# Counties Manukau District Health Board

# 2008/09 District Annual Plan

**June 2008**

COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership

## VISION AND VALUES

### COUNTIES MANUKAU DHBS SHARED VISION IS:

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

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

### VALUES

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

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## SIGNATORIES – MINISTER/CHAIR

District Annual Plan Dated This Day Of 2008

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

ISSUED BY
Counties Manukau DHB

Signed by _____ _____
Chair of Counties Manukau DHB CE of Counties Manukau DHB

CONSENT GIVEN BY

The Minister of Health _____
Hon David Cunliffe

# Part I INTRODUCTION

## 1.0 STATEMENT FROM THE CHAIR AND CHIEF EXECUTIVE

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

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

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

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

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

More immediate is the need to respond to the impact of increasing volumes on our emergency department, the largest in Australasia, and our maternity services where we deliver more babies than any other health care provider in Australasia. During 2007/08, we implemented changes to the models of care and internal processes within Emergency Care which has seen a significant improvement in our ability to meet patient demands including

the triage goals for patients presenting. We have also reviewed maternity services to identify opportunities to better utilise the resources available and better meet the needs of the women and babies accessing these services. These two services will continue to require focus during 2008/09.

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

# 2.0 ENVIRONMENT

Counties Manukau District Health Board (CMDHB) was established on 1 January 2001 under the provisions of the New Zealand Public Health & Disability Act 2000 (NZPH&D Act). The DHB is responsible for the funding of services and for the provision of hospital and related services for the people of Counties Manukau as set out in the DHB functions and objectives in the NZPH&D Act.

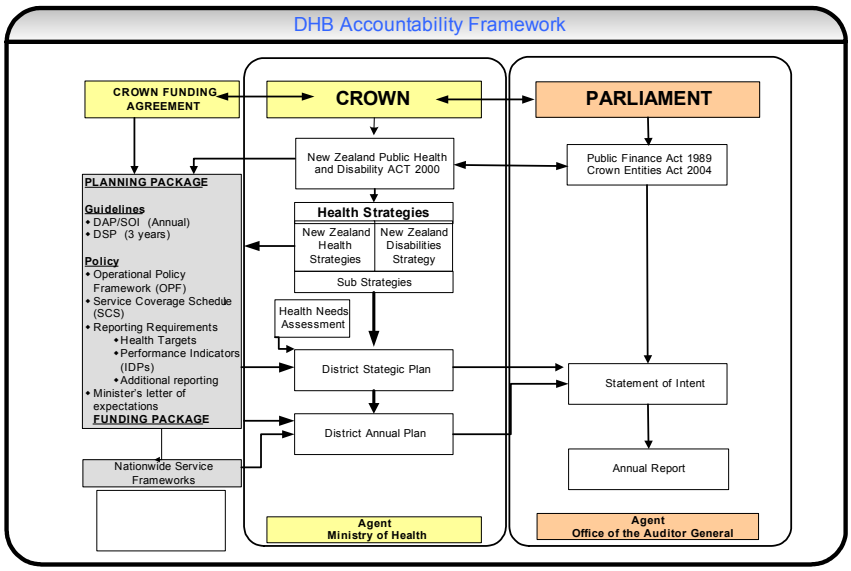
## 2.1 Accountability Framework

DHBs operate in an environment governed by legislation which is brought together in the DHB accountability framework (refer Fig 1), a comprehensive framework linking:

- legislative requirements – NZPH&D Act, Crown Entities Act, Public Finance Act
- national strategies – New Zealand Health Strategy, New Zealand Disability Strategy
- the planning package – planning guidelines, operational policy framework, service coverage schedule, reporting requirements
- nationwide service frameworks – a collection of definitions, methodologies and processes that provide for a consistent sector approach to funding, monitoring and analysing services
- DHB planning requirements – District Strategic Plan, District Annual Plan, Statement of Intent, Annual Report.

The DHB accountability framework describes how the New Zealand Health and Disability strategies, together, set the overarching guide for planning, developing and funding health and disability services in New Zealand. It is these overarching strategies, along with the local population's health and disability needs, identified through health needs assessments and DHBs prioritisation processes, which inform the development of the DHBs District Strategic Plan. The prioritisation process occurs within the planning framework at both the strategic level as well as the operational based on the DHBs specific approach to meeting Service Coverage, Health Targets, Indicators of DHB Performance and the Minister's annual priorities. The framework also shows the important link with the Crown Entities Act and Public Finance Act and key DHB planning and reporting documents. Copies of the documents referred to in the accountability framework for the current financial year are available from the Nationwide Service Framework Library http://www.nsfl.health.govt.nz/.

*Figure 1: Accountability Framework, Source Ministry of Health*



## 2.2 District Health Board Roles

The DHB has three key output areas or roles: governance and funding administration, planning and funding, and provision of health and disability services.

**Governance**

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

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

The elections for the current DHB Board members took place on 13 October 2007. Each DHB has seven members elected for a 3 year term. For CMDHB the elected Board members (until November 2010 and the next election) are:

- Arthur Anae
- Don Barker
- Colleen Brown
- Anne Candy
- Paul Cressey
- Bob Wichman
- Michael Williams.

