



MIDCENTRAL DISTRICT HEALTH BOARD
To Promote Health and Wellbeing in the District

M I D C E N T R A L D I S T R I C T H E A L T H B O A R D
DISTRICT ANNUAL PLAN
2010/2011

**Front cover photo taken at
Te Tahatai o Ōtaki - Otaki Beach, by Chateya Kamariera.**

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Foreword

This District Annual Plan sets out what MidCentral District Health Board (MDHB) will be doing over the next three years to improve the health and wellbeing of its community.

It will be implementing the Government's health strategy "Better, Sooner, More Convenient Health Care" and national priorities and targets. The focus is on:

- the establishment of five integrated family health centres
- increased collaboration across the health continuum
- better management of acute demand
- improved models of care for older people
- improved access and utilisation of health services amongst whanau
- more clinical leadership.

The DHB will also implement plans to further improve waiting times for cancer services and its emergency department. Elective service levels are to be increased, and work in national priority areas of diabetes, cardiovascular, smoking cessation and immunisation will continue.

The financial improvement of the DHB, particularly its hospital and health services, is a priority for the year. We will reduce our deficit and this will mean changes to the way services are delivered.

Financial reviews will be undertaken across a wide range of services and we will look at who should provide the services and where services should be based. Managing demands within available funding will mean limited ability for the DHB to increase remuneration, contract prices and service levels.

Savings through collective procurement activities will continue to be sought, and Enable New Zealand will increase its role in rehabilitation equipment procurement.

Closer links will be forged with Whanganui DHB through the centralAlliance. More clinical and support services (including back-office functions) will be established on a sub-regional basis similar to the women's health initiative.

Implementation of the Regional Clinical Services Plan for the central region will continue.



Phil Sunderland
Chair



Murray Georgel
Chief Executive Officer

21 June 2010



Hon Tony Ryall
Minister of Health

Setting the Scene: Characteristics of MidCentral DHB's Population

MidCentral DHB's health status is improving. Mortality rates for most of MidCentral DHB's ethnic groups, and MidCentral DHB overall have been improving. (NB: Mortality is used as a general indicator of population health status. As health status improves, mortality rates reduce.)

The five most common causes of mortality are: circulatory diseases, cancer, respiratory diseases, injuries, and endocrine diseases (mostly diabetes). These conditions have the greatest population health impact, when using mortality as a yardstick.

The area for which the MidCentral District Health Board has responsibility is based on territorial authority and ward boundaries and includes:

- Manawatu District
- Palmerston North City
- Tararua District
- Horowhenua District
- Kapiti District (Otaki Ward).



MidCentral DHB's district's population of approximately 160,000 is growing. The growth is mostly in Palmerston North and is paralleled by an increase in the district's proportion of Maori, Pacific and Asian residents.

MidCentral DHB's district's population structure is ageing, with increasing proportions aged 65 and over and reducing proportions aged 0 to 14. The distribution of people aged 65 years and older is not even across the MidCentral DHB district, it is higher in Horowhenua and MidCentral's portion of Kapiti Coast (Otaki and surrounding areas).

Mortality (and therefore health status) is improving for all the territorial authorities. The most common causes of mortality for each of the territorial authorities are the same as for MidCentral DHB overall: circulatory diseases, cancer, respiratory diseases, injuries, and endocrine diseases (mostly diabetes).

Although the gap may have narrowed, Horowhenua is still an area of disadvantaged health status, compared to MidCentral overall.

Horowhenua, MidCentral DHB's portion of Kapiti Coast (Otaki and surrounding areas), and Tararua have higher proportions of Maori residents than the rest of MidCentral district.

Maori and Pacific peoples experience disadvantaged health status. This is true for both MidCentral district and New Zealand overall. Maori and Pacific health status disadvantage is also reflected in their mortality rates for the five most common causes of mortality.

There is evidence that Maori and Pacific peoples experience lesser access to health services when compared to health need. This is suggested by comparisons between hospitalisation patterns (service access) to mortality patterns (health need).

Even though MidCentral DHB Maori are less likely to experience cancer (compared to New Zealanders overall) they are more likely to die from cancer. Pacific peoples also have higher cancer mortality, despite lower cancer incidence, compared to New Zealanders overall.

Planning Framework

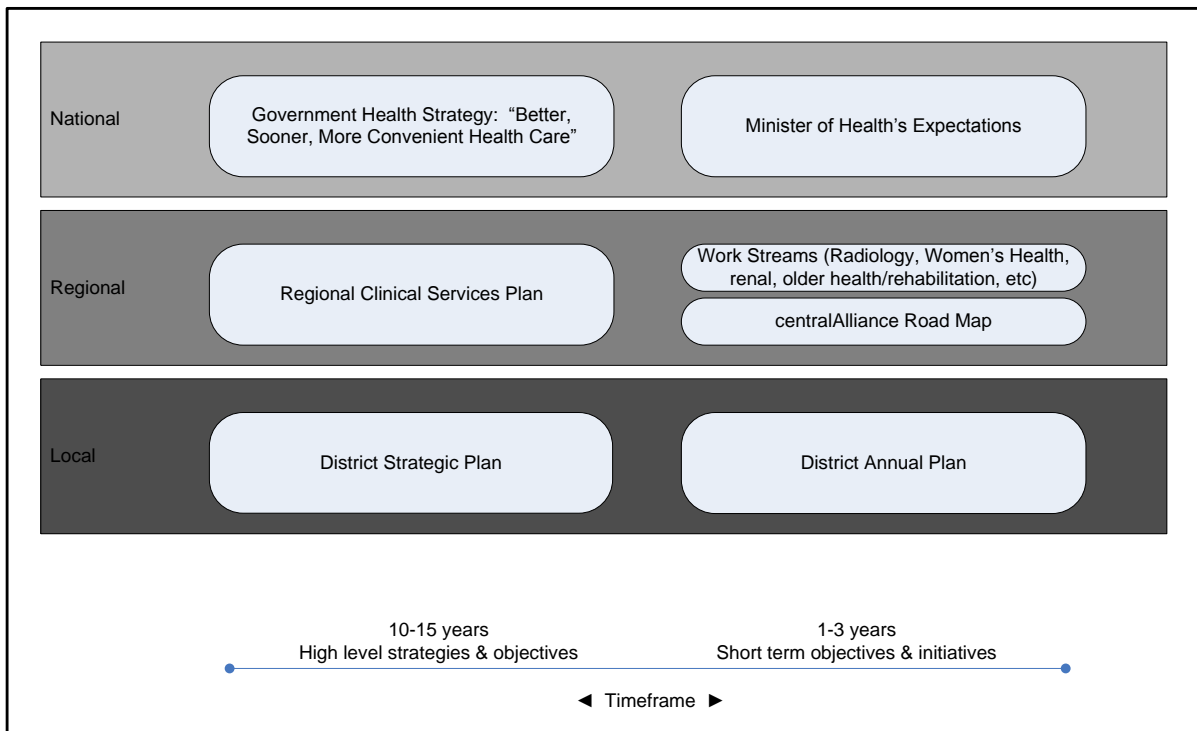
The Government’s health strategy sets the national direction for health. This guides planning at MidCentral DHB.

MidCentral DHB has a vision for its district – Quality Living – Healthy Lives, and a long term strategy (10 years) as to how this vision will be achieved. This strategy is documented in the District Strategic Plan.

Each year, the Board reviews progress toward achievement of its vision and long term strategy and identifies what further steps it will take over the coming three years. This work is documented in the District Annual Plan.

MidCentral DHB is located in the central region and it works closely with the five other DHB’s in the area: Capital & Coast, Hawke’s Bay, Hutt Valley, Wairarapa and Whanganui. The central region DHBs have developed a plan for hospital services over the long term (10-15 years). This is entitled the Regional Clinical Services Plan.

MidCentral DHB also plans closely with its neighbour, Whanganui DHB, regarding the provision of care for their joint communities. This work is formalised through a Foundation Agreement and implemented via a Road Map.



Government's Priorities for Health

The Government has established six national health targets and identified five priority areas for 2010/11 and beyond. The priority areas are focused on hospital services and

achieving value for money. Details of the Government's key expectations of DHBs and the national health targets are set below.

Key Expectations from Government		National Health Targets	
Improving service and reducing waiting times	<ul style="list-style-type: none"> • Increase elective surgical volumes year on year. • Improve emergency department waiting times in line with the six hour length of stay target. • Improve cancer treatment waiting times. 	Shorter stays in Emergency Department	<ul style="list-style-type: none"> • 95% percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours.
Next steps in the Primary Health Care Strategy	<ul style="list-style-type: none"> • Work with community & hospital clinicians to provide a wider range of services in a community setting. • Provide those services at not cost to patients. • Actively investigate & facilitate opportunities to consolidate PHOs where appropriate. 	Improved access to surgery	<ul style="list-style-type: none"> • The volume of elective surgery will be increased by an average of 4,000 discharges per year.
Clinical leadership*	<ul style="list-style-type: none"> • Strengthen clinical engagement from the governance level throughout the organisation. 	Shorter waits for cancer treatment	<ul style="list-style-type: none"> • Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.
Regional co-operation	<ul style="list-style-type: none"> • Accelerate closer collaboration with neighbouring and close DHBs, including Regional Service Plans and clinical networks. 	Increased immunisation	<ul style="list-style-type: none"> • 85 percent of two year olds will be fully immunised by July 2010; 90 percent by July 2011; and 95 percent by July 2012.
More unified system	<ul style="list-style-type: none"> • Work with National Health Board re shared services and other improvements flowing from the Ministerial Review Group report such as quality & safety. 	Better help for smokers to quit	<ul style="list-style-type: none"> • 80 percent of hospitalised smokers will be provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95 percent by July 2012. • Similar target for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme.
		Better diabetes and cardiovascular care	<ul style="list-style-type: none"> • Increased levels of: <ul style="list-style-type: none"> ○ The eligible adult population having their CVD risk assessed in the last five years ○ People with diabetes attending free annual checks ○ People with diabetes having satisfactory or better diabetes management.

*For details of MidCentral DHB's clinical leadership framework refer Appendix A.

How MidCentral DHB will Action the Government's Expectations

Expectation	Activity for 2010-11
Next steps in the Primary Health Care Strategy	<p>Establish five integrated family health centres (IFHCs).</p> <p>Integrated community nursing services into IFHCs.</p> <p>Increase collaboration across the health continuum, including care plans, health care case management model, and central clinical-led referral system.</p> <p>Better management of acute demand (establish clinical pathways and networks, provide advanced training for paramedics, and transfer responsibility for the community radiology budget to primary care).</p> <p>Improve models of care for older people and install InterRAI.</p> <p>Improve access and utilisation of health services amongst whanau.</p> <p>Clinical leadership development.</p> <p>Establish single point of access for after-hours care.</p> <p>Healthy Eating, Healthy Action initiatives.</p>
Clinical leadership	<p>Establish transformational clinical leadership programme.</p> <p>Appoint a Director of Medicine, Primary Health Care.</p> <p>Establish shared clinical governance arrangement.</p> <p>Establish integrated knowledge and skills framework for primary health workers.</p> <p>Clinical leadership and/or participation on service projects.</p>
Regional co-operation	<p>Implement Regional Clinical Services Plan (RCSP).</p> <p>Implement centralAlliance.</p> <p>Regional and national collaboration initiatives.</p> <p>Align regional asset and information systems plans to RCSP.</p>
More unified system	<p>Participate in national and lower North Island procurement projects.</p> <p>Extend Enable New Zealand's procurement activities in areas of rehabilitation equipment and housing modifications.</p> <p>Support other national health initiatives as they roll-out.</p>
Shorter stays in Emergency Department	<p>Implement MCH's Delivery Plan for Shorter Stays in Emergency Department.</p> <p>Implement a "fast track" streaming process through Emergency Department.</p> <p>Develop capacity model.</p>
Improved access to surgery	<p>Redesign pre-admission processes.</p> <p>Implement four additional clinical pathways.</p> <p>Increase the number of elective volumes.</p> <p>Implement electronic clinical workstations.</p> <p>Implement quality initiative, such as Optimising the Patient Journey.</p>
Shorter waits for cancer treatment	<p>Explore the feasibility of increasing regional radiation oncology capacity, ie additional linear accelerator.</p> <p>Implement Optimising the Patient Journey principles to improve the efficiency and effectiveness of the regional cancer services' clerical/administration processes.</p>
Increased immunisation	<p>Encourage general practice teams to immunise.</p> <p>Identify non-immunised children and those not on the register and link them to a health provider.</p> <p>Offer immunisation within the hospital, particularly paediatric clinics/ward.</p> <p>Increase influenza immunisation levels within the health workforce.</p> <p>Increase influenza immunisation levels of key priority groups: those over 65 years of age, and the chronically ill.</p> <p>Implement means of accurately measuring influenza immunisations delivered within general practice.</p>
Better help for smokers to quit	<p>Implement the ABC smoking cessation framework within secondary services.</p> <p>Implement ABC smoking cessation training within primary and secondary health providers.</p>
Better diabetes & cardiovascular care	<p>Target Maori and Pacific uptake of diabetes "get checked" programmes.</p> <p>Improve cardiovascular screening in priority populations.</p>
<p>Note: Initiatives regarding the Government's expectation of "improving service and reducing waiting times" noted against the ED, Improved Access to Surgery, and Shorter Waits for Cancer Treatment".</p>	

Performance Improvement Actions Aimed at Improving Value for Money

MidCentral DHB has identified five areas in which it seeks to improve performance with the aim of freeing up money for front-line resources and/or improving value for local health dollars.

The areas are:

- improved hospital productivity
- implementation of the primary care plan
- improved local and regional co-ordination of services
- quality improvement initiatives aimed at reducing preventable and adverse events
- improved purchasing and establishment of shared back-office functions.

The local improvement actions are aligned to the Government's health priorities and targets. For each target area for improvement there are several strategies which will be implemented over the planning period.

Savings identified from Performance Improvement Actions totalling \$6.8 million, of which \$4.588m fall in 2010/11, have been incorporated into financial assumptions:

	Performance Improvement Action	Impact 2010/11 \$000
1	Achieve Financial Security	3,088
2	Improve Productivity and Quality	-
3	Enhance Regional Cooperation	1,500

MidCentral DHB's Improvement Action Areas for 2010/11

No.	Actions	Deliverables/Timing	Responsibility	Impact	
Objective One: Improved Hospital Production (focus on theatre utilisation and hospital wards)					
<i>Rationale: A focus on hospital productivity will free up resources to enable patients to be seen faster and diagnosis intervention to occur in a timelier manner.</i>					
1.	Achievement of the national health targets for emergency department, elective services and cancer waiting times.	1.1	Implementation of MidCentral Health's Emergency Department Plan.	MCH	Successful delivery of improved performance to health delivery target for emergency department services. Improved hospital productivity.
		a.	Investigate streaming or a fast track pathway within the ED by 1 December 2010 to improve the prospect of streaming to a fast track/minors area.		
		b.	Progressively implement MidCentral Health's Delivery Plan for Shorter Stays in Emergency Department by 30 June 2011.		
		c.	Capacity model developed for Palmerston North Hospital by 30 June 2011 to provide greater flexibility in responding to fluctuations in demand for hospital resources.		
		d.	Implement suicide intervention "Whanaungatanga" initiative to reduce demand for acute beds by 30 June 2011.	FD/MCH	
		1.2	Improvement of Elective Services Plan and Improved Bed Management and Theatre Utilisation.	MCH	
		a.	Increase elective surgery throughput by 278 discharges by 30 June 2011 including an increase in the daycase rate to 60% of total elective surgery by streaming casemix selection and scheduling.		
		b.	The addition of at least four new clinical pathways in the areas of general medicine (cardiac and respiratory) and general surgery (including orthopaedics) by 30 June 2011.		
		c.	By 30 June 2011, streamline pre-admission processes to ensure all patients on the elective surgery waiting list are fit for surgery, with all patients of all specialties completing a health questionnaire at the time of booking for surgery from 30 September 2010 onward to assist with managing wait lists. <ul style="list-style-type: none"> >95% patients on the elective surgical booking lists are fit for surgery. 		
		d.	To assist with managing wait lists and theatre scheduling, all patients for major surgery and who have co-morbidities attend a service specific multi-disciplinary session prior to their surgical procedure: <ul style="list-style-type: none"> Establish weekly multi-disciplinary team pre-surgical sessions for all specialties. Two specialties to be underway by 1 August 2010. All other specialties by 30 June 2011. Establish mechanisms to ensure all patients attend pre-surgical 		

			treatment planning class. Two specialties to be underway by 30 September 2010. All other specialties by 30 June 2011.		
			e. Theatre capacity plan developed by 31 September 2010, incorporating the "productive theatre" principles and practises, with effectiveness measured by the new national theatre productivity indicators (as detailed in Appendix D).		
			f. By end July 2010, create an earlier trigger point for booking surgery dates for those who have been given certainty of treatment to increase the numbers of people treated within six months.		
			g. By end September 2010 and in conjunction with the surgeons, establish consistent service specific eligibility criteria and mechanisms at time of booking surgery to increase the rate of elective day case surgery.		
			h. By end July 2010, the theatre capacity plan includes schedule of elective day case volumes to be achieved to meet target.		
			i. Implement Concerto clinical workstation by September 2010.	Corporate	
		1.3	Cancer waiting times achieved.	MCH	Successful delivery of improved performance to health delivery target for cancer waiting times. Increased capacity to meet future demand for radiation oncology services.
		a.	Complete replacement and installation of LA3 linear accelerator by 31 December 2010.		
		b.	Review of new LA3 linear accelerator to be undertaken by 30 June 2011.		
		c.	Through the Central Cancer Network, review regional options for increasing radiation therapy capacity, such as a seventh linac for the region and formalising current shared capacity arrangements, by 30 September 2010.		
			Undertake a formal project and business analysis of the options for the location, configuration and funding of a fourth permanent linear accelerator for Palmerston North Hospital by 30 June 2011.		
		d.	Implement Optimising the Patient Journey principles within the Regional Cancer Treatment Service by December 2010 to improve booking processes and increase the responsiveness of the system to recognising queues and managing these in a timely manner.		
		e.	Maintain breast re-screen profiles (target 75% of women are re-screened within 24 months of last screening mammogram).		
		f.	Reduce inequalities in breast screening coverage for Maori and Pacific women (target 70% of eligible Maori and Pacific women screened within the last 24 month period).		
		g.	Implement digital mammography system by June 2012.	Corporate	
2.	Achievement of financial improvement of MidCentral Health (the DHB's provider arm).	2.1	\$10m reduction in the amount of unfunded activity by 30 June 2011.	MCH	Elimination of MDHB's deficit. Improved hospital productivity. Management of ER cost pressures within funded
		a.	Systematically implement the financial service reviews undertaken in each clinical speciality and implement findings by 30 June 2011, eg cardiology, orthopaedics, AT&R services.		
		b.	By 30 October 2010, implement the outcome of the Rehabilitation Services for people aged <65 years review, and by June 2012 implement		

		changes to the Assessment, Treatment & Rehabilitation (AT&R) services for people aged >65 years at Horowhenua Health Centre following establishment of the Levin based Integrated Family Health Centre.		parameters.
	c.	Establish and implement clinically-led review system for selected pharmaceutical and diagnostic use within MidCentral Health by 30 September 2010.		
	d.	Review road and air transport services by September 2010.		
	e.	Implement outcome of Sexual Health Service Review by end December 2010.		
	f.	Implement outcome of Diabetes Lifestyle Centre Review by end November 2010.		
	g.	Implement outcome of 24-hour District Nursing Service Review by end September 2010.		
	h.	Implement Board's decision regarding paid car parking at Palmerston North Hospital by 31 December 2010.	Governance	
	i.	By 31 December 2011 increase ACC revenue through improved collection systems and/or securing new contracts.	Corporate	
	j.	Manage labour costs within available funding through participation in national and regional workforce initiatives, benchmarking, and local service reviews.	Governance	

