COUNTIES MANUKAU HEALTH

Statement of Intent
2013/14 – 2015/16

Counties Manukau District Health Board Statement of Intent 2013/14 – 2015/16
Published 19 July 2013

The Mangere Community Health Centre pictured on the front cover is owned by the Mangere Health Resources Trust

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 2013/14 by Counties Manukau Health and contains non-financial and financial forecast information for the 2014/15 and 2015/16 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 2013/14.

Issued by
Counties Manukau District Health Board

Signed by

Professor Gregor Coster
Chair of Counties Manukau DHB

Jan Dawson
Counties Manukau DHB Board Member

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2013/14 represents year two of a four year whole of health system transformation journey for Counties Manukau Health (CM Health).

This year, CM Health will implement the system integration strategies we planned last year. This is to ensure that we deliver on our promise to be the best healthcare system in Australasia by 2015.

This plan emphasises significant investment and devolution with new models of care in primary and community services (refer Figure 1). We will be spending:

- $7m on service integration and innovation
- $4.5m on devolution of Maaori provider contracts to National Hauora Coalition
- $1.5m on devolution of Pacific provider contracts to Alliance Health Plus
- $5.5m to shift home health care (68 FTE) from secondary care into PHO/DHB jointly governed community based services

This is as a result of establishing in 2012/13 a new platform of locality clinical partnerships of primary and secondary care clinicians to lead delivery of new integrated services. Each of the four localities (Mangere/Otara, East, Franklin and Manukau - and their respective clinical leadership and management governance) now have a 4-year business plan that identifies priorities to deliver better, sooner more convenient services.

In 2013/14, we will deliver year one of the localities plans and move the second tranche of community and allied health services into that structure from 1 July 2013. The locality leadership groups will drive the work of ensuring that community based specialist services are aligned with the population and primary healthcare needs of our local communities.

In 2012/13, our primary care partners established Integrated Family Health Centres that will form the hub of our network of shared services across each locality. During the 2013/14 year, we will proceed with shifting community based specialist services as required by primary care Locality governance with the support of the District Health Board (e.g. school based nursing clinics, diabetes, palliative care, maternity, health of older people services, community mental health).

This year we intend to integrate the Better Sooner More Convenient business cases (BSMC) with the Greater Auckland Integrated Health Network (GAIHN), Alliance Health Plus and the National Hauora Coalition into this structure who will, by 2013/14 be in their final year of “business case” implementation. From 1 July 2013, $4.5m of Maaori health and $1.5m of Pacific health services that improve access to primary healthcare will be shifted to National Hauora Coalition and Alliance Health Plus to align with our desire for whaanau ora/fanau ola implementation.

In 2012/13 we established a first tranche of 8 programmes to reduce our acute inpatient bed demand by 20,000 days. In 2013/14 we will extend this to 13 programmes with additional clinical pathways and improvement initiatives to further reduce our acute growth by an additional 20,000 days. In addition, we expect to reduce Ambulatory Sensitive Hospitalisations (ASH) by 5,000 this year as a consequence of expanded access to Primary Options for Acute Care (POAC), Chronic Care Management (CCM) and other primary care initiatives.

We have set aside $7m service integration and innovation funding to support locality and 20,000 Days campaign of initiatives. We will also begin first year implementation of a “risk and gain” sharing funding model across our healthcare system that reinforces the shared accountability for outcomes such as reducing acute demand between primary and secondary services. While no services will be destabilised by

this introduction by the end of 2013/14, it will set a platform for services to have shared and common incentives on how they work across continuums of care to benefit patient flow.

In 2012/13 we invested an additional $500,000 to increase primary care access to diagnostics. In 2013/14 we extend this programme to provide additional $1.2m investment in additional community diagnostics for spirometry, endoscopy for dyspepsia and will plan ways to increase direct primary care access to CT and MRI.

In 2013/14 we will use the mental health funding carried forward from 2012/13 to significantly invest in the mental health services of children and young people as our contribution to the Prime Minister's Youth Mental Health project and to meet the needs of our very young, mostly Maaori and Pacific populations.

During 2012/13, much was reported publicly about the issues relating to the care and support that is too often disconnected for our vulnerable mothers and their babies. The 2013/14 year will be the year of an increased and focused investment in vulnerable mothers, babies and their whaanau. We will act with concentrated effort on joining up the multitude of services that mothers and babies interact with when planning their families, pregnancy and during the First 2000 Days of baby's life. We believe this is the best opportunity to invest for better population health outcomes in the long term.

In 2013/14, we commit publicly to being a Smokefree DHB by 2025 – we aim to reduce smoking prevalence to less than 5 percent by 2025 with an intermediary goal of 12 percent by 2018 for all ethnic groups - and will be implementing concrete actions to increase access to cessation support. We will also "up the anti" with our intersectoral colleagues to tackle the poor access to warm and safe housing for our most vulnerable people and their whaanau.

We will continue to deliver all our national health targets this year with a focus on reduced waiting times in Emergency Department, diagnostics and cancer services. Our ambition is to exceed expectations. We are committed as a regional player to ensure we do our part in achieving the Northern Region Health Plan. Consequently we will deliver increased access to elective surgery, cancer, cardiac and specialist mental health services in line with the Minister's expectations. We are excited to be opening our Clinical Services Block during the year and utilise the expanded capacity to meet our local health needs.

Importantly, we will move forward to improve the experience of patients and their whaanau when they come into our healthcare system. Year 2 of our First Do No Harm programme will continue our contribution to national and regional campaigns (e.g. CLAB). In 2012/13 we implemented the whaanau as "Partners in Care" that welcomed close whaanau to be with their loved ones in hospital as partners, not as visitors. In 2013/14 we will extend this approach to integrate the experiences of patients in how we design services. Critical to the achievement of our strategic objectives will be the successful development and implementation of a fully integrated patient centred Information and Communication Technologies (ICT).

We aim to be the best. How will we know we are the best? We aim to benchmark ourselves against well researched system level measures that enable our comparison against other systems/jurisdictions over the next 5 years. We will also be testing ourselves against an excellence framework based on the internationally renowned Baldrige Framework for performance success.

We will deliver this within our financial envelope. While 2013/14 will be a challenging year, we will continue our track record of delivering on health needs within our budget. CM Health has had a long term focus on clinical engagement - clinical quality is our highest priority. In this particular year, we aim to bend back our cost growth curve to align more closely with inflation by changing how we work, to provide better care more effectively. We will do this through scrutinising every opportunity and advantage to ensure that we have the optimal mix of people and skills at the front line and that our capital investment focuses on enabling integration through IS/IT. Balancing our budget has been the most difficult for some years and we recognise that this financial challenge will go on for some years. In order to achieve a $3m surplus in 2013/14 and 2014/15 some difficult decisions have had to be made. However, the completion of the System Integration Investment indicative business case, currently being developed jointly by CM Health,

Ministry of Health and Treasury in the spring of 2013, will set the framework as to how we can transform our services to be of the highest quality of care but within a sustainable financial environment. As ever, we are fully committed to regional and national relationships and will continue to be a high performing DHB.

We thank our partners in our local healthcare system – primary care, non-government organisations, communities for your support and ongoing contribution to improving our community's health. This is a responsibility we share with you and we look forward to working together with you this coming year.

Professor Gregor Coster
Chair

Geraint A Martin
Chief Executive

Figure 1: CM Health strategy actions at a glance

	We established in 2012/13	We will implement in 2013/14
Better Outcomes for our Population and intersectoral collaboration	➢ 85 percent of 8 month olds immunised ➢ 95 percent of hospitalised smokers provided with cessation advice ➢ Better Health Outcome for all programme prioritisation of housing, Smokefree and First 2,000 Days of life initiatives ➢ Devolved contract for throat swabs in schools	➢ Immunisation of 90 percent of 8 month olds ➢ Throat swab service in 53 schools ➢ Reduce incidence of rheumatic fever by 10 percent ➢ Improve access to quality housing through increased referrals to retrofit insulation to private/ rental homes ➢ 100 percent school based nursing clinic integration with primary care (targeting at care for risk students) ➢ 1 FTE specialist for community youth alcohol & drug services (contribution to regional plan)
System Integration **with** **Localities Development as a key strategic investment** through hospital and primary/ community care collaboration and whaanau ora service integration	**Incentivise System Integration and Change**	
	➢ District Alliance group ➢ Localities Partnership Agreement and shared performance accountability ➢ Initiative funding for acute demand reduction ➢ Efficiency programme savings over 3 years of approx. $60m ➢ Increase in funding for direct community referred radiology tests (plain film and ultrasound) by $500k	➢ $850k total funding for direct community referred radiology tests (plain film and ultrasound) and scoping of potential expansion to include CT and MRI in 2014/15 ➢ $1m for primary care achievement of health targets ➢ Clinical integration of primary/community health and hospital service structures ➢ Shared risk/gain framework and primary care practice budget holding ➢ Thriving in Difficult Times (efficiencies) programme expanded to the whole system ➢ Whole of system operational information hub ➢ $1.2m investment for increased range of community diagnostic tests for spirometry, endoscopy for dyspepsia, CT/MRI ➢ $6m devolution of Maaori & Pacific contracts to PHOs
	System Infrastructure Development	
	➢ Achieving a Balance Portfolio / Programme Office ➢ Franklin and Eastern locality leadership groups & operational management ➢ Localities Development 3 Year Business Cases ➢ Whaanau Ora Centre Business Case at Manukau ➢ Capacity and production planning systems ➢ Shared Care System pilot ➢ TestSafe Pharmacy to support Medicines Reconciliation	➢ Establish a whole of system strategy planning group of DHB and Primary Health Organisation leaders ➢ Mangere-Otara and Manukau locality leadership groups and operational management ➢ Year 1 of implementation of locality based Integrated Family Healthcare Centres (IFHCs) to deliver service shifts at a cost of $5.5m at: Manukau – Whaanau Ora Centre Otara - Dawson's Rd and Otara Mall Mangere – Community Centre Health Eastern – Botany Community Health Hub Franklin – Franklin Memorial Hospital Health Hub ➢ Information System infrastructure resilience investment through regional shared services ➢ Expansion of Shared Care and CareConnect clinical portal information to more primary/community based health workers
	Care Closer to Home and Service Change	
	➢ 20,000 Days campaign cumulative bed savings of 13,310 by 31 Jan 2013 ➢ Whaanau Ora service development through National Hauora Coalition and related localities business case development ➢ Localities business case proposals for service changes and community based pilot programmes ➢ Improved patient experience (AI2DET programme roll out) ➢ Pulmonary and heart failure rehabilitation programme implementation in localities ➢ High risk patient identification tool in localities ➢ Very High Intensive User team transition to localities ➢ Community Geriatric service expansion to rest homes	➢ $7m service integration and innovation fund ➢ Shift 70 percent (68 FTEs) of home health care workforce from secondary care into PHO/DHB jointly governed community based services ➢ Six more General Practitioner with Special Interest (GPwSI) training programmes - with 3 new GPwSI per locality working in the IFHCs ➢ Direct GP access for specific elective procedures for 850 patients with otitis media, carpal tunnel syndrome and tonsillitis ➢ Pilot expansion of community based cardiac and heart failure rehabilitation group programmes ➢ One credentialed Whaanau Ora network per locality ➢ $4.5m funding to embed the service changes from evaluation of 13 collaborative teams as part of the 20,000 Days Campaign that will save 20,000 bed days ➢ Franklin and Eastern locality wrap around services for older people to reduce acute admissions ➢ Six community midwifery specialist roles and minimum of six LMC midwives in partnership with general practice ➢ At least one Accident and Medical service operating per locality until 10pm ➢ Primary Options for Acute Care (POAC) extension to Transient Ischaemic Attacks (TIAs) and renal colic

1.0 Introduction

Counties Manukau District Health Board (CMDHB) is one of twenty District Health Boards (DHBs) established under the New Zealand Health and Disability Act 2000 (NZPHD 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.

CMDHB is owned by the Crown and is a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004). Accountability for CMDHB is through the Crown Funding Agreement and Annual Plan which is negotiated and agreed annually between the Minister of Health and the DHB. The Statement of Intent, included in this document, is also a key accountability document.

As a DHB we are influenced by and must balance national health goals and targets set by the government, alongside regional priorities set out in the Northern Region Health Plan and our own districts population health needs.

1.1 Treaty of Waitangi

CMDHB aims to fulfil our obligations as agent of the Crown, under the Treaty of Waitangi. Our relationship with the tangata whenua of our District is expressed through a Board to Board relationship with Manawhenua I Taamaki Makaurau. CMDHB has adopted a principles based approach to recognising the contribution that The Treaty of Waitangi can make to better health outcomes for all, inclusive of Maaori.

The principles of partnership, protection and participation implicitly recognise the important role the health sector plays in recognising the indigeneity of Maaori and therefore the status and rights of Maaori to achieve equitable health outcomes in comparison to the rest of the population.

1.2 Governance

CMDHB is governed by a Board of eleven members, seven of whom are elected by the community, and four, including the Chair, whom are appointed by the Minister of Health. The role of the Board is to provide governance and to ensure that CMDHB fulfils is statutory functions in the use of public resources. The current Board governance structure includes three statutory committees and five non-statutory committees (including Advisory Groups) assist the Board to meet its responsibilities. The committees include a mix of Board members, clinicians and community representatives. It is the intention of the incumbent Board to pilot consolidation of the Board subcommittee structure over the May to July 2013 period. Any changes made as a result of this pilot will be reflected in the system performance measurement reporting system.

Whilst the Board maintains overall responsibility for the DHB's performance, operational and management matters are assigned to the Chief Executive, Geraint Martin.

In recognition of the strategic requirement for shared system wide accountability and integration across primary and secondary care providers, CMDHB has established a District Alliance Group and related Agreement with the five Primary Health Organisation (PHO) partners operating within the Counties Manukau district. This includes ProCare, National Hauora Coalition, Alliance Health Plus, Total Healthcare and East Health Trust.

To better reflect a health system approach for effective resource planning to meet our population needs and health sector priorities, this document will refer to the collective delivery of all health services and related infrastructure as Counties Manukau Health (CM Health). This therefore includes CMDHB, PHO and related non-government organisation (NGO) service delivery and support resources.

1.3 Health profile of Counties Manukau populations

The Counties Manukau population is growing at 2 to 3 percent per year. This rapid growth places a significant load on health service provision and is compounded by an ageing population and relatively high prevalence of diabetes, obesity, smoking and other health issues. The net impact is demand on health services above demographic growth and has significant system capacity implications.

Counties Manukau population and health profile[1,2]

- CM Health provides health and disability services to an estimated 512,000 people who reside in the local authorities of Auckland, Waikato District and Hauraki District
- Our population is growing at a rate of approximately 2 percent per year. Overall, Counties Manukau population is expected to grow by approximately 8,500 residents each year for the next 20 years. From 2006 to 2026 the number of new residents in Counties Manukau is projected to be 169,800 - this is nearly the size of Wellington City in additional growth
- Four geographical locality areas have been defined covering Counties Manukau district: Mangere/Otara, Eastern, Manukau and Franklin. Each locality is diverse in terms of its demographics and health needs
- The Counties Manukau district has a diverse population: 38 percent Pakeha and Other, 23 percent Pacific, 16 percent Maaori, 22 percent Asian. 12 percent of all New Zealand's Maaori live in Counties Manukau and 40 percent of New Zealand's Pacific peoples live in our district
- We are a relatively young population with 24 percent of our population aged 14 years and younger. 14 percent of New Zealand's child population lives in Counties Manukau
- The population aged 65 and over in Counties Manukau is projected to more than double from 35,945 in 2003 (53,610 currently in 2013) to 80,010 by 2023. It is this group who will place the highest demands on health services in the years to come
- Overall, life expectancy (2008-2010 average) at birth in Counties Manukau is similar to that of the New Zealand average at 81 years. However, despite improvement, there are persistent and stark gaps for Maaori and Pacific populations compared with non-Maaori/non-Pacific. The life expectancy gap between Maaori and non-Maaori/non-Pacific remains in excess of 10 years while the gap between Pacific and non-Maaori/non-Pacific is 5 to 7 years
- 34 percent of the Counties Manukau population live in areas classified as being the most socio-economically deprived in New Zealand. 57 percent of Maaori, 79 percent of Pacific and 43 percent of 0-14 year olds in Counties Manukau live in areas with a deprivation index of 9 or 10
- Otara, Mangere and Manurewa are the most socio-economically deprived areas in the Counties Manukau District. The high proportion of the Counties Manukau population living in deprivation has a significant impact on health and health service provision
- In the 2006 census, 28 percent of adults in Counties Manukau had no educational qualifications and 6 percent of households had at least one person receiving an unemployment benefit
- Maaori and Pacific residents of Counties Manukau have relatively higher rates of hospitalisation than the NZ average while Asian and Europeans have a lower rate than the New Zealand average
- 80 percent of deaths, and a substantial proportion of illness and reduced quality of life in our communities are due to a 'package' of conditions – diabetes, cardiovascular disease, chronic respiratory conditions and cancer. There are significant opportunities for prevention of these conditions by addressing the shared risk factors of smoking, obesity, poor nutrition, lack of physical activity and misuse of alcohol

[1] Ministry of Health (2012) DHB Ethnic Group Population Projections, 2007–26 (2006-Base), and various CM Health population health status papers

[2] Counties Manukau Health Maaori Health Plan 2013-2014

1.4 Government focus on Better Sooner More Convenient Services

System integration is central to medium to long term management of our health system demand challenges. Our commitment to this national policy is demonstrable in our implementation of the localities approach. We recognise that the scale and pace of system wide service configuration and integration must be accelerated if we are to meet the rising demand of an ageing and growing population within our available resources. In partnership with primary care, CMDHB is committed to building on the infrastructure and services established in the 2012/13 year, which included:

- Establishment of a District Alliance Group and related agreement with the five PHOs
- Expanding on the range and scope of services delivered in the community
- Shared accountability for health system outcomes and performance and establishment of risk and gain sharing arrangements
- Development of a virtual budget
- Shifting services closer to home
- Continued delivery of government's expectations in national health targets

In the 2013/14 year we will achieve:

- An enhanced role for comprehensive primary health care services, and increased accountability for health system outcomes
- Shifting of some specialist and community based services provided by the DHB to Locality governance and management and, therefore primary care clinical governance
- Development of new models of care that maximise outcomes within the available global budget
- The use of whaanau ora services to support vulnerable families
- Reducing to near as zero as possible growth in unplanned hospital admissions through the provision of enhance primary and community services
- The use of regional service planning to reduce fragmentation and share resources in the metropolitan Auckland community
- Bending back our cost growth curve through initiatives to live within our means

1.5 Key areas of risk and opportunity

The constrained future funding growth forecasts do not match our current health service demand projections. We recognise that the existing service configuration and balance of related funding across the sector is not well designed to meet our population needs within available funding. Figure 2 below outlines the key system risks and related mitigation approaches/opportunities we are implementing to manage these.

