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- General Manager, Corporate Services
- Mike Grant, General Manager, Funding
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# MidCentral District Health Board

## A g e n d a

### Community & Public Health Advisory Committee

## Part 1

Date: 6 April 2010

Time: 1.00 pm

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

### Contact Details Committee Secretary

Telephone 06-3508626

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Next Meeting Date 4 May 2010

Deadline for Agenda Items 21 April 2010

# MidCentral District Health Board

## Community & Public Health Advisory Committee Meeting

Tuesday 6 April 2010

### Part 1

#### Order

**1. APOLOGIES**

**2. NOTIFICATION OF LATE ITEMS**

**3. CONFLICT AND/OR REGISTER OF INTERESTS**

**4. MINUTES**

**4.1 Minutes**

Pages: 4.1 – 4.4  
Documentation: minutes of 2 March 2010  
Recommendation: that the minutes of the previous meeting held on 2 March 2010 be confirmed as a true and correct record

**4.2 Recommendations to the Board**

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

**4.3 Matters arising from the minutes**

To consider any matters arising from the minutes of the meeting held on 2 March 2010 for which specific items do not appear on the agenda or in management reports.

**5. OPERATIONAL REPORTS**

**5.1 Funding Division Operating Report – March 2010**

Pages: 5.1 – 5.17  
Documentation: Funding Division, General Manager's Report dated 19 March 2010  
Recommendation: that this report be received

**5.2 Finance Report – March 2010**

Pages: 5.18 – 5.23  
Documentation: Finance Manager's Report dated 12 March 2010  
Recommendation: that this report be received

**6. GOVERNANCE ISSUES**

**6.1 2009/10 Work Programme**

Pages: 6.1 – 6.3  
Documentation: Chief Executive Officer's Report dated 29 March 2010  
Recommendation: that the updated work programme for 2009/10 be noted

**7. LATE ITEMS**

To discuss any such items as identified under item 2.

**8. DATE OF NEXT MEETING**

4 May 2010

**9. EXCLUSION OF PUBLIC**

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

Item	Reason	Reference
"In Committee" Minutes of the Previous Meeting	For reasons stated in the previous agenda	
2010/11 District Annual Plan	Under negotiation	9(2)(j)
Clinical Workstation Project Update	Contains competitive pricing information	9(2)(j)

# MidCentral District Health Board

## Community & Public Health Advisory Committee Meeting

Minutes of meeting held on Tuesday 2 March 2010 in the Board Room of Board Office, Gate 2B Heretaunga Street, Palmerston North

The meeting commenced at 1.07pm

### PRESENT:

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

### IN ATTENDANCE:

Murray Georgel, Chief Executive Officer  
Mike Grant, General Manager, Funding / Acting General Manager, Corporate Services  
Rebecca Bensemman, Committee Secretary

### OTHER:

Staff: (8)  
Public: (1)  
Media: (0)

### 1. APOLOGIES

There were none.

### 2. NOTIFICATION OF LATE ITEMS

There were none.

### 3. CONFLICT AND/OR REGISTER OF INTERESTS

There were no declarations of conflict.

There were no updates to the Register of Interests.

#### **4. MINUTES**

##### **4.1 MINUTES**

It was recommended:

*that the minutes of the previous meeting held on 2 February 2010 be confirmed as a true and correct record*

##### **4.2 RECOMMENDATIONS TO THE BOARD**

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

##### **4.3 MATTERS ARISING FROM THE MINUTES**

There were none.

A Committee Member queried whether the meaning of 'Te Pou roll out' had been clarified as was originally noted in the minutes. Management confirmed that this information was provided at paragraph 4.4.2 of the Funding Division Operating Report – March 2010.

It was also noted that the timeframe for the Better, Sooner, More Convenient Business Case had been updated at the Board meeting held on 16 February 2010.

#### **5. OPERATIONAL REPORTS**

##### **5.1 NON-FINANCIAL PERFORMANCE INDICATOR REPORT INCLUDING HEALTH TARGETS AND CONFIRMATION REPORTING FOR QUARTER 2, 2009/10**

It was advised that there are some indicators that may vary quarter by quarter for this standard report as the Ministry of Health sets the mould for this reporting format.

A Member asked for clarification as to provider details for Diabetes Management. Management responded that in this instance the reference is to all providers, particularly general practice.

Discussion followed on elective surgery targets and services being provided by other DHBs. It was noted that 38% of elective volumes are provided by other DHBs, with Capital & Coast DHB being the main provider. However, increased investment in neurology, cardiology and paediatric service areas is helping to reduce elective outflows to other DHBs.

It was also commented that no person is denied access to health services but access to a desired location for provision of such services may be refused due to reasons such as limited bed capacity, availability of specialist to perform, or availability of Emergency Department to receive patients.

Fundamentally, MidCentral Health has an open approach to people from the border areas accessing health services where they choose to, aside from situations where this may be clinically inappropriate.

A member of the public commented (under Standing Orders permission) that there is a significant difference between the terms Severe Mental Illness and Serious Mental Illness and suggested that the Committee be aware of which particular term is being referenced in this report.

It was recommended:

*that this report be received*

## **5.2 FUNDING DIVISION OPERATING REPORT – MARCH 2010**

### *Item 4.1.4 interRAI*

It was advised that a contact assessment may be completed via telephone or face to face, depending upon the individual concerned.

It was recommended:

*that this report be received*

## **5.3 FINANCE REPORT – FEBRUARY 2010**

A Committee Member requested that full financial information be provided in future to gain an overall understanding of the financial position for MidCentral DHB from a funding perspective.

It was suggested that the Hospital Advisory Committee financial report be appended to the Community and Public Health Advisory Committee agenda each month. It is important to receive this financial information as the Committee is placed in a position of responsibility to ensure that funding is allocated rightly and appropriately to each provider.

Management responded that this would be a significant departure from previous reporting formats. It was commented that the Hospital Advisory Committee reports on the provider arm financials, over which the Funder has very little influence. The relevance of this information to the Community and Public Health Advisory Committee was questioned.

It was noted that an expression of concern around the current financial reporting format has been received by two Committee Members and it was asked that this concern be addressed immediately and effectively. It was agreed that Mike Grant and Linda Gray would organise a meeting to clarify the level of financial information to be reported on and received and that feedback regarding this would be communicated to the Committee at its next meeting in April.

Discussion then moved on to the Finance Report for February 2010. A Member asked for an explanation regarding the refund of the Pacific Provider Development Fund. It was responded that the Ministry has funded \$50k per annum for the previous four years for the establishment of Pacific Provider Development. However, there is currently no Pacific provider in the district but the rules of the fund do not allow for this, hence the issue of an invoice from the Ministry to request repayment of this fund.

A query was then raised regarding the decreasing trend of IDF inflow, in particular from Whanganui DHB. Management advised that Whanganui DHB is presently trying to increase output, particularly surgical output. MidCentral DHB is supporting Whanganui DHB in this initiative via the combined leadership model which is likely to be an ongoing trend, therefore leading to a decrease of IDF inflow.

It was recommended:

*that this report be received*

**6. STRATEGIC REPORTS****6.1 LETTER OF EXPECTATIONS**

It was recommended:

*that the Minister of Health's letter of expectations dated 9 February 2010 be received*

**7. GOVERNANCE ISSUES****7.1 2009/10 WORK PROGRAMME**

There were no amendments to the 2009/10 Work Programme.

It was recommended:

*that the updated work programme for 2009/10 be noted*

**8. LATE ITEMS**

There were none.

**9. DATE OF NEXT MEETING**

6 April 2010

**10. EXCLUSION OF PUBLIC**

It was recommended:

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

Item	Reason	Reference
"In Committee" Minutes of the Previous Meeting	For reasons stated in the previous agenda	
Funding MidCentral Health Price Volume Schedule (2010/11)	Subject to negotiation	9(2)(j)
2010/11 District Annual Plan	Under negotiation	9(2)(j)
Community Breastfeeding Leadership and Coordination	Subject of a competitive tender process	9(2)(j)
Prioritisation of Funding Division Contract Renewals	Subject to negotiation	9(2)(j)

Meeting closed at 1.55pm

Confirmed Tuesday 6 April 2010

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Chairperson

**TO** Community and Public Health Advisory Committee



**FROM** General Manager  
Funding Division

**DATE** 19 March 2010

## Memorandum

**SUBJECT FUNDING DIVISION OPERATING REPORT – MARCH 2010**

### 1. RESPONSES TO COMMITTEE AND BOARD REQUESTS

Reference	Matter	Achieved	Comment
52	It was agreed that Mike Grant, Murray Georgel and Linda Gray would meet to clarify the level of financial information to be reported on and received at each meeting.	Y	This meeting was held on Friday 5 March 2010. The new report format is included in the agenda.

