Counties Manukau District Health Board

Statement of Intent
2009/10 – 2011/12

June 2009

Our Vision is

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 focussed 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 are

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

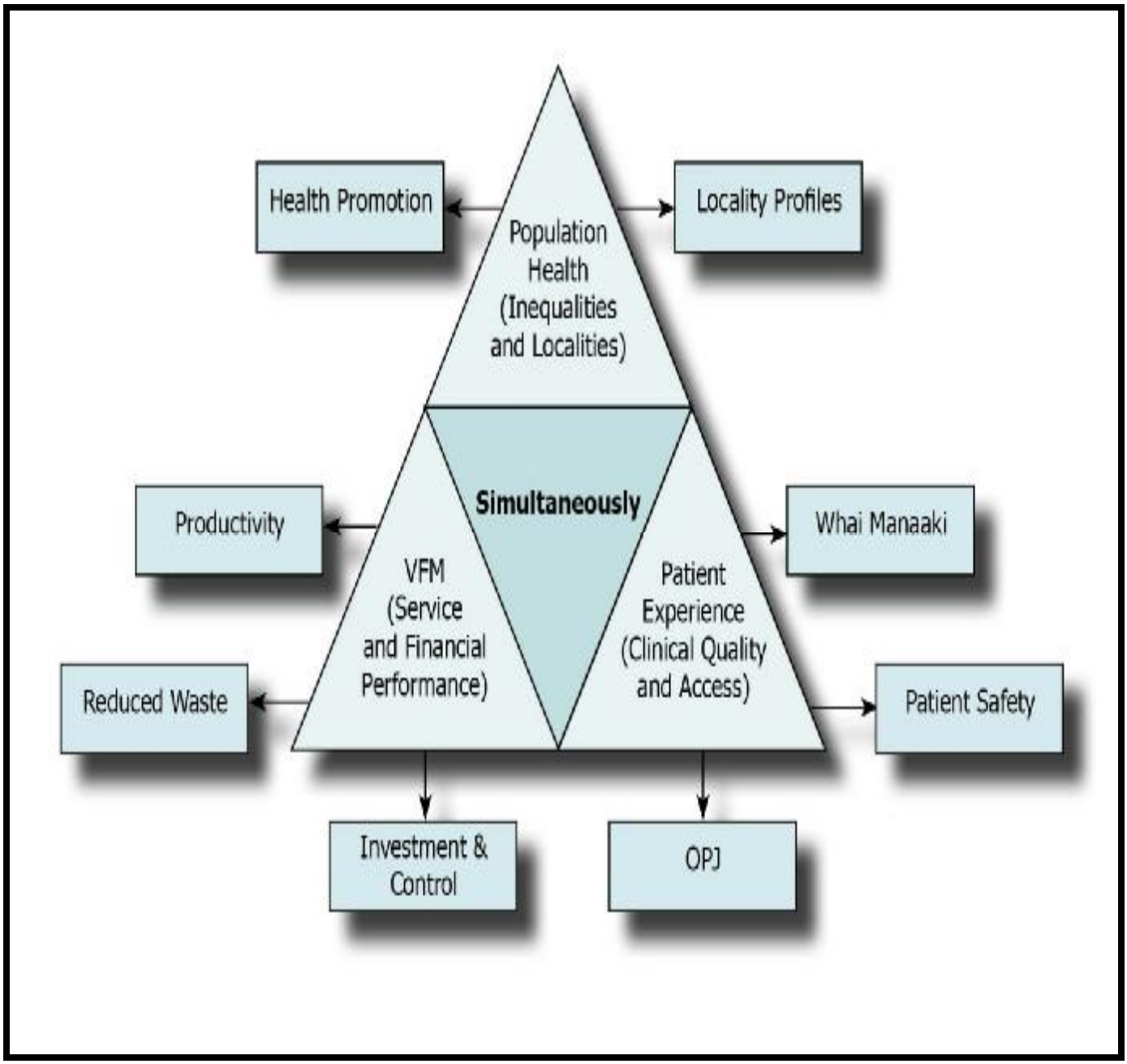
Innovation: Constantly seeking and striving for new ideas and solutions

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

Triple Aim is our Core Business

Counties Manukau DHB is focussed on planning and performance frameworks based on the Triple Aim



**OPJ – Optimising Patient Journey*

Face Reality, Seek New Designs & Involve Everyone

Don Berwick
Institute for Healthcare Improvement

Executive Summary

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

The document is intended to outline for Parliament and the general public the performance that will be delivered during 2009/10 by Counties Manukau DHB and contains non-financial and financial forecast information for the 2010/11 and 2011/12 years. The agreed performance measures are in the context of the Government's strategic and service priorities for the public health and disability sector and the DHB's District Strategic Plan

_____
Signature
Chair of Counties Manukau DHB

_____
Signature
Board Member of Counties Manukau DHB

_____
Signature
Chief Executive of Counties Manukau DHB

Statement from the Chair and Chief Executive

This coming financial year will be one of challenges and opportunities for Counties Manukau District Health Board and one in which we will need to build on the foundations of strong financial management and quality service delivery. Whilst the challenges are high, the Board are committed to ensuring that our history of innovation and strong clinical partnerships continues. Through our application of the Triple Aim framework we will address the balanced bottom lines of:

- Value for money (service and financial performance)
- Patient experience (clinical quality and access)
- Population health (inequalities and localities)

As a result of very intensive 'line by line' reviews throughout all areas of the organisation, we are able to present a DAP which reflects a zero deficit operating position forecast for the year 2009/10. It also proposes, based on this achievement, a further continuing investment "below the line" of $3m reflecting approved utilisation of carried forward operating surpluses from previous years.

Achieving this zero deficit position has presented a huge challenge to an organisation continuing to face above average demographic growth, complex clinical challenges, stretched facilities, ongoing clinical wage settlements well in excess of funded levels and the loss of a significant level ($24.6m) of PBF funding. To be tabling a final DAP at such a level without impacting on any frontline clinical services is a credit to the organisation. However, it will come at a potential cost as the action taken, both in people and support services reviews, means the organisation is more stretched than ever and will have very limited ability to further invest and expand services in those areas we see essential as priorities.

The development of this Plan signifies a new strategic emphasis incorporating the highest level of clinical engagement. This Plan has been developed on the clear premise that clinical partnership is crucial to our strategic direction and decision making.

We have some acute pressures in the year ahead of us and we will be focusing on ensuring that services are configured appropriately to manage these. This will require a comprehensive restructure of our costs while maintaining our strategic focus. To achieve the necessary cost containment and maintain our objectives we will ensure that any revision is undertaken in a balanced manner with full clinical engagement

We will continue to seek ways to manage the growth in demand for both our acute hospital and primary care and referred services. Pressure on these areas is growing at a rate exceeding funding and will need to be managed effectively to contain both costs, and to enable safe, quality service provision. We will be looking to deploy strategies around acute growth management and increased productivity during the next year to both positively impact the financial bottom line and to improve the patient journey.

We are very aware of the need to ensure timely access to those clinical services both provided by ourselves, our neighbouring DHBs and our contracted providers particularly with respect to:

- Provision of elective services
- Responding to acute growth pressures
- Implementation of quality EC services

Whilst we await confirmation of the capital required to progress the next phase of building redevelopment of the Middlemore site, we are confident of a successful outcome so that we can develop the 21st century services that our population deserves. This redevelopment is a crucial aspect of our Health Services Plan and is vital to the provision of the increased volumes in both acute and future elective services. The ability to provide better secondary services for our population is dependant upon access to sufficient capacity. Our currently capital-funded new ward capacity is due to be commissioned at the beginning of the new financial year and will provide a much welcomed expansion of hospital bed capacity.

This coming year will see us building on our improved relationships with our primary health care partners. We are developing a locality approach to our planning especially for those populations of the greatest need. This approach will enable us to develop integrated primary and community services to meet the pressures in Counties Manukau related to inequalities, population growth, ageing and the growth in chronic conditions. Over time, these locality "hubs" will evolve into the mechanism for the devolution of services from the hospital out into more convenient community settings.

The development of our workforce and the retention of key personnel remains a priority. We are actively developing the future in areas such as the Centre for Health Services Innovation. The Centre will provide a focus for workforce development, organisational innovation, learning and effective practice. Workforce development along with our other key enablers of Information Management, Health Intelligence and facilities development will continue to be highly visible as a focus for this DHB.

Our commitment remains to quality improvement, enhancing the responsiveness of our front line services and valuing the huge contribution of our health professional workforce.

Gregor Coster
Chair

Geraint Martin
Chief Executive

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Part 1 INTRODUCTION

1.1 OVERVIEW

Counties Manukau DHB is one of 21 DHBs established on 1 January 2001 in accordance with section 19 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act 2000). Counties Manukau DHB is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004). The CE Act 2004 (section 49) states that the Board of Counties Manukau DHB must ensure that the DHB acts in a manner consistent with its objectives, functions, and this Statement of Intent (SOI).

This SOI is for the period 2009/10-2011/12. The SOI describes to Parliament and the communities of the Counties Manukau District what the DHB intends to achieve over the next three years in terms of reducing inequalities, promoting, enhancing, and facilitating the health and well-being of the people in our district. This SOI incorporates the governance (the Board), funder and provider (e.g., hospitals, clinics) activities of the DHB.

Performance measures and targets are included describing how Counties Manukau DHB will endeavour to reduce inequalities and improve the health and well-being of our community over the next three financial (1 July to 30 June) years.

This SOI is aligned to and consistent with:

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

<u>This SOI includes</u>:

- a Statement of Forecasted Service Performance the DHB will seek to achieve during 2009/10 with non-financial performance measures and targets for one of the three output classes (i.e., the governance, funder and provider parts of the DHB) it delivers, and

- a financial forecast for 2009/10 and the two subsequent years. At the end of the year, auditors working on behalf of the Office of the Auditor-General compare the performance planned in the SOI with the actual performance described in the DHB's Annual Report.

1.2 REPORTING TO THE MINISTER OF HEALTH

Counties Manukau DHB will provide the Minister and the Ministry of Health with information that enables monitoring of performance against any agreement between the parties, and provide advice to the Minister in respect to this. This includes routine monitoring against the funding, DHB service delivery, and DHB ownership performance objectives.

Counties Manukau DHB will provide the Minister and the Director-General of Health with the following reports during the year:

- annual reports and audited financial statements
- quarterly reports
- monthly reports
- ad hoc reports

1.3 IMPROVING MAAORI HEALTH

In accordance with Government's health strategies and policies, Counties Manukau DHB is committed to reducing health inequalities and improving health outcomes for Maaori in accordance with our statutory responsibilities under the NZPHD Act 2000.

1.4 TE TIRITI O WAITANGI 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 gains 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."

The DHB 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.

The maintenance of POU (Maaori Health Committee) as the key interaction mechanism with the Board continues. POU continues to have authority to oversee the implementation of the Whaanau Ora Plan (Maaori Health plan). CMDHB has undertaken to express its commitment to Te Tiriti o Waitangi through the establishment of a number of key initiatives guided by the following principles:

- It is the DHB's intention to continue to develop its Tiriti commitment throughout the organisation. This approach will ensure Tikanga is fully integrated into our processes and indeed help lead our way forward.

- The Maaori Health Equity (Treaty Commitment) Group is to be established with input from POU and Manawhenua to determine the structure, processes and implementation of an organisation focussed on equity of health outcome for Maaori
- Te Kaahui Ora, the Maaori health team that provides Maaori operational expertise and advice for the whole organisation, will retain a dedicated divisional team, and will establish a matrix framework to planning and organisational delivery as part of a 'whole of organisation' approach.
- We are committed to developing an organisation that reflects the diversity of its population and responds accordingly through its work.

