Statement of Intent

2008/09 – 2010/11

Counties Manukau DHB

June 2008

COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership

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.

This document is intended to outline for Parliament and the general public the performance that will be delivered during 2008/09 by Counties Manukau DHB and contains non-financial and financial forecast information for the 2009/10 and 2010/11 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.

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Signature (Board Chair)

Signature (Board Member)

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Signature (Chief Executive)

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

- 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.

VALUES

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

STATEMENT FROM DHB CHAIR AND CHIEF EXECUTIVE

Counties Manukau District Health Board (CMDHB) has a history of innovation and a strong sense of achievement. However, the programmes and initiatives implemented to progress the strategic direction are only the foundation. We also need to ensure that we obtain the right balance between population health and the provider arm. We will look at the whole system and seek opportunities to rewire it so that it works together more effectively. We have done well building a platform and we have shown that we can deliver against our strategic imperatives; we now need to take this further.

We will continue to focus on quality including patient safety, releasing time to care, and improving patient flow. These strategies should not only improve quality within the provider arm in the first instance but they should also ensure that resources are applied more effectively and efficiently. This quality focus will see us move away from a "cost plus" environment to redesigning workflows within existing resources. This approach requires significant engagement with clinicians, nursing and allied health staff, so the initial work being undertaken right now is focussed on how best to involve staff and include them in the decision-making processes.

Our other area of focus is equity, that is ensuring equity of access to services (both within our community and compared with the rest of New Zealand) and reducing inequalities. We also need to be more sophisticated in our intersectoral approach and need to work with our partners - other DHBs, Councils and other Crown agencies - to identify areas where we can make the most impact and improve the services provided to our community and reduce inequalities. We have undertaken a number of pilots and experiments in the past, now is the time to get it all to work together.

While we are very pleased to yet again table a zero deficit operating position for the forthcoming year, this has proved a greater challenge than ever in the face of both a continuing growing population and wage settlements anticipated at levels well in excess of funding levels. To achieve this has required an even stronger containment of costs than ever (with associated financial risk) and a significant restriction around funding available for new or existing initiatives. The effect of this is very clear in the outer years of the plan where the achievement of a zero deficit will prove extremely challenging.

The development of the Health Services Plan during 2007 has helped focus our longer term thinking; its 20 year perspective has given us an opportunity to consider population growth and how we need to respond today to meet longer term requirements. Strategies include the establishment of modern facilities with capacity aligned to the community's needs and new models of care, and workforce strategies, to ensure we have a 21st century healthcare system. The Health Services Plan has already been presented to the Ministry of Health. Business cases that follow on from the Plan are in the process of being presented to the Ministry for each phase of the planned facilities development; this includes replacing the hospital facilities built soon after WWII and increasing capacity.

More immediate is the need to respond to the impact of increasing volumes on our emergency department, the largest in Australasia, and our maternity services where we deliver more babies than any other health care provider in Australasia. During 2007/08, we implemented changes to the models of care and internal processes within Emergency Care which has seen a significant improvement in our ability to meet patient demands including the triage goals for patients presenting. We have also reviewed maternity services to identify opportunities to better utilise the resources available and better meet the needs of the women and babies accessing these services. These two services will continue to require focus during 2008/09.

This will be a challenging year for CMDHB as we have to absorb the impact of significant population growth as well as the impact of national pay increases which are working their way through the system. Following the increase in funding for the health sector over the last few years, we have to meet the reasonable expectation of increased service delivery. However, we have a track record of delivery in the face of significant challenges, and we have staff, contracted providers and other agencies that are committed to working with us to achieve our objectives for the community of Counties Manukau which puts us in a good position for the start of the year. Our emphasis on quality improvement in health care delivery, and focus on reducing health inequalities will remain a key focus going forward.

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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 2008/09 to 2010/2011. 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 (eg, hospitals, clinics) activities of the DHB.

Performance measures and targets are included describing how Counties Manukau DHB will endeavour to reducing 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:

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

This SOI includes:

- a statement of forecasted service performance the DHB will seek to achieve during 2008/09 with non-financial performance measures and targets for one of the three output classes (ie, the governance, funder and provider parts of the DHB) it delivers, and
- financial forecast for 2008/09 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 providing 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 AND REDUCING MAAORI HEALTH INEQUALITIES

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

1.4 TE TIRITI O 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 DHB's responsibility to improve Maaori health gain through the provision of:

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

The DHB has taken a serious approach towards its engagement with Maaori and is developing a relationship which does not contest Rangatiratanga (authority), or the ability to participate in the decision making processes focussed on the improvement of health in this rohe (region). The recognition of those roles and responsibilities are a developing aspect of the relationship between Maaori and this DHB, and will continue to be reflected in the development of strategic documents and initiatives undertaken by this DHB.

The maintenance of POU as the key interaction mechanism with the Board continues to be vital. Made up of six Board members and six members elected by the Maaori community from a fully representative process, this group works in a

wholly open and transparent process, to the point where POU are ceded full authority to implement those actions to implement 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. They include:

- The on-going partnership of the Maaori health division of the DHB and Tainui MAPO to identify, implement and evaluate Maaori health gain strategies as a part of the Whaanau Ora Plan
- The on-going development of non-government Maaori health providers so as to allow an equitable choice of services to the community
- The maintenance of Maaori leadership at the Executive Management Team level with responsibility to provide Maaori strategic and operational impetus for the organisation
- The maintenance of significant Maaori health presence across both the Planning and Funding and Provider arm of the organisation. This capacity provides Maaori operational expertise and advice for the whole organisation, ensuring that all services are provided in a holistic manner with Maaori patients and their whaanau.

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 associated with obesity, smoking and alcohol and other drug misuse
- 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 in the right place, at the right time, with the right resources and right attitude.

Part 2 COUNTIES MANUKAU POPULATION PROFILE AND HEALTH NEEDS

Counties Manukau has been and remains one of the fastest growing areas in New Zealand. It is a diverse population with complex health needs and service requirements. Key features of the CMDHB population are:

- a high proportion of Māori
- 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.

The *Counties Manukau Population Health Indicators 2005* document (available on www.cmdhb.org.nz) provides a detailed analysis of the health of Counties Manukau residents. Key themes in this report, along with other work show:

- CMDHB residents' health is improving. For example 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 undiminished. Males, Maaori and Pacific people and those socio-economically deprived all do worse than their counterparts
- Hospitalisation volumes growth has slowed, and is now similar to population growth at around 3% per year. Of all hospitalisations, 34% would be considered potentially avoidable, much of the scope for prevention of these lies in the primary healthcare sector
- Infectious disease rates for Counties Manukau people, particularly children, remain high. Meningococcal meningitis disease rates halved in 2004/05 with the vaccination campaign to the fore
- Diabetes prevalence (type II diabetes) is likely to double in Counties Manukau by 2020
- Primary care is under-resourced in Counties Manukau compared with New Zealand. The implementation of the Primary Care Strategy, including the establishment of Primary Health Organisations (PHOs), is providing additional resourcing for primary care in Counties Manukau to ease this situation
- Teenage pregnancy rates are very high for Maaori and Pacific young people
- Elective surgery utilisation is up 11% over the past 4 years in Counties Manukau. Relative to the rest of New Zealand there is still a backlog of need to be addressed, but there has been a distinct improvement in access
- Total birth numbers continue to increase due to the relative youthfulness and cultural makeup of the Counties Manukau population, and counter to trends elsewhere in New Zealand.

2.1 KEY ISSUES AND RISKS

The impact of population growth on the community's need for health and disability services is the most significant issue the DHB is facing in 2008/09 and beyond.

To mitigate this issue or risk the DHB has a number of strategies:

- Working with our intersectoral partners on projects including healthy housing and Let's Beat Diabetes to improve community wellbeing (refer Outcome 1)
- Implementing the child and youth health plans and supporting initiatives to improve immunisation coverage and access to health services to improve health outcomes for children and young people (refer Outcome 2)
- Implementing structured programmes such as the chronic care management programme to reduce the incidence and impact of chronic conditions (refer Outcome 3)
- Implementing strategies across the DHB to reduce health inequalities including involvement of Maaori and Pacific people in decisionmaking, cultural responsiveness programmes and specific workforce strategies (refer Outcome 4)
- Providing additional elective volumes, providing programmes to support older people to remain in their homes, and supporting the implementation of the Primary Care Plan to improve sector responsiveness to individual and family/whaanau need (refer Outcome 5)
- Implementing facilities development projects to ensure the DHB has the facilities infrastructure to meet demand for hospital and related services, and implementing the workforce development plan including working with:
  - schools to encourage students into health related roles
  - training institutions to match workforce requirements with training provided,

  and providing scholarships to support students within our community to undertake health related study. (refer Outcome 6)
- Implementing a quality improvement culture within the DHB and with our contracted providers to ensure the services delivered are safe.

More specific financial risks are included in Part 6.

Part 3 NATURE AND SCOPE OF ACTIVITIES

The activities of our DHB fall into three groups (or "output classes"):
- Governance
- Planning and Funding
- Provision of Services.

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
- 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 on 13 October 2007. Each DHB has seven members elected for a 3 year term. For CMDHB the elected Board members (until November 2010 and the next election) are:
- Arthur Anae
- Don Barker
- Colleen Brown
- Anne Candy
- Paul Cressey
- Bob Wichman
- Michael Williams.

The Minister of Health has appointed the following additional Board members:
- 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:
- the *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
- the *Hospital Advisory Committee*: provides advice to the Board on the performance of DHB provider arm services

- the *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:

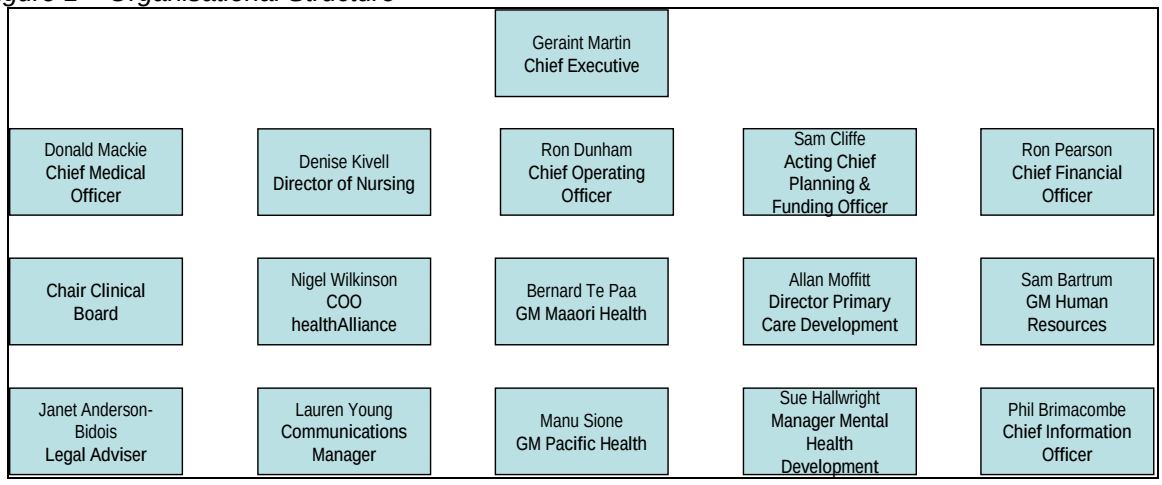
- *POU*: provides strategic and governance advice to the Board on Maaori health gain issues. It is a partnership committee made up from 50% Board members and 50% nominated Maaori community/health experts.
- the *Pacific Health Advisory Committee*: provides advice on strategies to reduce disparities in health status for Pacific people
- the *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

Organisational Structure

To support the achievement of the District Strategic Plan objectives and to meet its obligations under the NZPH&D Act the DHB is supported by the following management structure. The structure is based on funder and provider arms, supported by corporate functions such as finance, legal, communications and information systems. Clinical staff (medical and nursing) are 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 – Organisational Structure



Good Employer

CMDHB is committed to providing a working environment for our committed, skilled workforce which meets "good employer" criteria. This is a key organisational 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.

The seven key elements identified within the "good employer" model have been used as a base for developing CMDHB's human resource objectives within the Human Resources Strategic Plan. This directly links the Human Resources Strategic Plan with CMDHB's "good employer" obligations.

Capability

Outcome 6 within the District Strategic Plan focuses on improving the capacity of the health sector to deliver quality services. Refer section 5.2. 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 support services. These services include personal health (ie primary, secondary and tertiary care services, Maaori health, Pacific health, primary referred services and oral health), mental health, and services for older people, and DHB provided primary maternity services. The Ministry of Health retains funding responsibility for the remaining health and disability services including the balance of the primary maternity services, disability services for those under 65 years of age, (except for those clinically assessed by CMDHB geriatricians as close in age and interest), public health and national personal health contracts.

Service Devolved to CMDHB	Key activities and initiatives
Primary Health Care • Services provided by primary health organisations (PHOs) • Other primary care services such as	• Working with PHOs to deliver health promotion and services to improve access to primary care • Implementation of strategies to

Service Devolved to CMDHB	Key activities and initiatives
pharmacy, oral health and community laboratory services • A wide range of community health services providing first point of contact, primary health care related services	increase primary care utilisation and increase the number of patients with chronic conditions whose care is managed through structured programmes • Implementation of the recommendations of the oral health plan • Implementation of strategies to increase immunisation coverage • Implementation of strategies to support workforce development
Maaori Health Funding of 'by Maaori for Maaori' services including: • Chronic Care Management • Primary Health Care • Well child services including Outreach Immunisation • Breastfeeding support • Smoking Cessation • Public Health promotion • Sexual Health services	• Implementation of Whaanau Ora Plan (Maaori Health Plan)
Pacific Health • Funding of 'by Pacific for Pacific' services and targeted Pacific services	• Implementation of Tupu Ola Moui (Pacific Health and Disability Action Plan)
Mental Health and addiction services • Services focused on supporting people with the most serious mental health needs to achieve recovery of a full life within the community. The services are primarily delivered in the community, with access to inpatient services where this is deemed necessary. • Providers of mental health services include the DHB, NGOs and by other DHBs (ie regional services)	• Implementation of the Mental Health Plans to improve the outcomes for people severely affected by mental illness • Implementation of primary care mental health initiatives including the expansion of the CCM programme to include a depression module • Implementation of the Alcohol and Other Drugs Plan to address issues associated with substance misuse and addictions
Services for older people • Private hospitals, rest homes, respite and day care • Home based support • Community health • Information services, assessment, treatment and rehabilitation • Needs assessment and service co-ordination.	• Implementation of the Health of Older People plan • Specific initiatives to improve the continuum of care for services provided to older people
Secondary / Tertiary services (ie hospital and related services)	• Implementation of strategies to increase access to services so they

Service Devolved to CMDHB	Key activities and initiatives
• All of the services provided by the DHB's provider arm with the exception of those services directly funded by the Ministry of Health or funded by other DHBs (inter-district flows)	align with national levels • Continued focus on elective services • Continued focus on the delivery of programmes and initiatives to reduce the number of people admitted to hospital who could have been cared for in the community • Implementation of strategies to improve the capacity of the health sector to deliver quality services

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

- payment of providers
- 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
- 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, and 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
- operational relationships between CMDHB's funder and provider arms.

