COUNTIES MANUKAU DISTRICT HEALTH BOARD

A Community Partnership

Statement of Intent

2012/13 – 2014/15

FINAL – September 2012

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SIGNATORIES –CHAIR / BOARD

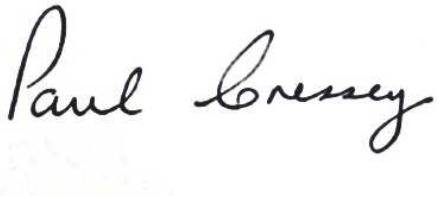
This Statement of Intent has been prepared by Counties Manukau District Health Board (DHB) to meet the requirements of Section 39 of the New Zealand Public Health and Disability Act, 2000 and Section 139 (1) of the Crown Entities Act, 2004.

This document is intended to outline for Parliament and the general public the performance that will be delivered during 2012/13 by Counties Manukau DHB and contains non-financial and financial forecast information for the 2012/13 and 2013/14 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 Northern Region Health Plan 2012.

ISSUED BY
Counties Manukau District Health Board

SIGNED BY

Professor Gregor Coster
Chair of Counties Manukau DHB



Paul Cressey
Counties Manukau DHB Board Member

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Foreword/ Executive summary

2012/13 represents the first year of a four year whole of health system transformation journey for Counties Manukau DHB.

Our objective is to transform the health system in Counties Manukau so it can deliver the better, sooner, more convenient services our growing population deserve. The strategy to deliver this is called "**Achieving a Balance: delivering sustainability and excellence in health".**

Our four year journey aims to make a reality the integration of healthcare in our district as we build upon the work that we have been doing in the last few years - at the regional level with our Northern Region DHB partners, within our own organisation, and with our primary care partners - in developing a common vision for lifting the health outcomes of our population.

The gains we have made through better regional services planning have translated into improved quality and safer hospital services, contributing to our improved hospital productivity; and the alliances and relationships we have with our primary care partners are better than ever through the work we have been doing via our localities development and locality clinical networks. All these improvements have put us in a strong position to work together as a whole system leading into the challenges of the coming financial year.

We have worked closely with our local primary care networks and the Ministry of Health in the development of this 2012/13 plan and we will continue to work with them to deliver better services by building a high performing, diverse but integrated health system, and to consolidate and improve on our delivery of health targets in the coming year. These are outlined throughout the plan.

Our first steps to make this happen this will take place in 2012/ 13 as we mark a shift toward closer integration between the hospital, primary care and community services. The intention is that primary care will play a key role as the building block upon which integrated care will drive improved management of unplanned and urgent care, long term conditions and wrap around services for older people.

We want to now progress our transformation at a more rapid pace and to that end the strategic direction we will take over the next four years will aim to balance the Triple Aim objectives of population health, patient experience and value-for-money via six key strategies which collectively aim to:

- **Keep our population well**,
- **Treat people and their families well when they are sick**, and
- **Deliver healthcare services which are affordable and of good value.**

Module 2 of this Annual Plan sets out our vision for how we will deliver to these three goals via our **Achieving a Balance** work programme.

In 2012/13 we will aim to deliver the following:

- **An Annual Plan which will target a financial breakeven in 2012/13**: This will be a challenging goal for us and will necessitate the implementation of a robust programme of cost savings but we remain confident of their achievability based on the assumptions within this document remaining true. The Plan will also demonstrate how we will maintain and improve further our performance in all key areas.

- **Continued commitment to collaborate with our regional counterparts** to implement the 2012/13 Northern Region Health Plan and Better, Sooner, More Convenient business cases to deliver the three regional goals of *First, Do No Harm*, *Life and Years* and *The Informed Patient.*

- **Better, Sooner, More Convenient integrated care** delivered through our four localities: Mangere-Otara, Eastern, Manukau and Franklin. This is a central piece of work for us and will involve a huge shift in the collective mindset of the health and social services sector to work together and reconfigure how we deliver health and social services which are better coordinated and easier for our population to navigate. Kickstarting this will be an initial investment of approximately $10m in 2012/13 to shift the balance of care from hospital to primary and community settings.

  This will be done through investment in:

  - The implementation of locality clinical partnerships (see *Section 3.2.6, page 51 of the Annual Plan)*)
  - Our BSMC business case partnerships to achieve regionally consistent clinical pathways and management for long term conditions like Diabetes, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Gout, Cellulitis (see *Sections 3.2.5, 3.2.6 of the Annual Plan*)
  - The development of integrated family health care/ Whanau Ora centres, which will culminate in six centres in various localities within the district by June 2014 (see *Section 3.2.6, page 51 of the Annual Plan*),
  - initiatives targeted at improving integration between primary and secondary care to improve our response to acute events in community settings, like our 20,000 Days campaign (see *Appendix 1* and *Module 3, Section 3.2 of the Annual Plan*); and
  - other demand management initiatives which will lead to better management of long term conditions and the challenges which present with an ageing population (see *Section 3.2.7 of the Annual Plan*) and accelerating demand.

We approach the coming year with a sense of urgency and focus but we are also excited at the opportunities and the prospect of a much stronger, better integrated, patient and family-centred, sustainable health system which awaits us at the end of this.

Professor Gregor Coster
Chair, Counties Manukau DHB

Geraint A. Martin
Chief Executive Officer, Counties Manukau DHB

Module 1: Context

1.1 BACKGROUND AND OPERATING ENVIRONMENT

Overarching system context

This section describes those environmental factors that have influenced this District Annual Plan. The key messages are:

- Although **what** we do has not changed, **how** we work is influenced increasingly by **regional and national** directions;
- To be relevant to our local population we must implement **locality focused** approaches to better join up our primary and secondary services;
- The health and disability needs of our population is **growing faster** than we can build and/or fund capacity to provide;
- **Clinical and service integration** through Better, Sooner, More Convenient and Locality Partnerships will bring about the service change required to efficiently and effectively deploy our resources to meet those needs.

Our statutory responsibility to improve our District's population health has not changed

Counties Manukau District Health Board (DHB) is a Crown Owned Entity, one of twenty[1] District Health Boards established on 1 January 2001 under Section 19 of the New Zealand Public Health and Disability Act 2000 to plan and fund the provision of personal health, public health and disability support services for the improvement of the health of the population. Working with the funding allocated by Government, Counties Manukau DHB is required under legislation to:

- collaborate with other DHBs, service providers, the community, and other stakeholders to plan and coordinate at local, regional and national levels for the most effective and efficient delivery of health services for the improvement, promotion and protection of health of the population;
- fund the provision of most health and disability services provided in Counties Manukau through service contracts with health and disability providers and non-governmental organisations;
- provide hospital based services for the population of Counties Manukau and some access to specialist or highly complex services for people referred from other DHBs;
- support and foster Maaori participation in the development of strategies for Maaori health improvement and the wider health and disability sector;

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

- assess and monitor the health status of the Counties Manukau population, any factors that may adversely affect the health status of the population and the needs of that population for services;
- promote, protect and improve the health of the Counties Manukau population through co-operation and collaboration with the health and disability sector and other sectors and the provision of health promotion, health education and evidence-based public health initiatives.

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

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

We receive 4.68% of new Vote: Health to plan and fund local services

In the 2012/13 year, CMDHB will receive approximately 4.68% or $52.4 million of the additional total Vote Health funding allocated to DHBs. In the 2012/13 year CMDHB will receive gross $1.3billion to meet our service and population health objectives. The level of funding for each DHB is determined by using a population based funding formula (PBFF) based on the size of the population living within the DHB's geographical boundaries and demographic and socio economic characteristics of that population.

The Board's role is to ensure that CMDHB fulfils its statutory functions in the use of those public resources

CMDHB is governed by eleven Board members of which seven Board members are elected by the community and four appointed by the Minister of Health. The CMDHB Board assumes the governance role and is responsible to the Minister of Health for the overall performance and management of the DHB.

Three statutory advisory committees and five non-statutory committees have been established to help the Board meet its responsibilities. Membership of these committees is a mix of Board members and community representatives including Maaori, Pacific, mana whenua and clinicians.

Whilst the Board is responsible for the DHB's overall performance, operational and management matters are assigned to the Chief Executive. The Chief Executive of CMDHB is Geraint Martin.

Although we are locally responsible, we are influenced by regional and national directions

While we are responsible for our district population, this plan reflects and is influenced by priorities set nationally and regionally. The national directions reflected in this plan comprise:

- The Minister's Letter of Expectations including Health Targets, expected improvements in access to services and implementation of *Better, Sooner, More Convenient* business case implementation;
- The Ministry's Statement of Intent and national translation of Government's service coverage and access expectations through our Crown Funding Agreement, Service Coverage and Operating Policy Framework statements;
- Our Maori Health Plan;
- National service strategies that are current e.g. Ala Mo'ui - Pacific Pathways to Health;
- Developments agreed with National Health IT Board, Health Workforce New Zealand;
- Realising the benefits of nationally shared services through Health Benefits Limited and healthAlliance NZ Limited.

We are in the second year of formal regional planning. The priorities we have agreed regionally that will be reflected in this plan are outlined in the Northern Region Health Plan. This year is the second year that we have planned regionally and continue the initiatives we progressed collectively in 2011/12 – *First, Do No Harm*, *Life and Years*, *the Informed Patient* as well as national health targets – will continue this year.

We are committed to the government's shared services agenda to help the health sector save money by reducing administrative, support and procurement costs for DHBs. Using a commercial model, Health Benefits Limited (HBL) works for all DHBs, to reduce the cost of shared services, as well as leading initiatives that make savings. Savings will be reinvested in clinical areas.

We support this national work and several work streams are underway via healthAlliance NZ Limited, our regional shared services organisation. These build sustainable national health services by:

- reducing costs
- achieving operational efficiencies in administration, procurement and support services
- sharing good practice in administration, procurement and support services

Section 3.2.15, Living Within Our Means, in Module 3, outlines HBL/ healthAlliance NZ Limited shared services planning activity.

1.2 HEALTH PROFILE OF COUNTIES MANUKAU POPULATIONS

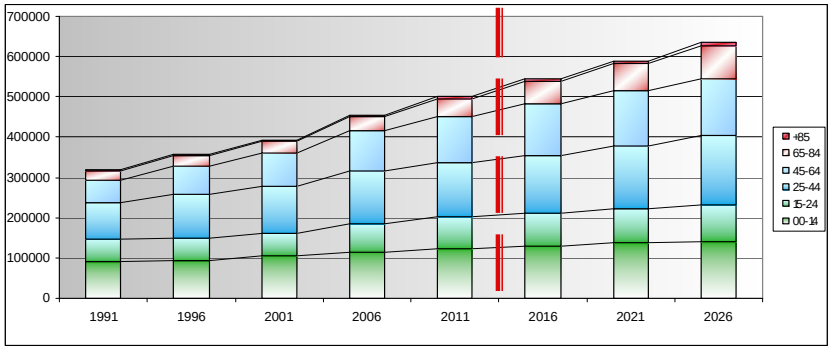
The following sections highlight the key population health features of CMDHB that drive the use of, planning for and delivery of our services. This Annual Plan should be read in line with the CMDHB "*Residential Health and Locality Profiles for CMDHB's population*" published October 2011 (www.cmdhb.org.nz/About_CMDHB/Planning/Health-Status/Health-Status.htm), and the "Northern Region Health Plan 2012/13".

Counties Manukau people are ethnically diverse, young, growing and aging fast.

Counties Manukau DHB provides health services to an estimated 500,800 people, covering a total area of 55,200 hectares that includes parts of the local authorities of Auckland, Waikato District and Hauraki District. The composition of the Counties Manukau population is diverse:

- 17% of our population identify as Maaori. This is 12% of New Zealand's total Maaori population
- 22% of our population identify as Pacific. This is 39% of New Zealand's total Pacific population
- 20% of our population identify as Asian. The term 'Asian' in this context refers to people of ethnic Pakistani and Indian origin, through to Southeast Asia and East Asia, including the Philippines, Indonesia and Japan
- 25% of Counties Manukau's population are aged 14 years and younger. 13% of New Zealand's child population lives in Counties Manukau
- The population aged over-65 in Counties Manukau is projected to more than double from 33,800 in 2001 (48,860 currently in 2011) to 74,710 by 2021. It is this group who will place the highest demands on health services in the years to come.

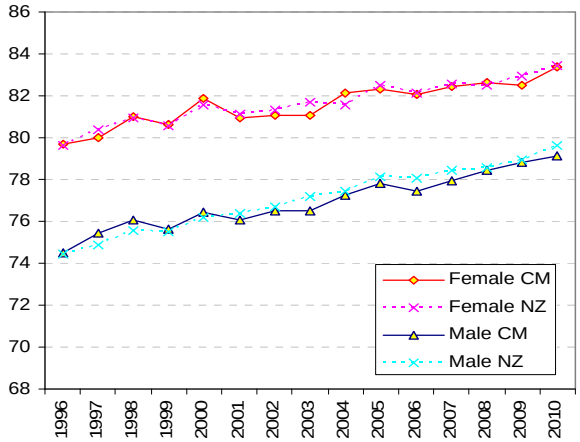
Figure 1: Counties Manukau DHB's population age structure: 1991 to 2016



But the benefits are not shared evenly among our populations ….

Overall, life expectancy (2008-2010 average) at birth in Counties Manukau is similar to that of the New Zealand average at 81 years. In 2010, life expectancy was 83 years for females and 79 years for males.

Figure 2: CMDHB versus New Zealand: Life expectancy at birth by gender, 1996 to 2010



Source: Jackson, G. & Papa, D. (2011) Life Expectancy Update for 2010 for Counties Manukau.

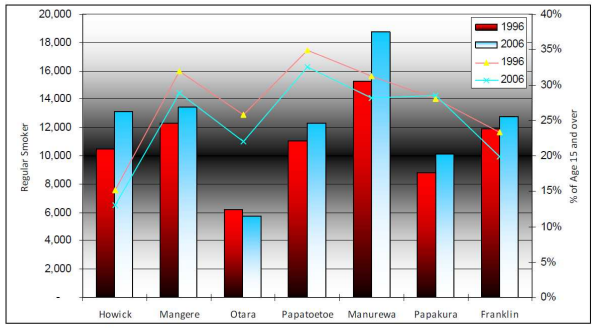
Despite improvement, life expectancy gap between Maaori and non-Maaori and non-Pacific population remains in excess of 10 years while the gap between Pacific and non-Maaori and non-Pacific is 5 to 7 years.

34% of residents live in areas that are very deprived (based on the NZ Deprivation Index). 57% of Maaori, 73% of Pacific and 43% of 0-14 year olds in Counties Manukau live in decile 9 or 10 areas (most deprived areas). High socio economic deprivation is prevalent in the Otara, Mangere and Manurewa areas. According to the 2006 census, 6% of households in Counties Manukau have at least one resident receiving an unemployment benefit. A further 28% of adults in Counties Manukau had no educational qualifications.

The high proportion of the Counties Manukau population living in deprivation has a significant impact on health and health service provision. For example, Counties Manukau has a high rate of illness related to overcrowded housing such as rheumatic fever. Maaori and Pacific residents of Counties Manukau DHB have relatively higher rates of hospitalisation that the NZ average while Asian and Europeans have a lower rate than the NZ average.

There are risk factors we can influence ……

Figure 3: Number of smokers per locality in Counties Manukau, in comparison to the rate, 1996 to 2006



Source: CMDHB Health Needs Assessment, 2008

Tobacco Control: Tobacco smoking continues to be a leading cause of preventable morbidity and mortality in New Zealand. The proportion of the adult population in Counties Manukau using tobacco had decreased slightly from 25% in 1996 to 22% in 2006. However, this rate is still higher than the New Zealand average. Furthermore, due to population growth, there has been an overall increase in the number of people who smoke of 9,000.

Smoking rates are higher amongst Maaori and Pacific people in comparison with other ethnicities.

Obesity: In 2006/07, 34% of Counties Manukau adults were identified as being overweight and 33% were obese (very overweight). 12.7% of children aged 5 – 14 years were obese. Obesity prevalence varies across ethnicities, with an estimated 76% of Pacific adults, 50% of Maaori adults and 15% of Asian adults classified as obese. Thus there are potentially 124,000 obese adults in Counties Manukau. These figures are concerning, as obesity is the main preventable cause for illnesses such as Type 2 diabetes. It is also a precursor of heart disease, stroke, certain cancers and arthritis.

Our children should be healthier and safer

The rate of child hospitalisations for medical conditions in Counties Manukau is higher than the NZ average. In 2010/11, there were a total of 14,744 avoidable hospital admissions for Counties Manukau children aged 0 – 14. According to MOH data, 1,856 of these admissions were for 0-4 year olds. The leading causes of these hospitalisations were asthma, dental conditions, cellulitis and respiratory infections (pneumonia).

Living conditions have an identified impact on child health. As of 2006, 30.3% of children and young people lived in crowded households, which is directly correlated to infectious diseases such as rheumatic fever. Counties Manukau has a rheumatic fever rate of 0.5 per 100,000 which is higher than the New Zealand average of 0.19 per 100,000. Cellulitis is another concern attributable to overcrowding. In 2010/11, there were 400 avoidable admissions for 0-4 year olds caused by cellulitis.

Sudden Unexpected Death in Infancy (SUDI) rates in Counties Manukau are high, with 84 infant deaths between 2000 and 2007. SUDI is significantly higher amongst Maaori and those in more deprived areas. There is an identified causal relationship between household smoking and the risk of SUDI, which is independent of the effects of maternal smoking during pregnancy.

Diabetes among other conditions contribute significantly to lives and quality of life lost …

In Counties Manukau, over 40,000 people are known to have CVD and / or diabetes, which accounts for 13% of the adult population, as of 2008. Maaori have the highest age standardised prevalence rate for CVD, compared to other ethnic groups, with males at 9% and females at 8%. CVD is one of the largest differences in mortality across the region.

For the four year period from 2005 – 2008, Counties Manukau had an annual mortality rate of 660 per 100,000 (approximately 2,250 deaths / year). Of these, an estimated 50% (4,485) of deaths were premature (occurring in those under 75 years of age). Of these, 49% (2,180) were amenable to preventative or treatment services (indicating that prior treatment would have improved health outcomes).

The leading causes of avoidable mortality for CMDHB were identified as ischaemic heart disease, lung cancer, suicide and self inflicted injury.

Health conditions and population demographics translate into higher demand for services

Acute demand growth: A large proportion of medical admissions are driven by self referrals to the Emergency Department, and this remains a challenge to the DHB. Closer work between primary and secondary care to reduce demand through greater use of integrated programmes which address unplanned and urgent care, long term conditions and services for supporting older people post hospital discharge are planned for 2012/13.

Health of Older People: Older people have complex and interacting needs and require a wide range of care services, from acute hospital care to longer-term rest home care and simple but essential home based care. Given the projected population growth in the 65+ age group, CMDHB will experience a higher demand for these age-related care services. For example, the current annual incidence of new cases of dementia is 989 people, leading to an overall prevalence of 2920 cases. By 2026, this number is expected to almost double (5723 cases). Because of the rapid increase in the numbers of those who are considered ‘very old’ (who have high rates of dementia), the rate of dementia will actually increase faster than the population growth of the 65+ age group.

Demand for services is evident in the community, where every month there are approximately 160 new referrals to 'Needs Assessment and Service Co-ordination' (NASC). Within NASC, 30% of clients are aged 85 years and older. Of all 'Health of Older People' clients, 29% are in residential care, which utilises 85% of total funding.

As a result of these increases in demand, it is projected that if the significant changes in models of care as proposed by CMDHB are not successfully implemented, inpatient bed numbers will grow from approximately 950 to 1,500 in 2020 and outpatient attendances will grow from approximately 200,000 to 300,000 in 2020.

Within our district, there are local differences…

The DHB is currently developing a Localities Strategy for meeting our population's health needs at the local level whilst delivering healthcare which is more accessible, timely and better coordinated. *Section 1.2.1 has more information on what the locality approach looks like for Counties Manukau DHB.*

From 2012/13, the DHB's geographical area will be divided into four 'enrolled population service localities': Mangere/Otara (including northern Papatoetoe), Eastern (Howick plus the Maraetai/ Beachlands and Clevedon), Manukau (Manurewa, Papakura and the majority of Papatoetoe) and Franklin.

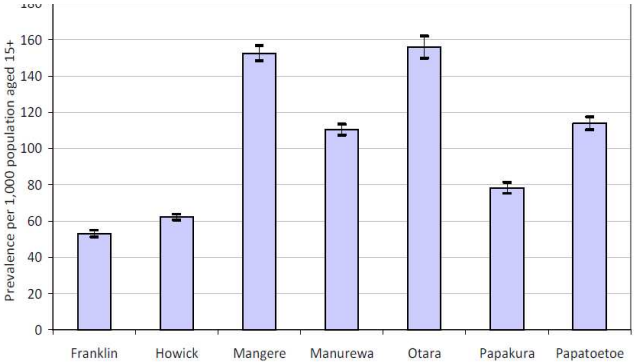
Each locality is diverse in terms of its population make-up.

- Manurewa and Howick are estimated to have the largest *number* of children of all the areas in CMDHB;
- Otara, Mangere and Manurewa have the highest *percentages* of children in their populations, but even the areas with lower child percentages are above the New Zealand average of 20% (with the exception of Howick);
- Howick has the highest number and percentage of adults aged 15-64 years and is the only area to exceed the CMDHB average of 66%. Papatoetoe and Franklin also reach the average;
- One third of the CMDHB population aged ≥ 65 years reside in Howick;
- Howick and Franklin have the highest percentages of residents aged ≥ 65 years – approaching the New Zealand average of 13%;
- Howick's population is expected to increase by approximately 67,000 residents by 2026, driven by development in the Flat Bush area;
- Larger growth expected in established areas such as Papatoetoe by 2026 will be driven by higher density housing.

There are also differences in health indicators across localities

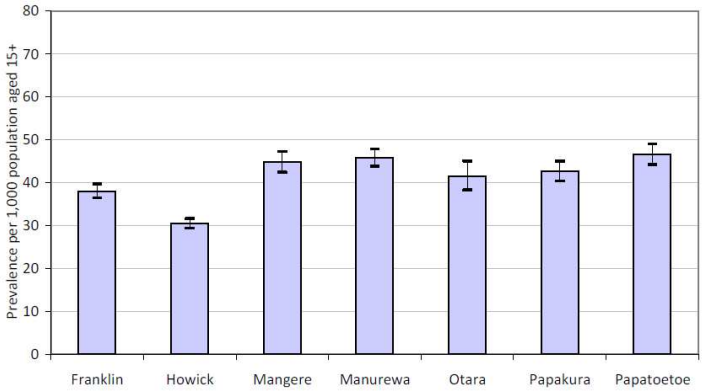
The following figures display the prevalence of disease in CMDHB by residential locality.

Figure 4: Prevalence of diabetes in CMDHB by locality, 2009



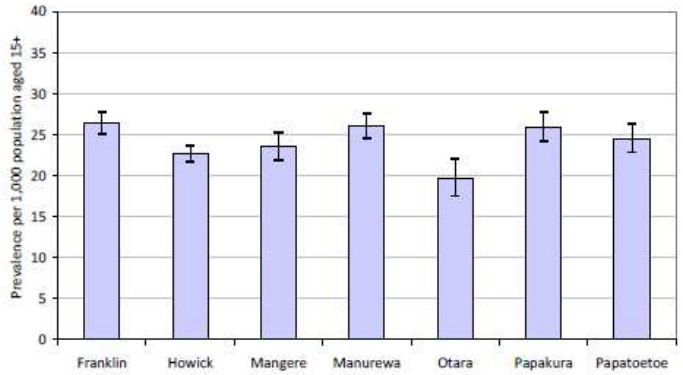
*Error bars indicate 95% confidence intervals
Sources: Ministry of Health National Collections (NMDS, Pharms, Labs, NNPAC), analysed by CMDHB

Figure 5: Prevalence of CHD in CMDHB by locality, 2009



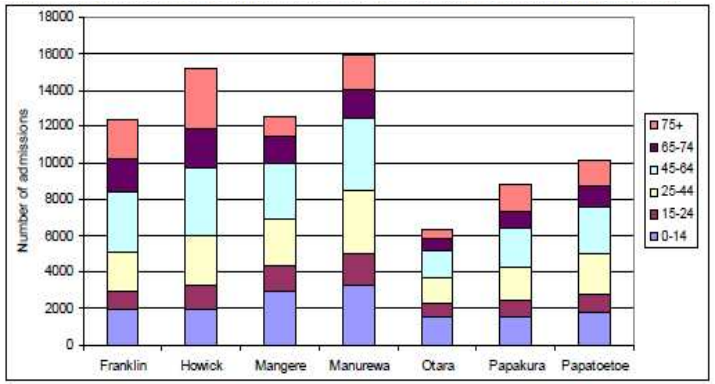
*Error bars indicate 95% confidence intervals
Sources: Ministry of Health National Collections (NMDS, Pharms), analysed by CMDHB

Figure 6: Prevalence of cancer in CMDHB by locality, 2009



*Error bars indicate 95% confidence intervals
Sources: Ministry of Health National Collections (NMDS, Pharms, NNPAC)

Figure 7: CMDHB medical-surgical-emergency care hospitalisations by age, locality, 2010 2009



Source: Ministry of Health, NMDS, analysed by CMDHB

Our most challenging risk is that the rate of demand grows faster than we can build capability and capacity to meet those needs …

The implications of the operating environment described above are the following risks:

- The health service demands from a rapidly ageing, socioeconomically deprived population and rapid migration is growing at a rate faster than we can build infrastructure or grow workforce;
- Government will continue to face fiscal constraints. This is, that the ability to flexibly apply funding allocations to reflect population need is constrained by the ability of other DHBs with declining populations to live within their means;
- Better, sooner and more convenient services need to be tailored to the needs of local communities. That is, some parts of our local communities face different challenges.