The Whaanau Ora Plan, as the key Maaori strategic document, sets out the parameters of the DHB/Maaori community relationship. The aspiration of this document is;

Whaanau Ora – Maaori Ora :

Kia whai kaha, whai mana painga, ki ngaa kawenga orange Iwi, ki tua o Rangi

Whaanau inspired, enabled, resourced and in control of their own health

It identifies six key priorities. They are:

- Addressing the lifestyle risk factors that affect Maaori in Counties Manukau
- Dealing specifically with the chronic conditions of Diabetes and Cardiovascular disease
- Improving the health of Tamariki (child) and Rangatahi (youth)
- Improving health and disability services provided to Kuia (elder female) and Kaumaatua (elder male)
- Meeting the needs of Maaori who engage in Mental Health services
- Developing appropriate infrastructure to support the provision of services to Maaori

Part 2 POPULATION PROFILE AND HEALTH NEEDS

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

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

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

- CMDHB residents' health is improving. For example, average life expectancy at birth is similar to the New Zealand average despite the material socio-economic disadvantage in Counties Manukau.
- Despite this improvement, health disparities remain a concern. Males, Maaori and Pacific people and those socio-economically deprived all do worse than their counterparts.
- For Maaori a quarter of the life expectancy gap is due to tobacco. Smoking remains the single largest preventable cause of disease and death in our communities.
- A third of all hospitalisations for CMDHB people would be considered potentially avoidable. Much of the scope for prevention of these lie in the population health and primary care sectors.
- Infectious disease rates for Counties Manukau people, particularly children, remain high. Improving the living conditions of pre-school children remains a priority.
- CMDHB has the largest number of people with diabetes in NZ (27,000, or 8.3% of the adult population in 2007). Diabetes prevalence is likely to double in Counties Manukau by 2020.
- CMDHB has the highest rate of obesity in NZ, with 33% of the adult population considered obese (BMI>30). In 2006/07, CMDHB was estimated to have 17,500 people, or, 5.7% of the adult population, who were morbidly obese (BMI>40). Modelled increases of 1,700 people per year reaching a BMI >40 increase the urgency of population approaches to reduce the rate of growth and stem the rising tide of associated morbidity and mortality.
- Teenage pregnancy rates are very high for Maaori and Pacific young people.
- Elective surgery rates are up 13% over the past year, with a compounding 6% per annum growth over the past 5 years. Counties Manukau now has age-standardised rates higher than the New Zealand average. There has been a distinct improvement in access for Maori, Pacific and more deprived populations.
- Total birth numbers have increased significantly over the past 5 years, placing large pressure on facilities and the maternity workforce.

2.1 KEY ISSUES AND RISKS

Counties Manukau DHB faces massive operational and fiscal challenges in the coming year. Whilst the line by line review – necessitated by the tabling of a zero deficit position – has not impacted on any frontline clinical services, the DHB is cautiously aware that this position has the potential to impact on the organisation's ability to further invest and expand services in essential areas, and heightens the organisation's exposure to clinical, financial, and operational risks.

Major risks to the organisation exist in the following areas:

- Affordability of organisational activities against budget
- Managing growth in acute and emergency demand
- Capacity of facilities to meet future growth
- Maintaining the Information Services infrastructure and affording future expansion
- Recruitment and retention of clinical staff

Part 3 NATURE AND SCOPE OF ACTIVITIES

The activities of the DHB fall into three groups:

- Governance (Section 3.1);
- Planning and Funding (Section 3.2); and
- Provision of health and disability services (Section 3.3).

3.1 GOVERNANCE

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

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

The elections for the current DHB Board members took place in October 2007. Each DHB has seven members elected for a three year term. For CMDHB the elected Board members are:

- Arthur Anae
- Donald Barker
- Colleen Brown
- Anne Candy
- Paul Cressey
- Robert Wichman
- Michael Williams

The Minister of Health has appointed the following additional Board members:

- Professor Gregor Coster (Chair)
- Lope Ginnen
- Ruth de Souza
- Miria Andrews

There are a number of sub-committees to the Board and these are made up of Board members, DHB staff, and community representatives. The Board is required to publish when and where it, or any of its subcommittees, is meeting.

Three are required by legislation:

- *Community & Public Health Advisory Committee*: provides advice to the Board on the mix and range of services that will best meet local health improvement and independence objectives, recognising both resource constraints and the requirements of national policy and strategy, and taking into account the diverse and unique needs of Maaori.

- *Hospital Advisory Committee*: provides advice to the Board on the performance of DHB provider arm services.

- *Disability Support Advisory Committee*: advises the Board on issues facing people with disabilities, and how these can best be addressed (in the context of the DHB not being the funder of disability support services for people aged under 65).

In addition, the Board has established three other committees:

- *POU*: provides strategic and governance advice to the Board on Maaori health gain issues. It is a partnership committee made up from 50% Board members and 50% nominated Maaori community/health experts.

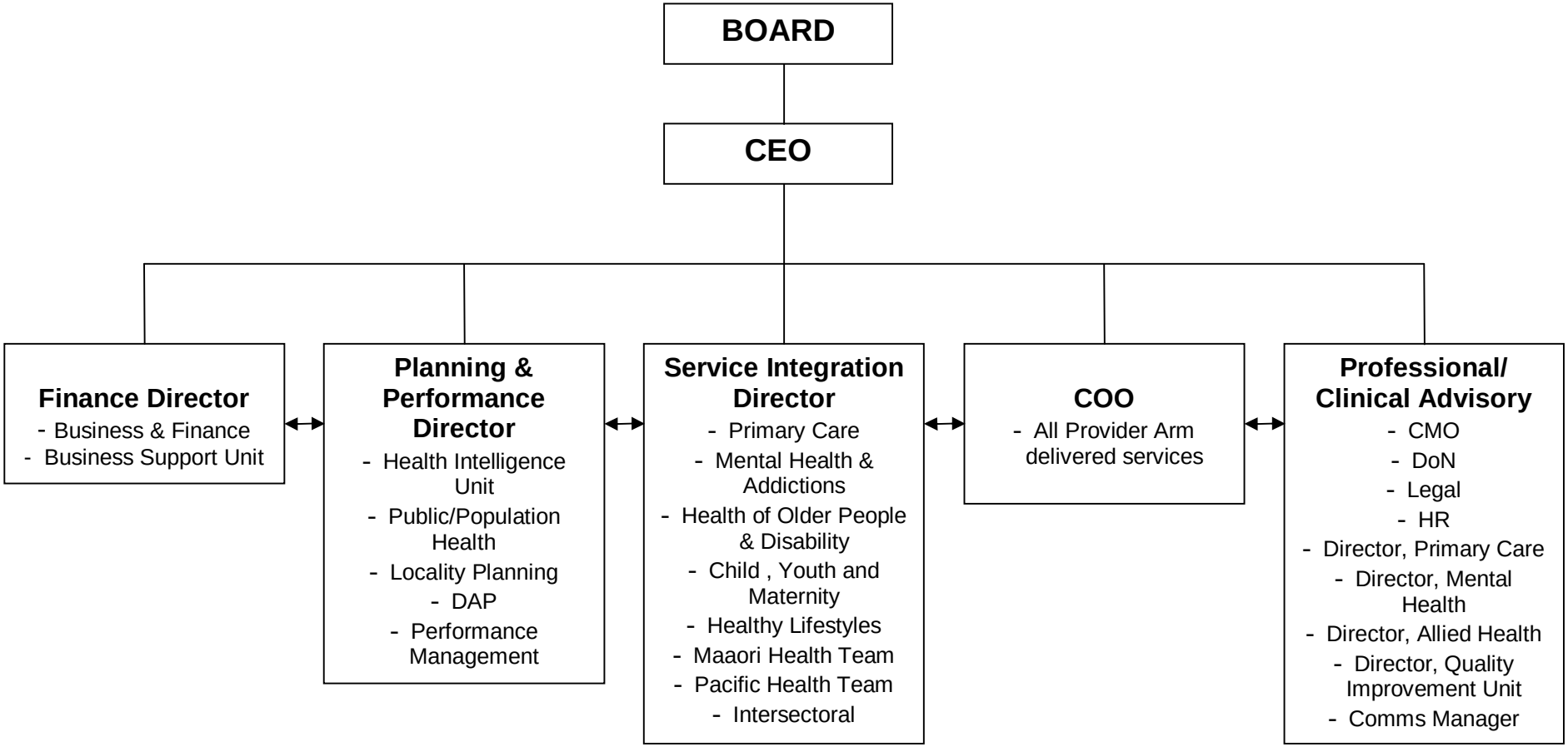
- *Pacific Health Advisory Committee*: provides advice on strategies to reduce disparities in health status for Pacific people.

- *Finance & Audit Committee*: reviews the annual financial statements, manages the relationship with external auditors, ensures compliance with statutory financial requirements, and approves annual budgets.

3.1.1 MANAGING ORGANISATIONAL HEALTH AND CAPABILITY ISSUES

To support the achievement of the District Strategic Plan objectives and to meet its obligations under the New Zealand Public Health & Disability Act 2000, the DHB is supported by the following management structure. The structure is based on planning, funding and provider arms, supported by corporate functions such as finance, legal, communications and information systems. Clinical staff (medical, nursing, allied health) is a key component of the structure and are represented at all levels in the organisation, and at the senior level through the Chief Medical Officer and Director of Nursing. Allied health is represented by the Director of Allied Health who reports to the Chief Operating Officer.

Figure 1: Counties Manukau DHB Organisational Structure as at June 2009



3.1.2 GOOD EMPLOYER

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

Key components of the strategy include:

- a Harassment Prevention Programme including policy, staff education and training, with a commitment to the effective and timely follow up to issues raised by staff.
- a yearly Staff Satisfaction Survey which provides an opportunity for the organisation to receive feedback regarding the success of specific interventions within teams and services. The results of this survey are one of the evaluation measures used to evaluate and plan annual activity to support the Harassment Prevention policy.
- a focus on Disability Awareness programmes supported by the appointment of a Disability Coordinator. This was identified as part of our Equal Employment Opportunities (EEO) work. Policy and support exists for the employment of people with a disability to be employed within their area of expertise.
- access to an Employee Assistance Programme, including self referral, for all staff.
- extension of the Occupational Health and Safety Service to include a Return to Work coordination function and a Liten Up programme (to provide training and equipment for manual handling activity).
- an Employee Wellness Programme to support healthy lifestyle change and choice by staff.

3.1.3 ORGANISATIONAL CAPABILITY

Outcome 6 within the District Strategic Plan focuses on improving the capacity of the health sector to deliver quality services. This outcome area focuses on workforce, communication, facilities, service development, information services, quality and efficient use of resources, to ensure that the DHB has the capability to deliver on its overarching objectives.

3.2 PLANNING AND FUNDING

Since 2001/02, funding responsibility has been progressively devolved to CMDHB for health and disability services. These services include:

- Personal health (i.e. primary, secondary and tertiary care services, Maaori health, Pacific health, primary referred services and oral health),
- Mental health,
- Services for older people and people with disabilities, and
- DHB provided primary maternity services.

The Ministry of Health retains funding responsibility for the remaining health and disability services including the balance of the primary maternity services, disability services for those under 65 years of age, (except for those clinically assessed by CMDHB geriatricians as close in age and interest), public health and national personal health contracts.

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

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

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

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

The legislative objectives and functions of CMDHB under the NZ Public Health and Disability Act 2000 are summarised below.

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

3.3 PROVISION OF HEALTH AND DISABILITY SERVICES

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

- Bone tumour surgery
- Plastic, reconstructive and maxillo-facial surgery
- National Burns service
- Spinal cord injury rehabilitation
- Renal dialysis
- Neonatal intensive care
- Breast reconstruction surgery.

The majority of inpatient services continue to be provided at the Middlemore Hospital site, with the majority of outpatients, community, and day surgery services being provided at our two SuperClinics™ (ambulatory care centres at Manukau and Botany Downs). Non-intensive care based elective surgery has been progressively transferred to the Manukau Surgery Centre (MSC) which is located on the same site as the Manukau SuperClinic™.

A number of tertiary and other services are not provided directly by CMDHB. Most of these are provided for Counties Manukau residents by Auckland DHB, for example, cardiothoracic surgery, neurosurgery, and oncology.

Forensic mental health and school dental services are provided by Waitemata DHB. This requires that CMDHB funds these services separately through inter-district flow (IDF) payments to these DHBs.

Part 4 OUTCOMES AND OBJECTIVES

This section outlines what CMDHB hopes to achieve for the population over the next three years.