### 2. WORK PROGRAMME

Reference	Matter	Achieved	Comment
7	A follow-up paper regarding Acute Demand was to be presented to the Committee at its April meeting	N	This paper is expected to be put forward to the Committee at the meeting to be held on 6 July 2010.

### 3. LOCAL MATTERS

#### 3.1 Health of Older Person

##### 3.1.1 InterRAI

Work is progressing nationally on the implementation plan for the rollout of the interRAI tools across all DHBs. The MoH reports a very active and enthusiastic Māori Strategy work stream associated with the National Project, which includes a variety of representatives from assessors, clinicians, academics as well as DHBNZ. In summary the outcome of this working group has determined there is no impediment to the tools being used with clients who identify as Māori, including use of laptops, however, there is additional input required into the training that is currently being incorporated. The National Senior Project Manager has been given advice about relevant strategies to mitigate any concerns that have arisen, a full progress report will be available in the near future.

Regionally, the MDHB interRAI Project Manager is supporting DHBs who are implementing or yet to implement the assessment tools. A presentation was given on the 12<sup>th</sup> March in Wellington to update the group on National initiatives as well as MDHB's implementation strategy. Conversations continue with Whanganui around combined use of resources and support.

Locally, the interRAI assessment rollout continues to be on target for June 2010. Current recruitment will see two roles sought, a Systems Clinician and Lead Practitioner/Trainer.

These roles support the ongoing establishment, training and reporting functionality of the assessment tools and process.

A communications strategy has been developed and GPs and stakeholders will be given information in April informing interested groups on the rollout and service configuration. Hardware requirements for Supportlinks have been identified and will be considered with the IT working group. Management from Supportlinks and staff from Health Development Team visited Tauranga recently to familiarise themselves with the process of the use of interRAI assessment tools. This was a valuable experience for this group as they were able to understand additional processes required to interface with use of the tool such as data entry requirements and process templates.

### **3.1.2 Audit**

Present work with DHB and Ministry representatives is looking at an integrated approach to routine Aged Residential Care audits. This would combine contract audits undertaken by DHBs with Health and Disability Sector Standard audits for certification as currently performed by HealthCert. MidCentral is a participant in the working group. This initiative arises from the recent investigation and criticism by the Auditor General's Office into aspects of the certification process and which expressed some criticism of current practice.

This initiative also aims to address the issue of providers being subjected to multiple audits by different regulatory authorities. The proposal for a combined approach is very similar to the DHB/MOH tag on audit arrangements that have been in existence for the last few years across our local central DHBs.

DHB stipulated points of discussion:

- There must be effective communication channels so that information flows readily between Designated Audit Agencies (DAAs), DHBs and HealthCert.
- DHBs must receive a copy of corrective actions from DAAs direct, not later via the Ministry
- DAAs must inform DHBs of issues requiring urgent management in a timely way
- DHBs must first be able to gain confidence in DAAs
- The process of engagement must be robust
- DHBs want a risk assessment tool
- DHBs want to comment on each draft report before it is finalised

### **3.1.3 Local ARC Stakeholder Engagement 2010**

The first Forum held in February was attended by 36 Managers and Nurses from the aged care sector all keen to discuss the DHB requirements for quality in service delivery. This year monthly workshops are planned with key topics addressed. March discussions will centre around clarification of the funding agreement and its requirements for unequivocal clinical care for the elderly.

Medicine management was highlighted as a key area needing improvement in recent issues audit reports and will be the theme in April's workshop. Such is the interest in this subject that people are wanting to come from other central region DHBs.

## **3.2 Māori Health**

### **3.2.1 Māori Cultural Responsiveness framework in Primary Health Care**

The second and third roll out of the Māori Cultural Responsiveness Programme have been put on hold in the short term with efforts prioritised for the Better, Sooner, More Convenient Business Case. Further the forum wishes to ensure that the development of the framework contributes to and supports the Whānau Ora pathway of the Business Case. Dates will be rescheduled within the next month; the forum hopes to have the final two rollout sessions in late April (Tararua) and late May (Horowhenua).

### **3.2.2 Iwi Māori Cancer Co-ordinators**

The Iwi Māori Cancer Co-ordinators continue to work with Riripeti Reedy on their action research project. The purpose of the project was for the cancer coordinators to learn how to undertake action research. It's quite clear that these positions are very important to local hapu, iwi, and whānau within the MidCentral Region. Whilst there are many challenges ahead for this group:

- Non clinical knowledge vs clinical knowledge
- Stronger relationships between Iwi/Māori providers and GP services.
- Lack of appropriate information resources
- Workforce development needed

To date, the Iwi Māori Cancer Co-ordinators have presented to a wide range of stakeholders at a local, regional level. Furthermore they presented at the National Symposium for the Central Cancer Network. The emphasis now is on the continuation of the action research skills learned and the findings of the action research.

### **3.2.3 Tu Kaha Symposium**

The Central Region Māori Managers recently met with Manawhenua, Non-Government Organisations and Tangata whenua in the Wairarapa to discuss the hosting of the Tu Kaha Symposium to be held Tuesday 31<sup>st</sup> August to Thursday 2<sup>nd</sup> September 2010. The objective of the symposium is to highlight workforce gains achieved in Māori Health across the Central region since the last Tu Kaha Conference held in Palmerston North in late 2008. The conference is primarily funded by DHBNZ

### **3.2.4 Whānau Ora Taskforce**

In June 2009 Cabinet approved the establishment of the Whānau Ora Taskforce. Its role is to develop a framework for a whānau-centred approach to whānau wellbeing and development. Recently the Māori GM Regional Chairs met with Minister Turia at Lakes District Health Board, Rotorua, Minister Turia confirmed that/ the Whānau Ora Task Force has prepared a comprehensive report which has been received by Minister Turia and presented to Cabinet. Key points to note include:

- It is recommended to establish an independent structure for the Whānau Ora Trust/Agency, rather than an existing government agency.
- The Whānau Ora Trust/Agency will be responsible to develop the policy framework and infrastructure to implement the policy but with a clear focus on the integration of existing contracts.
- An important issue is the willingness of Ministries to transfer funding to the Whānau Ora Trust/Agency given the constrained financial environment.
- Minister Turia made reference to the Alliance Agreement approach to contracting. This is seen as raising concerns about accountability for outcomes in the absence of contracts specifying outputs for delivery. It is proposed that if implemented the year 1 roll out will include a range of action research projects to enable the establishment of sound quality processes and systems as well as transparency of information to assure accountability.

## **3.3 Mental Health and Addiction**

### **3.3.1 Primary Mental Health Initiatives**

Funding for workforce development will be provided to Primary Health Organisations in alignment with Ministry of Health funding and focus on primary mental health promotion, leadership development and primary mental health core skills.

### 3.3.2 Lets Get Real Framework

Work is underway to progress the Lets Get Real Framework (Te Pou-National Workforce Development Mental Health). The Framework has a focus on the essential knowledge; skills attitudes required to deliver effective mental health and addiction treatment services and based on seven skills with various components encapsulated within these:

- **Working with Service Users;** every person working in a mental health and addiction treatment services uses strategies to engage meaningfully and work in partnership with service users and focus on service user strengths to support recovery
- **Working with Māori;** every person working in a mental health and addiction service contributes to whanau ora for Māori
- **Working with Families/Whanau;** every person working in mental health and addiction service encourages and supports families/whanau to participate in the recovery of service users, including access to information, education and support
- **Working within Communities;** every person working in mental health and addiction service recognises that service users and their families/whanau are part of the wider community
- **Challenging Stigma and Discrimination;** every person working in mental health and addiction service uses strategies to challenge stigma and discrimination and provides and promotes a valued place for service users
- **Law, Policy and Practice;** every person working in mental health and addiction service implements legislation, regulations, standards, codes and policies relevant to their role in a way that supports service users and their families
- **Professional and Personal Development;** every person working in mental health and addiction service actively reflects on their work and practice and works in ways that enhance the team to support the recovery of service users.

Initially a stock take of services competency and capability frameworks will be undertaken across the community sector with a view to how the Lets Get Real Framework will be endorsed in contracts.

## 3.4 Primary Health

### 3.4.1 CVD Risk Assessment

CVD risk assessment statistics for the district continue to improve. As well as being a component of the Ministry's Diabetes/CVD target, CVD risk assessment has been included in the PHO Performance Management Programme. This provides an added incentive for PHOs and general practice teams to improve performance.

