Counties Manukau District Health Board

Statement of Intent

2010/11 – 2012/13

June 2010
FINAL

For any queries regarding the Counties Manukau DHB Statement of Intent 2010/11, please contact:

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Signatories

This statement of intent has been prepared by Counties Manukau District Health Board (DHB) to meet the requirements of sections 39 and 42 of the New Zealand Public Health and Disability Act 2000 and section 139 (1) of the Crown Entities Act 2004.

This document is intended to outline for Parliament and the general public the performance that will be delivered during 2010/2011 by Counties Manukau DHB and contains non-financial and financial forecast information. The agreed performance measures are in context of the governments strategic and service priorities for the public health and disability sector and the DHB's District Strategic Plan.

ISSUED BY
Counties Manukau DHB

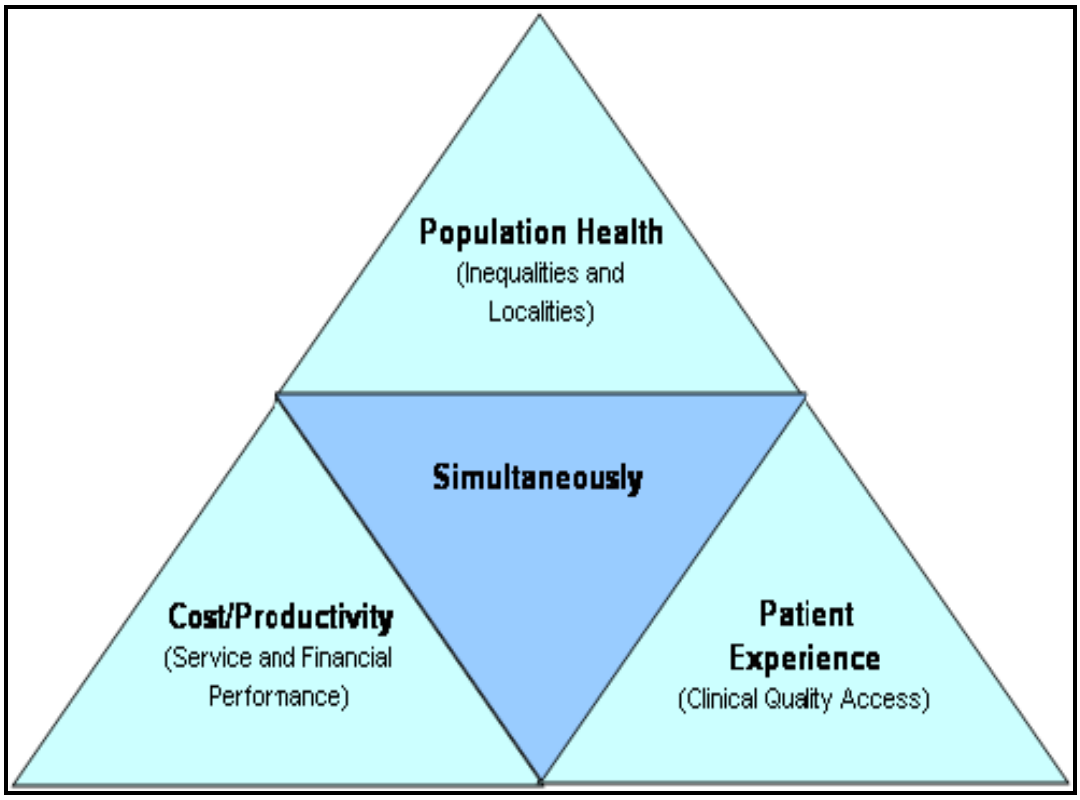
Statement of Intent Dated This 28th Day of June 2010.

Signed

Professor Gregor Coster
Chair of Counties Manukau DHB

Paul Cressey
Deputy Chair of Counties Manukau DHB

The Triple Aim is our Core Business



The Triple Aim is the core business of Counties Manukau DHB.

The objectives of Triple Aim encourage us to take an integrated approach to align improvement across the *whole system* by focusing on: *population health*, *cost per capita* and *patient experience*. These are all objectives of the health sector and provide the basis for our prioritisation process, ensuring that CMDHB delivers safe and high quality services which provide value for money and the best health outcomes for the population.

Our Vision

To work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori and Pacific peoples and other communities with health disparities

We will do this by leading the development of an improved system of healthcare that is more accessible and better integrated.

We will dedicate ourselves to serving our patients and communities by ensuring the delivery of both quality focused and cost effective healthcare, at the right place, right time and right setting.

Counties Manukau DHB will be a leader in the delivery of successful secondary and tertiary health care, and supporting primary and community care.

Our Values

Care and Respect	Treating people with respect and dignity: valuing individual and cultural differences and diversity
Teamwork	Achieving success by working together and valuing each other's skills and contributions
Professionalism	Acting with integrity and embracing the highest ethical standards
Innovation	Constantly seeking and striving for new ideas and solutions
Responsibility	Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions
Partnership	Working alongside and encouraging others in health and related sectors to ensure a common focus on, and strategies for achieving health gain and independence for our population

Commitment to the Treaty of Waitangi

Te Tiriti o Waitangi as the founding document of our nation establishes a partnership between Maaori and the Crown to work together under the principles of Partnership, Protection and Participation. The New Zealand Public Health and Disability Act 2000, emphasises this in reference to DHBs responsibility to improve Maaori health gain through the provision of:

"mechanisms to enable Maaori to contribute to the decision-making on and to participate in the delivery of health and disability services."

CMDHB has developed an open and inclusive approach towards its engagement with Maaori and is seeking to implement this approach in a manner that focuses on the promotion of healthy lifestyles in this rohe (region). The DHB continues to develop its relationship with Maaori, and this will continue to be reflected in strategic documents, initiatives and actions undertaken by this DHB.

CMDHB will express its commitment to Te Tiriti o Waitangi through the establishment of a number of key initiatives guided by the following principles:

- It is the DHB's intention to continue to develop its Tiriti commitment throughout the organisation. This approach will ensure Tikanga is fully integrated into our processes and indeed help lead our way forward.
- Te Kaahui Ora, the Maaori health team that provides Maaori operational expertise and advice for the whole organisation, will retain a dedicated divisional team, and will establish a matrix framework to planning and organisational delivery as part of a 'whole of organisation' approach.
- The DHB is committed to developing an organisation that reflects the diversity of the Counties Manukau population and responds accordingly through its work.

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1. EXECUTIVE SUMMARY

Counties Manukau DHB is one of 21 DHBs established on 1 January 2001 in accordance with section 19 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act 2000). Counties Manukau DHB is a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004).

The CE Act 2004 (section 49) states that the Board of Counties Manukau DHB must ensure that the DHB acts in a manner consistent with its objectives, functions, and this Statement of Intent (SOI).

This SOI has been prepared by Counties Manukau District Health Board (DHB) to meet the requirements of Section 39 of the New Zealand Public Health and Disability Act 2000 and Section 139 (1) of the Crown Entities Act 2004.

This SOI is for the period 2010/11-2012/13 and is intended to outline for Parliament and the general public the performance that will be delivered during 2010/11 by Counties Manukau DHB and contains non-financial and financial forecast information for the 2011/12 and 2012/13 years.

The agreed non-financial performance measures are in the context of the Government's strategic and service priorities for the public health and disability sector and the DHB's District Strategic Plan and are categorised by output class for ease of understanding. These are: *Public Health Services, Primary & Community Services, Hospital Services and Support Services.*

This SOI is aligned to and consistent with:

- New Zealand Public Health and Disability Act 2000
- Crown Entities Act 2004
- Public Finance Act 1989 (and subsequent amendment acts)
- Counties Manukau DHB's District Annual Plan (DAP),
- Counties Manukau DHB's District Strategic Plan (DSP)
- Counties Manukau DHB's District Crown Funding Agreements (CFA)
- The New Zealand Health Strategy (2000)
- The New Zealand Disability Strategy (2001)
- He Korowai Oranga (Māori Health Strategy, 2002)
- Te Tāhuhu: Improving Mental Health 2005-2015 (2005)
- The Health of Older People Strategy (2002)
- The Primary Health Care Strategy (2001)
- The Pacific Health and Disability Action Plan (2002)

This SOI includes:

- a Statement of Forecast Service Performance which sets out what the DHB will seek to achieve during 2010/11, with non-financial performance measures and targets for each of the four output classes;

- a financial forecast for 2010/11 and the two subsequent years. At the end of the year, auditors working on behalf of the Office of the Auditor-General compare the performance planned in the SOI with the actual performance described in the DHB's Annual Report.

2. OPERATING ENVIRONMENT

2.1 Population and health profile

Counties Manukau has one of the fastest growing populations in New Zealand. It has a diverse population with complex health needs and service requirements. Key features of the CMDHB population are described on the website: www.cmdhb.org.nz/About_CMDHB/Overview/population-profile.html.
They include:

- a high number of Maaori
- a high proportion of Pacific people
- a high proportion of Asian people
- the relative youthfulness of these populations, and the population as a whole
- the fast growth of this population
- the high proportion of the population who are socio-economically deprived.

Detailed analyses of the health of Counties Manukau residents are provided at www.cmdhb.org.nz/About_CMDHB/Planning/Health-Status/Health-Status.htm and www.cmdhb.org.nz/About_CMDHB/Overview/Our-Localities/default.htm.
Key themes are:

- CMDHB residents' health is improving. For example, average life expectancy at birth is similar to the New Zealand average despite material and socio-economic disadvantage in Counties Manukau.
- However, health disparities remain a concern. Males, Maaori and Pacific people and those socio-economically deprived all do worse than their counterparts.
- For Maaori, a quarter of the life expectancy gap is due to tobacco. Smoking remains the single largest preventable cause of disease and death in our communities.
- A third of all hospitalisations for CMDHB people are considered potentially avoidable. Much of the scope for prevention of these lie in the population health and primary care sectors.
- Although adult medical admission rates are among the highest in the country, an acute assessment team has increased the proportion discharged within 24 hours from 28% to 40% with consequential reduction in Average Length Of Stay (ALOS) to 2.7 days (the lowest in Australasia). Further improvements in ambulatory care and an Acute Assessment Unit would be expected to lead to further reductions in ALOS. However, the largest driver for medical admissions arises from self referrals to the Emergency Department (ED) and this will require innovative solutions as well as a much closer working relationship between the primary and secondary sectors.
- Infectious disease rates for Counties Manukau people, particularly children, remain high. Improving the living conditions of pre-school children remains a priority.
- CMDHB has the largest number of people with diabetes in NZ (29,000, or 8.3% of the adult population in 2008). Diabetes prevalence is likely to double in Counties Manukau by 2021.
- CMDHB has the highest rate of obesity in NZ, with 33% of the adult population considered obese (BMI>30). For morbid obesity, BMI>40, CMDHB was estimated to have 17,500 people in 2006/07 – 5.7% of the adult population. Modelled increases of 1,700 people per year reaching a BMI >40 increase the urgency of population approaches to reduce the rate of growth and stem the rising tide of associated morbidity and mortality.
- Teenage pregnancy rates are very high for Maaori and Pacific young people.
- Elective surgery rates are up 6% over the past year, with a 44% growth over the past five years. Counties Manukau has age-standardised rates higher than the New Zealand average with improvements in access for Maaori, Pacific and more deprived populations.

2.2 Counties Manukau DHB's Operating Environment

Financial Constraints	CMDHB received a reduced funding package from the Crown in 2009/10 which meant a loss in revenue of $24.0 million. This comes at a time when the DHB is experiencing the impact of the ageing population in Counties Manukau with costs for Aged Residential Care rising at approximately 9% per annum, industrial agreements being settled at a level greater than the rate of inflation, demand pressure for pharmaceutical and acute hospital services and the continuing challenge of reducing health inequalities in our district. To ensure that CMDHB is able to retain current levels of service and access over time whilst posting a zero deficit operating position for 2010/11, the DHB is looking at new ways of doing things to ensure the organisation will be able to operate in a sustainable manner. CMDHB's *Thriving in Difficult Times* Workstreams, Productivity and Quality Improvement initiatives and the work on improving productivity will be the catalysts for bringing about the transformational change needed to meet our community's expectations, national priorities and manage within a tighter funding path.
Social Environment, Population Demographics and Health Status	Please refer to *Section 2.1, Population and health profile.*
Workforce	As a result of population growth and increasing demand for health services, CMDHB forecasts a need to double the health workforce in the Counties Manukau district over the next twenty years. In the short term, the forecasts estimate that the CMDHB employed workforce will need to grow by more than 25% to meet demand for hospital services. These projections are based on expected growth in patient demand and current ratios of health workers and professionals to patients. The associated workforce growth is not seen as realistic or achievable within the current models, given expected fiscal constraints and the worldwide shortage of health professionals. CMDHB is faced with a critical business need to work differently, evolve new roles and grow the future health workforce from the local community. A continued focus on clinical leadership and laying the foundations for growing our own workforce through the development of the Centre of Health Services Innovations will be key to long term workforce sustainability.
Wage Settlements and Industrial Relations	Managing the cost of implementing wage and salary settlements within the constraints of our budget is a significant challenge. This is particularly the case when there are a number of wage negotiations due to be completed in 2010.

Health of Older People (HOP)	Demographic modelling anticipates a 5-6% increase in HOP demand. However demand significantly exceeded that in the latter half of 2008/09 and first half of 2009/10. The main external factor driving this seems to be the recessional impacts on household resources, leading to increased demand for publicly-funded services and residential care. There has been a small increase in budget for 2010/11, but if the factors that held sway in 2009 remain the DHB will continue to be exposed in 2010/11.
Better, Sooner, More Convenient Primary Care	Delivering *Better, Sooner, More Convenient Primary Care* is a national priority and focuses on a more personalised primary care system where services are provided closer to the home. Downstream this will make our populations healthier and reduce demand on public hospitals. The three BSMC consortiums in the metro-Auckland area cover over 95% of the population. They are: • The *Greater Auckland Integrated Health Network (GAIHN)*; covering over one million enrolled people across 11 PHOs • The *Alliance Health+* ; a coalition of the three Pacific led PHOs in Auckland across CMDHB and ADHB • The *National Māori PHO Coalition* ; a north island consortium of PHOs with a focus on Whānau Ora First year implementation plans to be delivered at the start of the 2010/11 financial year will deliver the following improvements to the region: • Direct access to radiology • More minor surgery in the community • Reduced impact on hospitals through increased referrals to the Primary Options for Acute Care (POAC) • Co-ordinated metro-Auckland approach to affordable after hours care • Primary secondary clinical pathways • Improving prescribing and safer use of medicines in community pharmacy • Increasing Maaori provider capability to support implementation of Whanau Ora • Supporting regional health targets for immunisation, diabetes, CVD risk management and smoking to improve performance on national health targets *For more details, please refer to the full implementation plan which is attached to the 2010-11 Counties Manukau District Annual Plan*
Regional	The Northern DHBs have been undertaking the foundation work required for developing a long term Regional Clinical Service Plan. Phase 1 and 2 are completed and the work will now contribute towards the development of a comprehensive regional plan that will describe the future configuration of services across the region in a manner which will best ensure clinical viability and financial affordability from a regional perspective. The plan will also inform resource allocation and service provision decisions at the regional and district level. The Regional Clinical Service plan will be completed by October 2010.

National	The newly established Shared Services Establishment Board (SSEB) will further drive the national partnership work. The DHBs will be working jointly with the SSEB to deliver a shared services change programme that offers best value to DHBs over the next three years. Other national level initiatives signalled for the 2010/11 year are listed below: • National Services Location – Options and a national service implementation plan by end of June 2011 in conjunction with the National Health Board (NHB); • High Cost Treatments – seek to be consistent in our menu of high cost treatments, appropriately linked with advanced care plans. Options and a national service implementation plan by end of June 2011 in conjunction with the NHB; • Health Procurement – Deliver a set of savings projects in 2010/11, Health Procurement to provide detail of current plans, potential and range of potential savings being sought. Each DHB assessing its likely share of this total based on expenditure and timing of contract renewal; • Low Evidence Activities & Treatments – seek a single agreed list of low-evidence activities and treatments, including better targeting of pharmaceuticals schedule. Options and a national service implementation plan by end of June 2011 in conjunction with the MOH/NHB.

3. WHAT WE DO

3.1 What we do – the role and function of the DHB

Counties Manukau District Health Board (CMDHB) was established on 1 January 2001 under the provisions of the New Zealand Public Health and Disability (NZPH&D) Act 2000. The DHB comprises the territorial authorities of Manukau City, Papakura District Council and Franklin District Council with a combined population estimated at around 455,000 – or about 11% of the New Zealand population[1].

Working with the funding allocated by Government, the DHB is responsible for working in collaboration with the community, other health and disability organisations and stakeholders in the provision of health and disability services in order to improve, promote and protect the health and independence of the people of Counties Manukau.

The legislative objectives and function of CMDHB under the NZPH&D Act 2000 are summarised in the table below.

Table 1: Objectives and Functions of the DHBs under the New Zealand Public Health & Disability Act 2000

Objectives of DHBs	***Functions of DHBs***
(a) improve, promote, and protect the health of people and communities (b) promote the integration of health services, especially primary and secondary health services (c) promote personal health services and disability support services (d) promote inclusion, participation and independence of people with disabilities (e) and (f) reduce health disparities (g) exhibit a sense of social responsibility (h) foster community participation (i) uphold ethical and quality standards (j) exhibit a sense of environmental responsibility (k) be a good employer	(a) ensure the provision of services as specified in its Crown Funding Agreement (b) develop collaborative arrangements in the health and disability sector (c) issue information relevant to promoting paragraphs (a) and (b) (d) enable Maori to participate in and contribute to strategies for Maori health improvement (e) continue to foster the development of Maori capacity (f) provide information relevant to promoting paragraphs (d) and (e) (g) regularly monitor the health status of the population (h) promote the reduction of adverse social and environmental effects (i) monitor the delivery and performance of services (j) participate in the training of health and disability workers (k) provide information to enable the performance of the DHB to be monitored

[1] Impending legislative changes indicated with Auckland boundaries may change this figure

3.2 Governance

Counties Manukau DHB has a governance and organisational structure as required by the NZPH&D Act 2000. There is a Board which assumes the governance role and a Funder arm and a Provider arm; the former performs the planning, performance management and purchasing functions of the DHB and the latter, the provision of health and disability services respectively.

3.3 The CMDHB Board

The CMDHB Board is responsible to the Minister of Health for:

- Setting strategic direction;
- Appointing the Chief Executive;
- Monitoring the performance of the organisation and the Chief Executive;
- Ensuring compliance with the law (including the Treaty of Waitangi), accountability requirements and relevant Crown expectations;
- Maintaining appropriate relationships with the Minister of Health, Parliament, Ministry of Health and the public.

Counties Manukau DHB has seven Board members elected by the community and four appointed by the Minister of Health:

Elected Board members	Ministerial appointments
Mr Paul Cressey (Dep Chairman)	Professor Gregor Coster (Chairman)
Ms Anne Candy	Ms Lope Ginnen
Anae Arthur Anae	Ms Ruth DeSouza
Mr Bob Wichman	Ms Miria Andrews
Ms Colleen Brown	
Mr Donald Barker	
Mr Michael Williams	

The Board has established a number of committees. The following three are required by legislation:

- Hospital Advisory Committee (HAC)
- Community and Public Health Advisory Committee (CPHAC)
- Disability Support Advisory Committee (DiSAC)

In addition, there are five other sub-committees which have been established to assist the Board in meeting its responsibilities. These are

- Maaori Governance Group (POU)
- Pacific Health Advisory Committee (PHAC)
- Audit, Risk & Finance Committee (ARF)
- Facilities Management & Planning Committee (FMP)
- Remuneration and Appointments Committee (RAC)

POU (Maaori Health Advisory Committee)
The maintenance of POU (Maaori Health Committee) as the key interaction mechanism for Maaori health advocacy with the Board continues. POU provides advice to the Board for Maaori health improvement and continues to play a governance role in overseeing the implementation of the Whaanau Ora Plan (Maaori Health plan).

Pacific Health Advisory Committee (PHAC)
A high proportion of the Counties Manukau population are of Pacific origin and the Pacific Health Advisory Committee (PHAC) is the mechanism which supports the Board and management in ensuring that there is a continued focus on the improvement of health outcomes for Pacific communities. PHAC ensures the health perspectives, views and input of Pacific communities are reflected in the DHB's planning and funding strategies, service delivery, and performance management processes.