CMDHB's services planning is done within the context of the New Zealand Health and Disability Strategies, and must consider national and regional priorities as well as the local health status, health needs and the expected impact of services on health outcomes.

CMDHB's District Strategic Plan (DSP) is the local high level plan which outlines how the DHB will fulfil its statutory objectives and functions over the next 5 to 10 years whilst meeting its longer term outcomes. It is the product of extended conversations with our communities, health professionals, and partner agencies. The current District Strategic Plan was developed during 2005/06. The next review will be undertaken during the 2009/10 fiscal year.

The vision and long term objectives set out in the DSP gives the strategic direction for prioritising the type and level of organisational activities which are to be undertaken by the DHB. CMDHB's district annual plan (DAP) sets out the DHB's activities for the 2009/10 year and is structured around the DSP's six outcome areas (Table 3) with specific objectives, outputs and performance measures identified for each outcome.

The DAP also links to the Minister of Health's "Letter of Expectation" for 2009/10 as summarised in Table 1.

4.1 NATIONAL AND REGIONAL PRIORITIES FOR 2009/10

4.1 .1 NATIONAL HEALTH TARGETS

The latest set of national health targets for 2009 reflects the Minister's priorities and is intended to focus the efforts of all DHBs to make more rapid progress against key national priorities.

The national health targets for 2009/10 are:

Targets	Indicators
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.
Improved access to elective surgery	Volume of elective surgery to be increased by an average of 4,000 discharges per year
Increased immunisation	85 percent of two-year-olds are fully immunised by 2010; 90 percent by July 2011; 95 percent by 2012

Better help for smokers to quit	80 percent of hospitalised smokers are provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95 percent by July 2012. Similar target for primary care to be introduced from July 2010 or earlier.
Better diabetes and cardiovascular services	• Increased percent of people with diabetes attend free annual checks • Increased percent of people with diabetes have satisfactory or better diabetes management • Increased percent of the eligible adult population have had their CVD risk assessed in the last 5 years

The national health targets are included within the selection of performance measures in Part 6 – Statement of Forecast Service Performance.

4.1 .2 MINISTER'S PRIORITIES

The Minister of Health's 'Letter of Expectations', sent on 19th February 2009 and identifies the national priorities for the 2009/10 financial year. The letter states that the new Government wants the public health system to deliver ***"better, sooner, more convenient*** healthcare for all New Zealanders".

The following table outlines the Minister's priorities alongside the relevant District Strategic Plan outcome area for CMDHB, showing how the system can deliver healthcare that will meet the Minister's and the public's expectations.

Table 1: Linking the Minister's Priorities to CMDHB Long Term Outcomes.

Minister's Priorities	CMDHB District Strategic Plan Outcome
Increase elective volumes year on year	**Outcome 4:** Reduce health inequalities
Improve emergency department waiting times	**Outcome 5:** Improve health sector responsiveness to individual and family/whaanau need
Improve cancer treatment wait times	**Outcome 3:** Reduce the incidence and impact of priority conditions
Improve clinical staff retention	**Outcome 6:** Improve the capacity of the health sector to deliver quality service
Foster clinical leadership	**Outcome 6:** Improve the capacity of the health sector to deliver quality services

4.1 .3 REGIONAL STRATEGIC PARTNERSHIPS

The Northern Region District Health Boards (DHBs) have moved from a competitive environment to one where they are progressively working together more as a region around a range of initiatives. Current arrangements include:

- A Regional Governance Group that comprises an Independent Chair, the four DHB chairs and the four CEOs
- A number of regional forums that have formed to progress the development of regional strategies but are predominantly involved in dealing with operational issues
- A range of regional networks and services including Network North for Mental Health and Addiction Services and the Northern Region Cancer Network
- Five regional organisations operating within the region for all four DHBs or a subset of the DHBs, namely the Northern DHB Support Agency (all four DHBs), Auckland Regional Resident Medical Officer Services (metro DHBs), Auckland Regional Dental Service (metro DHBs), Auckland Regional Public Health Services (metro DHBs) and healthAlliance (WDHB and CMDHB)
- Regional projects including, developing a Regional Information Systems Plan, Long term Regional Planning, Senior Medical Officer job sizing, resident doctors one employer project, Mental Health KPI development
- Workforce is an area of particular focus with an emphasis on recruitment, ER, Learning and Development, and Occupational Health and Safety.

The three metro Auckland DHBs (Auckland, Counties Manukau and Waitemata) will manage the transition of community laboratory services from the incumbent provider to the new provider ensuring at all times there is a quality service available to the people of metropolitan Auckland and their doctors.

Service improvements identified from the 2008 community laboratory service consultation process will be prioritised and implemented accordingly within funding availability.

4.2 COUNTIES MANUKAU DHB STRATEGIC DIRECTION

Counties Manukau DHB's shared vision is:

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

Supporting the aspirations of our vision, CMDHB's strategic direction focuses on 6 long term outcomes (*CMDHB District Strategic Plan 2006-11).* The overarching direction is towards community wellbeing and preventative strategies while maintaining and improving the quality of existing health services. These outcomes have been determined based on the community's health needs while considering national health priorities and the need to remain a sustainable organisation.

These outcomes are consistent with the purposes of the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000.

Table 2: District Strategic Plan Outcome Areas

1. Improve community wellbeing – a whole society approach involving the community and other agencies to support healthy lifestyles (physical activity and nutrition, and smokefree), improve environments such as homes, schools, marae and churches and improve access to information to support people make informed decisions about their health.
2. Improve child and youth health – improving care from conception through to adolescence where evidence shows the greatest impact can be achieved, including breastfeeding support, increased coverage of well child checks and immunisation, implementation of best practice guidelines, reducing obesity, and reducing the impact of risk taking behaviour in young people.
3. Reduce the incidence and impact of priority conditions – focussing on those conditions which are the leading causes of ill-health in Counties Manukau, implementing structured programmes, prevention strategies and co-ordinated services across community, primary, secondary and tertiary services.
4. Reduce health inequalities – working to ensure those groups within the community with the highest need and lowest health status receive health and disability services which lift their life expectancy to the level enjoyed by the rest of the Counties Manukau community and New Zealand.
5. Improve sector responsiveness to individual and family/whaanau need – a commitment to improving our community's access to timely and appropriate health and disability services in line with the rest of New Zealand; focussing on hospital and specialist services, elective services, primary care, services for older people and the integration between community based and hospital services.
6. Improve the capacity of the health sector to deliver quality services – to achieve the above five outcomes the DHB needs to ensure the appropriate infrastructure is in place, particularly workforce, facilities, information and quality systems, that all resources are efficiently applied, and all services provided from our hospital and by other contracted providers are safe.

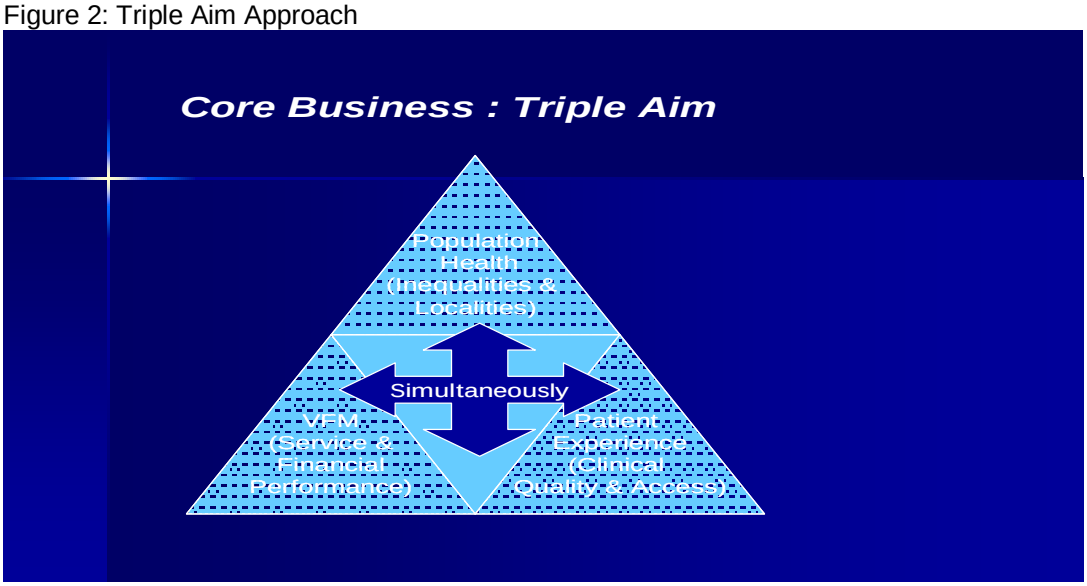
4.3 THE TRIPLE AIM APPROACH

There has been recent attention overseas to using a Triple Aim approach in providing health services to populations – achieving an optimal balance between three dimensions of care:

- the health of a defined population
- the experience of care by people in this population, and
- the cost per capita of providing care for this population.

The health of a population includes the distribution of health outcomes within the population as well as overall health outcomes. Triple Aim is consistent with CMDHB's strategic vision and has been adopted to reflect the underlying objectives of the Counties Manukau health system, i.e. to improve the health of the population and reduce inequalities, to improve the experience of patients and their whanau and achieve these while making best use of our population based funding. Triple Aim is a balanced approach simultaneously focusing on three bottom lines, rather than just the financial bottom line.

Figure 2: Triple Aim Approach



In 2008, our Quality Improvement Unit (QIU) coordinated the writing and release of the CMDHB Quality Improvement (QI) Strategic Plan and a Secondary Care Action Plan. These documents outline the principles for engagement for the entire DHB and the action plans for the next 3 years. Underpinning this is the adoption of the Triple Aim as the founding tenet.

The aim of the CMDHB QI Strategy is to make it explicit that QI needs to be considered in everything we do as a DHB – how we plan services, prioritise resources and measure our performance. For planning our 2009/10 year's activities we have linked each objective with the Triple Aim framework as well with specific national health indicators and targets to enable measurement of our performance across all dimensions.

Part 5 PERFORMANCE AND OUTCOMES FRAMEWORK

One of the functions of the SOI, in particular the Statement of Forecast Service Performance, is to show how we will measure our organisational performance against our priorities.

The purpose of the SOI is to provide a high level summary of how CMDHB's activities will fulfil Ministry and Government's priorities whilst contributing to Counties Manukau's long term outcomes, and as such, will only highlight a selection of CMDHB's key activities or interventions undertaken and their related performance measures. A comprehensive set of the DHB's objectives and activities for 2009/10 are already outlined in the District Annual Plan.

The key activities or interventions and their related performance measures have been chosen based on their link to priorities outlined in the District Strategic Plan and reference the Minister's priorities as well as national health targets.

5.1 KEY MECHANISMS FOR INTERVENTION

As described in Section 3.2, Counties Manukau DHB discharges its functions by:

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

5.2 INTERVENTION LOGIC

The activities undertaken by Counties Manukau DHB are planned and implemented to support the achievement of the DHB's outcomes and objectives as described in Part 4.

The DHB intervention logic model is illustrated below and show how CMDHB's activities (as outlined in Part 3) contribute to outcomes for the local population and meet national, regional and local priorities.

DHB intervention logic model

If we invest/ fund ➡	And undertake ➡	Then we produce ➡	That will achieve/ impact ➡	And contribute to
Inputs Resources Capability	**Activities** **Initiatives** **Projects**	**Outputs** Services provided **DHB enablers** Activities Programmes Projects	**Ministry of Health priorities** **MInister's expectations** **CMDHB Objectives**	**CMDHB Strategic Outcomes** • **Improved community wellbeing** • **Improved child and youth health** • **Reduced incidence and impact of priority conditions** • **Reduced health inequalities** • **Improved DHB responsiveness to individual and whaanau/ family need** • **Improved DHB capacity to deliver quality services**

Part 6 STATEMENT OF FORECAST PERFORMANCE FRAMEWORK

The Statement of Forecast Service Performance is structured along the four output classes of:

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

which essentially groups similar service areas together for ease of understanding.

Table 3 shows the spread of the DHB's activities across the four output classes.