The PHOs report that all general practice teams running the VIP Practice Management System have now had the DHB-funded Best Practice decision support system loaded. Best Practice (i.e., the vendor) has visited every VIP site to install the software and to train the users. Information about how to use the Best Practice tool for CVD risk assessments was sent to all MedTech and VIP practices in October. Over the next few months the PHO will be visiting practices that have been identified as not completing CVD risk assessment using the Best Practice tool. The PHOs also have other activities planned over the next few months to educate PHO and practice staff about CVD risk and CVD risk assessments using Best Practice.

### 3.4.2 Tangimoana service change

Manawatu PHO has advised us of their intention to cease funding a community nursing service in Tangimoana because of clinical risk issues. This was a service the PHO funded from its Services to Improve Access Funding and it was provided locally under the auspices of a contract with the Himatangi Health Trust.

The PHO's intention is to replace it with a visiting service with a more chronic care management focus. The new service will be based out of the PHO.

### 3.4.3 Public reporting of PHO Performance Management Programme

A report on the PHO Performance Management Programme was publicly released following an Official Information Act request from Radio New Zealand. The request sought to identify the 5 best and 5 worst performing PHOs across the standard Performance Management Programme indicators. MidCentral PHOs were within the normal range for all indicators, with the following exceptions:

Manawatu PHO *expenditure on pharmaceuticals* is in the worst 5. Performance on this indicator is improving. Also, pharmaceutical expenditure is a specific area of focus within the Better, Sooner, More Convenient Primary Health Care Business Case.

Otaki PHO *Acute Phase Response* is in the best 5.

Horowhenua and Manawatu PHOs *Diabetes Management (HbA1c levels)* is in the worst 5. Over the last two years, the DHB's focus has been on getting people with diabetes onto the Get Checked Register. This has had good results. A consequence of having increasing numbers of new people on the register is often a deterioration in the average HbA1c levels. MPHO's contract for the Get Checked Programme has been modified to include targets for the improvement in HbA1c levels. We expect HbA1c levels to start showing improvement with people receiving annual checks, and increased focus in this area.

Otaki PHO % *valid NHI* is in the best 5 with a perfect score of 100%

Tararua PHO *GP consults* (ratio of consults with high needs patients) is in the best five.

## 3.5 Health Care Development

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

### 3.5.1 Chronic Care Model (CCM) implemented into General Practice and a Māori Health Provider

*Key actions – facilitate implementation of the CCM into one urban and one rural general practice and one Māori health provider*

This MOH/DHBNZ funded project is designed to assist two general practices and a Māori Health provider offer more effective long term conditions management and support to their practice population. Over the past seven months action plans have been implemented in the participating organisations, with each working to achieve 4-6 goals applicable to their setting. These are based on an independent survey assessment as to how well each provider manages clients with chronic conditions and the gaps in service provision that were noted. The rural practice for example (which has over 6,000 enrolled patients) is focusing on the following:

- To have regular, structured, coordinated group meetings to develop practice guidelines to improve the management of patients with diabetes, cardiac problems and respiratory illness;
- Improve assessment, care planning and written documentation in relation to these patient populations;
- Enhancing self management and self management support taught and offered to patients;

- Strengthen the organisational structure and documentation to further embed chronic care management in the practice;
- Improve IT capabilities and support.

This practice has assigned a small group of clinicians, support staff and PHO chronic care team members to achieve the above aims. To do this they meet once a month as a group and once a month with HCD clinical facilitators who assist in ensuring team members adhere to plans and achieve milestones. As a result, for example, guidelines for the practice have been developed to improve the care provided to patients with type 2 diabetes. In terms of the organisational structure goal, plans are underway to develop Care Plus guidelines as numbers of enrolled clients are declining in this practice. This process is expected to detail significant system changes and the use of capitation money to pay for an additional contact per person. With regards to leadership discussions have been held with the practice owner and as a result they, along with the nurse manager, have been accepted onto the Transformational Leadership course.

Significant work has been undertaken by the clinical facilitator in terms of developing disease registers for the practice (replicating work undertaken for the other two participating organisations) so that they can now more effectively target specific population groups. A query build on patients with chronic vascular disease (CVD) for instance resulted in 1100 names – refining of this process has resulted in further meaningful data so that now the practice is considering holding regular CVD risk assessment clinics with identified high risk clients.

Overall, this type of work has been mirrored with the other two participating providers to enable these settings to provide more proactive care to patients living with long term conditions. The implementation phase of the project ends March 31. Thereafter the survey assessment tool will be reapplied to all three organisations with the hope that there is a marked improvement in the care being provided to the selected population groups. This would demonstrate that the chronic care capacity has increased in each practice. However the clinical facilitators note the need for providers to maintain momentum with this work once the project has ended.

### **3.6 Child & Youth Health**

#### **3.6.1 Improving Immunisation Coverage Project**

The Improving Immunisation Coverage Project Group continues to meet and work together to improve the immunisation coverage for the region. The current rates have improved from 76% June 2009, 83% January 2010, to 87% March 2010. It is very encouraging for the group and all providers of Immunisation services to have reached the MDHB June goal of 85% 3 months earlier than envisaged. It is important to now work consistently to instil successful service delivery models into every day business (as usual practices) and the team will work hard to ensure this occurs.

#### **3.6.2 Early bird Pandemic Vaccination Programme (H1N1)**

MidCentral DHB has completed the early bird vaccination programme. The programme ran for the month of February and was completed 5 March 2010. The Early Protection Programme offered early protection against pandemic H1N1 influenza to frontline health workers and those most at risk of more severe outcomes from pandemic H1N1 influenza. It is pleasing to see the excellent uptake of the vaccine by Primary Care frontline staff (see Table 1 below).

Table 1: H1N1 doses administered to 5 March 2010

	Dose 1	Dose 2	Total
MidCentral Health - Frontline staff	39	34	73
Primary Care - Frontline Staff	476	410	886
Eligible Population	126	109	235
<b>Total</b>	<b>641</b>	<b>546</b>	<b>1194</b>

The team involved in the programme, namely Immunisation Coordinators and Compass Health staff are proud of their minimal wastage (2 vials) which is to be commended alongside the efficient and professional manner in which they delivered this campaign.

### 3.6.3 Seasonal Vaccination Programme

The second stage of the Ministry of Health campaign commenced on the 8<sup>th</sup> of March 2010. Both MidCentral Health Infection control staff and Primary Care are encouraged by the steady flow of people accessing the vaccine.

The Ministry of Health have also extended the eligibility criteria for 2010 to enable General Practices to use their discretion to offer free flu immunisation to children from high deprivation backgrounds who are aged between six months and five years.

The following people are eligible for free vaccination under the annual Seasonal Influenza Immunisation Programme from 8 March 2010:

1. All people who are 65 years of age and older
2. People aged six months to 64 years of age who:
  - are pregnant
  - are morbidly obese
  - have cardiovascular disease (ischaemic heart disease, congestive heart failure, rheumatic heart disease, congenital heart disease and cerebrovascular disease)
  - have chronic respiratory disease (asthma if on regular preventive therapy; other chronic respiratory disease with impaired lung function)
  - have diabetes
  - have chronic renal disease
  - have any cancer, excluding basal and squamous skin cancers if not invasive
  - have other conditions (autoimmune disease, immune suppression, HIV, transplant recipients, neuromuscular and central nervous system disease, haemaglobinopathies, children on long term aspirin).
3. For 2010 only, general practices can use their discretion to offer free flu immunisation to children from high deprivation backgrounds who are aged between six months and five years. Children with certain chronic conditions are already eligible, which is the case every year.

Evidence from 2009 suggests that children with chronic medical conditions, particularly respiratory and neurological; children from areas of high deprivation (quintile 5); and Māori and Pacific children are more at risk of hospitalisation from swine flu and this is why the specific changes have been made.

## 3.7 Pharmacy

### **3.7.1 Pharmacy Services Agreements**

All Community Pharmacies in the MidCentral district have signed and returned their new Pharmacy Services Agreements within the time permitted. No Pharmacy Services Agreements are outstanding and none will be being paid on draft.

This enables uninterrupted supply of pharmaceuticals to the MidCentral population via 32 Community Pharmacies (plus two Pharmacy Depots) through to the end of August 2011.

In the period until August 2011, the Pharmacy Services Advisory Group (the membership of which consists of DHB, PHARMAC, Sector Services and pharmacy sector representatives) will work on revising the existing pharmacy services agreement so that it better aligns with population and DHB need, reduces the burden of administrative compliance for pharmacy (where possible) and realises some of pharmacy's potential as a core member of the primary health network. The aim is to have a revised Agreement acceptable to all parties ready for implementation on September 1<sup>st</sup>, 2011.

### **3.7.2 Medicines Management in Residential Care Facilities**

Special audits of aged residential care facilities in the MidCentral region have highlighted significant issues with medicines management causing medication errors, resulting from system inefficiencies.