The Northern region's triple aim is the framework we have adopted to organise our response and proactively reorganise our collective CM Health capacity and capability to better meet our population needs, deliver service excellence and meet the government's expectations and targets while remaining financially sustainable. Our guiding strategy is to:

- Improve health and equity for all populations
- Improve quality, safety and experience of care
- Ensure best value for public health system resources

Figure 2: CM Health key areas of risk and opportunity

Risk	Opportunities / Mitigations
Increasing demand for health services and infrastructure	▪ Increased focus on preventative measures and early intervention through our Better Health Outcomes for All programme focussed on improved population health outcomes ▪ Patient and whaanau centred care to guide system redesign and fit for purpose services ▪ Driving investment towards improved models of care ▪ System wide service integration ▪ Improving performance through both financial and non-financial incentives ▪ Shared accountability to deliver BSMC services ▪ Intersectoral collaboration to address health and other priorities ▪ Strengthening leadership while supporting front line innovation ▪ Increasing the proportion of community based services
Ongoing fiscal constraints and affordability	▪ Increasing acute services productivity and effectiveness ▪ Reducing unexplained clinical variation ▪ Primary and secondary care shared accountability for financial performance ▪ Improving the way we work regionally and nationally to realise the efficiency benefits of shared services and joint procurement ▪ Sustainable labour cost growth model ▪ More effective utilisation of private and regional capacity/capability
Diverse needs and challenges within local communities	▪ System wide service integration ▪ New models of service delivery and workforce development ▪ Community engagement, patient and whaanau centred care ▪ Strengthening and expanding intersectoral work programmes

1.6 Nature and Scope of Functions / Intended Operations

1.6.1 Whole of system planning

CMDHB has recently reshaped the governance structure to better integrate system wide thinking into short to long term planning. The restructure saw CMDHB move away from being organised along traditional funding and planning functions. Planning functions are now coordinated across strategic prioritisation and related service development planning.

The strategic planning function is supported by a Whole of System Strategy Board that includes PHO and CMDHB executive leadership. Six strategy working groups, some of which are in the process of being established, provide population and service specific strategic advice for this group. As a result, we will be in a better position to consistently focus on a health systems perspective in setting our planning priorities and monitoring progress against agreed outcomes.

Planning involves close collaboration between the Strategic Development and Primary Health and Community Services Directorates. In 2012/13 we worked with our PHO partners through the District Alliance Group to implement locality based infrastructure to support service development closer to where people live. In the coming year we plan to shift community and primary care service functions, which currently sit with the Director of Hospital Services, to the Director of Primary and Community Health. The Whole of System Strategy Board plays a key role in jointly determining the strategic direction of CM Health and resource allocation. Aligned with this is the asset planning functions that are managed by the Business and Corporate Services Directorate.

To better reflect a system approach to health service planning, the collective health resources and associated infrastructures to deliver services for our resident population is referred to as Counties Manukau Health (CM Health). This approach supports a more collaborative approach to planning with the local (primary, community and hospital) and regional care partners. This provides more effective integration of strategic objectives, outcomes and shared implementation planning where there are clear benefits for joined up action plans.

1.6.2 Provider

CM Health is a major provider of both community-based and secondary health services to the estimated 512,130 people residing in the Counties Manukau district.

The PHO associated primary care practices are distributed throughout the district, with more recent investment related Integrated Family Heath Centres with a view to increasing the scale and diversity of services closer to where people live. This will enable integration of primary and secondary services and new models of care as part of our strategic response to the health system challenges. CMDHB operated services are largely delivered from seven inpatient and numerous leased or owned outpatient and community health facilities across the District – the Manukau Health Park and Middlemore Hospital sites contain the largest elective, ambulatory and inpatient facilities.

1.6.3 Funder

As a funder, CMDHB funding responsibilities cover the totality of CM Health services to the people residing in our district. This includes funding for primary care, hospital services, public health services, aged care services, and services provided by other non-government health providers including Maaori and Pacific providers. Some specialist tertiary services and services that are covered by regional contacts are provided by other DHBs. This includes Auckland DHB and Waitemata DHB cardiothoracic, neurosurgery, oncology, forensic mental health and school dental services. Regional public health services are provided by Auckland Regional Public Health Service, under a Ministry of Health contract.

In the 2013/14 year CMDHB will receive $1.3 billion in funding, of this:

- $705.2m is for the provision of services delivered through the DHBs Provider Arm
- $313.4m is for the provision of services delivered through contracts with NGOs
- $268.6m is for the provision of services delivered by providers or contracts that sit outside of Counties Manukau district
- $12.8m is to cover Governance and funding related capability and administration

1.6.4 Owner of Crown Assets

As an owner of Crown Assets, CMDHB is required to operate in a fiscally responsible manner and be accountable for the assets we own and manage. This includes ensuring strong governance and accountability, risk management, audit and performance monitoring and reporting. CMDHB carries out formal asset management planning to determine planned future asset replacement and expected financing arrangements.

We revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. CMDHB land and buildings are revalued every three years. The last revaluation occurred in 2010 on an “Optimised Depreciated Replacement Costs” basis.

2.0 Strategic Direction

2.1 Vision and Values

Our shared vision is *to work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori and Pacific peoples and other communities with health disparities.*

We will do this by:

- Leading the development of an improved system of healthcare that is more accessible and better integrated
- Dedicating ourselves to serving our patients and communities by ensuring the delivery of both quality focussed and cost effective healthcare, at the right place, right time and right setting
- Being a leader in the delivery of successful secondary and tertiary healthcare, and supporting primary and community care

Integrated into our planning and related action plans are the following organisation values:

- *Care and Respect* - by treating people well, with respect and dignity that embraces individual and cultural diversity
- *Teamwork* - achieving success by working together with patients, whaanau and health service providers
- *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

2.2 Strategic Context

2.2.1 National health sector priorities

The 2013/14 government's Better Public Health Services, six national health targets as indicated in the Minister's Letter of Expectations set the context for our priority setting. We have a particular focus on the integration of health services across the region and between primary and secondary health service providers. CM Health cannot succeed in meeting these challenges without aligning key initiatives with strategic partners including other Northern Region District Health Board's (DHBs), Counties Manukau based Primary Health Organisations (PHO) and related service providers and BSMC business case organisations.

Our context is also shaped by the priorities set by other national agencies – Health Benefits Limited, Health Workforce New Zealand, National Health Board, National Health IT Board, National Capital Investment Committee, Health Quality and Safety Commission. CM Health aims to integrate and align these national entity priorities within agreed budget commitments, ensuring they are relevant and can be adapted to our local context.

2.2.2 Northern region priorities

We are in year 3 of implementation of the Northern Region Health Plan (http://www.ndsa.co.nz) which has been developed by the four DHBs (Auckland, Waitemata, Northland and Counties Manukau) and their primary care partners. For 2013/14, this builds on the region's previous two plans and with an emphasis on longer term planning and the provision of better, sooner, more convenient healthcare for patients and

communities within constrained funding increases. There is a focus on demonstrative collaboration and delivering on regional workforce, IT and capital objectives and more detailed planning across regional priorities. This will include significant changes to our business support systems, and in particular the regional focus around information systems, procurement and the supply chain.

Regional planning focuses on where regional health system collaboration will make a real difference (tangible benefits) and addresses important health issues for the population. Identified new themes for 2013/14 include:

- Health gain for Maaori
- Better integration between services
- Supporting our population to have greater involvement in their care

The Northern Region DHBs, assisted by the Northern Regional Alliance and regional shared services organisation healthAlliance have agreed the following priority goals as part of the Northern Region:

- *First, Do No Harm* - reducing harm and improving patient safety
- *Life and Years* - reducing disparities and achieving longer, healthier and more productive lives
- *The Informed Patient* - ensuring patients and their whaanau get care, information and support appropriate to their context

CM Health's Annual Plan priorities align to the Northern Region goals as shown in the high level Intervention Logic (refer section 2.5).

CM Health is an active participant in the regional governance structure, related clinical networks and programmes of work. In addition to this, examples of key regional leadership roles served by CM Health staff include Lead Chief Executive for the Northern Regional Alliance, Clinical Leader of the Cardiology Network, Chair of the Regional Radiology Network and others.

The Northern Regional Alliance Limited (NRA) is an amalgamation of two previous subsidiary companies, the Northern Region DHB Support Agency Limited and the Northern Regional Training Hub Limited. The NRA is owned in equal shares by Waitemata, Auckland, and Counties Manukau DHBs.

NRA has applied for exemption from producing a Statement of Intent (SOI) for the 2013/14 year as a restructuring process is under way and key outputs and budgets are not able to be set until the new structure is in place. NRA will produce a Business Plan, including budgets and key outputs for 2013/14, and will report both internally and to shareholding DHBs against that Business Plan commencing with a report in October 2013 for the first quarter of 2013/14. The NRA Annual Report for 2013/14 will report actual results against the Business Plan in a similar manner to that which the two amalgamated companies reported against their annual Statements of Intent. The shareholding DHBs will monitor NRA performance against its Business Plan on a quarterly basis throughout 2013/14.

2.3 Our Priorities for 2013/14 and Beyond

In 2012/13 we made significant progress towards our goal to become the best healthcare system in Australasia through implementation of our Triple Aim Strategy objectives:

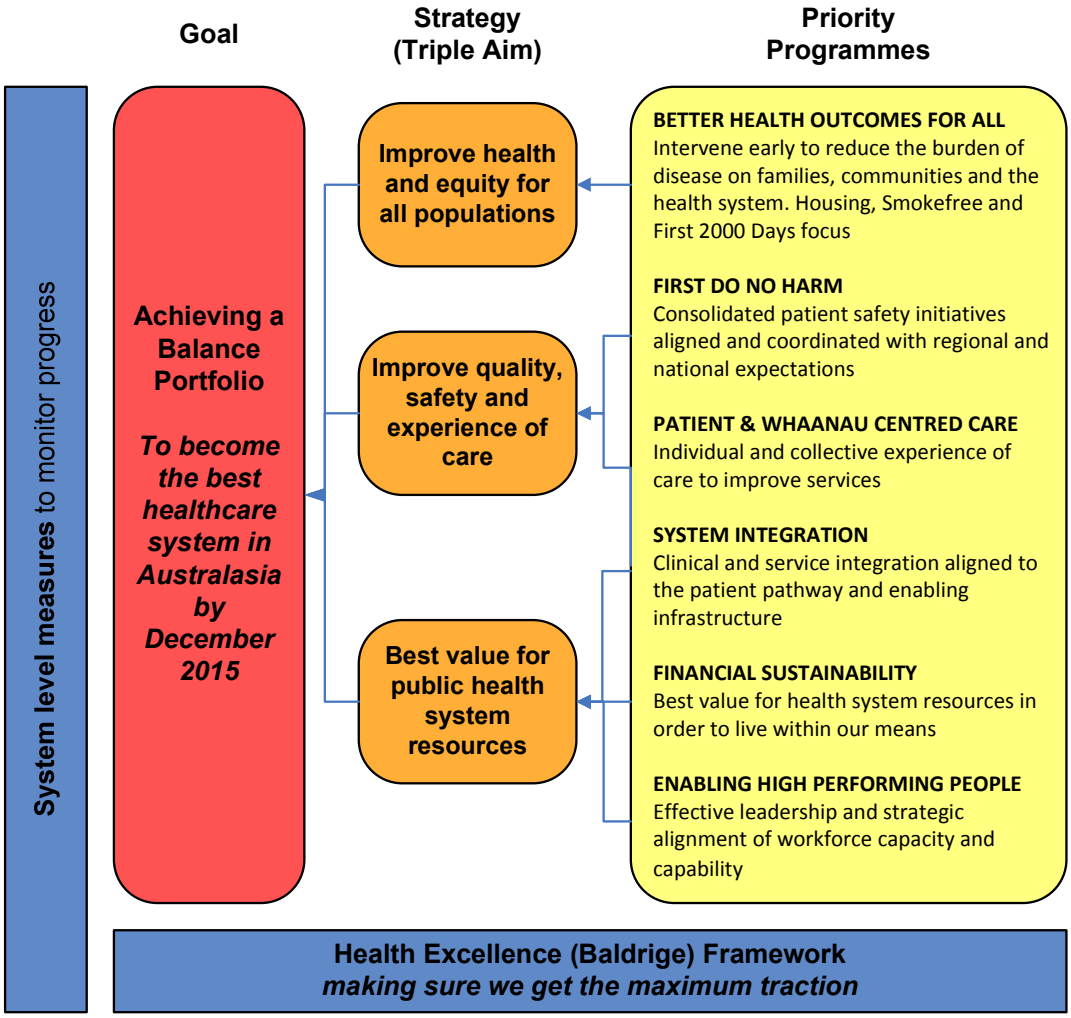
- Improve health and equity for all populations
- Improve quality, safety and experience of care
- Ensure best value for public health system resources

These objectives align with the Northern Region triple aim that simultaneously considers health system decision making in relation to, population health, cost and productivity and quality of patient experience. Each Triple Aim has a programme of change and organisation delivery to enable effective direction of

resources to implement agreed actions plans. This is summarised in Figure 3 and related programme descriptions.

Targeted investment in Information and Communication Technologies (ICT) is critical to achieving our strategic priorities and has been confirmed by our clinical leaders as the highest 3-5 year investment priority (refer section 4.2.1). This will enable us to work smarter through technologies that enable patients and whaanau to take a more central role in their health, integrate and remove duplication of services and associated service delivery efficiencies, and provide end to end clinical integration for our patients (i.e. whole of system).

Figure 3: Achieving a Balance Portfolio: Delivering excellent healthcare while also being sustainable



The practical application of this strategy means that CM Health is working alongside our health system partners to align workstreams where appropriate and utilise our outcomes framework to track how the contributing activities perform against targets. This enables logical links to national health targets and priorities alongside CM Health specific outcomes that references our Maaori Health Plan, Annual Plan and Locality Development Plans.

The identified performance measures associated with this portfolio and Annual Plan are aligned and common across all ethnic groups, with targeted action plans to address health inequalities and integrate with our Maaori Health Plan.

2.4 Key Risks and Opportunities

A complete summary of organisational risks, mitigation strategies and status are managed through routine business review process and related register updates. In addition to these core organisational management systems key **system level** risks relate to:

- Revenue growth is forecast to be less than current cost growth; therefore
- The existing models of care and service configuration are unsustainable

The most critical strategic risks and management strategies CM Health faces in 2013/14 are outlined in Figure 4.