No.	Actions	Deliverables/Timing	Responsibility	Impact	
Objective Two: Primary Care Implementation Action Plan (strengthen focus on chronic disease management, acute demand, and reducing hospital admissions)					
<i>Rationale: more services closer to community will keep our community well and out of hospital. It will enable early intervention, particularly chronic conditions, thus reducing unnecessary progression/side effects of disease and hospital admissions. The elderly are a target population as they accessing high cost secondary services because alternative better targeted community services are not available.</i>					
3.	Support the implementation of MidCentral PHOs' primary health care proposal through: <i>Core Initiatives:</i> <ul style="list-style-type: none"> • establish five integrated family health centres • increased collaboration across the health continuum • improved acute care and after hours services • improved care for older people • whanau ora assessments • planned clinical leadership development. <i>Key Enablers:</i> <ul style="list-style-type: none"> • clinical leadership and innovation • integration of four PHOs into a single-district wide PHO • information management Refer Appendix B for	3.1	PHOs are supported to create five Integrated Family Health Centres across the district covering 57% of the population.	FD	New models of care for primary health which will enable effective and efficient service delivery.
		a.	Establish one IFHC in Tararua by 30 December 2010.		
		b.	Three IFHCs (Horowhenua, Otaki and Palmerston North) are established by 30 June 2011.		
		c.	One IFHC established in Feilding by 30 June 2012.		
		3.2	Increased collaboration across the health continuum.	FD	Improved clinical and self management. Improved value for money.
		a.	Implement comprehensive health assessment/care plan and health and wellness plans into primary health patient management system by 30 December 2011.		
		b.	Develop primary health care case management model by 30 June 2011.		
		c.	Establish central clinical-led referral management system for primary health, including district nursing services, by 30 June 2011.		
		d.	Whole of sector information analysis unit in place by 30 June 2011.		
		e.	Support integration of four PHOs into a single-district wide PHO by 30 December 2010.		
		f.	Implement an e-referral information system for hospital services by February 2012.	Corporate	
		3.3	Improved acute care by better management of chronic conditions and enhanced after-hours and acute primary health care services.	FD	Reduction in avoidable hospital admissions. Improved clinical and self management. Services provided closer to home. Improved mortality and morbidity rates. 30% reduction in Emergency Department presentations by people aged 65 years and over, by 30 June 2013. (Baseline: 2009/10 actual.)
		a.	Advanced paramedic training offered to ambulance officers within the Horowhenua and Tararua districts by January 2011.		
		b.	Single point of access for primary health after-hours care established by 31 January 2011.		
c.	Four collaborative clinical pathways established each year for the next three years for chronic conditions (diabetes, cardiology, respiratory and mental health; 12 pathways in total by 30 June 2013.)				
d.	Three child health clinical pathways established each year for the next three years (10 pathways in total by 30 June 2013.)				
e.	Four clinical networks established across district by 31 January 2011. (Child health, chronic care, acute care, and mental health.)				
f.	Community nursing services integrated into Integrated Family Health Centres by 30 June 2011.				

further information re this PHO initiative.	g.	Improve access to community-based diagnostics with community radiology budget of \$3.9m managed by PHOs by 31 December 2010.		
	h.	By 30 June 2011 review effectiveness of trans-ischaemic attack service devolved to GPs to assist them in assessing patients for TIA, including ordering of CT service.		
	i.	Support devolution of services to GPs through implementation of clinical decision computer system for assessment of anaemia, blackouts and epilepsy by 30 December 2012.		
	j.	Develop extended advanced medical registrar pathways in Palmerston North by December 2010 and in Integrated Family Health Centres as they develop.		
	k.	Improved access to healthy food choices and physical activity opportunities for Maori.		
		<ul style="list-style-type: none"> Develop and implement one joint HEHA steering group project to commence by 31 July 2010. 	MCH/FD	
		<ul style="list-style-type: none"> Quips planning tool operational and training provided to at least 80% of Health Promotion workforce in district by 30 June 2010. 		
		<ul style="list-style-type: none"> At least two joint projects developed or expanded per annum. 	FD	
		<ul style="list-style-type: none"> Develop HEHA workforce development and training needs framework for both community and HEHA related workforce by 31 August 2010. 		
		<ul style="list-style-type: none"> At least two HEHA related training opportunities offered per year. 		
	3.4	Improved access and utilisation of health services amongst whanau.	FD	Reduction in avoidable hospital admissions. Improved clinical and self management. Improved mortality and morbidity rates for Maori.
	a.	Maori enrolments with PHOs increased by 10% per year for each of the next three years. (Baseline: 24,000 enrolments December 2009.)		
	b.	Whanau ora assessments offered to Maori who are not enrolled with PHOs by 31 January 2011.		
	c.	By 30 June 2011, work with ACC to identify options to reduce the level of hospital admissions for Maori due to accidents.		
d.	By 31 December 2010, investigate options to reduce the high representation of Maori children in the number of children hospitalised for respiratory conditions, and implement findings by 30 June 2011.			
3.5	Improved models of care for older people, including case management for people with high and complex needs.	FD	Reduction in avoidable hospital admissions. Improved clinical and self management. Services provided closer to home. Improved mortality and morbidity rates.	
a.	Integrated model of care for older people established throughout district: Tararua by 30 June 2010, Horowhenua by 30 June 2011, and Palmerston North by 30 June 2012.			
b.	Four gerontology specific clinical pathways established each year for the next three years (12 pathways in total by 30 June 2013.)			
c.	Clinical network for older health established across district by 31 January 2011.			
d.	InterRAI introduced throughout district, with InterRAI assessments for			

			those aged 65+ to be provided as part of the IFHC in Tararua from 30 June 2011.		
		e.	Community based inter disciplinary gerontology clinical teams holding clinics in Horowhenua by 30 September 2010 and Tararua by 30 December 2010.		
		f.	Options identified to improve Maori-focused disability support for kaumatua and kuia by 30 June 2011 (including marae-based support).		
		g.	People employed in aged care are able to gain access to appropriate education and skills commensurate with their work requirements by 30 June 2011. This work to be done in liaison with DHBNZ national work programme to develop consistent sector-wide skills/knowledge framework for regulated and non-regulated age residential care workforce.		
		3.6	Planned clinical leadership development.	FD	District leadership in line with best practice.
		a.	Transformational clinical leadership development programme is in place by 30 July 2010.		
		b.	Appointment of Director of Medicine, Primary Health Care by 31 January 2011.		
		c.	Visible and shared clinical governance arrangement in place across MidCentral DHB's district by 30 December 2010.		
		d.	Integrated knowledge and skills framework and programmes for primary health workers (regulated and non-regulated) established by 31 January 2011.		
4.	Improved accessibility and capability of mental health services.	4.1	Improved accessibility and capacity of mental health services.	FD	Services provided closer to home. Increased uptake of health services by Maori Skilled workforce.
		a.	Whanau healing centre established 30 December 2011 to enable the practice of innovative initiatives that support whanau ora, and, to provide linkages with Maori providers and primary care sector for whanau ora.		
		b.	Rollout of the Lets Get Real workforce framework for all mental health services occurs by 30 December 2010.		
		c.	The infant and maternal mental health service delivery is redesigned by 30 June 2011.	FD/MCH	
		d.	Integrated services in mental health and addictions are progressed by 30 June 2011.		
		e.	Implementation Plan and service model for increasing home based acute treatment options developed by 31 December 2010.	FD	
		f.	By 31 December 2010 investigate options for mental health and addiction services for young Maori, and implement findings by 30 June 2011.		
		g.	Together with other DHBs in the central region, review the current Regional Mental Health Strategic Plan by June 2011 to ensure consistency with current and emerging Government policy. (To occur via the Mental Health & Addictions Clinical Network.)		

5.	Achievement of the national health targets for diabetes and cardiovascular, immunisation, and smoking cessation.	5.1	Implement MidCentral DHB's immunisation plan.	FD	Successful delivery of improved performance to health delivery target for immunisation.	
			a.			Increased uptake in number of children immunised in a hospital setting by June 2011.
			b.			Reduce number of babies discharged from maternity units without a health provider by 50% by December 2010. (NB: base line data July 2009 actual.)
			c.			Increased uptake in BCG immunisation in MCH's child and women's health service (particularly for those at risk) by December 2010.
			d.			At least 1,000 MidCentral Health staff receive the influenza vaccine by December 2010 and this is maintained yearly thereafter.
			e.			Establish baseline data for primary care health workforce uptake of influenza vaccine by December 2010.
			f.			Establish baseline data for priority health groups (over 65 age group and the chronically ill) by December 2010.
			g.			Increase uptake of priority health groups receiving influenza vaccine by December 2011. (Target to be established once baseline information available.)
		5.2	Diabetes and Cardiovascular Plans implemented.	FD	Successful delivery of improved performance to health delivery target for diabetes and cardiovascular.	
			a.			Achieve a 10% increase in the number of cardiovascular risk assessments in the district by 30 June 2010 by increased focus on the use of this tool by general practice.
			b.			Increase by 10% community cardiology assessments by 30 June 2011 as part of devolution of services to primary care. (Funding devolved 09/10.)
		c.	Proportion of diabetes registrants who have satisfactory or better diabetes management as at June 2011 HBA1c=8.0% or less): Maori – 72%; Pacific – 72%; Other – 81%; Total – 80%.			
		5.3	Implement the ABC smoking cessation programme, achieving 95% by July 2012.	MCH/FD	Successful delivery of improved performance to health delivery target for smoking cessation.	
			a.			Implement the ABC Smoking Cessation Programme within MidCentral Health by 30 June 2011, including continued engagement with primary care providers to ensure processes & systems support achievement of the target.
			b.	25% of hospitalised smokers are using NRT (lozenges, patches, gum) as part of a patient care plan (annual target).		MCH
c.	At least 35 people are referred to PHS Quit Smoking Services per month from secondary services.					
d.	At least 20 ABC staff training sessions are delivered per month (primary and secondary).					
e.	100% of contracted Maori Health care providers undertake ABC training by 30.6.2011.					

		f.	Establish a Tobacco Chair-advisory group to ensure integration across all health care providers within MidCentral by 1 December 2010. Chairs from the Tobacco Maori Leadership group, MidCentral Health Tobacco Taskforce, and Primary Health Care Tobacco Advisory group will meet 4-6 weekly. (NB: these groups include clinical representation.)	
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No.	Actions	Deliverables/Timing	Responsibility	Impact	
Objective Three: Improved local and regional co-ordination of Services (to minimise and eliminate vulnerable services and delivery improved service coverage)					
<i>Rationale: Moving services to a regional model of care will reduce vulnerable services, enabling services to be provided to the community on a sustainable basis. It will also ensure the scarce specialist workforce is used to best effect.</i>					
6.	Implementation of the Regional Clinical Services Plan, with a focus on vulnerable services (radiology and women's health), cardiology and renal services. NB: Refer Appendix C for a summary of the Regional Clinical Services Plan.	6.1	Integrated service frameworks established across central region in priority specialities.	FD	Sustainable model of care in place, and vulnerable services eliminated.
		a.	Integrated radiology service in place by 31 December 2010.		
		b.	Integrated women's health service in place (covering maternity, gynaecology, gynae-oncology and maternal foetal medicine) by 30 June 2011.		
		c.	Older adults and rehabilitation service framework established by 30 June 2010.		
		d.	Children's service framework established by December 2010.		
		e.	Integrated renal service in place by December 2010.		
		f.	Integrated cardiology service in place by June 2011.		
		6.2	Regional Service Plan established.		
a.	Regional services Plan in place by September 2010.				
7.	Establishment of shared clinical services arrangements with Whanganui DHB (as per centralAlliance).	7.1	Implement the clinical and health planning components of the centralAlliance work programme.		Sustainable model of care in place.
		a.	In conjunction with the introduction of InterRAI, investigate options for joint NASC and HBSS service developments between MidCentral and Whanganui DHBs with a feasibility report prepared by December 2010.	FD	
		b.	Common nursing education framework in place by June 2011.	MCH	
		c.	Joint RMO/SMO unit established by 30 August 2010.	Governance	
		d.	Investigate the feasibility of a sub-regional service for urology, ophthalmology and ENT between Whanganui and MidCentral DHBs by 31 December 2010, and implement findings by 30 June 2011.	MCH	
		e.	Child health care network is established with Whanganui DHB, including an agreed work programme by December 2010.		

8.	Improve access to DHB funded dental services for children and adolescents.	8.1	Implement the planned action plans and milestones in accordance with the approved business case for the development of oral health services in MidCentral's district.	MCH	New model of care in place which increases access to oral health services. National health measures for oral health achieved. Service has sustainable workforce.	
			a.			Additional mobile dental clinics for district in place by June 2011.
			b.			Fixed dental clinic arrangements for district by September 2010 and co-located dental clinic arrangements confirmed by June 2011.
			c.			New workforce configuration in place by June 2011.
			d.	Post event audit review of business case completed by June 2012.		
e.	Implement dental information system by February 2011.	Corporate				

No.	Actions	Deliverables/Timing	Responsibility	Impact	
Objective Four: Quality Improvements (including reduction and the elimination of preventable and adverse events)					
<i>Rationale: Adverse events in hospital, which are potentially preventable, are costly, both to the patient and the sector. Through implementing new systems and culture, we will reduce personal and cost impact.</i>					
9.	Implementation of quality initiatives to improve standard of care, including: <ul style="list-style-type: none"> • Optimising the Patient Journey • Releasing Time to Care • NZ Incident Management System • Accreditation/certification • Medicines reconciliation • Consumer participation 	9.1	Optimising the Patient Journey (OPJ) approach is applied in all Palmerston North Hospital settings by June 2012.	MCH	More effective and efficient health services.
		a.	Value stream mapping for stroke, general surgery, orthopaedics and respiratory services completed by September 2010.		
		b.	A taskforce approach to the top four issues identified from the mapping is in process by October 2010.		
		c.	Average length of stay (ALOS) is reduced by one day for each of the four pathways by June 2012 (baseline: 2010/11 ALOS).		
		9.2	Releasing Time to Care (RTC) is implemented in all acute wards, Palmerston North Hospital by June 2011.	MCH	Staffing levels aligned to patient need.
		a.	10% increase in available direct nursing time is achieved by June 2012 (baseline: 2010/11 trendcare data).		
		b.	10% reduction in patient complaints is achieved by June 2012 (baseline 2010/11 results).		
		c.	Overall patient satisfaction improved by two places by June 2012 when compared to other DHBs.		
		9.3	Implementation of the New Zealand Incident Management System (NZIMS) throughout MidCentral DHB is completed by June 2011.	MCH	Reduction and elimination of preventable and adverse events.
		a.	Senior nurses and allied health clinical leaders are trained in the use of NZIMS by December 2010.		
		b.	Clinical Directors and Medical Heads are trained in undertaking inquiry/investigation by June 2011.		
		c.	Ten staff are trained and available to undertake Root Cause Analysis (RCA) by December 2010.		
		9.4	Opportunities for consumer participation within MidCentral Health are increased.	MCH	
		a.	A consumer panel for MidCentral Health is in place by December 2011.		
9.5	Improve the level of achievement for accreditation and certification.	MCH			
a.	All recommendations from the June 2009 EQUIP 4 Accreditation and Health & Disability Sector Standards Certifications Surveys are fully implemented.				
9.6	Increase in medicines reconciliation (MR) throughout MidCentral Health.	MCH	Reduction in medication errors.		
a.	Medicine reconciliation rolled out to at least four MidCentral Health departments by 31 August 2010.				

			b.	By June 2011 30% of eligible patients (ie patients over 65 years of age who are on four or more medications), will undergo MR within 24 hours of admission to areas of Palmerston North Hospital where MR has been rolled out to, increasing to 40% by December 2011.		
10.	Implement information systems to improve quality.	10.1	Implement tracking system for sterile services.		Corporate	Reduction in preventable incidents.
			a.	Implement a sterile services tracking system by June 2011.		
		10.2	Replace management reporting systems with business intelligence model.		Corporate	Robust decision-making.
			a.	Implement a business intelligence system by June 2012.		

