MidCentral District Health Board

A g e n d a

Community & Public Health Advisory Committee

Part 1

Date: 4 August 2009

Time: 1.00 pm

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

Distribution

Committee Members
- Mrs D Anderson (Chair)
- Mr D Emery (Deputy Chair)
- Mrs L Gray
- Dr G Campbell
- Mr O Stock
- Dr C Hamilton
- Mrs A Chapman (ex officio)
- Mr I A Wilson (ex officio)
- External Appointee

Board Members
- Mr L Burnell
- Dr J Drummond
- Mr J Jefferies
- Mrs B Robson
- Mr S Paewai

Management Team
- Mr M Georgel, Chief Executive Officer
- Mr M Grant, General Manager, Funding
- Mr S Wilson, General Manager, Corporate Services
- Ms J M Matthews, Principal Administration Officer
- Mrs R Bensemann, Committee Secretary
- Communications Dept MDHB
- External Auditor
- Board Records

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Next Meeting Date 1 September 2009
Deadline for Agenda Items 19 August 2009

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Tuesday 4 August 2009

Part 1

Order

1. **APOLOGIES**

   Dr G Campbell (leave of absence)

2. **NOTIFICATION OF LATE ITEMS**

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

4. **MINUTES**

4.1 **Minutes**

Pages:	4.1 – 4.5
Documentation:	minutes of 7 July 2009
Recommendation:	that the minutes of the previous meeting held on 7 July 2009 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 7 July 2009 for which specific items do not appear on the agenda or in management reports.

5. **OPERATIONATIONAL REPORTS**

5.1 **Investigate the Feasibility of Community Pharmacy in CVD Risk Assessment (DAP 5)**

Pages:	5.1 – 5.5
Documentation:	Pharmacy Advisor's Report dated 30 June 2009
Recommendation:	that this report be received

5.2 Antenatal HIV Screening Programme - Update

Pages: 5.6 – 5.14
Documentation: Project Manager's Report dated 16 July 2009
Recommendation: that this report be received

5.3 Health Awards 2009

Pages: 5.15 – 5.18
Documentation: Executive Assistant to General Manager's Report dated 15 July 2009
Recommendation: that this report be received

6. OPERATIONAL REPORTS

6.1 Funding Division Operating Report – July 2009

Pages: 6.1- 14
Documentation: General Manager's Report dated 17 July 2009
Recommendation: that this report be received

6.2 Finance Report – July 2009

Pages: 6.15 – 6.27
Documentation: Finance Manager's Report dated 15 July 2009
Recommendation: that this report be received

7. GOVERNANCE ISSUES

7.1 Contracts Update 1

Pages: 7.1
Documentation: General Manager Corporate Services' Report dated 27 July 2009
Recommendation: that this report be received

7.2 2009/10 Work Programme

Pages: 7.2 – 7.4
Documentation: Chief Executive Officer's Report dated 27 July 2009
Recommendation: that the updated work programme for 2009/10 be noted

8. LATE ITEMS

To discuss any such items as identified under item 2.

9. DATE OF NEXT MEETING

1 September 2009

10. EXCLUSION OF PUBLIC

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

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

4.1

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Minutes of meeting held on Tuesday 7 July 2009 in the Board Room of Board Office, Gate 2B Heretaunga Street, Palmerston North

The meeting commenced at 1.03pm

PRESENT:

Mrs D Anderson (Chair)
Mr D Emery
Mrs L Gray
Mr O Stock
Dr C Hamilton
Mr I Wilson (ex officio)
Mrs A Chapman (ex officio)

IN ATTENDANCE:

Mr M Grant, General Manager, Funding
Mr S Wilson, General Manager, Corporate Services
Mrs R Bensemann, Committee Secretary

OTHER:

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

1. APOLOGIES

Dr C Campbell, Committee Member
Mr M Georgel, Chief Executive Officer

2. NOTIFICATION OF LATE ITEMS

There were none.

3. CONFLICT AND/OR REGISTER OF INTERESTS

Health Care Development
Dr C Hamilton declared her conflict regarding the above due to her employment at Massey University and due to her position as a Member of Ucol Council.

Dr C Hamilton requested that her name be removed from the Register of Interests in respect of Massey University as her employment ceases at end July 2009.

4.2

Mr I Wilson requested that his name be removed from the Register of Interests in respect of the Institute of Environmental Sciences & Research Limited (and associate and subsidiary) as his term has been completed.

4. MINUTES

4.1 MINUTES

It was recommended:

that the minutes of the previous meeting held on 2 June 2009 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.

5. STRATEGY REPORTS

5.1 ANNUAL HEALTH NEEDS ASSESSMENT UPDATE

The Committee received the report with interest and noted the importance of identifying areas of improvement for health service access for those people within the district who are experiencing health status disadvantage.

The Committee discussed the reasoning behind the decision for Central Region's Technical Advisory Services to cease supplying its district health boards with health needs assessment data. Management responded that this decision was made in order to free up resources at Central Region's Technical Advisory Services in order to focus on implementation of the Regional Clinical Leadership plan. This decision was in line with other central region district health boards and that it may be possible in the future to reignite a regional collection of data under the auspices of the Regional Clinical Leadership plan.

The Committee acknowledged that health needs data interpretation was important to create an accurate understanding of the health status profile within the district and to use this information for future planning to identify and build on health programmes going forward.

It was recommended:

that this report be received

5.2 HEALTH CARE DEVELOPMENT

Dr C Hamilton declared her conflict regarding the above due to her employment at Massey University and due to her position as a Member of Ucol Council.

The Committee did not perceive the declared conflict to be significant in relation to this item.

Management provided the Committee with background and context to the establishment and work of the Health Care Development Team. The Committee sought assurance around the team's work programme being in line with our strategic direction and requested future briefings on certain strategic outcomes on a regular basis.

Discussion then ensued on the career pathway for Nurse Practitioners. Management updated the Committee on potential opportunities for Nurse Practitioners working in Primary Care in an integrated manner. Management reassured the Committee that ongoing work in this area would be the feature of regular updates by the Health Care Development Team.

A member (having heard a verbal submission on the quality of nursing care in MidCentral Health) enquired what levers the Funder had in relation to holding the provider responsible for quality of care. Management replied that it would seek assurance from MidCentral Health that appropriate follow up was in progress and would report back to the Committee in relation to the outcome. Further it would provide general advice to the Committee on its role as a Funder of services and the contractual accountabilities of the provider.

It was recommended:

that this report be received

5.3 PSYCHOGERIATRIC STRATEGY UPDATE

The Committee received this comprehensive report with interest and discussion ensued regarding dementia prevalence within MidCentral and the care service delivery options available to these people, especially those at each end of the dementia spectrum.

Management responded that by adopting a preventative approach which targets funding to lower levels may reduce the demand for higher-level services. Education and training for staff working in community care has the potential to reduce the prevalence and severity of dementia symptoms and the subsequent demand for more specialised (and more expensive) services.

It was recommended:

that this report be received

5.4 PRIMARY HEALTH SERVICES FOR CHILDREN AND YOUNG PEOPLE RESIDENT IN CHILD YOUTH AND FAMILY'S LOWER NORTH YOUTH JUSTICE RESIDENCE

The Committee noted that MidCentral DHB will now be funding the primary health care services for children and young people in the local Lower North Youth Justice residence. These health care services were previously provided by CYFS and the funding stream has now shifted to MidCentral DHB.

The Committee sought clarification around the financial impact for MidCentral DHB. Management responded that funding is tracked per youth in the domiciled area and that the funding will be managed through a National IDF process.

It was recommended:

that this report be received

4.4

6. OPERATIONAL REPORTS

6.1 FUNDING DIVISION OPERATING REPORT – JUNE 2009

Item 2.4.2 After Hours Proposal
The Committee commented favourably on the Ministry's response to this proposal to provide additional funding for after hours services.

Item 2.5.3 Before School Checks (B4SC) and Appendix 1
The Committee acknowledged the success of MidCentral DHB in achieving the B4SC targets and commented positively on this result in comparison to the performance of other DHBs around the country.

It was recommended:

that this report be received

6.2 FINANCE REPORT – JUNE 2009

Management advised a forecasted deficit of $0.5m and confirmed that the Funder is working to achieve a break-even position. It was advised that the financial reporting is for May 2009 but that the June 2009 forecast is similar.

It was recommended:

that this report be received

7. GOVERNANCE ISSUES

7.1 2009/10 REPORTING FRAMEWORK

Management verified the approval of the new reporting structure and confirmed that this framework integrates all Committee reporting into a standardised format, which has greater transparency and visibility, together with a more strategic focus.

It was recommended:

that the 2009/10 work programme be noted

8. LATE ITEMS

There were none.

9. DATE OF NEXT MEETING

4 August 2009

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	
General Approach to Contract Review and Renewal for 2009/10	Negotiating strategy	9(2)(j)

Meeting closed at 2.57pm

Confirmed Tuesday 4 August 2009

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Chairperson

TO Community and Public Health Advisory Committee

FROM Pharmacy Advisor
Funding Division

DATE 30 June 2009

Memorandum

SUBJECT **INVESTIGATE THE FEASIBILITY OF COMMUNITY PHARMACY IN CVD RISK ASSESSMENT (DAP 5)**

1. SUMMARY

1.1 Purpose

This paper provides the Committee with a report on the feasibility of community pharmacy in CVD risk assessment (DAP 08/09 - initiative).

1.2 Executive summary

The MidCentral DHB Cardiovascular Service Plan lists cardiovascular disease (CVD) recognition as a Ministry of Health primary care clinical indicator with an associated target of an increase in early recognition of CVD. The plan included an investigation into the feasibility of community pharmacy in CVD risk assessment.

The investigation found that with some investment from MidCentral DHB, it is feasible that CVD risk assessment can be provided from community pharmacy. However, until integrated communication networks are developed, duplication of services will remain an issue and such investment from MidCentral DHB at this time is not considered judicious.

1.3 Recommendation

It is recommended:

that this report be received.

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MidCentral District Health Board
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5.2

2. INTRODUCTION

The fourth aspect of DAP Deliverable No. 5 states, "Investigate the feasibility of community pharmacy in CVD risk assessment by 30 June 2009". This report provides the Committee with a report on that investigation.

3. BACKGROUND

3.1 MidCentral DHB Cardiovascular Service Plan

The MidCentral DHB Cardiovascular Service Plan lists cardiovascular disease (CVD) recognition as a Ministry of Health primary care clinical indicator with an associated target of an increase in early recognition of CVD.

The Plan includes as Objective 2, "Ensure early detection and early intervention to reduce the impact of cardiovascular disease on wellbeing". This objective includes the following initiatives:

Initiative 13 Provide regular cardiovascular screening to the general population to be provided through general practice and in other community settings such as workplaces.

Initiative 14 Provide opportunistic screening to target population groups such as Maori and Pacific peoples using appropriate providers and in appropriate settings. For example, Maori providers working in marae or community settings.

Initiative 15 Promote regular screening to the elderly by working with relevant agencies such as residential care providers.

Initiative 19 Encourage all health professionals, particularly in the primary health care setting, to identify cardiovascular risk factors in their clients and provide appropriate interventions or referral to other services. This includes screening for heart failure of at risk people.

The Cardiovascular Service Plan also identifies that, "The pharmacist is an integral part of the health care team. The practice of pharmacy includes ... the provision of advice on health and wellbeing, including health screening..."

On the surface, pharmacists in community pharmacy are currently well placed in terms of access (no appointment necessary) and competence (minimal professional development required) to offer regular CVD risk assessment to the general population and opportunistic screening to target population groups such as Maori and Pacific peoples. However, pharmacists in community pharmacy may be less well placed to offer such services in a setting other than in a community pharmacy.

3.2 Services Provided Overseas

As part of the new community pharmacy contractual framework, the UK Pharmacy Services Negotiating Committee, the UK Department of Health, and the NHS Confederation jointly developed a number of template service specifications to describe Enhanced Services to be provided from community pharmacies in the UK.

The Enhanced Services form the third tier of the new pharmacy contract in the UK and can be commissioned by Primary Care Trusts (PCTs) in response to the needs of their local population.

A service specification has been developed for a NHS Health Check (Vascular risk assessment and management service) via UK community pharmacies.[1] The service specification describes the service as follows:

- The pharmacy will provide a vascular risk assessment and management service for people in the target group (people aged 40 to 74 years of age who have not had a previous diagnosis of vascular disease) in order to improve the person's awareness of their vascular risk and how to minimise or manage that risk. The service will comply with the DH national requirements, in order that NHS Health Checks are delivered in a uniform, systematic, and integrated manner.
- The results of the risk assessment will be communicated to the person and will be added to the person's pharmacy record and shared with their GP.
- The pharmacy will offer brief healthy lifestyle advice and support to all people receiving the service to assist them with managing and / or reducing their risk.
- People who are found to be at moderate or high risk will be offered appropriate interventions and referral, where required, in line with national and local guidance.
- Where pre-existing disease is suspected or identified the person will be referred to their GP.

4. MANAWATU COMMUNITY PHARMACY GROUP

The Manawatu Community Pharmacy Group (MCPG) was asked to help assess the feasibility of CVD risk assessment in community pharmacies in the MidCentral district. Feedback from MCPG included the following points:

- Community pharmacies want to be involved in providing such services to the MidCentral population.
- Pharmacies have no wish to duplicate the work or "tread on the toes" of PHOs and general practices and would prefer to provide CVD risk assessments as part of a wider primary health network.
- Currently, it would be difficult to provide CVD risk assessment without duplicating general practice/PHO services, as communication networks to enable community pharmacy to identify patients in need of CVD risk assessment are not yet developed.
- Provision of CVD risk assessment could be linked with current community pharmacy work on reducing medicines wastage and potential community pharmacy work around improved patient adherence with statin therapy.
- CVD risk assessment in community pharmacy would require access to extra resources such as subsidised laboratory tests, or point-of-care testing, and blood pressure measurement equipment. Maintenance and regular calibration of such equipment would also be required, as would the provision of professional development around CVD and CVD risk assessment. Some investment from MidCentral DHB to enable this would likely be expected.