Figure 4: CM Health strategic risks and opportunities

Category	Risk/Opportunity	Management Strategy
Clinical	*Whole of system capacity and capability*: To integrate services and to increase the type and scale of primary and community care based services	A *Whole of System Strategy Group* comprising Primary Health Organisation Chief Executives and CM Health Executive Leadership Team to focus on the longer term health system vision to clarify investment (hard and soft) priorities. This will determine the most effective use of resources with a focus on the short, medium and longer term priorities *Prioritised investment in shared information systems* that support health service delivery and decision making in the most effective care setting, i.e. national, regional and local system development *Whaanau ora* promises to bring a greater focus on addressing the issues of employment, housing and educational achievement, as well as working with vulnerable whaanau. This is consistent with a strengthened population health approach *Locality Development* with a service integration and implementation focus for 2013/14
Corporate	*Revenue*: The forecast revenue increase of 2.7 percent is just over half of what is anticipated to maintain operations. This is a longer term forecast constraint that has impacts for the affordability of capacity expansion	This provides an opportunity/stimulus for *increased scale and pace of system wide service integration* and shared accountability (as for whole of system capacity and capability above), to deliver services closer to where people live, intervene earlier for improved health outcomes and resulting reduction in acute service demand *Significantly increased focus on clinical models of care*, reducing clinical variation and improving acute service productivity across the health system (from primary care to hospitalisation). These are seen as critical to further cost containment and clinical leadership is an essential factor for success *Acute system capacity and production planning* capability expansion to inform the most effective use of available resources, e.g. the Peak Workload Plan, daily capacity reporting *System wide value for money review* which is looking systematically at our costs, how we are working, how we are spending across the whole of system and revenue-generating opportunities

Corporate	*Constrained public health capital funding for hard and soft assets*: This has impacts for infrastructure resilience (e.g. IS), facilities and equipment condition and fitness for purpose	*Regional prioritisation of IS infrastructure* to assure business continuity and platform for future system investments, e.g. regional upgrade of Microsoft software upgrades in workspace and infrastructure, Shared Care system implementation *Whole of system strategy priorities* to align facilities investment planning (under review currently) *Reduce reliance on (new) capital* for managing service demand, i.e. different models of care, primary and community care (Locality Development Plans), better leverage regional and private capacity and capability *Collaboration with regional and national partners* (DHBs and Health Benefits Limited) to leverage of aggregated savings and efficiency benefits and local system level accountability for financial and non-financial performance

2.5 Key Counties Manukau Health Outcomes and Impacts

CM Health planning priorities align with national, regional and local planning goals and link to strategic outcomes. Our prioritised goals for the Statement of Intent three year period aligned to the regional triple aim outlined in section 2.3 above.

A more detailed CM Health performance measures output/capability summary is currently in development with a view to providing our intervention logic and integrating system level 'big dot' measures. The working elements of this are represented in our intervention logic (refer Figure 15, page 23), with refinement and implementation expected in the form of a revised reporting scoreboard as part of our performance measurement system review during the 2013/14 year.

2.5.1 Improved health and equity for all populations

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

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 / 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 long term measure of health status and Counties Manukau resident data highlights large disparities between Maaori, Pacific and non-Maaori/non-Pacific populations[3].

Long Term Impact Measures (5 to 10 years)

We will know when we are succeeding when there is:	
Continued improvement in overall life expectancy and narrowing of ethnic disparity Of principle concern is the persistent wide gap (in excess of 10 years) for Maaori compared to non-Maaori/non-Pacific groups. In addition, Maaori in Counties Manukau are falling behind Maaori nationally. The gap for Pacific, although smaller (6-years), is also of ongoing concern.	**Impact Measure**: The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific.

[3] O'Brien B, Winnard D, Wang K, Papa D (2012). Life expectancy update to 2011 for Counties Manukau DHB. Auckland: Counties Manukau District Health Board, unpublished

Figure 5: Life expectancy at birth by ethnicity, 3 year rolling average, 1996-2012

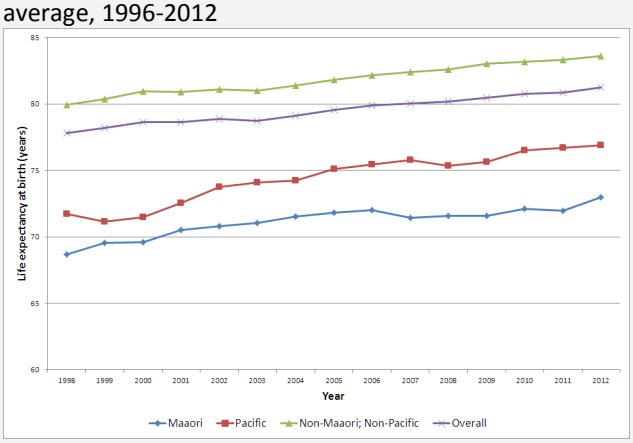


Figure 5 shows that while life expectancy overall has increased, the gaps between Maaori and non-Maaori/non-Pacific, and Pacific and non-Maaori/non-Pacific remain and have not decreased. There is projected to be a significant increase in the percentage of the Counties Manukau Maaori population who will be aged over 65 yrs.

Targeted actions to support the health and wellbeing of the older Maaori population are detailed in the CM Maaori Health Plan 2013/14.

Medium Term Impact Measures (1 to 5 years)

Previous CM Health analysis identified the main causes of death that contribute to differences in life expectancy as:

- Lung diseases related to smoking
- Cardiovascular diseases
- Cancer (non-lung)
- Diabetes
- Infant mortality[4]

Based on our review of current and previous activity, the current policy settings, emerging national priorities, expert advice and international experience, three priority areas of action and related impact measures are housing, Smokefree and the first 2,000 days from peri-conception to 5 years of life. This is the focus of our Better Health Outcomes for All programme that focuses on reducing the impact of long term conditions such as diabetes, heart disease and others.

The selection of these priority areas takes into account that there is significant work which will continue in the other areas, such intersectoral partnership interventions in education, housing, employment and the health system work to improve management of long term conditions, along with the considerable national policy drivers. 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.

Over the next one to five years we seek to make a positive impact on the health and wellbeing of Counties Manukau population and contribute to the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides will be evaluated using the following impact measures.

[4] Smith J, Jackson G, Sinclair S (2008) Life expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB. Auckland: CMDHB

We will know when we are succeeding when there is:

A reduction in smoking prevalence

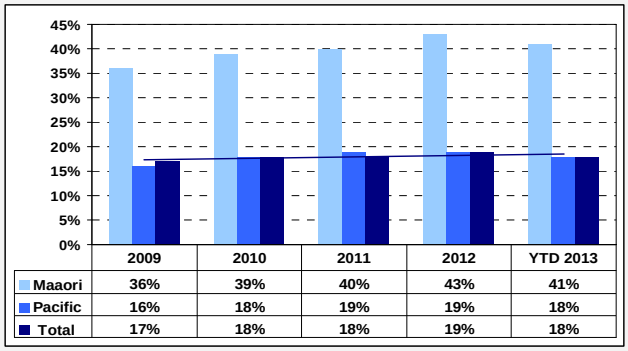
Tobacco smoking is one of the leading causes of death and hospitalisations in Counties Manukau. An estimated 5,000 people in New Zealand die every year due to tobacco smoking and second hand smoke exposure. Smoking is a major contributor to preventable illness and long-term conditions such as cancer, heart disease, stroke and respiratory diseases.

The increase in inpatient smoking prevalence shown in **Figure 6** is likely a reflection of improved data accuracy, and increase in inpatient smoking cessation activity over time. The 2012 New Zealand Health survey, suggests a 2% fall in smoking prevalence in the Counties Manukau community since 2006.

The government health targets related to smoking add to our understanding of success in this area with the related primary care initiatives involving smoking cessation advice and support.

Impact Measure:

Figure 6: Percentage of CM Health inpatients who smoke



	2009	2010	2011	2012	YTD 2013
Maaori	36%	39%	40%	43%	41%
Pacific	16%	18%	19%	19%	18%
Total	17%	18%	18%	19%	18%

A reduction in the incidence of rheumatic fever

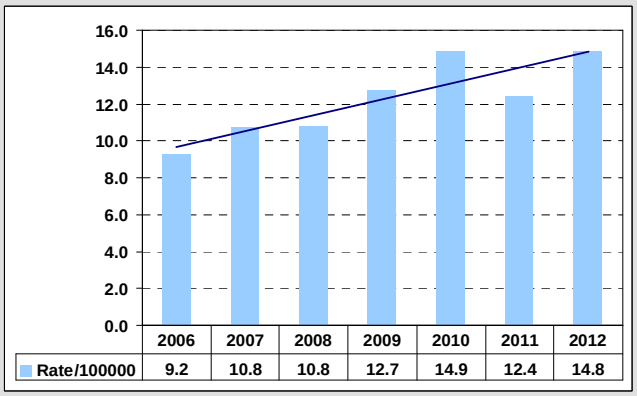
Acute rheumatic fever (ARF) is a preventable, life limiting illness that continues to be diagnosed in children across New Zealand. The potential of ARF to cause damage to the heart is that which is of most concern as this can lead to permanent disability and in severe cases, death. Acute rheumatic fever occurs most commonly in children and young people aged 5-14 years. The long term sequelae results in a considerable burden of disease in the adult population.

Rheumatic heart disease and acute rheumatic fever are potentially preventable conditions if Group A streptococcal throat infections are identified and treated appropriately. CM Health has the highest numbers of rhematic fever notifications and factors such as household overcrowding[5], and poor access to healthcare increase the risk of rheumatic fever.

Rheumatic fever disease (acute and chronic) disproportionally affects Maori and Pacific children and young people. Primary prevention strategies are required if the disease burden is to be reduced.

Impact Measure:

Figure 7: CM Health Admission rates for acute rheumatic fever



	2006	2007	2008	2009	2010	2011	2012
Rate/100000	9.2	10.8	10.8	12.7	14.9	12.4	14.8

Improved diabetes control in our population

Diabetes is one of the leading causes of cardiovascular disease and kidney failure in Counties Manukau. In 2009 there were approximately 29,600 adults identified as having diabetes living in the CM region. The increase in

Impact Measure: Improved access to diabetes support services

[5] At 2006 Census, 25% of residents in former Manukau City were living in housing requiring additional rooms compared with 15.7% for the whole of Auckland.

the number of diabetes annual reviews is a reflection of continued improved access and coverage of diabetes support services over time. The challenge is to provide optimal diabetes management for people with diabetes.

The Chronic Care Management program is currently under review with the aim to increase emphasis on the quality of diabetes management. The diabetes screening coverage is expected to improve further with the progressive increase in the number of cardiovascular risk assessments. More people with less severe form of diabetes are likely to be detected potentially contributing to an average lower HbA1c test measure.

The 2013/14 plan includes actions to improve the outcomes for the at risk population. There are also linkages to the Northern Region Health Plan work plans related to diabetes pre-screening in primary care to assist with earlier intervention for improved outcomes.

Figure 8: Increase in the number of diabetes annual reviews where HbA1C ≤ 64mmol/mol

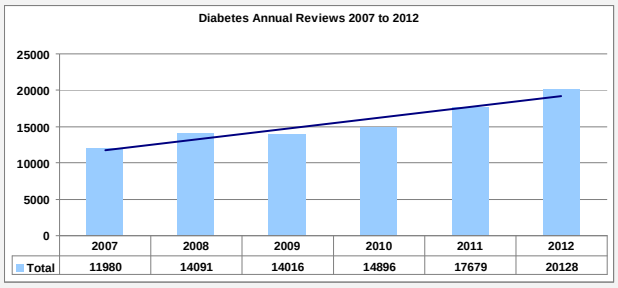
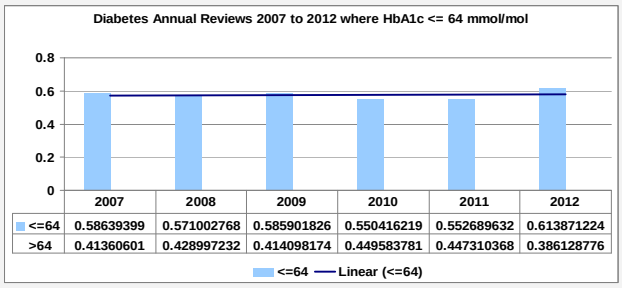


Figure 9: Diabetes annual reviews where HbA1C ≤ 64mmol/mol



2.5.2 Improved quality, safety and experience of care

Being a more patient and whaanau centred health system and working with primary and community partners 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. Our First Do No Harm and Patient and Whaanau Centred Care programmes will coordinate related action plans to improve outcomes. The role of consumer participation is particularly important for this strategic objective.

CM Health has a well established structure for consumer representation as part of the governance structure that provides an avenue for information provision and high level information gathering and community input. This currently includes our Community Advisory Panel, Pacific and Maaori advisory committees that provide high level input and identification of other groups and individuals that can contribute to our understanding of issues and options for service development.

Enhancing the consumer voice in our health system development will be supported through a targeted community engagement approach that currently includes community advisory groups to our Executive Leadership Team and other service specific groups, e.g. in mental health, health of older people services and others. In future, this will further leverage off locality based Community Advisory Networks through our localities development. Mental Health services have led the way within CM Health through use of the Health Co-design[6] processes that involves consumers in detailed service feedback and service redesign. The Northern Cancer Network is using this approach for the Cancer Care Coordination project (http://www.northerncancernetwork.org.nz). This is a template for expansion to other health service areas.

Outcome 2: People are at the centre of our health system with earlier access to quality health services

Monitoring and understanding a patient's experience of care is an integral part of positive improvement in care. Rather than measuring overall satisfaction for an episode of care alone, patient experience better reflects the entire continuum of care, from admission to discharge, whilst also identifying components of

[6] Health Service Co-design (Co-design) involves patients, whaanau/family and healthcare providers all working together to identify issues and develop solutions to healthcare issues. One of the key principles of Co-design is the importance of the experience of the journey for patients.

care that are of significant importance to patients and their whaanau. Section 3.0 outlines the high level work plans associated with the Health Quality and Safety Commission's quality safety programmes.

Long Term Impact Measures (5 to 10 years)

We will know when we are succeeding when there is:

Improved patient experience of care

By July 2013 the new CM Health Patient Experience web-based system will be fully functional. This will include a range of tools (e.g. online survey, community portal) that covers a much greater scope than the previously available. This will enable identification of areas that will drive improvement in patient experience. Development of a new suite of measures (and related baseline data) more reflective of patient and whaanau centred care will be completed in 2013/14.

Medium Term Impact Measures (1 to 5 years)

Over the next one to five years we seek to make a positive impact on the health and wellbeing of Counties Manukau population and contribute to the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides will be evaluated using impact measures that focus on improved access to health services to enable timely (and early) intervention, thereby mitigating the potential harm to patients through delayed health assessment and treatment. This supports the government's health targets aimed at improving service access, e.g. elective services (outpatient assessments and elective procedures), Emergency Department care and mental health services.

We will know when we are succeeding when there is:

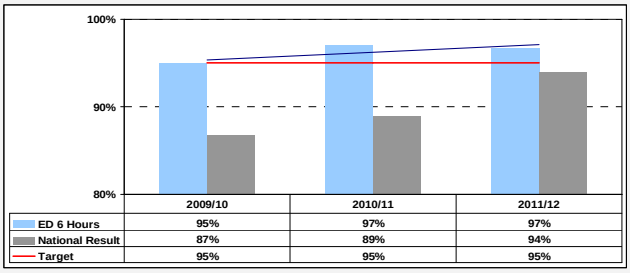
Improved access to emergency care

A whole of system response and good teamwork is essential to ensuring that people needing acute care are seen in a timely manner.

Shorter Stays in Emergency Department have been shown as a proxy measure for timeliness of acute care. Poor performance against this measures reflected in long stays in Emergency Departments are linked to poorly coordinated health systems leading to overcrowding, negative clinical outcomes and compromised standards of privacy and dignity for patients. Reducing this 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.

Impact Measure: Percentage of patients presenting at CM Health emergency departments who are admitted, discharged or transferred within 6 hours

Figure 10: Shorter stays in our Emergency Department



	2009/10	2010/11	2011/12
ED 6 Hours	95%	97%	97%
National Result	87%	89%	94%
Target	95%	95%	95%

Improved access to mental health services

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.

CM Health's focus is to support community wellbeing and ensure the people of Counties Manukau experience seamless, empowering Mental Health and Addiction services and are able to access them in a timely and appropriate manner.

Mental health service access rates is a proxy measure for determining the impact of CM Health

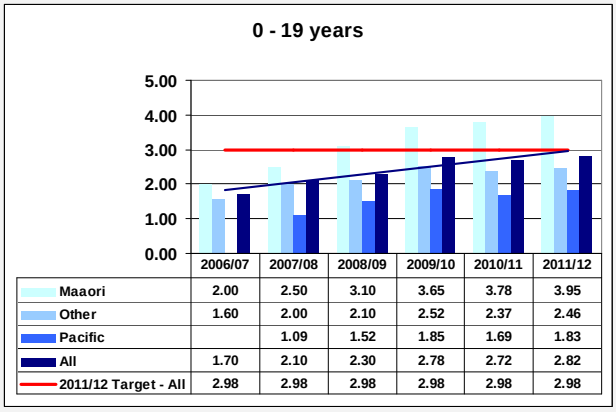
Impact Measures:

mental health services delivery on improving the quality of life for members of our population who are suffering from mental illness or issues with alcohol or drug addiction.