Funding Division has undertaken to work with residential care providers to identify the root cause of medicine management issues, provide education on regulations and policies that pertain to safe and effective medicines management, and assist facilities to develop improved systems that improve their management of medicines. The process will include working with prescribers and pharmacies to raise understanding of issues and find ways of making medicines management easier and safer for all. Interest in being involved in this process has also been expressed by Whanganui and Wairarapa DHBs.

## **3.8 Population Health**

### **3.8.1 Tobacco Control**

#### **3.8.1.1 Tobacco Health Target - ABC**

'More quit attempts more often' remains the focus for the DHB at this time. The ABC implementation project is currently being implemented in Secondary Care and will be expanded to encompass Primary Health Care providers in July 2010.

The ABC Smoking Cessation launch was held at Palmerston North Hospital cafe on Friday 19 February 2010.

ABC training has now commenced. Nursing staff have been quick to pick up on the trainings provided to them in their own settings. Other disciplines including pharmacy, physiotherapy and dietitians are participating enthusiastically. The task of ensuring all disciplines and night duty staff are trained is a key challenge. The availability of the onsite Hospital Based quit smoking services has ensured a prompt response to cessation referrals and is an integral part of this campaign.

From July 2010 attention will broaden to the Primary Health Care sector and will include general practice. The target is that providers should routinely ask about smoking status and then provide brief advice and the offer of quit support to current smokers. Performance will be monitored through the PHO Performance Programme.

MidCentral DHB has seen an improvement from 14 percent at the baseline check in September 2009, up to 24 percent, in January 2010. The ABC approach has been an opportunity for processes and documentation around smoking and smoke exposure to be improved.

### 3.8.1.2 Review of Cessation Services

Currently nearly one in four people in the MidCentral district are smokers. Of this number it can be expected that up to 70-80% want to quit. Smokers have a significantly better chance of making a quit attempt and staying quit if they receive cessation support, which is why the ABC framework has been developed.

A review of contracted cessation services is now underway. This review will investigate new forms of cessation delivery including; working within settings such as workplaces and sporting clubs; group based cessation support, and train the trainer models of cessation delivery. Consultation is underway within tobacco control and cessation arenas. A review of alternative cessation delivery, both nationally and internationally, will also be explored. Smokers will be included within this consultation to ensure any suggested alterations to services match the needs of those who will use them.

The review is expected to be completed in April 2010 and recommendations will then be made on potential new service delivery models to support smokers to make "More quit attempts More often".

### 3.8.2 Healthy Eating Healthy Action (HEHA)

The HEHA steering group, after working collaboratively for the past year, have completed the Workplace Wellness planning. In the coming months, members of the group will be involved in reviewing proposals and make a recommendation for delivery of the service.

QIPPS (web based project planning tool) training was held as an addition to the Manawatu PHO Health Promotion training for GPs. Four workshops were held with 8 different GP practices, who will utilise the tool to complete their project planning as part of the course. QIPPS will now be a regular component in the PHO course for GPs. This will enable practices to work with health promotion practitioners on collaborative projects and share information on project successes and considerations.

Pan DHB use and distribution of QIPPS was discussed with Hawkes Bay DHB. A joint proposal will be made to the Eastern Institute of Technology to include QIPPS on the Health Promotion Certificate, and the Health Promotion Short Course, aiming to have it included in this years curriculum if possible.

NAPAG (Nutrition and Physical Activity Group) joint project Kumu off the Couch (physical activity radio show on Kia Ora FM) has just launched into season 2. This year the project is considering monitoring it's impact on people, including looking at numbers of people attending specific programme related activities, as well as numbers registering with local sports clubs.

### 3.8.3 Breastfeeding Action Plan

The main implantation of MDHB's Breastfeeding Action Plan is now underway. A scoping report commissioned by the DHB has recently been received from Massey University. The recommendations from the report will now be implemented with the development of four community based breastfeeding initiatives including;

- Community Breastfeeding Leadership and Coordination
- Whanau Peer supporting and training programme
- Māori breastfeeding support and promotion hui/workshops
- Breastfeeding incentive and support project

All initiatives have received funding from the Ministry of Health and are based on the wide community consultation undertaken during the development of the Breastfeeding Action Plan and more recently the scoping project carried out by Massey.

All of the initiatives have the potential to be developed in partnership with neighbouring DHB's, in particular Whanganui, and these options will be explored.

### **3.8.4 Māori Community Action Plan (MCAP) Fund**

Phase two of the evaluation training for Māori community projects is now completed. Synexe consulting visited each organisation that was funded in round 2 and provided one on one sessions which were tailored to suit individual project frameworks developed in phase one.

Phase two focused on:

- expansion of individual evaluation frameworks developed in phase one;
- supporting individual projects to identify strengths and weaknesses, and providing recommendations that would enhance and improve the sustainability of projects.
- relevant information that is essential in the reporting template and how it benefits both organisation and MDHB.
- techniques used to improve the format in the reporting process.

The population health coordinator attended various trainings and will continue to support and monitor projects.

Round 3 of the Māori Community Action Plan fund and workforce development closed on 5<sup>th</sup> March 2010. There were a total of seven applications received for the Māori community Action projects.

The MCAP funding panel meet on the 6<sup>th</sup> April to consider and allocate funding to all eligible projects, which will then be submitted for GM approval.

### **3.8.5 Kai Totika me whakapakari Tinana (Te Hotu Manawa Māori Training - THMM)**

THMM is a national Māori Health provider delivering a health promotion service in the Kai Totika me Whakapakari Tinana. The Nutrition and Physical Activity service is committed to providing leadership, support, education and change communications to empower Māori communities to improved health through good nutrition and participation in regular physical activity.

Purpose of the course:

This 'train-the-trainer' course is designed for individuals working in the Māori health sector committed to promoting healthy lifestyle changes.

There is a partnership between MDHB and Whanganui DHB to the support the delivery of the 3 day training on the 23-25<sup>th</sup> March. We have 20 kaimahi from the MidCentral region attending this course.

## **3.9 Service Plan Implementation**

District Management Groups (DMG) have had data presented to them over the recent meetings that occurred in February. The intention is to provide each DMG with ongoing streams of information about the disease state they represent. Between the last meeting and the scheduled meetings in April DMG members are carrying out a more detailed review of the information. This will be discussed with key area's of focus and further attention to be identified.

### **3.9.1 Oral Health**

The Oral DMG is meeting late in March and is planning to discuss frequency of DMG meetings. The issue of an ageing workforce and recruitment challenges in the sector for dental therapists continues.

To date there have been no applications received for the scholarship for 2009 / 2010 financial year. This funding is no longer available after 30 June 2010. New strategies will need to be explored to meet this challenge in to the future.

### 3.9.2 Respiratory

The tables below demonstrate the higher incidence of respiratory presentations to the emergency department of people from Horowhenua. Given the issue of distance this is significant and presents questions around improving primary care community based services and access for this population group.

Table 2 : Respiratory Emergency Department Presentations by TLA and per thousand

#### Adult (Multiple Items) Presentations to the Emergency Department.

##### By Region and Financial Year.

Within Complete Year	C	Show only complete years
DHB	Midcentral DHB	Midcentral DHB
Category	DMG	DMG
Test Category	Respiratory	Respiratory
Age Range B	(Multiple Items)	Age ranges from 15 years plus

The data presented here covers the 4 financial years from - 2005-2006 thru to 2008-2009.

Count of EMGNO	Fin Year				%age presentations by region
	2005-2006	2006-2007	2007-2008	2008-2009	
TERRITORIAL AUTH N					
Horowhenua District	455	471	414	535	23.3%
Kapiti Coast District	47	62	60	62	2.9%
Manawatu District	304	277	272	331	14.7%
Palmerston North City	998	946	1011	1129	50.8%
Taranua District	150	169	183	171	8.4%
Grand Total	1954	1925	1940	2228	

Horowhenua	24221
Kapiti Coast	6254
Manawatu	21268
Palmerston North	60524
Taranua	14011

Source New Zealand Health Tracker 2008Q2  
 Analyst Craig Wright  
 Date 17/11/2009  
 Description NZHT Demographic and Usually Resident Population at 1 July 2006

50.7% of presentations for adult respiratory are from Palmerston North City.  
 23.3% of presentations for adult respiratory are from Horowhenua District.

Prevalence per Thousand	2005-2006	2006-2007	2007-2008	2008-2009	Average
Horowhenua	18.8	19.4	17.1	22.1	19.4
Kapiti Coast	7.5	9.9	9.6	9.9	9.2
Manawatu	14.3	13.0	12.8	15.6	13.9
Palmerston North	16.5	15.6	16.7	18.7	16.9
Taranua	10.7	12.1	13.1	12.2	12.0

The highest presentations per thousand is 19.4 for adult respiratory from Horowhenua .

