COUNTIES MANUKAU DISTRICT HEALTH BOARD

A Community Partnership

Annual Plan 2011/12

Incorporating the Statement of Intent 2011/12 – 2013/14

COUNTIES MANUKAU DISTRICT HEALTH BOARD

A Community Partnership

SIGNATORIES – MINISTER/CHAIR

Annual Plan Dated This _____ Day of _____ 2011.

(Issued under section 39 of the New Zealand Public Health and Disability Act 2000)

ISSUED BY
Counties Manukau District Health Board

Signed by

Professor Gregor Coster
Chair of Counties Manukau DHB

Geraint A. Martin
Chief Executive of Counties Manukau DHB

CONSENT GIVEN BY

The Hon Tony Ryall
The Minister of Health

Office of Hon Tony Ryall

Minister of Health
Minister of State Services

9 AUG 2011

Professor Gregor Coster
Chair
Counties Manukau District Health Board
Private Bag 94 052
South Auckland Mail Centre
AUCKLAND 2240

Dear Professor ~~Coster~~ Gregor

Counties Manukau District Health Board 2011/12 Annual Plan

This letter is to advise you I have approved and signed Counties Manukau District Health Board's (DHB) 2011/12 Annual Plan for three years.

This year has seen significant change to the accountability framework for all DHBs with the introduction of annual Regional Service Plans to replace District Strategic Plans and one Annual Plan that incorporates the Statement of Intent. These changes are designed to help improve the way we plan service delivery by setting a long term direction and clear pathways to get there, through an integrated approach linking the different levels of health care.

I want to thank you for your co-operation as we transition to this new way of thinking and look forward to your continued support as we strive for improved health services for all New Zealanders.

Clinical and financial sustainability

All DHBs are expected to budget and operate within allocated funding and identify specific actions to improve financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery. I expect you to build on the work your DHB has already undertaken to remain financially sustainable and note your commitment to find further savings to ensure a break even position if your estimated 2013/14 revenue is not available.

Primary Care

Delivering better, sooner and more convenient services closer to home has been a priority for the Government and DHBs for a number of years. Closer integration of services across primary and secondary care and a greater range of services being delivered in the community should not only reduce pressure on hospitals but also improve the patient experience. It is important that you collaborate with your regional DHB colleagues to develop this integration effectively.

I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan including more tangible actions and deliverables to show how you will achieve the objectives of your business cases. The Government expects significant progress to be made in implementing the business cases and deliverables this year and we will be watching developments with interest.

Regional Collaboration

Greater regional collaboration is a key aspect of the new accountability arrangements and supports more effective use of clinical and financial resources. Better collaboration amongst DHBs is essential to address priority vulnerable services and has the potential to maximise efficiencies through shared back office functions, as well as IT, workforce support and development and capital investment. As core elements of the National Health Board's work, I look forward to seeing the benefits of collaborative partnership with your fellow DHBs as these important regional initiatives are implemented.

Your Annual Plan incorporates a strong regional flavour. It is evident that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning.

Health of Older People

The prioritisation of investment in services to ensure the health and support needs of older people are met is important. An ongoing programme will be required to manage the impact of our ageing population on health services and support the provision of high quality and sustainable services in this area.

I am pleased to see more detail in your Annual Plan on how you are planning to deliver health services for older people. I am especially interested to follow your progress in relation to addressing the respite care needs of your community and the effective use of recent additional funding for this service.

How you will provide new and expanded services for people with dementia is of importance to me as is your DHBs continued application of the comprehensive clinical assessment tool (interRAI) currently being rolled out nationally. Better articulation of how improvements are being sought in this priority area will be expected from all DHBs in next years Annual Plan.

Clinical Leadership

Clinical leadership is fundamental to improving patient care and has an important role in supporting overall service delivery in a number of ways. Engagement with clinical leaders aids job satisfaction for health care professionals and improves delivery of workforce initiatives. The success of clinical networks is based on clinical input working across regions and nationally to assist with overall service delivery. Clinical leadership also plays an important part in the integration of service delivery closer to home.

I expect to see clinical leadership embedded as a way of working within your DHB and the ways in which you seek engagement with your clinicians continue to expand over coming years.

Health Targets

New Zealanders have high expectations that they will have access to quality health care services when they need them. The Government's Health Targets are selected to drive

ongoing improvements in specific priority areas in order to meet the growing expectations of the public.

I appreciate Counties Manukau DHBs efforts to deliver on the Health Targets and your progress in delivering on these. It is good to see that you have identified more specific actions within your Annual Plan that you will take to ensure you achieve your planned performance on the six Health Targets.

Mental Health Ringfence

I am approving your plan subject to an expectation that your DHB works closely with the Ministry of Health, to agree and ensure appropriate use of currently unallocated mental health ringfence funding in order to achieve improvements in mental health for your population.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. All service change or service reconfigurations must comply with the requirements of the Operational Policy Framework and you will need to advise the National Health Board of any proposals that may require my approval.

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

I acknowledge that the impacts for DHBs of the earthquakes in Christchurch are difficult to determine and that these have not been taken into account in producing Annual Plans. The impacts of these events are ongoing for the health sector and will need to be managed beyond what is included in your Annual Plan.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2011/12 Annual Plan.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

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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.

FOREWORD

We are pleased to present our Annual Plan and Statement of Intent for the 2011/12 financial year.

This document reflects our continuing commitment to improve the health and wellbeing of the Counties Manukau population and – in line with government and regional priorities – to reduce health disparities faced by Maaori, Pacific and other communities within the district whilst delivering a safe, patient-centred and cost effective health service.

Whilst our vision for the health of our population has remained steadfast, there are changes in emphasis in our annual planning which reflect the changes to the New Zealand Public Health and Disability Act and the priorities of the Government. Greater regional collaboration in service planning and shared services capabilities, with CMDHB taking a lead role, is all a part of this change of emphasis.

The inaugural *Northern Region Health Plan* launched in June 2011 has now supplanted the DHBs' District Strategic Plans and sets direction of travel for the Northern Region DHBs and wider health sector. The plan which - like our DHB's strategy - is also based on the Triple Aim aspires to:

- Build the safest health care system in Australasia;
- Deliver improvement to health and quality of life of our population and increase life expectancy; and
- Engage patients and their families in decisions about care.

As a first step, diabetes, cardiovascular disease, cancer and health of older people are the key conditions chosen for focus in the Northern Region Health Plan as we and our regional colleagues believe that by getting these areas right, we will be in a better position to assure the sustainability of our health system over the next 10 to 20 years. The next iteration of the plan will extend the scope of focus to include other key areas like child health where regional collaboration is already taking shape and regional mental health services planning. Our annual plans show alignment with these plans and outline the actions the DHB will be undertaking to progress regional goals and the achievement of national health targets.

With the continuing fragility of the global economy, slower domestic growth, and adding to that, the magnitude of the losses from the Christchurch earthquake, we are conscious that the Government will be looking towards the health sector to play its part.

Strong and effective leadership will be needed as we navigate our key challenges for 2011/12 which are:

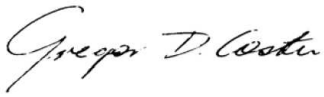
- Living within our budget;
- *Better, Sooner, More Convenient* primary health care;
- National and regional service configuration;
- An ageing population driving acute demand; and
- Workforce sustainability.

Ko Awatea, our Centre for Health Services Improvement & Innovation will be a key driver of healthcare improvement and innovation for the DHB and the region. The centre will sit at the heart of the DHB's activities to improve value for money and to deliver the transformational change which will be needed to keep apace with the demand for better and more health services whilst managing within tight financial constraints.

Strategic initiatives that the DHB started last financial year such as our patient safety campaigns, our productivity initiatives in surgical and medical services, *Better, Sooner, More Convenient* (BSMC) primary health care business case implementation and our *Thriving in Difficult Times* projects will be even more relevant to the DHB in the new financial year, as they have been in the last twelve months, if the DHB is to continue focusing on delivering value for money, improving frontline services, and reducing waste.

Continued commitment to our *Toward 20/20* facilities modernisation project is crucial if we are to support the transformation of our health service models and patient pathways and have adequate facilities to support our demographic growth. The DHB's locality based services planning which will progress BSMC goals of integrated care delivered in community based settings nearer to the patient will be paramount to minimising some of the impact for forecast demand for inpatient beds.

This coming year will be one of continuing challenge, both clinically and financially, but also one of quiet confidence - based on our track record - to meet and exceed local and national targets. For this, we thank all our staff, providers and partners who have worked together to contribute towards our success. We look forward to another year of achievement in 2011/12.



Gregor Coster
Chairman

Geraint Martin
Chief Executive

MODULE 1: CONTEXT

1.1 BACKGROUND

Counties Manukau District Health Board (DHB) is one of twenty[1] District Health Boards established on 1 January 2001 in response to government policy and legislation intended to present New Zealanders with the opportunity to exercise greater local influence over the planning, funding and delivery of health and disability services where they lived.

Counties Manukau DHB serves an estimated population of about 500,800 people – about 11 percent of the New Zealand population – within a geographical area covering the areas of the previous Manukau City, Papakura and Franklin districts.

Working with the funding allocated by Government, Counties Manukau DHB is responsible for:

- collaborating with other DHBs, service providers, the community, and other stakeholders to plan the strategic direction for health and disability services in the Northern Region and promote the integration of health services;
- funding the provision of most health and disability services provided in Counties Manukau through service contracts with health and disability providers and non-governmental organisations. The Ministry of Health retains funding responsibility for the remaining health and disability services including the balance of the primary maternity services, public health and national personal health contracts;
- providing hospital based services for the population of Counties Manukau and some access to specialist or highly complex services for people referred from other DHBs;
- promoting, protecting and improving the health of the Counties Manukau population through the provision of health promotion, health education and evidence-based public health initiatives.

Counties Manukau DHB is a major employer in South Auckland with over 5,700 staff employed across hospital and community-based settings.

1.1.1 Population profile

Counties Manukau DHB covers the previous Manukau City, Papakura and Franklin district areas in order to provide health services to an estimated population of 500,800 people. The population composition of Counties Manukau is diverse and includes:

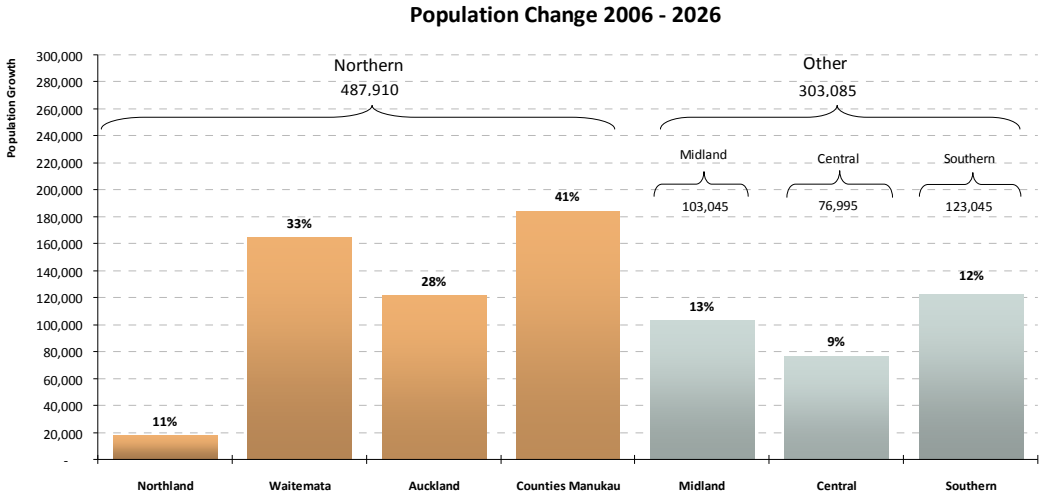
- A high proportion of Maaori. 17% of the Counties Manukau population is Maaori, which is 12% of the New Zealand Maaori population.
- A high proportion of Pacific people at 22%. This is 39% of New Zealand's total Pacific population, a rate which is expected to grow a lot faster compared to overall population growth.
- A high proportion of Asian people at 18% (the term 'Asian' refers to people of ethnic Pakistani and Indian origin, through to Southeast Asia and East Asia, including the Philippines, Indonesia and Japan).
- A relatively young population, with 25% of residents aged 14 and under.

The rate of population growth for the DHB currently sits at 2% to 3% per annum, and although it is due to slow down, the DHB's population is still projected to increase by 41% between 2006 and 2026. [2] See Figure 1.

1 There are now twenty District Health Boards in New Zealand following the amalgamation of Southland DHB with Otago DHB.

2 Wang, K & Jackson, G. The changing demography of Counties Manukau District Health Board. 2008. Counties Manukau District Health Board.

Figure 1: Population Change 2006 - 2026 - Northern Region DHBs compared to other regions



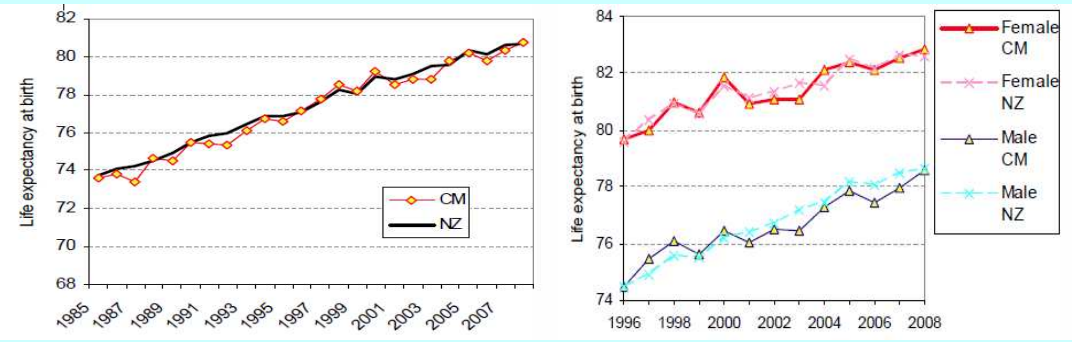
Reference: Northern Region Health Plan

1.1.2 Key health issues and contributing factors for the Counties Manukau Population

The following information has been pulled from the Counties Manukau DHB Health Needs Assessment 2008 and health status reports written by the DHB's Health Intelligence Unit.[3]

Life expectancy:

- As of 2005, life expectancy within Counties Manukau was similar to the New Zealand average of 83 for females and 78 for males despite higher levels of material and socio-economic disadvantage for Counties Manukau.
- However, health disparities remain with males, Maaori and Pacific people and those socio-economically deprived having worse outcomes than their counterparts.
- Maaori have a life expectancy of 73 for females and 70 for males, while Pacific people have a life expectancy of 78 for females and 74 for males.
- The figures below shows life expectancy at birth for the people of Counties Manukau cf. New Zealand, males cf. females, 1996 – 2008[4]



[3] These reports can be downloaded from the following site location: http://www.cmdhb.org.nz/About_CMDHB/Planning/Health-Status/Health-Status.htm

[4] Smith, J. Jackson, G & Sinclair, S. *Life expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB.* 2008. Counties Manukau District Health Board.

Socio-economic Status:

- Many of Counties Manukau residents live in socio-economic deprivation, with 5% of Counties Manukau households having at least one family member receiving an unemployment benefit as of 2006.
- Lack of adequate income leads to poorer health outcomes and thus contributes to health inequalities.
- A high proportion of children and youth living in the most deprived areas[5] compared to the New Zealand average. 25.9% of children and young people (0-24years) live in decile 10 compared to 12.75 nationally.

Smoking:

- Between 1996 and 2006 the rate of adult smokers within Counties Manukau reduced by 3% to 20% overall. However, this rate is still higher than the New Zealand average.
- Maaori and Pacific people have significantly higher smoking rates than the rest of the population.
- A study looking at the contribution to life expectancy gaps of major disease areas in Counties Manukau found that smoking was a key driver of mortality and health inequity, contributing not only to smoking related lung diseases such as lung cancer, chronic obstructive pulmonary disorder (COPD) but to the other five disease areas identified in the life expectancy study (infant mortality, cardiovascular disease, diabetes, cancers other than lung cancers and all other causes of mortality). Differences in smoking frequency accounted for at least 10% to 20% of the life expectancy gap between Maaori and non-Maaori, non-Pacific in Counties Manukau.[6]

Obesity:

- Counties Manukau has the highest rate of obesity in New Zealand, with more than 110,000 people being classed as obese (BMI >30).
- This is a concern as obesity is a risk factor for several non-communicable diseases such as diabetes, cardiovascular disease and some cancers.

Child Health:

Infectious disease:

- The rate of infectious disease amongst children in Counties Manukau remains high.
- Improving the living conditions of pre-school children continues to be of high priority.

Breast Feeding:

- Counties Manukau breastfeeding rates are lower than the overall New Zealand rate.
- As of December 2009, 42% of infants were exclusively or fully breastfed at 3 months.
- Rates were lower for Maaori, Pacific and Asian babies than European and other populations.

Diabetes:

- Counties Manukau has the largest proportion of people known to have diabetes in New Zealand. In 2009, 31,500 people or 8.4% of the adult population had diabetes.
- The disease is most prevalent amongst the Maaori and Pacific population, with Pacific women having the highest prevalence of any group, with an age standardised prevalence of 15%.[7]

Cardiovascular Disease (CVD):

- Cardiovascular disease is the leading cause of death for people in Counties Manukau.
- As of 2008, there was an estimated 20, 357 people (aged 15 years and over) with cardiovascular disease (CVD) in Counties Manukau.
- Maaori had the highest age standardised CVD prevalence compared to other ethnic groups, with Maaori male prevalence 54% higher than other non-Maaori males. Maaori female prevalence was 120% higher than other non-Maaori females.
- South Asian males had the second highest age standardised CVD prevalence among males at 8%.[8]

Avoidable Hospitalisations:

- Counties Manukau DHB has an avoidable hospitalisations rate of 4,163 per 100,000 admissions. This is significantly higher than the national rate.

[5] NZ Social Deprivation Index deciles 9 and 10

[6] Smith J., Jackson G., Sinclair S., *Life Expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB*, 2008, Counties Manukau District Health Board.

[7] Smith, J. Papa, D & Jackson, G. *Diabetes in CMDHB and Northern Region: Estimation using routinely collected data.* Counties Manukau District Health Board. 2008.

[8] Chan, W.C. Jackson, G & Papa, D. *Healthcare costs related to cardiovascular disease and diabetes in CMDHB.* Counties Manukau District Health Board. 2010.

- There are significant differences across ethnic groups, with Maaori having the highest rate of avoidable hospitalisations and Asian people having the lowest.

Avoidable Mortality:

- Counties Manukau has a higher rate of avoidable mortality compared to the rest of New Zealand.
- The leading causes of avoidable mortality were identified as ischaemic heart disease, lung cancer, suicide and self inflicted injury.

Infant Mortality:

- The Counties Manukau infant mortality rate (7.8 per 1000 births) is significantly higher than the rate for all of New Zealand (5.4 per 1000 births).
- Maaori and Pacific infants had a higher mortality rate than Asian infants.

Acute Demand:

- Counties Manukau DHB's adult medical admission rates are amongst the highest in the country.
- The Acute Assessment Team has been able to increase the proportion discharged within 24 hours from 28% to 40%, reducing ALOS to 2.7 days (the lowest in Australasia)
- A large proportion of medical admissions are driven by self-referrals to the Emergency Department and this remains a challenge to the DHB. Closer work between primary and secondary care to reduce demand through greater use of integrated programmes like the Primary Options for Acute Care (POAC) is needed to address this.

Elective Surgery:

- In 2010, Counties Manukau DHB had 14,786 elective surgical discharges. This is a 4.41% increase from 2009, or 625 extra discharges.
- Elective surgery rates in Counties Manukau have had over 40% growth over the past 5 years and age standardised rates are higher than the New Zealand average with improvements in access for Maaori, Pacific and more deprived populations.

1.2 OPERATING ENVIRONMENT

1.2.1 Health Sector Context

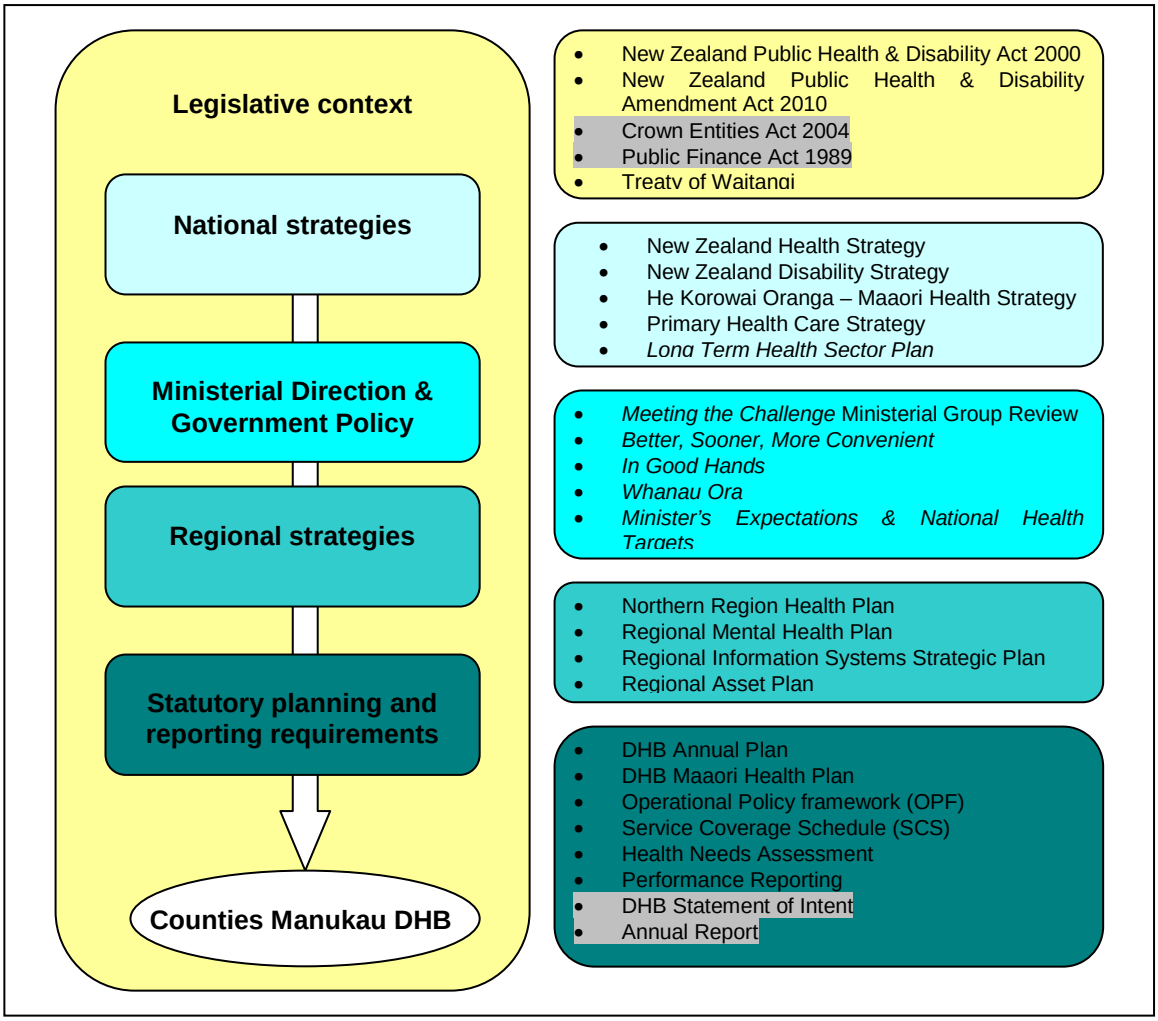
Counties Manukau DHB is accountable to the Minister of Health through his agent, the Ministry of Health, and to Parliament, whose agent is the Office of the Auditor-General.

The DHB operates in an environment governed by key legislation which is brought together in an accountability framework which links national and regional strategies, Ministerial direction, planning and reporting policy and guidelines stipulated by the Ministry of Health.

Figure 2 shows the overarching system context; the legislative environment and the cascade of priorities: national, Governmental and regional; within which the DHB operates.

Module 2 will give a further outline of the national and regional strategies and their influence on the DHB's strategic direction and operations.

Figure 2: Overarching system context that the DHB operates within



1.2.2 Demand Growth

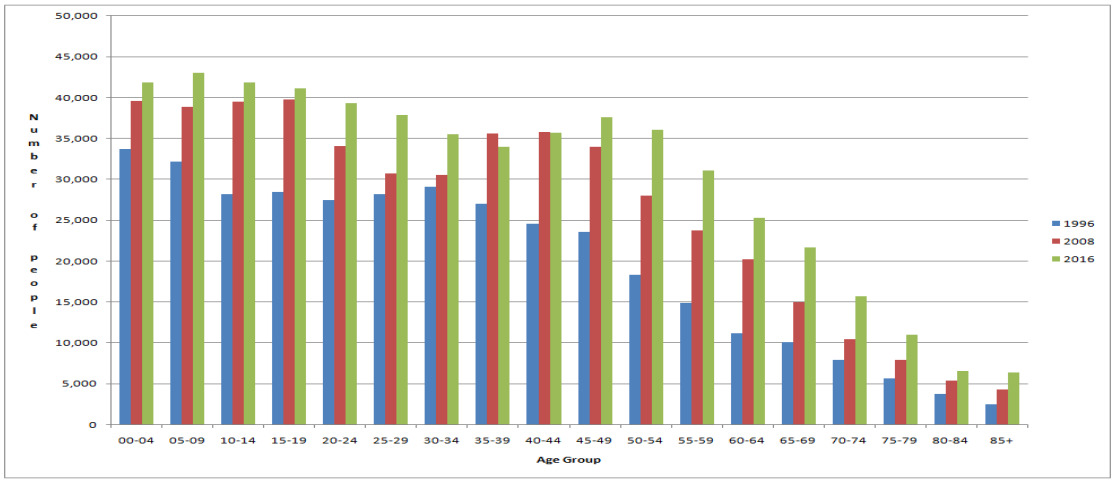
Demographic growth is the key driver of the Northern Region's strategic planning and operations. This is especially the case for Counties Manukau where there is:

- A high proportion of Maaori, Pacific and a growing immigrant population who have significant health needs.
- A significantly higher birth rate than the national average
- High growth in the 65+ age groups

For Counties Manukau, services which are currently experiencing the greatest pressure are those which are focused on providing care for people with chronic diseases such as cancer, diabetes and cardiovascular disease; maternity services; and those services which cater specifically for the elderly.

As pointed out in *Section 1.1.4, Population and Health Profile*, the population is projected to grow by 41% between 2006 and 2026 but more significantly, there will also be greater proportions of older people as seen in Figure 3 (the green columns).

Figure 3: Counties Manukau DHB population structure in 1996, 2008 and 2016 by age groups



The population aged over-65 is projected to more than double from 33,800 in 2001 (48,900 currently in 2011) to 74,700 by 2021.

This is significant because of the demand on services for this age group which includes Aged Residential Care, Home Based Support Services and hospital-based services for age-related chronic conditions. This age group is also strongly associated with high admission rates and longer lengths of stay.

Counties Manukau DHB has been working collaboratively with the Northern Region DHBs to improve regional services provision. This work was given further impetus last year when amendments to the NZPH&D Act conferred direct powers to the Minister of Health to direct DHBs to plan collaboratively within their regions.

The Northern Region is currently working together to develop a Northern Region Health Plan which will focus on long term strategies in the areas of high demand (and high costs) such as diabetes, cardiovascular disease and the health of older people in order to alleviate rising demand for these services.

1.2.3 Workforce

As a result of population growth and increasing demand for health services, Counties Manukau DHB 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 DHB- 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.

Historically it has been possible to meet local workforce shortages by importing health professionals. However, this approach is no longer sustainable due to the increasingly competitive global market for health professionals. In addition, to meet the needs of our local communities, we need a workforce which reflects our population instead of on relying on overseas trained health professionals.

The DHB is faced with a critical business need to work differently, evolve new roles and grow the future health workforce from the local community. There is a continued focus on fostering and supporting clinical leadership and laying the foundations for growing our own workforce through the DHB's *Grow Our Own* initiatives. These will be driven through *Ko Awatea*, the DHB's Centre for Health Services Innovation and Improvement which opened in May 2011.

1.3 NATURE AND SCOPE OF FUNCTIONS

1.3.1 The Funding Arm - Planning & Purchasing Health and Disability Services

Since 2001/02, funding responsibility has been progressively devolved to Counties Manukau DHB for health and disability services.

Services funded by the DHB include:

Personal Health
- Primary, secondary and tertiary care services,
- Maaori health services,
- Pacific health services,
- Primary-referred services
- Oral health services for children and young people and emergency dental care for adults on low incomes

Mental Health
- Adult community mental health services
- Child and adolescent mental health services
- Older adults mental health services

Services for Older People
- Needs Assessment & Service Coordination
- Palliative care
- Rehabilitation
- Aged Residential Care
- Home Based Support Services
- Respite care
- Day services

DHB-provided primary maternity services
- Primary maternity care is provided by Lead Maternity Carers (LMCs), GPs, midwives or specialists, who are independent (not employed by CMDHB) and midwives employed by CMDHB.
- Primary maternity support and education 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 the DHB's geriatricians as close in age and interest), public health and national personal health contracts.

Where services have been devolved to the DHB, responsibilities of the DHB encompass:
- Payment of providers;
- Service development and prioritisation of funding;
- Monitoring and audit of provider performance;
- Management of relationships with providers;
- Entering into, negotiating, amending and terminating 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 statue or contract with the Crown or other parties; and
- Identification of where the agreements fit into the district's priorities.

In addition, the DHB 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;
- Management of financial and clinical risk;
- Specific funding processes such as needs analysis, prioritisation and provider selection and monitoring service coverage;
- Leading on quality assurance and improvement through audits, reviews,
- Operational relationships between the DHB's funder and provider arms.

1.3.2 The Provider Arm – Providing Health and Disability Services

Counties Manukau DHB provides a wide but not complete range of secondary-level (hospital and specialist) health care, a selected range of community and domiciliary services, as well as a number of niche specialist tertiary services through its provider arm for the Counties Manukau population.

Specialist Tertiary 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.

Although not exclusively the case, the majority of services are provided at the following sites:

Inpatient Services	Middlemore Hospital Kidz First Children's Hospital Pukekohe Hospital Franklin Memorial Hospital
Outpatients Services ***Community Services*** ***Day Surgery***	Ambulatory Care Centres: • Manukau SuperClinic™ • Botany Downs SuperClinic™
Non-intensive care based elective surgery	Manukau Surgery Centre (MSC)
Primary Maternity Services	Botany Maternity Unit Papakura Maternity Unit Pukekohe Maternity Unit

A number of tertiary and other services are not provided directly by the DHB for Counties Manukau residents but are provided by Auckland DHB and Waitemata DHB. The DHB funds these separately through inter-district flow (IDF) payments to both DHBs.

Hospital-based health services provided for our population by neighbouring DHBs

Auckland DHB	• Cardiothoracic surgery, • Neurosurgery, • Oncology, • Emergency dental care for low income adults • Specialist children's surgical and medical services • Clinical genetics • Transplant surgery (liver, renal)
Waitemata DHB	• Forensic Mental Health, • School Oral Health Services for 0 – 17 year olds

MODULE 2: STRATEGIC DIRECTION

This module sets out Counties Manukau DHB's high level strategic direction and will demonstrate how the DHB's strategic objectives align with key national, regional and local health plans to deliver on key Government priorities and targets whilst also meeting the needs of our population.

2.1 COUNTIES MANUKAU DHB VISION

The Counties Manukau vision was developed in consultation with our communities shortly after the time of the health board's establishment in 2000.

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.

2.2 THE DHB'S STRATEGIC DIRECTION

Legislative changes and implications for DHBs' Strategic Planning

In the past five years, Counties Manukau DHB has been working toward the achievement of six district-level strategic outcomes. These outcomes were articulated in our District Strategic Plan, a statutory plan which was required of the DHB as a Crown Entity, and were influenced by national, regional and local priorities and agreed in consultation with our communities and stakeholders.

The Government passed the New Zealand Public Health and Disability Amendment Bill last year to help meet the many challenges faced by the public health and disability system. The NZPH&D Amendment Act 2010 removes the requirement for DHBs to prepare district strategic plans but instead provides the statutory framework for the National Health Board and DHBs to establish a more deliberate approach to ensure which services should be planned, funded and provided at the national, regional and local levels.

The changes in the Act and its regulations are also designed to put a much stronger emphasis on DHB collaboration to plan health services regionally in order to support better planning across the sector.

2.2.1 Our Transformational Platform

As outlined in the previous module, the challenges facing the DHB of growing demand for healthcare services, an increasingly ageing population and limited funds by which to meet this demand are widely acknowledged. **CMDHB will not have enough in-patient beds to meet the needs of the population it services by 2013, if we do not take radical action now.**

As a DHB, we understand that the health system/health economy is unsustainable and unaffordable in its current configurations and functions and that inaction will lead to system failure. We cannot continue doing what we have done and expect these challenges to be reversed. CMDHB plans bold and concerted action over the next three years to tackle these issues head on. We recognise that we cannot drive change alone and that much collaboration, cooperation and behavioural changes to how we approach health as a system, not a series of silos is vital. We are dependent in many domains on the will and ability of our partner organisations to execute shared ideas and solutions and for a significant portion of our key deliverables.

CMDHB recognises that this is a 2011-12 operating plan however we wish to clearly signal our intention to take a leadership role in the Health System transformation over the next three years. We plan to guide the system to the next evolutionary phase; the evolution from a dominant focus on doing things right, that is, technical advancement in quality improvement to also doing the right things i.e. ensuring that each investment and disinvestment decision is based on value added quality improvement criteria around outcomes achieved for each health dollar spent.

At CMDHB, transformational change will be driven by a strong organisational commitment to **healthcare improvement** and **increasing value** from the resources allocated to the DHB.

The Triple Aim concept of focusing on the three bottom lines of population health, patient experience of care and managing per capita cost of health, lies at the heart of the DHB's organisational planning and activities. It reflects the underlying objectives of the Counties Manukau Health System (see Figure 4), which is to:

- Improve the health of the population and reduce inequalities;
- Improve patients and their family/ whaanau's experience of care, and
- Make the best use of our population-based funding.

Primary health care with its *Better, Sooner, More Convenient* (BSMC) health care focus will be a key strategic platform from which to drive transformational change. CMDHB intends to make significant progress in realising BSMC intent by strengthening and broadening its partnerships with and support of the primary health care sector. CMDHB fully appreciates that strong ownership and accountability from primary health care providers will be key to realising the level of system transformation identified within BSMC.

CMDHB will through its role as health system integrator, over the next 36 months enable the primary health care sector to configure itself to operate as a key engine room of the health system and show tangible progress at a greater pace on health system provision priorities such as access to services, quality of services, integration of services and the ability of services to positively impact acute demand over time.

Successful, sustainable delivery of activities that impact on acute demand will have a priority focus for us as we understand that activities within this domain are strategically critical for the health sector's ability to meet future demand for public health care services.

As a DHB, we will be focussing on:

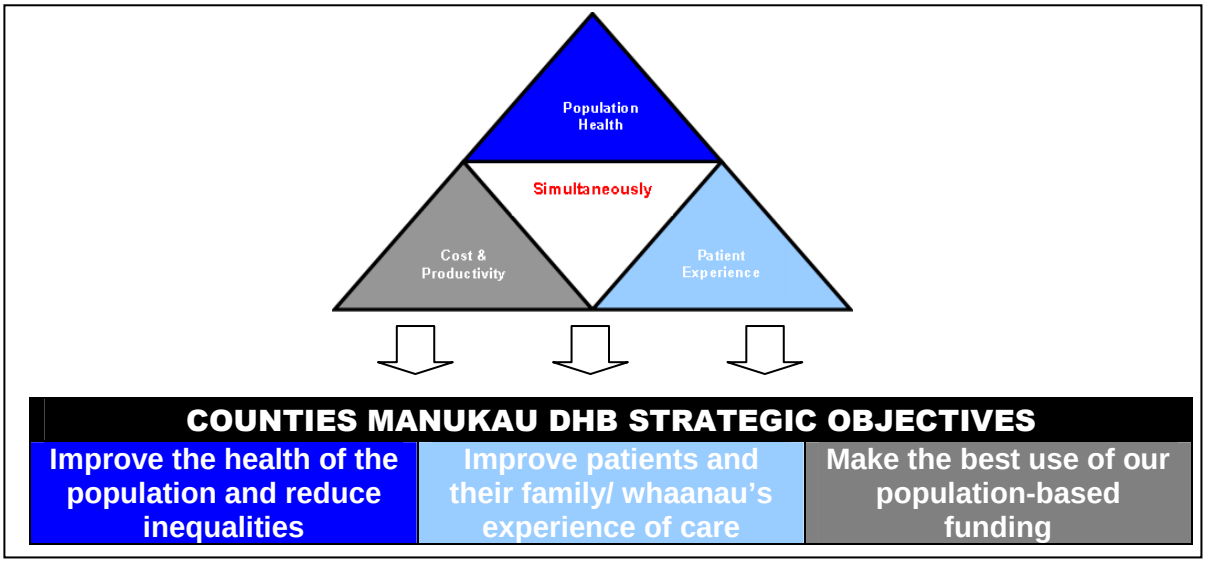
- Reducing disparities in personal health access and outcome and population health status of our Maaori and Pacific populations and other populations experiencing health disparity
- Reducing acute demand for health services through primary and secondary prevention by providing our population with high quality, affordable, integrated, equitable and readily accessible services that meet their needs
- Improving service and reducing waiting times for patient access to important services
- Ensuring our focus on Child, Youth and Maternity health and well being remains sharp and delivers on the provision of a Child and Youth Health Plan by December 2011 which will be aligned with the localities, mental health and Maaori Health plans. Focusing on reducing the incidence of communicable disease with the aim that our children are less likely to acquire chronic diseases in later life.
- Reducing risk taking behaviours (sexual health, smoking and suicide prevention) and improving youth engagement with health services
- Strengthening clinical leadership and supporting clinical engagement and regional clinical networks
- Delivering more services in community-based settings which are closer to the patient and improving integration of services across hospitals and the community
- Meeting the health and support needs of older people, particularly in the areas of dementia, disease and injury prevention
- Collaborating regionally in shared services planning and development of back office functions and regionalisation of key enablers like Information Systems and Workforce Development
- Budgeting and operating within the allocated funding and improving financial performance
- Working to reduce the incidence and impact of chronic disease and collaborating regionally and locally to deliver 'best designed' (cost, efficient, quality) systems and interventions with a particular focus on reducing the health disparities of our Maaori, Pacific and high needs populations in those key health areas of: diabetes, cardiovascular disease, cancer, child health, elective surgery, emergency care, health of older people, mental health

- Ensuring people affected by mental ill health have access to mental health services and mental health clients have fewer acute episodes
- Ensuring increased availability and access to health and disability services in primary and community settings

This will be enabled by:

- Continuing with our commitment to support the three Auckland Business Cases; Greater Auckland Integrated Health Network (GAIHN), National Hauora Coalition (NHC) and Alliance Health+ (AH+) to implement their business cases and deliver on their stated objectives
- Continuing to build on shared regional approaches to increasing efficiency and improving relationship management under Host and Partner DHB functions as defined in the collaborative agreement between DHBs and PHOs and Business Case entities
- Achieving the final consolidation of PHOs and supporting 4 large capable organisations linked with the BSMC business cases
- Delivering on our objectives identified in the Shared Primary Care District Annual Plan with our partner DHBs with a focus on after hours care and other acute demand activities, primary care quality, and defining key performance indicators, clinical leadership, patient centred decision making and service shift
- Continuing to work with the opportunities offered within the BSMC environment via the constructive, collaborative and transparent working philosophy inherent in an "alliancing approach"
- Implementing a locality based approach with a focus on approximately 6 localities based on geography and health need rather than organisational boundaries and utilising this approach to identify and implement solutions to system challenges.
- Building collaborative local health networks at various levels focused on delivering new and innovative models of care that positively impact on acute demand management particularly ED attendances; and improve integrated management of long term conditions particularly diabetes and cardio vascular disease
- Supporting the implementation of Integrated Family Health Centres (IFHCs) and Whanau Ora Centres (WOCs) in our district which will be delivered through public-private partnerships. These centres are key deliverables and mechanisms in primary care reconfiguration to build capacity and capability for better integrated services and service shifts. We will work to enable IFHCs/WoCs to provide a wide range of services including specialist assessments by GPs, extended and after hours services, walk in access and an increased focus on nursing, allied and social services
- CMDHB working in support of clinical and social movement activities required to support the Regional Health Plan and associated campaigns
- Progressing work on an Atlas of Healthcare Variation to identify variation in clinical outcomes, processes, spending, and value, and to use this information to drive healthcare improvement.

Figure 4: The Triple Aim and Counties Manukau DHB's Strategic Objectives



2.2.2 Our Strategic Objectives

<table>
<tr><th colspan="2">Improve patients and their family/ whaanau's experience of care</th></tr>
<tr><td>Why is this important?</td><td>
Counties Manukau DHB is cognisant of the fact that we do not yet have a health care system which is sufficiently patient-centred.

Consider the findings from this study by Peter Davis et al[9] of 6,579 records from 13 hospitals.
• 12.9% had adverse events,
• 15.0% of those were permanent or fatal,
• 20% occurred outside the hospital environment, and
• 33.0% could have been avoided.

Avoidable serious adverse events totalled 4,600 admissions which translate to 276,000 bed days. At a cost of approximately NZ$13,000 per adverse event, the cost of preventable adverse events is $573 million.

A culture of quality improvement needs to be grafted into all aspects of the DHB's operations and processes if the DHB is to deliver safe and high quality health care services which patients and their families can trust and use with confidence. QI will also drive the reduction of waste in the system so that resources can be re-directed to other areas.

A high quality healthcare system is marked by these six dimensions[10]
<table>
<tr><th>Quality Dimensions</th><th>What this means for our services</th></tr>
<tr><td>Safe</td><td>No unnecessary harm</td></tr>
<tr><td>Patient-centred</td><td>Involve patients in their care and in system improvements</td></tr>
<tr><td>Efficient</td><td>Reduce waste</td></tr>
<tr><td>Timely</td><td>No unnecessary waiting</td></tr>
<tr><td>Equitable</td><td>Services matched to the level of social and health need to provide equal opportunity of health outcomes</td></tr>
<tr><td>Effective</td><td>Doing things which are evidence based</td></tr>
</table>

The DHB launched the Aiming for Zero Patient Harm campaign in September 2010 (See Section 2.3.4 for more information on our Aiming for Zero Patient Harm Campaign) and is taking what we have learnt through our quality improvement initiatives out to the region, with the aim of developing a consistent regional structure and methodology for addressing patient safety.

Patient centred care is also about:
• Improving patient literacy about their health
• Better communication with patients about their management plans and involving patients and their families in the development of their care plans
• Advance care planning with patient and families to reduce inappropriate intervention at the end of life
</td></tr>
</table>

[9] Davis, P. Lay-Yee, R. Briant, R. Schus, S. Scott, A. Johnson, S & Bingley, W. *Adverse events in New Zealand Public Hospitals: Principal findings from a national survey.* 2001. Ministry of Health.