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, including:

- 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 Super*Clinics*™ (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 Super*Clinic*™.

A number of tertiary and other services are not provided directly by CMDHB. Most of these are provided for Counties Manukau residents by Auckland DHB, for example cardiothoracic surgery, neurosurgery, oncology; and forensic mental health and school dental services by Waitemata DHB. This requires that CMDHB funds these services separately through inter-district flow (IDF) payments to these DHBs.

Part 4 OUTCOMES AND OBJECTIVES

This section outlines what our DHB hopes to achieve over the next three years. It is based on the District Strategic Plan which outlines how the DHB will fulfill its statutory objectives and functions over the next 5 to 10 years and must consider:

- the health status of the community
- the needs of the community for health services
- the expected impact of health services on improving health outcomes
- the overall direction set out in the New Zealand Health and Disability Strategies.

4.1 OBJECTIVES FOR DHBS FROM THE NZPHD ACT 2000

Counties Manukau DHB's statutory objectives are:

- to improve, promote, and protect the health of people and communities
- to improve integration of health services, especially primary and secondary health services
- to promote effective care or support for those in need of personal health services or disability support services
- to promote the inclusion and participation in society and independence of people with disabilities
- to reduce health inequalities by improving health outcomes for Māori and other population groups
- to reduce, with a view to eliminating, health outcome inequalities between various population groups within New Zealand, by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders
- to exhibit a sense of social responsibility by having regard to the interests of people to whom it provides, or for whom it arranges the provision of services
- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services
- to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations
- to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations
- to be a good employer.

4.2 NATIONAL PRIORITIES FOR 2008/09

The Minister of Health's 'Letter of Expectations', which was sent to all DHB's in December 2007, identifies the national priorities for the 2008/09 financial year. The following table outlines the Minister's priorities alongside the relevant District Strategic Plan outcome area for Counties Manukau DHB.

• Value for money – better value for money provides more health care for more New Zealanders.	• Outcome 6
• Getting ahead of chronic conditions – maintain the pace of programme implementation.	• Outcome 3
• Reducing disparities, especially for Māori and Pasifika populations.	• Outcome 4

• Child and youth health – implement current programmes and build on the well child review.	• Outcome 2
• Primary health – improve the interface, through planning and working together with PHOs.	• Outcome 5
• Infrastructure – especially workforce development and coordinated information systems.	• Outcome 6
• Health of older people – continue to give priority to new service models.	• Outcome 5

These priorities incorporate the National Health Targets which were established in 2007/08 to help focus the sector's activities, detail of these is included section 5.1.

4.3 COUNTIES MANUKAU DHB'S STRATEGIC DIRECTION

Supporting the aspirations of the DHB's Vision statement, Counties Manukau DHB's strategic direction focuses on 6 long term outcomes (refer table 1 and the 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.

The current District Strategic Plan was developed during 2005/06, it responds to the national context and local needs and reflects our ways of working here at Counties Manukau DHB. It is the product of extended conversations with our communities, health professionals, and partner agencies - working together to make a difference. The next review will be undertaken during 2008/09.

This District Annual Plan and Statement of Intent are structured around the 6 outcome areas, with specific objectives, outputs and performance measures identified for each outcome. The DHB's strategic direction is aligned with national priorities, including the national health targets, and these are incorporated throughout the District Annual Plan.

More detailed service plans (eg Health of Older People Action Plan) and population group plans (eg Whaanau Ora Maaori Health Plan) have also been developed (refer reference list), with specific activities to be implemented during 2008/09 included in this Plan.

Table 1: 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 5 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.

Part 5 FORECAST SERVICE PERFORMANCE: MEASURES AND STANDARDS

One of the functions of the SOI, in particular the Performance Measures and Targets, and Statement of Forecast Service Performance, is to show how we will measure our organisational performance against our commitments for 2008/09. These measures and standards will be subject to an annual audit by auditors appointed by the Office of the Auditor General.

Where possible, we have used current performance as our baseline data against which progress will be measured. The performance measures included in the SOI have been chosen based on their link to key priorities and are outlined in the District Strategic Plan. The DHB recognises that some of these measures will not perfectly measure progress towards achieving the longer term outcomes but, at the time of writing, are the most reliable measures available.

The performance measure tables on the following pages include national measures (which are consistent across all DHBs) together with local measures and targets. This section is structured along the six long-term outcomes outlined in the District Strategic Plan. We have included only those performance measures from the District Strategic Plan which are measured annually or where there is an expectation that the measure will change within a year. CMDHB has identified 6 headline indicators, ie one per outcome, to annually monitor progress against the District Strategic Plan as part of the SoI. These are high level non-financial measures which will give the DHB an indication of how the implementation of the DSP is impacting health outcomes. These headline indicators are supported by other measures and objectives to provide a broad perspective of the DHB's activities.

For each measure, detail is provided on:

- The objective of the measure, ie what we are trying to achieve
- The performance measure itself, ie what is being measured
- Baseline/current performance figures and target performance figures for the next three years.

The measures are a reflection of how well the DHB is carrying out its main three functions or outputs of governance, planning and funding of health and disability services, and the provision of these services, against budgeted costs. The budgeted cost of these outputs for 2008/09 is as follows:

	Budget 2007/08 ($m)	Forecast 2007/08 ($m)	Budget 2008/09 ($m)
Governance & Funding Administration	10.4	10.1	11.3
Funder*	475.1	488.1	505.7
Provider Arm (Hospital)	529.8	532.9	579.4
TOTAL	1,015.2	1031.1	1096.4

* Priority initiatives included in the funder budget.

5.1 NATIONAL HEALTH TARGETS

As referenced in the Minister's 'Letter of Expectations', 2008/09 there are 10 health targets aligned to strategic priorities. The targets have been reviewed and updated for 2008/09, with increased focus on reducing inequalities and inclusion of a cardiovascular disease target. One target is to reduce the percentage of the health budget spent on the Ministry, and DHBs are not expected to provide direct contribution to achieving this. Nine of the targets form a key part of District Annual Plans, and are aligned with the Statements of Intent (SOI).

These targets are supported by the Director-General and DHBs' CEOs.

The following are the measures that reflect the Minister's Health Targets for 2008/09. These are:

<table>
<tr><th>Health Target</th><th>2008/09 Target</th></tr>
<tr><td>95% of two year olds are fully immunised</td><td><table><tr><td>CMDHB Total</td><td>80%</td></tr><tr><td>Maaori</td><td>72%</td></tr><tr><td>Pacific</td><td>77%</td></tr></table>
Note: This target is 5% above our 2007/08 target which was set against the 2005 National Immunisation Coverage Survey (NICS) results. To date our results using the NIR reporting have not achieved this level and are tracking approximately 5% behind the survey target. While the DHB is very committed to achieving a coverage rate above 80%, this is going to be very challenging using the NIR reporting and existing processes, systems and resources.</td></tr>
<tr><td>Progress is made towards 85% adolescent oral health utilisation</td><td>The 2008/09 target for CMDHB adolescent utilisation of oral health services is 57%</td></tr>
<tr><td>Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs).</td><td>2008/09 CMDHB targets

ESPI 1 – 97%
ESPI 2 – 1.6%
ESPI 3 – 4.0%
ESPI 4 – NA
ESPI 5 – 3.0%
ESPI 6 – 10%
ESPI 7 – 3.0%
ESPI 8 – 97%</td></tr>
<tr><td>Each DHB will set an agreed increase in the number of elective service discharges, and will provide the amount of service agreed</td><td><table><tr><td></td><td>Base</td><td>Add.</td><td>Total</td></tr><tr><td>Est. E Discharges</td><td>13052</td><td>1305</td><td>14357</td></tr></table></td></tr>
<tr><td>All patients wait less than 6 weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D)</td><td>The DHB acknowledges the Health Target that all patients (100%) to wait less than 6 weeks between first specialist assessment and the start of radiation oncology treatment and will work with the provider DHB towards achieving this target. The Auckland region has a very strong relationship with the ADHB provider with regular operational meetings held with issues discussed. Where the target is in danger of not being met, the DHB will discuss this with the provider as soon as possible with a view to looking at feasible solutions.</td></tr>
</table>

<table>
<tr><th>Health Target</th><th>2008/09 Target</th></tr>
<tr><td>Reducing ambulatory sensitive (avoidable) admissions (ASH): There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0 - 74 across all population groups.</td><td>2008/09 CMDHB Target standardised discharge ratios for the year ending 30th June 2008.

<table>
<tr><th></th><th>Maaori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>0-4</td><td><95</td><td><=107.9</td><td><95</td></tr>
<tr><td>45-64</td><td><=122.1</td><td><=104.5</td><td><=109.3</td></tr>
<tr><td>0-74</td><td><=111.4</td><td><=105.4</td><td><=101.4</td></tr>
</table>

This translates to the following number of admissions based on 2007 population data.

<table>
<tr><th>2008-09 Target</th><th>Maaori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>0-4</td><td>695</td><td>1,157</td><td>822</td></tr>
<tr><td>Expected if SDR = 100</td><td>732</td><td>1,073</td><td>865</td></tr>
<tr><td>45-64</td><td>757</td><td>1,008</td><td>1,997</td></tr>
<tr><td>Expected if SDR = 100</td><td>620</td><td>965</td><td>1,827</td></tr>
<tr><td>0-74</td><td>3,219</td><td>4,369</td><td>6,196</td></tr>
<tr><td>Expected if SDR = 100</td><td>2,890</td><td>4,146</td><td>6,111</td></tr>
</table></td></tr>
<tr><td>There will be an increase in the percentage of people in all population groups :
• estimated to have diabetes accessing free annual checks
• on the diabetes register who have good diabetes management
• risk assessment measures</td><td>
<table>
<tr><th></th><th>Total</th><th>Maaori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>Detection & Follow-up volumes</td><td>15,041</td><td>2,124</td><td>5,121</td><td>7,795</td></tr>
<tr><td>Diabetes Follow-up %</td><td>65%</td><td>63%</td><td>65%</td><td>65%</td></tr>
<tr><td>Diabetes Management %</td><td>68%</td><td>60%</td><td>52%</td><td>80%</td></tr>
</table>

Note the MoH has updated the prevalence rates for 08/09 - resulting in a 75% increase for CMDHB. The MoH has advised there will be no baseline for 08/09 so both the volumes and percentage have been included for detection and follow-up.

No information has been provided at the time of writing to determine a risk assessment target.</td></tr>
<tr><td>At least 90% of long-term clients have up to date relapse prevention plans (NMHSS criteria 16.4)</td><td>Children 90%

Adults and Older People 90%

DHB Total 90%</td></tr>
<tr><td>DHB activity supports achievement of these health sector targets:
• Proportion (percent) of infants exclusively and fully breastfed:
  • 74% at six weeks; 57% at three months; 27% at six months.
• Proportion (percent) of adults (15+ years) consuming at least three servings vegetables per day, and proportion (percent) of adults (15+ years) consuming at least two servings fruit per day:
  • 70% for vegetable consumption; 62% for fruit consumption</td><td>CMDHB is committed to improving nutrition, increasing physical activity and reducing obesity as outlined in the District Strategic Plan. Specific objectives for 2008/09 are included in section 5.2 Outcome 1 Improve community wellbeing and Outcome 2 Improve child & youth health.</td></tr>
</table>

Health Target	2008/09 Target
DHB activity supports progress towards achievement of the following indicators: *Year 10 'never smoker' target* • Increase the proportion of 'never smokers' among Year 10 students by at least 3 percent (absolute increase) over 2007/08 (baseline 57.9%) and • An increase for both Maaori Year 10 'never smokers' and Pacific Year 10 'never smokers' that is greater than that for European Year 10 'never smokers'. *Smokefree homes target* • To reduce the prevalence of exposure of non-smokers to second-hand smoke inside the home to less than 5% (baseline 2006 12.5%, 2007 7.5%) and • A reduction in the prevalence of exposure of non-smokers to second-hand smoke inside the home for Māori (baseline 2007 16.1%) and for Pacific (baseline 2007 16.4%) that is greater than that for European (baseline 2007 6.5%).	CMDHB is committed to reducing the harm caused by tobacco. Specific objectives for 2008/09 are included in Section 5.2 Outcome 1 Improve Community Wellbeing, including the implementation of the Counties Manukau Tobacco Control Plan.

5.2 CMDHB DISTRICT STRATEGIC PLAN MEDIUM TERM OUTCOMES

OUTCOME 1 - IMPROVE COMMUNITY WELLBEING

Why is this important to Counties Manukau DHB?
Tackling lifestyle risk factors like smoking, obesity, lack of physical activity and poor nutrition are some of the biggest challenges faced by CMDHB. The number of people with Type 2 diabetes is anticipated to increase over the next 20 years which will not only have a significant impact on health services in Counties Manukau but will be devastating for the social and economic wellbeing of the local population.