4. ORGANISATIONAL STRUCTURE

4.1 The Funding Arm - Planning and Purchasing Health, and Disability Services

Since 2001/02, funding responsibility has been progressively devolved to CMDHB for health and disability services. These services include personal health (i.e. primary, secondary and tertiary care services, Maaori health, Pacific health, primary referred services and oral health), mental health, and services for older people, and DHB provided primary maternity services. The Ministry of Health retains funding responsibility for the remaining health and disability services including the balance of the primary maternity services, disability services for those under 65 years of age, (except for those clinically assessed by CMDHB geriatricians as close in age and interest), public health and national personal health contracts.

Where services have been devolved to the DHB, responsibilities encompass:

- Payment of providers;
- Service development and prioritisation of funding;
- Monitoring and audit of provider performance;
- Management of relationships with providers;
- Entering into, negotiating and amending contracts in accordance with section 25 of the New Zealand Public Health and Disability Act 2000 on any terms that are appropriate in the view of the DHB in order to advance the strategic objectives and outcomes outlined in the annual plan or which are needed in order to deliver the services required by statute or contract with the Crown or other parties; and
- Identification of where the agreements fit into the district's priorities.

In addition, CMDHB is responsible for core ongoing business, including:

- Management of relationships with community organisations, including local government, central government departments and agencies;
- Support for the Board and its committees, in an environment of transparent public accountability;
- Accountability to the Crown through the funding agreement;
- Strategic and annual planning;
- Financial and clinical risk management;
- Specific funding processes such as needs analysis, prioritisation and provider selection as well as monitoring service coverage; and
- Operational relationships between CMDHB's funder and provider arms.

4.2 The Provider Arm – Providing Health and Disability Services

Through its provider arm CMDHB provides a wide but not complete range of specialist secondary services, a selected range of community services, as well as a number of niche specialist tertiary services. These specialist services include:

- Bone tumour surgery
- Plastic, reconstructive and maxillo-facial surgery
- National Burns service
- Spinal cord injury rehabilitation
- National and regional renal dialysis advisory service
- Neonatal intensive care
- Breast reconstruction surgery
- National interventional bronchoscopy (stent and valve placement) service and medical thoracoscopy
- Endoscopic ultrasound and endobronchial ultrasound.

The majority of inpatient services continue to be provided at the Middlemore Hospital site, with the majority of outpatients, community, and day surgery services being provided at our two SuperClinics™ (ambulatory care centres at Manukau and Botany Downs). Non-intensive care based elective surgery has been progressively transferred to the Manukau Surgery Centre (MSC) which is located on the same site as the Manukau SuperClinic™. A number of tertiary and other services are not provided directly by CMDHB. Most of these are provided for Counties Manukau residents by Auckland DHB, for example, cardiothoracic surgery, neurosurgery, oncology; and forensic mental health and school dental services by Waitemata DHB. This requires that CMDHB funds these services separately through inter-district flow (IDF) payments to these DHBs.

In summary, CMDHB relates in a variety of different ways to the components of the wider health system. The DHB:

- ***provides*** secondary (and some tertiary) care;
- ***funds through Inter-District Payments*** for access to specified secondary and tertiary care services from other DHBs and some Non-Government Organisation (NGO) services;
- ***currently contracts with*** PHOs to improve and maintain the health of their enrolled populations and integrate healthcare provision; it contracts with other NGOs to provide residential and support services; and
- ***works collaboratively with*** communities, local and regional authorities, public health funders and providers, disability support funders and providers, and other agencies and organisations that influence health.

5. COUNTIES MANUKAU DHB'S OUTCOMES AND PRIORITIES

5.1 CMDHB's strategic priorities

The current Counties Manukau District Strategic Plan (DSP) was developed in 2005/06 in line with the New Zealand Health and Disability Strategy and in response to the national and policy context of the time. It is also the product of extended conversations with our communities, health professionals, partner agencies, health needs assessments, and reflects local needs as well as our way of working here at Counties Manukau.

The overarching direction of the DSP is towards community wellbeing and preventative strategies while maintaining and improving the quality of existing health services. The DHB's strategic direction focuses on six long term outcomes articulated in the *CMDHB District Strategic Plan 2006-11.* They are:

Outcome 1: Improve Community Wellbeing

Outcome 2: Improve Child and Youth Health

Outcome 3: Reduce the Incidence and Impact of Priority Conditions

Outcome 4: Reduce Health Inequalities

Outcome 5: Improve Health Sector responsiveness to Individual and Whaanau/ Family need

Outcome 6: Improve the capacity of the Health Sector to deliver Quality Services

Section 2 of the 2010/11 CMDHB District Annual Plan outlines: why the DHB regards these outcomes as priority areas, what the DHB will undertake to deliver in 2010/11 to contribute towards achieving these outcomes (outputs), and how we will measure progress towards outcomes (using a combination of national targets, priority areas as well as local output measures which include quality, effectiveness and efficiency measures). A truncated version of this section is attached to the SOI as *Attachment 1*.

The Statement of Forecast Service Performance in the SOI is set out by output class, the national targets and other performance targets the DHB has set for 2010/11.

5.2 Achieving National Priorities

This section demonstrates how the priorities identified by CMDHB in the DSP and this DAP are aligned with national priorities and the Minister of Health's expectations.

The Minister of Health's 'Letter of Expectations', sent on 11th February 2010 identifies what he expects to see DHB's deliver for the 2010/11 financial year.

The letter states that the new Government wants the public health system to deliver ***"Better, Sooner, More Convenient*** healthcare for all New Zealanders", and to give priority to improving frontline services whilst operating within the DHB's financial budget.

Table 2 outlines the Minister's priorities alongside the relevant DSP outcome area for CMDHB, showing how the DHB will organise to deliver healthcare that will meet the Minister's expectations.

Table 2: Linking the Minister's Priorities to CMDHB Priorities

Minister's Priorities	CMDHB Actions 2010/11	CMDHB Priority
Improve service and reduce waiting times	➢ Improve the time from referral to First Specialist Assessment (FSA) for medical patients through: • Using electronic referrals • Ensuring adequate FSA appointment times • Improving processes for grading of referrals • Regular performance reporting ➢ Maintain compliance with MOH Elective Services Patient Flow indicators (ESPIs) ➢ Continue roll out of Whai Manaaki across Emergency Department and other areas to free up staff time and reduce wastage	**DSP Outcome 5:** Improve health sector responsiveness to individual and family/whaanau need
Increase elective volumes year on year	➢ Increase the proportion of elective services which are at or above national access levels ➢ Deliver to Surgical Intervention Rate targets for base elective contract and elective initiatives ➢ Plan to increase Day of Surgery Admission (DOSA) rates ➢ Improve elective theatre utilisation ➢ Long Term sustainable relationships with the private sector to grow electives	**DSP Outcome 5** Reduce health inequalities
Improve emergency department (ED) waiting times	➢ Implement agreed ED Delivery Plan ➢ Improve processes within Emergency Care and the wider organisation ➢ Develop Adult Observation Unit (AOU) ➢ Implement Charge Nurse Specialist (CNS) role in ED to support seen by times within ED ➢ Continue with communication strategy "6 hours can be ours" ➢ Continue implementation of Whai Manaaki to increase staff time for patient care	**DSP Outcome 6:** Improve the capacity of the health sector to deliver quality services
Improve cancer treatment waiting times	➢ Enhance regional collaboration by DHBs to work on access, consistent criteria for diagnosis and treatment timeframes as defined by tumour streams ➢ Redesign clinical pathways to reduce waiting times for lung and colorectal cancers ➢ Improve monitoring and reporting against tumour stream standards and reducing waiting times for cancer services	**DSP Outcome 3:** Reduce the incidence and impact of priority conditions

Minister's Priorities	CMDHB Actions 2010/11	CMDHB Priority
Better, sooner more convenient primary and community health services	➢ Improve access to radiology ➢ Increase minor surgery in the community ➢ Reduce impact on hospitals through increased referrals to the Primary Options for Acute Care (POAC) ➢ Co-ordinate metro-Auckland approach to affordable after hours care ➢ Develop primary secondary clinical pathways ➢ Improve prescribing and safer use of medicines in community pharmacy ➢ Increase Maaori provider capability to support implementation of Whanau Ora ➢ Support regional health targets for immunisation, diabetes, CVD risk management and smoking to improve performance on national health targets	**DSP Outcome 3:** Reduce the incidence and impact of priority conditions **DSP Outcome 5:** Improve health sector responsiveness to individual and family/whaanau need
Foster clinical leadership	➢ Continue strengthening and supporting nursing leadership and governance ➢ Continue strengthening the Clinical/ Management Partnership and maintaining high levels of clinical involvement in decision making forums like Clinical Management Executive Committee, Clinical Advisory Group, Strategic Forum ➢ Develop the Centre for Health Services Innovation.	**DSP Outcome 6:** Improve the capacity of the health sector to deliver quality services
Improve clinical staff retention	➢ Work regionally and on Registered Medical Officer (RMO) retention rates ➢ Develop succession planning for senior nursing roles ➢ Support the retention of Allied Health training roles into full professional roles	**DSP Outcome 6:** Improve the capacity of the health sector to deliver quality services

Minister's Priorities	CMDHB Actions 2010/11	CMDHB Priority
Greater regional collaboration	➢ Deliver regional clinical services plan	**DSP Outcome 6:** Improve the capacity of the health sector to deliver quality services
More unified system	➢ Engage with regional and national initiatives which create greater efficiency and value for money	**DSP Outcome 6:** Improve the capacity of the health sector to deliver quality services
Zero Deficit	➢ *"Thriving in Difficult Times* workstreams and ongoing Quality Improvement	These areas of work which focus on working more efficiently, targeting wastage, improving productivity and organisational performance, are important to the DHB if the DHB is to achieve its outcomes and meet national priorities whilst "living within our means". For more information on the *Thriving in Difficult Times* workstreams, *Productivity* workstreams, and Quality Improvement please refer to *Section 3.5, Transformational Change for Long Term Sustainability* of the 2010/11 District Annual Plan,
Productivity	➢ Cost per WIES ➢ Did Not Attend (DNA) rates: Maaori and Pacific focus ➢ Referral to procedure time: Selected electives ➢ Readmission rates for identified sub specialities ➢ Standardised inpatient mortality ➢ Ambulatory sensitive admissions ➢ Theatre utilisation ➢ Productive wards	
Performance Improvement Actions (PIAs)	➢ Achieving Financial Security ➢ Improve quality and productivity ➢ Enhancing Regional Cooperation	

5.3 Key Mechanisms for Intervention

Counties Manukau DHB discharges its functions by:

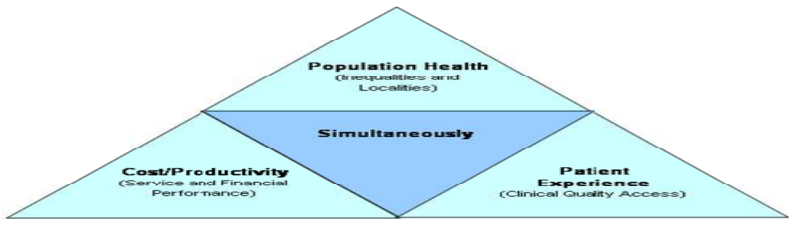
- *providing* secondary (and some tertiary) care;
- *funding (*through Inter-District Payments) other DHBs for access to specified secondary and tertiary care services and some Non-Government Organisation (NGO) services;
- *contracting with* Primary Health Organisations (PHOs) to improve and maintain the health of their enrolled populations and integrate healthcare provision;
- *contracting* with other NGOs to provide residential and support services; and
- *working collaboratively* with communities, local and regional authorities, public health funders and providers, disability support funders and providers and other agencies and organisations that influence health.

5.4 How we measure our progress – District Health Board Intervention Logic

The activities undertaken by CMDHB are planned and implemented to support the achievement of the DHB's outcomes and objectives which include national, regional and local priorities. These priorities have been determined as areas which will move our population to better health and wellbeing in the long term.

The CMDHB Intervention Logic model is illustrated in Figure 1 below showing the link between the DHB's inputs to outputs and outcomes, including high level societal outcomes.

FIGURE 1: COUNTIES MANUKAU DHB INTERVENTION LOGIC



CMDHB'S VISION

To work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori, Pacific peoples and other communities with health disparities

LEADING TO

HIGH LEVEL GOALS

High level societal outcomes derived from health needs assessment, organisational vision statement, Government goals

> Improved health status for all Counties Manukau People so that they lead longer, healthier and more independent lives
> Reduced health inequalities for Maaori and Pacific communities and other communities with health disparities
>Enhanced patient care experience via the delivery of high quality, accessible, timely, safe and effective services
> Services delivered efficiently and with minimal wastage

WHICH IS MEASURED BY

HIGH LEVEL MEASURES

> Life Expectancy at birth
> Rate of potentially avoidable hospitalisations
> Patient experience measures: Hospital DNA rate, (primary care measure to be developed)
> Financial performance

AND TRANSLATED INTO

CMDHB DSP PRIORITY OUTCOMES

Improved Community Wellbeing	Improved Child and Youth Health	Reduced Incidence and Impact of Priority Conditions	Reduced Health Inequalities	Improved Responsiveness to Individual and Family/ Whaanau Need	Improved Capacity to Deliver Quality Services
CMDHB MEDIUM TERM OUTCOMES					
Increased healthy school environments	Improved Maternal Health & Wellbeing	Increased access to structured programmes	Organisational systems and processes are inclusive	Improved access to health services in line with national levels : e.g. elective services	The health workforce meets the needs of the community
More people living healthy lifestyles	Improved Infant and Preschool health	Reduced incidence and impact of conditions like diabetes and cancer	Availability of targeted services and initiatives	Increased levels of primary care utilisation	Improved communication with patients and their families/ whaanau
Increased smokefree environments	Improved Youth Health	Improved outcomes for people affected by mental illness	Improved capacity of providers to deliver inclusive services	Improved continuum of care for older people	Ability to anticipate the future needs of the community
Working intersectorally to develop healthy communities				Reduced numbers of people admitted to hospital and increased numbers who are cared for in primary and community settings	Services are safe and effective
					Improved information exchange amongst health professionals
					Resources are used efficiently

MEASURED BY

CMDHB MEDIUM TERM OUTCOME MEASURES

HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan

Proportion of schools that are health promoting schools (DSP)	Proportion of 2 year olds immunised (HT4)	Hospitalisation rate for hospital discharges with principal diagnosis codes for diabetes and cardiovascular disease	Mortality rate for Maaori and Pacific men aged 45-64 years (DSP)	Standardised intervention rates for elective surgical services (SI4)	Proportion of patients admitted, discharged or transferred from the Emergency Department within 6 hours (HT1)
Proportion of Year 10 students who live in houses where there is smoking in the home (DSP)	Admission rates for babies admitted to hospital in their first year of life (other than at delivery) (DSP)	Proportion of individuals on the diabetes register who have good diabetes management (HT6)	Referral rates to cardiac rehabilitation for Maaori, Pacific and South Indian population	Rate of GP consultations for high needs population compared with non-high needs population (DSP)	Staff turnover by major professional group (OS1)
Proportion of adults who do at least 2.5 hours of physical activity (DSP)	Proportion of children aged 5 years who are caries-free (PP11/DSP)	Proportion of women 45-69 years who have had a breast screen in the last 24 months (DSP)	Ambulatory sensitive hospital admission rates for 15 years plus by ethnicity (SI1/DSP)	Ratio of the number of people receiving home-based support services to the number of people receiving aged residential care (DSP)	Number of days where medical and surgical services occupancy is greater than 90% in CMDHB facilities (DSP)
Proportion of people who are classified as obese (BMI scale)	Mean Decayed, Missing or Filled Teeth (DMFT) at 5 years	Proportion of cancer patients waiting less than 4 weeks between first specialist assessment and the start of radiation oncology treatment (HT3)		Proportion of PHO practices that demonstrate that all increased subsidies translate into low or reduced cost access for eligible patients	Rate of unplanned acute readmissions within 28 days of prior inpatient discharge (OS8)
Proportion of adults consuming at least 3 servings of vegetables per day	Mean Decayed, Missing or Filled Teeth (DMFT) at Year 8 (PP10)	Proportion of the population with severe mental illness accessing mental health services (PP6)		Implementation of Better, Sooner, More Convenient primary health care (PP2)	Proportion of inpatients surveyed who are Satisfied - Very Satisfied with service delivery
Proportion of adults consuming at least 2 servings of fruit per day	Proportion of infants exclusively and fully breastfed at 6 weeks (SI7)	Proportion of long term mental health service clients with current relapse prevention plans (PP7)			30 day mortality rate (OS9)
Proportion of inpatient smokers	Birth rates to teenage mothers 15-19 years (DSP)	Proportion of people with Ischaemic Heart Disease dispensed with at least three statin prescriptions in the past calendar year			Clinical leadership self assessment (PP1)
Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit Score (PP14)	Alcohol-related hospitalisation rate for 15-19 year olds* (proxy measure for youth health outcomes)				Quality of data provided to national collection systems (OS10)

CONTRIBUTING TO

DESIRED IMPACTS

The difference the DHB is making as a result of DHB investment and the given level and quality of outputs

Counties Manukau has healthier environments, lifestyles and communities	Women have access to antenatal and postnatal health services and support to enable them to give their babies the best start in life	Improved access to clinical care and specialist services for people with chronic conditions	Improved health outcomes and reduced health inequalities in areas like: Child and Youth Health, Primary Care, Prevention and Screening through the implementation of our Whaanau Ora and Pacific Health Plans	Appropriate health and disability services are able to be accessed in a timely manner when needed.	CMDHB has a healthy, motivated and skilled workforce that reflects the make-up of the community
	Children from infants to youth have improved health outcomes	Reduced Incidence and impact of Diabetes and Cancer	Services are delivered by our workforce and providers in a culturally sensitive and inclusive manner	Increased utilisation of primary care especially amongst high needs groups	CMDHB has a work environment that is supportive of the delivery of high quality, safe, effective, efficient, patient-centred care.
		Medium to long term impact of serious mental illness are minimised			Organisational resources are used efficiently and the health needs of the community have been anticipated with appropriate investment in infrastructure, workforce, and equipment.
					Patients are satisfied with the services they receive and the way staff communicate with them

DERIVED FROM SERVICES PROVIDED

CMDHB OUTPUTS

*Outputs marked with * is delivered by the DHB; Outputs marked with + are funded by the DHB; Outputs marked with *+ have a mix of services delivered by the DHB and some funded but provided by other DHBs and health and disability service providers.*

PUBLIC HEALTH OUTPUT	PRIMARY & COMMUNITY OUTPUT	HOSPITAL OUTPUT	SUPPORT SERVICES OUTPUT
Health Promotion and Education Services *+	Primary Health Care Services (Capitation/ First contact) +	Mental Health Services *+	Needs Assessment and Service Coordination +
Population-based Screening *	Oral Health Services +	Elective Services *+	Palliative Care Services +
Immunisation Services *+	Primary and Community Care Programmes *+	Acute Services *	Rehabilitation Services *
Well Child Services +	Pharmacist Services +	Maternity Services *	Home Based Support Services +
School Health Services *	Community Referred Test/ Diagnostics Services +	Assessment, Treatment and Rehabilitation Services *	Aged Residential Care Bed Services +
			Respite Care Services *

MADE POSSIBLE BY DHB CAPABILITIES AND ENABLERS:
Projects, Initiatives, Programmes, Workforce Development and Training, Finance & Management, Clinical Leadership, Quality Improvement and Safety, Regional and National Planning, Intersectoral and Interagency working

2010/11 INPUTS ($000)

Investment in the form of $$$, human resources, equipment and technology, planning and funding functions, perfomance management, research, time, collaboration, partnerships, consultation

-4,005	1,480	2,947	-393

6. OUTPUT CLASSES AND THE STATEMENT OF FORECAST SERVICE PERFORMANCE (SFSP) FOR 2010/11

The Statement of Forecast Service Performance is structured along the lines of four output classes for ease of understanding. These are:

- Public Health Services,
- Primary & Community Services,
- Hospital Services and
- Support Services.

Table 3 shows the spread of the DHB's activities (sub-outputs) across the four output classes and against that, which outputs are delivered by the DHB and which are funded by the DHB (actual service provision is provided via an external provider).

These sub-outputs/activities link to the DHB's desired impacts and contribute towards the DHB's outcomes as outlined in the CMDHB Intervention logic (See Figure 1)

Table 3: CMDHB Outputs as outlined in the CMDHB intervention logic

CMDHB OUTPUTS			
PUBLIC HEALTH SERVICES	**PRIMARY & COMMUNITY SERVICES**	**HOSPITAL SERVICES**	**SUPPORT SERVICES**
Health Promotion and Education Services *+	Primary Health Care Services (Capitation/ First contact) +	Mental Health Services *+	Needs Assessment and Service Coordination *
Population-based Screening *	Oral Health Services +	Elective Services *+	Palliative Care Services +
Immunisation Services *+	Primary and Community Care Programmes *+	Acute Services *	Rehabilitation Services *
Well Child Services +	Pharmacist Services +	Maternity Services *	Home Based Support Services +
School Health Services *	Community Referred Test/ Diagnostics Services +	Assessment, Treatment and Rehabilitation Services *	Aged Residential Care Bed Services +
			Respite Care Services *

N.B.