[10] Institute of Medicine Committee on Quality of Health Care in America, *Crossing the quality chasm: a new health system for the 21st century*. 2001,Washington D.C.: National Academy Press.

Improve patients and their family/ whaanau's experience of care

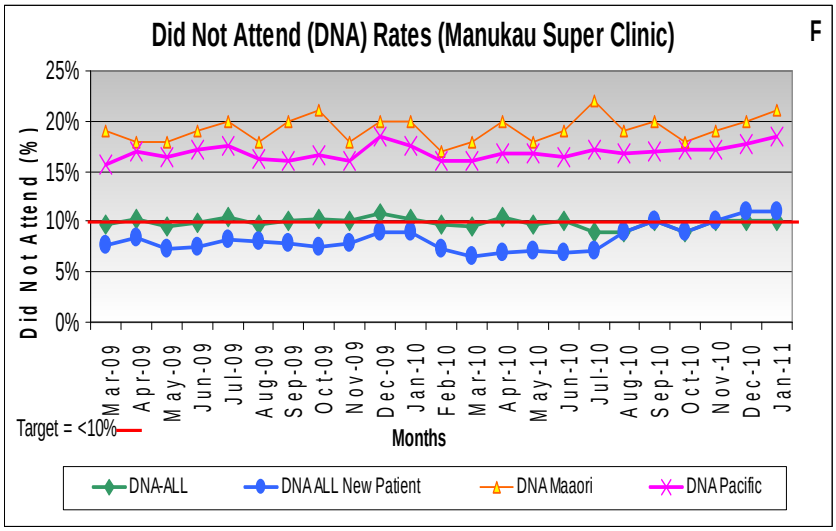
What is the current picture?

At Counties Manukau, harm is occurring in the following areas:

- Preventable Patient Falls: On average 80-90 patients fall each month at the DHB. Of these approximately 20 are harmed. 11 are Serious and Sentinel events.
- Preventable Pressure Injuries: Survey of all patients in 2009 showed 169 patients had 287 pressure injuries, 50% developed in the DHB's care.
- Patient harm does not just occur in our hospitals, for example up to 50% of preventable pressure injuries occur before the patient reaches secondary care.
- Preventable Central Line Acquired Bacteraemia (CLAB): In 2009 there were 51 preventable CLAB events hospital wide. These lead to increased costs, morbidity and potential mortality.

The outpatient Did Not Attend (DNA) rates for Maaori and Pacific remain high with rates in the last three years remaining between the 15% to 20% band. This signifies a significant amount of waste remains in the system and the DHB needs to continue with initiatives to address this issue including: ensuring Maaori and Pacific patients have the cultural support they need, that there is sufficient information given to patients and to referrers, and ensuring patients are given First Specialist Assessments and certainty of treatment within acceptable time frames.

DHB Outpatient Did Not Attend (DNA) rates[11]



Our priority as a DHB is to:

- Deliver patient and family/whanau-centred care by focusing on the six healthcare quality dimensions: safe, patient-centred, equitable, timely, efficient, and effective
- Develop and build capacity and capability in:
  - Quality
  - Workforce,
  - Health intelligence,
  - Health systems research and innovation,
  - Clinical leadership.

We will know we are making an impact on this objective when we have:

- Improved waiting times for services
- Improved patient satisfaction with services
- Fewer adverse clinical events
- Improved engagement of Maaori and Pacific with health services

This will be measured by our progress on the following key measures

- Patient satisfaction with services (rating it Good or Very Good) improve
- Inhospital patient mortality rate decreases
- Acute readmissions rate decreases

Other measures contributing to this objective are outlined in Module 4

[11] *CMDHB Board Dashboard*

Improve the health of the population and reduce inequalities	
Why is this important?	The commitment to improving the health of our population and reducing health inequalities is clearly stated in the Counties Manukau DHB vision. Whilst life expectancy as a whole has improved across the Counties Manukau population, the life expectancy gap between Maaori and 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 to 7 years[12]. Many other markers of ill-health show similar disparities.[13] Therefore, if the DHB is to improve the health status of the population it is important that we focus on reducing some of the disparities in health outcomes faced by our Maaori and Pacific populations; a high proportion of whom live in relative social and economic deprivation compared to the rest of the population. The DHB has a Health Equity Working Group who provide support for clinicians and managers to systematically consider equity as part of 'business as usual', and to capture and disseminate the organisational lessons so as to increase DHB capacity for addressing health disparities. Non Communicable Diseases like diabetes, lung disease and cardiovascular disease (CVD) in particular are key contributors to our mortality rates and affect our Maaori and Pacific population disproportionately. Increasing obesity, smoking prevalence and demographic changes in our population mean that the numbers of people with non-communicable disease like diabetes, CVD and cancers will increase. The burden of these diseases is not only one which has to be borne by the afflicted individual and their family but it affects all of society as the cost of management and treatment of these long term conditions account for a substantial proportion of health care expenditure, along with wider societal costs related to impacts on employment and related welfare expenditure. The implication for the DHB is that there needs to be continued focus and investment in interventions and programmes aimed at primary (before disease has been diagnosed) and secondary (reducing the impact of non-communicable disease after diagnosis) prevention which are evidence-based and effective. The Northern Region Health Plan will serve as a starting point for the coordination of a regionally consistent framework around issues relating to prevention, care and treatment of people who are either at risk of developing non-communicable disease or have non-communicable disease. Local implementation of these strategies is outlined in Module 3 of the DHB's 2011/12 Annual Plan and also our Maaori Health Plan 2011/12. The latter is the key document outlining priority areas for Maaori health and the activities which the DHB will be undertaking in relation to improving Maaori health outcomes. Locally, our *Creating a Better Future* programme is the vehicle for the DHB to work across sectors and with the community to address the growing burden of disease created through tobacco use, poor nutrition, inactivity and hazardous alcohol consumption. Improving the health and wellbeing of children and young people living in Counties Manukau is a priority for CMDHB as we have a young population: 40% under the age of 25 years. Hospitalisation rates for children and young people residing in CMDHB are above the national average for many diseases, the main ones being: lower respiratory infections, rheumatic fever and meningococcal disease. Continuing to advocate for improved housing and smokefree living environments are central to decreasing the risk of these infectious diseases and giving children a good start to life. The high prevalence of mental health and addiction issues is also of major importance for service planning and intersectoral action is particularly important to address these needs.

[12] Smith, J. Jackson, G & Sinclair, S. 2008. *Life expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB.* Counties Manukau District Health Board.
[13] Health and Disability Intelligence Unit. 2008. *Counties Manukau DHB Health Needs Assessment September 2008*. Manukau: Counties Manukau District Health Board.

Improve the health of the population and reduce inequalities

What is the current picture?

Major disease areas contributing to life expectancy gaps in CMDHB in 2005 and proportional contribution of each area[14]

Cause of death (disease area)	Maaori	Pacific
Infant mortality	5%	10%
Cardiovascular disease	16%	35%
Smoking-related lung disease	20%	9%
Cancer (non-lung)	17%	6%
Diabetes	7%	13%
Remainder	37%	27%

Our priority as a DHB is to:

- Reduce demand for health services through primary and secondary prevention
- Deliver more services in primary care and community based settings
- Collaborate regionally and locally to deliver 'best designed' (cost, efficient, quality) systems and interventions in key health areas
    - Diabetes
    - Cardiovascular
    - Cancer
    - Child health
    - Elective surgery
    - Emergency care
    - Health of older people
    - Mental Health
- Increase availability and access to health and disability services in primary and community settings

We will know we are making an impact on this objective when we have:

- Reduced incidence and impact of chronic disease
- Older people are supported and receive services appropriate to their needs
- People affected by mental ill health have access to mental health services and mental health clients have fewer acute episodes
- Children are healthier and safer

This will be measured by our progress on the following key measures:

- Life expectancy gaps between Maaori and Pacific and non-Maaori and non-Pacific reduce
- Proportion of the adult population who are smokers decrease
- Acute hospitalisation rates for cardiovascular disease and diabetes decrease
- Number of patient admissions avoided at Emergency Care through the Primary Options for Acute Care (POAC) programme increase
- Access rates to Mental health services increase
- The ratio of older people in Home Based Support Services compared to Aged Residential Care improves
- The number of 65+ year olds presenting at the Emergency Department decrease
- Rate of children's acute hospitalisation decrease

Other measures contributing to this objective are outlined in Module 4

[14] Smith, J. Jackson, G & Sinclair, S. 2008. *Life expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB.* Counties Manukau District Health Board.

Make the best use of our population-based funding

Why is this important?

The DHB faces significant demands on its funding due to a growing and ageing population. With the current constraints on the Government's fiscal position, it is unlikely that the health sector will receive much new funding over the next few years and DHBs will be expected to manage on lower levels of funding.

Whilst we are working hard to ensure that we are able to manage within our given budget to meet present need, measures are also being taken to future proof our current investment so that we are able to meet future health demands.

Our *Thriving in Difficult Times* programme which was launched in December 2009 is helping the organisation increase the value we get from our resources and free up funding for re-investment in other areas . This is done by focusing on improving patient safety, reducing inappropriate clinical variation and removing duplication and waste from our operations and processes.

All these actions are being made in the context of the Triple Aim so that whilst there is a focus on managing costs, the expectation is that there is also a simultaneous focus on population health outcomes and improved services.

Making the best use of our population-based funding also means working with the other Northern Region DHBs to ensure that our support and back room functions and key DHB enablers like information systems, workforce and facilities are planned in a collaborative manner which maximises value for money and reduces waste and duplication.

Growing Our Own Workforce is a key strategic workforce initiative for the DHB which aims to build a local workforce for the DHB and the wider health sector which will reflect our community and their needs.

What is the current picture?

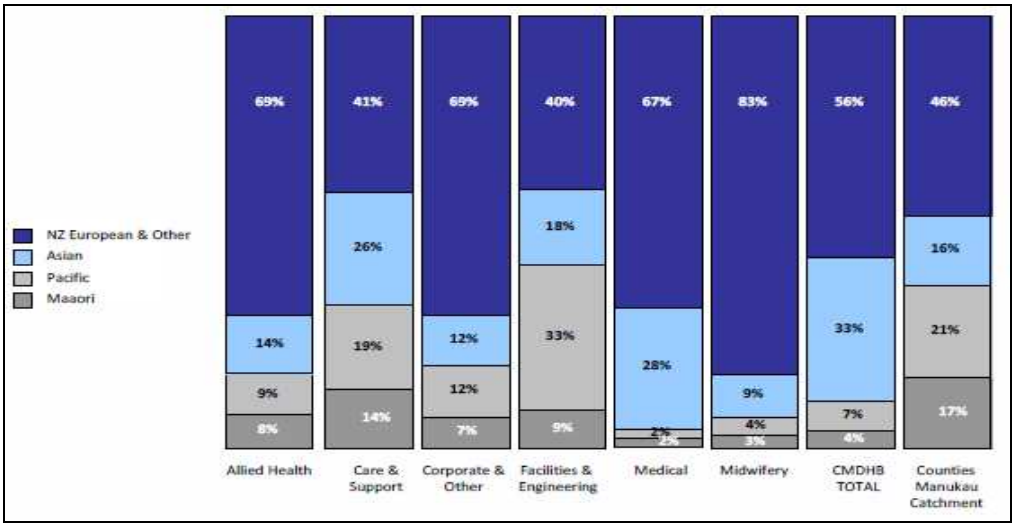
CMDHB's Financial Performance[15]

Actual Net result Combined Operating Arm c/f against budget net result ($000)

ANNUAL: Cost/Productivity	GOAL	Annual FY07	Annual FY08	Annual FY09	Annual FY10
Financial Performance	>=0	6435	8575	101	3018

CMDHB Workforce ethnicity by workgroup and Counties Manukau population[16]

FTE is shown here with n = 4931, on 30 September 2010



<table>
<tr><th colspan="4">Make the best use of our population-based funding</th></tr>
<tr><td>Our priority as a DHB is to:</td><td colspan="3">• 'Work smarter' to free up resources for re-investment in other areas
• Reduce inappropriate variation in clinical practice
• Reduce duplication and waste by working in a more unified manner within the organisation and with our regional colleagues
• Build a workforce which reflects our own communities and their needs</td></tr>
<tr><td>We will know we are making an impact on this objective when we have:</td><td>• Increased value from the resources allocated to the DHB
• Services delivered efficiently with minimal wastage and duplication
• Increased participation of Maaori and Pacific people from Counties Manukau in the health sector workforce</td><td>This will be measured by our progress on the following key measures:</td><td>• Zero deficit
• Proportion of Maaori and Pacific staff in DHBs by occupation class to increase
Other measures contributing to this objective are outlined in Module 4</td></tr>
</table>

2.3 OUR STRATEGIC OBJECTIVES IN THE NATIONAL, REGIONAL AND LOCAL CONTEXT

Counties Manukau DHB's strategic direction and planning has been shaped and influenced within a strategic context of national, regional and local plans and priorities. These include:

- The New Zealand Health and New Zealand Disability Strategies
- The Maaori Health Strategy (He Korowai Oranga) and Whanau Ora
- The Primary Health Strategy
- The Long Term Health Sector Plan
- Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014
- The Northern Region Health Plan
- The regional *Better, Sooner, More Convenient* primary health care business plans
- The Minister of Health's Expectations
- National Health Targets
- Other regional service plans and priorities (which are not covered in this first iteration of the NRHP but will be in subsequent years) for example, mental health, child and youth health,
- National and regional strategies for key DHB enablers like workforce development and information systems
- Local DHB priorities like the development of Ko Awatea (Centre for Health Services Innovation and Improvement), the *Thriving in Difficult Times* initiative, and the *Aiming for Zero Patient Harm* campaign.
- Local plans like the Maaori Health Plan and the DHB's Health Services Plans.

A brief summary of some of these key plans and strategies and how they shape the DHB's strategic objectives are outlined below.

2.3.1 At the National Level

At the national level, the *New Zealand Health Strategy* and the *New Zealand Disability Strategy* currently sets the strategic direction for all health services in New Zealand. The former establishes a vision for health services, principles for planning and provision of services and it outlines objectives for the health of the population, with a focus on tracking inequalities in health. The latter aims to improve the ability of people experiencing disability to participate in community life and is intended to move New Zealand towards becoming an inclusive society.

These strategies are supported by other national level strategies like the *Maaori Health Strategy* (*He Korowai Oranga*), the *Primary Health Care Strategy* and *Whaanau Ora.*

The *Maaori Health Strategy (He Korowai Oranga)* sets the basis for reducing health inequalities for Maaori by establishing the need to work with whaanau/ families as opposed to just individual patients. In particular the key pathways for better outcomes for Maaori include development of whaanau, hapu and Iwi, greater participation in development, delivery and evaluation of health services, delivery of effective services and the provision of services which work across sectors.

This in turn has led to the development of the *Whaanau Ora* policy framework which sets out the need to develop services which work alongside whaanau within communities and seeks to bring together all relevant services together to enable whaanau.

A *Long Term Health Sector Plan* (LTHSP) is currently being drafted by the National Health Board (with expected delivery of the final plan in June 2011). The LTHSP will outline the future direction for public health services, focusing on service planning and new models of care. It will provide high-level direction over the next 20 years and describe the challenges the sector faces and options for models of care that offer solutions and implications for the way services are configured in the future.

After the LTHSP is finalised by the NHB, it will guide future decisions about service configuration and investment at all levels of the system and support the DHB in their long term local and regional planning. The NHB will use the LTHSP to inform their review of national, regional, and district plans.

The Minister of Health's Expectations and the National Health Targets

The Minister of Health's annual *Letter of Expectations* sets out what DHBs are expected to deliver for the upcoming financial year. Together with the national health targets, they provide a clear focus for DHBs to plan for service and system improvements.

The Minister's expectations for 2011/12 are that DHBs will focus on:

- Improving service and reducing waiting times for patient access to important services
- Strengthening clinical leadership and supporting clinical engagement and regional clinical networks
- Delivering more services in community-based settings which are closer to the patient and improving integration of services across hospitals and the community
- Meeting the health and support needs of older people, particularly in the areas of dementia, disease and injury prevention
- Collaborating regionally in services planning and development of back office functions and regionalisation of key enablers like IS and Workforce Development
- Budgeting and operating within the allocated funding and improve financial performance

National Health Targets for 2011/12 are as follows:

- 95% of all people will be admitted, transferred or discharged within 6 hours of presenting at the Emergency Department
- 4,000 more elective procedures will be delivered to the population nationally
- 100% of all cancer patients awaiting radiotherapy treatment are treated within 4 weeks
- 95% of all children are fully immunised at the age of 2 years
- 95% of all hospitalised smokers are given advice and support to quit
- 90% of all primary care clients are given advice and support to quit by their GP
- People who are eligible will have had their cardiovascular disease risk assessed in the last 5 years
- People who are diabetic will attend free annual checks and have satisfactory or better diabetes management

Section 3.1 in Module 3 outlines specific activities that the DHB has committed to undertake in 2011/12 to deliver the Government's priorities and contribute towards national health targets.

2.3.2 At the Regional Level

The Northern Region Health Plan (NRHP)

Under the NZPH&D Amendment Act 2010, the requirement for the DHB to have a district-level strategic plan has been removed and as directed by the Minister of Health, the Northern Region DHBs are currently collaborating to develop the first Northern Region Health Plan (delivery of final plan expected in mid- April 2011).

The challenges the DHB faces are by no means unique to us. This is why we have sought to find a common strategic platform with our neighbouring DHBs in the Northern Region through the Northern Region Health Plan.

This whole-of-system regional health plan is expected to outline common regional outcomes, strategic goals and high level implementation plans in a few key areas of high priority and vulnerable services for DHBs and other stakeholders.

The NRHP has an intervention logic (*See Appendix 5*) framed by the Triple Aim concepts of: *Patient Experience*, *Population Health* and *Cost/ Value*, with a high level vision of:

Adding value through better health and healthcare to 1.6 million New Zealanders

The long term mission of the NRHP is to improve health outcomes and reduce health disparities by delivering better, sooner, more convenient services in a way which is financially sustainable.

In line with Ministerial expectations, Counties Manukau DHB's strategic direction will align with regional direction and the DHB's annual priorities for 2011/12 will include local implementation of regional objectives which will be evident in this Annual Plan and in the Counties Manukau Maaori Health Plan 2011/12.

Figure 5 shows the alignment of Counties Manukau's strategic objectives with the region's strategic goals within the Triple Aim framework.

Section 3.2 in Module 3 outlines specific activities that the DHB has committed to undertake in 2011/12 to implement the NRHP.

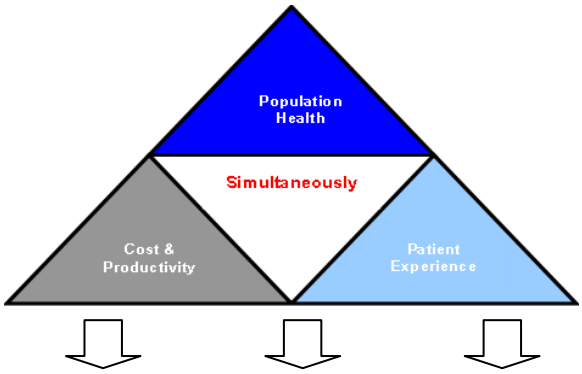
Alignment of our local priorities with regional and national direction

The DHB's strategic priorities are pulled together in Figure 6 in an intervention logic framework which establishes the links between Government/national priorities and regional priorities and the DHB's strategic objectives.

The framework also shows the key local strategies and plans that the DHB will undertake to progress regional and national outcomes and the desired impacts (or intermediate outcomes) which these strategies and plans will deliver, including key performance measures – medium term measures - which will tell us whether we are progressing towards our outcomes and ultimately achievement of our goals. In our *Statement of Forecast Service Performance* in Module 4 we outline in further detail why these measures are important markers of our performance.

The broad output classes which our activities fall within are presented in the framework but it is only in Module 4 that we will look at the specific outputs within each output class, the impacts that it is hoped these outputs will deliver, and the performance that we forecast to deliver for the financial year.

Figure 5: Alignment of Counties Manukau DHB Strategic Priorities with the Northern Region Health Plan Strategic Vision and Goals



REGIONAL GOALS		
POPULATION HEALTH	**PATIENT EXPERIENCE**	**COST/ PRODUCTIVITY**
Adding to and increasing the productive life of people in the Northern Region	**Delivering better services by Aiming for Zero Patient Harm, Performance Improvement and Informed Patient Choice**	**The region's health resources are efficiently and sustainably managed to meet present and future health needs**
REGIONAL PRIORITIES		
"Life & Years" • *Adding Life to Years*: To focus on a set of conditions which if "best designed" would deliver a significant improvement to health of the population, keeping citizens productive, reducing demand on hospital services • *Adding Years to Life*: To increase the number of years of life in the Northern Region by reducing risks of **diabetes** and **cardiovascular disease** This priority will also include: **Health of Older People**, **Cancer** and **Radiology**	**"First, Do No Harm"** • To be the safest healthcare system in Australasia through the systematic application of evidence based interventions which will save lives, prevent harm to patients, save money, free up capacity and improve productivity. **"Informed Patient Choice"** • *Advance Care Planning* To involve our patients in the decisions that impact their lives, their families/whanau	• Affordability • Asset Management • Workforce • Information Systems

COUNTIES MANUKAU DHB STRATEGIC OBJECTIVES		
Improve the health of the population and reduce inequalities	**Improve patients and their family/ whaanau's experience of care**	**Make the best use of our population-based funding**
WE WILL ACHIEVE OUR STRATEGIC OBJECTIVES BY		

• Reducing demand for health services through primary and secondary prevention
• Delivering more services in primary care and community based settings
• Collaborating regionally and locally to deliver 'best designed' systems and interventions in key health areas: diabetes, cardiovascular disease, cancer, child health, elective surgery, emergency care, health of older people, mental health
	• Delivering patient and family/whanau-centred care which is safe, patient-centred, equitable, timely, efficient, and effective
	• Developing and building capacity and capability in:
	  • Quality
	  • Workforce,
	  • Health intelligence,
	  • Health systems research and innovation,
	  • Clinical leadership.
		• 'Working smarter' to free up resources for re-investment in other areas
		• Reducing inappropriate variation in clinical practice
		• Reduce duplication and waste by working in a more unified manner within the organisation and with our regional colleagues
		• Building a workforce which reflects our own communities and their needs

Figure 6: Counties Manukau DHB Strategic Framework and Intervention Logic

High Level Outcomes	**All New Zealanders lead longer, healthier and more independent lives.**		
Regional Mission	**To improve health outcomes and reduce health disparities by delivering better, sooner, more convenient services. We will do this in a way that meets future demand whilst living within our means.**		
Regional Goals	**Population Health** **Adding to and increasing the productive life of people in the northern region**	**Patient Experience** **Delivering safe and good quality healthcare which is patient and family/ Whaanau centred**	**Cost / Productivity** The region's health resources are efficiently and sustainably managed to meet present and future health needs.
DHB Strategic Objectives	**Improved health of the population and reduced inequalities**	**Improved patients and their family / whaanau's experience of care.**	**Make the best use of our population based funding.**
We will do this in order to achieve our strategic objectives *NB: Linkage to the NRHP intervention logic in between brackets*	• Reducing demand for health services through prevention and delivering more services in primary care and community based settings (NRHP 1.1, 1.2, 1.3, 1.4). • Collaborating regionally and locally to deliver 'best designed (cost, efficient, quality) systems and interventions in key health areas including; - Diabetes - Cardiovascular - Cancer - Child Health - Elective Surgery - Health of Older People - Emergency Care - Mental Health (NRHP 1.1, 1.2, 1.3, 2.1) • Increasing availability and access to health and disability services in primary and community settings.	• Developing patient and family/ whanau centred care by focusing on the six healthcare quality dimensions: safe, patient centred, equitable, timely, efficient and effective. • Developing and building strategic capacity and capability in; - Workforce - Health systems research and innovation - Clinical leadership - Quality - Health Intelligence (NRHP 2.1, 2.2, 2.3)	• 'Working Smarter' to free up resources for re-investment in other areas (NRHP 3.1) • Reducing inappropriate variation in clinical practice (NRHP 3.1) • Reducing duplication and waste by taking a more unified systems approach (NRHP 3.4, 3.5, 3.6) • Building a workforce which reflects our own communities and their needs (NRHP 3.2)
High Level Impact sought	• Reduced incidence and impact of chronic disease. • Older people are supported and receive services appropriate to their needs. • People affected by mental ill health have access to mental health services and mental health clients have fewer acute episodes. • Healthier and safer children.	• Improved waiting times for services. • Improved patient satisfaction with services • Fewer adverse clinical events • Improved engagement of Maaori and Pacific with health services.	• Increased value from the resources allocated to the DHB. • Services delivered efficiently with minimal wastage and duplication. • Increased participation of Maaori and Pacific people from Counties Manukau in the health sector workforce.
Key Performance Measures	• Acute hospitalisation rates for Diabetes and Cardiovascular disease decrease (1 a) • Number of POAC patient admissions avoided at Emergency Care increase (1 b) • Life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific decreases (I c) • Proportion of adults in the population who are regular smokers decrease (1 d) • Rate of acute hospitalisations for children (0-14 years) decrease (2 a) • The ratio of older people in HBSS compared to ARC improves (3 a) • Proportion of people aged 65 years and above presenting to ED decreases (3 b) • Mental Health service access rates improve (4 a)	• Rate of acute readmissions within 28 days is maintained or reduced (5 b) • Patient Satisfaction with services (rated Good or Very Good) improves (5 a).	• Zero deficit • Proportion of Maaori and Pacific staff in DHBs by occupation class increases.
Key Strategies and Plans	• Better, Sooner, More Convenient Primary Health Care. • Creating a Better Future • Healthy Housing Programme • Whanau Ora • Lotu Moui *Northern Regional Health Plan* • Diabetes • Cardiovascular Disease • Cancer • Health of Older People *Regional services Plan:* • Child and Youth Health • Mental Health *Maaori Health Plan*	• Northern Regional Health Plan: First Do no Harm • Aiming for Zero Patient Harm • Ko Awatea • Innovation Hub	• Thriving in Difficult Times • Productivity Initiatives: *Electives Productivity* • Growing Our Own workforce • Regional Information Systems Plan • Regional Workforce Plan • Regional Asset Planning • Northern Regional Shared Services Organisation establishment
The DHB will achieve this through the delivery of the following services (grouped by Output Class)	**Prevention** • Health Promotion and Education • Statutory Regulation • Population Based Screening • Immunisation • Well Child Services	**Early Detection and Management** • Primary Health Care • Oral Health • Primary Community Care Programmes • Pharmacist • Community Referred Testing and Diagnostic • Mental Health	**Intensive Assessment and Treatment** • Mental Health • Elective (Inpatient / Outpatient) • Acute (Emergency Department / Inpatient / Outpatient) • Maternity Services	**Rehabilitation and Support** • Assessment, Treatment and Rehabilitation • Needs Assessment and Service Co-Ordination • Palliative Care • Rehabilitation • Aged Related Residential Care • Home Based Support • Life Long Disability • Respite Care • Day Services.

2.4 KEY RISKS

All of these risks are existing, known and managed as much as possible currently, but remain critical to the organisation in terms of either meeting our community's health needs, remaining financially viable, or adequately planning for the future. There is no particular order of ranking to the list below.

Risk Description	Mitigation Strategies
Growing Acute Demand Growth in acute medical admissions has been rising faster than population growth since 2007. Between 2008 and 2009 there was an 8% increase in acute adult medical admissions; this is 5% above expectations based on population growth. Ambulatory Sensitive Hospitalisation (ASH) rates and Emergency Care (EC) rates have also trended upwards since 2007. The majority of the increased admissions to Middlemore Hospital are avoidable admissions which are sensitive to timely primary care intervention.[17] Chronic and long term conditions like diabetes and cardiovascular disease (as outlined below) and respiratory conditions like chronic obstructive pulmonary disease (COPD) are the biggest contributors to acute demand. Given that our population will be growing by more than 40% over the next 20 years and we will be more than doubling the proportion of our population aged over 65 years (See *Section 1.2.2, Demand Growth*), acute demand and the burden of chronic disease will only be trending upwards. The pressure on facilities, workforce and resources is showing no signs of letting up. Current hospital bed demand is already in excess of what we forecasted for 2013 and last year, our outpatient services saw an unprecedented **299,412** patients attended to – about a 9% increase from the previous year.	• Continued focus and investment in interventions and programmes aimed at primary and secondary prevention which are evidence-based and effective. • At the primary prevention level: reduce the burden of disease through community-based interventions and programmes aimed at smoking cessation, improving maternal and child health (breastfeeding, immunisations, well child checks, oral health, infant and maternal mental health), healthier eating and a more active lifestyle. Regional collaboration across DHBs and PHOs to implement initiatives to reduce/ manage acute demand: • Continued investment in community and primary care based programmes to reduce the burden of chronic disease and growing acute demand: Chronic Care Management (CCM), Get Checked Diabetes programme, Care Plus and Primary Options for Acute Care (POAC). • Ensuring more equitable access to an integrated after-hours primary health care service • After hours care is made more affordable with standard co-payments across the network for high needs patients.
Cardiovascular disease (CVD) and diabetes Counties Manukau has the highest rate of diabetes in the country, with 8.4% of the adult population afflicted with this disease. This rate is due to double by 2021. People with CVD and/or diabetes account for 13% of the adult population in Counties Manukau. The cost of management and treatment of these diseases account for a substantial proportion of health care expenditure for the DHB. Some figures: • On average, each person with CVD and/or diabetes had healthcare costs of $2,400 more per head compared to a person without CVD or diabetes[18] • In 2008, 46% of the total in-hospitalisation costs (equivalent to $101million) were spent on patients with CVD and/or diabetes • In 2009, 24% ($133million) of the costs	• Continued focus and investment in interventions and programmes aimed at primary and secondary prevention which are evidence-based and effective. • At the primary prevention end: reduce the burden of disease through community-based interventions and programmes aimed at smoking cessation, improving maternal and child health (breastfeeding, immunisations, oral health, well child checks), healthier eating and a more active lifestyle. • Work with the Auckland Regional Public Health Service and across sectors to create greater awareness of diabetes in the region in order to influence policy settings Regional collaboration across DHBs and PHOs, primary and secondary care providers to: • Increase assessments of CVD risk particularly for eligible Maaori • Improve management of high risk CVD patients

Risk Description	Mitigation Strategies
allocated to the hospital, pharmaceuticals, and labs provision in Counties Manukau DHB were attributed to people with diabetes[19] The cost of treating and managing diabetes and CVD-related conditions is already incurring a disproportionate amount of the health spend. If no action is taken to curb the uptake of lifestyle factors like smoking, poor nutrition, inactivity and alcohol consumption, our ageing population profile means that the actual number of people with diabetes and CVD will increase significantly in the next 10 to 20 years, putting immense pressure on DHB resources.	• Increase the use of retinal screening as a preventative strategy for diabetes • Develop a clinical pathway for diabetes to improve primary and secondary integration of care • Develop a sustainable workforce to provide prevention, education, diagnosis, treatment and management activities for diabetes and CVD • Involve patients and their families in their management plans and improve patient health literacy by using care plans
Growing Demand for Cancer Services Significant volume growth is forecast for both radiation oncology and medical oncology for the next 10 years within the Northern Region. In addition to this there is the additional cost of excess capacity required to sustainably meet the Minister's health target. There is a risk that funders will not be able to reprioritise from other areas of health spend to meet this cost.	Work with the Northern Cancer Network on the following: • Regional Cancer Care Planning to identify the key priority areas for improvement in cancer care and what is needed to support future prioritisation and service delivery • Movement to a radiation therapy intervention rate which reflects appropriate clinical practice. • Management of access to medical oncology services and the implementation of national prioritisation criteria • Improve access to diagnosis and treatment of cancers through implementation of the cancer tumour streams so that cancers are diagnosed and treated early • Continued development of palliative care services
Growing Demand for Health of Older People Services The proportion of those aged 65 years and over in Counties Manukau is projected to increase by 131% from 2006 to 2026. For those aged 85+, the projected growth is 162%. Currently, about 29% of HOP clients are in residential care, accounting for more than 85% of the total HOP services funding. More than half the residential care clients are in age related hospital care. Overall, client numbers have increased in the last few years for many HOP services. These include: age-related hospital care, dementia rest home care, day care and carer support. If the current rate of intervention for HOP services remains the same, the rate of growth in the 65+ population will determine the rate of growth in HOP services. These projections also signal an urgent need to develop workforce capacity in both home-based care and residential care services. Failure to invest in workforce capacity development may result in compromised quality of care and patient safety issues.	• Enhancing NASC capacity to ensure provision of equitable assessment and service coordination • Continue to develop the Community Geriatric Service with specialist input and promotion of services in the community to support positive ageing. • Improving the continuum and quality of care for people in residential care by ensuring there are internal audits, ongoing training for staff, and clinical support • Limit unnecessary medical intervention by increasing Advance Care Planning for older people as per NRHP implementation plan

Risk Description	Mitigation Strategies
Managing the Cost of Wages and Salaries 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, Counties Manukau DHB 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 or by way of continuously increasing efficiencies. 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. The provision for the cashing up of the fourth weeks leave will present a significant cash flow challenge for the sector if all parties take full advantage of the change.	• Manage growing demand for services as outlined in the risks above on managing diabetes, CVD and acute demand • Taking a sector-wide approach to collective bargaining negotiations with different workforce groups. • The Auckland Region is due to complete the Senior Medical Officer (SMO) Regional Job Sizing exercise which will ensure there is regional wage comparability and establish safe clinical levels (FTE) • Regular review of job vacancies
Implementation of Regional Primary Care business cases Regional business case activity fails to achieve promised improvements	DHBs are committed to ensuring the success of the three Primary Care business cases operating in the Auckland region and will continue to resource them to succeed. In addition, DHBs recognise that a shared understanding and approach to locality based health planning & delivery are central to achievement of the promised improvements and are working toward this.

MODULE 3: DELIVERING ON PRIORITIES AND TARGETS

This module gives a brief outline of key DHB activities, actions and outputs to deliver on each of the priorities outlined in the Minister's *Letter of Expectations* for 2011/12, including the six National Health Targets.

Further sections outline what the DHB will deliver in 2011/12 to achieve regional priorities, including the Northern Region Health Plan as well as other regional priorities which do not have a major presence in the first iteration of the Northern Region Health Plan but are nonetheless key to DHBs collectively making an impact on Government direction and some of the national level strategies and targets.

The last section covers some of the DHB's local priorities.

Key for the 'Reference' column in the table:

NHT	National Health Target (1 = ED length of stay, 2 = Electives, 3 = Cancer waiting times, 4 = Immunisations, 5 = Smoking cessation, 6 = Diabetes and Cardiovascular disease detection and management)
OS	Ownership Dimension (Indicator of DHB Performance, see Appendix 3)
PP	Policy Priority (Indicator of DHB Performance, see Appendix 3)
SI	Systems Integration (Indicator of DHB Performance, see Appendix 3)
NRHP	Northern Region Health Plan outcome indicator (numbers link to the NRHP intervention logic, see Appendix 5)

3.1 ACTIONS TO DELIVER THE GOVERNMENT'S PRIORITIES AND HEALTH TARGETS

3.1.1 Improving service and reducing waiting times for patient access to important services

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Electives: Surgical Services Deliver to Elective Initiative targets for base and additional volumes contracts Deliver to negotiated Standardised Intervention Rate targets for base elective contract and elective initiatives	Increased availability of access to Elective Services Maintaining real access levels	**Achievement of CMDHB's target of 14,704 elective surgical discharges** Elective discharges from Surgical DRG rate of at least 308 per 10,000 population Delivery of 25,512 Elective Surgical First Specialist Assessment (FSA)	**NHT 2** NRHP 2.32	More New Zealanders living longer, healthier and more independent lives People receive better health and disability services. Improved hospital productivity Improved access to elective surgical services
• Review acute theatre management • Use theatre support facilities efficiently • Elective theatre utilisation quality improvement Standardise preadmission processes using the Elective Services Productivity and Workforce programme	Improved theatre utilisation to accepted best practice levels Increased bed availability Efficient use of staffing resources Improved productivity Reduced DOSA cancellations	Achievement of 60% Elective and Arranged Day Surgery rate Achievement of 90% DOSA rate Achievement of 82.5% theatre utilisation rate by year end Improved elective and arranged inpatient LOS: • Standardised: 3.92 days	OS 6 OS 7 OS 5 OS 3	
Ensure that all patients awaiting a first specialist assessment and/or treatment are not waiting longer than 6 months	Patients awaiting an elective service receive care within acceptable timeframes	Elective Services Patient Indicators		

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Emergency Care Continue to take steps towards sustaining the 6 Hours Can Be Ours campaign. • Set up an Assessment Observation Unit (AOU) • Work with primary care and the community to manage demand for emergency care and acute medical services: Very High Intensive User (VHIU) programme and the Greater Auckland Integrated Health Network (GAIHN) initiatives like Primary Option for Acute Care (POAC) • Set up an Acute Medical Clinic • Outpatients project (see also *Electives: Medical Services*) • *Safe Staffing* initiative and capacity planning to ensure adequate staffing (SMO, RMO, Acute Care Nurses and CNS) to meet patient needs in ED and AOU • Whai Manaaki (Quality Improvement)	Increased efficiency in management and processing of acute medical patients Reduced number of presentations to ED of acute medical patients Reduced number of self-referrals to ED Timely access to the Outpatient clinic for First Specialist Assessment and Follow Ups to avoid or support acute inpatient episodes Appropriate staffing numbers with the required skills to support the admission and assessment work for Medicine at the front of the hospital in an effort to minimise delays for patients Staff time freed up for more patient care Increased efficiency in the management and processing of acute medical patients	**At least 95 – 97% of patients admitted, discharged, or transferred from an Emergency Department (ED) within six hours** Increased enrolments in POAC and VHIU programmes Reduction in the number of patients admitted to the wards Nursing resources in the medical wards are matched to demand Time to admission	**NHT 1** NRHP 2.31	More New Zealanders living longer, healthier and more independent lives People receive better health and disability services. Improved hospital productivity and timely access to services The health and disability system and services are trusted and can be used with confidence.
Electives: Medical Services Outpatients Project with specialities • Timely grading of referrals; • Adequate FSA slots to meet patient demand by priority; • Electronic referrals Project (See *Regional Collaboration: Information Systems*)	Improved time from referral to First Specialist Assessment (FSA) for medical patients Improved performance on guideline timeframes to see Priority 1 to Priority 3 patients	More than 80% of FSA patients will be seen within their designated priority timeframe 70% of patients triaged to a chest pain clinic within 6 weeks.	NRHP 2.3 NRHP 2.3	

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Ensure that all patients awaiting a first specialist assessment and/or treatment are not waiting longer than 6 months	Patients awaiting an elective service receive care within acceptable timeframes	Elective Services Patient Indicators		
Cancer Treatment Sustainable service delivery system which aligns with the agreed regional Radiation Therapy Strategic Plan Medical oncology prioritisation criteria Regional lung tumour stream Regional bowel tumour stream Establish a regional mechanism to strengthen the capacity of palliative care providers Develop a haematology clinical network Develop a regional cancer plan See Appendix 8 for the 2011/12 Northern Cancer Network priorities	Improved access to timely radiation therapy Improved access to timely specialist assessment Improved access to timely chemotherapy Improved cancer wait times as defined by the tumour streams. Improved monitoring and reporting against tumour stream standards	**100% of patients in category A, B and C waiting less than 4 weeks between first specialist assessment (FSA) and start of radiation oncology treatment (excludes category D patients)** Percentage of all cancer patients who need a specialist assessment will have this within 4 weeks from date of referral Percentage of all cancer patients who are referred for chemotherapy will commence treatment within 4 weeks from decision to treat See Appendix 8 for lung cancer tumour stream targets Regional cancer plan by 2012	**NHT 3** NRHP 2.33 NRHP 1.31	More New Zealanders living longer, healthier and more independent lives All patients receive the same level of access to cancer treatment within the national guidelines for treatment. All patients within the region benefit from coordinated palliative care services provided in a number of care settings as per MoH Priorities for Cancer 2011/12 Early diagnosis and treatment of lung cancer to increase survival rates Improved cancer control in the Northern Region
Radiology Work collaboratively with other DHBs through the regional radiology clinical network. CMDHB will undertake the following actions to progress the regional radiology clinical network priorities: • Devolve diagnostics to community-based providers through the *Access to Diagnostics* Regional Project (see also Section 3.1.2, Regional Better	Reduced patient waiting times for Radiology procedures Improved access to diagnostics Improved timeliness for diagnostics Improved diagnostics capacity Improved ability to balance acute workloads with elective and arranged workloads	P3 examinations performed within 12 weeks P2 examinations performed within 6 weeks P1 examinations performed within 2 weeks	NRHP 2.33	More New Zealanders living longer, healthier and more independent lives People receive better health and disability services. Improved hospital productivity and timely access to key services The health and disability system and services are trusted and can be used with confidence.

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Sooner More Convenient Primary Healthcare) • Develop diagnostic capacity in-house and through outsourcing arrangements				

3.1.2 Delivering more services in community-based settings which are closer to the patient and improving integration of services across hospitals and the community

Better, Sooner, More Convenient (BSMC) Primary Healthcare

To meet the twin Government aims of providing better services for patients closer to home and to reduce pressure on hospitals, CMDHB primary care will continue to focus on the *Better, Sooner, More Convenient* (BSMC) goals to achieve large and capable community organisations in primary care that will provide opportunities for clinicians to establish new models of care within an integrated health system.

PHO consolidation means that there will only be four PHOs operating in CMDHB from 1 July 2012, enabling streamlining of management overheads to flow to front line services. All 4 PHOs will be part of the Primary Care Alliances established under BSMC – ProCare and East Health being part of the Greater Auckland Integrated Health Network (GAIHN) while the National Hauora Coalition (NHC) and Alliance Health + (AH+) represent both merged PHOs and Alliances in their own right.

As Host DHB for both Alliance Health + and the National Hauora Coalition, CMDHB will be responsible for managing their service agreements and liaising with partner DHBs to assist the alliances in meeting their Business Case deliverables. These include the establishment of robust Integrated Family Health Centres and Whanau Ora Centres that not only consolidate primary health care services but enable additional services to be shifted from hospital to these larger more capable primary care organisations.

The establishment of Alliance Leadership Teams (ALTs) in 2010/11 across the three coalition Business Cases provides a unique opportunity for clinicians from primary care and secondary care together with DHB funding and planning experts to jointly prioritise and plan future service delivery within their localities. This includes the review of current funding streams into more flexible funding packages that enable service redesign that better meet the BSMC goals of better, more convenient care for New Zealanders.

Locality Planning

A locality planning approach will be used in Counties Manukau to accelerate the rate of change and progress implementation of government and regional priorities at a local level. Change efforts in the first year will focus on six localities determined by health need and geography rather than organisational boundaries:

- Otara
- Eastern suburbs
- Pukekohe
- Papakura
- Mangere
- Manurewa

The DHB will facilitate clinically led partnerships at the locality level to effectively manage the business and develop the models of care required to support increased integrated health care delivery and the shifting of services into community settings.