In addition, it is clear that to help achieve the initiatives in Objective 2 of the MidCentral DHB Cardiovascular Service Plan, community pharmacy services would need to adjust the principle service focus (i.e. supply of pharmaceuticals) to enable the recognition and screening of people at risk of cardiovascular disease, and to focus those services on the needs of target population groups such as Maori and Pacific peoples.

MCPG surmise that efficient provision of CVD risk assessment from community pharmacy is not currently feasible. However, community pharmacy could easily support CVD risk assessment provided by other primary health providers, by working to raise public awareness of who should receive, and the benefits of CVD risk assessment and of healthy lifestyle choices.

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[1] Available at: www.psnc.org.uk/data/files/publications/260/EN15_NHS_Health_Check_service_spec.pdf

This could be achieved via in-pharmacy promotions, and/or targeted discussions with potential candidates who self-identify or who are identified via pharmacy practice management systems. Such an activity could also be linked with the DHB-funded community pharmacy provision of sharps bins for people with diabetes.

Such activities would align with the following initiatives in the MidCentral DHB Cardiovascular Service Plan:

Initiative 17 Provide improved community based resources for working with individuals identified by health professionals as at risk of cardiovascular disease:

- Enhancement of the Green Prescription programme at the regional level
- Physical activity and exercise promotion programmes–through PHOs at the local level
- Nutrition and health promotion programmes
- Psychological support for lifestyle change
- Smoking cessation programmes
- An "expert patient" programme to encourage and support better self management
- Increased collaboration with intersectoral partners such as Sport Manawatu and Sport Horowhenua.

Initiative 18 Provide cardiovascular resource material in appropriate languages including Maori and major Pacific and Asian languages.

Initiative 19 Encourage all health professionals, particularly in the primary health care setting, to identify cardiovascular risk factors in their clients and provide appropriate interventions or referral to other services. This includes screening for heart failure of at risk people.

Initiative 22 Offer marae/community based programmes for Maori with cardiovascular risk factors to improve physical activity, weight management, and smoking cessation, for example.

5. CONCLUSION

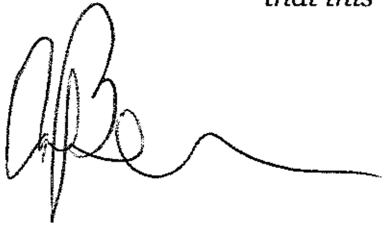
With some investment from MidCentral DHB, it is feasible that CVD risk assessment can be provided from community pharmacy. However, until integrated communication networks are developed, it is likely that a proportion of CVD risk assessment in community pharmacy will duplicate services provided by other primary health providers in the district and such investment from MidCentral DHB at this time is not considered judicious.

At this time, community pharmacy's role in the management of CVD could most easily be expanded from the provision of medications to include the provision of advice and support around CVD risk and healthy lifestyles. This expanded pharmacy service would also likely require some investment from MidCentral DHB over and above the Pharmacy Services Agreement, but alternatively, could be aligned with and funded from PHO Health Promotion services. MidCentral DHB should look to the Manawatu Community Pharmacy Group to work with local PHOs to develop such an opportunity.

6. RECOMMENDATION

It is recommended:

that this report be received



Andrew Orange
Pharmacy Advisor
Funding Division

TO Community and Public Health Advisory Committee

FROM Ross Smith
Project Manager
Antenatal HIV Screening Programme

DATE 16 July 2009

Memorandum

SUBJECT **ANTENATAL HIV SCREENING PROGRAMME - UPDATE**

1. SUMMARY

1.1 Purpose

This paper provides an update of the work carried out to implement this screening programme which is overseen by the National Screening Unit (NSU) of the Ministry of Health.

1.2 Executive summary

Routine screening of antenatal bloods for the HIV (human immunodeficiency virus) has commenced across the MidCentral DHB district. The programme has been implemented within the expected time frame and within budget.

1.3 Recommendation

It is recommended:

that this report be received.

2. INTRODUCTION

The Antenatal HIV Screening Programme (the programme) aims to detect HIV in pregnant women to reduce the number of babies born with HIV. The antenatal HIV screening programme has had a long gestation, both nationally and here in MidCentral.

This paper provides an update of the work carried out to implement this screening programme which is overseen by the National Screening Unit (NSU) of the Ministry of Health.

3. BACKGROUND

In June 2005, the Ministry of Health announced that New Zealand was moving to a policy of routinely offering HIV screening to all women as part of standard antenatal care. This was in response to failure of the previously released MOH guidelines of 1997 which had recommended a risk based screening approach. There had been a number of reports of the birth of babies who were positive for HIV where the status of the mother had not been checked antenatally. Conversely, there had been no reports of HIV positive babies born to women in NZ where the maternal diagnosis of HIV had been made antenatally or prior to pregnancy.[1]

The use of a combination of highly active antiretroviral therapy, the selective use of caesarean section and the avoidance of breast feeding has made perinatal HIV infection a preventable disease. This policy was in keeping with international practice which has demonstrated that, because of the high cost of antiretroviral therapy for children diagnosed with HIV, antenatal screening was cost effective even in low prevalence countries. [1]

Locally, obstetricians, both community based and hospital based midwives, and paediatricians were keen to implement the programme early. The Women's Health Unit had previously successfully managed HIV positive women during pregnancy and delivery and there was paediatric expertise in the management of HIV infection. There had been two 'near misses' with failure of the risk based screening approach and positive women having been diagnosed for reasons other than their pregnancy.

However, there has been national consumer concern that if there was routine antenatal HIV screening it would become a 'tick the box' test as Syphilis and Hepatitis B had become. [1] The programme consequently came under the National Screening Unit umbrella to ensure consistency of information provided to practitioners and consumers, monitoring of the programme and follow-up of women. Funding was provided for appointment of local coordinators to provide education, information, support and monitoring of the programme but not for testing. This resulted in slow roll out of the programme nationally. [1]

Locally, there were some initial difficulties in implementation because of changes in personnel and programme responsibility however in September 2008 a project team was established, supported by a regional advisory group, with the aim of implementing the programme by the end of 2008/09. In February 2009 a Coordinator was appointed to run the programme for MidCentral.

Universal screening of pregnant women for HIV commenced on 8 June 2009.

The programme offers the HIV test at the same time as other routine antenatal blood tests (blood group and Rhesus factor, full blood count, hepatitis B, rubella and syphilis). One sample of blood is used for all tests and all of the tests are free to most women.

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[1] Extracted from a paper by Anne Robertson, November 2008

A critical aspect of the programme is the issue of 'informed consent' or ensuring that women have had sufficient information to make an informed decision before they decide to have the test. Guidelines on informed consent and a number of other criteria were required to be met by the DHB prior to implementation. They were outlined very clearly in a comprehensive 'programme pack' provided by NSU.

4. PROGRAMME PROGRESS

In December 2008, MDHB presented our 'readiness to implement' plan to the National Antenatal HIV Screening Implementation Advisory Group (NAHSIAG) receiving a positive response and red light to progress with the project.

The NSU established an Advisory Group to support the national implementation of the programme. The purpose of the Advisory Group was to provide multidisciplinary advice to the NSU on matters pertaining to the national implementation of universal offer HIV screening in pregnancy'. The group includes members with a wide knowledge and experience of antenatal care, infectious diseases and HIV.[2]

The NAHSIAG developed criteria that DHBs should meet when commencing a universal offer of antenatal HIV screening programme. The criteria are listed below:

- Appointment of a local coordinator and development of a project plan.
- Support of local practitioners and stakeholders
- Ability to meet national requirements for obtaining informed consent.
- Professional endorsement of training/education programme(s) for health professionals.
- Laboratory test request forms meet agreed national specifications
- Implementation of agreed national testing and result confirmation algorithms
- Ability to ensure appropriate management, follow up and support for HIV positive women and their babies.
- Ability to collect, monitor and provide required data for local and national programme monitoring.
- Consideration of privacy, immigration, insurance and other key issues
- Reducing Inequalities issues addressed.

A Regional Advisory Group was established to guide the project team on local issues and to endorse the educational resources, communication plan, laboratory algorithms, management of positive women plans and other key aspects of the project. The composition of the group is attached as Appendix 1.

All of the criteria listed above have been met prior to 'go-live' on 8 June. There is some ongoing work on providing further education for referrers who did not attend one of the planned sessions. In addition work is continuing on finalising the method of extracting laboratory data and assisting General Practice with the changes required to Practice Management Systems.

Attendance at the education sessions was clearly impacted by the H1N1 flu virus pandemic planning. Where referrers could not attend a planned education sessions they have been provided with the educational resource, the management of positive woman guideline, the NSU 'Guidelines for Maternity Providers' booklet and information sheets for referrers to use when seeking informed consent from women.

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[2] Interim Programme Pack, NSU

5.9

5. FUNDING APPROVAL FRAMEWORK

5.1 Evidence to support approach

The most recent evidence on the problems with the risk assessment approach and the change to a universal offer programme is attached as Appendix 2. This information is an extract from the 'Interim Programme Pack' provided to DHBs by NSU.

5.2 Linkage to DHB strategies

MidCentral District Annual Plan 2008/09:

DAP initiative	Progress
DAP 20: Implement ante-natal HIV screening as from 1 October 2008	Complete

5.3 Equity summary

The programme is a universal offer to all pregnant women. In most cases the offer will be made by the woman's lead maternity carer or GP, therefore women who do not engage with antenatal or maternity services until they are ready to have their baby are more at risk. To mitigate this risk the programme specifically addresses the issue of 'unbooked women' through the provision of bedside test kits that can be used prior to birthing. Negotiations continue around ongoing management of this issue.

The project team has sought advice from the Maori and Pacific health advisors to MidCentral DHB and is aware of the development of tikanga best practice guidelines which will influence how the programme is delivered – for example phlebotomy services.

5.4 Measurement/evaluation/reporting

Antenatal HIV Screening Programme data is collected, recorded and stored in accordance with the requirements of the NSU. A minimum dataset has been provided. Data is delivered to NSU on a quarterly basis via spreadsheets which also provide the non-identifiable information to the Aids Epidemiology Group (AEG) in Dunedin.

The AEG has been contracted by NSU to provide monitoring and evaluation of certain aspects of the programme. The monitoring and evaluation plan has received multi-region Ethics Committee approval. AEG will report quarterly to NSU.

6. IMPACT ON THE REGION

The prevalence of HIV is relatively low in MidCentral. It is anticipated that 1-2 positive women will be identified every two or more years. The outcome for babies with appropriate timely intervention is very good with an extremely low risk of the baby contracting HIV.

7. FINANCIAL IMPACT

MidCentral DHB is funded through a CFA variation to deliver the programme. The funding and associated terms and conditions are included in a 'back to back' internal service level agreement with MidCentral Health. The programme comes under Public Health with expert advice and oversight from Sexual Health service.

Funding has been provided for a three year period with an upfront amount to cover project management and other one-off costs such as reprinting laboratory request forms. The majority of the annual funding is for the programme coordinator as MoH specifically excluded the additional cost of laboratory testing from the funding.

A satisfactory arrangement for the marginal cost of the additional HIV test for first antenatal bloods has been negotiated with Medlab Central and is part of the overall laboratory contract.

8. CONCLUSION

The programme has been implemented within the expected time frame and within budget.

9. RECOMMENDATION

It is recommended:

that this report be received.

Ross Smith
Project Manager - AHIV
Funding Division

5·11

Appendix 1

Regional Advisory Group – Antenatal HIV

Amanda Rouse	Hospital Midwife
Anne Robertson	O&G, Sexual Health
Barb Bradnock	Funding Division, MidCentral DHB
Bridie Thomas	LMC Midwife
Cheryl Benn	Midwifery Advisor, MidCentral DHB
Dr Andy De Vyer	GP
Dr Murray Shaw	GP
Dr Trevor Parry	GP
Francis Guthrie	Compass Health
Gill Stacey	Counsellor
Helen Talamaivao	Pacific Advisor, MidCentral DHB
Jean Hera	PN Womens Health
Jodie MacDonald	Radius, Practice Mgr
Judy Boxall	Service Manager Public Health (including Sexual Health), MidCentral DHB
Kelly Wylie	Pahiatua Early Services Hub
Nicky Pereira	Paediatrician
Nirmala Nand	Ethnic Council
Robert Holdaway	Public Health, MidCentral DHB
Ross Smith	Project Manager
Samuel Chan	Microbiologist, Medlab Central
Shane Ruwhiu	Maori Health Advisor, MidCentral DHB
Steven Grant	Obstetrician

Appendix 2

Background Information on the Universal Offer Antenatal HIV Screening Programme

1.1 HIV Screening in Pregnancy

1. Effective interventions that reduce the risk of pregnant women transmitting HIV to their infants have led to a greater emphasis on antenatal HIV screening worldwide. It is estimated that if women with HIV are identified during pregnancy and use a combination of interventions, the risk of perinatal transmission can be reduced from as high as 31.5% to less than 1%.[3] In fact there have been no cases of babies being infected perinatally where HIV has been diagnosed and treated in pregnancy in New Zealand.[4]

2. The primary benefits of antenatal HIV screening are to prevent perinatal transmission of HIV infection and to enable early treatment of women. It will also benefit the community by reducing potential transmissions.