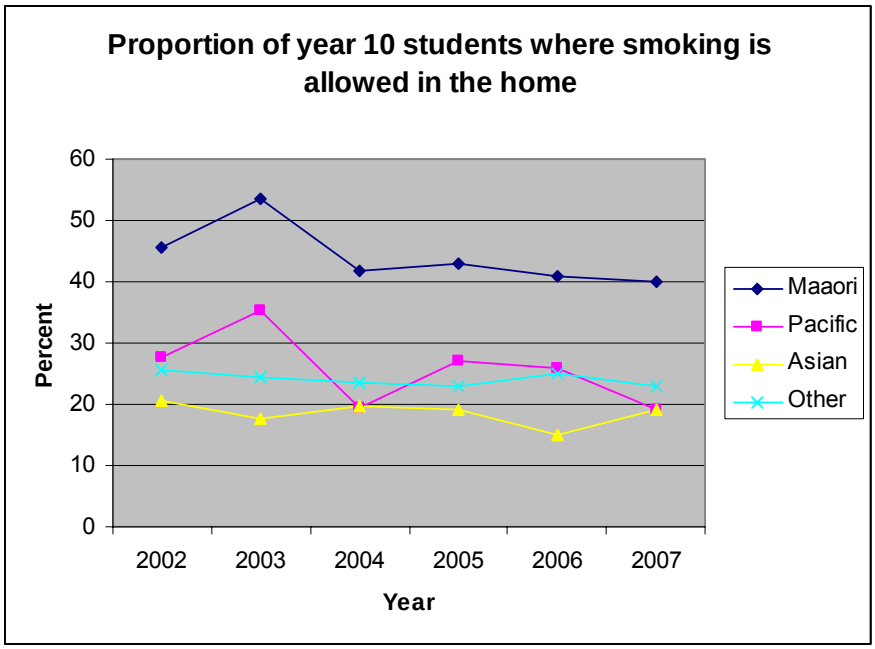
CMDHB is taking a 'whole society' approach toward tackling these challenges and continues to implement the 5 year Let's Beat Diabetes (LBD) workplan which addresses many of the national *Healthy Eating Healthy Action* goals and includes working with industry to develop a Food Industry Accord, supporting local communities and groups with resources and funds to develop local leadership and initiative, right down to interventions supporting individuals adopt healthier lifestyles. Much of this work is also done in partnership with other agencies, in particular, Manukau City Council through Tomorrow's Manukau, Franklin and Papakura district councils, the Ministry of Social Development and Housing New Zealand. The DHB is also working with these partners in family violence prevention planning and service development to improve the health sector's response to family violence.

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards improving community wellbeing (Outcome 1):

- Achieve the outcomes in the Let's Beat Diabetes Plan
- Increase levels of physical activity
- Increase healthy school environments
- Increase smokefree environments
- Develop healthy communities by working intersectorally
- Improve access to information to enable the community to make informed choices

Performance Measures

We have chosen the following headline indicator, *decrease the percentage of year 10 students from homes where smoking is allowed in the home*, because smoking is the single most important preventable cause of death and therefore contributor to community wellbeing. Passive smoking leads to 300 deaths per year in NZ and children exposed to smoking in the home are more likely to smoke themselves. To date the focus of the smoke free campaign has been on public buildings and other public places; smoke free homes is seen as the next priority in the campaign. Initiatives and programmes are currently in place to support the achievement of this measure; these will be supplemented during 2008/09 with the implementation of the CMDHB Tobacco Control Strategy.



Baseline Data 06/07	Performance Targets		
	08/09	09/10	10/11
Maaori 40%	39%	37%	36%
Pacific 19%	21%	19%	18%
Asian 19%	18%	18%	17%
Other 23%	20%	18%	17%

Objective	Deliverable/Outputs	Timeframe
Reduce smoking in Counties Manukau, particularly amongst Maaori and Pacific and families with children	CMDHB Tobacco Control Strategy and implementation plan completed	1 Jul 08
	Tobacco Control Strategy implemented	30 Jun 09

Other measures to monitor progress against this outcome area

Objective	Rationale	Performance Measure	Baseline Data		Performance Targets 08/09	09/10	10/11
Increase the proportion of adults who are regularly physically active (LBD survey)	Physical activity protects people from obesity, diabetes and cardiovascular disease. Physical activity levels are decreasing in NZ.	Percentage of adults who do at least 2.5 hours of physical activity per week with >30 minutes of activity per day on ≥ 5 days	Maaori	54%	No survey	60%	No Survey
			Pacific	49%		55%	
			Asian	43%		45%	
			Other	50%		53%	
			Total	48%		55%	
Increase the proportion of schools that are health promoting schools	Overweight and obesity is common and increasing in schools. Lifestyle patterns developed in	Number of health promoting schools within the DHB	80/185		120/202	140/202	160/202

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				08/09	09/10	10/11
	childhood affect adult behaviour.					
Complete the target number of joint health and housing assessments done in the Healthy Housing Programme	Housing has a significant effect on health, particularly infectious and respiratory disease. Poor housing is a significant issue for CMDHB's population, particularly for our Maaori and Pacific populations. There is evidence of effectiveness of this type of intervention.	Number of health and housing assessments done in calendar year	498 assessments done/ 300 target	480	480	480

Other outputs to monitor progress against this outcome area

Objective	Deliverable	Timeframe
Promote behaviour change through social marketing	The next phase of SWAP2WIN social marketing implemented	30 Jun 09
Align the implementation of national strategies, programmes and priorities such as Healthy Eating Healthy Action, Mission On, Fruit in Schools, breakfast clubs and Smokefree with the local initiatives of the Let's Beat Diabetes (LBD) project and existing Health Promoting School (HPS) programmes and initiatives	Fruit in schools initiative within the Tipu Ka Rea model implemented for HPS in 40 Schools	30 Jun 09
Development of Family Violence Prevention (FVP) role and FVP initiatives to improve identification and access to assault services within health services	Evaluation of current service and gaps. FVP screening is implemented within provider arm services	30 Jun 09
Improving the health, social and housing outcomes for families residing in the suburb of Wiri.	'Lifting the Game in Counties Manukau', an intersectoral initiative to address the needs of Wiri residents, is scoped and developed in collaboration with MCC, HNZC, MSD and NGOs	30 Jun 09

Output Class

The measures for Outcome 1 are included in the Funder and Provider Output classes.

OUTCOME 2. IMPROVE CHILD AND YOUTH HEALTH

Why is this important to Counties Manukau DHB?

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

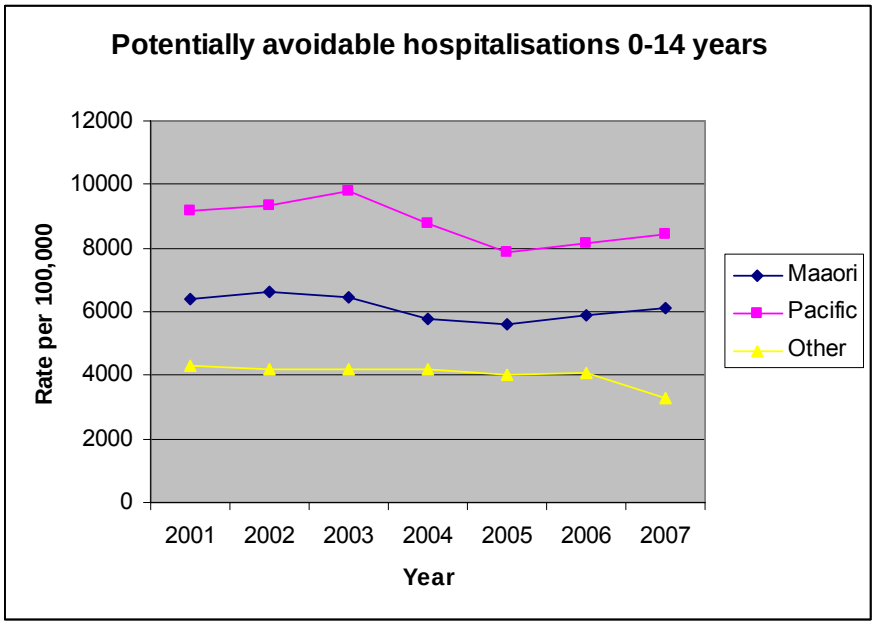
In 2008/09 CMDHB will continue to work with communities and partner agencies to ensure that the health needs of children and young people are met by improving access to health care services and by developing and implementing child and family-centred policies, programmes and initiatives to bring about improved health outcomes. Central to this work is the movement from a treatment-based model of care to a preventative model of care. Community-based health services like the outreach immunisation programme, Vision and Hearing services which are delivered to where people live makes access to health services possible for a wider group of people and is starting to make a real impact and difference to the health of children.

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards improving child and youth health (Outcome 2):

- Improve maternal wellbeing
- Improve health outcomes for infants and pre-school children
- Improve weight management in children and young people
- Decrease the incidence and impact of risk taking actions by young people

Performance Measures

We have chosen the following headline indicator, *decrease the number of preventable hospitalisations of children aged 0-14 years*, because potentially avoidable hospitalisations are an indicator of morbidity, avoidable by social change, public health measures and primary care. It is also a very sensitive measure of health inequalities.



Baseline Data 2006/07	Performance Targets		
	08/09	09/10	10/11
Maaori 5915	5857	5622	5397
Pacific 8138	8134	7835	7536
Other 4086	3709	3667	3625

Objective	Deliverable/Outputs	Timeframe
Reduce re-admissions of high risk Maaori newborns	Improved provision of information and referral access to community health services; and delivery of clinical information for patients and their whaanau.	30 Jun 09
Improve breastfeeding rates for fully breast fed at 6 months	First stage of the CMDHB Community breast feeding plan implemented	30 Jun 09

Other measures to monitor progress against this outcome area

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				08/09	09/10	10/11
Decrease the admission and readmission rate for infants	CMDHB has a significant higher infant admission rate than NZ as a whole. There are significant ethnic disparities. Infant admission rate is an indicator of infant health. Outcomes are affected by antenatal, natal and postnatal care, parenting skills, social conditions and access to primary care.	Percentage of babies born in the year who are admitted to hospital in their first year of life (other than at delivery)	Maaori 22%	21%	21%	21%
			Pacific 27%	26%	25%	25%
			Other 14%	14%	14%	14%
			Total 21%	20%	19%	19%
Decrease the mean number of Decay, Missing or Filled (DMF) teeth in 5 year olds	Oral health has a significant lifelong impact on health. Early enrolment with dental service and health promotion is important to ensuring oral health.	Number of decayed, missing or filled teeth of children enrolled with the Dental Service in CMDHB	Maaori 3.27	3	3	2.8
			Pacific 3.53	3.1	3.1	2.8
			Asian 1.93	2	2	1.9
			European 0.99	1	1	0.9
			Total 2.29	2.1	2.1	2

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				08/09	09/10	10/11
Reduce the number of births to teenage mothers (15-19 years)	Teenage births may limit opportunities for both mother and child. Rates amongst Maaori and Pacific are much higher than other groups. Teen pregnancy can be prevented by education and access to primary care.	Rate of babies born to women 15-19 years old who reside in CMDHB	(Per 1,000) Maaori 91.8	87	84	81
			Pacific 45.6	50	48	46
			Other 15.9	16	16	15
			Total 40.5	40	39	38

Other outputs to monitor progress against this outcome area

Objective	Deliverable	Timeframe
Improve early detection and hearing loss in children	Implementation of the national newborn hearing programme in accordance with the regional agreement commenced	30 Jun 09
Review the current outreach strategies to improve coverage for Maaori and Pacific children under 5 years	New models of care implemented, following review, in conjunction with outreach providers, PHOs and public health nursing service	30 Jun 09
Implement preschool oral health model and child and adolescent oral health business plan	Protocols agreed and in place with well child providers and community dental services Consultation and local oral health plans for Papatoetoe, Manukau-Manurewa and Papakura areas completed	30 Jun 09
Implement recommendations from Teen Parenting Evaluation Review to ensure best practice delivery of Teen Parent Unit services	Gaps identified by review implemented	30 Jun 09

Output Class

The measures for Outcome 2 are included in the Funder and Provider Output classes.

OUTCOME 3. REDUCE THE INCIDENCE AND IMPACT OF PRIORITY CONDITIONS

Why is this important to Counties Manukau DHB?

Diabetes, cardiovascular disease, chronic respiratory disease, cancer and mental health are leading causes of death and illness for our population, particularly for Maaori and Pacific people.

CMDHB continues to work toward the following objectives which are important for reducing the population's reliance on hospital-based care:

- Strengthening the delivery of primary and community-based care particularly through increasing the number of people enrolled in structured programmes like the Chronic Care Management programme which covers priority conditions like cardiovascular disease; diabetes; congestive heart failure; chronic obstructive lung disease; depression; and renal disease;
- Improving links with and access to specialist services to reduce the adverse impact of these and associated conditions;

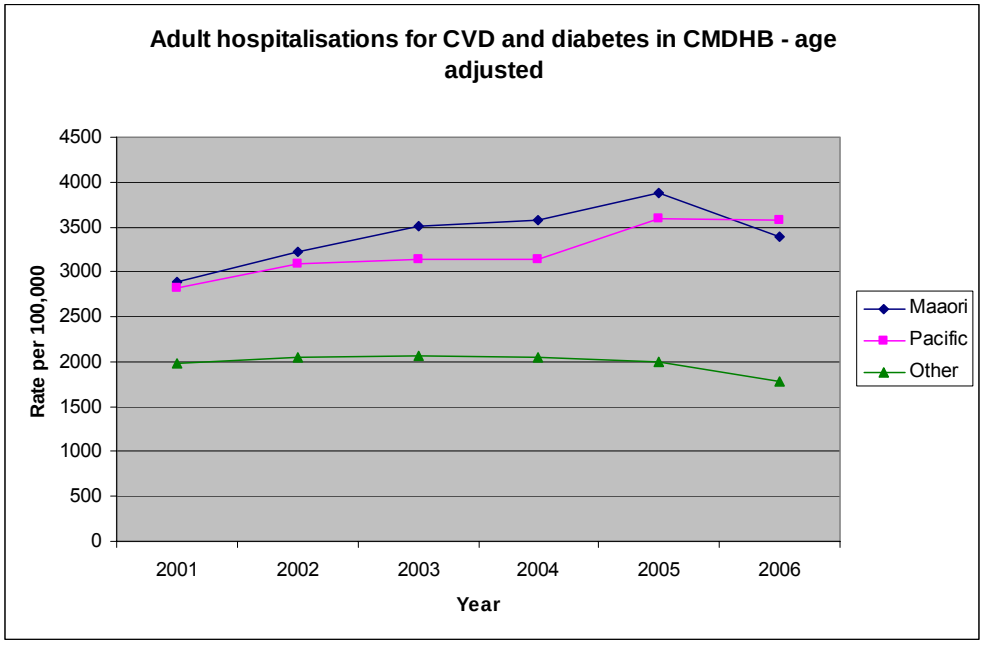
Diabetes and mental health have been identified as two of the ten action areas providing focus for the DHB. CMDHB is committed to working collaboratively with the other DHBs in the northern region, facilitated by the NDSA, to address regional mental health issues, fund regional mental health services, ensure efficient funding processes, improve quality of services and share information about new initiatives. In addition other actions areas, specifically primary health care, Maaori health and Pacific health include key strategies to reduce the incidence and impact of priority conditions. Further specific initiatives targeted at Maaori and Pacific health are found under Outcome 4.