There has been a substantial amount of work done since 2006 to increase mental health access for those with severe mental illness. CM Health has invested in number of community based support options including community support, respite and acute alternatives.

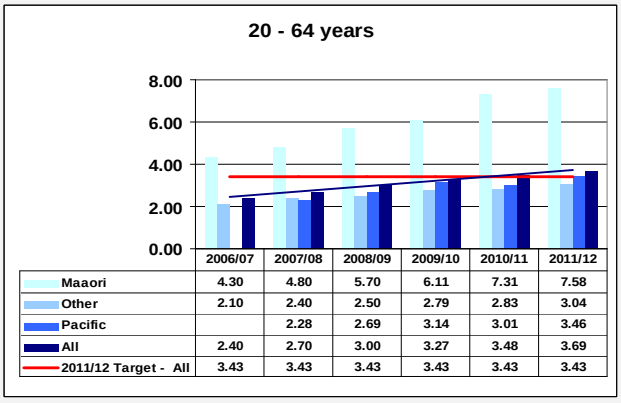
The expanded focus for the next 1 to 5 years relates to those with moderate to severe illness, with a need to look at system wide models of care that further enhance the role of primary care and community based services.

Figure 11: Percentage of people ≤ 19 years with access to mental health services



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Maaori	2.00	2.50	3.10	3.65	3.78	3.95
Other	1.60	2.00	2.10	2.52	2.37	2.46
Pacific		1.09	1.52	1.85	1.69	1.83
All	1.70	2.10	2.30	2.78	2.72	2.82
2011/12 Target - All	2.98	2.98	2.98	2.98	2.98	2.98

Figure 12: Percentage of people 20 to 64 years with access to mental health services



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Maaori	4.30	4.80	5.70	6.11	7.31	7.58
Other	2.10	2.40	2.50	2.79	2.83	3.04
Pacific		2.28	2.69	3.14	3.01	3.46
All	2.40	2.70	3.00	3.27	3.48	3.69
2011/12 Target - All	3.43	3.43	3.43	3.43	3.43	3.43

Improved access to elective services

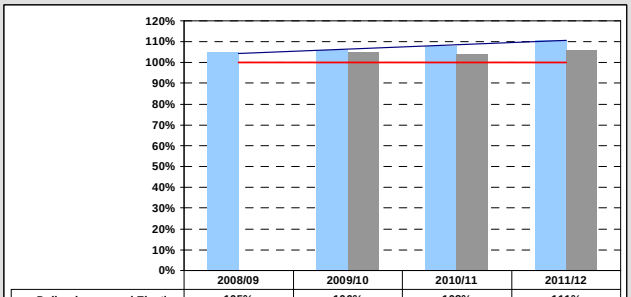
We have chosen the improved access to elective surgery health target of as a proxy medium term measure for our patient centred approach to better assessment and treatment access.

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 and service development innovations that involve surgical theatre efficiencies, expanded involvement of primary care in looking at ways in which to enhance patient flow through the system so that their waiting times are within acceptable limits and we can continue to meet nationally set service level expectations.

Impact Measure:

Figure 13: Improved access to elective surgery



	2008/09	2009/10	2010/11	2011/12
Delivering agreed Elective discharge volumes	105%	106%	108%	111%
National Result		105%	104%	106%
Target	100%	100%	100%	100%

2.5.3 Achieve the best value from health system resources

This outcome is vital for our long-term clinical and financial sustainability as we face an ever growing demand for health services driven by patient need and expectations that exceed our ability to fund. Although CM Health has lived within its means for the last three years, there are a range of activities needed to be able to meet the Minister's expectations for 2013/14 and following two years.

Outcome 3: Health system clinical and financial sustainability

The overall focus is to concurrently improve the acute health system effectiveness (across all care settings) and deliver more sustainable models of care services that provide care closer to where people live. The related measures for this outcome are financially based in the longer term but are significantly influenced by workforce skill mix requirements in line with model of care changes and overall labour cost growth. Development of related measures is a work in progress over the 2013/14 year.

Long Term Outcome Measures (5 to 10 years)

Work is in progress to develop other measures that will provide CM Health with ability to monitor progress and respond accordingly. This will need to include a balance of measures that monitor the effectiveness of primary and community based service alternatives to hospital settings and related labour cost growth curves.

We will know when we are succeeding when there is:

Reduced rate of annual health expenditure increase per capita

The key financial outcome measure will be CM Health expenditure per head of population as the sector forecasts a tightening of public funding and increasing demand for health services. The assumption is that CM Health will live within its means and Figure 14 below demonstrates how we must reduce the rate of annual cost increases in order to achieve future sustainability.

Figure 14: CM Health financial outcome trends from 2006 – 2012

Factor	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12
Total Revenue ($000's)[7]	$949,226	$1,013,884	$1,138,527	$1,216,356	$1,296,173	$1,352,493
Total Expenditure ($000's)[7]	$948,108	$1,053,385	$1,141,521	$1,216,193	$1,291,311	$1,349,584
Population[8]	459,040	467,210	475,585	484,920	494,465	502,475
CM Health expenditure per capita [7, 9]	$2,065	$2,255	$2,400	$2,508	$2,612	$2,686
Rate of CM Health expenditure increase per capita	-	9.2%	6.4%	4.5%	4.1%	2.8%

[7] Sourced from Counties Manukau District Health Board Annual Reports 2007-2012

8 Statistics New Zealand. (2012). DHB Age-Sex Projections 2006-2026 (2006 Base). Christchurch, New Zealand: Statistics NZ

9 Note that national services provided by CM Health are included in the total revenue and therefore includes services for people living outside our district, but this is a relatively small proportion of the total spend

Figure 15: High level planning priorities intervention logic

National and Regional			
National Goal	All New Zealanders live longer, healthier and more independent lives		
National Policy	Better sooner more convenient care		
Regional 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		
TRIPLE AIM	**Population Health**	**Patient Experience**	**Cost/Productivity**
National Priorities	Rheumatic Fever / Clinical Integration / Mental Health / Youth Mental Health / Vulnerable Children / Diagnostics / Cancer / Whaanau Ora / Living Within Our Means		
National Health Targets	Preventative health targets with a focus on: ▪ Increasing immunisation; reducing rheumatic fever ▪ Better help for smokers to quit ▪ More heart and diabetes checks	Improved access to: ▪ Emergency Departments (shorter stays) ▪ Elective services (surgical and outpatients) ▪ Cancer services	Living within our means by: ▪ Lifting productivity ▪ Keeping to budget
Regional Strategic Objectives	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
Regional Priorities	Life and Years	First Do No Harm /The Informed Patient	Life and Years
Counties Manukau Health			
Goal	Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015		
Strategy	Improved health and equity for all populations	Improved quality, safety and experience of care	Best value for health system resources
Priorities (3 year)	Better health outcomes for all programme targeting Housing, Smokefree by 2025 and First 2,000 Days Reducing the health impact of long term conditions	First Do No Harm programme Delivering Patient and Whaanau Centred Care programme	System integration (local and regional) programme Ensuring financial sustainability programme Enabling high performing people programme
Outcomes (10+ years)	People live healthier, longer more productive, disease free lives	People are at the centre of our health system with earlier access to quality health services	Health system clinical and financial sustainability
Key Impacts (5-10+ years)	▪ Continued improvement in overall life expectancy and narrowing of ethnic disparity ▪ Reduction in smoking related cancers and respiratory conditions ▪ Reduction in the differences in rates of housing related hospitalisations between ethnic groups and groups with different socioeconomic status	▪ Improved patient experience of care ▪ Increased proportion of whaanau as partners in care	▪ Reduced rate of annual health expenditure increase per capita ▪ Continued improvement in overall life expectancy and narrowing of ethnic disparity ▪ Increased workforce diversity and ethnicity ▪ Reduced labour cost growth
Key Impacts (1-5 years)	▪ Reduction in smoking prevalence ▪ Reduction in the incidence of rheumatic fever ▪ Improved diabetes control in our population	▪ Improved access to emergency care ▪ Improved access to mental health services ▪ Improved access to elective services ▪ Reduced hospital stays in the last 6-mths of life	▪ Increased percentage of total heath service delivery/spend in primary and community care ▪ Improved reliability of care
Output Classes	**Prevention** Health Promotion & Education, Immunisation, Health Screening, Statutory and Regulatory	**Early Detection and Management** Primary Health Care (GP), Long Term Conditions, Oral Health Diagnostics, Pharmacy	**Intensive Assessment and Treatment** Mental Health, Elective, Acute, Maternity, Additional Patient Safety	**Rehabilitation and Support** NASC, Assessment Treatment & Rehabilitation, Palliative Care, ARRC, Home Based Support

Figure 16: Summarised Strategic Actions for 2013/14

Strategy Action Summary - **Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015**	
Strategy	Improve health and equity for all populations - Improve quality, safety and experience of care - Provide best value for health system resources
Key Areas of Focus	**Key Actions (Annual Plan reference)**
Better Results for NZers:	
▪ **Increase infant immunisation**	▪ Target 8mth old Maaori children immunisation course completion ▪ Joint DHB, primary care, NGO immunisation education / events and seamless cross service handover
▪ **Reduce rheumatic fever incidence**	▪ Pathway for high risk families and children with offer of whaanau ora support community worker ▪ Deliver more throat swabs (registered nurse and whaanau support worker) to reach 53 schools through National Hauora Coalition contract
Service Integration:	
▪ **Establish localities**	▪ Complete establishment of four locality clinical partnership and Integrated Family Health Centres (IFHC)
▪ **Incentivise general practice / PHO for system performance**	▪ Implement Locality Partnership Agreement for shared accountability of population outcomes and health system resource utilisation ▪ Establish risk/gain share framework and budget holding at a practice level to incentivise performance against health system targets ▪ Integrate and devolve Maaori and Pacific Health NGO contracts to National Hauora Coalition / Alliance Health Plus ▪ $7m development fund for new service initiatives, integration pilots, additional clinical resource to reduce acute demand ▪ $1m investment for collective sustainable primary care strategies to achieve health targets ▪ $1.2m investment for increased range of community diagnostic tests
▪ **Direct primary care referrals**	▪ Direct GP referral for specific elective procedures directly to waiting list for patients with: otitis media, carpel tunnel and tonsillitis
▪ **Care closer to home and whaanau ora integration**	▪ 70% (68 FTE) home health care workforce shift from secondary into primary care through localities integration ▪ Implement six more GP with Special Interest (GPwSI) training programmes - with 3 new GPwSI per locality working in the IFHCs ▪ Lead SMO for primary care based Very High Intensive User team to wrap support for patients of high risk of hospital admission ▪ New Chronic Care Management Programme including outcomes based framework to reduce practice variation and improve care ▪ Locality (2) based wrap round services for older people through a Coordination/Rapid response team to reduce acute admissions ▪ Develop six community midwifery specialist roles and increase availability of LMC midwives in partnership with general practice ▪ Pilot expansion of community based cardiac and heart failure rehabilitation group programmes ▪ At least one Accident and Medical services operating per locality until 10pm as an alternative to hospital emergency department presentation ▪ At least one credentialed Whaanau Ora practice in place in each locality care cluster ▪ Reduced wait time for primary care follow up of youth from the secondary Child and Adolescent Mental Health services
Regional Integration	▪ Contribution to the Northern Region Health Plans for targeted areas, e.g. Improve specialist community based alcohol and drug services for youth, improve waiting times for diagnostic related cancer services ▪ Greater Auckland Integrated Health Network expansion of Primary Options for Acute Care to include Transient Ischaemic Attack; renal colic ▪ Increase number of PHO enrolled patients with a shared care record ▪ First Do No Harm regional patient safety campaign extension into Aged Related Residential Care sector (Northern Region Health Plan Appendix A2)
Intersectoral Integration	▪ Improve access to quality housing through increased referrals to retrofit insulation to private and rental homes; supported landlord agreements ▪ Improve access to affordable housing for mental health consumers ▪ Extend school based alcohol and drug services into Alternative Education settings ▪ 100% of school based nursing clinic integrated with primary care to facilitate comprehensive care for high risk students

3.0 Stewardship

3.1 Managing our Business

Counties Manukau Health (CM Health) has an established governance and management structure to meet our responsibilities to plan, provide, purchase and manage performance of health services for the Counties Manukau population. This section outlines how we organise our resources and systems in a manner that promotes best use of public health funding to deliver planned services.

As a District Health Board (DHB), we must balance government financial and non-financial target and priorities reporting alongside our own district's population health needs and the community's expectations about priorities for health, within our available funding.

3.1.1 Governance

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 of clinical and managerial leaders, clinical forums and networks and advisory committees. 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 2000 (NZPHD Act 2000) every member of the Board must receive Tikanga Maaori training.

CM Health clinical leadership is integrated with regional governance groups and associated regional work plans. The regional clinical networks have representation from each DHB and are clinically led. For example, any issues raised at a regional network or DHB level are communicated and managed back through the DHB leadership fora. Clinical leadership is also integrated at an executive level in relation to major capital investments. For example, the Regional Radiology Network, including managerial and clinical leaders, was tasked with making recommendations on DHB MRI and CT capital investment proposals. This integrated leadership approach is a critical approach to ensure dual attention to financial and clinical sustainability.

At a local level, our health system governance and accountability structure for performance management has been expanded from more traditional DHB planning and funding structures to better integrate primary/community care and hospital based services. The restructure has included introduction of the following governance groups:

- District Alliance of Primary Health Organisation (PHO) and CM Health Chief Executives
- Geographically based Locality[10] Clinical Partnerships (and related community advisory networks)
- A Whole of System Strategy Group (and related expert working groups) combining our PHO Executives and CM Health Executive Leadership Team including clinical and managerial leaders; and
- Change to the traditional Planning and Funding roles with establishment of the Strategic Planning and Primary and Community Health Services Directorates to support system level organisational change

In recognition of our more integrated governance and service delivery structures we now reference our collective district services as Counties Manukau Health (CM Health). All official and legally binding documents will also contain our legal name of Counties Manukau District Health Board (CMDHB).

[10] For Counties Manukau Health purposes, there are 4 localities and infrastructure being established to enable integration of health services within that geographical area. A locality typically contains a resident population of greater than 80,000 people. The four Localities include the Franklin, Eastern, Mangere/Otara and Manukau areas.

3.1.2 Performance management

In our role as provider of hospital and specialist services, we have an agreed set of financial and non-financial performance indicators with an established structure for reporting and review. Productivity and quality indicators are reported through operational and clinical management forums and to the Board and related sub-committees, i.e. the Hospital Advisory Committee (HAC) and Community and Public Health Advisory Committee (CPHAC) and others. Accountability for reporting is now better integrated with primary care as we seek to improve understanding of overall health system performance through shared accountability for population outcomes.

CM Health is in the process of extending this performance management process through development of 'System Level' and related impact and outcome measures to enable monitoring and evaluation of quality and service performance across the complete continuum of health care. This forms part of our commitment to system integration and we are currently working towards adoption of the Healthcare Excellence Framework in 2013/14, based on the Baldrige criteria for performance excellence.

Quality assurance is embedded within our quality and safety framework. We also have strategic partnerships with the Institute for Healthcare Improvement (IHI) to establish robust methods (e.g. Collaborative methodology) of system and service level analyses, innovation identification and implementation.

3.1.3 Financial management

The Minister for Health and National Health Board has indicated constrained funding increases from 2013/14 and this will require a highly effective financial planning and management system. Due to combined impacts of increased health service demand and reduced revenue increase of 2.7 percent that is just over half of what is anticipated to maintain operations, the financial management challenges over the next three years represent a significant and unprecedented challenge for CM Health.

The major driver of cost increases continues to be the total clinical wages cost, which inclusive of the automatic step function, is 3 to 4 times our funded cost growth. The 2013/14 plan is submitted with a $3m surplus and a commitment to achieve our national health targets.

We are committed to maintaining a secure and balanced financial position and are working to meet these financial challenges in a positive manner through national and regional collaboration, working in partnership with both healthAlliance and Health Benefits Limited (HBL) to leverage of aggregated savings and efficiency benefits and local system level accountability for financial and non-financial performance.

CM Health utilises 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. At a micro level, funding providers requires a commercial approach to ensure our non-government organisation (NGO) providers remain viable.

Within this plan, CM Health financial projections are fully reconciled to the latest information from Health Benefits Limited (HBL) but are noted as having very little net benefit during the planned period. Of greater benefit to the Northern Region over the next three years would be for enhanced procurement benefits arising from the Northern Region ownership of healthAlliance.

Refer to section 5.0 for details of how the funding envelope will be allocated and related service volumes managed.

3.1.4 Risk management

Organisation level corporate and clinical risks are managed centrally through established policy and procedures that enables consistent risk identification, mitigation/actions reporting and management. Organisation risks are reviewed by operational divisions for local management are presented to Counties Manukau DHB's Board monthly, and at Audit, Risk & Finance Committee quarterly to ensure effective escalation, appropriate and timely attention to enable effective risk management.