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

- Gregor Coster (chair)
- Lope Ginnen
- Ruth de Souza
- Miria Andrews.

**Planning and funding**

Since 2001/02, funding responsibility has been progressively devolved to CMDHB for health and disability support services. These services include personal health (ie primary, secondary and tertiary care services, Maaori health, Pacific health, primary referred services and oral health), mental health, and services for older people, and DHB provided primary maternity services. The Ministry of Health retains funding responsibility for the remaining health and disability services including the balance of the primary maternity services, disability services for those under 65 years of age, (except for those clinically assessed by CMDHB geriatricians as close in age and interest), public health and national personal health contracts.

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

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

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

**Provision of health and disability services**

Through its provider arm CMDHB provides a wide but not complete range of specialist secondary services, a selected range of community services, as well as a number of niche specialist tertiary services. These specialist services include:
- Bone tumour surgery
- Plastic, reconstructive and maxillo-facial surgery
- National Burns service
- Spinal cord injury rehabilitation
- Renal dialysis
- Neo-natal intensive care
- Breast reconstruction surgery.

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

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

## 2.3 Alignment with National and Regional Priorities

The priorities identified by CMDHB in its District Strategic Plan and District Annual Plans are aligned with both national and regional priorities.

### 2.3.1 National Priorities

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

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

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

These priorities incorporate the National Health Targets which were established in 2007/08 to help focus the sector's activities. Detail of these is included Part II.

### 2.3.2 Regional Priorities and Work Programme

Since 2001, the northern region DHBs have made considerable progress on regional collaboration activities and achievement of objectives; particularly in the areas of service planning, funding and capital planning. Progress has also been made in other key areas of activity around productivity and efficiency, and regional information services planning and implementation.

Much of the regional activity is undertaken by formally established regional groups (Regional CEO Forum, Regional Funding Forum, Regional Services Planning and the Regional Capital Group) as well as through entities such as the Northern DHB Support Agency (NDSA). These groups were established in response to a need for regional collaboration and discussion in relation to particular subject areas. Accountability for regional activity rests collectively with the Chief Executives of the northern region DHBs.

The northern region DHBs are committed to continuing to consolidate and improve on the regional collaboration framework, noting:

- That there is an increasing appetite for regional collaboration and a proliferation of regional activity
- The changing demands on, and evolving requirements of existing forums
- An increasing demand on CEOs for collective decision making at all levels of regional activity.

As a region we wish to achieve the following:

- Greater regional collaboration and a more planned approach with regards to service networks and planning
- Improved control of the northern region's destiny within the national context, ie ensuring adequate regional capability rather than reliance on national capability
- Continued improvement with regards to efficiency gains already achieved
- A sustainable support structure which is resilient and able to respond to potential changes in national frameworks and governance.

Work is underway to progress activity to achieve these goals and is incorporated in the following priorities and work programmes:

- Regional Chairs/CEOs group work programme, incorporating major projects, approved prior to the start of the financial year, eg the long term purchasing plan for community laboratory services
- By December 2008 the Regional Service Planning work plan will be reviewed
- By February 2009 the Regional Service Planning 2009 work plan will be approved by the Regional CEO Forum
- The agreed Auckland Regional Resident Officers Service (ARRMOS) business plan will be implemented. CMDHB will actively work to enhance RMO workforce development and the maximisation of efficiencies by supporting the implementation of this plan

- For the ongoing employee relations activity, regional collaboration will be critical in order to maintain one voice in relation to MECA settlements etc
- The Auckland region shared candidate data base will be utilised more effectively based on improved regional recruitment activity. Joint planning and implementation of international recruiting strategies will be a focus.

Most of the regional activity aligns with Outcome 5 (Increase access to services so they align with national levels) and Outcome 6 (Ensure the efficient use of resources).

## 2.4 Counties Manukau population profile and health needs

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

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

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

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

## 2.5 Key issues and risks

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

To mitigate this the DHB has a number of strategies:

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

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

Specific financial risks are described in Part III.

# 3.0 TE TIRITI O WAITANGI TREATY OF WAITANGI

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

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

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

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

process, to the point where POU are ceded full authority to implement those actions to implement the Whaanau Ora Plan (Maaori Health plan).

CMDHB has undertaken to express its commitment to Te Tiriti o Waitangi through the establishment of a number of key initiatives. They include:

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

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

***Whaanau Ora – Maaori Ora***
*Kia whai kaha, whai mana painga, ki ngaa kawenga orange Iwi, ki tua o Rangi*

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

It identifies six key priorities. They are:

- Addressing the lifestyle risk factors associated with obesity, smoking and alcohol and other drug misuse
- Dealing specifically with the chronic conditions of Diabetes and Cardiovascular disease
- Improving the health of Tamariki (child) and Rangatahi (youth)
- Improving health and disability services provided to Kuia (elder female) and Kaumaatua (elder male)
- Meeting the needs of Maaori who engage in Mental Health services
- Developing appropriate infrastructure to support the provision of services to Maaori in the right place, at the right time, with the right resources and right attitude.

## 4.0 STRATEGIC DIRECTION

Supporting the aspirations of the DHBs Vision statement, CMDHBs strategic direction focuses on 6 long term outcomes (refer table 1 and the District Strategic Plan 2006-11). The overarching direction is towards community wellbeing and preventative strategies while maintaining and improving the quality of existing health services. These outcomes have been determined based on the community's health needs while considering national health priorities and the need to remain a sustainable organisation.