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards reducing the incidence and impact of priority conditions (Outcome 3):

- Increase access to structured programmes to reduce the impact of disease for the priority conditions
- Reduce the incidence and impact of diabetes by implementing the Let's Beat Diabetes Plan
- Reduce the incidence and impact of cancer
- Improve outcomes for people severely affected by mental illness

Performance Measures

Cardiovascular disease and diabetes, as noted above, are amongst the leading causes of illness and death in Counties Manukau. CMDHB is committed to preventative strategies to reduce the impact of these conditions on those afflicted; one measure of the effectiveness of these strategies is the hospital admission rate, therefore this has been chosen as the headline indicator specifically relating to cardiovascular disease and diabetes in adults.



Baseline Data 2006 (per 100,000)	Performance Targets		
	08/09	09/10	10/11
Maaori 3400	3300	3200	3200
Pacific 3585	3600	3600	3600
Other 1778	1800	1800	1800

Objective	Deliverable/Outputs	Timeframe
Increase access to evidence based CVD risk management	>2850 patients who have a CVD risk >15% have received CVD management based on NZ guidelines	30 Jun 09
Expand availability of diabetes self-management education programme	Capacity of formal enrolments in diabetes self management programmes increased to enable 650 participants per year	30 Jun 09

Other measures to monitor progress against this outcome area

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				08/09	09/10	10/11
Increase the numbers of CCM enrolments for all five modules	Chronic conditions are becoming increasingly prevalent. Structured chronic care can lead to reduced mortality and morbidity, improved function and decreased hospitalisation.	Total enrolments in CCM programme (All enrolments minus disenrolments)	9,950	11,000	12,500	14,000

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				08/09	09/10	10/11
Increase the proportion (absolute number) of estimated number of people with diabetes who had an annual Get Checked free check	The prevalence of type 2 diabetes is rapidly increasing particularly in Maaori and Pacific people. Diabetes causes significant morbidity and mortality. Most diabetes needs to be managed primarily in primary care. There is a significant gap between recommended and in practice care.	Percentage of individuals with diabetes who have an annual free annual check. Note change from calendar year to financial year Absolute numbers only for baseline due to change in reporting and the introduction of updated prevalence rates which have increased more than 75% for CMDHB	Maaori 53% (1,585)	63% (2,124)	66%	70%
			Pacific 125% (4,036)	65% (5,121)	68%	70%
			Other 73% (5,090)	65% (7,795)	72%	75%
			Total 81% (10,710)	65% (15,041)	70%	73%
Increase the 2 year breast screening coverage for women aged 45-69	CMDHB has recently become provider of this service. Breast cancer is the leading cause of cancer mortality for women. Coverage rates are well below national targets of 70%.	Percentage of women aged 45-69 who have had a breast screen in the last 24 months	Maaori 41%	54%	56%	57%
			Pacific 40%	51%	52%	53%
			Other 49%	57%	60%	61%
			Total 47%	56%	58%	59%
Increase the proportion of the Counties Manukau population with severe mental illness accessing mental health services	Serious mental illness is a leading cause of morbidity. There is currently poor access to mental health services.	Percentage of people aged 20-64 seen by mental health services each month for the three months	0-19 years 1.6%	2.6	2.7	2.8
			20-64 years 2.3%	2.8	2.9	3.0
			65+ years 2.0%	2.6	2.7	2.8
			Total 2.0%	2.7	2.8	2.9
Note: the achievement of these targets is contingent upon the amount of additional Blueprint funding available each year.						

Other outputs to monitor progress against this outcome area

Objective	Deliverable	Timeframe
Implement recommendations for systems adaptation of CCM as part of phase two of CCM evaluation	• Recommendations finalised and implementation plan completed and accepted by PHOs	30 Jun 09
Continue implementation of the Cancer Control Strategy across CMDHB	• Implementation of local chemotherapy service at CMDHB	30 Jun 09
Improve the quality of mental health clinical services through audits of the Provider Arm	• Partnership in Evaluation towards Recovery audits completed and individual service recommendations implemented	30 Jun 09

Output Class

The measures for Outcome 3 are included in the Funder and Provider Output classes.

OUTCOME 4. REDUCE HEALTH INEQUALITIES

Why is this important to Counties Manukau DHB?

Ethnic identity plays a key role in determining a person's health outcomes. The health status of Maaori and Pacific people in Counties Manukau is poorer than people from European and other ethnic groups and life expectancies for both these groups are also considerably lower than that of their counterparts. Other groups with high health needs include refugees and migrants and those living in areas of high deprivation (decile 9 and 10).

CMDHB continues to take a 'whole society' approach (as outlined in Outcome 1) towards reducing health inequalities for these groups and through working in partnership with other agencies to develop specific initiatives to address the root causes of the social and economic determinants of health.

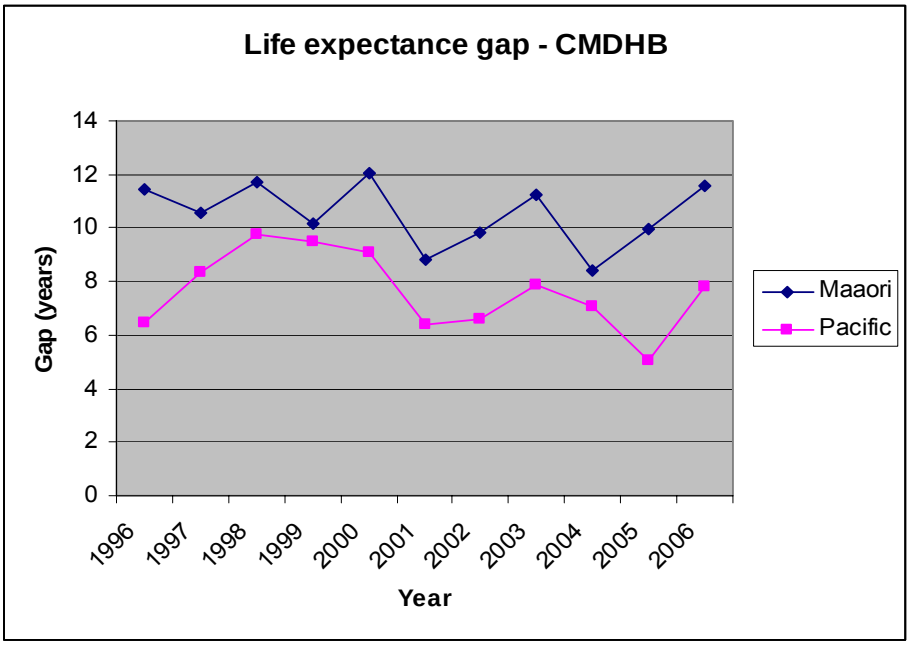
Key areas of focus include service development in Maaori, Pacific, and child and youth health (refer Outcome 2), and workforce development (refer Outcome 6). CMDHB will continue to implement key strategies from the Whaanau Ora Plan (Maaori Health Plan) and the Tupu Ola Moui (Pacific Health & Disability Action Plan).

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards reducing health inequalities (Outcome 4):

- Address the systemic origins of inequalities
- Implement specific initiatives to reduce inequalities
- Improve ethnicity data collection

Performance Measures

Life expectancy at birth is a key indicator of health status. Maaori people living in Counties Manukau have a life expectancy at birth 8 years less than their European and other counterparts, and for Pacific peoples in Counties Manukau the difference is 5 years. CMDHB will strive to lift life expectancy for our people to the level enjoyed by the rest of New Zealand.



Baseline Data 2004-2006	Performance Targets		
	08/09	09/10	10/11
Maaori 10.0	9.8	9.6	9.4
Pacific 6.7	6.4	6.2	6.0

Objective	Deliverable/Outputs	Timeframe
Implement Whaanau Ora Plan	Formalised health programmes in place in 15 Counties Manukau Marae, of which 2 are whare oranga pilots At least 40 Maaori enrolled in the Manukau Institute of Technology bachelor if nursing programme	30 Jun 09
Implement Tupu Ola Moui	Pacific Provider Development Plan completed Pacific Leadership workshop for Ministers Group held At least 30 Pacific nurse to have completed the return to nursing course	30 Jun 09

Other measures to monitor progress against this outcome area

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				08/09	09/10	10/11
Reduce the rate of potentially avoidable hospitalisations for adults	Potentially avoidable hospitalisations are an indicator of morbidity avoidable by social change, public health measures and primary care. It is a very sensitive measure of health inequalities.	Rate of adult hospital discharges considered potentially avoidable	(per 100,000) Maaori 8253	8600	8450	8281
			Pacific 8456	8722	8548	8377
			Other 4362	4600	4550	4500
			Total 5159	5640	5580	5520
Reduce the mortality rate for Maaori and Pacific men aged 45-64 years	Inequalities in ethnic mortality is extreme in this group and therefore should be a sensitive marker of progress. Maaori men of this age are often regarded as difficult to access and influence.	Rate of deaths of male CMDHB residents aged 45-64	(per 100,000) Maaori 1246	1,200	1,100	1,050
			Pacific 946	900	850	800
			Other 396	390	380	370
			Total 561	520	510	500

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				08/09	09/10	10/11
Ethnicity data is collected accurately and completely in secondary care	Inequalities cannot be effectively analysed, addressed or evaluated unless ethnicity data is accurately collected.	Percentage of patients seen as inpatients who have ethnicity recorded as Not stated or Not defined	1.3%	<3% (national target)	<3%	<3%

Other outputs to monitor progress against this outcome area

Objective	Deliverable	Timeframe
Continue to implement the Maaori responsiveness programme within CMDHB	Tikanga in practice implemented in partnership with Kidz First and Tiaho Mai	30 Jun 09
Ensure the CMDHB workforce reflects the local community	Review the processes and systems to capture workforce ethnicity data Identify recommendations to improve data collection	30 Jun 09
Develop formal processes to collect, analyse and monitor performance data appropriate for Counties Manukau	Develop and pilot Maaori quality measures/tools and IT support that will measure effectiveness of change	30 Jun 09

Note: Specific initiatives at a service level are included throughout the outcome areas with much of the DHB's activity focussed on reducing inequalities.

Output Class

The measures for Outcome 4 are included in the Governance, Funder and Provider Output classes.

OUTCOME 5. IMPROVE HEALTH SECTOR RESPONSIVENESS TO INDIVIDUAL AND FAMILY/WHANAU NEED

Why is this important to Counties Manukau DHB?

Health services must be available when people need them. This applies to the services people most commonly use – primary and community health care – and to those hospital and specialist services that must be there for those less frequent occasions when a major health event occurs. CMDHB is committed to improving our people's access to timely and appropriate services.

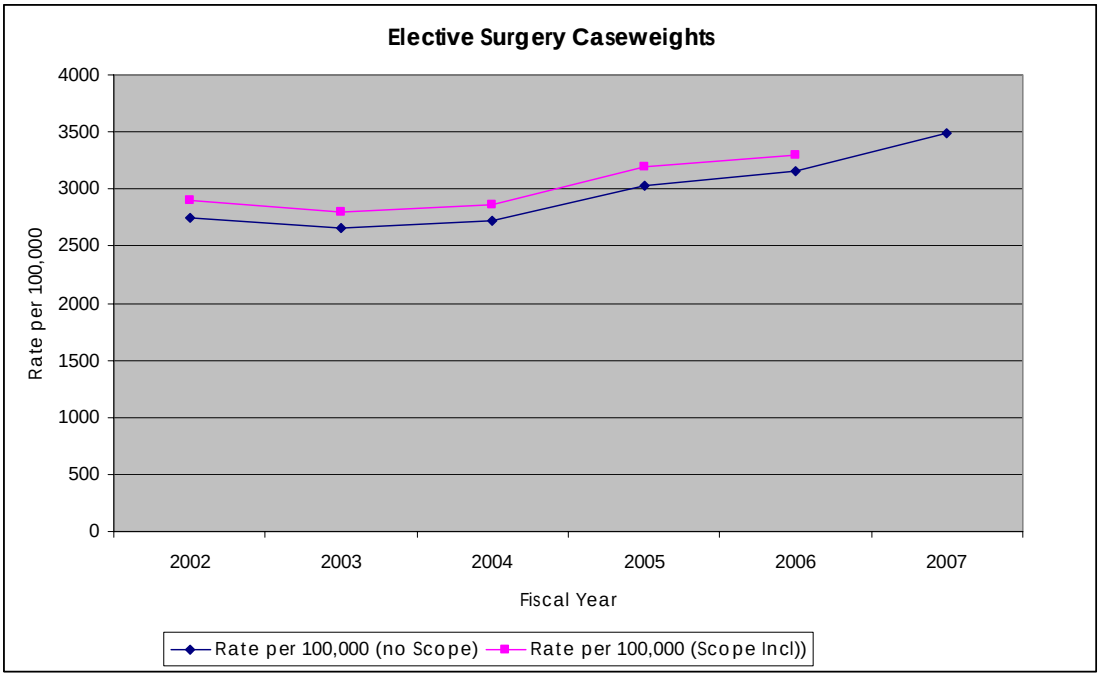
CMDHB will continue to focus on improving access to elective surgery, and progressing the implementation of the Primary Health Care Strategy, two of the ten action areas. The DHB will also continue to progress the initiatives underway to improve services for older people.