No.	Actions	Deliverables/Timing		Responsibility	Impact	
Objective Five: Improved purchasing (including smarter contracting, collective procurement and shared back-office functions)						
<i>Rationale: By establishing shared procurement and back-office functions, resources will be freed up for front-line health services.</i>						
11.	Implementation of regional information systems strategic plan.	11.1		Regional Information Systems Strategic Plan aligns to Regional Clinical Services Plan.	Corporate	Robust information systems and capex planning.
			a.	Regional Information Systems Strategic Plan updated to align to Regional Clinical Services Plan by June 2011.		
			b.	Regional PACS (picture archive system) implemented by December 2010.		
12.	Establishment and implementation of a regional asset management plan.	12.1		Regional Asset Plan aligns to Regional Clinical Services Plan.	Corporate	Robust asset management planning systems.
			a.	Regional Asset Plan updated to align to Regional Clinical Services Plan by August 2010.		
			b.	Regional Asset Plan reflected in MidCentral DHB's 2011/12 District Annual Plan.		
13.	Implementation of shared corporate (back-office) and governance functions with Whanganui DHB (as per centralAlliance).	13.1		Implement the support service and governance components of the centralAlliance work programme.		Common transactional information systems in place with Whanganui DHB. Reduced support services costs freeing up resources for front-line services. More effective and efficient support services.
			a.	Joint commercial support service arrangements in place by December 2010.	Governance	
			b.	Joint corporate service model in place by April 2011.	Corporate	
			c.	Common payroll system in place with Whanganui DHB by 30 June 2011.	Corporate	
			d.	Common Community & Public Health and Disability Support Advisory Committees in place by June 2011.	Governance	
			e.	Joint human resource and organisational development function in place by December 2010.	Governance	
			f.	Implement a replacement maternity information system on sub-regional basis with Whanganui DHB by June 2011.	Corporate	
g.	Implement a replacement patient administration information system on sub-regional basis with Whanganui and Wairarapa DHBs by December 2013.	Corporate				

14.	Participation in regional and national procurement initiatives.	14.1	Participate in national and Lower North Island procurement projects.	Governance	More efficient and effective purchasing systems. Agreed DHB-wide procurement savings confirmed. Further target areas for savings identified.		
			a.			Support national procurement initiatives being managed through DHBNZ. Areas identified for 2010/11 include: furniture, stationery, printing, specialist wound care, staff relocation, desk top computers/laptops, multi-functional devices (photocopiers) and vehicles.	
			b.			Support Lower North Island Group procurement activities, providing lead role where required. Areas identified for 2010/11 include: non-sterile examination gloves*, negative pressure wound products*, sterilisation wrap, plastic bags, endoscopes, personal protective equipment, patient warming blankets*, and syringes and needles. *MDHB is lead DHB.	
		14.2	14.2	Expand Enable New Zealand's Online Application System.	ENZ	More efficient and effective service. Faster turnaround times. Will enable administrative staffing levels to remain within cap.	
				a.			Online application process is extended to include the following contracts by June 2011: <ul style="list-style-type: none"> • Ministry of Health's Equipment & Modification Service • ACC's Managed Rehabilitation Equipment Service • ACC's National Housing Modification Services • DHB Short Term Loan Equipment Service.
		14.3	14.3	Enable New Zealand expands its procurement activities in the areas of rehabilitation equipment and housing modification services.	ENZ	More efficient and cost effective procurement.	
				a.			Implementation and roll-out of the panel contract methodology for purchase of equipment and housing materials completed by June 2011.
				b.			A proposal is submitted by December 2010 for a cost effective freight and logistics model for the recall and distribution of rehabilitation equipment for the Ministry of Health, ACC and relevant DHBs.
				c.			A proposal is submitted by December 2010 for other "supply chain" initiatives on behalf of the Ministry of Health, ACC and DHBs for rehabilitation equipment items and spare parts.
15.	Support the development of a unified system.	15.1	National Services Location.	Governance	More efficient & cost effective health system Reduced duplication More funding for front line services.		
			a.			Options and a national service implementation plan by end June 2011 in conjunction with the National Health Board.	
		15.2	High Cost Treatments.				
			a.			Seek to be consistent in our menu of high cost treatments, appropriately linked with advanced care plans. Options and a national service implementation plan by end June 2011 in conjunction with the National Health Board.	
		15.3	Health Procurement.				
			a.			Deliver a set of savings projects in 2010/11 to a total of \$30m, Health Procurement to provide detail of current plans, potential and range of potential savings being sought. Each DHB assessing its likely share of	

			this total based on expenditure and timing of contract renewal.
	15.4	Shared Services.	
		a.	Working jointly with the Shared Services Establishment Board to deliver a shared services change programme that offers best value to DHBs over the next three years with appropriate risk management given the importance of shared services as an enabler for DHB delivery of health and disability services to their populations.
	15.5	Low Evidence Activities and Treatments.	
		a.	Seek a single agreed list of low-evidence activities and treatments, including better targeting of pharmaceuticals schedule. Options and a national service implementation plan by end June 2011 in conjunction with the Ministry of Health/National Health Board.

Indicators of DHB Performance

The Ministry of Health monitors DHB performance on behalf of the Minister.

The non financial monitoring framework is a key tool to provide assurance that the DHB systems delivers in terms of Government priorities and legislative requirements (particularly the New Zealand Public Health and Disability Act 2000). This is “to the extent they are reasonably achievable within the funds provided” (NZPHD Act S3(2)).

The non financial monitoring framework is part of wider accountability arrangement managed by the Ministry.

The monitoring framework for 2010/11 places more of a focus on activity, outputs and impacts monitoring than in previous years. There is increasing interest in the DHB’s Provider arm because of the high level of financial investment in this part of the DHB, and its impact on overall health spending. Productivity and value for money is featured more strongly in the monitoring framework as a consequence.

The framework has four dimensions of performance that reflect the DHB’s functions as owners, funders and providers of health and disability services. These dimensions cover:

- Achieving Government’s priorities and targets
- Meeting service coverage requirements and supporting sector interconnectedness
- Providing quality services efficiently
- Purchasing the right mix and level of services within acceptable financial performance.

The aim of the dimensions framework is to highlight key DHB functions that if monitored via performance indicators, alongside financial performance, provide the Minister of Health with confidence that required expectations are being met. It is intended that the structure of the framework assist stakeholders to ‘see at a glance’ how well DHBs are performing across the breadth of their activity, but with the balance of measures focused on government priorities.

Each DHB is required to set out the target or expected deliverable for each measure in its District Annual Plan. The District Annual Plan also describes the key activities that will be undertaken in the year to advance achievement of the national Health Targets and other measures contained in the monitoring framework. Progress towards each target or measure will be assessed by the Ministry of Health (using standard assessment criterion), reported to the Minister of Health and publicly reported on the Ministry’s website according to the reporting frequency for each measure.

The measures identified in the framework replace the Indicators of DHB performance, additional reports and Hospital Benchmark Information of previous years. The measures, together with their targets where they apply and reporting frequency, are set out in Appendix D.

Service Coverage and Service Change

Pursuant to Clause 25 of the New Zealand Public Health and Disability Act 2000, MidCentral DHB may enter into service agreements for the provision of services outlined in this Plan.

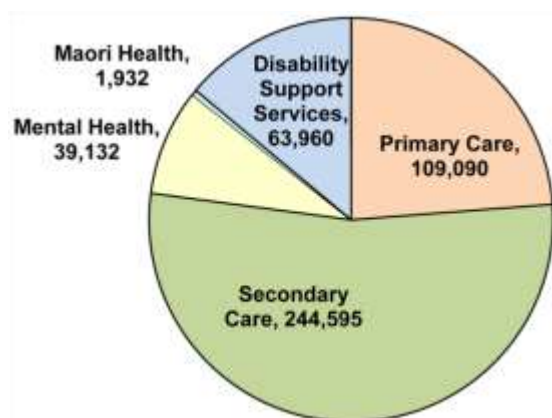
In 2010/11 MidCentral District Health Board expects to spend \$543.6 million on health services for its population. A breakdown of expenditure is shown – see table below. This money will be used for existing services and more initiatives in the national priority and target areas.

2008/09 Actual	2009/10 Budget	2010/11 Budget	
			<i>Hospital Based Services</i>
59.4	63.6	65.1	Surgical Specialties/ICU/Anaesthetics
44.5	43.3	45.2	Medical Services
31.7	31.7	33.3	Regional Cancer Treatment Service
29.6	30.1	27.7	Elderly Health / Rehabilitation & Therapy
27.7	26.9	27.6	Women/Children's Health
27.0	26.3	26.6	Mental Health
12.2	13.0	13.4	Emergency Department
7.2	8.4	7.7	Clinical Support
6.5	7.6	7.0	Public Health
2.9	3.2	3.5	Dental Health
1.7	1.3	1.6	Rural Health
14.2	8.8	17.8	Other
264.6	264.2	276.5	<i>Total Hospital Based Services</i>
			<i>Community Based Services</i>
40.2	43.9	44.5	Pharmaceuticals
34.3	36.4	37.4	Residential Care
23.5	27.2	28.0	Primary Practice
9.4	9.6	9.9	Laboratories
9.2	9.6	9.9	Home Support
8.5	10.7	9.2	Mental Health
4.2	4.4	4.5	Chronic Disease Management
23.1	26.3	27.2	Other
152.4	168.1	170.6	<i>Total Community Based Services</i>
23.6	24.1	44.7	Disability Services, Needs Assessment
42.1	45.6	46.4	Inter District Flows
5.7	5.5	5.4	Governance
488.4	507.5	543.6	Total DHB Expenditure

Allocation of Expenditure by Provider Group - \$m's			
264.6	264.2	276.5	MidCentral Health
152.4	168.1	170.6	Primary Health Providers
42.1	45.6	46.4	Other DHB's
23.6	24.1	44.7	Enable New Zealand
5.7	5.5	5.4	MidCentral DHB - Governance
488.4	507.5	543.6	Total DHB Expenditure

The receipt and allocation of funding occurs through six health portfolios. These portfolios are: primary health, public health, secondary/tertiary care, Maori health, mental health, and support services for the disabled and older people. (Definitions of the six portfolios are set out in MidCentral DHB's 2010/11 District Annual Plan Funding Arrangements Document available on line at www.midcentraldhb.govt.nz.) The allocation of funding to each portfolio for 2010/11 is as follows:

Funding Allocation by Portfolio (\$'000s)



Service Coverage

The Service Coverage Schedule describes the minimum range of health and disability support services the District Health Board must provide for its population. The Service Coverage Schedule is promulgated by the Ministry of Health and is a national standard. It includes: Maori health, mental health, personal health (primary, secondary and limited tertiary), public health and disability support services.

Currently, MidCentral District Health Board is meeting all the requirements of the Service Coverage Schedule. A summary of the services available in each area (Horowhenua/Otaki, Tararua, Manawatu and Palmerston North) and service type is provided in the "2010/11 District Annual Plan Funding Arrangements Document", and includes details of any cost to the consumer for accessing these services.

Potential issues maintaining service coverage have been identified in a number of areas. In the event that service coverage problems arise in these areas, the District Health Board will seek an exception to the national service coverage requirements. Particular issues are as follows:

- Medical oncology services

The ongoing provision of medical oncology services assessment and treatment services to contract levels is dependent upon staffing levels being maintained at establishment. Recruitment is underway to meet FTE establishment. If this continues to be unsuccessful, or takes longer than planned, outsourcing to other regional cancer treatment services will be necessary. This may have an impact on referring DHBs.

- General practice services

The availability of general practice services is under pressure in a number of communities as a result of declining GP numbers and changes in their working patterns. The DHB has invested considerable additional resources in enhanced primary health care services. This includes both expanding the community workforce through additional clinical positions and investment in the existing workforce. It is expected that over time the primary health care needs of all communities will continue to be met, but in the short term issues may arise with service availability in specific communities. The DHB and PHOs will work together to address these issues.

- Air Transport Services

Air transport services arrangements between Palmerston North and Wellington Hospitals are provided by external organisations. These must comply with Civil Aviation Authority regulations and currently there is some dispute regarding the "class" of aircraft which can use these facilities. A regional solution is being sought, and DHBs are working through TAS with the other organisations involved. If not resolved, air transport services may be limited.

Service Changes

The implementation of the plans outlined on the previous pages will affect current service arrangements in terms of:

- the level and type of inpatient services at Horowhenua Health Centre (excluding maternity)
- the level of sexual health services
- the level of diabetes services provided by the secondary care provider

- the level of after-hours district nursing services
- the configuration and location of assessment, treatment and rehabilitation services, including those based at Horowhenua Hospital
- the level, configuration and provider of specialist rehabilitation services for people aged <65 years.
- the configuration of services, including regional services, and, the provider of services
- co-operative agreements and arrangements which exist or will be established
- the level of private/public involvement.

MidCentral DHB is reviewing a number of services, professional/occupational and management structures. This may result in some changes to the internal configuration of services.

Financial Planning

Our Financial Forecast

MidCentral DHB is forecasting a small deficit in 2010/11 and 2011/12 and breakeven in the outer year. The deficit in the first two years includes \$1m which relates to the Assessment, Treatment & Rehabilitation Service Review for people aged 65 years and over being suspended, with National Health Board support, while an Integrated Family Health Centre is established based on Horowhenua Health Centre. (See Appendix E for detailed financial tables.)

	Actual 2008/09	Forecast 2009/10	Budget 2010/11	Budget 2011/12	Budget 2012/13
Operating surplus/(deficit)	(9,949)	(9,880)	(3,739)	(1,046)	17

Capital Expenditure

General

MidCentral DHB is planning to contain capital expenditure as far as possible in order to reduce operating costs. All items critical to the operation of the DHB will be given priority. Refer Appendix F.

Information Systems Strategic Plan

MidCentral DHB has nine major information systems projects scheduled to be implemented over the next 2-3 years. Eight projects relate to clinical systems. A business intelligence system is planned to improve management reporting systems.

A schedule detailing this expenditure is set out in Appendix G.

Financial Performance

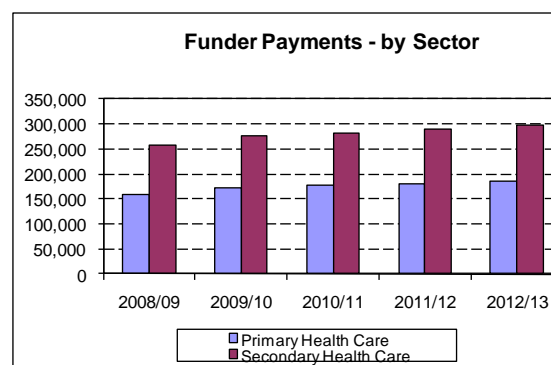
Allocation of Funding

The table below shows the overall allocation of funding by the DHB through its Funding Division.

\$000	2008/09	2009/10	2010/11	2011/12	2012/13
Revenue	419,601	450,957	461,813	474,522	487,284
Funding to MidCentral Health	222,747	236,746	242,982	249,688	256,430
Funding to MidCentral DHB Governance	1,920	2,384	2,384	2,450	2,516
Funding to External Providers	152,476	165,088	170,589	174,074	178,717
Inter-district flows	42,073	46,709	46,358	47,638	48,924
Operating Surplus/(Deficit)	385	30	(500)	672	697

The Funding Division is planning a small deficit in 2010/11 and a small surplus in outer years.

The graph below shows the allocation of funds between primary and secondary care services.



Service Provision

Service delivery operations owned by MidCentral DHB include MidCentral Health and Enable New Zealand.

The Provider Division is planning a small deficit in the first two years, of which \$1m relates to the AT&R service review being suspended.

\$000	2008/09	2009/10	2010/11	2011/12	2012/13
Revenue	277,757	287,968	318,835	326,691	334,625
Expenditure	288,064	296,696	321,255	327,561	334,424
Operating Surplus/(Deficit)	(10,307)	(8,728)	(2,420)	(870)	201

Meeting demand and the associated cost growth is challenging for the health sector. This is particularly true of personnel costs. MidCentral Health will continue work at a local, regional and national level to live within available funding.

The financial forecasts are based on significant efficiencies being achieved through:

- service reviews
- adjustments to threshold levels (access)
- reduced capacity
- capped FTE growth
- service prioritisation
- strong leadership
- working differently
- service and process improvements.

Staffing Levels

The following table shows the staff full-time equivalents (FTEs) at the beginning of 2010/11.

Management/administration staff numbers remain within the established cap of 535 ftes.

MDHB	2009/10 Budget	1 July 2009 Actual	2010/11 Budget	Change from 2009/10 Budget	Change from 1 July Actual
Medical	259	257	290	31	33
Nursing & Midwifery	901	954	915	14	-39
Allied Health	363	377	404	41	27
Support	45	43	46	1	3
Mgmt/Admin	521	518	517	-4	-1
TOTAL	2,089	2,149	2,172	83	23

Sensitivity Analysis

The cost structure of MDHB is predominantly fixed in nature, with staff costs being the most significant component. A sensitivity analysis of staff costs is shown below.

Sensitivity Analysis - Personnel Costs	
(\$000's)	Increase in DHB Costs
Average cost increase of 1.5% above budget	2,531
Additional 20 FTE's above that budgeted	1,608
Additional 20 FTE's & additional 1.5% cost increase	4,163

Reconciliation between 2009/10 and 2010/11 Plans

A reconciliation between the forecast financial performance for 2010/11 as contained in the 2009/10 District Annual Plan, and, the proposed budget for 2010/11 is set out in Appendix E.

Financial Assumptions

National Assumptions

General Assumptions

- Interest rates are assumed to remain at 2009 levels until mid 2010 when they are expected to rise.
- Exchange rate fluctuations may materially impact the cost of supplies and will be offset by clinical supply saving initiatives, and the use of hedging contracts by suppliers.
- No change in capital charge rate of 8%.
- All changes resulting from implementation of the Ministerial Review Group's recommendations including any devolution during the term of the plan will be at least cost neutral or better to MidCentral DHB. This includes the impact of the establishment of the National Health Board (NHB) and National Shared Services Establishment Board (NSSEB). Future impacts of the NHB and NSSEB are not able to be factored into DAPs, including planning and funding of national services, ICT and workforce.
- Revenue for capital and operating costs, as detailed in MidCentral DHB's business case for Child & Adolescent Oral Health Services will be provided from national funds.
- Material compliance costs arising from regulatory and legislative changes are not budgeted.
- No material costs have been included for a pandemic.
- Savings identified from Performance Improvement Actions totalling \$6.8 million, of which \$4.588m fall in 2010/11, have been incorporated into financial assumptions:

	Performance Improvement Action	Impact 2010/11 \$000
1	Achieve Financial Security	3,088
2	Improve Productivity and Quality	-
3	Enhance Regional Cooperation	1,500

Personnel

- Workforce costs have been budgeted at actual known costs including step increases.
- Future increases in workforce costs have been budgeted based on national employment relations strategies.