** These outputs are delivered by the DHB;*

+ These outputs are funded by the DHB;

**+ These outputs have a mix of services delivered by the DHB and some funded but provided by other DHBs and health and disability service providers.*

The Statement of Forecast Service Performance (SFSP) sets out non-financial measures for sub-outputs within each output class. These output measures – which include measures of quality/ efficiency/ effectiveness - give CMDHB an indication progress on meeting national priorities and on the implementation of the DSP/ DAP.

Each output class is prefaced with the inputs for the year, a mini intervention logic which shows the link between sub-outputs, their desired impact, and contribution to longer term outcomes.

For each measure, detail is provided on:

- The performance measure itself, i.e. what is being measured
- Baseline/current performance figures and target performance figures for the first financial year covered by the SOI and year out targets where available.

A summary table of CMDHBs reporting requirements and frequency is attended as Attachment 2

6.1 SFSP for Output Class – Public Health Services

Output Class	Definition
Public Health Services	Public health services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from the curative services which repair / support health and disability dysfunction. Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public health services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and individual health protection services such as immunisation and screening services.

6.1.1 Public Health Services Input

Public Health	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
$000	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Revenue					
Crown	9,372	791	10,330	10,893	11,208
Other	1,585	246	48	157	293
Total Revenue	10,956	1,037	10,379	11,050	11,501
Expenditure					
Personnel	3,919	7,046	7,519	7,630	7,743
Depreciation		-	-	-	-
Capital Charge		-	-	-	-
Other	6,777	4,108	6,866	7,002	7,138
Total Expenditure	**10,696**	11,154	14,384	14,632	14,881
Net Surplus (Deficit)	**260**	**(10,118)**	**(4,005)**	**(3,581)**	**(3,380)**

6.1.2 Public Health Services Intervention Logic

High Level Goals	Improved health status for all Counties Manukau People so that they lead longer, healthier and more independent lives
	Reduced health inequalities for Maaori and Pacific communities and other communities with health disparities
	Enhanced patient care experience via the delivery of high quality, accessible, timely, safe and effective services
	Services delivered efficiently and with minimal wastage

Desired Outcome for Public Health Services	**Improved population health and community wellbeing** *Contributing to national priorities on immunisation, smoking cessation, breastfeeding and DSP Outcomes 1, 2, 3, 4*

Impact Sought	Early detection of health issues which may impact on children's development and wellbeing	Protection against communicable diseases	Improved youth health and wellbeing	Healthier communities and safer living environments	Early detection of cancer or pre-cancerous conditions
			Increasing Health Promoting Schools in Counties Manukau		Early detection of hearing impairment in newborns

DHB Outputs/ Services	**Well Child/ Tamariki Ora Services**	**Immunisation**	**School Health Services**	**Health Promotion & Education**	**Population based screening**
	Before School Checks*+	Immunisation for 0 - 2 year olds+	School Clinics+	Healthy Housing*	BreastScreen Aotearoa Programme*
		human papillomavirus (HPV) immunisation+	Health Promoting Schools Programme*	Snug Homes*/ Warm Up*	Newborn Hearing Checks Programme*
			Health services for youth in alternative education/ youth justice system/ teenage pregnancy unit*	Family Violence Prevention+	Cervical Screening +
				Whaanau Ora Marae Programmes+	
				Lotu Moui+	

N.B.
** These outputs are delivered by the DHB;*
+ These outputs are funded by the DHB;
**+ These outputs have a mix of services delivered by the DHB and some funded but provided by other DHBs and health and disability service providers.*

6.1.3 Output Measures for Public Health Services

Ref *column definitions:*
HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan, DAP = District Annual Plan; P = Productivity Initiatives

Outputs	Output Measures	Ref	Responsibility	Baseline	2010 / 2011	2011/2012	2012/2013
Health Promotion and Education Services	***"Creating a better future" - Smokefree***			Q3, 2009/10 57%	90%	95%	95%
	Proportion of hospitalised smokers provided with advice and help to quit	HT5	Service Integration – Healthy Lifestyles				
	Proportion of patients who will have their current smoking status recorded within 6 hours of admission	DAP	Provider Arm	20%	100%	100%	100%
	Proportion of primary care patients provided with advice and help to quit smoking	HT5	Service Integration – Primary Care Service Integration – Healthy Lifestyles	Baseline to be set in 2010/11	50%	80%	80%
	Lotu Moui			Result at Dec 2009: 57%	90%	90%	90%
	Proportion of Lotu Moui churches with a smokefree policy	DAP	Service Integration – Pacific Health				
	Proportion of Lotu Moui churches with a nutrition policy	DAP	Service Integration – Pacific Health	Result at Dec 2009: 56%	90%	90%	90%
	Family Violence Prevention			Combined audit score, Oct 2009 Family violence: 85/ 100 Child protection : 52/ 100 Total: 137 / 200	FV: 70/100 CP: 70/100 Total: 140/200		
	Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit Score	PP14	Family Violence Prevention Provider				
Population-based Screening	Proportion of women 45-69 years who have had a breast screen in the last 24 months	DSP	Medicine and Clinical Support	Q3, 2009/10 Maaori: 43.9% Pacific: 46.8% Total: 53.5%	Total 67%		
Immunisation Services	Proportion of eligible young women who have completed the full human papillomavirus vaccination course through the school-based programme	DAP	Kidz First. Service Integration-Child, Youth and Maternity	Year to date Dec 2009, Completion of: Dose 3: 46.8% Dose 2: 57.6% Dose 1: 60.9%	Completion of: Dose 3: 55% Dose 2: 60% Dose 1: 65%		

<table>
<tr><th>Outputs</th><th>Output Measures</th><th>Ref</th><th>Responsibility</th><th>Baseline</th><th>2010 / 2011</th><th>2011/2012</th><th>2012/2013</th></tr>
<tr><td></td><td>Proportion of children referred to the outreach immunisation service who are then immunised.</td><td>DAP</td><td>Service Integration - Child, Youth and Maternity
Service Integration - Pacific Health
Service Integration - Maaori Health</td><td>Current rate 2009/10:
30%</td><td>50%</td><td></td><td></td></tr>
<tr><td>Well Child Services</td><td>Proportion of 2 year olds fully immunised</td><td>HT6</td><td>Service Integration – Child, Youth and Maternity</td><td>Q3, 2009/10:
Maaori: 73%
Pacific: 87%
Total: 84%</td><td>Maaori: 83%
Pacific: 90%
Total: 90%</td><td></td><td></td></tr>
<tr><td></td><td>Proportion of infants exclusively and fully breastfed at 6 weeks, 3 months and 6 months.</td><td>SI7</td><td>Service Integration - Child, Youth and Maternity</td><td>2008 Plunket
6 weeks:
51.6%
3 months:
42.7%
6 months:
18.2%</td><td colspan="3"><table><tr><td>2010/11 targets</td><td>6 weeks</td><td>3 months</td><td>6 months</td></tr><tr><td>Maaori</td><td>50%</td><td>48%</td><td>27%</td></tr><tr><td>Pacific</td><td>50%</td><td>40%</td><td>27%</td></tr><tr><td>Other</td><td>60%</td><td>57%</td><td>27%</td></tr><tr><td>Total</td><td>55%</td><td>50%</td><td>27%</td></tr></table></td></tr>
<tr><td rowspan="2">School Health Services</td><td colspan="3">Health Promoting Schools (HPS)</td><td rowspan="2">2008/09:
98 schools</td><td rowspan="2">110 Schools</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Number of schools in which the Tipu Ka Rea model for HPS is implemented.</td><td>DAP</td><td>Kidz First</td></tr>
</table>

6.2 SFSP for Output Class – Primary and Community Services

Output Class	Definition
Primary and Community Services	Primary and community healthcare services comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. These include general practice, community and Maaori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

6.2.1 Primary and Community Services Inputs

Primary and Community	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
$000	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Revenue					
Crown	441,626	481,847	483,773	505,270	527,046
Other	-	76	9	10	10
Total Revenue	441,626	481,922	483,782	505,280	527,056
Expenditure					
Personnel	2,847	2,731	2,523	2,568	2,615
Depreciation		-	-	-	-
Capital Charge		-	-	-	-
Other	437,501	476,439	479,779	501,262	523,025
Total Expenditure	**440,348**	479,170	482,302	503,830	525,639
Net Surplus (Deficit)	**1,278**	**2,752**	**1,480**	**1,449**	**1,417**

6.2.2 Primary and Community Services Intervention Logic

High Level Goals	Improved health status for all Counties Manukau People so that they lead longer, healthier and more independent lives
	Reduced health inequalities for Maaori and Pacific communities and other communities with health disparities
	Enhanced patient care experience via the delivery of high quality, accessible, timely, safe and effective services
	Services delivered efficiently and with minimal wastage

Desired Outcomes for Primary & Community Services	➢ **Increased primary and community-based healthcare services utilisation especially amongst the high needs groups like Maaori and Pacific including Community pharmaceuticals** ➢ **Reduced incidence and impact of priority conditions** *Contributing to national priorities on primary care, children's oral health, quicker diagnosis and treatment in the community and DSP Outcomes 1, 2, 3, 4*

Impact Sought	Increased access to primary and community-based healthcare services	Improved access to oral health services
	Reduced number of admissions to hospital that are avoidable or preventable	Improved oral health of children and young people in Counties Manukau.
	Earlier resolution of health problems, lessening the chance of complications	

DHB Outputs/ Services	**Primary healthcare services**	**Primary and Community Care programmes**	**Oral Health**	**Pharmaceutical Services**
	➢ Subsidised primary healthcare+ ➢ After hours primary healthcare+ ➢ Community labs+ ➢ Community radiology+	➢ Chronic Care Management programmes+ ➢ Diabetes 'Get Checked'+ ➢ Cardiac monitoring: CVD risk assessments, Lipid and Glucose tests+ ➢ Primary mental health+ ➢ Heart Guide Aotearoa+ ➢ Primary Options for Acute Care+ ➢ Community-based Cardiac rehabilitation services*+ ➢ General Practitioners with Special Interest providing First Specialist Assessments in a primary care setting: Tubal ligation, ORL, Plastics+ ➢ Retinal Screening by community optometrists+ ➢ Self-management education*+	➢ Oral health services for children aged 0 -17 years+ ➢ Emergency dental services for adults+	➢ Subsidised community pharmaceuticals+

N.B.
** These outputs are delivered by the DHB;*
+ These outputs are funded by the DHB;
**+ These outputs have a mix of services delivered by the DHB and some funded but provided by other DHBs and health and disability service providers.*

6.2.3 Output Measures for Primary and Community Services

Ref *column definitions:*
HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan, DAP = District Annual Plan; P = Productivity Initiatives

Outputs	Output Measures	Ref	Responsibility	Baseline	2010 / 2011	2011/2012	2012/2013
Primary Health Care Services (Capitation/ First contact)	Rate of GP consultations for high needs population compared with non-high needs population	DSP	Service Integration – Primary Care	1.1	> 1	> 1	> 1
Oral Health Services	***Adolescent Oral Health***						
	Proportion of adolescents utilising DHB-funded oral health services	PP12	Service Integration – Child, Youth and Maternity	2009: 57%	60%		
	Proportion of Yr 8 children transferred to the Adolescent Dental Service	DAP	Service Integration - Child, Youth and Maternity	2009: 97.2%	> 95%	> 95%	> 95%
	Child Oral Health						
	Proportion of children under 5 years enrolled in DHB-funded oral health services	PP13	Service Integration- Child, Youth and Family	2009: All: 47% Maaori: 38% Pacific: 39% European/ Other: 59%	All: 58% 0 -2 years: 50% 3 – 4 years: 85%		
	Proportion of enrolled children who did not receive their annual exam	PP13	Service Integration – Child, Youth and Maternity	2009: 31%	15%	< 10%	
	Mean Decayed, Missing or Filled Teeth (DMFT) at Year 8	PP10	Service Integration - Child, Youth and Maternity	Maaori: 1.47 Pacific: 1.61 Other: 0.88 Total: 1.19 Fluoridated: 1.21 Non Fluoridated: 0.93 All Areas: 1.19	Maaori 1.50 Pacific 1.30 Other 0.88 Total 1.10 Fluoridated: 1.10 Non Fluoridated: 1.10 All Areas: 1.10		

Outputs	Output Measures	Ref	Responsibility	Baseline	2010 / 2011	2011/2012	2012/2013
	Proportion of children aged 5 years who are caries-free	PP11	Service Integration - Child, Youth and Maternity	Maaori: 34% Pacific: 27% Other: 61% Total: 44% Fluoridated: 43% Non Fluoridated: 55% All Areas: 44%	Maaori 40.0% Pacific 35.0% Other 68.0% Total 52.0% Fluoridated: 52% Non Fluoridated: 60% All areas: 52%		
	Oral Health Workforce			2007 1 DA to 3.5 DTs	1 DA to 1.5 DTs		
	Ratio of Dental Assistants to Dental Therapists.	DAP	Service Integration - Child, Youth and Maternity				
Primary and Community Care Programmes	***Chronic Care Management***			Net enrolments May 2010: 17,411	>17,500		
	Number of enrolments in the CCM Programme	DSP	Service Integration- Primary Care				
	Proportion of Maaori, Pacific and Asian enrolments into Chronic Care Management (CCM) programme (excluding depression)	DAP	S I- Primary Care	Year to date May 2010 Maaori: 21% Pacific: 37% Asian to be tracked in 2010/11	Maaori: 22% Pacific: 38% Asian: 11%		
	Self Management Education			2009/10: 850	> 850		
	Number of additional patients enrolled in self management (SM) programme.	DAP	Service Integration – Primary Care				
	Number of enrolments in the Very High Intensive User (VHIU) programme	DAP	Service Integration – Primary Care	Pilot Programme Baseline to be established	> 400		
	Diabetes			Q3, 2009/10 Maaori: 68% Pacific: 66% Total: 68%	Maaori: 80% Pacific: 69% Other: 54% Total > 62%		
	Proportion of individuals with diabetes who have a free annual check.	HT6	Service Integration- Primary Care				

<table>
<tr><th>Outputs</th><th>Output Measures</th><th>Ref</th><th>Responsibility</th><th>Baseline</th><th>2010 / 2011</th><th>2011/2012</th><th>2012/2013</th></tr>
<tr><td></td><td>Proportion of individuals on the diabetes register who have satisfactory or better diabetes management.</td><td>HT6</td><td>Service Integration – Primary Care</td><td>Q3, 2009/10
Maaori: 54%
Pacific: 47%
Total: 59%</td><td>Maaori: 53%
Pacific: 48%
Other: 70%
Total > 60%</td><td></td><td></td></tr>
<tr><td rowspan="2"></td><td colspan="7">Cardiovascular Disease</td></tr>
<tr><td>Proportion of the eligible adult population who have had their CVD risk assessed in the last 5 years.</td><td>HT6</td><td>Service Integration – Primary Care</td><td>Q3, 2009/10
Maaori: 73.6%
Pacific: 74.1%
Total: 78.9%</td><td>Maaori: 74%
Pacific: 75%
Other: 82%
Total: 79%</td><td></td><td></td></tr>
<tr><td rowspan="2"></td><td colspan="7">Hospital Admissions</td></tr>
<tr><td>Ambulatory Sensitive (avoidable) Hospitalisations</td><td>SI1</td><td>Service Integration – Primary Care</td><td colspan="4">Targets for 2010/11:

<table><tr><th>Age</th><th>Maaori</th><th>Pacific</th><th>Other</th></tr><tr><td>0-4</td><td>95</td><td>113.0</td><td>95</td></tr><tr><td>45-64</td><td>139</td><td>132.7</td><td>113.4</td></tr><tr><td>0-74</td><td>117.0</td><td>125.2</td><td>103.0</td></tr></table></td></tr>
<tr><td></td><td>Number of Primary Options for Acute Care (POAC) patient admissions avoided at Emergency Care</td><td>DSP / P</td><td>Service Integration – Primary Care</td><td>Year to date May 2010: 5645</td><td>> 6,800</td><td></td><td></td></tr>
</table>

6.3 SFSP for Output Class – Hospital Services

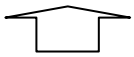
Output Class	Definition
Hospital Services	Hospital services comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include: • Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic and rehabilitative services. • Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services. • Emergency Department services including triage, diagnostic, therapeutic and disposition services.

6.3.1 Hospital Services Inputs

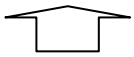
Hospital	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
$000	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Revenue					
Crown	588,771	628,043	648,261	677,834	707,442
Other	24,385	20,952	18,576	19,415	20,256
Total Revenue	613,157	**648,995**	666,837	697,249	727,698
Expenditure					
Personnel	386,434	424,764	434,839	454,640	474,466
Depreciation	23,346	25,604	27,081	27,581	28,081
Capital Charge	14,316	14,000	14,004	14,000	14,000
Other	193,107	179,837	187,968	198,095	208,231
Total Expenditure	**617,203**	**644,204**	663,892	694,316	724,778
Net Surplus (Deficit)	**(4,047)**	**4,791**	**2,945**	**2,933**	**2,919**

6.3.2 Hospital Services Intervention Logic

High Level Goals	Improved health status for all Counties Manukau People so that they lead longer, healthier and more independent lives
	Reduced health inequalities for Maaori and Pacific communities and other communities with health disparities
	Enhanced patient care experience via the delivery of high quality, accessible, timely, safe and effective services
	Services delivered efficiently and with minimal wastage



Desired Outcome for Hospital Services	**Appropriate secondary, tertiary and quaternary services are accessed in a timely manner when needed** *Contributing to national priorities on elective services, shorter stays in ED, shorter waits for cancer treatment, mental health services access, improved maternity care, better hospital productivity and DSP Outcomes 2, 3, 4, 5, 6*



Impact Sought	Improved access and support for people with mental illness	More people receive better, sooner, more convenient elective services	Reduced length of stay in the Emergency Department	Better equipped maternity services and improved outcomes on discharge.
			Timely access to acute or emergency care treatment	Increased post natal Average Length of Stay (ALOS) for first time mothers.
	Quality improvement initiatives contribute to more efficient delivery of services			

DHB Outputs/ Services	**Mental Health Services**	**Elective Services**	**Acute Services**	**Maternity Services**
	➢ Adult community-based services*+ ➢ Child and adolescent services*+ ➢ Older adults inpatient and community-based services*+	➢ Elective Services*+	➢ Oncology services*+ ➢ Emergency Department*	➢ Antenatal care*+ ➢ Community-based maternity units* ➢ Secondary maternity services* ➢ Postnatal care *+ (including breastfeeding support and extended postnatal stays where appropriate)

N.B.
** These outputs are delivered by the DHB;*
+ These outputs are funded by the DHB;
**+ These outputs have a mix of services delivered by the DHB and some funded but provided by other DHBs and health and disability service providers.*

6.3.3 Output Measures for Hospital Services

Ref *column definitions:*
HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan, DAP = District Annual Plan; P = Productivity Initiatives; QI = Quality Improvement