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards improving health sector responsiveness to individual and family/whanau need (Outcome 5):

- Increase access to services so they align with national levels
- Improve access to and management of elective services
- Increase primary care utilisation
- Improve the continuum of care for services provided to older people
- Reduce the number of people admitted to hospital who could have been cared for in the community.

Performance Measures

CMDHB is committed to increasing the volume of elective surgery provided to its community. Surgery is measured by caseweights, a method which recognises the complexity of the procedure, and for the headline indicator is monitored as a rate per 100,000 population.



Baseline Data 200708	Performance Targets		
	08/09	09/10	10/11
Total 3402	3531	3714	3809

Objective	Deliverable/Outputs	Timeframe
Increase internal capacity to achieve elective services provision at CMDHB	Internal capacity for the delivery of 1100 elective surgery WIES per month (including gynaecology) developed	31 Dec 08
Ensure that modality of service provided is aligned with best practice	Eligible day of surgery rates >90% by service Day of surgery admission rates >95% by service	30 Jun 09

Other measures to monitor progress against this outcome area

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				08/09	09/10	10/11
Increase the proportion of elective services which are at or above national access levels	CMDHB wishes to provide elective services to its population at national access rates as a minimum.	Number of service groups (e.g. orthopaedics) where access is below the NZ average	5/13	3/13	3/13	2/13
Decrease the number of patients who have not been managed according to their assigned status and who should have received treatment	It is important to give certainty to patients as to their treatment and then provide treatment within specified timeframes.	Percentage of patients with a priority score above the treatment threshold who have not received treatment within 6 months, or have been placed on active review but have not received a clinical assessment within the last 6 months	2.1%	<3%	<3%	<3%
Increase rate of GP consultations for high needs (Maaori, Pacific, or living in decile 9 or 10 area) compared with non-high needs populations	High needs populations have higher health needs but face barriers to access to primary care.	Rate of GP consultations per high needs person	1.16	>1	>1	>1

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				08/09	09/10	10/11
Increase the ratio of expenditure on home based care to expenditure on residential care	Older people should be maintain independence in their own homes whenever this is possible.	Ratio of number of people receiving Home Based Support Services to number receiving Aged Residential Care	2.5	≥3	≥3	≥3

Other outputs to monitor progress against this outcome area

Objective	Deliverable	Timeframe
Deliver to base elective contract, orthopaedic and cataract initiative targets	Delivery against agreed contract schedule	Monthly ongoing
Ensure all elective patients are seen and managed in a timely manner, consistent with Ministry of Health guidelines	Green ESPI compliance is maintained on a monthly basis, and where a service moves out of compliance it is returned within three months	Monthly ongoing
Implement the Counties Manukau Primary Health Care Plan	Extension of Primary Options to Acute Care programme (POAC) to rest homes piloted A clear direction for future PHO configuration confirmed including role of primary and community health centres and locality planning	30 Jun 09
Build opportunities for health promotion, disability prevention and rehabilitation through the expansion of community geriatric services and developing links with primary care	Proposal for co-location of PHO/GP, needs assessment and service co-ordination and home health care services developed Community geriatric service with PHO and residential care providers extended as per implementation plan	30 Jun 09

Output Class

The measures for Outcome 5 are included in the Funder and Provider Output classes.

OUTCOME 6. IMPROVE THE CAPACITY OF THE HEALTH SECTOR TO DELIVER QUALITY SERVICES

Why is this important to Counties Manukau DHB?

Growing and retaining a workforce that serves the needs of our community and reflects its diversity is critically important. With competition increasing to recruit and retain health professionals, significant change needs to occur. It is not just about increasing workforce supply but also "how we work". The current model is not sustainable and we need to design better models of care across hospital and community/ primary health care settings.

The gaps and shortages in the workforce are significant and cut across professional groupings and services. As a result workforce plans have been developed targeting key services and occupational groups. The focus is on attracting young people in our district, particularly Maaori and Pacific youth, to take up health-related studies, and to encourage those in other sectors of the workforce to consider a change to a career in health. This combined with a strong focus on learning and development, and other "employer of choice" initiatives, mean we are making the most of opportunities to "grow our own" workforce, and providing a work environment which assists in retaining existing employees.

Similarly the infrastructure that supports the workforce must meet the capacity needs of the community it serves, including:

- adequate facilities to safely treat people
- information systems to assist with the delivery and planning of health services
- quality systems and processes including the key quality dimensions of people centred, access and equity, safety, effectiveness and efficiency which underpin CMDHB's Quality Framework and Quality Plans.

CMDHB is committed to the improvement of patient safety and the delivery of efficient services. The quality improvement team was established in 2007/08 and the work of the team in 2008/09 will initially focus on the delivery of hospital and related services but will be expanded in the medium term to include community services such as residential care and primary care. The DHB is also providing leadership for the national Quality Improvement Committee initiative "Optimising the Patient Journey".

CMDHB will continue to focus on productivity, value for money and efficient use of resources during 2008/09, as well as the enablers of the 10 action areas: service re-design, workforce, and quality and safety. Regional collaboration with the other metro-Auckland DHBs will be important to ensure progress in these key areas.

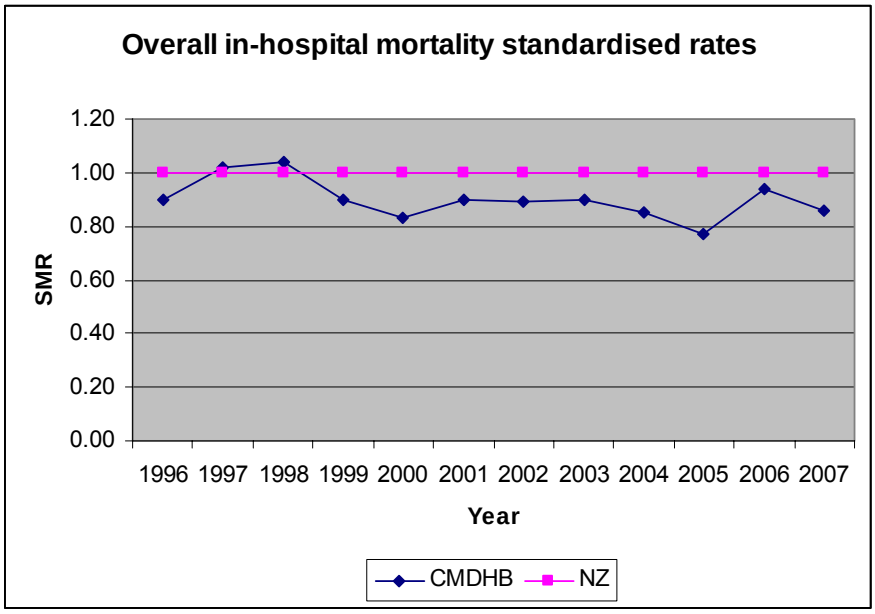
Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards improving the capacity of the health sector to deliver quality services (Outcome 6):

- Ensure the health workforce meets the community's need for services
- Improve health professionals communication skills in their dealings with patients and their families/whanau
- Ensure that services and facilities are planned to meet the future needs of the community

- Support information exchange amongst health professionals
- Ensure the delivery of safe and effective services
- Ensure the efficient use of resources.

Performance Measures

Quality and safety within the provider arm is a key focus for CMDHB. One of the measures of quality systems in the hospital environment is the in-hospital mortality standardised rate (SMR), or the number of deaths in a hospital environment compared with those expected based on the New Zealand average.



Baseline Data 2007	Performance Targets		
	08/09	09/10	10/11
0.86	≤0.9	≤0.9	≤0.9

Objective	Deliverable/Outputs	Timeframe
Improve Patient Safety	Physiologically Unstable Patient Programme implemented ICU bundles in place and used on all appropriate patients	31 Oct 08 30 Jun 09
Improve performance within the ward environment through the Releasing Time to Care programme	Programme completed for 4 wards each quarter until April 2009	30 Apr 09

Other measures to monitor progress against this outcome area

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				07/08	08/09	09/10
Reduce the percentage of employees who voluntarily resign (Staff turnover – FTE)	High staff turnover indicates an unhappy staff base. High staff turnover will lead to poorer service delivery.	Percentage of employees who resigned in the year	9.33%	<14%	<14%	<14%

Objective	Rationale	Performance Measure	Baseline Data	Performance Targets		
				07/08	08/09	09/10
Reduce the ratio of communication patient complaints to the number of admissions	Communication is essential to achieving good health outcomes.	Proportion of communication complaints received to the number of admissions	0.36%	0.3%	0.3%	0.3%
Increase the proportion of inpatients surveyed who are satisfied with service delivery	Patient satisfaction is essential to achieving good health outcomes.	Percentage of inpatient satisfaction survey respondents who rate service satisfaction good/very good	82%	83%	85%	86%
Reduce the number of days where occupancy is greater than 90% in CMDHB facilities	When facilities are overfull it reduces the quality and efficiency of delivery of services to patients.	Number of days in a financial year when more than 90% of beds in CMDHB facilities are occupied	19	30	30	30
Note: this is a new indicator, the target reflects the tradeoff between having adequate facilities for peaks and an efficient use of capital resources so at this stage they are estimates only. In addition CMDHB is in the middle of a building programme with wards being commissioned and decommissioned which will mean achieving the target this year is less certain						
The percentage of laboratory test and pharmaceutical transactions with a valid NHI	Having valid NHIs on pharmaceutical and laboratory test transactions will enable tracking of expenditure and usage by the DHB's resident population. This allows for more accurate analysis of expenditure against population-based budgets.	*Pharmaceuticals*: Percentage of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted. *Laboratory tests*: Percentage of tests carried out by community laboratories in the DHB district with a valid NHI submitted.	*Pharms:* 92% *Labs:* 92.8%	92% 93%	94% 94%	95% 95%

Other outputs to monitor progress against this outcome area

Objective	Deliverable	Timeframe
Recruit and retain staff	Implement the CMDHB workforce development plan	30 Jun 09
Enhance staff-patient communication	Coaching and mentoring programme reviewed and implemented Patient-focused communication modules to support building a culture of quality implemented	30 Jun 09

Objective	Deliverable	Timeframe
Improve utilisation of the Manukau Surgery Centre	Physical occupancy increased from 38% to 50%	30 Jun 09
Increase bed capacity to meet increasing requirements	New Adult Medical Building available	30 Jun 09
Integrate health information from secondary services to primary care	Primary care access to regional repository of health event summaries piloted	30 Jun 09

Output Class

The measures for Outcome 6 are included in the Funder and Provider Output classes.

Part 6 STATEMENTS OF FINANCIAL PERFORMANCE

6.1 FINANCIAL STATEMENTS

Statement of Financial Performance						
$000	**2006/07 Actual**	**2007/08 Budget**	**2007/08 Forecast**	**2008/09 Draft Budget**	**2009/10 Estimate**	**2010/11 Estimate**
Revenue	949,226	1,026,462	1,041,098	1,098,297	1,142,889	1,228,645
Personnel	310,601	335,400	338,132	376,059	398,622	422,539
Outsourced	39,690	39,659	48,771	46,531	49,171	51,958
Clinical Supplies	69,635	70,019	70,659	72,957	75,940	79,050
Infrastructure	49,695	56,958	56,926	57,936	60,792	62,531
Provider Payments	432,198	474,892	475,176	497,129	520,467	574,283
Operating Costs	901,819	976,928	989,664	1,047,412	1,102992	1,190,361
EBITDA	**47,407**	**49,534**	**51,434**	**45,885**	**39,897**	**38,284**
Depreciation	21,555	22,774	22,598	22,212	23,500	25,000
Interest	6,410	11,056	9,138	9,564	9,500	10,500
Operating Results before Capital Charge	**19,442**	**15,704**	**19,698**	**14,109**	**6,897**	**2,784**
Capital Charge	12,988	15,585	12,084	14,004	14,004	14,004
Operating Surplus	**6,454**	**119**	**7,614**	**105**	**(7,107)**	**(11,220)**
Carried Forward surpluses	(5,336)	(1,500)	(1,500)	(3,200)	(2,000)	-
Surplus / (Deficit)	**1,118**	**(1,381)**	**6,114**	**(3,095)**	**(9,107)**	**(11,200)**

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	**2006/07**	**2007/08**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
	Actual	**Budget**	**Forecast**	**Draft Budget**	**Estimate**	**Estimate**
Funder - Arm						
Government & Crown	803,683	870,389	886,004	954999	1,003,704	1,088,798
Non Government and Crown Agency		625	54	1,566	1,566	1,566
Inter DHB & Internal	65,663	80,513	80,513	73,264	71,107	68,580
Revenue	**869,346**	**951,527**	**966,571**	**1,029,829**	**1,076,377**	**1,158,944**
Expenditure						
Personal Health	676,728	747,286	754,998	802,929	838,309	904,590
Mental Health	109,644	109,950	109,312	114,525	121,398	128,680
DSS	71,818	80,175	80,494	96,432	102,219	108,353
Public Health	1,161	1,021	727	216	229	243
Maori	3,948	4,904	7,572	7,101	7,279	7,460
DHB Governance	9,303	7,728	7,719	8,573	8,980	9,407
Expenses	**872,602**	**951,064**	**960,969**	**1,029,776**	**1,078,414**	**1,158,733**
Surplus / (Deficit)	**(3,256)**	**463**	**5,602**	**53**	**(2,037)**	**211**
Governance - Arm						
Revenue						
Government & Crown	10,801	7,978	7,947	8,573	8,980	9,407
Total Revenue	**10,801**	**7,978**	**7,947**	**8,573**	**8,980**	**9,407**
Personnel	6,903	6,425	6,177	7,483	7,932	8,407
Outsourced Service	427	112	17	(72)	(122)	(181)
Infrastructure	4,812	3,640	3,905	3,902	4,054	4,217
Total Expenses	**12,142**	**10,177**	**10,099**	**11,313**	**11,864**	**12,443**
Surplus / (Deficit)	**(1,341)**	**(2,199)**	**(2,152)**	**(2,740)**	**(2,884)**	**(3,036)**

