prompt and inform on the importance of EPOA.

At first assessment 61 percent do have EPOA, by the time older people enter permanent residential care this rises to 80 percent in our district.

- 93 percent have no documented advanced care plan (97%)

Other areas of analysis/planning for better outcomes include advance care planning (ACP).
ACP is the process of exploring what matters to you and sharing this information with your loved one and your health care team so treatment and care plans can support what is important to you.

The data shows us that advance care planning is not formalised to any great degree. 93 percent have no documented care plan. Ensuring better care, less intensive care where this is not required and a better patient experience are a basis for ensuring we raise the volume of those individuals with an advance care plan. The uptake of ACP is not well advanced but is gaining traction. Initiatives are being put into place to raise awareness and "tell the story".

Interestingly, the data tells us that while only 6 percent have an advance care plan when they are first assessed, by the time older people are in permanent aged care, this rises to 24 percent.

Health Quality and Safety Commission New Zealand are partnering with a consumer of services, “Arthur” to advance awareness of ACP in the community. Arthur is 67 and Maori, has chronic obstructive pulmonary disease and knows this will limit his life. His workshop has been developed to support more Maori see the benefits of having an ACP.

- Three percent of people trigger dehydration this is comparable with New Zealand

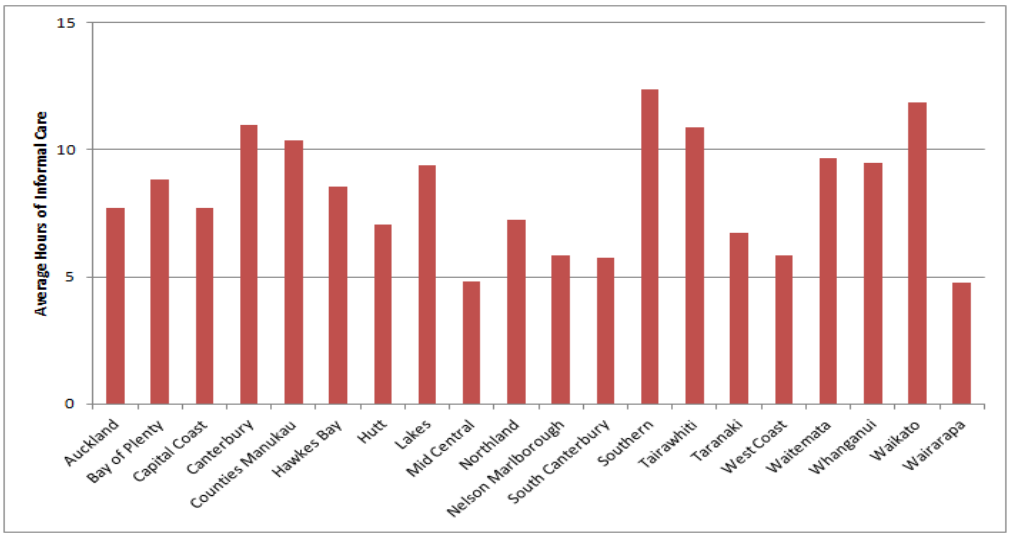
Dehydration is reported as low; we know that hydration is ‘key’ to better health. Older people generally do not hydrate themselves sufficiently particular in the warmer weather.

- Five percent of people had not seen a GP in the last three months.

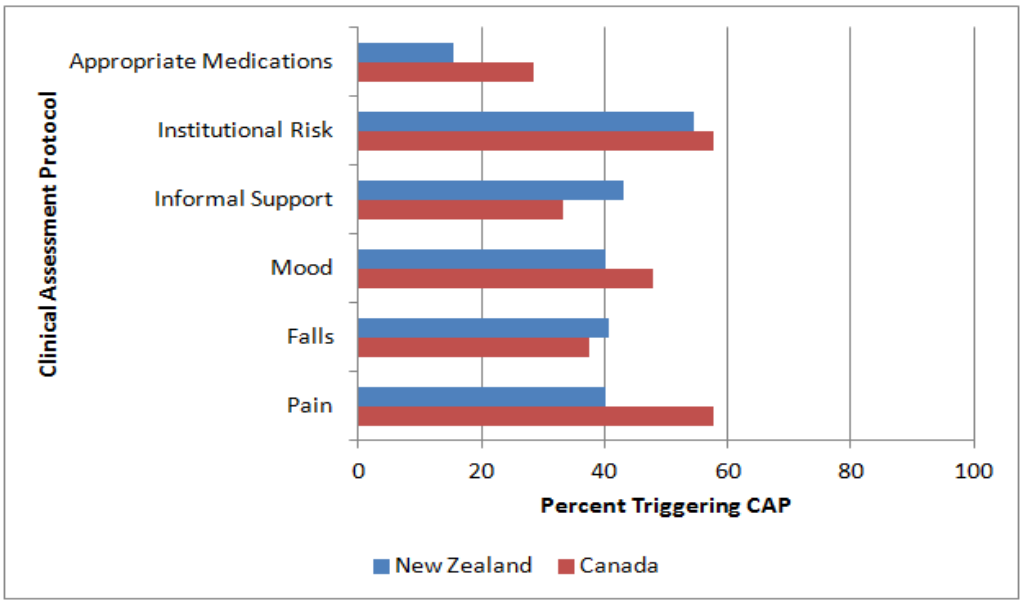
As a district we score quite well on this aspect. Most people are seeing their primary care provider regularly. For older people this often aligns with renewal of prescriptions but is also an opportunistic time for a good check-up. Nationally, the percentage ranged from two percent to 42 percent with our district in the lowest range. This might indicate good access to primary care services in this district for people who live in the community!

Participating in the Needs Assessment process is a time for identification of deficit areas for people, and making recommendations/referrals for aspects that are important to the older person. The data is used to inform the consumer, the general practice team and other services in order that appropriate planning can be made for both current and future needs.

Data helps us to understand if we are an outlier from other DHBs. Within this example on informal care, the average hours of informal care given to older people in this district are at the bottom end of the scale. These people benefit from additional home support hours to enable them to live at home safely.



In addition to comparing ourselves locally, regionally and nationally, we are being compared internationally. In this graph we can see the percentage of CAPs triggered between Canada and New Zealand.



The level of data we can now obtain is significant. Our obvious next step is to rally analyst and clinical support to make sense of the data and duly apply sound planning going forward.

The analysis of data is currently achieved in an ad hoc fashion usually precipitated by a problem area rather than looking at the population as a whole with determined focus. Older people are complex; by the time they have reached their eighties they have a range of disability impairments often one impacting on the other.

Overall, we are headed in the right direction, have the right tools to support us with data collection and have a good sense of where the priorities lie. Emphasis for future development is getting back to some basics of care ensuring pathways are straight forward and older people understand where to enter and gain support for services.

End/

TO Healthy Communities Advisory Committee

FROM Senior Portfolio Manager
Children, Youth & Intersectoral Partnerships

DATE 3 October 2016

Memorandum

SUBJECT **IMMUNISATION STAKEHOLDER GROUP WORK PLAN 2016/17**

1. PURPOSE

This update provides the Healthy Communities Advisory Committee with the 2016/17 Immunisation Plan for MidCentral District Health Board. An updated plan has been provided annually since 2007.