There are opportunities…

These risks offer significant opportunity to:

- Work better with our regional and national colleagues to realise the efficiency benefits of shared services, joint procurement and ensure consistency is applied where it can be safer for patients. This will help us shift more resources to front line clinicians and services rather than supporting multiple back or corporate service functions;
- Further tailor *Better, Sooner, More Convenient* business case priorities and primary care developments to more sharply respond to locality needs that involve clinical and community partnerships;
- Look for opportunities with private and other public sector partners to be involved in how we shape and build infrastructure (e.g. capital investment, workforce development and service provision).

1.2.1 Nature and scope of functions/ intended operations

We are trying to achieve a balance between delivering excellent healthcare whilst being sustainable…

In 2011, we committed to a four year journey of health system integration that aims to **Achieve a Balance** between healthcare excellence and sustainability. We do this through six executable strategies that aim to:

- Keep people well through improved population health and ensuring that we achieve **(1) Better Health Outcomes for All** people in our district. This means that all populations in Counties Manukau can and should expect the same level of access and health improvement regardless of socio economic deprivation and ethnicity;
- When people become sick or unwell, we ensure that they 'receive the right care, at the right time and place, by the right person', by **(2) First, Do No Harm** when they enter our system for care AND improve their experience through **(3) Patient and Whaanau Centre Care** models and approaches.
- We want to ensure our system is affordable and aim to achieve this through establishing **(4) Whole of System Commissioning** approaches, ensuring we are **(5) Financially Sustainable** while **(6) Building Organisation Capacity and Capability** to continue to improve.

Whilst our core function in planning, funding and provision of health services continue[2], 2012/13 marks a shift toward provision of integrated care between the hospital, primary care and community services, with the intention that primary care will play a key role as the building block and has increased accountability for health system outcomes.

Form follows function… Better. Sooner. More Convenient services will be achieved through integration

The Government's desire for *Better, Sooner, More Convenient* services will, in Counties Manukau DHB, be achieved through better clinical and service integration in our District. This means that integration as "…*an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs*." [3] must be enabled through more flexible provider and funding arrangements.

The DHB implemented an organisational structure based on five functions that will achieve:

- ***Clinical Leadership Team****:* we have a clinical leadership team comprising of our most senior primary and hospital clinicians and health professional leaders including Chief Medical Officer, Director of Nursing, Director of Allied Health, Chief Medical Advisor Primary and Community, Chief Nursing Advisor, Primary and Community all as part of Executive Leadership Team;
- ***Health System Integration and Operations:*** Directorates for Hospital and Primary/Community Services are responsible for ensuring the provision of hospital, primary and community services and their alignment to local needs;
- ***Innovation:*** Ko Awatea as our centre of excellence for bringing the best of international and national improvement methods and techniques locally to ensure we continue improving services;
- ***Planning, Organisation Development and Change****:* Strategic Development Directorate is responsible for the alignment of our local strategic directions with regional and national planning. With Ko Awatea are responsible for ensuring that we are continuously building capacity to change and adapt; and
- ***Corporate and Business Services****:* Directorate for Corporate Services (e.g. finance, commercial and business services, facility management) are responsible for ensuring we have the infrastructure in place to support provision.

Local clinical partnership will enable Better Sooner More Convenient implementation within localities

Counties Manukau plans to enable more rapid implementation of *Better, Sooner, More Convenient* business cases for integrated primary and community based services through locality clinical partnerships (LCP). There are two planning and funding perspectives that Counties Manukau aim to integrate:

- The contributions of providers – primarily general practice and primary care based NGOs who work in the Counties area; and
- The needs of localities who require services targeted specifically at their local area.

[2] Please follow this link on our website for the list of services funded by our DHB and the hospital and specialist services we provide: ***http://www.cmdhb.org.nz/Funded-Services/default.htm***

[3] Goodwin, N, Smith J, Davies A, Perry C, Rosen R, Dixon A, Dixon J, Ham C (2011) *Integrated care for patients and populations: Improving outcomes by working together*. A report to the Department of Health and the NHB Future Forum. London: The Kings Fund, Nuffield Trust

Each BSMC Business Case has an Alliance Leadership Team (ALT) with both DHB and primary care clinical engagement who agree the nature of services and priorities for their enrolled populations. 2012/13 sees the continuation of an agreed implementation plan based on the original business cases agreed in 2009. The ALTs are formed based on the **provider groupings** who make up the business cases – the three that operate in the Counties Manukau district are National Hauora Coalition, Alliance Health+ and Greater Auckland Integration Health Network (GAIHN).

At this time, those provider groupings are primarily those contracted under PHO and related agreements. It is likely that, over the 2012/13 year, other providers and services will join those groups.

Parallel to primary service integration, in 2012/13, Locality Clinical Partnerships will be established in the four locality areas of enrolled populations to work collaboratively with ALTs from a **locality health need perspective** to design, plan and ensure resources are allocated to meet local health needs. LCPs include hospital and primary clinicians governing the assessment of health needs, agreement on priorities based on health need and where service developments need to be targeted. As described above, Franklin, Manukau, East (Howick) and Mangere/Otara have different population demographics and different needs. We will be working with our PHOs to use risk stratification tools like the Patients at Risk of Re-hospitalisation (PARR) tool[4] and the GAIHN predictive risk planning tool to achieve better management and identification of high risk individuals in primary care settings. This will enable more coordinated care for people with long term conditions and targeted utilisation of funding.

ALTs and LCPs will provide the implementation levers for district wide campaigns such as "*Saving 20,000 Days"* that aim to reduce acute demand through early intervention and prevention programmes and potential for *"Whanau Ora"* to be integrated into health service provision. It is through these groups, that Counties Manukau DHB will realise the Government's desire for DHBs to push as much clinical decision making to local clinical and service partnerships rather than centralised in the DHB.

We will have to plan, fund and provide differently…. but the Crown is still owner of our key assets

In this new integrated care environment, the DHB will need to work differently:

- Our core responsibility for district planning will be based on the service and health need priorities identified through ALTs and LCPs in future;
- Our funding and commissioning responsibilities will be led by the resource allocation priorities identified by ALTs and LCPs in future;
- The role of the DHB as Provider will integrate more closely with primary and community based services.

The DHB will strengthen its capacity to monitor the above networks for impact on health outcomes and performance manage where service coverage and access fall below expectations. The DHB also retains ownership over assets as agent of the Crown.

[4] We have been running the Patients at Risk of Re-hospitalisations (PARR) tool over CMDHB events for our enrolled population using information from PHO registers since Novermber 2011. As a part of our Chronic Care Management (CCM) programme re-design, we will work with PHOs in 2012/13 to implement a practice based risk stratification model, define and identify clinically high risk patients with a view to improving diabetes management.

Module 2: Strategic Direction

2.1 OUR STRATEGIC DIRECTION

2.1.1 Our vision and values

Our vision

CMDHB's 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 achieve this by:

- leading the development of an improved system of healthcare that is more accessible and better integrated
- We will dedicate ourselves to serving our patients and communities by ensuring the delivery of both quality focused and cost effective healthcare, at the right place, right time and right setting
- Counties Manukau DHB will be a leader in the delivery of successful secondary and tertiary health care, and supporting primary and community care.

Our strategic goal ….

In realising our vision, our strategic goal is to be **the best healthcare system in Australasia by December 2015**.

CMDHB is committed to honouring our Treaty obligations as an agent of the Crown

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

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

In the 2012/13 year, CMDHB will reset our approach to engagement with Maaori that is fit for purpose for an integrated healthcare system. This means that the operational delivery of the organisation will focus on how we are achieving and continuously improving outcomes for Maaori in a demonstrable way. The DHB continues to develop its relationship with manawhenua and Maaori who live in this District. Our Maaori HealthPlan

Our values ….

Our values are:

- Care and Respect - Treating people with respect and dignity: valuing individual and cultural differences and diversity
- Teamwork - Achieving success by working together and valuing each other's skills and contributions

- Professionalism - Acting with integrity and embracing the highest ethical standards
- Innovation - Constantly seeking and striving for new ideas and solutions
- Responsibility - Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions
- Partnership - Working alongside and encouraging others in health and related sectors to ensure a common focus on, and strategies for achieving health gain and independence for our population

2.1.2 Strategic outcomes in national, regional and local context

The national service priorities we will implement this year…

The national service priorities indicated in the Minister's Letter of Expectations (e.g. Health Targets, improved access to diagnostics and child and youth access to drug and alcohol treatment will be implemented locally). Some of these improvements will be realised through regional working (e.g. cancer) but will be supported by implementation teams within the district.

A work programme to develop National Services and National Service Improvement programmes was introduced by the National Health Board in 2010 aimed at improving equity of access, quality, consistency and sustainability for vulnerable services, particularly high cost low volume specialist services for example, paediatric and congenital cardiac services.

Building on the DHB model, lead DHB providers were selected to be responsible for the provision and development of a national service, most of which were funded from "top slice". DHBs that were recipients of the service were expected to work collaboratively with the national service provider, supporting outreach clinic arrangements to improve access for their populations.

National Service Improvement programmes required the commitment of clinicians and managers within DHBs across a designated service pathway to identify areas of opportunity and work together on interventions to improve equity of access, quality, consistency and sustainability nationwide.

The regional service priorities we will implement this year…

We have agreed the following priority goals as part of the Northern Region:

First, Do No Harm: 20% reduction in falls causing harm; 20% reduction in pressure injuries; 40% reduction in central line-associated bacteraemia infections (CLAB). The local translation of this activity is through our local campaign (**2) First, Do No Harm** (formerly Aiming for Zero Patient Harm)

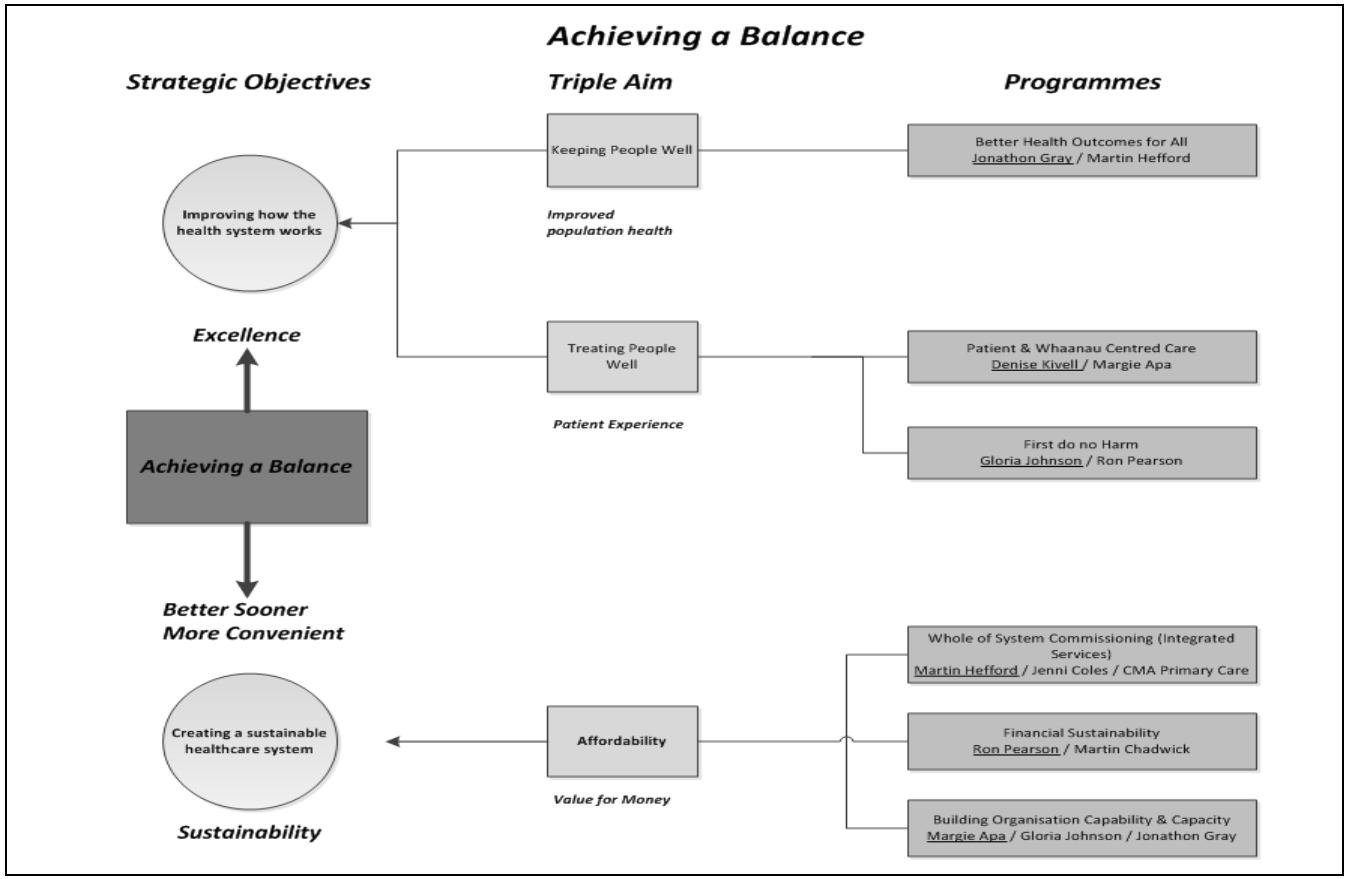
Life and Years: we will continue to work with regional clinical networks to improve access to services in diabetes, CVD, cancer and health of older people. In 2012/13 we have extended this programme to include new areas in child health, mental health and respiratory disease. This will be implemented through our local implementation of BSMC Business Cases and Locality Clinical Partnership as well as hospital service improvements.

The Informed Patient: achieving greater patient participation and improved health care through patients being better informed will be implemented locally through our **(3) Patient and Whaanau Centred Care** executable strategy.

We translate those regional and national objectives into six Executable Strategies ….

The DHB's strategic priority is to be the best Australasian healthcare system by 2015. We will achieve this through the implementation of the following six strategies that implement the national and regional directions in a way that is relevant to our local communities. The diagram below shows how we have translated this into Achieving a Balance.

Figure 8: Achieving a Balance: delivering sustainability and excellence in health



Keeping people well (Improved Population Health)

1. Better Health Outcomes for All aims to move intervention upstream by focusing on proven preventions that have a demonstrable effect on:

- preventing and/or slowing the progression of non communicable disease,
- help those living with a long term condition including mental health conditions to live well in the community and at home;
- promote those proven health promotion and prevention initiatives that empower our patients and communities to positively influence their own wellbeing

Although we can improve the health of our population with a view to reducing demand on the health system, CMDHB believes that a healthy community will add greater benefits to the community – healthier populations who lead productive lives influence our local economy. Better health outcomes for all means that all CMDHB populations – regardless of deprivation of ethnic groups should experience the same benefits from our healthcare system. Key strands to this goal include:

- refreshing our intervention logic to our approach to public health policy within our District;
- promoting healthier lifestyles with proven interventions; and
- delivering accessible preventative care services such as screening and immunisation campaigns.

We will be challenged this year with the exit of funding for what were previously known as Healthy Eating, Healthy Action programmes. CMDHB will consider the implications of reduced national resourcing. This means that we will need to draw on local resources to implement new initiatives.

When people become sick, we want to treat them well (Improved Patient Experience)

2. First, Do No Harm is the local implementation of the regional service plan "**Goal One: First, Do No Harm**" initiatives - reduce falls, pressure injuries, central line associated bacteraemia. National initiatives set by the Health Safety & Quality Commission as they are agreed and our own local initiatives. It is well known that many quality and safety interventions – if applied systematically and consistently will save lives, reduce cost and prevent unnecessary harm to patients.

3. Developing Patient and Whanau centred care aims to use the experience of patients to inform opportunities we have to improve our services. This is the workstream that will implement the regional service plan '**Goal Three: *The Informed Patient***".

We will be modifying the way we collect information from patients and their families about their experience so that we use appropriate and useful data. We will also develop and implement ways of inviting and supporting patients to give us direct feedback about where we should be redesigning the way we do things to improve their experience.

Current initiatives include Ai2DET which is about improving staff to patient face-to-face interactions and work with services to see families as a part of the care team and having appropriate policies to support this. 2012/13 will focus on the hospital experience and we will ask our primary and community service partners how we might extend this approach to support their work.

Our system needs to be affordable (Value for Money)

4. Whole of System Commissioning recognises that, to enable clinical and service integration, we need an approach to commissioning and allocating resources that aligns with patient pathway. Whole of System Commissioning builds on localities and clinical pathways to engage our health professional leaders alongside their communities to be part of making decisions about where resources might best be allocated based on what patients need and the clinical and service pathways that will best meet those needs.

This is particularly so where primary and community based clinicians face different arrangements to their secondary and hospital based colleagues. If we are going to encourage integration, we must revisit the way that we allocate resources to better align with a whole of system clinical pathway. We will work with our localities and primary care partners to assess the flexibility we need in contracting and funding settings and, where agreed with Ministry and other stakeholder, implement changes to those settings where agreed.

This strategy will implement the regional service plans "**Goal Three: Life and Years**" focus on diabetes, CVD, cancer and health of older people. Locality clinical partnerships will have confirmed their priority work programmes for 2012/13 that are consistent with this goal. This is based on locally determined priorities that are specific to that locality. For example, Franklin and East have prioritised health of older people initiatives. Mangere/Otara and Manukau have prioritised long term conditions. These priorities will aim to join up secondary clinical pathways and align further with regional clinical networks.

5. Financial Sustainability is going to be critical if we are going to be able to afford our health system and continue to meet the health needs of our population and provide safe and high quality public healthcare and health services in the long term. We aim to bend the cost curve by ensuring that - alongside innovation and continuous improvement - we are also building evidence behind initiatives that reduce costs, demonstrate efficiencies and productivity improvements. CMDHB will need to revisit our medium term capital needs in light of the Crown's reprioritising capital investment to Christchurch earthquake recovery. CMDHB will need to explore – with the support of central agencies – alternative ways of continuing investment in facilities that will help us meet our growing demand for hospital infrastructure.

6. Build our Organisation Capacity and Capability aims to ensure that we have invested in our most precious resource – people, both those employed directly by the DHB and our wider team of healthcare professionals in the community/primary care setting – to sustain themselves. More information on building capacity and capability is outlined in Module 4 of this plan.

The locality priorities within our district are…

Our BSMC Business Case Alliance partners are: National Hauora Coalition (NHC), Alliance Health+ and the Greater Auckland Integrated Health Network (GAIHN). The 2012/13 priorities and implementation of the Alliance Leadership Team business cases are reflected in Module 3 of this Annual Plan. An important development planned for 2012/13 is the completion of business cases for Integrated Family Health Centres. They are due for submission in May 2012 and will be assessed and decisions made on which to proceed to implementation by July 2012..

The four localities are in the process of confirming their service priorities for the 2012/13 year. Our *Saving 20,000 Days* campaign which aims to save 20,000 bed days a year through a programme of integrated services and activities will be an initial focus for all our primary care and community partners so that fewer people need to be admitted to hospital for conditions that can be treated or managed sooner and closer to home.

By the end of September 2012, all four localities will have the following in place:

- Clinical leadership teams established in all four localities;
- Locality outcomes-based contracts;
- Weekly feedback against bed day targets;
- Locality collaborative learning sessions run through Ko Awatea.

2.2 WHAT WE ARE TRYING TO ACHIEVE FOR OUR POPULATION – OUR INTERVENTION LOGIC

We are making a positive change for our population through sustainability and excellence

This section will give an overview of how our *Achieving a Balance* strategic objectives will contribute towards making a positive difference to the health of our population.

Achieving a Balance will mean the following for our population:

- ***People live healthier, longer, more productive, disease free lives*** - we will support people through population health education and primary and secondary prevention programmes to live healthier lifestyles and to reduce the incidence and delay the onset of preventable conditions.
- ***People are at the centre of our health system*** – we will ensure that patients are engaged as partners in their own care and their families are seen as a part of the care team. Patients and families will also be engaged in decisions around models of care and service improvement so that they receive the right care, at the right time and place, delivered by the right person
- ***People stay well in the community*** – we will develop our locality based commissioning framework to ensure that people with chronic conditions, older people, people with mental health problems, people with disabilities have services in primary care and the community to support them to stay well and manage their conditions in community based settings.

In alignment with regional direction and the national goal for health of all New Zealanders.

These three outcomes are in line with the Northern Region's strategic priorities of: ***Life and Years, First, Do No Harm*** and the ***Informed Patient*** and contributes to the Government's vision of "***All New Zealanders living longer, healthier and more independent lives***".

Our outcomes framework will track whether our activities are contributing towards the change we seek

A core set of long term (five to ten year time frame) outcome measures has been identified and will give us an indication over time whether our actions are contributing toward the positive change we seek for our population.

We have identified a set of impacts that we expect our service delivery - expressed as plans, strategies, work programmes – will have on our population and the contribution of these impacts to our outcomes. These impacts are expected to be seen within the next two to five years and we have outlined a set of medium term measures which will track our progress over this timeframe.

The Figure 9 presents our "intervention logic" which shows how our activities (outputs) will make a difference to our population (impacts) and contribute toward our strategic outcomes.

Figure 9: Intervention Logic Diagram

NATIONAL GOAL	**All New Zealanders live longer, healthier and more independent lives**		
Northern Region VISION	**To improve health outcomes and reduce health disparities by delivering better, sooner, more convenient services. We will do this in a way that meets future demand whilst living within our means.**		
GOALS	**Adding to and increasing the productive life of people in the Northern Region**	**Delivering safe and good quality healthcare which is patient and family centred**	**The region's health resources are efficiently and sustainably managed to meet present and future health needs**
Counties Manukau DHB VISION	**To work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori and Pacific peoples and other communities with health disparities**		
MISSION	**Achieving a Balance: Delivering Sustainability and Excellence** *Becoming the best healthcare system in Australasia by December 2015*		
OUTCOMES **These are long term outcomes – 5 to 10+ year + timeframe.**	**People live healthier, longer, more productive, disease free lives**	**People are at the centre of our health system**	**People stay well in the community**
Outcome Measures (long term)	• **Reducing the gap: life expectancy at birth between Maaori and Pacific with non-Maaori and non-Pacific** • **Decrease in smoking prevalence** • **Decrease in obesity prevalence** • **Decrease in rheumatic fever**	• **Patient experience measure**	• **Increase in the ratio of home based support services to aged residential care services**
IMPACT What difference will we make for our population over the next 3 to 5 years?	1. **Fewer young people started smoking** 2. **More people engaged in increased physical activity and healthier eating** 3. **Fewer children admitted to hospital for preventable conditions**	4. **More people had access to treatment when required** 5. **People needing acute care were seen in a timely manner** 6. **More people were engaged in managing their health and treatment decisions**	7. **Fewer people were admitted to hospital for preventable conditions** 8. **People with long term conditions were supported to manage their condition** 9. **Older people were supported to live safely and independently in their own homes** 10. **People with mental health problems had fewer acute admissions**
Impact measures (medium term)	1. **Proportion of Year 10 students who have never smoked** 2. **Proportion of adults (a) engaged in 30+ minutes of physical activity a day, and (b) eating 3 servings of vegetables and 2 servings of fruit per day** 3. **(a) Children's acute hospitalisation rate, (b) Proportion of five year olds caries free at 5 years old**	4. **Improved access to elective surgery** 5. **Shorter stays in Emergency Departments** 6. **Number of advance care "conversations" taken place**	7. **Ambulatory sensitive hospitalisation rate for 0-75+** 8. **More heart and diabetes checks** 9. **Proportion of ED admissions by 75+ year olds** 10. **Mental health access rate**
OUTPUTS	Prevention	Early Detection and Management	Intensive Assessment and Treatment / Rehabilitation and Support
ENABLERS	Workforce / Networks & Relationships / Financial Resources / Quality Systems & Processes / Information Technology / Clinical & Sector Leadership / Assets & Infrastructure		

2.2.1 Outcome 1: People live healthier, longer, more productive, disease free lives

Why is this a priority?