3. Previous antenatal HIV screening policy in New Zealand, developed in 1997 recommended the assessment of all pregnant women for their risk of HIV. The policy stipulated that where risk factors were identified or not clear, counselling and voluntary testing should be offered. There is evidence that risk based guidelines were not being appropriately implemented.[5 6]

4. Current estimates suggest that HIV prevalence among pregnant women is 1.5-4.0 per 10,000.[7] Overall incidence of HIV is rising, and we are now seeing further increases in HIV among women. The implications of HIV are significant to all people in society.

5. Submissions to the National Health Committee expressed concern that the policy on HIV screening in pregnancy had not been promoted or supported and that there had been a lack of training for maternity care providers about HIV and antenatal HIV screening. In October 2004 the National Health Committee (NHC) released its report *HIV Screening in Pregnancy: A report to the New Zealand Minister of Health.* The report reviewed antenatal HIV screening practices in New Zealand and the way current guidelines are being implemented. The NHC recommended a dual approach:

   - Improve the implementation of the existing guidelines on HIV risk assessment in pregnancy in New Zealand with appropriate education and funding of Lead Maternity Carers (LMC's); and
   - Pilot the feasibility and acceptability of a universal offer of HIV screening in the Auckland region.

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3 National Health Committee, 2004. *HIV Screening in Pregnancy.* Wellington: Ministry of Health.

4 AIDS Epidemiology Group. University of Otago. 2006. *Universal Routine-Offer Antenatal HIV screening Programme: Monitoring and Evaluation Plan.* Wellington: Ministry of Health. P.46

5 Chambers S et al. 2001. Maternity care providers' attitudes and practices concerning HIV testing during pregnancy; results of a survey of the Canterbury and upper South Island region. In *NZ Med Journal* Nov 23 114(1144). P. 507-8

6 Heckert. K. et al. 2001. Women's acceptability of screening for HIV in pregnancy. In *NZ Med Journal.* Nov 23 114(1144). P. 509-12

7 Dickson N et al. 2002. Estimates of HIV prevalence among pregnant women in New Zealand. In *New Zealand Public Health Report.* Wellington: Ministry of Health. (A copy of this is included in this pack on page 40 of the monitoring and evaluation plan.)

6. In New Zealand between 1997 and 2007, despite risk assessment guidelines, at least 16 children were born HIV positive to mothers who had undiagnosed HIV[8].

7. On 13th June 2005 the Health and Disability commissioner (HDC) released his findings in a case relating to antenatal HIV screening [Case 04HDC14171]. The commissioner noted that the case highlighted the urgent need for education of antenatal providers and for clear guidance from the Ministry of Health. The Commissioner recommended that national policy on HIV screening in pregnancy be determined and appropriate guidelines implemented in a more consistent and effective manner, with education of antenatal providers as a matter of urgency.

1.2 The Ministry's policy approach

1. After consideration of the National Health Committee (NHC)'s report, public and stakeholder responses and the HDC report, the Ministry of Health recommended a staged national implementation of a universal routine offer of antenatal HIV screening for women in New Zealand. The offer includes the woman's right to decline HIV screening. This started in Waikato DHB because they had already done significant work around the development of a local programme. It was recognised that further work would be required to address some of the possible issues associated with a staged implementation of a routine offer of antenatal HIV screening.

2. The policy approach decided upon was not specifically what the NHC had recommended. However, the Ministry of Health believed that the approach being pursued was most likely to achieve the outcome of reducing perinatal HIV infection.

   The reasons for this difference in approach included the following:

   - It is more efficient use of resources than implementing both enhanced high-risk screening and a universal screening pilot simultaneously.
   - The duel approach recommended by the NHC was likely to have caused confusion and created inequalities. Rolling out a universal offer of an HIV test in pregnancy is likely to reduce confusion and ensure greater consistency of practice.
   - For the investment of additional resources, there was no guarantee that offering screening to those considered to be at high-risk would have been effective in reducing perinatal infection rates. However, the United Kingdom experience has shown that a routine offer, with the option of declining the test, has significantly decreased its perinatal infection rates.

3. The National Screening Unit (NSU) is responsible for national oversight of the programme. It provides nationally consistent consumer information, professional guidelines and education, training and resources, funding for regional AHIV coordinators, data collection and monitoring and evaluation of the programme.

1.3 Staged implementation of the programme

1. Maternity Providers will be responsible for ensuring the provision of a universal offer to pregnant women. District Health Boards and the National Screening Unit of the Ministry of Health will provide leadership and oversight of the programme in the regions. DHBs will need to engage with Lead Maternity Carers and other antenatal care providers in order to implement and evaluate the routine offer of HIV screening in the regions.

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[8] Aids Epidemiology Group. (2008). HIV and AIDS in New Zealand – 2007. in *AIDS – New Zealand.* February Issue 61. ISSN 1170-2656.

Section DA 19 (b) and section DB 10 (b) of the section 88 'primary maternity services Notice 2007' notes that, "for a women in the first trimester of pregnancy, the LMC (or non-LMC first trimester care providers) must provide the following services", "(b), providing appropriate information and education about screening and offering referral for the appropriate screening tests that the Ministry of Health may, from time to time, notify maternity providers about". [9]

2. DHBs will be responsible for funding the service costs associated with antenatal HIV screening. This will include the laboratory costs including screening and confirmatory testing. In the event of a positive diagnosis, resources required for referral to specialist antenatal care, infectious diseases and HIV counselling and treatment will be provided. This is extended to include pregnant women who would not usually be eligible for publicly funded health care on immigration grounds. In this case the baby will be entitled to continued care required to prevent perinatal transmission. This has been communicated to DHBNZ and the DHB Chief Executives.

3. The Ministry of Health will provide the programme funding to DHBs, with phased national roll-out occurring over three years. The funding will provide for training and education, data collection, monitoring and evaluation and DHB programme co-ordination. All DHBs will have implemented the programme in their regions by December 2008.

4. The AIDS Epidemiology Group of the University of Otago will work with the NSU, to gather data for the monitoring and evaluation of antenatal HIV screening. The AIDS Epidemiology Group has established a monitoring and evaluation framework for the Antenatal HIV Screening Programme in New Zealand under contract to the Ministry.1

5. The Ministry of Health has a national travel assistance policy available at the following site: www.moh.govt.nz/travelassistance. It would be ideal for travel arrangements for low income women to be made and paid for in advance where possible so as to reduce the stress involved with having to pay for travel and claim back costs from the DHB.

[9] Ministry of Health. 2007. Primary maternity Services Notice 2007. Section 88.

TO Community and Public Health Advisory Committee

FROM Executive Assistant to General Manager Funding Division

DATE 15 July 2009

Memorandum

SUBJECT **HEALTH AWARDS 2009**

1. SUMMARY

1.1 Purpose

This report informs the Committee of the planning, development and progress of the Health Awards 2009.

1.2 Executive summary

MidCentral DHB has hosted the Health Awards ceremony since 2005. Each year the event has grown in numbers and prestige the Awards are considered a resounding success in terms of recognising and honouring excellence in health service delivery. The event will be held on Friday 30 October (downscaled slightly).

1.3 Recommendation

It is recommended:

that this report be received.

Funding Division
MidCentral District Health Board
PO Box 2056
Palmerston North
Phone +64 (6) 350 8626

2. INTRODUCTION

This report informs the Committee of the planning, development and progress of the Health Awards 2009.

3. BACKGROUND

MidCentral DHB has hosted the Health Awards ceremony since 2005. The Guests of Honour in the past have included the Hon. Annette King in 2005, the Hon. Steve Maharey in 2006, the Hon. Pete Hodgson in 2007 and the Hon. Darren Hughes in 2008 on behalf of the Prime Minister.

Each year the event has grown in numbers and prestige and in 2008 the Awards ceremony was attended by over 650 people. The Awards are considered a resounding success in terms of recognising and honouring excellence in health service delivery, and as such the event will be held again in 2009. Due to fiscal constraints it is intended that the event be downscaled slightly, and accordingly, planning is underway for 500 guests to attend the Awards dinner and ceremony to be held on Friday 30 October.

Given the current economic climate and the high levels of high need within our population we are faced with an increasing challenging environment as we strive to improve the health of our communities. The difficulties and complexities faced by services have allowed us to witness more innovative service delivery across the district. It is fitting that the theme of year's Health Awards is innovation, with our supreme award celebrating unique and creative approaches to health care.

This year the Health Awards are open to any individual, team or organisation working to benefit the health and wellbeing of the people within MidCentral District. Eighty applications were received in 2008 and this number is expected to increase to a target of 100 across primary and secondary providers.

A judging panel will be convened, comprising representatives of the Board, the community, and health sector professionals, to determine the award winners which will be announced during the ceremony in October.

3. BUDGET

The budget for the 2009 Health Awards is reduced to two thirds of the budget of the 2008 event. Budgeted expenditure has been largely reduced in the areas of venue hire, audio visual and lighting. Additional measures taken to increase other sources of funding for the event include slight increase in the ticket prices, and a focus on increasing the sponsorship contribution to the awards (expected to surpass 2008 levels).

3. COMPONENTS OF THE PROGRAMME

3.1 Award categories

The categories chosen for this year's awards reflect on the themes of previous years. The categories are designed to attract interest from a large number of providers in the District.

Comments and feedback from last year's judging panel have also been taken into consideration. The award categories for 2009 are:

- Supreme Award 2009 – Innovation of the Year
- Leadership Award
- Kotahitanga Award – Operational Quality Controls
- Excellence in Addressing Health Inequalities Award
- Excellence in Child and/or Youth Health Services Award
- Excellence in Mental Health and Addictions Award
- Excellence in Services for Older People Award
- Excellence in Chronic Care Services Award
- Excellence in Collaboration and Integration Award
- Excellence in Training and Education Award

3.2 Application process

Application packs will be sent out to potential applicants, both electronically and in hard copy, by end July. Applications close 5.00pm Friday 11 September 2009.

3.3 The Awards ceremony

The Awards ceremony will be held at the Awapuni Function Centre (Palmerston North Racecourse). This venue can comfortably seat 500 guests.

Tickets to the ceremony - which include dinner and beverages, will be sold for $35 each or $300 for a table of ten people (15% discount).

A trophy and prize money will again be offered to the winner of each award category.

3.4 Promotion of the Awards

Media releases will be sent out during the application process and leading up to the Awards ceremony. Paid advertising will also run in the Manawatu Standard.

The Awards will generate opportunities for post event media activity through coverage of the category winners and their services.

A web page for the Awards is currently being developed to be hosted on the MidCentral DHB website.

3.5 Organising Committee

An organising committee has been established to prepare for the Health Awards. The Awards committee is made up of members of the Funding Division and will be coordinated by Rebecca Bensemann and Caroline Rowe.

4. CONCLUSION

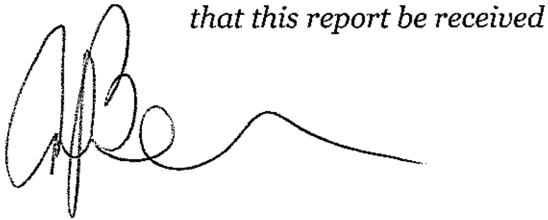
Since their inception in 2005, the Awards have been very successful in honouring those who work to benefit the health and wellbeing of the people within the MidCentral District. We anticipate that over 100 nominations for awards will be received this year. The ceremony and dinner will be held on 30 October 2009 and it is planned to cater for 500 attendees.

The organising committee is meeting regularly to progress the event and ensure its success.

5. RECOMMENDATION

It is recommended:

that this report be received



Rebecca Bensemann
Executive Assistant to General Manager
Funding Division

TO Community and Public Health Advisory Committee

FROM General Manager
Funding Division

DATE 17 July 2009

Memorandum

SUBJECT **FUNDING DIVISION OPERATING REPORT – JULY 2009**

1. WORK PROGRAMME

Reference	Matter	Achieved	Comment
58	Maori Scholarships and Internships	N	Delayed due to funding limitations.

2. LOCAL MATTERS

2.1 Health of Older Person

2.1.1 Special Issues Audit

This month Funding Division instigated a formal audit of Karaka Court Limited which operates two Woodlands facilities in Palmerston North and Feilding respectively. The draft report is to hand and identifies a raft of shortcomings both in terms of breach of legislation, breach of DHB contract and breach of Best Practice. Sixteen of the 36 findings are rated as high risk requiring immediate urgent attention, eight are medium risk and eight low risk. Four findings have no specific recommendation. Most of the serious risk areas pertain to the Palmerston North facility. DHB intervention has commenced and will initially require the provider to urgently submit a corrective actions plan after which further decisions will follow relating to any need for contract enforcement.

2.1.2 Improving effectiveness of certified aged residential care provider audits

Issues identified in the quality of care provided in aged residential care services has brought into question the effectiveness of certified aged residential care provider audits.

The audit regime consists of an independent audit programme, as required under the Health and Disability Services (Safety) Act 2001 and an implemented District Health Board contractual audit programme.

Designated Audit Agencies (DAAs) are now required to have third party accreditation in relation to their health and disability services auditing activities. Conflicts of interest have arisen in the way that DAAs are actioning the third party accreditation. Over auditing of services has been raised as a concern by residential care providers who contend that this is both disruptive and costly. Further, there are indications that the quality and consistency of audits between DAAs themselves, and between DAAs and DHBs requires review.

As a consequence the Ministry of Health, in collaboration with District Health Boards has determined the need to improve the efficiency and effectiveness of monitoring approaches of aged residential care services. Furthermore the Government has publicly committed to strengthening the auditing and monitoring of rest homes and has signalled its intention to introduce "spot auditing", publish audit and compliance reports and reduce multiple audits.

6·2

These issues are being worked on in four distinct but related work streams:

Enhancing Designated Audit Agency (DAA) quality

- Identify third party accreditation bodies suitable to accredit DAAs for health and disability services audits within the New Zealand context that would be endorsed by the Ministry of Health
- Work with any such bodies to ensure Ministry of Health requirements (assurance of quality) can be met
- Introduce a requirement for third party accreditation of DAAs and associated implementation plan
- Enhance current monitoring and reporting requirements of DAAs in order to achieve a higher level of consistency of approach and reporting to the Ministry of Health.