This paper is for discussion and information only.

2. SUMMARY

MidCentral District Health Board has had an Immunisation Stakeholder Group since 2007. This group was formed to provide oversight for improving immunisation coverage for the district. The group is led by the Medical Officer of Health and has a range of key immunisation stakeholders at the table.

Initially the group led the improvement and stabilisation of immunisation coverage for children and while this remains a key focus, it now provides guidance and oversight for all immunisation matters, including quality improvement.

The key issues facing the district for the 2016/17 year will centre on maintaining existing immunisation targets at milestone ages while improving the 4-year coverage rate to reach 95 percent (currently 93 percent).

Immunisation remains a population health issue with key national health targets. The Plan covers the intended activities for the immunisation of infants and children, seasonal influenza and other aspects related to the National Immunisation Schedule.

Implementing the changes to the Immunisation Schedule to be introduced in the 2017 year, as discussed in the General Manager's Operating Report, are paramount. While many changes are minor, the key impact will relate to the extension of the Human Papillomavirus (HPV) programme to incorporate boys.

The Medical Officer of Health will be available to discuss the plan with the Committee.

3. RECOMMENDATION

It is recommended:

that this report be received

Barb Bradnock
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Strategy, Planning & Performance

Immunisation Stakeholder Group Work Plan 2016/17

Goals:

1. Meet or exceed the Minister's national immunisation targets

2. Increase coverage levels for National Immunisation Schedule vaccination events at four; eleven and twelve years

3. Maintain equity in coverage levels for vaccinations on the National Immunisation Schedule, by ethnicity and deprivation

Objectives

1. Children

– Achieve and maintain the national health targets:

- 95% of 8 month old infants are fully immunised
- 95% of two year olds are fully immunised and coverage is maintained
- 95% of four year olds are fully immunised by age 5 years reported quarterly.

2. Influenza

- Achieve the National Indicator for Maori Health (Maori health Plan 2016/17)
  ≥75% of the eligible PHO and enrolled Maori population aged 65 years and over will have had their immunisation for seasonal influenza each year

- Increase influenza uptake for pregnant women

- ≥65% of hospital staff and General Practice Teams will have an annual influenza vaccination

3. School Based Health Service (SBHS)

- > 70% of all 12 year old girls will have completed all doses of their HPV vaccine by 30 June 2017 (2003 Birth cohort)

Outcome	Action	Responsibility	Timeframe	Performance Measure	Progress
1. 95% of children turning 8 months will be fully immunised	Prompt PHO enrolment: • Provide ongoing support to the newborn enrolment programme's integration & alignment with General Practice Monitor & maintain equity of coverage. Milestone ages reports will be presented at Steering group & any discrepancies between ethnic groups and Decile groups will be discussed.	NE Coordinator NEP Steering Group & NIR Team NIR Team & Steering Group	Ongoing	98 % of MDHB babies will be enrolled with General Practice by 2 weeks of age. (This will include each child being enrolled)	
	Continue to work with General Practice Teams to ensure they use a precall policy • Encourage GP Teams to precall rather than recall	Immunisation coordinator IMAC Regional advisor Immunisation Stakeholder Group	Ongoing	75% of MDHB Practices will have adopted precall policies by 30 June 2017 for all immunisations	
	Addressing decliners: • Continue to work with GP Teams to ensure they are using a recognised decliner process with families	Immunisation NIR Team	Ongoing	95% of General Practice teams will have adopted the CPHO recognised "decline at this time" process, which includes documentation of declines in the patient management system.	

	Referral from Primary Care to OIS: • Encourage integration between GP Teams and NIR Administration, to ensure prompt referral of children who meet priority criteria to OIS in a timely and efficient manner. • Priority criteria = children overdue for immunisation 2 weeks after their due event at 6 weeks, 3 months, 5 months & 15 months of age.	Immunisation Stakeholder Group OIS GP Team	Ongoing	All children who meet the priority criteria are referred to OIS	
	Professional Development/Education: Ensure that MDHB supports providers with professional development and that at a minimum the following courses are provided: • A two day Vaccinator Training Course • A Flexible Vaccinator Training Course • Two Vaccinator Update Courses	IMAC Immunisation Coordinator	Revisit annually in Nov/Dec	Professional Development courses are available and delivered each year as specified	

	Additional Education • Midwifery Courses – dependant on demand & funding • Immunisation Information Courses – dependant on demand & funding • DHB Staff vaccinator Training – depend on demand and funding Influenza Professional Development for Providers				
	Continue to ensure the Authorized Vaccinator data base is up to date.	Public Health Unit	Ongoing	The Authorised Vaccinator database accurately records the authorised vaccinators operating in MDHB.	
	Improve NIR Integration with Practices: NIR continue to supply bi-monthly overdue reports for GP Teams or monthly if required by specific practices.	NIR Immunisation Coordinator	Ongoing	Overdue reports are provided to GP Teams bi-monthly.	
2. 95 % of four year olds are fully immunised by age 5 years	Improve 4 year coverage rates measured by NIR reporting	Immunisation Stakeholder Group	Ongoing	95% of all 4 year olds are fully immunised by age 5 years	

3. (a) Achieve the National Indicator for Maori Health (Maori health Plan 2016/17)	Collaborate with Central PHO to develop & implement programmes for the 2016/17 Influenza season. Commence 4-5 month influenza immunisation campaign targeting 65+ age group and vulnerable populations (e.g. those with chronic respiratory conditions and pregnant women) from April each year with a range of communication activities, including: Use of billboards Patients meal tray liners Media campaign around influenza vaccination in pregnancy Continue to work with Central PHO and Maori/Iwi providers to promote and support offers of free immunisations to their enrolled older populations and kaumatua.	Immunisation Coordinator General Practice Teams	Ongoing	>75% of the eligible PHO and enrolled Maori population aged 65 years and over will have had their immunisation for seasonal influenza each year.	
3. (b) Influenza coverage for Healthcare staff will improve	Multiple clinics to be held within MidCentral Health to increase the pool of available vaccinators within the DHB	Lorraine	June 2017	65% of all MidCentral Health Staff will be vaccinated against influenza.	

	The MDHB Immunisation Stakeholder Group will support MidCentral Health to continue to implement a ward based vaccinator programme.	Immunisation Stakeholder Group	March 2017	Further extension to the Ward-based vaccinator programme will be in place by March 2017 to accommodate succession planning.	
	Continuing Professional Development/Education: - Annual Influenza Immunisation Update will be delivered with invited speaker.				
4. (a) Increase HPV Immunisation rates for 12 year old girls (2003 birth cohort)	Promote HPV immunisation programme through school newsletters and one month of radio advertising. Develop a system to identify and recall 14 year olds in General Practice. Develop a joint approach between School Based Immunisation Programme and GP Teams to increasing coverage rates across the age band 10-12 years.	Clinical Nurse Manager, PHNs & Education Sector. GP Teams		>70% of all 12-year-old girls will have completed all doses of their HPV vaccine by 30 June 2017 (2003 birth cohort). All Year 8 female students will have received HPV education/information by 31 March 2017. >98% return rate of consent forms across all ethnicities is achieved. All parental declines of the school-based programme are notified to General Practice within one month of the school based immunisation programme receiving a notification of parental intent.	