Table 3: CMDHB priority activities across the output classes

Public Health	**Primary & Community**	**Hospital**	**Support Services**
Well Child immunisation B4SC Breast screening Smoking cessation Let's Beat Diabetes/HEHA Healthy Housing	Chronic Care Management Diabetes 'Get Checked' Devolution of secondary services to primary care Locality Planning Oral health	Emergency Care Cancer treatment Electives Acute care including mental health services Maternity services Health Services Planning Workforce development Quality improvement	Respite care Aged residential care

The Statement of Forecast Service Performance (SFSP) sets out high level non-financial measures for priority areas within each output class. These measures give CMDHB an indication of how the implementation of the DSP/ DAP is impacting upon health outcomes for the local population.

For each measure, detail is provided on:

- The performance measure itself, i.e. what is being measured
- Baseline/current performance figures and target performance figures for the next three years.

6.1 SFSP FOR PUBLIC HEALTH SERVICES

Activities/ initiatives/ Projects undertaken →	Services provided to our community →	Impact →	Outcomes
Health Promotion	Smoking cessation health promotion in schools/ workplaces/ DHB services	Fewer smokers/ smokefree homes Reduce incidence of smoking-related illnesses	Improved community wellbeing Improved child and youth health Reduced health inequalities
	Pacific health initiatives like Lotu Moui	Increase awareness of health issues and access to services/ programmes amongst Pacific peoples	
	Maaori health initiatives like the Whaanau Ora marae programmes	Increase awareness of health issues and access to services/ programmes amongst Maaori	
Lets Beat Diabetes (Healthy Eating/ Healthy Action) Programme	Health Promoting Schools Pacific health initiatives Maaori health initiatives South Asian initiatives	Initiate lifestyle changes within the community to improve health and reduce obesity via better nutrition and increased physical activity levels	
Well child/ Tamariki Ora services	Immunisations Health checks Support, information and advice for parents	Protect against communicable diseases Early detection of health and development problems Support for parents to keep children healthy and safe	

Activities/ initiatives/ Projects undertaken	Services provided to our community	Impact	Outcomes
Intersectoral work to improve community health and wellbeing	Healthy Housing joint health and housing assessments 'Lifting the Game' in Wiri Snug Homes Reducing Family Violence	Healthier and safer living environments Improved health; less respiratory and infectious diseases	Improved community wellbeing Improved child and youth health Reduced health inequalities
Population screening	B4SC programme	Early detection of health issues which may impact on children's development and wellbeing	
	Newborn hearing programme	Early detection of hearing loss in children	
	Breast screening	Early detection of cancer or pre-cancerous conditions	

Output Measures for Public Health Services

Outputs	Measures	Baseline	2009/10	2010/11	2011/12
Smoking cessation initiatives	National Health Target: 80% of hospitalised smokers are provided with advice and help to quit by July 2010; 90% by July 2011; and 95% by July 2012. Similar target for primary care to be introduced from July 2010 or earlier.	80% by July 2010 90% by July 2011 95% by July 2012 Similar targets for primary care will be introduced by July 2010 or earlier, through the PHO Performance Programme			

Outputs	Measures	Baseline	2009/10	2010/11	2011/12
Immunisations	National Health Target: 85 percent of two-year-olds are fully immunised by 2010; 90 percent by July 2011; 95 percent by 2012	75%	85%	90%	95%
Lets Beat Diabetes (Healthy Eating/ Healthy Action) initiatives	Number of health promoting schools	95	100	105	105
	At least 70% adults eat three or more services of vegetables per day by 2014	CDMHB remains committed to improving nutrition, increasing physical activity and reducing obesity as outlined in the District Strategic Plan. From the Let's Beat Diabetes benchmark survey in 2007 , the mean number of fruit and vegetable servings consumed are: Total 4.6 Maaori 4.8 Pacific 4.3 Asian 4.1 Other 4.8 This survey will be repeated in June 2009.			
	At least 62% of adults eat two or more servings of fruit per day by 2014				
Intersectoral initiatives	Number of joint health & housing assessments	480	480	480	480
	POP-11: Progress towards taking a systematic approach towards the identification and intervention of child and partner abuse. Audit score from the AUT hospital responsiveness to family violence, child and partner abuse.	Baseline audit score as at May 2009 was 73/100 Audit does not include child abuse for CMDHB as this is managed under another contract. Audit score target for 2009/10 of at least 70/100.			

Outputs	Measures	Baseline	2009/10	2010/11	2011/12
Population screening	% of women aged 45-69 who have had a breast screen in the last 24 months	Maaori 40% Pacific 43% Other 49% Total 47%	Maaori 56% Pacific 52% Other 51% Total 58%	Maaori 65% Pacific 65% Other 65% Total 65%	Maaori 70% Pacific 70% Other 70% Total 70%

6.2 SFSP FOR PRIMARY & COMMUNITY SERVICES

Activities/ initiatives/ Projects undertaken →	Services provided to our community →	Impact →	Outcomes
Population screening for chronic conditions in primary & community settings	Diabetes 'Get Checked' Cardiac monitoring: - CVD risk assessments - Lipid and Glucose tests	Better management of diabetes and fewer complications Identification of those who have not had their annual diabetes checks Identification of developing CVD and associated risks	Reduce the incidence and impact of priority conditions Reduce health inequalities Improve community wellbeing Improve child and youth health Improve sector responsiveness to individual and family/whaanau need
Management of Long Term Conditions in primary and community settings	CCM modules: - Diabetes - Mental Health - CVD Community-based Cardiac rehabilitation services Heart Guide Aotearoa	Improved management of chronic conditions Reduce the number of admissions to hospital that are avoidable or preventable	
Devolution of secondary services to primary care and community settings	General Practitioners with Special Interest providing First Specialist Assessments in a primary care setting: Tubal ligation, ORL, Plastics Retinal Screening provided by community optometrists	Faster clinical assessment and referral for treatment	

Activities/ initiatives/ Projects undertaken	Services provided to our community	Impact	Outcomes
Primary care sector capacity and capability development	Access to capitated primary care services	Increase primary care utilisation especially amongst the high needs groups like Maaori and Pacific Improved provision of information and referral access to community health services, and delivery of clinical information for patients and their whaanau/families Earlier resolution of health problems, lessening the chance of complications Reduce the number of admissions to hospital that are avoidable or preventable	Reduce the incidence and impact of priority conditions Reduce health inequalities Improve community wellbeing Improve child and youth health Improve sector responsiveness to individual and family/whaanau need
Locality Planning	After-hours primary care services Development of primary and community health centres targeted at the local population needs	Targeting of health needs and inequalities at a local level Better coordination between primary and community providers and the interface with secondary care	
Reorganisation of oral health services into community-based oral health services	Free oral health services for 0-18 Targeted oral health promotion to Maaori and Pacific communities Development of community based oral health clinics	Improved access to oral health services Improved oral health particularly for Maaori and Pacific preschoolers Retention of dental workforce	

Output Measures for Primary & Community Services

<table>
<tr><th>Outputs</th><th>Measures</th><th>Baseline</th><th>2009/10</th><th>2010/11</th><th>2011/12</th></tr>
<tr><td>Diabetes Get Checked screening</td><td>National Health Target:
Increased percent of people with diabetes attend free annual checks</td><td colspan="4">
<table>
<tr><th></th><th>Baseline 2008/09</th><th>2009/10</th><th>2010/11</th><th>2011/12</th></tr>
<tr><td>Maori</td><td>63%</td><td>67%</td><td>68%</td><td>70%</td></tr>
<tr><td>Pacific</td><td>65%</td><td>75%</td><td>76%</td><td>77%</td></tr>
<tr><td>Other</td><td>65%</td><td>65%</td><td>68%</td><td>70%</td></tr>
<tr><td>Total</td><td>65%</td><td>68%</td><td>70%</td><td>72%</td></tr>
</table>
</td></tr>
<tr><td>Diabetes Get Checked screening</td><td>National Health Target:
Increased percent of people with diabetes have satisfactory or better diabetes management (HBA1c = 8% or less)</td><td colspan="4">
<table>
<tr><th></th><th>Baseline 2008/09</th><th>2009/10</th><th>2010/11</th><th>2011/12</th></tr>
<tr><td>Maaori</td><td>52%</td><td>54%</td><td>55%</td><td>57%</td></tr>
<tr><td>Pacific</td><td>46%</td><td>48%</td><td>50%</td><td>52%</td></tr>
<tr><td>Other</td><td>69%</td><td>71%</td><td>72%</td><td>74%</td></tr>
<tr><td>Total</td><td>57%</td><td>60%</td><td>62%</td><td>64%</td></tr>
</table>
</td></tr>
<tr><td>CVD monitoring</td><td>National Health Target:
Increased percent of the eligible adult population have had their CVD risk assessed in the last 5 years</td><td colspan="4">
<table>
<tr><th></th><th>Baseline 2008/09</th><th>2009/10</th></tr>
<tr><td>Maaori</td><td>70.3%</td><td>72.3%</td></tr>
<tr><td>Pacific</td><td>71%</td><td>73%</td></tr>
<tr><td>Other</td><td>79%</td><td>80.5%</td></tr>
<tr><td>Total</td><td>76.2%</td><td>78%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Outputs</th><th>Measures</th><th>Baseline</th><th>2009/10</th><th>2010/11</th><th>2011/12</th></tr>
<tr><td>Management of Long Term Conditions in primary and community settings</td><td>POP-15: Reduction in the number of ambulatory sensitive hospital (ASH) admissions</td><td colspan="4">Targets for the year ending 30th June 2010

<table><tr><td></td><td>Maaori</td><td>Pacific</td><td>Other</td></tr><tr><td>0-4</td><td>96.3</td><td>106.8</td><td>97</td></tr><tr><td>45-64</td><td>116.9</td><td>108</td><td>113.2</td></tr><tr><td>0-74</td><td>108.5</td><td>107</td><td>106</td></tr></table>These targets (SDRs) equate to the percentage of the national average for the year ending June 2010.</td></tr>
<tr><td></td><td>Care Plus enrolled population</td><td colspan="4">2009/10 target is 70%</td></tr>
<tr><td></td><td>Reduction in the mortality rate for Maaori and Pacific men aged 45-64 years</td><td>(per 100,000)

Maaori 1222
Pacific 811
Other 393
Total 542</td><td>(per 100,000)

Maaori 1200
Pacific 900
Other 390
Total 520</td><td>(per 100,000)

Maaori 1100
Pacific 850
Other 380
Total 510</td><td>(per 100,000)

Maaori 1050
Pacific 800
Other 370
Total 500</td></tr>
<tr><td></td><td>Rate of GP consultations for high needs groups (Maaori, Pacific and/or living in decile 9 or 10 areas) compared with non-high needs</td><td>>1.1</td><td>>1</td><td>>1</td><td>>1</td></tr>
<tr><td>Primary Care Services</td><td>SER-07: Lower or reduced cost access to primary care services</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td></td><td>% of pharmaceutical transactions with a valid NHI</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr>
<tr><td></td><td>% of laboratory test transactions with a valid NHI</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr>
</table>

Outputs	Measures	Baseline	2009/10	2010/11	2011/12
Reorganisation of oral health services and facilities	POP-04: Reduction in the mean DMFT for 5 yr olds enrolled with the oral health service at year 8	Baseline 2009/10 Maaori 1.51 1.5 Pacific 1.35 1.30 Other 0.94 0.90 Total 1.15 1.10 Baseline: ARDS			
	POP-05: Percentage of children caries free at age five years	Baseline 2009/10 Maaori 34.3% 35% Pacific 29.6% 35% Other 63.2% 65% Total 46.1% 52% Note: 'Other' includes European, Asian and other ethnicities. Baseline: ARDS			
Reorganisation of oral health services and facilities	POP-14: Utilisation of oral health services by adolescents from Yr 9 up to and including age 17 years	53%	57%	60%	65%