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

This District Annual Plan is structured around the 6 outcome areas, with specific objectives, outputs and performance measures identified for each outcome. The DHBs strategic

direction is aligned with national priorities, including the national health targets, and these are incorporated throughout the District Annual Plan.

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

**Table 1: District Strategic Plan Outcome Areas**

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

# Part II 2008/09 ACTIONS TO ACHIEVE THE DHBS LONG TERM OUTCOMES

## 1.0 SUMMARY OF CMDHBS OBJECTIVES & MEASURES FOR 2008/09

### Outcome 1 - Improve Community Wellbeing

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

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

Within CMDHB, any planning and initiatives funded by the national *Healthy Eating Healthy Action* programme are managed under the overarching LBD framework, with its existing collaborative infrastructure and programme that places primary emphasis on improving nutrition and physical activity. The *Healthy Eating Healthy Action* Ministry Approved Plan (HEHA MAP) developed by CMDHB provides more detail as to the specific HEHA-related initiatives underway across Counties Manukau. As this HEHA-funded activity forms an integral part of the overarching LBD workplan, for the purposes of this document, HEHA objectives and activity are included within the LBD sections.

#### Key Objectives and Milestones

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **Achieve the outcomes of the Let's Beat** | Support community leadership and action | • Maaori and Pacific nutrition and physical activity workforce development initiatives scoped and | 30 Jun 09 | Funder (LBD) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **Diabetes Plan (and related HEHA Ministry Approved Plan)** | | implemented at the community level | | |
| | | • Specific South Asian initiatives targeting improved nutrition and/or physical activity developed and implemented | 30 Jun 09 | Funder (LBD) |
| | | • LBD Community Action Fund to be promoted and allocated | 30 Jun 09 | Funder (LBD) |
| | Develop and implement an Obesity Action Plan for the Pacific population | • Range of interventions scoped for obese Pacific population at high risk of chronic disease<br>• HEHA nutrition and activity Pacific community action implemented | 31 Dec 08<br>30 Jun 09 | Funder (Pacific Health) |
| | Develop the Bariatric surgery service | • Services for the provision of Bariatric Surgery at Manukau and Middlemore developed<br>• Provision for Plastic Surgery post bariatric surgery developed | 31 Dec 08<br>31 Dec 08 | Provider (Surgical & Ambulatory Care) |
| | Promote behaviour change through social marketing | • The next phases of SWAP2Win social marketing campaign to be planned, implemented and reviewed | 30 Jun 09 | Funder (LBD) |
| | Support a healthy environment through a Food Industry Accord | • Initiatives that support and promote the reduction of sugar, fat, salt or portion size and/or increase fruit and/or vegetable consumption are implemented by significant food industry members | 30 Jun 09 | Funder (LBD) |
| **Increase levels of physical activity** | Change urban design to support healthy active lifestyles | • Health promoting transportation initiatives to be investigated and implemented | 30 Jun 09 | Funder (LBD) |
| | Strengthen health promotion co-ordination and activity | • The joint Active Communities project (CM Active) is implemented across Counties Manukau | 30 Jun 09 | Funder (LBD) |
| | Support the development of a holistic Marae-based health model, based on physical activity and nutritional health gain | • Marae based Whare Oranga sites contracted and service provision commenced<br>• Marae programmes commenced | 1 Jul 08<br>30 Mar 09 | Funder (Maaori Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | • Service developed and rolled out | 30 Jun 09 | |
| **Increase healthy school environments** | Align the implementation of national strategies, programmes and priorities such as Healthy Eating Healthy Action, Mission On, Fruit in Schools, breakfast clubs and Smokefree with the local initiatives of the Let's Beat Diabetes (LBD) project and existing Health Promoting School (HPS) programmes and initiatives | • Fruit in schools initiative within the Tipu Ka Rea model implemented for HPS in 40 Schools<br>• In conjunction with LBD school support infrastructure, partnerships are established with community agencies for health promotion eg National Heart Foundation, and Counties Manukau Sport<br>• Health promoter working with Kura Kaupapa, Kohanga Reo and immersion unit, parents and young people to support smokefree<br>• Evaluation for the Tipu Ka Rea model for HPS completed in partnership with Manukau Institute of Technology | 30 Jun 09<br>31 Dec 08<br>31 Dec 08<br>31 Dec 08 | Provider (Kidz First) |
| | Develop a Schools Accord to ensure children are "active, healthy and ready to learn" | • Promotion and practical assistance provided to Schools and Early Childhood Education Centres to implement the Food and Beverage Classification system. | 30 Jun 09 | Funder (LBD) |
| | Increase the number of secondary schools involved in comprehensive school based health services delivery | • The number of schools delivering school-based health services increased to 11 | 30 Jun 09 | Funder (Youth health) |
| **Increase smokefree environments** | Reduce smoking in Counties Manukau, particularly amongst Maaori and Pacific people, and families with children | • CMDHB Tobacco Control Strategy and Implementation Plan completed<br>• Tobacco Control Strategy implemented | 1 Jul 08<br>30 Jun 09 | Funder (Pacific Health) |
| | Decrease smoking by teenagers in Counties Manukau | • Cessation services for Pacific youth developed as part of the youth health initiative<br>• Smoking cessation programmes for high schools scoped through the AimHi project<br>• Youth development programme contracted to support youth-led Auahi Kore mahi | 30 Jun 09<br>30 Sep 09<br>31 Dec 08 | Funder (Pacific Health)<br>Funder (Youth Health)<br>Funder (Maaori Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | | | |
| **Develop healthy communities by working intersectorally** | Establish Police Watch House Project (using funding from NZ Police) | • Service established | 1 Nov 08 | Provider (Mental Health) |
| | Continuation of the Healthy Housing programme in Counties Manukau in partnership with Housing New Zealand | • 450 joint Health and Housing assessments completed | 30 Jun 09 | Funder (Intersectoral) |
| | Determine the potential for a 'Healthy Homes' programme in Counties Manukau and work with the other DHBs in the metro-Auckland region, EECA (Energy-wise home grant scheme), and the ASB Trust | • Complete scoping of potential 'Healthy Homes' programme in Counties Manukau targeting homes of low income families that were constructed prior to 1978 | 30 Jun 09 | Funder (Intersectoral) |
| | Work in partnership with local councils, HNZC and developers to ensure there is appropriate supported housing for older people in Counties Manukau | • Work in collaboration with MCC and HNZC to refurbish MCC pensioner housing stock<br>• Potential redevelopment of two existing complexes scoped<br>• A cooperative model of supported housing for older adults in Counties Manukau developed | 30 Jun 09 – ongoing<br>30 Jun 09<br>30 Jun 09 | Funder (Intersectoral/ARHOP) |
| | Improving the health, social and housing outcomes for families residing in the suburb of Wiri | • 'Lifting the Game in Counties Manukau' - an intersectoral initiative to address the needs of Wiri residents - is scoped and developed in collaboration with MCC, HNZC, MSD and NGOs | 30 Jun 09 | Funder (Intersectoral) |
| | Maintain the PATHS programme in partnership with the Ministry of Social Development and Work and Income to improve employment opportunities for people on Invalid or Sickness benefits | • 220 people enrolled onto the PATHS programme<br>• Implementation of broader health initiatives for Invalid and Sickness beneficiaries scoped | 30 Jun 09 | Funder (Intersectoral) |
| | Support Tomorrow's Manukau Family Violence Project to develop an intersectoral family violence and abuse workplan for Counties Manukau | • Plan developed and implementation of recommendations commenced<br>• Health plan developed encompassing Family Violence, Sexual Assault of children and young people, sexual abuse and Elder Abuse | 30 Jun 09 | Funder (Intersectoral) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | • Health will support the development of a Multi-Agency Centre in Counties Manukau | | |
| | Develop Family Violence Prevention (FVP) role and FVP initiatives to improve identification and access to assault services within health services | • Evaluation of current service and gaps and the funding proposal for FVP service expansion developed.<br>• FVP screening is implemented within provider arm services | 30 Jun 09<br>30 Jun 09 | Funder (Youth Health) |
| | Address the incidence of child abuse and the impact of violence on children and young people for families presenting at health services | • Scoping completed of profile and needs for more active support around frequent re-presenters<br>• A health plan for addressing child abuse implemented<br>• Developments from the Youth Outcomes Intersectoral Project supported | 30 Jun 09 | Funder (Intersectoral)<br>Funder (Youth Health) |
| **Improve access to information to enable people to make informed choices** | Maintain CMDHB service directory and enhance usefulness of Webhealth site content | • Provider selected for service directory maintenance and the service is established<br>• First draft service directory compiled | 1 Nov 08<br>30 Jun 09 | Funder (Mental Health) |
| | Improve medication knowledge and patient compliance | • Referral and medication management system for "at risk" patients returning to the community implemented with CMDHB contracted retail pharmacists<br>• 250 care plans/referrals completed | 31 Dec 08<br>30 Jun 09 | Funder (Pharmacy) & Provider (Medicine) |
| | Improve quality and access of personal health information regarding self management for people with chronic conditions | • Report with recommendations for resource development and/or integration completed following stock take of current resources and needs assessment including patients and practice staff. | 30 Jun 09 | Funder (Primary Care) |

## National Health Targets

**Improving nutrition, increase physical activity**

The DHBs commitment to Let's Beat Diabetes is the key activity being undertaken to contribute to the achievement of this health target. Let's Beat Diabetes also provides the local framework for implementation of HEHA in Counties Manukau. The approach being taken by Let's Beat Diabetes is that well constructed strategies across the life course work in synergy. For example a person who is obese may be better at making the changes to their nutrition and activity levels with a supportive church environment, supportive social marketing, healthy eating being promoted in the school environment, an appropriately trained nutrition and physical activity workforce, community led physical activity and nutrition initiatives, healthier food options available in their locality, an urban design that is conducive to physical activity, and a practice team that is proactive and motivational.