The second highest presentations per thousand is 16.9 for adult respiratory from Palmerston North .

As outlined in the March report the socio-economic impact on health is reflected in presentations to emergency department. The table below demonstrates this showing that the largest number of presentations to the emergency department for Respiratory are people who form part of the districts most deprived population. Again, there may be ways to provide community based interventions for larger numbers of people as outlined in the PHO business case. This is a common factor across all disease states.

Table 3: Respiratory Emergency Department presentations by Quintile, from 15 year plus

**Adult (Multiple Items) Presentations to the Emergency Department.****By Quintile and Ethnicity.**

Within Complete Year	C	Show only complete years
DHB	Midcentral	Midcentral DHB
Category	DMG	DMG
Test Category	Respirator	Respiratory
Age Range B	(Multiple I)	Age ranges from 15 years plus

The data presented here covers the 4 financial years from - 2005-2006 thru to 2008-2009.

Count of EMGNO	Fin Year			
Quintile	2005-2006	2006-2007	2007-2008	2008-2009
1	80	90	103	113
2	126	145	128	160
3	402	369	397	516
4	617	627	644	732
5	729	694	668	707
Grand Total	1954	1925	1940	2228

%age presentations by region

Quintile 1	Least Deprived	4.8%
Quintile 5	Most Deprived	34.8%

Quintiles are a measure of deprivation.

## Populations per quintile

Quintile 1	2973
Quintile 2	5796
Quintile 3	7427
Quintile 4	8347
Quintile 5	9657

Source: New Zealand Health Tracker 2008Q2  
 Analyst: Craig Wright  
 Date: 17/11/2009  
 Description: NZHT Demographic and Usually Resident Population at 1 July 2008

67.4% of presentations for adult (multiple items) are from Quintile 4 or below.

88.3% of presentations for adult (multiple items) are from Quintile 3 or below.

The Respiratory DMG continues to review information and consider ways to improve service delivery across the care continuum.

### 3.9.3 Cardiovascular

The One Heart Many Lives project is beginning to take shape. The project team are exploring ways to support sustainability of the program once it is established. As the focus is improving Māori men's cardiac health and reducing risk factors, the success of the program is clearly around establishing and maintaining Māori engagement and supporting individual champions that are able to role model positive change in lifestyle. It is important that the community based champions have the time and resource to support engagement, mentorship and presentation activities.

### 3.9.4 Cancer

The Cancer DMG have prepared an application to the Central Cancer Network for funding support that is available to reduce inequities. If approved it is proposed that this small amount of funding ( \$10,000 ) be used to develop a Māori Survival Kit with multiple resources. The kit will encourage and support Māori awareness and engagement in services at an earlier time along the cancer journey. If the ground work in this project is done well , reproducing a similar resource for Pacific people could be explored and is likely to be completed with minimal further investment. The project will work closely with the Iwi cancer coordinators and cancer society to develop and implement use of the survival kit.

### 3.9.5 Conclusion

Further data and information will be presented to the DMG groups in the April meetings. Understanding activity levels of the services and how the population access health services will assist in targeting of services and awareness of at risk populations. DMG activity is therefore very focused on evaluation and review of current service delivery and the health gains they are beginning to produce.

## 4. NATIONAL MATTERS

### 4.1 Kiaora Health Launch

As previously reported The “Kia Ora Hauora – Māori Health as a Career” Programme is an innovative new Māori health workforce development programme for Aotearoa, New Zealand. The overarching goal of the Māori Health as a Career Programme is to recruit 1000 new Māori onto a health study pathway in secondary or tertiary study over the next 4 years. The programme aims to achieve this through:

- **increasing access to** Māori health career information nationally, regionally and locally
- **increasing uptake and achievement by Māori students** in Secondary School science
- **increasing recruitment of Māori tertiary students studying a health** or health related qualification
- **increasing retention rates for Māori tertiary** students studying a health or health related qualification

Although ambitious, the programme calls for a whole-of-sector response to Māori workforce development, challenging the sector to take an integrated planning approach to achieve common goals. The programme will build on the successes of existing programmes, without competing with or diminishing existing health brands. The programme was officially launched on Thursday 11 March 2010 at Te Manukanuka o Hoturoa Marae in Manukau, Auckland. The launch focused on the programme website, resource collateral, and programme infrastructure.

### 4.2 Programme Objectives

The Programme aims to implement a range of strategies that influence, motivate and support Māori choice of and entry into a health career pathway. Accordingly, the Programme will offer a comprehensive and coordinated suite of Information and Support Services, at both national and regional levels, dedicated to assisting more Māori into their preferred health career pathway.

Examples of Information Services include a dedicated **Kia Ora Hauora** website; national and regional communications activities linked to health career promotion; toolkits for partner schools with information about health career educational requirements and the journey a student would need to follow; and access to a range of Māori learning and education scholarships. Examples of Support Services, at both national and regional levels, include study resources for students; access to mentors; connecting Māori with existing health workforce programmes; wānanga to motivate Māori student success and a ‘track and trace’ database to support Māori progress through their health career pathway.

The Programme will also enter into new partnered relationships with key ‘third party’ stakeholders, ranging from secondary schools and tertiary institutions through to Government Departments, Whānau and Māori health providers.

On Wednesday 24<sup>th</sup> March 2010, the programme co-ordinator will be welcomed into her role by the Māori Health Unit of Capital and Coast DHB and assisted by the presence of the Regional and National members of Tumu Whakarae.

**5. REGIONAL MATTERS**

**5.1 Breast Reconstruction**

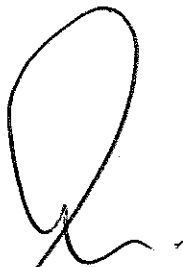
Hutt Valley DHB has advised it is instigating Breast Reconstruction for women who have had their surgery delayed over the past three years.

Hutt Valley DHB estimate approximately 300 women are potentially waiting for this service. They also advise they will perform 100 per year additional to the 50 per year currently performed. The numbers of women and the financial impact on MidCentral is yet to be determined.

**6. RECOMMENDATION**

It is recommended:

*that this report be received*

A handwritten signature in black ink, appearing to be 'Mike Grant', written over a diagonal line that extends from the bottom left towards the center.

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

# Update for Central Region DHB CEOs and Boards – March 2010

## HIGHLIGHTS:

- ❖ **Regional Decision making.** The Terms of reference for both the RCSP Regional Committee (RRC) and RCSP Leadership Committee (RLC) are now finalised (see note below), with the first RRC meeting occurring on 12 April 2010. The RRC committee has overall responsibility for guiding the regional work programme and its processes.

Chairs of the Central Region DHBs are pleased to announce the appointment of **Dr Bruce Gollop** as **Independent Chair of the RRC**. Bruce brings a pragmatic and unique insight to health service management from his wide range of experience in all aspects of the health sector. Bruce holds degrees in engineering and medicine and has a background in environmental engineering, clinical medicine and senior management. Bruce has specialist registration in both occupational medicine and medical administration.

Bruce has undertaken a number of leading roles in the sector including being General Manager of Auckland Hospital and Chief Executive of Northland Health, Healthcare Otago and District Health Boards, NZ. The Ministry of Health and District Health Boards have drawn on Bruce's experience of all aspects of the NZ health system to plan the range, volume and distribution of health services for both metropolitan and rural areas. Bruce has considerable experience with all aspects of health planning, hospital management and quality improvement.

**RCSP Leadership Committee.** The nomination process is currently underway and is expected to conclude 26 March 2010, with the first RRC meeting in April confirming the appointments.

- ❖ **Combined DHB Board meeting.** A combined Boards meeting is planned to occur on 3 May 2010. Invitations will be sent out soon finalising the details.
- ❖ **Strengthening Hospital Services project.** Three new regional projects (Radiology services, Women's services and Older Adults and Rehabilitation services) began in the period December 2009 to March 2010. They resulted from the Strengthening Hospital Services project in 2009. Initial meetings have been to identify specific service issues and to implement practical actions. Meetings have been characterised by good clinician attendance and a keenness to share information and work together to resolve a broad range of issues.
- ❖ A summary communications document, "Planning for the Future" (see note below) has been developed for DHBs to use to help explain the Regional Clinical Services Plan.

To conclude, key contacts are provided for RCSP Projects.