				Review School Based Immunisation Programme approach with GP Teams by 28 February 2017.	
4 (b) Achieve 85% dTap coverage rate for Year 7 students in the 2016/17 year	School based dTap programme is delivered to children of primary school age in state and non-state schools	Clinical Nurse Manager, PHS & Education Sector	2015 Programme developed by Oct 2016	School based Year 7 immunisation rates for dTap will be 85%.	
4 (c) Achieve 90% of eligible babies receiving BCG vaccination by 6 months of age when a consistent supply of BCG vaccine is available	Eligible babies will be identified using the established newborn enrolment process. Parents will be offered the opportunity to have their children vaccinated.	PHS Clinical Nurse Manager/ PHNs	2016/17	90% of eligible babies receive BCG by 6 months of age (pending vaccine availability)	

TO Healthy Communities Advisory Committee

FROM Mahashweta Patel
Intern Portfolio Manager
Strategy, Planning and Performance

DATE 3 October 2016

SUBJECT **Health Shuttle Arrangements, MidCentral DHB**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

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1. PURPOSE

This paper provides an overview of patient transport options with a particular focus on health shuttle services in the MidCentral District Health Board. This paper is for information only.

2. SUMMARY

The responsibility of transport provision is not explicitly part of the DHB's accountability. However, DHBs value transport support as it is connected to 'access', which drives health service utilisation and health outcomes.

The six area health shuttle services in the MidCentral DHB are operated by community volunteers and rely on donations from service users. The services are connected within the community and offer responsive transport to meet the needs of the community. In recent times the fundraising environment has tightened, as the level of grant funding from pub charities has reduced; this has caused some contention among service providers.

Providing transportation for the community is a significant component of the Horizons Regional Council's mandate. They provide a range of passenger services and allocate funding to shuttle services in the region to support residents in attending health appointments.

MidCentral DHB also provides a small annual contribution to the health shuttle services delivered by the Foxton Beach Community and the Horowhenua District Health Transport Trust, which have a particular focus on transporting people for appointments at the Renal Unit. A financial 'underwrite' is also available to all shuttle services in the event that the provider cannot cover costs through fundraising.

In line with the new MidCentral DHB strategy, to achieve better health outcomes and better health care for all, it is timely that the DHB develops a unified approach for the funding of health shuttle services in the district.

Consultation with Horizons Regional Council and Whanganui DHB has identified the opportunity to work in collaboration to develop a coordinated funding approach for health shuttle services in both DHBs.

This area of work will continue to progress during the annual planning process for the 2017/18 financial year, leading to a robust and transparent funding approach for health shuttle services in MidCentral and Whanganui DHB. MidCentral DHB is not committing to additional resources for the delivery of health shuttle services. If additional resourcing is required, approval from the Healthy Communities Advisory Committee will be requested.

3. RECOMMENDATION

It is recommended:

that this report be received.

Mahashweta Patel
Intern Portfolio Manager
Strategy, Planning & Performance

4. BACKGROUND

4.1 Population to service and geography of district

MidCentral DHB has a relatively high rural population, more than twice the national rate. The rural territorial authorities (Manawatu, Horowhenua, Tararua and Otaki) have their own unique population characteristics, and some areas are demonstrating population growth.

Palmerston North Hospital is centrally located in the district and provides a comprehensive range of specialist secondary services and specific regional treatment services. The table below shows that the majority of the population live within one hour driving time of Palmerston North Hospital. There are some general services provided in each area, however, with the increase in priority populations, there is a growing need to ensure that these groups are able to access specialist health services in a timely and safe manner.

Area (main town)	Distance from main town (km)	Approximate travel time from main town (minutes)	Population *
Horowhenua (Levin)	50.9	44	31,400
Otaki	71.8	58	5,778
Tararua (Dannevirke)	54.1	47	17,400
Manawatu (Feilding)	16.1	15	29,300

Table one: Travel distance to from rural centres to Palmerston North Hospital (times calculated on the basis of no traffic)

*As at 30 June 2015 (Statistics New Zealand population estimates)

4.2 Importance of health shuttle services

Health shuttle services provide non-emergency transport to ensure that people receive timely and safe commutes to avoid preventable deterioration, to facilitate access to DHB services, and enable services to effectively and efficiently manage their service. Most people are able to access hospital services using their own vehicle, a family member's or using public or private transport. However, there are also vulnerable people who face multiple barriers, whether physical, cognitive or financial and may find it challenging to access health service.

The health shuttle services provided in the MidCentral DHB rely on volunteers community support. Volunteers are predominately retired people wanting to remain active and contribute to their community. The services provide their volunteers with a level of social connectedness, motivation, sense of achievement and community spirit, all of which contribute to overall health and wellbeing. The high number of volunteers being utilised by shuttle services does however require strong coordination to ensure services are connected with effective systems.

5. STRATEGIC ALIGNMENT

Individually and together MidCentral DHB is committed to achieving quality and excellence by design, partnering with people and whānau to support health and wellbeing, connecting and transforming primary, community and specialist care, and achieving equity of outcomes across communities.

Transport is a critical component in people and whānau being able to access the health care they need. Within the MidCentral DHB the shuttle services are used by people living in outlying rural areas, the majority of whom are elderly, patients with chronic health conditions, and those on government benefit. Transport services that are provided across the district need to be supported to ensure people have safe and timely access to services, regardless of location, ethnicity, socio-economic status, age or gender. The shuttle services contribute to achieving equity of outcomes across all communities, they support priority populations minimize barriers and reduce inequalities for those most in need.

6. TRANSPORT SERVICES IN THE MIDCENTRAL DISTRICT

The six shuttle services in the MidCentral district are highly regarded in their respective communities, and receive strong support and positive feedback from service users. MidCentral DHB does not have individual contracts with each shuttle provider to obtain utilisation and financial data. However, anecdotal feedback has expressed that the services are highly utilised by the rural community; predominately the elderly, people from low socio economic status and those with chronic health conditions.

Information outlining the scheduling and areas covered by each health shuttle service is available on both the MidCentral DHB and Horizons websites. Table one in the Appendix section provides an overview of the shuttles services in the MidCentral district and the sub-region.

St John Health Shuttle operates four of the six shuttle services provided in the MidCentral district. The services are based in Dannevirke, Feilding, Otaki and Pahiatua and provide return trips to Palmerston North Hospital and medical centres. The services operate on a flexible schedule to try and meet the needs of the users. There is no charge for shuttle transport, however donations are encouraged.

The Otaki St John Health Shuttle service prioritises journeys to Palmerston North Hospital and the Horowhenua Health Centre. On request, the shuttle can provide transport to health appointments in Waikanae, Paraparaumu and Wellington. The St John service operating from Feilding facilitates home pick-ups throughout the Manawatu, including Bulls in the Whanganui DHB district. There is also a door-to-door service provided by St John for residents in Pahiatua, Woodville, Eketahuna and Dannevirke.

In the Horowhenua there are two health shuttle services: the Horowhenua and Districts Health Transport Trust service and the Foxton Beach Community Centre service. The Foxton Beach community health shuttle offers a door-to-door shuttle service at a "suggested donation" of $30.00 per person. Two vehicles generally service two types of appointments, one for patients requiring renal dialysis and the other general health appointments. The service can be used for appointments at the Horowhenua Health Centre and Palmerston North Hospital.