Expanding unannounced audits including the introduction of a spot audit process

- Consider the most appropriate mechanism for implementing an unannounced audit process[1] in addition to current unannounced processes (Consider who is responsible for undertaking the audit)
- Determine the scope and intended purpose of an unannounced audit including spot audits
- Identify the most cost effective and efficient means of introducing unannounced audits consistent with the framework proposed to reduce multiple audits
- Evaluate the effectiveness of an unannounced audit process through a pilot or series of pilots if applicable.

Publishing summary certification audit findings

- Agree with providers and DAAs what factual information (or metrics) will be presented in a summary of audit findings to ensure a consistent approach to what will be published for each provider
- Consult with consumer groups to ensure information is fit for purpose
- Publish an informative summary of audit findings that will enable consumers and their families to make more informed choices regarding aged residential care services[2]
- Develop a process to update or remove the summary in the event that it is no longer factual (for example in the event of an HDC complaint being upheld where standards of care can not be assured through prior audit evidence).

Reducing multiple audits and removing duplication between audits

- Develop a framework for statutory and contractual audits undertaken by the Ministry of Health and District Health Boards that results in a reduction in the number of multiple audits and improve the alignment of audits ensuring duplication between different audits are removed

2.1.3 Spot Audits

The Minister expects DHBs and the MoH to find a solution that rationalises the number of multiple audits occurring. The Minister's view is that an unannounced audit should provide a reliable insight into the quality of services which the public can then rely on for decision making. Several working parties have been set up and include representatives from MOH, DHB and aged care providers association. The MidCentral Portfolio Manager is participating in these.

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[1] Note that unannounced audit processes undertaken in Australia are not comparable as the party undertaking the audits is a government agency.

[2] Work currently underway for a go-live phased in approach 1 June 2009

The following table describes the emerging quality audit framework which gets progressively more robust from top to bottom.

In future what we have known as surveillance audits will likely be substituted by unannounced audits to meet the Minister's expectation for spot audits. These typically occur at 18 months, or half way through the 3 year cycle of routine auditing. They are not a substitute for special issues audits where serious complaints are laid and DHBs will still carry out such in depth investigations as necessary.

Table 1: Emerging quality audit framework

Audit description	Current MOH[3]	Current DHB	HDC	Proposed
New Service	Provisional Partial Provisional	Pre-agreement audits		Manage requirements of pre-agreement audits under provisional and/or partial provisional audits. (Other aspects – non-audit related continue to be managed by DHBs for establishing new contracts for services)
Routine	Certification Re-certification Surveillance	Routine audits Routine audits with issues Clip on audit tool to HDSS (Central Region DHBs)		Certification, re-certification and surveillance audits meet the requirements for contractual auditing. **Surveillance audits become unannounced.** District Health Board involvement in certification audits via DAA's including requirements and access to all reporting via MoH website.
Related audit activities	Progress reporting	Progress reporting		Progress reporting managed through certification process. Information shared with DHBs via MoH website.
Exception	Inspection	Issues Based Audits – announced & unannounced	Complaints investigations	Unchanged[4]
Related legislation	Health & Disability Services (Safety) Act 2001	NZ Public Health & Disability Act 2000	Health & Disability Commissioner Act 1994	Unchanged
Other monitoring activities		Quality initiatives Expert practitioner support visits Self-auditing & reporting Relationship visits		Unchanged

The goal behind the tool's development is an audit that is "not paper based or policy centred, but which looks at how care is actually delivered." Additionally, it is reiterated that the audit needs to be unannounced.

In practice an unannounced audit will function as a 'test' or key indicator check. If an audit raises flags, then a more substantial audit could be commissioned as a follow up.
A possible modular structure that allows for a core focus and sampling of other areas of service delivery as chosen by auditors on the day is also being considered. Both DHB and MoH want to incorporate Certification requirements into the tool's development, so that it has the potential to be used within either the Certification framework or as part of contract monitoring by DHBs.

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[3] As related to the ARC contract and Specialist Hospital (psychogeriatric) contract (note other contracts excluded)

[4] Includes the current approach to concurrently conduct inspections and issues based audits where appropriate or have one agency act on behalf of the other

2.1.4 Publishing of summary audit information – Aged Residential Care

The purpose is to provide informative information to the public which can assist them in building knowledge of a service.

From 1 June 2009 summary audit information from Health and Disability Service Standards is being published on the MOH website under the HealthCERT link. This includes a narrative summary written by the lead auditor of the Designated Audit Agency (DAA) conducting the certification audit and a quantitative matrix which summarises levels of attainment against standards which are grouped by the 6 categories that describe the principle outcomes which support the safe provision of services to consumers.

From 1 August 2009, it is intended to include addenda written in the form of a summary statement which can include:

- An update on the level of attainment against progress reporting criteria and surveillance audits as monitored and audited by a Designated Audit Agency.
- Links to HDC reports where a service has been found in breach of the Code of Rights where there has been open disclosure to identify the service concerned.
- A summary of inspection findings where the Ministry of Health has conducted an inspection in relation to a substantiated complaint.
- A summary of audit findings where a District Health Board or their agent (Shared Support Agency) has conducted an 'issues based' audit in relation to a substantiated complaint.

An operational policy has been written to support the publication process. This includes a requirement of the Ministry of Health to provide notification to the service provider on where complaint information will be published. It is intended that information for publication is developed in consultation with service providers.

The Ministry of Health is adopting a national approach to the publication of audit information which is fair and meets with open disclosure principles. District Health Boards are also able to publish summary statements of the outcome of substantiated issues based audits on the HealthCERT website which have been developed in consultation with the service provider.

2.2 Maori Health

2.2.1 Maori Health Workforce Strategy

Whakatutuki Moemoea Maori Health Workforce Development Group (WMMH WDG) continue to meet once a month. Due to the restraints of Funding for Maori Workforce Activities. A stocktake of achievements in Maori health workforce is being collated for the past 3 financial years. The stocktake results will be used in setting the 09/10 workplan for Maori health workforce.

Table 2: The current MidCentral Health Workforce by ethnicity (June 2009):

Head Count	Ethnicity						
Occupational Work Force	Asian	European	Maori	Not Stated	Other	Pacific Island	Total
Allied Health	2	250	43	100	28	1	424
Management / Admin	4	403	33	139	15	4	598
Medical	16	82	2	82	52	2	236
Nursing	3	752	66	297	62	15	1195
Support		28	1	12	5		46
Total	25	1515	145	630	162	22	2499

2.2.2 Primary Health Care Cultural Competency Framework

The Cultural Competency Framework in Practice is being led by Health Care Development and is a joint initiative between MidCentral Funding, Te Puna O Te Ora Maori Managers, Iwi/Maori Service Providers, and MidCentral PHO's.

The project is on track and plans are in place to engage with Maori health workforce across the region toward development of the cultural competency framework.

2.2.3 Pandemic planning in Maori Communities

Maori Management team is working through and drafting some key points about pandemic planning such as managing Swine Flu in Maori communities. The purpose of the engagement is to ensure that Maori health implications are included in discussions on the emergency operations response including those for Maori communities, marae and so forth.

2.3 Mental Health

2.3.1 Regional Mental Health Strategic Plan (RMHSP)

Steady progress has been made toward the implementation of the Strategic Plan for the Central Region. Quarter four has seen sectorwide consultation to test the Integrated Regional Mental Health Strategic Plan across the Central Region. Clinical Directors are meeting regionally and Portfolio Managers also continue to meet regionally.

A particular focus for the region is to scope potential costs and benefits of the 0800 Mental Health Line becoming a regional service. A final discussion document will be completed this quarter as networks and a governance framework needs to be aligned with the Regional Clinical Services Programme processes, which have yet to be finalised.

Central Region key achievements:

- Central Region DHBs have an approved Regional Mental Health Strategic Plan (RMHSP) articulating the vision for mental health services in 2016
- A gaps analysis report identifies where current services are not well aligned with the vision for services in 2016
- Regional priorities have been identified through workshops involving Clinical Directors, Senior Managers, Funding and Planning Portfolio Managers, a wide range of clinical staff, Māori, Consumers and other key stakeholders
- An implementation plan for RMHSP has been approved and is now in place. A key project is the development of a decision making framework for the development of mental health and addiction services (IRMHSP)
- An IRMHSP Steering Group is in place along with other recently developed network groups including Regional Workforce Development Strategy Group, Clinical Directors. A regional detoxification advisory group is now in place.

2.3.2 Regional Specialty Services (RSS)

A timely review of the Memorandum of Understanding for the four central regional services that the MidCentral DHB (population) has access to, will begin this month. This Memorandum of Understanding is an agreement between the Capital & Coast DHB and the Central Region /Tairawhiti DHBs for the provision of Regional Mental Health Specialty Services (RSS) to the region.

The services provided are based on the "Commissioning Plan" developed in 2000 and the current IDF Contract. These are:

6.6

- Mental Health Intellectual Disability Team (MHCS31)
- Regional Personality Disorder Service (MHCS10)
- Specialist Maternal Mental Health (MHCS28)
- Regional Early Intervention Services (MHCS08)

The Portfolio Manager will coordinate a meeting in Palmerston North with the assistance of the Technical Advisory Service, to discuss any interface issues and benefits of the regional services. There are several interested groups thus far in participating in the discussion, including the Supporting Parents In Need group (led by Paediatrician Dr Giles Bates).

2.3.3 Local Advisory Group (LAG)

Progress is being made to develop a work plan for the local mental health and addictions sector 2009-2014.

The approach is to stimulate community and consumer ownership, with a vision of enhanced coordination and service delivery in the primary and secondary sectors. The configuration of LAG infrastructure, processes and membership will also be reviewed.

2.4 Primary Health

2.4.1 Rural Workforce Retention Funding 2009/2010 year

The workforce retention fund is a flexible resource to assist with retention and recruitment of all primary healthcare workers serving rural communities.

The fund is paid to PHO's by DHB's according to a formula based on degrees of "remoteness" (indicated by the rural ranking score of the General Practitioners). The current workforce retention funding allocation formula and rural workforce retention funding is specified in clause 1 of Schedule J3 of Part J of the PHO contract.

PHO's may apply the funding to a range of strategies to create favourable working conditions including, but not limited to:

(a) Time off duty;
(b) A supportive professional working environment;
(c) Access to continuing professional development and peer support;
(d) Financial incentives; and/or
(e) The ability to enter and leave rural practice with minimal restrictions.

Each year the Funding Division allocates the amount of Rural Retention Funding per PHO. To access this funding, each PHO is required to provide a Rural Workforce plan to the DHB for formal sign off prior to payment.

For the 2009/10 year the total funding allocated to all four PHO's is $296,094.51. This is a slight increase in the 2008/09 year but takes into account the increased General Practice enrolments and the compulsory FFT of 3.116% that is required to be added by the Ministry.

<u>Foxton collocation project</u>

A meeting was recently held in Foxton to discuss the Foxton collocation project. The meeting was attended by the key stakeholders from the community, the Horowhenua District Council and MidCentral DHB. Murray Georgel, Mike Grant and Craig Johnston were in attendance from the DHB. The DHB set out its position:

- While the DHB supports the collocation concept and believes it is the foundation of sustainable primary health care services in the future, the key health providers in Foxton are already adequately accommodated so there is no pressing problem to be addressed.

- To be meaningful collocation needs the support of the cornerstone primary health care providers. The collocation project needs to be led and managed at the local level by the Foxton community.
- The DHB has already provided funding of about $50,000 to support Foxton collocation and it is unlikely that any further direct financial contribution will be made to the development of the project.
- Once a centre is in place the DHB will move its services into it. The DHB would expect to pay a market rent for the space occupied.
- Once a centre is set up the DHB will contribute $25,000 a year for three years to support its viability during the transition period (which is often difficult for this type of facility).
- When DHB staff are relocated to a new centre the DHB's White Street property will be surplus to requirements. The DHB will then begin the disposal process. The DHB will not donate the property or the proceeds of the property to the community for the collocation project. The DHB considers that the offer of $25,000 a year for three years is equivalent in value and will be the full extent of the DHB's financial support.

The meeting culminated with unanimous agreement that it is the community's responsibility to drive the collocation project from this point forward, and that the Foxton Medical Trust is to keep the DHB and Horowhenua District Council informed of its progress.

2.5 Health Care Development

Because of the quantity and breadth of the workplan currently being undertaken by HCD, this report will cover aspects of chronic care in the MDHB district. Over the next three months more detail will be provided about these followed by reports of professional development.

2.5.1 Chronic Care Model (CCM) implemented into General Practice and a Maori Health provider

This MOH/DHBNZ funded project ($320K) is designed to facilitate implementation of the CCM into one urban and one rural general practice and one Maori health provider. It is a collaborative, interdisciplinary project which continues to meet key milestones. A survey as to how each organisation undertakes the management of chronic conditions has recently been completed to gain some baseline data against which the results of a repeat survey in 12 months time can be assessed.

A key finding from this process has been that participating general practices provide a basic level of chronic care support to clients whereas the Maori health provider scored higher indicating a reasonably good level of support. Areas requiring improvement have been highlighted for each organisation through the survey process and an action plan has been developed to help them address these. Work will now occur alongside these organisations to assist them in implementing these improvement processes.

2.5.2 Renal Model of Care

This MOH funded project ($180k) focuses on assisting Horowhenua general practice teams to develop improved Chronic Kidney Disease (CKD) management processes. It is collaborative and interdisciplinary, requiring that HCD, MCH renal services and primary health care teams work together to achieve this goal. Recent achievements include finalisation of the project plan, establishment of an Advisory Group and an Implementation Team and development of Letters of Agreement with all relevant general practice teams. Education on an array of topics has been planned and will commence in August with a presentation from Dr. Norman Panlilio. All health professionals in the Horowhenua region have been invited to attend.