RCSP Project	CEO Sponsor	Chair
Radiology Services	Michael Hundleby (Hutt Valley)	Michael Hundleby (Hutt Valley)
Women's Services	Tracey Adamson (Wairarapa)	Dr Iwona Stolarek (deputy Chief Medical Officer (CMO) Hutt Valley)
Older Adult & Rehabilitation Services	Julie Patterson (Whanganui)	Dr Colin Feek (Capital & Coast)
Central Cancer Network	Murray Georgel (MidCentral)	Mike Grant (MidCentral)
Cardiac Network	Ken Whelan (Capital & Coast)	Dr Mark Simmonds (Capital & Coast)
Mental Health & Addictions Network	Ken Whelan (Capital & Coast)	Dr Alison Masters (Capital & Coast)
Plastic Surgery Services Network	Michael Hundleby (Hutt Valley)	Mr Colin Calcinaï (Hutt Valley)
Renal Network	Dr Kevin Snee (Hawke's Bay)	Dr Grant Pidgeon (Capital & Coast)
Regional Credentialling of SMOs	Dr Geoff Robinson (Chief Medical Officer, Capital & Coast)	Mr Ken Clark (Chair, Regional CMO forum)

Note: To view Terms of Reference for the RRC or RLC, or the "Planning for the Future" document please see <http://www.centraltas.co.nz/RegionalWorkProgramme/RegionalClinicalServicesPlan/>

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## Central Region Consumer Representative Forum

### Calling for applications to be a consumer representative on the Central Region Consumer Representative Forum

#### Background

The Central Region consists of six DHBs in the Lower North Island; Capital & Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa, and Whanganui. The DHBs first worked together on mental health and addiction services. They then took a regional approach to improve services across a small number of specialties. In 2007, driven by concern over the clinical and financial sustainability of hospital services, the DHBs developed an overarching clinical services plan to guide regional clinical service development over the next 10-15 years. The Minister of Health has also focused his attention on regional initiatives. In the next year he expects DHBs will collaborate and accelerate development of regional clinical services, including clinical networks.

#### Regional Clinical Services Programme (RCSP)

The intention of the Regional Clinical Services Programme (RCSP) is to ensure lasting improvements in the sustainability, quality and accessibility of clinical services. It has the long term goal (2020) 'to create a regionally co-ordinated system of health service planning and delivery'. While the focus of the regional programme is largely on hospital services, continuing development of primary and community based health care is necessary to provide the essential base for the changes proposed to hospital services. The Regional Clinical Service Plan or a summary of the Plan can be viewed on the Central Region's Technical Advisory Service web site ([Full document](#) or [Summary](#))

Regional service development projects are underway to strengthen hospital services including:

- Radiology
- Women's Health - Maternity, Gynaecology, Gynae-oncology, Maternal Foetal medicine
- Older Adults and Rehabilitation
- Medical Oncology

The five (5) clinical networks established across the Central Region so far are:

- Central Cancer Network (also includes Tairāwhiti, Taranaki and Nelson/Marlborough DHBs)
- Cardiac Network
- Mental Health and Addictions Network
- Plastic Surgery Services Network
- Renal Network

These networks have had and/or continue to have consumer representative input.

#### Establishment of the Central Region Consumer Representative Forum (the Forum)

As regional clinical services development gains momentum, it is important to ensure consumer perspectives are factored into decisions about those services. A Consumer Representative Forum is to be established to ensure the RCSP has access to a pool of experienced consumer representatives to contribute to discussion and decision making about regional clinical services development. The consumer representatives who are already involved in the existing clinical networks are being invited to join the Forum as well as recruiting a wider pool of consumer representatives from around the Central Region. The Forum will be answerable to the RCSP Leadership Committee and supported by the Central Region's Technical Advisory Service (CRTAS).

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### What will be asked of members of the Forum?

Members will be invited to participate as they are able. Participation is likely to involve at least some of the following activity:

- Become familiar with and have an understanding of the Central Region's RCSP
- Receive updates from the DHBs shared service agency, CRTAS, about the RCSP and share this information with your networks as appropriate.
- Provide advice, including feedback from local networks, regarding RCSP projects to the Regional Clinical Leadership Committee. This may be through submissions, special interest focus groups, consumer representative appointments to a clinical network.
- Liaise with other members of the Forum as appropriate.
- A smaller group of members will be selected to participate in a Regional Meeting, to be held in Palmerston North in mid June. Participants will be introduced to the RCSP and given an opportunity to discuss how the Forum may function.
- A member of the Forum will be appointed to the RCSP Leadership Committee.

### Will members of the Forum be paid?

Due to current financial constraints, members of the Forum are being asked to participate on a voluntary basis. It is acknowledged this is less than ideal. It is likely that only travel costs will be covered to attend any Forum meetings. Meeting attendance fees and reasonable travel costs are paid to consumer representatives appointed to clinical network groups. A fee payment schedule is yet to be established for members of the RCSP Leadership Committee.

### What are the key attributes required of a consumer representative on the Forum?

- Be a member of a health or disability consumer organisation; have networks into the community; be known to the local DHB
- Have a current working knowledge of the health and/or disability sectors in NZ
- Have the ability to take a regional perspective as well as a local perspective
- Recent experience as a consumer representative on a committee or board; a track record of contributing effectively and constructively at committee level
- Understand and respect confidentiality when this is required
- Strong communication skills and computer literacy; confidence with using email and internet
- Understand the principles of the Treaty of Waitangi
- Respect cultural diversity

### Interested in being a member of the Central Region's Consumer Representative Forum?

Please complete the attached Application Form and return:

By email  
cari\_napoles@centraltas.co.nz

OR post to  
Central Region's Technical  
Advisory Service

OR courier/hand to  
Central Region's Technical  
Advisory Service

For assistance phone  
Cari on 04 801 2781

PO Box 23 075  
WELLINGTON 6140

Level 4, 186 Willis St  
WELLINGTON 6140

Applications close at 12 noon on Thursday 8<sup>th</sup> April 2010

Barbara Robson,  
Consumer Representative, RCSP Steering Group  
08 March 2010

Coordinated by

**TO** Community and Public Health Advisory  
Committee



**FROM** Finance Manager  
Funding Division

**DATE** 12 March 2010

## Memorandum

**SUBJECT FINANCE REPORT – MARCH 2010**

### 1. KEY EVENTS OF NOVEMBER AND FEBRUARY 2010

#### 1.1 Forecast for 09-10

The Funder has maintained its full year forecast at \$0.8m surplus to budget taking into account the likely lower than expected Elective income.

This month the Funder has also undertaken a sensitivity analysis on its forecast with the likely forecast range. These include a worst case scenario, current scenario and a best case scenario. Based on the latest information available and the key assumptions, the estimated surplus/(deficit) to budget are as follows:-

	Budget	Forecast	Variance	Worst Case	Variance (Note)	Best Case	Variance (Note)
	\$m	\$m	\$m	\$m	\$m	\$m	\$m
EI Income	8.3	7.7	(0.6)	7.5	(0.8) (a)	8.3	0.0 (e)
09-10 inpatient IDF Inflow	13.1	12.9	(0.2)	11.7	(1.4) (b)	13.1	0.0 (f)
Other Income	427.3	430.3	3.1	430.3	3.1	430.3	3.1
	<u>448.6</u>	<u>450.9</u>	<u>2.3</u>	<u>449.5</u>	<u>0.9</u>	<u>451.7</u>	<u>3.1</u>
09-10 inpatient IDF Outflow	23.5	23.7	(0.2)	24.0	(0.5) (c)	23.5	0.0 (g)
Other Costs	428.1	429.4	(1.3)	429.9	(1.8) (d)	428.9	(0.8) (h)
	<u>451.6</u>	<u>453.1</u>	<u>(1.5)</u>	<u>453.9</u>	<u>(2.3)</u>	<u>452.4</u>	<u>(0.8)</u>
Net Result	(2.9)	(2.1)	0.8	(4.3)	(1.4)	(0.7)	2.2
Variance as % of budget			0.2%		-0.3%		0.5%

#### Note

- (a) Expected \$0.8m reduction of EI income based on current YTD projection
- (b) Expected \$1.4m reduction of inpatient IDF inflow mainly due to Whanganui DHB
- (c) Expected \$0.5m extra inpatient IDF outflow washup as projected from YTD reports from C&C and Auckland DHBs
- (d) Provide an extra cost of \$0.5m for forecast error
- (e) Expected no reduction of EI income
- (f) Expected no drop in inpatient IDF inflow
- (g) Expected no extra inpatient IDF outflow washup
- (h) Provide a reduction of \$0.5m cost due to forecast error

#### 1.2 MidCentral Health Washup

The total year to date (YTD) washup position for MidCentral Health (MCH) was \$0.1m under-production (mainly due to under-production of Medical Inpatient).