The table below outlines the work that CMDHB will be undertaking over the next 12 months to deliver on the Government's BSMC priorities using a localities approach. See Appendix 12 for detail about the primary care business cases.

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Better Sooner More Convenient Demonstration Sites that provide more integrated health care services in the community We will provide clinical leadership from secondary teams to develop new models of care to address the issues of acute demand growth and the management of long term complex conditions. We will develop local clinical partnerships in each of the localities comprising an alliance of the most appropriate clinicians and managers. We will strategically plan for assets and facilities based upon integrated solutions. Development of new models of nursing utilising the shared provider arm and primary	The focus for change will be in the agreed areas of : • Acute demand management • Long term conditions management (CVD, CHF, Diabetes and COPD) • Frail elderly support although this will not preclude other areas of logical focus where clinically viable. Shifting specialist services into community settings for priority conditions e.g. spirometry, pulmonary rehab utilising the already forming general practice clinical networks to create critical mass and primary expertise. Supporting NHC and AH+ in the	Clinical indicators of best practice inputs and outcomes for the targeted conditions as agreed by the regional networks for each locality site developed by September 2011. Local clinical network governance arrangements established by July 2011 in: • Otara • South eastern suburbs • Pukekohe • Papakura And by December 2011 in: • Mangere • Manurewa Establishment of IFHCs/Whanau Ora Centres in Papakura, Otara and Mangere by June 2012.		More New Zealanders living longer, healthier and more independent lives *Better, sooner, more convenient* primary health care People receive better health and disability services.

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
care nurse workforce	development of Whanau Ora Centres and Integrated Family Health Centres (IFHCs). Utilisation of the IFHC Implementation Support Groups to support more rapid progress towards BSMC care. Reduced demand on other clinics and tertiary settings as nurse run clinics provide services for Chronic Care Management Improved patient experience through integrated health service planning and delivery across the whole spectrum of care. An intersectoral approach with other government and non-government agencies who have an influence on health and its broader determinants.	Collaborative agreement with primary care on the achievable reduction in hospital presentations and admissions as a result of improvements to integration and BSMC by September 2011. Partnering with North Waikato Tainui to develop a public/private agreement to build a Whanau Ora centre in South Auckland. A business case for this development will be completed by September 2011. Establishment of the first integrated nurse-led clinic for long term conditions management in Mangere by 31 December 2011. Establishment of a district wide integrated cardiac community service based in NHC and managed jointly by NHC and MMH cardiac services by 31 December 2011 Development of an appropriate framework for progressive shift of services into community settings and establishment of Local Clinical Partnership arrangements by December 2011.		
Reducing acute demand Agree with Primary Care the achievable reduction in hospital presentations and admissions as a result of improvements to integration and BSMC. Provision of clinical leadership from secondary teams to develop new models of care to address the issues of acute demand growth and the management of long term complex conditions. Continue implementation of the following	Faster progress towards achievement and improvement on national health targets. Faster referral and treatment times. Reduced waiting times for services. Services provided more conveniently and closer to home for patients. Regionally consistent processes. Better integration and working together to improve services for patients.	425 minor skin lesions in Counties Manukau DHB by accredited providers. Implement GP opinion survey in Q1; patient satisfaction survey completed Q2 and Q4 and clinical audit completed on outcome data Q2. Investigate purchasing dermoscopy services to improve efficacy for pigmented lesions by end of December 2011. Investigate widening the scope of the		More New Zealanders living longer, healthier and more independent lives *Better, sooner, more convenient* primary health care People receive better health and disability services.

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
GAIHN led Auckland Regional projects that deliver the *better, sooner, more convenient* primary care policy: • Minor Surgery (skin lesions) • Clinical Pathways • Access to Diagnostics – Radiology • Primary Options for Acute Care Support **GAIHN**'s goal to reduce unplanned hospital admissions through better response to acute events by reviewing the range of options available for acute response in primary care including: • Telephone triage and after hours • Same day and urgent access to the medical home • Better management of self referrals to ED	Alignment with the clinical networks for Diabetes, Cardiology and Radiology established under the regional Health Plan.	regional project to include other minor procedures, completed by March 2012 to inform 2012/13 planning. Evaluate the 2 clinical pathways implemented in 2010-11 by December 2011, update as necessary. Implement the 4 pathways developed in 2010-11 by July 2012 and develop a further 5 clinical pathways by July 2012. Investigate electronic solutions and complete a business case for preferred options by March 2012. The volume of DHB-funded GP-requested diagnostic radiology procedures performed in the community will increase by 10% across the Metro Auckland DHBs, on 2010/11 volumes by 30 June 2012. Through engagement with primary and secondary clinicians, agree an appropriate target for waiting times for routine imaging and report performance against the target for Metro Auckland DHBs from January 2012. 9,000 enrolments in POAC by June 2012 with increased focus on rest home and hospital referrals. 800 referrals in CMDHB's Very High Intensive User (VHIU) programme by June 2012.		

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
		Expanded range of 'options' included in POAC service by 30 June 2012.		
	. .	Regional networks will be instrumental at setting targets for priority areas. Local targets will be developed as part of the models of care. A full set of outcomes based indicators for locality sites will be developed by September 2011. *There are already high level system performance indicators agreed as part of BSMC business case development and the Northern Regional Health Plan. Local indicators will mirror those as a baseline for KPIs.*		
Management of long term conditions Continued focus on community and primary care based programmes to improve better management of targeted individuals in primary care and better response to acute events • Expansion of self management programmes to enable better management of diabetes and cardiovascular disease **(GAIHN, NHC)** • Expansion of Primary Options for Acute Care (POAC) and Very High Intensive User (VHIU) programmes **(GAIHN, NHC)** • Chronic Care Management (CCM) **(GAIHN, NHC)** • Support **GAIHN** development and use of a risk stratification tool for individuals with a high risk of presentation to ED	Collectively reduce demand on hospital services through community and primary care based programmes. Faster progress towards achievement and improvement on national health targets	• 750 additional patients enrolled in self management programmes by June 2012 • >19,500 CCM enrolments by June 2012 • Ensuring >3,000 patients with a CVD AR >15% receive appropriate guidelines management by June 2012 • Risk stratification at practice level by 31 December 2011 • Initial management programmes in place for 100% of individuals identified as high risk in trial localities by June 2012. Effectiveness of programmes monitored and reported to ALT monthly. • Increasing the CVD national health targets		More New Zealanders living longer, healthier and more independent lives *Better, sooner, more convenient* primary health care People receive better health and disability services.

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
		<table><tr><td></td><td>Baseline</td><td>By July 2012</td></tr><tr><td>Maaori</td><td>75%</td><td>90%</td></tr><tr><td>Pacific</td><td>76%</td><td>90%</td></tr><tr><td>Other</td><td>83%</td><td>90%</td></tr><tr><td>Total</td><td>79%</td><td>90%</td></tr></table>		
Support establishment of an Auckland Regional After Hours Network (ARAHN)	Better and more equitable access to an integrated after-hours primary health care service. An integrated after hours service which is representative of multiple service providers across the system (Triage & Disposition, St John, General Practice, Accident & Medical, Emergency Departments) and supports the patient's medical home as the main provider of care and coordination. Has a focus on the reduction of inequalities by ensuring more affordable after hours care with standard co-payments across the network for high needs patients.	Phased implementation of ARAHN from 1 September 2011 as determined through the primary care led process. Fully implemented by 30 June 2012. Maximum co-pay levels and opening hours maintained as per contract for all funded clinics.		*Better, sooner, more convenient* primary health care

3.1.3 Strengthening Clinical Leadership

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Clinical Engagement Strong clinical governance and input in the development and ongoing implementation of the Northern Region Health Plan Support our clinicians to lead and/or engage in the development of Regional Clinical Networks	Improved health services planning informed by clinical expertise and close collaboration between clinicians and administrators Increased job satisfaction for clinicians leading to better retention of the clinical workforce Development of career pathways resulting in increased opportunities for career advancement	Improved retention rates of clinical staff Number of Health Workforce New Zealand-funded staff with career plans	PP 1 PP16	Clinical engagement and clinical leadership at all levels of the organisation from the bedside to the boardroom Clinicians involved in all critical strategic and operational decisions (including all major business cases)
Fostering Clinical Leadership Develop and implement advanced nursing practice roles Review priority condition areas and identify where Allied Health staff can lead on development of best practice Work with Health Workforce New Zealand to provide career planning support				

3.1.4 Health of Older People

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Dementia Work with the Regional Dementia Network to pilot development of a clinical pathway for dementia. Recommendations from this project will inform both local implementation and regional planning.	Improved access to multi-disciplinary expertise and a consistent approach to management for people with dementia Improved coordination of services between Assessment, Treatment & Rehabilitation and Mental Health Service for Older People	Project to commence in July 2011 with recommendations expected in January 2012 and full roll out by July 2012 Baselines to be scoped and measures developed	NRHP 1.25	More New Zealanders living longer, healthier and more independent lives Improved care and services for the frail elderly The health and disability system and services are trusted and can be used with confidence

<table>
<tr><th>We will undertake these initiatives / activities and actions</th><th>This will contribute to the Government's priority through:</th><th>Measured by</th><th>Reference</th><th>In support of system outcomes</th></tr>
<tr><td>Provide support and education to regional residential dementia care providers through development of a regional dementia service.</td><td>Improved residential service for clients suffering from dementia

Appropriate and timely residential care for people who have dementia.</td><td>Number of residential dementia care services who have support/education/training</td><td></td><td rowspan="4">National goal for the elderly to maintain their independence and age in place with appropriate support</td></tr>
<tr><td>Respite Care
Expand and develop respite and community support programmes with additional capacity expected to be funded in 2011/12.

NASC service to identify client and family requirements for residential respite care as a part of a community support package</td><td colspan="2">CMDHB has used additional SLA funding for respite over the last 12 months to provide an extended range of levels of care in residential care. This provision currently exceeds the funding and CMDHB target volumes for the year.

We will be completing RFP for 4 dedicated respite beds in residential care

2009/10 Target for Respite = 2469 bed days per annum, 208 bed days per month
2009/10 Actual for Respite = 2689 bed days per annum
2010/11 Target for Respite = 3430 beds days per annum, 285 bed days per month
<table>
<tr><th></th><th>ARRC Rest home level facility use</th><th>ARRC Dementia Care facility use</th><th>ARRC Hospital Care facility use</th><th>Totals</th></tr>
<tr><td>2010/11 bed day target</td><td>1029</td><td>171</td><td>2230</td><td>3430</td></tr>
<tr><td>2010/11 clients bed days total (June to Mar actual)</td><td>1119</td><td>290</td><td>1833</td><td>3242</td></tr>
<tr><td>2010/11 clients bed days total (extrapolate 9 months plus 3rd quarter volume repeated in 4th quarter)</td><td>1604</td><td>374</td><td>2531</td><td>4509</td></tr>
<tr><td>2011/12 bed days target as per SLA commitment</td><td>1029</td><td>171</td><td>2230</td><td>3430</td></tr>
</table></td><td></td></tr>
<tr><td>Supporting Ageing in Place

Create a forum for family and informal carers in CMDHB.</td><td>Provision of specialist expertise and the promotion of services in the community to support positive ageing</td><td></td><td></td></tr>
<tr><td>Participate in the InterRAI assessment implementation

Implement inteRAI in all community services (NRHP action)</td><td>Regionally consistent implementation at CMDHB, with eligible people able to access assessment and service funding</td><td>All NASC assessors to be trained in the use of InterRAI for community assessment over the next 12 months

100% of NASC assessments will be using</td><td></td></tr>
</table>

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
		InterRAI by July 2012		
Promote Ageing in Place in line with the national strategy	Ensure sufficient availability of an appropriate mix of funded community based programmes: respite care and home based multi-disciplinary support services	Sufficient availability of an appropriate mix of funded community based programmes to support older people and their family/ carers to remain living as independently as possible	NRHP 1.22	
Increase support to primary care providers: • Joint clinics by the Community Geriatric Team at General Practices • More input to frail older people living in the community • Enhanced continence management in primary care	Supports the Continuum of Care and Quality of Care/ support services for people with chronic health conditions	100 CGS team contacts per month, < 55 EC presentations per month from residential care residents		
Improve community support for older people through the use of innovated clinically led service models: • *Walking On* programme - supports older people retain mobility • *Meals for Independence* nutrition programme • Spectrum Care pilot to work with provider to support people with intellectual disability as they age • Franklin Integration Project – developing community capacity				
Support Home based Support providers workforce development and capacity building with Careerforce programmes	Ensure Home Based Support Services are sustainable and responsive to older people			
Where appropriate, working with Auckland Council to refurbish pensioner units: • Supportive Independent Living Service to complete home based assessments with residents of pensioner housing in our community				

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Improving quality of care for older people Patient Safety Initiatives – falls, pressure injuries, medication reviews Provision of Age Friendly hospital services and environments See ***Advance Care Planning*** below	Improved quality of care and patient centred care Provides specialist expertise / philosophy for creating effective clinical care environments that support improved patient outcomes		NRHP 1.2	
Aged Residential Care Participate in study to look at reasons for ASH admissions from Aged residential Care facilities Continue developing the Community Geriatric Service to facilitate access to clinical input	Better understanding of the drivers of admission to ARC Improve the continuum and quality of care for people in residential care Reduce avoidable admissions to hospital by having the resources and capacity to provide care at ARC facilities	Complete baseline data collection of current research and service initiatives within Aged Residential Care.	NRHP 1.2, 1.22, 1.24, 1.25, 2.2.	
Work with residential providers to maintain quality standards and build provider capacity (Regional Project)	Improved quality of residential care	100% of all residential care facilities in CMDHB undertake their certification audit process Establish and maintain reporting systems linked to outcomes such as serious incidents and complaints.		
Advance Care Planning(ACP) [20] Undertake a pilot project to implement ACP in secondary care and gain understanding of the infrastructure and resources required to sustain ACP Continue to introduce ACP in Aged Related Residential Care (ARRC) facilities and Primary Care	Supporting the provision of patient-centred care and quality healthcare	The evaluation criteria approach is under development		

3.1.5 Greater regional collaboration and a more unified system

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Regional Services Planning The DHB Chief Executive is a sponsor for the Northern Region Health Plan Work collaboratively with the region's DHBs to develop a whole of system Northern Region Health Plan Implement the NRHP priorities for 2011/12 Work with the Auckland BSMC consortia to implement their business cases for 2011/12.	Improved efficiencies from joint planning services planning: less duplication and waste A more unified system will deliver a better patient experience for our patients and their families	Year 1 DHB actions from the Northern Region Health Plan are implemented		More New Zealanders living longer, healthier and more independent lives Improved coordination and sharing of expertise leading to improved services planning across the Northern Region DHBs Improved health sector planning through greater regional collaboration and unified systems The health and disability system and services are trusted and can be used with confidence
Shared Services Work collaboratively with the region's DHBs to establish healthAlliance NZ Ltd (formerly known as the Northern Region Shared Services Organisation) See Section 8.5 for further information on healthAlliance NZ Ltd establishment	Shared functions across the Northern Region DHBs' information systems, procurement and supply chain roles which will streamline transactional activities with standardised systems and processes	Successful implementation of Phase 2 of project.		
Regional Information Systems Plan implementation Single regional secondary care patient administration system (PAS) Single regional secondary care clinical work station (CWS) TestSafe regional clinical data repository	Regional consistency across Northern Region DHBs regarding IS projects, support for clinical workflows, safety and decision making across the sector Shared IS platform facilitates better sharing of clinical information for improved decision making across the Northern	Achievement of RISP objectives	NRHP 3.6	

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
DHB prioritisation to bring the region's core IT infrastructure to the required levels to meet the health needs of the population Regional population health data repository across DHBs and PHOs See *Appendix 6* for full details of the Regional Information Systems Plan (RISP) priorities for 2011/12.	Region DHBs Reduced duplication and wastage of resources			
Regional Workforce Planning Implementation of Taleo Version 10 across the region Regional management of Resident Medical Officers (RMOs) Regional alignment with national workforce programmes School-based initiatives aimed at getting young Maaori and Pacific into health careers Expansion of Physician Assistant pilot See *Appendix 7* for full details of the regional workforce priorities for 2011/12.	Retaining talent within our region via enhanced recruitment and retention practices Retention of RMOs • SMO job sizing • aligning remuneration to the MECA • implementing regional remuneration relativity strategies across like specialities Increased Maaori and Pacific participation in the health workforce	Organisational savings RMO vacancy rates held within a range of 2.5-7.5% RMO retention rates of 4/5 from the current 3.75/5 Achievement of National Work Programmes	MHP	

3.1.6 Living within our means and improving financial performance

Please see Module 8: Financial Performance for more information

We will undertake these initiatives / activities and actions	This will contribute to the Government's priority through:	Measured by	Reference	In support of system outcomes
Continue to maximise value from our resources through our *Thriving in Difficult Time*s programme, with a focus on critical examination of our services and processes to: • Reduce variation in clinical practice • Target waste and duplication • Identify areas where value can be added • Identify areas which are not delivering to core business and stopping them Continue to drive patient safety and quality improvement within the organisation See Appendix 10 for the *Aiming for Zero Patient Harm* initiatives	Increased value from every health dollar spent Reduced unnecessary wastage and duplication Resources are freed up for re-investment in other areas	Zero deficit Cost of healthcare per capita	NRHP 3.1	Minister's priority for DHBs to manage within budget and improve productivity

3.2 ACTIONS TO DELIVER THE NORTHERN REGION HEALTH PLAN (NRHP)

<table>
<tr><th>We will undertake these initiatives / activities and actions</th><th>This will contribute to the NRHP priorities through:</th><th>Measured by</th><th>Reference</th><th>In support of system outcomes</th></tr>
<tr><td>Life and Years: Diabetes

Support the Regional Diabetes Network to deliver first year implementation actions

Prepare and evaluate Self-Management tools and ensure plans are discussed with adult patients during consultation.

Greater collaboration between primary and secondary care services, including the development of reporting frameworks.

See also the Better, Sooner, More Convenient Primary Health Care Plan for chronic conditions management initiatives in Section 3.1.2.</td><td>Improved patient understanding of diabetes leading to better self-management and control of diabetes

Improved primary care services for people with diabetes leading to reduction in the development of secondary complication for people diagnosed with diabetes.</td><td>Number of enrolments into Self Management Education programmes.

Reporting on:
Proportion of people who will have had their annual review: 60%.

60% percent of people who have a HbA1c < 8% will have had their annual review.
<table><tr><td></td><td>Baseline</td><td>By July 2012</td></tr><tr><td>Maaori</td><td>53%</td><td>54%</td></tr><tr><td>Pacific</td><td>45%</td><td>49%</td></tr><tr><td>Other</td><td>70%</td><td>71%</td></tr><tr><td>Total</td><td>58%</td><td>60%</td></tr></table>
Proportion of diabetes patients with a HbA1c > 10 (Target = < 10%)

Proportion of patients who receive a Get Checked check.
<table><tr><td></td><td>Baseline</td><td>By July 2012</td></tr><tr><td>Maaori</td><td>78.5%</td><td>99%</td></tr><tr><td>Pacific</td><td>68.4%</td><td>90%</td></tr><tr><td>Other</td><td>52%</td><td>73%</td></tr><tr><td>Total</td><td>60.6%</td><td>82%</td></tr></table></td><td>NRHP 1.1
MHP

NHT 6
MHP</td><td rowspan="2">More New Zealanders living longer, healthier and more independent lives

Improved health outcomes of the Northern Region population and reduced health disparities between different population groups</td></tr>
<tr><td>Life and Years: Cardiovascular Disease

Support the Regional CVD network to deliver first year implementation actions

Establish systems to identify the number of patients who have received their management plans during consultation (Heart Forecast tool)</td><td>Reduced severity of cardiovascular disease and ensure better management of patients.

Identify cardiovascular disease early and minimise complications.</td><td>Proportion of eligible people screened for cardiovascular risk.
<table><tr><td></td><td>Baseline</td><td>By July 2012</td></tr><tr><td>Maaori</td><td>75%</td><td>90%</td></tr><tr><td>Pacific</td><td>76%</td><td>90%</td></tr><tr><td>Other</td><td>83%</td><td>90%</td></tr><tr><td>Total</td><td>79%</td><td>90%</td></tr></table></td><td>NHT 6
MHP

NRHP 2.3.3</td></tr>
</table>

We will undertake these initiatives / activities and actions	This will contribute to the NRHP priorities through:	Measured by	Reference	In support of system outcomes
Improve Outpatient services: Time from referral to FSA General practice will develop and implement an annual plan for people identified with significant risk (15% or greater likelihood of having a cardiovascular event in the next five years) See also the *Better, Sooner, More Convenient Primary Health Care Plan* for chronic conditions management initiatives by the three Auckland coalitions in Section 3.1.2	Reduced prevalence of cardiovascular disease in the population.	70% of patients triaged to a chest pain clinic within 6 weeks. Maintain target cardiac surgery ESPI compliance		More New Zealanders living longer, healthier and more independent lives Improved health outcomes of the Northern Region population and reduced health disparities between different population groups
First, Do No Harm Agree a consistent methodology for the prevention of falls and pressure injuries Continue to drive patient safety and quality improvement within the organisation. See also Appendix 10 for CMDHB's *Aiming for Zero Patient Harm* initiatives which will contribute to the NRHP goal of a safer healthcare system	Reduced harm from falls and pressure injuries Improved quality of care provided to patients to ensure that their safety needs are met.	Reduction in the number of harmful falls in hospital by 20% across the sector Reduction in the number of patients who have pressure injuries in hospital or aged residential care by 20% across the sector Reduction in CLABs by 40% in at least one specified unit.	NRHP 2.1	
Life and Years: Cancer See Section 3.1.1, *Cancer Treatment* for CMDHB's actions to progress Northern Cancer Network/ NRHP objectives for cancer				
Health of Older People See Section 3.1.4, Health of Older People for CMDHB's actions to progress NRHP objectives for ***Health of Older People*** and the ***Informed Patient: Advance Care Planning***				

3.3 ACTIONS TO DELIVER: PRIORITIES WHICH SIT OUTSIDE THE NORTHERN REGION HEALTH PLAN

The local and regional priorities outlined in this section do not have a major presence within the NRHP but are nonetheless important to the DHB because they outline how the DHB will progress national, regional and local priorities in key areas like mental health, child health, Whanau Ora.

3.3.1 Child and Youth Health

CMDHB has a Child, Youth and Maternity strategic forum with strong clinical leadership through its three expert advisory groups. A key priority for the forum will be the development of a Child and Youth Health Plan by December 2011 which will be aligned with the localities, mental health and Maaori Health plans.

We will undertake these initiatives / activities and actions	This will contribute to the national and regional priorities through:	Measured by	Refer-rence	In support of system outcomes
Child Health • Regional collaboration with primary care to pilot practice-based multidisciplinary teams working to support high needs children and their families/whanau in high need localities • Implement the National Hauora Coalition Mama, Pepi and Tamariki programme with agreed provider networks within agreed localities • Increase the uptake of well child programmes with church congregations in the Lotu Moui programme	Integrated models of care for improved services coordination for children and their families	Roll out of model of care across the region following pilot Reduction in ASH rates for children aged 0-4 Reduction in acute hospitalisation rates for children 0-4	SI1	Healthier and safer children More New Zealanders living longer, healthier and more independent lives Improved immunisation rates (National Health Target) *Better, Sooner, More Convenient* care for children and their families Improved youth health and well being
Breastfeeding Work collaboratively with and provide support to community providers to improve breastfeeding rates Maintain Baby Friendly Hospital Initiative (BFHI) accreditation in community maternity facilities and continue to work towards BFHI accreditation for secondary maternity facilities at Middlemore Hospital	Increased breastfeeding rates leading to improved health outcomes for children	Increase in the number of community organisations who receive Breastfeeding Baby Friendly Community Initiative accreditation Breastfeeding rates at 6 weeks, 3 months and 6 months Breastfeeding rates upon discharge	SI7 MHP	
Infectious Diseases - Immunisations Explore new models of care to increase community-based opportunistic initiatives for immunisations aimed specifically at Maaori,	Children have fewer incidences of communicable disease and are less likely to acquire chronic disease in later life	**95% of two year olds are immunised by July 2012**	**NHT4** MHP	

We will undertake these initiatives / activities and actions	This will contribute to the national and regional priorities through:	Measured by	Refer-rence	In support of system outcomes
Pacific Tamariki and Whaanau: • Reconfigure the outreach immunisation support service to expand its role beyond support and facilitation to delivering immunisations • Pilot project trialling vaccinating in homes • Intersectoral programme with partner agencies within the Auckland Social Sector Leaders Group to boost immunisation rates and increase engagement with primary care				Healthier and safer children More New Zealanders living longer, healthier and more independent lives Improved immunisation rates (National Health Target) *Better, Sooner, More Convenient* care for children and their families Improved youth health and well being
Infectious Diseases - Rheumatic Fever Work collaboratively with Northern Region DHBs and the National Sector Rheumatic Fever Steering Group to develop an integrated and coordinated approach to the management and eradication of Rheumatic Fever and subsequently Rheumatic Heart Disease • Pilot a school based primary health care initiative which includes identification and treatment of Gp A Streptococcal throat infections Work with general practice to increase awareness of National Heart Foundation sore throat guidelines	Early detection and management to reduce the rate of acute rheumatic fever and Rheumatic Heart Disease	Rate of acute rheumatic fever Reduction in rheumatic fever rates particularly for Maaori and Pacific	MHP	
Infectious Diseases - Healthy Housing Ongoing implementation of the Healthy Housing programme, in conjunction with Housing New Zealand	Reduction in household over crowding and housing related potentially avoidable illness for participating families			
B4SCHOOL CHECK Delivery of the check to our priority population under 5 year olds	Identification of issues in child health before school enrolment	Increase in numbers of vision and hearing and school nurse checks		

We will undertake these initiatives / activities and actions	This will contribute to the national and regional priorities through:	Measured by	Refer-rence	In support of system outcomes
Sudden Unexpected Death in Infancy (SUDI) Engage in the development of the regional SUDI prevention strategy	Reducing the exposure of CMDHB infants to SUDI risk factors *See also key initiatives under* ***Smoking Cessation*** *targeted at pregnant mothers*	Reduction in SUDI rates (Long term goal)	MHP	Healthier and safer children More New Zealanders living longer, healthier and more independent lives Improved immunisation rates (National Health Target) *Better, Sooner, More Convenient* care for children and their families Improved youth health and well being
Youth Health Building on our current health assessment programmes with the Auckland Youth Support Network (partners: Youth Justice, Ministries for Social Development and Education, Local Government) for Year 9s and children in state care: • Work with the education sector to develop a youth development programme targeted at risk Year 7 and 8 students to be implemented in 2013 • Scope unmet health needs to develop services for youth in supervised homes	Supporting at risk youth to develop life skills that will contribute to better decision making, self esteem, leading to better health outcomes			
Mental Health Services - Youth Develop an acute mental health spectrum framework for youth Expansion and reconfiguration of specialist mental health services for youth in order to better meet the needs of young people with moderate to severe mental health problems	Young people with moderate to severe mental health problems have timely access to effective youth specific services	Youth Assertive Outreach team is fully staffed and operational The number of young people assessed and treated by the Youth Assertive Outreach Team		
Infant and Maternal Mental Health Continue our infant and maternal mental health programmes: • Mellow Parenting/ Hoki ki te Rito • Specialist infant mental health service Promotion of infant social and emotional needs awareness with new mothers	Improving understanding of infant and toddler social and emotional development and needs Supporting maternal mental health and reducing parenting stress for families facing relationship issues with their babies and toddlers			

3.3.2 Smoking Cessation

We will undertake these initiatives / activities and actions	This will contribute to the national and regional priorities through:	Measured by	Refer-ence	In support of system outcomes
Smoking Cessation – <u>Hospital-based services</u> Work with hospital leaders (managers and clinicians) to continue to promote and champion the Smokefree ABCs to establish it as a routine part of patient care Work with the Clinical Nurse Director to reinstate mandatory smokefree training for all nurses as part of their annual update requirement. Train Smokefree ABC trainers throughout all hospital departments.	Reduced incidence and impact of chronic disease. See *Smoking under Section 1.1.5, Population Health Profile* Achievement of the National Smokefree Health Targets, thereby reducing the smoking prevalence in NZ.	**95% of hospitalised smokers will be provided with advice and health to quit by July 2012** Nurses attend and are assessed on Smokefree Best Practice once a year.	**NHT 5** MHP	More New Zealanders living longer, healthier and more independent lives. Increased smokefree environments and reduced number of smokers
Smoking Cessation - <u>Primary Care-based service</u> Support Primary Care staff to be trained and confident in addressing the Smokefree ABC's and providing quality smokefree care to patients by: ▪ Encourage and support Primary Care staff to attend the National STEPS (Smokefree train the trainer course). ▪ Ensure regular communication with PHOs to promote and encourage the Smokefree ABCs ▪ Re-establishment of a Smokefree PHO working group - a group of PHO management and clinical leaders that meets monthly to discuss smokefree progress and challenges within primary care and plans strategies for improved performance.	Supporting Primary Care staff to be trained and confident in the ABCs of Smokefree and providing quality smokefree care to patients.	**90% of enrolled patients who smoke and are seen in General Practice will be provided with help to quit by July 2012**	**NHT5** MHP	

We will undertake these initiatives / activities and actions	This will contribute to the national and regional priorities through:	Measured by	Refer-ence	In support of system outcomes
Fund and support community cessation providers in the community including: ▪ Te Awatea – a new smokefree pregnancy support service ▪ A new Maaori smokefree leadership and cessation service (additional to the existing MOH funding Aukati Kai Paipa service) ▪ Pacific cessation support service ▪ Community Link service (WINZ based) Support good linkages between primary care and community cessation services by ensuring there are easy referral pathways and reliable feedback systems. Support town centres seeking to become smokefree through encouraging links with Primary Care and other community groups working on raising awareness of tobacco related harm Funding Otara Health Charitable Trust to maintain and extend the smokefree Otara town centre including working with community groups to raise awareness of tobacco related harm	Reducing the number of women who smoke during pregnancy, leading to a reduction in admissions due to tobacco exposure in children. Reducing the number of Maaori people and families that smoke.	Reduced proportion of women identified as currently smoking on the birth of their baby Reduced smoking prevalence for Maaori	MHP	Increased smokefree environments and reduced number of smokers

3.3.3 Mental Health

We will undertake these initiatives / activities and actions	This will contribute to the national and regional priorities through:	Measured by	Reference	In support of system outcomes
Mental Health – Regional Work collaboratively with the Northern Region mental health services planning group to deliver the 2011/12 regional mental health priorities See Appendix 11 for the 2011/12 regional mental health priorities	Strong intersectoral and inter-regional collaboration Improved access to services	Mental Health Services access rate	PP6	More New Zealanders living longer, healthier and more independent lives. The health and disability system and services are trusted and can be used with confidence
Consumer Network Develop a mental health consumer network	Formalised structures for provision of feedback and advice from mental health service users leads to improved acceptability of services	Mental Health Consumer Network represented at key mental health planning forums.		
Eating Disorders Local eating disorder clinicians to provide assessment and treatment for moderate disorders, consult liaison services and provide support to primary care	Improved access to services for people with eating disorders in collaboration with the Regional Eating Disorder Services	Increased number of clients accessing eating disorder services.		
Alcohol and Drug Addiction Services Establish a new comprehensive community based Alcohol and other Drug assessment and treatment service for people with highest level of need.	Improved wellbeing for people with addictions problems and increased choice and acceptability of services.	60 people accessing the service by June 2012		
Develop a new peer driven locality based service focused on wellbeing that is highly valued by people with mental health and addiction issues	Improved wellbeing for people with addictions problems and increased choice and acceptability of services.	60 people accessing the service by June 2012		

We will undertake these initiatives / activities and actions	This will contribute to the national and regional priorities through:	Measured by	Reference	In support of system outcomes
Reducing Inequalities Improve linkages with Primary Care, community agencies and other referral sources to ensure healthcare equity for Pacific communities	Improved access to mental health services for Pacific communities	Increase in number of Pacific people accessing Mental Health Services	PP6	More New Zealanders living longer, healthier and more independent lives The health and disability system and services are trusted and can be used with confidence
Mental Health First Aid for Whaanau Deliver Mental Health First Aid for Whaanau to Counties Manukau community.	Improve mental health literacy amongst Maaori families	Two providers to be engaged to deliver Mental Health First Aid for Whanau Mental Health First Aid programme accessed by 200 Maaori in Counties Manukau area		

MODULE 4: DHB PERFORMANCE

4.1 STATEMENT OF FORECAST SERVICE PERFORMANCE

The DHB is required under Section 142 of the Crown Entities Act 2004 to provide a statement of forecast service performance. The measures in the Statement of Forecast Service Performance are non financial measures and consist of key outputs which the DHB is planning to deliver through its planned activities/ actions for 2011/12.

Figure 6 in Module 2 shows the DHB's strategic framework and how our strategic objectives - influenced by national and regional priorities - guide the DHB's decisions around what level of **input** (that is, resources) and mix of services best meets our population's health needs, how they are to be delivered and to what level.

The mix of services delivered – that is, **outputs** - are expected to contribute towards measurable **impacts** – improvement of which will provide good indication that the DHB is on track to deliver on its high level outcomes.

These are measured against health quality measures like timeliness, access, patient safety, efficiency, effectiveness and equity.[21]

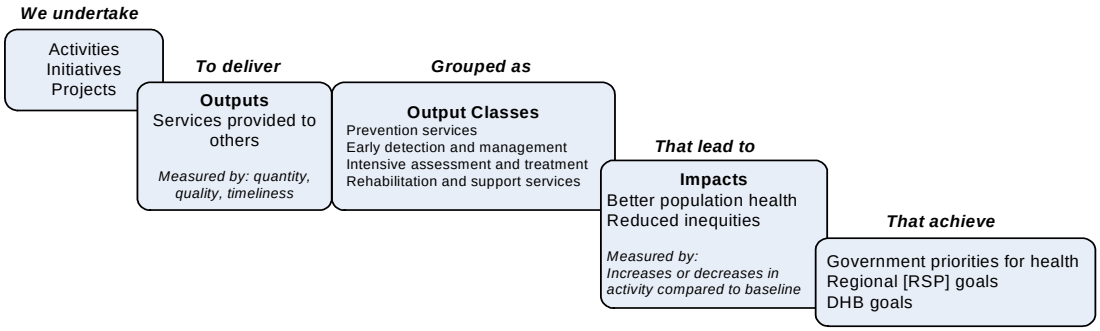
Where possible, we have included past performance (baseline data) along with each performance target to give some context of what we are trying to achieve and to better evaluate our performance.

Health is a complex business as such the relationship between the activities provided by the DHB and the impacts expected and the outcomes sought are seldom a direct one to one relationship but rather a many-to-many relationship.

The reader will note that for expediency, we have chosen only the key few measures of output and impact for each output class which best describes the activities that will contribute to the DHB's achievement of key strategic objectives and improved outcomes for our population.

The actual results of our service performance will be published in our 2011/12 Annual Report.

The intervention logic that underpins this Statement of Intent



4.1.1 High Level Impact - what we are trying to achieve for our population

Figure 8 below shows the five key impacts that we are trying to achieve for our population through the DHB's role as planner, funder and provider of health services. These impacts are consistent with our strategic objectives, the regional vision for a healthier Northern Region and the government's desire for the health sector to contribute toward New Zealanders living longer, healthier and more independent lives.

The first four key impacts are *population health* impacts, achievement of which will bring about a healthier Counties Manukau with fewer health inequities between different population groups.

The fifth key impact is a *patient experience* impact which aims to provide patient and family/whaanau centred care which in Counties Manukau is care which is safe, patient centred, equitable, timely, efficient and effective.[22]

Each impact has measures which have been chosen as main measures relating to the full period of this Statement of Intent and information has been provided alongside each impact (figures 8(a), 8(b), 8(c), 8(d), 8(e)) explaining why this measure is important and an indication of what our current picture is.

Figure 8: What Counties Manukau DHB is trying to achieve for its population

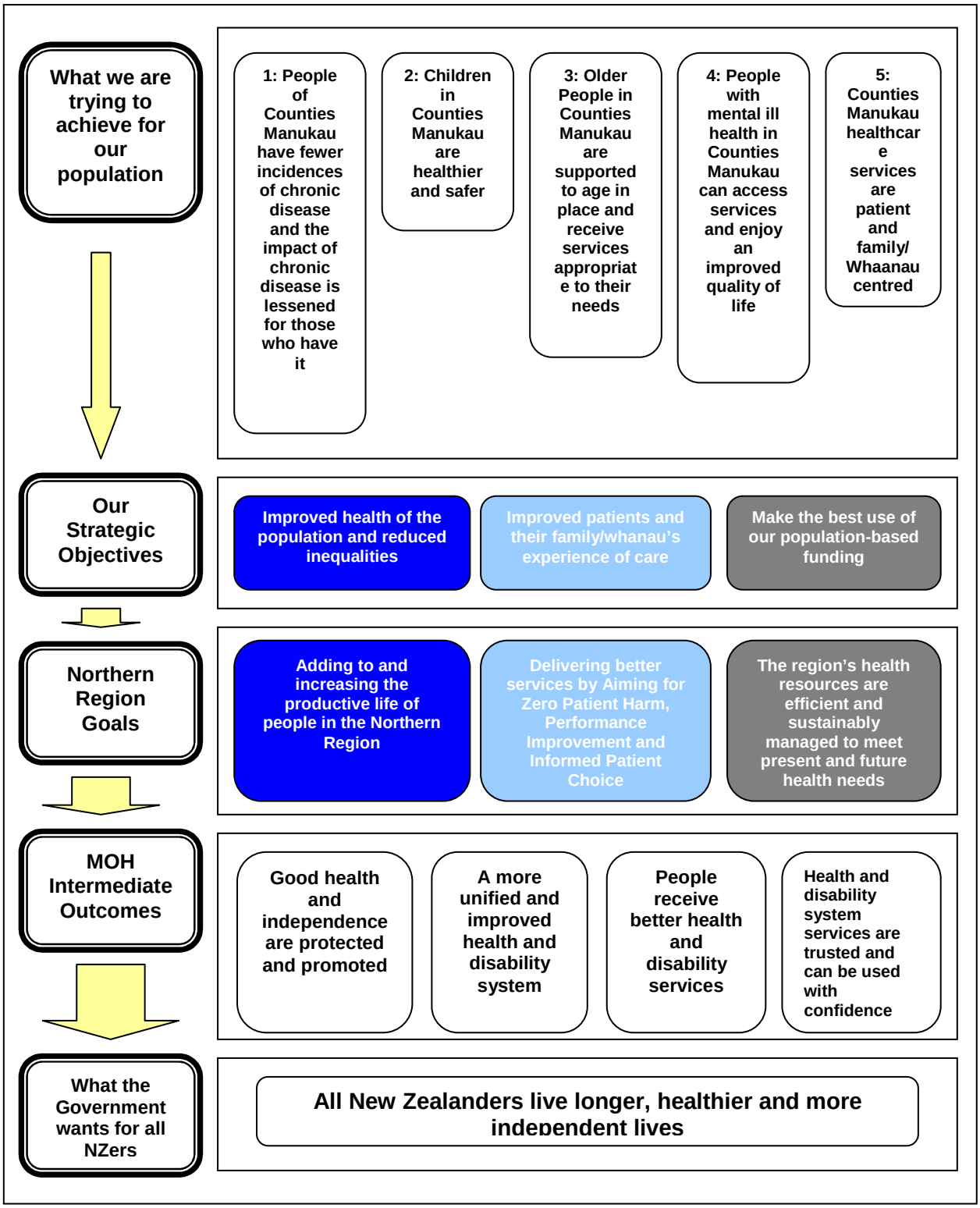


Figure 8(a): Key Impact 1

1.
People of Counties Manukau have fewer incidences of chronic disease and the impact of chronic disease is lessened for those who are affected

- Reduced incidence of disease.
- Earlier detection and better management of chronic conditions in primary care
- Reduced acute demand

We will know this is happening when:
1(a): Acute hospitalisation rates for Diabetes and Cardiovascular Disease decrease
1(b): Number of POAC patient admissions avoided at Emergency Care increase
1(c): the life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific reduce
1(d): Proportion of adults in the population who are regular smokers decrease

To achieve this impact we will also be monitoring these measures:

1(e): Rate of GP consultations for high needs populations vs non high needs populations.

1(f): Proportion of diabetics who have had an annual check (NHT6)

1(g): Proportion of diabetes who have satisfactory or better diabetes management (NHT6)

1(h): Proportion of eligible adult population who have had their CVD risk assessment in the past 5 years. (NHT6)

1(i): Number of enrolled patients who smoke and are seen by General Practice are given advice and help to quit (NHT5)

1(j): Potentially preventable hospital admissions by primary care improve (SI1)

1(k): Proportion of eligible young women who have completed the full Human Papillomavirus (HPV) vaccination course

1(l): Proportion of women aged 45 – 69 years who have had a breast screen in the last 24 months.

1(m): Proportion of women who have had a cervical smear

1(n): Number of inpatients given advice and help to quit smoking increase (NHT5)

1(o): Proportion of primary care patients screened for smoking status across all PHOs

1(p): Number of patients enrolled in Self Management programmes

1(q): Number of enrolments in Chronic Care Management (CCM) programmes

1(r): Number of enrolments in Primary Options for Acute Care (POAC) programme

1(s): Number of enrolments in Very High Intensive User (VHIU) programme

By utilising these outputs

Prevention
- Healthy Lifestyle Initiatives aimed at smoking cessation, excessive alcohol intake, improved nutrition and physical activity.
- Population based screening programmes: breast screening, cervical screening.
- Population based immunisation: HPV immunisation for cervical cancer

Early Intervention & Detection Services
- First contact primary health care services
- Structured primary care programmes like Chronic Care Management (CCM), Get Checked (Diabetes), Primary Options for Acute Care (POAC)
- After hours care.

Key Measure	1(a): Acute hospitalisation rates for Diabetes and Cardiovascular Disease

Expected Performance

Baseline (2007)		July 2012 Target	Expected performance
Maaori	3300	The impact of primary care initiatives will lead to a reduction in diabetes and CVD hospitalisations.	
Pacific	3735		
Other	1841		

Rationale

Cardiovascular disease and diabetes as noted in previous *Sections 1.1.2, 2.2.2*, and *2.4* are leading causes of illness and death in Counties Manukau and account for a substantial proportion of healthcare expenditure. Reducing the impact of cardiovascular disease and diabetes requires an integrated response from both primary and secondary care.