3.2 Building Capability

Quality improvement and patient safety processes, workforce, information and technology services, information intelligence, assets, and other infrastructure are all critical enablers to deliver our strategic goals and effect national and regional collaboration.

Building capability in an environment of transformational change requires more than alignment of typical enablers. It needs a strategic approach to change management and transparency of investment prioritisation to optimise outcomes. Based on our strategic priorities, capability building is centred on the following systems, each benefiting from local, regional and national initiative alignment.

Figure 17: High level summary of capability drivers and related plans

Capability	Capability Contribution	High Level Plan Linkages
*Workforce**	Alignment to capacity management and emerging models of care See section 3.4 for the CM Health approach to implementation	CM Health: ▪ Enabling High Performing People programme with deliverables examples: Leadership Academy; Integrated HR framework; Workforce planning and modelling; Performance development framework Regional: ▪ Northern Region Training Hub (NoRTH) ▪ Engage the Workforce ▪ Change Leadership ▪ Integrated Care Models ▪ Grow a workforce that reflects communities National (Health Workforce NZ): ▪ Regional Training Hubs ▪ Supporting new roles/ways of working
*Quality and Safety**	Delivering excellence while being sustainable requires integration of quality safety from the campaign/initiative stages into business as usual See section 3.4 for the CM Health approach to implementation	CM Health: ▪ First, Do No Harm (combines quality & safety initiatives) Regional: ▪ First, Do No Harm National (Health Quality & Safety Commission & others): ▪ Improving medication safety ▪ Infection prevention and control (preventing healthcare-associated infections) ▪ Reducing harm from falls in healthcare settings ▪ Making surgery safer ▪ Target CLAB Zero (locally lead for NZ)
*Service Innovation**	Essential requirement for health system transformation and building capability in non-traditional service	CM Health: ▪ System Integration Programme including initiatives such as 20,000 Days campaign, Localities Development and others ▪ Innovation Hub

Capability	Capability Contribution	High Level Plan Linkages
	approaches in order to enable future health system sustainability	Regional: ▪ Better Sooner More Convenient (BSMC) business cases, e.g. Care Pathways, Primary Options for Acute Care etc, Whaanau Ora National: ▪ Innovation Hub (joint venture with Counties Manukau, Auckland, Waitemata and Canterbury DHBs) ▪ Shared services, supply chain and procurement (HBL)
*Information Technology& Information Intelligence**	How and where health information is accessed, data analyses and health scenarios modelling combined with hard infrastructure – these are critical clinical and service enablers	CM Health: ▪ Locality information systems Regional: ▪ Refer section 3.3.8 below National (Health IT Board & Others): ▪ eMedicines programme ▪ National Solutions ▪ Regional (DHB) Information Platforms ▪ Integrated (Shared) Care Initiatives ▪ Maternity Shared Care
Capital investment	An integrated asset management plan (equipment, hard infrastructure) that links service requirements (maintenance and developmental) with fixed and non-fixed investments	CM Health ▪ Investment Strategy (10 year – in development) ▪ Facilities Masterplan - Towards 20/20 aligned with; ▪ Enterprise Asset Management System Regional: ▪ Regional Capital Group National (Health Benefits Limited): ▪ Procurement and Supply Chain

*Note: Our Centre for Health Services Innovation (Ko Awatea) supports system level growth and continuous improvement through the Centres of Excellence, strategic partnerships with education organisations[11] and the Institute for Healthcare Improvement. This directorate is central to system transformation in collaboration with CM Health and PHO leadership.

3.2.1 Capital and infrastructure development

Towards 20/20 is our major long-term investment in building and refurbishment of CM 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 based on a 20 year Health Services Plan (2008). Of significant capacity expansion and improved models of care are our acute surgical theatres and medical assessment and planning facility. The commissioning of our new Clinical Services Block in 2013/14 will support this.

The national economic and local health policy direction changes since that time has required an in-depth reassessment of our planning assumptions. In regard to our longer term asset plan, developing health system integration and Localities are cornerstone strategies to reduce long term acute demand through integrated non-acute and elective services (including a Whaanau Ora Centre, Integrated Family Health Care Centres).

[11] 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.

Work completed in 2012 in collaboration with Treasury and the National Health Board, using the Better business case process (http://www.infrastructure.govt.nz), modelled a range of non-acute service and procurement model options against a forecast revenue assumption of 2.7 percent growth (compared to historically an excess of 5 percent growth). The outcomes of this process highlighted the need to revisit investment assumption affordability in light of the probable reduced funding growth scenarios.

Critical work planned for 2013/14 to identify and implement best 'value for money' solutions and aligned investment priorities include the following deliverables:

- *Whole of System Strategy formation* – utilising an integrated governance structure of PHO and CMDHB clinical and managerial leaders. This is critical to implementing the scale and pace of change required to be sustainable. This group will re-define the 'look' of the health system in 10 years and re-define our 5-year investment/development priorities to achieve this. This will then inform our investment strategy
- *Development of a 10 Year Health System Integration Investment Strategy* – that reviews, aligns and prioritises critical enabler programmes of work to align to Strategy priorities, i.e. realignment of related plan priorities for Asset Management, Workforce and Information Systems programmes that integrates related national and regional capacity and capability developments
- *Development of a System Integration Investment Programme Business Case* – with continued collaboration with Treasury and the National Health Board based on agreed strategic health system priorities

The Programme business case was initiated in 2013 with our clinical leaders from across the health system evaluating CM Health's 10 year investment (i.e. services) priorities. When we refer to 'investment' this is not only capital expenditure, but recognises that some initiatives require significant operational investment, (including borrowing costs for any new facilities) over coming years to sustainably create the capacity and capability to meet the health. Criteria to rate relative service area investment priority were based on the regional asset prioritisation approach and locally agreed importance weightings. Consistent with the clinical approach to this prioritisation, 50 percent of the criteria weighting related to 'health gain' and 'clinical risk'.

Although specific investment projects cannot be confirmed until the Programme business case is approved by the CMDHB Board for submission to the National Capital Investment Committee later in September/October 2013, our options evaluation is based on the clinical investment priorities. The top five areas over the next 3 to 5 years for the programme business case to evaluate options includes:

- Information Communication Technologies
- Acute adult mental health
- Radiology services
- Outpatient services – that are locality based
- Rehabilitation, Health of Older People and Spinal services

The CM Health major capital projects provided as part of the northern region capital intentions summary is outlined in section 5.4.9 will be confirmed subject to outcomes of local, regional and national approvals of the Programme business case in late 2013.

In the interim period, with the constraints on government supported capital investment, it will be critical for CM Health to be able to utilise locally available capital funds in a flexible manner in order to achieve best value for money.

3.2.2 Asset management

CM Health collaborates regionally with Northern Regional Alliance (NRA) and our partner DHBs to coordinate capital intentions and priorities for major project investments (refer section 3.2.1 above). In addition to major projects, there are two major areas of asset management of concern to the region:

- Financial burden for a large 'fleet' of clinical equipment (hospital and community based) that requires regular replacement to support delivery of services
- Historic under investment in information systems and technology (refer section 3.3.8 for agreed regional investment priorities)

CM Health has a long standing Asset and Capital committee and annual processes for prioritising capital investments, but recognises that more is needed to maximise our management, planning and renewals prioritisation systems.

Asset management is now recognised as more than a term for maintenance management. Asset management practiced correctly will help us realise the organisation-wide impact and interdependencies within operations, design, asset performance, personnel productivity and lifecycle costs. Enterprise Asset Management is the business process and enabling information systems that support management of an organisation's assets. "Enterprise" refers to the management of the assets across departments, locations, facilities and, in some cases, business units. This enables organisations to maximise value by improving utilisation and performance, reduce capital costs, reduce asset-related operating costs and extend asset life. Further, by aligning these systems across a region, optimal selection and use of some assets can be enabled over and above that within an individual DHB.

CM Health has taken the initiative to investigate a suitable system and have engaged with Canterbury, Capital and Coast and Northern Region DHBs. We are seeking Health Benefit Limited's endorsement and CM Health's Board approval to progress this project in 2013/14. We will work with the clinical engineering groups (local and national) to prioritise roll out this system due to the high value/high risk nature of this group of assets.

3.3 Strengthening our Workforce

3.3.1 Local context

As at 30 June 2011, CM Health employed a headcount of 6553 people, who worked an equivalent of 5183 FTEs. Nursing is by far the largest clinical workforce comprising 46 percent of staff, medical 17 percent, allied health 13 percent and care and support workers 11 percent. A further 9 percent make up technical and scientific workforce groups and 4 percent in the midwifery occupation group. Over a third of CM Health's workforce are on casual and part time contracts.

In the last five years from 2008 to 2012 Counties Manukau DHB Full Time Equivalent (FTE) workforce numbers have increased by approximately 22 percent overall. Capacity expansion has focused clinical health professional resource and reduction in administration and clerical staff (3.4 percent) in line with Ministry of Health expectations. Refer to Figure 18 below for a five year summary by workforce group.

Figure 18: CM Health FTE by Workforce Group

Group	Year as at 31 December				
	2008	2009	2010	2011	2012
Nursing	2,131	2,250	2,299	2,470	2,577
Allied	778	968	940	1,040	1,096
Medical	539	649	659	720	679
Admin/Clerical	601	577	564	597	580

Support	360	368	385	397	431
Management	144	212	197	203	202
Grand Total	**4,553**	**5,025**	**5,044**	**5,429**	**5,566**

CM Health's workforce is an aging one, with half of employees aged between 30 and 49 years – a mature and experienced core. A third of our staff are likely to retire in the next 20 years. While clinical and all staff have similar ethnic ratios, when compared to the population we serve, there is much we must to do to address the significant under-representation of Maaori and Pacific workforce in clinical staff groups At the same time, emphasis on growing our non-regulated and non-clinical workforce would greatly increase the proportion of Maaori and Pacific people on our staff while clinical staff may take longer.

Figure 19: CM Health workforce representation by ethnicity

Ethnicity	All Staff	Clinical	CM Population	CM Health Patient Discharge
Asian	25 %	28 %	19 %	11 %
Maaori	6 %	6 %	17 %	17 %
Pakeha & Other	59 %	58 %	42 %	44 %
Pacific	10 %	8 %	23 %	27 %

CM Health's 2011 workforce report highlighted several issues that continue to guide our workforce development for 2013/14:

- 15 percent of CM Health's clinical staff that make up 34 percent of our organisation experience in length of service is likely to retire by 2021. Career development and succession management is critical to support this transition in our capability
- A large proportion of our workforce work part time or casual hours – 34 percent of women in clinical roles work part time. CM Health needs to consider ways of getting the best out of a workforce who require flexibility in their work schedules. Generation changes in our workforce mean that lifestyle balance is increasingly important to our staff. This means creative approaches to role development and scope of practice changes are important
- Increasing the diversity of our workforce to better reflect the community and patient populations we serve requires more effort, in particular in highly skilled clinical roles
- Although we will continue to invest in workforce supply from our local community through scholarship and training support, we must step up service changes to ensure that we get the best out of our current workforce mixes

A strategic approach needs to be taken to ensure our workforce is ready to provide services in the way we need them now, and in the future. It is crucial that our workforce capabilities and competencies resonate with health system needs. One of our Enabling High Performing People programme objectives is to ensure that our workforce supply meets immediate and emergent workforce needs, i.e. how to better match workforce supply and skills with service demand across the health system. Workforce planning and modelling is a core part of this programme and work is currently underway to merge workforce and financial models. This will enable us to scenario test the impact of different service models on forecast capacity and capability requirements within expected budget constraints to inform our planning.

3.3.2 Whole of system collaboration is needed

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, are the ability to attract, retain and motivate key performers, those with high potential or sought after skills.

The Northern Regional Health Plan (http://www.ndsa.co.nz) provides integrated planning for capacity and capability needs for identified government priority areas and targets. CM Health supports regional workforce initiatives in addition to CM Health specific developments and national workforce development direction. With the establishment of the Northern Region Training Hub (NoRTH), our postgraduate education and clinical placement activity will be more coordinated and with heightened clinical leaders engagement.

CM Health supports the Regional Directors of Training in the development of the regional workforce planning with our Human Resources General Manager and Director of Nursing contributing to the Clinical Leads Group that develops the regional workforce plans. An example of CM Health contribution to regional workforce plan implementation is the development of Community Youth Forensics workers and related model of care implementation.

Our workforce strategy follows the domains contained in the State Services Commission workforce strategy framework. The approach we take to workforce development is underpinned by our workforce pipeline concept that engages key stakeholders, e.g. education and primary care providers, to look at key points where people enter training, the workforce and ongoing development and retention.

The following sets out the four dimensions of Capability, Capacity, Culture and Change Leadership that are core to our workforce strategy.

3.3.3 Capability

Our health system requires new roles and structures that enable a more sustainable health system that includes 'fit for purpose' role scope, education, training, support and supervision. Core strategies aligned to the northern region includes:

- Competency and performance development framework (in pilot phase) that aligns individual work plans with organisational strategy and priorities and development plans
- Workforce scope of practice and role changes to support integrated models of care, new clinical pathways and future service design
- Career development through a dedicated consultant to guide career planning for staff. This process has been adopted by Health Workforce New Zealand
- Implement the NoRTH regional training hub requirements (see section 3.3.7 below)

3.3.4 Capacity

In order to meet future service requirements we need to attract and recruit the right staff with the right skills and have robust mechanisms for retaining quality health professionals and employees within our organisation. Activity focus will include:

- Expand and retain local Maaori and Pacific people into a health career pathway, e.g. Maaori and Pacific Recruitment Strategy, high school programmes, Health Could B 4 U and health science academies, tertiary health scholarships)
- Work regionally to find vulnerable workforce solutions to recruit and retain, e.g. sonographers, rehabilitation consultants
- Strengthen training capacity through strategic partnerships with tertiary education providers and undergraduate inter-professional trainee placements
- Implement new models of employment, e.g. Bachelor of Nursing Pacific students at MIT

- Workforce planning and modelling (establish workforce requirements for new models of integrated care and pipeline approach to growth the workforce)

3.3.5 Culture

Our Enabling High Performing People programme recognises the importance of staff engagement in order to build organisation capacity and capability that enables our people to deliver their best in a changing environment. Key activities associated with include:

- Staff Satisfaction Survey – the baseline completed in October 2012, will allow us to compare our 2013/14 progress against previous results and identify and ongoing or new 'hotspots'. We will work with employee representative groups to identify actions to respond to key improvement areas identified and monitor progress against these over the next twelve to eighteen months
- Organisational values review to ensure we have a set of values that fit with the CM Health vision and are meaningful to staff when working with our community, stakeholders and each other
- Strategies which increase opportunities for engagement from employees and their representative groups e.g. 2013/14 whole of system strategy forming process
- Effective staff communication to keep our people informed regarding key strategies, projects and initiatives through a range of forums including our local intranet (SouthNet sites about our key programmes, CEO Blog and others), consolidated email information (Daily Dose) and participation in workstreams and projects

3.3.6 Change leadership

Our goal is to become the best healthcare provider in Australasia by 2015. This requires us to achieve a balance between the delivery of excellent health care and maintaining sustainability. This will require significant clinical leadership and consumer participation to redesign services, supported by the Strategic Programme Management Office, to structure agreed Achieving a Balance Portfolio. This will include:

- An integrated change management framework that maps out how we will get from our current state to the future vision
- Develop the capacity for change leadership at all levels of the organisation including implementation of a Leadership Academy
- Strategic Programme Management Office to support processes and resources to assist managers and staff respond to changes in the way they do their work
- Build organisational resilience and capability to respond proactively to meet changing demands with innovation support from the Innovation Hub
- Engage patients and whaanau in specific service feedback and involvement in service redesign

3.3.7 Regional training hub (NoRTH)

The activities and governance of the training hub, for the 2013/2014 year, will be more closely aligned with the Northern Region Health Plan as the former NoRTH and NDSA organisations have been amalgamated into the Northern Regional Alliance (NRA). NRA, and in particular the training hub, will work closely with the DHBs, Health Workforce New Zealand (HWNZ), tertiary education providers and the Northern Region Clinical Leaders Forum to implement its work plan.

The training hub will collaborate with the other three regional training hubs and HWNZ to share ideas and initiatives that can be rolled out to other professional groups and hubs. This will be achieved by participating in the monthly national teleconference and quarterly meetings organised by HWNZ.

The Northern Region Health Plan has detailed regional action plans (http://www.ndsa.co.nz) through the following initiatives:

- Strengthen systems and processes to support placement and workforce development activity
- Align recruitment and workforce planning with capacity and model of care requirements
- 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
- Broaden NoRTH clinical and managerial governance

We are aware of the 70/20/10 model for the allocation of postgraduate medical education funds, and our regional service plan takes account of this. Some of the metrics still need to be defined, and as such we endeavour to work collaboratively as a region with the training hubs and HWNZ to achieve these targets. This 70/20/10 model means that we receive 70% of the funds through monthly payments, with the remaining 30 percent paid periodically subject to:

- Meeting HWNZ education expectations such as career planning for RMOs; and
- Having RMO positions in disciplines which HWNZ feel need additional financial support

3.3.8 Regional information systems

Information systems (IS) are fundamental to the Northern Region's ability to deliver on the whole of system approach to health service delivery. A key clinical driver is to improve the continuity of care for patients in our region across primary, secondary and tertiary care. This relies on consistent and reliable access to core clinical documents and facts for all clinicians involved in a patient's care.