An assessment tool has been developed which will be used to determine how well the processes and systems that general practice teams currently have established, assist those people who have CKD. This tool is based on the work of Wagner and the RNZCGP 'Aiming for Excellence' Cornerstone document. Those involved in the project include pharmacists, specialists, HCD, practice and PHO nurses.

2.5.3 Improving Care for People with Chronic Illness' Research

This two year project funded by MDHB examines the client perspective of living with a chronic condition, and the clinician perspective of managing populations with long term conditions, both at an individual (through a survey) and at a general practice level (through survey and focus groups). Some recent results from the focus groups showed that, from a nursing perspective, chronic care management could be improved at a practice level if the following barriers could be overcome:

- more time with patients
- a structure within which to provide care
- patients to be more engaged and managing regular attendance at the clinic
- more nurse-led clinics
- the need for mechanisms for evaluation of practice
- the time and resources to update skills

Doctors indicated the need for:

- better communication links with the community
- professional development programmes for practice nurses
- more mobile nurses
- resources for more nurse-led clinics
- group care processes (as opposed to focusing solely on individuals)
- less time pressure and time for reflection on practice
- more responsive funding mechanisms
- education around existing practices and structures for new staff

The first research cycle is now complete and a repeat survey of clients is due to commence in September. Clinicians will be re-surveyed in late 2009 and into 2010. Three papers focusing on the results from the first stage of the research will soon be ready for publication.

2.6 Child & Youth Health

2.6.1 Child Youth Mortality Review Coordinator

MidCentral DHB and Whanganui DHB have been successful in recruitment of a new Child Youth Mortality Group Coordinator. The successful applicant commenced 13th July 2009. An orientation package across both DHB's has been developed. The opportunity for the new coordinator to work across both DHB's will give them extensive experience and insight into the role quickly.

2.6.2 School Based Health Services

MidCentral District Health Board signed the Crown Funding Agreement early 2009 to enable the development of School Based Health Services for Dep one to three schools, teen parent unit and alternative education providers. As a result of the value for money expenditure review process being undertaken at the Ministry of Health the Minister indicated to DHB's in June 2009 that dep three schools would no longer be involved in this initiative and that funding would only be made available for a three year term.

Funding Division have worked with the Ministry to develop a new CFA to take these factors into account.

Previous discussions with Schools and stakeholders included the Decile 3 schools in the proposals and planning. The recent changes reduce the financial resources available to undertake the work and the planning will need to start anew.

Key stakeholders meet again 23 July 2009 to revisit how we can best meet the health needs for the young people in this new configuration given the reduction in funding.

2.7 Pharmacy

2.7.1 Access to Medicines Information Resources

In April 2008 the Funding Management Board approved up to $20,000 for the Centennial Clinical Library to purchase a 5-concurrent user, 12-month licence to allow all health providers in our region access to five medicines information resources via the MedicinesComplete website.

MedicinesComplete is a web-based service from RPS Publishing (a wholly owned publishing organisation of the Royal Pharmaceutical Society of Great Britain) that provides access to world-leading drug and healthcare references, some of which are considered seminal texts in medicines information.

While all health professionals in the MidCentral district can access these resources, this service is especially useful for pharmacy as it largely (if not wholly) meets the Ministry Pharmacy Quality Audit requirement that pharmacies have access to certain information sources. Utilisation data is presented below.

Figure 1: Total Utilisation of MedicinesComplete Databases

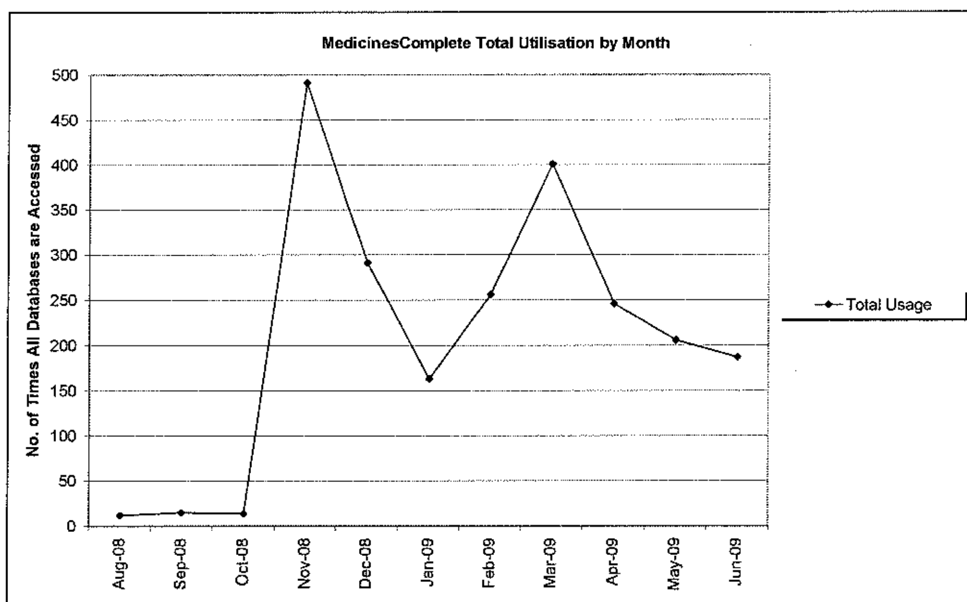
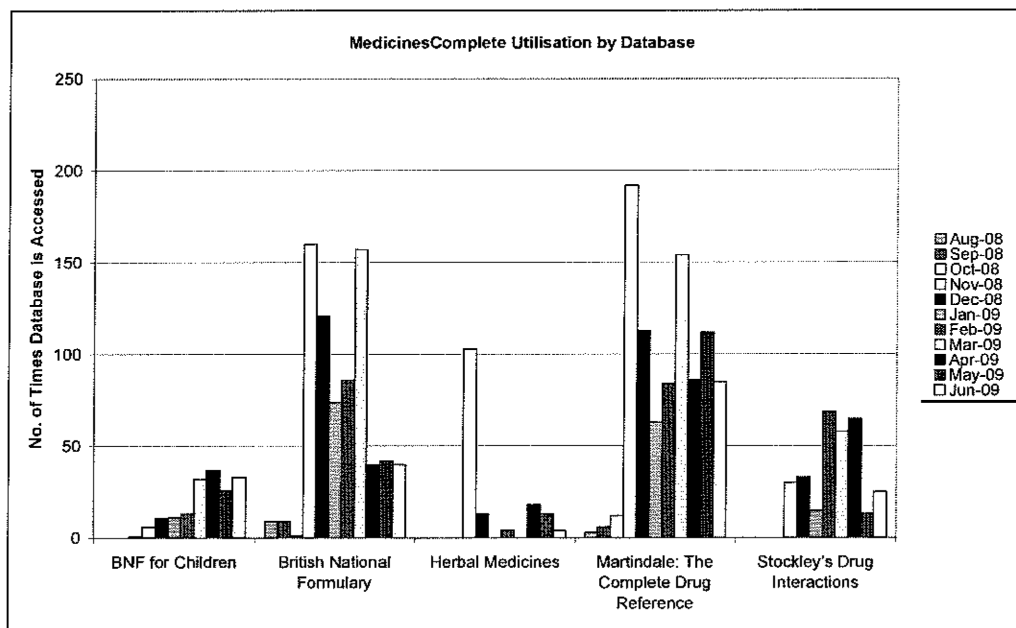


Figure 1 shows the utilisation of all MedicinesComplete databases to which MidCentral DHB health providers have access. Note that the service was only offered to health providers in the MidCentral region from November 2008. Activity prior to that time represents a few health professionals trialling the service prior to it being offered more widely, whilst activity after that time show a steady decline in utilisation, notwithstanding a dip reflective of the impact of the holiday season on the need for medicines information resources.
The utilisation rate for June 2009 is an average of just under 44 "hits" on the website per week, which is somewhat disappointing.

The databases most commonly accessed (indicated in figure 2 below) are the British National Formulary and Martindale, which are general texts on medicines. These are also texts that pharmacies are recommended to have available.

Figure 2: MedicinesComplete Database Utilisation



The licence for these services expires on September 30th, 2009. In preparation for this, the Pharmacy Advisor, Funding Division is working with the MidCentral Centennial Clinical Library to ascertain whether or not this service is cost-effective. A recommendation for continuation or otherwise, of the licencing for this service will result from this exercise.

2.7.2 Emergency Contraception

MidCentral DHB has recognised the need for access to the Emergency Contraceptive Pill (ECP) by funding its provision via general practices, nursing clinics, and other agencies such as the Youth One Stop Shop (YOSS). The ECP may also be obtained at a community pharmacy from ECP Accredited Pharmacists,[5] though pharmacy provision is not funded by MidCentral DHB.

In spite of its availability, barriers to access due to capacity (e.g. general practice and YOSS) and service cost (e.g. general practice and community pharmacy) have been reported. Additionally, rates of teen pregnancy and rates of pregnancy terminations and the costs associated with these continue to increase in the MidCentral district. Maori women are over-represented in teen pregnancy and pregnancy termination statistics for the MidCentral district.

Currently, community pharmacy has capacity to provide the ECP, but the cost of the service (a prerequisite consultation together with the medication if appropriate) must be borne by the patient, which creates barriers to access and inequity.

Several DHBs have provided subsidy for the ECP via community pharmacy, including Waikato, Nelson-Marlborough, and Auckland. Preliminary results from Auckland DHB's pilot project to offer free emergency contraception from community pharmacies, has coincided with a 13% reduction in the number of pregnancy terminations performed at the Epsom Day Unit in Auckland during October-December.

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[5] Pharmacists become accredited to provide ECP by undertaking training run by the New Zealand College of Pharmacists in conjunction with the New Zealand Family Planning Association. Once accredited, Pharmacists may provide ECP without the need for a prescription after appropriate consultation with the woman to ascertain appropriateness.

In line with initiative 16 of the MidCentral DHB Youth Health Strategy, funding to the Manawatu Community Pharmacy Group (MCPG) of $42,500 for the provision of free emergency contraception via community pharmacy to 1000 women 25 years and under, has been approved under GM delegated authority. This funding enables access from ECP Accredited Pharmacists (after an initial pharmacist consultation to assess the appropriateness of emergency contraception) to the ECP, information on locally available sexual health services, and 12 condoms, for a period of 12 months. MCPG will collect and collate annonymised data to report on service utilisation

Any potential impact from this service on unwanted pregnancy and pregnancy termination rates in the MidCentral district will also be monitored.

2.8 Secondary Care

A member wished to know the extent of influence that the Funder has over the quality of care within the Provider arm. In response:

Since the Provider arm and Funding division are not separate legal entities, no contract exists between the two. Instead, an Internal Service Level Agreement (ISLA) is in place between the parties defining the obligations of each.

The quality section of the ISLA requires the Provider arm to deliver services according to the Nationwide Service Framework (NSF). The NSF is the framework for delivery of services and is covered off in a number of accountability documents.

Under the terms of the ISLA agreement the Funder has no leverage over Provider quality.

Within the DHB structure the quality of MidCentral Health service provision is the responsibility of the Provider arm. Provider arm accountability arrangements are through the Hospital Advisory Committee through to the District Health Board. Accordingly the Funder is not involved in these areas and the Funders' influence is based on a good working relationship with the provider.

Quality requirements are set out in National Service Specifications, the Service Coverage Schedules and the Operational Policy Framework. These are Ministry documents ensuring national standardisation and include 'quality improvement', 'acceptability of service', 'quality audits' and 'clinical effectiveness'. Ministry sponsored service guidelines elaborate further on minimum quality expectations.

Many of the quality requirements are operational and clinically specific and are monitored and controlled directly by the Ministry. Further, clinicians are also accountable to their particular professional boards in terms of their professional conduct.

2.9 Population Health

2.9.1 HEHA

The Ministry has launched its new HEHA site and the opportunity for sharing information, strengthening collaboration and aligning health promotion planning templates is being explored.

The HEHA Steering group has received the Workplace Health Programme document and is scheduled to meet early next month to discuss implementing the recommendations.

2.9.2 Community Based Maori Action Projects

The second round of the Maori Community Action Plan Fund (MCAP) closed on the 26th June. A total of 11 applications were submitted ranging from:

- Gardens
- Traditional methods of gathering kai
- Mau Raukau
- Sport & wellness programme for youth
- Water safely awareness programme
- Wahine Triathlon
- Nutrition workshops

The funding panel have met to review and discuss the weighting grid and criteria. Applications have also been distributed to members to be assessed and to make recommendations for each individual application. The panel will reconvene on the 21st July to allocate and confirm partial funding, full funding or support to resubmit. These recommendations will then be forwarded to the GM for funding approval.

Planning is underway to expand the evaluation and monitoring process from round 1. The next phase is to provide evaluation and monitoring training. The components include:

- External expertise will lead the training process.
- Training will be required as a component of the reporting process for MDHB, which will support individuals in gaining the skills and knowledge to ensure the sustainability of projects and to identify any issues or barriers.
- Deliver evaluation and monitoring training for successful applications in round 2 by the end of August.

Projects will continue to be supported by the HEHA team.

At a National level, the Ministry of Health (MoH) are working across the 21 DHBs to discuss the following questions and ideas:

- What's working well, areas of success, highlights
- What are the areas for improvement, issues, concerns
- Models of good practice that can be shared with other DHBs
- Identify the sort of support required from the ministry by DHBs

This process will also support our direction for MCAP funding around HEHA projects in our region.

2.9.3 Tobacco Control

Improving the quality of smoking cessation for Maori is a primary focus for Tobacco Control this month.