The Horowhenua and District's Health Transport Trust shuttle service covers Levin, Shannon and Foxton. The service operates four vehicles on a fixed schedule, including Saturday morning when renal dialysis is provided. MidCentral DHB provides an annual contribution toward operational costs. Passenger numbers fluctuate from year to year and in 2014 a total of 10,282 passengers accessed the service; an average of 857 passengers per month.

Horowhenua Transport reports a positive working relationship with its neighbouring St John Otaki Health Shuttle and connects with this service when maximum capacity of the Horowhenua Transport service is met. The shuttles are accessed by diverse health groups such as the elderly, patients requiring dialysis, and those on government benefits.

6.1 Public transport

Public transport is varied across the district; there are regular bus services within Palmerston North and from Feilding to Palmerston North Hospital. These services are operated by the Horizons Regional Council. The service from Feilding to Palmerston North via Bunnythorpe runs approximately every 30 minutes with several stops in Palmerston North including the hospital. This service is free for SuperGold Card holders, $3.50 for adults who have a concession card, or $2.50 for those with a community services card.

Despite the pockets of bus services available throughout the district, there are areas that are not covered by public transport, or have a limited service schedule. The ability to use public transport also relies on affordability, ability to identify the services available to them, and the navigation of bus transfers. Furthermore, service users must have the physical ability to get to and from the bus stop, and stamina to endure the journey.

6.2 Other Transport Options for Patient Travel

There are multiple informal and semi-formal ways to get assistance with transport to health appointments. Community groups, Community Health Workers and Maori health providers are able to provide support with transport to scheduled appointments.

The Cancer Society offers free transportation for those with cancer who are unable to provide their own transport to medical appointments. The option for car pooling is becoming increasingly popular for regular and one-off journeys. 'Let's Carpool' is an initiative accessible through the Horizon Regional Council website and allows people undertaking similar journeys to connect and travel together. A personalised fee for service option is also available through Driving Miss Daisy. The service extends further than a standard taxi services and offers physical accompaniment and special assistance for those requiring service.

7. NATIONAL TRANSPORT POLICIES

7.1 National Travel and Accommodation Policy

The National Travel and Accommodation (NTA) policy financially assists those who are referred by their specialist to see another specialist service, and need to travel long distances, such as to other district health boards or travel a route frequently.

The scheme is a form of DHB contribution towards transport; it is direct to the patient and prioritised to long-distance travel.

Reimbursement is aligned to set eligibility criteria. One-off visits to hospital for people in the MidCentral district may mean many do not qualify. Adults and children may be eligible if more than five visits in a six month period occur and travel exceeds 50 kilometres (adults) or 25 kilometres (children) one way. The Welfare and Travel Office is located in Palmerston North Hospital and will provide assistance to people seeking financial support under the policy.

7.2 Total Mobility Scheme

The Total Mobility Scheme provides subsidised taxi services to people with a long-term disability who are unable to use public passenger transport. The service is provided by the Regional Council who funds the service up to the maximum fare of $20.00 in Palmerston North and $10.00 in Feilding, Levin and Foxton. Any additional fare over the specified maximum is paid by the passenger. There are six transport providers participating in the scheme in the MidCentral district.

7.3 Disability Allowance

People with a long-term (expected to last more than six months) illness or disability may be eligible for the Disability Allowance through Work and Income. This is a maximum of $61.69 weekly to cover all additional disability related costs (as of September 2015). This includes travel to hospital.

8. TRAVEL ARRANGEMENTS IN OTHER DISTRICT HEALTH BOARDS

The need for health shuttle services in other DHBs vary according to the unique characteristics of the community and geography. Some DHBs have expansive rural areas and greater emphasis on transport, whereas others are urban with stable city services resulting in minimal assistance required.

Of the DHBs contacted for this exercise, it was found that DHBs do not have individual and local policies to guide direction. It is inferred funding is on a case-by-case basis; some DHBs fund comprehensive services and some less than MidCentral DHB.

MidCentral DHB encompasses a spread out geographic area with tertiary services centrally located in Palmserston North. Other DHBs cover districts that are slightly linear in their geography assisting in the delivery of transport services. For example, Taranaki DHB is able to provide a bus service from Opunake/New Plymouth via intermediate towns. The service is free for residents that need to access essential commitments, which includes social services as well as medical and hospital appointments. The New Plymouth connector is operated by Pickering Motors, under contract with the Taranaki Regional Council, with funding support from the region's three District Councils, Taranaki DHB and the Western Institute of Technology.

Capital and Coast DHB provide a free shuttle service between Wellington and Kenepuru hospitals. DHB has a fundholding contract with 'TaxiCharge' for capped fares for people whose clinical condition requires door-to-door travel and who have no other means of getting home from the Emergency Department.

Wairarapa DHB contract for a service aimed primarily at transporting people receiving haemodialysis in Wellington and Kenepuru Hospital. Across Wairarapa, Hutt Valley and Wellington, there are also a number of charitable options available for people who are unable to access public transport.

The St John health shuttle service operating in Bay of Plenty DHB provides similar transport arrangements to services available in the MidCentral district. The New Zealand Red Cross Hospital Transport Service is also available in the Bay of Plenty.

8.1 Whanganui DHB

The centralAlliance strategic framework highlights the importance of transport for both DHBs. Within Whanganui DHB there are two area health shuttle services operated by St John's. One service operates from Waimarino to Whanganui Hospital, the other from Whanganui to Palmerston North Hospital. Both services are operated through a booking system and passengers are requested to contribute a donation. The drivers of the shuttle services are volunteers and reimbursement is sought from the NTA policy, but at times the process for this claim can be fragmented.

In 2010, Whanganui DHB provided funding to St John's for the establishment of a health shuttle service for the Waimarino district. This included consultation with the community to develop transport arrangements between Wanganui, Palmerston North and other rural areas. Currently, there is no ongoing funding from Whanganui DHB to St John's for the delivery of the health shuttle services. The funding arrangements for health shuttle services continue to be a priority for Whanganui DHB.

9. HEALTH SHUTTLE FUNDING ARRANGEMENTS IN THE MIDCENTRAL DHB

A large proportion of the MidCentral population are able to access health services using their own vehicle, a family member's or using public or private transport. However, there are vulnerable people who face multiple barriers, whether physical, cognitive or financial and may find it challenging to access health service.

DHBs are responsible for providing or funding the provision of health services in their district. Under the New Zealand Public Health and Disability Act 2000 DHBs are to seek optimum arrangements for the most effective and efficient delivery of health services in order to meet local, regional, and national needs. DHBs are concerned with health shuttle services as they are linked to ensuring that access to transport is not a significant barrier to people using DHB services. However, the responsibility of transport provision is not explicitly part of the DHB's accountability.

MidCentral DHB's support for patient travel is, in the first instance, through the National Travel and Accommodation policy. As discussed in section 7.1, the policy is a patient-centred mechanism based on a set of eligibility and entitlement criteria and it targets those patients with the highest need and travelling the greatest distance. Underpinning the NTA policy is the expectation that for most people, travelling to and from the hospital to receive care or to visit relatives is the responsibility of the patient.