We have outlined in Module 1 the key health statistics and issues facing our population and how non communicable diseases like diabetes, lung disease and cardiovascular disease are key contributors to our mortality rates and affect our Maaori and Pacific population disproportionately.

Bearing in mind these conditions are largely preventable, for example:

- Two thirds of the population predicted to develop diabetes can be prevented
- Stopping smoking is at least as effective for reducing CVD risk as reducing cholesterol, controlling blood pressure and reducing blood sugar levels

Yet, 81% of avoidable deaths in Counties Manukau are due to the 'package' of diabetes, cardiovascular disease, smoking related respiratory disease and cancer.

With fewer than one in ten adults in Counties Manukau living a healthy lifestyle[5] there is an urgent need to invest in targeted, evidence based interventions and programmes aimed at keeping people well and disease-free and also that which will help reduce the impact and delay the onset of non communicable disease for those who are at risk.

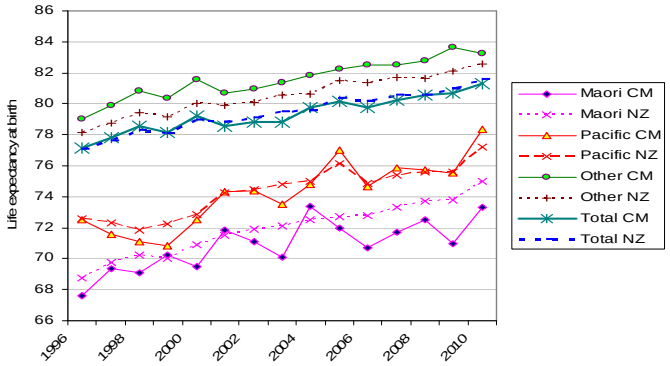
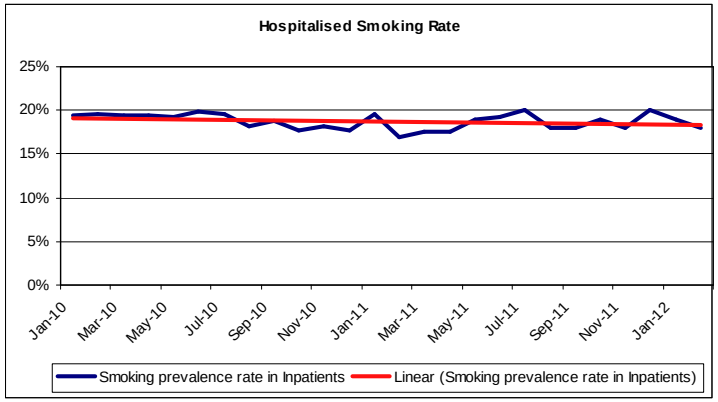
We have a young population with 40% of our population under the age of 25 years; improving the health and wellbeing of our children and young people is vital to making a difference to our long term outcome of longer life expectancy and reduced burden of non communicable disease.

The hospitalisation rate for our children and young people is above the national average and largely for preventable conditions like sudden unexpected death in infants, lower respiratory infections, rheumatic fever, skin conditions and meningococcal disease.

Continuing to work intersectorally and advocate for improved environmental and social conditions like improved housing, better urban planning and more Smokefree environments are central to decreasing some of these risk factors and giving children and young people a better start in life.

[5] A healthy lifestyle which is based on not smoking, 'safe' alcohol consumption, being regularly physically active, eating five plus portions of fruit and vegetables a day and not being obese.

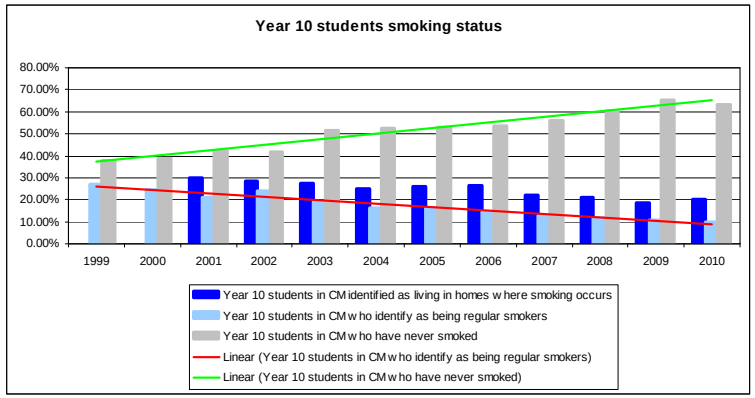
OUTCOME MEASURES LONG TERM (5 TO 10 YEARS)

We will know we are successful when there is a:	Outcome Measure
Reduction in health disparities between Maaori and Pacific and non-Maaori and non-Pacific Given Counties Manukau's high proportion of Maaori and Pacific people, if we are to improve the health status of the population it is important that we focus on reducing some of the disparities in health outcomes. As such, the life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific is an important point of focus for the DHB as a marker of the impact we are making in lifting Maaori and Pacific health outcomes and reducing health inequalities. Life expectancy at birth is a key indicator of health status. Maaori people living in Counties Manukau have a life expectancy at birth of 10 years less than their European and Other Counties Manukau residents whilst Pacific people in Counties Manukau have a life expectancy at birth of 5-7 years less than their European and Other Counties Manukau residents. The graph on the right details the changes in life expectancy for CM Maaori, Pacific, Other and Total populations in comparison to the New Zealand average for each ethnicity. This shows that, while life expectancy overall has increased, the gap between Maaori and Non-Maaori, and Pacific and Non-Pacific remain and has not decreased.	***Figure 10: The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific***  *Source: Jackson, G., & Papa, D (2011) Life expectancy update to 2010 for Counties Manukau* **Baseline (Dec 2010)** / **2012/13 Target** / **Expected Performance** Maaori — 10 years — Reduce current rate. — The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific will *reduce* in the long term. Pacific — 5 – 7 years
Reduction in smoking rates Our population has the highest smoking rates in New Zealand with 12% of the total smokers in the country living in the district. Smoking is the 'big ticket item' contributing to not only smoking related lung diseases such as lung cancer but also to the major disease areas: diabetes, CVD, infant mortality and all other causes of mortality. Smoking is the single most important preventable cause of death and therefore, strategies to decrease the number of smokers in the community and/or to reduce the number initiating smoking has the ability to make an impact on the community's health and well being and also on reducing health inequities between Maaori and Pacific with non-Maaori and non-Pacific in Counties Manukau. We will continue public health policy advocacy at national, regional and local levels for increasing smokefree environments, tobacco pricing and ensuring compliance with regulated sales to minors. Our smoke-free initiatives, within both primary care and community services and in the hospital, will support a further reduction in the prevalence of inpatient smokers.	***Figure 11: In-hospital smoking prevalence rate Middlemore Hospital***  **Baseline (YTD Jan 2012)** / **2012/13 Target** / **Expected Performance** 18.6% — Reduce current rate — It is expected that the combination of smoke-free initiatives both in the community, primary care and the hospital will lead to a *decrease* in the prevalence of hospitalised smokers (as a proxy indicator of smoking prevalence in the population)

We will know we are successful when there is a:	Outcome Measure
Reduction in preventable infectious disease in our children Improving the health and wellbeing of children and young people living in Counties Manukau is a priority for CMDHB as we have a young population: 40% under the age of 25 years. We have chosen this as a proxy outcome measure for child health. Rheumatic fever is a preventable, life limiting illness that is rare in other developed counties yet continues to be diagnosed in children across New Zealand. Ethnic disparities are evident, with Maaori and Pacific children having the highest incidence of rheumatic fever. The national goal is for Maaori and Pacific rheumatic fever rates to have decreased to the same level as other children by 2020.	***Decrease of rheumatic fever rate*** **Baseline (2005 – 2009):** 37.7 per 100,000 **2012/13 Target:** Reduce current rate **Expected Performance:** In the long term, the rate of rheumatic fever in CM will *decrease.* CMDHB continues to have the highest number of rheumatic fever notifications in comparison to all other DHBs, and has an overall rheumatic fever rate of 37.7 per 100,000 which is double the national average. While secondary prevention plays an important role in the management of rheumatic fever, primary prevention strategies are required if the disease burden is to be reduced.

IMPACT MEASURES MEDIUM TERM (3 TO 5 YEARS)

Over the next three to five years we seek to make a positive difference (impact) on the health and wellbeing of our population by contributing to the longer term outcomes. The effectiveness of the services the DHB funds and provides will be evaluated using the following measures:

Impact	Impact Measures
Fewer young people taking up smoking Ensuring that children grow up in a smokefree environment is important in preventing lower respiratory tract infection and smoke exposure is a significant risk factor for Sudden Unexplained Infant Death (SUDI). Furthermore, in order for smoking rates to decrease overall in the long term, a generational change needs to occur in which fewer younger people take up smoking. The graph on the right shows the correlation between Year 10 students who live in homes where smoking occurs, the proportion of year 10 students who are regular smokers and the proportion of year 10 students who have never smoked. As the rate of smoking in homes decreases, so does the rate of Year 10 students who are regular smokers. Furthermore, a decrease in the proportion of homes where smoking occurs leads to an overall decrease in the proportion of Year 10 students who have never smoked. Thus, children raised in homes where smoking does not occur are less likely to start smoking themselves.	***Figure 12: Year 10 students who have never smoked***  *Source: ASH Year 10 Snapshot Survey*

Baseline (Dec 2010)	2012/13 Target	Expected Performance
63.3%	65%	The proportion of year 10 students who have never smoked will *increase.*

Impact	Impact Measures
More people are engaged in physical activity and healthier eating Within Counties Manukau, 34% of adults were identified as being overweight and 33% were obese (2006/07). These rates can be attributed to poor nutrition, such as decreased intake of fruit and vegetables and increased intake of high fat / sugar foods, and low physical activity. This is of significant concern as obesity is the main preventable causes of several long term conditions including diabetes, and precursor of heart disease, stroke and certain cancers. It is therefore imperative to improve levels of adequate nutrition and physical activity in order to promote better health outcomes. We will be challenged this year with the exit of funding for what were previously known as *Healthy Eating, Healthy Action* programmes. CMDHB will consider the implications of reduced national resourcing. This means that we will need to draw on local resources to implement new initiatives. The NZ Health Survey measures are the best measures available at this point in time. The survey was undertaken in 2003/04 and 2006/07. The next survey is currently underway.	**Counties Manukau adults engaged in 30 + minutes of physical activity per day** Baseline (2006/07): 54.7% 2012/13 Target: > 51.4% Expected Performance: The proportion of adults engaging in physical activity (30+ minutes of physical activity per day) will increase **Counties Manukau adults eat 3 servings of vegetables and 2 servings of fruit per day** Baseline (2006/07): 51.8% 2012/13 Target: > 51.8% Expected Performance: Proportion of adults eating 3 servings of vegetables and 2 servings of fruit per day will increase

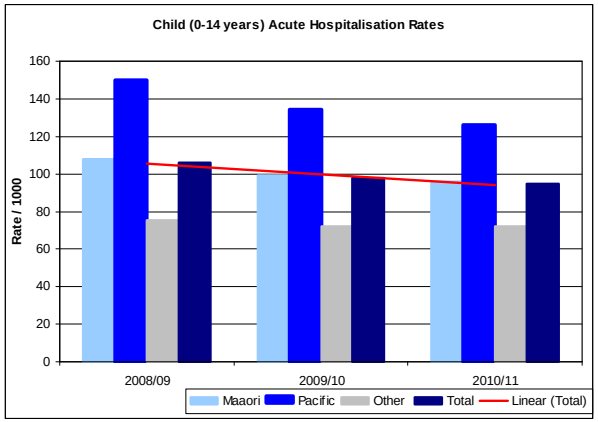
Fewer children are admitted to hospital for preventable conditions: Child acute hospitalisation rates

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

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

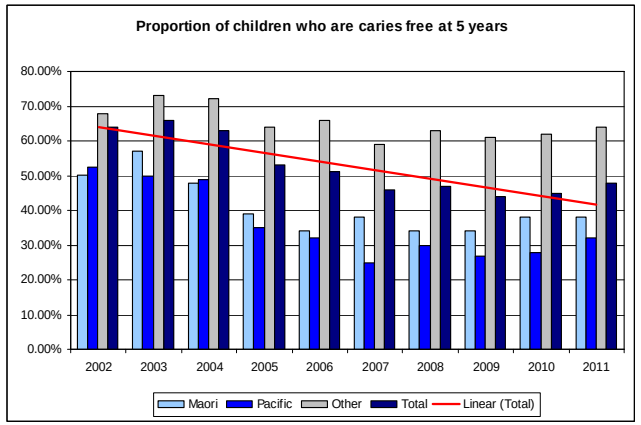
Note: The figures are based on the following methodology: Include casemix acute and arranged medical and surgical admissions. Does not include maternity or mental health. Includes transfers.

Figure 13: Child acute hospitalisation rates



Baseline (2010/11)		2012/13 Target	Expected Performance
Maaori	96.0 / 1000	Reduce current rates.	Acute hospitalisation rates for children (0-14 years) will *reduce*. Disparities between Maaori, Pacific and non-Maaori / non-Pacific will also *reduce.*
Pacific	125.9 / 1000		
Other	72.2 / 1000		
Total	94.9/1000		

Impact	Impact Measures
Fewer children are admitted to hospital for preventable conditions: Children caries free at 5 years of age Dental caries is a preventable disease with socio-behavioural risk factors in common with several other prominent non-communicable diseases, such as diabetes, cancer and cardiovascular disease. These common risk factors include socioeconomic deprivation, poor diet, and lack of reinforcement of oral hygiene practice. Health inequities exist with Maaori and Pacific children having poorer oral health status than other children in the district and we have had an increasing number of children, some as young as three years old, having to undergo general anaesthesia for surgical removal of teeth. All oral health conditions are potentially preventable and increasing the proportion of five year olds who have never experienced tooth decay is a proxy impact measure which will show that our investment in our publicly-funded child oral health programmes (oral health promotion, prevention and treatments) are appropriately targeted and oral health messages are being reinforced through the health system.	***Figure 14: Children caries free at 5 years old*** .



Baseline (2010/11)		2012/13 Target	Expected Performance
Maaori	38%	52%	The proportion of children who are caries free at 5 years of age will *increase* in the long term. .
Pacific	32%	52%	
Total	48%	52%	

2.2.2 Outcome 2: People are at the centre of our health system

Why is this a priority?

In section 2.1, we outlined one of the *Achieving a Balance* goals as *Treating People Well*. This is in line with one of the three critical objectives of the Triple Aim which is about enhancing the patient's experience of care. Patient experience of care is shaped by whether the care received meets their physical as well as emotional needs.

We are already making strides in service quality improvement and patient safety with initiatives like our *Releasing Time to Care*, and *First, Do No Harm* programmes. The latter aligns with the regional First, Do No Harm work programme.

We want to take this work further by becoming a patient and family centred DHB. Healthcare organisations who have achieved outstanding improvements in their health systems have cited putting patients and families in a position where they could influence redesign and improvement of care systems as being the single most powerful transformational change in their history. [6]

This concept of putting people and their families at the centre of care aligns with the concept of Whānau Ora – an approach to service delivery which acknowledges whaanau, their values and cultural contexts, and empowering them to be self-determining. It is also aligned with the Northern Region's *Informed Patient* work programmes which include Whanau Ora and advance care planning.

We have chosen putting people at the centre of our health system as a strategic outcome even though it is actually an organisational enabler rather than a population health outcome. However, we believe that this cultural transformation to being a more patient and family centred organisation will be central to the achievement of greater gains in the improvement of health outcomes and sustainability than can be achieved through hospital driven quality improvement initiatives alone.

OUTCOME MEASURES LONG TERM (5 TO 10 YEARS)

<table>
<tr><th>We will know we are successful when there is:</th><th>Outcome Measures</th></tr>
<tr><td>Positive patient experience of care of our health system

Monitoring and understanding patient's experience of care is an integral part of positive improvement in care. Rather than measuring overall satisfaction for an episode of care, patient experience details levels of satisfaction throughout the entire continuum of care, from admission to discharge whilst also identifying components of care that are of significant importance to patients and their whaanau.

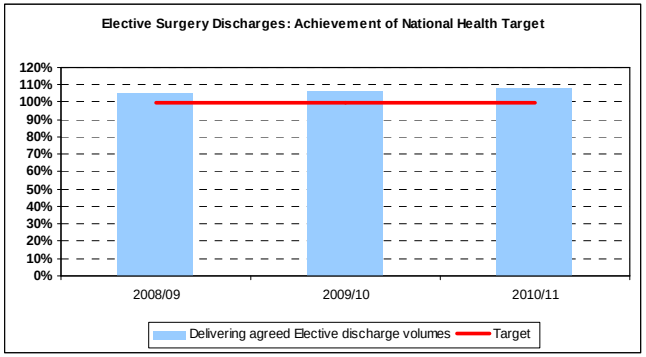
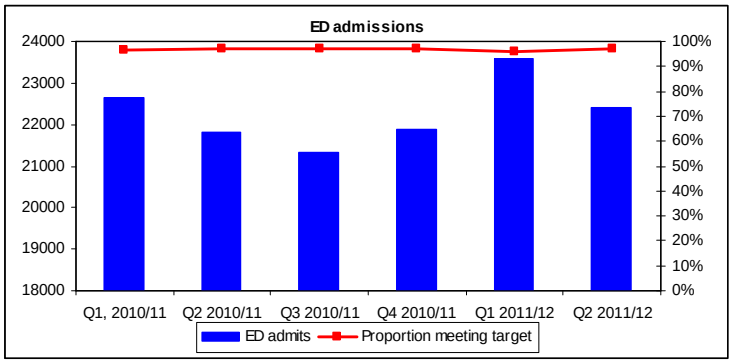
By July 2013, the new CMDHB Patient Experience system will be fully functional. This includes an online survey which covers a much greater scope than the previous postal survey system and will therefore identify areas which will drive improvement in patient experience.</td><td>Implementation of new patient experience system

<table>
<tr><th>Baseline</th><th>2012/13 Target</th><th>Expected Performance</th></tr>
<tr><td>Business case in development.</td><td>Patient experience system to be functional</td><td>The new Patient Experience System will lead to improved understanding of patient and whaanau experience of care.</td></tr>
</table>
</td></tr>
</table>

[6] *Seven Leadership Leverage Points for Organizational-Level improvement in Healthcare*. 2nd Edition, IHI Innovation Series, 2008

IMPACT MEASURES MEDIUM TERM (3 TO 5 YEARS)

Over the next three to five years we seek to make a positive difference (impact) on the health and wellbeing of our population by contributing to the longer term outcomes. The effectiveness of the services the DHB funds and provides will be evaluated using the following measures:

Impact	Impact Measures
People have access to treatment when it is required We have chosen the national health target of *Improved Access to Elective Surgery* as a proxy measure for our patient centredness impact of people being able to access treatment when it is required. Elective services are an important component of the health care system for the treatment, diagnosis and management of health problems. Timely access to a first specialist assessment or elective surgery will improve quality of life by ensuring early diagnosis, intervention or treatment and therefore reducing pain and discomfort for the patient whilst improving independence and wellbeing. We are undertaking quality improvement initiatives and looking at ways in which to use our in-house theatre capacity more efficiently and also patient flow through the system so that patients are not waiting beyond mandated timeframes for assessment and treatment and we can continue to provide the increased number of elective surgical discharges as expected by the Minister.	***Figure 16: Improved access to elective surgery***  Baseline (Q2, 2011/12): 106.8% 2012/13 Target: 100% (15,382 discharges) Expected Performance: The number of elective surgical discharges will *increase*.
People needing acute care are seen in a timely manner A whole of system response and good team work between different disciplines is essential to ensuring that people needing acute care are seen in a timely manner. We have chosen the national health target *Shorter Stays in Emergency Department* as a proxy measure for timeliness of acute care as long stays in ED are linked to poorly coordinated health systems leading to overcrowding, negative clinical outcomes and compromised standards of privacy and dignity for patients. Reducing ED length of stay also improves the public's confidence in being able to access services in a timely manner when they need to, increasing their level of confidence in health services as well as improving the outcomes from those services.	***Figure 17: Shorter stays in emergency department***  Baseline (Q2, 2011/12): 97% 2012/13 Target: 95% Expected Performance: The proportion of patients admitted, transferred or discharged within 6 hours will *increase*

Impact	Impact Measures
More people will be engaged in managing their health and treatment decisions Actively engaging people in the management of their health and treatment decisions leads to an improvement in health outcomes and greater patient experience Advance Care Planning will ensure patients and their families are better informed about future care and treatment choices and healthcare providers are better informed about what patients' care preferences are particularly around end of life care. This is why we have chosen the number of advanced care conversations as a proxy measure to demonstrate improved communication and engagement with patients, their families and clinicians around end of life care and treatment. This impact measure will be a good measure of our regional commitment to achieve greater patient participation and improved health care through better informed patients. This is goal three of the Northern Region Health Plan: The Informed Patient.	***Number of advanced care "conversations" taken place*** Baseline 2011/12: 50 conversations 2012/13 Target: 240 conversations Expected Performance: The number of advanced care conversations will *increase* in the long term. We will contribute to the NRHP goal of increasing advanced care 'conversations' (1500 across the region by July 2013) by ensuring at least 20 discussions are held each month with patients. This will ensure that patients are aware of their health and treatment options.

2.2.3 Outcome 3: People stay well in the community

Why is this a priority?

This outcome is a priority for us as we recognise that getting people to stay well in their homes and community will be essential to improving health outcomes particularly for our ageing population, people with long term conditions and people with complex needs.

This outcome is also vital for our long term sustainability as we face an ever growing demand for health services driven by patient need and expectations. Our bed modelling projections point to a shortage of inpatient beds by 2013 but many of our staff believe this tipping point has already been reached and there is an urgent need to reduce acute hospitalisations and unplanned hospital admissions.

With an ageing population, we need to ensure that we have strong primary and community based needs assessed services which will support older people, particularly those with chronic conditions, to maintain a good level of function and independence even where returning to full health is not possible.

Ensuring people stay well in their homes and communities means having good quality integrated services across the continuum of care. At CMDHB we are developing a whole of system commissioning framework which seeks to integrate secondary and primary and community care so that care is organised around the needs of an individual and provided in co-located primary or community settings with multidisciplinary teams. Primary care is an important integrator of services as they play a key role in being the first point of contact for many people seeking health services. Primary care is also supported and complemented by a range of health professionals and providers who are based in the community and can often provide prevention and early intervention services to support people to stay well in their communities and to link them with other services and community agencies.

Our Locality Clinical Partnerships within each of our localities will be the point for prioritisation and coordination of care to meet the health needs within each locality.

Our *Saving 20,000 Days* campaign which aims to save 20,000 bed days a year through a programme of integrated services and activities will be an initial focus for all our primary care and community partners so that fewer people need to be admitted to hospital for conditions that can be treated or managed sooner and closer to home, which research has shown to contribute to better health outcomes.

See Appendix 1 for information on our Saving 20,000 Days campaign.