In phase two of the cessation scoping project we will:

- Undertake a national literature review of Smoking Cessation Services for Maori
- Undertake a regional evaluation of cessation services within the MidCentral district
- Develop a framework for Smoking Cessation Services for Maori
- Provide Ministry of Health with a framework for Smoking Cessation Services for Maori

An advisory group of regional cessation experts has been established to assist the project. Consultation with key stakeholders has commenced and will continue throughout July-August 2009.

Rangatahi Maori are a priority. The Rangatahi scoping project has now been completed and recommendations will be sent to the Ministry in the week beginning July 20th.

A project manager has been retained to progress the Smokefree DHB component of the Tobacco Control Plan.

The Kai-Arahi Maori attended the ABC train the trainer training in Wellington early July.

2.10 Service Plan Implementation

2.10.1 Summary

Many of the service plan initiatives are moving to business as usual with the emphasis of the District Management Groups (DMG's) on establishing an evaluation framework.
This is complimented with the desire to continue to identify service gaps and service improvement opportunities. The Building Information project is a large piece of work that will extend over the next three years.

The DMG structure continues to be of value and the collaboration of group members remains a strength.

2.10.2 Cancer

Massey University presented the evaluation research on the Psycho-oncology Service to the DMG in July. This included quantative and qualitative data. This service is clearly delivering positive patient outcomes for patients suffering acute distress that are on the cancer journey.

A cancer stakeholder Hui is planned for August. The purpose is to strengthen service integration and grasp the complex patient journey that occurs. The consumer representative on the DMG will be attending this forum to assist clinicians in understanding how the patient feels engaging with the various parts of the treatment and support services.

Cancer Nurses have all completed the competency framework and are preparing to submit their portfolios for recognition at level 3. This is a great achievement by a group of dedicated clinicians.

2.10.3 Respiratory

Spirometers are now back in place within the PHO community settings. A considerable effort has been made to ensure the quality cycle is in place to support the use of those in practice. Calibration is a key aspect to the quality cycle and test result validity. Ongoing support from MidCentral Respiratory services is required to maintain this.

The Respiratory DMG meeting did not occur in July as scheduled due to a number of members being unwell. The sleep apnoea evaluation recommendations are being considered by the group but possible initiatives and actions are not likely until September when they meet again.

2.10.4 Diabetes

Pump Therapy expertise within MidCentral is recognised in the National Diabetes treatment sector. Due to the pump therapy initiative a considerable amount of knowledge has developed both clinically and within policy and procedure frameworks. This knowledge is being accessed by the wider national treatment network.

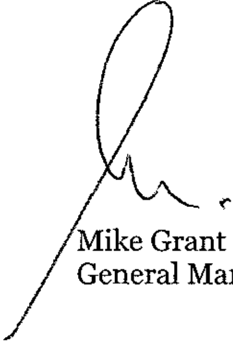
Recent work has occurred to support scheduling and follow up of young people. This has been an identified problem that was causing some delays. This has now working well with good patient flows.

Feilding diabetes support group has been running successfully for 2 years, the Diabetes Society is supporting the development of a Palmerston North group. The Palmerston North group needs a couple of strong advocates to lead and manage the group in to the future.

3. RECOMMENDATION

It is recommended:

that this report be received



Mike Grant
General Manager, Funding Division

TO Community and Public Health Advisory Committee

FROM Finance Manager
Funding Division

DATE 15 July 2009

Memorandum

SUBJECT FINANCE REPORT – JULY 2009

1. KEY EVENTS OF JUNE 09

1.1 Preliminary Result for 08-09

The Funder has a preliminary result of $1.7m surplus to budget for 08-09. However the impact of the Norovirus outbreak on IDF inflow has not been provided for. This impact may reduce the result back to $0.8m surplus to budget (May 09 forecast level). Other major estimates that may affect the final result are:-

(a) Ministry of Health payment methodology for Electives included unfunded electives
(b) IDF washup
(c) PCT and Herceptin IDF washup
(d) Accrual provision

For details please refer paragraph 1.5.

1.2 MidCentral Health Washup

The total year to date (YTD) washup position for MidCentral Health (MCH) was over-production of $2.3m (with $1.6m over-production of Medical Inpatient, $0.9m over-production of Medical Outpatient, $0.7m under-production of Regional Cancer Treatment Services, $0.2m over-production in DSS and over-production of $0.3m in Mental Health). Please note that this washup is calculated based on the lower price volume schedule target without the OI/CI targets.

1.3 Orthopaedic, Cataract, Ambulatory and Electives Initiatives (OI/CI/AI/EI)

The Funder has accrued income for the various Electives Initiatives assuming that MoH will follow the practice of last year to pay all electives delivered with the exception of the $1.4m non-compliant funding penalty. The elective estimate is based on Jun 09 EI report from PPU and the Jun 09 Central Region EI report from Capital and Coast DHB.

The main risk to the estimate is that some electives may not be considered as claimable by MoH. This may be due to the non-delivery of OI/CI or unplanned EI. The YTD of this risk is $1.0m, the difference between version 1 and version 2. However, based on the latest expressed Government policy intention to simplify the EI arrangement to provide more flexibility for DHB to deliver more electives, the estimate assumptions are considered reasonable and in line with these new directions.

The unfunded EI of $1.1m caused by MCH non-compliance performance has not been charged back to MCH. No assumption for any payment of unfunded EI from MoH has been made at this stage. Any payment of unfunded EI will improve the result of the Funder.

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Revenue expected from Elective Initiative, Orthopaedic Initiative and Cataract Initiative

Inpatient	Available	Version 1 Jun YTD	Note	Version 2 Jun YTD	Note	Estimated unfunded EI
Elective Initiative including AI						
Elective Surgery Initiative (CWD Volumes)	$3,399,478	$1,476,982	(a)	$3,520,199	(b)	$120,721
Outpatient Appointments						
First Specialist Assessments and procedures	$567,233	$301,792		$301,792		
Subsequent Attendances	$233,915					
	$801,148	$301,792		$301,792		
	$4,200,626	**$1,778,773**		**$3,821,990**		
ESPI Rules - Note (c)	($1,400,209)			($1,021,573)		$1,021,573
Net Available Funds	$2,800,417	$1,778,773		$2,800,417		$1,142,294
Orthopaedic and Cataract Initiatives						
Orthopaedic CQI Facilitator	$45,691	$45,691		$45,691		
Orthopaedic Initiative	$3,066,674	$1,843,102		$1,843,102		
Cataract Initiative	$429,017	$217,093		$217,093		
	$3,541,382	$2,105,886		$2,105,886		
Total	$7,742,008	$3,884,659		$4,906,303		
Difference between version 1 and 2				$1,021,644		

Version 1 : Existing CFA rules
Version 2 : Assume all EI claimable with exception of non compliant funding penalty

Note (a) Over base target YTD by 371 CWD.
Note (b) Adjusted IDF with C & C report
Note (c) Lost funding for 4 months due to ESPI 2 being non compliant for 5 non consequative months

1.4 IDF 08-09 washup estimate

The actual washup will only be known by end of August 09. The latest IDF return from Capital and Coast shows an estimated YTD IDF washup of $1.5m. The Funder has revised its estimates for IDF washup to $1.5m and the elective income to $4.9m taking into account of the latest info from the Jun 09 Central region elective report produced by Capital and Coast and the May 09 IDF return from Auckland DHB. Any reduction of IDF outflow from this estimate will improve the result of the Funder.

At the time of writing this report, the Funder has yet to receive the IDF washup file from MoH. As stated in para 1.1, no provision has been made for IDF inflow washup due to the Norovirus outbreak in Jun 09.

1.5 Major assumptions in the Preliminary result

The major assumptions in the preliminary result are as follows:

(a) MoH will follow the practice of last year to pay all electives delivered with the exception of the $1.4m non-compliant funding penalty.
(Please refer to para 1.3 for the claiming risk and sensitivity analysis on OI/CI/AI/EI.)

(b) There is no requirement for Breast Screening IDF washup for 08-09 and the current IDF washup provision (including PCT and Herceptin) is sufficient.

(c) The current accrual level of demand driven expenditure is sufficient as compared to subsequent payment.

2. FUNDER FINANCIAL PERFORMANCE

The Funder had a surplus to budget of $1,795k for the month of Jun 2009. For notes see adjacent page.)

Month ($000) Category of Services	Actual	Budget	Variance	
	$000	$000	$000	
Health Service Income - Personal Health	29,326	26,137	3,189	(note 2)
Service exp - Personal Health	27,433	26,650	-783	(note 2)
Operating Surplus/(Deficit)	1,893	-513	2,406	
Health Service Income - Mental Health	3,002	2,928	74	
Service exp - Mental Health	3,266	3,073	-193	(note 3)
Operating Surplus/(Deficit)	-264	-145	-119	
Health Service Income -Disability Support	4,976	4,976	0	
Service exp - Disability Support	5,399	4,933	-466	(note 4)
Operating Surplus/(Deficit)	-423	43	-466	
Health Service Income - Maori Health	157	157	0	
Service exp - Maori Health	183	157	-26	
Operating Surplus/(Deficit)	-26	0	-26	
Income - Governance	160	160	0	
Expenses- Governance	160	160	0	
Operating Surplus/(Deficit)	0	0	0	
Total Operating Surplus/(Deficit)	**1,180**	**-615** (note 1)	**1,795**	

The Funder had a cumulative surplus to budget of $1,694k up to the end of Jun 2009.

Year to Date ($000) Category of Services	Actual	Budget	Variance	
	$000	$000	$000	
Health Service Income - Personal Health	321,009	313,650	7,359	(note 2)
Service exp - Personal Health	318,844	313,650	-5,194	(note 2)
Operating Surplus/(Deficit)	2,165	0	2,165	
Health Service Income - Mental Health	36,138	35,132	1,006	
Service exp - Mental Health	37,480	36,796	-684	(note 3)
Operating Surplus/(Deficit)	-1,342	-1,664	322	
Health Service Income -Disability Support	59,702	59,717	-15	
Service exp - Disability Support	60,824	59,718	-1,106	(note 4)
Operating Surplus/(Deficit)	-1,122	-1	-1,121	
Health Service Income - Maori Health	1,883	1,883	0	
Service exp - Maori Health	1,555	1,883	328	
Operating Surplus/(Deficit)	328	0	328	
Income - Governance	1,918	1,918	0	
Expenses- Governance	1,918	1,918	0	
Operating Surplus/(Deficit)	0	0	0	
Total Operating Surplus/(Deficit)	**29**	**-1,665** (note 1)	**1,694**	

Notes:

1. Due mainly to budgeted deficit for Mental Health and phased budget versus monthly income of 1/12 yearly income budget received from Ministry of Health.

6.18

2. Personal Health comprises:

Personal Health Surplus comprises:	This Month Actual	Budget	Variance	YTD: Actual	Budget	Variance
Crown Funding Agreement	22,738	22,738	-0	272,860	272,860	-0
IDF inflow (Note A)	2,686	2,754	-68	32,732	33,048	-316
EI/OI/CI/AI 08-09 (Note B)	1,886	645	1,241	4,906	7,742	-2,836
EI/OI/CI 07-08 washup	0		0	1,050		1,050
Haemophilia Nurse Specialist	0		0	150		150
Funding for Senior Medical Officers (SMO)	29		29	342		342
Breast Cancer Funding	106		106	1,274		1,274
Cancer network	0		0	700		700
PHO additional Funding	268		268	1,994		1,994
HEHA	78		78	754		754
Projects and misc adjustment (Note C)	227		227	997		997
Reduction of Herceptin funding (Note D)	-217		-217	-217		-217
Expected Hereceptin washup (Note D)	118		118	118		118
Smoke free	410		410	483		483
National Coordination of LCP	195		195	195		195
After Hours Primary Healthcare Services	186		186	186		186
Primary Health Care Innovations Fund	457		457	457		457
B4 School Check	0		0	374		374
HPV	84		84	874		874
Extra Pharm Funding (Note E)	28		28	309		309
NTA	15		15	92		92
Pandemic Funding	32		32	378		378
Income	29,325	26,138	3,188	321,009	313,650	7,359
Expenditure						
MCH - deficit support (Note F)	437	437	0	5,245	5,245	0
MCH - Deficit support in dispute (Note G)	272		-272	3,262		-3,262
MCH -PVS and other SLA	14,606	14,772	166	169,935	170,653	718
MCH - Pandemic Funding	29		-29	352		-352
MCH - $2m unfunded projects	69		-69	1,629		-1,629
MCH - Service Plan	216	283	68	2,716	3,401	685
MCH - Haemophilia	93	93	-0	1,120	1,120	-0
MCH - Central Cancer Network	0		0	55		-55
MCH - PCT (Note A)	354	284	-70	2,120	3,407	1,287
Funders EI/AI	0	142	142	0	1,698	1,698
Non-Government Organisation - Service Plan	466	537	71	6,058	6,446	388
Oral Health	15	46	31	165	550	385
Depression Plan	1	67	66	26	800	774
Travel & accommodation	114	117	3	1,016	1,398	382
Cancer network	50		-50	505		-505
Primary/secondary integration	90	167	77	1,067	2,000	933
HEHA	103		-103	488		-488
Non-Government Organisation (Note H)	994	808	-185	11,157	9,701	-1,456
IDF outflow (Note I)	2,824	2,738	-86	34,503	32,851	-1,652
Pharmacy expenditure	3,405	3,290	-114	40,764	39,826	-938
PHO	1,899	1,760	-139	23,339	21,118	-2,221
GMS/PNS	103	127	24	1,141	1,524	383
Other Health Benefit payment	1,235	983	-252	12,182	11,912	-270
	27,373	26,650	-723	318,844	313,650	-5,194
Personal Health Surplus	1,953	-513	2,465	2,165	0	2,165