9.1 Underwriting

MidCentral DHB currently supports shuttle services across the district and has a funding arrangement in place with most services, whereby the DHB financially 'underwrites' the service in the event that a community-based shuttle provider cannot cover its costs. The health service is able to contact the DHB and support will be provided on the basis of an open book assessment of the service's financial position, as well as the context of available funding, urgency, and sustainability of the provider. This arrangement does not often get called on and is restricted to available resources.

9.2 Direct contracting

The Horowhenua District Health Transport Trust is funded directly by MidCentral DHB. The Trust receives $31,000.00 per annum and has a particular focus on providing transport for renal patients. The Foxton Beach Health Shuttle receives a small amount of funding from the DHB via the Central PHO. This is set at $3,600.00 per annum. The arrangement for this funding sits within a wider contract and is a single component to assist with access. Other shuttle services have not received any financial assistance from the DHB in recent years.

Additionally, MidCentral DHB provides letters of support for fundraising activities, assistance in obtaining support through the national Patient Travel and Accommodation policy, and with liaison around the interface with Palmerston North Hospital and other DHB health services. MidCentral DHB provides 'in kind' arrangements to shuttle providers including access to tea and coffee in the emergency department.

9.3 Horizons Regional Council

Horizons Regional Council are responsible for providing safe and accessible transport systems throughout the regional boundaries, this includes Tararua, Manawatu, Horowhenua, Rangitikei, Whanganui, Ruapehu districts and Palmerston North city. Providing transportation for the community is a significant component of the Horizons mandate. This encompasses passenger transport services, subsiding bus services, and managing the Total Mobility Service. Under this precedent, Horizons Regional Council provides funding support to four health shuttles in the district. Horizons provide funding support to the Horowhenua Health Shuttle and the St John health shuttle in Feilding, Dannevirke and Pahiatua.

Horizons Regional Council contributes approximately $80,000 to health shuttle services in their region. Of the funding allocated to the shuttle services 50 percent of the contribution is from the Land Transport Authority subsidy.

The current funding approach for the health shuttle services is based on a "funding gap" formula. Whereby, Horizons Regional Council fund the difference or 'gap' between the total operational cost and funding raised from donations, fundraising and other sources of income. The Regional Council have expressed concern that with their current approach there is potential risk of new shuttle services developing in the community requesting funding support.

10. FUTURE PLANNING

Providing health services closer to home is a key priority which aligns with the New Zealand Health Strategy and the MidCentral DHB Strategy. By supporting opportunities for outreach clinics and services in the community closer to home the need for long distance travel will logically be reduced.

The health shuttle services delivered by the Foxton Beach Community and the Horowhenua District Health Transport Trust have a particular focus on transporting people for appointments at the Renal Unit. A key outcome of the Renal Services Plan is the development of a three chair service in the Horrowhenua. The delivery of this service may reduce the need for health shuttles services between Horrowhenu and Palmerston North Hospital.

It is also important to note that MidCentral DHB population has a high proportion of people with high health and transport needs, including rural communities, older people and people of low socio-economic status. Furthermore, Horowhenua has a very large proportion of older people, with a quarter of the population over 65 years of age. The impact of this demographic composition will continue to have major implications on service planning and access to services.

11. WAY FORWARD FOR MIDCENTRAL DHB

The health shuttle services in the MidCentral DHB are well connected in the community and provide a safe and reliable service to those who may experience financial, physical or cognitive barriers to accessing health services. In line with the MidCentral DHB strategy there is opportunity to work in collaboration with Whanganui DHB and Horizons Regional Council to establish a coordinated approach to the funding of health shuttle services. This approach will not require additional resourcing from MidCentral DHB, but will assist Horizons to continue its involvement and provide a clearer environment for service providers. If additional resourcing is required, approval from the Healthy Communities Advisory Committee will be requested.

This area of work will commence during the 2017/18 annual planning process with the expectation of a coordinated approach developed by the end of the 2017/18 financial year. The approach will subsequently be reviewed annually to ensure the needs of the community continue to be prioritised and that the arrangements for the health shuttle services in both districts contribute to improving health outcomes for all.

Appendix 1. Shuttle services available in the MidCentral district and regional areas

MidCentral Area	Shuttle Provider	Operational hours	Locations covered	Payment
Dannevirke	St John Health Shuttle	Monday-Friday 8am to 5pm	Dannevirke area	Donations accepted
Feilding	St John Health Shuttle	Monday-Friday 9am to 1pm	Operated from Feilding	Donations welcome
Foxton Beach	Foxton Beach Community Centre	Monday-Friday 9am-2pm	Travels from Foxton and Foxton Beach to Palmerston North Hospital and Horowhenua Health Centre	Suggested donation of $30.00 per person
Horowhenua	Horowhenua and Districts Health Transportion Trust	Monday-Friday Saturday for dialysis patients	Return trips daily from Horowhenua Health Centre to Palmerston North Hospital via Shannon and Foxton	Donations are welcome
Otaki	St John Health Shuttle	Monday-Friday 9am-3pm	Three trips a day from Otaki to Horowhenua Health Centre, Palmerston North Hospital and other healthcare appointments. On request to Waikanae, Paraparaumu and Wellington.	Donations are welcome
Pahiatua/Eketahuna/Woodville	St John Health Shuttle	Monday-Friday 10am-4pm	Covers the Pahiatua, Eketahuna and Woodville districts	Voluntary donation welcome

Regional Shuttles	Shuttle Provider	Operational hours	Locations covered	Payment
Takapau	Takapau Red Cross	Monday-Friday	Provides a service for those with specialist appointments	No charge
Marton/Ratana	St John Health Shuttle	As and when required	Marton/Ratana	Donations are welcome
Whanganui	St John Health Shuttle	Monday-Friday 9.30am-2.30pm	Wanganui	Donations are welcom

Appendix 2. References and key documentation

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Horizons Regional Council (2016) http://www.horizons.govt.nz/getting-people-places/passenger-transport/bus-timetables-and-routes/levin-palmerston-north-commuter-service/

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Palmerston North City Council (2016) Ride Share- Let's Car Pool http://www.letscarpool.govt.nz/in-your-area/manawatu-wanganui-region/

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Ride Parliamentary Counsel Office (2015) New Zealand Public Health and Disability Act 200 http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html

TO Healthy Communities Advisory Committee

FROM GM, Strategy, Planning & Performance

DATE 29 September 2016

Memorandum

SUBJECT **CONSUMER COUNCIL**

1. PURPOSE

This paper updates the Committee on the development of the Consumer Council. It is for information only; no decision is required.

2. SUMMARY

New Board and Committee structures have been agreed to position MidCentral DHB for the future and, in particular, to give effect to the DHB's new Strategy. In terms of the strategic imperatives, consumer engagement features strongly under *Partner with people and Whanau to support health and wellbeing*. The first objective is to establish an organised consumer voice to ensure consumers actively participate at all levels of the organisation to help improve health outcomes. The Consumer Council parallels a newly established Clinical Council and it is proposed that its establishment follows a similar process to that of the Clinical Council. It is expected that there will be a strong relationship between the Consumer Council and the Clinical Council and their respective programmes of work will be strongly aligned. The Consumer Council will link to the Healthy Communities Advisory Committee.