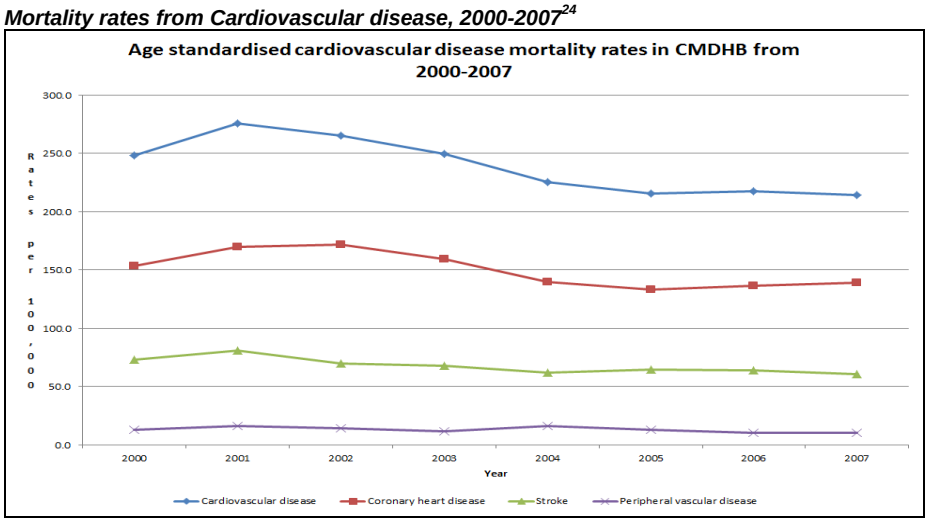
There are currently 35,000 people with diabetes in Counties Manukau (9,000 of these undiagnosed). On the current trajectory, this is expected to **double to over 72,000 by 2027**.

Diabetes Prevalence by DHB, 2010[23]

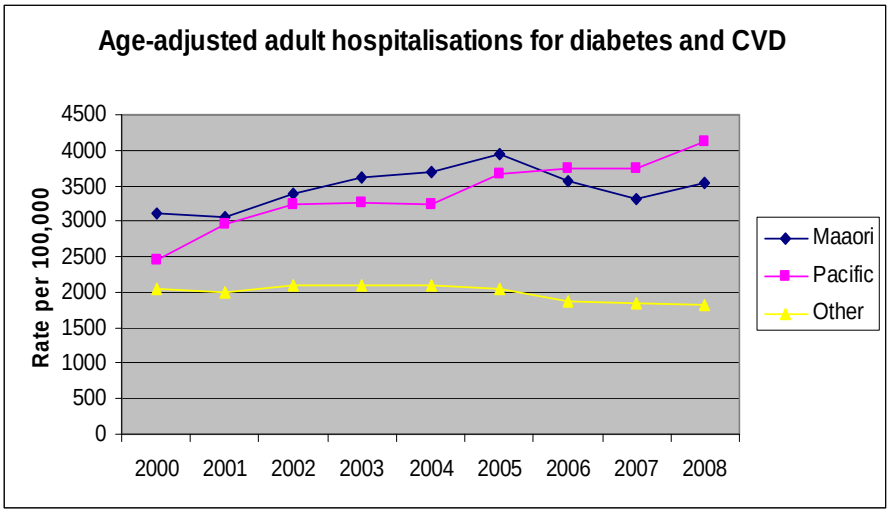
DHB area	Prevalence (95% CI)	Number of adults
Northland / Tairawhiti / Hawke's Bay / Lakes / Whanganui	4.5 (3.4–5.7)	17000
Waitemata	4.0 (2.8–5.2)	15200
Auckland	4.9 (3.4–6.3)	15600
Counties Manukau	8.2 (6.4–9.9) +	26400
Waikato	5.6 (4.2–7.0)	14400
Bay of Plenty / Taranaki / MidCentral	4.8 (3.5–6.1)	16900
Wairarapa / Hutt Valley / Capital and Coast	5.1 (3.6–6.7)	17700
Canterbury	4.4 (2.7–6.1)	16500
Nelson Marlborough / West Coast / South Canterbury / Otago / Southland	4.4 (3.0–5.8)	17400
New Zealand total	5.0 (4.6–5.5)	157100

Cardiovascular disease is the leading cause of death for people in Counties Manukau. As of 2008, there was an estimated 20, 357 people (aged 15 years and over) with cardiovascular disease (CVD) in Counties Manukau.

Mortality rates from Cardiovascular disease, 2000-2007[24]



Designing better health systems and interventions to tackle diabetes and cardiovascular disease is a key priority for the Northern Region DHBs and primary care partners and will be a major focus for the health sector for the foreseeable. In selecting a measure for this area, we recognise that evidence suggests that it is unlikely that there will be early savings for the health sector but if done correctly, there is the opportunity for reducing morbidity and premature mortality. A measure of the efficacy of the work in this area is the hospital admission rate for diabetes and CVD which we will be aiming to reduce in the long term.



Source: CMDHB Annual Report 2008/09

Key Measure	**1(b): Number of POAC patient admissions avoided at Emergency Care**

Expected Performance

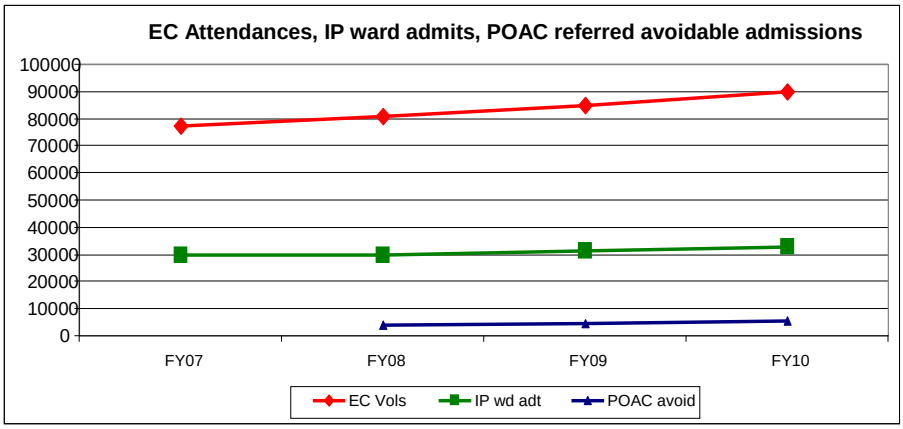
Baseline	July 2012 Target	Expected performance
6375	7650	The number of POAC patient admissions avoided at EC will *increase.*

Rationale

The challenges facing the DHB are that of growing demand in acute hospital admissions which has been rising faster than population growth since 2007. If the status quo remains, the DHB is in the position of not being able to have enough inpatient beds to meet the needs of the population it services by 2013. See *Key Risks, Section 2.4*.

The Primary Options for Acute Care (POAC) programme is one of our key strategies for reducing the demand on hospital-based care and the expansion of POAC will be one of the key areas undertaken by our primary care partners, the Greater Auckland Integrated Health Network (GAIHN).

The figure below shows the DHB's rising EC attendances (red line) and the inpatient hospital admissions (green line) against our POAC attendances avoided (blue line). We can infer that the red and green lines would be much steeper if there was no investment in POAC.



Source: CMDHB Board Dashboard

Key Measure	1(c): The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific

Expected Performance

Baseline		July 2012 Target	Expected performance
Maaori	8 years	Reduce current rate	The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific will *reduce*
Pacific	5 years		

Rationale

Life expectancy at birth is a key indicator of health status. As outlined in *Section 1.1.2*, Maaori people living in Counties Manukau have a life expectancy at birth of 8 years less than their European and Other Counties Manukau residents whilst Pacific people in Counties Manukau have a life expectancy at birth of 5 years less than their European and Other Counties Manukau residents.

These disparities are mirrored in many other markers of ill health. If the DHB is to improve the health status of the population it is important that we focus on reducing some of the disparities in health outcomes faced by our Maaori and Pacific populations. As such, the life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific is an important point of focus for the DHB as a marker of the impact we are making in reducing health inequalities.

For trend graphs see Section 1.1.2 under *Life Expectancy.*

Key Measure	1(d): Proportion of adults in the population who are regular smokers

Expected Performance

Baseline		July 2012 Target	Expected performance
Maaori	47%	37%	The proportion of adults in the population who are regular smokers will *decrease*
Pacific	30%	25%	
European	20%	18%	

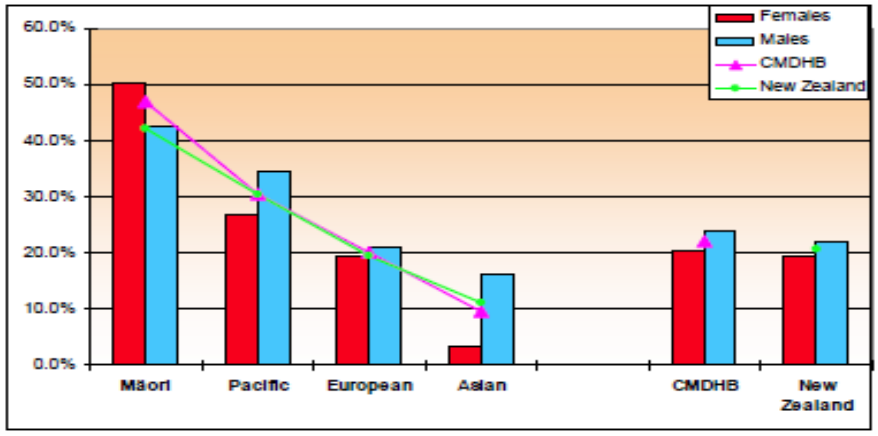
Rationale

Smoking is the 'big ticket item' contributing to not only smoking related lung diseases such as lung cancer but also to the major disease areas: diabetes, CVD, infant mortality and all other causes of mortality as outlined in *Section 1.1.2.*

This measure has been chosen as a key measure because smoking is the single most important preventable cause of death and therefore, strategies to decrease the number of smokers in the community and/or to reduce the number initiating smoking has the ability to make an impact on the community's health and well being and also on reducing health inequities between Maaori and Pacific with non-Maaori and non-Pacific in Counties Manukau.

Counties Manukau has the highest smoking rates in New Zealand. 12% of the total smokers in the country are in the district.

Prevalence of regular smokers, aged 15+, by gender and ethnicity, 2006[25]

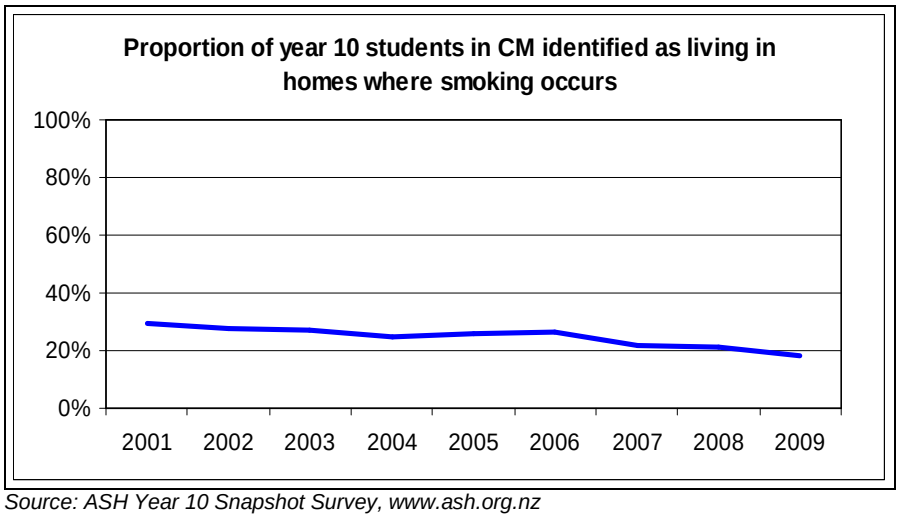


Source: CMDHB Board Dashboard

CMDHB is also committed to addressing high maternal smoking rates in order to improve child health outcomes in Counties Manukau and reducing the initiation of smoking amongst high school students.

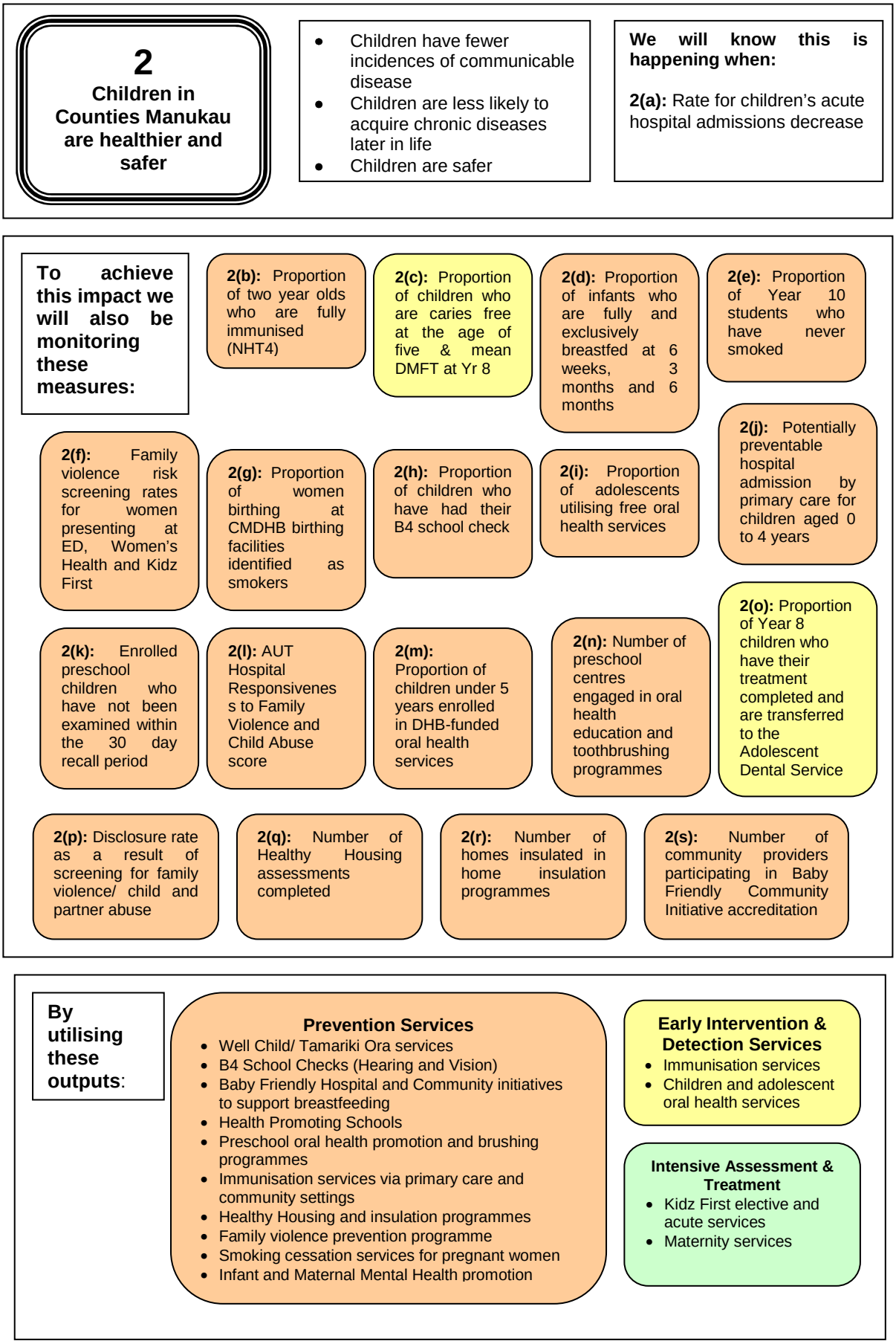
Ensuring that children grow up in a smokefree environment is important in preventing lower

respiratory tract infection and smoke exposure is a significant risk factor for Sudden Unexplained Infant Death (SUDI). *See Key Impact 2 – Children in Counties Manukau are healthier and safer*



Source: ASH Year 10 Snapshot Survey, www.ash.org.nz

Figure 8(b): Key Impact 2



Key Measure

2(a): Rates for children's acute hospital admissions

Expected Performance

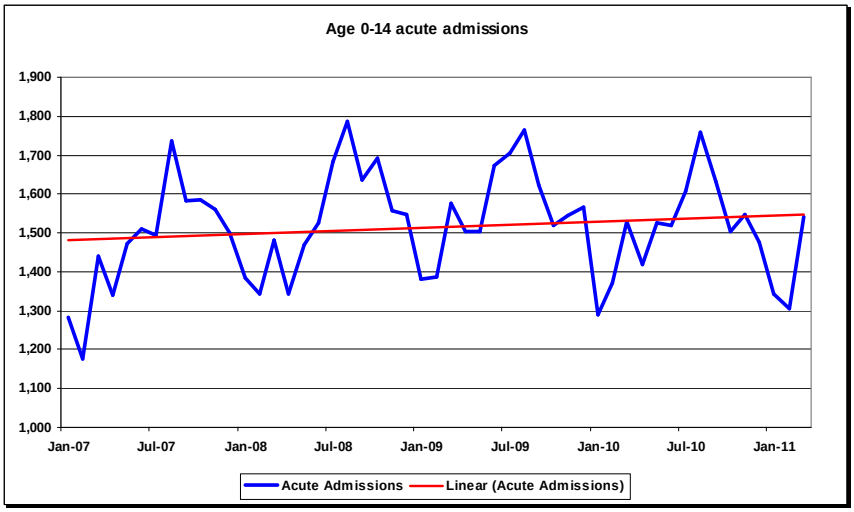
Baseline		July 2012 Target	Expected performance
Maaori	3,402	Maintain or lower current rate	Rates for children's acute hospital admissions will *decrease*
Pacific	6,045		
Other	5,188		

Rationale

We have chosen our children's hospital admission rate as a headline measure as hospital admission rates are a good indicator for whether our child health initiatives and programmes including primary care, intersectoral working and public health measures are making an impact on improving child health and reducing the number of children being admitted to hospital for preventable conditions like skin infections, respiratory disease and rheumatic fever.

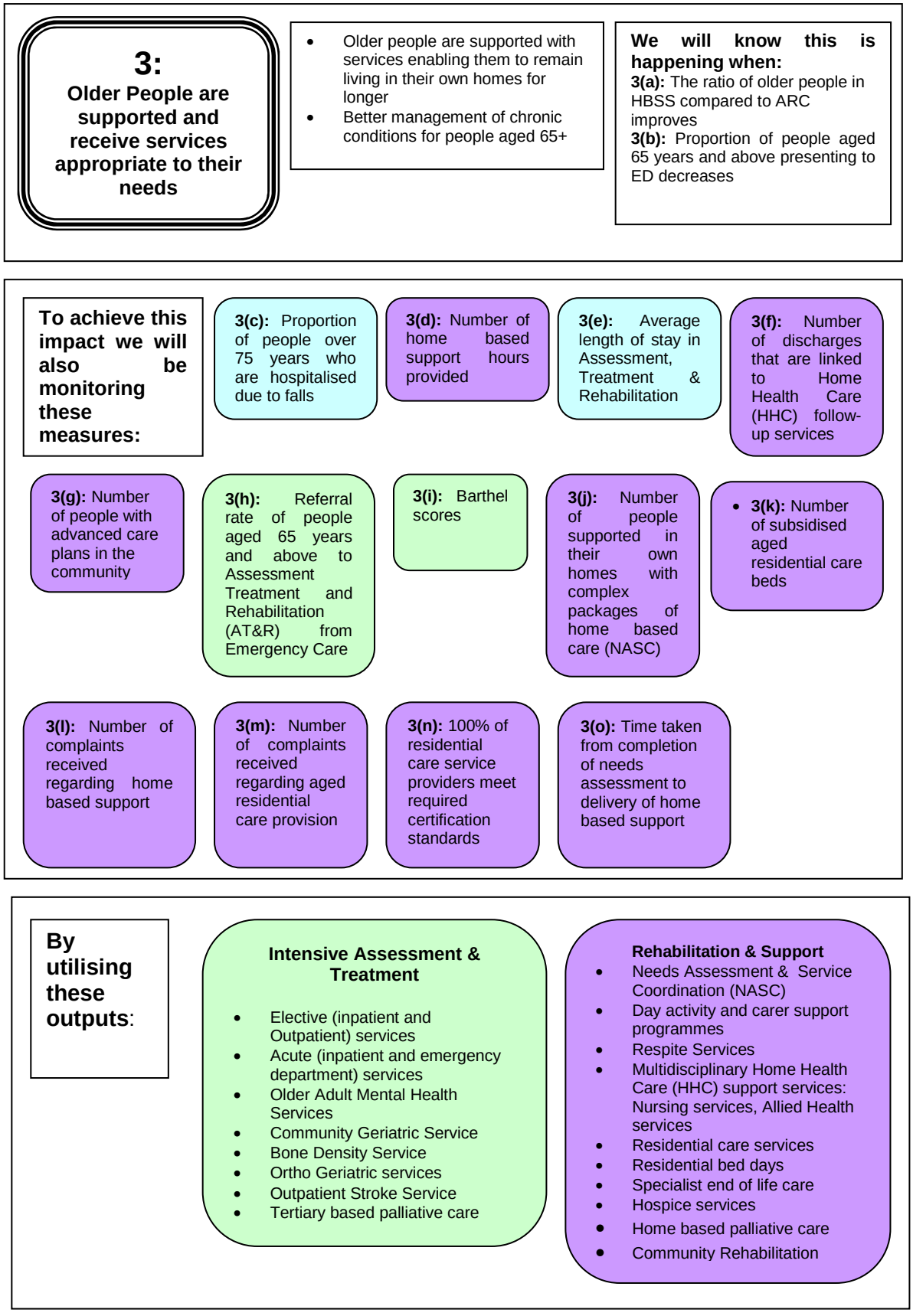
The linear trend for child acute admissions has been on the rise over the past few years This is due to an increase in child Emergency admissions, and birthing admissions. However, in 2010/11 we are starting to see acute admissions decrease but emergency care presentations remain high.

Overall hospitalisation rates for children and young people residing in CMDHB are above the national average for infectious diseases such as lower respiratory infections, with the quality of housing being recognised as a risk factor.



Source: Counties Manukau DHB Decision Support Service

Figure 8(c): Key Impact 3



Key Measure

3(a): The ratio of older people in home based support services (HBSS) compared to aged residential care (ARC)

Expected Performance

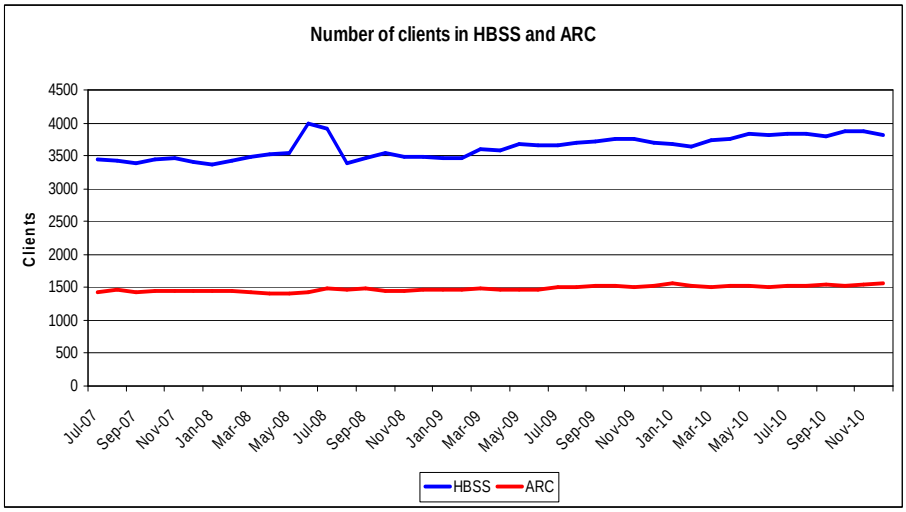
Baseline		July 2012 Target	Expected performance
HBSS	71%	Increase rate	The proportion of people receiving HBSS will *increase*, thereby *reducing* the number of people in ARC.
ARC	29%	Decrease rate	

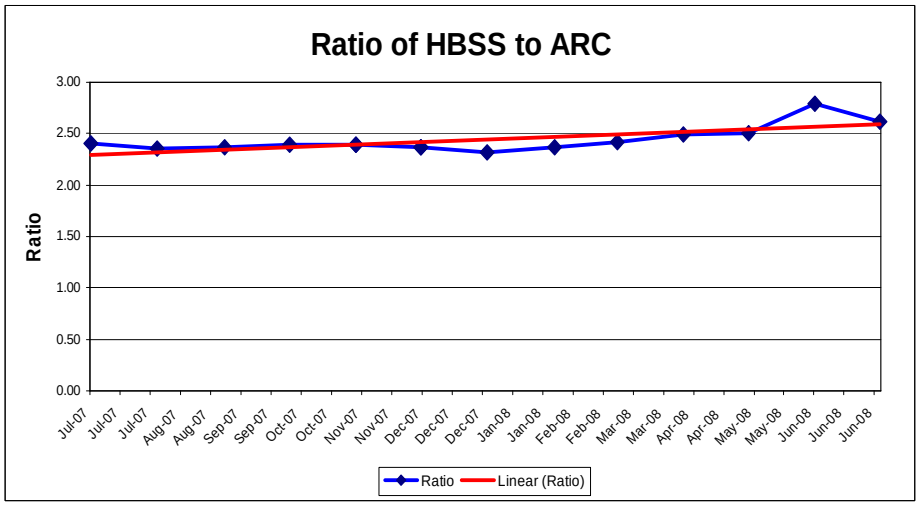
Rationale

We support the Government goal for older people of 'ageing in place' and that older people are supported to help them maintain independence in their own homes where this is appropriate and possible.

As such, we want to increase the ratio of the number of older people receiving Home Based Support Services to the number of older people receiving Aged Residential Care. This is supported by our strategic direction for older people which seeks to improve and expand the range of home and community based services available for supporting our older population, whilst also ensuring that we have enough beds for older people who need to be in long term residential care.

To date, CMDHB has seen steady growth in people using home based support services over the last few years, while residential care numbers are stable. In addition the ratio of spending on the two areas has been gradually shifting towards home based services. We expect current service development plans to enhance and strengthen these strategic directions

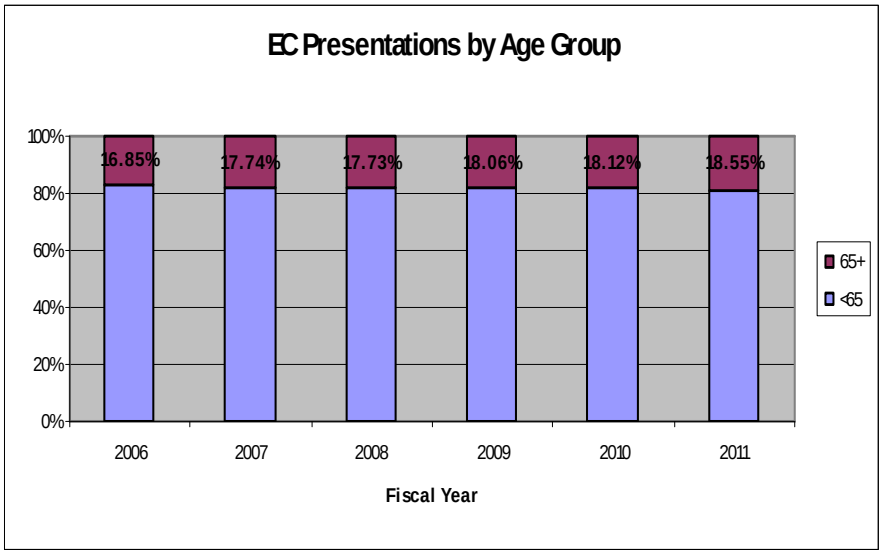




Source: Counties Manukau DHB Health of Older People Service

<table>
<tr><td>Key Measure</td><td>3(b): Proportion of ED presentations by 65+ year olds</td></tr>
<tr><td>Expected Performance</td><td>
<table>
<tr><th>Baseline</th><th>July 2012 Target</th><th>Expected performance</th></tr>
<tr><td>18.32%</td><td>Decrease current rate</td><td>The proportion of ED presentations by 65+ year olds will decrease</td></tr>
</table>
</td></tr>
<tr><td>Rationale</td><td>
A key objective for the DHB is to reduce demand for our hospital services. With our increasingly ageing population, the burden of chronic conditions like cardiovascular disease, Chronic Obstructive Pulmonary disease (COPD) and co-morbidities will inevitably increase leading to more presentations at ED, more hospital admissions and thus, placing huge stress on the health infrastructure and resources.

Counties Manukau DHB is actively working with regional primary care partners and with local residential care providers and health of older people services to ensure that there is better management of chronic conditions for older people in primary care so that there are fewer presentations at ED.



Source: Counties Manukau DHB Decision Support Service
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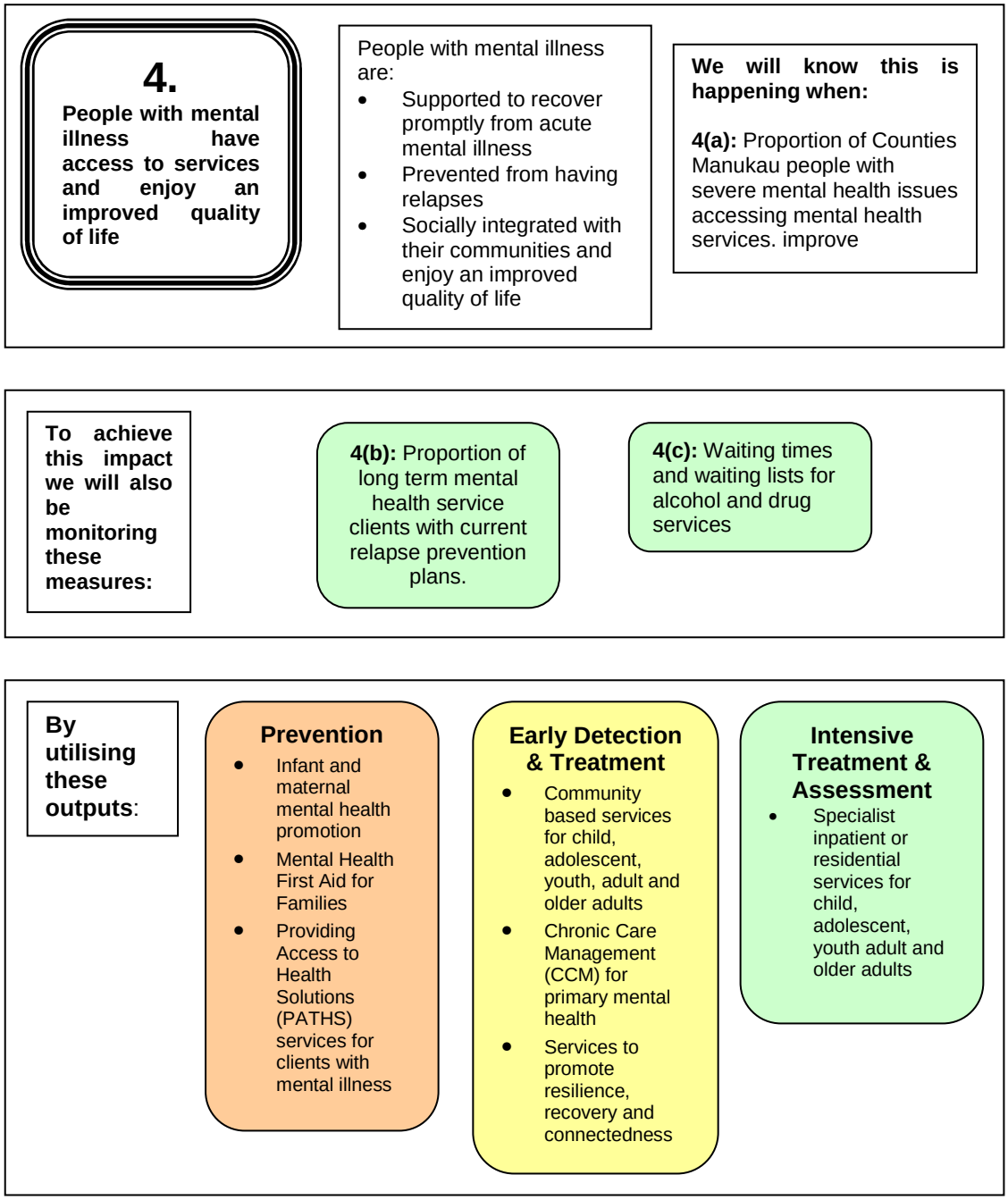
Figure 8(d): Key Impact 4



Key Measure: **4(a): Rate of people with severe mental illness accessing mental health services**

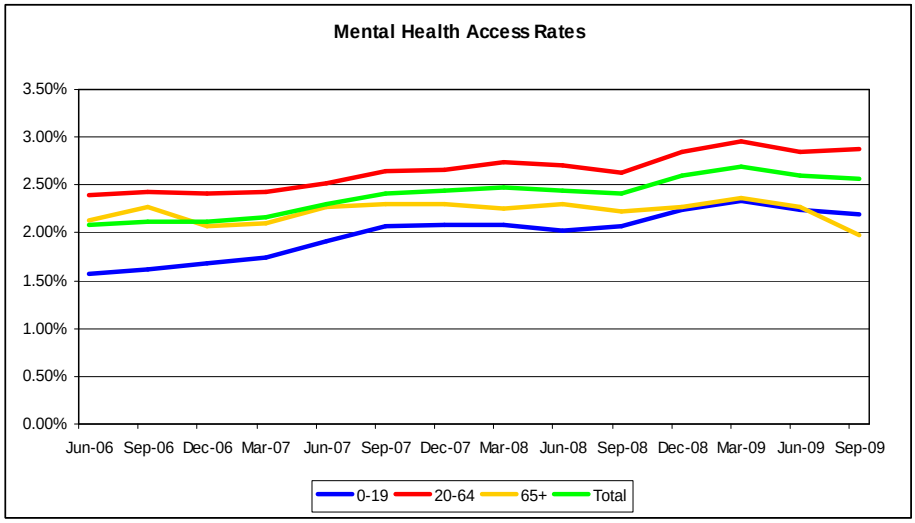
Expected Performance

Baseline			July 2012 Target	Expected performance
Age 0 -19	Maaori	3.95%	4.00%	Mental health access rates will *increase*.
	Other	2.65%	2.67%	
	Total	2.96%	2.98%	
Age 20 - 64	Maaori	6.66%	6.66%	
	Other	2.89%	2.89%	
	Total	3.43%	3.43%	
Age 65+	Total	2.63%	2.63%	

Rationale

Mental health access rates is a proxy measure for determining the impact of the DHB's mental health services delivery on improving the quality of life for members of our population who are suffering from severe mental illness or issues with alcohol or drug addiction .

Mental health access rates have been gradually increasing in the district for all age groups with the exception of the 65+ age group which decreased in the last financial year. The access rate across all age groups for the DHB's Mental Health Services was 3.04% for the reporting period ending 31 March 2010. The New Zealand average for the same period was 2.46%.



Source: Counties Manukau DHB Mental Health Services

Figure 8(e): Key Impact 5

5.
Counties Manukau healthcare services are patient and family/ Whaanau centred

- Patients experience fewer adverse clinical events whilst under our care.
- Patients are referred, seen, treated and managed in a timely and appropriate manner.
- Patients and their families have improved health literacy and are involved in the management and care of their own health.
- Patients have greater trust and confidence in our services.

We will know this is happening when:
5(a): Patient satisfaction with services (rating it Good or Very Good) improves.
5(b): Rate of acute readmissions (OS8) is maintained or reduced

To achieve this impact we will also be monitoring these measures:

5(c): ED waiting times (NHT)

5(d): Standardised intervention rate for elective surgery (NHT2)

5(e): Central Line Acquired Bacteraemia rates per 1,000 line days.

5(f): Falls per 1,000 admissions.

5(g): Proportion of patients affected by hospital acquired pressure injuries.

5(h): Cancer (radiotherapy) waiting times (NHT3)

5(i): Cancer (chemotherapy) waiting times

5(j): The rate of adverse drug events

5(k): Proportion of Maaori and Pacific 'Did Not Attend' (DNA) at outpatient clinics

5(l): Elective surgical and medicine specialities are compliant with all eight Elective Services Patient Indicators (ESPI)

5(m): Elective and arranged day surgery rate (OS6)

5(n): Day of Surgery admission (DOSA) rate 9OS7)

5(o): Theatre utilisation rate (OS5)

5(p): Elective and arranged inpatient length of stay (OS3)

5(q): Acute inpatient length of stay (OS4)

5(r): More than 80% of First Specialist Assessment medical patients are seen within their designated priority timeframe

5(s): All cancer patients who need a specialist assessment will have this within 4 weeks from date of referral.

By utilising these outputs:

Early Intervention & Detection Services
- Primary health care services
- Primary community care programmes

Intensive Assessment & Treatment
- Elective medical and surgical services (inpatient and outpatient)
- Acute inpatient and emergency department services.

Key Measure	5(a): Patient satisfaction with services (rating it Good or Very Good)

Expected Performance

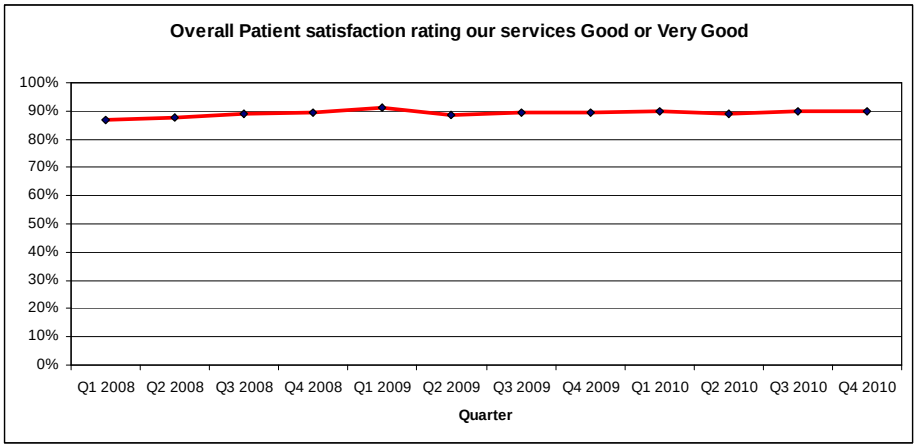
Baseline	July 2012 Target	Expected performance
90%	> 90%	Patient satisfaction with services will *improve*

Rationale

Overall patient satisfaction with hospital inpatient and outpatient services remain high with more than 83% of patients rating our services 'Good or Very Good' in the last two years.

Outpatient satisfaction with services has had smaller levels of variance over the years and remained higher than inpatient satisfaction, reaching the target of 90% satisfaction. Overall, inpatient satisfaction has been increasing though variance between quarters remains large. While still not at the 90% target level of patient satisfaction, CMDHB is confident this will be achieved in the upcoming year.

Patient Satisfaction Survey



Source: CMDHB Board Dashboard

Key Measure	5(b): Rate of acute readmissions

Expected Performance

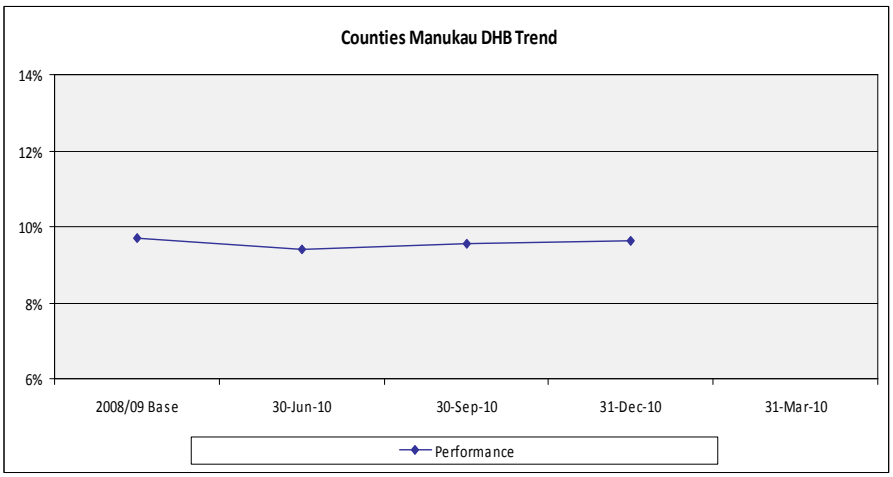
Baseline	July 2012 Target	Expected performance
10.37%	9.55%	The rate of acute readmissions will *improve*

Rationale

Monitoring acute readmission rates allows the DHB to determine an average rate for readmissions due to unforeseen medical circumstance. Unplanned acute readmissions above this average rate may indicate short comings in quality of care such as early discharge, inadequate home support and efficiency of hospital care. Furthermore, acute readmissions to hospital are correlated to shorter lengths of stay.

Acute readmissions are measured as a standardised acute readmission rate. This means the readmission rate is adjusted to account for case mix and different population composition between DHBs to allow for comparison.

CMDHB's acute readmissions rate is better than the national average and has remained relatively unchanged over the last two years but overall is trending downwards.



4.2 OUTPUT CLASS

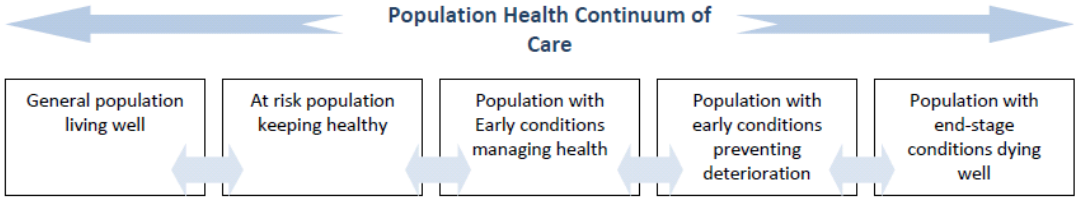
To provide further structure to the outputs, they have been organised into four **Output Class** categories:

- Prevention Services
- Early Detection and Management
- Intensive Assessment and Treatment
- Rehabilitation and Support

Figure 7 below sets out the relationship between Output Classes and specific stages within the Population Health Continuum of Care, that is, the range of states of health that is to be found amongst the population.

Tables showing the level of input the DHB has allocated to each output class is included in Section 4.2.1 below.

Figure 7: Relationship between output classes and specific stages within the Population Health Continuum of Care



Output Class 1: Prevention Services
Prevention services are those used to support healthy living, educate communities on health issues and services and safe-guard against preventable diseases.

Output Class 2: Early Detection and Management
Early detection and Management services support those with health problems to promote better quality of life and, if possible, resolve these health issues.

Output Class 3: Intensive Assessment and Treatment
Intensive assessment and treatment services are those which cannot be provided within a community setting due to the severity of health condition and subsequent treatment required.

Output Class 4: Rehabilitation and Support
Rehabilitation and support services are delivered following a needs assessment process and coordination input by Needs Assessment and Service Coordination (NASC) services for a range of services including palliative care services, home based support services and residential care services.