Note A: No provision for IDF inflow washup other than PCT
Note B : Forecasted target based on YTD result and assume all EI claimable after provision of $1.4m non-compliant funding penalty
Note C: additional project funding including NIR, VIP and HIV funding
Note D : Due to change in funding arrangement of Herceptin
Note E: Extra funding for $3 co-payment of specialist and pandemic antibiotics
Note F: Deficit support is reduced to correct the error in PVS
Note G : Keep this to show the real underperformance of MCH
Note H: Include expenditure provision of HPV, B4 school check and other projects with additional funding
Note I: Forecast assume no washup for Breast Screening but with other IDF washup estimated from Capital and Coast Jun 09 report

3. Mental Health comprises:

Mental Health expenditure comprises:	This Month Actual	Budget	Variance	YTD: Actual	Budget	Variance
Crown Funding Agreement	2,915	2,915	0	34,975	34,975	0
MoH additional Mental Health Funding (Note J)	52		52	743		743
IDF inflow	35	13	22	420	156	264
Income	3,002	2,928	75	36,138	35,131	1,007
MCH - Price Volume Schedule and SLA	2,090	2,051	-39	25,046	24,525	-521
Budgeted ring fence surplus b/f	79	79	0	950	950	0
Non-Government Organisation	837	707	-129	8,464	8,490	26
IDF outflow	259	236	-23	3,020	2,831	-189
	3,266	3,073	-192	37,480	36,796	-684
Mental Health Surplus	-264	-146	-118	-1,342	-1,665	323

Note J: additional funding due to Primary Mental Health

4. DSS comprises:

DSS expenditure comprises:	This Month Actual	Budget	Variance	YTD: Actual	Budget	Variance
Crown Funding Agreement	4,724	4,724	0	56,691	56,691	-0
IDF Inflow	252	252	-0	3,011	3,026	-15
Income	4,976	4,976	-0	59,702	59,718	-16
MCH - Price Volume Schedule	1,283	878	-406	10,795	10,583	-212
Non-Government Organisation (Note K)	3,777	3,718	-60	45,940	45,079	-861
IDF outflow	338	338	0	4,088	4,056	-32
	5,399	4,933	-466	60,824	59,718	-1,106
DSS Surplus	-423	43	-466	-1,122	-1	-1,121

Note K: Due mainly to higher national price than budget and increase in capacity of Dementia and continue care beds

3. SUMMARY OF FUNDING ADMINISTRATION FINANCIALPERFORMANCE

Funding Administration has a cumulative deficit to budget of $77k up to the end of Jun 2009. This is mainly due to the drop in interest rate (The interest rate at the time of budget (Dec 07) was around 9% whereas the interest rate in Jun 09 was only 2.7%) For details see Appendix 2.

Month ($000)

Funding Admin	Actual	Budget	Variance
Revenue	202	281	(79)
Expenses	313	313	0
Surplus/(Deficit)	(111)	(32)	(79)

Year to Date ($000)

Funding Admin	Actual	Budget	Variance
Revenue	3,179	3,366	(187)
Expenses	3,666	3,776	110
Surplus/(Deficit)	(487)	(410)	(77)

6.20

4. EXPENDITURE BUDGET

4.1 Demand Driven Expenditure (DDE)

The rebate risk identified by Pharmac as reported last month remains a potential funding risk (about $0.3m).

The Funder will continue to monitor this expenditure closely in the coming months. The charts in Appendix 5 show the cumulative actual and forecast of each major DDE items as compared to their budget.

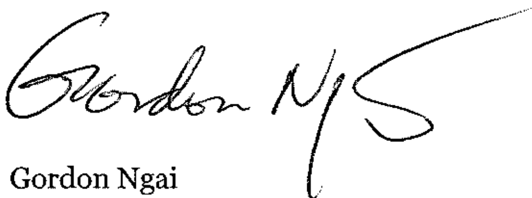
5. FINANCIAL STATEMENTS

The Financial statements and other relevant information are shown in Appendices 1-5.

6. RECOMMENDATION

It is recommended:

that this report be received



Gordon Ngai
Finance Manager
Funding Division

MidCentral DHB - Funder
Income and Expenditure - By Ring Fenced Area
For the period ending 30 June 2009

Note	This Month Actual	This Month Budget	This Month Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance	
	$000	$000	$000	%	$000	$000	$000	%
1 ***Personal Health***								
Personal Health Income	26,640	23,383	3,257	14%	288,277	280,602	7,675	3%
IDF Inflow Income - Personal Health	2,686	2,754	-68	-2%	32,732	33,048	-316	-1%
Total Personal Health Income	29,326	26,137	3,189	12%	321,009	313,650	7,359	2%
Personal Health exp	24,609	23,912	-697	-3%	284,341	280,799	-3,542	-1%
IDF Outflow exp - Personal Health	2,824	2,738	-86	-3%	34,503	32,851	-1,652	-5%
	27,433	26,650	-783	-3%	318,844	313,650	-5,194	-2%
Personal Health Operating Surplus/(Deficit)	1,893	-513	2,406		2,165	0	2,165	
2 ***Mental Health***								
Mental Health Income	2,967	2,915	52	2%	35,718	34,976	742	2%
IDF Inflow Income - Mental Health	35	13	22	169%	420	156	264	169%
Total Mental Health Income	3,002	2,928	74	3%	36,138	35,132	1,006	3%
Mental Health exp	3,007	2,837	-170	-6%	34,460	33,965	-495	-1%
IDF Outflow exp - Mental Health	259	236	-23	-10%	3,020	2,831	-189	-7%
Total Mental Health Expenses	3,266	3,073	-193	-6%	37,480	36,796	-684	-2%
Mental Health Operating Surplus/(Deficit)	-264	-145	-119		-1,342	-1,664	322	
3 ***DSS***								
DSS Income	4,724	4,724	0	0%	56,691	56,691	0	0%
IDF Inflow Income - DSS	252	252	0	0%	3,011	3,026	-15	0%
Total DSS Income	4,976	4,976	0	0%	59,702	59,717	-15	0%
DSS exp	5,061	4,595	-466	-10%	56,736	55,662	-1,074	-2%
IDF Outflow exp - DSS	338	338	0	0%	4,088	4,056	-32	-1%
Total DSS Expenses	5,399	4,933	-466	-9%	60,824	59,718	-1,106	-2%
DSS Operating Surplus/(Deficit)	-423	43	-466		-1,122	-1	-1,121	
4 ***Maori Health***								
Maori Health Income	157	157	0	0%	1,883	1,883	0	0%
Maori Health exp	183	157	-26	-17%	1,555	1,883	328	17%
Maori Health Operating Surplus/(Deficit)	-26	0	-26		328	0	328	
Governance								
Income	160	160	0	0%	1,918	1,918	0	0%
Expenses	160	160	0	0%	1,918	1,918	0	0%
Governance Operating Surplus/(Deficit)	0	0	0		0	0	0	
Total Operating Surplus/(Deficit)	**1,180**	**-615**	**1,795**		**29**	**-1,665**	**1,694**	

6.22

Appendix 1 cont.

Note

1 Personal Health Surplus comprises:

	This Month Actual	Budget	Variance	YTD: Actual	Budget	Variance
Crown Funding Agreement	22,738	22,738	-0	272,860	272,860	-0
IDF inflow (Note A)	2,686	2,754	-68	32,732	33,048	-316
EI/OI/CI/AI 08-09 (Note B)	1,886	645	1,241	4,906	7,742	-2,836
EI/OI/CI 07-08 washup	0		0	1,050		1,050
Haemophilia Nurse Specialist	0		0	150		150
Funding for Senior Medical Officers (SMO)	29		29	342		342
Breast Cancer Funding	106		106	1,274		1,274
Cancer network	0		0	700		700
PHO additional Funding	268		268	1,994		1,994
HEHA	78		78	754		754
Projects and misc adjustment (Note C)	227		227	997		997
Reduction of Herceptin funding (Note D)	-217		-217	-217		-217
Expected Hereceptin washup (Note D)	118		118	118		118
Smoke free	410		410	483		483
National Coordination of LCP	195		195	195		195
After Hours Primary Healthcare Services	186		186	186		186
Primary Health Care Innovations Fund	457		457	457		457
B4 School Check	0		0	374		374
HPV	84		84	874		874
Extra Pharm Funding (Note E)	28		28	309		309
NTA	15		15	92		92
Pandemic Funding	32		32	378		378
Income	29,325	26,138	3,188	321,009	313,650	7,359
Expenditure						
MCH - deficit support (Note F)	437	437	0	5,245	5,245	0
MCH - Deficit support in dispute (Note G)	272		-272	3,262		-3,262
MCH -PVS and other SLA	14,606	14,772	166	169,935	170,653	718
MCH - Pandemic Funding	29		-29	352		-352
MCH - $2m unfunded projects	69		-69	1,629		-1,629
MCH - Service Plan	216	283	68	2,716	3,401	685
MCH - Haemophilia	93	93	-0	1,120	1,120	-0
MCH - Central Cancer Network	0		0	55		-55
MCH - PCT (Note A)	354	284	-70	2,120	3,407	1,287
Funders EI/AI	0	142	142	0	1,698	1,698
Non-Government Organisation - Service Plan	466	537	71	6,058	6,446	388
Oral Health	15	46	31	165	550	385
Depression Plan	1	67	66	26	800	774
Travel & accommodation	114	117	3	1,016	1,398	382
Cancer network	50		-50	505		-505
Primary/secondary integration	90	167	77	1,067	2,000	933
HEHA	103		-103	488		-488
Non-Government Organisation (Note H)	994	808	-185	11,157	9,701	-1,456
IDF outflow (Note I)	2,824	2,738	-86	34,503	32,851	-1,652
Pharmacy expenditure	3,405	3,290	-114	40,764	39,826	-938
PHO	1,899	1,760	-139	23,339	21,118	-2,221
GMS/PNS	103	127	24	1,141	1,524	383
Other Health Benefit payment	1,235	983	-252	12,182	11,912	-270
	27,373	26,650	-723	318,844	313,650	-5,194
Personal Health Surplus	1,953	-513	2,465	2,165	0	2,165

Note A: No provision for IDF inflow washup other than PCT
Note B : Forecasted target based on YTD result and assume all EI claimable after provision of $1.4m non-compliant funding penalty
Note C: additional project funding including NIR, VIP and HIV funding
Note D : Due to change in funding arrangement of Herceptin
Note E: Extra funding for $3 co-payment of specialist and pandemic antibiotics
Note F: Deficit support is reduced to correct the error in PVS
Note G : Keep this to show the real underperformance of MCH
Note H: Include expenditure provision of HPV, B4 school check and other projects with additional funding
Note I: Forecast assume no washup for Breast Screening but with other IDF washup estimated from Capital and Coast Jun 09 report

2 Mental Health expenditure comprises:

	This Month Actual	Budget	Variance	YTD: Actual	Budget	Variance
Crown Funding Agreement	2,915	2,915	0	34,975	34,975	0
MoH additional Mental Health Funding (Note J)	52		52	743		743
IDF inflow	35	13	22	420	156	264
Income	3,002	2,928	75	36,138	35,131	1,007
MCH - Price Volume Schedule and SLA	2,090	2,051	-39	25,046	24,525	-521
Budgeted ring fence surplus b/f	79	79	0	950	950	0
Non-Government Organisation	837	707	-129	8,464	8,490	26
IDF outflow	259	236	-23	3,020	2,831	-189
	3,266	3,073	-192	37,480	36,796	-684
Mental Health Surplus	-264	-146	-118	-1,342	-1,665	323

Note J: additional funding due to Primary Mental Health

3 DSS expenditure comprises:

	This Month Actual	Budget	Variance	YTD: Actual	Budget	Variance
Crown Funding Agreement	4,724	4,724	0	56,691	56,691	-0
IDF Inflow	252	252	-0	3,011	3,026	-15
Income	4,976	4,976	-0	59,702	59,718	-16
MCH - Price Volume Schedule	1,283	878	-406	10,795	10,583	-212
Non-Government Organisation (Note K)	3,777	3,718	-60	45,940	45,079	-861
IDF outflow	338	338	0	4,088	4,056	-32
	5,399	4,933	-466	60,824	59,718	-1,106
DSS Surplus	-423	43	-466	-1,122	-1	-1,121

Note K: Due mainly to higher national price than budget and increase in capacity of Dementia and continue care beds

4 Maori Health expenditure comprises:

	This Month Actual	Budget	Variance	YTD: Actual	Budget	Variance
Crown Funding Agreement	157	157	-0	1,883	1,883	-0
Income	157	157	-0	1,883	1,883	-0
Non-Government Organisation	175	116	-59	1,448	1,393	-55
Workforce Development	8	41	33	107	490	383
	183	157	-26	1,555	1,883	328
Maori Surplus	-26	0	-26	328	0	328
	1,240	-615	1,856	29	-1,665	1,695

6.24

MidCentral DHB -Funding Administration
Statement of Financial Performance
For the period ending 30 June 2009

	note	This Month				Year to Date			
		Actual	Budget	Variance		Actual	Budget	Variance	
Income		$000	$000	$000	%	$000	$000	$000	%
Health Service Income - Governance and Admin		160	160	0	0%	1,918	1,918	0	0%
Interest and misc income		42	121	(79)	(65%)	1,261	1,448	(187)	(13%)
Total Income		**202**	**281**	**(79)**	**(28%)**	**3,179**	**3,366**	**(187)**	**(6%)**
Expenditure									
Personnel		89	112	23	21%	1,101	1,365	264	19%
Interest and Financing Charges		22	24	2	8%	335	284	(51)	(18%)
Administration		155	130	(25)	(19%)	1,665	1,562	(103)	(7%)
Total Expenditure		**266**	**266**	**0**	**0%**	**3,101**	**3,211**	**110**	**3%**
Operating Surplus/(Deficit)		**(64)**	**15**	**(79)**		**78**	**155**	**(77)**	
Board-wide Provisions		47	47	0	0%	565	565	0	0%
Net Surplus/(Deficit) Before Tax		**(111)**	**(32)**	**(79)**		**(487)**	**(410)**	**(77)**	