Policy

- Budgeted on current Government policy settings and known Government health service initiatives.
- The impact of changes to the income and asset testing regime will be cost neutral, with revenue equating to current costs.
- The impact of changes to the national Travel & Accommodation Policy (announced March 2009) will be at least cost neutral to MidCentral DHB.

Regional/Local

General Assumptions

- No external deficit funding will be required during the planning period. National Health Board support for a deficit of \$1m in 2010/11 and 2011/12 is assumed, and relates to the AT&R service review being suspended.
- Early payment of funding from the Ministry of Health will continue.
- Total capital expenditure of up to \$16 million is planned for 2010/11.
- MidCentral DHB's land and buildings are re-valued every three years. The last revaluation occurred on 30 June 2009. A further valuation is planned for 2010 on an Optimised Depreciated Replacement Costs basis and this is expected to be cost neutral.
- MidCentral DHB's share of the national population based funding formula will be 4.16%, 4.15% and 4.15% in 2010/11, 2011/12 and 2012/13 respectively.
- Inter-District Flows. MidCentral DHB will use its funding envelope as a base. There will be marginal changes to intervention rates and inter-district flows with no significant impact on net costs.
- Inter-district flows for MidCentral Health's Regional Cancer Treatment Service have been based on 50% actual and 50% historic levels for 2010/11, and 100% actual in 2011/12.

- Price Volume Schedule (refer Appendix H) will be accommodated within the application of the service level agreement (SLA) rules with the Funding Division. Any new or additional costs will be offset by equivalent cost reductions elsewhere in MidCentral Health.
- No new ownership investments in other businesses are included in this Plan.
- Shared services:
 - Allied Laundry will not require any funding in the 2010/11 year
 - Central TAS Service Level Agreement will not require any increase in SLA funding in the 2010/11 year.
- Any collaborative regional and sub-regional initiatives will be cost-neutral.
- Land-holding costs associated with Kimberley Centre will continue to be met by the Ministry of Health. (NB: this property is being disposed off via the Crown land disposal process.)

Personnel

- Any restructuring costs will be met from budgeted operating costs.
- Administration/management numbers will not exceed the established cap of 535 FTEs except by agreement of the Minister of Health.

Demand for Services

- MidCentral DHB will live within its budgets.
- Overall acute demand will be similar or less to that of 2009/10, thus allowing planned levels of elective procedures to be undertaken.
- Elective throughput will be in accordance with the Elective Services Plan.
- All elective surgical work will be performed in-house.
- Central Region DHBs will meet the Minister of Health's requirement to clear the backlog of women waiting for delayed breast reconstructions from elective services plans.

Contracted Providers: Pricing

- For 2010/11 no price increases will be applied to external providers unless directed by the Minister or Ministry of

Health, agreed through a national process or specifically included in a service contract.

Disposal of Land

Asset sales planned over coming years are:

2010/11

- Kimberley Centre property.
- Portion of Horowhenua Hospital Surplus Land (to St John Ambulance Service).

2011/12

- Horowhenua Hospital Surplus Land.

Accounting Policies

MidCentral DHB has a Statement of Accounting Policies. These are contained in the Statement of Intent.

Risks and Mitigations

MidCentral DHB continuously identifies its risks – both current and emerging – and implements strategies to minimise those risks. Some risks can be completely mitigated (ie controlled) and some are more difficult to mitigate. Many of the risks in the more difficult mitigation category are imposed from an external source, eg national wage settlements. As part of the 2010/11 planning process, the Board has identified the high level risks associated with implementing this Plan and/or likely to be faced during the planning period (three years to 30 June 2012).

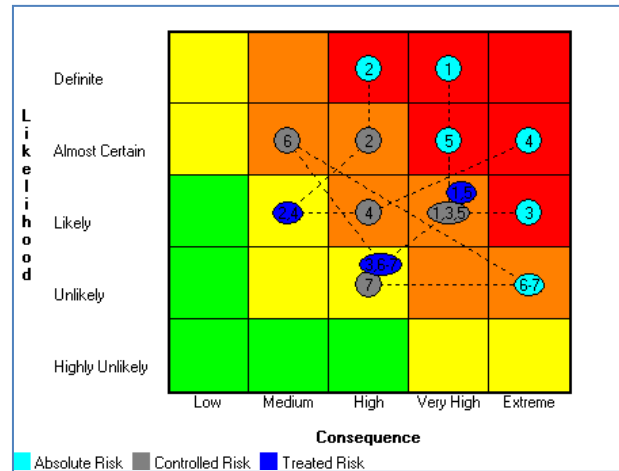
The risk assessment process identifies the potential barriers to achieving the deliverables outlined in this Plan and for each risk assessed the likelihood of it actually occurring, together with the potential consequences. The end result is given a rating known as the raw (untreated) risk rating. Mitigations for each risk are then identified and the risk re-evaluated with those mitigations strategies in place. A mitigation is an action or strategy that may already exist and reduces the likelihood or consequences of the risk. If the level of risk is regarded as unacceptable after the mitigations have been evaluated then further treatments are developed and the risk again evaluated as to determine its treated risk level. This is the level that will be attained once all the treatments have been implemented. In some cases the risk is not removed but the cost of further treatments is not justifiable.

Some of MidCentral DHB’s raw risks could have major consequences, specifically:

- Failure to provide reasonable access to and/or deliver critical health and disability services to the district
- Reduced confidence in MidCentral DHB’s performance.

Risk Profile

MidCentral DHB’s risk profile is set out below:



Risk Categories:

	Extreme risk – Immediate action required.
	High risk – Senior management attention needed. Specific strategies required.
	Medium risk – Manage through ongoing review and existing organisational strategies.
	Low risk – Manage through organisational procedures and service improvements.

Risk	Description	Mitigations
<p>Risk 1: Cost pressures exceed the increase in revenue provided by the Ministry of Health. Assessed Risk Level: Major.</p>	<p>Economic situation has reduced funding for new Government services. Increases for Health (funding for cost growth) will be modest.</p> <p>DHBs face increased demand, increased supply costs and wage settlements in excess of the funding for cost growth allowance.</p> <p>The cost of secondary service delivery has exceeded revenue for several years, and the DHB's ability to offset this from savings in other divisions is now exhausted. Therefore, if MidCentral Health does not manage expenditure growth in line with funding for cost growth, investment in other areas, such as primary care, will be jeopardised. It will also erode the DHB's ability to invest in new or replacement capital, including the results of the Clinical Services Plan.</p>	<ul style="list-style-type: none"> • Financial Recovery Programme established to reduce cost structure of DHB, particularly its provider arm, MidCentral Health. Programme is currently being implemented. • National procurement and workforce strategies are in place. • A regional clinical services plan is being finalised. • Clinical involvement in decision making occurs, and this has been strengthened through the elective service plan arrangement in 2009/10. • Lean thinking is being introduced through national quality programmes, and MidCentral DHB continues to participate in benchmarking activities. • National pricing is used, and MidCentral DHB has a strong delegations policy. • MidCentral Health has an elective services plan and has initiatives in train to improve admission/discharge processes, including the establishment of a Medical Assessment Unit. MidCentral Health will be reviewing services to ensure clinical and financial sustainability, and aligning new models of care and staffing levels. These changes will require strong leadership, including clinical leadership and support. • The centralAlliance between MidCentral and Whanganui DHBs will assist in sharing back-office and support functions. National and regional procurement and other support initiatives will also assist in creating efficiencies.
<p>Risk 2: MidCentral DHB is unable to maintain the rate of change required. Assessed Risk Rating: Major.</p>	<p>There is currently a mis-match between the rate and level of change, and, the ability to undertake change. The health sector is currently undergoing change in line with the Ministerial Review Group's report. This change is expected to continue over the next 18-24 months.</p> <p>The move to regionalisation and other long term solutions requires significant resource and attention. There is a misconception that regionalisation will be the panacea to workforce and service issues. Regionalisation will take time to achieve to ensure sustainable structures are put in place, and that key risks such as a significant reduction in access, are offset. It will also have a cost implication.</p> <p>Concurrently, the level of change required to enhance business as usual activities (such as financial recovery, quality improvement, and workforce) is increasing. There is also a need to address short term issues within hospital services in line with the</p>	<ul style="list-style-type: none"> • To mitigate this risk MidCentral DHB will ensure a project management approach, and either separate out the initiatives from business as usual or ensure they are undertaken in a structured manner. Realistic timeframes will be developed, and the workload shared amongst DHBs. Close working relationships with the Ministry of Health and other stakeholders are also essential. • A financial recovery programme has been established to prioritise projects and resources. This has been developed in conjunction with the National Health Board. Support from the NHB has also been committed.

Risk	Description	Mitigations
	<p>Government's priorities.</p> <p>MidCentral DHB's ability to increase resources to manage the level of change is severely restricted due to financial and staff pressures.</p>	
<p>Risk 3: MidCentral Health is unable to deliver elective service volumes. Assessed Risk Rating: Moderate.</p>	<p>Demand for acute medical services continues to grow. The medical demand overflows into the surgical area, using resources (both beds and staff) allocated for surgical services, reducing the ability to perform elective surgical procedures. The current economic climate may increase demand on emergency department services as people attempt to avoid costs of accessing primary care.</p> <p>There is a risk that this timeframe will slip further due to resource issues, increased demand and the level of change required to manage acute demand. In addition, MidCentral Health's ability to use private and other DHB facilities is restricted due to the negative impact on its financial position.</p>	<ul style="list-style-type: none"> • MidCentral Health has a robust elective service process, with a dedicated Manager. Referral acceptance levels are kept under regular review. There is regular monitoring and review of waiting lists and times. • An elective services plan has been developed which has the support of clinical staff. Medical Heads have signed off on the proposed volumes. • The centralAlliance provides opportunity for sub-regional elective service planning. A regional approach is also planned through the Regional Clinical Service plan in due course. • Surgical bed capacity has been reviewed and reconfigured to match demand. • A Medical Assessment Unit is in place to assist in managing acute demand. • Further work is planned through the PHO's "Better, Sooner, More Convenient Primary Health Care" business case to better manage acute demand and reduce avoidable hospitalisations. • Regular monitoring and review of elective service performance is maintained at both management and governance levels.
<p>Risk 4: A shortage of General Practitioners (GPs) impacts on community and secondary services. Assessed Risk Level: Moderate .</p>	<p>The district's General Practitioner workforce is operating below optimum levels.</p> <p>The failure of primary care services will impact severely on patients and will also place a greater reliance on hospital services.</p>	<ul style="list-style-type: none"> • The four PHOs in the district, supported by the DHB, have developed a business case for "Better, Sooner, More Convenient Primary Health Care". This will assist recruitment of GPs and the development of general practice teams. This initiative includes the establishment of a transformational clinical leadership development programme, and, an integrated knowledge and skills framework and programmes for primary health workers. Appointment of a Director of Medicine – Primary Health Care is planned. • MidCentral DHB is supporting GPs to develop Family Health Care Centres where they collocate with other primary health practitioners. These larger practices enable expertise, staff and costs to be shared. • Through the roll-out of its disease state plans, MidCentral DHB has funded the establishment of chronic care teams and specialist nursing positions. This creates primary care teams, reducing the reliance/burden

Risk	Description	Mitigations
		<p>on GPs.</p> <ul style="list-style-type: none"> • GP training and support packages have also been developed together with a GP trainee placement scheme. Where services are transferred from the secondary to primary sector, training is provided. • In addition practice managers will be supported to undertake professional development. • The trainee intern programme managed through Palmerston North Hospital includes a GP placement. • General practices are being encouraged to achieve cornerstone accreditation. • The DHB is supporting the implementation of an after-hours plan so that service coverage is maintained as well as demands on GPs minimised. Palmerston North Hospital provides an after-hours service for GPs for a certain period each night. A single point of access for primary health after-hours care is to be established. • Infrastructural support is being provided to general practice, including clinical decision-making software, and clinical leadership is a fundamental component of service development.
<p>Risk 5: An ageing population. Assessed Risk Level: Moderate.</p>	<p>MidCentral DHB's population is ageing, increasing the demand on health services. Elderly people generally present with higher complexity as they have co-morbidities, take longer to recover/rehabilitate from illness, and require more support. As people age, the likelihood of developing a major illness or disability increases significantly. Rising rates of dementia, both within the district and the central region, are also expected. Issues of social isolation also exist.</p> <p>The elderly population is also vulnerable to downturns in the economy as a higher proportion are on low/fixed incomes. Voluntary support structures can also be adversely impacted by economic downturns.</p> <p>The impact of the ageing population is beginning to be felt, with increased hospitalisation levels and higher lengths of stay. This is considered a medium to long term risk, rather than an immediate issue.</p>	<ul style="list-style-type: none"> • Roll out of disease state plans, such as cancer, cardiovascular, respiratory and diabetes. The elderly are high users of these services. • More work is now required to work smarter in the area of aged care, ensuring early intervention and maintaining independence levels. MidCentral DHB will be working with aged residential care facilities to enact the Government's priority to improve the quality of supervision and nursing in rest homes. It will participate in the national roll-out of InterRAI. • The "Better, Sooner, More Convenient Primary Health Care" business case has a specific focus on health for older people. This includes development of an older health model of care, clinical networks, and gerontology specific clinical pathways. Options for improved Maori-focus disability support are also planned, as is up-skilling of the aged care workforce. <p>These initiatives will support people across the older health spectrum, including those who are well and those who have aged-related and other illnesses.</p>

Risk	Description	Mitigations
<p>Risk 6: A Major Disaster/Pandemic impacts MDHB's ability to deliver Health and Disability Services. Assessed Risk Level: Moderate.</p>	<p>The likelihood of a major pandemic has increased over recent years, eg Avian Bird Flu. If a pandemic or major disaster occurred within MidCentral's district there is a risk that local health and disability services will be unable to respond in a timely and effective manner.</p> <p>In any pandemic situation, the risk of communication breakdowns exist.</p>	<ul style="list-style-type: none"> • MidCentral DHB has business continuance and pandemic plans in place. • MDHB participates in local, regional and national emergency planning exercises and conducts a number of internal evaluative exercises. • MDHB is working with the Primary sector to assist in the development of Emergency Management Plans. • Communication planning forms an integral part of the Pandemic and Emergency Management Plans.
<p>Risk 7: The DHB's workforce is of insufficient size or skill to meet demand Assessed Risk Level: Minor</p>	<p>The delivery of health and disability services in both the primary and secondary care is heavily reliant on having the appropriate sized and skilled workforce.</p> <p>Nationally and internationally difficulties have been experienced in recruiting and retaining health professionals. However, there has been a slight improvement as a result of the international economic downturn.</p> <p>Workforce issues are compounded by the increase in aging population and the associate demand together with increase in age of the current DHB workforce. The average of MidCentral DHB's workforce is 47 years.</p> <p>To provide a long-term solution to workforce and service sustainability issues, the Regional Clinical Services Plan is to be implemented. This aims to create regionally co-ordinated health services. There is a risk implementation may be delayed due to conflicting priorities at a local level.</p>	<ul style="list-style-type: none"> • MidCentral DHB has developed a workforce plan and is actively involved in both regional and national health workforce initiatives. This includes extending the scope of practice of specific health professionals to compensate for a lack of another speciality, and promoting health as a career. MDHB has ACC accredited employer tertiary status. • Palmerston North Hospital is a teaching hospital. In addition, it is a site for medical undergraduate placements (University of Otago's Wellington campus). • MidCentral DHB has a strong clinical governance and partnership model. • A health care development team is employed by the DHB to support primary care nursing. • MidCentral DHB has instigated a number of healthy staff initiatives to assist staff to adopt healthy lifestyles. A no-lift policy has been introduced within MidCentral Health's facilities. • A regional clinical plan has been developed. The intention of which is to utilise regional resources to address speciality medical shortages and imbalances between geographical areas. • DHBs within the central region have developed a Regional Clinical Services Plan. Implementation is occurring, supported by a regional governance structure. Strong clinical input is occurring. This is a long term solution. • At a sub-regional level, the centralAlliance offers opportunity for shared staffing arrangements.

Appendix A: MDHB's Clinical Leadership Framework

MidCentral DHB has established a strong clinical leadership framework and this continues to be developed. The following is a broad outline of the framework:

Hospital & Health Services

- MidCentral Health's senior management team is based on clinical:management partnership. Similarly, at service level, a clinical:management partnership exists.
- Medical leadership is provided within MCH by the Medical Director. All medical specialities and most sub-specialities within a service line have a Clinical Director and/or a Medical Head.
- MidCentral Health has a strong professional nursing structure, led by the Director of Nursing. There is a strong midwifery professional structure.
- A professional advisory function is in place for medicine, nursing, allied health, and clerical. This includes professional advisory roles and professional reference groups.
- Clinical governance within MidCentral Health is led by its Clinical Board. All professional committees within MCH report to the Clinical Board. These are many and include, among others, the Medicines Advice & Policy Committee, the Infection Control Committee, Clinical Ethics Advisory Committee, and Credentialing Committee. An annual report on the Board's work is provided to the DHB's Hospital Advisory Committee.
- Service teams within MidCentral Health are multi-disciplinary.

Funding & Planning Health Services

- MidCentral DHB's Funding Division includes a medical Clinical Advisor role, a Midwifery Advisor, Pharmacy Advisor, and the Director of Primary Health Care Nursing. It also has a Professor of Nursing – research role.
- Clinical expertise is also contracted in as required in the development of service plans, and for specific projects.
- District Management Groups develop and oversee the implementation of health service plans. Membership comprises representatives (particularly clinical) from primary and secondary care, consumers, and providers.

Primary Care

- Clinical governance within the primary sector is led by the Combined PHOs Clinical Board. An annual report on the Board's work is provided to the DHB's Community & Public Health Advisory Committee.
- MDHB's professional development healthcare team works with general practice. This is led by the Director of Primary Health Care Nursing.