Summary by Output Source						
$000	**2006/07**	**2007/08**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
	Actual	**Budget**	**Forecast**	**Draft Budget**	**Estimate**	**Estimate**
Provider - Arm						
Revenue						
Government & Crown	60,253	59,705	54,289	40,962	43,103	45,355
Non Government and Crown Agency	17,799	14,696	15,850	22,266	23,158	24,083
Inter DHB & Internal	426,097	461,232	470,462	515,741	540,238	565,899
Total Revenue	**504,149**	**535,633**	**535,572**	**578,969**	**606,499**	**635,337**
Personnel	303,698	328,228	331,955	368,576	390,690	414,132
Outsourced	39,263	39,559	41,035	38,030	40,313	42,732
Clinical Supplies	69,635	71,172	74,863	79,912	83,109	86,434
Infrastructure & Non Clinical Supplies	85,836	96,320	90,084	92,859	96,573	100,434
Expenses	**498,433**	**535,279**	**532,883**	**579,377**	**610,685**	**643,732**
Surplus / (Deficit)	**5,716**	**354**	**2,689**	**(408)**	**(4,186)**	**(8,395)**
Eliminations						
Revenue	(435,070)	(470,260)	(478,510)	(524,074)	(548,967)	(575,043)
Expenses	(435,070)	(470,260)	(478,510)	(524,074)	(548,967)	(575,043)
Surplus / (Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
DHB – Total	**1,118**	**(1,382)**	**6,114**	**(3,095)**	**(9,107)**	**(11,220)**

Statement of Financial Position						
$000	**2006/07 Actual**	**2007/08 Budget**	**2007/08 Forecast**	**2008/09 Draft Budget**	**2009/10 Estimate**	**2010/11 Estimate**
Current Assets	36,290	27,624	39,566	34,681	34,681	37,681
Current Liabilities	(174,354)	(205,644)	(199,640)	(190,094)	(187,672)	(177,943)
Working Capital	(138,064)	(178,020)	(160,074)	(155,413)	(152,991)	(140,262)
Non-Current Assets	387,153	447,163	439,277	481,521	469,992	446,043
Net Funds Employed	**$ 249,089**	**$ 269,143**	**$ 279,203**	**$ 326,108**	**$ 317,001**	**$305,781**
Total Non-Current Liabilities	78,536	77,990	78,536	128,536	128,536	128,536
Crown Equity	170,553	191,153	200,667	197,572	188,465	177,245
Net Funds Employed	**$ 249,089**	**$ 269,143**	**$ 279,203**	**$326,108**	**$ 317,001**	**$305,781**

Statement of Movement in Equity						
$000	**2006/07**	**2007/08**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
	Actual	**Budget**	**Forecast**	**Draft Budget**	**Estimate**	**Estimate**
Opening Balance	169,868	195,351	170,553	200,667	197,572	188,465
Surplus / (Deficit)	1,118	(1,381)	6,114	(3,095)	(9,107)	(11,220)
Transfer of restricted funds	(755)	(30)				
Crown Equity Injection	741					
Crown Equity Withdrawal	(419)					
NZIFRS adjustment		(2,787)				
Revaluation Assets			24,000			
Closing Balance	**$170,553**	**$191,153**	**$200,667**	**$197,572**	**$188,465**	**$177,245**

Statement of Movement in Cash Flow						
$0	**2006/07**	**2007/08**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
	Actual	**Budget**	**Forecast**	**Draft Budget**	**Estimate**	**Estimate**
Operating	44,844	23,135	35,370	15,984	17,338	19,554
Investing (Capital Expenditure less Interest received)	(37,407)	(57,380)	(56,010)	(62,260)	(14,916)	(14,825)
Financing	(14,139)	34,245	24,909	41,391	(2,422)	(4,729)
Net Cash Flow	**(6,702)**	**-**	**4,269**	**(4,885)**	**-**	**-**
Opening Cash	8,331	515	1,629	5,898	1,013	1,013
Closing cash	$1,629	$515	5,898	1,013	1,013	1,013

*Completion of existing approved major capital expenditure, forecast completion by 30 June 2009. Does not include any unapproved major capital expenditure requests.

6.2 OVERVIEW

After many years of successful achievement of break even or better, as well as very significant investment in initiatives to progress the objectives of the District Strategic Plan, the financial position forecast for 2008/09 while still achieving a break even position reflects a significant underlying deterioration in the fundamental financial drivers. These changes unless addressed will compound over future years.

The key drivers of this change in financial position are:

- The high level of wage settlements in the Provider Arm, either settled or anticipated to be agreed, in excess of FFT and directly impacting on operating performance.

- The annualisation of commitments made in 2007/08, including the continuing investment in quality which is not expected to make a return on investment until the outer years.

- The continuing significant IDF outflow and pricing adjustments.

- Continuing population growth in excess of the census projections used to calculate the population based formula revenue.

While the 2007/08 financial result is expected to disclose a significant surplus, this result is misleading unless analysed further. Many of these gains are "one off" in the non-operating cost areas. Depreciation and interest costs are significantly lower reflecting timing issues of new facility developments. In order to meet construction completion dates and clinical deadlines, they will self correct in 2008/09. The capital charge in 2007/08 will also be lower than budgeted as a result of not re-valuing assets at 30th June 2007. However this looks very likely to occur in 2008/09 and is budgeted as unfunded.

Other "one off" revenue gains have assisted the 2007/08 position, such as release of risk pool provisions no longer required and the "wash up" of MOH Elective Revenue Contracts straddling the last two financial years.

In previous years the DHB has benefited from the change to Population Based Funding (PBF), specifically through the demographic growth component of the funding which is in addition to FFT. Unfortunately the very significant benefit and resulting financial stability this has provided appears to have been completely eroded by the magnitude of the unfunded actual and anticipated wage settlements and other key drivers, for 2008/09 and immediately beyond.

The forecast financial position, both for the current and outer years of the DAP, has the potential to severely limit CMDHB's ability to continue to invest in, and to achieve many of, its objectives. These severe funding constraints are of critical concern, as many of the existing and new objectives and initiatives will be placed at risk as a result. Many of these are essential to the long term sustainability of the organisation.

This becomes a difficult balancing act as the focus moves to ensuring financial stability and away from enhancing the District Strategic Plan objectives and clinical and quality imperatives. If the financial pressures continue as forecast, increased innovation will become even more important as the primary driver to addressing our strategic objectives and meeting our financial obligations. Also to be considered are the huge clinical pressures already on CMDHB, staff are severely stretched resulting in increasing clinical risk.

The forecast small operating surplus of $0.1m at the operating financial position level includes the revenue and cost impact of confirmed Ministerial elective initiatives. It is proposed that, given the operating break even position, the balance of previous years operating surpluses (up to $13.8m carried forward) continue to be utilised over future years to assist the achievement of these targeted national and DHB objectives. Specifically this would be a targeted commitment to national health targets including elective volumes and immunisation coverage targets, and investment in further priority initiatives aligned with the District Strategic Plan. Provisionally $3.20m has been included in the first year of the DAP, however it is likely that the Board will seek to review the investment level in these areas, within the limits of the carried forward earnings. The DAP currently includes restricted/limited new or incremental investment in the 'Action Areas', as only curtailment of growth costs (including demand driven) would release further funds for further investment.

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 identify and "ring fence" significant investment in initiatives aligned with the District Strategic Plan. These initiatives and investment in the future health of CMDHB's community now total well over $15M annually, a similar level to the previous year. Many of these are now so embedded in the core operational activity of the organisation, that it is virtually impossible to stop or reverse these investments in order to lessen the financial impact/cost on the bottom line and as previously discussed, any that could be stopped in the short term will only increase the negative impact/cost in the long term.

In order to achieve the break even position tabled in the DAP, we have "capped" the allowable and fundable growth both within the Provider Arm, as in previous years, and even in the Funder Arm. This will present a huge challenge to contain the growth and related costs within these parameters, but we recognise we have no choice, in order to attempt to avoid a deficit budget position.

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

- It is likely that an asset revaluation will need to be carried out during the future financial years (2008/09 and likely, 2009/10, 2010/11) due to increasing land and building costs. At the current point in time we have budgeted for a relatively small revaluation in June 2008 on the basis that commercial values appear to have steadied and stabilised and therefore the exposure is slightly diminished. However this will ultimately depend on whether or not the valuation has a material impact on the financial statements. If this did occur, then there would be related

depreciation and capital charge costs, which based on advice previously received, are unlikely to be reimbursed by Ministry of Health on a yearly basis.

- Funding for the Health of Older People income and asset testing recalculation is sufficient to match our forecast level, with the "irony" that if house prices fall, Health of Older People accessibility levels will drop, entitling more people to claim. Reconciliation and resolution of this issue is still outstanding.
- PHO Top-Up reimbursements continue from the Ministry of Health as previously.
- All mental health funds, including "Blue-Print", continue to be "ring-fenced", with a neutral impact on the consolidated position. Note Mental Health is being instructed to absorb its related excess wage settlement within its ring fence on the basis it has its own 'ring fenced' FFT and demographic growth and must operate within those parameters.

It is particularly important to note that the break even position has been reached after:

- Recognising anticipated wage and salary settlements well in excess of the 2.6 percent (net) funded level, specifically:
    - Significant national wage settlements, with flow on-costs, well in excess of the MoH funded levels (including recognition of the automatic ongoing step function on-cost implications)
    - While a number of the wage settlements have or are expected to have 'affordable cost' in 2007/08 year, the full impact will not be felt until 2008/09. As important, this level is expected to carry through to the full 3-year period of the DAP, for example the NZNO 39 month settlement, where the outer years are significantly heavier or more financially onerous. Therefore the wages funding shortfall in 2008/09 compounds to double in 2009/10 and treble by 2010, driving the worsening deficit position for all three years.
    - The relative absence of any material quantifiable efficiency benefits arising from MECA settlements to date. While these are referred to in settlement documents, there is no sound financial basis on which DHBs can determine any potential level of savings and incorporate them within their DAPs with any reasonable level of confidence.
    - The introduction of the Kiwi saver funding and the excess non-rebateable position which is provisionally expected to cost CMDHB approximately $1m.
    - Increasing roster and compliance costs around RMO's terms of employment
    - Generally increasingly demanding terms and conditions of employment which significantly lessen flexibility.
- The continuing 'sunk' committed investment in priority initiatives aligned with the District Strategic Plan, including those focussed on lessening the growth in hospital services and improving overall clinical quality outcomes
- The ongoing internal efficiencies being generated, including those within healthAlliance.. Again, while there is a National Procurement initiative well under

way, it is extremely difficult to quantify this or any current additional material financial benefit arising other than a very risky 'lump sum unspecified' saving, a risk or estimation CMDHB is unable to take.

- The absorption of increasing pharmaceutical demand, reflecting greater access and usage by our community.
- The absorption of continuing renal growth volumes, albeit at a growth level below the extremes of previous years.
- The absorption of continuing pricing adjustments to inter-district flows (IDFs) and to a lesser extent, the volume of IDF outflows.

Again despite the position forecast, there are also still a number of significant financial risks inherent in the DHB's responsibilities. These include:

- The significantly increased difficulty in meeting the Minister's and Government's expectations regarding a break-even financial result (zero deficit) and compliance with Government strategies and policies, in all years of this DAP.
- Meeting the communities' expectations, now that the DHB has been moved to equity from a population based funding perspective and with regard to community participation in decision-making.
- The financial risks associated with demand driven services, in which volume growth continues to outstrip funding in many areas. Also, risks arise from poor historical data, assumed targeted savings being built into the forecast, price pressures, and pricing inequalities between providers.
- Wage price pressure continuing to emanate from union expectations and the increasing international nature of the health labour market, leading to both significantly higher wages and clinical staff shortages arising from a much more mobile workforce. There are also potential relativity flow-on risks associated with the recent nursing wages settlement which will directly impact on other salary/wage levels initially within the Provider Arm. Ultimately these will almost certainly flow through to the NGO Sector with huge potential financial ramifications for the sector.

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

- An organisation wide, commitment to quality and quality improvement. This initiative, led by the CEO, has resulted in the formation of a formal quality unit within the organisation. The quality initiative will ultimately lead to financial benefit and be self funding or better, but initially requires considerable financial commitment.
- Continued development of audit, evaluation and monitoring systems to ensure that CMDHB is receiving value for money.
- Significantly lifting the level and frequency of all internal and external audit reviews. Increasing emphasis is currently being placed on widening the audits in the NGO/PHO areas, with notable results to date. The primary focus here has been around ensuring full delivery of contracted services, as well as ensuring appropriate health outcomes. Further strategies include maximising the benefits

of the now well established regional internal audit function across the three metro-Auckland DHB's which is expected to lead to ensuring best value for services.

- Continued application/utilisation of a robust expenditure and long term forecasting monitoring tool.
- Continued very strong focus on efficiency and cost opportunities, particularly through the use of healthAlliance, but increasingly through regional collaboration. The latter will ensure a consistent approach and common policy and also ensure appropriate benchmarking is regularly carried out to maximise efficiencies. Note the absolute dollar level of cost reduction opportunities is lessening in many areas with an increasing focus around consistency of regional purchasing and common systems development.
- Working with the unions to realise the efficiency benefits included in the MECA settlements.
- Support of national initiatives that will lead to cost reductions, subject to the perceived risks being manageable such as the Procurement and Value for Money projects.
- Continuing to place very high emphasis on robust, regular monthly performance reviews at all levels of the organisation to ensure that CMDHB meets or this year exceed both its financial and operational targets.