In 2013/14 the focus will be on infrastructure upgrades and improving system resilience to address the continuity risk for IS services in the region. IS investment will be reprioritised to address these underlying service risks in the following areas:

- Microsoft software upgrades in workspace and infrastructure to keep licensing at formally supported levels
- Clinical and business systems upgrades to ensure systems can operate in these upgraded workspace and infrastructure environments
- Ongoing improvement of IS process, capability and capacity to cope with the levels of complexity and volume of IS service requirements
- Improve resilience of (existing) IS systems to improve system availability, access, data integrity and security

Consistent with the direction set by the National Health IT Board, nine workstreams are identified to progress over the 3-year time period of the plan. These are outlined below with some examples (with the top 5 in prioritised order):

- Safe Sharing Foundations – major focus with infrastructure and electronic system upgrades
- Safe Medication Management – progress ePrescribing, Medicines Reconciliation, eMedicines
- Shared Care - operationalise Regional Shared Care platform and agree patient portal strategy
- Patient Administration Systems – select regional system
- Business Support – national and regional Finance Procurement and Supply Chain systems
- Quality information for primary healthcare - Implementation Clinical Pathways Stage 1
- Continuum of care - eReferrals phase 2; e Discharge Summaries upgrade
- Clinical Support – range of national and DHB system developments and roll-outs
- Population Health – regional dataset and reporting capability development

Further information is available in the Northern Regional Information Strategy 2010 to 2020 (http://www.healthalliance.co.nz) and the related Northern Region Information Systems Implementation Plan.

3.4 Quality and Safety

If CM Health is to be the best healthcare system in Australasia by December 2015, we must put in place a quality and safety programme which not only sets high standards for patient care and minimises harm in hospital, but also addresses those issues wherever patients are receiving care, be that in hospital, at home, in an age-related, residential care facility or in a general practice setting.

Our First Do No Harm programme (aligned to the regional programme) consolidates the governance of all CM Health patient safety initiatives into one group to provide the alignment and coordination of national (Health Quality and Safety Commission), regional and local programmes. It will provide support for implementing and maintaining existing initiatives. CM Health has now extended the patient safety initiatives to Primary Care and Aged Related Residential Care with a focus on falls, pressure injuries and vitamin D prescribing. Our programmes extend to national leadership in quality and safety with a focus on sharing lessons learnt with the rest of the sector.

In October 2012 CM Health partnered with the Health Quality and Safety Commission to lead the national Target CLAB Zero programme aimed at preventing central line associated bacteraemia (CLAB) in public hospital Intensive Care Units throughout the country.

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. This will include driving a large and diverse range of quality improvement and quality assurance programmes and initiatives across CM Health in the following areas:

- Reducing CM Health's prevalence of falls, pressure Injuries, venous thomboembolism (VTEs)
- Improving Patient Identification to prevent 'never events' from patient misidentification
- Reducing healthcare associated Infections such as CLAB and Surgical Site Infections (SSI)
- Reducing perioperative harm, for example Surgical Safety Checklist initiative[12], health screening questions for elective surgery, medical and anaesthetic preadmission for surgery
- Improving hand hygiene and environmental cleaning practices
- Improving the Dignified and Safe Handling of patients

Our surgical services have a number of programmes in place aimed at improving patient safety through improved clinical practice as identified above. The SSI initiatives noted above highlight a focus on procedures most at risk of post operative infection, e.g. prosthetic joint infections, surgical site infection surveillance programme pre- and post hospital discharge, caesarean and gastrointestinal surgery.

Other quality and safety improvement initiatives include areas of operational effectiveness such as Capacity Management and Beds across the hospital system, improving 'Did Not Attend' (DNA) rates, supporting and developing work in relation to family / whaanau as partners in care.

3.4.1 Improving 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. We will continue our work on:

[12] Including prophylactic antibiotics before knife to skin; VTE risk assessment and prophylaxis, 2 person check before regional blocks; check - is Blood available; Ask - is there other risks we need to know about

- Roll out of electronic medicines reconciliation[13] (eMR) across the services and divisions in the 2013/14 year
- IHI Adverse Drug Event (ADE) Trigger Tool in conjunction with Canterbury and Capital & Coast DHBs
- Medication safety campaign work including the Dirty Dozen (identifying the top 12 medicines associated with harm) and 5 Rights in relation to safe medicines administration

3.4.2 Preventing healthcare-associated infection

- Compliance with Hand Hygiene by participating in the national gold audit, promoting the importance of Hand Hygiene and related initiatives/activities
- Working actively with the wards and other clinical areas to identify improvements to hand hygiene practices
- Central Line Associated Bacteraemia (CLAB) prevention collaborative at a local and national level

3.4.3 Making surgery safer

Our Centre for Quality Improvement 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 Health Quality and Safety Commission (HQ&SC) for the national SSI system. Reducing perioperative harm initiatives also includes implementation of a Surgical Safety Checklist, i.e. checking that everyone knows each other at the outset of a procedure, checking that we have the right patient and are carrying out the correct operation. Refer to section 3.4 above.

3.5 Organisational Health

As a Good Employer, we promote equity, fairness and safe and healthy workplaces. CM Health 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. CM Health is committed to this principle and will actively seek to uphold any legislative requirements in this regard.

3.5.1 Maaori participation in decision making

We will strengthen this aspect of our governance in 2013/14 to ensure that Maaori are engaged and participate in decision making and the development of plans and strategies to improve health outcomes for Maaori. CM Health has two types of relationships and two governance forums with Maaori:

- As agents of the Crown, we engage in a Treaty based relationship with the tangata whenua of our district. The CM Health Board has established a Board to Board relationship with Mana Whenua I Tamaki Makaurau representatives Board
- As a DHB responsible for services to all Maaori in the district, CM Health has established a sub-committee to the Board the Maaori Health Advisory Committee (MHAC) to provide a channel for engagement with all Maaori communities in the district

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.

3.5.2 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

[13] Refer http://www.hqsc.govt.nz for further information

currently working with them to determine how we can best develop and enhance Pacific leadership across the DHB.

3.6 Reporting and Consultation

CM Health 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 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.

3.7 Associate and Subsidiary Companies

3.7.1 HealthAlliance NZ Limited

CM Health 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.

3.7.2 Innovation Hub

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

3.7.3 Locality Clinical Partnerships

We are finalising a collaborative agreement with PHOs for the delivery of locality clinical partnerships.

3.7.4 Integrated Family Health Centres/ Whaanau Ora Centres

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

4.0 Forecast Service Performance

4.1 Statement of Forecast Service Performance

Counties Manukau Health (CM Health) 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 CM Health plan to deliver through its planned activities and actions for 2013/14.

Our intervention logic in section 2.5 shows how our strategic outcomes guide our decisions around what level of resources (inputs) and mix of services (outputs) best meets our population's health needs, how they are delivered and to what level. The mix of services delivered are expected to contribute towards measurable impacts on our population's health, improvement of which will provide good indication that CM Health is on track to deliver on its high level outcomes.

Outputs are measured against six dimensions of quality[14]

Figure 20: Dimensions of quality

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

Past performance (baseline data or current performance) is included where possible along with performance targets. A number of key measures of output and impact for each output class which best reflect activities that make the largest contribution to CM Health's achievement of key strategic objectives have been included. Actual results of service performance against what was forecast here will be published in our 2013/14 Annual Report.

4.2 Input Levels Against Output Classes

Prevention	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**17,738**	**18,887**	**20,127**	**21,133**	**22,190**
Personnel costs	3,177	4,637	4,760	4,998	5,248
Outsourced Services	1,368	1,261	1,881	1,975	2,074
Clinical Supplies	1,482	1,441	1,926	2,022	2,123
Infrastructure & Non-Clinical Supplies	14	907	1,464	1,537	1,614
Other	11,697	10,641	10,096	10,601	11,131
Total costs	**17,738**	**18,887**	**20,127**	**21,133**	**22,190**
Surplus (Deficit)	-	-	-	-	-

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

Early Detection	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**212,199**	**212,793**	**208,287**	**218,701**	**229,636**
Personnel costs	-	-	-	-	-
Outsourced Services	-	-	-	-	-
Clinical Supplies	-	-	-	-	-
Infrastructure & Non-Clinical Supplies	-	-	-	-	-
Other	212,199	212,793	208,287	218,701	229,636
Total costs	**212,199**	**212,793**	**208,287**	**218,701**	**229,636**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Intensive	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**1,048,921**	**1,074,866**	**1,101,079**	**1,126,517**	**1,149,157**
Personnel costs	478,066	502,709	525,221	543,786	557,646
Outsourced Services	56,665	56,269	56,487	56,977	61,967
Clinical Supplies	105,662	105,181	102,571	103,521	105,474
Infrastructure & Non-Clinical Supplies	100,586	100,569	107,466	112,765	114,832
Other	302,532	307,113	306,302	306,450	309,220
Total costs	**1,043,511**	**1,071,841**	**1,098,047**	**1,123499**	**1,149,139**
Surplus (Deficit)	**5,410**	**3,025**	**3,032**	**3,018**	**18**

Rehabilitation	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**101,572**	**107,994**	**113,441**	**119,113**	**125,069**
Personnel costs					
Outsourced Services					
Clinical Supplies					
Infrastructure & Non-Clinical Supplies					
Other	101,572	107,994	113,441	119,113	125,069
Total costs	**101,572**	**107,994**	**113,441**	**119,113**	**125,069**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Total	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**1,380,430**	**1,414,540**	**1,442,934**	**1,485,464**	**1,526,052**
Personnel costs	481,243	507,346	529,981	548,784	562,894
Outsourced Services	58,033	57,530	58,368	58,952	64,041
Clinical Supplies	107,144	106,622	104,497	105,543	107,597
Infrastructure & Non-Clinical Supplies	100,600	101,476	108,930	114,302	116,446
Other	628,000	638,541	638,126	654,865	675,056
Total costs	**1,375,020**	**1,411,515**	**1,439,902**	**1,482,446**	**1,526,034**
Surplus (Deficit)	**5,410**	**3,025**	**3,032**	**3,018**	**18**

Output Classes

This section is structured as follows.

5.3	Output class: Prevention Services
5.3.1	Health Promotion and Education Services ▪ Smoking cessation ▪ Healthy environments ▪ Family violence prevention
5.3.2	Immunisation Services
5.3.3	Health Screening ▪ Breast screening ▪ Cervical screening ▪ Well child/ Tamariki Ora
5.3.4	Statutory and Regulatory Services
5.4	Output class: Early Detection and Management Services
5.4.1	Primary Health Care Services (GP)
5.4.2	Long Term Conditions Management
5.4.3	Oral Health Services
5.4.4	Diagnostics
5.5	Output class: Intensive Treatment and Assessment Services
5.5.1	Mental Health
5.5.2	Elective Services
5.5.3	Acute Services ▪ Emergency department ▪ Cancer services ▪ Cardiac services
5.5.4	Maternity Services
5.5.5	Additional Patient Safety Measures for our Hospital Services
5.6	Output class: Rehabilitation and Support Services
5.6.1	NASC
5.6.2	Assessment, Treatment and Rehabilitation Services
5.6.3	Aged Related Residential Care (ARRC)
5.6.4	Home Based Support

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

4.3 Output class: Prevention Services

Prevention services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.

4.3.1 Health Promotion and Education Services

Outputs and Related Measures	Forecast Performance		Reference
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	Baseline (Q3 2012/13) 95 %	June 2014 95 %	NHT C
Proportion of enrolled primary care patients who are smokers and are seen in General Practice are provided with advice and help to quit	Baseline (Q2 2012/13) 42.96 %	June 2014 90 %	NHT 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	Baseline To be established	June 2014 90 %	NHT C
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 District Health Boards (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			
Completed health and housing assessments	Baseline (2011/12) 328	June 2014 320	V
Number of homes insulated	Programme Warm Up CM	June 2014 1000	V
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			
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*	 Partner Abuse Child Abuse and Neglect	Baseline (March 2012) 92 / 100 91 / 100	June 2014 90 / 100 90/ 100	F

4.3.2 Immunisation Services

Outputs and Related Measures	Forecast Performance			Reference
▪ 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: Target will increase to 95 percent by Dec 2014		Baseline Q3, 2012/13	June 2014	NRHP NHT
	Maaori	76 %	90 %	
	Pacific	88 %		
	Total	86 %		
Proportion of older people (65+) who have had their flu vaccinations	Baseline (Dec 2012)		Dec 2013	
	61.9 %		75 %	

4.3.3 Health Screening

Outputs and Related Measures	Forecast Performance			Reference
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 50 – 69 years who have had a breast screen in the last 24 months		Baseline (December2012)	June 2014	C
	Maaori	66.5 %	70 %	
	Pacific	67.9 %		
	Total	67.6 %		
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 2012)	June 2014	C
	Total	70.42 %	80 %	
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 Before School Checks (B4SC) ▪ 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				
Proportion of the eligible population who have had their B4 School Checks		Baseline (FY2012/13)	June 2014	C E
	Vision and Hearing (2 components)	80% 7,022 (including 3,058 of high dep)	90 % of eligible population 8,058 (including 3612 of high dep)	
	Nurse (Well child – core 8			

4.3.4 Statutory and Regulatory Services

Outputs and Related Measures	Forecast Performance		Reference
▪ 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			
Number of license premises risk assessed by Auckland Regional Public Health Service (ARPHS).	Baseline (12/13)	2013/2014	C
	1269	1200	

Number of license premises assessed as high risk. 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	Baseline (12/13) 608	Estimate 2013/14 400	F
Numbers of joint Controlled Purchase Operations conducted	Baseline (2012/13) 237	Estimate 2013/14 200	V

4.4 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.

4.4.1 Primary Health Care Services (GP)

Outputs and Related Measures	Forecast Performance		Reference
▪ We fund PHOs to deliver primary care services to improve, maintain or restore people's health			
Number of bed days saved through our Saving 20,000 Days Campaign initiatives Note: 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	Baseline (Jul 2011-Dec 2012) 11,565	June 2014 20,000 days	F

4.4.2 Long Term Conditions Management

Outputs and Related Measures	Forecast Performance			Reference
▪ 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: ▪ Early detection and intervention services like diabetes checks and minor skin lesions surgery provided by GPs ▪ Education programmes to support patients' self-management of long term conditions ▪ Structured primary care programmes aimed at better management of individuals with chronic conditions like the Diabetes Care Improvement Package, Chronic Care Management (CCM) and the Very High Intensive User Programme				
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c of equal to or less than 64 mmol/mol)		Baseline (Q3, 2012/13)	June 2014	PP20 F
	Maaori	57%	66 %	
	Pacific	52%		
	Total	62%		
Number of additional patients enrolled in Self Management (SM) programmes	Baseline 2011/12 551		June 2014 700	V
Percentage of all primary care practices engaged in Chronic Care Management (CCM) programme Note: CCM programmes allow for those with Chronic Conditions to actively manage their health in primary care in the community. This in turn leads	Baseline New measure - to be established		June 2014 70 %	V DD

to decreased acute admissions and avoidable mortality.			
Total number of new patients enrolled in the Very High Intensive User (VHIU) programme (with minimum 200 primary care enrolled)	Baseline (Jan – Dec 2012) 358/(36 primary enrolled)	June 2014 411 (72 primary enrolled)	V
Provide VHIU community based care where possible to avoid hospital admissions	Baseline (Dec 2012) 20 % bed days for identified high risk individuals (350 bed days saved)	June 2014 25 % saving in bed days for identified high risk individuals (438 bed days saved)	V
Number of enrolments/referrals in Primary Options for Acute Care (POAC) Note: 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 2012) 9,429	June 2014 12,261	V

4.4.3 Oral Health Services

Outputs and Related Measures	Forecast Performance			Reference
▪ We contract the Auckland Regional Dental Service to deliver free oral health services for children aged 0 to 12 years old at our community and DHB based clinics and mobile dental facilities ▪ We contract with private dentists and ARDS to deliver free oral health services for our adolescents aged 13 up and including to 17 years old ▪ We deliver targeted preschool oral health promotion and brushing programmes with our partners in the Kohanga reo, Language nest and Early Childhood Education sector				
Proportion of children under 5 years enrolled in DHB-funded oral health services	Baseline (Dec 2012) 71 %	By Dec 2013 75 %	By Dec 2014 85 %	PP13a C
Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)	Baseline (Dec 2012) 19 %	By Dec 2013 12 %	By Dec 2014 7 %	PP13b T
Proportion of Year 8 children who have their treatment completed and are transferred to the Adolescent dental service	Baseline (December 2012) 100 %	June 2014 100 %		PP12 C
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services	Baseline (Interim Dec 2012) 66 %	Dec 2013 80%	Dec 2014 85 %	PP12 C

4.4.4 Diagnostics

Outputs and Related Measures	Forecast Performance			Reference
Proportion of accepted referrals for CT and MRI scans will receive their scan within 6 weeks	Baseline (Q2 2012/13) CT 84 % MRI 63 %	Dec 2013 75 % 75 %	June 2014 85 % 75 %	NRHT DV2 T
Proportion of patients accepted as priority 1 for diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Baseline (Dec 2012) 39 %	Dec 2013 50 %	June 2014 50 %	NRHT DV2 T
Proportion of patients accepted as priority 2 for diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Baseline(Dec 2012) 29 %	Dec 2013 50 %	June 2014 50 %	NRHT 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 (Dec 2012) 73 %	Dec 2013 50 %	June 2014 50 %	NRHT DV2 T

4.5 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.