Planning is underway to establish the Consumer Council. It is intended to use a co-design approach, starting with the Consumer Panel that previously functioned as part of the Master Health Services Plan. A workshop is planned for mid-October, at which Terms of Reference and various other matters will be discussed. This is essentially the same process as has been used for the Clinical Council.

Updates on progress will be provided to future Committee meetings.

3. RECOMMENDATION

It is recommended:

that this report be received

Craig Johnston
General Manager
Strategy, Planning & Performance

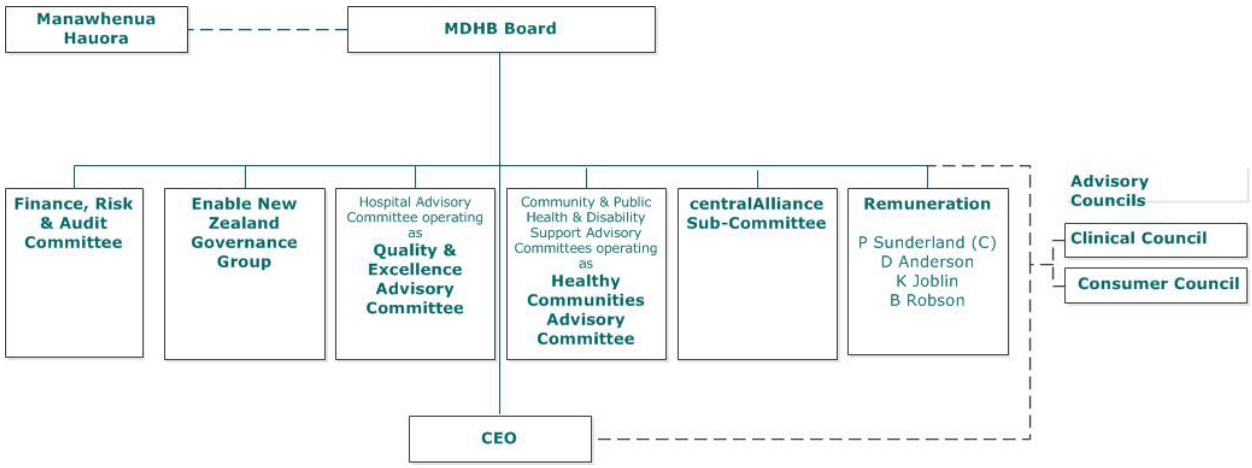
4. BACKGROUND

The development of a new strategic framework for MidCentral DHB has been a catalyst for a review of the DHB's governance structure. It was important to ensure that these arrangements are appropriate, in line with best practice and supportive of the successful implementation of the strategic framework.

As a result of the review, the three statutory committees (Community & Public Health Advisory Committee - CPHAC, Disability Support Advisory Committee – DSAC and the Hospital Advisory Committee – HAC) have been refocused, and joint meetings are scheduled in line with the integration focus of the DHB. At the same time, the roles of CPHAC and DSAC were combined to give a greater focus on disability matters in the DHB's planning activity, and the previous audit committees were reconstituted as a single Finance, Risk and Audit Committee.

The new governance arrangements feature stronger engagement with the Board's iwi partner, Manawhenua Hauora. There is also to be increased consumer and clinical engagement through the establishment of a Clinical Council and a Consumer Council.

The following diagram represents the new structure.



It is intended that the new Consumer Council have a relationship with the Healthy Communities Advisory Committee. It has been included in the Committee's Terms of Reference and in its draft workplan.

5. STRATEGIC RELEVANCE

Consumer engagement has been a recurring theme in the development of the MidCentral Strategy and now features strongly in the document. It is central to the statements about the future we want, particularly:

1. People families and whanau have a positive experience of health care
2. People are experts in their own lives and are partners in their healthcare'

In terms of the Strategic imperatives, consumer engagement features strongly under *Partner with people and Whanau to support health and wellbeing.*

The first objective under this heading is to establish an organised consumer voice to ensure consumers actively participate at all levels of the organisation to help improve health outcomes.

6. CONNECTED WORK

Within MidCentral DHB there are already a variety of consumer engagement and co-design activities underway. For example, there is a 'Partners in Care' programme underway in MidCentral Health, and there is the long standing Customer Relations office which is involved with patient-level issues including Health and Disability Commission complaints. There are also consumer/whanua representatives employed in some departments, most notably Mental Health.

Going forward, the Consumer Council needs to be joined up with all the resources and activities that already exist. This is partly to avoid duplication, but mainly to ensure we get the best possible impact from a coordinated approach to consumer engagement.

It should be noted that it is intended that the Consumer Council have a district-wide focus and it will therefore be important that it also links in with activities in the primary and community sectors.

The function of the Council is expected to be strategic, providing the framework for how we interface and engage with consumers, rather than being the point of access for feedback on specific projects. The Council might provide a pathway through which we would get relevant consumers involved in specific projects.

7. PROPOSAL

It is intended that the establishment of the Consumer Council proceed on a similar basis to that used for the Clinical Council. This means using a co-design approach starting with the Consumer Panel that previously functioned as part of the Master Health Services Plan. This group has a good range of representation including Maori and disability perspectives. It has been in abeyance for some time but members are willing to come together to support the DHB to get the Consumer Council set up under the leadership of John Hannifin, the previous Chair.

A workshop is planned for mid-October, subject to the availability of the participants. The workshop will also include some representatives from the Clinical Council (community and hospital) – it has previously been agreed that there needs to be some cross representation for the two new committees – and from the Executive Team.

The workshop will consider draft Terms of Reference and the scope of work of the Council. Going forward the Council will need to be adequately supported, particularly administrative support. There will also be issues of remuneration and Consumer training that will need to be addressed.

8. CONCLUSION

The establishment of a Consumer Council is an important step forward in the implementation of the MidCentral Strategy. It has been detailed in the refresh of MidCentral DHB's governance arrangements. Once established, the Consumer Council will have a relationship with the Healthy Communities Advisory Committee.
It is intended that establishment of the Council begin with a co-design workshop including members of the Consumer Panel from the Master Health Services Plan and representatives of Board/Committee and the Executive Team.

TO Healthy Communities Advisory Committee

FROM General Manager
Strategy, Planning & Performance

DATE 28 September 2016

Memorandum

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

1 PURPOSE

This report provides the Committee with an update on the activities of Strategy, Planning and Performance group. It is for the Healthy Communities Advisory Committee's information and discussion – no decision is required.

2 SUMMARY

The penultimate draft of MidCentral DHB's Strategy and the draft Strategic Framework for the centralAlliance were approved by the Board at their meeting in September.

The look and feel of the DHB's Strategy is now being refined and a plan is being developed for wider engagement in rolling out the Strategy across the district. Work is underway to finalise the Memorandum of Understanding and development of the implementation approach for the centralAlliance programme of work.

PHARMAC has announced changes to the immunisation schedule for funded vaccines to take effect in the 2017 year. Notably this includes extending the Human Papillomavirus Vaccine (HPV) to those aged from nine to 26 years, including boys and men, and an update to the Gardasil vaccine to protect against nine types of HPV. These changes will impact on the capacity of the Public Health Service and School Based Health Service; an impact assessment, including costs, has yet to be determined.