OUTCOME MEASURES LONG TERM (5 TO 10 YEARS)

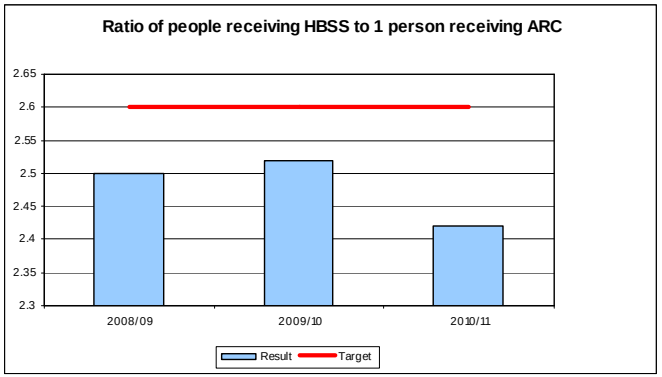
We will know we are successful when there is a:	Outcome Measures

Increase in the amount of home based support provided to older people

We want to increase the ratio of the number of older people receiving home based support services to the number of older people receiving age related residential care. This is supported by our strategic direction for older people which seeks to improve and expand the range of home and community based services available for supporting our older population, whilst also ensuring that we have enough beds for fragile older people who need to be in long term residential care.

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

Figure 18: Ratio of home based support services to aged residential care services.



Baseline	2012/13 Target	Expected Performance
2.1	2.6	The ratio of HBSS to ARC will *increase* in the long term.

IMPACT MEASURES MEDIUM TERM (3 TO 5 YEARS)

Over the next three to five years we seek to make a positive difference (impact) on the health and wellbeing of our population by contributing to the longer term outcomes. The effectiveness of the services the DHB funds and provides will be evaluated using the following measures:

Impact	Impact Measures

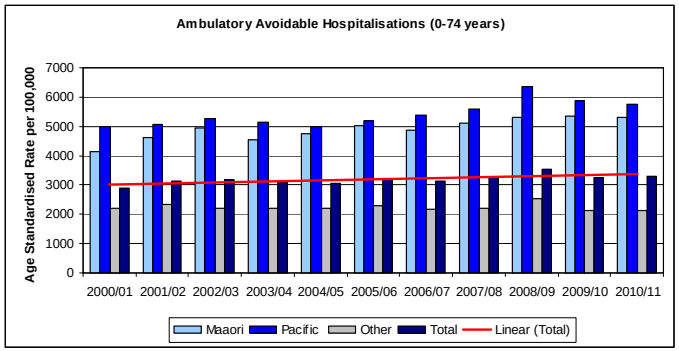
Fewer people admitted to hospital for preventable conditions

A key objective for the DHB is to reduce demand for our hospital services. A significant proportion of our hospitalisations are due to medical conditions that could have been avoided or prevented through primary care intervention, including outpatient services. These are defined as ambulatory sensitive hospitalisations.

Our ambulatory sensitive hospitalisation rate is above the national average and a large proportion of ambulatory sensitive hospitalisations are Maaori and Pacific.

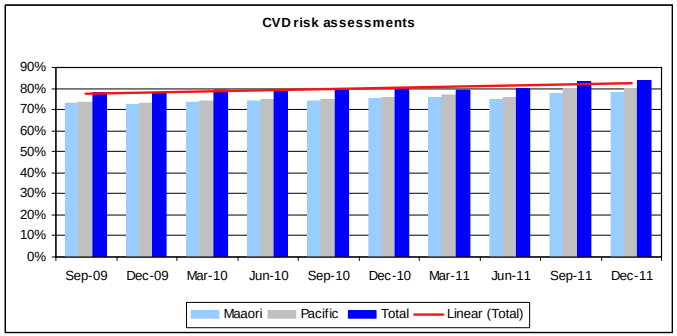
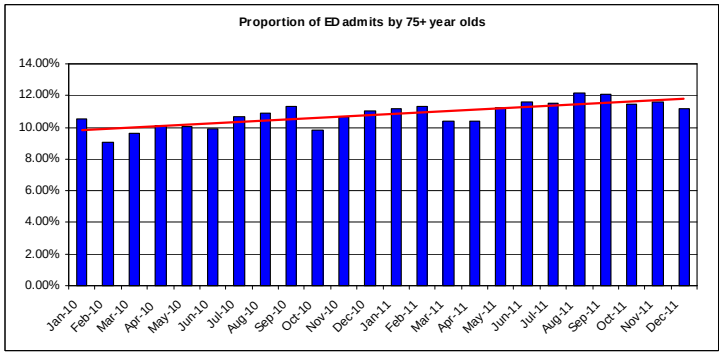
The reduction in the number of ambulatory sensitive hospital admissions will show that we are ensuring that patients who need services that can be provided in community settings are receiving them in the primary/ community care space rather than at hospital. Our whole of system integration programme will contribute to a more unified health system and will see more

Figure 19: Ambulatory sensitive hospitalisation rate for 0-74 year olds



Baseline (Year to Dec 2011)		2012/13 Target	Expected Performance
0-4 years	104%	102%	The rate of ASH will *decrease* in the long term
45-64 years	152%	135%	
0-74 years	128%	118%	

Note: The above graph is based on CMDHB domicile ASR per 100,000. This differs from the MOH benchmarking results.

Impact	Impact Measures
services made available in primary care and community settings which should improve access to early intervention and management. As outlined above, many of the *Saving 20,000 Days* prioritised interventions will make an impact on ambulatory sensitive hospitalisations and we are aiming for our ASH rates to decrease over the medium term.	
People with long term conditions are supported to manage their condition As outlined above, getting people to stay well in their homes and community will be essential to improving health outcomes particularly for our ageing population, people with long term conditions and people with complex needs. This is also linked to our *Saving 20,000 Days* campaign and the programme of activities which includes improving the way we support people with long term conditions like chronic obstructive pulmonary disease, cardiovascular disease to manage their condition. We have chosen the national health target of *More Heart and Diabetes Checks* as a proxy indicator for this impact. The delivery of good detection and management practices in primary care and ongoing support in the community is essential for ensuring that people at risk of CVD and diabetes are being identified early and managed appropriately.	***Figure 20: More Heart and Diabetes Checks***  *Source: NMDS (extracted by MOH) Note that graph is based on previous (2011/12) CVD risk assessment methodology.* **Baseline** / **2012/13 Target** / **Expected Performance** Maaori 55.1% Pacific 61.6% Other 47.7% Total 52.6 % 75% We expect to achieve this result and track further improvements to achieve 90% by June 2014.
Older people are supported to live safely and independently in their own homes Our philosophy for health of older people aligns with the Government's goal that older people are supported to help them maintain independence in their own homes where this is appropriate and possible. Research shows that 75% of older people in institutional care in New Zealand do not want to be there. And that admitting people to acute hospitals can have negative impacts on their independence and mental health. CMDHB is actively working with regional primary care partners, local aged residential care providers and health of older people services to ensure that older people are able to receive support services within their community which will enable better management of long term conditions. This includes ensuring there are wrap around services supporting older people upon discharge from hospital that will ensure frail older people can continue living safely and independently in their own homes or in age related residential care. This measure has been chosen as a proxy for demonstrating increased cohesiveness amongst services and disciplines and the availability of alternative models of care in meeting the needs of older people.	***Figure 21: Presentations at ED of 75+ year olds***  The graph above indicates that the proportion of ED admissions by 75+ year olds has been increasing over the past 2 years, with significant increases during the winter months. **Baseline (YTD average)** / **2012/13 Target** / **Expected Performance** 11.34% Reduce current rate The rate of presentations to ED by 75+ year olds will *decrease* in the long term

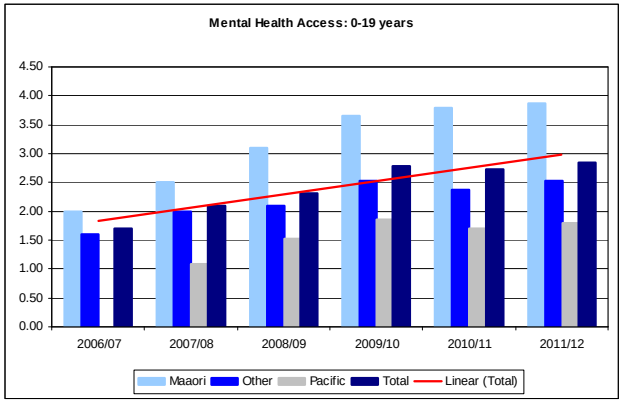
Impact	Impact Measures

People with mental health problems have fewer acute episodes

A reduction in acute mental health episodes is an indication of people having access to appropriate support and thus receiving the right care at the right time.

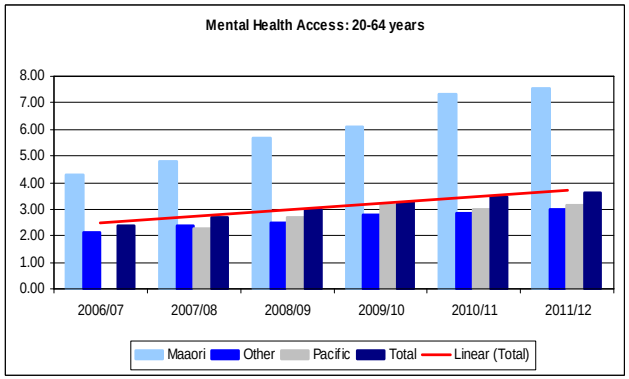
Mental health access rates is a proxy measure for determining the impact of the DHB's mental health services delivery on improving the quality of life for members of our population who are suffering from severe mental illness or issues with alcohol or drug addiction.

Figure 22: Mental health access rates 0-19 years



Baseline Q2, 2011/12			2012 / 13 Target	Expected Performance
0- 19 Years	Maaori	3.86	4.00	Mental health access rates will *increase* in the long term.
	Total	2.85	3.00	
20- 64 years	Maaori	7.55	7.55	
	Total	3.63	3.63	
65 + years	Total	2.70	2.70	

Figure 23: Mental health access rates 20-64 years



Module 3: Stewardship

We are strengthening organisational capability to support our future direction

Organisational capability is defined as "*what an organisation needs in terms of access to leadership, people, culture, relationships, processes, technology, physical assets and structures to efficiently deliver the outputs required to achieve its goals*".[7]

Through our Health System Integration (HSI) Programme, we have reviewed our organisational capabilities to determine what we need to strengthen, or, where necessary, capabilities that we need to develop. We have a two year transition work programme to ensure that these are in place to support our cultural transformation to an integrated health system.

At the same time, we continue to build capacity in areas like quality and safety, workforce development, information systems, facilities and research and innovation to support the delivery of our strategic priorities.

3.1 MANAGING OUR BUSINESS – OUR ORGANISATIONAL STRENGTHS

We have Good Governance

The DHB has a well-functioning Board with members bringing a good mix of skills and expertise to their governance roles. Governance capability is maintained through regular forums and training sessions. All newly appointed Board members are provided with training on what their responsibilities are in relation to performance management and in accordance with the NZ Public Health and Disability Act every member of the Board must receive Tikanga Maaori training.

Our organisational structure has been reviewed and adapted to reflect the need for coordination across settings and levels of care to deliver integrated care.

We have strong Clinical Leadership

At CMDHB, our clinical leaders are leading on the transformation of our health system. Our clinical leaders have always been active and joint partners with management in decision making and oversee the development of clinical governance within the DHB and across the health system.

In the face of our challenges, strong clinical leadership will be key to the development and implementation of innovative models of care and solutions to improve health outcomes for our population. This is why we will be undertaking work through our Health System Integration programme to see how we can further enhance and extend our Clinical Leadership processes and mechanisms to increase clinical input in decision making. To date, our HSI programme has established a Clinical Leadership Team all of whom are also members of the Executive Leadership Team.

There is more under the next section *Building Capacity* on what we are doing to develop and strengthen clinical leadership at Counties Manukau DHB.

We have strong business systems for managing organisational performance and risk

Our Board and Chief Executive hold overall responsibility for the performance, operation and management of the DHB and are supported at all levels of strategic or operational decision making by the Executive Leadership Team, the Clinical Leadership Team and their supporting clinical forums and networks, and our advisory committees.

[7] *Guidance and Requirements for Crown Entities preparing the Statement of Intent*. (2010) Treasury New Zealand.

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

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

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

The management of risk in funding arrangements and ongoing operations is one of measured mitigation, balancing the application of appropriate mitigation strategy/cost to the degree and size of risk. CMDHB risk management is managed centrally via a formalised process using specific risk management technology to assist and record the various DHB risks. High organisation risks are reviewed by CMDHB's Board monthly, and at Audit, Risk & Finance Committee quarterly, to ensure that appropriate attention is given to these risks.

We apply the same principles of high level contractual rigour for high value complex funding agreements to simple letters of agreement for low cost "one off" arrangements. Operational risk is determined by population related pressures, with mitigation strategies developed which centre around bed modelling, models of care, and capital planning. The continued approach of using a combination of informal relationship monitoring with external resourced audit and monitoring ensure risks are managed prudently.

We are a Good Employer

As a Good Employer, we promote equity, fairness and safe and healthy workplaces. CMDHB discharges its Good Employer obligations by operating under a Human Resources policy containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment and the provision of a safe and healthy workplace. CMDHB is committed to this principle and will actively seek to uphold any legislative requirements in this regard.

Capabilities we will be enhancing through our transition programme

Shared Decision Making

As a part of delivering Better, Sooner More Convenient integrated care and move towards a locality planning approach, we are looking at new ways of working with our partners within Locality Clinical Partnerships. This will include setting out a clear process around decision making which will outline which decisions will be made by the DHB, which decisions will be devolved to Locality Clinical Partnerships and which decisions will be decided by Primary Care.

Maaori participation in decision making

We are currently looking at how we can strengthen this aspect of our governance to ensure that Maaori are engaged and participate in decision making and the development of plans and strategies to improve health outcomes for Maaori. A key decision from the Planning and Funding review is the establishment of a Treaty Relationships Advisory Group which will ensure that relationship development across the health system will focus on the engagement of Mana Whenua, Waikato Tainui Iwi, the National Hauora Coalition and other primary health care organisations in the delivery of Whanau Ora and improved health outcomes for Maaori.

Our Maaori Health Plan will continue to be the key document outlining priority areas for Maaori health and the activities the DHB will be undertaking to improve Maaori health outcomes.

Pacific Leadership

We are home to the largest Pacific population in New Zealand and many of our Pasifika communities bear a disproportionate burden in terms of non communicable disease and poorer health outcomes. We recognise that engagement with our Pasifika communities is essential to improving their health outcomes and we are currently working with them to determine how we can best develop and enhance Pacific leadership across the DHB.

3.2 BUILDING CAPACITY AND CAPABILITY

Building capability through Ko Awatea and our Centres of Excellence

Ko Awatea is our new Centre for Health System Innovation and Improvement, located at Middlemore Hospital. Our educational partners include the University of Auckland, Manukau Institute of Technology and Auckland University of Technology. Each day, over 300 students visit the centre and utilise lecture space. Our strategic partners are the Institute for Healthcare Improvement (IHI), Better Value Healthcare, Ltd. and NHS Wales. Ko Awatea is the first innovation and improvement centre to be fully integrated within a health system. We are producing systematic, sustainable change at a local level and will share our innovative solutions with the rest of the country.

Ko Awatea brings together innovation and improvement through engagement, education, capacity building for change, research and knowledge. We now have approximately 190 MIT nursing students, 60 AUT midwifery students and 160 South Auckland Clinical School medical trainees attending lectures onsite. The joint venture partnership and co-location of undergrads is fostering our vision for multi-disciplinary training.

In partnership with the IHI, we are delivering quality improvement and leadership courses to health professionals and staff across the country. We can now use advanced technology to work with our colleagues locally, nationally and globally to tap into the best of thinking and new evidence in developing answers to challenges.

Ko Awatea operates three multi-disciplinary Centres of Excellence.

- *The Centre for Workforce and Leadership Capability* - aims to foster development of a workforce skilled in both their core skill set and able and willing to improve the quality, safety and value of patient care.
- *The Centre for Research, Knowledge and Information Management* - aims to discover new knowledge and capture and effectively use information.
- *The Centre for Quality Improvement* - provides a focus on both the quality improvement knowledge and technical skills needed to ensure healthcare is reliable in practice. The centre will also ensure our people have the knowledge and skills needed to appraise and evaluate scientific evidence, and the forum to utilise proven healthcare interventions, leading to improvements in patient care.

Key campaigns running from Ko Awatea in 2012/13 include the national *Target CLAB Zero* collaborative and our *Saving 20,000 Days* campaign.

3.2.1 Workforce Strategy

Strengthening our workforce

In order to be able to transform our health system, we need to ensure that we have the right people with the right skills in the right place. Some of the challenges facing us and the wider health sector in New Zealand is the ability to attract, retain and motivate key performers, those with high potential or sought after skills.

The focus of workforce data intelligence is to analyse current and historical employee data to identify key trends and environmental factors and use this when planning the workforce needed for the future. Workforce data intelligence assists us to identify issues, prepare options, analyse the gaps and determine the appropriate actions to ensure a sustainable and appropriate workforce for the future. Our workforce data analyst produced data dashboards and forecast reports for the organisation so we can identify our workforce needs and gaps.

Over the coming years, we will strengthen and utilise the ability of the Centre for Research, Knowledge and Information Management within Ko Awatea to improve our intelligence capability. Information and knowledge of our workforce will be easily accessible for workforce and service planning.

The following sets out the four dimensions of Capability, Capacity, Culture and Change Leadership which are core to our Workforce Strategy.

Capability	***Capacity***
In order to meet the demands and needs of our population, we need the right people in the right place at the right time. Our health professionals need 'fit for purpose' education, training, support and supervision. Working differently requires us to test workforce innovations. We are exploring how to better utilise the existing workforce and create care teams that improve the patient journey. Planning for the right skill mix and configuration of our workforce is based on integrated models of care, new clinical pathways and future service design. Our localities development work and Saving 20,000 Days campaigns are aimed at transitioning care to more appropriate settings so our population can receive *Better Sooner More Convenient* care. Ongoing identification of the workforce requirements for the integration of care is integral to this process. We are working with NoRTH to ensure our RMOs undertaking vocational training in general practice are supported through employment and accessing national schemes.	In order to meet future service requirements we need to attract and recruit the right staff with the right skills at the right time and have robust mechanisms for retaining quality health professionals and employees within our organisation. Given the global competition for health professionals, our strategy is to prioritise recruitment of local people, both through a pipeline approach to grow health workers from the local community and to target staff from the locality we serve. In order to increase training capacity, we are creating new opportunities for undergraduate trainee placements. Our Nurse Entry to Practice programme places new graduates in employment both within the DHB and with community healthcare providers. New models of employment (e.g. 'earn and learn' models like the Anaesthetic Technician trainees) are being expanded into other roles. We have developed an 'earn and learn' employment pilot for the Bachelor of Nursing Pacific students at MIT and are constantly exploring new opportunities for innovation to increase our workforce capacity. We employ undergraduate placement coordinators to work closely with our tertiary partners to find quality training placements for students. In order to increase training capacity, we are creating new opportunities to place undergraduate trainees. Our successful nursing Dedicated Education Unit model is being expanded into primary and residential care. Our work in localities development provides an opportunity to

	strengthen training capacity in community based services across all professional groups. We are working with NoRTH to ensure that adequate placements have been allocated across all medical and other critical specialty areas.
Culture	***Change Leadership***
We are working in an increasingly complex local, national and regional health environment with a range of challenges across all areas of service delivery. However this environment also provides an opportunity for CMDHB to build on its strong culture of innovation and leadership in providing services that respond to the specific health needs of our community. Our workforce is our most valuable resource. Engaging our employees through positive human resource practices which foster leadership at all levels and create a dynamic and supportive organisational culture is integral to retaining and developing a workforce which contributes at the highest levels in providing the best health services to our population. Through previous staff satisfaction surveys we have identified some of the key priorities for our employees and developed frameworks and tools for teams and services to work together to implement strategies to enhance their working environment. We need to continue building on the progress to date with a particular emphasis on supporting managers to lead their teams towards the directions set by *Achieving a Balance* and foster their commitment involvement through effective engagement strategies. We have a performance development framework in which managers can have structured conversations with their individual team members about their role in contributing to service outcomes and how these link to the organisations vision and objectives. This also provides an opportunity to discuss individual development needs and plans to meet these. There is an opportunity to review this in the wider context of the organisation's future direction to develop an aligned and integrated framework which supports achievement of our aims and provides a clear and supported career pathway for individual employees. Our Chief Executive has been engaging the organisation through his weekly CEO Blog. This is an online forum where he gives updates, shares strategic visions and progress on campaigns like MiddleNOmore, our collective goal of tackling obesity. Staff are invited to make comments and suggestions to the CEO inbox on the blog.	Our *Achieving a Balance* change process has signalled a need to adapt our business model, our culture, the way we manage delivery and how we measure our performance and our successes. We have revised our organisational structure and governance framework to deliver: • An integrated whole of system delivery across CMDHB • Improved clinical effectiveness through clinical and managerial partnerships working to improve care of the CMDHB population • Improved lines of reporting, decision making and effectiveness/response to change • Clinical leadership and clinical governance to guide design, delivery and monitoring of health care services • Delivery on policy and on the intent of "Better, Sooner, More Convenient" • High quality care in the right place by the right provider and reducing avoidable hospitalisations • Better value health care through the Triple Aim methodology (where value = Quality/Cost) Our focus on quality improvement training and initiatives is creating an organisational culture that will yield improved productivity and efficiency in our health system.

Aligning our workforce strategies with national and regional workforce initiatives

NoRTH, our regional training hub

In 2011 the Northern Region Training Hub (NoRTH) was established to play a key role in improving the support provided to post entry medical, nursing and allied health trainees. This role builds on the administratively focused function that had previously been undertaken regionally for RMOs by ARRMOS. NoRTH will work closely with HWNZ, the NoRTH Board, tertiary education providers and DHBs through the Northern Region Clinical Leaders Forum to agree its work plan and alignment with wider workforce planning work being undertaken regionally and nationally.

Our RMO workforce is supported by NoRTH and our Learning and Development team is involved with regional RMO orientation package development. In order to maintain our workforce development pipeline, it is critical that we provide effective recruitment and orientation processes for all new graduates. We are also working with NoRTH to standardise PGY1 and 2 programmes across the region.

We are supporting NoRTH, in collaboration with our partner DHBs in the Northern region, through the following initiatives.

Initiative	Expected benefits
Broaden NoRTH clinical and managerial governance	• Strong clinical oversight from medical, nursing, midwifery and allied health and technical scientific professions and all four DHBs • Continued integration of Northland DHB into NoRTH at a governance level and where appropriate operationally
Delivery of key element s of workforce training and development for professional groups with an initial focus on RMOs and specialist nursing and allied health roles	• Appoint Regional Programme Director of Training supported by professional advisors • Training/education programmes progressively standardised and aligned with national service delivery needs and the NRHP • Standardise PGY1 and PGY2 training programme • All HWNZ funded post entry trainees supported to develop and implement career plans and provided effective mentoring services • Co-ordinate clinical placements to support specialist training programmes
Align recruitment and workforce planning with capacity and model of care requirements	• Effective management of a single regional locum workforce pool • Roll out of ACE recruitment tool pilot for new graduate nurses • Extend NoRTH activities and support development of alternative workforce by implementing 2011 recommendations on the Technical Scientist workforce, and further developing business cases and implementation for Nurse Specialist training and midwifery complex care initiatives
Strengthen systems and processes to support placement and workforce development activity	• Administering workforce initiatives, for example, voluntary bonding, Advanced Trainee Fellowship Scheme and other HWNZ innovations • Improve data collection and analysis for clinical workforces to improve long term planning

Engaging our clinical staff to create change

Strengthen Clinical leadership

Our clinical leaders are increasingly being involved in decision making and accountability across the spectrum of care within our organisation. At CMDHB, we rely on clinical leadership in service development, future workforce planning, professional development and day-to-day operations of clinical teams. We engage our front line clinical staff in creating innovative solutions to improving the patient journey.

CMDHB has appointed a Clinical Director of Clinical Leadership responsible for strengthening clinical leadership linkages to promote our culture of quality improvement and innovation and the development of a Clinical Leadership Academy. We are developing a framework for outlining how clinical leadership is linked to accountability and expectations at various levels within our organisation. The role of leadership is about lifting performance from the bottom up. Our recent organisational redesign established a Clinical Leadership Team[8] to strengthen clinical leadership capability and decision making functions. All members of the Clinical Leadership Team are members of the Executive Leadership Team. We have a commitment to fostering clinical and managerial partnerships throughout our organisation and have demonstrated this by partnering a clinical director with senior managers across the organisation.