4.2.1 INPUT LEVELS AGAINST THE FOUR OUTPUT CLASSES 2009/10 – 2013/14

Level of input against all four output classes

Total	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**1,216,354**	**1,277,653**	**1,328,957**	**1,395,344**	**1,477,047**
Personnel costs	427,485	451,327	479,325	503,269	524,365
Outsourced Services	50,273	52,674	50,028	52,527	54,729
Clinical Supplies	94,442	101,702	98,975	103,938	115,933
Infrastructure & Non-Clinical Supplies	95,178	95,867	100,697	105,729	125,484
Other	548,813	573,134	599,889	629,857	656,488
Total costs	**1,216,191**	**1,274,704**	**1,328,914**	**1,395,320**	**1,476,999**
Surplus (Deficit)	**163**	**2,949**	**43**	**24**	**48**

Level of input for Prevention Services

Prevention	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**22,834**	**20,860**	**18,801**	**19,742**	**20,729**
Personnel costs	3,049	3,251	3,295	3,460	3,633
Outsourced Services	2,584	1,843	1,938	2,035	2,137
Clinical Supplies	941	1,631	1,792	1,882	1,976
Infrastructure & Non-Clinical Supplies	2,119	2,321	1,615	1,696	1,781
Other	14,141	11,814	10,161	10,669	11,202
Total costs	**22,834**	**20,860**	**18,801**	**19,742**	**20,729**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Level of input for Early Detection and Management services

Early Detection	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**207,374**	**207,208**	**177,150**	**186,008**	**195,308**
Personnel costs	-	-	-	-	-
Outsourced Services	-	-	-	-	-
Clinical Supplies	-	-	-	-	-
Infrastructure & Non-Clinical Supplies	-	-	-	-	-
Other	207,374	207,208	177,150	186,008	195,308
Total costs	**207,374**	**207,208**	**177,150**	**186,008**	**195,308**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Level of input for Intensive Assessment and Treatment services

Intensive	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**900,847**	**962,092**	**1,036,348**	**1,088,103**	**1,154,444**
Personnel costs	424,436	448,076	476,030	499,809	520,732
Outsourced Services	47,689	50,831	48,090	50,492	52,592
Clinical Supplies	93,501	100,071	97,183	102,056	113,957
Infrastructure & Non-Clinical Supplies	93,059	93,546	99,082	104,033	123,703
Other	241,999	266,619	315,920	331,689	343,412
Total costs	**900,684**	**959,143**	**1,036,305**	**1,088,079**	**1,154,396**
Surplus (Deficit)	**163**	**2,949**	**43**	**24**	**48**

Level of input for Rehabilitation and Support services

Rehabilitation	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**85,299**	**87,493**	**96,658**	**101,491**	**106,566**
Personnel costs					
Outsourced Services					
Clinical Supplies					
Infrastructure & Non-Clinical Supplies					
Other	85,299	87,493	96,658	101,491	106,566
Total costs	**85,299**	**87,493**	**96,658**	**101,491**	**106,566**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

4.2.2 STATEMENT OF FORECAST SERVICE PERFORMANCE BY OUTPUT CLASS

Key for the 'Reference' column in the Output Class tables:

NHT	National Health Target (1 = ED length of stay, 2 = Electives, 3 = Cancer waiting times, 4 = Immunisations, 5 = Smoking cessation, 6 = Diabetes and Cardiovascular disease detection and management)
OS	Ownership Dimension (Indicator of DHB Performance, see Appendix 3)
PP	Policy Priority (Indicator of DHB Performance, see Appendix 3)
SI	Systems Integration (Indicator of DHB Performance, see Appendix 3)
MHP	Maaori Health Plan
NRHP	Northern Region Health Plan outcome indicator (numbers link to the NRHP intervention logic, see Appendix 5)

Output Class: Prevention Services

Prevention 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 treatment services which repair/support health and disability dysfunction.
Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They 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, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>To achieve this outcome</th></tr>
<tr><td colspan="6">Smoking Cessation</td></tr>
<tr>
<td>Provide smoking cessation advice and support for hospitalised patients and primary care patients. (NRHP 1.18)

Train clinical staff to deliver smoke-free interventions. (NRHP 1.18)

Fund community-based programmes to support people living smoke-free and reduce smoking initiation (NRHP 1.18)

Support smoking cessation programmes in primary care and community-based settings (NRHP 1.18)</td>
<td>Smoking cessation advice and support delivered by health professionals in secondary and primary care

Quality:
Proportion of hospitalised smokers provided with advice and help to quit
<table>
<tr><td>Baseline (Q2, 2010/11)</td><td>Target 2011/12</td></tr>
<tr><td>66%</td><td>95%</td></tr>
</table>
Proportion of enrolled primary care patients who are smokers and are seen in General Practice are provided with advice and help to quit
<table>
<tr><td>Baseline (Q2, 2010/11)</td><td>Target 2011/12</td></tr>
<tr><td>17%</td><td>90%</td></tr>
</table>
Smokefree training and support to community health services and providers

Quality:
Proportion of primary care patients screened for smoking status across all PHOs
<table>
<tr><td>Baseline (2010)</td><td>Target 2011/12</td></tr>
<tr><td>52%</td><td>80%</td></tr>
</table>
</td>
<td>NHT5 1(n)

NHT5 1(i)

1(o)</td>
<td>These outputs will lead to a reduced proportion of smokers in the population and reduced incidence and impact of smoking related harm. These are measured by:

Percentage of adult smokers in the population:
<table>
<tr><td></td><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>47%</td><td>37%</td></tr>
<tr><td>Pacific</td><td>30%</td><td>25%</td></tr>
<tr><td>European</td><td>20%</td><td>18%</td></tr>
</table>
Percentage of Year 10 students who never smoked:
<table>
<tr><td></td><td>Baseline (2008)</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>30.7%</td><td rowspan="3">Maintain or lower current rate.</td></tr>
<tr><td>Pacific</td><td>52.1%</td></tr>
<tr><td>European</td><td>65.1%</td></tr>
</table>
</td>
<td>NRHP 1.8

MHP

1(d)

2(e)</td>
<td>Improved health of the population and reduced inequalities</td>
</tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>To achieve this outcome</th></tr>
<tr><td></td><td>Programmes for pregnant women and Maaori and Pacific people.

One region wide comprehensive cessation service for each of the following:
Pregnant women and their whaanau (additional to the MOH funded service)
Maaori people (additional to current Aukati Kai Paipa service)
Pacific people</td><td></td><td>Percentage of women birthing at a CMDHB birthing facility identified as currently smoking.<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>System to measure baseline currently under development.</td><td>Average of 15% across all ethnicities</td></tr></table></td><td>2(g)</td><td></td></tr>
<tr><td colspan="6">Infant Health</td></tr>
<tr><td>Breastfeeding

Collaborate with local providers and fund initiatives to encourage and promote breastfeeding. (NRHP 1.4)</td><td>Breastfeeding and promotion services:

Quantity:
Number of community providers participating in Baby Friendly Community Initiative accreditation<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td colspan="2">This is a new initiative and we are aiming to get 3 community providers participating in BFCI accreditation this financial year</td></tr></table>
The Baby Friendly Community Initiative (BFCI) aims to protect, promote and support breastfeeding for healthy mothers and babies</td><td>2(s)</td><td>Child health will be improved thus reducing the risk of chronic disease, obesity and promoting healthy growth. This will be measured by:

Infants exclusively and fully breastfed at:<table><tr><th></th><th></th><th>By July 2012</th></tr><tr><td rowspan="4">6 weeks</td><td>Maaori</td><td>62%</td></tr><tr><td>Pacific</td><td>67%</td></tr><tr><td>Other</td><td>70%</td></tr><tr><td>Total</td><td>67%</td></tr><tr><td rowspan="4">3 Months</td><td>Maaori</td><td>46%</td></tr><tr><td>Pacific</td><td>51%</td></tr><tr><td>Other</td><td>59%</td></tr><tr><td>Total</td><td>55%</td></tr><tr><td rowspan="4">6 Months</td><td>Maaori</td><td>18%</td></tr><tr><td>Pacific</td><td>22%</td></tr><tr><td>Other</td><td>29%</td></tr><tr><td>Total</td><td>26%</td></tr></table></td><td>NRHP 1.4
MHP

SI7
2(d)</td><td>Improved health of the population and reduced inequalities</td></tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>To achieve this outcome</th></tr>
<tr>
<td>Immunisation

Fund a range of providers to deliver immunisation services through general practice, outreach, school and other community setting (NRHP 1.4)</td>
<td>Immunisation services (through general practice, outreach, school and other community settings).

Proportion of two year olds fully vaccinated:
<table>
<tr><td></td><td>Baseline</td><td>2011/12 Target</td></tr>
<tr><td>Maaori</td><td>80%</td><td>95%</td></tr>
<tr><td>Pacific</td><td>90%</td><td>95%</td></tr>
<tr><td>Total</td><td>87%</td><td>95%</td></tr>
</table>
</td>
<td>NHT 4
2(b)</td>
<td rowspan="3">Immunisation will reduce the incidence of vaccine preventable and prophylaxis preventable diseases among children.

Well child services promote the early detection and resolution of health issues.

Improving living conditions leads to a reduction in health conditions caused by poor housing.

These impacts will be measured by:

Acute hospitalisation rates for children aged 0 to 4 year
<table>
<tr><td></td><td>Baseline</td><td>July 2011/12</td></tr>
<tr><td>Maaori</td><td>3,402</td><td rowspan="3">Maintain or lower current rate</td></tr>
<tr><td>Pacific</td><td>6,045</td></tr>
<tr><td>Other</td><td>5,188</td></tr>
</table>

Ambulatory Sensitive Hospitalisation rate[26] for children aged 0 to 4 years
<table>
<tr><td></td><td>Baseline</td><td>July 2011/12</td></tr>
<tr><td>Maaori</td><td>96.0</td><td>95.0</td></tr>
<tr><td>Pacific</td><td>98.4</td><td>95.0</td></tr>
<tr><td>Other</td><td>74.5</td><td>95.0</td></tr>
</table>
</td>
<td rowspan="3">2(a)

SI 1
2(j)</td>
<td rowspan="3"></td>
</tr>
<tr>
<td>Well Child/ Tamariki Ora

Fund Well Child/ Tamariki Ora services to support new mothers and their infants (NRHP 1.4)</td>
<td>Well child checks and home visits
Quantity:
B4 School Checks
<table>
<tr><td></td><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>Vision and Hearing (2 components)</td><td>722</td><td rowspan="3">7076 combined</td></tr>
<tr><td>Nurse (Well child – 6 components)</td><td>2213</td></tr>
<tr><td>Children who have 1 component missing from their check</td><td>100</td></tr>
</table>
</td>
<td>2(h)</td>
</tr>
<tr>
<td>Living Conditions

Work with Housing New Zealand and other non-governmental agencies to improve the housing conditions in the community[27]</td>
<td>Joint assessments with Housing NZ
Quantity:
Completed health and housing assessments
<table>
<tr><td>Baseline (YTD March 2011)</td><td>By July 2012</td></tr>
<tr><td>540</td><td>320</td></tr>
</table>

Home insulation programmes
Number of homes insulated
<table>
<tr><td>Programme</td><td>By July 2012</td></tr>
<tr><td>Snug Homes</td><td>500</td></tr>
<tr><td>Warn Up CM</td><td>1000</td></tr>
</table>
</td>
<td>2(q)

2(r)</td>
</tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>To achieve this outcome</th></tr>
<tr><td colspan="6">Family Violence Prevention</td></tr>
<tr><td>Deliver family violence prevention (VIP) programme</td><td>Training of staff in designated areas (Women's Health, Kidz First and Emergency Department) to screen for VIP risk

Proportion of women presenting in Emergency Care who are screened for VIP risk
<table><tr><td></td><td>Baseline</td><td>By July 2012</td></tr><tr><td>EC</td><td>19%</td><td>100%</td></tr></table>
AUT Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit Score:
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>173/200</td><td>140/200</td></tr></table></td><td>2(f)

PP14
2(l)</td><td>Early intervention for families and children in situations of domestic violence or child abuse, measured by:

Increase in disclosures as a result of screening
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>14%</td><td>Increase current rate</td></tr></table></td><td></td><td rowspan="3">Improved health of the population and reduced inequalities</td></tr>
<tr><td colspan="6">Population based screening</td></tr>
<tr><td>Provide breast screening services.</td><td>Breast screening for women aged 45 – 69 years

Quantity:
Women aged 45 – 69 years who have had a breast screen in the last 24 months
<table><tr><td></td><td>Baseline Q2, 2010/11</td><td>By July 2012</td></tr><tr><td>Maaori</td><td>55.5%</td><td rowspan="3">Total: 70%</td></tr><tr><td>Pacific</td><td>62.5%</td></tr><tr><td>Total</td><td>62.9%</td></tr></table></td><td>1(l)</td><td>Improved outcomes for women through earlier detection of breast cancer. This is measured by:

Breast cancer mortality:
<table><tr><td colspan="2">Baseline (2003- 2005, 25+ years, age standardised rate per 100,000)</td></tr><tr><td>Maaori</td><td>66.3</td></tr><tr><td>Pacific</td><td>41.8</td></tr><tr><td>Asian</td><td>16.3</td></tr><tr><td>European/Other</td><td>30.0</td></tr></table>Source: CMDHB Health Needs Assessment, 2008</td><td></td></tr>
<tr><td>Fund primary care providers to deliver cervical screening (MHP)</td><td>Cervical smears for women aged 20 – 70 years

Quantity:
Women aged 20 - 70 years who have had a cervical smear in the last three years.</td><td>1(m)</td><td>Improved outcomes for women through earlier detection of cervical abnormalities. Measured by:

Cervical cancer rates</td><td></td></tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>To achieve this outcome</th></tr>
<tr><td></td><td><table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>67%</td><td>>75%</td></tr></table></td><td></td><td><table><tr><td colspan="2">Baseline (2003- 2005, 25+ years, age standardised rate per 100,000)</td></tr><tr><td>Maaori</td><td>10.4</td></tr><tr><td>Pacific</td><td>12.8</td></tr><tr><td>European/Other</td><td>2.0</td></tr></table>Source: CMDHB Health Needs Assessment, 2008</td><td></td><td></td></tr>
<tr><td colspan="6">HPV immunisation</td></tr>
<tr><td>Fund school based HPV vaccination programme. (NRHP 1.4)</td><td>Schools providing the HPV vaccination programme.

Proportion of eligible young women who have completed the full human papillomavirus (HPV) vaccination course through the school based programme<table><tr><td></td><td>Year to Date, Dec2010</td><td>By July 2012</td></tr><tr><td>Dose 3</td><td>45%</td><td>60%</td></tr></table></td><td>1(k)</td><td>Reduced incidence of cervical cancer measured by:

Cervical cancer rates (see above)</td><td></td><td>Improved health of the population and reduced inequalities</td></tr>
</table>

Output Class: Early Detection and Management services.

Early detection and management services 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. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

<table>
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<tr><td colspan="6">Primary Care</td></tr>
<tr>
<td>Create greater access to primary care for high needs patients.

Provide early detection services for chronic conditions. (National Health Target) (NRHP 1.16, 1.17)

Fund education programmes to support patients with long term conditions. (NRHP 1.16, 1.17)</td>
<td>Increased consults for high needs patients.
Rate of GP consultations for high needs population compared with non-high needs population
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>1.03</td><td>> 1</td></tr>
</table>
After hours care
The implementation of ARAHN (Auckland Regional After Hours Network) including a number of clinics open until 10pm with lower maximum co-pays for CSC and HUHC holders

CVD risk assessments.
Proportion of the eligible adult population who have had their CVD risk assessment in the past 5 years
<table>
<tr><td></td><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>75%</td><td>90%</td></tr>
<tr><td>Pacific</td><td>76%</td><td>90%</td></tr>
<tr><td>Other</td><td>83%</td><td>90%</td></tr>
<tr><td>Total</td><td>79%</td><td>90%</td></tr>
</table>
Self Management (SM) Programmes.
Quantity:
Number of additional patients enrolled in SM programme.</td>
<td>1(e)

NHT6
1(h)

1(p)</td>
<td>Reduced avoidable admissions and acute demand for conditions that can be effectively managed in general practice. This will be measured by:

Ambulatory Sensitive (Avoidable) Hospitalisations: 0-74 years
<table>
<tr><td></td><td>Baseline</td><td>Target</td></tr>
<tr><td>Maaori</td><td>112</td><td>103</td></tr>
<tr><td>Pacific</td><td>110</td><td>96</td></tr>
<tr><td>Other</td><td>106</td><td>100</td></tr>
</table>
45-64 years:
<table>
<tr><td></td><td>Baseline</td><td>Target</td></tr>
<tr><td>Maaori</td><td>117</td><td>119</td></tr>
<tr><td>Pacific</td><td>151.5</td><td>98</td></tr>
<tr><td>Other</td><td>134.6</td><td>115</td></tr>
</table>
0-4 years: See previous section

Number of Primary Options for Acute Care (POAC) patient admissions avoid ED
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>6375</td><td>7650</td></tr>
</table>
</td>
<td>SI1

1(j)

1(b)</td>
<td>Improved health of the population and reduced inequalities</td>
</tr>
</table>

<table>
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<tr>
<td>Fund services to provide structured evidence based care to people with Chronic Conditions (NRHP 1.14, 1.16, 1.17).

Fund services and programmes to reduce acute demand (NRHP 2.1)</td>
<td>
<table>
<tr><td>Baseline (YTD Jan 2011)</td><td>By July 2012</td></tr>
<tr><td>513</td><td>850</td></tr>
</table>
Structured primary care programmes for management of chronic conditions

Uptake of programmes aimed at managing people with chronic conditions in primary care and reducing reliance on hospital based services

Chronic Care Management (CCM) Programmes.
- Diabetes
- Depression
- CVD
- COPD
- CHF
Quantity:
Number of enrolments in all CCM programmes
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>18,500</td><td>>19,500</td></tr>
</table>
Diabetes management
Timeliness:
Proportion of people with diabetes who have had an annual check
<table>
<tr><td></td><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>78.5%</td><td>99%</td></tr>
<tr><td>Pacific</td><td>68.4%</td><td>90%</td></tr>
<tr><td>Other</td><td>52%</td><td>73%</td></tr>
<tr><td>Total</td><td>60.6%</td><td>82%</td></tr>
</table>
Proportion of people with diabetes who have satisfactory or better diabetes management.
<table>
<tr><td></td><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>53%</td><td>54%</td></tr>
<tr><td>Pacific</td><td>45%</td><td>49%</td></tr>
<tr><td>Other</td><td>70%</td><td>71%</td></tr>
<tr><td>Total</td><td>58%</td><td>60%</td></tr>
</table>
</td>
<td>1(q)

NHT6
1(f)

NHT6
1(g)

1(r)</td>
<td>Hospitalisation rate for diabetes and cardiovascular disease (aged adjusted).
<table>
<tr><td></td><td>Baseline (2007)</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>3300</td><td rowspan="3">The impact of primary care initiatives will lead to a reduction in diabetes and CVD hospitalisations .</td></tr>
<tr><td>Pacific</td><td>3735</td></tr>
<tr><td>Other</td><td>1841</td></tr>
</table>
</td>
<td>1(a)</td>
<td></td>
</tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
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<tr><td></td><td>Primary Options for Acute Care (POAC) programme and Very High Intensive User (VHIU) programme.
Number of enrolments in POAC<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>7,500</td><td>9,000</td></tr></table>Number of referrals to VHIU:<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>450</td><td>800</td></tr></table></td><td>1(s)</td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Oral Health</td></tr>
<tr><td>Support the improvement of child and adolescent oral health status (NRHP 1.4)

Providing targeted oral health promotion and tooth brushing programmes for under 5 year olds (NRHP 1.4)

Facilitating adolescent access to free oral health services. (NRHP 1.4)</td><td>Oral health services for children aged 0 years to School year 8 (12/13 years).
Proportion of children under 5 years enrolled in DHB-funded oral health services<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>45%</td><td>65%</td></tr></table>Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>42%</td><td>10%</td></tr></table>Oral health education and tooth brushing programmes targeting Maaori, Pacific, and children from High Deprivation communities

Number of preschool centres engaged in the oral health education and tooth brushing programme.<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>40</td><td>150</td></tr></table>Increased access to adolescent services for all adolescents from School year 9 up to and including 17 years.</td><td>2(m)

2(k)

2(n)</td><td>Improved oral health outcomes for preschool children (0-4 years) and school aged children though:
- Reduction in arrears.
- Increased dental services enrolment.
Measured by:

Proportion of children aged 5 years who are caries free<table><tr><td></td><td>Base line</td><td>By July 2012</td></tr><tr><td>Maaori</td><td>38%</td><td>43%</td></tr><tr><td>Pacific</td><td>28%</td><td>35%</td></tr><tr><td>Other</td><td>62%</td><td>65%</td></tr><tr><td>Total</td><td>45%</td><td>52%</td></tr><tr><td>Fluoridated</td><td>44%</td><td>45%</td></tr><tr><td>Non-Fluoridated</td><td>57%</td><td>58%</td></tr></table></td><td>PP11
2(c)</td><td>Improved health of the population and reduced inequalities</td></tr>
</table>

<table>
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<tr>
<td></td>
<td>
Quality:
Proportion of Year 8 children who have their treatment completed and are transferred to the Adolescent dental service
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>99%</td><td>100%</td></tr>
</table>

Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services.
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>56%</td><td>80%</td></tr>
</table>
</td>
<td>2(o)

2(i)</td>
<td>
Mean, Decayed, Missing or Filled (DMFT) at Year 8.
<table>
<tr><td></td><td>Base Line</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>1.59</td><td>1.50</td></tr>
<tr><td>Pacific</td><td>1.72</td><td>1.63</td></tr>
<tr><td>Other</td><td>0.90</td><td>0.88</td></tr>
<tr><td>Total</td><td>1.29</td><td>1.20</td></tr>
<tr><td>Fluoridated</td><td>1.31</td><td>1.30</td></tr>
<tr><td>Non-Fluoridated</td><td>0.87</td><td>0.86</td></tr>
</table>
</td>
<td>PP10
2(c)</td>
<td></td>
</tr>
</table>

Output Class: Intensive Treatment and Assessment services.

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital' or surgery centre. 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

On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these initiatives/activities	**Deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**Toward delivering these outcomes**
Mental Health					
Provide and/or contract mental health inpatient, outpatient, community, residential, rehabilitation, support and liaison services	**A matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health & Addiction services covering Child, Adolescent & Youth; Adult; and Older Adult Age bands.** **The matrix of services comprise** - **Acute & Intensive services;** - **Community based clinical treatment & therapy services; and** **Services to promote resilience, recovery and connectedness** Access Rates for total and specific population groups (defined as the proportion of the population utilising MH&A services in the last year). The population groups for which this indicator is	PP6 4(a)	**Mental Health initiatives will lead to the prompt recovery from acute mental illness, the prevention of mental illness relapses and further social integration and improved quality of life.** **The Mental Health Regional Services Planning Group will be looking into developing measures in the future.**	PP6 PP7	Improved health of the population and reduced inequalities

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>Deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr><td></td><td>measured are:

<table>
<tr><th></th><th></th><th>Baseline</th><th>By July 2012</th></tr>
<tr><td rowspan="3">Age 0-19</td><td>Maaori</td><td>3.95%</td><td>4.00%</td></tr>
<tr><td>Other</td><td>2.65%</td><td>2.67%</td></tr>
<tr><td>Total</td><td>2.96%</td><td>2.98%</td></tr>
<tr><td rowspan="3">Age 20-64</td><td>Maaori</td><td>6.66%</td><td>6.66%</td></tr>
<tr><td>Other</td><td>2.89%</td><td>2.89%</td></tr>
<tr><td>Total</td><td>3.43%</td><td>3.43%</td></tr>
<tr><td>Age 65+</td><td>Total</td><td>2.63%</td><td>2.63%</td></tr>
</table>

Quality
Proportion of long term clients with Relapse Prevention Plan (RPP) in the above population groups
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>56%</td><td>95%</td></tr>
</table>

Quality
Alcohol and drug service waiting times
<table>
<tr><td>Baseline</td><td>By July 212</td></tr>
<tr><td>24.5 days (NGOs)</td><td>Decrease current rate</td></tr>
</table></td><td>PP7
4(b)

PP8
4(c)</td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Elective (Inpatient/ Outpatient)</td></tr>
<tr><td>Provide and purchase elective inpatient and outpatient services
(NRHP 2.32)

NOTE: A detailed description of activities to achieve</td><td>Elective inpatient services.
Elective outpatient services.

Quantity:
Delivering agreed elective surgery discharge volume
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>100%</td><td>100%</td></tr>
</table></td><td>NHT2
5(e)</td><td>Elective services ensure the restoration of functional independence and longer life for patients.</td><td>NRHP 2.3</td><td>Improved health of the population and reduced inequalities

Improved patients and their family/ whaanau's experience of care</td></tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>Deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr><td>elective surgery health target is provided in Module 3.</td><td>Quality:
Elective and arranged inpatient Average Length of Stay:<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>4.21</td><td>3.92</td></tr></table>Timeliness:
ESPI compliance<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>100%</td><td>100%</td></tr></table>>80% of FSA patients to be seen within designated priority timeframes.

Elective and Arranged Day of Surgery Rate:<table><tr><td>Baseline</td><td>Target 2011/12</td></tr><tr><td>55%</td><td>60%</td></tr></table>Elective Theatre Utilisation Rate<table><tr><td>Baseline</td><td>Target 2011/12</td></tr><tr><td>81.5%</td><td>82.5%</td></tr></table></td><td>OS3
5(q)

5(m)

5(s)

OS6
5(n)

OS5
5(p)</td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Acute Inpatient Services</td></tr>
<tr><td>Provide an acute care service with the following characteristics:
timely access to all service components (including diagnostics) and appropriate timely discharge.
capacity to meet needs
right treatment in the right place
good access to support services in the</td><td>Acute inpatient services

Quality:
Acute readmissions to hospital<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td>10.37%</td><td>9.55%</td></tr></table>Acute Inpatient Length of Stay:<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>4.19</td><td>3.96</td></tr></table></td><td>OS8
5(b)

OS4
5(r)</td><td>Acute services provide timely assessment and treatment to support patient's recovery and prevent deterioration and reduce mortality.</td><td>NRHP 2.3</td><td>Improved health of the population and reduced inequalities

Improved patients and their family/ whaanau's experience of care</td></tr>
</table>

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these initiatives/activities	**Deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**Toward delivering these outcomes**
community or primary care level to support patient recovery. (NRHP 2.1, 2.3)					
Emergency Department					
Provide an emergency and acute care service with the following characteristics: • timely access to all service components (including diagnostics) and appropriate timely discharge. • capacity to meet needs • right treatment in the right place • timely patient transfer to appropriate services from Emergency Department. • good access to support services in the community or primary care level to support patient recovery. (NRHP 2.1, 2.31) **NOTE:** A detailed description of activities to achieve the emergency department length of stay health target is provided in Module 3.	**Emergency department services:** • **Referral** • **Assessment** • **Treatment**		**Timely referral, assessment and treatment for acute conditions, measured by** 95% of admitted patients discharged or transferred from the Emergency Department within six hours: Baseline: 97% By July 2012: 95%	NHT1 5(d)	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these initiatives/activities	**Deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**Toward delivering these outcomes**
Assessment Treatment and Rehabilitation					
Provision of ambulatory and inpatient rehabilitative services. (NRHP 2.3)	**Bone Density Service** **Community Based Rehabilitation** **Community Geriatric Service** **Inpatient/ Outpatient HOP services** **Ortho Geriatric service** **Outpatient** **Stroke Service** *Quality:* Number of falls per month Baseline: By July 2012 23: < 15 Proportion of pressure areas acquired during ARHOP admissions Baseline: By July 2012 5%: 5%	5(g) 5(h)	**Improved mobility and daily functioning for inpatients, measured by:** Barthel score improvement [28] Baseline: By July 2012 74%: Continue to maintain a rate > 60% Referral rate to ATR from EC Baseline: By July 2012 26%: Continue to maintain a rate > 15% Average length of stay in AT&R Baseline: By July 2012 23.57 days: < 15 days	3(i) 3(h) 3(e)	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care
Maternity Services					
Provide readily accessible maternity, obstetric and neonatal care services. (NRHP 1.4, 2.3)	**Non-specialist antenatal consultations** **Obstetric antenatal consultations** **Postnatal inpatient and outpatient care.** **Delivery Services** **Specialist neo-natal inpatient and outpatient care.** **Amniocentesis** MOH ESPI compliance reports for gynaecology Baseline: By July 2012 100%: 100%	5(m)	**Improved maternity services will lead to safer pregnancies with reduced complications and safer childbirth, thus ensuring healthier infants.** Proportion of women who have not been managed according to their assigned status (ESPI). Baseline: By July 2012 2.7%: 0%	MHP 5(m)	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care
Quality and Safety					
Implement Quality Improvement Initiatives which	**Quality systems improvement** - **CMDHB Optimising the patient journey**		**Quality systems contribute to enhancing patients and their families experience of care**		

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>Deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr>
<td>focus on reducing clinical risks, improving patient safety, minimising wastage, improving workflows</td>
<td>- Safe Medication Management Programme
- Hand Hygiene Programme
- Whai Manaaki (searching for a better way to provide care)</td>
<td></td>
<td>Rate of adverse drug events (per 100 patient admissions)
Baseline | By July 2012
48.7% | 0%

Number of total CLAB (hospital wide per month)
Baseline | By July 2012
8 | 0

Patient satisfaction with services (rating it Good or Very Good) improves
Baseline | By July 2012
90% | > 90%

Outpatient Did Not Attend (DNA) rates for Maaori and Pacific
| Baseline | By July 2012
Maaori | 19% | < 10%
Pacific | 16% | < 15%</td>
<td>5(k)

5(f)

5(a)

5(l))</td>
<td></td>
</tr>
</table>

Output Class: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum of care these services provide support for individuals.

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these initiatives/activities	**Deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**Toward delivering these outcomes**
Palliative Care					
Contract with Hospice services to provide care. Provide specialist palliative care services. Fund Home based palliative care services. (NRHP 1.2, 2.2, 2.3)	**Specialist end of life care.** **Advance Care Planning in aged residential care and secondary care** *Quality:* Number of people with advance care plans in the community Baseline: Currently being established — By July 212: Increase current rate	3(g)	**Reduced inappropriate admissions / demand on acute hospitals**		Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care
Aged Residential Care Beds (ARC)					
Provide access to subsidised beds based on assessed need. Fund a sufficient supply of contracted beds available to people assessed as requiring long term residential care. (NRHP 1.2)	**Residential care services.** **Residential bed days** *Quantity:* Total number of subsidised aged residential care bed days. Baseline: 1,043 — By July 212: Increase to accommodate population growth *Quality* Proportion of residential care service providers who meet required certification standards. Baseline: 100% — By July 212: 100%	3(k) 3(n)	**Better management of chronic conditions for those aged 65 years and over.**	NRHP 1.2	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>Deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr><td></td><td>Number of complaints received regarding residential care service
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>10</td><td>Reduce current rate</td></tr></table></td><td>3(m)</td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Home Based Support</td></tr>
<tr><td>Use of the InterRAI tool to ensure people who need home based support services receive them in a consistent way. Provide timely access to assessment, treatment and support services for older people with complex health problems (NRHP 1.2, 2.3).

Provide information and support to older people and their carers about community support options (NRHP 1.2, 1.25)

Provide Home and Clinic based specialist Nursing services and allied health services to support community care (NRHP 1.2, 2.3).</td><td>Home based support services
Home based Nursing services
• Wound care
• Continence/ Ostomy
• Lymphodema
• Home IV
Home based Allied Health services

Quantity:
Number of home based support hours provided.
<table><tr><td>Baseline (2010)</td><td>By July 212</td></tr><tr><td>484,146</td><td>Increase current rate</td></tr></table>
Number of complaints received regarding home based support.
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>0</td><td>Maintain current rate</td></tr></table>
Quality / Timeliness:
Time taken from completion of initial needs assessment to delivery of service.
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>Currently being established</td><td>80% of cases within 10 working days
20% of cases within 20 working days.</td></tr></table></td><td>3(d)

3(l)

3(o)</td><td>Older people with complex needs are able to remain living in their home for longer periods (living to their ‘functional ability’). This is measured by:

Proportion of elderly receiving health of older people services in residential care or via HBSS
<table><tr><td></td><td>Baseline</td><td>By July 2012</td></tr><tr><td>HBSS</td><td>71%</td><td>Increase current rate</td></tr><tr><td>RC</td><td>29%</td><td>Decrease current rate</td></tr></table>
Number of people supported in their own homes with complex packages of home-based care (NASC)
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>332</td><td>Increase current rate</td></tr></table>
Proportion of ED attendances by 65+ year olds
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>18.32%</td><td>Decrease current rate</td></tr></table>
Proportion of people over 75 years who are hospitalised due to falls
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>14.02%</td><td>Decrease current rate</td></tr></table></td><td>NRHP 1.2

3(a)

3(j)

3(b)

3(c)</td><td>Improved health of the population and reduced inequalities

Improved patients and their family/ whaanau’s experience of care</td></tr>
</table>

MODULE 5: STEWARDSHIP

Every week in CMDHB

- **110** people are admitted to hospital due to cardiovascular disease.
- **160** people are admitted to hospital due to respiratory conditions.
- **250** people with diabetes will be admitted to hospital.
- **860** free annual checks for diabetes.
- **40** patients receiving radiation therapy treatment
- **1,600** attendances in the emergency department
- **4,300** people are seen in outpatients.
- **23,700** adult and **7,900** child GP visits
- **37,600** prescriptions dispensed
- **54,300** lab tests ordered
- **3,440** people received **51,600** hours of home based care
- **610** immunisation visits for children under 2 years.

The scale of our **Capacity:**

- **1057** inpatient hospital beds
- **21** surgical theatres
- **73** school dental clinics / mobile dental facilities
- **6590** full time equivalent staff including **2680** nurses and **830** doctors

This section details how the organisation manages its business effectively and efficiently to deliver on the priorities described in modules 2, 3 and 4. It shows how the DHB's high level strategic planning translates into action in an organisational sense within the DHB and details the supportive infrastructure requirements to achieve this. As both funder and deliverer of health services, the DHB must operate in a fiscally responsible manner and be accountable for the assets it owns and manages.

5.1 GOVERNANCE AND ORGANISATIONAL STRUCTURE

CMDHB has a governance and organisational structure as required by the New Zealand Public Health & Disability Act 2000.

The CMDHB Board assumes the governance role and is responsible to the Minister of Health for the overall performance and management of the DHB.

Responsibilities of the Board include:

- Setting strategic direction and policies which are in line with Government objectives and priorities;
- 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

The CMDHB Board has seven Board members elected by the community and four appointed by the Minister of Health.

Three statutory advisory committees and five non-statutory committees have been established to help the Board meet its responsibilities.

Membership of these committees is a mix of Board members and community representatives including Maaori, Pacific, mana whenua and clinicians.

See Figure 8 for the DHB's governance structure and key functions of the Board committees.

5.1.1 Management Structure

Whilst the Board is responsible for the DHB's overall performance, operational and management matters are assigned to the Chief Executive who is supported by the Business Group and Strategic Forum.

Strategic Forum consists of Business Group members as well as the General Managers and Clinical Directors from all the divisions across the organisation.

See Appendix 1 for the Counties Manukau DHB organisational chart.

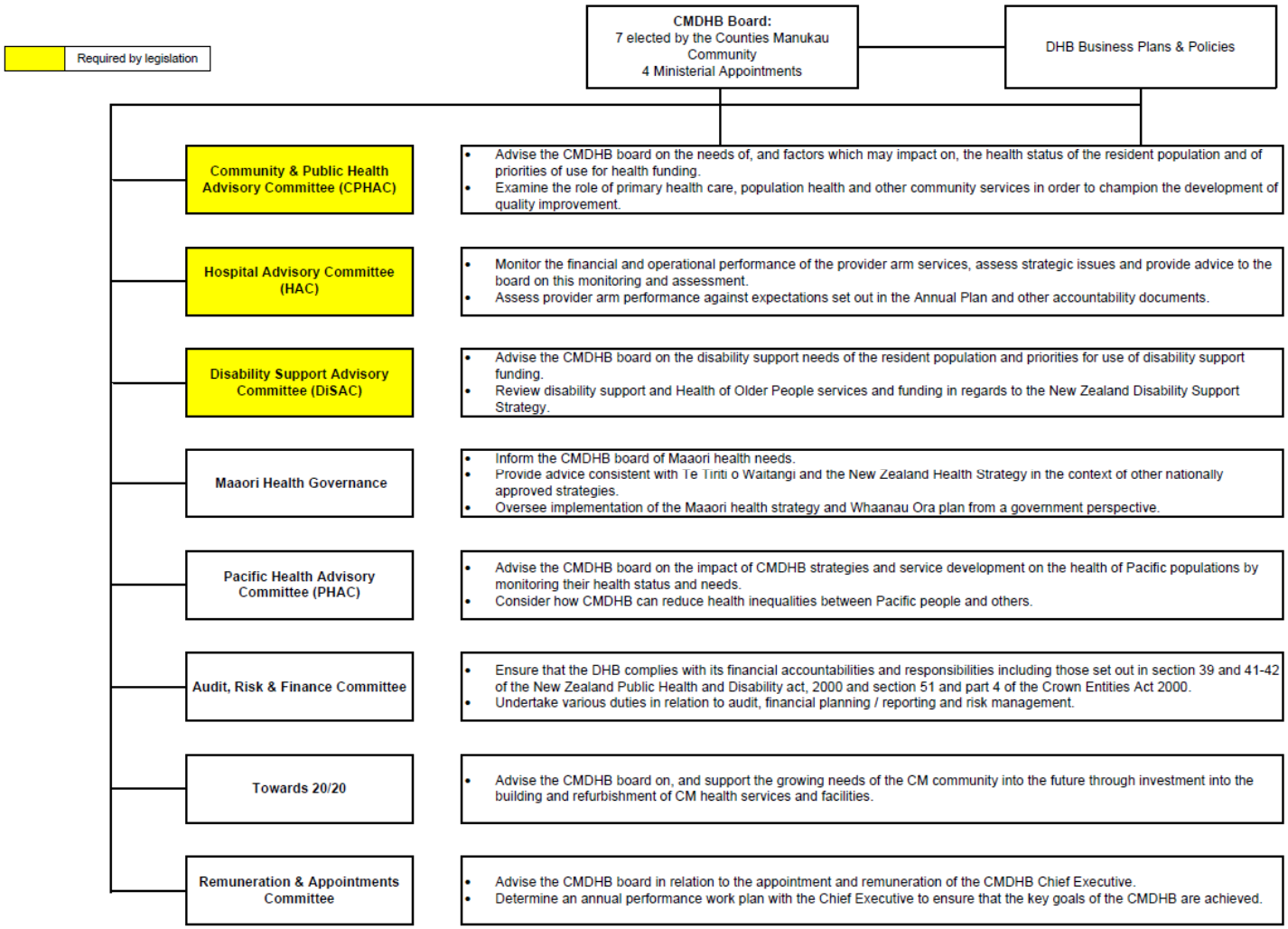
Business Group membership

- Finance Director
- Chief Operational Officer
- Chief Medical Officer
- Director of Nursing
- Director of Allied health
- Director of Planning & Performance
- Director of Services Integration
- Director of Primary Care
- Director of Quality Improvement
- Director of Ko Awatea

Additional support is provided by:

- Senior Legal Advisor
- Communications Manager
- Chief Information Officer for healthAlliance
- General Manager, Human Resources
- General Manager, Maaori Health

Figure 9: Counties Manukau DHB Governance Structure



5.1.2 Clinical Engagement and Leadership

Counties Manukau DHB is committed to the philosophy and practice of clinical leadership where clinicians are accountable for outcomes they have the ability to affect. To facilitate this, CMDHB has a governance structure that ensures active, robust decision making and partnership between clinicians and management.

- Clinical leadership is led by the Chief Medical Officer (CMO), and Directors of Nursing (DoN), Allied Health (DAH), Primary Care and Quality Improvement; through to Clinical Directors, Clinical Nurse Directors, Heads of Department, and formal and informal networks of primary and secondary care clinicians.
- Clinical leaders are represented on the Counties Manukau Board and Board advisory committees like the Community and Public Health Advisory Committee (CPHAC) and the Hospital Advisory Committee (HAC). The CMO reports to the Board monthly and the CMO, DoN and DAH jointly report to HAC monthly.
- Clinicians are well-represented on the Strategic Forum where there are ten clinicians represented alongside the other twenty senior executives of the management team.
- Clinical leaders are a part of advisory committees such as Asset and Capital, and Workforce and are represented on advisory/ steering committees for key projects such as the Emergency Department *6 Hours Can Be Ours* campaign and major capital works like the development of the Edmund Hillary Block.
- The current work undertaken to develop the Northern Region Health Plan is an example of close collaboration between clinicians and health sector administrators. All the work stream groups are lead by a clinical leader and consist of a mix of senior clinicians, managers and other key stakeholders.

CMDHB also has formal mechanisms for broader based participation from clinical staff through the *Clinical Advisory Group* and the *Clinical Management Executive Committee (CMEC) Secretariat*. See Appendix 2 for more information on these groups.

5.2 FUNDER INTERESTS

5.2.1 How the DHB ensures value for money

The concept of value for money is evident is all phases of the procurement life cycle. Our funding processes follow closely the Office of the auditor General's procurement guidelines which includes contestable provider selection. This allows the DHB to compare proposals from a number of providers, including pricing, in order to find the most effective provider for the services sought. There are some circumstances where a contestable provider selection process may not be appropriate. Management of funding agreements includes formal performance monitoring and auditing by external organisations as well as continuing an informal relationship to ensure accountability for service value.

5.2.2 Funding and financial management

CMDHB apply industry and public sector standard practices that ensure best practice financial management at both the macro and micro level. At a macro level there are robust budget, forecasting and reporting processes that link in all levels of management in a structured framework accountable to the Chief Executive and Board. Clear documented management, operational and financial delegations combined with the latest IT applications ensures the highest level of financial accountability resulting in the DHB's consistency in achieving zero deficit results in recent years. At a micro level funding providers requires a commercial approach coupled with the need to ensure our NGO providers remain viable. A continuing tight fiscal environment continues to put pressure on greater reliance on financial management and our providers to deliver sustainable value for money health services.

5.2.3 Risks

The management of risk in funding arrangements is one of measured mitigation, balancing the application of appropriate mitigation strategy/cost to the degree and size of risk. CMDHB risk management is managed centrally via a formalised process using specific risk management technology to assist and record the various DHB risks. At a micro level we apply the same principles of high level contractual rigour for high value complex funding agreements to simple letters of agreement for low cost "one off" arrangements. The continued approach of using a combination of informal relationship monitoring with external resourced audit and monitoring ensure risks are managed prudently.

5.2.4 Quality assurance and improvement

Quality Assurance

To help ensure that contracts are prepared to an acceptable standard, all CMDHB Funder Arm agreements are reviewed internally before they are released to the providers. Funder Arm personnel involved in this internal review process includes General Managers, the Finance Manager, the Director Service Integration, the Senior Legal Advisor (and/or the Procurement & Accountability Coordinator). To facilitate ongoing improvement in Funder Arm contracts, the CMDHB Procurement Guidelines for Funder Arm services requires that all service agreements are reviewed at least on an annual basis.