Year to date financial performance against the Funder budget shows a positive variance of $110k.

3 RECOMMENDATION

It is recommended:

that this report be received

Craig Johnston
General Manager,
Strategy, Planning & Performance

4 STRATEGY AND PLANNING

4.1 Strategic Planning

The penultimate draft of MidCentral DHB's Strategy was approved by the Board at their meeting in September. The next step is to refine the look and feel of the document. This process may result in minor editorial amendments, but no significant changes. Once the presentation of the Strategy has been finalised, it will be presented back to the Board.

An engagement strategy is under development. To date engagement has focused on input and testing. The next phase involves dissemination and will consider how the Strategy will be rolled out across the organisation and broader district.

4.2 centralAlliance Strategic Framework

MidCentral's Board endorsed the draft Strategic Framework for the centralAlliance at their meeting in September, and will be considered by Whanganui's Board at their meeting on 30 September.

The Strategic Framework supports a clear focus on improving health outcomes for the sub-regional population through building primary and community services, strengthening specialist and hospital services, and, directing investment to areas that make a difference.

The next stage is finalising the Memorandum of Understanding setting out how the DHBs will work together, and then developing a systematic implementation approach to the potential programme of work at service level. This requires a significant degree of input from clinician and management teams with the right planning and engagement processes deployed that will support effective service development and implementation of change. The implementation planning approach is being led by the respective Chief Medical Officers on behalf of the centralAlliance subcommittee.

4.3 2015/16 Annual Report

The Annual Report for the 2015/16 year, including the Statement of Service Performance, has been prepared for consideration by the Finance, Risk and Audit Committee. All Committee members will receive a copy of the report once it is signed off in October.

4.4 Other Planning Activities

The Strategy, Planning and Performance group has also been involved in developing a Long Term Investment Plan and a System Level Measures Improvement Plan, that are new requirements to be submitted to the Ministry of Health by the end of the quarter. The Committee will be updated on these pieces of work in due course, once the draft documents have been reviewed by the Ministry and are subsequently finalised.

5. LOCAL PORTFOLIO MATTERS

5.1 Health of Older Persons

5.1.1 National Strategies

Key national projects on the table include the palliative care review and the refresh of the Health of Older Persons strategy. Consultation on the latter has recently concluded. Both documents represent a consideration of what is needed to deliver to the aging population over a ten year period.

Our local direction is consistent with the proposed actions to deliver on better health and social services. District wide feedback was sought and a number of local stakeholders and professional groups engaged in one form or another to give comment. The Health of Older Persons strategy has a strong focus on prevention, services closer to home, living and dying well.

5.1.2 Aged Residential Care Facility Audits

Poor results from the routine surveillance or certification audits of two aged residential care facilities have been identified this quarter. The issues are not generally related to care of residents but a broader issue around inadequate quality systems being in place. The necessary interventions have occurred with the providers to address these concerns.

A recent report from Auckland University illustrates an overall improvement within the aged care sector since the integrated auditing programme was implemented. This is a trend we have seen in our own district and which we have commented on to the Committee in previous reports. The current poor audits are isolated instances and not generally representative of the sector.

Our own spotlight on these issues shows a strong link to unfilled clinical or facility manager positions. We are working closely with organisations where this is the case to highlight the risk and ensure the quality of care for residents is not compromised.

5.2 Mental Health and Addictions

5.2.1 Co-creating a Mental Health and Addictions System Framework (Te Pou National Workforce Centre)

The local mental health and addictions sector has been focusing their service development discussions around delivering more streamlined and integrated addiction services to ensure sustainability, value for money and alignment to the national and local strategies. The local network is keen to increase system capability through a strong primary care sector and a well-developed NGO sector that is well connected to the secondary services. This aligns to MidCentral's strategic intentions and goals of an integrated mental health and addictions service.

As part of the overall Mental Health and Addictions plan, the NGO and primary mental health sector has commenced planning towards implementing the 'On Track' framework (Platform Trust and Te Pou National Workforce Centre).

This framework identifies a stream of small transformative actions that could be undertaken by different people in different places, all working in a consistent way toward addressing the challenges faced by the mental health and addiction system.

The Connected Workforce Leadership Group (leaders and managers from the NGO and primary mental health sector) has identified specific projects under each action area for a collaborative work programme, as outlined in the table below.

Table 1

	Action Areas	Emerging	Evolving	Partnering	System Outcomes
1	**Support self determination**	Service providers recognise and build on the strengths of service users and their families/whanau	Service providers share power & responsibility with service users as active partners in defining agendas and making decisions	People are supported to monitor and improve their own health and wellbeing	People have the information that they need to take care of their own health and wellbeing
2	**Focus on system redesign**	All service providers promote equitable, timely access to services	The MHA system operates as one system of care for the benefit of service users, families/whanau	The health and social system operate as one system of care for the benefit of service users, their families/whanau	Providers are able demonstrate shared accountability for improved outcomes for people, families/whanau
3	**Improve workforce capability**	Frontline roles are refocused on the values and skills of co-production and making reciprocal relationships work well	The workforce acts as partners, mentors, facilitators and catalysts in helping people to shape the lives that they value	Co-production becomes the default model of service delivery for the workforce	People and their families/whanau have a positive experience of service provision
4	**Address investment and sustainability issues**	The barriers to sustainable and productive community MHA service provision are recognised and addressed	Community organisations are able to demonstrate value for money	Co-production is built into a new MHA commissioning framework	Community organisations are sustainable and offer value for money
5	**Enhance community engagement**	Effective local alliances between service providers and their community partners are established and fostered	Service providers and community partners allocated and align each of their resources in order to improve population level outcomes	Service providers and community partners effectively mobilise the collective resources of the community to improve population level outcomes	Provider and community resources are aligned with what is known to improve population health and community wellbeing
6	**Use the evidence**	Treatment and support decisions are made on the basis of people's personal preferences, the evidence about what works and professional judgement	All service providers are engaged in applying the evidence and evaluating the outcomes	Service providers benchmark their performance against some agreed national performance measures	The implementation of the evidence results in improved outcomes for service users and their families/whanau
7	**Strengthen organisational infrastructure**	Providers upgrade and share infrastructure (where possible) and standardise IT systems across multiple providers locally and regionally	Providers accelerate the uptake of technologies that enhance workforce practices and increase productivity	Service providers are equipped to operate as equal partners in the system of care	Community organisations are fit-for-purpose and are sustainable over time

5.3 Primary Health / Child and Youth Health

5.3.1 Immunisation Schedule Changes

PHARMAC has recently announced changes to funded vaccines, which will benefit an extra 100,000 people nationally. The changes will commence 1 January 2017 and are outlined below.

Human Papilloma Virus (HPV) Immunisation Programme

From 1 January 2017, all those aged 9 to 26 years, including boys and young men, will be eligible for free HPV immunisation. Boys will be included in the existing school-based immunisation programme at year 8 from 2017, increasing the number of students for whom the vaccine will be provided at school. Boys-only schools will be invited to host HPV immunisation for the first time.