We offer a number of programmes aimed at developing leadership in clinical and non-clinical staff. For the past five years, our Nursing Professional Development Unit has facilitated over 300 senior nursing, midwifery and managerial staff through our Coaching for Change programme. We recognise that coaching and mentoring is a key component of transformational leadership and building coaching cultures. Part of this programme involves ongoing leadership development that includes building internal capability. We now have more nurses providing internal facilitation of courses and mentoring of staff thus building capacity. We have also embedded a successful internship model called CREAM for developing our senior nurses. This is based on the Waikato DHB model

Through our partnership with the Institute for Healthcare Improvement, we provide our staff with access to the IHI Open School online modules which have a focus on patient safety and improvement science. Ko Awatea is now running the following three national quality improvement and leadership courses with endorsement and sponsorship from the Health Quality and Safety Commission:

- Improvement Science in Action is a six month professional development programme, specially designed for people actively involved in health care improvement projects. The course involves a three day workshop, combined with pre and post conference calls. The programme aims to enhance participant's perspective on improvement science and advance capabilities as a leader in this critical discipline.

- The Breakthrough Series (BTS) College is a collaborative improvement model to accelerate improvement worldwide. BTS is a powerful way to help organisations adapt proven methods to spread outstanding improvements across their work. The initial three days of intensive workshops are designed to prepare participants to perform the key roles of Project Manager and Improvement Advisor. Participants have access to ongoing development through conference calls, an email listserv, and access to the College website.

- The Executive Quality Academy is aimed at equipping hospital executives to lead whole system improvement. Quality improvement is now a strategic imperative. Responsibility for measured performance in clinical quality and safety rests with each member of the senior executive team, regardless of whether or not they have a clinical background.

In addition to the Executive Quality Academy, our senior executives and clinical leaders attend Hardy Group International Executive Learning Sets. These Learning Sets consist of six to eight executives who meet at regular intervals with an experienced facilitator. Three or four meetings a year are held in the major cities on Australia's Eastern seaboard and New Zealand. Learning Sets build a network of executives to share ideas, approaches and learn from each other.

[8] Membership includes: Chief Medical Officer for Hospital Services, Director of Nursing for Hospital Services, Director Allied Health, Chief Medical Adviser Primary and Integrated Care, Chief Nursing Adviser Primary and Integrated Care and includes facilitation by the Clinical Director Clinical Leadership

The IHI Open School is an online learning programme which includes seven programmes relating to patient safety, teamwork and communication, system analysis and leadership.

Additionally, we have access through active membership to clinical and management programmes coordinated by the Health Round Table and Advisory Board International as well as a sub group called Global Centre for Nurse Executives.

Career planning

Our Career Development Consultant, based in Learning and Development, has created a career planning process for our staff. This process has been adopted by HWNZ. All staff members who receive HWNZ funding will create a career plan. In addition to these requirements, the Career Development Consultant is continuing to progress a career pathway mapping project. By mapping out career options, staff have the opportunity to have meaningful conversations with their managers about their personal aspirations. Career planning can be a useful engagement tool for staff and should also be linked to service and workforce planning.

3.2.2 Quality and Patient Safety

Our commitment to Quality and Safety

Our Centre for Quality Improvement provides a focus on both the quality improvement knowledge and technical skills needed to ensure healthcare is reliable in practice; and the knowledge and skills needed to appraise and evaluate scientific evidence, the development of proven healthcare interventions, leading to improvements in patient care. The Centre is integral to the *Achieving a Balance*, *Aiming for Zero Patient Harm* work programme which is aligned with the northern region health plan goal of *First, Do No Harm* and will be involved in driving a large and diverse range of quality improvement and quality assurance programmes and initiatives across CMDHB in the these areas:

- Reducing CMDHB's prevalence of Falls, Pressure Injuries, VTEs
- Improving Patient Identification
- Reducing healthcare associated Infections such as CLAB and SSI,
- Improving hand hygiene and environmental cleaning practices; and
- Improving the Dignified and Safe Handling of patients.

The Centre also supports and facilitates other quality improvement initiatives across the whole organisation such as work piloting and rolling out electronic medicines reconciliation (eMR), medication safety campaigns like the Dirty Dozen and the 5 Rights, facilitating the use of a trigger tool to identify and quantify adverse events (patient harm) from medicines as a way of targeting patient safety efforts, as well as work around Capacity Management and Beds across the hospital system. Another example of quality improvement work across the organisation includes supporting and developing work in relation to family / whaanau as partners in care.

Service / division specific work includes initiatives such as work in MSC across a range of issues like improving DNA rates and developing patient focussed booking as well as work on improving theatre capacity and improving time to PCI for STEMI patients.

We are supporting the following national programmes

Medication Safety

The national medication chart has been adopted across Middlemore Hospital and the long stay chart has been piloted in several long stay wards.

The Centre has successfully led an electronic medicines reconciliation (eMR) process in a number of areas including plastics, burns and AT & R over the last 18 months and will facilitate the roll out of eMR across the services and divisions in the 2012/13 year.

The Centre will continue its work on the IHI Adverse Drug Event (ADE) Trigger Tool in conjunction with Canterbury and Capital & Coast DHBs.

The Centre will continue its medication safety campaign work in conjunction with the Pharmacy Service that includes the Dirty Dozen (identifying the top 12 medicines associated with harm) and 5 Rights in relation to safe medicines administration.

Quality Accounts

The Centre will develop a framework for producing CMDHB's first Quality Account by June 2013. The Quality Account will report publicly current and planned quality improvement activities to foster confidence amongst the patients that use CMDHB's services that clinicians and managers are focused on learning to continuously improve the systems and processes involved in the delivery of patient care.

Reportable Events

The Centre plays a pivotal role in the Serious and Sentinel Events (SSE) Committee and the national release. The national Reportable Events Policy will be adopted when it is finalised.

Infection Prevention and Control

The Centre will continue to actively support the divisions and services in efforts to improve CMDHB's compliance with Hand Hygiene by participating in the national gold audit, promoting the importance of Hand Hygiene across CMDHB including organising events around International Hand Hygiene Days in May and October 2012 as well as working actively with the wards and other clinical areas to identify improvements to hand hygiene practices.

The Centre has advanced planning towards the implementation of a Surgical Site Infection surveillance database and monitoring system and will contribute its learning on this to the lead agency appointed by the HQ&SC for the national SSI system. The Centre has taken and continues to take an active role in the Central Line Associated Bacteraemia (CLAB) prevention collaborative at a local and national level.

3.2.3 Information Systems

Integrated Information Systems to drive better information sharing and clinical decision making

The Northern region is currently implementing nine workstreams to deliver on the region's IS priorities and the National IT Plan 2010 priorities, which include: Quality Information for Primary Care; Continuum of Care; Safe Medication Management; Clinical Support; Patient Administration System; Population Health; Business Support; Safe Sharing Foundations (incl. Infrastructure); Shared Care.

Detailed implementation plans for each workstream can be found in the Northern Region Health Plan 2012/13 (expected publication date June 2012). Our regional Information Systems strategy will move the region towards a common, regional IT platform to support regional clinical systems which enable greater sharing of information and continuity of care for the patient in the region across the continuum of services. The Northern Region's IS priorities are summarised below:

- Single Patient Administration System – the region will progressively move to a common patient administration system underpinned by standardised processes and improved data quality related to patient registration (NHI, demographics) and administration (referring, scheduling, booking, administration, transfer and discharge) of patients through our facilities. For primary care, improved access and contribution to NHI, demographics and visit information is required. Seamless integration with primary care patient management systems will be required to support primary care access to the regional clinical work station and regional clinical data repository outlined below.
- Single Clinical Workstation – to provide a consistent user experience, improve clinical communication options and reduce the complexity of integration and audit functions, the four DHBs will progressively standardise on a single clinical workstation (CWS) – in practice a single version of Concerto. This activity will be supported by the national initiative to standardise the clinical workstation.
- Regional Clinical Data Repository – to achieve the requirements of continuity of care, a regional clinical data repository (CDR) is required and the most important step to be taken now is for Northland to join the use of the Regional TestSafe system; that is, Northland clinicians must be able to both access and contribute to this regional clinical repository. An additional objective should be to improve primary care access and contribution to TestSafe.
- Population Health Data Repository – create a single source of truth for regional population health information potentially supported by a shared population health intelligence team. This will improve collection, quality, availability and sharing of population health data across DHBs and PHOs.
- IS Infrastructure Resilience – to maintain current capability and support ongoing development, resilience of core IS infrastructure in all four DHBs must be reinforced.
- Electronic solutions to support Safe Medication Management – this supports the national eMedicines programme of work and for the Northern Region will encompass the roll-out of medicine reconciliation for secondary care and a pilot for hospital ePrescribing.
- Shared Care Plan – critical to the future new models of care is the ability to bring multidisciplinary te4ams across primary, community and secondary care together with the patient in a shared care planning environment. The investment in a truly patient centred clinical management system is critical to promote ongoing investment in integrated care, devolution, acute demand management and empowerment of patients.

3.2.4 Innovation and our Health Innovation Hub

Fostering a research and development culture

We believe innovation is a key to long term sustainability for our health system. We have within our organisation many people who are experts and specialists in their fields. We want to be able to harness their great ideas and innovation to help improve our services and where possible, to turn those innovations and ideas with high commercial potential into actual products.

To that end, we have jointly established with Auckland DHB, Waitemata DHB and Canterbury DHB, a national health innovation hub ('Hub') to grow New Zealand's health innovation sector. The Hub will engage with industry to develop, validate and commercialise health technologies and service improvement initiatives that will deliver health and economic benefits to New Zealand.

The Hub will act as a specialist intermediary between private sector industry and the public health system, creating a clinically, ethically and commercially 'safe' environment for industry, clinicians, and the health sector to engage in innovation projects identify health technology and service innovation projects that have high commercial potential.

We believe our Health Innovation Hub will be a great asset to the DHB and will attract new people to work for the DHB as well as retain the workforce that we already have onboard.

3.2.5 TOWARDS 20/20 – Our Facilities Masterplan

Facilities which are fit for purpose

We are fully committed to the redesign of our health facilities to support the transformation of our health system towards more collaborative, integrated and interdisciplinary models of care which support patient centred care.

TOWARDS 20/20 is our major long term investment into the building and refurbishment of Counties Manukau health facilities and services to support the growing needs of our community into the future. We have currently completed two phases of our three phase development master plan.

Phase 3 will be the most challenging and will consider the impact our future growth will have on our clinical and facility requirements over the next 12 years to 2020. Clinical service planning along with asset review and master planning exercises are identifying options for accommodating the growth across the District Health Board. This will include a new Clinical Services Building on the Middlemore Site and development of the Manukau Health Park.

Manukau Health Park

With full support of our Board, the 52ha Manukau site on Browns Road was renamed the Manukau Health Park (MHP) in 2009. The long term objective is that the **MHP** will house numerous health related, but wellness orientated services as well as the current clinics and hospital services which may well retain their names but within a health park complex – The **Manukau Health Park.** The emphasis within which will be **wellness** and with a strong community integration and service innovation focus.

The Master Plan of CMDHB has embedded links and dependencies between Middlemore redevelopment (from its 1940s establishment), expansion of Manukau Super Clinic, the Manukau Surgical Centre and eventual rationalisation of a number of its inefficient and aged satellite site buildings.

By far the greatest dependency however is driven by the need to modernise and expand Middlemore Acute Hospital (MMH) to cater for the known growth from increased volumes. By taking non acute capacity out of MMH to an expanded MHP would result in much needed increased surgical and clinical capacity at Manukau, relocation of Mental Health, ARHOP and District Nurse base and also allowing the decanting of MMH to facilitate its much needed rebuild and expansion.

In December 2011, the Northern Region presented a collaborative Capital Intentions summary to the Capital Investment Committee. The Counties Manukau DHB component of prioritised major projects for the 2012-2017 period included the Manukau Health Park business cases. Further to that, we have been asked by the Ministry of Health to 'realign' our 2009 Manukau Health Park development business cases to the new Treasury Better, Business Case guidelines. CMDHB will use this process to refresh our business strategy and reaffirm how capital investment will best support our aspirations to improve the health of our community.

3.3 ASSOCIATE AND SUBSIDIARY COMPANIES

Shareholdings in other companies

HealthAlliance NZ Limited

Counties Manukau DHB together with Waitemata DHB established healthAlliance NZ Limited, a non clinical shared services agency some ten years ago as an early commitment to ensuring a value for money approach to health .This has been extremely successful in all areas of activity in both consistently achieving considerable savings and ensuring a standardisation of approach wherever possible. It was expanded in April 2011 to include Auckland DHB and Northland DHB and will be working in close alignment with HBL to build on these gains for both local and national benefit.

Innovation Hub

Counties Manukau DHB together with Auckland DHB, Waitemata DHB and Canterbury DHB jointly established *The Hub* - a national innovation hub which will engage with industry to develop, validate and commercialise health technologies and services improvement initiatives that will deliver health and economic benefits to New Zealand.

The DHB is finalising arrangements that may require Ministerial approval to either the changes or new investment

Ko Awatea

The establishment of Ko Awatea has necessitated an unincorporated joint venture which will function through a limited liability nominee company incorporating the four shareholders – Counties Manukau DHB, University of Auckland Faculty of Medicine & Health Sciences, Manukau Institute of Technology and AUT University – to hold the shared educational assets related to Ko Awatea. This approval request is presently with the Minister.

Locality Clinical Partnerships

We are exploring options including the use of special purpose vehicle or joint venture arrangements with PHOs for the delivery of locality clinical partnerships.

Integrated Family Health Centres/ Whanau Ora Centres

Likely establishment of a special purposes vehicle for Integrated Family Health Care / Whanau Ora Centre, in conjunction with Tainui on land owned by CMDHB at the Manukau Health Park.

3.4 ACCOUNTABILITY AND CONSULTATION

As required by legislation

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

- Significant changes to the way in which we invest/ deliver services (as per MOH Service Change Guidelines)
- Entering into new arrangements such as the changes in shareholding with healthAlliance NZ Limited, and Ko Awatea and the Innovation Hub.
- Any proposal for significant capital investment or the disposal of Crown land

We will also comply with requirements in relation to any specific consultation expectations that the Minister communicates to us.

Module 4: Forecast Service Performance

The DHB is required under Section 142 of the Crown Entities Act 2004 to provide a statement of forecast service performance. The measures in the Statement of Forecast Service Performance are non financial measures and consist of key outputs which the DHB is planning to deliver through its planned activities/ actions for 2012/13.

Figure 9 in Module 2 shows our intervention logic and how our strategic outcomes - influenced by national and regional priorities - guide our decisions around what level of **input** (that is, resources) and mix of services best meets our population's health needs, how they are to be delivered and to what level.

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

Outputs are measured against the following six dimensions of quality[9]:

Dimension	What this means for our services
Safe	No unnecessary harm
Patient Centred	Involve patients in their care and in system improvements
Efficient	Reduce waste
Timely	No unnecessary waiting
Equitable	Services matched to the level of social and health need to provide equal opportunity of health outcomes
Effective	Doing things which are evidence based

Where possible, we have included past performance (baseline data or current performance) along with each performance target to give some context of what we are trying to achieve over the next 12 months and to better evaluate our performance.

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

For expediency, we have chosen only the key few measures of output and impact for each output class which best describes the activities that will make the biggest contribution to the DHB's achievement of key strategic objectives and improved health outcomes for our population.

The actual results of our service performance against what was forecast here will be published in our 2012/13 Annual Report.

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

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

Table 1: Level of input against all four output classes

Total $000	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**1,296,172**	**1,376,893**	**1,418,668**	**1,485,339**	**1,555,141**
Personnel costs	453,525	485,786	511,984	535,821	560,773
Outsourced Services	54,515	54,338	52,942	55,052	57,255
Clinical Supplies	101,766	102,759	103,697	108,568	113,667
Infrastructure & Non-Clinical Supplies	101,999	101,291	96,118	100,543	105,177
Other	579,506	627,719	650,922	682,282	715,122
Total costs	**1,291,311**	**1,371,893**	**1,415,663**	**1,482,266**	**1,551,994**
Surplus (Deficit)	**4,861**	**5,000**	**3,005**	**3,073**	**3,147**

Table 2: Level of input for Prevention Services

Prevention	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**19,878**	**16,689**	**20,222**	**21,233**	**22,294**
Personnel costs	3,524	3,177	4,758	4,996	5,246
Outsourced Services	1,621	1,368	1,430	1,502	1,577
Clinical Supplies	1,983	1,482	1,226	1,287	1,351
Infrastructure & Non-Clinical Supplies	1,330	14	1,146	1,203	1,263
Other	11,420	10,648	11,662	12,245	12,857
Total costs	**19,878**	**16,689**	**20,222**	**21,233**	**22,294**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Table 3: Level of input for Early Detection and Management services

Early Detection	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**188,712**	**214,325**	**222,703**	**233,838**	**245,530**
Personnel costs	-	-	-	-	-
Outsourced Services	-	-	-	-	-
Clinical Supplies	-	-	-	-	-
Infrastructure & Non-Clinical Supplies	-	-	-	-	-
Other	188,712	214,325	222,703	233,838	245,530
Total costs	**188,712**	**214,325**	**222,703**	**233,838**	**245,530**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Table 4: Level of input for Intensive Assessment and Treatment services

Intensive	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**994,400**	**1,046,215**	**1,067,090**	**1,116,182**	**1,167,527**
Personnel costs	450,001	482,609	507,226	530,825	555,527
Outsourced Services	52,894	52,970	51,512	53,550	55,678
Clinical Supplies	99,783	101,277	102,471	107,281	112,316
Infrastructure & Non-Clinical Supplies	100,669	101,277	94,972	99,340	103,914
Other	286,192	303,082	307,904	322,113	336,945
Total costs	**989,539**	**1,041,215**	**1,064,085**	**1,113,109**	**1,164,380**
Surplus (Deficit)	**4,861**	**5,000**	**3,005**	**3,073**	**3,147**

Table 5: Level of input for Rehabilitation and Support services

Rehabilitation	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**93,182**	**99,664**	**108,653**	**114,086**	**119,790**
Personnel costs					
Outsourced Services					
Clinical Supplies					
Infrastructure & Non-Clinical Supplies					
Other	93,182	99,664	108,653	114,086	119,790
Total costs	**93,182**	**99,664**	**108,653**	**114,086**	**119,790**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Reference Key:

NHT	National Health Target (MOH accountability)	**C**	Coverage
PP	Policy Priority measure (MOH accountability)	**V**	Volume
OS	Ownership measure (MOH accountability)	**S**	Safe (Quality measure)
SI	System Integration measure (MOH accountability)	**P**	Patient Centred (Quality measure)
DV	Developmental measure (MOH accountability)	**W**	Efficient (Quality measure)
NRHP	Regional Target (Northern Region Health Plan)	**T**	Timely (Quality measure)
DD	Demand Driven measure	**E**	Equitable (Quality measure)
		F	Effective (Quality measure)

4.2 OUTPUT CLASS: PREVENTION SERVICES

Output Class Description

Prevention services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.
Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.

Outputs and related measures	Forecast Performance		Reference
Health Promotion and Education Services			
Smoking Cessation • *We deliver smoking cessation advice and support in secondary and primary care* • *We fund community based programmes to support people living Smokefree.*			
Proportion of hospitalised smokers provided with advice and help to quit	Q3 2011/12 Result 93.66%	By July 2013 95%	NHT5 C
Proportion of enrolled primary care patients who are smokers and are seen in General Practice are provided with advice and help to quit	Q2 2011/12 Result 16%	By July 2013 90%	NHT5 C
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Care are offered advice and support to quit *Note: MOH is currently developing a system in order to capture and report on results of this new measure*	Baseline *New measure - to be established*	By July 2013 90%	NHT5 C
Breastfeeding education and promotion services • *We will collaborate with local providers and fund initiatives to encourage and promote breastfeeding.*			
Number of community providers participating in Baby Friendly Community Initiative (BFCI) accreditation: *The BFCI aims to protect, promote and support breastfeeding for mothers and babies.*	2011/12 Baseline 0	By July 2013 3	V

<table>
<tr><th>Outputs and related measures</th><th>Forecast Performance</th><th>Reference</th></tr>
<tr><td>Proportion of infants fully and exclusively breastfed at 6 weeks, 3 months and 6 months.
The proportion of women breastfeeding is a measure of service quality, demonstrating the effectiveness of consistent breastfeeding messages delivered before birth and post birthing.</td><td>
<table>
<tr><th></th><th></th><th>Baseline (Dec 2011)</th><th>By July 2013</th></tr>
<tr><td rowspan="3">6 weeks</td><td>Maaori</td><td>56%</td><td rowspan="3">67%</td></tr>
<tr><td>Pacific</td><td>54%</td></tr>
<tr><td>Total</td><td>56%</td></tr>
<tr><td rowspan="3">3 Months</td><td>Maaori</td><td>37%</td><td rowspan="3">55%</td></tr>
<tr><td>Pacific</td><td>43%</td></tr>
<tr><td>Total</td><td>43%</td></tr>
<tr><td rowspan="3">6 Months</td><td>Maaori</td><td>14%</td><td rowspan="3">26%</td></tr>
<tr><td>Pacific</td><td>17%</td></tr>
<tr><td>Total</td><td>18%</td></tr>
</table>
</td><td>SI7
F</td></tr>
<tr><td colspan="3">Healthy Environments
• We work with Housing New Zealand and other non-governmental agencies to improve the housing conditions in the community. This includes the ongoing implementation of the healthy housing programme in Counties Manukau conjunction with Housing New Zealand and other participating DHBs which includes a holistic health and housing assessment as its central plank.
• We are also retrofitting insulation for low income families/ households to reduce the high levels of chronic respiratory conditions arising from poorly insulated and damp homes.</td></tr>
<tr><td>Completed health and housing assessments</td><td>
<table>
<tr><th>Baseline (2011)</th><th>By July 2013</th></tr>
<tr><td>482</td><td>320</td></tr>
</table>
</td><td>V</td></tr>
<tr><td>Number of homes insulated</td><td>
<table>
<tr><th>Programme</th><th>By July 2013</th></tr>
<tr><td>Warn Up CM</td><td>1000</td></tr>
</table>
</td><td>V</td></tr>
<tr><td colspan="3">Family Violence Prevention
• We deliver coordination of the Violence Intervention Programme which includes training staff in Adult and Children’s Emergency Care, and Children’s Surgical and Medical wards in family violence intervention and screening for partner and child abuse and neglect.</td></tr>
<tr><td>Proportion of woman over 16 years of age presenting to designated areas routinely screened for partner and child abuse</td><td>
<table>
<tr><th></th><th>Baseline</th><th>By July 2013</th></tr>
<tr><td>Adults - EC</td><td>7%</td><td>20%</td></tr>
<tr><td>Kidz First -EC</td><td>8%</td><td>20%</td></tr>
<tr><td>Kidz First - Medical and Surgical wards</td><td>3%</td><td>5%</td></tr>
</table>
</td><td>C</td></tr>
<tr><td>Hospital Responsiveness to Family Violence, Child and Partner Abuse Programmes Audit Score (self audit using AUT tool):
The audit score is a measure of the quality of the integrated family violence and child and partner abuse programmes implemented within health services like routine enquiry and child assessments in Emergency Departments and health professional training methods.</td><td>
<table>
<tr><th></th><th>Baseline (Q4, 2010/11)</th><th>By July 2013</th></tr>
<tr><td>Partner Abuse</td><td>89 / 100</td><td>90 / 100</td></tr>
<tr><td>Child Abuse and Neglect</td><td>84 / 100</td><td>90/ 100</td></tr>
</table>
</td><td>F</td></tr>
</table>