Finally, it is important to acknowledge that CMDHB has over the past three years absorbed the impact of both FFT and demographic growth funding levels being understated as per the following tables.

Impact of inflation (FFT) short funding over past three years

Year ending	**2005**	**2006**	**2007**
Actual Inflation	4.2%	4.0%	4.9%
MOH FFT	2.6%	3.3%	2.9%
Short fall	(1.6)%	(0.7)%	(2.0)%
$000 per Year	**9,380**	**4,472**	**13,500**
Cumulative Impact	**$ 9,380**	**$ 13,852**	**$ 27,352**

Note: Data not available for 2008 year

Impact of under-estimated population growth as reported through Census/Statistics NZ

Estimation made in	Estimate 2006 pop	Est 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 '06	**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 is constantly short funded between $8 - 15m per annum

Therefore, when any assessment of efficiencies being achieved is made, there needs to be acknowledgement or recognition that CMDHB is already absorbing between $18m and $25m per year through revenue under funding. This presents a huge challenge from a clinical or health perspective. While this is a very solid financial absorption, it is ultimately at the cost of improved health services to our very diverse, growing and generally deprived, community.

6.3 FINANCIAL MANAGEMENT

6.3.1 Specific Cost Pressures – Wage pressure

Within the Provider arm, basic wage increases are built in at the levels of actual settlements, either finalised or indicative settlement levels, most of which are now MECA based. Over and above those base salary and wage movements, CMDHB is, along with other DHBs, experiencing very significant levels of on-costs, including ever-increasing step functions, allowances and superannuation (Kiwi saver), primarily around medical and nursing staff entitlements. Of note is the virtual certainty of the flow on of the nursing settlement levels to all other (union) negotiations. This is already occurring in award claims with potential huge financial consequent impact on all DHBs.

Step function increases: In most cases staff are entitled to move up a step after each year of service, which results in an average 2.5% (net) increase. The step function increases have to be absorbed by direct funding or by way of efficiencies. Note: step functions for clinical personnel, are automatically applied and can almost double the base increases, which in turn are further compounded by equivalent changes to related terms and conditions. As the level of current step function increases, it is becoming impossible for any DHB to simply absorb this and this is now having to be

included in budgets, at least in part, given these are national settlements and agreed to on this basis.

Actual and anticipated changes in leave entitlement, due 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 both observing the extra leave entitlement and filling the consequent vacancies this is causing. In setting the DAP, the DHB has fully reviewed current vacancy levels. At a service level the opportunity to continue to maintain vacancy levels have been severely restricted due to volume, and most importantly, safety constraints.

6.3.2 Capital Planning and Expenditure

Despite the forecast tight DAP position, the DHB must remain committed to the major capital projects previously either approved by MOH or under consideration/application. These projects will ultimately utilise all available cash funds, sourced from either current or accumulated depreciation, remaining available debt funding or new equity/debt. Many of these projects were initially approved under the general heading of Facilities Modernisation Programme (FMP). More latterly, as a completely separate development, the next phase of which has been renamed “Towards 20:20”. This latter phase reflects the long term forecast impact of current and future growth in the CMDHB catchment area and is seen as absolutely essential to meet the ‘organic’ growth of our region.

We are, and will continue to, work closely with all other Auckland Region DHB’s to ensure non-duplication or under utilisation of asset investment. However CMDHB’s independently reviewed growth and bed projections are such that this planned investment is essential simply to meet our communities 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 will total over $300M on completion and will have been almost totally funded from CMDHB free cash flow or existing debt facilities. It will have come in ‘on time’, under budget, and within specification – an almost unique occurrence in the public health sector.

Most recently this has resulted in a new Radiology Department, Middlemore wide infrastructure upgrade, new Neonatal Intensive Care Unit, National Burn Unit, Catheterisation Lab, Manukau Surgical Hospital Ward fit outs, and additional floors on the Adult Medical Centre at Middlemore.

Having received Ministerial sign-off for Stage 3 of the Core Consolidation, encompassing the building of a new ward and clinical services block on the Middlemore site and the full refurbishment/upgrade of the gynaecology and early pregnancy service on the same site, we are now well advanced in implementing this project. This has a non moveable completion date of May 2009 given a severe shortage of in-patient beds at that stage if not achieved. The capital cost of this is $36.5m of which funding support of $25m has been agreed although nothing drawn down to date. The National Capital Committee supported the Business Case in

December 2006 and the formal Ministerial approval letter was received in March 2007.

As part of "Towards 20:20" we are now very well advanced in determining the medium to long term organisational requirements (15-20 year horizon). This has being driven by extensive internal and external consultation, the roll out of the Clinical Services Plan (primarily Provider focused) to the Health Services Plan (community-wide focus), coordinated with the earlier Asset Management Plan as supported by the Ministry of Health, and has recently been progressed via the finalisation of the Strategic Asset Plan and the support of National Capital Committee. The development of the Business Case encompassing the first stages of the long term plan will now proceed to completion and presentation to National Capital Committee in August 2008.

Simplistically the initial stages of the project envisage a new Clinical Services Block encompassing a new suite of theatres, HDU and teaching facilities at Middlemore, and significant growth/relocation of support services to the Browns Road/Manukau Super Clinic/Surgical Centre site.

It is anticipated that 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 and Treasury officials in regard to these requirements. There is a very clear need for significant further ministerial support in future "Towards 20:20" phases, given the anticipated significant overall capital requirement outlined in the 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 continuing significant growth of CMDHB will have to be met through improved or additional facilities, incorporating substantial clinical equipment purchase or replacement.

CMDHB is currently rolling out the findings and asset information from the 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 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 that the future funding requirements for CMDHB are large and will present a national funding issue. CMDHB has fully reviewed and updated its Health Services Plan, re-run the bed model forecasts, aggressively considered new models of care, and re-assessed community based health solutions, forecast growth, facility timing and other options in order to lessen this forecast demand and related impact on capital requirements. Extensive resource has been applied to this exercise, including significant independent external input and a very high level of regional collaboration to ensure non duplication and aligned timing of new facilities

and capacities. Further, CMDHB initiated a series of national sustainability conferences in recognition of the wider national issues arising from these forecasts. The first of these addressed workforce planning, the second "Funding Tomorrow's Health" ie fundability and affordability and the third (planned for August 2008) to consider and challenge current models of care/change management. While the funding issues within this DAP relate specifically to CMDHB, nonetheless there are clear indications that our challenges will be mirrored ultimately throughout the public health sector.

6.3.3 Banking Covenants

CMDHB continues to operate under existing banking covenants with its remaining major New Zealand bank and now Crown Health (replacing the previous institutional bond holders). The organisation has transitioned all term bank debt facilities to the Crown Health Financing Agency. The Board maintains a working capital facility with ASB Bank/Commonwealth Bank which continues to fall under the existing covenant requirements as well as lease facilities with Westpac. Despite the fact that the covenants were re-negotiated to more favourable requirements, over the past two years the DHB has fully complied with the original covenants.

Clearly the tightening of the financial position as forecast will have a significant impact on existing covenants. We have, for many months now, forewarned both banks and CHFA of the likely tighter position in 2008/09.

Facilities	Existing
CHFA	$197.0m
Commonwealth Bank (working capital)	$45.0m
Westpac (lease agreement)	$10.0m

6.3.4 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 2008/09 including both new and replacement assets. Although we have still to complete the final review of all capital expenditure requests (and therefore confirm the associated depreciation levels), capital expenditure related to the 2008/09 year will be limited to $46.1m, increased by the existing approved Towards 20:20 projects relating to current and future years.

Overall we are confident of meeting all reasonably anticipated cash outflows for 2008/09 through both the achievement of the positive operating cash and utilisation for capital purposes of the existing unutilised/approved debt facilities.

However, the forecast cash position is anticipated to deteriorate as referred to under the later paragraph 'Outlook for 2009/10 and 20010/11 years'. This position is anticipated given the assumed non-reimbursement of the 2008/09 higher wage settlements.

Covenants
The only convenants now required by any lender to CMDHB are ASB/Commonwealth's requirement of a 'positive operating cashflow' i.e. before depreciation and capital investment.

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

6.3.5 Capital Charge

The District Annual Plan continues to include the matching of cost and revenue on the higher capital charge arising from the anticipated asset revaluation on a three yearly cycle. This Plan does not include a revenue offset for any anticipated asset revaluation in 2008/09, being only year two of the three year cycle.

6.3.6 Advance Funding

The 2008/09 District Annual Plan, continues to incorporate the fiscal benefit of the one month advance funding, based on achieving a break even operating position, and maintenance of the other Ministry of Health requirements necessary to access this benefit.

6.4 COST CONTAINMENT & EFFICIENCY GAINS

As in previous years, the District Annual Plan reflects continuing growth containment within the organisation, particularly within the Provider arm but increasingly necessary within the Funder Arm through management of demand driven services. Where previously there appeared significant opportunity to continue to improve efficiencies and limit the cost impact of growth, the current outlook provides much more limited opportunities. Further the Board initiated many necessary but significant initiatives around clinical safety and quality, a position fully reinforced by subsequent public national announcements from the Health & Disability Commissioner and Quality Improvement Committee.

In many of these cases demand continues to significantly outstrip projections and therefore levels of funded growth, which has required even tighter cost containment simply to achieve the forecast break even level.

Renal dialysis outpatient volumes are still growing at over 5% compounded annually – a level which is both clinically and financially unsustainable and which, in current financial terms, incurs $0.5m per year unfunded operating cost growth and a further million dollars of capital/facility requirements for every new 12 bed module required to meet this demand.

Women's health cost pressures continue particularly relating to meeting service coverage requirements, as well as a birth rate well in excess of national averages (over 4%) and growing well beyond population based funding levels.

With the exception of the areas identified above, there has been some encouraging stability around hospital acute growth levels overall. March 2008, WIES volumes on the base MoH contracts are up 3% on the previous year, only marginally ahead of population growth. The District Annual Plan therefore has been based on absorption of any increases in acute growth levels within overall funding limitations.

CMDHB remains committed to maintaining the very high level of elective volumes that are forecast for 2007/08. This has been achieved previously through a combination of both internal and external resources but these volumes are planned to be provided primarily within internal resources in 2008/09, hence the significant shift from Outsourced Services to 'Wages and Salaries'.

In achieving the desired zero deficit operating target, we have placed even greater emphasis on containing our costs and achieving further efficiency gains, with all areas of the organisation expected to build into their plans continuing and significant but achievable efficiency targets. As would be expected many of these are the same areas targeted in the 2006/07 and 2007/08 District Annual Plans. In order to achieve this we have effectively "short funded" both the Funder and the Provider Arm by 0.5% (or approximately $3m each) to be able to contribute to the significant investment in new and existing District Strategic Plan initiatives.

CMDHB continue to express concern around forecast increases in utility costs in the areas of gas, electricity, fuel costs and particularly huge waste water and water following on from similar increases over the last two years. Again as previously there appears to be little and probably no financial advantage in metro-Auckland DHB regional negotiations as these prices are primarily geographical site-related, rather than collectively related. These forecast increases are known to be well above the funded inflation and population growth adjustments.

Efficiency gains continue to be a major focus for CMDHB within the District Annual Plan and are essential to offset both volume cost growth and to fund essential investment in primary care initiatives to ultimately minimise secondary care volume impacts and improve health outcomes for the Counties Manukau community.

The nursing structure review initiated almost three years ago under the Director of Nursing continues, with significant benefits accruing through improved reporting lines, clarity of objectives and anticipated benefits from improved regional collaboration and alignment. Reducing the cost of the external bureau continues to be a priority. To date this has resulted in a reduction of total nursing costs, but also clinical improvement and patient care as a result of the reduction in numbers, and reliance on, part time, less experienced bureau staff.

New resourcing models within theatres are improving both clinical efficiency and reducing costs as anticipated.

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

CMDHB continues to maintain a very close focus on FTE management given that salary and wage costs are two thirds of the Provider budget. As a result there is a relatively modest increase in overall approved FTE levels. However as noted previously, there is significant 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. 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. As previously, FTE increases are subject to regular close scrutiny to ensure justification.

6.5 HEALTHALLIANCE (CMDHB & WDHB SHARED SERVICE ORGANISATION)

healthAlliance continues to perform well as a shared support service for Information Services, Accounting/Finance, Human Resource Support, Procurement and Payroll. Cost savings, particularly within procurement, as well as reduced human resource recruitment costs, are again expected to significantly benefit CMDHB and WDHB. These achievements are expected to continue, but as noted last year the level of savings cannot be expected to be as high as previously achieved. Further, there is increasing cost pressure on healthAlliance as a result of shareholder expectations, particularly in regard to information technology opportunities. While costs have been managed in this area over the last three years, an earlier external review highlighted the potential need for increased investment, relative to shareholders very high level of expectation. Further reviews of previous cost benefit analysis work will be done in this regard over the next six months. It is likely that investment will be necessary to maintain the momentum required by the provider arm as well as the very significant needs around the capture of primary care and community level information.

As this is seen as a critical area for both DHBs, it is essential that we maintain existing investment in this area and seek innovative ways of funding the necessary continuing strategic development of information technology as a key tool of the two shareholding DHBs.

It is very pleasing to confirm that all Auckland region DHB's are working very closely together to maximise benefits without Auckland DHB formally being part of healthAlliance. This is particularly the case with regional information technology development and payroll where all three metro-Auckland DHBs now each use the same payroll software and can thus share and learn from each others experiences.

Note: healthAlliance costs, which were previously incurred within the DHB as direct wage expense or non clinical costs, are classified as outsourced costs.

A particular risk for healthAlliance, which will directly impact on CMDHB, WDHB and ultimately all DHBs, is the potential position that will be taken by the Inland Revenue Department around the taxability of recruitment costs. This was highlighted in last years DAP, but given no legislative correction or clarification has occurred, remains a material exposure. CMDHB, given the international shortage of health professionals, is forced to recruit extensively overseas with associated recruitment and relocation costs. The position being taken by the Inland Revenue Department, if successful, could increase our employee-related recruitment costs by 64% relating to the "grossing up" of relocation costs. This is a material potential exposure for all DHBs and is the subject of a formal submission to IRD from CMDHB on behalf of the sector.