### 1.3 Electives Initiatives (EI)

Based on the PPU EI Jan 2010 report, the Funder has accrued \$4.6m for YTD EI income. Taking into account the latest information, the DHB is \$0.6m behind the YTD budget.

## 2. FUNDER FINANCIAL PERFORMANCE

The Funder had a cumulative surplus to budget of \$1,483k up to the end of Feb 2010.

#### MidCentral DHB - Funder

#### Income and Expenditure - By Ring Fenced Area

For the period ending 28 February 2010

	Note	YTD			Annual		
		Actual	Budget	Variance	Forecast	Budget	Variance
		\$000	\$000	\$000	\$000	\$000	\$000
Personal Health Income	(a)	227,833	226,767	1,066	342,333	340,150	2,183
Personal Health Expenditure	(b)	224,084	224,981	897	340,748	340,150	-598
Personal Health Surplus/(Deficit)		3,749	1,786	1,963	1,585	0	1,584
Mental Health Income		25,172	25,170	2	37,757	37,754	3
Mental Health Expenditure	(c)	26,700	27,108	408	40,247	40,675	428
Mental Health Surplus/(Deficit)		-1,528	-1,938	410	-2,490	-2,921	431
Disability Support Income		44,334	44,284	50	66,476	66,426	50
Disability Support Expenditure	(d)	45,480	44,211	-1,269	68,080	66,426	-1,654
Disability Support Surplus/(Deficit)		-1,146	73	-1,219	-1,604	-0	-1,604
Maori Health Income		1,308	1,288	20	1,990	1,932	58
Maori Health Expenditure	(e)	979	1,288	309	1,623	1,932	309
Maori Health Surplus/(Deficit)		329	0	329	367	0	367
Governance Income		1,589	1,589	0	2,384	2,384	0
Governance Expenditure		1,589	1,589	0	2,384	2,384	0
Governance Surplus/(Deficit)		0	0	0	0	0	0
<b>Total Funder Surplus/(Deficit)</b>		<b>1,404</b>	<b>-79</b>	<b>1,483</b>	<b>-2,143</b>	<b>-2,921</b>	<b>778</b>

#### Note on YTD Variance

(a) Mainly due to favourable variance from 08-09 IDF washup (\$1.3m), CYF (\$0.3m), PCT (\$0.2m), other income (\$0.4m) and unfavourable variance from EI income (\$0.9m), 09-10 provision for reduction in inflow (\$0.2m)

(b) Mainly due to favourable variance from project underspend (\$1.4m), under-performance of MCH (\$0.6m) and unfavourable variance from 08-09 IDF washup (\$0.9m), 09-10 IDF washup provision (\$0.2m)

(c) Mainly due to favourable variance from project underspend (\$1.1m) and unfavourable variance from MCH over-performance (\$0.7m)

(d) Mainly due to over-performance of MCH (\$0.2m) and higher than budgeted HBSS and Age Residential Services (\$1.1m)

(e) Mainly due to favourable variance from workforce project underspend (\$0.3m)

MidCentral DHB - Funder and Funding Administration  
Statement of Financial Position as at 28 February 2010

	Year-Ended	Actual	
	Jun-09	Current Position Feb-10	Change
	\$000	\$000	\$000
<b>ASSETS EMPLOYED</b>			
<b>Current Assets</b>	<b>22,576</b>	<b>26,348</b>	<b>3,772</b>
Bank	16,241	22,212	5,971
Intercompany Advance Account	0	0	0
Debtors and Prepayments	6,336	4,136	(2,199)
Inventories	0	0	0
Properties Intended for Sale	0	0	0
<b>Current Liabilities</b>	<b>21,884</b>	<b>27,401</b>	<b>5,517</b>
Bank Overdraft	0	0	0
Intercompany Current Account	2,294	8,180	5,886
Trade Creditors and Accruals	18,659	16,398	(2,261)
GST	818	2,562	1,743
Income in Advance	0	149	149
Provisions (Payroll)	113	113	0
Current Portion of Term Loans	0	0	0
<b>Net Working Capital</b>	<b>692</b>	<b>(1,053)</b>	<b>(1,746)</b>
<b>Net Assets Employed</b>	<b>692</b>	<b>(1,053)</b>	<b>(1,746)</b>
<b>SHAREHOLDERS EQUITY</b>			
	0	0	0
Retained Earnings	40,735	41,922	1,186
Transfer to Co 41	(40,043)	(42,975)	(2,932)
	<b>692</b>	<b>(1,053)</b>	<b>(1,746)</b>
Other Reserves	0	0	0
<b>Total Shareholders Equity</b>	<b>692</b>	<b>(1,053)</b>	<b>(1,746)</b>

### 3. MIDCENTRAL HEALTH PROVIDER DIVISION RESULT

MidCentral Health - Provider Division Statement of Financial Performance									
Year-to-1 February-10									
	MTD Actual	MTD Budget	Variance	Variance	YTD Actual	YTD Budget	Variance	Variance	Annual Budget
	\$000	\$000	\$000	%	\$000	\$000	\$000	%	\$000
<b>Revenue</b>									
Govt. & Crown Agency Sourced	20,543	19,962	581	3%	171,005	169,545	1,460	1%	256,743
Patient/Consumer Sourced	77	55	22	39%	547	440	107	24%	660
Other Income	308	495	(187)	(38%)	3,749	3,960	(212)	(5%)	5,940
<b>Total Revenue</b>	<b>20,928</b>	<b>20,512</b>	<b>416</b>	<b>2%</b>	<b>175,301</b>	<b>173,945</b>	<b>1,356</b>	<b>1%</b>	<b>263,344</b>
<b>Expenditure</b>									
Personnel	12,002	10,980	(1,022)	(9%)	102,020	98,468	(3,552)	(4%)	146,480
Outsourced Services	1,502	1,353	(149)	(11%)	13,154	10,827	(2,327)	(21%)	16,240
Clinical Supplies	3,405	3,530	125	4%	29,257	28,371	(886)	(3%)	42,625
Infrastructure & Non-Clinical	3,835	4,044	209	5%	32,037	32,355	318	1%	48,534
<b>Total Expenditure</b>	<b>20,744</b>	<b>19,908</b>	<b>(836)</b>	<b>(4%)</b>	<b>176,468</b>	<b>170,021</b>	<b>(6,447)</b>	<b>(4%)</b>	<b>253,879</b>
<b>Operating Surplus/(Deficit)</b>	<b>184</b>	<b>604</b>	<b>(420)</b>	<b>(70%)</b>	<b>(1,167)</b>	<b>3,924</b>	<b>(5,091)</b>	<b>(130%)</b>	<b>9,465</b>
Corporate Services	771	756	(14)	(2%)	6,160	6,049	(110)	(2%)	9,074
<b>Surplus/(Deficit)</b>	<b>(587)</b>	<b>(152)</b>	<b>(435)</b>	<b>286%</b>	<b>(7,327)</b>	<b>(2,125)</b>	<b>(5,201)</b>	<b>245%</b>	<b>391</b>

Revenue is now \$1.4m or 0.78% over budget. Clinical Training Agency accounts for \$917k (being arrears) and additional funding in both medical and nursing. There is a related training cost against this revenue. Mental Health received \$450k additional funding to cover the wash up shortfall.

Total personnel costs (including outsourced) are now \$5.3m adverse to budget.

FTE vacancies (SMO's and junior medical staff) are creating high costs in outsourced locum costs. Recruitment costs are running high trying to replace locums with staff.

Clinical supplies are up through high pharmaceutical costs linked to the mix and level of production.

High cost cancer pharmaceuticals are recovered and included within revenue variances.

### 4. MIDCENTRAL DHB RESULT

Feb-10 (000's)	DHB RESULT	Funding Division	Provider Division	Governance
<b>Net Result</b>				
YTD - Actual	(6,540)	1,405	(7,177)	(768)
YTD - Budget	(2,981)	(75)	(2,414)	(492)
Variance	(3,559)	1,480	(4,763)	(276)

After eight months, the DHB result is an unfavourable variance to budget of \$3.6m. There is an unfavourable variance of \$4.8m in the provider division, which is partially offset by a favourable variance of \$1.5m in the Funding division. The Funding division's surplus year to date arises from delays on programmed expenditure. MidCentral Health is experiencing significant fiscal pressure in the areas of personnel (largely due to delays in implementing the restructuring programme), locums and clinical supplies. Management is addressing these issues.