<table>
<tr><th>Outputs</th><th>Output Measures</th><th>Ref</th><th>Responsibility</th><th>Baseline</th><th>2010 / 2011</th><th>2011/2012</th><th>2012/2013</th></tr>
<tr><td>Mental Health Services</td><td>Proportion of the population with severe mental illness accessing mental health services</td><td>PP6</td><td>Service Integration – Mental Health and Addictions</td><td colspan="4">Targets for 2010/11:
<table><tr><td>Ethnicity</td><td>Maaori</td><td>Other</td><td>Total</td></tr><tr><td>0 – 19 yrs</td><td>3.00%</td><td>1.99%</td><td>2.20%</td></tr><tr><td>20 – 64 yrs</td><td>5.58%</td><td>2.43%</td><td>2.88%</td></tr><tr><td>65+ yrs</td><td></td><td></td><td>1.98%</td></tr></table></td></tr>
<tr><td></td><td>Proportion of long term mental health service clients (in contact for 2 years or more) with current relapse prevention plans</td><td>PP7</td><td>Service Integration- Mental Health and Addictions</td><td>Jul 09 – Dec 09:
66%</td><td>95%</td><td></td><td></td></tr>
<tr><td>Elective Services</td><td>Number of elective surgical services discharges</td><td>HT2</td><td>Surgical & Ambulatory Care</td><td>Q3, 2009/10:
106% of planned elective surgical services discharges</td><td>14,174</td><td></td><td></td></tr>
<tr><td></td><td>Standardised intervention rates for elective surgical services</td><td>SI4</td><td>Surgical & Ambulatory Care, Women's Health, Planning and Performance</td><td>Electives Intervention Rate:
292 per 10,000</td><td>Electives Intervention rate: 292 per 10,000
Number of procedures:
Major joint - 812
Cataract - 1147
Cardiac – 273</td><td></td><td></td></tr>
<tr><td></td><td>Elective and arranged inpatient length of stay</td><td>OS3</td><td>Provider Arm</td><td>2008/09:
4.51 days</td><td>3.92 days</td><td></td><td></td></tr>
<tr><td></td><td>Proportion of elective and arranged surgery undertaken on a day surgery basis</td><td>OS6</td><td>Surgical & Ambulatory Care</td><td>2008/09
58%</td><td>60% standardised</td><td></td><td></td></tr>
<tr><td></td><td>Proportion of elective and arranged surgery on a day of surgery admission (DOSA) basis</td><td>OS7</td><td>Surgical & Ambulatory Care, Women's Health, Medical Services</td><td>2008/09:
81%</td><td>90%</td><td></td><td></td></tr>
<tr><td></td><td>Elective Theatre utilisation rate</td><td>DAP</td><td>Surgical & Ambulatory Care and Women's Health</td><td>Current theatre utlilisation rate: 81%</td><td>82.5%</td><td></td><td></td></tr>
</table>

Outputs	Output Measures	Ref	Responsibility	Baseline	2010 / 2011	2011/2012	2012/2013
	Did Not Attend rates for Maaori and Pacific outpatients	DAP / P	Service Integration – Maaori Health. Service Integration – Pacific Health	Year to date, May 2010 Maaori: 15.3% Pacific: 13.3%	Maaori: < 10% Pacific: < 10%	Maaori: < 10% Pacific: < 10%	Maaori: < 10% Pacific: < 10%
	Meet MOH Elective Services Patient Flow Indicators (ESPIs) to ensure all elective patients are seen and managed in a timely manner	DAP	Surgical & Ambulatory Care	ESPI Targets for 2010/11: ESPI 1 =97% ESPI 2 =1.6% ESPI 3 = 4% ESPI 4 = N/A ESPI 5 = 3% ESPI 6 = 10% ESPI 7 = 3% ESPI 8 =97%.			
Acute Services	Proportion of patients admitted, discharged or transferred from the Emergency Department within 6 hours	HT1	Emergency Care Medicine and Clinical Support	Q3, 2009/10 94%	95%	95%	95%
	Average length of stay (ALOS) for acute inpatients	OS4	Provider Arm	4.03 days	4.01 days		
	Acute readmissions to hospital	OS8	Provider Arm	9.70	9.70		
	Proportion of high needs (> 3 times in last 6 months) Maaori patients seen by a cultural support worker	DAP	Service Integration – Maaori Health	Year to date Apr 2010: 67%	> 70%		
	Proportion of high needs (> 3 times in last 6 months) Pacific patients seen by a cultural support worker	DAP	Service Integration – Pacific Health	Year to date, Mar 2010: 76.5%	> 80%		
	Cancer Services						
	Proportion of patients in category A, B, C that wait less than 4 weeks between first specialist assessment (FSA) and the start of radiation oncology treatment	HT3	This service is delivered by ADHB	Q3, 2009/10 92%	100%	100%	100%

Outputs	Output Measures	Ref	Responsibility	Baseline	2010 / 2011	2011/2012	2012/2013
	Proportion of patients waiting less than 6 weeks between first specialist assessment (FSA) and the start of chemotherapy oncology treatment	PP5	This service is delivered by ADHB	Q3, 2009/10: 98%	100%.	100%	100%
Workforce	Staff turnover rate (Full time equivalent (FTE) leavers within 6 months)	P	Human Resources	0.9%	0.7%	0.5%	0.5%
Quality Improvement	Proportion of patients with hospital acquired pressure injuries.	DAP / QI	Quality Improvement	Audit 2009 10%	8% of inpatients affected (annual whole hospital audit).		
	Number of patient falls which cause harm.	DAP / QI	Quality Improvement	24 falls causing harm per month	18 patient falls causing harm per month		
	Rate of Adverse Drug Events (ADEs)	DAP / QI	Quality Improvement. Pharmacy Services	Current rate (Adverse Drug Event Trigger Tool) 11.6%	9%		
	Compliance with World Health Organisation hand hygiene guidelines	DAP / QI	Quality Improvement	Baseline audit of current compliance 50%	80%		
	Reduction in Central Line Associated Bacteraemia	DAP / QI	Quality Improvement	Feb 2010 5.5 per 1000 line days	4.5 per 1000 line days		

6.4 SFSP for Output Class 4 – Support Services

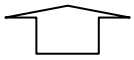
Output Class	Definition
Support Services	Support services comprise services that are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Support Coordination (NASC) Services for a range of services including palliative care services, home-based support services and residential care services.

6.4.1 Support Services Inputs

Support	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
$000	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Revenue					
Crown	72,788	93,584	92,294	96,467	100,646
Other		15	2	2	2
Total Revenue	**72,788**	**93,598**	92,295	96,469	100,648
Expenditure					
Personnel	574	536	590	601	611
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	72,699	93,450	92,097	96,270	100,449
Total Expenditure	**73,273**	**93,986**	92,687	96,871	101,060
			-	-	-
Net Surplus (Deficit)	**(485)**	**(388)**	**(392)**	**(402)**	**(412)**

6.4.2 Support Services Intervention Logic

High Level Goals	Improved health status for all Counties Manukau People so that they lead longer, healthier and more independent lives
	Reduced health inequalities for Maaori and Pacific communities and other communities with health disparities
	Enhanced patient care experience via the delivery of high quality, accessible, timely, safe and effective services
	Services delivered efficiently and with minimal wastage



Desired Outcomes For Support Services	**Older people and people with disabilities are able to maintain their independence and quality of life at home and in the community where appropriate, and where this is not possible, they are supported in a residential care setting** *Contributing to national priorities on elective services, shorter stays in ED, shorter waits for cancer treatment, mental health services access, improved maternity care, better hospital productivity and DSP Outcomes 2, 3, 4, 5, 6*

Impact Sought	The right care is delivered at the right time and place by the right person	People and their whaanau/ family with end stage conditions are supported to live well and die with dignity	Restoration of health to maintain independence and quality of life	People are able to live independently in their own homes for as long as appropriate	People are able to access supported care when they need it

DHB Outputs/ Services	**Needs Assessment and Support Coordination (NASC) Services***	**Palliative Care Services* +**	**Rehabilitation Services***	**Home Based Support Services***	**Aged Residential Care+**	**Respite Care+**	**Day Services +**

N.B.
** These outputs are delivered by the DHB;*
+ These outputs are funded by the DHB;
**+ These outputs have a mix of services delivered by the DHB and some funded but provided by other DHBs and health and disability service providers.*

6.4.3 Output Measures for Support Services

Ref *column definitions:*
DSP = District Strategic Plan, DAP = District Annual Plan

Outputs	Output Measures	Ref	Responsibility	Baseline	2010 / 2011	2011 / 2012	2012/ 2013
Home Based Support Services and Aged Residential Care Bed Services	Ratio of the number of people receiving Home Based Support Services to the number of people receiving Aged Residential Care	DSP	Service Integration – Health of Older People	2008/09: 2.5	2.6	2.6	2.6
Respite Care Services	Number of community respite bed days used for 65+ year olds	DAP	Service Integration – Health of Older People	Mar 2010 Year to date: 200	208 bed days per month		

7. Organisational Capability

7.1 Workforce Development

CMDHB, as a "good employer", is committed to providing a supportive, safe and healthy working environment for our skilled workforce. This is a key component of our Human Resources strategy implemented and supported by human resources at a regional, organisational and service level.

Key components of the strategy include:

- membership of the EEO Trust as an enabler to achieving the workforce development vision " To grow and develop a workforce that serves the health needs of our community with competence and respect and reflects the diversity of Counties Manukau
- a Harassment Prevention Programme including policy, staff education and training, with a commitment to the effective and timely follow up to issues raised by staff
- a bi-annual Staff Satisfaction Survey which provides an opportunity for the organisation to receive feedback regarding the success of specific interventions within teams and services. The results of this survey are one of the evaluation measures used to evaluate and plan annual activity to support the delivery of quality services to our population by recruiting and retaining an engaged workforce
- a focus on Disability Awareness programmes supported by a Disability Coordinator. This was identified as part of our Equal Employment Opportunities (EEO) work. Policy and support exists for the employment of people with a disability to be employed within their area of expertise.
- access to an Employee Assistance Programme, including self referral, for all staff.
- provision of an Occupational Health and Safety Service which includes a Return to Work management function and a Liten Up programme (to provide training and equipment for manual handling activity).
- a three staged management and leadership development programme which is designed to enhance leadership capability across the organisation and clinical professions leading to a stable and healthy workplace.

7.2 Regional collaboration

The Northern DHBs have been working regionally through:

- Formally established fora with delegated decision making authorities (for example, Regional Governance Group, Regional CEO Forum and the Regional Funding Forum, Regional Capital Group)
- A range of clinical networks and regional clinical services (Network North for Mental Health and Addiction Services, the Northern Region Cancer Network, Auckland Regional Public Health Service, Auckland Region Dental Service)
- Shared support agencies (Northern DHB Support Agency (all four DHBS), healthAlliance (Waitemata and Counties Manukau DHBs) and Auckland Regional Resident Medical Officers Service (metro Auckland)).

7.2.1 Northern Region Network Strategy

The Northern Regional Network (NRN) will support each DHB to make the most effective use of their health resources. This will ensure they are able to achieve the greatest possible health gain for the population of the region, provide equitable and appropriate access to DHB services and reduce transactional costs and leverage scale where there is a benefit from doing so.

The DHBs have agreed on an overall framework and will work with the Ministry of Health, National Health Board and Shared Services Establishment Board to ensure appropriate alignment. During 2010/11 the DHBs will progressively work to implement the recommendations outlined in the NRN Strategy.

7.2.2 Northern Regional Clinical Service Planning

The Northern DHBs have undertaken the foundation work required to develop a long term Regional Clinical Service Plan by October 2010. This plan will describe the future configuration of services across the region that will best ensure clinical viability and financial affordability from a regional perspective, and to inform resource allocation and service provision decisions at the regional and district level.

7.2.3 Process related Regional Initiatives

Better Sooner More Convenient Primary Care	Across the Northern Region there is a common objective to maintain a focus on reducing inequalities and have a neighbourhood or locality dimension to primary and community services. In the metro Auckland area, the primary implementation for national and local objectives will be through the national expressions of interest process. At present over 95% of the metro Auckland population is covered by one of three successful expressions of interest in Auckland.
Northern Region Mental Health and Addictions	The Mental Health and Addiction sector (DHBs) is engaged in regional strategic planning and collaboration to result in improved outcomes for Northern region residents with mental health and addictions needs. The Regional Services work programme for 2010/11 will be informed by a service coverage document that has identified the priorities for activity including: • Implementation of agreed changes to the delivery of Alcohol and Other Drug services by the NGO sector • Increasing the capacity of Regional Forensic Psychiatry Services • Establishment of a new Regional Dementia Advisory Service • Implementation of the Regional Child & Adolescent Mental Health Inpatient Unit service delivery model reconfiguration • Development of a Clinical Network for services configured to provide for persons with High and Complex needs
Northern Region Cancer Network (NCN)	The Network and DHBs will work towards meeting consistent and timely targets for patients with lung and bowel cancer, and standardised models of care. Tumour streams will be the main mechanism through which these improvements will be realised in 2010/11. The region will work to: • Improve cancer wait times as defined by lung and bowel tumour streams • Standardise the model of care for cancer care co-ordination within the Northern region • Ensure that everyone needing public radiation treatment will have this within 6 weeks by July 2010 and 4 weeks by December 2010 • Achieve regional radiotherapy intervention rate of 46% by 2014 / 2015
Pharmacy	The four northern DHBs will continue to work collaboratively and collectively on community pharmacy in three key areas: • Contract Review • e-prescribing • Relationship development

Auckland Regional Public Health Service (ARPHS)	ARPHS provides public health services for the people within the three DHBs in the Auckland region and aims to keep people well through preventing disease, prolonging life and promoting health. ARPHS focuses on those public health services that are most effectively and efficiently undertaken at the regional level. The focus for 2010 – 2011 will be on: • Consolidating inter-agency regional emergency planning • Working with other sectors to ensure that decisions outside the health sector consider health and health inequalities consequences • Working with the inaugural Auckland council to try and influence the development of strategies, policies and operational practices
Auckland Regional Settlement Strategy (ARSS) Migrant Health Activity	The ARSS is a region-wide approach to improving the health of Asian, refugee and migrant populations. Improving access for these groups to health and disability services, and improving the cultural responsiveness of the services provided is vital to the improvement of their health outcomes. Regional activities include: • Primary Health Interpreting Pilots • Cultural competency training for the DHB primary and secondary workforce • Culturally responsive child services • South Asian CVD, Diabetes and obesity prevention projects • Auckland Region Middle Eastern / Latin American / African Health Needs Assessment
Procurement	The Northern DHBs intend to work closely with the newly established Shared Services Establishment Board (SSEB) to ensure that procurement continues to meet the DHB's needs. In support of this work the Northern DHBs will improve their collaborative procurement work in 2010-11 through a number of initiatives, including: • Establishing joint procurement clinical governance arrangements • Developing a joint procurement plan

7.2.4 Service Delivery related Regional Initiatives:

Elective Services	Northern Region has developed a proposal which encompasses the establishment of the Regional Elective Services Network (RESN). This will support the development and design of regional referral pathways, workforce development and training, service delivery models, and intervention and demand analysis. The elective workstream will increasingly be separated from the acute workstream, with the exception of the most complex cases. CMDHB will expand the current Manukau Surgical Centre by 4 theatres, and extend the CSSD and bring a blood bank on site to support the additional theatres. Indicative timing for this extension is 2014/15.
Tertiary Eating Disorders	Implementation of the Northern Region Eating Disorders Services Plan 2008-2013. Key elements of this plan include: • Services for People Aged 15 Years and Under will be provided by Starship Hospital, involving the establishment of 5 specialist beds

	• Services for People Aged over 15 Years with the intention that this will be provided from a residential treatment facility with the clinical services provided by the existing Regional Eating Disorders Service.
Community Laboratory Services	The three Auckland Region DHBs will continue to work collaboratively and collectively on the management of the community laboratory service to ensure a quality service is provided that meets expectations. This will consist of ongoing monitoring and management of the contracts that are in place with Labtests and Diagnostic Medlab. In addition, a strategic review of the future provision of histopathology services will also be undertaken that encompasses both community and hospital laboratory services.
Oral Health	Regional priorities for oral health include reducing inequalities, improving child and adolescent oral health and ensuring efficient resource utilisation and distribution. In order to address these priorities, regional initiatives include: • Implementation of the Oral Health Business case • Establishment of Community Based Workers to target preschool populations in Auckland Regional Dental Service (ARDS) • Track preschool enrolments / examinations and effectively communicate with primary care providers and DHBs

7.3 National DHB Partnerships

The 21 DHBs work in partnership to progress common issues and initiatives and have established District Health Board New Zealand (DHBNZ) to provide coordination of activities at a national level. DHBNZ supports the 21 DHBs in a range of areas including: primary health, workforce development, industrial relations, pricing and prioritisation tools, procurement, and information systems. This collaboration happens across all levels of professional groupings such as Chief Executives, Medical Directors, Nursing Directors, Planning and Funding Managers, Chief Financial Officers, Human Resource Management, Quality and Information Services.

7.4 Building Capacity for Long Term Sustainability

Thriving in Difficult Times (TiDT)

Thriving in Difficult Times (TiDT) was initiated by CMDHB in November 2009 as a response to the challenge of having to post a zero deficit position for 2009/10, 2010/11 and into the future years.

The TiDT project is a clinically led programme to review the DHB's plans, processes and identify opportunities for improvement in what we currently do. The scope specifically refers to :

- identifying what services and processes can be improved/ changed to deliver better care, without compromising patient safety or quality or investment in staff and facilities, whilst achieving value for money;
- identifying areas where value could be added;
- identifying and eliminating duplication of effort and wastage;
- identifying those activities which do not deliver to the DHB's core business and stopping them.

Two main activities have emerged from the scoping work: A *Saver* workstream and an *Enabler* workstream - the implementation of which will be clinically led. A summary of the workstreams is outlined in Table 4 below.

Table 4: Summary of Thriving in Difficult Times Focus Areas

Saver Workstream	➢ Operating costs/Productivity ➢ Waste Reduction ➢ Contracts Review ➢ Revenue Maximisation ➢ Inter District Flows ➢ Regional ➢ Patient safety ➢ Service Configuration ➢ Capital Affordability
Enabler Workstream	➢ Decision making ➢ KPI Alignment ➢ Prioritisation

The CMDHB Board has given its endorsement and support to the TiDT plan which outlines how the workstreams are going to contribute to the zero deficit position and future savings. Implementation of the core actions from the TiDT have been incorporated into the DHB's 2010/11 Performance Improvement Actions.

*For further detail on Thriving in Difficult Times and Performance Improvement Actions (PIAs), please refer to the **2010/11 Counties Manukau DHB District Annual Plan**.*

7.5 Productivity Initiatives

Further to the TiDT work is the work on improving the productivity of the organisation which aims to improve the efficiency of the way we do things whilst bearing in mind the core objectives of the Triple Aim.

Counties Manukau DHB's approach is that in order to improve its costs per case, it also need to simultaneously focus on the dimensions of quality, patient experience and population health.

CMDHB's productivity initiatives will look at these areas:

- Cost per Weighted Inlier Equivalent Separations (WIES)
- Did not Attend (DNA) rates: Maaori and Pacific focus
- Referral to procedure time: Electives
- Readmission rates for identified sub specialities
- End of life planning
- Standardised inpatient mortality
- Primary Options for Acute Care (POAC) rates
- Ambulatory sensitive admissions
- Cost per immunisation
- Theatre utilisation
- Productive wards
- Staff turnover / sickness absence

*For further detail on Productivity Initiatives, please refer to the **2010/11 Counties Manukau DHB District Annual Plan**.*

7.6 Information Services

In 2009 the Northern DHBs, together with a wide range of sector stakeholders developed the Regional Information Strategy for 2010 to 2020 (RIS10-20). The strategy supports the transformation to new models of care and underpins the development of a person centred model to achieve better, sooner, more convenient healthcare. In 2010-2011 the Northern Region DHBs will establish an enhanced regional governance structure to oversee and progress the implementation of the new regional strategy. In addition the DHBs will engage in some smaller initiatives to start the implementation of this new strategy, as well as progress and complete some significant regional projects that have already been started under the previous strategy. Priority deliverables for the 2010-2011 year include:

- Shared Care Planning - In partnership with PHOs and GPs, DHBs will implement a number of pilot projects which are clinically lead and enable the use of shared care plans between providers
- Electronic Referrals - Implementation of a regional electronic Referrals solution between primary and secondary care providers (eReferrals phase 1). In addition planning for enhancements to allow faster turnaround and improved response to referrals (eReferrals phase 2 & 3) will also start this year

Enhancement of the regionally shared clinical data repository:
The DHBs will expand the use and content of the regional clinical data repository for sharing of pharmaceutical dispensing information between Pharmacies, General Practices and DHBs (TestSafe Pharmacy project), sharing of outpatient letters between DHBs and GPs (Regional Clinical Documents project) and sharing of various additional diagnostic test results between DHBs and GPs (Regional Éclair Enhancement projects).

7.7 Quality and Safety

With the Triple Aim underpinning the DHB's overall direction, a key driver of achieving our goals is the organisational commitment to Quality Improvement. The "*6 Hours Can Be Ours*" campaign has demonstrated what the organisation can achieve when attention is paid to the drivers of quality like timeliness, patient safety and patient centred care, supported by enablers of strong clinical management leadership and a comprehensive communication campaign.

The DHB will continue as an organisation to focus on planning and delivering health care services which reflect the six care dimensions which define healthcare quality. These are:

- Safe care
- Effective care
- Patient-centred care
- Timely care
- Clinically efficient care
- Equitable care

These same dimensions are reflected in the Ministry of Health's "*Improving Quality Strategy*".