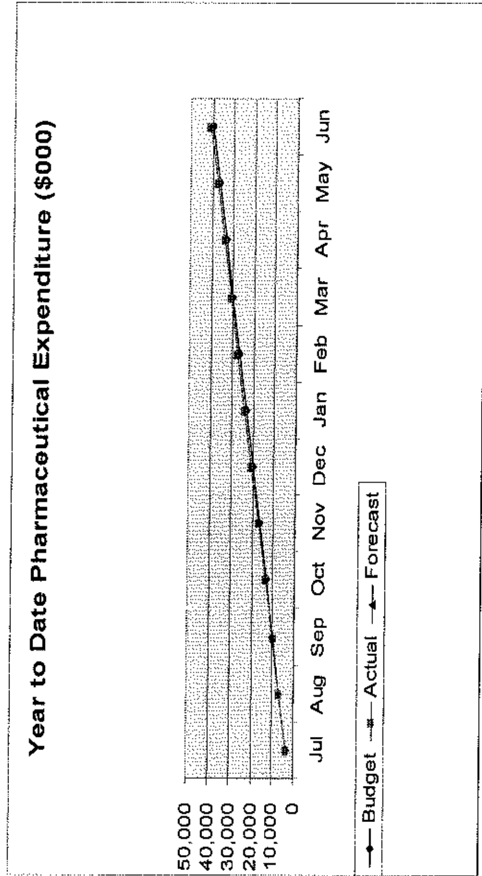
MidCentral DHB - Funder and Funding Administration (Service Expenditure by Ring Fence)
Statement of Financial Performance
For the period ending 30 June 2009

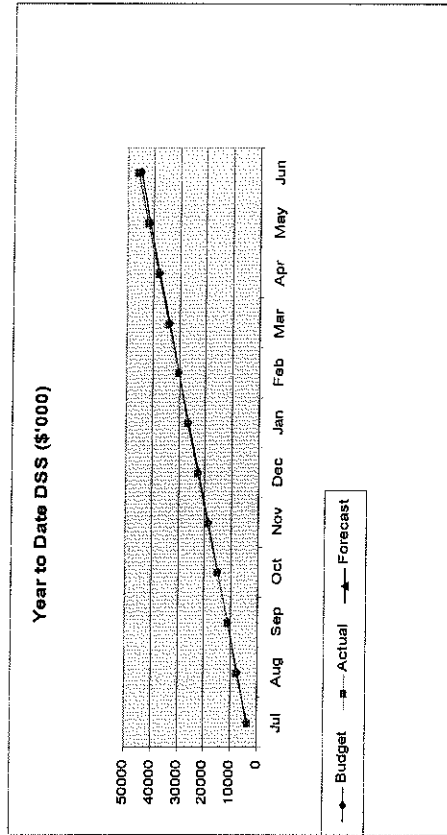
	This Month				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
Income	$000	$000	$000	%	$000	$000	$000	%
Health Service Income - Personal Health	29,326	26,137	3,189	12%	321,009	313,650	7,359	2%
Health Service Income - Mental Health	3,002	2,928	74	3%	36,138	35,132	1,006	3%
Health Service Income - Maori Health	157	157	0	0%	1,883	1,883	0	0%
Health Service Income - Disability Support	4,976	4,976	0	0%	59,702	59,717	(15)	(0%)
Health Service Income - Governance and Admin	160	160	0	0%	1,918	1,918	0	0%
Interest	42	121	(79)	(65%)	1,261	1,448	(187)	(13%)
Total Income	**37,663**	**34,479**	**3,184**	**9%**	**421,911**	**413,748**	**8,163**	**2%**
Expenditure								
Personnel	89	112	23	21%	1,101	1,365	264	19%
Interest and Financing Charges	22	24	2	8%	335	284	(51)	(18%)
Administration	155	130	(25)	(19%)	1,665	1,562	(103)	(7%)
Service exp - Personal Health	27,433	26,650	(783)	(3%)	318,844	313,650	(5,194)	(2%)
Service exp - Mental Health	3,266	3,073	(193)	(6%)	37,480	36,796	(684)	(2%)
Service exp - Disability Support	5,399	4,933	(466)	(9%)	60,824	59,718	(1,106)	(2%)
Service exp - Maori Health	183	157	(26)	(17%)	1,555	1,883	328	17%
Total Expenditure	**36,547**	**35,079**	**(1,468)**	**(4%)**	**421,804**	**415,258**	**(6,546)**	**(2%)**
Operating Surplus/(Deficit)	**1,116**	**(600)**	**1,716**	**286%**	**107**	**(1,510)**	**1,617**	**107%**
Board-wide Provisions	47	47	0	0%	565	565	0	0%
Net Surplus/(Deficit) Before Tax	**1,069**	**(647)**	**1,716**		**(458)**	**(2,075)**	**1,617**	

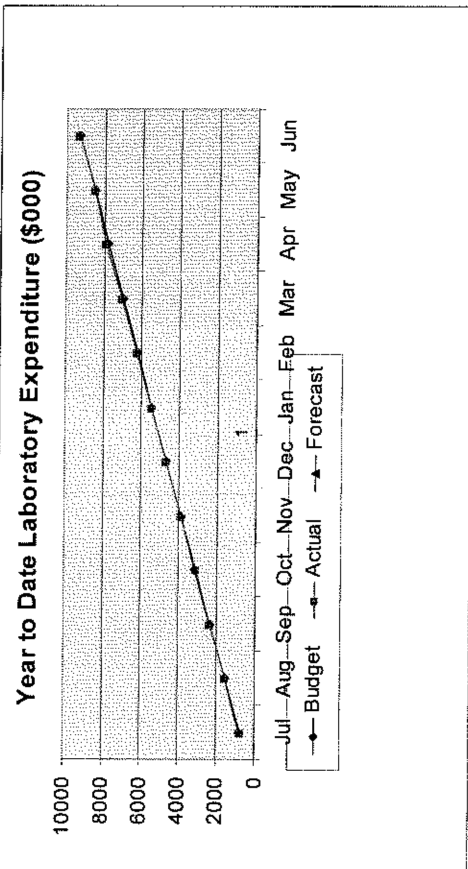
6·26

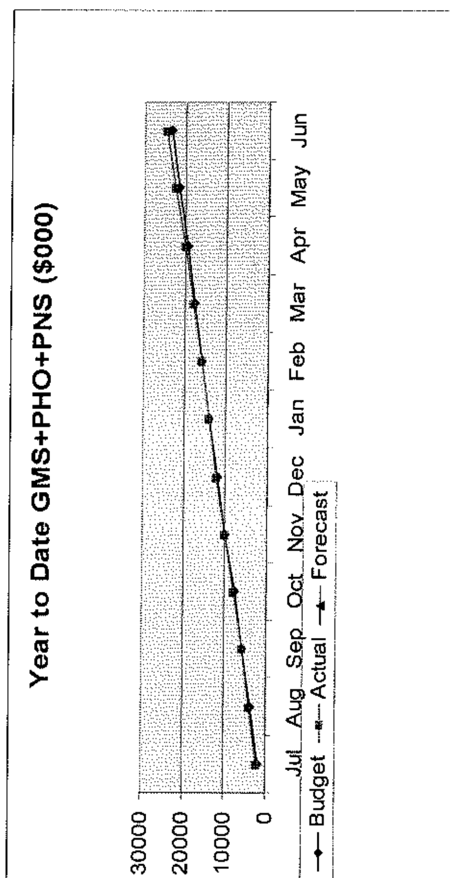
MidCentral DHB - Funder and Funding Administration
Statement of Financial Position as at 30 June 2009

	Year-Ended Jun-08	Actual Current Position Jun-09	Change
	$000	$000	$000
ASSETS EMPLOYED			
Current Assets	**22,706**	**22,337**	**(369)**
Bank	19,336	16,241	(3,095)
Intercompany Advance Account	0	0	0
Debtors and Prepayments	3,370	6,096	2,727
Inventories	0	0	0
Properties Intended for Sale	0	0	0
Current Liabilities	**18,220**	**22,003**	**3,782**
Bank Overdraft	0	0	0
Intercompany Current Account	2,995	3,137	142
Trade Creditors and Accruals	15,002	17,934	2,932
GST	110	818	708
Income in Advance	0	0	0
Provisions (Payroll)	113	113	0
Current Portion of Term Loans	0	0	0
Net Working Capital	**4,486**	**335**	**(4,151)**
Net Assets Employed	**4,486**	**335**	**(4,151)**
SHAREHOLDERS EQUITY			
	0	0	0
Retained Earnings	40,834	40,378	(457)
Transfer to Co 41	(36,348)	(40,043)	(3,695)
	4,486	**335**	(4,151)
Other Reserves	0	0	0
Total Shareholders Equity	**4,486**	**335**	**(4,151)**


Year to Date Pharmaceutical Expenditure ($000)
50,000
40,000
30,000
20,000
10,000
0
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
Budget
Actual
Forecast


Year to Date DSS ($'000)
50000
40000
30000
20000
10000
0
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
Budget
Actual
Forecast


Year to Date Laboratory Expenditure ($000)
10000
8000
6000
4000
2000
0
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
Budget
Actual
Forecast


Year to Date GMS+PHO+PNS ($000)
30000
20000
10000
0
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
Budget
Actual
Forecast

TO Community & Public Health Advisory Committee

FROM General Manager, Corporate Services

DATE 27 July 2009

SUBJECT **Contracts**

MEMORANDUM

We were to provide a list of contracts that have been signed in the quarter up to June for the Funding Division. We are still compiling that information into the contract management system and therefore the report is not available this month.

The report will be provided next quarter or sooner if possible and the number and value of contracts are substantial.

Recommendation

It is recommended:

that this report be received.

Stuart Wilson
General Manager
Corporate Services

Corporate Services
MidCentral DHB
Heretaunga Street
P O Box 2056
Palmerston North
Phone +64(6) 350 8350
Fax +64(6) 355 0616

TO Community & Public Health Advisory Committee

FROM Chief Executive Officer

DATE 27 July 2009

SUBJECT **2009/10 Work Programme**

MEMORANDUM

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

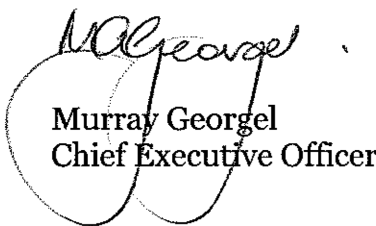
Reporting is generally occurring in accordance with the timeline. As noted previously, an update against the Maori scholarships will not be provided until the financial position has changed. The pharmacy paper workshopped previously will be submitted next month.

The quarterly contract report introduced this year was to be reported this month. Unfortunately, delays have been experienced. An update on progress has been provided instead.

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
Fax +64 (6) 355 0616

7.3

ID	Indicators	Task Name
1		**COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE, 2009/10**
2		
3		**STRATEGIC PLANNING**
4		Chronic disease strategies: progress against long term measures: update 1
5		Chronic disease strategies: progress against long term measures: update 2
6		**ANNUAL PLANNING**
7		**2010/11 DAP Development**
8	✓	Annual Review of Health Needs Assessment, 2009
9		Annual Review of Health Needs Assessment, 2010
10		Annual Review of Prioritisation Framework
11		Price Volume Schedule 2010/11
12		Draft 1
13		Draft 2
14		**2009/10 DAP Implementation**
15		Health Promotion Update 1
16		Health Promotion Update 2
17		Primary Health (all bar 12a&b): update 1
18		Primary Health (all bar 12a&b): update 2
19		Maori Health (DAP 17-19): update 1
20		Maori Health (DAP 17-19): update 2
21		Mental Health (DAP 21-22): update 1
22		Mental Health (DAP 21-22): update 2
23		Child & Youth (DAP 31-33, 34A, 35, 38-39, 41): update 1
24		Child & Youth (DAP 31-33, 34A, 35, 38-39, 41): update 2
25		Health of Older Persons (all): update 1
26		Health of Older Persons (all): update 2
27		Workforce: update 1
28		Workforce: update 2
29		**For Information**
30		Primary Health - Provider (12a&b re post natal stays): update 1
31		Primary Health - funding (12a&b re post natal stays): update 2
32		Maori Health - provider (DAP 20): update 1

ID	Task Name
33	Maori Health - provider (DAP 20): update 2
34	Mental Health - provider (DAP 23): update 1
35	Mental Health - provider (DAP 23): update 2
36	Child & Youth - provider (DAP 34b&c, 36, 37 & 40): update 1
37	Child & Youth - provider (DAP 34b&c, 36, 37 & 40): update 2
38	Secondary Care (all): update 1
39	Secondary Care (all): update 2
40	**REGIONAL PLANNING**
41	**Regional Clinical Services Plan**
42	Project Newsletters (as issued)
43	**OPERATIONAL REPORTS**
44	General Manager's Monthy Report (including portfolip updates)
45	Health Care Development Team: work programme & budget (ex Bd 21.7.09)
46	Quality of nursing care: assurance from MCH that appropriate follow-up in progress & outcome
47	Contracts Update 1
48	Contracts Update 2
49	Contracts Update 3
50	Contracts Update 4
51	Annual Report from PHO Combined Clinical Board
52	Proposed Contracting Strategy 2009/10
53	Proposed Contracting Strategy 2010/11
54	**Performance Indicators**
55	Report 1
56	Report 2
57	Report 3
58	Report 4
59	**Carried Forward from 2008/09**
60	Maori Scholarship & Internships
61	Pharmacy Options Paper
62	**GOVERNANCE PROCESSES**
63	Terms of Reference Review

2010
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

7.4