Improvement

In 2010, the CMDHB Funder Arm commenced a 'Procurement Improvement Project'. The four main components of the project were as follows:

- **Formally define the roles and responsibilities** of all persons involved in the Procurement Process;
- **Review procurement processes** used in the CMDHB Funder Arm, investigate ways to improve the processes as required, and ensure implementation of new processes;
- **Clearly document all policies and procedures relating to the procurement process**, incorporating any process improvements developed; and
- **Develop and ensure the implementation of a comprehensive training programme** to educate all staff involved in procurement about CMDHB Procurement Policies and Processes, as well as their roles and responsibilities at each stage of the Procurement Process.

In addition to the above, one of the main objectives of the project was to ensure CMDHB Funder Arm staff procurement activities and practices comply with OAG guidelines.

The new procurement processes developed through this project are described in the DHB's '*Procurement Guidelines for Funder Arm services'* which were also developed as part of the project. Changes are currently being made to the guidelines, based on feedback received from staff during the Procurement Training. Formally, the Procurement Guidelines, and the processes contained within them, will be reviewed at least on an annual basis.

5.2.5 Audit and review

Audit

The CMDHB Funder Arm coordinates a Routine Audit Programme to assess the extent to which Personal Health, Maaori Health and Pacific Health NGO providers are complying with terms of their contract with the DHB. Additional issues based audits can be commissioned if there are particular concerns about a provider's performance.

The NDSA coordinates the Routine Audit Programme for Mental Health services.

In addition to the Routine Audit Programmes, Audit & Compliance (Sector Services) and MedSafe provide additional audit and investigation services on behalf of CMDHB.

Wherever possible, CMDHB will endeavour to coordinate audit activity with other District Health Boards and the Sector Services teams.

Contract Review

The Procurement Guidelines for Funder Arm Services require that service agreements are reviewed at least on an annual basis. This is an opportunity for CMDHB to assess how well a provider has performed over the term of an agreement, review the services that we have purchased, and review and improve our contract documentation.

5.3 PROVIDER INTERESTS

5.3.1 How the DHB ensures value for money

The concept of value for money is evident is all phases of the review of service performance. We work closely with the Health Round Table to ensure we are aware of both best practice, best performers in Australasia for public hospitals, and we follow up on what is required for CMDHB to be on the leading edge of best practice. CMDHB has put a very high emphasis on quality to help drive good outcomes at an affordable price, with quality and safety being one of the fundamental planks of our Triple Aim strategy. There is continuous work on reviewing and implementing improvements to clinical pathways, which are focused on delivering patient centred results.

There is also the Health Service Plan (HSP) and Asset Management Plan (AMP) which are prepared to determine ongoing capital requirements to meet CMDHB's service objectives. These plans are prepared to best practice standards in New Zealand and incorporated into the Regional HSP and AMP, which are then incorporated into the national HSP and AMP. These various plans are critically reviewed for their value for money prospects for health care delivery, with an eye for being prepared for emerging health needs.

CMDHB together with WDHB established healthAlliance, a non clinical shared services agency some ten years ago as an early commitment to ensuring a value for money approach to health .This has been extremely successful in all areas of activity in both consistently achieving considerable savings and ensuring a standardisation of approach wherever possible. It has recently [1st April 2011] been expanded to include ADHB and NDHB and will be working in close alignment with HBL to build on these gains for national benefit

5.3.2 Funding and financial management

CMDHB apply industry and public sector standard practices that ensure best practice financial management at both the macro and micro level. At a macro level there are robust budget, forecasting and reporting processes that link in all levels of management in a structured framework accountable to the Chief Executive and Board. Clear documented management, operational and financial delegations combined with the current IT applications ensures the highest level of financial accountability resulting in the DHB's consistency in achieving zero deficit results in recent years despite extraordinary clinical and fiscal pressures. At a micro level funding for clinical services requires a commercial approach which is based on nationally based Price / Volume (P/V) schedules. Where PV funding is deemed to be inadequate, additional funding is provided where justified to ensure quality delivery of core and high profile services. A continuing tight fiscal environment continues to put pressure on increased reliance on financial management and our clinical services to deliver sustainable value for money health services.

5.3.3 Risks

The management of risk in ongoing operations is one of measured mitigation, balancing the application of appropriate mitigation strategy/cost to the degree and size of risk. CMDHB risk management is managed centrally via a formalised process using specific risk management technology to assist and record the various DHB risks. High organisation risks are reviewed by CMDHB's Board monthly, and at Audit, Risk & Finance Committee quarterly, to ensure that appropriate attention is given to these risks. At a micro level the Providers' operational risk is determined by population related pressures, with mitigation strategies developed which centre around bed modelling, models of care, and capital planning. The continued approach of using a combination of informal relationship monitoring with external resourced audit and monitoring ensure risks are managed prudently.

5.3.4 Quality assurance and improvement

Quality Assurance

To help ensure that services are delivered to an acceptable standard, CMDHB Provider Arm clinical results are reported on by the Health Intelligence Unit and reviewed internally by the Quality Improvement team as well as each Services internal quality team. There is also a Clinical Management Executive Committee and various clinical committees involved in internally reviewing quality results and processes. Committee members include the COO, General Managers, Finance Manager, Directors of Nursing and Allied Health, CMO, clinical and service directors.

5.3.5 Audit and review

Audit

The CMDHB Provider Arm is actively involved in regular programmed internal audits as well as CMDHB's annual audit to ensure the accuracy and integrity of its financial results. Additionally, there are certification and assurance audits carried out to verify the hospital's ability to perform to acceptable standards.

Wherever possible, CMDHB will endeavour to coordinate audit activity with other District Health Boards. An example of this is the Regional Internal Audit team which services the four Northern DHB's. CMDHB's Finance Director acts as lead CFO over this activity, coordinating both CMDHB Board and management requirements with those of the other three DHB's to ensure a consistent approach, value for money as a shared service and a sharing of outcomes.

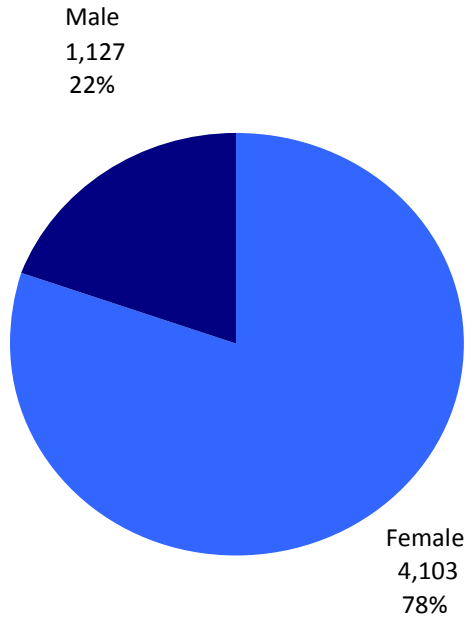
5.4 ORGANISATIONAL HEALTH

5.4.1 Good Employer

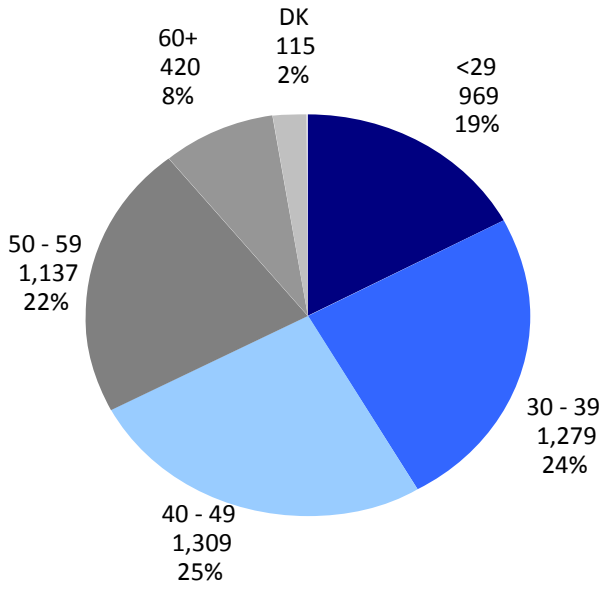
Counties Manukau DHB is a major employer in South Auckland with over 5,700 staff employed across hospital and community-based settings.

A snapshot of our workforce profile at 30 March 2010 is shown below.

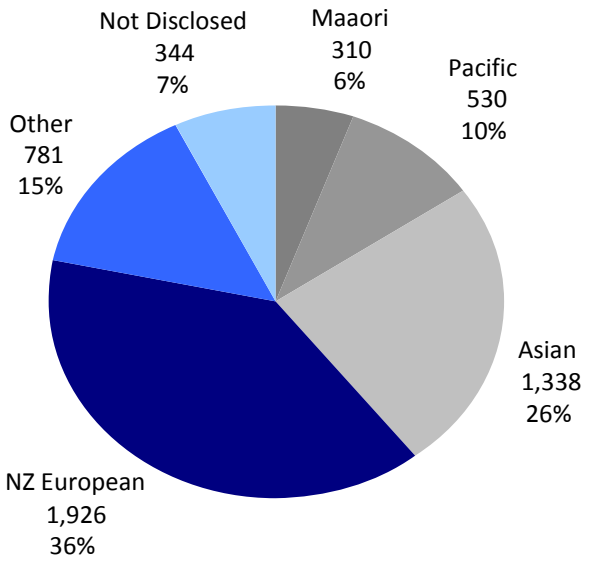
CMDHB Workforce by Gender
Data shown is for FTE *n*= 5230



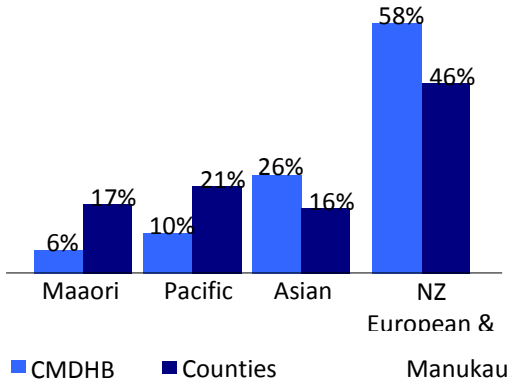
CMDHB Workforce by AGE
Data shown is for FTE n= 5230



CMDHB Workforce by Ethnicity
Data shown is for FTE *n*= 5230



CMDHB Workforce compared to Population by Ethnicity
Data shown is for FTE *n*= 5230



Principle

CMDHB discharges its Good Employer obligations by operating under a Human Resources policy containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment.

CMDHB is committed to this principle and will actively seek to uphold any legislative requirements in this regard.

5.4.2 Good Employer principles in practice

Provisions which reflect the General Principles include:

- **Good and safe working conditions**
  Evidenced by: CMDHB being an approved Accredited Employer within the ACC Partnership Programme at tertiary level. This decision reflects tertiary standards of both health and safety systems and processes and work injury management processes.

  Evidenced by: OHSS roll out of a safety cannula device to all clinical workplaces. Introduction of this device was as result of OHSS injury prevention project aimed at reducing needlestick injuries and workplace blood/body fluid exposures. Since roll out, there have been nil needlestick injuries reported resulting from cannulation activity. OHSS continues to carry out injury prevention project work which aims to improve workplace safety, therefore demonstrating CMDHB commitment to acting as a good employer.

  Evidenced by: Development and publication of de-escalation and restraint minimisation e-learning modules now available for all staff. Future goal is to achieve roll out of de-escalation training to all clinical workplaces.

- **An equal opportunities programme**
  Evidenced by: CMDHB has revised its Good Employer Policy to ensure it is more inclusive of EEO principles and practices relevant for this DHB. An EEO Action Plan is currently in development which will identify a stage implementation approach from awareness to practice across the organisation which both celebrates diversity to activity influencing recruitment and retention. The Plan identifies a range of activities and links existing networks to foster a cohesive approach to equal opportunities practice.

- **The impartial selection of suitably qualified persons for employment**

Evidenced by: CMDHB uses a variety of selection processes comprehensively linked to competencies. Behavioural based interviews and or assessment centres are conducted linking applicant ability to deliver the functions and purpose of each position we hire into. Panels are utilised to cover both clinical and management representation – with specific cultural participation and support factored into our hiring process. Post interview CMDHB managers also conduct thorough reference checks.

- **Recognition of the aims, aspirations and employment requirements of Maaori people**
- **Recognition of the aims, aspirations cultural differences and employment requirements of Pacific peoples, and people from other ethnic or minority groups**

  Evidenced by: CMDHB has established cultural diversity programmes focussed both on service delivery for a culturally diverse and improving the employment environment for staff from diverse ethnic groups. An expected outcome of this programme is to enhance the ethnic diversity of staffing by providing an environment which is rewarding and engaging for a diverse workforce.

  Evidenced by: CMDHB has a specific management programme for managers about managing within a culturally diverse workforce which is part of a compulsory orientation for managers and all new managers undertake a comprehensive training programme which includes a specific module on diversity and inclusion.

  Evidenced by: CMDHB is also focussing resources on encouraging students from groups under-represented in tertiary qualified roles within the organisation, such as Pacific peoples to participate in advanced qualifications to improve the representation Pacific peoples in the clinical roles in the DHB (and across the broader sector workforce), and to encourage existing staff to undertake further qualifications to enable career advancement.

  Evidenced by: CMDHB is running a Language, Literacy and Numeracy programme to enhance the career opportunities and long term workforce participation of staff who currently have limited skills in these areas.

  Evidenced by: CMDHB has also established an Aspiring Leaders programme specifically to build the leadership capacity and capability of CMDHB's Maaori, Pacific and Asian staff, to provide opportunity career advancement and improved representation of these groups at higher levels in the organisation, and also the broader sector workforce.

- **Opportunities for the enhancement of the abilities of individual employees**
  Evidenced by: A range of services are provided throughout CMDHB in primary, secondary and planning & funding. This takes many forms and includes leadership and management training and development, career development consultancy, customised in-service programmes for individual, teams and managers, e-learning and the provision of internal and external courses and training over a range of skills and knowledge.

- **Recognition of the employment requirements of women**
  Evidenced by: CMDHB provides opportunities for flexible employment in almost all roles; employment agreements for female dominated workforces provide better provisions for parental leave and extended absence for childcare beyond the statutory requirements. Dedicated breastfeeding facilities are provided on the larger campuses.

  Evidenced by: CMDHB has dedicated career development resources to encourage career planning for all staff and a significant programme of learning and development opportunities, and has plans to further extend the programmes and development opportunities available on-site.

- **Recognition of the employment requirements of men**
  Evidenced by: CMDHB has dedicated career development resources to encourage career planning for all staff and a significant programme of learning and development opportunities and has plans to further extend the programmes and development opportunities available on-site.

- **Recognition of the employment requirements of persons with disabilities.**
  Evidenced by: CMDHB Disability Support Services are here to help assist staff and patients by implementing the NZ Disability strategy which is to eliminate barriers for disabled people and to promote a more inclusive society.

CMDHB will measure this by assessing how staff and consumers with disabilities are provided for, in terms of environmental access, support, employment and inclusion, with particular reference to CMDHB policies.

Standards

CMDHB shall ensure that employees maintain proper standards of integrity and conduct, in keeping with the vision and values of CMDHB.

Complaints and appeals

CMDHB supports the right of all employees to pursue resolution of any complaint through the procedures contained in the relevant legislation (e.g. Human Rights Act, Race Relations Act, and Employment Relations Act). In the first instance, an employee can obtain assistance in the pursuit of a complaint or appeal, by contacting the Human Resources Service Manager.

5.4.3 Equal Employment Opportunities (EEO)

Principles

Discrimination in employment occurs whenever factors or personal characteristics which are not relevant to the job are used. Discrimination can be direct (e.g. by refusing to hire people with certain characteristics) or, more often, indirect (e.g. when people appear to be treated in the same way but are in fact denied equal opportunity).

CMDHB believes that by ensuring our workplaces reflect and value the differences within our workforce, we will be able to deliver quality health services more efficiently, effectively, and appropriately.

CMDHB believes that by removing seen and unseen barriers which prevent people from reaching their full potential, we can deliver top performance at every level of the organisation.

Equal Employment Opportunities (EEO) is an integral part of being a good employer.

Policy

CMDHB is committed to the concept of EEO and will work towards the elimination of all forms of unfair discrimination in employment evidenced by:

- inclusive, respectful and responsible organisational culture which enable access to work, equitable career opportunities and maximum participation for members of designated groups and all employees
- procedural fairness as a feature of all human resource strategies, systems, and practices
- employment of EEO groups at all levels in the workplace

CMDHB's Human Resource policies and practices will be free from any discriminatory element that has the potential to deny a person equal opportunity.

In the past year CMDHB has joined the Equal Employment Opportunity (EEO) trust. This assists the organisation to champion our EEO goals.

Over the next year EEO initiatives will continue to develop as we grow and celebrate our diverse workforce.

EEO Benefits for Counties Manukau DHB

EEO will help CMDHB develop a more united and diverse workforce which is responsive to change, is more flexible and has a richer workplace culture.

EEO is a way of honouring our obligations under the Treaty of Waitangi.

EEO will assist CMDHB to:

- deliver improved customer service by better matching our services with our clients
- improve its productivity through valuing its employees and treating them fairly

EEO can improve staff relations and morale, lower absenteeism and reduce staff turnover. CMDHB has one of the lowest staff turnover rates within the public health sector.

5.5 BUILDING CAPABILITY

The capabilities that the DHB needs over the next three to five years are outlined here.

5.5.1 Thriving in Difficult Times

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 the DHB currently does. 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 were scoped in 2010/11: A *Saver* work stream and an *Enabler* work stream. The CMDHB Board gave its endorsement and support to the TiDT plan in 2009 which outlines how the workstreams are going to contribute to the zero deficit position and future savings.

The workstreams are now in various stages of implementation, with some having been completed and savings achieved. Some of the initiatives like the patient safety initiatives, quality improvement activities targeting waste, reducing variation in clinical practice will require ongoing effort so that these are not just one off imperatives but a way of life for the DHB.

5.5.2 Workforce and Human Resource

For 2011/12 the four DHBs in the Northern Region will strengthen and build on the cooperative and collaborative activity already undertaken across a range of human resource (HR) functions over past years. This work provides an enabling platform on which to progress regional activity in line with health policy and ministerial expectation of greater collaboration and sharing of resources across support services. The establishment of the shared services Health Benefits Ltd at a national level and the Northern Regional Shared Services organisation (now incorporated as healthAlliance Limited) including all four Northern Region DHB's locally provides the organisational mechanisms for the formalisation of ongoing planning and implementation of shared strategies and projects within the greater human resource field.

The regional collaboration work is maturing in a range of speciality areas of human resource activity. This includes work in the areas of Employment Relations, Recruitment, Workforce Development, Learning and Development, Occupational Health and Safety, special projects, HR infrastructure and systems development and shared services. .

A key objective is for the DHBs to have common systems and organisational structures that enable them to better plan for and manage the HR issues across the spectrum of the employment relationship of our large and diverse workforces. Previously this has only been achieved where DHB specific strategic objectives and local and regional contexts have aligned. It is expected and valued that in the current environment this alignment will be more overt and supported by other regional planning in the areas of systems and organisational infrastructure and clinical service planning.

The Northern Region DHBs Human Resource Management Strategy 2009-2013 is developed. It incorporates findings from research, meetings and stakeholders at ADHB, CMDHB, NDHB, WDHB and healthAlliance. It includes the strategy and problem definition, prioritisation criteria and principles for applying resources to HRMS and the steps and high level action plan for implementation of the strategy. This document aligns with the Regional Information Strategy 2010 - 2020 and will be reviewed depending on the direction taken nationally regarding the scope of this strategy. The achievement of this strategic document and agreement confirms the existence of significant regional competency and commitment to the process of planning and moving towards the implementation of HR systems and processes which enhance the recruitment and retention of our workforce whilst effectively managing the costs of that workforce.

It is critical that our talent is retained within our region or sector so that service delivery goals can be achieved.

5.5.3 Information Systems

The *Northern Region Information Systems Implementation Plan (NRISIP)* outlines the programme of work required to achieve the objectives of the *National IT Plan 2010* and the *Regional Information Strategy 2010 -2020* for the next 3 to 5 years. Due to challenges around resourcing, complexity and governance the programme may need to be spread over a longer timeframe.

As agreed by the regional Chief Medical Officers, the main clinical driver is to improve the continuity of care for patients in our region across the continuum of services through providing consistent and reliable access to core clinical documents and facts for all clinicians involved in a patient's care.

A significant technical driver is the need to ensure that basic aspects of IS development and functioning are both resilient and comparable across the four DHBs. This will provide a platform from which all can continue to develop regional information systems in a coordinated fashion. A key business driver is the need to replace Northland's legacy systems, as identified in the Readiness Assessment produced by the National IT Board. It will likely be necessary to delay progress on some projects in some, if not all, DHBs during the period of catch-up required to establish a more uniform regional platform.

Two key processes will require active, strong leadership by senior management:

1. The development of regionally agreed and consistent business and clinical processes, which the regional technical information systems will underpin and enable.
2. The reprioritisation required within each DHB to match IS developments to available resources and to ensure that the order in which projects are undertaken takes account of crucial interdependencies and the need for regional consistency.

The January 2011 Minister's Letter of Expectations requires regional plans which focus on a small number of high priorities and regionalisation of IT platforms and IT support. The 16 February 2011 letter to DHB CEOs from the Chair of the DHB Information Group and from the Director of the National Health IT Board states that each DHB will need to significantly reduce the number of local health IT projects and focus on regional clinical projects. Furthermore, replacing legacy applications must be a priority so that each region has a common and standard regional IT platform. In this context the Chief Information Officers and Chief Medical Officers have identified a shortlist of key foundation projects in the attached table which need to be planned, funded and implemented regionally.

Other priorities

Regional project teams will be established over the next few months to plan these programmes of work and project the necessary funding for the coming years. These programmes of work should be the key focus for regional investment and activity and should be "protected" in local DHB capital and operational expenditure prioritisation processes.

Some investment will also be possible and required in other regional projects that underpin the delivery of key clinical priorities in the short to medium term. Other regional priorities that have been identified include:

- E Referrals Phase 2
- E Discharges implemented to national standards
- E Medicines including e medicines reconciliation, community & hospital e prescribing
- Shared Care Plan Phase 2
- E Rostering
- establishment of NRSSO including network integration, single sign-on and single service desk
- shared financial management systems
- IS support for Better Sooner More Convenient business case workstreams

Please refer to the Regional Information Strategy 2010 to 2020 for more information.

5.5.4 Capital planning and infrastructure development

See Module 8, Section 8.3.2 for our capital planning and expenditure priorities for 2011/12

5.5.5 Innovation

Ko Awatea – Counties Manukau DHB's Centre for Health System Innovation and Improvement

Ko Awatea	*(First Light)* A light to ignite energy and illuminate knowledge to enable health system change.

To help achieve the DHB's aim of being the best performing health system in Asia-Pacific by 2015, the organisation is establishing a new capability - Ko Awatea.

Ko Awatea is an education and innovation centre, located at Middlemore Hospital, which brings together expertise and relationships to improve the effective and efficient application of healthcare.

Its goal is to help the DHB move from successful individual projects to sustainability and spread of best and new practice which will enable better care, better population health and lower cost.

Ko Awatea's core functions are capacity building and knowledge development, management and dissemination to increase capability and deliver whole of health system improvement. The majority of Ko Awatea's $2.35 million budget in 2011/12 is directed towards capacity building.

The capacity building aspects of Ko Awatea link to partnerships with the Institute of Healthcare Improvement, the Oxford Centre for Healthcare Transformation, and three tertiary education organisations – University of Auckland, AUT University and Manukau Institute of Technology to jointly develop and grow a future workforce that meets the needs of our community.

This partnership approach is reflected in the recent joint appointment of Ko Awatea's Director, Professor Jonathon Gray with the University of Auckland where he is the Stevenson Professor of Health Improvement.

Ko Awatea will open in May 2011.

NZ Health Innovation Hub

Subject to pending approvals, the four largest District Health Boards (Counties Manukau, Auckland, Waitemata and Canterbury) plan to establish a national Health Innovation Hub to grow New Zealand's health innovation sector by engaging clinicians, facilities and patients with industry in the commercialisation of product and service innovations.

The Hub's goals are to improve healthcare for our communities, retain and attract clinical and technical expertise and generate economic benefits for NZ in this high value, export focussed sector.

The Hub will work in policy alignment with central and local government agencies - in health, research and development, and economic development - and be supported in its formative period by their funding, with partner DHBs contributing financial and in-kind support. Counties Manukau DHB's contribution in the 2011/12 year will be $300,000 and the equivalent of one full time in-kind resource.

5.6 LEGISLATIVE REQUIREMENTS

Counties Manukau DHB will undertake to consult/ notify the Minister if the following takes place, and before making a decision:

- Significant changes to services (as per MOH Service Change Guidelines);
- Entering into new arrangements such as the changes in shareholding with healthAlliance NZ Limited, and Ko Awatea and the Innovation Hub.

In this regard, the DHB is presently finalising arrangements that may require Ministerial approval to either the changes or new investment.

- Expansion of healthAlliance NZ Limited to encompass Auckland DHB, Northern DHB and Health Benefits Limited alongside the existing shareholding of Counties Manukau DHB and Waitemata DHB. This approval request is presently with the Minister.
- The establishment of the Innovation Hub which, for Counties Manukau DHB, sits under the umbrella of Ko Awatea. The Hub will be a partnership owned by the DHBs of Auckland, Waitemata, Canterbury and Counties Manukau. All of this will be fully documented in a Section 28 request to the Minister (expected in early May).
- The establishment of Ko Awatea has also necessitated an unincorporated joint venture which will function through a limited liability nominee company incorporating the four shareholders (Counties Manukau DHB, University of Auckland Faculty of Medicine & Health Sciences, Manukau Institute of Technology and AUT University) to hold the shared educational assets related to Ko Awatea.
- The likely establishment of a special purposes vehicle (SPV) for Integrated Family Health Care / Whanau Ora Centre, in conjunction with Tainui on land owned by CMDHB at the Manukau Health Park.

MODULE 6: SERVICE CONFIGURATION

6.1 SERVICE COVERAGE AND SERVICE CHANGE

6.1.1 Service Coverage

No service coverage issues are anticipated by the DHB in 2011/12.

6.1.2 Service Change

- CMDHB started a Chronic Pain Service in December 2010 in response to demand from our community. This will be gradually grown and will enable more Counties Manukau patients to be seen locally and closer to home rather than at the Auckland Regional Pain Service in Greenlane.
- CMDHB's Ophthalmology Department started cornea transplantation in January 2011 (after discussion with Auckland DHB) and plans to continue this. At this stage Auckland DHB has agreed to us doing 12 cornea transplants per year.

6.1.3 Service Issues

To date there are no service issues to highlight in the annual plan.

MODULE 7: PRODUCTION PLANNING

7.1 SUMMARY DESCRIPTION OF PRODUCTION PLAN

Explanatory Notes - Summarised Outputs (DHB of Service)

The information used to build this table has been drawn from volume data in the 2011/12 Production Plan, across forecast (2010/11), and planned (2011/12) years. The scope of services counted has been limited to those purchase unit codes that meet two criteria: a national price must exist; and the unit of measure must be output (not input or programme) based. The list of relevant purchase unit codes, and their grouping in this table, is available on request.

The most important results in the table are those in the 'Total volume growth' line, which gives the percentage change in outputs across planned growth from 2010/11 to 2011/12.

The percentage growth weight column contains the weighted contribution to output growth, relative to each service. The weights are based on volume weighted to the national case-mix price.

Summarised Outputs (DHB of Service)	Counties Manukau			
	2010/11 Output Plan		% growth	% growth weights
	2010/11 Forecast	2011/12 Planned		
Case-weighted inpatient discharges				
Maternity	**8,477**	**8,646**	**2.00%**	**0.16%**
Medical	**29,852**	**29,863**	**0.04%**	**0.01%**
Medical electives	427	456	*6.76%*	*0.03%*
Medical acute	29,356	29,336	*-0.07%*	*-0.02%*
Medical other	69	71	*2.60%*	*0.00%*
Surgical	**39,271**	**39,809**	**1.37%**	**0.50%**
Surgical electives	*15,616*	*15,833*	*1.39%*	*0.20%*
Surgical acute	*22,748*	*22,999*	*1.11%*	*0.23%*
Surgical other	*907*	*977*	*7.72%*	*0.07%*
Total case-weighted inpatient discharges				
Total	77,600	78,318	0.93%	0.67%
Outpatient services (expressed as events)				
ED	37,660	35,962	-4.51%	-0.11%
Medical first	12,666	13,703	8.19%	0.08%
Medical follow up	36,239	38,448	6.10%	0.14%
Oncology	-	-	0.00%	0.00%
Renal	42,039	43,477	3.42%	0.21%
Scope	6,308	8,225	30.40%	0.41%
Surgical first	27,094	26,202	-3.29%	-0.04%
Surgical follow up	76,621	79,457	3.70%	0.11%
Other services (expressed as events)				
Maternity	44,228	44,316	0.20%	0.04%
Medical	36,891	37,436	1.48%	0.05%
Surgical	3,662	5,043	37.68%	0.14%
Health of Older People	19,401	20,011	3.14%	0.08%
Miscellaneous	162,583	161,589	-0.61%	-0.03%
All non-inpatient services (expressed as case-weighted outputs)				
Total	29,577	30,724	3.88%	1.07%
Total volume growth	**107,176**	**109,041**		**1.74%**

Volume Comments

Acute Services– Planning was done utilising historical trends to look at past discharge and WIES volumes. Conversion has also been built in to allow for the impact of the methodology changes from WIES NZ10 to WIES NZ11.

For Medicine the impact of the WIES conversion was a decrease in case-weights which has had an impact on the Medical Acute portion of the table above showing it as an overall decrease between Forecast and Planned. With no conversion factor in place Medicine would show a 1.5% increase in case-weights.

The Counties Manukau service provider has had some very unusual peaks in acute activity especially within surgical services. This has meant that our extrapolations for the year end position are larger than we had anticipated in our planning stage. As it was determined there was not strong enough evidence to suggest this growth will be sustained, it was decided to increase the contracts rather than the actuals. These were increased at 3.2% which is more than demographic but less than the current growth. A similar issue occurred in the previous

year with Medical services and this year has seen the WIES growth settle back to a more reasonable level.

Compared to our last years volume plans we have a combined growth of 2.7% on the previous years contracts.

Elective Services – Have been planned in line with Ministerial expectations to enable us to meet health target. Calculated case-weighted growth in Electives services has been impacted on by the removal of Skin Lesion procedures from eligible case-weighted volumes. These volumes are now reflected in Other Services.

Outpatient Services – Have been planned to meet the demand with in the services. Planned volumes for firsts will meet ministerial targets. Significant volume growth in Scopes is planned to address demand on the service and reduce risk.

Other Services – Growth of 38% in Surgical services is the result of the removal of Skin Lesion volumes from case-weighted discharges to procedural events as noted above.

MODULE 8: FINANCIAL PERFORMANCE

8.1 FINANCIAL STATEMENTS

Summary by Funding Arm	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Forecast	2013/14 Plan
Provider	7,584	(55)	(4,235)	(4,465)	(9,584)
Governance	(2,577)	(2,174)	(24)	(27)	57
Funder	(4,844)	5,178	4,302	4,516	9,575
Operating Surplus	**163**	**2,949**	**43**	**24**	**48**
Other Comprehensive Income (devaluation of Land)	(8,775)	-	-	-	-
Surplus (Deficit)	**(8,612)**	**2,949**	**43**	**24**	**48**

Statement of Comprehensive Income

Net Result $000	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Forecast	2013/14 Plan
Revenue					
Crown *	1,188,368	1,249,078	1,303,616	1,368,737	1,449,111
Other	27,986	28,575	25,341	26,607	27,936
Total Revenue	**1,216,354**	**1,277,653**	**1,328,957**	**1,395,344**	**1,477,047**
Expenses					
Personnel	427,485	451,327	479,325	503,269	524,365
Outsourced	50,273	52,674	50,028	52,527	54,729
ISP	548,813	573,134	599,889	629,857	656,488
Clinical Sup.	86,376	93,702	90,475	95,898	107,893
Infrastructure	59,662	56,660	60,866	58,938	63,408
Operating Exp	**1,172,609**	**1,227,497**	**1,280,583**	**1,340,489**	**1,406,883**
Operating surplus	**43,745**	**50,156**	**48,374**	**54,855**	**70,164**
Depn.	23,283	26,361	23,831	25,331	31,601
Interest	7,713	8,681	12,500	17,500	26,014
Capital Chg.	12,586	12,165	12,000	12,000	12,501
Operating Surplus	**163**	**2,949**	**43**	**24**	**48**
Other Comprehensive Income (devaluation of Land)	(8,775)	-	-	-	-
Surplus (Deficit)	(8,612)	2,949	43	24	48

**NOTE: Revenue in 2013/14 is subject to CMDHB receiving its full allocation as currently estimated under the Population Based Funding (PBF) formula but is still subject to review and formal confirmation by the Ministry of Health and the Minister of Health.*

Funder	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	1,143,863	1,190,890	1,255,812	1,318,545	1,396,412
Other	52	-	-	-	-
Total	**1,143,915**	**1,190,890**	**1,255,812**	**1,318,545**	**1,396,412**
Personnel	-	-	-	-	-
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	1,148,759	1,185,712	1,251,510	1,314,029	1,386,837
Total Expenditure	1,148,759	1,185,712	1,251,510	1,314,029	1,386,837
Net Surplus	**(4,844)**	**5,178**	**4,302**	**4,516**	**9,575**

Eliminations	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	(599,946)	(612,578)	(651,621)	(684,172)	(730,349)
Other					
Total	(599,946)	(612,578)	(651,621)	(684,172)	(730,349)
Personnel	-	-	-	-	-
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	(599,946)	(612,578)	(651,621)	(684,172)	(730,349)
Total Expenditure	(599,946)	(612,578)	(651,621)	(684,172)	(730,349)
Net Surplus	**-**	**-**	**-**	**-**	**-**

Provider	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	636,021	662,803	689,261	723,692	771,843
Other	27,564	28,522	25,341	26,607	27,936
Total	**663,585**	**691,325**	**714,602**	**750,299**	**799,779**
Personnel	421,174	444,958	472,689	496,301	517,107
Depreciation	23,283	26,361	23,831	25,331	31,601
Capital Charge	7,713	8,681	12,500	17,500	26,014
Other	203,831	211,380	209,817	215,632	234,641
Total Expenditure	**656,001**	**691,380**	**718,837**	**754,764**	**809,363**
Net Surplus	**7,584**	**(55)**	**(4,235)**	**(4,465)**	**(9,584)**
Other Comprehensive Income (devaluation of Land)	(8,775)	-	-	-	-
Surplus (Deficit)	**(1,191)**	**(55)**	**(4,235)**	**(4,465)**	**(9,584)**

Governance	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	8,430	7,963	10,164	10,672	11,205
Other	370	53	-	-	-
Total	**8,800**	**8,016**	**10,164**	**10,672**	**11,205**
Personnel	6,311	6,369	6,636	6,968	7,258
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	5,066	3,821	3,552	3,731	3,890
Total Expenditure	**11,377**	**10,190**	**10,188**	**10,699**	**11,148**
Net Surplus	**(2,577)**	**(2,174)**	**(24)**	**(27)**	**57**

Total	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	1,188,368	1,249,078	1,303,616	1,368,737	1,449,111
Other	27,986	28,575	25,341	26,607	27,936
Total	**1,216,354**	**1,277,653**	**1,328,957**	**1,395,344**	**1,477,047**
Personnel	427,485	451,327	479,325	503,269	524,365
Depreciation	23,283	26,361	23,831	25,331	31,601
Capital Charge	7,713	8,681	12,500	17,500	26,014
Other	757,710	788,335	813,258	849,220	895,019
Total Expenditure	**1,216,191**	**1,274,704**	**1,328,914**	**1,395,320**	**1,476,999**
Net Surplus	**163**	**2,949**	**43**	**24**	**48**
Other Comprehensive Income (devaluation of Land)	(8,775)	-	-	-	-
Surplus (Deficit)	**(8,612)**	**2,949**	**43**	**24**	**48**

Balance Sheet

$000	2009/10	2010/11	2011/12	2012/13	2013/14
Current Assets					
Cash and Bank	1,577	1,866	1,878	1,888	1,898
Debtors	46,738	48,618	50,558	52,582	54,543
Inventory	613	613	613	613	613
Current Assets total	**48,928**	**51,097**	**53,049**	**55,083**	**57,054**
Non Current Assets	449,085	476,875	511,431	585,686	597,914
Total Assets	**498,013**	**527,972**	**564,480**	**640,769**	**654,968**
Current Liabilities					
Creditors	82,914	76,859	78,270	77,675	74,049
Loans *(Working Capital)*	7,500	21,600	33,600	35,000	40,000
Employee Provisions *(current)*	89,186	94,459	97,807	99,894	102,822
Total Current Liabilities	**179,600**	**192,918**	**209,677**	**212,569**	**216,871**
Working capital	**(130,672)**	**(141,821)**	**(156,628)**	**(157,486)**	**(159,817)**
Net Funds Employed	**318,413**	**335,054**	**354,803**	**428,200**	**438,097**
Non Current Liabilities					
Employee Provision *(Long term)*	13,938	14,290	14,622	14,725	14,795
Term Loans	150,000	160,741	177,514	248,185	255,365
Restricted funds	844	854	866	876	886
Total Non Current Liabilities	**164,782**	**175,885**	**193,002**	**263,786**	**271,046**
Crown Equity	**153,631**	**159,169**	**161,801**	**164,414**	**167,051**
Net Funds Employed	**318,413**	**335,054**	**354,803**	**428,200**	**438,097**

Movement of Equity	**2009/10 Audited Actual**	**2010/11 Forecast**	**2011/12 Plan**	**2012/13 Plan**	**2013/14 Plan**
Total Equity at beginning of period	**159,655**	**153,631**	**159,169**	**161,801**	**164,414**
Surplus / (Loss) for period	(8,612)	2,949	43	24	48
Crown Equity injection	3,009	3,009	3,009	3,009	3,009
Crown Equity withdrawal	(421)	(420)	(420)	(420)	(420)
Total Equity at beginning of period	**153,631**	**159,169**	**161,801**	**164,414**	**167,051**

Cash flows from operating activities	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Operating Activities					
Crown Revenue	1,173,903	1,243,218	1,309,890	1,375,424	1,444,152
Other	45,786	13,720	16,487	17,135	18,181
Interest rec.	647	1,000	1,000	1,050	1,102
Suppliers	749,766	763,756	805,772	840,098	893,251
Employees	424,327	446,767	475,713	501,259	525,557
Interest paid	8,737	8,681	12,500	17,500	26,014
Capital charge	13,404	12,165	12,011	11,889	12,401
GST (Net)	317	95	96	95	90
Net cash from Operations	**23,785**	**26,474**	**21,285**	**22,768**	**6,122**
Investing activities					
Fixed assets					
Baseline	(16,502)	(14,000)	(14,500)	(14,500)	(14,500)
Strategic	(29,268)	(40,151)	(38,147)	(82,926)	(29,329)
Total Fixed Assets	**(45,770)**	**(54,151)**	**(52,647)**	**(97,426)**	**(43,829)**
Restricted & Trust Funds	10	10	12	10	10
Net cash from Investing	**(45,760)**	**(54,141)**	**(52,635)**	**(97,416)**	**(43,819)**
Financing					
Private Debt	500	14,100	12,000	1,400	5,000
Crown Debt	18,500	11,267	16,773	70,669	30,118
Equity - Capital	2,590	2,589	2,589	2,589	2,589
Net cash from Financing	**21,590**	**27,956**	**31,362**	**74,658**	**37,707**
Net increase / (decrease)	(385)	289	12	10	10
Opening cash	1,962	1,577	1,866	1,878	1,888
Closing cash	**1,577**	**1,866**	**1,878**	**1,888**	**1,898**

Capital Expenditure	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Baseline Capital					
Clinical Equipment	9,085	5,000	5,500	5,500	5,500
Other Equipment	613	2,400	2,400	2,400	2,400
Information Technology	3,170	3,900	3,900	3,900	3,900
Intangible Assets (Software)	3,198	1,800	1,800	1,800	1,800
Motor Vehicles	436	900	900	900	900
Subtotal	**16,502**	**14,000**	**14,500**	**14,500**	**14,500**
Strategic Capital					
Clinical Services Block	29,268	40,151	38,147	82,926	29,329
Total	**45,770**	**54,151**	**52,647**	**97,426**	**43,829**

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 continuing constrained funding levels from 2011/12 onwards resulted in CMDHB taking similarly early action through its *Thriving in Difficult Times* and Productivity Initiatives initially established in 2010/11 in order to achieve an Annual Plan reflecting a zero deficit operating position.

Despite the challenges, a budgeted 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, the organisation has been put in a position of higher clinical and financial risk as a result, which we acknowledge must be managed despite the continuing escalating pressures.

While a nationally consistent application of the PBF formula would have significantly benefited CMDHB's current financial position by a minimum of $12m, and allowed CMDHB to continue to self fund the significant number of initiatives around primary care and hospitalisation avoidance, this is not presently available under the MoH capped percentage funding envelope.

Previously the MoH cap increase was limited to 7% (2009/10) in total funding. This was reduced in the 2010/11 year to 5%, and maintained at the same capped level for 2011/12. CMDHB was 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 Population Based Formula (PBF) formula will accrue to CMDHB in future years albeit at the current capped level. This is a very fundamental and important assumption to highlight, as without this recognition the financial position of CMDHB would be at risk (as highlighted later in this document), 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 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 full annualised impact of operating costs relating primarily to the full opening 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 with significant cost impacts in the third year of this Annual Plan (2013/14). This has been funded by way of return to current calculations of full revenue allocation of PBF (as stated above).
- Middlemore hospital bed capacity is expected to be reached in 2013, which will cause other constraint related issues and which will be compounded by the opening of CSB Stage 1. The reaching of capacity is two years ahead of earlier forecasts on bed capacity.
- The need to achieve Government health targets/priorities around ED waiting times, Electives, Cancer waiting times, Elective Service Patient Indicators and the increased costs, primarily FTE related, associated with those targets within the forthcoming constrained budget.
- The annualisation of commitments made in 2010/11, 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 years and forms a very significant and important part of our *Thriving in Difficult Times* targets.
- Acute demand growth is increasing, particularly in the Department of Medicine, Provider Arm, after a period of relatively lower growth.

While the 2010/11 financial result is forecast to achieve a surplus position, this result could be perceived as misleading in comparison to the forecast 2011/12 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 2010/11 reflecting both the timing issues of the new facility developments and lower depreciation levels on assets reaching the end of their economic lives.

We are also forecasting in 2010/11 a "surplus" within the ring fenced Mental Health spend which is essentially a timing issue rather than a permanent underspend. These benefits offset the demand driven cost increases occurring within the Funder Arm, particularly Health of Older People, and Pharmaceutical costs.

In previous years, CMDHB has benefited from the PBF formula specifically through the demographic growth component of the funding which is additional to CCP. This has allowed CMDHB the opportunity to invest in areas directed towards primary health care and early intervention, which would result in a lessening in hospital 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 Annual Plan (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 at the level it seeks. CMDHB remains committed to achieving its Triple Aim objectives. In order to do so we implemented a process of organisational wide review last financial year 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 Annual Plan 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, they are impossible to quantify at this stage.