DHB-Wide

- MidCentral DHB has a Clinical Council which covers the continuum of health care. It provides advice to the DHB's Executive Management Team, and reports annually to the Board.
- MidCentral Health's Medical Director provides clinical advice to the CEO. A formal monthly meeting arrangement is in place, with considerable other contact on issues as required.
- The development of strategic and annual plans includes clinical involvement.
- Major projects and initiatives include clinical leadership. For example, Women's & Child Health Taskforce, and the centralAlliance clinical work stream.
- A Leadership Forum, comprising senior clinicians and managers throughout the DHB, exists and looks at a broad range of issues.

Regional

- Clinical networks established. Currently, four clinical networks exist: cancer, cardiology, plastic surgery and renal services. Further clinical networks are being developed as part of the Regional Clinical Services Plan (RCSP).
- The RCSP is the key strategy document for regional collaboration. Clinical staff were integral to its development and the implementation structure includes a Leadership Group which will advise the Governance Group. The Leadership Group includes clinical representation and will be clinically led.
- Clinical leadership of sub-regional projects, such as the women's and child health service collaboration between MidCentral and Whanganui DHBs.
- The centralAlliance sub-committee meets with leaders of the clinical work stream monthly.

- The Central Region has established a network for professional forums, including Directors of Nursing and Chief Medical Officers. It also ensures a regular forum involving CEOs, Chief Operating Officers, Funding & Planning General Managers, Corporate General Managers, and HR Managers.

Governance

- Clinical expertise identified as a key skill for its Hospital Advisory and Community & Public Health Advisory Committees, and it has at least two members with a clinical background on each committee. Membership arrangement for audits committee ensures a member with a clinical background is on each.
- The Board's annual work programme for itself and each of its committees include regular updates regarding quality, clinical indicators (via balance scorecard and national indicators), and the long term health outcomes being sought in priority areas, such as cancer, cardiovascular, diabetes and respiratory.
- The Board's work programme includes an annual update on the work of the Clinical Council. An annual report from MidCentral Health's Clinical Board and the Combined PHOs' Clinical Board is provided to the Hospital Advisory Committee and the Community & Public Health Advisory Committee respectively.
- Clinical staff participate in the development and presentation of significant papers for the Board/Committees' consideration, such as business cases, capital expenditure applications, and service proposals. They are also involved in various board/committee workshops on specific issues.
- Performance measures for the CEO, and his direct reports, include achievement of key targets contained in annual and strategic planning documents. These are a mix of clinical, business and other measures.
- The Board's centralAlliance sub-committee (a committee comprising representatives of both MidCentral and Whanganui DHBs' boards, and each Board's CEO) meets with the leaders of the centralAlliance work stream on a monthly basis.

Appendix B: Primary Care Project

Executive Summary

In November 2009, MidCentral PHOs were successful with an Expression of Interest to the Ministry of Health to transform Primary Health Care services to achieve the Better, Sooner, More Convenient Vision. A business case has been developed to outline how the transformed Primary Health Care service will be implemented and operate.

The following logic was followed to develop the MidCentral DHB approach:

- Aspirational targets were developed to provide a clear and compelling focus identifying what was to be achieved
- Common business concepts (borderless health care, focus on the patient's experience, redeveloped practice model, innovation and implementation pipeline and bottom up approach to service development) provided a framework for developing a sound and considered approach to the changes required to deliver outcomes aligned to the aspirational targets
- Four key programmes of activity (Integrated Family Health Centres, Acute Demand Management, Older Persons Services and Whanau Ora) were chosen that would make the most difference for health system delivery and health outcomes experienced
- A number associated interventions were developed as components of the programmes of activity
- System enablers were developed which will support all programmes in the transformed primary health care service.
- High level Business Cases were developed to present what is planned to be done and the resultant outcomes
- A detailed Business Case was developed to provide the background, detail and the evidence required to support the direction of travel.

This proposal has first and foremost been designed by considering the needs of patients and families/whanau in the MidCentral area and engaging local clinicians and providers in wide ranging discussion and redesign of services. Over 150 clinicians, managers, business owners, Maori/Iwi health and social service organisations and more

have participated in the process bringing significant, diversity, expertise and value. The Business Case has also been developed in close partnership with MidCentral Health and DHB.

From this participatory process has emerged MidCentral's response to developing a better sooner more convenient experience for patients and their family/whanau, health professionals and our community.

Aspirational Targets

The targets that will be aspired to by MidCentral DHB in the next three years are to:

- Reduce presentations to the emergency department (ED) by 30%
- Reduce avoidable hospital admissions to Medical Wards and Assessment Treatment and Rehabilitation for over-65-year-olds by 20%
- Reduce poly-pharmacy in the over-65-year-olds by 10%
- Reduce the rate of growth in total aged residential care expenditure to 5% per year
- Reduce the rate of growth of GP-referred pharmacy expenditure to 1% per year until MidCentral's expenditure is similar to national benchmark expenditure
- Increase enrolment by Maori in PHOs to 100%.

And achieve the following:

- 80% of people aged over 65 with moderate complexity health needs will receive coordinated structured care through General Practice teams
- 100% of enrolled patients will have access to their own health records by 2013
- 100% of health professionals will have access to up to date patient health record
- All Primary Health Care providers will work within a common assessment and care planning framework
- Clinical leadership will actively drive service development across the sector.

DHB Governance & Participation

MidCentral DHB supports the “Transforming Primary Health Care Services” business case. The strategies and vision outlined in this document are consistent with the DHB’s Primary Health Care Strategy. Implementation of the business case is a priority project for 2010/11 and beyond. That

is why it forms such a significant part of this District Annual Plan.

The DHB is involved at all levels of the project being represented on the Steering Committee and the various working groups. This includes both clinical and management/funding representation.

Appendix C: Regional Clinical Services Plan

Central Region Collaboration

Central Region DHB's (Capital and Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa, and Whanganui) continue to build on a strong foundation of regional collaboration, to collectively achieve a shared vision (see Regional Clinical Services Programme), financial security and improve productivity.

Regional Clinical Services Programme

In 2008, Central Region DHBs collaborated to produce a Regional Clinical Services Plan (RCSP) intended to guide joint efforts over the coming years. The RCSP is a conceptual document setting out a vision for the future to the year 2020 and provides a framework for the region's future service.

The vision of the RCSP is to create a regionally co-ordinated system of health service planning and delivery, thus creating lasting improvements in the sustainability, quality and accessibility of clinical services.

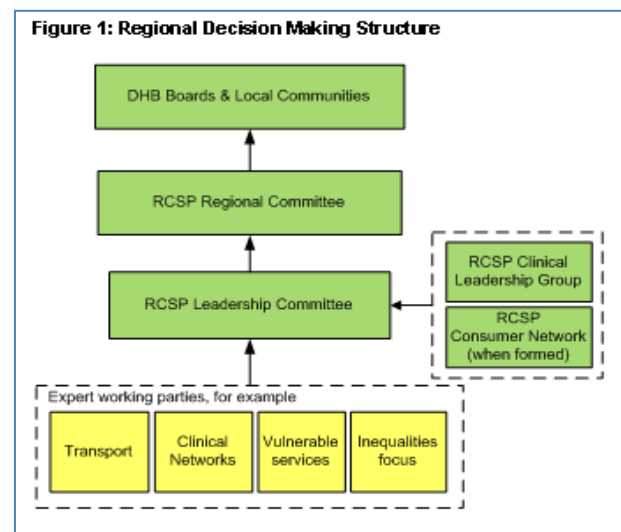
Underpinning this vision are two aims: 1) improved clinical outcomes and 2) patients and their families and whanau to have an enhanced experience of the Central Region health service. These aims are balanced with the need for an affordable health service that is able to demonstrate value for money and to live within available resources.

Clinical Networks

Enabling the implementation of the RCSP requires clinical leadership and direction. In addition to this occurring through the regional governance and decision making framework, regional Clinical Networks have been established for Cancer (part of the national Cancer programme), Cardiology, Mental Health, Plastic Surgery, and Renal Services. These networks solve identified regional issues for a service or group of 'like' services through an agreed work programme. They provide the opportunity for clinical leadership, coordination and information sharing across the continuum of care (primary, secondary and tertiary level settings).

Regional Governance and Decision Making

Being able to implement the RCSP requires a framework that supports regional decision making whilst still recognising the autonomy of the local DHB Boards. The following decision making committee framework has been put in place.



A regional governance group (called RCSP Regional Committee) comprising board chairs and CEO's has been established to lead regional decision making for the region. An independent chair will be appointed in the first quarter of 2010 to facilitate a consensus approach to decision making by DHB Boards. Decisions will be based on expert recommendations from the RCSP Leadership Committee (RLC), a group representative of different disciplines from across the region and DHBs. The RLC is a clinical and managerial partnership that will provide direction to the programme and ensure regional proposals are of the highest quality and have undergone rigorous review.

Supporting the RLC is a regional Clinical Leadership Group (CLG). CEOs directed in February 2009 that a clinical group be formed to ensure a broad base of clinical participation and leadership, with Chief Medical Officers (CMO) and Directors of Nursing (DON) as the nucleus group. The CLG convened in June 2009, has a membership of primary and secondary clinicians from across the region and has worked in partnership with the interim RCSP Steering Group (and future RLC when formed in March 2010) to shape the direction of the work programme.

Regional Productivity

In line with the Ministers expectation of increased productivity, the Central Region is committed to a range of projects that will achieve this end during 2010/11 such as implementing the Regional Elective Surgery Plan, progressing clinical pathway development for key procedures across the region and undertaking the "Strengthening Hospital Services: Regional Action Plan" and which, when added to existing regional projects has agreed the following priority areas by way of the work programme for 2010/11:

- Clinical services – Cancer, Cardiac, Mental Health, Older Adults (AT&R and Specialist Rehabilitation for under 65 years), Plastics, Radiology, Renal, and Women's Services (Maternity, Gynaecology, Gynae Oncology Surgery and Maternal Foetal Medicine)
- Long Term Conditions (chronic conditions management)
- Regional Electives Surgery Collaboration
- Regional Credentialling of Medical Clinicians
- Information Communication and Technology (ICT).

Links to the Government Priorities

The Government's strategic direction and planning framework for New Zealand's health and disability service is set out in the "New Zealand Health Strategy" and the "New Zealand Disability Strategy".

Each year the Government reviews progress toward achievement of its health and disability strategies, and sets its expectations and priorities for District Health Boards. For the 2010/11 year these are:

- Enhance regional cooperation
- Improve productivity and quality
- Achieve financial security.

Regional Planning Assumptions

The regional DHBs have agreed the following planning assumptions:

- All Central Region DHBs participate and share in an enduring, joint effort to achieve the vision of the RCSP

- Each Central Region DHB ensures that their local planning and decision making is aligned with the direction, aims and objectives of the RCSP
- All decisions of regional importance are made by consensus, using an agreed regional decision making process and structures
- Regional collaboration is across the continuum of care, linking to sub-regional collaboration:
 - Choosing to work together in order to find new innovative ways of better organising, funding, delivering and continuously improving health services in the region
 - Clinical leadership (including clinical networks) is vital to achieve improving health outcomes and lasting service change.
- Reducing health inequalities across the Central Region:
 - Working together to ensure equity in access, utilisation and outcomes of health services in the region. In particular, high priority should be accorded to solutions that contribute to reducing disparities for Maori and Pacific Peoples and rural communities.
- Within regional resources, providing sustainable quality health services and an optimal health service which is sustainable (clinical and financial), innovative and accessible:
 - People of the region will have health services provided locally where appropriate as long as services are safe, affordable and sustainable, and of high quality. This may require DHBs to work collaboratively together to share health resources. Constant evaluation is required along with the continued development of a health system that will deliver quality care while maintaining value for money
 - Workforce issues dominate regional collaboration and underpin concepts relating to sustainability, quality and access, and are therefore recognised here.
- Need to look at the future in the context of the future whilst learning from the past:

- Solutions of the past may not be appropriate to solve the challenges that are currently being faced.
- Central Region DHBs will collaborate to ensure that all DHBs make progress toward their achievement of Health Targets
- Improved DHB productivity will arise from Performance Improvement Actions (PIAs); improved quality; enhanced regional collaboration; and Health Target achievement, and will contribute to DHB financial security
- Enhanced regional collaboration involves a commitment to the Regional Clinical Services Plan and to sub-regional collaboration. Examples of sub-regional collaboration are numerous, but include the sub-regional women's health services between Whanganui and MidCentral DHBs, Allied Laundry Services, and the cancer network
- The National Health Board (NHB) and National Shared Services Establishment Board (NSSEB) may possibly request new regional or sub-regional initiatives be undertaken.

Appendix D: DHB Non-Financial Monitoring Framework and Performance Measures 2010/11

MidCentral DHB Performance Measures Targets for 2010/11							
Policy Priorities Dimension							
Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information		Frequency of reporting
HT1	Shorter stays in emergency departments		Total	95%	Increased % of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	95%	Quarterly
HT2	Improved access to elective surgery		Total	5,717 (excludes IDF inflows)	The volume of elective surgery will be increased by a minimum of 176 discharges by end June 2011.	4,000	Quarterly
HT3	Shorter waits for cancer treatment		Total	100%	All patients in category A, B and C wait less than four weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients) by December 2010.	100%	Quarterly
HT4	Increased Immunisation		Maori	90%	Increased % of eligible two year olds fully immunised by July 2011.	90%	Quarterly
			Total	90%			
HT5	Better help for smokers to quit	1. Hospitalised smokers	Total	90%	Increased % of hospitalised adult smokers provided with advice and help to quit by July 2011.	90%	Quarterly
		2. Primary Care	Total	80%	% of enrolled patients aged 15-75 years attending primary care provided with advice and help to quit by July 2011.	80%	Quarterly
HT6	Better diabetes and cardiovascular services	1. Diabetes Management	Maori	≥72%	Increased percent of people with diabetes have satisfactory or better diabetes management.		Quarterly
			Other	≥81%			
			Total	≥80%			
		2. Diabetes Checks	Maori	≥82.8%	Increased percent of people with diabetes attend free annual checks.		
			Other	≥81.5%			
			Total	≥81.5%			

		3. CVD Risk	Maori	≥73%	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years.	
			Other	≥84%		
			Total	≥81%		
PP1	Clinical leadership self assessment			Self-assessment completed and progress against criteria reported	<p>The DHB provides a qualitative report in the form of a self assessment identifying progress achieved; What's worked; what hasn't; Planned actions - for each of the following areas of focus:</p> <ul style="list-style-type: none"> • whether managers and clinical leaders feel valued and recognised for their leadership capability • whether joint management and clinical relationships are effective • whether strong and effective engagement is in place at all levels, across management and clinicians, and across disciplines • whether there is shared ownership of organisational outcomes across management and clinical leadership, and across disciplines. 	Annual
PP2	Implementation of Better, Sooner, More Convenient primary health care			<p>The DHB is to supply a report confirming it has implemented the changes to primary care service delivery models agreed in its DAP OR a report identifying why changes to primary care service delivery models agreed in its DAP have not been implemented, with an associated resolution plan.</p>	Those DHBs involved in the development of business cases with successful Expression of Interest providers are required to report on progress of the implementation of those changes as agreed to in their DAP.	Annual
PP3	Local Iwi/Maori engagement and participation in DHB decision making, development of strategies and plans	Measure 1		100%	% of PHOs with Maori Health Plans (MHPs) that have been agreed to by the DHB.	Six-monthly
		Measure 2		100%	% of DHB members that have undertaken Treaty of Waitangi training.	

for Maori health gain	Measure 3		<p>Provide a report demonstrating:</p> <ul style="list-style-type: none"> • Achievements against the Memorandum of Understanding (MoU) between a DHB and its local Iwi/Maori health relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties during the reporting period • Provide a copy of the Memorandum of Understanding (MoU). 	
	Measure 4		Report on how (mechanisms and frequency of engagement) local Iwi/Maori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs).	
	Measure 5		Report on how MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs).	
	Measure 6		Describe when Treaty of Waitangi training (including any facilitated by the Ministry) has, or will, take place for Board members.	
	Measure 7		<p>Two Key Milestones from your Maori Health Plan:</p> <ul style="list-style-type: none"> • Increase Maori enrolments with PHOs by 10% by June 2011. (Baseline 24,000 enrolments December 2009) • Whanau ora assessments offered to Maori who are not enrolled with PHOs by end January 2011. 	Identify at least two key milestones from your Maori Health Plan to be achieved in 2010/11. For reporting in Quarter 2, provide a progress report on the milestones, and for reporting in Quarter 4, provide a report against achievement of those milestones during the current year.