The major workstreams which were mapped out in the CMDHB QI Secondary Care Action Plan 2008 – 2011 will continue to be progressed in 2010/11 (see Table 2 below). The primary focus of quality improvement remains improving patient safety, which will be measured through implementation of the Institute for Healthcare Improvement Global Trigger Tool (GTT), and continuation of the Adverse Drug Event Trigger Tool (ADE TT). A baseline measure has already been established using the ADE TT; the GTT baseline will be established by the start of the new financial year.

Table 5: Specific quality improvement programmes to improve patient safety in 2010/11

Improving medication safety	• Improved communication between primary and secondary care through medication reconciliation and effective discharge medication records • Standardisation of management of medications on wards by the use of Pyxis© technology • Improved management of IV medications through the introduction of Guardrail© technology
Reducing Hospital Acquired Infections	• Compliance with Hand Hygiene practices • Reduction in Central Line Associated Bacteraemia
Perfecting Patient Care	• Reduction in patient falls causing injury • Reduction in hospital acquired pressure injuries
Creating efficient patient flow	• Patients discharged from EC within 6 hours
Creating safer surgery	• Implementation of the World Health Organisation Surgical Checklist

8. FINANCIAL PERFORMANCE

8.1 Financial Statements

Summary by Funding Arm	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Provider	(378)	6,166	5	5	5
Governance	(2,564)	(3,052)	(2,005)	(2,095)	(2,186)
Funder	2,949	(3,077)	2,028	2,488	2,725
Operating Surplus	**7**	**37**	**28**	**399**	**544**
Below the Line	(3,000)	(3,000)			
Surplus (Deficit)	**(2,993)**	**(2,963)**	**28**	**399**	**544**

Statement of Comprehensive Income

Net Result $000	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Crown	1,121,892	1,211,366	1,242,566	1,298,730	1,354,965
Other	16,635	14,186	12,083	12,736	13,416
Total Revenue	**1,138,527**	**1,225,552**	**1,254,649**	**1,311,466**	**1,368,381**
Expenses					
Personnel	393,775	435,077	445,471	465,440	485,435
Outsourced	49,494	42,296	44,250	46,250	48,253
ISP	509,961	570,840	572,844	598,475	624,388
Clinical Sup.	79,950	81,838	85,398	89,120	92,847
Infrastructure	62,847	50,668	57,053	60,467	64,084
Operating Exp	**1,096,027**	**1,180,719**	**1,205,016**	**1,259,751**	**1,315,006**
Operating surplus	**42,500**	**44,833**	**49,633**	**51,715**	**53,375**
Depn.	23,346	25,604	27,081	27,581	28,081
Interest	7,831	8,192	8,520	9,735	10,750
Capital Chg.	14,316	14,000	14,004	14,000	14,000
Net Surplus	**(2,993)**	**(2,963)**	**28**	**399**	**544**

Funder Revenue	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Crown	969,021	1,051,964	1,106,232	1,156,234	1,206,299
Other	74,587	83,484	82,536	86,373	90,242
Total	**1,043,608**	**1,135,448**	**1,188,768**	**1,242,607**	**1,296,541**
Personnel	-	-	-	-	-
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	1,043,659	1,141,525	1,186,740	1,240,119	1,293,816
Total Expenditure	**1,043,659**	**1,141,525**	**1,186,740**	**1,240,119**	**1,293,816**
Net Surplus	**(51)**	**(6,077)**	**2,028**	**2,488**	**2,725**

Eliminations	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	(533,698)	(570,685)	(613,896)	(641,644)	(669,427)
Other					
Total	(533,698)	(570,685)	(613,896)	(641,644)	(669,427)
Personnel					
Depreciation					
Capital Charge					
Other	(533,698)	(570,685)	(613,896)	(641,644)	(669,427)
Total Expenditure	**(533,698)**	**(570,685)**	**(613,896)**	**(641,644)**	**(669,427)**
Net Surplus	**-**	**-**	**-**	**-**	**-**

Provider	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	594,050	630,654	653,222	682,748	712,311
Other	24,497	20,850	18,563	19,402	20,242
Total	**618,547**	**651,504**	**671,785**	**702,150**	**732,553**
Personnel	386,917	428,984	439,266	459,121	479,001
Depreciation	23,346	25,604	27,081	27,581	28,081
Capital Charge	14,316	14,000	14,004	14,000	14,000
Other	194,346	176,750	191,429	201,443	211,466
Total Expenditure	**618,925**	**645,338**	**671,780**	**702,144**	**732,547**
Net Surplus	**(378)**	**6,166**	**5**	**5**	**5**

Governance	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	10,070	9,091	7,968	8,328	8,689
Other	-	194	24	25	26
Total	**10,070**	**9,285**	**7,992**	**8,353**	**8,715**
Personnel	6,858	6,093	6,205	6,319	6,434
Depreciation					
Capital Charge					
Other	5,776	6,244	3,792	4,129	4,467
Total Expenditure	**12,634**	**12,337**	**9,997**	**10,448**	**10,901**
Net Surplus	**(2,564)**	**(3,052)**	**(2,005)**	**(2,095)**	**(2,186)**

Total Revenue	**2008/09 Audited Actual**	**2009/10 Forecast**	**2010/11 Plan**	**2011/12 Plan**	**2012/13 Plan**
Crown	1,039,443	1,121,024	1,153,526	1,205,665	1,257,871
Other	99,084	104,528	101,123	105,801	110,511
Total	**1,138,527**	**1,225,552**	**1,254,649**	**1,311,466**	**1,368,381**
	-	-	-	-	-
Personnel	393,775	435,077	445,471	465,440	485,435
Depreciation	23,346	25,604	27,081	27,581	28,081
Capital Charge	14,316	14,000	14,004	14,000	14,000
Other	710,083	753,834	768,065	804,046	840,321
Total Expenditure	**1,141,520**	**1,228,515**	**1,254,621**	**1,311,067**	**1,367,837**
Net Surplus	**(2,993)**	**(2,963)**	**28**	**399**	**544**

Balance Sheet	**2008/09 Audited Actual**	**2009/10 Forecast**	**2010/11 Plan**	**2011/12 Plan**	**2012/13 Plan**
Assets					
Fixed Assets					
Property, plant and equipment	433,531	457,662	486,808	527,885	579,677
Intangibles	1,196	762	1,562	2,362	3,162
Total Non current assets	**434,727**	**458,424**	**488,370**	**530,247**	**582,839**
Current Assets					
Inventories	493	493	493	493	493
Trade and other receivables	51,063	62,150	73,650	73,650	73,650
Cash	1,128	1,012	1,012	1,012	1,012
Trust / Special funds	834	858	882	882	882
Total Current Assets	**53,518**	**64,513**	**76,037**	**76,037**	**76,037**
Total Assets	**488,245**	**522,937**	**564,407**	**606,284**	**658,876**
Equity					
Crown equity	118,368	118,985	119,602	120,219	120,836
Revaluation Reserves	119,073	119,073	119,073	119,073	119,073
Retained Earnings	(77,786)	(80,749)	(80,721)	(80,322)	(79,778)
Trust / Special funds	834	834	834	834	834
Total Equity	**160,489**	**158,143**	**158,788**	**159,804**	**160,965**
Liabilities					
Borrowings	70,000	120,000	144,000	184,286	217,840
Employee benefits	62,982	36,103	52,389	45,657	52,318
Total non-current liabilities	**132,982**	**156,103**	**196,389**	**229,943**	**270,158**
Current Liabilities					
Borrowings	18,500	29,196	39,396	44,396	49,396
Trade and other payables	89,323	95,544	85,296	84,396	87,412
Employee benefits	86,951	83,951	84,538	87,745	90,945
Total Current Liabilities	**194,774**	**208,691**	**209,230**	**216,537**	**227,753**
Total Liabilities	**327,756**	**364,794**	**405,619**	**446,480**	**497,911**
Total Equity and Liabilities	**488,245**	**522,937**	**564,407**	**606,284**	**658,876**

Movement of Equity	2009/10	2008/09	2010/11	2011/12	2012/13
	Forecast	Audited Actual	Plan	Plan	Plan
Total Equity at beginning of period	**160,489**	**181,486**	**158,143**	**158,788**	**159,804**
Surplus / (Loss) for period	(2,963)	(2,994)	28	399	544
Interest received from Restricted funds		24			
Crown Equity injection	1,037	1,037	1,037	1,037	1,037
Crown Equity withdrawal	(420)	(419)	(420)	(420)	(420)
Revaluation of Fixed Assets		(18,645)			
Total Equity at beginning of period	**158,143**	**160,489**	**158,788**	**159,804**	**160,965**

Cash flows from operating activities	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Cash receipts from Ministry of Health and patients	1,129,586	1,225,552	1,254,649	1,311,466	1,368,381
Cash paid to suppliers	707,983	745,857	751,749	783,447	814,842
Cash paid to employees	381,689	435,808	445,471	465,440	485,435
Cash generated from operations	**39,914**	**43,887**	**57,429**	**62,579**	**68,104**
Net taxes refunded/(paid) (goods and services tax)	767	9,803	9,600	9,600	9,600
Capital charge paid	11,883	14,000	14,000	14,000	14,000
Net cash flows from operating activities	**27,264**	**20,084**	**33,829**	**38,979**	**44,504**
Cash flows from investing activities					
Interest received	1,771	2,004	996	1,041	1,086
Acquisition of property, plant and equipment	61,850	49,301	57,027	69,458	80,673
Net appropriation from trust funds					
Net cash flows from investing activities	**(60,079)**	**(47,297)**	**(56,031)**	**(68,417)**	**(79,587)**
Cash flows from financing activities					
Proceeds from/(Repayment of) equity injection	618	618	618	618	618
Borrowings raised	39,500	34,696	30,128	38,554	45,215
Interest Paid	7,598	8,192	8,520	9,735	10,750
Other Movements	24				
Net cash flows from financing activities	**32,544**	**27,122**	**22,226**	**29,437**	**35,083**
Net increase in cash and cash equivalents	(271)	(91)	24	(1)	0
Cash and cash equivalents at beginning of year	2,233	1,962	1,871	1,895	1,894
Cash and cash equivalents at end of year	1,962	1,871	1,895	1,894	1,894

Capital Expenditure	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Baseline Capital				
Clinical Equipment	1,251	1,251	1,250	1,248
Other Equipment	600	600	600	600
Information Technology	975	975	975	975
Intangible Assets (Software)	450	450	450	450
Motor Vehicles	225	225	225	225
Subtotal	**3,501**	**3,501**	**3,500**	**3,498**
Strategic Capital				
Clinical Services Block	12,423	5,998	8,041	6,615
CHSI	800	6,000	3,150	-
Subtotal	**13,223**	**11,998**	**11,191**	**6,615**
Total	**16,724**	**15,499**	**14,691**	**10,113**

Capital expenditure is subject to timing of equipment and projects, sign off, purchase, lead times, charges, weather and other variations (best estimates have been made on timing).

8.2 Overview

The early indications from the Minister and Ministry of Health of lower funding levels from 2010/11 onwards resulted in Counties Manukau DHB taking similarly early action through it's Thriving in Difficult Times and Productivity initiatives in order to achieve a DAP reflecting a zero deficit operating position. Compounding this challenge has been the requirement that the final DAP be presented virtually two months ahead of previous year's timeframes. Despite these challenges, a full consolidated breakeven position has been achieved without any reduction in front line clinical services, as required both by management and the Board.

However, as this has meant a reduction in support staff, this has put the organisation in a position of higher clinical and financial risk as a result, which we acknowledge must be managed, despite the continuing escalating pressures.

While the nationally consistent application of the Population Based Formula (PBF) formula would have significantly benefited the financial position by almost $24m and allowed CMDHB to continue to self fund the significant number of initiatives around primary care and hospitalisation avoidance, the reality is that this is not available under the lowered MoH capped percentage funding envelope. Previously the MoH cap increase was limited to 7% in total funding. This has now been reduced in the 2010/11 year to 5%, with CMDHB the only DHB negatively impacted by this. Consequently CMDHB has achieved breakeven through further very intensive reviews of its existing investments and structures. We highlight however that it is anticipated that the benefit of the PBF formula will accrue to CMDHB in future years. This is a very fundamental and important assumption to highlight, as without this recognition, the financial position of CMDHB would be at risk, particularly given the increasing cost impact as the new facility investments come on stream in later years.

The key drivers of this change in financial position are:

- Despite the international economic position, the anticipated continuing relatively high level of clinical wage settlements will continue, primarily in the Provider Arm. These are expected to be settled at levels around double the general inflationary levels, on an all up basis, i.e. base and step function increases.
- The continuing significant IDF outflows and pricing adjustments primarily related to ADHB provision of tertiary services.
- The continuing population growth in excess of the census projections used to calculate the population based formula revenue, albeit this gap is diminishing gradually.

- The annualised impact of operating costs relating primarily to the opening of Stage One of the new Edmund Hillary Ward block on the Middlemore site. Of future critical importance will be the impact of the $208m Clinical Services Block Stage 1 which is anticipated to come on stream in the year after this DAP period, i.e. 2013/14
- The need to achieve Government health targets/priorities around ED waiting times, Electives, Cancer waiting times, ESPIs and the increased costs, primarily FTE related, associated with those targets within the forthcoming constrained budget.
- The annualisation of commitments made in 2009/10, including the very significant continuing investment in all quality related areas, with significant initial "hump" funding. This is expected to start producing a return on investment in the coming year and forms a very significant and important part of our Thriving in Difficult Times targets.
- Acute demand growth is again increasing, particularly in the Department of Medicine, Provider Arm, after a period of relatively lower growth.

While the 2009/10 financial result is forecast to achieve a breakeven position, this result could be perceived as misleading in comparison to the forecast 2010/11 position, without further analysis. There are a number of current year gains that are, from a timing perspective, "one off". Depreciation and interest costs are anticipated to be significantly lower than budget for 2009/10 reflecting both the timing issues of the new facility developments and lower depreciation levels on assets reaching the end of their economic lives. These benefits offset the very significant demand driven cost increases occurring within the Funder Arm, particularly Health of Older People, and Pharmaceutical costs. In addition, the anticipated unfunded capital charge revaluation cost did not occur, which has also helped offset other cost increases.

In previous years, CMDHB has benefited from the PBF formula specifically through the demographic growth component of the funding which is additional to FFT. This has allowed CMDHB the opportunity to invest in areas directed towards primary health care and early intervention, while lessening the provider or hospital arm demand. Both the "capping" of the PBF and the anticipated wage increases allow no opportunity for such continuing additional investment, although the core investment of previous years continues.

This forecast financial position, particularly for the first year of the DAP (but also obviously impacting on the outer years) has severely limited CMDHB's ability to continue to invest in and achieve many of its wide-ranging objectives. CMDHB remains absolutely committed to achieving its Triple Aim objectives, but in order to do so has implemented a process of organisational wide review under the project "Thriving in Difficult Times" which highlighted initially five key areas of focus. The funding constraints CMDHB will be under to achieve breakeven will be of critical concern in determining where and how these impact on the Triple Aim objectives. It is important to note, as referred to elsewhere, that there is not and cannot be at this stage, any recognition with confidence in CMDHB's DAP of the impact of external initiatives being taken whether jointly by the DHBs or by Government, i.e. regionalisation, national procurement, shared services initiatives, integrated family health centres. While clearly these initiatives are intended to produce ultimate clinical and financial gain, it is impossible to confidently quantify such at this stage.

The 2010/11 year becomes a difficult balancing act as the focus moves to ensuring financial stability and potentially diverts away from enhancing the District Strategic Plan objectives and our clinical and quality imperatives. If the financial pressures continue as forecast, even greater efficiencies and increased innovation become more important as the primary drivers to addressing the organisation's strategic objectives and meeting its financial obligations. These increased financial constraints and targets are imposed at the same time as the initial costs of the new facilities investments are being incurred, i.e. CMDHB is being asked to absorb long term capital investment costs in the initial years of occurrence in order to breakeven, as opposed to a normal commercial model where the norm would be over a period of time, probably for many years. This challenge will compound as the facility investment grows significantly both in capital and consequent increased operating cost over the next five years. What also needs to be considered are the huge clinical pressures already imposed on CMDHB staff who are severely stretched given the continuing growth pressures, resulting in increasing clinical risk.

The forecast DAP position shows a current deficit of $Nil, In a change from previous years, we are now looking to retain and maintain carry forward surpluses of $10m. This is in order to build up a reserve to offset any future likely investment related deficits in order to achieve a continuing zero deficit result. With regard to the targeted national and DHB objectives, these would be around investment in priority initiatives aligned with our District Strategic Plan and Ministerial areas of emphasis and change such as Chronic Care Management (CCM) and Maaori Health. Again as previously, it is likely that the Board will continue to seek to review the investment levels in these areas within the limits of the carried forward earnings. It also includes recognition of the Minister's "tagged" funding and costs related to the specific tags.

CMDHB has continued to put considerable pressure and demand on the financial management of the organisation in order to meet the Board's requirement to ultimately achieve both breakeven and maintain an appropriate level of investment in initiatives aligned with the District Strategic Plan, while safeguarding clinical quality and safety. Many of these are now so embedded in the core operational activity of the organisation that it is extremely difficult to stop or reverse all of these investments in order to lessen the financial impact on the bottom line. CMDHB, however, as part of the continuing DAP review process, assessed how these could be stopped or reduced in the short term without increasing the negative or cost impact in the longer term and not increasing core clinical costs or risk.

In order to reduce our deficit to $Nil for the organisation, we have already had to cap the allowable and fundable growth, both within the provider and the funder arms. This continues to present a huge challenge to contain the growth, related costs and quality investment throughout the organisation within these parameters. However the organisation recognises that CMDHB will have to further constrain these areas in order to achieve the zero deficit budget position. It should be noted very clearly that we have maintained our Lets Beat Diabetes (LBD) investment at existing investment levels ($2m per annum), increased our investment in Primary Options for Acute Care (POAC) by a further $0.8m per annum and lifted our investment in Oral Health through significant volume increases costing over $1.7m per annum. These investments are seen as critical and unavoidable, despite the intense financial constraints, with even more significant clinical and financial downside, if not addressed now.

8.2.1 Key Assumptions and Risks

As in previous District Annual Plans, it has been necessary to make a number of assumptions due to some areas not being finalised or resolved at the time of the preparation of the Plan. Specific revenue assumptions include:

- A mandatory asset revaluation was carried out last 30 June 2009 under the 3 year minimum asset revaluation period requirement. As a result, devaluation occurred reversing some of the very significant revaluations of previous years. A further high level review is required annually to ensure there are no material variations. Given the much earlier deadline for this DAP finalisation and based on current market conditions, it is expected that there will be no material change in asset valuations and therefore no related change in the capital charge.
- All mental health funding, including existing "blueprint", continues to be "ring fenced". At the time of writing, there has been no indication of any further blueprint funding for 2010/11. As in previous years, mental health has been instructed to absorb its related excess wage settlements within its own ring fence, on the basis it has its own "ring fenced" FFT equivalent (CCP) and demographic growth and must operate within those parameters without top up from any other source.
- No PHO top up reimbursements are anticipated as continuing from the Ministry of Health
- Funding for Health of Older People income and asset testing recalculation is insufficient to match our forecast level, given that as house prices stabilise or fall (as is currently happening), health of older people accessibility levels will drop, entitling more people to claim. This needs to be offset by savings elsewhere.
- That the current ACC arrangements both in regard to revenue levels and cost recoveries are maintained at current levels. Publicly ACC has indicated a tighter fiscal affordability envelope and as well, a tightening of their payment parameters. While this is difficult to

quantify currently, CMDHB expects to offset any downside by further opportunities or enhancement of existing contracts.

- That all revenue allocated to CMDHB, other than ministerially tagged funding, remains at CMDHB's discretion to allocate and contractually commit. This is a very important and fundamental assumption, as there appears to be increasing consideration from the Centre around potential claw back of untagged funds.