The University of Auckland's School of Population Health (SOPH) is contracted to work with Let's Beat Diabetes. SOPH have implemented a framework that allows an independent assessment of the progress of LBD, and provides opportunities for continuous learning and quality improvement throughout the duration of the plan. It also recognises Maaori and Pacific peoples in Counties Manukau as priority population groups and incorporates practices and measures that are culturally appropriate and meaningful to these groups and the wider community. These cultural considerations will be maintained throughout the evaluation process, adapted when/as required, and/or if other ethnic groups become priorities.

Let's Beat Diabetes covers both the prevention of diabetes and the care of individuals that do have the disease. The budget for the component of the programme which works to improve nutrition and increase physical activity will be approximately $2m for 2008/09.

| Health Target | 2008/09 Target | Responsibility |
|---|---|---|
| DHB activity supports achievement of these health sector targets:<br>• Proportion (percent) of infants exclusively and fully breastfed:<br>  • 74% at six weeks; 57% at three months; 27% at six months.<br>• Proportion (percent) of adults (15+ years) consuming at least three servings vegetables per day, and proportion (percent) of adults (15+ years) consuming at least two servings fruit per day:<br>  • 70% for vegetable consumption; 62% for fruit consumption | CMDHB is committed to improving nutrition, increasing physical activity and reducing obesity. Specific objectives for 2008/09 are included in Part II Outcome 1 Improve community wellbeing and Outcome 2 Improve child & youth health. | Funder (Let's Beat Diabetes) |

**Reduce the harm caused by tobacco use**

CMDHB will be completing development of the Tobacco Control Strategy and associated implementation plan in July 2008. Subject to Ministry confirmation of funding, strategies to reduce the use of tobacco in Counties Manukau, particularly initiatives targeted at Maaori and Pacific people, will be implemented. These include resource support for cessation services in maternity, outpatient services, mental health services and providers with high Maaori and Pacific enrolled populations. Maaori specific initiatives are also being planned, and in particular engaging maraes to be smokefree. Young people will also be targeted for cessation programmes through the AimHi project and youth development programmes/services for both Maaori and Pacific youth.

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

## Indicators of DHB Performance

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| **Outcome 1: Improving Community Wellbeing** | | | | | |
| **Develop healthy communities by working intersectorally** | Progress towards taking a systematic approach towards the identification and intervention of child and partner abuse<br>Audit score from the AUT hospital responsiveness to family violence, child and partner abuse audit. | New indicator for 2008/09<br>Baseline audit score as at 16/10/06 was 70/100<br>Audit does not include child abuse for CMDHB as this is managed under another contract | Audit score target for 2008/09 is a minimum of 75/100 | IDP - POP-11 | Funder (ARHOP) |

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| **Increase smokefree environments** | Numerator: The number of enrolled persons >14 years with smoking status on record<br>Denominator:<br>The total number of enrolled persons >14 years. | CMDHB has had a process in place since 2002/03 where we have agreed with PHOs that they should report on this indicator. We have only four of our seven PHOs who do so, on a regular basis. Discussions continue with the other PHOs re their readiness to report on this indicator and in particular as a requirement to measure cardiovascular risk.<br><br>Progress with PHOs reporting this data has not been as rapid as expected despite repeated attempts. To assist with achieving this reporting requirement it is suggested that a change is negotiated in the PHO contract nationally. Agreement on reporting and targets for PHO Performance Management has been delayed pending agreement on governance arrangements. However, work is being considered at a national level to automate this reporting and then it will be DHBs' role to work with PHOs and their providers to improve data entry and recording. | 30% increase for those PHOs who are regularly reporting and are currently recording smoking status for less than 40% of their enrolled population<br>10% increase for those PHOs who are regularly reporting and are currently recording between 41% & 75%, and a 5% increase for those over 75%<br><br>For the remaining PHOs who are not regularly reporting, targets to be agreed as part of the PHO Performance Management implementation | IDP – POP-01 | Funder (Primary Care) |