CMDHB recently entered into a significantly expanded regional shared services arrangement with ADHB, NDHB and HBL, utilising the existing healthAlliance model previously jointly owned by CMDHB and WDHB. Based on the track record of the "old "healthAlliance, we can expect with confidence that there will be material benefits arising for the region over the next few years.

The 2011/12 year will be a difficult balancing act as the focus moves to ensuring financial stability and potentially diluting efforts to deliver on the Northern Region Health Plan objectives and our clinical and quality imperatives. If the financial pressures continue as forecast, greater efficiencies and increased innovation will 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 come at a time when the initial costs of our 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 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 increased operating cost over the next five years.

The 2011/12 Annual Plan shows a breakeven position. In a change from previous years, we are now looking to retain and maintain the existing carried forward surpluses of $15.5m. This is to build up a reserve to offset any future likely investment related deficits in order to achieve a continuing zero deficit return. With regard to the targeted national and DHB objectives, these would be around investment in priority initiatives aligned with the Northern Region Health Plan and Ministerial areas of emphasis and change such as Chronic Care Management (CCM) and Maaori Health. 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. The Annual Plan 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 Northern Region Health 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. As part of the continuing Annual Plan review process, CMDHB has 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 financially cap the level of allowable and fundable growth as well as initiatives, 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, management and Board recognise 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 ($1m-$2m per annum), increased our investment in Primary Options for Acute Care (POAC) by a further $0.6m 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.

We continue to take the lead in terms of implementing local, regional and national initiative around earlier and higher primary care intervention as we work to implement Better, Sooner, More Convenient (BSMC) business plans. The financial consequence of these initiatives will bring unavoidable upfront costs in the early years before the full desired benefits occur. The Planning & Funding function has undergone, and will continue to undergo, changes to meet the evolving Primary Care sector. The need to work cohesively, regionally, has necessitated both formal ("Collaborative Agreement") and informal arrangements to create Alliance agreements with merged PHO's across the region.

8.2.1 Key Assumptions and Risks

As in previous 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 June 30th, 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. 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 continues to be "ring fenced". 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.
- 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 MOH around potential claw back of untagged funds.
- Return to full PBF, as currently calculated, in 2013/14 in order to assist in achieving a breakeven.

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 1.72% 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.
- This Annual Plan has been prepared based on the latest information available around existing and 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 at very similar levels. The 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.
- The significant annual financial impact, particularly this coming year, of the formal introduction in the Auckland region of SMO job sizing
- The continuing committed (albeit constrained) investment in priority initiatives aligned with the Northern Region Health 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 the expanded healthAlliance, now covering the full Northern Region. Again, while there are national procurement and shared services initiatives well under way via HBL as a result of recent government initiatives, we have reviewed the likely outcome of these as they impact on this year's Annual Plan. They appear 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 the "old" healthAlliance. We do not believe it is appropriate to build into the Annual Plan 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 CCP 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 and maintaining 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 clearly having a negative impact on these volumes and the consequent pressure on CMDHB.
- Minister's expectation that each DHB pick up their share of Christchurch Elective volumes. This may cause capacity issues in Auckland which could adversely affect third party prices, which CMDHB will have to access to achieve these volumes given our current capacity constraints.

There remain a number of significant financial risks inherent in CMDHB's Annual Plan 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 Annual Plan 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.
- 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 continuing 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 to 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, 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 continue to impact CMDHB during this and next financial year through focussed action under the *Thriving in Difficult Times* initiative, but will still remain a challenging financial target despite the significant resource commitment.

In recognition of the continuingly tightening fiscal constraints and capped funding, CMDHB management, with full Board support, last year initiated a series of efficiency projects under the general heading "*Thriving in Difficult Times*". Those same initiatives together with newly identified areas of opportunity are reflected in the three year Plan. The overall objectives of the projects are 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. One of the positive outcomes of Quality initiatives has been a reduction in ALOS which has enabled CMDHB to absorb some of the volume growth with existing capacity.

Further (medium to longer term) focus will be around the critical area of service configuration and related capital affordability, as well as extending Quality initiatives into the Primary sector.

- 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 MOH 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 including procurement, quality and clinical enhancement.

- 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. Increased emphasis and scrutiny has been placed on the role and scope of the Northern Region Internal Audit team by CMDHB Board and Audit, Risk and Finance Committee, in order to receive maximum benefit through value for money audits

- As referred to elsewhere in the Annual Plan, considerable effort and development of appropriate strategies are occurring relative to maximising and increasing the benefits of the existing or expanded 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 un-quantified national benefits that may fundamentally change the financial viability of any of the participating organisations.

- 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 Annual Plan.

- 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.

- The increasing northern regional focus has now extended to include support services, capital planning, asset management and the early stages of a regional clinical support services plan.

- 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 Annual Plan, that CMDHB has over the past 6 years now, fully absorbed the impact of CCP [previously FFT] and demographic growth funding levels being understated as per the following two tables:

Table 9: Impact of Inflation (FFT/CCP) Short Funded Over Past 6 Years

Year Ending	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Actual Inflation	4.2%	4.0%	4.0%	3.8%	3.5%	2.0%
MOH FFT	2.6%	3.3%	2.9%	2.8%	3.1%	1.7%
Shortfall	(1.6)%	(0.7)%	(2.0)%	(1.0)%	(0.4)%	(0.3)%
$000 per year	9,380	4,472	13,500	9,390	4,554	2,979
Cumulative Impact $000	$9,380	$13,852	$27,352	$36,742	$41,296	$44,275

Table 10: Impact of Under-estimated Population Growth as Reported through Census/Statistics NZ

Note we have included last year's chart as Statistics New Zealand has not issued the updated census information at time of Annual Plan preparation. Therefore, comments made below are extrapolations based on previous information, and that the planned 2011 census has recently been deferred which will have a material effect on quantifying (and therefore recognising) the continuing CMDHB growth well in excess of sector averages.

Estimation Made In	**Estimate 2006 Pop**	**Estimate Growth**	**% Undercount**	**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 $18.773m
- at $1,000 $8.158m

Note: On this basis, CMDHB has been consistently short funded between $8m - $19m 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 $26m per year through effective revenue or cost recognition under-funding. 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 level of last year's settlements. 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. The provision for the cashing up of the fourth weeks leave will present a significant cash flow challenge for the sector if all parties take full advantage of the change.

In finalising the Annual Plan, CMDHB has again 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.

Regional Job Sizing

As part of an Auckland regional standard approach, CMDHB has previously agreed to participate and abide by SMO regional job sizing standardisation. While most specialties are known and budgeted, there remains significant financial exposure to those specialties not yet finalised. Further, the costs of the existing settlements are at levels somewhat higher than anticipated.

8.3.2 Capital Planning & Expenditure

CMDHB continues to work closely with 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.

It is recognised and acknowledged that the future funding requirements for the greater Auckland region (and CMDHB) are huge, which will present major national funding issues and are therefore almost certainly unsustainable and unaffordable from a fiscal perspective. 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, 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.

While acknowledging the Regional Annual Plan 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, with the CSB Stage 1 project, 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 therefore 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.

Over the past few years, CMDHB has successfully completed all phases of its building programme under the auspice of FMP. This investment totalled over $400m and was almost all fully funded from CMDHB free-cashflow or existing approved debt facilities. They have come in "on time", "under budget" and "within specifications" – an almost unique occurrence in the public health sector.

Last year we 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 additional in-patient beds. This facility incorporates significant improvement in models of care through both layout changes and staffing structures. These beds are fully utilised, reflecting the existing severe shortage of in-patient beds, and were central to helping the DHB achieve the 6 hour ED length of stay target. The "shelled" levels of the Edmund Hillary Block were fitted out as part of the subsequently approved "Clinical Services Block Project Stage 1" and are fully occupied already emphasising the capacity constraints and growth CMDHB continues to operate under

The Clinical Services Block [CSB] Stage 1 [$208m] is now progressing well with the main contract for construction due to be finalised shortly .We continue to refine and improve the original concept as the design is finalised. We remain very confident around the outcomes both clinical and financial

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 with initial construction well advanced and 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 [now complete and occupied] fit out of the remaining (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 [MHP] (Browns Road), Stage 1a. In this regard an amended Business case is currently awaiting Ministerial consideration and approval The original MHP stage 1 has at MOH's request, been split into smaller more financially affordable stages, but is seen as essential in regard to establishing the infrastructure necessary to developing the Health Park concept. Ultimately this health park concept is seen as a true public private alignment and utilisation of health facilities on a single easily accessible site.

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.

As highlighted in Module 5, CMDHB as lead partner, together with Auckland University School of Medicine, MIT and AUT, is well advanced around completing and opening in May 2011, a modular interim educational facility [Ko Awatea] aimed at addressing both current and short term health workforce planning requirements, as well as replacing existing teaching and learning 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 much larger concept for Ko Awatea was originally presented to senior management of the National Health Board in April last year but severe short term capital funding constraints and the urgent need to address the workforce requirements has resulted in CMDHB scaling back the physical size but not the objectives of Ko Awatea to ensure affordability and accessibility.

As a result of further discussions with NHB an interim or modular solution was agreed. This is being internally funded and neutral in overall cost amongst the interested partners. However, the requirement of a permanent solution will be needed by the latest 2013 (for completion 2015 /16), given the limited growth capacity of the interim solution.

Table 11: Towards 20/20 Projects Schedule – Current Projects

Current Projects	Budgeted Approval	Projected finish date	Value	Status
Middlemore, Clinical Services Block Stage 1	Late May 09	Jan 2013	$208m	Underway ($108m internal funded)
Centre for Health Services Innovation	June 10	May 2011	$9.95mm	Completed and operational.

Table 12: Towards 20/20 Projects Schedule – Future Projects

Future Projects	Budgeted Approval	Projected finish date	Value	Status
Manukau Health Park, Stage 1a (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre) Now programmed into 3 phases as per MOH discussions	April 2011 April 2012 April 2013	Nov 2012 Nov 2013 Nov 2014	$33.1m $32.4m $57.0m ($122.5m)	Staged 2011 - 2014
Manukau Health Park, Stage 1b (Mental Health Unit, Mental Health Services for Older People, site infrastructure)	April 2013	Nov 2014	$49.4m	
Women's Health Building (replacing Galbraith, NICU, delivery suites, ante and postnatal wards and gynaecology wards)	April 2014	2018	$80m	
Manukau Health Park, Stage 2 (theatre expansion – 4 elective theatres, MICU, biomed, endoscopy, surgical wards - 40 beds, Women's Health primary maternity unit - 36 beds, community midwives, oncology – haematology unit)	April 2015	2018-2020	$71m	
Middlemore, Clinical Services Block Stage 2 (Radiology service fitout, laboratory service fitout, emergency department expansion, C-Pod Kidz First refurbishment)	April 2012	2015	$108m	
Middlemore Stage 3 (Inpatient Replacement & Expansion) **Manukau Health Park** (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre)	Nov 2015	2018	$80m	
Middlemore Stage 4 (decommission old ARHOP wards) **Manukau Health Park** (Outpatient expansion, ARHOP expansion - 25 beds, Mental Health Services for Older People expansion – 5 beds, surgical wards and theatre expansion)	2016	2017-2018	$55m	
Middlemore, Stage 5 (Decommission Galbraith, new entrance)	Nov 2017	2018-2020	$50m	
Ko Awatea replacement	Mid 2013	Mid 2015	$80m	PPP or equivalent
Staff Car Park	Mid 2013	Mid 2015	~$25m	PPP or equivalent
Integrated Family Healthcare Centre/ Whanau Ora Centre/Tainui	2011/2012	2013/2014	$?	3rd party/SPV
Grand Total			**$615.9m Excluding last 3 items above**	

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 (currently transitioning to Westpac) 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 2011/12 which we have managed through without any major issues but are now indicating that further significant tightening is increasingly likely to occur in 2012/13.

Table 13: Banking Covenants

Facilities ($m)	Existing Limit	Utilisation @ 30 June 2011	Available Facility @ 1 July 2011
CHFA	297.0	150.0	147.0
Commonwealth Bank (working capital)	50.0	7.5	42.5
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.

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 2011/12, 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 2011/12 will be limited to $53.0m. We have not included within the cash flow forecast any capital requirements still requiring MoH/Minister's approval, therefore specifically exclude the MHP Stage 1a and MMH WH Theatres.

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2011/12 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

There are currently no specifically identified asset sales within the time period of this Annual Plan. 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 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 Annual Plan for 2011/12 is immediately following the June 30th 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 2011/12 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 Annual Plan 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 Annual Plan operating breakeven position.

As a result of this, CMDHB has, as part of the preparation of this 2011/12 Annual Plan 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 and then continuance 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.

CMDHB remains committed to maintaining and exceeding in 2011/12, its existing very high level of access and elective volumes that are forecast for 2010/11. 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 2011/12. 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.

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 constantly reconsidering layouts and resourcing levels and mix prior to finalisation of design and layout 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 hiring. 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 Annual Plan, 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 14: 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 CMDHB's share of healthAlliance, NDSA, ARMOS or DHBNZ which are reported separately.

These caps will require adjustment relative to the expansion of hA and the transfer of ADHB and NDHB staff to the enlarged hA.

8.5 HEALTHALLIANCE (PREVIOUSLY A 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 objectives through HBL 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. As advised earlier, ADHB and NDHB together with HBL are now all partners in an expanded shared service entity. The three metro-Auckland DHB's do not anticipate material gains in the early stages of this project as it is expected that NDHB will have significant procurement gains from the leveraging advantage they will now gain.

The current financial constraints imposed on all DHBs have meant we have had to restrict healthAlliance activities for the past year in order to enable them to live within the overall funding package. Regrettably this meant a year 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 all the new DHB shareholders and essential to the future development of the region.

Despite the financial constraints currently imposed, the need for greater investment in our IS/IT resources in full alignment with the national IT Health Board's objectives, 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 a zero operating deficit.

8.6 2011/12 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 2011 "October" forecast describes an increase of $4m or 4.3% 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.

At time of writing, Pharmac is seeking DHB response to its amended budget bid. CMDHB with the Northern Region, support Option A - a reduction in the current level of investment. This will provide greater ability to fund the huge growth in dispensing cost, outside of Pharmac's control.

8.7 OUTLOOK FOR 2012/13 AND 2013/14 YEARS

The outer years of the Annual Plan 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 2011/12 financial year, the outer years "base" positions have relatively speaking, improved significantly, based on the continuing revenue and cost assumptions. We are therefore anticipating that the 2012/13 of the Plan can be maintained at a nil deficit level. The 2013/14 year of the plan however includes the part year impact of the new Clinical Services Block coming on stream with increasing material impact on our operating financial position. While the incremental costs of the CSB Stage 1 are, as forecast in the original business case, expected to be in excess of $40m per annum, much of this has been absorbed and the remainder funded by (the as yet unapproved) return to the currently assessed level of full PBF.

   - Years 2 and 3 of the CMDHB Annual Plan 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 Annual Plan, the full impact of the cost relating to the opening of Edmund Hillary Block at Middlemore is recognised at almost $6m per year as detailed in the original Business Case and has been fully absorbed.

   - The outer years of the Annual Plan 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 last year. This is similarly likely to put even greater pressure around workforce levels, recruitment and training,

underlining the criticality of the investment in Ko Awatea (formerly the Centre for Health Services Innovation)

- The Annual Plan does not include the cash flow impact and initial operating expense impacts of any current or future, but as yet unapproved, business cases, i.e. it only includes the capital cost [and operating cost in 2013/14] of the approved $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 together with other widespread cost savings initiatives and revenue enhancements, thus underlining how important the achievement of these project outcomes are, 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

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 surplus or loss
An instrument is classified as at fair value through **surplus** 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 comprehensive income 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 comprehensive income when incurred. Subsequent to initial recognition, financial instruments at fair value through comprehensive income are measured at fair value, and changes therein are recognised in the surplus or loss.

Other non derivative financial instruments
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.

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

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 surplus or loss over the period of the borrowings on an effective interest basis.

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 re-measurement to fair value is recognised immediately in the surplus or loss. 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.

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 in other comprehensive income unless it offsets a previous decrease in value recognised in the surplus or loss. 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 comprehensive income.

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 comprehensive income 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.

An operating lease is a lease that does not transfer substantially all risks and rewards incidental to ownership of an asset.

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 comprehensive income as an expense as incurred.

Depreciation

- Depreciation is recognised as an expense 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**

Type of asset	Estimated life	Amortisation rate
Buildings - 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	3 - 5 years	20% 33%
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 recognised as an expense 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 comprehensive income.

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 comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive income 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 comprehensive income.

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 comprehensive income.

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.

Employee benefits

Defined contribution plans
Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive income as incurred.

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 is recognised as revenue 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

In accordance with Generally Accepted Accounting Practice and NZIFRS, surpluses of Income over expenditure are reported through the Statement of comprehensive income. 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. For year end 30 June 2011 there is estimated to be $3.5M unspent in respect of Mental Health Ring Fenced Revenue (as at 30 June 2010 $4.4 m).

Expenses

Operating lease payments
Payments made under operating leases are recognised as an expense on a straight-line basis over the term of the lease. Lease incentives received are recognised 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 comprehensive income 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.

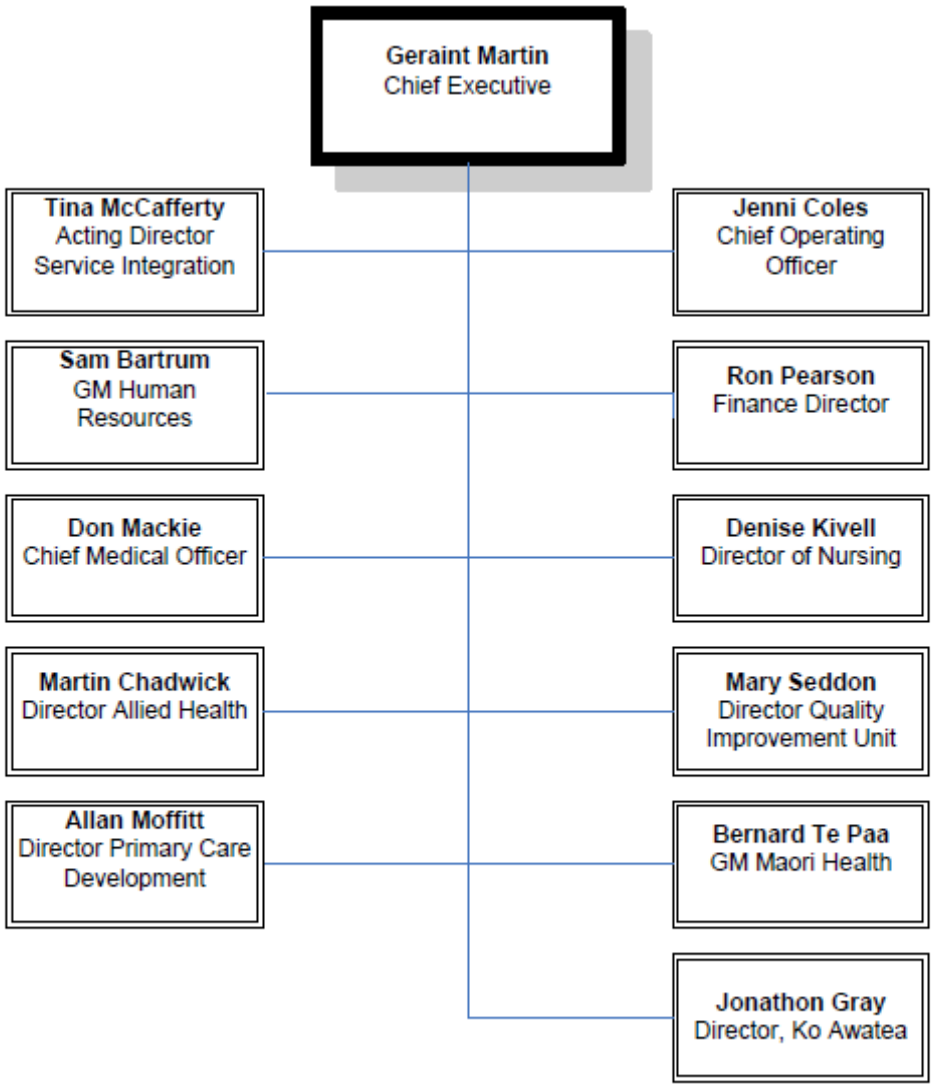
Cost Allocation Policy
Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

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.

MODULE 9: APPENDICES

APPENDIX 1: CMDHB ORGANISATIONAL STRUCTURE CHART (AS OF MAY 2011)



APPENDIX 2: CLINICAL LEADERSHIP STRUCTURES AT CMDHB

Clinical Advisory Group (CAG)

The Clinical Advisory Group provides overarching clinical governance of the health sector in Counties Manukau, with particular emphasis on the interface issues and to assist CMDHB achieve service integration. The forum provides advice on matters of clinical quality and clinical risk management and escalation of clinical risks where there is no other appropriate forum for cross-sector issues.

The forum will also advise on clinical and patient safety issues, for example, issues relating to clinical quality between primary, secondary and tertiary care interfaces; accountability for hand-over between primary and secondary care; and, the implementation of appropriate systems to support clinical governance in provider services.

Other functions of CAG include informing the development of, and monitoring the progress of, whole of sector performance indicators; providing provider feedback, and, informing the development of clinical services.

Clinical Management Executive Committee (CMEC)

The Clinical Management Executive Committee Secretariat is responsible for the entire patient journey, including horizontal integration across the sector and across primary and secondary/tertiary services.

The roles and functions of the Clinical Management Executive Committee include:

- Responsibility for setting policies and guidelines on clinical and ethical issues; Monitoring the outcomes of the policies it defines and clinical quality throughout the organisation;
- Commissioning of audits or specific investigations and to make recommendations to the Executive Management Team, Clinical Directors and Service Managers;
- Resolving disagreements about clinical and ethical standards;
- Monitoring credentialing processes;
- Encouraging good practice and the introduction of good practice; and
- Investigating patient safety issues.

APPENDIX 3: DIMENSIONS OF DHB PERFORMANCE MEASURES

Policy Priorities Dimension

Performance Measure and description	2011/12 Target	National Target	Frequency
PP1 Clinical leadership self assessment			
The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and the DHB engagement with it across their region. This will include a summary of the following – how the DHB is: ● Contributing to regional clinical leadership through networks ● Investing in the development of clinical leaders ● Involving the wider health sector (including primary and community care) in clinical inputs ● Demonstrating clinical influence in service planning ● Investing in professional development ● Influencing clinical input at board level and all levels throughout the DHB – including across disciplines. What are the mechanisms for providing input?	No quantitative target qualitative deliverable required.	NA	Annual
PP2 Implementation of *Better, Sooner, More Convenient* primary health care			
The DHB is to supply a progress report on the implementation of changes to primary health care services that deliver on the core elements of *Better, Sooner, More Convenient* primary health care. In particular progress must be described regarding: 1. the shifting of services from secondary care to primary care settings; 2. the development of Integrated Family Health Centres; and 3. any specific reporting requirements that may be identified in the Minister's Letter of Expectations (to be confirmed). **AND (as applicable)** 1. Those DHBs involved in *Better, Sooner, More Convenient* (BSMC) primary health care business case(s) are required to supply a progress report on the implementation of the business case(s) it is involved in. The BSMC Monitoring Framework includes indicators at three levels: 2. Those DHBs involved in *Better, Sooner, More Convenient* primary health care business case(s) are required to supply a progress report on the operation and expenditure of the flexible funding pool, including how pool funding has been prioritised to deliver services to meet the four high-level objectives. Where problems are identified, resolution plans are to be described.	No quantitative target qualitative deliverable required.	NA	Quarterly
PP3 Local Iwi/Maaori engagement and participation in DHB decision making, development of strategies and plans for Maaori health gain			
Measure 1 - PHO Maaori Health Plans Percentage of PHOs with MHPs that have been agreed to by the DHB.	100%	**100%**	
Measure 2 - PHO Maaori Health Plans Report on how MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs) **OR** for newly established PHOs, a report on progress in the development of MHPs (include a list of the names of these PHOs).			
Measure 3 - DHB – Iwi/Maaori relationships Provide a report demonstrating: • Achievements against the Memorandum of Understanding (MoU) between a DHB and its local Iwi/Maaori health relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties during the reporting period. • Provide a copy of the MoU.			
Measure 4 - DHB – Iwi/Maaori relationships Report on how (mechanisms and frequency of engagement) local Iwi/Maaori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs).			

Measure 5 - DHB Maaori Health Plan Provide a report by exception on national level priorities that have not been achieved in the DHB Maaori Health Plan. The report will say why the priority has not been achieved, what the DHB will do to rectify it, and by when.			
PP4 Improving mainstream effectiveness DHB provider arms pathways of care of Maaori			
Measure1 Provide a report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Maaori.	No quantitative target qualitative deliverable required.	NA	Six-Monthly
Measure 2 Report on examples of actions taken to address the issues identified in the reviews. The report should identify:• what issues/ opportunities were brought to your attention as a result of the reviews of pathways of care that you identified in Measure one• the follow up actions you intend to take/ are taking as a result of the issues and opportunities that you identified above.The report should include timeframes for implementing the actions you identify.			

Performance Measure and description				2011/12 Target	National Target	Frequency
PP5 Waiting times for chemotherapy treatment						
Provide a report confirming the DHB has reviewed the monthly wait time templates produced by either the relevant Cancer Centre(s) or its own DHB where treatment commenced at that DHB for the quarter. Where the monthly wait time data identifies: • any patients domiciled in the DHB waiting more than four weeks, due to capacity issues, and/or • wait time standards were not met, for patients in priority categories A and B DHBs must provide a report outlining the resolution path.				100 % at four weeks	**100% at four weeks**	Quarterly
PP6 Improving the health status of people with severe mental illness						
The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for: • child and youth aged 0-19, specified for each of the three categories Maaori, Other, and in total • adults aged 20-64, specified for each of the three categories Maaori, Other, and in total • older people aged 65+, specified for each of the three categories Maaori, Other, and in total.	**Age 0-19**	Maaori		4.00%	**4.00%**	Six-Monthly
		Other		2.67%	**2.67%**	
		Total		2.98%	**2.98%**	
	Age 20-64	Maaori		6.66%	**6.70%**	
		Other		2.89%	**3.00%**	
		Total		3.43%	**3.53%**	
	Age 65+	Total		2.63%	**2.76%**	
PP7 Improving mental health services using crisis intervention planning						
Provide a report on: 1. The number of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (* in treatment = at least one provider arm contact every three months for two years or more.) The subset of alcohol and other drug only clients will be reported for the 20 years plus. 2. The number of Child and Youth who have been in secondary care treatment* for one or more years (* in treatment = at least one provider arm contact every three months for one year or more) who have a treatment plan. 3. The number and percentage of long-term clients with up to date relapse prevention/treatment plans (NMHSS criteria 16.4 or HDSS [2008]1.3.5.4 and 1.3.5.1 [in the case of Child and Youth]). 4. Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided. DHBs that have fully implemented KPP across their long-term adult population should state KPP as the methodology.	**Adult (20+)**	Maaori	95%		**95%**	Six-Monthly
		Non Maaori	95%		**95%**	
	Child & Youth	Maaori	95%		**95%**	
		Non Maaori	95%		**95%**	

PP8 DHBs report alcohol and drug service waiting times and waiting lists					
Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm. Reporting will be on the longest waiting time in days, plus the number of people on the waiting list for treatment at the end of the month, i.e. volume and time. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment. DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period.			No quantitative target. Supply of quantitative data required.	NA	Six-Monthly
PP9 Delivery of Te Kokiri: the mental health and addiction action plan					
DHBs are to provide a summary report on progress made towards implementation of Te Kōkiri: the Mental Health and Addiction Action Plan. A template for this report can be found on the nationwide service framework library web site NSFL homepage: http://nsfl.health.govt.nz.			No quantitative target qualitative deliverable required.	NA	Annual
PP10 Oral Health DMFT Score at year 8					
Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the total number of: (i) permanent teeth of children in school Year 8 (12/13-year olds) that are – • Decayed (D), • Missing (due to caries, M), and • Filled (F); and (ii) children who are caries-free (decay-free).		Maaori	1.50	**1.46**	Annual
		Pacific	1.63	**1.30**	
		Other	0.88	**0.87**	
		Total	1.20	**1.10**	
	Total	***Fluoridated***	1.30	**1.20**	
		Non Fluoridated	0.86	**0.87**	
PP11 Children caries free at 5 years of aged					
At the first examination after the child has turned five years, but before their sixth birthday, the total number of: (i) children who are caries-free (decay-free); and (ii) primary teeth of children that are – • Decayed (d), • Missing (due to caries, m), and • Filled (f).		Maaori	43%	**41%**	Annual
		Pacific	35%	**36%**	
		Other	65%	**69%**	
		Total	52%	**53%**	
	Total	***Fluoridated***	45%	**43%**	
		Non-Fluoridated	58%	**57%**	

Performance Measure and description		2011/12 Target	National Target	Frequency
PP12 Utilisation of DHB funded dental services by adolescents				
In the year to which the reporting relates, the total number of adolescents accessing DHB-funded adolescent oral health services, defined as: (i) the unique count of adolescent patients' completions and non-completions under the Combined Dental Agreement; and (ii) the unique count of additional adolescent examinations with other DHB-funded dental services (e.g. DHB Community Oral Health Services, Maaori Oral Health providers and other contracted oral health providers). To reduce duplication of effort, at the end of each quarter in the year to which the reporting relates, the Ministry will organise a data extract from Sector Services for all DHBs for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for DHBs' use in determining part (i) of the Numerator.	Total	80%	**85%**	Annual
PP13 Improving the number of children enrolled in DHB funded dental services				
Measure 1 - In the year to which the reporting relates, the total number of children under five years of age, i.e. aged 0 to 4 years of age inclusive, who are enrolled with DHB-funded oral health services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Maaori oral health providers).	Children Enrolled **0-4 years**	65%	NA	Annual
Measure 2 - In the year to which the reporting relates:(i) the total number of pre-school children and primary school children in total and for each school decile who have not been examined according to their planned recall period in DHB-funded dental services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Maaori oral health providers); and(ii) the greatest length of time children has been waiting for their scheduled examination, and the number of children that have been waiting for that period.	Children not examined **0-12 years**	12%		

Performance Measure and description	2011/12 Target	National Target	Frequency
PP14 Family violence prevention			
Confirmation report based on audit scores for partner abuse and child abuse and neglect programme components. (Data source: Provided to DHBs by the Auckland University of Technology (AUT) Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit.)	140/200	**140/200**	Annual
PP15 Improving the safety of elderly: Reducing hospitalisation for falls			
The number of people 75 yrs and older hospitalised for falls domiciled in the DHB region, per year.	No targets expected for this FY	NA	Six-Monthly
PP16 Workforce - Career Planning			
The DHB provides quantitative data to demonstrate progress achieved for career planning in their staff. For each of the following categories of staff a measure will be given for Numbers receiving HWNZ funding/ number with career plan for required categories: ● Medical staff ● Nursing ● Allied technical ● Maaori Health ● Pacific ● Pharmacy ● Clinical rehabilitation ● Other	No quantitative target. Supply of quantitative data required.	NA	Annual

System Integration Dimension

Performance Measure and description			2011/12 Target	National Target	Frequency
SI1 Ambulatory sensitive (avoidable) hospital admissions					
Each DHB is expected to provide a commentary on their latest 12 month ASH data that's available via the nationwide service library. This commentary may include additional district level data that's not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions. Each DHB should also provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Maaori 45-64 year olds.	**Age 0-74**	Maaori	103	101.00	Six-Monthly
		Pacific	96	95.00	
		Other	100	99.00	
	Age 0-4	Maaori	95.00	95.00	
		Pacific	95.00	95.00	
		Other	95.00	95.00	
	Age 54-64	Maaori	119	116.00	
		Pacific	98	97.00	
		Other	115	112.00	
SI2 Regional service planning					
A single progress report on behalf of the region agreed by all DHBs within that region. The report should focus on the actions agreed by each region as detailed in its regional implementation plan. For each action the progress report will identify: • the nominated lead DHB/person/position responsible for ensuring the action is delivered • whether actions and milestones are on track to be met or have been met • performance against agreed performance measures and targets • financial performance against budget associated with the action. If actions/milestones/performance measures/financial performance are not tracking to plan, a resolution plan must be provided. The resolution plan should comment on the actions and regional decision-making processes being undertaken to agree to the resolution plan.			No quantitative target qualitative deliverable required.	NA	Quarterly
SI3 Service coverage					
Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through:• analysis of explanatory indicators• media reporting • risk reporting• formal audit outcomes• complaints mechanisms• sector intelligence.			No quantitative target qualitative deliverable required.	NA	Six-Monthly
SI4 Elective services standardised intervention rates					
For any procedure where the standardised intervention rate in the 2011/12 financial year or 2011 calendar year is significantly below the target level a report demonstrating: 1. what analysis the DHB has done to review the appropriateness of its rate **AND** 2. whether the DHB considers the rate to be appropriate for its population **OR** 3. a description of the reasons for its relative under-delivery of that procedure; and 4. the actions being undertaken in the current year (2011/12) that will ensure the target rate is achieved.	**Intervention rate**		308 per 10,000	**308 per 10,000**	Six-Monthly
	Major joint replacement procedures		21 per 10,000	**21 per 10,000**	
	Hip		10.5 per 10,000	**10.5 per 10,000**	
	Knee		10.5 per 10,000	**10.5 per 10,000**	
	Cataract Procedures		27 per 10,000	**27 per 10,000**	
	Cardiac procedures		6.5 per 10,000	**6.5 per 10,000**	

Performance Measure and description			2011/12 Target	National Target	Frequency
SI5 Expenditure on services provided by Maaori Health providers					
Measure 1 DHB to report actual expenditure (GST exclusive) on Maaori providers by General Ledger (GL) code. **Measure 2** DHBs to report actual reported expenditure for Maaori providers in comparison to estimated expenditure for Maaori providers in their Annual Plan for the same reporting period, with explanation of variances.			No quantitative target. Supply of quantitative data required.	NA	Annual
SI7 Improving breast-feeding rates DHBs are expected to set DHB-specific breastfeeding targets with a focus on Maaori, Pacific and the total population respectively (see Reducing Inequalities below) to incrementally improve district breastfeeding rates to meet or exceed the National Indicator. DHBs will be expected to maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeted Maaori and Pacific communities. The Ministry will provide breastfeeding data sourced from Plunket, and DHBs must provide data from non-Plunket Well Child providers. DHBs are to report providing the local data from non-Plunket Well Child providers.	**6 weeks**	Maaori	62%	**74%**	Annual
		Pacific	67%		
		Other	70%		
		Total	67%		
	3 Months	Maaori	46%	**57%**	
		Pacific	51%		
		Other	59%		
		Total	55%		
	6 Months	Maaori	18%	**27%**	
		Pacific	22%		
		Other	29%		
		Total	26%		

Ownership Dimension

Performance Measure and description	2011/12 Target	National Target	Frequency
OS3 Elective and arranged inpatient length of stay			
The standardised ALOS is the ratio of 'actual' to 'expected' ALOS, multiplied by the nationwide inpatient ALOS. The DHB's 'actual' ALOS, and the nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The 'expected' ALOS is derived by taking the nation-wide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents, and summing the result across all discharge groups.	3.92 Days	3.92 days	Quarterly
OS4 Acute inpatient length of stay			
The standardised ALOS is the ratio of 'actual' to 'expected' ALOS, multiplied by the nationwide inpatient ALOS. The DHB 'actual' ALOS, and nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The 'expected' ALOS is derived by taking the nationwide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents for the DHB, and summing the result across all discharge groups.	3.96 days	3.96 days	Quarterly

OS5 Theatre Utilisation			
Each quarter, the DHB is required to submit the following data elements, represented as a total of all theatres in each Provider Arm facility. • Actual theatre utilisation, • resourced theatre minutes, • actual minutes used as a percentage of resourced utilisation The expectation is that DHBs will supply information on the template quarterly. Baseline performance should be identified as part of the establishment of the target. The goal for 2011/12 will be one of the following: a. For DHBs whose overall utilisation is less than 85%, a target that is a substantial incremental step towards achieving the 85% target is recommended b. For DHBs whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended	82.5%	**85%**	Quarterly
OS6 Elective and arranged day surgery			
The standardised day surgery rate is the ratio of the 'actual' to 'expected' day surgery rate, multiplied by the nationwide day surgery rate, expressed as a percentage. The DHBs 'actual' day surgery rate, and the nationwide day surgery rate, are both defined as the number of day surgery discharges for the 12 months to the end of the quarter (for elective and arranged surgical patients), divided by the total number of surgical discharges in the 12 months to the end of the quarter (for elective and arranged surgical patients). The 'expected' day surgery rate is derived by taking the nationwide day surgery rate for discharges in each DRG, multiplying this by the proportion of total discharges the DRG represents for the DHB, and summing the result across all DRGs.	60%	**62% Standardised**	Quarterly
OS7 Elective and arranged day of surgery admissions			
The number of DOSA discharges, for elective and arranged surgical patients (excluding day surgical cases) during the 12 months to the end of the quarter, divided by the total number of discharges for elective and arranged surgical patients (excluding day surgical cases) for the 12 months to the end of the quarter, to give the DOSA rate as a percentage.	90%	**90% Standardised**	Quarterly
OS8 Acute readmissions to hospital			
The standardised acute readmission rate is the ratio of the 'actual' to 'expected' acute readmission rate, multiplied by the nationwide acute readmission rate, expressed as a percentage. The DHB's 'actual' acute readmission rate, and the nationwide acute readmission rate, are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The 'expected' acute readmission rate is derived using regression methods from the DRG cluster and patient population characteristics of the DHB.	9.55%	9.55%	Quarterly
OS9 30 Day mortality			
The measure is for a standardised mortality rate, in order to improve the comparability of the measure across the sector. The standardised mortality rate is the ratio of the 'actual' to 'expected' mortality rates, multiplied by the nationwide mortality rate, expressed as a percentage. The DHB's 'actual' mortality rate, and the nationwide mortality rate, are both defined as the number of in-hospital patient deaths within 30 days of admission, as a proportion of all patient discharges, including daycases. The 'expected' mortality rate is derived using regression methods from the DRG and patient population characteristics of the DHB.	Baseline: 1.41 Maintain current rate or lower	1.51	Annual
OS10 Improving the quality of data provided to national collection systems			
Measure 1: National Health Index (NHI) duplications Numerator: Number of NHI duplicates that require merging by Data Management per DHB per quarter. The Numerator excludes pre-allocated NHIs and NHIs allocated to newborns and is cumulative across the quarter. Denominator: Total number of NHI records created per DHB per quarter (excluding pre-allocated NHIs and newborns)	<6%	**<6%**	Quarterly

Measure 2: Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI Numerator: Total number of NHI records created with ethnicity of 'Not Stated' or 'Response Unidentifiable' per DHB per quarter Denominator: Total number of NHI records created per DHB per quarter	<2%	**<2%**	
Measure 3: Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS) Numerator: Number of versions of text descriptor for specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB Denominator: Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB	>50%	**>55%**	
Measure 4: Timeliness of NMDS data Numerator: Total number of publicly funded NMDS events loaded into the NMDS more than 21 days post month of discharge. Denominator: Total number of publicly funded NMDS events in the NMDS per DHB per quarter.	<5%	**<5%**	
Measure 5: NNPAC Emergency Department admitted events have a matched NMDS event Numerator: Total number of NNPAC Emergency Department admitted events that have a matching NMDS event Denominator: Total number of NNPAC Emergency Department admitted events	>97%	**>97%**	
Measure 6: PRIMHD File Success Rate Numerator: Number of PRIMHD records successfully submitted by the DHB in the quarterDenominator: Total number of PRIMHD records submitted by the DHB in the quarter	>98%	**>98%**	

Output Dimension

Performance Measure and description			2011/12 Target	National Target	Frequency
OP1 Output Delivery					
DEFINITION TO BE DEFINED					Quarterly

APPENDIX 4: GLOSSARY OF TERMS

Activity	What an agency does to convert inputs to Outputs.
Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve the Government's goals.
Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister. One of the three types of statutory entities (see also Crown entity; autonomous Crown entity and independent Crown entity)
Crown entity	A generic term for a diverse range of entities within 1 of the 5 categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
Impact	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. E.g. The change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations. (Public Finance Act 1989)
Impact measures	Impact measures are attributed to agency (DHBs) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can be measured after delivery, promoting timely decisions; reveal specific ways in which managers can remedy performance shortfalls. (http://www.ssc.govt.nz/upload/downloadable_files/performance-measurement.pdf)
Input	The resources such as labour, materials, money, people, information technology used by departments to produce outputs, that will achieve the Government's stated outcomes. (http://www.ssc.govt.nz/glossary/)
Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group. (Refer (http://www.ssc.govt.nz/glossary/)
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes (Refer State Services Commission 'Performance Measurement – Advice and examples on how to develop effective frameworks: www.ssc.govt.nz)
Intermediate outcome	See Outcomes
Management systems	Are the supporting systems and policies used by the DHB in conducting its business?
Measure	A measure identifies the focus for measurement: it specifies what is to be measured
Objectives	Is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve "outputs". E.g. Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving Governance…etc are 'internal to the organisation and enable the achievement of 'outputs'.
Outcome	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more

generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. (Refer http://www.ssc.govt.nz/glossary/)

A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).

Output agreement

Output agreement/output plan - See Purchase Agreement (refer to http://www.ssc.govt.nz/glossary/)

An output agreement is to assist a Minister and a Crown entity (DHB) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs (see s170 (2) CE Act 2004.

Output classes

Are an aggregation of outputs. (Public Finance Act 1989)
Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures (s 142 (2) (b) CE Act 2004). Are groups of similar outputs (Public Finance Act 1989).

Outputs

Are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).

Ownership

The Crown's core interests as 'owner' can be thought of as:
Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown;

Capability - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future;

Performance - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively. (Refer http://www.ssc.govt.nz/glossary/)

Performance measures

Selected measures must align with the DHBs DSP and DAP. The use four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year (2010/11) and show intended results for the two subsequent financial years. (Refer to www.ssc.govt.nz/performance-info-measures)

Priorities

Statements of medium term policy priorities.

Purchase agreement

A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs. Some departments piloting new accountability and reporting arrangements now prepare an output agreement. An output agreement extends a purchase agreement to include any outputs paid for by third parties where the Minister still has some responsibility for setting fee levels or service specifications. The Review of the Centre has recommended the development of output plans to replace departmental purchase and output agreements. (Refer http://www.ssc.govt.nz/glossary/)

Regional collaboration

Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist.

- Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB
- Midland: Bay of Plenty DHB, Lakes DHB, Tairawhiti, Taranaki, Waikato DHB,
- Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB, Whanganui DHB
- Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB

Regional collaboration for some clinical networks may vary slightly. For example Central Cancer Network contains eight DHBs, Taranaki DHB and Tairawhiti DHB in addition to the Central Region DHBs.

Results

Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once. (http://www.ssc.govt.nz/glossary/)

Standards of Service Measures

Measures of the quality of service to clients focus on aspects such as client satisfaction with the way they are treated; comparison of current standards of service with past standards; and appropriateness of the standard of service to client needs.