6.6 OUTLOOK FOR 2009/10 AND 2010/11 YEARS

The outer years of the DAP are significantly impacted by two key drivers:

1. The impact of the higher than funded wage settlements rolling out, with the cumulative level of underfunding increasing significantly in each year. This is driven by both the actual NZNO and SMO (ASMS) settlement and forecast settlements for greater than three years and at levels well in excess of funded or estimated FFT.

   It should be noted that CMDHB has applied different financial revenue drivers to the outer years than those indicated by MOH. As in previous DAP's the reason for this is that the demographic adjuster advised is a national average. With CMDHB at the "top end" of such growth, applying the national average significantly understates CMDHB's revenue requirements and if applied, would create "artificially" worsened deficits in the outer years.

   FFT has been maintained conservatively at 3.2% for outer years, while the demographic adjuster has also been maintained at the existing 1.9% pa growth level.

2. The above impact is partially offset by continuing improvement in efficiency achievements but more particularly full application of all available funding to minimise the forecast deficit. As noted in the earlier narrative, this may well have to be at the expense of increased investment in our Strategic Objectives or 'Action Areas'.

The DAP does NOT include the cash flow impact and initial operating expense impacts of the, as yet unapproved, Strategic Asset Business Case investment.

6.7 ACCOUNTING POLICIES

Reporting Entity
Counties Manukau District Health Board is a Crown entity in terms of the Public Finance Act 1989. The financial statements have been prepared in accordance with the requirements of NZ Public Health and Disability Act 2000 and the Public Finance Act 1989.

For the purposes of financial reporting the District Health Board is a public benefit entity.

Statement of Compliance
These financial statements have been prepared in accordance with New Zealand generally accepted accounting practice. They comply with New Zealand equivalents to IFRS (NZ IFRS) and other applicable Financial Reporting Standards, as appropriate for public benefit entities. These are the District Health Board 's first financial statements complying with NZ IFRS and NZ IFRS 1 has been applied. On 1 July 2007 the District Health Board adopted NZ equivalents to IFRS for the first time. This required retrospective application of all NZ IFRS to comparative information.

An explanation of how the transition to NZ IFRS has affected the reported financial position, financial performance, and cash flows of the District Health Board is provided in the accounting policies.

Accounting Policies
The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements and in preparing an NZ IFRS balance sheet as at 1 July 2006 for the purposes of the transition to NZ IFRS.

The measurement base applied is historical cost modified by the revaluation of certain assets and liabilities as identified in this statement of accounting policies.

The accrual basis of accounting has been used unless otherwise stated. These financial statements are presented in New Zealand dollars rounded to the nearest million.

Judgements and Estimations
The preparation of financial statements in conformity with NZ IFRS requires judgments, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future period if the revision affects both current and future periods.

Budget Figures
The budget figures were approved by the Board. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of the financial statements.

Goods and Services Tax
All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, then it is recognised as part of the related asset or expense.

Cash and Cash Equivalents
Cash and cash equivalents means cash balances on hand, held in bank accounts in which the District Health Board invests as part of its day to day cash management. This includes short term deposits held by the District Health Board that have maturities less than or equal to three months.

Intangible Assets
Computer software that is not integral to the operation of the hardware is recorded as an intangible asset and amortised on a straight line basis over a period of 3-5 years.

Taxation
Counties Manukau District Health Board is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 2004. Accordingly, no charge of income tax has been provided for.

Trust and Bequest Funds
Donations and bequests to Counties Manukau District Health Board are recognised as income when money is received, or entitlement to receive money is established. Expenditure subsequently incurred in respect of these funds treated as expenditure in the Statement of Financial Performance. Trust Funds without restrictions are included within Retained earnings.

Impairment
The District Health Board considers at each reporting date whether there is any indication that a non-financial asset may be impaired. If any such indication exists, the assets recoverable amount is estimated. Given that the future economic benefits of the District Health Board's assets are not directly related to the ability to generate net cash flows the value in use of these assets is measured on the basis of depreciated replacement cost.

At each balance date financial assets such as receivables are assessed for impairment. The recoverable amount is the present value of the estimated future cash flows.

An impairment loss is recognised in the statement of financial performance whenever the carrying amount of an asset exceeds the recoverable amount. Any reversal of impairment losses is also recognised in the statement of financial performance.

Inventories
Inventories classified as held for distribution are valued at the lower of cost and *current replacement* cost. The replacement cost of inventory sourced from overseas will be assessed to determine if there has been any impact due to changes in the exchange rate. Inventory will be assessed for impairment annually.

Property, Plant and Equipment
Fixed assets 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) vested in Counties Manukau District Health Board on 1 January 2001. Accordingly, assets were transferred to the Board at their net book value as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost, and accumulated depreciation amounts from the Hospital and Health Service. The vested assets have since been re-valued and will be depreciated over their remaining useful lives.

Revaluation of land and buildings
Land and buildings will be revalued every three years to the fair value as determined by an independent registered valuer by reference to the highest and best use. Assets for which no open market evidence exists are revalued on an Optimised Depreciation Replacement Cost basis. Additions between revaluations are recorded at cost. The results of revaluing land and buildings are
credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the Statement of Financial Performance.

The carrying amount of all property, plant and equipment are reviewed at least annually to determine if there is any indication of impairment. Where an assets recoverable amount is less than its carrying amount it will be reported at its recoverable amount and an impairment loss will be recognised. Losses resulting from impairment are reported in the statement of financial performance unless the asset is carried at a revalued amount in which case any impairment is treated as a revaluation decrease.

Disposal of fixed assets
When a fixed asset is disposed of, any gain or loss is recognised in the Statement of Financial Performance and is calculated as the difference between the sale price and the carrying value of the fixed asset.

Depreciation
Depreciation is provided on a straight-line basis on all fixed assets other than freehold land, at rates which will write off the cost of the assets to their estimated residual values over their useful lives. The useful lives of major classes of assets have been estimated as follows:

Buildings	
Structure/Envelope	10 – 80 years (1.7% - 10%)
Electrical services	10 – 15 years (4% - 6%)
Other services	15 – 25 years (4% - 10%)
Fit out	5 – 10 years (10% - 20%)
Plant	3-25 years (4%-33%)
Clinical Equipment	3-25 years (4%-33%)
Information Technology Equipment	3-5 years (20%-33%)
Motor Vehicles	4 years (25%)
Other Equipment	3-25 years (4%-33%)

Capital work in progress is not depreciated. The total cost of a project is transferred to buildings, building fit-out and/or plant and equipment on its completion and then depreciated.

Employee Entitlements
Provision is made in respect of Counties Manukau District Health Boards' liability for annual leave, long service leave, retirement leave, sick leave, medical education, sabbatical leave and conference leave. Annual leave, conference leave, sick leave and medical education have been calculated on an actual entitlement basis at current rates of pay.

Long service leave, retirement leave and sabbatical leave have all been valued on an actuarial basis.

Restructuring
A provision for restructuring is recognised when Counties Manukau District Health Board 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.

Leases
Finance Lease
Leases which effectively transfer to Counties Manukau District Health Board substantially all the risks and benefits incident to ownership of the leased asset are classified as finance leases. These are capitalised at the lower of the fair value of the asset or the present value of the minimum lease payments.

The leased assets and corresponding lease liabilities are recognised in the Statement of Financial Position. The leased assets are depreciated over the period the Board is expected to benefit from their use.

Operating leases
Leases where the Lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as expenses in the periods in which they are incurred.

Financial Instruments
Counties Manukau District Health Board is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short term deposits, debtors, creditors and loans. All financial instruments are recognised in the Statement of Financial Position and all revenues and expenses in relation to financial instruments are recognised in the Statement of Financial Performance. Except for loans, which are recorded at cost, and those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which Counties Manukau District Health Board invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of Counties Manukau District Health Board and records the cash payments made for the supply of goods and services.
Investing activities are those activities relating to the acquisition and disposal of non-current assets.
Financial activities comprise the change in equity and debt capital structure.

Change in Accounting Policies
Accounting policies are changed only if the change is required by a standard or interpretation or otherwise provides more reliable and more relevant information.

Counties Manukau District Health Board did not change its accounting policies since the date of the last audited financial statements prepared under NZ GAAP other than the impact of adoption of NZ IFRS (see note below) . All policies have been applied on a consistent basis with the pervious year.

Comparatives
When presentation or classification of items in the financial statements is amended or accounting policies are changed voluntarily comparative figures are restated to ensure consistency with the current period unless it is impracticable to do so.

Impact of adoption of NZ IFRS
On 1 July 2007 the District Health Board adopted NZ equivalents to IFRS for the first time. This requires retrospective application of all NZ IFRS to comparative information.

The changes arising from the adoption of NZ IFRS are as follows:

Reconciliation of taxpayers funds

The following table shows the changes in equity resulting from the transition from previous NZ GAAP to NZIFRS as at 30 June 2006 and 1 July 2007:

Asset balance	Note	Previous NZ GAAP 1 July 2006	Effect on Transition to NZ IFRS 1 July 2007	NZ IFRS 1 July 2007
		$000	***$000***	***$000***
Sick Leave	Introduction under NZIFRS	nil	190	190
ACC future claims	Introduction under NZIFRS	Nil	365	365
Interest Swap	Introduction under NZIFRS	Nil	Nil	Nil
HealthAlliance	NZIFRS change	Nil	352	352
Long Service leave	Adjustment due to NZIFRS	2,388	1,376	3,718
Retirement	Adjustment due to NZIFRS		(770)	(770)
CME	Adjustment due to NZIFRS	44,516	1,744	1,744
Total taxpayers funds			(3,257)	(3,257)

6.8 DISPOSAL OF LAND

Counties Manukau DHB will seek the consent of the Minister of Health before disposing of surplus assets. Consultation with the shareholding ministers will be undertaken and consent obtained prior to any disposal as required by the NZ Public Health and Disability Act.

Part 7 JARGON & ACRONYMS

Acronyms	Description
ACC	Accident Compensation Corporation
ADHB	Auckland District Health Board
AL	Annual Leave
ALOS	Average Length of Stay
AOD	Alcohol and Other Drug
ASH	Ambulatory Sensitive Hospital Admissions
AUT	Auckland University Technology
BSA	Breast Screening Aotearoa
BSI	Blood Stream Infections
CAG	Clinical Advisory Group
CCM	Chronic Care Management
*CFA	Crown Funding Agency (future debt funder)
CHF	Congestive Heart Failure
CIU	Cardiac Investigation Unit
CLS	Community Living Skills
CMDHB	Counties Manukau District Health Board
CME	Continuing Medical Education
COPD	Chronic Obstructive Pulmonary Disease
CPHAC	Community and Primary Health Advisory Committee
CQI	Clinical Quality Improvement
CTA	Clinical Training Agency
CVD	Cardio Vascular Disease
CWD	Case Weighted Discharges
CYFH	Children, Young People and Family Health Services
DAP	District Annual Plan
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DiSAC	Disability Support Advisory Committee
DNA	Did Not Attend
DOSA	Day of Surgery Admission
DRGs	Diagnostic Related Groups
DSP	District Strategic Plan
DSS	Disability Support Services
ECLAOP	Emergency Care Local Anaesthetic Operative Procedure
EMT	Executive Management Team
ESPI	Elective Service Performance Indicator
FAMA	Frequent Adult Medical Admissions
FMP	Facilities Modernisation Project
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full-time equivalent (Employees)
GAAP	Generally Accepted Accounting Principles
GL	General Ledger
GP	General Practitioner

Acronyms	Description
hA	healthAlliance
HBI	Hospital Benchmark Information
HNA	Health Needs Analysis
HOP	Health of Older People
HR	Human Resources
HSP	Health Services Plan
ICU	Intensive Care Unit
IDF	Inter District Flows
IDP	Indicator of DHB Performance
IFRS	International Financial Reporting Standards
IS	Information Systems or Services
ISSP	Information Services Strategic Plan
IT	Information Technology
KF	Kidz First
KPIs	Key Performance Indicators
LOS	Length of Stay
MACS	Medicine, Acute Care and Clinical Support Services
MAPO	Maaori Advisory Purchasing Organisation
MECA	Multi Employment Collective Agreement
MeNZB	Meningococcal B Vaccine New Zealand
MHAC	Maaori Health Advisory Committee
MHINC	Mental Health Information National Collection
MIT	Manukau Institute Technology
MMH	Middlemore Hospital
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSC	Manukau Surgical Centre
MVS	Meningococcal Vaccine Strategy
NASC	Needs Assessment and Service Co-ordination
NCTN	Northern Clinical Training Network
NDSA	Northern DHB Support Agency (DHB Shared Services)
NGO	Non-Governmental Organisation
NHI	National Health Index
NICU	Neonatal Intensive Care Unit
NIR	National Immunisation Register
NMDS	National Minimum Data Set
NNU	Neonatal Unit
NZIER	New Zealand Institute of Economic Research
NZIFRS	New Zealand International Financial Reporting Standards
P&L	Profit and Loss
PAH	Potentially Avoidable Hospital Admissions
PAM	Performance, Assessment and Management
PCD	Primary Care Development
PHAC	Pacific Health Advisory Committee
PHO	Primary Health Organisations
POAC	Primary Options to Acute Care
RC	Responsibility Centre

Acronyms	Description
RISSP	Regional Information Services Strategic Plan
SAC	Surgical and Ambulatory Care Services
SIA	Services to Improved Access
SLA	Service Level Agreement
TBC	To Be Confirmed
TLA	Territorial Local Authority
TPU	Teen Parent Unit
WDHB	Waitemata District Health Board
WIES	Weighted Inlier Equivalent Separation = Weighted Relative Value Purchasing Unit for medical and surgical Inpatient services
YJN	Youth Justice North
YTD	Year to Date