Outputs and related measures	Forecast Performance	Reference
Immunisation Services		
• *We work in collaboration with immunisation providers (including general practice, outreach, school and other community settings) to deliver immunisation service*		
Proportion of 8 month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time *Note: Current Immunisation reports are for 6, 12 and 24 months. The 8 month milestone report is being developed by MOH as it is a new national health target*	Baseline: *New measure - to be established* By July 2013: 85% Maaori Pacific Total	NHT 4 C
Proportion of eligible children fully immunised at 24 months	Q3 2011/12 / By July 2013 Maaori 87% Pacific 96% Total 93% By July 2013: 95%	PP21 C
Proportion of older people (65+) who have had their flu vaccinations	Baseline (Dec2011): 62.39% By Dec 2012: 63.95%	C
Health Screening		
Breast Screening		
• *We provide free breast screening services for women aged 45 to 69 years old through the BreastScreen Aotearoa programme* •		
Proportion of women aged 45 – 69 years who have had a breast screen in the last 24 months	Baseline (December2011) / By July 2013 Maaori 66.3% Pacific 66.1% Total 67.4% By July 2013: 70%	C
Cervical Screening • *We fund primary care providers to deliver free cervical screening for women aged 20 – 70 years*		
Proportion of women aged 20 - 70 years who have had a cervical smear in the last three years.	Baseline (Dec 2011) / By July 2013 Total 63.83% By July 2013: 75%	C

<table>
<tr><th>Outputs and related measures</th><th>Forecast Performance</th><th>Reference</th></tr>
<tr><td colspan="3">Well Child/ Tamariki Ora
• We fund Well Child/ Tamariki Ora providers to deliver services to support new mothers and their infants. This includes Well Child Checks, home visits and B4 School Checks
• The B4 School Check includes hearing and vision, oral health, weight and height checks. It is the final core Well Child/ Tamariki Ora check which ensures that any health problems are identified early and children are ready for learning and to reach their full potential</td></tr>
<tr><td>Proportion of the eligible population who have had their B4 School Checks</td><td><table><tr><td></td><td>Baseline (FY2011/12)</td><td>By July 2013</td></tr><tr><td>Vision and Hearing (2 components)</td><td rowspan="2">7061 (80% of eligible population)</td><td rowspan="3">80% of eligible population (including 80% of high dep)</td></tr><tr><td>Nurse (Well child – 6 components)</td></tr><tr><td>Children who have 1 component missing from their check</td><td>0</td></tr></table></td><td>C
E</td></tr>
<tr><td colspan="3">Statutory and Regulatory Services</td></tr>
<tr><td colspan="3">• The Auckland Regional Public Health Service is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau DHB and Waitemata DHB under a contract with the Ministry of Health. The service provides statutory and regulatory public health services including responding to outbreaks, environmental hazards and other emergencies. They also deliver health promotion services and advise and/or advocate for healthy public policy.
• The following baselines and targets are regional and relate to all 3 metro-Auckland DHBs.</td></tr>
<tr><td>Proportion of premises who submit a liquor licence application to ARPHS and all problematic premises that receive a compliance check</td><td><table><tr><td>Baseline (December 2011)</td><td>By July 2013</td></tr><tr><td>82%</td><td>100%</td></tr></table></td><td>C</td></tr>
<tr><td>Proportion of liquor licensing alcohol compliance protocol for visits adhered to
Compliance of liquor retailers with protocol and current legislation is seen as a measure of the quality of information, training and advice services provided to retailers</td><td><table><tr><td>Baseline (December 2011)</td><td>By July 2013</td></tr><tr><td>97%</td><td>100%</td></tr></table></td><td>F</td></tr>
<tr><td>Numbers of submissions made</td><td><table><tr><td>Baseline (December 2011)</td><td>By July 2013</td></tr><tr><td>12</td><td>15</td></tr></table></td><td>V</td></tr>
</table>

4.3 OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT SERVICES.

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. These include general practice, community and Maaori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

<table>
<tr><th>Outputs and related measures</th><th>Forecast Performance</th><th>Reference</th></tr>
<tr><td colspan="3">Primary Health Care Services (GP)</td></tr>
<tr><td colspan="3">• We fund PHOs to deliver primary care services to improve, maintain or restore people's health
• We work in collaboration with primary care services to achieve better identification and management of high risk individuals.</td></tr>
<tr><td>Rate of GP consultations for high needs population compared with non-high needs population
The rate measures if GP services are matched to the level of health need to provide equal opportunity of health outcomes</td><td><table><tr><td>Baseline (September 2011)</td><td>By July 2013</td></tr><tr><td>1.04</td><td>> 1</td></tr></table></td><td>E</td></tr>
<tr><td>Number of bed days saved through our Saving 20,000 Days Campaign initiatives
Achievement of this target will give our community 20,000 healthy and well days and it is also a measure of the effectiveness of improved processes and systems within the suite of initiatives that make up our 20,000 Days campaign</td><td><table><tr><td>Baseline</td><td>By July 2013</td></tr><tr><td>0</td><td>20,000 days</td></tr></table></td><td>F</td></tr>
<tr><td colspan="3">Long Term Conditions Management</td></tr>
<tr><td colspan="3">• In conjunction with our primary care and community partners we fund the delivery of targeted programmes aimed at people with high health needs due to long term conditions to reduce the incidence and impact of their conditions through early detection and intervention and better management in primary care and community care settings.
• These include:
o Early detection and intervention services like diabetes checks and minor skin lesions surgery provided by GPs
o Education programmes to support patients' self-management of long term conditions
o Structured primary care programmes aimed at better management of individuals with chronic conditions like the Diabetes Care Improvement Package, Chronic Care Management (CCM), Primary Options for Acute Care (POAC) and the Very High Intensive User Programme</td></tr>
<tr><td>Proportion of people with diabetes who have had an annual check</td><td><table><tr><td>Baseline (Q3, 2011/12)</td><td>By July 2013</td></tr><tr><td>77%</td><td>82%</td></tr></table></td><td>PP20
C</td></tr>
<tr><td>Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c of equal to or less than 64 mmol/mol)
Improving the management of diabetes will reduce avoidable complications that require hospitalisation, and will improve quality of life for diabetics.</td><td><table><tr><td></td><td>Baseline (Q3, 2011/12)</td><td>By July 2013</td></tr><tr><td>Maaori</td><td>55%</td><td rowspan="3">66%</td></tr><tr><td>Pacific</td><td>48%</td></tr><tr><td>Total</td><td>60%</td></tr></table></td><td>PP20
F</td></tr>
</table>

Outputs and related measures	Forecast Performance	Reference
Number of additional patients enrolled in Self Management (SM) programmes	Baseline (YTD Jan 2012): 800 By July 2013: 1100	V
Number of patients registered in all Chronic Care Management (CCM) programmes *CCM programmes allow for those with Chronic Conditions to actively manage their health in primary care in the community. This in turn leads to decreased acute admissions and avoidable mortality.*	Baseline: Total 18,200 By July 2013: > 19,000	V DD
Number of enrolments / referrals in Primary Options for Acute Care (POAC) *POAC contributes to the regional work we are doing to decrease hospital admissions that can be avoided through primary care intervention for conditions like cellulitis*	Baseline (Jan – Dec 2011): 9,167 By July 2013: 11,600	V
Oral Health Services		
• *We contract the Auckland Regional Dental Service to deliver free oral health services for children aged 0 to 12 years old at our community based clinics and mobile diagnostic vans* • *We contract with private dentists to deliver free oral health services for our adolescents aged 13 to 17 years old* • *We deliver targeted preschool oral health promotion and brushing programmes with our partners in the kohanga reo, early childhood education sector.*		
Proportion of children under 5 years enrolled in DHB-funded oral health services	Baseline (December 2011): 66% By Dec 2012: 73% By Dec 2013: 75%	PP13a C
Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)	Baseline (December 2011): 12% By Dec 2012: 12% By Dec 2013: 7%	PP13b T
Number of preschool centres engaged in the oral health education and tooth brushing programme.	Baseline (December 2011): 0 By July 2013: 150	V
Proportion of Year 8 children who have their treatment completed and are transferred to the Adolescent dental service	Baseline (December 2011): 100% By July 2013: 100%	C
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services.	Baseline (December 2011): 67% By Dec 2012: 80% By Dec 2013: 85%	PP12 C

Outputs and related measures	Forecast Performance		Reference
Diagnostics			
Proportion of accepted referrals for CT and MRI scans will receive their scan within 6 weeks	Baseline *New measure - to be established*	By July 2013 75%	DV2 T
Proportion of patients accepted as priority 1 for diagnostic colonoscopy who receive the procedure within 2 weeks (14 days) :	Baseline *New measure - to be established*	By July 2013 50%	NRHP DV2 T
Proportion of patients accepted as priority 2 for diagnostic colonoscopy who receive their procedure within 6 weeks (42 days):	Baseline *New measure - to be established*	By July 2013 50%	NRHP DV2 T
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date	Baseline *New measure - to be established*	By July 2013 50%	NRHP DV2 T

4.4 OUTPUT CLASS: INTENSIVE TREATMENT AND ASSESSMENT SERVICES.

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital' or surgery centre. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services

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

<table>
<tr><th>Outputs and related measures</th><th>Forecast Performance</th><th>Reference</th></tr>
<tr><td colspan="3">Mental Health</td></tr>
<tr><td colspan="3">• We provide and/or contract a matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health & Addiction services covering Child, Adolescent & Youth; Adult; and Older Adult Age bands.
• The matrix of services comprise:
o Acute and intensive services
o Community based clinical treatment and therapy services
o Services to promote resilience, recovery and connectedness.</td></tr>
<tr><td>Proportion of people referred for non-urgent mental health or addiction services seen within three weeks and 8 weeks.</td><td><table><tr><td></td><td>Baseline (Q2, 2011/12)</td><td>By July 2013</td><td>By July 2015</td></tr><tr><td>3 weeks</td><td>71.3%</td><td>75%</td><td>80%</td></tr><tr><td>8 weeks</td><td>81.2%</td><td>85%</td><td>95%</td></tr></table></td><td>PP8
T</td></tr>
<tr><td>Proportion of long term clients with Relapse Prevention Plan (RPP).
Relapse prevention plans identify early relapse warning signs of clients. The plan identifies what a client can do for themselves and what the service will do to support the client. Relapse prevention planning contributes to better outcomes for people with serious mental illness and is a quality measure of patient centred care.</td><td><table><tr><td></td><td></td><td>Baseline (December 2011)</td><td>By July 2013</td></tr><tr><td>Child and Youth</td><td>Maaori</td><td>70.7%</td><td rowspan="4">95%</td></tr><tr><td></td><td>Total</td><td>78.1%</td></tr><tr><td>Adult (20+)</td><td>Maaori</td><td>86.5%</td></tr><tr><td></td><td>Total</td><td>90.5%</td></tr></table></td><td>PP7
P</td></tr>
</table>

Outputs and related measures	Forecast Performance	Reference
Elective Services		
• *We provide and purchase elective inpatient and outpatient services*		
Elective Services Performance Indicator (ESPI) compliance: • ESPI 1: DHB services that appropriately acknowledge and process all patient referrals within 10 working days. • ESPI 2: Patients waiting longer than five months for their first specialist assessment (FSA) by July 2013, • ESPI 3: Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT) • ESPI 5: Patients given a commitment to treatment but not treated within five months by July 2013. • ESPI 6: Patients in active review who have not received a clinical assessment within the last 6 months. • ESPI 8: Proportion of patients treated who were prioritised using nationally recognised tools and processes. *As a patient moves through the Electives system there are a number of key decision/ indicator points – from when the person is first referred for specialist assessment, through to when decisions are made about whether or not assessment and treatment will be given, to the point when the patient returns to the care of their GP (or primary care provider). The ESPIs measure whether DHBs are meeting the required performance standard at each of these points.*	ESPI 1: Baseline (Dec 2011): 100% — By July 2013: 100% ESPI 2: Baseline (Dec 2011): 0.0% — By July 2013: 0.0% ESPI 3: Baseline (Dec 2011): 0.2% — By July 2013: 0.0% ESPI 5: Baseline (Dec 2011): 0.2% — By July 2013: 0.0% ESPI 6: Baseline (Dec 2011): 0.0% — By July 2013: 0.0% ESPI 8: Baseline (Dec 2011): 100% — By July 2013: 100%	T T E T T E
Elective and Arranged Day of Surgery Admission:	Q3, 2011/12: 86.2% — By July 2013: 90%	OS 7
Elective Theatre Utilisation Rate *Theatre utilisation rate is a quality measure of how well theatre resources are being used. Optimising theatre utilisation will create additional capacity for delivering more services.*	Q3, 2011/12: 87% — By July 2013: 85%	OS 5 W

Outputs and related measures	Forecast Performance			Reference
Elective Services Standardised Intervention Rates (SIRs) per 10,000 of population *The SIRs target rates reflect equitable levels of access to elective surgery*		Current Rate (Q3 2012/13)	By July 2013	SI 4 E
	Major joints	20.05	21.00	
	Cardiac	6.10	6.50	
	Cataracts	40.11	27.00	
Acute Services				
Emergency Department *We provide an emergency and acute care service with the following characteristics:* • *timely access to all service components (including diagnostics) and appropriate timely discharge.* • *capacity to meet needs* • *right treatment in the right place* • *timely patient transfer to appropriate services from Emergency Department.* • *good access to support services in the community or primary care level to support patient recovery.*				
Cancer Services • *We work in collaboration with the Northern Region Cancer Network to improve cancer wait times and access to diagnosis and treatment to ensure cancer patients and their families have access to good information about support services available*				
All Medical Oncology and Haematology patients needing Radiation Therapy or Chemotherapy treatment (and are ready to start treatment) will have this within four weeks from decision to treat.	*Radiotherapy*	Q3, 2011/12	By July 2013	NHT 3 NRHP T
	Maaori	100%	100%	
	Pacific	100%		
	Total	100%		
	Chemotherapy	Q2, 2011/12	By July 2013	NHT 3 NRHP T
	Maaori	88%	100%	
	Pacific	70%		
	Total	96%		
Proportion of patients referred urgently with high suspicion of Lung cancer to first cancer treatment (62 days). *Note: The Northern Cancer Network is currently developing a system to monitor this measure.*	Baseline	By July 2013		NRHP DV1 T
	New measure – to be established	60%		

Outputs and related measures	Forecast Performance		Reference
Proportion of patients referred urgently with high suspicion of lung cancer to first specialist appointment (all treatment types) within 14 days.	Treatment Type	Q2, 2011/2 / By July 2013	NRHP DV1 T
	Radiation oncology	66.7% / 50%	
	Medical oncology	33.3%	
Proportion of patients with confirmed lung cancer diagnosis who receive first cancer treatment within 31 days of decision of treat (all treatment types) *Note: The Northern Cancer Network is currently developing a system to monitor this measure.*	Baseline	By July 2013	NRHP DV1 T
	New measure - to be established	50%	
Cardiac Services *We provide intensive treatment and assessment services for patients with cardiovascular disease*			
Proportion of all outpatients triaged to chest pain clinics who are seen within 6 weeks for cardiology assessment and stress test	Q2, 2011/12	By July 2013	NRHP T
	97%	70%	
Proportion of outpatient coronary angiograms with a waiting time of < 3 months	Q2, 2011/12	By July 2013	NRHP DV2 T
	96%	85%	
Proportion of patients presenting with an acute coronary syndrome who are referred for angiography and receive it within 3 days of admission	Q2, 2011/12	By July 2013	NRHP T
	83%	70%	
Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions (PCI) who receive this within 120 mins	Q2, 2011/12	By July 2013	NRHP T
	77%	80%	
Maternity Services			
• *We provide readily accessible maternity, obstetric and neonatal care services.*			
Proportion of women who have not been managed according to their assigned status (ESPI). .	Baseline (Jan 2012)	By July 2013	T
	0%	0%	
Proportion of CMDHB newborns screened within 4 weeks of birth *All CMDHB maternity facilities to have newborn hearing screening facilities including a mop-up programme for those babies discharged before screening has been completed.*	Baseline	By July 2013	T
	To be confirmed	90%	

Outputs and related measures	Forecast Performance	Reference
Additional Patient Safety Measures for our hospital services		
Acute readmissions to hospital *Unplanned acute readmissions to hospital can occur as a result of the care provided by the health system, related to inadequate length of stay, and puts pressure on hospital resources. Reducing unplanned hospital readmissions can be interpreted as an indication of improving quality of acute care in our health system*	Q3, 2011/2: 9.48% — By July 2013: 9.52% 65+: Baseline (2011) 13.8% — By July 2013 <=13.8% 75+: Baseline (2011) 14.2% — By July 2013 <=14.2%	OS8 S F
Inpatient Average Length of Stay: *As stated above, inadequate length of stay can lead to increased readmission. Optimal inpatient LOS ensures patients receive sufficient care to avoid readmission.*	Baseline: To be established (new measure) — By July 2013: 3.63 days	OS 3 S F
Wards (excluding Mental Health) that have electronic medication reconciliation systems in place	Baseline (FY 2011): Currently implemented in Burns, Plastics and AT&R — By July 2013: 100%	S
Rate of Central Line Associated Bacteraemia in the Intensive Care Unit	Baseline (FY 2011): < 1 / 1000 lines — By July 2013: 0	S
Number of in-hospital falls causing major harm (SAC 1-2) per year	Baseline (FY 2011): 29 — By July 2013: < 20	S
Number of pressure Injuries hospital wide	Baseline (FY 2011): 3.5% to 4.4% per 100 patients — By July 2013: 3% per 100 patients	S
Hand hygiene compliance rate (based on Gold Audit)	Baseline (FY 2011): 60% — By July 2013: 85%	S
Outpatient Did Not Attend (DNA) rates for Maaori and Pacific	Maaori: Baseline (March 2012) 21% — By July 2013 < 10% Pacific: Baseline (March 2012) 17% — By July 2013 < 15%	P

4.5 OUTPUT CLASS: REHABILITATION AND SUPPORT SERVICES

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

Outputs and related measures	Forecast Performance		Reference
NASC			
• *We provide timely access to assessment, treatment and support services for older people with complex health needs.* • *We provide information and support to older people and their carers about community support options.*			
Proportion of CMDHB NASC staff who have participated in interRAI training and can deliver appropriate assessments in the community and allocate support using CMDHB contracted HBSS	Baseline (Dec 2011) 44%	By July 2013 100%	C
Proportion of CMDHB NASC clients who have a comprehensive interRAI assessment completed	Baseline (Dec 2011) 20%	By July 2013 100%	S F
Assessment, Treatment and Rehabilitation Services			
• *We provide readily accessible AT & R services both within the hospital and in the community.*			
Community Services Provision of AT & R services for the Franklin locality through Pukekohe hospital. Pilot increase from 2 to 8 AT&R beds at Pukekohe Hospital and monitor occupancy.	Baseline (Dec 2011) 87% occupancy of current 30 beds including long stay and palliative	By July 2013 80% occupancy of 8 AT&R beds at Pukekohe Hospital	W
Number of referrals to the Very High Intensive User (VHIU) programme	Baseline (Jan – Dec 2011) 800	By July 2013 1000	V
Provide VHIU community based care where possible to avoid hospital admissions	Baseline (Dec 2011) 9400 bed days for identified high risk individuals	By July 2013 20% saving in bed days for identified high risk individuals (1880 bed days saved)	V
Hospital Services Average length of stay in AT&R (Pukekohe hospital beds)	Baseline (Dec 2011) 16 days	By July 2013 < 15 days	F

Outputs and related measures	Forecast Performance		Reference
Reduced inpatient length of stay for orthogeriatric patients > 75 years of age	Baseline (Dec 2011) 18 days	By July 2013 < = 16 days	F
Reduced inpatient length of stay for frail elderly patients > 75 years of age	Baseline (Dec 2011) 15 days	By July 2013 < = 14 days	F
Reduction in hospital readmissions of elderly patients > 75 years of age* who represent to hospital within 28 days of admission with the same condition as previously in hospital ** only our ARHOP clients aged 75+ who are a part of our Rapid discharge project (Saving 20,000 Days initiative)*	Baseline (Jan – Dec 2011) 12% (YTD)	By July 2013 < = 10%	F
Palliative Care • *We provide specialist palliative care services.* • *We contract with hospice services to provide care.* • *We fund home based palliative care services.*			
Advanced Care Planning (ACP) in aged residential and secondary care Completion of ACP training rollout to first and second pilot sites (designated secondary and primary care services)	Baseline (Dec 2011) 0%	By July 2013 100%	C
Increase utilisation of Pukekohe and Franklin palliative care beds	Baseline 39% Pukekohe Hospital (2 beds) 74% Franklin Hospital (1 bed)	By July 2013 59% Pukekohe Hospital 84% Franklin Hospital	W
Aged Related Residential Care (ARRC) • *We provide access to subsidised beds based on assessed need.* • *We fund a sufficient supply of contracted beds available to people assessed as requiring long term residential care.*			
Proportion of long term residents who have a Long Term Care Facility Assessment completed	Baseline 0	By July 2013 20%	S F
Proportion of residential care service providers who meet required certification standards.	Baseline (Dec 2011) 100%	By July 2013 100%	C
Number of EC presentations from ARC *Fewer EC presentations from ARC should result from effective services put in place to support ARRC like specialist input into ARRC, enhanced access to assessment and intervention within ARRC, including diagnostics and point of care testing, and consistent access to in and after hours acute assessment and treatment.*	Baseline (Jan – Dec 2011) Average of 48 presentations per month	By July 2013 < 45 presentations per month	F

Outputs and related measures	Forecast Performance		Reference
Home Based Support			
We improve Home Based Support by: • *Promoting the use of the InterRAI tool to ensure people who need home based support services receive them in a consistent way.* • *Providing Home and Clinic based specialist Nursing Services and Allied Health Services to support community care.*			
Proportion of clients receiving long term HBSS have an interRAI Comprehensive Clinical Assessment *More clients with an InterRAI CCA means they are likely to receive better health and disability services due to service decisions based on a robust internationally verified assessment tool that will provide the best information for forming care plans.*	Baseline (2011) 5%	By July 2013 25%	PP18 S F
Proportion of new clients receiving HBSS who have an interRAI assessment completed either while in hospital or on their return to the community.	Baseline (2011) 20%	By July 2013 95%	S F

Module 5: Financial Performance

Summary by Funding Arm	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Forecast	2014/15 Plan
Provider	809	(6,529)	(838)	(874)	(912)
Governance	(2,329)	995	(1)	-	(3)
Funder	6,381	10,534	3,844	3,970	4,108
Operating Surplus	**4,861**	**5,000**	**3,005**	**3,073**	**3,147**
Other Comprehensive Income (devaluation of Land)	-	-			
Surplus (Deficit)	**4,861**	**5,000**	**3,005**	**3,073**	**3,147**

Statement of Comprehensive Income

Net Result $000	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Forecast	2014/15 Plan
Revenue					
Crown *	1,262,591	1,349,379	1,387,989	1,453,225	1,521,526
Other	33,581	27,514	30,679	32,114	33,615
Total Revenue	1,296,172	1,376,893	1,418,668	1,485,339	1,555,141
Expenses					
Personnel	453,525	485,786	511,984	535,821	560,773
Outsourced	54,515	54,338	52,942	55,052	57,255
ISP	579,506	627,719	650,922	682,282	715,122
Clinical Supplies	93,740	93,759	95,201	99,673	104,354
Infrastructure	63,006	63,272	57,595	62,419	67,471
Operating Exp	**1,244,292**	**1,324,874**	**1,368,644**	**1,435,247**	**1,504,975**
Operating surplus	**51,880**	**52,019**	**50,024**	**50,092**	**50,166**
Depreciation	25,453	25,453	25,453	25,453	25,453
Interest	9,458	9,458	9,458	9,458	9,458
Capital Charge	12,108	12,108	12,108	12,108	12,108
Operating Surplus	**4,861**	**5,000**	**3,005**	**3,073**	**3,147**
Other Comprehensive Income (devaluation of Land)	-	-	-	-	-

Surplus (Deficit)	**4,861**	**5,000**	**3,005**	**3,073**	**3,147**

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

Funder	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	1,215,267	1,290,874	1,339,305	1,402,252	1,468,157
Other	610	-	541	566	592
Total	**1,215,877**	**1,290,874**	**1,339,846**	**1,402,818**	**1,468,749**
Personnel					
Depreciation					
Capital Charge					
Other	1,209,496	1,280,340	1,336,002	1,398,871	1,464,687
Total Expenditure	1,209,496	1,280,340	1,336,002	1,398,871	1,464,687
Net Surplus	**6,381**	**10,534**	**3,844**	**3,947**	**4,062**