# Outcome 2 - Improve child and youth health

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

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

## Key Objectives and Milestones

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **Improve maternal wellbeing** | Maintain and increase the number of general practitioners (GP) providing antenatal services (primary maternity services) | • Clinical guidelines for maternity antenatal shared care developed and implemented<br>• Shared electronic information systems implemented between GPs and Women's Health services | 30 Jun 09<br>30 Sep 08 | Provider (Women's Health) & Funder (Maaori Health) |
| | Implement antenatal HIV screening for all pregnant women | • Begin regional plan implementation by local providers | 01 Jul 08 | Provider (Women's Health) |
| | Review of the models of care for maternity services provided to young women (13-19 years of age) | • Model of care for teen pregnancy including maternity services provided at the teen parent units reviewed<br>• Recommendations developed and implemented for the best use of the scarce midwifery workforce available to this priority group | 30 Sep 08<br>31 Nov 08 | Provider (Women's Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | • Implementation evaluated | 31 May 09 | |
| | Establish Maternal Mental Health Respite Services | • Maternal Mental Health Respite Service Provider to be selected and services established | 1 Dec 08 | Funder (Mental Health) |
| | Establish and promote research to inform service development in Pacific women's health | • Methodology to be developed and research conducted on postnatal depression in Pacific Women | 30 Jun 09 | Funder (Pacific Health) |
| | Improve Pacific women's health through increased access to screening and well women programmes | • Increased number of Pacific women participating in LotuMoui churches and community groups Breast Screening awareness and education workshops<br>• All LotuMoui churches to be participants in cervical awareness and education workshops | 31 Dec 08<br>30 Jun 09 | Funder (Pacific Health) |
| | Ensure expectant Maaori mothers receive the best quality and culturally responsive care | • Gaps within the pathway of care identified<br>• Actions identified to deal with service delivery gaps implemented | 31 Dec 08<br>30 Jun 09 | Funder (Maaori Health) |
| **Improve health outcomes for infants and preschool children** | Reduce re-admissions of high risk Maaori newborns | • Improved provision of information and referral access to community health services; and delivery of clinical information for patients and their Whaanau | 30 Jun 09 | Funder (Maaori Health) |
| | Improve breastfeeding rates for fully breast fed at 6 months | • First stage of the CMDHB Community breast feeding plan implemented | 30 Jun 09 | Funder (Personal Health) |
| | Improve breastfeeding data collection within CMDHB and develop clear and meaningful reporting requirements | • Recommendations implemented following the evaluation of systems and processes to identify baseline data and gaps in data collection mechanisms to enable target setting | 30 Jun 09 | Funder (Personal Health) |
| | Improve early detection and reduce hearing loss in children | • Implementation requirements for the national newborn hearing screening programme scoped<br>• Implementation of the service in accordance with the regional agreement commenced | 31 Mar 09<br>30 Jun 09 | Provider (Kidz First) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | | | |
| | Consolidate and expand B4Baby service to increase access across DHB area | • Sustainable 3 year plan developed for the B4Baby service<br>• Coverage of service to high needs areas extended | 30 Dec 08<br>30 Jun 09 | Funder ( Maaori Health) |
| | Review the current outreach immunisation strategies and scope additional services to reach Maaori and Pacific children <5 years of age | • Models of outreach service delivery reviewed<br>• Recommendations developed for new models or changes/enhancement to current models | 30 Jun 08 | Funder (Maaori Health/Pacific Health) |
| | Improve immunisation coverage through further development of opportunistic vaccination programmes | • Pilot of the current opportunistic vaccination programme in outpatient services reviewed<br>• Opportunistic vaccination opportunities for in-patient services reviewed<br>• Recommendations for future programmes and staffing requirements developed | 30 Sep 08<br>30 Dec 08<br>30 Jun 09 | Funder (Maaori Health/Pacific Health) |
| | Increase involvement in the research of prevention and treatment of respiratory disease in children | • Findings from lower respiratory infection retrospective and prospective epidemiology studies undertaken in 2007/08 year published<br>• Early intervention study of young infants with severe lower respiratory infection to be implemented if HRC funding application successful | 30 Dec 08<br>30 Sep 08 | Provider (Kidz First) |
| | To improve access to Paediatric dermatology services for Maaori and Pacific children | • Review options and models of care for multidisciplinary paediatric dermatology clinics in Kidz First Outpatient Care<br>• Develop evidence based GP referral guidelines for eczema inclusive of Health Point electronic access | 30 Jun 08<br>31 Dec 08 | Provider (Kidz First and Adult Dermatology) |
| | Improve access to health services for Maaori and Pacific children with bronchiectasis | • Develop a community support worker role for both Maaori and Pacific children with bronchiectasis | 30 Jun 09 | Provider (Kidz First) Subject to CMDHB |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | who have frequent admissions or outpatient visits to either Starship or Kidz First | | funding |
| | Establish Maaori infant mental health service | • 2 FTEs to be recruited to deliver Infant Mental Health within He Kakano Maaori Child and Youth Clinical Service | 1 Nov 08 | Provider (Mental Health) |
| | Implement preschool oral health model and the Child and Adolescent Oral Health Business Plan | • Protocols agreed and in place with Well Child Providers and Community Dental Services<br>• Consultation and local OH plans for Papatoetoe, Manukau-Manurewa and Papakura areas completed | 31 Dec 08<br>31 May 09 | Funder (Oral Health) |