6.3 SFSP FOR HOSPITAL SERVICES

Activities/ initiatives/ Projects undertaken	Services provided to our community	Impact	Outcomes
Northern Region Cancer Network	Cancer treatment services provided through the Auckland Regional Cancer and Blood Service	Reduced waiting times for access to cancer treatment Reduce the incidence and impact of cancer	Improved health status Reduced health inequalities Improve the capacity of the health sector to deliver quality services Improve sector responsiveness to individual and whaanau need Improve patient experience (Triple Aim) Value for Money (Triple Aim)
Acute and Emergency Care Services	Acute care services including mental health services Emergency care services	Timely access to Acute care or emergency care treatment Reduced length of stay in the Emergency Department	
Achieving Baby Friendly Hospital Accreditation	Maternity services including: - Antenatal care - Community-based maternity units - Secondary maternity services - Postnatal care including breastfeeding support and extended postnatal stays where appropriate	Improved breastfeeding rates Reduction in the admission/readmission of newborns to hospital in their first year of life Improved maternal wellbeing and postnatal experience	
Electives Planning	More elective procedures available	More people receive better, sooner, more convenient elective services Reducing transactional costs and enabling better leverage of financial and workforce constraints	

Activities/ initiatives/ Projects undertaken	Services provided to our community	Impact	Outcomes
CMDHB Health Services Planning	Fit-for-purpose facilities Increased number of hospital beds Workforce development to recruit and retain staff	Implementation of new models of care which support operational efficiency Retention of workforce through improved job satisfaction	Improved health status Reduced health inequalities Improve the capacity of the health sector to deliver quality services Improve sector responsiveness to individual and whaanau need
Workforce Development	Safe and supportive workplaces for staff The CMDHB workforce reflects the local population Workforce development including coaching and mentoring	Retention of workforce through improved job satisfaction CMDHB to be an 'employer of choice' for new graduates Improve patient – staff communication Improve cultural responsiveness to Maaori and Pacific populations	
Quality Improvement	Clinical Leadership Patient Safety initiatives: - ICU bundles - Physiologically Unstable Patient Programme Patient-centred care through Releasing Time to Care	Safer and higher quality hospital care Staff spend more time on patient care Better patient communication	

Output measures for Hospital Services

Outputs	Measures	Targets
Emergency Services	National Health Target: 95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	MOH Note: Date for achieving this target will be set once all current performance data has been collected. CMDHB is committed to achieving the target of 95% patients admitted, discharged or transferred from and Emergency Department (ED) within 6 hours.
Cancer treatment	National Health Target: Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010
Elective Services	National Health Target: Volume of elective surgery to be increased by an average of 400 discharges per year	Volume of elective surgery to be increased by an average of 400 discharges per year. CMDHB will provide at least 13,504 surgical discharges in 2009/10 (excludes Cardiology/ Dental) and is projecting 13,940 discharges in 2009/10. 2010/11 2011/12 Forecast Discharge at MOH conversion rate: 13,504@ 3.28% =>13,947 13,947@3.28% =>14,404
	Compliance with all eight national elective service performance indicators	CMDHB 2009/10 targets ESPI 1 – 97% ESPI 2 – 1.6% ESPI 3 – 4% ESPI 4 – N/a ESPI 5 – 3% ESPI 6 – 10% ESPI 7 – 3% ESPI 8 – 97%

<table>
<tr><th>Outputs</th><th>Measures</th><th colspan="4">Targets</th></tr>
<tr><td></td><td></td><td>Baseline</td><td>2009/10</td><td>2010/11</td><td>2011/12</td></tr>
<tr><td>Elective Services</td><td>% of patients with a priority score above the treatment threshold who have not received treatment within 6 months</td><td>3%</td><td>3%</td><td>3%</td><td>3%</td></tr>
<tr><td></td><td>% of patients who have been placed on active review who have not received a clinical assessment within the last 6 months</td><td>10%</td><td>10%</td><td>10%</td><td>10%</td></tr>
<tr><td>Mental Health services</td><td>POP-06: Access to mental health services</td><td colspan="4">
<table>
<tr><th>Ages</th><th>Baseline</th><th>2009/10</th><th>2010/11</th><th>2011/12</th></tr>
<tr><td>0-19</td><td>2.07%</td><td>2.20%</td><td>2.20%</td><td>2.20%</td></tr>
<tr><td>20-64</td><td>2.63%</td><td>2.81%</td><td>2.81%</td><td>2.81%</td></tr>
<tr><td>>64</td><td>2.23%</td><td>2.40%</td><td>2.40%</td><td>2.40%</td></tr>
<tr><td>Total</td><td>2.41%</td><td>2.57%</td><td>2.57%</td><td>2.57%</td></tr>
</table>
<u>2009/10 target breakdown</u>
<table>
<tr><th>Ages</th><th>Total</th><th>Maaori</th><th>Other</th></tr>
<tr><td>0-19</td><td>2.20%</td><td>3.0%</td><td>1.95%</td></tr>
<tr><td>20-64</td><td>2.81%</td><td>5.2%</td><td>2.4%</td></tr>
<tr><td>>64</td><td>2.4%</td><td>2.4%</td><td>2.4%</td></tr>
</table>
</td></tr>
<tr><td></td><td>POP-17: At least 90% of long term clients have up-to-date relapse prevention plans</td><td colspan="4">Children 90%
Adults and Older People 90%
Adults and Older People – Maaori 90%
DHB Total 90%</td></tr>
</table>

Outputs	Measures	Targets			
Maternity Services	POP-18: Improve breastfeeding rates. At least 74% of infants are fully and exclusively breastfed at six weeks by 2014, at least 57% at 3 months by 2012, and at least 27% at 6 months by 2012	Exclusive and fully breastfed rates at 6 weeks: Maaori 47.2% Pacific 49.9% Total 53.6%			
Workforce development	% of employees who voluntarily resign	9.33%	<14%	<14%	<14%
Quality Improvement	% of inpatient satisfaction survey respondents who rate service satisfaction as 'Good'/ 'Very Good'	82%	83%	85%	86%
	% of communication complaints received to the number of admissions	0.4%	0.3%	0.3%	0.3%

6.4 SFSP FOR SUPPORT SERVICES

Activities/ initiatives/ Projects undertaken	Services provided to our community	Impact	Outcomes
Needs Assessment and Coordination Services	Personal Care Home Help Carer Support Home Based Support Services Dementia Day Care Aged Residential Care	Older people and people with disabilities are able to maintain their independence and quality of life at home and in the community where appropriate, and where this is not possible, they are supported in a residential care setting	Improve the capacity of the health sector to deliver quality services Improve sector responsiveness to individual and whaanau need Reduce health inequalities

Output Measures for Support Services

Outputs	Measures	Baseline	2009/10	2010/11	2011/12
Home based support services	Ratio of people receiving Home Based Support to those receiving Aged Residential Care	2.5	2.5	2.5	2.5

Part 7 MANAGING FINANCIAL RESOURCES

7.1 FINANCIAL STATEMENTS

Statement of Financial Performance						
$000	**2007/08 Actual**	**2008/09 Budget**	**2008/09 Forecast**	**2009/10 Draft Budget**	**2010/11 Estimate**	**2011/12 Estimate**
Revenue	**1,060,578**	**1,093,297**	**1,052,585**	**1,225,552**	**1,306,923**	**1,366,720**
Personnel	345,660	376,059	385,891	435,808	472,989	496,488
Outsourced	46,780	46,531	40,073	41,296	36,300	31,305
Clinical Supplies	71,066	72,957	76,923	81,838	86,818	91,159
Infrastructure	62,245	57,936	61,489	51,493	53,905	54,184
Provider Payments	475,481	486,500	434,746	555,086	592,839	617,068
Maaori	5,451	7,629	8,845	7,754	8,142	8,549
Operating Costs	**1,006,683**	**1,047,612**	**1,007,967**	**1,173,275**	**1,250,994**	**1,298,754**
EBITDA	**53,895**	**45,685**	**44,618**	**52,277**	**55,929**	**67,966**
Depreciation	23,638	22,212	22,213	28,604	31,624	32,493
Interest	7,842	9,564	7,500	9,636	11,676	11,910
Operating Results before Capital Charge	**22,415**	**13,909**	**14,905**	**14,037**	**12,629**	**23,564**
Capital Charge	13,722	14,004	14,000	14,000	14,000	14,000
Operating Surplus	**8,693**	**(95)**	**905**	**37**	**(1,371)**	**9,564**
Below The Line	(1,500)	(3,000)	(3,000)	(3,000)	(3,000)	
Surplus / (Deficit)	$ 7,193	$(3,095)	$ (2,095)	$ (2,963)	$ (4,371)	$ 9,564

These budgets are prepared in accordance with CMDHB's accounting policies as fully disclosed under Section 3 of this DAP and also within the SOI.

Summary by Output Source						
$000	**2007/08**	**2008/09**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
	Actual	**Budget**	**Forecast**	**Draft Budget**	**Estimate**	**Estimate**
Funder - Arm						
Government & Crown	890,660	954,999	890,660	1,051,964	1,125,601	1,176,882
Non Government & Crown Agency	1,003	1,566	1,566	244	250	256
Inter DHB & Internal	78,640	73,264	78,640	83,240	87,401	91,773
Revenue	**970,303**	**1,029,829**	**970,866**	**1,135,448**	**1,213,253**	**1,268,910**
Personal Health	756,612	792,300	734,408	900,514	964,881	1,007,712
Mental Health	109,834	114,525	119,191	126,212	134,523	141,249
DSS	82,231	96,432	96,432	91,254	94,634	99,366
Public Health	859	216	216	77	81	85
Maaori (consolidated)	5,451	7,629	8,845	7,754	8,142	8,549
DHB Governance	8,089	8,573	8,573	8,514	8,727	8,945
Expenses	**963,076**	1,026,776	**967,665**	**1,134,325**	**1,210,987**	**1,265,905**
Surplus / (Deficit)	**7,227**	**3,053**	**3,201**	**1,123**	**2,266**	**3,005**
Below The Line	(1,500)	(3,000)	(3,000)	(2,200)	(3,000)	
Surplus / (Deficit)	**$ 5,727**	**$ 53**	**$ 201**	**$ (1,077)**	**$ (734)**	**$ 3,005**

Governance - Arm	2007/08 Actual	2008/09 Budget	2008/09 Forecast	2009/10 Draft Budget	2010/11 Estimate	2011/12 Estimate
Revenue						
Government & Crown	8,089	8,573	8,573	9,091	9,318	9,551
Other	548	-	0	194	0	0
Revenue	**8,637**	**8,573**	**8,573**	**9,285**	**9,318**	**9,551**
Personnel	6,550	7,483	7,483	6,824	5,995	6,144
Outsourced	(134)	(72)	0	169	173	178
Infrastructure	4,398	3,902	3,321	4,544	4,628	4,744
Expenses	10,814	11,313	10,804	11,537	10,796	11,066
Surplus / (Deficit)	**(2,177)**	**(2,740)**	**(2,231)**	**(2,252)**	**(1,478)**	**(1,515)**
Below the line				(800)		
Surplus / (Deficit)	**$ (2,177)**	**$(2,740)**	**$ (2,231)**	**$ (3,052)**	**$ (1,478)**	**$ (1,515)**

Provider - Arm						
	2007/08 Actual	**2008/09 Budget**	**2008/09 Forecast**	**2009/10 Draft Budget**	**2010/11 Estimate**	**2011/12 Estimate**
Government & Crown	67,648	40,962	59,202	68,241	71,653	75,236
Non Government & Crown Agency	21,726	22,266	22,266	20,850	21,171	21,701
Inter DHB & Internal	474,408	515,741	515,752	562,413	601,534	631,610
Revenue	**563,782**	**578,969**	**597,220**	**651,504**	**694,358**	**728,547**
Personnel	339,110	368,576	378,408	428,984	466,994	490,344
Outsourced	46,914	38,030	40,073	41,127	36,127	31,127
Clinical	79,071	79,912	84,445	89,327	94,693	99,428
Infrastructure	95,044	92,859	94,359	90,900	98,702	99,574
Expenses	**560,139**	**579,377**	**597,285**	**650,338**	**696,517**	**720,473**
Surplus / (Deficit)	**$ 3,643**	**$ (408)**	**$ (65)**	**$ 1,166**	**$ (2,159)**	**$ 8,074**