Eliminations	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	(629,990)	(652,121)	(685,080)	(716,934)	(750,278)
Other					
Total	**(629,990)**	**(652,121)**	**(685,080)**	**(716,934)**	**(750,278)**
Personnel					
Depreciation					
Capital Charge					
Other	(629,990)	(652,121)	(685,080)	(716,934)	(750,278)
Total Expenditure	**(629,990)**	**(652,121)**	**(685,080)**	**(716,934)**	**(750,278)**
Net Surplus	**-**	**-**	**-**	**-**	**-**

Provider	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	669,330	699,962	720,974	754,861	790,340
Other	30,153	27,285	29,873	31,278	32,748
Total	**699,483**	**727,247**	**750,847**	**786,139**	**823,088**
Personnel	446,676	479,511	503,612	527,282	552,063
Depreciation	25,453	24,911	21,996	23,030	24,113
Capital Charge	12,108	12,160	12,204	12,778	13,379
Other	214,437	217,194	213,873	223,923	234,445
Total Expenditure	**698,674**	**733,776**	**751,685**	**787,013**	**824,000**
Net Surplus	**809**	**(6,529)**	**(838)**	**(874)**	**(912)**
Other Comprehensive Income (devaluation of Land)					
Surplus (Deficit)	**809**	**(6,529)**	**(838)**	**(874)**	**(912)**

Governance	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	7,984	10,664	12,790	13,046	13,307
Other	2,818	229	265	270	275
Total	**10,802**	**10,893**	**13,055**	**13,316**	**13,582**
Personnel	6,849	6,275	8,372	8,539	8,710
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	6,282	3,623	4,684	4,777	4,875
Total Expenditure	**13,131**	**9,898**	**13,056**	**13,316**	**13,585**
Net Surplus	**(2,329)**	**995**	**(1)**	**-**	**(3)**

Total	2010/11	2011/12	2012/13	2013/14	2014/15
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	1,262,591	1,349,379	1,387,989	1,453,225	1,521,526
Other	33,581	27,514	30,679	32,114	33,615
Total	**1,296,172**	**1,376,893**	**1,418,668**	**1,485,339**	**1,555,141**
Personnel	453,525	485,786	511,984	535,821	560,773
Depreciation	25,453	24,911	21,996	23,030	24,113
Capital Charge	12,108	12,160	12,204	12,778	13,379
Other	800,225	849,036	869,479	910,637	953,729
Total Expenditure	**1,291,311**	**1,371,893**	**1,415,663**	**1,482,266**	**1,551,994**
Net Surplus	**4,861**	**5,000**	**3,005**	**3,073**	**3,147**
Other Comprehensive Income (devaluation of Land)					
Surplus (Deficit)	**4,861**	**5,000**	**3,005**	**3,073**	**3,147**

Balance Sheet

$000	2010/11	2011/12	2012/13	2013/14	2014/15
Current Assets					
Cash and Bank	(2,235)	1,856	1,862	1,867	1,872
Debtors	38,116	47,379	49,566	51,653	53,740
Inventory	868	1,015	1,161	1,308	1,455
Assets held for sale	8,675	-	-	-	-
Current Assets total	**45,424**	**50,250**	**52,589**	**54,828**	**57,067**
Non Current Assets	475,011	505,615	578,460	608,405	605,492
Total Assets	**520,435**	**555,865**	**631,049**	**663,233**	**662,559**
Current Liabilities					
Creditors	84,560	94,846	106,463	121,965	137,969
Loans *(Working Capital)*	7,500	7,500	7,500	7,500	7,500
Employee Provisions *(current)*	102,079	118,928	126,096	134,662	143,060
Total Current Liabilities	**194,139**	**221,274**	**240,059**	**264,127**	**288,529**
Working capital	**(148,715)**	**(171,024)**	**(187,470)**	**(209,299)**	**(231,462)**
Net Funds Employed	**326,296**	**334,591**	**390,990**	**399,106**	**374,030**
Non Current Liabilities					
Employee Provision *(Long term)*	14,590	15,500	15,595	15,694	15,793
Term Loans	150,000	150,000	203,713	209,072	181,165
Restricted funds	839	844	850	855	860
Total Non Current Liabilities	**165,429**	**166,344**	**220,158**	**225,621**	**197,818**
Crown Equity	**160,867**	**168,247**	**170,832**	**173,485**	**176,212**
Net Funds Employed	**326,296**	**334,591**	**390,990**	**399,106**	**374,030**

Movement of Equity	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Total Equity at beginning of period	**153,631**	**160,867**	**168,247**	**170,832**	**173,485**
Surplus / (Loss) for period	4,861	5,000	3,005	3,073	3,147
Crown Equity injection	2,375	2,380	(420)	(420)	(420)
Crown Equity withdrawal					
Total Equity at beginning of period	**160,867**	**168,247**	**170,832**	**173,485**	**176,212**

Capital Expenditure	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Baseline Capital	-	14,704	17,000	17,000	19,700
Strategic Capital					
Clinical Services Block	30,508	35,734	74,158	36,767	2,239
Total	**30,508**	**50,438**	**91,158**	**53,767**	**21,939**

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

Cash flows from operating activities	2010/11 Audited Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan
Operating Activities					
Crown Revenue	1,260,517	1,337,876	1,385,884	1,450,725	1,519,526
Other	31,283	26,578	29,743	31,134	32,589
Interest rec.	1,172	936	936	980	1,026
Suppliers	775,551	834,725	851,895	888,131	930,995
Employees	440,146	468,069	504,762	527,175	552,272
Interest paid	9,458	9,622	9,144	9,574	10,024
Capital charge	11,910	14,458	12,204	12,778	13,379
GST (Net)	2,161	(1,851)	-	-	-
Net cash from Operations	**53,746**	**40,367**	**38,558**	**45,181**	**46,471**
Investing activities					
Fixed assets	(58,928)	(41,836)	(91,848)	(50,093)	(18,093)
Restricted & Trust Funds	(5)	5	6	5	5
Net cash from Investing	**(58,933)**	**(41,831)**	**(91,842)**	**(50,088)**	**(18,088)**
Financing					
Private Debt	(1,000)	3,175	(3)	(4)	(5)
Crown Debt	-	-	53,713	5,359	(27,907)
Equity - Capital	2,375	2,380	(420)	(420)	(420)
Net cash from Financing	**1,375**	**5,555**	**53,290**	**4,935**	**(28,332)**
Net increase / (decrease)	(3,812)	4,091	6	28	51
Opening cash	1,577	(2,235)	1,856	1,862	1,890
Closing cash	**(2,235)**	**1,856**	**1,862**	**1,890**	**1,941**

5.2 OVERVIEW

2012/13 is a transitional year for us. The following financial section of the Annual Plan provides a sound financial basis to begin the transformation of our health system. A $10m provision has been set aside to support the development of integration initiatives including priorities established by Locality Clinical Partnerships. Alternative approaches to commissioning that will enable service and clinical integration will be developed and implemented in the 2013 calendar year in agreement with primary and community providers. Hence, the financial assumptions below do not yet reflect any significant change in those funding or risk sharing arrangements. This year the planned changes are intended to significantly shift the bed pressures within the hospital environment to one of earlier intervention and treatment within the community setting, thus lessening acute demand.

The key issues impacting on our financial performance during the 2012/13 year are:

- **Revenue growth:** we are receiving and forecasting to receive less than we expected under a fully implemented PBFF model;
- **Cost growth:** we will constrain cost growth in both provider and funder arms despite unprecedented demand growth. We are uncertain what benefit we can expect from regional shared service agency efforts at the time of writing of this plan – both healthAlliance NZ Limited and Health Benefits Limited – but we are committed to their delivery.The full cost of wage settlements will come to bear this year. National agencies are directing DHBs to bear the cost of national policy changes (e.g. funding for GP and junior doctor training). These cost increases will need to be met by re-allocated funding for other areas.
- **Capital Infrastructure:** We are progressing ***Towards 20/20*** plans. CMDHB requires the development of Manukau Health Park and significant Integrated Family Health Centres (IFHCs) in primary care as part of an overall strategy to enable the shifting of services away from the Middlemore site and earlier for primary care intervention. This will further enable Middlemore to be the acute hub for unplanned and unscheduled care that requires specialist services.

Our Annual Plan will continue to reflect a zero deficit operating position whilst meeting the Minister's expectations

The clear indications from the Minister and Ministry of Health of more modest increases in funding from 2012/13 onwards have resulted in CMDHB continuing to taking action through its *Thriving in Difficult Times* and *Productivity Initiatives* initially established in 2010/11 in order to achieve an Annual Plan reflecting a zero deficit operating position. The Minister has also indicated the there is to be a 3% reduction in Management and Admin staff from the start of the New Financial Year which, while a challenge to the organisation experiencing huge growth, will be met.

Given those challenges, a budgeted full consolidated breakeven position has been achieved without any reduction in front line clinical services, as required both by Management and the Board.

In previous years, CMDHB has benefited from the PBF formula specifically through the demographic growth component of the funding which is additional to CCP. While a nationally consistent application of the PBF formula would have significantly benefited CMDHB's current financial position by a minimum of $3.0m (and possibly almost $20m on recognition of population growth), and allowed CMDHB to continue to self fund the significant number of initiatives around primary care and hospitalisation avoidance, this is not presently available under the MoH capped percentage funding envelope.

Previously the MoH cap increase was limited to 7% (2009/10) in total funding. This was reduced in the 2010/11 year to 5% and reduced again to 4.71% for the 2012/13 year. CMDHB is the only DHB negatively impacted by the cap over the last four years. Consequently CMDHB has achieved breakeven through further very intensive reviews of its existing investments and structures, but this has severely limited its ability to invest for the increasingly challenging future demands.

Given the current financial environment we do not anticipate that the full benefit of the Population Based Formula (PBF) formula will accrue to CMDHB in future years. Without a return to non capped PBF, CMDHB is at risk (as highlighted later in this document), particularly given the increasing cost

impact as the new facility investments come on stream in 2013/14 year.

Tables 9 and 10 below highlight the impact of CCP [previously FFT] and demographic growth funding levels being understated and the levels of absorption CMDHB has had to undertake in the last 7 years.

The key drivers of this change in financial position are:

- Despite the international economic position, the anticipated relatively high level of clinical wage settlements will continue, primarily in the Provider Arm. These are expected to be settled at levels around double the general funded 1.49% inflationary level, on an all up basis, i.e. base and step function increases 3.5% - 4.5%.

- The continuing significant IDF outflows and pricing adjustments primarily related to increasing provision of tertiary services.

- The continuing population growth in excess of the census projections used to calculate the population based formula revenue, albeit this gap is diminishing gradually.

- Of future critical importance will be the impact of the $208m Clinical Services Block Stage 1, which is anticipated to come on stream with significant cost impacts in the year of this Annual Plan (2013/14). This has been funded by way of return to current calculations of full revenue allocation of PBF (as stated above).

- Middlemore hospital bed capacity, already under severe pressure in 2011/12, is expected to be further stretched in 2013, which will cause other constraint related issues and which will be compounded by the opening of CSB Stage 1. The reaching of capacity is two years ahead of earlier forecasts on bed capacity.

- The need to achieve Government health targets/priorities around ED waiting times, Electives, Cancer waiting times, Elective Service Patient Indicators and the increased costs, primarily FTE related, associated with those targets within the forthcoming constrained budget.

- The annualisation of commitments made in 2011/12, including the very significant and essential continuing investment in all quality related areas, with significant initial “hump” funding. This is expected to start producing a return on investment in the coming years and forms a very significant and important part of our *Thriving in Difficult Times* targets.

- Acute demand growth is increasing, particularly in the Department of Medicine, Provider Arm, after a period of relatively lower growth.

While the 2011/12 financial result is forecast to achieve a surplus position, this result could be perceived as misleading in comparison to the forecast 2012/13 position, without further analysis. There are a number of current year gains that are, from a timing perspective, “one off”. Depreciation and interest costs are anticipated to be significantly lower than budget for 2011/12 reflecting both the timing issues of the new facility developments and lower depreciation levels on assets reaching the end of their economic lives.

We are also forecasting in 2011/12 a “surplus” within the ring fenced Mental Health spend which is essentially a timing issue rather than a permanent under-spend. These benefits offset the demand driven cost increases occurring within the Funder Arm, particularly Health of Older People, and Pharmaceutical costs.

This forecast financial position, particularly for the first year of the Annual Plan (but also obviously impacting on the outer years) has severely limited CMDHB’s ability to continue to invest in and achieve many of its wide-ranging objectives at the level it seeks.

There will be material benefits arising for the region from shared services but they will be minimal for CMDHB

It is important to note, as referred to elsewhere, that there is not any recognition in CMDHB's Annual Plan of the impact of external initiatives being taken whether jointly by the DHBs or by Government, i.e. regionalisation, national procurement, shared services initiatives, integrated family health centres. While clearly these initiatives are intended to produce ultimate clinical and financial gain, they are not quantifiable at this stage. But we are committed to deliver them.

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

The 2012/13 year will be a difficult balancing act as the focus moves to ensuring financial stability and potentially lessening efforts to deliver on the Northern Region Health Plan objectives and our clinical and quality imperatives. If the financial pressures continue as forecast, greater efficiencies and increased innovation will become more important as the primary drivers to addressing the organisation's strategic objectives and meeting its financial obligations.

These increased financial constraints and targets come at a time when the initial costs of our new facilities investments are being incurred, i.e. CMDHB, along with all other DHBs, is being asked to absorb long term capital investment costs in the initial years of occurrence in order to breakeven, as opposed to a commercial model where the norm would be over a period of time, probably for many years. This challenge will compound as the facility investment grows significantly both in capital and increased operating cost over the next five years.

We are capping the level of allowable and fundable growth both within provider and funder arms to breakeven

The 2012/13 Annual Plan shows a breakeven position. In a change from previous years, we are now looking to retain and maintain the existing carried forward surpluses of $18.1m. This is, as agreed with MOH, to build up reserves to offset any future likely investment related deficits in order to achieve a continuing zero deficit return. With regard to the targeted national and DHB objectives, these would be around investment in priority initiatives aligned with the Northern Region Health Plan and Ministerial areas of emphasis and change such as Chronic Care Management (CCM) and Maaori Health. Many of these are now so embedded in the core operational activity of the organisation that it is extremely difficult to stop or reverse all of these investments in order to lessen the financial impact on the bottom line. It is likely that the Board will continue to seek to review the investment levels in these areas within the limits of the carried forward earnings. The Annual Plan also includes recognition of the Minister's "tagged" funding and costs related to the specific tags.

It should be noted very clearly that we increased our investment in Primary Options for Acute Care (POAC) and lifted our investment in Oral Health through significant volume pressures. These investments are seen as critical and unavoidable, despite the intense financial constraints, with even more significant clinical and financial downside, if not addressed now.

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

Table 7: Impact of Inflation (FFT/CCP) Short Funded Over Past 6 Years

Year Ending	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Actual Inflation	4.2%	4.0%	4.0%	3.8%	3.5%	2.0%	2.9%[1]
MOH FFT	2.6%	3.3%	2.9%	2.8%	3.1%	1.7%	1.7%
Shortfall	(1.6)%	(0.7)%	(2.0)%	(1.0)%	(0.4)%	(0.3)%	(1.2)%
$000 per year	9,380	4,472	13,500	9,390	4,554	2,979	11,916
Cumulative Impact $000	$9,380	$13,852	$27,352	$36,742	$41,296	$44,275	$ 56,191

Note 1 Excludes GST movement

Table 8: Impact of Under-estimated Population Growth as Reported through Census/Statistics NZ

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

Note: We have included last year's chart as Statistics New Zealand has not issued the updated census information at time of Annual Plan preparation. Therefore, comments made below are extrapolations based on previous information, and that the planned 2011 census has recently been deferred to 2013 which will have a material effect on quantifying (and therefore recognising) the continuing CMDHB growth well in excess of sector averages.

Value of understated revenue: - at PBFF $18.773m
- at $1,000 $8.158m

Note: On this basis, CMDHB has been consistently short funded between $8m - $19m per annum

Therefore, when any assessment of efficiencies being achieved is made, there needs to be acknowledgement and recognition that CMDHB is already absorbing between $18m and $26m per year through effective revenue or cost recognition under-funding. This represents a huge challenge from a clinical or health perspective for an organisation that is experiencing the highest level of growth in the NZ health sector. While this represents a very solid financial absorption which could be argued is simply "getting rid of existing inefficiency", to do so would be ignoring reality.
The absorption is ultimately made at the cost of additional or improved health services to Counties Manukau's very diverse, growing and generally deprived community.

5.2.1 Key Assumptions and Risks

Specific revenue assumptions

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

- A mandatory asset revaluation was carried out June 30th, 2009 under the 3 year minimum asset revaluation period requirement. As a result, devaluation occurred reversing some of the very significant revaluations of previous years. A full review is currently being under taken (March / April 2012) to ascertain if there have been any material variations. Based on current market conditions, it is expected that there will be no material change in asset valuations and therefore no related change in the capital charge.

- All mental health funding continues to be "ring fenced". As in previous years, mental health has been instructed to absorb its related excess wage settlements within its own ring fence, on the basis it has its own "ring fenced" CCP equivalent and demographic growth and must operate within those parameters without top up from any other source.

- That the current ACC arrangements both in regard to revenue levels and cost recoveries are maintained. Publicly ACC has indicated a tighter fiscal affordability envelope and as well, a tightening of their payment parameters. While this is difficult to quantify currently, CMDHB expects to offset any downside by further opportunities or enhancement of existing contracts.

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

- Return to full PBF, as currently calculated, in 2013/14 in order to assist in achieving a breakeven.

Recognising anticipated wage and salary settlements

The forecast zero deficit position has been reached after recognising anticipated wage and salary settlements well in excess of the 1.49% funded level, specifically:

- The flow on effects of significant national three year wage settlements agreed in previous years, with the flow on costs well in excess of the MoH funded levels. These are earlier driven primarily by additional leave entitlements, automatic ongoing step function on–cost implications, a doubling of CME entitlements, significantly enhanced call out charges and the resultant increase in back-filling.

- This Annual Plan has been prepared based on the latest information available around existing and likely wage settlements. It is anticipated based on this, that there will be an "across the board" agreed settlement rate for all CTU related unions, with the exception of specifically junior doctors, and under separate award, senior doctors at very similar levels. The base settlements are in excess of the funded levels which, together with the add-on costs and automatic step functions applicable to most awards, continues to present a huge challenge to all DHBs.

- There is no evidence of any material quantifiable efficiency benefits arising from previous MECA settlements or likely in current negotiations. Thus the onus is on the DHBs to manage these costs.

- Increased roster and compliance costs around RMOs terms of employment from previous settlements.

A number of significant financial risks remain inherent in CMDHB's Annual Plan

- Generally increased, more demanding terms and conditions of employment across earlier MECAs which significantly lessens flexibility.
- The significant annual financial impact, of the continuing adjustments in the Auckland region of SMO job sizing
- The continuing committed (albeit constrained) investment in priority initiatives aligned with the Northern Region Health Plan, including those focused on lessening the growth of hospital services and improving quality clinical outcomes.
- The ongoing internal efficiencies being generated including those within the expanded healthAlliance NZ Limited, now covering the full Northern Region. Again, while there are national procurement and shared services initiatives well under way via HBL as a result of recent government initiatives, we have reviewed the likely outcome of these as they impact on this year's Annual Plan. They appear extremely difficult to identify and therefore quantify any current additional material financial benefit arising from these given the level of efficiency in these targeted areas already being achieved by the "old" healthAlliance. We do not believe it is appropriate to build into the Annual Plan a potentially very risky "unspecified lump sum" saving when there appears to be a high likelihood that we will be unable to achieve this. This Annual Plan currently shows a significant HBL 'investment' costs with matching or greater benefit yet to be identified.
- The absorption of increasing pharmaceutical demand, reflecting greater access and usage by our community.
- The absorption of the very significant and increasingly unfavourable costs around Health of Older People, specifically around private hospital funding. This is a national trend reflecting the ageing population shift, growing at a rate which by itself is completely unsustainable financially. It is only through savings in other unrelated areas that this level can at least be managed.
- The absorption of continuing renal growth volumes, albeit it at a growth level below the extremes of previous years.
- The absorption of continuing price adjustments to inter-district flows (IDFs) and to a lesser extent the volume of IDF outflows. These relate primarily to provision of services by ADHB with recent upward changes in prices far in excess of CCP and requiring strong challenge as to the level of efficiency built into tertiary pricing and the perpetuation of a 'cost plus' mentality. Much firmer disciplines have been put in place to enable both principles agreement and management of volumes and costs with IDF partners to minimise this significant exposure. This change has given rise to a greater level of stability and lessened risk.
- The combined impact of meeting and maintaining the Ministerial ED 6 Hour target and the absorption of increasing ED volumes with consequent flow-on bed impact. This Annual Plan does not reflect any further reduction in waiting times that the Minister has indicated will come.
- The international financial crisis and flow-on impact to our community is clearly still having a negative impact on these volumes and the consequent pressure on CMDHB.
- The quantification and management of the change to the 'Localities Approach', together with the necessary incentives to achieve this fundamental change.
- The increasing challenge in both meeting the Minister's and Government's health targets/priorities of a breakeven financial while complying with all government strategies and policies and investing in and opening significant new facilities, through all years of this Annual Plan and beyond.
- Meeting the community's expectations, now that CMDHB has moved (relatively speaking) to equity from a population based funding perspective,

despite the restrictive financial constraints.

- The financial risks associated with demand driven services, in which volume growth continues to far outstrip funding in many areas.

- The outcome of earlier wage price pressure and settlements has led to significantly higher wages and clinical staff shortages arising from a much more mobile workforce. CMDHB still remain exposed to "relativity" flow on risks from these wage settlements. This risk is also relative to the likelihood of flow through to the NGO sector with huge potential ramifications for the overall sector.

- The extreme pressure now placed on the organisation in regards to capital funding and therefore how these can be managed through other unspecified options.

Risk mitigation strategies - minimising the negative impact of any changes to the base assumptions

- An organisational wide commitment to clinical safety and quality improvement. This initiative led by the CEO, and now picked up on a national basis, resulted in the formation of a formal quality unit within the organisation, but working across and within each area of CMDHB. The quality initiatives will ultimately lead to significant clinical and thus financial benefit and will ultimately be self funding. It is anticipated that these benefits will continue to impact CMDHB during this and next financial year through focussed action under the *First, Do No Harm* initiative, but will still remain a challenging financial target despite the significant resource commitment.

- CMDHB remains committed to achieving its Triple Aim objectives. In order to do so we implemented a process of organisational wide review two years ago, with full Board support, under the project "*Thriving in Difficult Times*". Those same initiatives together with newly identified areas of opportunity are reflected in the Plan. The overall objectives of the projects are around cost reduction and efficiency improvement with a deliberate avoidance of any negative clinical impact or where possible, material redundancies. The core principles of the project are a commitment to a transformational culture change, a disciplined methodology, a commitment to the Triple Aim, investment in effective and disinvestment in ineffective and reshape, resize, rather than restructure and redundancies.

- One of the positive outcomes of Quality initiatives has been a reduction in ALOS which has enabled CMDHB to absorb some of the volume growth within existing capacity. The rollout of the Localities programme in conjunction with the 'Saving 20,000 Days' project to shift wherever possible some of the care provision to the community rather than within the hospital will also help to address capacity issues.

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

- A significant lift in emphasis and focus around continued development of evaluation, monitoring and auditing processes and systems to ensure that CMDHB is receiving Value For Money (VFM) in all key areas of its operations. While there is increasing emphasis from the MOH around VFM, it should be recognised and acknowledged that CMDHB has for many years applied the VFM principles, albeit in a less formalised manner. We will continue to apply a VFM methodology in all areas of the organisation including procurement, quality and clinical enhancement.

- An increased commitment, which is already occurring, to lifting the level and frequency of all internal and external audit reviews. Increasing emphasis has been placed on widening the audits in the NGO/PHO areas with solid results to date. The primary focus here is around ensuring appropriate contracting of services, full delivery of those contracted services, as well as ensuring appropriate health outcomes. Increased emphasis and scrutiny has been placed on the role and scope of the Northern Region Internal Audit team by CMDHB Board and Audit, Risk and Finance Committee, in order to receive maximum benefit through value for money audits

- As referred to elsewhere in the Annual Plan, considerable effort and development of appropriate strategies are occurring relative to maximising and increasing the benefits of the existing or expanded regional or quasi regional functions to ensure significantly greater regional benefit. While there are potential savings to be made through this "roll out", CMDHB (and WDHB) are already benefiting significantly from their existing formal relationship and it would be fiscally imprudent to anticipate further un-quantified national benefits that may fundamentally change the financial viability of any of the participating organisations.