4.5.1 Mental Health

<table>
<tr><th>Outputs and Related Measures</th><th>Forecast Performance</th><th>Reference</th></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:
  - Acute and intensive services
  - Community based clinical treatment and therapy services
  - Services to promote resilience, recovery and connectedness

</td></tr>
<tr><td>Proportion of long term clients with Relapse Prevention Plan (RPP)</td><td>
<table>
<tr><td></td><td></td><td>Baseline (Q2, Dec 2012)</td><td>June 2014</td></tr>
<tr><td>Child and Youth</td><td>Maaori</td><td>91.2 %</td><td rowspan="2">95 %</td></tr>
<tr><td></td><td>Total</td><td>96.7 %</td></tr>
<tr><td>Adult (20+)</td><td>Maaori</td><td>89 %</td><td rowspan="2"></td></tr>
<tr><td></td><td>Total</td><td>90.4 %</td></tr>
</table>
</td><td>PP7
P</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, 2012/13)</td><td>July 2013</td><td>June 2014</td></tr>
<tr><td>3 weeks</td><td>83 %</td><td>75 %</td><td>80 %</td></tr>
<tr><td>8 weeks</td><td>97 %</td><td>85 %</td><td>95 %</td></tr>
</table>
</td><td>PP8
T</td></tr>
</table>

4.5.2 Elective Services

<table>
<tr><th>Outputs and Related Measures</th><th>Forecast Performance</th><th>Reference</th></tr>
<tr><td colspan="3">

- We provide and purchase elective inpatient and outpatient services

</td></tr>
<tr><td>ESPI 2: Patients waiting longer than four months for their first specialist assessment (FSA) by December 2014</td><td>
<table>
<tr><td>Baseline (Dec 2012)</td><td>Dec 2014</td></tr>
<tr><td>26.9 %</td><td>0.0 %</td></tr>
</table>
</td><td>T</td></tr>
<tr><td>ESPI 5: Patients given a commitment to treatment but not treated within four months by December 2014</td><td>
<table>
<tr><td>Baseline (Dec 2012)</td><td>Dec 2014</td></tr>
<tr><td>0.1 %</td><td>0.0 %</td></tr>
</table>
</td><td>T</td></tr>
<tr><td>Number Elective Surgical Discharges</td><td>
<table>
<tr><td>Q2, 2012/13</td><td>July 2013</td><td>June 2014</td></tr>
<tr><td>8,326</td><td>15,381</td><td>15,635</td></tr>
</table>
</td><td>NHT2</td></tr>
<tr><td>Elective Services Standardised Intervention Rates (SIRs) per 10,000 of population

The SIRs target rates reflect equitable levels of access to elective surgery</td><td>
<table>
<tr><td></td><td>Current Rate (Q2 2012/13)</td><td>June 2014</td></tr>
<tr><td>Major joints</td><td>21.6</td><td>21.00</td></tr>
<tr><td>Cardiac</td><td>7.18</td><td>6.50</td></tr>
<tr><td>Cataracts</td><td>39.91</td><td>27.00</td></tr>
</table>
</td><td>SI 4
E</td></tr>
<tr><td>Outpatient Did Not Attend (DNA) rates for Maaori and Pacific</td><td>
<table>
<tr><td></td><td>Baseline (April 2013)</td><td>June 2014</td></tr>
</table>
</td><td>P</td></tr>
</table>

	Maaori	18.3 %	< 10 %	
	Pacific	16.8 %	< 10 %	

4.5.3 Acute Services

Outputs and Related Measures	Forecast Performance	Reference
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		
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours	Q3, 2012/13: 97 % June 2014: 95 %	NHT1
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, 2012/13: Maaori 100 %; Pacific 100 %; Total 100 % June 2014: 100 % Chemotherapy Q3, 2012/13: Maaori 100 %; Pacific 100 %; Total 100 % June 2014: 100 %	NHT3 NRHP T NHT3 NRHP T
Proportion of patients referred urgently with high suspicion of Lung cancer to first cancer treatment (62 days)	Baseline: 54 % June 2014: Not established	NRHP DV1 T
Proportion of patients referred urgently with high suspicion of lung cancer to first specialist appointment (all treatment types) within 14 days	Dec 2012/13: Radiation oncology 59 %; Medical oncology 60 % June 2014: Not established	
Proportion of patients with confirmed lung cancer diagnosis who receive first cancer treatment within 31 days of decision of treat (all treatment types)	Baseline: 54 % June 2014: Not established	NRHP DV1 T
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	Q3, 2012/13: 79 % June 2014: 80 %	NRHP T
Proportion of outpatient coronary angiograms with a waiting time of < 3 months	Q3, 2012/13: 95 % (National Target): (85 %) Regional Target June 2014: 90 %	NRHP DV2 T
Proportion of patients presenting with an acute coronary syndrome who are referred for angiography and receive it within 3 days of admission	Q3, 2012/13: 82 % June 2014: 70 %	NRHP T
Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions (PCI) who receive this within 120 mins	Q3, 2012/13: 74 % June 2014: 80 %	NRHP T

4.5.4 Maternity Services

Outputs and Related Measures	Forecast Performance		Reference
▪ We provide readily accessible maternity, obstetric and neonatal care services			
Proportion of CM Health newborns screened within 4 weeks of birth All CM Health maternity facilities to have newborn hearing screening facilities including a mop-up programme for those babies discharged before screening has been completed	Baseline To be confirmed	June 2014 90 %	T

4.5.5 Additional Patient Safety Measures for our Hospital Services

Outputs and Related Measures	Forecast Performance			Reference
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		Baseline Q3 12/13	June 2014	OS8 S F
	Total	9.66	<= 8.0% (unstandardised)	
	75+	11 %	<= 12.0% (unstandardised)	
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 (Dec 2012) 3.93		June 2014 3.21 days	OS3 S F
Wards (excluding Mental Health) that have electronic medication reconciliation systems in place	Baseline (FY 2012) Implemented in 5 wards		June 2014 100 %	S
Average rate of Central Line Associated Bacteraemia (CLAB) in the Intensive Care Unit	Baseline (FY 2012) 2.3 / 1000 line days		June 2014 0	S
Number of in-hospital falls per bed-day	Baseline (April 2013) 2.7/1000 bed-days		Dec 2013 <3.5 / 1000 bed-day	S
Number of pressure Injuries hospital wide	Baseline (FY 2012) 3 % to 5 % per 100 patients		Dec 2013 3.5 % per 100 patients	S
Hand hygiene compliance rate (based on Gold Audit)	Baseline (Mar 2013) 69 %		June 2014 80%	S

4.6 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

4.6.1 NASC

Outputs and Related Measures	Forecast Performance		Reference
▪ 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 CM Health NASC staff who have participated in interRAI training and can deliver	Baseline (Dec 2012) 100 %	June 2014 100 %	C

appropriate assessments in the community and allocate support using CM Health contracted HBSS		

4.6.2 Assessment, Treatment and Rehabilitation Services

Outputs and Related Measures	Forecast Performance		Reference
▪ 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	Baseline (Dec 2012) 53 % occupancy of 10 AT&R beds at Pukekohe Hospital	June 2014 80 % occupancy of 10 AT&R beds at Pukekohe Hospital	W
Hospital Services Average length of stay in AT & R (Pukekohe hospital beds)	Baseline (Dec 2012) 17.7 days	June 2014 < 16 days	F
Average length of stay for patients included in acute geriatric pilot at Middlemore Hospital	Baseline (Dec 2012) Average of 5 days acute episode across all MMH medical wards	June 2014 5 days	F

4.6.3 Age Related Residential Care (ARRC)

Outputs and Related Measures	Forecast Performance		Reference
▪ 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 residential care service providers who are trained in Long Term Care Facility interRAI	Baseline (Dec 2012) 14 %	June 2014 32 %	C
Number of avoidable 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 (Dec 2012) Average of 22 low acuity presentations per month	June 2014 Decrease by 15 % (19 avoidable presentations	F
Number of emergency care presentations from retirement villages	Baseline (Dec 2012) 11 mean presentations per 100 residents	June 2014 Decrease by 5 %	

4.6.4 Home Based Support

Outputs and Related Measures	Forecast Performance		Reference
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 CM Health NASC clients receiving Home Base Support Services who have a comprehensive interRAI assessment completed in the last 12 months	Baseline (2012) 34 %	June 2014 50 %	S F

5.0 Financial Performance

5.1 Introduction

5.1.1 Tightening Financial Position

Counties Manukau Health (CM Health) and its Primary Health Organisation (PHO) partners remain fully committed to achieving the Government's priorities despite the fiscal constraints the health sector is facing. Clear indications from the Minister and Ministry of Health are of a very significant tightening of fiscal position from 2013/14 onwards. Despite capital and operational constraints, demand on CM Health system services is expected to grow at fiscally unsustainable levels unless significant change and related innovations are implemented. This changing funding forecast has accelerated the scale and pace of health system change needed for future sustainability.

The next major step in how we will address this challenge will come when the indicative business case for System Integration Investment is finalised in the spring of 2013. This joint piece of work between CM Health, Ministry of Health and Treasury will establish the framework for our future financial and service sustainability. This will set the context for our strategic change programmes related to the integration of services through our Localities Development Programme, expanded acute care system efficiencies/model of care changes and an in-depth challenge to existing cost structure, service delivery models, care settings and health system performance accountabilities (Financial Sustainability Taskforce).

Acknowledging significant fiscal challenges the health sector is facing, we are committed to achieving a $3m surplus in 2013/14 and 2014/15. While the outer years are anticipated to be increasingly challenging, CM Health is focused on continuous improvement and innovation as a way of living within our means.

5.1.2 Cost Structure Change to Effect Integration

The 2012/13 year was a transitional year for CM Health as we established essential infrastructure and organisational changes to effect health system wide integration. Our cornerstone investments were establishment of the following:

- District Alliance Group comprising the CM Health Board and CM PHO Chairs and Chief Executives
- Two of our four Locality Clinical Partnerships (LCP) and related Leadership Groups; with the final two to be established in 2013/14
- Locality Clinical Partnership Agreement to provide primary health care providers with greater opportunities to share system resources, and accountability to collectively ensure the best use of those resources
- Framework for global budget holding to incentivise general practice to take shared accountability and increased flexibility to best manage population health needs

These include operational (management) and health service programme budgets that integrates primary health, community, CM Health (shared accountability services[15]) and third party provided services accessed within each locality. We recognise that elements of these changes are leading edge 'risk/gain' share models to incentivise general practice and any potential financial risk will managed through a 2013/14 focus on careful monitoring and evaluation of pilot implementation.

[15] Shared Accountability Services are those specialist or hospital level services which are provided across localities, but over which the primary healthcare and community sector has an important influence. This may include, inter alia, acute medical surgical services, emergency services, elective inpatient and outpatient services, diagnostic services, specialist mental health services, pathology services, and residential care services. The cost of these services will be apportioned across localities according to transparent allocation mechanisms, such as actual or forecast utilisation.

5.2 Forecast Financial Statements

5.2.1 Summary by Funding Arm

Net Result	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Forecast 000's	2015/16 Plan 000's
Provider	(6,539)	(5,482)	(7,929)	(8,310)	(8,675)
Governance	1,210	(629)	221	220	220
Funder	10,739	9,136	10,740	11,108	8,473
Operating Surplus	5,410	3,025	3,032	3,018	18
Other Comprehensive Income	(2,500)	-	-	-	-
Surplus (deficit)	2,910	3,025	3,032	3,018	18

5.2.2 Statement of Comprehensive Income

Net Result	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Forecast 000's	2015/16 Plan 000's
Revenue					
Crown *	1,338,039	1,378,401	1,412,652	1,454,431	1,494,247
Other	42,391	36,139	30,282	31,033	31,805
Total Revenue	**1,380,430**	**1,414,540**	**1,442,934**	**1,485,464**	**1,526,052**
Expenses					
Personnel	481,243	507,346	529,981	548,784	562,894
Outsourced	58,033	57,530	58,368	58,952	64,041
Clinical Sup.	99,531	99,039	93,913	94,459	95,513
Infrastructure	66,037	63,268	62,552	61,130	62,007
Personal Health	472,116	473,993	468,840	481,279	494,057
Mental Health	54,502	56,987	57,906	59,310	63,752
Disability Support	97,055	103,675	109,107	111,943	114,854
Public Health	2,908	1,661	946	971	996
Maaori	1,419	2,225	1,327	1,362	1,397
Operating Costs	**1,332,844**	**1,365,724**	**1,382,940**	**1,418,190**	**1,459,511**
Operating surplus	**47,586**	**48,816**	**59,994**	**67,274**	**66,541**
Depn.	20,109	22,106	30,516	37,545	39,545
Capital Chg.	12,441	12,648	12,996	13,126	13,257
Interest	9,626	11,037	13,450	13,585	13,721
Operating Surplus	**5,410**	**3,025**	**3,032**	**3,018**	**18**
Other Comprehensive Income	(2,500)	-	-	-	-
Surplus (Deficit)	**2,910**	**3,025**	**3,032**	**3,018**	**18**

Funder Revenue	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Crown	1,285,061	1,329,353	1,360,587	1,395,963	1,432,261
Other	7,606	5,148	2,734	2,805	2,878
Total	**1,292,667**	**1,334,501**	**1,363,321**	**1,398,768**	**1,435,139**
Personal Health	1,013,881	1,045,074	1,05,781	1,083,478	1,111,912
Mental Health	131,122	135,240	137,772	141,253	147,826
Disability Support	121,689	128,375	142,034	145,727	149,516
Public Health	2,990	1,661	946	971	996
Maaori	1,419	2,225	1,327	1,362	1,397
Governance	10,827	12,790	14,721	14,868	15,017
Total Expenditure	**1,281,928**	**1,325,365**	**1,352,581**	**1,387,659**	**1,426,664**
Net Surplus	**10,739**	**9,136**	**10,740**	**11,109**	**8,475**

Eliminations Revenue	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Crown	(653,928)	(686,824)	(714,455)	(732,795)	(751,610)
Other	-				
Total	**(653,928)**	**(686,824)**	**(714,455)**	**(732,795)**	**(751,610)**
Personal Health	(541,765)	(571,081)	(586,941)	(602,200)	(617,857)
Mental Health	(76,620)	(78,253)	(79,866)	(81,943)	(84,074)
Disability Support	(24,634)	(24,700)	(32,927)	(33,784)	(34,662)
Public Health	(82)	-	-	-	-
Maaori	-	-	-	-	-
Governance	(10,827)	(12,790)	(14,721)	(14,868)	(15,017)
Total Expenditure	**(653,928)**	**(686,824)**	**(714,455)**	**(732,795)**	**(751,610)**
Net Surplus	**-**	**-**	**-**	**-**	**-**

Provider Revenue	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Crown	696,079	719,419	749,639	774,180	796,308
Other	34,397	34,389	29,344	30,075	30,826
Total	**730,476**	**753,808**	**778,983**	**804,255**	**827,134**
Personnel	476,110	499,536	520,082	538,785	552,794
Outsourced	57,340	56,424	57,636	58,212	63,293
Clinical Sup.	99,531	98,955	93,797	94,342	95,395
Infrastructure	61,858	58,584	58,435	56,970	57,084
Operating Costs	**694,839**	**713,499**	**729,950**	**748,309**	**769,286**
Operating surplus	**35,637**	**40,309**	**49,033**	**55,946**	**57,848**
Depreciation	20,109	22,106	30,516	37,545	39,545
Capital Charge	12,441	12,648	12,996	13,126	13,257
Interest	9,626	11,037	13,450	13,585	13,721
Total Expenditure	**737,015**	**759,290**	**786,912**	**812,565**	**835,809**
Net Surplus	**(6,539)**	**(5,482)**	**(7,929)**	**(8,310)**	**(8,675)**
Other Comprehensive Income	(2,500)	-	-	-	-
Surplus (Deficit)	**(9,039)**	**(5,482)**	**(7,929)**	**(8,310)**	**(8,675)**