| | Improve oral health outcomes for Maaori and Pacific children and adolescents | • Recommendations from Ministry Pacific Oral Health Project implemented following Ministry approval and Ministry funding support<br>• Ensure the development of oral health facilities that provide a culturally safe environment. | 30 Jun 09 | Funder (Oral Health/Pacific Health/Maaori Health) |
| | Identify health issues for children prior to school entry and facilitate access to appropriate services | • B4 School Checks rollout plan prepared<br>• First checks offered to initial targeted group (to be agreed with Ministry) | Roll out will commence from 1 Aug 08 | TBC (depending on service delivery model chosen) |
| | Develop a realistic work programme for Middlemore Hospital base maternity services to achieve Baby Friendly Hospital Accreditation (BFHI) | • Training requirements required to achieving BFHI scoped<br>• Training packages are developed that recognise the ongoing workforce midwifery and junior doctor shortages<br>• A timeline for BFHI assessment is developed | 30 Sep 09 | Provider(Women's Health) |
| **Improve weight management in children and young people** | Develop and implement an obesity management plan for Pacific children and young people. | • Findings of the Kids in Action Programme Evaluation implemented<br>• Implementation plan for obesity management for | 30 Sep 08<br>30 Jun 09 | Funder (Pacific Health)<br>Funder (Pacific |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | Pacific children and young people is scoped and developed<br>• Physical activity and nutrition guidelines implemented for 15 licensed Pacific early childhood education centres in Counties Manukau | 30 Jun 09 | Health/LBD)<br>Funder (Pacific Health) |
| **Improve health outcomes for young people** | Increase Adolescent uptake of free oral health services | • Resources increased by 5 FTE locally to support adolescent dental enrolment and services | 30 Jun 09 | Funder (Personal Health) |
| | Increase the number of young people receiving Year 9 assessments and appropriate follow-up | • 2500 young people assessed and followed up | 30 Jun 09 | Funder (Youth health) |
| | Improved access to primary care services for Pacific young people. | • A peer support service for Pacific young people is developed as part of the youth health initiative | 31 Mar 09 | Funder (Pacific Health) |
| | Increase the number of children and young people accessing child protection and sexual assault services | • Work with ADHB to improve uptake and access<br>• Sexual assault services reviewed and recommendations implemented | 30 Jun 09 | Intersectoral (CMDHB/ADHB) |
| | Identify and expand clinical services for youth in Alternative Education (AE) | • Current model of delivery expanded to more AE settings | 28 Feb 09 | Funder (Youth Health) & Provider (Kidz First) |
| | Implement recommendations from Teen Parenting Evaluation Review to ensure best practice delivery of TPU services | • Gaps identified from the evaluation implemented<br>• All mothers and babies in TPUs will have comprehensive health assessments completed | 31 Dec 08<br>30 Jun 09 | Funder (Maaori Health/Pacific Health/Youth Health) |
| | Increase access of AE young people to High and Complex Needs services | • 60 AE young people's needs reviewed for referral to High and Complex needs services | 30 Jun 09 | Funder (Youth Health) |
| | Improve transitional support for young people from children's services to adult services for those with chronic conditions | • Proposed project on transitioning young people is implemented<br>• Resources and training developed to support adult services in the management of young people with chronic disease | 30 Jun 09 | Funder (Youth Health)/Provider ( Kidz First/Medicine/Surgical & Ambulatory Care)<br>Funder (Youth Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | Enhance clinical services for young people in Youth Justice facility | • Clinical capacity and capability are increased for young people in Youth Justice facility | 30 Jun 09 | Funder (Youth Health) |
| | Increase access to health services for young people involved in gangs and those under 16 who are out of the education system | • Scoping of needs completed for young people involved in gangs and strategy implemented.<br>• Implementation plan to be developed within two local communities to address the needs of young people out of school | 30 Jun 09<br>30 Jun 09 | Funder (Youth Health) |
| | Increasing access to specific health and social services for young people with disabilities | • Scoping of needs completed and strategy implemented | 30 Jun 09 | Funder (Youth Health) |
| | Support initiatives that aim to improve sexual health | • Review sexual health guidelines for primary health care reviewed and primary healthcare training around sexual health expanded<br>• Work with ADHB and NDSA around improving access to regional sexual health services | 30 Jun 09 | Funder (Sexual Health) and Provider (Women's Health) |
| **Decrease the incidence and impact of risk taking actions by young people** | Establish Integrated Transition Age Youth MH/AOD Service | • Additional Funds allocated to Provider Arm<br>• Service design completed with Centre for Youth Health and Youth One Stop Shop | 1 Jul 08<br>1 Dec 08 | Funder ( Mental Health)/Provider (Mental Health) |
| | Expand StandUp! Service and Establish Sector Training | • Expanded service operational<br>• Sector Training Programme operational | 1 Oct 08<br>1 Mar 09 | Funder (Mental Health) |
| | Scope the delivery of youth health and sexual health services to at risk youth | • Feasibility study of current services with Rangatahi scoped and a regular Maaori Youth Forum established<br>• A sexual health service is scoped and implemented for Pacific young people<br>• Primary healthcare training around sexual health and youth health expanded | 30 Jun 09<br>31 Mar 09<br>30 Jun 09 | Funder (Maaori Health)<br>Funder (Pacific Health)<br>Funder (Youth Health) |