Eliminations						
	2007/08 Actual	**2008/09 Budget**	**2008/09 Forecast**	**2009/10 Draft Budget**	**2010/11 Estimate**	**2011/12 Estimate**
Revenue	(482,144)	(524,074)	(524,074)	(570,685)	(610,006)	(640,289)
Expenses	(482,144)	(524,074)	(524,074)	(570,685)	(610,006)	(640,289)
Surplus / (Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
DHB – Total	**$7,193**	**$(3,095)**	**$ (2,095)**	**$ (2,963)**	**$ (4,371)**	**$ 9,564**

Statement of Financial Position						
$000	**2007/08 Actual**	**2008/09 Budget**	**2008/09 Forecast**	**2009/10 Draft Budget**	**2010/11 Estimate**	**2011/12 Estimate**
Current Assets	36,880	34,681	35,329	36,036	36,756	37,491
Current Liabilities	190,133	190,094	190,046	179,995	193,671	200,319
Working Capital	**(153,253)**	**(155,413)**	**(154,717)**	**(143,959)**	**(156,915)**	**(162,828)**
Non-Current Assets	414,616	481,521	460,004	480,896	508,107	597,261
Net Funds Employed	**$261,363**	**$326,108**	**$305,287**	**$336,937**	**$351,192**	**$434,433**
Total Non-Current Liabilities	80,689	128,536	127,117	161,730	180,356	254,034
Crown Equity	180,674	197,572	178,170	175,207	170,836	180,399
Net Funds Employed	**$261,363**	**$326,108**	**$305,287**	**$336,937**	**$351,192**	**$434,433**

Statement of Movement in Equity						
$000	**2007/08**	**2008/09**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
	Actual	**Budget**	**Forecast**	**Draft Budget**	**Estimate**	**Estimate**
Opening Balance	169,791	200,667	180,674	178,170	175,207	170,835
Surplus / (Deficit)	7,494	(3,095)	(3,305)	(2,963)	(4,371)	9,564
Transfer of restricted funds			801			
Revaluation Assets	3,389					
Closing Balance	**$180,674**	**$197,572**	**$178,170**	**$175,207**	**$170,836**	**$180,399**

Statement of Movement in Cash Flow						
$0	**2007/08**	**2008/09**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
	Actual	**Budget**	**Forecast**	**Draft Budget**	**Estimate**	**Estimate**
Operating Cash	31,243	15,984	14,592	12,065	21,195	42,590
Investing (Capital)	(45,145)	(62,260)	(60,868)	(47,492)	(53,767)	(115,659)
Financing	14,506	41,391	45,866	35,427	32,572	73,069
Net Cash Flow	**604**	**(4,885)**	**(410)**	**-**	**-**	**-**
Opening Cash	1,629	5,898	2,233	1,823	1,823	1,823
Closing Cash	**$2,233**	**$ 1,013**	**$1,823**	**$1,823**	**$1,823**	**$1,823**

7.2 OVERVIEW

After an extended period of intensive 'line by line' review within Provider, Funder and Governance Arms of CMDHB and a resultant severe curtailment in costs and new or extended investment opportunities, we are able to present the DAP reflecting a zero deficit Operating position. This has been achieved without any reduction in front line clinical services as required. However this has obviously put the organisation in a position of higher clinical and financial risk as a result, which we acknowledge must be managed, despite the continuing escalating pressures. As a result of tabling a zero Operating position, we have retained our 'below the line' costs, albeit at a slightly lower level. These reflect continuing investment in priority areas funded as previously agreed, through the utilisation of previous year's accumulated surpluses.

While the nationally agreed correction in the PBF formula would have significantly benefited this current financial position by $24.5m and allowed CMDHB to continue to self fund the significant number of initiatives around primary care and hospitalisation avoidance, the financial reality is that this has already been reallocated within the sector and is not available under the MoH capped percentage funding envelope. Consequently CMDHB has achieved Operating breakeven through further very intensive reviews of its existing investments and structures. We highlight however, that it is anticipated within this DAP's financial projections that the benefit of the PBF formula change will accrue to CMDHB in the outer years of the DAP within the existing MoH cap limits. This is a very fundamental and important assumption to highlight, as without this recognition, the financial position of CMDHB would be at severe risk, particularly given the increasing cost impact as the new facility investments come on stream.

As with the previous year, the key drivers of this change in financial position are:

- The high level of clinical wage settlements, primarily in the Provider arm which have been settled at levels virtually double of FFT on an "all up" basis, for generally periods of three years (i.e. two years still remaining) and which are directly impacting on Operating performance.
- The continuing significant IDF outflows and pricing adjustments primarily related to ADHB provision of 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 initial impact of operating costs relating primarily to the opening of the new Edmund Hillary Ward block on the Middlemore site, but also the associated facility developments on both the Middlemore and Browns Road sites.
- The need to achieve Ministerial objectives around waiting times, ED, ESP's and the increased costs associated with those targets within the forthcoming constrained budget.
- The annualisation of commitments made in 2008/09, including the very significant continuing investment in all quality related areas, which is not expected to make a return on investment until the outer years of the DAP.
- The impact, as classified "below the line" of CMDHB's development investment costs in establishing the Centre for Health Services Innovation proposed for the Western Campus, prior to considering capital funding options, i.e. establishment costs having to be written off in both 2008/09 and 2009/10.
- The resurgence, after a period of relatively lesser level of demand growth, particularly within the medicine division of the provider arm.

While the 2008/9 financial result is expected to achieve an Operating breakeven position, this result could be perceived as misleading in comparison to the forecast 2009/10 position, unless analysed further. There are a number of gains that are from a timing perspective "one off". Depreciation and interest costs are anticipated to be significantly lower than budget for 08/09 reflecting the timing issues of the new facility developments. There is now greater certainty around required construction completion dates and clinical deadlines that must be achieved which will mean these will self correct in 2009/10. Further, while we anticipated a capital revaluation impacting on 2008/9, this did not occur to the level forecast and although unfunded was therefore a lesser cost than is budgeted.

Other one off revenue gains that have assisted the 2008/9 position are the further release of remaining risk pool provisions no longer required, the "wash-up" of MoH elective revenue contracts, higher National Burn recoveries and ongoing vacancies in areas such as Allied Health, with the latter unable to be maintained into 2009/10 given the increasing demographic growth pressures.

In previous years, CMDHB has benefited from the population based funding formula (PBF) specifically through the demographic growth component of the funding which is in addition to FFT. This has allowed CMDHB the opportunity to invest in areas directed towards primary health care focus while lessening the provider or hospital arm demand. As with the current year, unfortunately the very significant benefit and resulting financial stability this has provided has now been completely eroded by the magnitude of the unfunded committed wage settlements for both 2009/10 and 2010/11 years in all our key clinical areas.

This forecast financial position, particularly for the first year of the DAP (but also obviously impacting on the outer years) has already resulted in action to severely limit CMDHB's ability to continue to invest in and achieve many of its wide objectives. CMDHB remain absolutely committed to the achieving of its Triple Aim objectives, but in order to do so has implemented a process of organisational wide review and challenge. The severe funding constraints CMDHB will be under to achieve Operating breakeven will be of critical concern in determining where and how these impact on the Triple Aim objective.

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

The **tabled** forecast DAP position shows a current operating deficit of $NIL, further increased by $3m below the line costs. As in previous years, we are proposing to continue to utilise the balance of previous years operating surpluses (forecast as

$13m carried forward as at 30 June 2009) to continue to be utilised over future years to assist firstly, the achievement of targeted national and DHB objectives and secondly, to fund one off non-core up front funding such as the assessment, evaluation and business case preparation related to the development of the Centre for Health Services Innovation on the CMDHB Western Campus. The latter is likely to be in the region of $0.8m after recovery of third party contributions. In regard to the targeted national and DHB objectives, these would be around investment in priority initiatives aligned with our District Strategic Plan and ministerial areas of emphasis and change such as Chronic Care Management (CCM) and Maaori Health, with a sum of $2m included in the first year of the DAP. Again as previously, it is likely that the Board will continue to seek to review the investment levels in these areas within the limits of the carried forward earnings. It also includes recognition of the Minister's "tagged" funding and costs related to the specific tags.

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

In order to reduce our operating deficit to $0m for the organisation, we have already had to cap quite severely the allowable and fundable growth, both within the provider and the funder arms. This continues to present a huge challenge to contain the growth, related costs and quality investment throughout the organisation within these parameters, but the organisation recognises that CMDHB will have to further constrain these areas in order to achieve a zero deficit operating budget position.

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

- A mandatory asset revaluation exercise must be carried out by 30 June 2009 under the 3 year minimum asset revaluation period. A number of factors will impact on this. While a small net increase in asset values was incurred as at 30 June 2008, with a consequent unfunded increase in capital charge, indications are that, given the current world wide financial crisis, the likelihood of material increases in fixed asset valuation is low and there is prospect now that this may be a negative revaluation. We would also highlight that the actual valuation exercise will determine whether any existing asset values are diminished as a result of Ministerial approvals for new facility developments. This information is unlikely to be available with integrity until closer to current year end and well after the DAP is finalised.
- All mental health funding, including existing "blueprint", continues to be "ring fenced", with a neutral impact on the consolidated position. At the time of writing there has been no indication of any increase in blueprint funding for 2009/10 and therefore no increase anticipated in mental health revenue. 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 and demographic growth and must operate within those parameters without top up from any other source.

- No PHO top up reimbursements are anticipated as continuing from the Ministry of Health.
- Funding for Health of Older People income and asset testing recalculation is sufficient to match our forecast level, given that as house prices fall (as is currently happening), health of older people accessibility levels will drop, entitling more people to claim.

It is important to note that the current zero deficit position has been reached after:

- Recognising anticipated wage and salary settlements well in excess of the 2.6% (nett) or 3.1% (gross) funded level, specifically:

    - Significant national three year wage settlements already agreed in previous years, with flow on costs well in excess of the MoH funded levels. These are driven primarily by additional leave entitlements, automatic ongoing step function on–cost implications, a doubling of CME entitlements, significantly enhanced call out charges and the resultant increase in back-filling.
    - As indicated in last year's DAP, only now are the full impacts of the settlements being incurred, as for example within the NZMO 39 month settlement, the outer years of 2009/10 and 2010/11 are significantly heavier and more financially onerous. The total wage funding shortfall in 2008/9 ($9m) has compounded to double this year in 2009/10 ($19.9m) and will treble next year 2010/11 ($30m+), driving the financial position over these years.
    - The relative absence of any material quantifiable efficiency benefits arising to date from MECA settlements. While these were referred to in settlement documents, there was no sound financial basis on which DHBs could determine potential levels of savings and incorporate them within their DAPs with any reasonable degree of confidence. With now over a year since the agreements were made, there is no evidence of this occurring in practice.
    - The change in the Kiwisaver funding deductability from 1 April 2009 and the excess non-rebatable position under the recently revised government changes is expected to cost CMDHB approximately $1m per year.
    - Increased roster and compliance costs around RMOs terms of employment.
    - Generally increased, more demanding terms and conditions of employment across many MECAs which significantly lessens flexibility.
    - Note also that in December 2008, CMDHB brought cleaners and orderlies back into its Payroll from the previous outsourcer. This means approximately $9.5m has been transferred into "wages and salaries" annually from "infrastructure".

- The continuing committed (albeit constrained) investment in priority initiatives aligned with the District Strategic Plan, including those focussed on lessening the growth of hospital services and improving quality clinical outcomes.
- The ongoing internal efficiencies being generated including those within healthAlliance. Again, while there are National Procurement initiatives well under way, we have reviewed the likely outcome of these. It appears extremely difficult to identify and therefore quantify any current additional

material financial benefit arising from these given the level of efficiency in these targeted areas already being achieved by healthAlliance. We do not believe it is appropriate to build into the DAP a potentially very risky "lump sum unspecified" 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 continuing renal growth volumes, albeit it at a growth level below the extremes of previous years.
- The absorption of continuing price adjustments to inter-district flows (IDFs) (and to a lesser extent the volume of IDF outflows. These relate primarily to provision of services by ADHB with recent upward changes in prices far in excess of FFT and requiring strong challenge as to the level of efficiency built into tertiary pricing and the perpetuation of a 'cost plus' mentality.
- The absorption of increasing ED volumes with consequent flow on bed impact. The deepening international financial crisis and flow on impact to our community is likely to have an even greater as yet, unquantified impact on these volumes and the consequent pressure on CMDHB.