It is important to note that the forecast zero deficit position has been reached after recognising anticipated wage and salary settlements well in excess of the 1.73% funded level, specifically:

- The flow on effects of significant national three year wage settlements agreed in previous years, with the flow on costs well in excess of the MoH funded levels. These are driven primarily by additional leave entitlements, automatic ongoing step function on–cost implications, a doubling of CME entitlements, significantly enhanced call out charges and the resultant increase in back-filling.
- As earlier noted, this DAP has been prepared based on the latest information available around likely wage settlements. It is anticipated based on this, that there will be an "across the board" agreed settlement rate for all CTU related unions, with the exception of specifically junior doctors, and under separate award, senior doctors. The likely base settlements are in excess of the funded levels which together with the add on costs and automatic step functions applicable to most awards, continues to present a huge challenge to all DHBs.
- There is no evidence of any material quantifiable efficiency benefits arising from previous MECA settlements or likely in current negotiations. Thus the onus is on the DHBs to manage these costs.
- Increased roster and compliance costs around RMOs terms of employment from previous settlements.
- Generally increased, more demanding terms and conditions of employment across earlier MECAs which significantly lessens flexibility.
- Note that in regard to previous historical financial comparisons, CMDHB has from December 2008 brought Cleaners and Orderlies back onto its payroll from the previous outsourced classification.
- The continuing committed (albeit constrained) investment in priority initiatives aligned with the District Strategic Plan, including those focused on lessening the growth of hospital services and improving quality clinical outcomes.
- The ongoing internal efficiencies being generated including those within healthAlliance. Again, while there are national procurement and shared services initiatives well under way as a result of recent government initiatives, we have reviewed the likely outcome of these as they impact on this year's DAP. It appears extremely difficult to identify and therefore quantify any current additional material financial benefit arising from these given the level of efficiency in these targeted areas already being achieved by healthAlliance. We do not believe it is appropriate to build into the DAP a potentially very risky "unspecified lump sum" saving when there appears to be a high likelihood that we will be unable to achieve this.
- The absorption of increasing pharmaceutical demand, reflecting greater access and usage by our community.
- The absorption of the very significant and increasingly unfavourable costs around Health of Older People, specifically around private hospital funding. This is a national trend reflecting the ageing population shift, growing at a rate which by itself is completely unsustainable financially. It is only through savings in other unrelated areas that this level can at least be managed.
- The absorption of continuing renal growth volumes, albeit it at a growth level below the extremes of previous years
- The absorption of continuing price adjustments to inter-district flows (IDFs) and to a lesser extent the volume of IDF outflows. These relate primarily to provision of services by ADHB with recent upward changes in prices far in excess of FFT and requiring strong challenge as to the level of efficiency built into tertiary pricing and the perpetuation of a 'cost plus' mentality. Much firmer disciplines have been put in place to enable both principles

agreement and management of volumes and costs with IDF partners to minimise this significant exposure.

- The combined impact of meeting the Ministerial ED 6 Hour target and the absorption of increasing ED volumes with consequent flow-on bed impact. The international financial crisis and flow-on impact to our community is likely to have an even greater as yet, unquantified impact on these volumes and the consequent pressure on CMDHB.

There remain a number of significant financial risks inherent in CMDHB's DAP in addition to the above. These include:

- The increasing challenge in both meeting the Minister's and government's health targets/priorities of a breakeven financial result (zero deficit) while complying with all government strategies and policies and investing in and opening significant new facilities, through all years of this DAP and beyond.
- Meeting the community's expectations, now that CMDHB has moved (relatively speaking) to equity from a population based funding perspective, despite the restrictive financial constraints.
- The financial risks associated with demand driven services, in which volume growth continues to far outstrip funding in many areas.
- As above, the outcome of earlier wage price pressure and settlements has led to significantly higher wages and clinical staff shortages arising from a much more mobile workforce. Despite the world wide financial crisis, we still remain exposed to "relativity" flow on risks from these wage settlements. This risk is also relative to the likelihood of flow through to the NGO sector with huge potential ramifications for the overall sector.

Risk mitigation strategies (refer also Part 1) to minimise the negative impact of any changes to the base assumptions, will include:

- An organisational wide commitment to clinical safety and quality improvement. This initiative led by the CEO, and now picked up on a national basis, has resulted in the formation of a formal quality unit within the organisation, but working across and within each area of CMDHB. The quality initiatives will ultimately lead to significant clinical and thus financial benefit and will ultimately be self funding. It is anticipated that these benefits will begin to arise during this financial year through focused action under the Thriving in Difficult Times initiative, but will still remain a challenging financial target despite the significant resource commitment.
- As mentioned earlier, in recognition of the continuingly tightening fiscal constraints and capped funding CMDHB management, with full Board support, initiated a series of efficiency projects under the general heading "Thriving in Difficult Times". The overall objective of the projects is around cost reduction and efficiency improvement with a deliberate avoidance of any negative clinical impact or where possible, material redundancies. The core principles of the project are a commitment to a transformational culture change, a disciplined methodology, a commitment to the Triple Aim, investment in effective and disinvestment in ineffective and reshape, resize, rather than restructure and redundancies. Further (medium to longer term) focus will be around the critical area of service configuration and also capital affordability.
- A significant lift in emphasis and focus around continued development of evaluation, monitoring and auditing processes and systems to ensure that CMDHB is receiving Value For Money (VFM) in all key areas of its operations. While there is increasing emphasis from the centre around VFM, it should be recognised and acknowledged that CMDHB has for many years applied the VFM principles, albeit in a less formalised manner. We will continue to apply a VFM methodology in all areas of the organisation; from procurement through quality, clinical enhancement, etc.
- An increased commitment, which is already occurring, to lifting the level and frequency of all internal and external audit reviews. Increasing emphasis has been placed on widening the audits in the NGO/PHO areas with solid results to date. The primary focus here is around ensuring appropriate contracting of services, full delivery of those contracted services, as well as ensuring appropriate health outcomes.

- As referred to elsewhere in the DAP, considerable effort and development of appropriate strategies are occurring relative to maximising and increasing the benefits of the existing regional or quasi regional functions to ensure significantly greater regional benefit. While there are potential savings to be made through this "roll out", CMDHB (and WDHB) are already benefiting significantly from their existing formal relationship and it would be fiscally imprudent to anticipate further unquantified national benefits that may fundamentally change the financial viability of any of the participating organisations.
- CMDHB is continuing to focus around maximising the benefits of the now well established Regional Internal Audit function which is leading to ensuring best value for services.
- Continued application/utilisation of a robust expenditure and long term forecasting monitoring tool which has proven invaluable in anticipating and therefore confirming the financial trends now being indicated in this DAP.
- Continued focus on efficiency and cost opportunities, throughout the whole of CMDHB, but particularly through the use of healthAlliance and increasingly as referred to above, through greater regional collaboration. The latter is ensuring a consistent approach, a common policy and also ensuring appropriate benchmarking is carried out to maximise efficiencies. There is a potential downside risk in the regional benchmarking however, relative to targets as opposed to "clinical standards" which must be managed.
- Continuing to place very high emphasis on robust, regular monthly performance reviews throughout all levels of the organisation to ensure that CMDHB ultimately meets or exceeds its financial and operational targets.
- The DHB continues to support national initiatives that may lead to cost reductions, subject to the perceived risks being manageable and incremental gains being achieved, within the Procurement and Value for Money projects.

Finally, it is important to highlight within this DAP, that CMDHB has over the past 5 years now, fully absorbed the impact of FFT (now CCP) and demographic growth funding levels being understated as per the following two tables:

Table 6: Impact of Inflation (FFT/CCP) Short Funded Over Past 5 Years

Year Ending	2005	2006	2007	2008	2009
Actual Inflation	4.2%	4.0%	4.0%	3.8%	3.5%
MOH FFT	2.6%	3.3%	2.9%	2.8%	3.1%
Shortfall	(1.6)%	(0.7)%	(2.0)%	(1.0)%	0.4%
$000 per year	9,380	4,472	13,500	9,390	4,554
Cumulative Impact $000	$9,380	$13,852	$27,352	$36,742	$41,296

Please note we have included last year's chart as Statistics New Zealand has not issued the updated census information at time of DAP preparation. Therefore, comments made below are extrapolations based on previous information.

Table 7: Impact of Under-estimated Population Growth as Reported through Census/Statistics NZ

Estimation Made In	Estimate 2006 Pop	Estimate Growth	% Under count	Error in Growth	% to Inflate Growth	Annual Error
2001	418,000	30,000	9%	31,000	103%	6,200
2002	436,000	42,000	4%	19,000	45%	4,750
2003	440,000	46,000	3%	15,000	33%	5,000
2004	441,000	47,000	3%	14,000	30%	7,000
2005	441,000	47,000	3%	14,000	30%	14,000
2006	443,000	49,000	3%	12,000	24%	12,000
Actual Census 2006	454,800	61,100			Average	8,158

Value of understated revenue: - at PBFF $17.042m
- at $1,000 $8.158m

Note: On this basis, CMDHB has been consistently short funded between $8m - $17m per annum

Therefore, when any assessment of efficiencies being achieved is made, there needs to be acknowledgement and recognition that CMDHB is already absorbing between $18m and $25m per year through effective revenue or cost recognition underfunding. This represents a huge challenge from a clinical or health perspective. While this represents a very solid financial absorption which could be argued is simply "getting rid of existing inefficiency", to do so would be ignoring reality.

The absorption is ultimately made at the cost of additional or improved health services to Counties Manukau's very diverse, growing and generally deprived community.

8.3 Financial Management

8.3.1 Specific Cost Pressures – Wage Pressure

Within the Provider Arm, wage increases have been built in at the estimated level of settlements, as almost all awards have or are about to currently expire. Over and above these base salary and wage movements which in themselves are higher than the core FFT/CCP reimbursement level, CMDHB is, along with all other DHBs experiencing very significant levels of oncosts. These include increasing step functions, additional leave, allowances and superannuation (Kiwisaver), primarily around medical and nursing staff entitlements.

In many cases wage staff are entitled to move up a step virtually automatically after each year of service (step function increases) which result in an average of 2 – 2.5% (net) increases. The step function increases have to be absorbed by direct funding (none available) or by way of continuously increasing efficiencies.

As above, the step functions for clinical personnel are virtually automatically applied and can almost double the base increases, which are further compounded by equivalent changes to related terms and conditions as per the previous paragraph. It has become virtually impossible for any DHB to simply absorb this level of excess costs and this is now having to be included in budgets given these are national settlements and agreed to on this basis.

Actual changes in leave entitlements over the past three years, some related to the implementation of the Holidays Act, are already having both a material financial and resourcing impact on the organisation with particular challenges around the impact of observing the extra leave entitlement and then filling the consequent vacancies this is causing.

In finalising the DAP, CMDHB has fully reviewed current vacancy levels as an opportunity to manage within the fiscal constraints. However, at a service level these opportunities have been severely restricted due to continuing volume increases and more importantly, the increasing focus on maintaining a safe clinical working environment.

IEA Wage/Salary Freeze

CMDHB, along with all DHBs took a very prudent and responsible approach to this over the past year with a total salary freeze across all IEAs. However, it is unrealistic to expect this to continue into the 2010/11 year and we are thus anticipating wage settlements in this area similar to the general MECA settlements.

Regional Job Sizing

As part of an Auckland regional approach, CMDHB has previously agreed to participate and abide by SMO regional job sizing standardisation. While some specialties are known and budgeted, there remains significant financial exposure to those specialties not yet finalised. Almost all regional job sizing quantifications are now complete, but have still to be rolled out and include in many cases, back dating of the adjustments. This has been a costly but necessary, exercise for CMDHB, both in regard to ensuring strict regional wage comparability, but also actual safe clinical establishment levels (FTEs).

8.3.2 Capital Planning & Expenditure

While acknowledging the forecast DAP position, CMDHB, with full Board support, must remain committed to the major capital projects currently under construction and nearing completion as previously approved by MoH or NCC/Minister, or those presently under consideration/application with MoH, the NCC replacement or the Minister. As we have indicated in the separate capital submissions, these capital projects, given their magnitude and continuing growth demand within CMDHB, will ultimately fully utilise all existing available cash funding, sourced from either current or accumulated depreciation or remaining available approved debt funding or approved equity/debt. It is critical that CMDHB receives its equitable portion of funding under PBF in order to ensure affordability of these future projects, thus ensuring all DHBs are on a fair level playing field in terms of capital requests.

In essence the projects that were initially approved under the heading of Facilities Modernisation Programme (FMP) are now complete and operational. Latterly, as a completely separate development reflecting the CMDHB Health Services Plan, we have developed the next phase of our facilities programme, renamed *Towards 20/20*. This growth phase reflects the medium to long term forecast impact of current and future growth in the CMDHB catchment area and is seen as absolutely critical to meet the continuing "organic" growth of our region.

We are and will continue to, work closely with all the other northern region DHBs (through the Regional Capital Forum) to ensure non-duplication or maximum utilisation of regional asset investment. However, CMDHB's independently reviewed and confirmed growth and bed projections, are such that this planned and very significant investment is essential simply to meet our own community's current and forecast health needs with no apparent regional duplication or under utilisation evident.

Over the past few years, CMDHB has successfully completed all phases of its building programme under the auspice of FMP. This investment totalled over $300m and was fully funded from CMDHB free-cashflow or existing approved debt facilities. It has come in "on time", "under budget" and "within specifications" – an almost unique occurrence in the public health sector.

We have recently completed the final stage (3) of the Core Consolidation Project encompassing the building of a new stand alone ward block on the Middlemore site (Edmund Hillary Block) which has provided a significant number of in-patient beds. This facility incorporates significant improvement in models of care through both layout changes and staffing structures. These beds have been immediately utilised, reflecting the existing severe shortage of in-patient beds, but have equally assisted in helping achieve the 6 Hour ED target. As noted following, the "shelled" levels of the Edmund Hillary Block are currently being fitted out as part of the subsequently approved "Clinical Services Block Project Stage 1".

Put simply, *Towards 20/20* involves the development of a wider and more comprehensive CMDHB service delivery strategy reflecting future growth requirements.

It is well recognised and acknowledged that the future funding requirements for CMDHB (and the greater Auckland region) are large and will present national funding issues. CMDHB has attempted to lessen this forecast demand and related impact on capital requirements. Steps taken include fully reviewing and updating its Health Services Plan, rerun bed model forecasts, aggressively considered new models of care, reassessed community based health solutions, forecast growth, facility timing and other options.

Extensive resource has been applied to this exercise on numerous occasions including significant independent external input as well as the achievement of a very high level of regional collaboration to ensure non-duplication and aligned timing of new facilities and capacities.

In recognising these challenges, CMDHB initiated a series of three national Sustainability Conferences over earlier years to address the wider national issues arising from these forecasts. These consisted initially of "workforce planning", "funding and affordability" and more recently, "future models of care/building tomorrow's health services".

These conferences were recognised as very successful and there was a high degree of mutual agreement around the issues. However, the underlying drivers have not changed and those challenges are still facing the whole public health sector.

As part of *Towards 20/20* the DHB is well advanced in determining the medium to long term organisational requirements (15 – 20 year horizon). This has been driven earlier by extensive internal and external consultation, the roll out of the Clinical Services Plan (primarily provider or hospital focused) to the Health Services Plan (community wide focus), co-ordinated with the earlier Asset Management Plan as supported by the Ministry of Health. The Business Case encompassing the first stage of the long term plan (CSB Stage 1) was approved by the Minister and planning around this is now well advanced with completion date commencement 2013 calendar year.

Simplistically, this project, albeit that it has technically been split into two stages, proposed a new Clinical Services Block encompassing a completely new replacement suite of theatres, High Dependency Unit (HDU) and Assessment and Observation Unit (AOU) facilities at Middlemore and the fit out of the remaining incomplete (shelled) wards in the Edmund Hillary Block. It is envisaged that completion of this new CSB, Stage 1, will be followed by the relocation of support services to the Manukau Health Park (Browns Road), Stage 1a.

It is anticipated that the strong demographic growth requirements for CMDHB will continue and as such, outstrip the ability for CMDHB to fund future facility development, either internally or from existing debt facilities. Ongoing discussions continue with Ministry of Health and Treasury officials in regard to these requirements and the financial implications.

There is a very clear need for significant further governmental support in future *Towards 20/20* phases, given the anticipated capital requirements outlined in the previous Asset Management Plan and the current Business Case.

While there may be some fine tuning (driven by the benefits of primary care initiatives or other rationalisations) of these requirements, nonetheless the underlying forecast of continuing significant demographic growth and demand within CMDHB, will have to be met through improved or additional facilities, incorporating substantial clinical facility equipment purchase or replacement.

CMDHB is currently updating its existing Asset Management Plan to assist in the planning and forecasting around replacement of existing clinical and IT equipment. This information will be utilised by both clinical and support staff to further improve our disciplines around asset management and to ensure that a balance is achieved between clinical replacement and “facility” improvement.

CMDHB as lead partner, together with Auckland University School of Medicine, MIT and AUT, is well advanced around developing a modular interim educational facility aimed at addressing both current and short term health workforce planning requirements, as well as replacing existing facilities that are being demolished as part of the redevelopment described above. This is a very significant and critical project to ensure that there is adequate and appropriate clinical workforce, given both CMDHB’s and the greater Auckland’s population growth and ageing populations.

A comprehensive presentation of all aspects of the proposal was recently given by the proposed partners to senior management of the National Health Board (See Attachment 3). While originally this was proposed as a form of public private partnership (PPP), given that the intent of the project was a “whole of life” financial risk management/mitigation concept, the indications have been that this is either inappropriate or would not meet government requirements for such in the constrained timeframe available.

As a result of further discussions with NHB, particularly around severe short term capital funding constraints, CMDHB (and its partners) have formulated an interim or modular solution. This will be internally funded and be neutral in overall cost amongst the interested partners. However a permanent solution will be required by the latest of 2013 (for completion 2015/16) given the capacity constraints of the interim solution.

Table 8: Strategic Capital Developments Schedule

Project	Budgeted Approval	Projected finish date	Value	Status
Middlemore (Clinical Services Block Stage 1)	Late May 09	Jan 2013	$208m	Underway ($108r internal funded)
Centre for Health Services Innovation	June 10	Jan 2013	$9.95m	Approved by Board
Maternity Theatres			$10m	Staged 2010 – 2013.
Manukau Health Park (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre) Stage 1a.	Nov 2012	2016	$122m	Staged 2010- 2013.
Middlemore (Clinical Services Block stage 2) Manukau Health Park (SuperClinic and Surgery Centre)	Nov 2013	2017	$75m	As above
Middlemore (Clinic Services Block Radiology and Laboratory C Pod Kidz First) Manukau Health Park (SuperClinic, Rehab Centre, Mental Health Campus) Satellite Sites	Nov 2015	2019	$100m	As above
Middlemore (Inpatient Replacement & Expansion) Manukau Health Park (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre)	Nov 2017	2021	$70m	Unknown
Middlemore (Decommission Galbraith, New Entrance)	Nov 2023	2027	$50m	Unknown
Grand Total			**$644.95m**	

8.3.3 Banking Covenants

CMDHB now operates under only one remaining banking covenant, with all its term debt facilities now transitioned fully across to Crown Health Financing Agency (CHFA). The Board maintains a working capital facility with ASB Bank/Commonwealth Bank which is the only relationship falling under this remaining covenant, together with lease/finance facilities with both Commonwealth Bank and Westpac. Despite the fact that the covenants were renegotiated subsequently down to a single requirement, over the past 3 years CMDHB has fully complied with the original covenants.

Clearly our existing banking relationships in these times are more important than ever. We have, over the past year communicated regularly with the external banks and CHFA of our likely tighter position for 2009/10 which we have managed through without any major issues but are now indicating that significant tightening is increasingly likely to occur in 2010/11.

Table 9: Banking Covenants

Facilities ($m)	Existing Limit	Utilisation @ 30 June 2010	Available Facility @ 1 July 2010
CHFA	197	120	53
Commonwealth Bank (working capital)	45	29.1	15.9
Commonwealth Bank (lease facility)	10	-	10.0
Westpac (lease facility)	10	1.6	8.4

Note: The above CHFA limit INCLUDES the funding approved for the CSB Stage 1, but EXCLUDES any facility relating to MHP Stage 1a and MMH WH theatres which are still under consideration at the time of writing.

8.3.4 Cash Position

The forecast cash position of CMDHB assumes effectively a cash neutral position through full utilisation of free cash flow and available approved debt facilities to match the level of capital expenditure requirements in 2010/11, including both new and replacement assets. Although we have still to complete the final review of all capital expenditure requests, (and therefore confirm the final associated depreciation levels), capital expenditure related to 2010/11 will be limited to $56.0m. We have not included within the cash flow forecast any capital requirements still requiring MoH/Minister approval, therefore specifically the MHP stage 1a and MMH WH theatres.

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2010/11 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing unutilised/approved debt facilities.

Fundamental to our forecast financial position is that the current low interest rates remain relatively stable through the 3 year period. However, from CMDHB's perspective, it has a significant proportion of its long term borrowings in a fixed interest rate spread maturity timeframe portfolio, thus minimising, certainly on current borrowings, any material exposure to upward interest rates.

Covenants
The only covenant now required by external lenders to CMDHB is the ASB/Commonwealth requirement of a "positive operating cashflow", i.e. before depreciation and capital investment.

Asset Sales
Within the time period of this DAP, there are currently no specifically identified asset sales. As part of the long term *Towards 20/20* we will be identifying any potential surplus assets that may be disposed of to assist in funding future developments.