PP4	Improving mainstream effectiveness DHB provider arms pathways of care of Maori	Measure 1		Provide a report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Maori.		Six-monthly	
		Measure 2		Report on an example(s) of actions taken to address issues identified in the reviews.			
PP5	Waiting times for chemotherapy treatment			100%	% of patients wait less than six weeks between first specialist assessment and the start of chemotherapy treatment. Wait times templates are to be supplied each quarter. The templates should display results for each month within the quarter. Qualitative comment on reasons (and management plans) for people with chemotherapy waits longer than 6 weeks is to be supplied in quarterly reports.	Quarterly	
PP6	Improving the health status of people with severe mental illness	Age 0-19	Maori	1.8%	% of people domiciled in the DHB region, seen per year (average).	Six-monthly	
			Other	2.7%			
			Total	2.4%			
		Age 20-64	Maori	3.97%			
			Other	2.9%			
			Total	3.07%			
Age 65+	Total	0.5%					
PP7	Improving mental health services using crisis intervention planning			95%	% of long-term clients (in contact for 2 years or more) who have up-to-date crisis prevention plans.	90%	Six-monthly
PP8	DHBs report alcohol and drug service waiting times and waiting lists			Waiting times and waiting lists are to be measured, for one month, every six months, to inform Ministry policy and, to determine the variation and extent of waiting times and waiting lists to determine if targets will be required to be set in the future. DHBs will report	Service type: Inpatient Detoxification, Specialist Prescribing, Structured Counselling, Day Programmes and Residential Rehabilitation. DHBs will report waiting times by Maori and Other ethnicities.		Six-monthly

				<p>their longest waiting time, in days, for each service type for one month prior to the reporting period.</p> <p>A narrative is also required to:</p> <ol style="list-style-type: none"> 1. Identify the name and location of service(s) with the longest waiting time and waiting list 2. Explain variances of more than 10% in waiting times or waiting lists 3. Explain/identify targets that the DHB may have for reducing waiting times and or waiting lists. 			
PP9	Delivery of Te Kokiri: the mental health and addiction action plan			DHBs are to provide a summary report on progress made towards Implementation of Te Kokiri: the Mental Health and Addiction Action Plan.			Annual
PP10	Oral Health DMFT Score at Year 8		Maori	2.00	Mean score of permanent teeth of children with decayed, missing or filled permanent teeth at Year 8.		Annual
			Pacific	2.20			
			Other	1.30			
			Total	1.45			
			Total	Fluoridated: 1.50 Non-Fluoridated: 1.30			
PP11	Children caries free at five years of aged		Maori	40%	% of children carries free at five years of age.		Annual
			Pacific	40%			
			Other	68%			
			Total	58%			
			Total	Fluoridated: 62% Non-Fluoridated: 52.5%			
PP12	Utilisation of DHB funded dental services by adolescents		Maori	75%	% of adolescent utilisation of DHB funded dental services.		Annual
			Other	78%			
			Total	78%			
PP13	Improving the number of children enrolled in	Measure 1	Total	58% (n 6,794)	% of children under five enrolled in DHB funded dental services.		Annual

	DHB funded dental services	Measure 2	Total	≤5% (n 1,300)	% of preschool and primary enrolled with DHB funded dental services who have not been examined according to their planned recall.	
PP14	Family violence prevention		Total	140/200	Combined audit score.	Annual

System Integration Dimension							
Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information		Frequency of reporting
SI1	Ambulatory sensitive (avoidable) hospital admissions	1. Age 0-74	Maori	95% of national rate	Each DHB is expected to provide a commentary on their latest 12 month ASH data that's available via the nationwide service library. This commentary may include additional district level data that's not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions. Each DHB should also provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Maori 45-64 year olds.		Six-monthly
			Other	95% of national rate			
		2. Age 0-4	Maori	95% of national rate			
			Other	95% of national rate			
		3. Age 45-64	Maori	95% of national rate			
			Other	95% of national rate			
SI2	Regional service planning			<p>DHBs are to report confirming:</p> <ul style="list-style-type: none"> The DHB has progressed the RCSP according to plan submitted to Ministry of Health If the DHB cannot provide the confirmation report outlined above, it is expected that the DHB will transition to compliance no later than six months after the non-compliance is first reported. A planned pathway to full compliance, including key milestones and timelines, should be formalised and 		Six-monthly	

				provided to the Ministry no later than three months after the non-compliance is first reported.		
S13	Service coverage			Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: <ul style="list-style-type: none"> • analysis of explanatory indicators • media reporting • risk reporting • formal audit outcomes • complaints mechanism • sector intelligence. 		Six-monthly
S14	Elective services standardised intervention rates	Intervention rate (case mix included elective discharges - surgical DRGs)	Total	292 per 10,000	Intervention rates not significantly below the expected level. For any procedure where the standardised intervention rate is significantly below the target level a report demonstrating: <ol style="list-style-type: none"> 1. What analysis the DHB has done to review the appropriateness of its rate, and 2. whether the DHB considers the rate to be appropriate for its population OR <ol style="list-style-type: none"> 3. A description of the reasons for its relative under-delivery of that procedure; and 4. The actions being undertaken in the current year (2010/11) that will ensure the target rate is achieved. 	Six-monthly
		Major joint procedures intervention rate for Hip and Knee	Total	21 per 10,000		
		Cataract procedures intervention rate	Total	27 per 10,000		
		Cardiac procedures intervention rate	Total	6.23 per 10,000		
S15	Increased Funding for Maori Health and disability initiatives	Measure 1 DHB to report actual expenditure on Maori Health Providers by General Ledger (GL) code				Annual
		Measure 2 DHBs to report				

		actual expenditure for Specific Maori Services provided within mainstream services targeted to improving Maori health by Purchase Unit (PU)				
		Measure 3 Where information is available, DHBs to provide a table that reflects the DHB predicted expenditure for Maori health in the DHB 2010/11 DAP in comparison to actual expenditure, with explanation of variances				
SI6	Risk Reporting			<p>DHBs are to report confirming:</p> <ul style="list-style-type: none"> • the DHB uses a formal risk management and reporting system to manage DHB risks and report them to its Board • the system meets current Australia/New Zealand Standard requirements relating to risk management • how frequently the DHB submits formal risk report updates to its Board (or a Board approved sub-committee). <p>If the DHB cannot provide the confirmation report outlined above, it is expected that the DHB will transition to compliance no later than six months after the non-compliance is first reported. A planned pathway to full compliance, including key milestones and timelines, should be formalised and provided to the Ministry no later than three months after the non-compliance is first</p>		Six-monthly

				reported.			
SI7	Improving breast-feeding rates	Six Weeks	Maori	≥67.5%	% of infants exclusively and fully breastfed at six weeks.		Annual
			Pacific	≥76.5%			
			Other	≥76.5%			
			Total	≥70.0%			
		Three Months	Maori	≥57%	% of infants exclusively and fully breastfed at three months.		
			Pacific	≥57%			
			Other	≥57%			
			Total	≥57%			
		Six Months	Maori	≥27%	% of infants exclusively and fully breastfed at six months.		
			Pacific	≥27%			
			Other	≥27%			
			Total	≥27%			

Ownership Dimension							
Code	Performance measure title	Measures	Area	2010/11 Target/deliverable	Further information		Frequency of reporting
OS1	Staff turnover by major professional group			Total: ≤8.3% Medical: ≤5.3% Nursing: ≤8.5% Allied Health: ≤8.4% Support: ≤17.5% Admin/mgmt: ≤7.6%	Proportion of staff employed by the DHB's provider arm who cease employment due to voluntary resignation.		Quarterly
OS2	Capital expenditure in line with plan	Deviation from plan in the YTD		In line with 2010/11 capital expenditure plan	Expenditure should not be materially greater than set out in plan (or changed for good reason).		Quarterly
OS3	Elective and arranged inpatient length of stay	Average length of stay for elective and arranged patients with a length of stay of one night or more. The measure is indirectly standardised for DRG cluster and co-morbidities.		2008/09 base: 4.44 days* Target: 4.02 days* *unstandardised	DHBs will have individual targets towards shorter length of stay. The suggested benchmark is the average length of stay of the 'fifth-best' DHB in the 2008/09 financial year.		Quarterly
OS4	Acute inpatient length of stay	Average length of stay for acute patients with a length		2008/09 base: 4.78 days* Target: 4.20 days*	DHBs will have individual targets towards shorter length of stay. The		Quarterly

		of stay of one night or more. The measure is indirectly standardised for DRG cluster and co-morbidities.		*unstandardised	suggested benchmark is the average length of stay of the 'fifth-best' DHB in the 2008/09 financial year.	
OS5	Theatre productivity	The DHB is expected to reduce the number of theatre sessions that start late, finish early, or are cancelled		Baseline (12 months to 30 April 2010): 38.5% of scheduled elective theatre sessions start late, finish early, or are cancelled. Target: ≤28.5% (annual)	Each quarter, the DHB is required to submit the following data elements for each theatre in each Provider Arm facility: <ul style="list-style-type: none"> • number of scheduled theatre sessions in the quarter (may be zero if the theatre is not in use) • number of cancelled theatre sessions in the quarter • number theatre sessions that start late (and do not finish early) • number of theatre sessions that finish early (and started on time) • number of theatre sessions that start late and finish early. 	Quarterly
OS6	Elective and arranged day surgery	The rate of day surgery for elective and arranged surgical patients (operating room and non-operating room). The rate is indirectly standardised for DRG.		2008/09 base: 59% Standardised rate: 60%	DHBs will have individual targets towards higher rates of day surgery. The suggested benchmark is the rate of the 'fifth-best' DHB in the 2008/09 financial year.	Quarterly
OS7	Elective and arranged day of surgery admissions	The rate of day of surgery admissions for elective and arranged surgical patients		≥95%	Of surgery on a day of surgery admission basis (with some room for flexibility). This benchmark is based on Australian experience.	Quarterly
OS8	Acute readmissions to hospital	The rate of unplanned acute readmissions within 28 days of original discharge from hospital. The rate is indirectly standardised for a range of factors using regression methods.		2008/09 base: 10.25% Standardised rate: ≤10%	DHBs will set individual targets for improvement of acute readmission rates. The suggested benchmark is the national average acute readmission rate during 2008/09.	Quarterly
OS9	30 day mortality	The mortality rate within 30 days of admission for patients in hospital. The rate is indirectly standardised for a range of		2008/09 base: 1.62% Standardised rate: 1.62%	DHB will set individual targets. The suggested benchmark is that DHBs aim to maintain mortality at least at the 2008/09 level for the DHB, or improve it, during the year.	Annual

		factors using regression methods.				
OS12	National patient satisfaction survey	Overall patient satisfaction rate		≥85%		Quarterly
OS10	Improving the quality of data provided to national collection systems	Measure 1 Timeliness of NMDS Data		>2% - ≤5%	Proportion of publicly funded NMDS events loaded more than 21 days post month of discharge.	Quarterly
		Measure 2 NHI Duplications		>2% - ≤3%	Proportion of NHI duplicates that require merging.	
		Measure 3 Ethnicity not stated in NHI		>2% - ≤4%		
		Measure 4 Standard vs specific text descriptors in the NMDS		≥60%		
OS11	Hospital outputs are delivered to plan	The delivery of actual hospital outputs delivered in the year to date as a proportion of the planned outputs expected in the year to date expressed as a percentage		Overall: ≤3% Service sub-groups: ≤5%	DHBs are expected to deliver total outputs for the year with a variance of less than three percent from plan overall, and a variance less than five percent in sub-groups of outputs.	Quarterly- for three quarters

Appendix E: Financial Statements

Consolidated Position

Statement of Financial Performance					
MidCentral DHB					
(\$'000's)	Actual 2008/09	Forecast 2009/10	Budget 2010/11	Budget 2011/12	Budget 2012/13
Revenue	478,397	504,122	539,893	553,820	567,843
% change		5.38%	7.10%	2.58%	2.53%
less Expenditure					
Personnel	160,117	167,700	174,627	178,964	183,336
Outsourced Services	25,229	20,861	16,512	16,923	16,236
Clinical Supplies	39,919	46,116	45,929	47,063	48,207
Infrastructure & Non-Clinical	58,790	57,276	79,286	79,614	81,555
Financing Charges	9,742	10,252	10,331	10,590	10,851
External Provider Payments	152,476	165,088	170,589	174,074	178,717
Inter-District Payments	42,073	46,709	46,358	47,638	48,924
Corporate costs	-	-	-	-	-
	488,346	514,002	543,632	554,866	567,826
% change		5.25%	5.76%	2.07%	2.34%
Operating Surplus/(Deficit)	(9,949)	(9,880)	(3,739)	(1,046)	17

Statement of Financial Position**MidCentral DHB**

(\$'000's)	Actual 2008/09	Forecast 2009/10	Budget 2010/11	Budget 2011/12	Budget 2012/13
Current Assets	44,727	34,280	31,756	30,078	26,963
Current Liabilities	58,941	58,941	58,941	58,941	58,941
Working Capital	(14,214)	(24,661)	(27,185)	(28,863)	(31,978)
Non current assets	164,748	166,456	166,496	166,496	168,996
Assets Employed	150,534	141,795	139,311	137,633	137,018
Non Current Liabilities	52,013	52,013	52,013	52,013	52,013
Equity	98,521	89,782	87,298	85,620	85,005
Funds Employed	150,534	141,795	139,311	137,633	137,018

Statement of Cashflows**MidCentral DHB**

(\$'000's)	Actual 2008/09	Forecast 2009/10	Budget 2010/11	Budget 2011/12	Budget 2012/13
Total Receipts	470,329	502,718	538,397	552,270	566,237
Total Payments	(465,978)	(497,596)	(525,665)	(536,100)	(548,760)
Operating Cash flow	4,351	5,122	12,732	16,170	17,477
Investing Cashflow	(10,079)	(13,120)	(12,922)	(13,627)	(16,371)
Financing Cashflow	(3,763)	(2,450)	(2,334)	(4,221)	(4,221)
Net Capital Cashflow	(13,842)	(15,570)	(15,256)	(17,848)	(20,592)
Net Cashflow	(9,491)	(10,448)	(2,524)	(1,678)	(3,115)
Opening Cash	35,615	26,124	15,676	13,152	11,474
Closing Cash	26,124	15,676	13,152	11,474	8,359

Statement of Debt & Equity
MidCentral DHB

(\$'000's)	Actual 2008/09	Forecast 2009/10	Budget 2010/11	Budget 2011/12	Budget 2012/13
Debt:					
Facility Utilised:					
Working Capital	-	-	-	-	-
Long-Term Debt	54,700	54,700	54,700	54,700	54,700
	54,700	54,700	54,700	54,700	54,700
Facility Available:					
Crown	56,700	56,700	56,700	56,700	56,700
Private Sector	15,000	15,000	15,000	15,000	15,000
	71,700	71,700	71,700	71,700	71,700
Unused Facility	17,000	17,000	17,000	17,000	17,000
Equity:					
Opening	89,620	98,521	89,782	87,298	85,620
Net Surplus/(Deficit)	(9,949)	(9,880)	(3,739)	(1,046)	17
Revaluation Reserve	18,974	-	-	-	-
Equity Injection/(Repayment)	(124)	1,141	1,255	(632)	(632)
	98,521	89,782	87,298	85,620	85,005

Schedule of Lenders

Available Facility (\$000)	2008/09	2009/10	2010/11	2011/12	2012/13
Crown Health Financing Agency:					
Loan Facility	47,000	47,000	47,000	47,000	47,000
Horowhenua Hospital	9,700	9,700	9,700	9,700	9,700
Bank of New Zealand:					
Working Capital Facility	15,000	15,000	15,000	15,000	15,000
Total Facility	71,700	71,700	71,700	71,700	71,700

Provider Division

Statement of Financial Performance					
Provider					
(\$'000's)	Actual 2008/09	Forecast 2009/10	Budget 2010/11	Budget 2011/12	Budget 2012/13
Revenue	277,757	287,968	318,835	326,691	334,625
% change		3.68%	10.72%	2.46%	2.43%
less Expenditure					
Personnel	151,479	158,859	165,992	170,091	174,224
Outsourced Services	24,581	20,237	15,793	16,184	15,477
Clinical Supplies	39,901	46,108	45,924	47,058	48,202
Infrastructure & Non-Clinical	54,531	52,995	75,085	75,206	76,924
Financing Charges	8,249	8,820	9,298	9,528	9,760
Corporate costs	9,323	9,677	9,163	9,494	9,837
	288,064	296,696	321,255	327,561	334,424
% change		3.00%	8.28%	1.96%	2.10%
Operating Surplus/(Deficit)	(10,307)	(8,728)	(2,420)	(870)	201

Funding Division

Statement of Financial Performance					
Funder					
(\$'000's)	Actual 2008/09	Forecast 2009/10	Budget 2010/11	Budget 2011/12	Budget 2012/13
Revenue	419,601	450,957	461,813	474,522	487,284
% change		7.47%	2.41%	2.75%	2.69%
less Expenditure					
Provider and Governance Divisions	224,667	239,130	245,366	252,138	258,946
External Providers	152,476	165,088	170,589	174,074	178,717
Inter-District Outflows	42,073	46,709	46,358	47,638	48,924
	419,216	450,927	462,313	473,850	486,587
% change		7.56%	2.53%	2.50%	2.69%
Operating Surplus/(Deficit)	385	30	(500)	672	697

Total Provider Division Revenue by Type

(\$000s)	MidCentral Health	Enable NZ	Total
Funding Division	242,982	-	242,982
Price Volume Schedule	242,982		242,982
Additional DSS Funding			-
Clinical Training Agency	2,360		2,360
Ministry of Health	13,680	9,644	23,324
Personal Health	7,275		7,275
Mental Health	(378)		(378)
Public Health	4,354		4,354
DSS	2,429	9,644	12,073
Other Government	9,316	34,688	44,004
Inter Provider Revenue	2,181		2,181
Training Fees and Subsidies	272		272
Accident Insurance	4,349	34,688	39,037
Other	2,514		2,514
Patient/Consumer Sourced	660		660
Other Income	4,924	581	5,505
Total Revenue	273,922	44,913	318,835

**Note*

<i>Output Related</i>	242,982
<i>Non-output Related</i>	-
Total Price Volume Schedule	242,982

Governance Division

Statement of Financial Performance					
Governance					
(\$'000's)	Actual 2008/09	Forecast 2009/10	Budget 2010/11	Budget 2011/12	Budget 2012/13
Revenue	5,706	4,327	4,611	4,778	4,950
% change		-24.17%	6.56%	3.62%	3.60%
less Expenditure					
Personnel	8,639	8,841	8,635	8,947	9,270
Outsourced Services	648	624	719	745	772
Clinical Supplies	18	8	5	5	5
Infrastructure & Non-Clinical	4,259	4,519	4,201	4,353	4,512
Financing Charges	1,493	1,194	1,033	1,070	1,109
Corporate costs	(9,324)	(9,677)	(9,163)	(9,494)	(9,837)
	5,733	5,509	5,430	5,626	5,831
% change		-3.91%	-1.43%	3.61%	3.64%
Operating Surplus/(Deficit)	(27)	(1,182)	(819)	(848)	(881)

Reconciliation with 2009/10 District Annual Plan

(\$000's)	Budget 2010/11
Forecast 2010/11 surplus from 2009/10 DAP	8
Additional Revenue	16,575
Additional Costs	
Personnel	6,918
Clinical Supplies	86
Infrastructure & Non-Clinical	15,990
Total Additional Costs	22,994
Reduced Costs	
Outsourced Services	863
Financing Charges	179
Inter-District Payments	927
External Provider Payments	703
Total Reduced Costs	2,672
Operating Surplus/(Deficit)	(3,739)