Statement of service performance (SSP)

Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year. (http://www.ssc.govt.nz/glossary/)

Strategy

See Ownership
(http://www.ssc.govt.nz/glossary/)

Sub regional collaboration

Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping. Typically this is groupings of two or three DHBs and may be formalized with an agreement e.g. Memorandum of Understanding. Examples include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (centralAlliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.

Targets

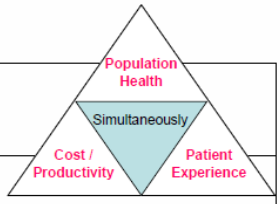
Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.

Values

The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. (http://www.ssc.govt.nz/glossary/)

APPENDIX 5: NORTHERN REGION HEALTH PLAN OUTCOMES FRAMEWORK

Northern Region Health Service Plan



Our Mission:
"To Improve health outcomes and reduce disparities by delivering better sooner more convenient services. We will do this in a way that meets future demand whilst living within our means"

Our Region's Strategic Challenges

- Inequalities in health status and health outcomes linked to ethnicity and socio-economic deprivation
- Demand for health care services, and particularly acute care, is predicted to exceed the level of health care resources
- The cost of providing publicly funded health services is growing at an unsustainable rate, influenced by demand pressures, new technologies and labour costs
- Delivery of care is fragmented between primary and secondary services and is based around an episodic model of care which does not work well for people with long term and complex conditions.
- There are substantial human and financial costs to our community associated with failures in health and disability services.

Our Strategic Goals

	1. Population Health: Lift Health Outcomes of Northern Region Population; Life and years (Longer, healthier, more independent lives); and reduce health inequalities	2. Patient Experience: Better Services; First do no harm; Informed choice; and performance improvement	3. Cost / Productivity: Ensure capacity to meet demand whilst living within our means
Objectives and expected outcomes	1.1 Minimise impacts from diabetes and cardiovascular disease evidenced by • Improved outcomes for patients and reduced inequality gap • Reduced incidence of disease • Regionally consistent response and methodology to prevention, care and treatment of those at risk of, or with disease. • Development and support of workforce to meet demand 1.2 Improve outcomes for older people and have a regionally consistent approach to best ensure the alignment of capacity and demand, by: • Reducing the need for older people to enter residential care • Reducing older people acute demand on hospital through development and implementation of alternative care settings and care processes • Ensuring dementia care needs are met by consistent regional co-ordination and care pathways • Improving the safety and quality of care for older patients in hospital and aged residential care • **Development and support of workforce to meet demand** 1.3 Minimise impacts from cancer and improve quality of cancer care by ensuring regional equity of access to care, improved treatment times and appropriate screening mechanisms, these approaches evidenced by: • **Further develop/ improve lung cancer and bowel cancer pathways for the region** • **Improved early diagnosis and management of bowel cancer** • Partnering with private sector to increase region capacity • **Reducing wait times for care** 1.4 Healthier safer children evidenced by : • Increased immunisation	2.1 Improve safety and quality of Regions health care across the whole sector • Ensure fewer adverse clinical events result from patient care • Understand what harm is occurring (also where and how it is occurring) • Raise patient satisfaction with their care • Implement regionally consistent methodologies to address regional issues • Implement a structured regional collaboration approach to drive progress of safety and quality priorities 2.2 Informed patient choice to ensure patients get appropriate care that best suits their context • Develop and promote consistent Advanced Care Planning (ACP) • **Implement Whanau Ora Assessments** 2.3 Appropriate health and disability services are able to be accessed in a timely manner when needed • Rapid access for patients with acute needs • Improved access to elective services to restore/ maintain peoples' functional independence • Maintain / reduce target wait times for patients accessing the hospital system	3.1 Regional resources are used effectively and services delivered efficiently with minimal wastage 3.2 Improve Regional radiology services by: • Improving access to, and timeliness of, radiology diagnostics 3.3 Manage infrastructure and assets to ensure safe, efficient and effective services evident by • Regional collaboration on spatial planning to inform capital planning • Delivering major infrastructure developments on time within budget 3.4 Work in partnership to effectively influence health and wellbeing outcomes evident by • Improving involvement of internal and external partners in the planning and provision of health services 3.5 Ensure a consistent region wide service investment-mix prioritisation process to help each DHB determine the optimum service mix 3.6 Invest in information systems and technology in five priority areas • Common PAS with standard processes and improved data quality related to patient registration • Provide a consistent user experience, improve clinical communication options and reduce the complexity of integration and audit functions • Meet the requirements of continuity of care • Create a single source of truth for regional population health information • Maintain current capability and support ongoing development
Expanded Outcomes / High Level Measures (short, medium and long term)	1.11 Develop and implement an auditable clinical pathway for Diabetes 1.12 Develop and implement a GP mentoring system and nurse practitioner model supported by training as required 1.13 Develop outcomes based framework 1.14 Improve data capture and information quality with regard to diabetes and CVD. 1.15 Align Diabetes / CVD workforce to meet demand 1.16 Reduce morbidity and mortality from Diabetes and Cardiovascular disease (including inequalities between different population rates) 1.17 Better diabetes and cardiovascular services [HT6] 1.18 Better Help for smokers to quit [HT5] 1.19 Appointment of a Diabetes and a Cardiology Clinical Network with supporting resource 1.21 Understand and manage drivers for admission to ARC 1.22 promote Aging in Place in line with national strategy 1.23 Expand implementation of community gerontology model 1.24 Development of regional strategies to: reduce ASH rates for older people; manage hospital acute demand from ARC 1.25 Better support older people with cognitive decline - mental health issues 1.26 Reduce falls and pressure injuries in hospitals and ARC facilities 1.27 Appointment of an Older People Clinical Network with supporting resource 1.28 engage in workforce modeling and development 1.31 Improved lung cancer and Bowel cancer pathways 1.32 Implemented Northern Region prioritisation criteria for colonoscopy 1.33 Deliver a successful bowel screening pilot at Waitemata DHB 1.34 Source a long term, sustainable RT solution 1.35 Monitor time from date of waitlist to colonoscopy 1.41 Increased Immunisation rates [HT4]	2.11 Develop a safety and quality outcomes based framework with performance indicators, measures and targets 2.12 Develop 'how to' guides for areas of focus (inc falls, pressure injuries CLABs, care transfer and patient ID) 2.13 Establish pilot site for medication safety 2.14 Complete 50 deaths audit in each DHB 2.15 Implement 'Trigger Tool' across the Region 2.16 Establish a campaign with collaborative structure and resource. 2.21 Stock take existing ACP activities especially in relation to ARC 2.22 Develop capacity of staff to undertake ACP 2,23 Increase number of people having an advanced care plan 2.22 Number of Whanau Ora Assessments with agreed goal oriented plans 2.31 Shorter stays in emergency departments [HT1] 2.32 Elective surgical services to be increased in line with elective service Health Target [HT2] 2.33 Shorter waits for treatment - maintain 4 week radiotherapy [HT3] - reduce wait time for chemotherapy - meet door to cath- lab target time	3.11 Maximise gains through regional provision of back office shared services 3.12 Minimal Region delivery variation once good clinical practice is identified 3.21 Develop a Radiology Clinical Network and agree regional workplan with priorities likely to encompass: models of care; workforce; IS and capital expenditure 3.31 Develop Regional Spatial and Asset Plan 3.41 Clinicians engaged in development and management activities 3.42 Number of planned clinical networks successfully established across Region 3.43 Number of public/ private partnerships explored and converted to successful implementation 3.44 Number of IFHC's implemented with social service solutions and implementation of Whanau Ora 3.51 Prioritisation process developed and agreed for implementation 3.61 Improved regional alignment of Patient Administration System [PAS] and PAS processes 3.62 Improved data quality (consistency of identification & event data) 3.63 Improved clinician satisfaction with access to clinical information

For next level of detail (Outcomes / Measures / Primary accountabilities) refer :
1 - Regional Goal Matrices (Appendix xxxx)
2 – District Annual Plans incorporating Statement of Intent 2011/14

APPENDIX 6: 2011/12 REGIONAL INFORMATION SYSTEMS PRIORITIES

While the region will progress many other IT enabled business and clinical projects such as e referrals, shared care plan, e business, these 5 initiatives are prioritised in the DAP because: they represent the priority foundations for single regional patient systems which will underpin shared care; as DAP priorities they will have a focus they will not get elsewhere; they are consistent with and supportive of the national health IT plan.

The expectation is that the size and complexity of initiatives 1) and 2) is such that the most that can be achieved in FY11-12 is agreement on the common processes. Therefore the IT project will begin preparation in FY12-13, with implementation likely in FY13-14.

We will undertake these initiatives / activities and actions	We expect these actions will support improved performance in the following ways	To deliver	Measured by	In support of system outcomes	General Manager responsible
1) Work with DHB business owners to define common regional processes, data structures, work flows and reporting that will enable the subsequent implementation of a single regional secondary care patient administration system (PAS).	Common, standard and rationalised patient administration work practices across the region	Improved data quality (consistency of identification, event data and patient flows)	(These measures assume that a regional program is established by 1 July 11 with a governance group and scope defined). DHB services engaged, iSoft engaged, stocktake current processes & differences, agreed future state & roadmap by 30 Sep 11. Agreed Patient Administration process alignment changes; capex bid submitted; agreement on preferred regional PAS supplier; by 31 March 12 High Level Project Plan and Business Case for regional roll-out of preferred PAS by 30 June12	Better continuity of care Lower cost, greater efficiency	COO TBD
2) Work with DHB clinical owners to define common regional clinical processes, data structures, work flows and reporting that will enable the subsequent implementation of a single regional secondary care clinical work station (CWS).	Easy access for secondary clinicians to relevant patient clinical information which will improve quality and safety of patient care. It will also enable clinicians to work regionally	Shared information for shared patients	(These measures assume that a regional program is established by 1 July 11 with a governance group and scope defined). DHB services engaged, Orion engaged, stocktake current processes & differences, agreed future state &	Improved patient care	CMO TBD

We will undertake these initiatives / activities and actions	We expect these actions will support improved performance in the following ways	To deliver	Measured by	In support of system outcomes	General Manager responsible
			roadmap by 30 Sep 11. Agreed clinical workstation process & configuration alignment changes; capex bid submitted; by 31 March 12 High Level Project Plan and Business Case for roll-out of regional CWS by 30 June12		
3) Further develop the TestSafe regional clinical data repository, in particular add Northland DHB and improve primary care access to TestSafe (CDR) by improved ease of use and improved value of shared information.	Multiple care providers in community, primary and secondary are able to access relevant patient clinical information for shared patients	Further support of the CWS and shared care	Northland DHB clinicians will have access to TestSafe by 30 June 2012 Northland community and hospital lab results will be available in TestSafe by 30 June 2012 >80% of discharge summaries and >80% of Meddocs outpatient letters and notes will be available in TestSafe by 30 June 2012 The number of primary clinicians (GPs, practice nurses, community pharmacists) actively using TestSafe increased from the current 350 to >700 by 30 June 2012	Improved patient care	CMO TBD
4) Develop the business case for DHB prioritisation to bring the region's core IT infrastructure to the required levels of resilience, redundancy and performance to meet DHB service level expectations	Improved IT systems performance Improving ease of use	Robust IT systems with the required capacity	Business case submitted to FY12-13 budgeting and planning process by 31 March 12	Greater efficiency of IT users	Funder TBD
5) Improve collection, quality, availability and sharing of population health data across DHBs and PHOs	Create a single source of truth for regional population health information potentially supported by a shared	Better informed and consistent health planning decisions and regional resource	"Phase 1" Regional minimum population health data set (cardiovascular & diabetes) agreed by 30 Sep 2011	Improved health outcomes	Funder TBD

We will undertake these initiatives / activities and actions	We expect these actions will support improved performance in the following ways	To deliver	Measured by	In support of system outcomes	General Manager responsible
	population health intelligence team.	prioritisation	High level business case and implementation plan to collect minimum regional population data set completed by 30 March 2012		

APPENDIX 7: REGIONAL WORKFORCE AND HR PRIORITIES 2011/12

We will undertake these initiatives / activities and actions	We expect these actions will support improved performance in the following ways	To deliver	Success will be measured by	In support of system outcomes
Common systems and organisational structures across the region via the Northern Regional Shared Services organisation	align Human Resource activity to health policy and ministerial expectations of greater collaboration and sharing of resources across support services	DHBs better equipped to plan and manage the HR issues associated with a large and diverse workforce	Recruitment, learning, education and workforce plans demonstrate regional alignment	Best use and management of available resources
The Northern Region DHBs Human Resource Management Strategy 2009-2013 Implement Taleo Version 10, which includes the 4 northern DHBs and 2 other North Island DHBs Introduce a new Onboarding module	Retaining talent within our region via enhanced recruitment and retention practices Enhanced candidate experience on joining our organisations	Savings achieved Improved HR reporting and planning	Savings achieved	Best use and management of available resources
Regional work to progress national projects: – Senior Medical Officer job sizing project – aligning remuneration to the MECA – implementing regional remuneration relativity strategies across like specialities	Regional alignment to national priorities	National work programme	Projects deliver results	Best use and management of available resources
Regional management of Resident Medical Officers (RMOs) Work closely with Health Workforce NZ on regional training hubs Develop compulsory career plans Implement the recommendations of the RMO Commission for a seamless training experience regardless of employer Improve run evaluation results for RMOs (a measure of workforce satisfaction)	Good regional management of Resident Medical Officers (RMOs)	Better retention of RMOs	DHB demand for RMO positions is aligned with the ability of the Universities to supply RMOs Vacancy rates held within a range of 2.5-7.5% Increased RMO retention rates to a minimum score of 4/5 from the current 3.75/5 Improved RMO access to Medical Education and Annual Leave	Best use and management of available resources
Physician Assistant role	The four Northern Region DHBs and the University of Auckland Faculty of Medical and Health Sciences are			

We will undertake these initiatives / activities and actions	We expect these actions will support improved performance in the following ways	To deliver	Success will be measured by	In support of system outcomes
	undertaking a pilot of the USA trained, medical model Physician Assistant role. The objective 2011-12 is to further expand the physician assistant trial to other services within the region.			
Centres of learning Implement initiatives: – the Centre for Research and Innovation (Ko Awatea) at Counties Manukau DHB – the Health Campus at Waitemata DHB	Enhanced learning opportunities in technical and clinical training, leadership and management development and professional development			
Advance school-based programmes that prepare Maaori and Pacific young people for tertiary study and employment in health	Initiatives aimed at Maaori and Pacific students	Maaori and Pacific students in education, in good jobs and earning higher incomes	Increase in Maaori and Pacific participation in the health workforce	Better health outcomes for Maaori and Pacific

APPENDIX 8: 2011/12 NORTHERN CANCER NETWORK PRIORITIES

Regional cancer planning and activity is facilitated through the Northern Cancer Network (Network) in collaboration with all four Northern Region District Health Boards (DHBs) and wider cancer control stakeholders. The planning process has evolved over recent years to the point where planning for cancer is firstly considered from a regional perspective and each DHB then in turn identifies further local priorities for their district populations.

The Northern Region DHBs and the Network Cancer Network will focus on the following national cancer priorities for 2011/12:

- Radiation oncology and the shorter waits for cancer treatment health target
- Lung and bowel cancer tumour streams
- Medical oncology services and the implementation of national prioritisation criteria
- Palliative care services.

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver	Measured by	In support of system outcomes
Establish a sustainable service delivery system which aligns with the agreed regional Radiation Therapy Strategic Plan	Improved access to radiation therapy within 4 weeks.	100% of patients requiring radiation therapy will commence treatment within 4 weeks	The percentage of patients in category A, B and C waiting less than 4 weeks between first specialist assessment (FSA) and start of radiation oncology treatment (excludes category D patients)	Movement to a radiation therapy intervention rate which reflects appropriate clinical practice. All patients receive the same level of access to cancer treatment within the national guidelines for treatment.
Implementing the medical oncology prioritisation criteria	Identify opportunities for service improvement in the management of access to medical oncology services	Patients referred for specialist assessment receive access in accordance with national criteria	A. Percentage of all cancer patients who need a specialist assessment will have this within 4 weeks from date of referral B. Percentage of all cancer patients who are referred for chemotherapy will commence treatment within 4 weeks from decision to treat	All patients receive the same level of access to cancer assessment and treatment services within the national prioritisation criteria
Continue regional lung tumour stream activity facilitated by the NCN.	Identify areas where service improvement is needed in the lung cancer care pathway	Improved access to diagnosis and treatment of lung cancer	<u>Lung cancer</u> Percentage of primary lung cancer patients discussed at Thoracic Multidisciplinary meeting (TMDM) within 28 days of referral. Target – 60% Percentage of patients who have surgery as first treatment within 14 days of TMDM* Target - 50%	Early diagnosis and treatment of lung cancer to increase survival rates

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver	Measured by	In support of system outcomes
			Percentage of patients who have FSA for radiation oncology within 14 days of TMDM, when radiotherapy is first treatment* Target – 50% Percentage of patients who have FSA for medical oncology within 14 days of TMDM, when chemotherapy is first treatment* Target -50% * treatment data lags by one quarter	
Continue regional bowel cancer tumour stream activity facilitated by the NCN Implement the bowel cancer screening pilot at Waitemata DHB	Implement the Northern Region prioritisation criteria for colonoscopy. Identify areas where service improvement is needed in the bowel cancer care pathway. The pilot will provide essential information that will help determine whether a bowel screening programme should be rolled out nationally.	Improved early diagnosis and management of pre malignant bowel conditions Improved early diagnosis and management of bowel cancer	Median time from the date patient is placed on the waitlist for colonoscopy to date of colonoscopy procedure by priority category 1-4[29] Achievement of milestones identified in contract with MOH	Improved access to diagnosis and treatment of bowel cancer A bowel cancer screening programme that can significantly reduce the incidence of bowel cancer, and the number of people who die from the disease, through early diagnosis and interventions.
Establish a regional mechanism to strengthen the capacity of palliative care providers which will enable continued development of palliative care services including the MoH priorities for 2011/12.	Begin/continue to address funding and implementation of 24/7 specialist palliative telephone advice to all health care providers. Begin/continue to implement an end-of-life care pathway within all settings in which people may die A strategic/prioritised approach to provision of palliative care education for health care providers and others as appropriate, Grief and loss support for those with	Timely and equitable access to funded palliative care services across all care settings	Specialist pall care services to demonstrate how they do/ or plan to introduce 24/7 telephone advice to generalist providers in the hospital and community. Begin to develop reporting mechanism for no. and % of people who die with a care pathway in place at the end of life in hospital, hospice, home and residential care. Documentation of strategic approach to education and of education delivery.	All patients within the region benefit from coordinated palliative care services provided in a number of care settings as per MoH Priorities for Cancer 2011/12

We will undertake these initiatives/activities and actions	We expect these actions will support improved performance in the following ways	To deliver	Measured by	In support of system outcomes
	complex needs		Clear pathway for accessing grief and loss support available to all health care providers NB THE MEASURABLES MAY NEED TO BE ADJUSTED FOR EACH DHB IN VIEW OF VARIABLE SERVICE DEVELOPMENT ACROSS THE REGION	
Develop a Regional Cancer plan	Enable the region to identify the key priority areas for the improvement in Cancer Care within the Northern Region	A comprehensive overview of the issues and actions needed to support future prioritisation and planning for Cancer care in the Northern Region	A regional Cancer plan is completed by June 2012	Improved Cancer control in the Northern Region
Support the development of a Haematology Clinical network	Provides a mechanism to address ongoing service improvement and clinical issues regionally	A formal plan to address identified priority areas requiring improvement	The network is established and beginning to address service priorities by the end of Quarter 1 2011/12.	Regional alignment and equity of access

APPENDIX 9: 2011/12 REGIONAL EMERGENCY PLANNING

We will undertake these initiatives / activities and actions	We expect these actions will support improved performance in the following ways	To deliver	Success will be measured by	In support of system outcomes
Completion of all regional work plans, in particular the update of the regional Health Emergency Plan, and testing DHB and regional Health Emergency Management function and capability	Readiness of DHBs to co-ordinate a sustainable response if an emergency arises	Meeting the emergency planning and management requirements of the Operating Policy Framework	A coordinated sustainable response across all DHBS in the event of an emergency	
Rugby World Cup Ensure that our incident management plans are fully aligned with Auckland DHB and the Regional Emergency Response Plan so that we are able to participate in a co-ordinated response throughout the RWC	Timely notification, and accurate communication and liaison in the event of an emergency.	Special emergency planning for RWC	A coordinated response across all DHBs and emergency services in each district and the region in the event of an emergency during the RWC	

APPENDIX 10: AIMING FOR ZERO PATIENT HARM CAMPAIGN

The *Aiming for Zero Patient Harm* campaign aims to decrease iatrogenic patient harm. The campaign focuses on patient safety issues at an organisational, team and individual level.

The six key areas that the campaign focuses on are:

1. *Healthcare Acquired Infections:*
   Hand Hygiene: Compliance with hand hygiene regulations has a great impact on hospital associated infections.
   Central Line Associated Bacteraemia (CLAB): Central line infections are serious with a 15-30% mortality rate and are known to be avoidable in the ICU setting. This work stream has introduced the IHI CVL insertion and maintenance checklists to ICU and this work is now being spread throughout the hospital

2. *Falls:* In 2010 CMDHB had a rate of 39 falls resulting in injury for every 1000 admissions. This has a significant impact on the patient and family, as it results in additional treatment, longer stays in hospital and possible prolonged recovery time

3. *Correct Patient Identification:* The mis-identification of patients results in harm, such as drug errors, inappropriate procedures and unnecessary x-rays. Staff often do not correctly identify their patients due to a busy workload, a lack of understanding of the standard and because patient identification is not custom practice.

4. *Pressure Injury:* This work stream aims to reduce hospital-acquired pressure injuries. As voluntary reporting is an imprecise method for determining the incidence of these injuries, a baseline audit of 5 patients per ward per month has started. Pressure injuries can cause significant morbidity and healthcare costs.

5. *Venous Thromboembolism* (*VTE):* VTE – Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) are serious complications of prolonged bed rest, immobiliation by Plaster of Paris (POP) and other risk factors. They can be decreased with adequate VTE prophylaxis to high risk patients. This work stream aims to increase VTE risk assessment (currently 3 %) to 100% starting in surgical areas.

6. *Medication Safety.* Medication errors are common and harm from the medication process is also relatively common. This work stream has a number of working groups reporting to it on efforts to reduce harm from incorrect prescribing (e-safe prescribing module, dirty dozen - high risk medications - campaign and medication reconciliation), incorrect administration of medications (5 rights campaign, Pyxis medstations, top 20 drugs, National Drug chart) and poor communication of medication information at points of transfer and between primary and secondary care (e-MR, high risk patient identification, e-yellow card, Medication table in EDS).

The operational group and working groups are closely linked and report to the Patient Safety Governance Group, who in turn reports to the Clinical Management Executive Committee (CMEC) and the Business Group.

APPENDIX 11: MENTAL HEALTH & ADDICTION SERVICES – PLANNED 2011/12 REGIONAL ACTIVITY

Service Area	Activities	Regional components
Forensics	Implementing and embedding an agreed Prison model of care for Northern & Midland regions prison population	Strengthening intersectoral and inter-regional collaboration
Child & Youth specialist services	Devolution of Intensive Clinical Support services and Child Adolescent Liaison Services	Support the development of regionally consistent local models of care for children, adolescents and youth in the devolution from regional services
Alcohol and Other Drug (AOD)	Northern Region AOD Sector development strategy	Implement agreed sector changes from AOD report via contractual process
Electronic Document System (EDS)	Implementation of the Northern Region EDS Strategic Plan 2008-2013	Embedding new care pathways and arrangements across Northern & Midland regions. Establishing ongoing Governance arrangements. Evaluation of Northern Region EDS Strategic Plan implementation
Auckland Regional Mental Health Information Technology (ARMHIT) project Phase II	Broaden EHR to include NGO, Primary MH & Service-Users	To provide a point of coordination and ensure alignment of local activity

APPENDIX 12: PRIMARY CARE BUSINESS CASES

Better, Sooner, More Convenient Business Case Support

As noted in Module 3, section 8, DHBs are committed to supporting business cases to achieve their stated objectives subject to appropriate agreements being reached between all parties. The following sections are taken directly from the three business case work programmes, or have been provided by the business cases. They are included in this appendix to provide context for the DHB commitment of support made within Module 3 of this Annual Plan.

Note: Neither Alliance Health+ nor the National Hauora Coalition have any practices in Waitemata DHB

1. Alliance Health+ (AH+)

Alliance Health+ Primary Health Organisation ("AH+") is a consolidated entity made up of three former Pacific-led Primary Health Organisations ("PHOs"); TaPasefika PHO, AuckPac PHO and Tongan Health Society PHO.

The Alliance Health+ mission is:

"We will improve health outcomes and promote the wellbeing of Pacific peoples, families and all communities. We will achieve this by:

- Working with health providers, community carers and our enrolled population;
- Improving the scope and quality of health services, we will strive to serve as leaders in Pacific health regionally and nationally."

Action areas	To deliver for communities and patients	As measured by
Structural Change – Consolidation of Pacific PHOs	Maintain the consolidated PHO functions of AH+ and continue to identify efficiencies through this process so potential opportunities can be identified to allocate resources to the front line Continue to Strengthen Clinical Governance and Clinically led processes	PHO Performance Programme (PPP) data collection consistent and improved
Establishment of Integrated Family Health Centres In line with DHB locality plans	Better, Sooner and More Convenient - Improved and timely access for communities, families and patients where a range of services will be made available in one setting	Patient satisfaction survey Capture outcomes through the Results Based Accountability Tool: How much did we do? (Volumes against Target / Volume growth) How well did we do it? (Evaluation of intervention) Are we better off? (Target Population Improvement). Utilisation rates of services within Integrated Family Health Centre of enrolled patients. Performance of national health targets for: Increased Immunisation, Child Health; Better CVD Services, Better Diabetes Services; Better help for Smokers to Quit. PHO Performance Programme targets achieved

Action areas	To deliver for communities and patients	As measured by
Enhanced Primary Health Care Services (Whanau Ora)	Providing an extended range of primary care health services to enrolled and non enrolled patients through Integrated Family Health Centres and also creating linkages to key social agencies for more holistic care i.e. whanau ora. This includes use of scheduling and community health wrap-around services to support patients and their families navigate and access social and healthcare services	Volumes of cases per Navigator / Care Co-ordinator to be agreed once this service is resourced and operational. Also capture outcomes through the Results Based Accountability Tool: How much did we do? (Volumes against Target / Volume growth) How well did we do it? (Evaluation of intervention) Are we better off? (Target Population Improvement).
Establishment of 4 Nurse-led services / networks	Focusing on early prevention screening and education with support by Community Health Workers/Social Workers/Youth Workers for patients and their families Develop a Nurse workforce, retention and recruitment programme that will enable and sustain nurse led clinics	Volumes for assessments to be agreed as Nurse led clinics / networks have been formally established PHO Performance Programme (PPP) targets achieved. Capture outcomes through the Results Based Accountability Tool: How much did we do? (Volumes against Target / Volume growth) How well did we do it? (Evaluation of intervention) Are we better off? (Target Population Improvement)
New Population Health Programmes	Community Awareness and Health Education/Promotion programmes that continue to promote attitude and behaviour change in Pacific communities	Capture outcomes through the Results Based Accountability Tool: How much did we do? (Volumes against Target / Volume growth) How well did we do it? (Evaluation of intervention) Are we better off? (Target Population Improvement)
Acute Demand Management	Collaboration with DHBs, GAIHN (Greater Auckland Integrated Health Network) and National Maaori Coalition to address acute demand	
Alliance Leadership Team **The Role of the Alliance Health+ Alliance Leadership Team is as follows:** Ensure initiatives and services are aligned with Alliance Health + Organisational Strategy and Business Plans and appropriately resourced, from a financial and human resource perspective; Assist with resolving strategic	Strengthen the quality of decision making which ensure areas of prioritisation will benefit patients, families and communities	Alliance Leadership Team deliverables are met

Action areas	To deliver for communities and patients	As measured by
level issues when requested by Alliance Health; Use individuals influence and authority to advocate for Alliance Health + initiatives Support Alliance Health + to adopt an evidence-based approach in project and service planning processes Monitor the progress of initiatives Ensure that projects are appropriately evaluated Coordination of the Alliance Support Team (AH+ AST) Advocate for required resources and skills to support the Alliance Health+ Alliance Leadership Team, Alliance Health + Alliance Support Team, and the implementation of initiatives and services within Alliance Health + business case		

2. The Greater Auckland Integrated Health Network (GAIHN)

GAIHN is an alliance of seven independent partners.

- Auckland District Health Board
- Auckland PHO Limited
- Counties Manukau District Health Board
- East Health Trust PHO
- ProCare Networks Limited
- Waitemata District Health Board
- Waitemata PHO.

The GAIHN goal is: "Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions"

A key emphasis in the GAIHN approach is placed on empowering the alliance partners to manage a greater proportion of people's health care needs in community settings. GAIHN is also committed to ensuring that it maintains a second focus on reducing inequalities through all of its activity with a particular emphasis on better health of child health

To attain the GAIHN goal, and to address the second area of focus, a programme of work has been developed for the next 2-3 years

The fully integrated programme of work comprises seven aligned work streams

Workstream	Deliverables
Better Management of Targeted Individuals **(Workstream 1)**	Identify individuals (enrolled and non-enrolled) at high risk of acute events Encourage and facilitate individuals to enrol with a primary care provider (medical home) if they currently do not have one Ensure the primary care provider is aware of their enrolled high-risk patients Support the primary care provider in providing an individual care programme for their enrolled high-risk patients

	Milestones: Risk Stratification tool delivered 30 September 2011 Register of at risk individuals developed 30 October 2011
Better Primary Response to Acute Events **(Workstream 2)**	Building the capability of the primary/community sector to manage acute episodes through planning and implementing improvements to a range of options including: i. Triage ii. Primary Options for Acute Care (POAC) iii. Same day and urgent access to medical home iv. After hours availability v. Better management of self referrals vi. Others as necessary Milestones: • Range of options for acute triage developed by 30 September 2011 • Increased community based options, including Primary Options increased volumes (to 20,000) by 30 June 2012
Enablers of Better Individual Care **(Workstream 3)**	a. e-Practice: Integrating the multiple initiatives relating to electronically enabled best practice including; i. Access to Diagnostics ii. Clinical Pathways iii. Optimising Prescribing iv. e-Referrals v. e-Shared Care Planning vi. Advance Care Planning Milestones: Integrated overview complete 30 September 2011 Business Case developed 20 November 2011 b. Ensuring effective linkages with local health networks and locality approach to infrastructure development (e.g. Integrated Family Health Centres, Whanau Ora Centres and/or Community Health Hubs) c. Specialist support: Ensuring that the specialist support services needed to support enhanced primary care are developed including: i. Clinical Pathways ii. Access to Diagnostics iii. Nursing Development Project iv. Community Specialist Clinics v. Advanced Care Planning vi. Optimising Prescribing Project (clinical pharmacist support) d. Where appropriate, develop new organisational guidelines for models of care for people with long term conditions, in support of work streams 1 & 2 above
Population Prevention Programmes **(Workstream 4)**	Programmes to enhance community awareness and better self/whanau care to prevent or response to acute events including: a. Smoking cessation in primary care b. Cellulitis, prevention/early intervention c. Stroke d. Falls prevention e. Others Milestones: • Smoking Cessation programme rolled out to 50% of GAIHN practices – 30 June 2012 • Relevant and accessible stroke programme available 30 June 2012

	• Relevant and accessible cellulitis programme available 30 June 2012 • Relevant and accessible fall prevention programme available 30 June 2012
Alliance Support and Development **(Workstream 5)**	All normal Management Office functions including: alliancing contracting, communications and engagement, funding partner capability building
Systems Improvement **(Provider Arrangements)** **(Workstream 6)**	a. Information project developing a better understanding of the drivers of acute demand b. Redesigned incentives and contracting Milestones: • Performance baseline established for acute demand by 22 July 2011 • Performance forecast counterfactual established and agreed by 19 August 2011 • GAIHN population performance reporting established by 23 Sept 2011 • PHO datasets and regular distribution established by 21 October 2011 • Practice level reporting in place by 18 November 2011 • Return on Investment formula established and agreed by 9 December 2011 • Incentives contract agreed by 23 March 2012 • Roll-out of education and training plan once the detailed work programme for intervening has been determined
Child Health Project **(Workstream 7)**	a. Incorporation of child health equity issues into 2011-12 focus on better management of acute events b. Development and planning for 2012-13 roll out Milestones: Plan for commencement for child health project, March 2012

3. National Hauora Coalition (NHC)

The National Hauora Coalition is a national coalition of 11 Maaori-led Primary Health Organisations (PHOs) which supports a range of primary care services for over 200,000 Maaori and non-Maaori high needs Whānau throughout New Zealand. The Coalition represents urban, rural and tribal groups that serve growing communities.

"Whānau Ora" is the driving force and ideology behind everything we do. For us, this means:

- Māori led, Māori owned and Māori protected
- A Whānau-centred approach that anticipates how the health sector activities interact with Whānau activities
- An integrated approach for improved outcomes across sectors
- Offering Māori experience Whānau-centred services

Our most important task is improving social and health outcomes for Maaori and any other communities who use our services."

The year two implementation plan focuses on three priority areas:

1. Whanau Ora Clinical Outcomes

The National Hauora Coalition Clinical Governance Group have identified specific clinical outcomes for Year 2 under the Mama, Pepi, Tamariki and Oranga ki Tua (Long term conditions) focus areas

Standardisation and refinement of the Whanau Ora system

Year One involved the development of tools and systems which are being tested in demonstration sites. In year two these will be evaluated, refined and then rolled out across the National Hauora Coalition membership in a staged approach

2. Reconfiguration of the National Hauora Coalition PHO infrastructure

The merge of National Hauora Coalition PHO members under a national PHO agreement, from 1 July 2011, requires the consolidation of resources, systems and staff.

The change management process will ensure front-line services are uninterrupted and provider members continue to receive back office support functions

3. High Performing Organisations and Provider Networks

Producing a high performing organisation and high performing provider members involves the development of a fit for purpose framework. This framework will be linked to Results Based Accountability outcomes and will encourage kaupapa Maaori, clinical and business excellence standards which will be defined and adopted nationally by the National Hauora Coalition and its provider networks.

Note: the target figures in the below are for the entire Coalition i.e. not just the Auckland region

Priority 1: Whanau Ora Outcomes

Objective	Action	By
Mama, Pepi, Tamariki Programme	• Increase breastfeeding rates • Increase Rheumatic fever screening rates • Percentage increase in children with B4 checks completed • Increase proportion of babies<1 enrolled	June 2012
Increase Immunisations rates	• Increased percentage of 2 year olds fully immunised	June 2012
Safe Homes	• Reduce smoking rates in homes/cars • Reduce smoking in pregnancy • Increase family violence screening • Increase insulated – damp free homes	June 2012
Reduce Emergency Department Presentation rates	• Improve cellulitis rates • Improve whänau education and self management of respiratory conditions • Improve whänau adherence to antibiotic use • Improved asthma management • Improved pneumonia management • Early screening/better management of chronic cough	June 2012
Oranga ki Tua Programme Improved CVD Risk Assessment and Management	• Increase % of patients eligible for a Cardiovascular Risk Assessment who have had a Cardiovascular Risk Assessment completed • Percentage with Cardiovascular Risk Assessment completed that have an active case managed care plan	June 2012
Improved Diabetes Screening and Management	• % patients with a TC/Cholesterol ratio above 4.5 mmol/l who are on a lipid lowering agent • % increase in DARs • % patients with HbA1c <8 • % of people with diabetes who have a cardiovascular risk of <15% • Increase diabetes screening and management rates	June 2012
Smoking	• No. of patients with smoking status recorded • No. of coded smokers offered brief advice to stop smoking • No. of people coded as smokers who have been offered smoking cessation support or referred to a provider	June 2012
PHO Performance Programme (PPP) Targets	• Active monitoring of performance in real time • Improve quality and clinical performance	Ongoing Mthly meetings

Objective	Action	By
	• Disseminate success stories and share learning across the provider network • Focus on areas of underperformance and put remedial actions in place	Ongoing
Non PHO Performance Programme Indicator • ASH rates • Breastfeeding • B4 School Checks • Oral Health	• Whänau Ora Clinical Governance to review and agree on these target areas for 2011-12 • Develop Results Based Accountability indicators and performance measures for each identified programme • Pilot in providers • Evaluate effectiveness of programmes /interventions • Staged rollout across membership	August 2011 June 2012
Whanau Ora Assessments	• Complete 2,900	June 2012
Case Management	• Complete 1,450	June 2012
Whanau Ora Centres	• Open 2 in Otara with provider members to open • Negotiate with members, the opening of 3 additional Whänau Ora Centres	Sept 2011 June 2012

Priority 1: Refinement and Standardisation of the Whanau Ora System

Objective	Action	By
Testing of the Whanau Ora Assessment, Case Management Tool and Processes Evaluation of the Tools and Processes National Rollout of Tools, Processes and IT Platform	• Test the 3 whanau ora tools within 8 demonstration sites • Te Hononga PHO will test their existing Mohio database system and processes. • East Tamaki Health Care will test their existing system which uses a combination of their existing IT platform and clinical family navigators • All other demonstration sites (Turuki, Papakura, Ngati Porou Hauora, Toiora, Kokiri Trust, Te Tihi Hauora o Taranaki) are testing the Whanau Ora triage assessment and case management tool developed by TOIORA PHO Coalition • Recruit an external contractor to undertake evaluation • Undertake formative evaluation • Final report due • Work with provider members to introduce standardized suite of tools as recommended in the evaluation • Purchase Results Based Accountability software license • Train End Users • Install in National Hauora Coalition Office and provider members	October 2011 October 2011 October 2011 October 2011 July 2011 July – Sept 2011 October 2011 December 2011 July 2011 August 2011 August 2011
1.2 Mama, Pepi, Tamariki and Oranga ki Tua Programme Development	• Establish Service Level Alliances (SALTS) • Develop programmes • Test in 3 demonstration sites • Evaluate • National rollout	July 2011 October 2011 Feb 2012 March 2012
1.3 IT/IM Systems	• Connectivity of IT systems, including provider	Dec 2011

Objective	Action	By
	networks and National Hauora Coalition	
	• Develop Whanau Ora Dashboard in collaboration with PHO Performance Programme Manager	August 2011
	• Provide regular newsletters to members	August 2011
	• Update and maintain website	Ongoing
1.4 Reconfigure Alliance Leadership Team Structure	• Complete review of the interim Alliance Leadership Team	Sept 2011
	• Define funding arrangements / support for Alliance Leadership Team operations	July 2011
1.5 Workforce Development Plan	• No. of practices willing to take undergraduate, postgraduate and new graduate primary care staff	June 2012
	• Increase Mäori/Pacific Island workforce	
	• Develop individual professional development plan for regulated and unregulated workforce	
	• Develop workforce plan for whänau ora/navigator roles - unregulated workforce	
	• No. of new permanent multi disciplinary team members recruited into primary care with vocational registration	
1.6 Integrated Contracts	• Provide Results Based Accountability training to DHBs	June 2012
	• Establish a Service Level Alliance to reconfigure existing services and develop a funding / contracting mechanism that integrate contracts/funds	
1.7 Te Ao Auahatanga Innovations contract	• Continue implementation of relationship strategy	June 2012
	• Continued population of the national Maaori health and social services database	

Priority 2. Reconfiguration of the NHC PHO Infrastructure

Objective	**Action**	**By**
2.1 Plan Transition of Functionality to National Hauora Coalition	• Clarify functions of National Hauora Coalition PHO office	December 2011
	• Establish structure, staff, resources, policies, processes, systems, branding	
	• Review back to back agreements and revenue streams with provider members	
	• Scope funding/business model	
	• Build out National Hauora Coalition centre and regional platforms (locality networks)	
	• Manage provider contracts	
2.2 HR Management	• Develop change management plan	July 2011
	• Staff redeployment plan for Te Hononga staff	July 2011
	• Manage staff /FTE transition from DHBs to National Hauora Coalition via devolution process	October 2011
2.3 Clinical Governance Structure and Functions	• Review clinical governance structure and membership as transitional Clinical Governance Group ceases on 1 July 2011	1 July 2011
	• Schedule regular practice visits with provider clinicians and GPs to ensure connection with the Whanau Ora strategy	Ongoing
	• Provide Continuing Medical Education, Continuing Nursing Education sessions	Ongoing

Objective	Action	By
2.4 Grow and Retain National Hauora Coalition Membership	• Develop a "value add proposition" for existing members by undertaking a survey of member needs and expectations of the National Hauora Coalition • Roadshow (kanohi ki te Kanohi) schedule developed and actioned to grow membership	August 2011 July 2012 Ongoing
2.5 After Hours	• Actively contribute to the after- hours solution for primary care within metro Auckland • Commence discussions and develop plans of action to create accessible and affordable after hours solutions across our regional provider members	July 2012
2.6 Iwi Relationship Strategy	• Develop iwi accords which clearly stipulate the relationship, rules of engagement and functions of each party (National Hauora Coalition and Iwi)	July 2012
2.7 Governance	• Develop board KPIs based on outcomes framework • National Hauora Coalition strategic plan signed off (3-5 years) • AGM to be held where board member composition will be reviewed to enable a fit for purpose board is in place for year two deliverables	July 2011 July 2011 November 2011

Priority 3: High Performing Organisation and Provider Networks

Objective	Action	By
3.1 High Performing Coalition Centre	• Review Governance composition and structure of membership to support the growth of the Coalition • Undertake a fit for purpose assessment of the National Hauora Coalition based on the Baldridge model • Develop KPIs, measures and goals against strategic and operational activities. Develop an organisational scorecard/based on outcomes • Undertake survey of customer needs and wants, and tailor service provision/support to each provider member • Review existing Clinical Governance Group structure, functions and membership at a national level and develop mechanisms to ensure regional connectivity • Develop iwi accords with existing members and arrange kanohi ki te kanohi hui with additional iwi leaders. Meet regularly with iwi leaders forum • Implement the newly developed communication strategy that addresses key stakeholders at multiple levels using various communication platforms	November 2011 July 2011 August 2011 July 2011 July 2011 July 2012 August 2011
3.2 High Performing Providers and Provider Networks	• Clarify regional/local roles and functions of a Whanau Ora network lead • Develop KPIs for each Whanau Ora network lead based on the Baldridge model then monitor and provide support where required • Benchmark key processes and results against high performing provider members and implement plans	July 2011 August 2011 August 2011

Objective	Action	By
	to get others up to speed	
	• Ensure all members are accredited providers (e.g. Cornerstone) or are in the process of gaining accreditation	July 2012
	• Improve IT interoperability across the provider network	December 2011
	• Develop local mechanisms for networks to share and disseminate successful interventions / practices / stories across the networks	August 2011
3.3 Clinical Governance	• Lead and support accreditation of all GP clinics, providers	
	• Develop clinical leaders across the network	July 2012
	• Develop and implement a clinical placement programme within networks	
	• Provide Continuing Medical Education, Continuing Nursing Education sessions, Professional Development Programmes	Ongoing