## National Health Targets

### Improving immunisation coverage

In addition to general and specific Primary Health Care strategies related to immunisations, we have identified that opportunistic and outreach strategies can be further developed based on earlier experiences during the MeNZB campaign, and during 2007/08 in our opportunistic vaccination pilot programme. Specific actions are included in Outcome 2 above. The budget for immunisation provision and specific immunisation initiatives (ie Kidslink/NIR, outreach, provider liaison services and primary care NIR support services) is approximately $3.7m.

| Health Target | 2008/09 Target | Responsibility |
|---|---|---|
| 95% of two year olds are fully immunised | CMDHB Total 80%<br>Maaori 72%<br>Pacific 77%<br><br>Note: This target is 5% above our 2007/08 target which was set against the 2005 National Immunisation Coverage Survey (NICS) results. To date our results using the NIR reporting have not achieved this level and are tracking approximately 5% behind the survey target. While the DHB is very committed to achieving a coverage rate above 80%, this is going to be very challenging using the NIR reporting and existing processes, systems and resources. | Funder (Well Child) |

### Improving oral health

In Counties Manukau, the Auckland regional Adolescent Oral Health Coordination Service (AOHCS) works with schools, children and their parents, and dental therapists to facilitate the transfer and enrolment of Year 8 children from the school dental service to an adolescent provider. They are also actively engaged with private dental practices in the district, supporting existing adolescent oral health contractors and encouraging new practices to come onboard.