Appendix F: Schedule of Capital Expenditure

MidCentral District Health Board				
Three Year Capital Expenditure Programme				
Description	Forecast 2009/10	Budget 2010/11	Budget 2011/12	Budget 2012/13
Items greater than \$250k				
ISSP Plan 2009/10				
Concerto Clinical Workstation	1241			
Inter RAI Needs Assessment Software	64			
Telephony Upgrade	50			
ISSP Plan 2004-2009				
Rostering Upgrade.NET	247			
Contract Management System	345			
HR Yourself	49			
ISSP Plan 2010/11				
Regional PACS Archive		275		
eReferrals		200		
Maternity System		190		
Dental		385		
Sterile Tracking System		340		
ISSP Plan Outer Years				
Document Archiving Compliance			300	
Telephony Upgrade			255	255
Business Intelligence/Data Warehouse			1,200	
Regional Clinical Repository			500	
Homer Replacement-PAS & ED				2,500
Homer Replacement-Pharmacy				535
Network Infrastructure				750
ISSP Projects (see separate Schedule)				
Total ISSP	1,996	1,390	2,255	4,040
ICU Patient Monitors	430			
Replacement LA3 (Balance in Prior Years CAPEX approvals)	375			
Linac Sinking Fund	360	360	360	360
Ultrasound-Radiology	300			
Theatre Electrical Upgrade	473			
Surgical /HDU Anaesthetic Relocation			1,100	
Switchboard Upgrades			2,100	
CAOHS- Denistry Business Case	1,709	1,887		
Gamma Camera			2,000	
Planning Workstations		450		
Emergency Rooms 11 & 12 (Radiology)		1,000		
Bed Replacement Programme			325	425
Treatment Planning System			800	
Ultrasound			350	
DSA Upgrade			1,100	
IT Building Upgrade			500	
LA1 Replacement				3,500
PNH Reconfiguration Stage 1				2,500
CT Simulator				2,000
Philips Omnidiagnostic				700
Under \$250k	3,560	7,052	1,836	1,901
Corporate				
Virtual Server Upgrades			250	
Under \$250K	1,039	1,629	1,751	2,101
Enable				
Capital Plan 2009/10 (Items under \$250k)	243	450	450	450
Hamilton Store Relocation & ACC Modifications	319			
Demand for Capital Expenditure	10,804	14,218	15,177	17,977

Clinical Records Building	2,202			
Linear Accelerator Upgrades & Replacement Costs	797			
Cytoxics Suite & equipment	368			
Items under \$250k	353			
Capex brought forward prior years approvals	3,720			
Demand for Capital Expenditure	14,524	14,218	15,177	17,977
Funding Sources				
Depreciation funding	10,846	12,331	15,177	15,477
MOH Funding Enhancements Child & Adolescent Oral Health (\$3,896)	1,709	1,887		
MOH Funding inter RAJ	64			
Retained Earnings Funding-Other	1,905			
Other Funding-Redevelopment				2,500
Total Funding	14,524	14,218	15,177	17,977
<i>Indicative Asset Sales (not included in financial results)</i>	<i>Budget</i>	<i>Budget</i>	<i>Budget</i>	<i>Budget</i>
<i>Buildings</i>	<i>2009/10</i>	<i>2010/11</i>	<i>2011/12</i>	<i>2012/13</i>
<i>Land</i>		2900	1,000	
<i>Additional requests (not included in financial results)</i>	<i>Budget</i>	<i>Budget</i>	<i>Budget</i>	<i>Budget</i>
<i>Additional (4th) Linear Accelerator + Bunker (to be confirmed)</i>	<i>2009/10</i>	<i>2010/11</i>	<i>2011/12</i>	<i>2012/13</i>
	-	5,500		

Appendix G: Information Systems Strategic Plan Information

DHB NAME: MidCentral

Prepared: 2 February 2010 by Brian Woolley, Manager Information Systems - Strategy & Planning

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	Project rank/priority	Project Reference #	Planned Start (Month/Yr)	Expected Completion (Month/Yr)	HIS-NZ Action Zone #	Project Type	Significance: National, Regional, Local	Approx Capital Cost (\$000)	Funding Source	Project reference in DAP. State how project aligns to specific DHB Objectives	Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved
Implement a Dental System	1	110	Feb 2010	Feb 2011	7	R	N L	385	1	Integral part of new model of care being implemented for child and adolescent health services. PIA 3, Action 8.	Review and install Titanium system Supports new service delivery model for children and adolescent dental care in the district. Faster turnaround of processing for children – less backlog DHB meets national targets and can share information.
Implement Concerto Clinical Workstation	1	77 CIS 1	Started	Sep 2010	5, 6, 7, 8	N	N R	1,241	1	Part of plans to improve hospital productivity, support clinical decision-making, and facilitate primary/secondary integration. PIA1, Action 1.	Delivers clinical workstation incorporating single sign-on to MDHB application systems, laboratory results viewing, patient key health information summaries, patient searches, discharge summaries and clinical documents. Required for eReferrals.
Implement a Sterile Services Tracking	1	107	Started	Jun 2011	7	N	L	340	1	Part of quality improvement plans to reduce number of avoidable incidents.	Business completed by Jun 2010 Allows theatre instruments to be tracked at the patient level.

System										PIA 4, Action 10.	
Implement a Regional PACS Archive	1	6	Started	Dec 2010	7	N	L R	275	1	Component of Regional Information Systems Strategic Plan to enable clinical networks and regional secondary care service delivery model. PIA 5, Action 11.	With the other five DHBs, provide a regional PACS archiving solution. Regional off-site storage is cheaper than individual DHB solutions. Clinicians have access to all studies in the central region.
Implement a Maternity System	1	14	July 2010	June 2011	7	R	L (sub Regional)	190	1	Component of sub-regional women's health service being implemented with Whanganui DHB. PIA 4, Action 7.	Replaces aging Terranova Maternity System. Also a centralAlliance project (the new system will serve both MidCentral and Whanganui DHBs). Automates national reporting requirements.
Implement Business Intelligence	2	12	Jan 2011	Jun 2012	9, 10	N	L R N	1,200	1	Quality improvement initiative to improve decision-making tools. Flow-on impact to reducing administration requirements. PIA 4, Action 10.	Replaces existing management reporting systems and provides analytical and reporting toolsets. Will allow current staff to deliver current and future reporting requirements. More time spent on analysis instead of information gathering. Will reduce the number of ad hoc and uncontrolled databases.
Implement eReferrals	3	7 / CIS 5	Apr11	Feb12	7	N	R L	200	1	Integral part of plans to increase collaboration between primary and secondary care. Flow-on impact to increased hospital production and reduce administration requirements. PIA 2, Action 3.	Install new version eReferrals application. Increased coverage of system, increased ease of use. Less manual resource applied to exception processing.
Implement Digital Mammography	4	510	Jan 2013	Jun 2014	7	R	R	2,000	1	Aligned to achievement of breast cancer targets. MDHB is regional service provider. PIA 1, Action 1.	Implements digital mammography.
Replace Homer Patient Administration System	7	3	Jan 2011	Dec 2013	9	R	L R	2,500	1	Acknowledges upcoming end of life software agreement and capability. Integral part of established sub-regional service structure. PIA 5, Action 13.	Current system not supported after June 2014. Expected to be a sub-regional system with Wairarapa and Whanganui DHBs.

Table Key:

Column 2: Project Ranking	Column 6: HISAC Action Zone	Column 7: Project type	Column 8: Project significance	Column 10: Project Funding Source
<ol style="list-style-type: none"> 1. Must Do in 2010/2011 2. Should Do in 2010/2011 - Probable Do in 2011/2012 3. Nice to Do in 2010/2011 - Should Do in 2011/2012 4. Non-urgent - Requested by Clinicians 5. Non-urgent - Requested by Board/Staff 6. Non-urgent - Requested by Ministry 7. Early Warning-upcoming work - probable future Rank 1 8. Early Warning-upcoming work - probable future Rank 2 9. Early Warning-upcoming work - probable future Rank 3 	<ol style="list-style-type: none"> 1. National Network Strategy 2. NHI Promotion 3. HPI Implementation 4. ePharmacy 5. eLabs 6. Discharge Summaries 7. Clinical Care and Disease Management' 8. Electronic Referrals 9. National Outpatient Collection 10. National Primary Care Collection 11. National Systems Access 12. Anchoring Framework 	<p>N: New U: Upgrade R: Replacement</p>	<p>N: National R: Regional L: Local</p>	<p>I: Internal (in approved DAP) M: MoH New Funding P: Third Party N: Not yet determined</p>

Appendix H: Price Volume Schedule

Health Service	Purchase Unit	Purchase Unit Description	Unit of Measure	Volume	Total (\$)
Mental Health Acute Mental Health	MHA01	Acute 24 Hour Clinical Intervention (inpatient)	Available bed day	6,770	5,348,232
	MHA02	Intensive Care	Available bed day	1,400	1,279,205
	MHA03	Adult Crisis Respite	Occupied bed day	70	22,119
	MHA03C	Adult Crisis Respite - Nursing and/or allied health staff	FTE	12	106,371
	MHA06C	Acute Package of Care - Nursing and/or allied health staff	FTE	48	425,482
	MHA06D	Acute Package of Care - Non-clinical staff	FTE	24	200,227
	MHA07	Subacute Extended Care - Inpatient beds	Available bed day	795	377,898
	MHA09A	Community Clinical Mental Health Service - Senior medical staff	FTE	84	2,100,000
	MHA09B	Community Clinical Mental Health Service - Junior medical staff	FTE	42	744,594
	MHA09C	Community Clinical Mental Health Service - Nursing and/or allied health staff	FTE	611	5,416,036
	MHA10A	Early Intervention for people with first time psychosis - Senior medical staff	FTE	6	150,000
	MHA10B	Early Intervention for people with first time psychosis - Junior medical staff	FTE	6	106,371
	MHA10C	Early Intervention for people with first time psychosis - Nursing and/or allied health staff	FTE	24	212,741
	MHA16C	Community Day Programme - Nursing and/or allied health staff	FTE	84	744,594
	MHA17	Planned Adult Respite	Occupied bed day	50	11,471
	MHA17C	Planned Adult Respite - Nursing and/or allied health staff	FTE	6	53,185
	MHA18C	Needs Assessment and Service Coordination - Nursing and/or allied health staff	FTE	12	106,371
	MHA20C	Adult Community Support Services - Nursing & allied health staff	FTE	64	530,602
	MHAD14C	Co-existing disorders (mental health & addiction) - Nursing and/or allied health staff	FTE	24	212,741

	MHAK09C	Community Services for Maori People - Snr Med - Nursing/Allied	FTE	132	1,170,077
	MHAK09D	Community Services for Maori People - Snr Med - Non-Clinical	FTE	12	100,114
	MHC36F	Peer support service-Adults	FTE	12	87,599
			FTE	12	87,599
			FTE	12	106,371
	MHCS29.1	Methadone Programmes GP	Case	876	183,084
	MHCS29.2	Methadone Programmes Specialist	Case	2,136	553,224
	MHD74A	Community A&D Snr Med	FTE	12	300,000
	MHD74C	Community A&D Nursing/Allied	FTE	144	1,276,447
	MHD77	Managed Withdrawal	Bed Days	10	7,296
	MHDI48C	Child, adolescent and youth alcohol and drug community services - Nursing and/or allied health staff	FTE	14	124,099
	MHE29C	Clinical outpatient services for eating disorders - Nursing and/or allied health staff	FTE	24	212,741
	MHI44A	Infant, child, adolescent & youth community mental health services - Senior medical staff	FTE	24	600,000
	MHI44B	Infant, child, adolescent & youth community mental health services - Junior medical staff	FTE	48	850,965
	MHI44C	Infant, child, adolescent & youth community mental health services - Nursing/allied health staff	FTE	288	2,552,894
	MHI52C	Infant, child, adolescent & youth planned respite - Nursing/allied health staff	FTE	30	265,927
		Primary Mental Health Liaison Program	Programme	125,880	125,880
				20,000	20,000
				20,000	20,000
	SLACDP	Conduct Disorder Project Pacific Liaison	Programme	298,000	298,000
			Programme	80,000	80,000
					27,170,558
	<i>Acute Mental Health Total</i>				
	Mental Health Total				27,170,558
	Personal Health				
	Child Health				
	Neonatal Unit				
	W06002	Neonatal home care	Services	1	90,808
	W06003	Neonatal Inpatient Services (CWD)	Cost weighted discharges	852	3,757,567
					3,848,375
	<i>Neonatal Unit Total</i>				
	Paediatrics				
	DOM101	Community Services - professional services	Contacts	4,125	396,097
	M50009	Oncology - Blood transfusions	International Units	17	23,695

	D01004	Adolescent dental services	Clients	2,186	131,295
	D01020	Administration of Adolescent Dental Services	Services	9,785	25,353
<i>Dental Services Total</i>					2,474,920
<i>Dental Health Total</i>					2,474,920
Elderly Health					
Elderly	HOP1001	Transitional care: Facility Based Level 1	Bed Days	300	52,800
	HOP2004	Needs Assessment	Assessments	318	62,867
	HOP214	ATR Inpatient	Bed Days	6,242	4,308,508
	HOP215	ATR Outpatient - Clinics	Attendances	4,374	824,302
	HOP217	ATR Outpatient - domiciliary assessments & education sessions	Visits	3,335	810,789
	HOP235	ATR Inpatient - Mental Health Services for Elderly	Bed Days	4,959	3,813,863
	HOPR260	Accredited equipment assessment	Assessments	531	77,069
	RU104	Rural Inpatients	Bed Days	6,416	1,005,313
<i>Elderly Total</i>					10,955,511
<i>Elderly Health Total</i>					10,955,511
Emergency					
Emergency	AdjED	One line Adjustment 06/07 GP After hours	Programme	100	56,518
	ED05001	Emergency Dept - Level 5	Attendances	21,366	7,054,563
	M05001	Emergency Dept - Level 5	Cost weighted discharges	1,484	6,545,002
<i>Emergency Total</i>					13,656,083
<i>Emergency Total</i>					13,656,083
Hospital & Associated Services					
Quality Improvement	SLAQI	Quality Improvement	Programme	1	43,625
<i>Quality Improvement Total</i>					43,625
<i>Hospital & Associated Services Total</i>					43,625
Human Resources					
Human Resources	SLAHSGPR	House Surgeons GP Rotations	Programme	1	200,000
<i>Human Resources Total</i>					200,000
<i>Human Resources Total</i>					200,000
ICU / Anaesthetics					
Anaesthetics	PC0001	Pain Clinic - 1st attendance	First Attendances	24	13,033
	PC0003	Pain Clinic - Subsequent attendance	Follow-up Attendances	264	92,581
<i>Anaesthetics Total</i>					105,614
<i>ICU / Anaesthetics Total</i>					105,614
Internal Medicine					

Cardiology	CS04001	Community referred tests - cardiology	Tests	3,281	820,932	
	M10001	Cardiology - Inpatient Services (CWD)	Cost weighted discharges	1,280	5,644,100	
	M10002	Cardiology - 1st attendance	First Attendances	856	385,605	
	M10003	Cardiology - Subsequent attendance	Follow-up Attendances	1,116	364,552	
	M10004	Cardiac Education and Management	Clients	1,224	262,968	
	M10012	Pacemaker Checks	Tests	460	126,541	
	M50009	Oncology - Blood transfusions	International Units	6	8,363	
	MS01001	Nurse Led Outpatient Clinics	Attendances	183	25,340	
	<i>Cardiology Total</i>					7,638,402
Endocrinology	CS04005	Community referred tests - endocrinology	Tests	73	12,328	
	M20002	Endocrinology - 1st attendance	First Attendances	193	100,079	
	M20003	Endocrinology - Subsequent attendance	Follow-up Attendances	357	116,701	
	M20004	Diabetes - 1st attendance	First Attendances	134	53,859	
	M20005	Diabetes - Subsequent attendance	Follow-up Attendances	734	198,833	
	M20006	Diabetes Education and Management	Clients	675	169,968	
	MS01001	Nurse Led Outpatient Clinics	Attendances	1,330	184,162	
	SLADiaE	Diabetes education and management service	Programme	1	24,000	
	SLADiaP	Diabetes pump therapy	Programme	1	110,000	
	SLADiaY	Diabetes youth nurse clinician	Programme	1	100,000	
	SLADMGD	DMG Chair - Diabetes	Programme	1	25,000	
	<i>Endocrinology Total</i>					1,094,930
	Gastroenterology	M25001	Gastroenterology - Inpatient Services (CWD)	Cost weighted discharges	60	262,837
M25002		Gastroenterology - 1st attendance	First Attendances	400	223,223	
M25003		Gastroenterology - Subsequent attendance	Follow-up Attendances	1,216	374,932	
M25004		Gastroenterology - ERCP	Procedures	45	81,121	
M25005		Gastroenterology - Colonoscopy	Procedures	1,011	998,893	
M25006		Gastroenterology - Gastroscopy	Procedures	536	473,452	
MS01001		Nurse Led Outpatient Clinics	Attendances	50	6,923	
<i>Gastroenterology Total</i>						2,421,382
Internal Medicine Other	M00001	General Internal Medical Inpatient Services (CWD)	Cost weighted discharges	5,212	22,986,893	
	M00002	General Medicine - 1st attendance	First Attendances	222	91,502	
	M00003	General Medicine - Subsequent attendance	Follow-up Attendances	436	112,941	