8.3.5 Capital Charge

The District Annual Plan continues to include the matching of cost and revenue on any higher capital charge that may arise from asset revaluations on a three yearly cycle. While this DAP for 2010/11 is immediately following the 30 June 2009 three year requirement, as earlier, CMDHB is not anticipating any material valuation change. Rather, there is a likelihood of either a nil or devaluation given the current financial environment.

8.3.6 Advance Funding

The 2010/11 District Annual Plan continues to incorporate the fiscal benefit of the one month advance funding, based on achieving an breakeven operating position and the maintenance of the other Ministry of Health requirements necessary to access this benefit.

8.4 Cost Containment Efficiency Gains

As in previous years, the DAP reflects a continuing trend of significant growth and cost containment within the organisation. This has been particularly so in the past within the provider or hospital arm, but has become increasingly necessary to achieve within the funder arm through management of demand driven services. Where previously there still appeared to be significant opportunity to continue to improve efficiencies and limit the cost impact of growth, the current outlook provides much more limited opportunities in the historical areas. This future opportunity is now even more limited, given the very significant cost cutting exercises throughout the organisation in order to achieve the DAP operating breakeven position.

As a result of this, CMDHB has, as part of the preparation of this 2010/11 DAP and the early low funding indications, taken immediate formal action to address the need for cost containment and clinical improvement. As earlier indicated, we have formally recognised these challenges through the initiation of the Thriving in Difficult Times projects, and further roll out of productivity initiatives essentially aimed at thinking differently about cost and quality, while still committed to achieving our core objectives around the Triple Aim. The DHB recognises the overarching expectation that core clinical services cannot be cut. In fact, despite the financial pressures, the expectation is that they will be enhanced. However, in order to achieve the financial target facing CMDHB, it has been absolutely essential that we address, and correct as necessary, the level of investment in certain marginal areas and refocus our efforts in proven areas.

Generally throughout the organisation, demand continues to significantly outstrip projections and therefore levels of funded growth. Where there were signs of the steepness of growth slightly flattening over recent years, there are now indications of those growth pressures escalating again. This will require even tighter cost containment than ever to ultimately achieve zero operating deficit, but will in itself put very considerable clinical strain on an organisation experiencing these growth pressures and increase the focus on risk management and minimisation.

Women's health cost pressures continue, particularly relating to meeting service coverage requirements and higher ministerial expectations of bed availability, as well as birth rates (while slightly lower over previous years) still continuing at levels well in excess of national averages and well beyond current population based funding levels.

As noted earlier in the financial narrative, the previous signs of stability around hospital acute growth levels appear to have been temporary as these volumes grow again and are likely to worsen as a result of health and poverty issues potentially increasing through the effects of the international financial crisis. The DAP has been based on realistic levels of increase in acute growth levels, but there remains significant risk that these will exceed funded levels and therefore put further pressure on the organisation.

CMDHB remains committed to maintaining and exceeding in 2010/11, its existing very high level of access and elective volumes that are forecast for 2009/10. These levels have been achieved previously through a combination of both internal and external resources and, while a year later than planned, many of these elective volumes are proposed to be provided primarily within internal resourcing capacity and capability in 2010/11. However, where financially or clinically appropriate, in order to continue the strong reduction in waiting lists, we will access third party providers through formal longer term contracts.

In previous years CMDHB has quite deliberately "short funded" both the funder and provider arms by 0.5% of the demographic growth funding allocation to be able to contribute to the significant investment in new and existing District Strategic Plan initiatives. This has proved impossible in this year's DAP given the very significant growth and financial pressures imposed to reach a zero deficit operating position.

CMDHB continues to express concern around the forecast level of increases in utility costs in the areas of gas, electricity, fuel costs and particularly again indications of high waste water and water increases following on from similar increases over the last 2 years. The latter area is forecast to sustain significant high increases as Watercare takes full responsibility under the Auckland 'Super City' concept. As previously, there appears to be little or no financial advantage from metro Auckland DHB regional negotiations as these prices are primarily geographically site related, rather than collectively related, or they are flat non-negotiable equally applied prices in the case of water/waste water. These forecast increases are well above funded inflation and population growth adjustments and represent in some of the cases, the need for very significant infrastructure investment (and subsequent cost recovery) for the greater Auckland region.

We continue to focus on efficiency gains through reduced costs and improved processes which is seen as essential to offset both volume cost growth and to fund where possible, essential investment in primary care initiatives to ultimately minimise secondary care volume impacts and improve health outcomes for the Counties Manukau community.

As a fundamental core driver of our new facilities development and implementation, new or improved models of care considerations are mandatory for all new developments. This is accomplished with extensive input, deliberation, challenge and resolution coming from full clinical and management representation on the respective committees. As an example, when we opened the initial wards within the Edmund Hillary block last May, we had both different staffing levels and mixes of doctors, nurses and support staff even over those developed for the previous ward blocks of only three years previous. As these are implemented and proven, we will where possible and practicable roll out and enhance where possible, the new models of care to the older blocks. Similarly, as the new full replacement theatre suite is being built within the new Clinical Support Block, we are reconsidering layouts and resourcing levels and mix to improve both clinical efficiency and reduce costs.

These efficiency gains are critical in achieving our objectives and are absolutely essential in order to assist in absorbing increased costs from the introduction of new services and facilities within the *Towards 20/20* projects. Despite the improved clinical conditions and outcomes, the cost of operating these new areas are significantly higher, particularly around service functions such as gas, power and cleaning.

CMDHB has and always will continue to maintain a very close focus on FTE management, given that salary and wage costs are 2/3rds of the provider budget. These are monitored and managed on a monthly basis, both in terms of absolute head count and cost per FTE by division, by RC.

We continue to administer and comply with the Minister's requirement around the freeze on management and admin FTEs. As noted previously, we had already implemented an equivalent instruction across the organisation with only the 4 senior organisational executives with the authority to approve. Further, CMDHB has closely monitored vacancies to ensure maximum efficiency, but at minimum clinical risk in order to optimise financial performance. The continuing challenge to CMDHB is that with the significant demographic growth and consequent bed capacity, direct clinical services are increasing without any further administrative support. While we continue to remain within the capped management and admin FTEs, nonetheless the increasing clinical staff levels and our commitment to keeping their jobs clinically and patient focused, represents an increasing challenge in staying within the cap.

As we noted in the previous DAP, it is notable that within the overall FTE trend analysis, virtually all growth is within the clinical areas or direct clinical support, other than those directly associated with primary care initiatives in the funder arm. Unfortunately, the latter are classified as "management and administration" for MoH and ministerial reporting purposes, but are directly involved in and leading programmes and projects with a direct clinical benefit.

Table 10: Management and Admin Resource Levels

Objective	Deliverables	Target (Actual as at 31/12/08)		Timeframe
Contain the level of investment in Management and Administration resourcing	Manage the FTE's categorised as Management and Administration within the District Health Board within the target FTE cap		Number	Monthly
		FTEs employed (Accrued)	833.8	Compliance
		+ contractors	17.90	
		+ advertised vacancies	35.80	
		+ subsidiaries	-	
		+ other	-	
		= TOTAL	887.5	

The total above does not include CMDHBs share of healthAlliance, NDSA, ARMOS or DHBNZ which are reported separately.

8.5 healthAlliance (CMDHB and WDHB Shared Services Organisation)

healthAlliance continues to perform very well as a shared support service for information services, accounting/finance/human resource support, procurement and materials management and payroll. Cost savings particularly within procurement as well as reduced Human Resource recruitment costs are again expected to significantly benefit CMDHB and WDHB, albeit at a lower level than achieved over previous years. This is occurring as healthAlliance's procurement focus becomes more about tackling the difficult costs negotiations. These achievements are expected to continue but CMDHB cannot expect the level of savings to be as high as previously achieved. CMDHB is working very closely with and contributing to, the national procurement objective although the current assessment is that neither CMDHB nor WDHB can currently have any material expectations around additional national savings over levels currently being achieved.

The current financial constraints imposed on all DHBs have meant we have had to restrict healthAlliance activities for the current year in order to enable them to live within the overall funding package. Regrettably this means a year (or possibly a number of years) of consolidation and in some cases, reduced ability to meet the needs and expectations of its shareholders as a shared services organisation. These cost pressures have meant that focus on areas such as information technology and management opportunities that are seen as essential by all parties, have had to be deferred or in fact reduced for fiscal compliance at a time when both organisations should be investing in this area given the shareholders very high level of expectations and needs. This increased investment, particularly in IS, is necessary to recapture the momentum previously given to the provider arm as well as the very significant needs around the capture and integration within one system of primary care and community level information. This is seen as a critical area for both DHBs and essential to the future development of both.

Despite the financial constraints currently imposed, the need for greater investment in our IS/IT resources is seen by all levels of the organisation right through to Board as a priority. Further management and Board consideration is seen as essential in the coming months to determine how this increased investment and absorption of related costs can be managed whilst still achieving zero operating deficit.

While CMDHB is working towards a more formal regional structure, all northern region DHBs continue to work very closely together to maximise benefits, without ADHB and Northland DHB formally being part of healthAlliance. This is particularly the case with regional information technology development and payroll where all three Auckland metro DHBs now use the same payroll software and thus can share and learn from each other's experiences.

8.6 2010/11 Pharmaceutical Budget

CMDHB is committed to the Government's medicines boost initiative by engaging with Pharmac via our representations on SIG and the GMs' Planning and Funding forums. Pharmac's CMDHB 2010 forecast (January) on 10/2/2010 describes an increase of $3M or 2.9% increase at "reimbursement cost" (drug cost plus dispensing less rebates and co-payments). This forms the base budget to which is added local and regional initiatives. The base budget includes the continued investment of Pharmaceutical Cancer Treatments and the Ministry's funding of 12 month Herceptin treatments. Locally/Regionally the pharmaceutical budget allows for initiatives in the areas of gout, patient drug switching incentives, regional pharmacy development and the continuation of pharmacy quality audits.

8.7 Outlook for 2011/12 and 2012/13 Years

The outer years of the DAP are significantly impacted by a number of key drivers and assumptions.

1. As a result of the budgeted forecast of a zero deficit position for 2010/11 financial year, the outer years "base" positions have improved significantly, based on the continuing revenue and cost assumptions. We are therefore anticipating that the outer 2 years of the Plan, can be maintained at a nil deficit level.

   - Years 2 and 3 of the CMDHB DAP will benefit from the assumption that PBF funding will continue at the current levels, thus assuming the reduced 5% maximum increase cap in any one year continues to be applied.

   - Within all years of the DAP, the full impact of the cost relating to the opening of the Stage 1 Edmund Hillary Block at Middlemore is recognised at almost $6m per year as detailed in the original Business Case.

   - The outer years of the DAP assume a continuing level of wage and salary settlements at the current proposed settlement levels, which means CMDHB will have to continue to absorb settlements at virtually twice the funded levels. This remains a huge challenge for any organisation to absorb, while still continuing to provide both essential and increasing clinical services in a constrained fiscal environment. It is expected that there will be even greater pressure from medical staff for parity with Australian terms and conditions, given the significant easing/accessibility of New Zealand medical staff to Australia from April of this year.

     This is similarly likely to put even greater pressure around workforce levels, recruitment and training, underlining the criticality of the need for early resolution of, and support for, the Centre for Health Services Innovation.

- The DAP does NOT include the cash flow impact and initial operating expense impacts of any current or future, but as yet unapproved Business Cases, OTHER THAN the capital cost of the approved current $208m Clinical Services Block Business Case and the Operating costs of the fitted out additional wards in the Edmund Hillary Block.

2. The challenges as described above are anticipated to be significantly offset by recognition of the continuing benefits of the rollout of the Thriving in Difficult Times project, thus underlining how important the achievement of the project outcomes is, both clinically and financially, to the organisation.

3. The savings and efficiencies arising from above, are also seen as critical in contributing to funding of what are likely to be significant infrastructure challenges around IS and Facilities.

8.8 Significant Accounting Policies

Reporting entity
Counties Manukau District Health Board ("CMDHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Counties Manukau DHB is a crown entity in terms of the Crown Entities Act 2004 owned by the Crown and domiciled in New Zealand. The CMDHB group consists of the ultimate parent, Counties Manukau District Health Board and its "deemed" subsidiaries, Manukau Health Trust (0% owned), and South Auckland Health Foundation (0% owned) - these are not considered to be material and have not been consolidated into the accounts. Its associate companies are healthAlliance Ltd (50%), Auckland Regional RMO Services Ltd (33%) and the Northern DHB Support Agency (33.3%) – these entities are not equity accounted as they are not considered material to CMDHB. All CMDHB subsidiaries and associates are incorporated and domiciled in New Zealand. Counties Manukau DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Public Finance Act 1989 and the Crown Entities Act 2004. Counties Manukau DHB is a public benefit entity, as defined under NZIAS 1.
Counties Manukau DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.
The financial statements were authorised for issue by the Board on 20/10/09.
Statement of compliance
The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.
Standards, amendments and interpretations issued that are not yet effective and have not been early adopted Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to CMDHB include: • NZ IAS 1 *Presentation of Financial Statements (revised 2007)* replaces NZ IAS 1 *Presentation of Financial Statements (issued 2004)* and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. The revised standard gives CMDHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income).

CMDHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.

 NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)* and is effective for reporting periods beginning on or after 1 January 2009.

The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. The revised standard will also require borrowing costs to be considered when revaluing property, plant and equipment to fair value based on depreciated replacement cost. Any necessary adjustments to depreciated replacement cost carrying values will have flow on effects to depreciation expense. CMDHB intends to adopt this standard for the year ending 30 June 2010 and has not yet quantified the potential impact of the new standard.

Basis of preparation

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (interest rate swap contracts) and financial instruments classified as available-for-sale and land and buildings.

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements the DHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Refer to note 1 for the treatment of income in-advance

Management discussed with the Audit Risk & Finance Committee, the development, selection and disclosure of CMDHB's critical accounting policies and estimates and the application of these policies and estimates.

Basis for consolidation

Subsidiaries

Counties Manukau District Health Board is required under the Crown Entities Act, to consolidate into its statutory Accounts those entities "deemed" subsidiaries under this Act. The definition of subsidiaries extends to those entities, whose sole or primary purpose gives "benefit to Counties Manukau District Health Board. This is irrespective of legal ownership.

The Manukau Health Trust Board which is operated by a group of trustees includes nominees from Counties Manukau District Health Board. This entity is not consolidated as it is not material to Counties Manukau District Health Board.

The South Auckland Health Foundation operates as a registered Charitable Trust controlled by a group of trustees and includes three nominees from Counties Manukau District Health Board. Counties Manukau District Health Board has no legal right or equally, obligation in respect of SAHF. This entity is not consolidated as it is not material to Counties Manukau District Health Board.

Associates

The Board holds share holdings in associate companies. The interests in these associates are not accounted for as they are not material to Counties Manukau District Health Board.

Budget figures

The budget figures are those approved by the health board in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by CMDHB for the preparation of these financial statements.

Financial instruments

Non-derivative financial instruments

Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

Non-derivative financial instruments are recognised initially at fair value plus, for instruments not at fair value through profit or loss, any directly attributable transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.

A financial instrument is recognised if CMDHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if CMDHB's contractual rights to the cash flows from the financial assets expire or if CMDHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with the banks, other short term highly liquid investments with original maturities of three months or less, and bank overdrafts.

Bank overdrafts are shown within borrowings as a current liability in the statement of financial position.

Instruments at fair value through profit or loss

An instrument is classified as at fair value through profit or loss if it is held for trading or is designated as such upon initial recognition. Financial instruments (interest rate swaps) are designated at fair value through profit or loss if CMDHB manages such investments and makes purchase and sale decisions based on their fair value. Upon initial recognition, attributable transaction costs are recognised in profit or loss when incurred. Subsequent to initial recognition, financial instruments at fair value through profit or loss are measured at fair value, and changes therein are recognised in profit or loss.

Other

Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment losses.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at their amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

Interest-bearing loans and borrowings

Interest-bearing loans and borrowings are classified as other non-derivative financial instruments.

Trade and other payables

Trade and other payables are initially measured at fair value and subsequently at amortised cost using the effective interest rate

Derivative financial instruments

CMDHB uses foreign exchange and interest rate swap contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments that do not qualify for hedge accounting are stated at fair value. The gain or loss on remeasurement to fair value is recognised immediately in the statement of financial performance. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

The fair value of interest rate swaps is the estimated amount that CMDHB would receive or pay to terminate the swap at the balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price.

Hedging

Cash flow hedges

The Board has no financial instruments by way of interest rate options or foreign currency hedges, although it has entered into these in prior years.

Hedge of monetary assets and liabilities

Where a derivative financial instrument is used to hedge economically the foreign exchange exposure of a recognised monetary asset or liability, no hedge accounting is applied and any gain or loss on the hedging instrument is recognised in the statement of financial performance.

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings
- plant and equipment
- clinical equipment
- motor vehicles
- other equipment

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance.

Additions to property, plant and equipment between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, Plant and Equipment Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Counties Manukau Health Ltd (a hospital and health service company) vested in COUNTIES MANUKAU DHB on 1 January 2001. Accordingly, assets were transferred to COUNTIES MANUKAU DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets continue to be depreciated over their remaining useful lives.

Disposal of Property, Plant and Equipment

Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance is calculated as the difference between the net sales price and the carrying amount of the asset.

Leased assets

Leases where CMDHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

Operating Leases
An operating lease is a lease that does not transfer substantially all risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.
Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to CMDHB. All other costs are recognised in the statement of financial performance as an expense as incurred.

Depreciation

Depreciation is charged to the statement of financial performance using the straight line method. Land and Work in Progress are not depreciated.
Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life	Depreciation rate
• - Structure/Envelope	10 - 50 years	2% - 10%
• - Electrical Services	10 – 15 years	6% - 10%
• - Other Services	15 – 25 years	4% - 6%
• - Fit out	5 – 10 years	10% - 20%
• Plant and equipment	5 - 10 years	10% - 20%
• Clinical Equipment	3 - 25 years	4% - 33%
• Information Technology	3 – 5 years	20% - 33%
• Vehicles	4 years	25%
• Other Equipment	3 - 25 years	4% - 33%

The residual value of assets is reassessed annually.
Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Other intangibles

Intangible assets comprise software that is acquired by CMDHB are stated at cost less accumulated amortisation and impairment losses.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
• Software	2 - 5 years	20% - 50%

Inventories

Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Inventories held for distribution

Inventories held for distribution are stated at the lower of cost and current replacement cost.

Impairment

The carrying amounts of CMDHB's assets, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance.

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on numbers of days overdue, and taking into account the historical loss experience in portfolios with a similar amount of days overdue**.**

Calculation of recoverable amount

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of financial performance.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

Long service leave, sabbatical leave and retirement gratuities

CMDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

Annual leave, conference leave, sick leave and medical education leave

Annual leave, conference leave, sick leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount CMDHB expects to pay. CMDHB accrues the obligation for paid absences when the obligation relates to employees' past services.

Provisions

A provision is recognised when CMDHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation

Restructuring

A provision for restructuring is recognised when CMDHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Income tax

CMDHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Goods sold and services rendered

Revenue from goods sold is recognised when CMDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and CMDHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to CMDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by CMDHB.

Rental income

Rental income is recognised in the statement of financial performance on a straight-line basis over the term of the lease.

Revenue relating to service contracts

CMDHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or CMDHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Mental Health Ring Fenced Revenue

8.8.1.1.1.1 In accordance with Generally Accepted Accounting Practice and NZIFRS, surpluses of Income over expenditure are reported through the Statement of Financial Performance. Where such surpluses are in respect of Mental Health Ring Fenced Revenue, the unspent portion of the revenue is only available to be spent on Mental Health Services in subsequent accounting periods. As at 30 June 2009 there were no unspent amounts in respect of Mental Health Ring Fenced Revenue (as at 30 June 2008 - nil)

Expenses

Operating lease payments

Payments made under operating leases are recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.

Finance lease payments

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Interest Expense

The interest expense component of finance lease payments is recognised in the statement of financial performance using the effective interest rate method.

Cost of Service (Statement of Service Performance)

The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of CMDHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost Allocation

CMDHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Criteria for Direct and Indirect Costs

Direct costs are those costs directly attributable to an output class.
Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Cost Drivers for Allocation of Indirect Costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

ATTACHMENTS

Attachment 1: CMDHB Strategic Outcomes

Attachment 2: CMDHB Reporting Requirements

Attachment 3: List of matters which CMDHB will consult with the Minister

Attachment 1: CMDHB Strategic Outcomes

Outcome 1 – Improve Community Wellbeing

Why is this important?