Boys and men will also be able to get immunised free through General Practice.

The existing Gardasil vaccine protects against four types of HPV. From 2017 it will be replaced with an updated version, Gardasil 9, which protects against nine types of HPV. The five extra types will mean that HPV immunisation will protect against a greater proportion of HPV-related cancers, including around 90 percent of cervical cancers.

Currently, Gardasil vaccine is administered as three doses given over 6 months. Recent trials of Gardasil 9 have demonstrated that for younger teenagers, two doses are sufficient to provide protection against HPV. In 2017, two doses will be given six months apart to ensure that children in Year 8 have the opportunity to be fully vaccinated during the course of one school year. Those aged 15 years and older do not develop immunity as strongly and will still need three doses.

There will be some initial impact on the capacity of Public Health Service and School Based Health Service. While HPV immunisation will continue to be delivered in Year 8 in 2017, the Ministry of Health's Immunisation Team is working with DHB school-based programme leads to plan for the new schedule, which is likely to deliver HPV immunisation alongside the existing school-based immunisations in Year 7.

Other changes from 1 July 2017

- The varicella (chickenpox) vaccine will be funded for all children as a part of the childhood immunisation schedule
- The pneumococcal vaccine will change from a 13 strain to a 10 strain version
- The rotavirus vaccine will change brand and move to a two-dose regimen
- The measles, mumps and rubella (MMR) and haemophilus influenza type b (Hib) vaccines will move to new brands.

These significant changes will affect General Practice and School Based Health Service teams. The DHB will support the Ministry of Health and the sector to ensure all staff receive the appropriate professional development required in respect of these changes.

5.3.2 Change at City Doctors, Palmerston North

The DHB has been advised that the shareholders of City Doctors have agreed to a joint venture with White Cross Health Care. City Doctors is the main after hours provider for the district and operates from Victoria Avenue in Palmerston North. As from 01 October 2016, White Cross will own 60 percent of the new joint venture entity and will be the managing shareholder. The name of the new entity will be City Doctors White Cross Ltd (CDWX), however it will continue to trade under the name of City Doctors. The current shareholders of City Doctors will retain 40 percent of the shares.

White Cross is a New Zealand-owned provider of primarily accident and urgent medical care, although it does own some general practice teams. It has eight clinics in the greater Auckland area and one in Whangarei.

The change in ownership of City Doctors is being seen as a positive move toward strengthening the management capability and viability of City Doctors as well as drawing on the expertise of White Cross in the area of acute care in particular. It is intended that City Doctors will continue to provide after-hours services, which is supported by the General Practitioners across the district that utilise City Doctors to fulfill their back to back agreements.

Once the changeover period settles, City Doctors White Cross will be looking at other areas in which they could grow services that would add value to their patients and the community. White Cross has signalled their intention to be available to partner and work with any party in the region where support or further development would add value, including assistance to the smaller general practices if there is an appetite from the General Practitioners to do so.

6. FINANCE REPORT

6.1 Summary

The Funder's result for the month to 31 August 2016 is a $1.185m deficit, which is a $15,761 positive variance against budget. This brings the year to date position to a positive variance of $110,127 to budget.

The DHB is receiving income for "Additional Contribution to DHB Demographic and Cost Pressures" sourced from the Ministry of a budgeted $1.313m pa. This is being received in monthly instalments which differs from the 2015/16 financial year when the equivalent sourced income was budgeted and received as a one-off payment in June 2016.

6.2 Inter District Flows (IDF)

The Inter district (IDF) inflows and outflows are on budget for the month.

The financial result from the Ministry-based IDF national wash up process for 2015/16 has been received. MidCentral DHB incurred an additional net $275k cost of IDF outflows over inflows to the Ministry's forecasted wash up at end of June 2016. However, sufficient provision was made for this additional cost in the budget for year ending June 2016 based upon prior years' patterns.

Any further IDF wash ups outside of the Ministry's national process will be negotiated between DHBs; none have been signalled at this stage.

6.3 Price Volume Schedule

The monthly phasing for the income passed to MidCentral Health has been developed substantially by MidCentral Health through the Price Volume Schedule (PVS) production planning mechanism. The bulk of the income is based upon the standard national price per unit for the total volume of each purchase unit. MidCentral Health has a full year plan for the production of volumes by purchase unit each month and the phasing has been agreed to match that production plan.

The monthly funding passed to MidCentral Health is based upon the phasing of the PVS and is reflected as income by MidCentral Health and matched as expenditure in the Funder, thereby neutral to the DHB. Some variation will occur with some of the Regional Cancer Treatment Service and cancer drug treatment (PCT) to recognise those purchase units that are washed up through the national IDF process.

In July 2016 reporting period MidCentral Health did not meet the PVS volumes as for RCTS cancer treatments; accordingly no additional amount was passed to MidCentral Health. The shortfall of $145k in volume was caught up in August 2016. An additional $42k was also passed to MidCentral Health for RCTS cancer treatments that were completed above the planned volume for July and August.

6.4 Financial Forecast

The financial forecast for the year to 30 June 2017 is consistent with the Annual Plan and annual financial budget. With two months passed in the new financial year, the Funder is forecasting a positive variance to budget of $110k at year end.

No issues have been identified that will negatively impact on the forecast financial year end result for the Funder at this time.

6.5 Financial Performance

The year to date financial performance of the Funder by major service group is as follows:

Income and Expenditure	Aug-16 YTD Actual	YTD Budget	Variance	Annual Forecast	Annual Budget	Variance
	$000	$000	$000	$000	$000	$000
Personal Health Income	68,649	69,291	-642	415,745	415,745	0
Personal Health Expenditure	71,487	72,181	-694	414,443	414,503	60
Personal Health Surplus/(Deficit)	-2,838	-2,890	52	1,302	1,242	-60
Mental Health Income	7,452	7,391	61	44,348	44,348	0
Mental Health Expenditure	7,665	7,425	240	44,348	44,348	0
Mental Health Surplus/(Deficit)	-213	-33	-179	-0	-0	0
Disability Support Income	13,824	13,338	486	80,027	80,027	0
Disability Support Expenditure	13,997	13,531	466	79,955	79,955	0
Disability Support Surplus/(Deficit)	-173	-194	21	71	71	0
Maori Health Income	384	384	-0	2,307	2,307	0
Maori Health Expenditure	167	385	-217	2,257	2,307	50
Maori Health Surplus/(Deficit)	217	-0	217	50	0	-50
Governance Income	967	967	0	5,802,180	5,802	0
Governance Expenditure	967	967	0	5,802,180	5,802	0
Governance Surplus/(Deficit)	0	0	0	0	0	0
Total Funder Surplus/(Deficit)	-3,007	-3,117	110	1,423	1,313	-110

7 STAFF CHANGES

Strategy, Planning and Performance welcomes two new staff members to the group. Gopyraj Sundararajah has taken up the position of Portfolio Manager, Clinical Support and David Jermey has been appointed to the Portfolio Manager, Primary Health Care position. Gopyraj comes to MidCentral from the Hawke's Bay and will be responsible for Pharmacy, Laboratory, diagnostic and other support services.
David comes to the DHB after six years in Canada and will be responsible for rural health services and contracted providers in the primary health care setting (including Central PHO).