Governance Revenue	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Crown	10,827	12,790	14,805	14,953	15,103
Other	388	265	280	283	286
Total	**11,215**	**13,055**	**15,085**	**15,236**	**15,389**
Personnel	5,133	7,810	9,899	9,999	10,100
Outsourced	693	1,106	732	740	748
Clinical Sup.	-	84	116	117	118
Infrastructure	4,179	4,684	4,117	4,160	4,203
Total Expenditure	**10,005**	**13,684**	**14,864**	**15,016**	**15,169**
Net Surplus	**1,210**	**(629)**	**221**	**220**	**220**

Balance Sheet Current Assets	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Cash and Bank	6,165	1,104	886	890	890
Debtors	32,166	37,002	29,597	39,150	39,550
Inventory	835	1,990	3,990	3,990	3,990
Assets Held for Sale	-	-	-	-	-
Current Assets total	**39,166**	**40,096**	**34,473**	**44,030**	**44,430**
Non-Current Assets	533,815	608,297	649,896	653,471	646,416
Total Assets	**572,981**	**648,393**	**684,369**	**697,501**	**690,846**
Current Liabilities					
Creditors	85,377	90,055	89,880	73,971	74,507
Loans	30,000	5,000	5,000	-	25,000
Employee Provisions	107,087	113,269	126,414	128,605	121,065
Total Current Liabilities	**222,464**	**208,324**	**221,294**	**202,575**	**220,572**
Working capital	**(183,298)**	**(168,228)**	**(186,821)**	**(158,545)**	**(176,142)**
Net Funds Employed	**350,517**	**440,069**	**463,075**	**494,926**	**470,274**
Non-Current Liabilities					
Employee Provision	16,563	16,357	16,600	16,700	15,300
Term Loans	167,600	252,600	270,600	297,600	272,600
Restricted funds	848	853	856	860	860
Total Non-Current Liabilities	**185,011**	**269,810**	**288,056**	**315,160**	**288,760**
Crown Equity	**165,506**	**170,259**	**175,019**	**179,766**	**181,514**
Net Funds Employed	**350,517**	**440,049**	**463,075**	**494,926**	**470,274**

Movement of Equity	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Total Equity at beginning of period	**160,868**	**165,506**	**170,259**	**175,019**	**179,766**
Surplus / (Loss) for period	5,410	3,025	3,032	3,019	20
Crown Equity injection	2,148	2,148	2,148	2,148	2,148
Crown Equity withdrawal	(420)	(420)	(420)	(420)	(420)
Revaluation Reserve	(2,500)	-	-	-	-
Total Equity at beginning of period	**165,506**	**170,259**	**175,019**	**179,766**	**181,514**

5.3 Accounting Policies

The CM Health financial statements 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 International Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

The accounting policies applied in the projected financial statements are set out in 5.6.

5.4 Significant Assumptions

5.4.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2013/14 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing unutilised/approved debt facilities. To ensure we achieve a $3m surplus where cost growth is higher than forecast revenue, CM Health will cap the level of allowable and fundable growth within provider and funder arms

Where previously there 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.

In response, CM Health has commissioned an internal Financial Sustainability Taskforce to undertake an in-depth review of additional savings. Agreed 'savings' actions resulting from this work will be confirmed in mid 2013, with implementation planned for the 2013/14 year.

5.4.2 Personnel Costs

Despite the international economic position, the anticipated relatively high level of clinical wage settlements will continue to be an ongoing challenge in relation to the mismatch of health worker wage/salary expectations and affordability. The average national Agreement have settled between 0.7 percent to 1.5 percent for 2013/14, overall personnel cost increase is about 3.5 percent – 4.5 percent due to automatic ongoing step functions, on-cost implications and increasing entitlements. Combined, these largely nationally set Agreement costs are greater than the Crown Funding growth and will be absorbed by internal efficiencies and other initiative savings.

We continue to reduce management and administration FTEs. Despite this, we have prioritised personnel costs to support acceleration of essential health system integration and related activities. This requires commitment to project, programme, analytical and change management resource to be successful.

5.4.3 Third Party and Shared Services Provision

The System Integration Investment programme remains a core enabler of system level change. Our focus for 2013/14 will be alignment of localities development and related primary care/community based capital investment (e.g. whaanau ora centre, integrated family healthcare centres). The form that this programme will take is still evolving and there is an expectation of increased third party participation and provision of public services integrated with core/essential CM Health services.

Capital investment constraints and increasing health target expectations (notably radiology and elective wait time) are likely to require a closer look at third party and shared regional capacity expansion. This will

include a strong direction regarding increased provision of shared services, through healthAlliance and Health Benefits Ltd (HBL); with heightened reliance around realisation of tangible savings.

5.4.4 Supplies

CM Health is working very closely with and contributing to, the national procurement and supply chain efficiency objectives through HBL although the estimated savings expectations are yet to be formalised through NHB advice to the DHBs (as at 8 March 2013).

Regional efficiencies through shared services provided by healthAlliance will be included in our local Thriving in Difficult Time programme.

5.4.5 Services by Other DHBs and Regional Providers

There is a significant commitment to regional cooperation and alignment of service provision to reduce wastage from unnecessary variation. CM Health contributes to the regional Better Sooner More Convenient business cases through an expanded investment in Primary Options for Acute Care (POAC) and Access to Diagnostics to better manage significant volume pressures through more effective service access in the community

Agreement has been reached to invest $250,000 for (operational funding of) point of care testing services in primary care settings to effect improved performance in health targets.

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.

5.4.6 Other Funder Contracts

There is a forecast 2012/13 ‘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.

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, CM Health expects to offset any downside by further opportunities or enhancement of existing contracts.

CM Health is integrating its Whaanau Ora contracts with Maaori and Pacific providers through funding devolvement to the National Hauora Coalition and Alliance Health Plus.

5.4.7 IS Infrastructure

Prioritised Information System (IS) infrastructure investment has been agreed regional (refer section 2.2.2) and is essential for health system business continuity and effective implementation of integration models of care between secondary and primary/community care settings. The capital commitment for the regional DHBs collectively is significant and has been endorsed as a strategic priority by the CM Health Board. This investment will target IS infrastructure resilience that will provide a sound foundation for shared clinical and business information systems. Refer to section 3.3.8 for an outline of regional IS investments.

The net financial impacts will include both capital and operational costs.

5.4.8 Capital Servicing

Commissioning of the new Clinical Services Block (CSB) Stage 1 project in 2013/14 will fully utilise all existing available cash funding, sourced from either current or accumulated depreciation or remaining available approved debt funding or approved equity/debt.

This will have a material valuation change to Land and Buildings from when the building is handed over from the main contractor to CM Health in late September 2013.

5.4.9 Capital Investment

The CSB Stage 1 [$208m] is now progressing to schedule with building completion and commissioning scheduled to start in September 2013, with approved service migrations staggered over 7 months. Despite planned efficiencies as a result of more effective department floor layouts, building flows and models of care, this will materially impact on our operating financial position, notably due to service functions such as gas, power and non-clinical support services.

Figure 21: Major capital investment projects – Current

Project	Budgeted Approval	Project Finish Date	Value	Status
Middlemore Hospital, Clinical Services Block Stage 1	Late May 2009	Nov 2014	$208m	Underway ($108m internally funded)

CM Health recognises the need to move away from reliance on physical brick and mortar solutions to manage capacity growth and adopt whole of organisation solutions with a focus on community based service expansion. In line with this, forecast inpatient bed capacity expansion investments will be deferred to prioritise investment in primary and community services integration and expansion to mitigate forecast requirements. In order to manage risks due to potential lag time, likely future requirement for (reduced scale) inpatient hospital bed expansion will be managed as a contingency investment in order to maintain the focus and prioritisation on health system change.

The changing Crown funding forecasts from 2013/14 have required a reassessment of local capital investment prioritisation. Figure 22 below outlined likely major capital investment projects, recognising that this is subject to confirmation by the CM Health Board, NHB and Treasury through submission of a 10 Year System Integration Investment business case and related regional capital planning processes.

Figure 22: Major capital investment projects – Future

Project	Budgeted Approval	Project Finish Date	Value	Status
IS Strategic (healthAlliance)	2013/14	2014-2023	$25m	Local/Regional Capital Intentions planning (indicative only[16])
System Integration Investment Programme (1st tranche)	2013/14	2014-2019	$201m	Programme business case in development (indicative only[17])
System Integration Investment Programme – including women's health, elective services and others (2nd tranche)	2013/14	2016-2023	-	Business case to be developed
Radiology (replacement upgrades)	2013/14	2014-2023	$9m	Local/Regional Capital Intentions planning
Southern Car Park	2013/14	2016	$19m	PPP or equivalent
Regional Food Service/Kitchen	-	-	-	Pending HBL business case outcomes
Grand Total			**$254m**	

Note: The above does not include the cash flow impact and initial operating expense impacts of unapproved business cases

[16] Subject to Programme Business case

5.4.10 Capital Investment Funding

Capital investment will be funded from a number of sources including working capital, crown funding and operating surpluses.

5.4.11 Banking Covenant

CM Health operates under one banking covenant, with all its term debt facilities transitioned fully across to Ministry of Health (MoH). The Board maintains a working capital facility with HBL via Westpac which is the only relationship falling under this remaining covenant, together with lease/finance facilities with both Commonwealth Bank and Westpac.

Figure 23: Banking facilities

Facilities ($M)	Existing Limit	Utilisation @ 30 June 2013	Available Facility @ 1 July 2013
Crown Debt	$297.6	$297.6	-
HBL / Westpac (working capital)	$64.4	-	$64.4
Westpac (lease facility)	$10.0	-	$10.0
Commonwealth Bank (lease facility)	$10.0	-	$10.0

5.4.12 Pharmaceutical Budget

CM Health is committed to supporting the effective implementation of the three-year Community Pharmacy Services Agreement (1 July 2012 to 30 June 2015).

There were significant changes included in this Agreement that came into effect from 1 July 2012. Changes included: incentivising pharmacists to better use their clinical medicines management expertise; re-orienting community pharmacy services around the patient and facilitating increased integration with prescribers across all settings, in particular with Primary care; and linking funding to patient outcomes.

5.4.13 Property, Plant and Equipment

We revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. CM Health land and buildings are revalued every three years. The last revaluation occurred in 2010 on an "Optimised Depreciated Replacement Costs" basis.

There are currently no specifically identified asset sales within the time period of this Annual Plan. As part of the long term 10 Year System Integration Strategic Investment programme, we will be identifying any potential surplus assets that may be disposed of to assist in funding future developments.

There is recognition of the rising burden of clinical equipment replacement and this has accelerated CM Health's commitment to an enterprise Asset Management System; with roll out scheduled for 2013/14 (refer 2.2 for more detail).

5.5 Additional Information and Explanations

5.5.1 Disposal of Land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, CM Health will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. CM Health 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 Maaori sites of significance.

5.6 Significant Accounting Policies

5.6.1 Subsidiaries

Subsidiaries are entities controlled by the Group. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

5.6.2 Loss of control

On the loss of control, the Group derecognises the assets and liabilities of the subsidiary, any non-controlling interests and the other components of equity related to the subsidiary. Any surplus or deficit arising on the loss of control is recognised in profit or loss. If the Group retains any interest in the previous subsidiary, then such interest is measured at fair value at the date that control is lost. Subsequently it is accounted for as an equity-accounted investee or as an available-for-sale financial asset depending on the level of influence retained.

5.6.3 Investments in associates and jointly controlled entities (equity accounted investees)

Associates are those entities in which the Group has significant influence, but not control, over the financial and operating policies. Significant influence is presumed to exist when the Group holds between 20 percent and 50 percent of the voting power of another entity. Joint ventures are those entities over whose activities the Group has joint control, established by contractual agreement and requiring unanimous consent for strategic financial and operating decisions.

5.6.4 Jointly controlled operations

A jointly controlled operation is a joint venture carried on by each venturer using its own assets in pursuit of the joint operations. The consolidated financial statements include the assets that the Group controls and the liabilities that it incurs in the course of pursuing the joint operation and the expenses that the Group incurs and its share of the income that it earns from the joint operation.

5.6.5 Transactions eliminated on consolidation

Intra-group balances and transactions, and any unrealised income and expenses arising from intra-group transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with equity accounted investees are eliminated against the investment to the extent of the Group's interest in the investee.3 Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

5.6.6 Revenue

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

Crown funding
Funding is provided by the MoH through 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 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

Revenue from services rendered is recognised in profit or loss in proportion to the stage of completion of the transaction at the reporting date. The stage of completion is assessed by reference to surveys of work performed.

5.6.7 Interest income

Interest income is recognised using the effective interest method.

5.6.8 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).

5.6.9 Capital charge

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

5.6.10 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.

5.6.11 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 that 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 straight-line 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.

5.6.12 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 as borrowings in current liabilities in the statement of financial position.

5.6.13 Debtors and other receivables

Debtors and other receivables are recorded at their face value, less 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).

5.6.14 Investments

Bank deposits
Investments in bank deposits are initially measured at fair value.

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.

5.6.15 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 lower of cost or 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.

5.6.16 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.

5.6.17 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.

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.

5.6.18 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%)

5.6.19 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.

5.6.20 Creditors and other payables

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

5.6.21 Borrowings

Borrowings are initially recognised at their fair value. 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.

5.6.22 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.

5.6.23 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.

5.6.24 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.

5.6.25 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.

5.6.26 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 GST (net) component of cash flows from operating activities reflects the net GST paid to and received from the IRD. The GST (net)

component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes and to be consistent with the presentation basis of the other primary financial statements.

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.

5.6.27 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.

5.6.28 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
CM Health has arrived at the net cost of service for each significant activity using the cost allocation system outlined below uses the following.

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.

5.6.29 Use of estimates and judgements

The preparation of the financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of accounting policies and the reported amounts of assets, liabilities, income and expenses. Actual results may differ from these estimates.

Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimates are revised and in any future periods affected.

Information about critical judgements in applying accounting policies that have the most significant effect on the amounts recognised in the financial statements is included in the following notes:

- Note 9 – business combinations, acquisition of subsidiary
- Note 10 – commission revenue, determination of whether the Group acts as an agent in the transaction rather than as the principal

- Note 19 – classification of investment property
- Note 28 – accounting for an arrangement containing a lease
- Note 35 – lease classification

Information about assumptions and estimation uncertainties that have a significant risk of resulting in a material adjustment within the next financial year are included in the following notes:

- Note 17 – key assumptions used in discounted cash flow projections
- Note 17 – measurement of defined benefit obligations
- Notes 32 and 37 – provisions and contingencies

5.6.30 Property, plant and equipment

Recognition and measurement

Items of plant and equipment are measured at cost less accumulated depreciation and accumulated impairment losses.

Land and buildings are measured at fair value, less accumulated depreciation on buildings and accumulated impairment losses recognised after the date of the revaluation. Valuations are performed with sufficient frequency to ensure that the fair value of a revalued asset does not differ materially from its carrying amount.

Cost includes expenditure that is directly attributable to the acquisition of the asset. The cost of self-constructed assets includes the following:

- The cost of materials and direct labour
- Any other costs directly attributable to bringing the assets to a working condition for their intended use
- When the group has an obligation to remove the asset or restore the site, an estimate of the costs of dismantling and removing the items and restoring the site on which they are located
- Capitalised borrowing costs

Cost also includes transfers from equity of any gain or loss on qualifying cash flow hedges of foreign currency purchases of property, plant and equipment. Purchased software that is integral to the functionality of the related equipment is capitalised as part of that equipment.

When parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

Any gain or loss on disposal of an item of property, plant and equipment (calculated as the difference between the net proceeds from disposal and the carrying amount of the item) is recognised in profit or loss.

5.6.31 Reclassification to investment property

When the use of a property changes from owner-occupied to investment property, the property is remeasured to fair value and reclassified as investment property. Any gain arising on re-measurement is recognised in profit or loss to the extent that it reverses a previous impairment loss on the specific property, with any remaining gain recognised in other comprehensive income and presented in the revaluation reserve in equity. Any loss is recognised immediately in profit or loss.

5.6.32 Subsequent costs

Subsequent expenditure is capitalised only when it is probable that the future economic benefits associated with the expenditure will flow to the Group. Ongoing repairs and maintenance is expensed as incurred.

5.6.33 Depreciation

For plant and equipment, depreciation is based on the cost of an asset less its residual value,

CM Health has adopted the following revisions to accounting standards during the financial year, which have had only a presentational or disclosure effect:

- Amendments to NZ IAS 1 Presentation of Financial Statements. The amendments introduce a requirement to present, either in the statement of changes in equity or the notes, for each component of equity, an analysis of other comprehensive income by item. The DHB has decided to present this analysis in note 19
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – The purpose of the new standard and amendments is to harmonise Australian and New Zealand accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The main effect of the amendments on the DHB is that certain information about property valuations is no longer required to be disclosed. Note 13 has been updated for these changes.

Standards, amendments, and interpretations issued that are not yet effective and have not been early Adopted Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the DHB, are:

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1: Classification and Measurement, Phase 2: Impairment Methodology, and Phase 3: Hedge Accounting. Phase 1: Has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

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