Within CMDHB, one of the biggest challenges is to tackle lifestyle risk factors and poor health behaviours such as smoking, obesity, lack of physical activity and poor nutrition. These risk factors and behaviours contribute to noncommunicable diseases (NCD) including diabetes, cardiovascular disease (CVD), cancers and chronic respiratory disease. Though largely preventable, these diseases are responsible for a substantial portion of deaths, long term illnesses and disability and reduced quality of life within the Counties Manukau population. Further concerns include:

- The disproportionate effect of lifestyle risk factors on Maaori and Pacific.
- The growing prevalence of Type 2 diabetes.
- The large proportion of individuals and families living in crowded conditions and poor quality housing, resulting in poor health status and conditions such as tuberculosis, rheumatic fever, gastroenteritis and skin infections.

How are we going to do this?

"Creating a Better Future"	In 2010/11, CMDHB will continue to work on the foundation laid by 'Lets Beat Diabetes' through the "Creating a Better Future" plan. This Plan aims to: • Prevent or delay the onset of NCD. • Improve health outcomes and quality of life for those with disease. • Reduce health inequalities.
Intersectoral partnerships to develop healthy environments	CMDHB will continue to work collaboratively and in partnership with other agencies, in particular schools, Manukau City Council, the Ministry of Social Development, and Housing New Zealand in order to bring about the social and environmental changes which are needed for better health outcomes for the population. *Healthy Housing* • CMDHB will continue to deliver joint health and housing assessments in partnership with Housing New Zealand. • CMDHB will also run programmes to retrofit insulation into the homes of low income households. *Healthy Schools* • Using the Tipu Ka Rea – 3-step – model, CMDHB will continue to work with schools in the district to be self-sustaining health promoting schools. 60% of schools in deciles 1-3 are targeted for this work. *Family Violence Prevention (FVP)* CMDHB will: • continue to maintain intersectoral links with agencies working to address family violence and identify opportunities to work collaboratively with stakeholders. • support the Family Violence Prevention Policy and promote the implementation of the FVP programme action plan for staff at CMDHB • identify and respond to remedial actions arriving from the annual service audit.
Better help for smokers to quit	***Secondary Care*** CMDHB has been working hard to support system development in our hospital settings and behaviour change amongst clinicians to routinely address and document smoking with all patients. Actions to date include: • Development of the Patient Smokefree Assessment sticker to support

	easy and standard documentation of patient interventions • NRT Standing orders for Nurses • NRT available on Pyxis for easy access for all wards • "Train the trainer" to develop capacity within the hospital to deliver the Smokefree Best Practice Training. • As of May 2010, having smoking information as a mandatory field in the Electronic Discharge Summary ***Primary Care*** Actions to support Primary Care in achieving its smoke-free target include: • Providing the Train the Trainer course for PHO/Primary Care Nurses • Providing resources for both practitioner and patient • Providing on-going feedback and communication to PHOs.

How we will measure our progress:

- An increase in the availability of smoking cessation advice and support for the community
- A decrease in the proportion of inpatient smokers
- A decrease in the proportion of students living in homes where there is smoking
- An increase in the proportion of adults who are regularly physically active
- A reduction in the proportion of adults who are classified as obese
- An increase in the proportion of adults who eat at least 3 portions of vegetables and 2 portions of fruits a day
- An increase in the number of schools which are health promoting schools
- An increase in hospital responsiveness to Family Violence, Child and Adult Abuse
- A increase in joint health and housing assessments
- An increase in homes in Counties Manukau retrofitted with insulation

Outcome 2 – Improve Child and Youth Health

Why is this important?

Counties Manukau has a relatively youthful population, with 13% of the nation's children living in the district, and 25% of the Counties Manukau population being aged 14 years and under. In Counties Manukau, a significant proportion of children live in areas of high deprivation and many are at risk of poor health outcomes due to a combination of social and economic factors like housing, parental employment and incomes.

How are we going to do this?

Immunisation	Immunisation is a top priority for improving child health. CMDHB is looking at ways of working more innovatively and cost effectively to improve the immunisation rates for the population.
Community-based health services	CMDHB will continue to work with communities and partner agencies to ensure that the health needs of children and young people are met by • Improving access to health care services • Developing and implementing child and family centred policies, programmes and initiatives Community-based health services which are delivered to where people live make access to health services possible for a wider group of people. These include: • The outreach immunisation programme • Mobile vision and hearing services • Mobile oral health clinics • Preschool brushing programmes • B4 School Checks delivered by Well Child and community providers
Maternal and	CMDHB has been working towards achieving Baby Friendly Hospital

infant health	accreditation for Middlemore Hospital. At present: • All three community maternity units have achieved accreditation and continue to maintain this • Work is ongoing at the Maternity Unit on the Middlemore campus to achieve accreditation Infant mental health is also a focus for the DHB and resources have been developed for the community which will now be extended to resources to support health professionals working with mothers.
Youth Health	The DHB continues to support school-based health services and clinics and also health assessments for children and young people who are in the care of CYFS and those young people who have been excluded from school or are incarcerated. The DHB HPV vaccination programme is delivered via primary care and through the school-based programme.

How we will measure our progress:

- An increase in the proportion of two year olds fully immunised
- A reduction in the admission to hospital rates for infants in their first year of life
- A reduction in ambulatory sensitive (avoidable) hospitalisations for children aged 0- 4 years
- An improvement in the caries free rate and mean Decayed, Missing, Filled (DMF) teeth score for children
- An improvement in the utilisation of oral health services by adolescents up to the age of 17 years
- An improvement in breastfeeding rates
- A reduction in the rate of alcohol-related hospitalisations for 15 – 19 year olds

Outcome 3 – Reduce the incidence and the impact of Priority Conditions

Why is this important?

In order for CMDHB to better manage long term conditions and reduce acute demand and unnecessary hospital admissions, the incidence and impact of priority conditions must be reduced. These include:

- Diabetes
- Cardiovascular Disease
- Chronic Respiratory Disease
- Cancer
- Poor mental health

How are we going to do this?

Management of Long Term Conditions	In 2010/11, CMDHB will work towards key deliverables including: • Increasing Maaori (22%), Pacific (38%) and Asian (11%) enrolments into the Chronic Care Management (CCM) programme to ensure equitable coverage for those with long term conditions by June, 2011. • Measuring improved engagement and self management perception for people with Long Term Conditions by ensuring at least 450 patients have completed the pre and post intervention questionnaire by June, 2011. • Increasing awareness of long term/ chronic care management programmes to nurses and undergraduate nursing students throughout 2010 and 2011.

	• Increasing access to evidence-based CVD risk management for 3000 patients who have a CVD risk of > 15% by June, 2011. • Reducing the impact of chronic diseases for Maaori through the continuing development of Heart Guide Aotearoa as part of the CCM programme by June, 2010. • More consistent utilisation of the Primary Options to Acute Care (POAC) programme across CMDHB while focusing on those practices with nil/ low POAC utilisations and high hospital admissions by June, 2011. • Development of an agreed Quality Improvement framework in order to provide clinical governance to the diabetes and CVD care provided across Counties Manukau by December, 2010. • Continue with the establishment of collaborative clinical networks for quality improvement within two localities
Cancer Control	Regional collaboration through the Northern Cancer Network (NCN) will be pivotal to CMDHB and the other northern DHBs improving cancer treatment waiting times. • Specific standards have been regionally agreed on in order to reduce wait times and improve the pathway of care from first diagnosis to treatment • A referral pathway to improve access of Maaori patients to the Maaori Community Cancer Support Services will be developed in collaboration with the Regional Blood and Cancer service • CMDHB will be exploring the development of an outreach chemotherapy treatment service at Middlemore Hospital
Mental health	• The CMDHB Mental Health Service is moving towards a more restorative model of care with a shift away from hospital-based care towards community-based care where people are encouraged to actively manage their own recovery, backed up by specialist services • Access to primary mental health services will be further developed in 2010/11 where PHOs with more than 20,000 patients enrolled will be able to offer the CCM Depression module • Services for youth with moderate to severe mental health will be reconfigured in order to improve access

How we will measure our progress

- An increase in the proportion of people with diabetes who have had an annual check
- An increase in the proportion of people with diabetes have satisfactory or better diabetes management
- And increase in the proportion of eligible adult population have had their CVD risk assessed in the last 5 years
- A reduction in adult hospital discharge rates for cardiovascular disease and diabetes
- An increase in the proportion of women aged 45 – 69 who have had a breast screen in the last 24 months
- All people needing radiation oncology treatment will have this within 6 weeks of their first specialist assessment
- An increase in the proportion of Counties Manukau people with severe mental health issues accessing mental health services

Outcome 4 – Reduce health inequalities

Why is this important?

The commitment to reducing health disparities is clearly stated in the CMDHB vision and highlighted as one of the key outcome areas in the current Counties Manukau DHB *District Strategic Plan 2006 - 2011*.

The life expectancy gap between Maaori and the non-Maaori and non-Pacific population remains in excess of 10 years while the gap between Pacific and non-Maaori and non-Pacific is 5 - 7 years. Mortality rates and potentially avoidable hospitalisations show similar disparities.

In response to growing health disparities amongst Asian communities, the DHB has taken the step to develop an Asian Health Plan which identifies the key risks and disease burden for Asian sub-groups and outlines the DHB's approach to addressing Asian Health.

How are we going to do this?

The Triple Aim and Health Equity	Within Triple Aim, reducing health inequalities is one of the components to improving the population's health. The Triple Aim underpins the CMDHB Quality Improvement Strategy which includes equity as one of the six dimensions of quality. To that end, the DHB's pursuit of quality improvement, value for money and population health must be mindful of the needs of the population. A Health Equity Working Party has been established in order to further increase CMDHB's commitment to reducing health inequalities. The Health Equity Approach will be implemented from July 2010
Priority Actions	CMDHB has three work plans which specifically outline what initiatives are being taken across the organisation to reduce inequalities for their targeted populations. These actions span the continuum of care from primary and community healthcare services to secondary and specialist services provided at the hospital.
Whaanau Ora	The Whaanau Ora Plan, as the key Maaori strategic document, sets out the parameters of the DHB/Maaori community relationship.
Tupu Ola Moui (Pacific Health Plan)	The Tupu Ola Moui outlines how the DHB will implement the CMDHB District Strategic Plan for Pacific people who live in the Counties Manukau District. The plan identifies priority areas for Pacific Health in CMDHB and describes the actions that will be undertaken to progress those priority areas.
Asian Health Plan	The vision for Asian Health is: ***"Collective action towards ensuring equity and reducing health disparities among Asian people, their families and communities"*** Priorities for Asians have been identified through measures such as utilisation, prevalence, and incidence data. An action plan will be developed for 2010/11 with the intention that interventions identified will be delivered through existing services and initiatives.

How we will measure our progress

- A reduction in the rate of potentially avoidable hospitalisations
- A reduction in ambulatory sensitive hospital (ASH) admission rates
- A reduction in outpatient Did Not Attend (DNA) rates
- A closing of the gap in life expectancy between Maaori and Pacific with non-Maaori and non-Pacific.
- A reduction in the mortality rate for Maaori and Pacific men aged 45 – 64 years.
- An increase in the referral rates to cardiac rehabilitation for the Maaori, Pacific and South Indian population

Outcome 5 – Improve Health Sector responsiveness to individual and family/ whaanau need

Why is this important?

Health services must be available when people need them. This applies to the services people most commonly use – primary and community health care – and to those hospital and specialist services that must be there for those less frequent occasions when a major health event occurs.

How are we going to do this?

Electives	CMDHB will continue to focus on improving access to elective surgery. • In 2010/11, the DHB will be increasing elective surgical discharges in line with the national target and will also be focusing on improving service quality and productivity within elective surgical services.
Better, sooner more convenient primary and community health	The *Better, Sooner, More Convenient Primary Care* consortia have agreed to deliver the following improvements for 2010/11. • Direct access to radiology • More minor surgery in the community • Reduced impact on hospitals through increased referrals to the Primary Options for Acute Care (POAC) • Co-ordinated metro-Auckland approach to affordable after hours care • Primary secondary clinical pathways • Improving prescribing and safer use of medicines in community pharmacy • Increasing Maaori provider capability to support implementation of Whanau Ora • Supporting regional health targets for immunisation, diabetes, CVD risk management and smoking to improve performance on national health targets
Health of Older People	CMDHB will continue to progress the initiatives underway to improve the continuum of care for older people. The DHB will continue to: • Develop the Community Geriatric Service • Raise the profile of specialist rehabilitation services and community support services InterRAI which is a nationally consistent assessment tool for older people requiring community and long term support services will be rolled out in 2010/11 via a regional implementation.

How we will measure our progress

- Increased access to elective surgery for the population
- A decrease in the number of elective patients who have not been managed according to their assigned status and who should have received treatment
- Improved clinical pathways across primary and secondary care contributing to improved utilisation of primary health care and appropriate referral to secondary services when needed.
- An increase in GP consultations for high needs people compared with non-high needs people
- An increase in ambulatory sensitive hospital (ASH) admission rates
- An increase in the numbers of older people receiving home based care where it is appropriate to do so

Outcome 6 – Improve the Capacity of the Health Sector to Deliver Quality Services

Why is this important?

Growing and retaining a workforce that serves the needs of our community and reflects its diversity is critically important. The DHB is focusing investment on developing the infrastructure that needs to be in place to support the workforce in meeting the needs of the community it serves.

How are we going to do this?

Workforce Development	• The DHB offers scholarships in health training programmes to local people with the intention of offering them employment at the completion of their studies. CMDHB's long term vision for "Growing Our Own" workforce includes the Centre for Health Services Innovation project. • The DHB positions itself as an "employer of choice" and there is a strong focus on learning and development within the organisation. E-learning continue to be developed in 2010/11 with more learning materials available. • The DHB has two cultural acclimatisation programmes, Tikanga Best Practice and Pacific Cultural Competency, which aim to support staff in delivering culturally safe services to a predominantly Maaori and Pacific patient population. • Regional collaboration on recruitment and workforce development initiatives remain strong. One of the regional workforce development initiatives CMDHB is trialling as a pilot site in 2010/11 is the Physician Assistant role
Emergency Department (ED)	In 2010/11, CMDHB will continue to run the "6 hours can be ours" communication campaign and the MOH agreed ED Delivery Plan which includes: ➢ Improving processes within EC and the wider organization ➢ Developing the Adult Observation Unit (AOU) ➢ Implementing the Clinical Nurse Specialist (CNS) role in ED to support seen by times within ED ➢ Continue implementation of Whai Manaaki (improving work processes and environments) to free up staff time for patient care.
Quality Improvement and Patient Safety	The quality improvement team will initially focus on the delivery of hospital and related services but will be expanded in the medium term to include community services such as residential care and primary care.
Information Systems	The Northern Regional Information Strategic Plan (RISP 10-20), which is also CMDHB's Information Systems Strategic Plan (ISSP), outlines the five year vision for information management and technology to support the delivery of healthcare services in the Northern Region. The plan is closely aligned to the Health Information Systems New Zealand (HISNZ) objectives and national activities. Key IS activities which will be delivered in 2010/11 include: • eReferrals • Single hosted Radiology information system (RIS) • Phase 2 of the Mental Health electronic patient records (EPR) system. • Regional Clinical Records *The RISP 10-20 is available at:* *http://www.healthpoint.co.nz/default,157023.sm*

How we will measure our progress

- Maintaining or improving on the national target for shorter stays in Emergency Departments
- A reduction in turnover rate of staff
- Greater patient satisfaction with the care they receive and communication with staff
- A reduction in the number of unplanned readmissions
- A reduction in the number of incidents related to patient safety and quality of care
- Assessment of performance against published Standards of Care
- Improved financial management

Attachment 2: CMDHB Reporting Requirements: Summary of the 2010/11 Framework Reporting.

Dimension	Policy Priorities	Code	Indicator	Area	Frequency	Quarter Due			
						Q1	Q2	Q3	Q4
		HT1	Shorter stays in emergency departments	Health Target	Quarterly	✓	✓	✓	✓
		HT2	Improved access to elective surgery	Health Target	Quarterly	✓	✓	✓	✓
		HT3	Shorter waits for cancer treatment	Health Target	Quarterly	✓	✓	✓	✓
		HT4	Increased immunisation	Health Target	Quarterly	✓	✓	✓	✓
		HT5	Better help for smokers to quit	Health Target	Quarterly	✓	✓	✓	✓
		HT6	Better diabetes and cardiovascular services	Health Target	Quarterly	✓	✓	✓	✓
		PP1	Clinical leadership self assessment	Ministerial Priority Area	Annual				✓
		PP2	Implementation of Better, Sooner, More Convenient primary health care.	Ministerial Priority Area	Annual				✓
		PP3	Local Iwi / Maaori engagement and participation in DHB decision making, development of strategies and plans for Maaori health gain.	Ministerial Priority Area	Six Monthly		✓		✓
		PP4	Improving mainstream effectiveness DHB provider arms pathways of care of Maaori.	Ministerial Priority Area	Six Monthly		✓		✓
		PP5	Waiting times for chemotherapy treatment.	Selected NZHS priority area	Quarterly	✓	✓	✓	✓
		PP6	Improving the health status of people with severe mental illness.	Selected NZHS priority area	Six Monthly		✓		✓
		PP7	Improving mental health services using crisis intervention planning.	Selected NZHS priority area	Six Monthly		✓		✓
		PP8	DHBs report alcohol and drug service waiting times and waiting lists.	Selected NZHS priority area	Six Monthly		✓		✓
		PP9	Delivery of Te Kokiri: The mental health and addiction action plan.	Selected NZHS priority area	Annual			✓	
		PP10	Oral health DMFT score at year 8.	Selected NZHS priority area	Annual			✓	
		PP11	Children caries free at 5 years of age	Selected NZHS priority area	Annual			✓	
		PP12	Utilisation of DHB funded dental services by adolescents	Selected NZHS priority area	Annual				✓
		PP13	Improving the number of children enrolled in DHB funded dental services.	Selected NZHS priority area	Annual			✓	
		PP14	Family violence prevention.	Selected NZHS priority area	Annual				✓

Dimension		Code	Indicator	Area	Frequency	Quarter Due			
						Q1	Q2	Q3	Q4
	System Integration	SI 2	Regional service planning		Six-Monthly		✓		✓
		SI 3	Service coverage		Six-Monthly		✓		✓
		SI 4	Elective services standardised intervention rates		Six Monthly	✓		✓	
		SI 5	Agreed funding for Maaori health and disability initiatives		Annual				✓
		SI 6	Risk Reporting		Six Monthly		✓		✓
		SI 7	Improving breast-feeding rates.		Annual				✓
		OS 1	Staff turnover by major professional group	Stewardship of resources	Quarterly	✓	✓	✓	✓
		OS 2	Capital expenditure in line with plan	Stewardship of resources	Quarterly	✓	✓	✓	✓
		OS 3	Elective and arranged inpatient length of stay	Hospital throughput and production efficiency	Quarterly	✓	✓	✓	✓
		OS 4	Acute inpatient length of stay	Hospital throughput and production efficiency	Quarterly	✓	✓	✓	✓
		OS 5	Theatre productivity	Hospital throughput and production efficiency	Quarterly	✓	✓	✓	✓
		OS 6	Elective and arranged day surgery	Hospital throughput and production efficiency	Quarterly	✓	✓	✓	✓
		OS 7	Elective and arranged day of surgery admissions	Hospital throughput and production efficiency	Quarterly	✓	✓	✓	✓
		OS 8	Acute readmissions to hospital	Quality	Quarterly	✓	✓	✓	✓
		OS 9	30 Day mortality	Quality	Annual				✓
		OS 10	Improving the quality of data provided to national collection systems	Production Control	Quarterly	✓	✓	✓	✓
		OS 11	Hospital outputs are delivered to plan	Quality	Quarterly (for three-quarters)		✓	✓	✓
		OS 12 *	National patient satisfaction survey	Quality	Quarterly	✓	✓	✓	✓
	* This measure is a place holder for a patient satisfaction survey or similar tool – currently there is no detailed measure in the ownership dictionary as a piece of work on the future of the current survey and consideration of alternative models is yet to take place. A place holder measure is included in the summary tables and diagrams so that the measure is captured in the analysis of reporting burden, but the shape of future surveys and associated measures is yet to be confirmed.								

Attachment 3: List of matters which CMDHB will consult with the Minister.

The following are a list of key issues and projects which CMDHB will consult on with the Minister before any decisions are made regarding their future implementation:

- Major changes to capital planning.
- Major service delivery changes.
- Significant risk issues.
- Primary Care *Better, Sooner, More Convenient* implementation.
- *Towards 20/20* Capital Projects.
- Centre for Health Services Innovation.