	M00010	Non Contact FSA	Programme	680	102,000
	M15002	Dermatology - 1st attendance	First Attendances	403	103,827
	M15003	Dermatology - Subsequent attendance	Follow-up Attendances	527	105,367
	M40002	Infectious Diseases (incl HIV/Aids) - 1st attendance	First Attendances	34	16,418
	M40003	Infectious Diseases (incl HIV/Aids) - Subsequent attendance	Follow-up Attendances	43	13,598
	M50009	Oncology - Blood transfusions	International Units	5	6,969
	SLAStro	Stroke Service	Programme	1	280,500
	TR0201	Patient transport - non emergency and inpatient transfers	Programme	1	171,548
<i>Internal Medicine Other Total</i>					23,991,562
Neurology	CS04002	Community referred tests - neurology	Tests	278	123,143
	M45002	Neurology - 1st attendance	First Attendances	828	457,845
	M45003	Neurology - Subsequent attendance	Follow-up Attendances	659	262,046
	M45004	Neurology - Botulinum toxin therapy	Attendances	207	135,830
<i>Neurology Total</i>					978,864
Renal	M50009	Oncology - Blood transfusions	International Units	7	9,757
	M60001	Renal Medicine - Inpatient Services (CWD)	Cost weighted discharges	253	1,115,839
	M60002	Renal Medicine - 1st attendance	First Attendances	100	52,074
	M60003	Renal Medicine - Subsequent attendance	Follow-up Attendances	743	197,787
	M60004	Renal Medicine - Recurrent home based CAPD	Patient Months	336	680,991
	M60005	Renal Medicine - CAPD Training	New Clients	8	21,832
	M60006	Renal Medicine - Recurrent home based Haemodialysis	Number of Patients	210	522,484
	M60007	Renal Medicine - Haemodialysis Training	New Clients	8	120,085
	M60008	Renal Medicine - Incentre Haemodialysis	Attendances	8,708	3,210,690
	M60009	Renal Medicine - Incentre self managed dialysis	Attendances	778	177,610
	MS01001	Nurse Led Outpatient Clinics	Attendances	50	6,923
<i>Renal Total</i>					6,116,072
Respiratory	CS04008	Community referred tests - respiratory	Tests	440	103,697
	DOM102	Community Services - home oxygen	Clients	81	44,612
	M65001	Respiratory - Inpatient Services (CWD)	Cost weighted discharges	565	2,491,071
	M65002	Respiratory - 1st attendance	First Attendances	551	260,108

	M65003	Respiratory - Subsequent attendance	Follow-up Attendances	1,172	417,674
	M65004	Respiratory Education and Management	Clients	713	171,069
	M65005	Respiratory - Bronchoscopy	Procedures	57	65,120
	M65006	Sleep apnoea - assessment	Clients	370	574,737
	M65007	Sleep apnoea - long term treatment	Clients	277	135,291
	MS01001	Nurse Led Outpatient Clinics	Attendances	105	14,539
	SLAApn	Community based sleep apnoea service	Programme	1	282,300
	SLADMGC	DMG Chair - Cardiovascular	Programme	1	25,000
	SLADMGR	DMG Chair - Respiratory	Programme	1	25,000
	SLAIRPR	Integrated Resp & Pulmonary Rehab Services	Programme	1	394,499
<i>Respiratory Total</i>					5,004,716
<i>Rheumatology</i>	M70002	Rheumatology (incl immunology) - 1st attendance	First Attendances	390	217,505
	M70003	Rheumatology (incl immunology) - Subsequent attendance	Follow-up Attendances	1,619	477,313
<i>Rheumatology Total</i>					694,818
<i>Social Services</i>	AH01001	Dietetics	Contacts	606	69,682
<i>Social Services Total</i>					69,682
<i>Internal Medicine Total</i>					48,010,428
Patient Safety & Clinical Effv					
<i>Hospital Services</i>	SLATransA	Transport administration	Programme	1	109,819
<i>Hospital Services Total</i>					109,819
<i>Patient Safety & Clinical Effv Total</i>					109,819
Public Health					
<i>Other</i>	SLATCW	Tobacco Control Workforce	Programme	1	100,000
<i>Other Total</i>					100,000
<i>Paediatrics</i>	SLAHIV	SLAHIV ref BB	Programme	1	70,000
	SLAHPVIP	HPV Immunisation Programme	Programme	1	418,182
	SLAHPVV	HPV Immunisation Programme	Programme	1	108,138
<i>Paediatrics Total</i>					596,320
<i>Public Health Other</i>	C01010	New Child Well Framework	Programme	0	17,669
	C01013	Preschool Health Services	Clients (Enrolled Children)	2	46,525
	C01014	School Health Services	Clients (Enrolled Children)	35,626	898,788
	M40005	HIV/AIDS Viral Load Testing	Tests	48	26,608
	SH01001	Sexual Health - First Contact	Contacts	1,896	374,572
	SH01002	Sexual Health - Follow Up	Contacts	1,881	307,834
	SH01003	Family Planning Services	Clients	644	38,610
	SH01006	Free Contraception Services	Services	1	106,260

	SLACDN	Communicable Disease Nurse	Programme	1	16,000	
	SLAFIS	Fruits in School	Programme	1	120,000	
	SLANIR	NIR OIS Administrator	Programme	1	35,000	
	SLANIRS	NIR Ongoing Services	Programme	1	104,150	
	SLASC	Smoking Cessation	Programme	1	180,000	
	<i>Public Health Other Total</i>				2,272,016	
	<i>Public Health Total</i>				2,968,336	
	Regional Cancer Treatment Service					
	Blood Transfusion	AdjPB	Private Blood	Programme	1	163,086
	<i>Blood Transfusion Total</i>				163,086	
	Haematology	AdjHRP	Haemophilia Risk pool	Programme	1	1,119,805
		M30001	Haematology - Inpatient Services (CWD)	Cost weighted discharges	751	3,313,681
		M30002	Haematology - 1st attendance	First Attendances	580	322,954
		M30003	Haematology - Subsequent attendance	Follow-up Attendances	2,814	1,056,906
		M30005	Haematology - Phoresis	Procedures	52	37,752
		M30006	Haemophilia - Case Management	Clients	16	9,768
		M30007	Haemophilia - Clinics	Attendances	41	10,022
		M30020	IV Chemotherapy - cancer - haematology (non paediatric)	Attendances	324	217,859
		M30021	Oral Chemotherapy Oversight - cancer - haematology (non paediatric)	Attendances	695	127,468
		M50009	Oncology - Blood transfusions	International Units	224	312,215
		MS01001	Nurse Led Outpatient Clinics	Attendances	50	6,923
	<i>Haematology Total</i>				6,535,352	
	Medical Oncology	AdjPCTD	PCT Drug	Programme	1	2,384,000
		AdjRCTS	Tertiary adjuster - RCTS	Programme	1	351,000
		M50001	Oncology - Inpatient Services (CWD)	Cost weighted discharges	949	4,183,492
		M50002	Oncology - 1st attendance	First Attendances	629	401,499
		M50003	Oncology - Subsequent attendance	Follow-up Attendances	4,431	1,924,378
		M50009	Oncology - Blood transfusions	International Units	30	41,814
		M50018	Oncology Coordination of Adolescent Young Adult (AYA) Oncology	Clients	50	90,000
		MS01001	Nurse Led Outpatient Clinics	Attendances	173	23,955
		MS02009	IV Chemotherapy - cancer - Any health speciality	Attendances	3,734	1,905,969
		MS02012	Oral Chemotherapy Oversight - cancer - any health speciality	Attendances	480	87,944

	SLACCNDC	Central Cancer Network - Clinical Director	Programme	1	55,000
	SLADMG	DMG Chair - Cancer	Programme	1	25,000
	SLAHATC	SLA - Herceptin adjustment Treatment costs	Programme	1	150,000
	SLAPCMS	Palliative carer medical specialist	Programme	1	250,000
	SLASMO	SLA - SMO	Programme	1	560,000
<i>Medical Oncology Total</i>					12,434,051
<i>Radiation Oncology</i>	M00001	General Internal Medical Inpatient Services (CWD)	Cost weighted discharges	27	118,263
	M50002	Oncology - 1st attendance	First Attendances	1,361	868,744
	M50003	Oncology - Subsequent attendance	Follow-up Attendances	7,535	3,272,442
	M50005	Oncology - Radiotherapy	Attendances	28,181	10,227,460
	SLACC	Cancer Coordinator (630)	Programme	1	30,000
<i>Radiation Oncology Total</i>					14,516,909
<i>Regional Cancer Treatment Serv Total</i>					33,649,398
Rehab & Therapy					
<i>Community Services</i>	DOM101	Community Services - professional services	Contacts	55,352	5,315,095
	DOM103	Community Services - stomal services	Clients	350	740,182
	DOM104	Community Services - continence services	Clients	500	204,909
	DOM107	Community Services - personal services	Hours	776	18,371
	M80005	Palliative Care - Community Services	Clients	460	537,543
	SLALO	Lymphoedema Orthotics	(blank)	1	20,000
<i>Community Services Total</i>					6,836,100
<i>Elderly</i>	DOM105	Community Services - home help	Hours	15,555	339,098
<i>Elderly Total</i>					339,098
<i>Equipment Services</i>	DOM110	Community Services - orthotics	Services	1	222,414
	DSS218	Orthotics	Items & Repairs	1,104	145,958
	DSSR260	Accredited equipment assessment - Hearing	Assessments	3,828	555,594
<i>Equipment Services Total</i>					923,966
<i>Public Health Other</i>	SLAVIP	Violence Intervention Programme (Where is SLA)	Programme	1	100,000
<i>Public Health Other Total</i>					100,000
<i>Social Services</i>	AH01003	Occupational Therapy	Contacts	2,470	345,435
	AH01005	Physiotherapy	Contacts	10,769	778,461
	AH01007	Social Work	Contacts	2,332	341,539
	AH01008	Speech Therapy	Contacts	626	98,487
	AH01010	Psychologist Services - Non Mental Health	(blank)	63	13,923

<i>Social Services Total</i>	M15004	Dermatology - UV Treatment	Treatment	1,476	151,541
					1,729,386
<i>Rehab & Therapy Total</i>					9,928,550
Surgical Specialties					
General Surgery	M50009	Oncology - Blood transfusions	Inter-national Units	9	12,544
	MEOU0071	Redesign- GP Liaison	Services	1	91,492
	MEOU0073	Elective Services Co-Ordinator	Services	1	88,951
	MS01001	Nurse Led Outpatient Clinics	Attendances	311	43,063
	MUBIOPb	MH DNA Testing	Services	255	186,412
	S00001	General Surgery - Inpatient Services (CWD)	Cost weighted discharges	4,862	21,442,698
	S00002	General Surgery - 1st attendance	First Attendances	3,484	913,890
	S00003	General Surgery - Subsequent attendance	Follow-up Attendances	5,262	1,171,752
	S00008	Minor Operations - General Surgery	Procedures	779	209,998
	SLAMB	Mobile Bus	(blank)	1	20,000
<i>General Surgery Total</i>					24,180,801
Ophthalmology	AH01004	Orthoptist	Contacts	2,214	426,767
	M20007	Diabetes - Fundus Screening	Procedures	1,692	156,427
	MS01001	Nurse Led Outpatient Clinics	Attendances	215	29,771
	S40001	Ophthalmology - Inpatient Services (CWD)	Cost weighted discharges	587	2,586,761
	S40002	Ophthalmology - 1st attendance	First Attendances	1,513	307,819
	S40003	Ophthalmology - Subsequent attendance	Follow-up Attendances	6,950	1,183,343
	S40004	Minor Eye Procedures	Procedures	765	157,377
	S40005	Eye - laser treatments	Procedures	272	68,868
<i>Ophthalmology Total</i>					4,917,132
Oral Maxillofacial Surgery	D01001	Inpatient Dental treatment (CWD)	Cost weighted discharges	209	921,125
	D01002	Outpatient Dental treatment	Attendances	3,170	754,551
	S60002	Plastics (incl Burns and Maxillofacial) - 1st attendance	First Attendances	319	68,161
	S60003	Plastics (incl Burns and Maxillofacial) - Subsequent attendance	Follow-up Attendances	627	126,697
<i>Oral Maxillofacial Surgery Total</i>					1,870,533
Orthopaedics	MS01001	Nurse Led Outpatient Clinics	Attendances	1,250	173,085
	S45001	Orthopaedics - Inpatient Services (CWD)	Cost weighted discharges	4,121	18,173,786
	S45002	Orthopaedics - 1st attendance	First Attendances	3,650	1,056,305
	S45003	Orthopaedics - Subsequent attendance	Follow-up Attendances	5,068	1,124,642

	S45004	Fracture Clinic - 1st attendance	First Attendances	22	5,087
	S45005	Fracture Clinic - Subsequent attendance	Follow-up Attendances	1,691	378,900
<i>Orthopaedics Total</i>					20,911,806
Otorhinolaryngology	CS04003	Community referred tests - audiology	Tests	1,037	179,044
	DSSR260	Accredited equipment assessment - Hearing	Assessments	55	7,983
	S25001	Ear, Nose and Throat - Inpatient Services (CWD)	Cost weighted discharges	637	2,809,562
	S25002	Ear Nose and Throat - 1st attendance	First Attendances	1,874	547,527
	S25003	Ear Nose and Throat - Subsequent attendance	Follow-up Attendances	4,108	914,181
	S25006	ENT Minor operations	Procedures	842	179,047
<i>Otorhinolaryngology Total</i>					4,637,343
Surgical Services Other	AH01006	Podiatry	Contacts	1,907	252,136
<i>Surgical Services Other Total</i>					252,136
Urology	MS01001	Nurse Led Outpatient Clinics	Attendances	775	107,313
	MS02009	IV Chemotherapy - cancer - Any health speciality	Attendances	208	106,185
	S70001	Urology - Inpatient Services (CWD)	Cost weighted discharges	1,015	4,476,915
	S70002	Urology - 1st attendance	First Attendances	680	197,499
	S70003	Urology - Subsequent attendance	Follow-up Attendances	2,516	643,915
	S70005	Urology - Cystoscopy	Procedures	771	385,676
	S70006	Urology - Lithotripsy	Procedures	70	192,635
	S70007	Urodynamics	Procedures	56	19,933
<i>Urology Total</i>					6,130,070
<i>Surgical Specialties Total</i>					62,899,822
Women's Health					
Gynaecology	M50009	Oncology - Blood transfusions	International Units	1	1,394
	S30001	Gynaecology - Inpatient Services (CWD)	Cost weighted discharges	899	3,966,223
	S30002	Gynaecology - 1st attendance	First Attendances	1,759	621,126
	S30003	Gynaecology - Subsequent attendance	Follow-up Attendances	2,171	600,104
	S30007	Tertiary Infertility Services	Assessments	102	67,895
	S30008	Gynaecology - High cost Minor Procedures	Procedures	20	9,485
<i>Gynaecology Total</i>					5,266,226
Obstetrics	TR0201	Patient transport - non emergency and inpatient transfers	Programme	1	171,548

	W01007	DHB non-specialist antenatal consults	Contact	1,059	152,200
	W01008	DHB non-specialist postnatal consults	Contact	1,607	230,942
	W02007	Labour and delivery in a primary maternity facility	Attendance	88	97,963
	W02008	Postnatal stay in a primary maternity facility (mother)	Attendance	90	151,326
	W02010	Labour, delivery and postnatal stay in a primary facility	Attendance	91	254,520
	W03002	Obstetric FSA	Attendance	340	132,423
	W03003	Obstetric Follow Up	Attendance	752	286,163
	W03005	Amniocentesis		80	100,152
	W03010	BreastFeeding/Lactation Clinic		200	20,401
	W10001	Maternity inpatient (DRGs)	Cost weighted discharges	1,982	8,740,880
					10,338,519
					15,604,745
					<i>Obstetrics Total</i>
					<i>Women's Health Total</i>
					Adjuster
					<i>Adjuster</i>
	SLAOLA	One Line Special Adjuster		303,078	303,078
					<i>Adjuster Total</i>
					<i>Adjuster Total</i>
					Personal Health Total
					215,811,093
					Grand Total
					242,981,651

Appendix I: Minister's Letter of Endorsement



Office of Hon Tony Ryall

Minister of Health
Minister of State Services

Mr Phil Sunderland
Chair
MidCentral District Health Board
PO Box 2056
Palmerston North Central
PALMERSTON NORTH 4440

Dear Mr Sunderland

MidCentral District Health Board: 2010/11 District Annual Plan

This letter advises you that I have signed MidCentral District Health Board's (DHB) 2010/11 District Annual Plan (DAP) for one year.

I appreciate the efforts your Board and management have put in over the past year to manage your DHB in a sustainable manner. More work lies ahead to achieve long lasting sustainability, while ensuring that New Zealanders get an improved delivery of services. The challenge for us all is to achieve this.

Clinical and Financial Sustainability

All DHBs must budget within their allocations and improve financial performance. I note that your planned financial position for 2010/11 is a deficit of \$3.7M. This has emerged from poor financial performance in 2009/10. The development of your Financial Recovery Programme is a move in the right direction. I note your DAP is appropriately aligned to the recovery programme.

Additionally it is important that you achieve the performance improvement actions and efficiencies identified in your DAP for 2010/11. Finding further efficiencies and cost control measures for the out years are critical in the current fiscal environment. My approval of your DAP does not mean acceptance of your assumptions in the out years.

Health Targets and Priorities

I appreciate the DHB's emphasis on the Government's health targets and priority areas, and on providing clear actions to drive continual improvement. I note that your Board is a consistently high performer in the health targets: Immunisation; Shorter Waits for Cancer Treatments and Better Diabetes and Cardiovascular Services. Thank you for your attention and hard work with these targets.

However, the Ministry of Health (Ministry) has advised that it considers there are heightened risks associated with your achievement of the agreed health targets for Shorter Stays in Emergency Departments and Improved access to Elective Surgery. I expect that your DHB remains focused on improving performance in these, and that it

will work closely with the Ministry, and in particular, the Health Target Champions, to ensure good progress is made.

Mental Health Ringfence

I note you are increasing mental health funding ahead of the assumed ringfence expectation.

Policy Priorities

New Zealanders want better access to a wider range of services closer to home. Your progress with your primary health organisations in implementing the Better Sooner More Convenient is commendable. However, I expect your DHB to make substantial progress with integrating hospital services into community settings in 2010/11. The DHB will need to keep the Ministry well informed of its progress in this priority area.

I note that your Board plans to work closely with other Central Region DHBs in continuing to support implementation of the Regional Clinical Services Plan with its current focus on vulnerable services (radiology and women's health) together with cardiology and renal services. Additionally, building on promising actions from 2009/10 I expect your Board to continue its direction with Whanganui DHB in implementation of the centralAlliance roadmap. I remain convinced that this will assist both Boards with long term clinical and financial sustainability.

DAP Approval


The approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry where any proposals may require my approval.

My approval of your DAP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependant on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I wish you, your Board and management every success with the implementation of your 2010/11 DAP, and thank you for your contribution and efforts towards a unified health system.

Finally, please ensure that a copy of this letter is attached to the copy of your signed DAP held by the Board and to all copies of the DAP made available to the public.

Yours sincerely



Hon Tony Ryall
Minister of Health



Hon Bill English
Minister of Finance