## 5. CONSOLIDATED FINANCIAL POSITION

<b>MidCentral District Health Board</b>				
<b>Statement of Financial Position (summary)</b>				
	<b>Jun 2008</b>	<b>Jun 2009</b>	<b>Feb 2010</b>	<b>Change</b>
	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>
<b>Assets Employed</b>				
Current Assets	48,911	44,727	38,318	(6,409)
Current Liabilities	(47,498)	(54,841)	(50,066)	4,775
Fixed Assets and Investments	144,480	164,748	160,788	(3,960)
	<b>145,893</b>	<b>154,634</b>	<b>149,040</b>	<b>(5,594)</b>
<b>Funds Employed</b>				
Equity	89,620	98,521	92,468	(6,053)
Bank Loans	54,943	54,867	55,326	459
Long Term Liabilities	1,330	1,246	1,246	0
	<b>145,893</b>	<b>154,634</b>	<b>149,040</b>	<b>(5,594)</b>

## 6. COVENANTS

<i>Feb-10</i>	Actual	Limit / Covenant
YTD - Variance to Budget	(\$3.6)	< (\$2.0m)
Bank Loans (net debt)	\$33.0	\$71.7m
Equity	\$92.5	> \$30m
Debt & Equity	\$125.5	
Debt Ratio	26.3%	< 55.0%
YTD Interest Cover	1.36	> 3.00

At the end of February, two covenants (YTD – Variance to Budget and YTD Interest Cover) were not being met, due to the DHB being in deficit for the year to date. As has been reported previously, the covenants are no longer contractually monitored by the CHFA, but they do review their debt portfolio with us. The CHFA will be monitoring our financial situation closely this year. Management does hold six-monthly meetings with the CHFA at which such matters are discussed.

**7. DEBT POSITION**

	<b>Jun-08</b>	<b>Jun-09</b>	<b>Feb-10</b>
<b>MidCentral District Health Board</b>	<b>\$m</b>	<b>\$m</b>	<b>\$m</b>
Available Bank Facility	71.7	71.7	71.9
Net Debt (CHFA & Banks)	19.7	29.0	33.1
<b>Debt Facility Surplus / (Shortfall)</b>	<b>52.0</b>	<b>42.7</b>	<b>38.8</b>
Reserved Funds	18.7	18.7	18.7
<b>Debt Facility Available</b>	<b>33.3</b>	<b>24.0</b>	<b>20.1</b>

**8. CASH POSITION**

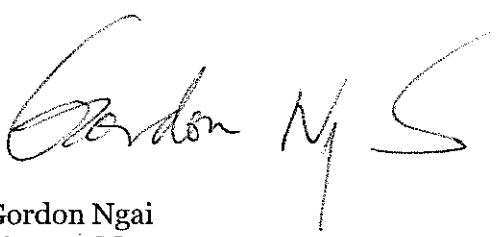
A summary of the cash position by division is shown below.

<b>Cash / investment Summary as at 28 February 2010</b>	
	<b>\$m</b>
Treasury Division	19.2
Funding Division	13.0
MidCentral Health	-12.3
Trust Funds - Short Term	0.2
Enable	2.1
<b>Total</b>	<b>22.2</b>

**9. RECOMMENDATION**

It is recommended:

*that this report be received*



Gordon Ngai  
 Finance Manager  
 Funding Division

**TO** Community & Public Health Advisory Committee

**FROM** Chief Executive Officer

**DATE** 29 March 2010

**SUBJECT** 2009/10 Work Programme

**MEMORANDUM**

The Committee's work programme for 2009/10 is attached and shows progress as at the end of March 2009.

Reporting is occurring in accordance with the timeline, with one exception. The third report on Acute Demand was originally scheduled for April. This has been delayed and will be submitted in July.

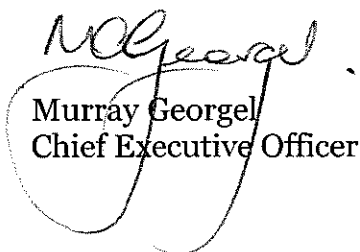
For the Committee's next meeting, the regular updates regarding achievement of the long term measures for chronic disease management, contract renewals, and performance indicators will be provided.

If there are any new items which members require, or any issues they would like canvassed in future reports, please advise.

**Recommendation**

It is recommended:

*that the updated work programme for 2009/10 be noted.*

  
Murray Georgel  
Chief Executive Officer

**COPY TO:**

**CEO's Department**  
MidCentral DHB  
Heretaunga Street  
PO Box 2056  
Palmerston North  
Phone +64 (6) 350 8910  
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ID	Task Name	2010																		
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1	<b>COMMUNITY &amp; PUBLIC HEALTH ADVISORY COMMITTEE, 2009/10</b>																			
2																				
3	<b>STRATEGIC PLANNING</b>																			
4	Chronic disease strategies: progress against long term measures: update 1																			
5	Chronic disease strategies: progress against long term measures: update 2																			
6	Follow-up paper re acute demand																			
7	Follow-up paper 3 re acute demand (NOW JULY 10)																			
8	<b>ANNUAL PLANNING</b>																			
9	<b>2010/11 DAP Development</b>																			
10	Annual Review of Health Needs Assessment, 2009																			
11	Annual Review of Health Needs Assessment, 2010																			
12	Annual Review of Prioritisation Framework																			
13	Price Volume Schedule 2010/11																			
14	Price Volume Schedule 2010/11: low value services review outcome																			
15	Price Volume Schedule 2010/11: details of significant changes (from current year) and knock on effect																			
16	Draft 1																			
17	Draft 2																			
18	<b>2009/10 DAP Implementation</b>																			
19	Health Promotion Update 1																			
20	Health Promotion Update 2																			
21	Primary Health (all bar 12a&b): update 1																			
22	Primary Health (all bar 12a&b): update 2																			
23	Maori Health (DAP 17-19): update 1																			
24	Maori Health (DAP 17-19): update 2																			
25	Mental Health (DAP 21-22): update 1																			
26	Mental Health: outcome of audit of multi systemic therapy youth A&D service																			
27	Mental Health (DAP 21-22): update 2																			
28	Child & Youth (DAP 31-33, 34A, 35, 38-39, 41): update 1																			
29	Child & Youth (DAP 31-33, 34A, 35, 38-39, 41): update 2																			
30	Health of Older Persons (all): update 1																			
31	Health of Older Persons (all): update 2																			
32	Workforce: update 1																			
33	Workforce: update 2																			
34	<b>For Information</b>																			
35	Primary Health - Provider (12a&b re post natal stays): update 1																			
36	Primary Health - funding (12a&b re post natal stays): update 2																			
37	Maori Health - provider (DAP 20): update 1																			
38	Maori Health - provider (DAP 20): update 2																			
39	Mental Health - provider (DAP 23): update 1																			
40	Mental Health - provider (DAP 23): update 2																			
41	Child & Youth - provider (DAP 34b&c, 36, 37 & 40): update 1																			
42	Child & Youth - provider (DAP 34b&c, 36, 37 & 40): update 2																			

ID	Task Name	2010																		
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
43	Secondary Care (all): update 1																			
44	Secondary Care (all): update 2																			
45	Workforce: update re national workforce papers																			
46	<b>REGIONAL PLANNING</b>																			
47	Regional Clinical Services Plan																			
48	Project Newsletters (as issued)																			
49	<b>OPERATIONAL REPORTS</b>																			
50	General Manager's Monthly Report (including portfolio updates)																			
51	Financial report: new exception based report																			
52	Financial report: feedback from L Gray & M Grant meeting																			
53	Health Care Development Team: work programme & budget (ex Bd 21.7.09)																			
54	Quality of nursing care: assurance from MCH that appropriate follow-up in progress & outcome																			
55	Regional Specialty Services: likelihood of change within region																			
56	Financial report: clarification re top slicing for child, youth & family residences service																			
57	MoH letter re integrity of PHO Enrollment Registers																			
58	Chronic Care Diseases: precis of ACC work re cultural competencies																			
59	EOI Update																			
60	EOI Presentation																			
61	EOI Update, inc clarification of "Te Pou roll out"																			
62	Contracts Update 1																			
63	Contracts Update 2																			
64	Contracts Update 3																			
65	Contracts Update 4																			
66	Acute Demand: indicative timeframe for future reports																			
67	Annual Report from PHO Combined Clinical Board																			
68	Proposed Contracting Strategy 2009/10																			
69	Proposed Contracting Strategy 2010/11																			
70	Tangimoana Update																			
71	<b>Performance Indicators</b>																			
72	Report 1																			
73	Report 2																			
74	Report 3																			
75	Report 4																			
76	<b>Carried Forward from 2008/09</b>																			
77	Maori Scholarship & Internships																			
78	Pharmacy Options Paper																			
79	<b>GOVERNANCE PROCESSES</b>																			
80	Terms of Reference Review																			
81	2009/10 work programme: need for central Alliance update																			
82	Apology: A Chapman																			
83	Apology: P Sunderland																			