- Continued application/utilisation of a robust expenditure and long term forecasting monitoring tool which has proven invaluable in anticipating and therefore confirming the financial trends now being indicated in this Annual Plan.

- Continued focus on efficiency and cost opportunities, throughout the whole of CMDHB, but particularly through the use of healthAlliance NZ Limited and increasingly as referred to above, through greater regional collaboration. The latter is ensuring a consistent approach, a common policy and also ensuring appropriate benchmarking is carried out to maximise efficiencies. There is a potential downside risk in the regional benchmarking however, relative to targets as opposed to "clinical standards" which must be managed.

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

- Continuing to place very high emphasis on robust, regular monthly performance reviews throughout all levels of the organisation to ensure that CMDHB ultimately meets or exceeds its financial and operational targets.

- The DHB continues to support national initiatives that may lead to cost reductions, subject to the perceived risks being manageable and incremental gains being achieved, within the Procurement and Value for Money projects.

5.3 FINANCIAL MANAGEMENT

5.3.1 Specific Cost Pressures – Wage Pressure

Wage increases and staff entitlements have a material financial impact

Within the Provider Arm, wage increases have been built in at the level of last year's settlements. Over and above these base salary and wage movements which in themselves are higher than the core FFT/CCP reimbursement level, CMDHB is, along with all other DHBs experiencing very significant levels of on-costs. These include increasing step functions, additional leave, allowances and superannuation (Kiwisaver), primarily around medical and nursing staff entitlements.

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

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

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

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

5.3.2 Capital Planning & Expenditure

We continue to actively look at how we can sustainably manage forecast demand and its impact on capital requirements

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

It is recognised and acknowledged that the future funding requirements for the greater Auckland region (and CMDHB) are huge, which will present major national funding issues and are therefore almost certainly unsustainable and unaffordable from a fiscal perspective. CMDHB has attempted to lessen this forecast demand and related impact on capital requirements by taking steps including: fully reviewing and updating the Health Services Plan, bed model forecasts, considered new models of care, reassessed community based health solutions through the Localities initiative, forecast growth, facility timing, and other options.

We remain committed to the major capital projects under our Towards 20/20 programme

While acknowledging the Regional Annual Plan position, CMDHB with full Board support, must remain committed to the major capital projects currently under construction and nearing completion as previously approved by MoH or NCC/Minister, or those presently under consideration/application with MoH, the NCC replacement or the Minister.

As we have indicated in the separate capital submissions, these capital projects, given their magnitude and continuing growth demand within CMDHB will, with the CSB Stage 1 project, fully utilise all existing available cash funding, sourced from either current or accumulated depreciation or remaining available approved debt funding or approved equity/debt. It is therefore critical that CMDHB receives its equitable portion of funding under PBF in order to ensure affordability of these future projects, thus ensuring all DHBs are on a fair level playing field in terms of capital requests.

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

Our newly commissioned buildings are fully occupied already…

Last year we commissioned the final stage (3) of the Core Consolidation Project encompassing the building of a new stand alone ward block on the Middlemore site (Edmund Hillary Block) which has provided a significant number of additional in-patient beds. This facility incorporates significant improvement in models of care through both layout changes and staffing structures. These beds are fully utilised, reflecting the existing severe shortage of in-patient beds, and were central to helping the DHB achieve the 6 hour ED length of stay target. The "shelled" levels of the Edmund Hillary Block were fitted out as part of the subsequently approved "Clinical Services Block Project Stage 1" and are fully occupied already emphasising the capacity constraints and growth CMDHB continues to operate under

The Clinical Services Block [CSB] Stage 1 [$208m] is now progressing well with the main contract for construction being appointed.

As part of *Towards 20/20* the DHB is well advanced in determining the medium to long term organisational requirements (15 – 20 year horizon). This has been driven earlier by extensive internal and external consultation, the roll out of the Clinical Services Plan (primarily provider or hospital focused) to the Health Services Plan (community wide focus), co-ordinated with the earlier Asset Management Plan as supported by the Ministry of Health. The Business Case encompassing the first stage of the long term plan (CSB Stage 1) was approved by the Minister with initial construction well advanced and a completion date at the commencement of the 2014 calendar year.

Simplistically, this project, albeit that it has technically been split into two stages, proposed a new Clinical Services Block encompassing a completely new replacement suite of theatres, High Dependency Unit (HDU) and Assessment and Observation Unit (AOU) facilities at Middlemore and the [now complete and occupied] fit out of the remaining (shelled) wards in the Edmund Hillary Block. It is envisaged that completion of this new CSB, Stage 1, will be followed by the relocation of support services to the Manukau Health Park [MHP] (Browns Road), Stage 1a. The original 'staged' Business Cases relating to the Manukau Health Park site have now been rejected on the basis of CMDHB reapplying within the new Treasury 'Better Business Case (BBC) requirements. The DHB is working with Treasury and the Ministry on a streamlined time process to prepare a 'whole of site' development Business Case, considering as required a full range of options, both in terms of services and funding models.

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

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

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

Table 9: Towards 20/20 Projects Schedule – Current Projects

Current Projects	Budgeted Approval	Projected finish date	Value	Status
Middlemore, Clinical Services Block Stage 1	Late May 09	Jan 2013	$208m	Underway ($108m internal funded)

Table 10: Towards 20/20 Projects Schedule – Future Projects

Future Projects	Budgeted Approval	Projected finish date	Value	Status
***Manukau Health Park, Stage 1a** (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre) Now programmed into 3 phases as per MOH discussions	April 2012 April 2013 April 2014	Nov 2015 Nov 2017 Nov 2017	$33.1m $32.4m $57.0m ($122.5m)	Staged 2012 - 2017
***Manukau Health Park, Stage 1b** (Mental Health Unit, Mental Health Services for Older People, site infrastructure)	April 2013	Nov 2016	$49.4m	
Women's Health Building (replacing Galbraith, NICU, delivery suites, ante and postnatal wards and gynaecology wards)	April 2014	2017	$80m	
***Manukau Health Park, Stage 2** (theatre expansion – 4 elective theatres, MICU, biomed, endoscopy, surgical wards - 40 beds, Women's Health primary maternity unit - 36 beds, community midwives, oncology – haematology unit)	April 2016	2018-2020	$79m	
Middlemore, Clinical Services Block Stage 2 (Radiology service fitout, laboratory service fitout, emergency department expansion, C-Pod Kidz First refurbishment)	April 2013	2020	$108m	
Middlemore Stage 3 (Inpatient Replacement & Expansion) ***Manukau Health Park** (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre)	Nov 2015	2018	$80m	
Middlemore Stage 4 (decommission old ARHOP wards) ***Manukau Health Park** (Outpatient expansion, ARHOP expansion - 25 beds, Mental Health Services for Older People expansion – 5 beds, surgical wards and theatre expansion)	2016	2018-2020	$55m	
Middlemore, Stage 5 (Decommission Galbraith, new entrance)	Nov 2018	2020-2022	$50m	
Ko Awatea replacement	Mid 2013	Mid 2016	$70m	PPP or equivalent
Staff Car Park	Mid 2013	Mid 2015	~$20m	PPP or equivalent
Integrated Family Healthcare Centre/ Whanau Ora Centre/Tainui	2011/2012	2013/2014	$?	3rd party/SPV
Grand Total			**$623.9m Excluding last 3 items above**	

Note:
Projects with a * against them are presently under consideration (strategic analysis stage) for a consolidated Business Case application with a particular emphasis and/or consideration under Treasury Better Business Cases requirements as a Public Private Partnership opportunity.

5.3.3 Banking Covenants

We operate under only one banking covenant

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

Clearly our existing banking relationships in these times are more important than ever. We have, over the past year communicated regularly with the external banks and CHFA of our likely tighter position for 2012/13 which we have managed through without any major issues but are now indicating that further significant tightening is increasingly likely to occur in 2013/14.

Table 11: Banking Facilities

Facilities ($m)	Existing Limit	Utilisation @ 30 June 2011	Available Facility @ 1 July 2012
CHFA	297.0	150.0	147.0
Commonwealth Bank (working capital)	50.0	7.5	42.5
Commonwealth Bank (lease facility)	10	-	10.0
Westpac (lease facility)	10	1.2	8.8

Note:

1. *The above CHFA limit INCLUDES the funding approved for the CSB Stage 1.*
2. *CMDHB is currently transitioning to working capital facilities with Westpac on a result of the national Health Benefits Limited tender outcome*

5.3.4 Cash Position

We are confident of meeting all reasonably anticipated cash outflows for 2012/13

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 2012/13, including both new and replacement assets. Although we have still to complete the final review of all capital expenditure requests, (and therefore confirm the final associated depreciation levels), capital expenditure related to 2012/13 will be limited to $91.9m. We have not included within the cash flow forecast any capital requirements still requiring MoH/Minister's approval, therefore specifically exclude the MHP Stage 1a and MMH WH Theatres.

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2012/13 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing unutilised/approved debt facilities.

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

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

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

Disposal of Land
In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, Counties Manukau DHB will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. Counties Manukau DHB will comply with the relevant protection mechanism that addresses the Crown's obligations under the Treaty of Waitangi and any processes related to the Crown's good governance obligations in relation to Mâori sites of significance.

5.3.5 Capital Charge

The Annual Plan continues to include the matching of cost and revenue on any higher capital charge that may arise from asset revaluations on a three yearly cycle. The Annual Plan for 2012/13 is not anticipating any material valuation change to Land and Buildings.

5.3.6 Advance Funding

The 2012/13 Annual Plan continues to incorporate the fiscal benefit of the one month advance funding, based on achieving an breakeven operating position and the maintenance of the other Ministry of Health requirements necessary to access this benefit.

5.4 COST CONTAINMENT EFFICIENCY GAINS

As in previous years, the Annual Plan reflects a continuing trend of significant growth and cost containment within the organisation

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

As a result of this, CMDHB has, as part of the preparation of this 2012/13 Annual Plan and the early low funding indications, taken immediate formal action to address the need for cost containment and clinical improvement. As earlier indicated, we have formally recognised these challenges through the initiation and then continuance of the *Thriving in Difficult Times* projects, and further roll out of productivity initiatives essentially aimed at thinking differently about cost and quality, while still committed to achieving our core objectives around the Triple Aim. The DHB recognises the overarching expectation that core clinical services cannot be cut. In fact, despite the financial pressures, the expectation is that they will be enhanced. However, in order to achieve the financial target facing CMDHB, it has been absolutely essential that we address, and correct as necessary, the level of investment in certain marginal areas and refocus our efforts in proven areas.

We remain committed to maintaining and exceeding in 2012/13 the very high level of access and elective volumes that are forecast for 2011/12

These levels have been achieved previously through a combination of both internal and external resources and, while a year later than planned, many of these elective volumes are proposed to be provided primarily within internal resourcing capacity and capability in 2012/13. However, where financially or clinically appropriate, in order to continue the strong reduction in waiting lists, we will access third party providers through formal longer term contracts.

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

As a fundamental core driver of our new facilities development and implementation, new or improved models of care considerations are mandatory for all new developments. This is accomplished with extensive input, deliberation, challenge and resolution coming from full clinical and management representation on the respective committees. As an example, when we opened the initial wards within the Edmund Hillary block May 2010, we had both different staffing levels and mixes of doctors, nurses and support staff even over those developed for the previous ward blocks of only three years previous. As these are implemented and proven, we will where possible and practicable roll out and enhance where possible, the new models of care to the older blocks. Similarly, as the new full replacement theatre suite is being built within the new Clinical Support Block, we are constantly reconsidering layouts and resourcing levels and mix prior to finalisation of design and layout to improve both clinical efficiency and reduce costs.

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

CMDHB has and always will continue to maintain a very close focus on FTE management, given that salary and wage costs are 2/3rds of the provider budget. These are monitored and managed on a monthly basis, both in terms of absolute head count and cost per FTE by division, by RC. The recent Ministerial request seeking a further 3% reduction in existing levels will be a challenge for CMDHB in the face of clinical demand pressures.

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

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

Table 12: Management and Admin resource levels.

Objective	Deliverables	Target (Actual as at 31/12/08)		Timeframe
Contain the level of investment in Management and Administration resourcing	Manage the FTE's categorised as Management and Administration within the District Health Board within the target FTE cap		Number	Monthly
		FTEs employed (Accrued)	833.8	Compliance
		+ contractors	16.0	
		+ advertised vacancies	37.70	
		= TOTAL	887.5	

The total above does not include CMDHB's share of healthAlliance NZ Limited, NDSA, ARMOS or DHBNZ which are reported separately. These caps will require adjustment relative to the expansion of hA and the transfer of ADHB and NDHB staff to the enlarged hA.

5.5 HEALTHALLIANCE NZ LIMITED (PREVIOUSLY A CMDHB AND WDHB SHARED SERVICES ORGANISATION)

healthAlliance NZ Limited continues to perform well as a shared support service but cost savings are anticipated to be at a lower level to previous years

healthAlliance NZ Limited continues to perform well as a shared support service for information services, accounting/finance/human resource support, procurement and materials management and payroll. Cost savings particularly within procurement as well as reduced Human Resource recruitment costs are again expected to benefit CMDHB and WDHB, albeit at a lower level than achieved over previous years. This is occurring as healthAlliance NZ Limited's procurement focus becomes more about tackling the difficult costs negotiations. These achievements are expected to continue but CMDHB cannot expect the level of savings to be as high as previously achieved.

CMDHB is working very closely with and contributing to, the national procurement objectives through HBL although the current assessment is that neither CMDHB nor WDHB can currently have any material expectations around additional national savings over levels currently being achieved. As advised earlier, ADHB and NDHB together with HBL are now all partners in an expanded shared service entity. The three metro-Auckland DHB's do not anticipate material gains in the early stages of this project as it is expected that NDHB will have significant procurement gains from the leveraging advantage they will now gain.

The current financial constraints imposed on all DHBs have meant we have had to restrict healthAlliance NZ Limited activities for the past year in order to enable them to live within the overall funding package. Regrettably this meant a year of consolidation and in some cases, reduced ability to meet the needs and expectations of its shareholders as a shared services organisation.

These cost pressures have meant that focus on areas such as information technology and management opportunities that are seen as essential by all parties, have had to be deferred or in fact reduced for fiscal compliance at a time when both organisations should be investing in this area given the shareholders very high level of expectations and needs.

This increased investment, particularly in IS, is necessary to recapture the momentum previously given to the provider arm as well as the very significant needs around the capture and integration within one system of primary care and community level information. This is seen as a critical area for all the new DHB shareholders and essential to the future development of the region. It will thus have increasing strategic focus by both its own Board and its shareholders, given the consequential impact on the DHB.

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

5.6 2012/13 PHARMACEUTICAL BUDGET

We are committed to the Government's medicines boost initiative

CMDHB is committed to the Government's medicines boost initiative by engaging with Pharmac via our representations on SIG and the GMs' Planning and Funding forums. Pharmac's February 2012 forecast describes a drug cost budget reduction of $28.9M nationally against Pharmac's Oct 2011 forecast for 2012/13 ($2.2M for CMDHB or 7.6% of the total reduction). These savings are to be reinvested in a number of other initiatives including extended free GP care for under sixes after hours, Dementia residential care bed day price subsidy and providing support for child and adolescent mental health services. There is a funding challenge regarding this reinvestment in that Pharmac has out year plans to regain the previous trajectory of their funding path therefore making the 2012/13 saving "one-off". The proposed savings reinvestment plan is on going and therefore will create further funding challenges in out years.

The Pharmac budget forms the base budget to which is added local and regional initiatives. The base budget includes the continued investment of Pharmaceutical Cancer Treatments and the Ministry's funding of 12 month Herceptin treatments. Locally/Regionally the pharmaceutical budget allows for initiatives in the areas of gout, patient drug switching incentives, regional pharmacy development and the continuation of pharmacy quality audits.

At time of writing the Pharmacy agreement is under negotiation. The proposed new agreement has changes which have the potential to significantly improve health outcomes for long term conditions and improve efficiency of resource utilization. In addition, 2012 dispensing fees are budgeted to reduce by 22mill with an ongoing CCP adjustment, thereby curtailing the historic 9% growth in dispensing costs.

5.7 OUTLOOK FOR 2013/14 AND 2014/15 YEARS

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

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

    - Years 2 and 3 of the CMDHB Annual Plan will benefit from the assumption that PBF funding will continue at the current levels, thus assuming the reduced 4.7% maximum increase cap in any one year continues to be applied.

    - The outer years of the Annual Plan assume a continuing level of wage and salary settlements at the current proposed settlement levels which means CMDHB will have to continue to absorb settlements at virtually twice the funded levels. This remains a huge challenge for any organisation to absorb, while still continuing to provide both essential and increasing clinical services in a constrained fiscal environment. It is expected that there will be even greater pressure from medical staff for parity with Australian terms and conditions, given the significant easing/accessibility of New Zealand medical staff to Australia from April 2010. This is similarly likely to put even greater pressure around workforce levels, recruitment and training, underlining the criticality of the investment in Ko Awatea (formerly the Centre for Health Services Innovation)

    - The Annual Plan does not include the cash flow impact and initial operating expense impacts of any current or future, but as yet unapproved, business cases, i.e. it only includes the capital cost [and operating cost in 2013/14] of the approved $208m Clinical Services Block Business Case and the operating costs of the fitted out additional wards in the Edmund Hillary Block.

2. The challenges as described above are anticipated to be significantly offset by recognition of the continuing benefits of the rollout of the *Thriving in Difficult Times* project together with other widespread cost savings initiatives and revenue enhancements, thus underlining how important the achievement of these project outcomes are, both clinically and financially, to the organisation.

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

5.8 SIGNIFICANT ACCOUNTING POLICIES

BASIS OF PREPARATION

Statement of compliance
The financial statements of the DHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement base
The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land and buildings at fair value.

Functional and presentation currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the DHB, its subsidiaries, and its associates and its jointly controlled entity is New Zealand dollars (NZ$).

Changes in accounting policies
There have been no changes in accounting policies during the financial year.

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

Associates and jointly controlled entities
The DHB's associates (Auckland Regional RMO Services Ltd , 33% and Northern DHB Support Agency Ltd , 33.3%) are not equity accounted as they are not considered material to CMDHB.
The DHB's jointly controlled entity (healthAlliance NZ Ltd , 50%) is not equity accounted or accounted for using the proportionate method as it is not considered material to CMDHB.

Revenue
Revenue is measured at the fair value of consideration received or receivable.

Crown funding
The majority of revenue is provided by the MoH through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.
ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled

Rental income
Rental income is recognised as revenue on a straight-line basis over the term of the lease.

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

Interest income
Interest income is recognised using the effective interest method.

Donations and bequests
Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/(deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

Capital charge
The capital charge is recognised as an expense in the financial year to which the charge relates.

Interest expense
The DHB has elected to defer the adoption of the revised NZ IAS 23 *Borrowing Costs (Revised 2007)* in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities.
Therefore, all borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases

Finance leases
A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.
At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.
The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.
The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straightline basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Cash and cash equivalents
Cash and cash equivalents includes cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.
Bank overdrafts are shown within borrowings in current liabilities in the statement of financial position.

Debtors and other receivables
Debtors and other receivables are recorded at their face value, less any provision for impairment.
A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired.
The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

Investments

Bank deposits
Investments in bank deposits are initially measured at fair value plus transaction costs.
After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.
A bank deposit is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the bank, probability that the bank will enter into receivership or liquidation, and default in payments are considered indicators that the deposit is impaired.

Derivative financial instruments
CMDHB uses foreign exchange and interest rate swap contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities.
Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments that do not qualify for hedge accounting are stated at fair value. The gain or loss on re measurement to fair value is recognised immediately in the statement of comprehensive income. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.
The fair value of interest rate swaps is the estimated amount that CMDHB would receive or pay to terminate the swap at the balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price.

Inventories
Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. The loss of service potential of inventories held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.
The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the period of the write-down.

Non-Current assets held for sale
Non-Current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-Current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.
Any impairment losses for write-downs of Non-Current assets held for sale are recognised in the surplus or deficit.
Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.
Non-Current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

Property, plant, and equipment consist of the following asset classes:

- land;
- buildings and plant;
- clinical equipment, IT and motor vehicles;
- other equipment;
- work in progress;

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years.

The carrying values of land and buildings are assessed annually by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive income and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive income.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Work in progress is recognised at cost, less impairment, and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

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

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.
The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

- Acquired computer software 2-5 years (20% - 50%)

Impairment of Property, Plant & Equipment and Intangible Assets
Property, Plant & Equipment and Intangible Assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.
Value in use is depreciated replacement cost for an asset where the service potential of the asset is not primarily dependent on the asset's ability to generate net cash inflows and where the DHB would, if deprived of the asset, replace its remaining service potential.
If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.
For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.
The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.
For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Creditors and other payables
Creditors and other payables are generally settled within 30 days so are recorded at their face value.

Borrowings
Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.
Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date. Borrowings where the DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date are classified as current liabilities if the DHB expects to settle the liability within 12 months of the balance date.

Employee entitlements

Short-term employee entitlements
Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.
These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, and sick leave.
A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

Long-term entitlements
Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as sabbatical leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows for entitlements. The inflation factor is based on the expected long-term increase in remuneration for employees.
Presentation of employee entitlements
Sick leave, continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, sabbatical leave, and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes
Employer contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement
Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Provisions
A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditure will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.
Provisions are not recognised for future operating losses.

Restructuring
A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Partnership Programme
The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of two years up to a specified maximum amount. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.
The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date.
Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity
Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- Crown equity;
- accumulated surpluses;
- revaluation reserves; and
- trust funds.

Revaluation reserves
These reserves are related to the revaluation of land and buildings to fair value.

Trust funds
This reserve records the unspent amount of donations and bequests provided to the DHB.

Goods and services tax
All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense.
The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.
The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.
Commitments and contingencies are disclosed exclusive of GST.

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

Budget figures
The budget figures are derived from the statement of intent as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

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

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

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

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

Critical accounting estimates and assumptions
In preparing these financial statements, the Board has made estimates and assumptions concerning the future.
These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations
Note 13 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

Estimating useful lives and residual values of property, plant & equipment and intangible assets
The useful lives and residual values of property, plant, and equipment are reviewed at each balance date.
Assessing the appropriateness of useful life and residual value estimates requires the DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the DHB, and expected disposal proceeds (if any) from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciable amount of an asset, therefore affecting the depreciation expense recognised in the surplus or deficit and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second-hand market prices for similar assets; and
- analysis of prior asset sales.

The DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Critical judgements in applying accounting policies
Management has exercised the following critical judgements in applying accounting policies:
Leases classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB.
Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments.
Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.
The DHB has exercised its judgement on the appropriate classification of leases, and has determined a number of lease arrangements are finance leases.

Appendices

APPENDIX 1: CMDHB'S SAVING 20,000 DAYS CAMPAIGN

CMDHB's 'Saving 20,000 Days' campaign

What it is?

- A campaign based on Institute for Healthcare Improvement (IHI) methodology used in the Saving 100,000 Lives campaign to systematically improve standards of healthcare in America. Though this methodology, an additional 100,000 people were alive who otherwise may have been harmed by America's healthcare system.
- This methodology is an effective way of helping organisations deliver complex change on a large scale

Why this is needed?

- We need to meet the challenge of transforming the quality of care we provide through radically different processes and systems that not only save money, but produce better health outcomes.

What are the campaigns objectives?

- To develop a health system which sends the fewest number of patients to hospital while ensuring that those who are treated in hospital receive timely and high quality care.
- To build primary and secondary care to deliver the right care at the right time, in the right place and in the right way, including keeping people at home where possible.
- To develop a body of practice to share with other DHBs to help redevelop the health system more widely.

How will we achieve these objectives?

- We will achieve these objectives by drawing upon and integrating expertise from local settings, with proven methodology and expert advisers, to deliver an integrated programme of activities.
- We will support local implementation of best practice relating to four drivers of system change

What are our targets for 2012/13?

By the 30th June, 2013 we will:

- Give back to our community 20,000 healthy and well days, by reducing hospital bed days by 20,000.
- Reduce 5,000 unnecessary hospital admissions.
- Reduce requirements for beds by 66 beds.