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

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

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

- An organisational wide commitment to quality and quality improvement. This initiative led by the CEO, and now picked up on a national basis, has resulted in the formation of a formal quality unit within the organisation, but working across and within each area of CMDHB. The quality initiatives will ultimately lead to financial benefit and be self funding or better by the end of the next financial year, but initially requires considerable financial and resource commitment.
- A significant lift in emphasis and focus around continued development of evaluation, monitoring and auditing processes and systems to ensure that CMDHB is receiving Value For Money (VFM) in all key areas of its operations. While there is increasing emphasis from the centre around VFM, it should be recognised and acknowledged that CMDHB has for many years applied the VFM principles, albeit in a slightly less formalised manner. We will and are

continuing to apply a VFM methodology in all areas of the organisation; from the obvious procurement focus, through quality, clinical enhancement, etc.

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

Finally, it is important to highlight within this DAP, that CMDHB has over the past 4 years now, fully absorbed the impact of FFT and demographic growth funding levels being understated as per the following tables:

Impact of Inflation (FFT) Short Funded Over Past 4 Years

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

Impact of Under-estimated Population Growth as Reported Through Census/Statistics NZ

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 $14,954,225
- at $1,000 $8,158,333

Note: On this basis, CMDHB has been constantly short funded between $8m - $15m per annum

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

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

7.3 FINANCIAL MANAGEMENT

7.3.1 Specific Cost Pressures – Wage Pressure

Within the Provider Arm, wage increases have been built in at the level of actual settlements, most of which are finalised, but with some indicative settlement levels applied in outer years and most of which are now MECA based. Over and above these base salary and wage movements which in themselves are higher than the core FFT reimbursement level, CMDHB is, along with all other DHBs experiencing very significant levels of oncosts. These include ever increasing step functions, additional leave, allowances and superannuation (Kiwisaver), primarily around medical and nursing staff entitlements. The levels set through these two core employment areas have flowed on to other (Union) negotiations with significant financial impact.

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 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 two years, some related to the implementation of the Holidays Act, are already having both a material financial and resourcing impact on the organisation with particular challenges around the impact of observing the extra leave entitlement and then filling the consequent vacancies this is causing. In finalising the DAP, CMDHB has fully reviewed current vacancy levels as an opportunity to manage within the fiscal constraints. However, at a service level these opportunities have been severely restricted due to continuing volume increases and more importantly, the increasing focus on maintaining a safe clinical working environment.

IEA Wage/Salary Freeze

One of the cost areas focussed on as part of the comprehensive reviews undertaken to achieve the zero operating deficit DAP position was IEA's (Individual Employment Agreements) annual salary reviews. As a result, CMDHB has taken a prudent and responsible approach to this; relative to its overriding fiscal responsibility to table a zero deficit DAP by deferring all current year reviews. This approach aligns and complies with the Minister's expectations. However the majority of our wage costs are clinically related and are 'locked in' at high levels for the next two years. Thus while the IEA wage freeze is beneficial, it only impacts on approximately 7.5% of our wage costs.

Regional Job Sizing

As part of an Auckland regional approach, CMDHB has previously agreed to participate and abide by SMO regional job sizing standardisation. While some specialties are known and budgeted, there remains significant potential exposure for those specialties as yet unquantified.

7.3.2 Capital Planning & Expenditure

While acknowledging the forecast tight DAP position, CMDHB must remain committed to the major capital projects currently under construction and nearing completion, either as previously approved by MoH or those presently under consideration/application with MoH, NCC or the Minister. As we have indicated in the separate capital submissions, these capital projects, given their magnitude and continuing growth demand within CMDHB, will ultimately fully utilise all

available cash funding, sourced from either current or accumulated depreciation, remaining available approved debt funding or new equity/debt.

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 a 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.

As previously, we are and will continue to, work closely with all the other greater Auckland region DHBs (through the Regional Capital Forum) to ensure non-duplication or under-utilisation of regional asset investment. However, CMDHB's independently reviewed 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.

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

We are currently completing 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 will provide a significant number of in-patient beds by its due date of completion, May 2009. This facility will incorporate significant improvement in models of care through both layout changes and staffing structures. Many of these beds will be immediately utilised reflecting the existing severe shortage of in-patient beds.

As indicated above, as part of the "Towards 20/20" we are very 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 was presented to MoH in August 2008 and ultimately considered by National Capital in November 2008. NCC's recommended support of our Business Case is currently with the Minister of Health awaiting final consideration. However, we understand it is likely to be favourably considered and therefore have included, with specific MOH support, the capital financial cost for this project, within this initial DAP. We are advised that the decision will be confirmed well prior to the finalisation of this DAP, thus allowing any adjustment if the likely decision were to change. Given the magnitude and materiality of this investment and the financial implications around that, it is believed

appropriate to include this project within the DAP despite the formal approval still being outstanding.

Simplistically this project, albeit that it may technically be split into two parts, envisages 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 fitout of the remaining incomplete wards in the Edmund Hillary Block. Completion of this new CSB will in turn allow the significant growth/relocation of many support services, i.e. non-acute, to be domiciled at the Browns Road Surgical Centre site. This latter move is the key focus of the next Business Case to MoH/National Capital and has recently been communicated to them through the filing of an "Options Analysis Paper for the 2009 Business Case".

It is now anticipated that the strong demographic growth requirements for CMDHB will continue and as such, outstrip the ability for CMDHB to fund 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 unfortunately a very clear need for significant further governmental support in future "Towards 20/20" phases, given the anticipated very large overall capital requirement 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.

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

It is well recognised and acknowledged that the future funding requirements for CMDHB (and the greater Auckland region) are large and will present national funding issues. CMDHB has attempted to lessen this forecast demand and related impact on capital requirements. Steps taken include fully reviewing and updating its Health Services Plan, rerun bed model forecasts, aggressively considered new models of care, reassessed community based health solutions, forecast growth, facility timing and other options. Extensive resource has been applied to this exercise on numerous occasions including significant independent external input as well as the achievement of a very high level of regional collaboration to ensure non-duplication and aligned timing of new facilities and capacities. In recognising these challenges, CMDHB initiated a series of three

national Sustainability Conferences over the past two years to address the wider national issues arising from these forecasts. These consisted initially of "workforce planning", "funding and affordability" and more recently, "future models of care/building tomorrow's health services". These conferences were recognised as very successful and there was a high degree of mutual agreement around the issues. However, the underlying drivers have not changed and those challenges are still facing the whole public health sector.

Statement of Strategic Capital Expenditure

Project	Budgeted Approval	Projected finish date	Value	Status
Middlemore (Clinical Services Block Stage 1)	Late May 09	Oct 2012	$208m	Awaiting final sign-off ($108m internal funded)
Manukau (SuperClinc, Rehab Centre, Mental Health Campus and Surgery Centre)	Nov 2009	2013	$135m	Likely to be delayed one year
Middlemore (Clinical Services Block stage 2) Manukau (SuperClinic and Surgery Centre)	Nov 2010	2014	$75m	As above
Middlemore (Clinic Services Block Radiology and Laboratory C Pod Kidz First) Manukau (SuperClinc, Rehab Centre, Mental Health Campus) Satellite Sites	Nov 2012	2016	$100m	As above
Middlemore (Inpatient Replacement & Expansion) Manukau (SuperClinc, Rehab Centre, Mental Health Campus and Surgery Centre)	Nov 2014	2018	$150m	Unknown
Middlemore (Decommission Galbraith, New Entrance)	Nov 2020	2024	$50m	Unknown
Grand Total			**$718m**	

7.3.3 Banking Covenants

CMDHB now operates only under one remaining banking covenant, with all its term debt facilities now transitioned fully across to Crown Health Financing Agency (CHFA). The Board maintains a working capital facility with ASB Bank/Commonwealth Bank which is the only relationship falling under this remaining covenant, together with lease 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 2008/09 which we have managed through without any major issues but are now indicating that significant tightening is highly likely to occur in 2009/10.

Facilities ($m)	Existing Limit	Utilisation @ 30 June 2009	Available Facility @ 1 July 2009
CHFA	197	149.6	47.4
Commonwealth Bank (working capital)	45	29.9	15.1
Commonwealth Bank (lease facility)	10	-	10.0
Westpac (lease facility)	10	1.6	8.4

Note: The above CHFA limit EXCLUDES the current Capital request awaiting Ministerial approval.

7.3.4 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 2009/10, 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 2009/10 will be limited to $49.5, adjusted by existing approved Towards 20/20 Projects relating to current and future years. We have not included within the cash flow forecast any capital requirements still requiring MoH/NCC approval other than the August 2008 Clinical Service Block Business Case currently awaiting ministerial approval.

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2009/10 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing unutilised/approved debt facilities.

However, the forecast uncommitted cash position (while a year later than initially anticipated) is anticipated to tighten considerably as referred to under the latter section, “Outlook for 2010/11 and 2011/12 years”. This position is anticipated given the assumed continuing non-reimbursement of higher wage settlements, the increasing impact of and drawdown related to the new facilities and the continuing growth pressures.

CMDHB is also actively leading and co-ordinating the proposal to establish a “Centre for Health Services Innovation” on its Western Campus at Middlemore. This venture is intended to establish a multi-disciplinary educational training centre in close proximity to CMDHB’s facilities to ensure training and education of the health workforce for the future. While still to be formally/legally finalised, it is intended to be a common partnership, negotiated with parties such as Auckland School of Medicine, Manukau Institute of Technology (MIT), Auckland University of Technology (AUT), St Johns Ambulance Training Centre and others well advanced. A Business Case is currently being

prepared which will be presented to the Minister and Ministry of Health in July 2009. It is proposed, subject to governmental approval, that the actual capital requirements for the project will be financed/owned by a third party, supported by long term joint rental agreements by the educational partners. CMDHB will provide the land to the investor/developer under a long term right to occupy/lease. For this reason, there is no capital requirement or provision showing under the strategic or non-approved capital requirements for future years.

Covenants

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

Asset Sales

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

7.3.5 Capital Charge

The District Annual Plan continues to include the matching of cost and revenue on any higher capital charge that may arise from asset revaluations on a three yearly cycle. While this DAP for 2009/10 is immediately following the 30 June 2009 three year requirement, as earlier, CMDHB is not anticipating any material revaluation. Rather, there is a likelihood of either a nil or devaluation given the current financial environment. As well there is the need to recognise, if finalised, the impact of any diminution in economic lives of assets affected and impacted by replacement under current Business Case requests.

7.3.6 Advance Funding

The 2009/10 District Annual Plan continues to incorporate the fiscal benefit of the one month advance funding, based on achieving an breakeven operating position and the maintenance of the other Ministry of Health requirements necessary to access this benefit.

7.4 COST CONTAINMENT EFFICIENCY GAINS

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

As a result of this, CMDHB has, as part of the preparation of this 2009/10 DAP looked much more widely and aggressively at areas of cost containment through ensuring lean, effective, and efficient structures. We have reviewed all structures, projects, initiatives, investments, to determine how these can be changed or eliminated to improve our operating position whilst still maintaining and achieving all essential clinical expectations and outcomes. In considering this organisational-wide approach, CMDHB is committed to maintaining its core objectives around its Triple Aim objectives. We recognise the overarching expectation that core clinical services cannot be cut (in fact, despite the financial pressures, the expectation is that they will be enhanced!). However, in order to achieve the financial target facing CMDHB, it has been absolutely essential that we address, and correct as necessary, the level of investment in certain marginal areas and refocus our efforts in proven areas.

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

In last year's DAP we talked of the continuing renal dialysis outpatient growth occurring at a level which was clinically and financially unsustainable. Within the last month, the Minister has opened another module on our Manukau site which replaces a much smaller and considerably outdated clinic on our Middlemore Western Campus. The capital cost of this was $2.5m and further reinforces our previous advice of an almost annual need for a new 12 bed module to meet this continuing demand.

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

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

CMDHB remains committed to maintaining its existing very high level of access and elective volumes that are forecast for 2008/09. 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 2009/10.

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

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

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

As a fundamental core driver of our new facilities development and implementation, new or improved models of care considerations are mandatory for all new developments. This is accomplished with extensive input, deliberation, challenge and resolution coming from full clinical and management representation on the respective committees. As an example, the opening of the wards within the Edmund Hillary block planned for May of this year have 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 ago. As these are implemented and proven, we will where possible and practicable roll out the new models of care to the older blocks. Similarly, when the new full replacement theatre suite is being built within the new Clinical Support Block, we will be seriously reconsidering layouts and resourcing levels and mix to improve both clinical efficiency and reduce costs.

These efficiency gains are critical in achieving our objectives and 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.

Over 3 months prior to the Minister advising a likely freeze on management and admin FTEs, CMDHB had already implemented an equivalent instruction across those and support areas (non-clinical only) with only the four senior organisational executives with authority to approve. Further, CMDHB has closely monitored vacancies to ensure maximum efficiency, but at minimum clinical risk in order to optimise financial performance. As a result, there is a very modest increase in overall approved FTE levels. As volumes grow however, there is significant and increasing clinical pressure to fill existing vacancies to cope with demand and clinical safety pressures. These are primarily driven by new services, funded services or clinical safety drivers, but are now further impacted by ministerial expectation of improved services without additional cost.

It is notable that within the 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.

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 healthAlliance's share of 151.54; the addition of which would give a total of 1039.04, in line with Ministerial advice.

7.5 HEALTHALLIANCE (CMDHB AND WDHB SHARED SERVICES ORGANISATION)

healthAlliance continues to perform 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 around underlying hard core costs negotiations rather than the earlier easier wins of "low hanging fruit". These achievements are expected to continue but CMDHB cannot expect the level of savings to be as high as previously achieved. CMDHB is working very closely with and contributing to, the national procurement objective although the current assessment is that neither CMDHB nor WDHB have any material expectations around additional national savings over levels currently being achieved.

The current severe financial constraints imposed on all DHBs have meant we have had to severely restrict healthAlliance activities for the current year in order to enable them to live within the overall funding package. Regrettably this means a year (or possibly a number of years) of consolidation and in some cases, reduced ability to meet the needs and expectations of its shareholders as a shared services organisation. These cost pressures have meant that 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 investment, particularly in IS, is necessary to recapture the momentum previously given to the provider arm as well as the very significant needs around the capture and integration within one system of primary care and community level information. This is seen as a critical area for both DHBs and essential to the future development of both.

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

While CMDHB is still working towards a more formal regional structure, all Auckland region DHBs continue to work very closely together to maximise benefits, without ADHB and Northland DHB formally being part of healthAlliance. This is particularly the case with regional information technology development and payroll where all 3 Auckland metro DHBs now use the same payroll software and thus can share and learn from each other's experiences.

CMDHB can advise that the potential risk highlighted in last year's DAP around taxability of recruitment costs appears to have now been overcome. While there is no formal legislative change being made, we understand a more pragmatic position has been taken by Inland Revenue which will result in a material potential exposure for all DHBs being removed.

7.6 2009/10 PHARMACEUTICAL BUDGET

CMDHB is committed to the Government's medicines boost initiative by engaging with Pharmac via our representations on SIG and the GM's Planning and Funding forums. Pharmac's 2009/10 final budget bid to DHBs on 9/2/2009 describes the increase in the proposed level of the Community Pharmaceutical Budget to a total of $31M or a 4.7% increase. In addition there is a $3.7M increase in Pharmaceutical Cancer Treatments and the Ministries $5.3M funding of 12 month Herceptin treatments.

CMDHB's share of the Community Pharmaceutical Budget increase will be in the region of $3M with an indication from Pharmac that an emphasis on funding autoimmune biologics group of medicines is highly likely.

CMDHB continues to work with Pharmac in providing PCT treatment data to assist Pharmac's ability to forecast and manage to target savings.

7.7 RECONCILIATION OF RINGFENCED MENTAL HEALTH FUNDING FOR 2009/10

The following table shows the reconciliation of CMDHB's DAP Mental Health ringfence funding with Ministry of Health expectations.

	CMDHB DAP	MOH Expectations	Variance	Comment
08/09 agreed Ring fence	**98,523,296**	**98,522,746**	**550**	
09/10 opening ring fence adjustments:				
- Devolution of Mental Health Solutions	4,255,820	4,255,820	0	
- Tfr 12 psychogeriatric beds from MH to HOP*	-803,336	0	-803,336	
IDF changes:			0	
- ADHB Hapai devolution (from IDF)	51,393	0	51,393	
- ADHB Richmond Deaf Service	-27,723	0	-27,723	
- CMDHB Refugees as survivors	319,884	0	319,884	Agreed IDF service changes
- ADHB Eating Disorders	-76,330	0	-76,330	
- WDHB Prison liaison	-176,422	0	-176,422	
09/10 adjusted opening ring fence	**102,066,581**	**102,778,566**	**-711,985**	
FFT @ 3.116%	3,180,395	3,202,580	-22,185	Variance due to above adjustments to base calculation
Demographic share @ 2.62%	2,674,144	2,692,798	-18,654	Variance due to above adjustments to base calculation
Final 09/10 Ring fence - Service view	**107,921,120**	**108,673,944**	**-752,824**	
IDF Outflows	**18,145,537**	**18,145,536**	1	
DAP Funder revenue - Provider view	**126,066,657**	**126,819,480**	**-752,823**	

*The region has agreed to CMDHB converting 12 of the 24 Guardian beds to psychogeriatric beds from July 1, 2009, and provider has agreed to this change.

7.8 OUTLOOK FOR 2010/11 AND 2011/12 YEARS

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

1. As a result of the budgeted forecast of a zero operating position for 2009/10 financial year, the outer years "base" position have improved significantly. The second year of the DAP, 2010/11, now shows only a modest and manageable small operating deficit and the third year, 2011/12, a strong surplus operating position. As indicated earlier, the recognition in 2010/11 of part of the 'capped' PBF monies from 2009/10 has assisted, offset by anticipated new facility costs detailed in reference 3 below. The overall net operating position forecast for 2010/11 has therefore been improved over the approved Business Case cost - net impacts by over $4m - and over previous estimates by over $10m.

2. Years 2 and 3 of the CMDHB DAP benefit from the assumption (fully endorsed by CMDHB's Board) that the additional PBF funding top sliced in the 2009/10 funding envelope under the "maximum percentage cap" will be available, again on the assumption that it is within the same percentage cap in those years, i.e. CMDHB anticipates receiving $19m in 2010/11 of the $24.6m capped this year and the remaining $5m in 2011/12. This assumes the same 7% maximum increase cap in any one year continues to be applied.

3. Within the second year of the DAP, 2010/11, the provider arm operating position is significantly impacted by the first full year of cost relating to the new Edmund Hillary ward block at Middlemore. The net unfavourable impact of this is almost $6m as clearly documented in the Business Case approved by National Capital, Ministry and Treasury last year.

4. Years 1 and 2 of the DAP are, as signalled previously, significantly impacted by the continuing cumulative impact of the higher than funded wage settlements which have a financial marginal cost of almost $20m in 2009/10 ($10m of this absorbed in the previous year) rising to $30m for 2010/11. This is a huge challenge for any organisation to absorb while still continuing to provide all essential clinical services in a constrained fiscal environment. In the third year of the DAP with many of the MECA's having expired, there is a national expectation that they must be renegotiated within the funded levels and as a result, this has a very positive impact on CMDHB's financial position.

5. The DAP does NOT include the cash flow impact and initial operating expense impacts of any current or future, but as yet unapproved Business Cases OTHER THAN the current $208m Clinical Services Block Business Case for which ministerial approval appears likely prior to finalisation of this DAP in May 2009.

6. The above impact is partially offset by continuing improvement in efficiency achievements, but requires full application of all available funding to achieve the forecast position in the 2010/11 year. As noted in the earlier narrative, in order to achieve this, this may well have to be at the expense of decreased or ceased investment in some of our action areas.

7.9 SIGNIFICANT ACCOUNTING POLICIES

Reporting entity
Counties Manukau District Health Board ("CMDHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Counties Manukau DHB is a crown entity in terms of the Crown Entities Act 2004 owned by the Crown and domiciled in New Zealand.

The CMDHB group consists of the ultimate parent Counties Manukau District Health Board and its "deemed" subsidiaries, Manukau Health Trust, and South Auckland Health Foundation these are not considered to be material and have not been consolidated into the accounts. Its associate companies are healthAlliance Ltd (50%), Auckland Regional RMO Services Ltd (33%) and the Northern DHB Support Agency (33.3%) are equity accounted. All CMDHB subsidiaries and associates are incorporated and domiciled in New Zealand.
Counties Manukau DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

Counties Manukau DHB is a public benefit entity, as defined under NZIAS 1.

Counties Manukau DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

Statement of compliance
The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These are CMDHB's first NZIFRS financial statements and NZIFRS 1 has been applied.
An explanation of how the transition to NZIFRS has affected the reported financial position and financial performance of CMDHB is provided in note 25.

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

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements and in preparing an opening NZIFRS Statement of Financial Position at 1 July 2006 for the purposes of the transition to NZIFRS.

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

Basis for consolidation
Subsidiaries
Counties Manukau District Health Board is required under the Crown Entities Act, to consolidate into its statutory Accounts those entities "deemed" subsidiaries under this Act. The definition of subsidiaries extends to those entities, which's sole or primary purpose gives "benefit to Counties Manukau District Health Board. This is irrespective of legal ownership.
The Manukau Health Trust Board which is operated by a group of trustees includes nominees from Counties Manukau District Health Board. This entity is not consolidated as it is not material to Counties Manukau District Health Board.
The South Auckland Health Foundation operates as a registered Charitable Trust controlled by a group of trustees and includes three nominees from Counties Manukau District Health Board. Counties Manukau District Health Board has no legal right or equally, obligation in respect of SAHF. This entity is not consolidated as it is not material to Counties Manukau District Health Board.

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

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

Financial instruments

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

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

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

Cash and cash equivalents comprise cash balances and call deposits with maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of CMDHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Accounting for finance income and expense is explained in a separate note.

Instruments at fair value through profit or loss
An instrument is classified as at fair value through profit or loss if it is held for trading or is designated as such upon initial recognition. Financial instruments (interest rate swaps) are designated at fair value through profit or loss if CMDHB manages such investments and makes purchase and sale decisions based on their fair value. Upon initial recognition, attributable transaction costs are recognised in profit or loss when incurred. Subsequent to initial recognition, financial instruments at fair value through profit or loss are measured at fair value, and changes therein are recognised in profit or loss.
Other
Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment losses.

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

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

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

Derivative financial instruments
CMDHB uses foreign exchange and interest rate swap contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities.
Derivatives that do not qualify for hedge accounting are accounted for as Interest Rate swaps.

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 statement of financial performance. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

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

Hedging

Cash flow hedges

The Board has entered into financial instruments by way of interest rate options and foreign currency hedges which give rise to off-balance sheet exposures, in order to reduce exposure to fluctuations in interest rates and foreign currencies. Any gains or losses arising from exposure to these instruments are offset against the related losses or gains on the assets or liabilities being hedged. Any premiums paid on interest rate options are amortised over the period to maturity.

Hedge of monetary assets and liabilities

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

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land
- freehold buildings
- plant and equipment
- clinical equipment
- motor vehicles
- other equipment
- work in progress.

Owned assets

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

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

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

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

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

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

records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

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

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

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

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

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

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

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

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

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

Type of asset	Estimated life	Amortisation rate
• Software	2 - 3 years	33% - 50%

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

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

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

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

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

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

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

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

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

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

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

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

Employee benefits
Defined contribution plans
Obligations for contributions to defined contribution plans are recognised as an expense in the statement of financial performance 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 both relates to employees' past services and it accumulates.

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.

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 Financial Performance. Where such surpluses are in respect of Mental Health Ring Fenced Revenue, the unspent portion of the revenue is only available to be spent on Mental Health Services in subsequent accounting periods.

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

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

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

Goods sold and services rendered
Revenue from goods sold is recognised when CMDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and CMDHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.
Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to CMDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by CMDHB.

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

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

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

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

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

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

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

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

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