One of the key roles of the AOHCS is to ensure that adolescents and their families are aware of the availability of publicly funded oral health care and how to access services. AOHCS recently introduced a new initiative which allows students to complete the transfer form themselves and return to the AOHCS. This is starting to yield results – CMDHBs transfer rate has gone from 31% in 2006/07 to 76% in 2007/08. A new database has also been set up to record details from transfer forms which will collect information such as ethnicity and the secondary school the child will be attending. This will assist AOHCS and CMDHB with service planning particularly around mobile coverage to schools with low enrolment rates.

In 2008/09, CMDHB will focus on improving the delivery of oral health education and prevention messages to children and their families, based on the premise that, over time, these strategies will bring about better oral health outcomes for children (particularly Maaori and Pacific) from an earlier age and reduce the need for intervention by treatment services.

Current and planned health promotion and education activities which will have an impact on adolescent oral health utilisation in the long term include:

- Working with Auckland Regional Public Health (ADHB), regional health promotion providers, oral health providers, Colgate and New Zealand Dental Association on the coordination and development of health promotion and education resources – both public and educator level resources
- Supporting oral health promotion and education activities provided by primary and community providers (e.g., PHOs).

The 2008/09 budget for adolescent oral health services is approximately $2.9m.

| Health Target | 2008/09 Target | Responsibility |
|---|---|---|
| Progress is made towards 85% adolescent oral health utilisation | The 2008/09 target for CMDHB adolescent utilisation of oral health services is 57% *Note this is dependent on the final results for 2007 which have not yet been received.* | Funder (Oral Health) |

## Indicators of DHB Performance

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| **Outcome 2: Improve child and youth health** | | | | | |
| **Improve health outcomes for infants and pre-school children** | NIR immunisation coverage at 6, 12, and 18 months of age, by:<br>• ethnicity | Coverage baseline at age two years is 68% based on Q2 2007/08 NIR Datamart "previous 12 months" report | The overall target for 2008/09 coverage at age two years is 80% (refer national health target).<br><br>This is calculated according to the Ministry guidelines for target setting for 2008/09.<br><br>Refer to the table at the end of this table for detailed targets.<br><br>Given the NIR issue of extreme slowness and consequent difficulties with producing overdue reports, outreach | IDP – POP-08 | Funder ( Well Child) |

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| | | | referrals, and entering the outcomes of these into NIR, our Datamart reporting is likely to reflect slower progress towards these targets. Should the NIR difficulties and the associated impacts continue into 2008/09, CMDHB would expect to re-negotiate the targets and measure of success. | | |
| **Improve health outcomes for infants and pre-school children** | Oral health – Mean DMFT score at year eight<br>Numerator: The total number of permanent teeth of Year eight children, Decayed, Missing (due to caries) or Filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB SDS.<br>Denominator: The total number of children who have been examined in the Year eight group, in the year to which the reporting relates. | Total - 1.52<br>Maaori - 1.97<br>Pacific - 1.94<br>Other – 1.25<br><br>Source: ARDS | Total - 1.30<br>Maaori – 1.75<br>Pacific - 1.80<br>Other – 1.28<br><br>Note: Other includes European, Asian and other ethnicities | IDP – POP-04 | Funder (Oral Health) |
| **Improve health outcomes for infants and pre-school children** | Oral health - Percentage of children caries free at age five years<br>Numerator: The total number of caries free children at the first examination after the child has turned five years, but before their sixth birthday, examined by the DHB School Dental Service.<br>Denominator: The total number of children who have been examined in the age five group, in the year | Total - 52.24%<br>Maaori - 38.51%<br>Pacific - 34.66%<br>Other - 60.08%<br><br>Source: ARDS | Total - 52%<br>Maaori – 35%<br>Pacific - 35%<br>Other - 65%<br><br>Note: Other includes European, Asian and other ethnicities. | IDP – POP-05 | Funder (Oral Health) |

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| | to which the reporting relates. | | | | |

**POP-08b NIR Immunisation Coverage Targets**

| | CMDHB ALL | Maaori | Pacific |
|---|---|---|---|
| 6 months fully immunised for age | 65 | 50 | 61 |
| 12 months fully immunised for age | 81 | 73 | 81 |
| 18 months fully immunised for age | 68 | 57 | 65 |

## Outcome 3 – Reduce the incidence and impact of priority conditions

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

In addition to the Community Wellbeing initiatives described in Outcome 1, CMDHB continues to work toward the following objectives which are important for reducing the population's reliance on hospital-based care:

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

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

### Key Objectives and Milestones

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **Increase access to structured programmes to reduce the impact of disease for the priority conditions** | Implement recommendations for systems adaptation of CCM as part of phase two of CCM Evaluation | • Recommendations finalised and implementation plan completed and accepted by PHOs<br>• Wider implementation into the sector is phased in | 31 Dec 08<br>31 Mar 09 | Funder (Primary care) |
| | Increase access to all modules of the Chronic Care Management Programme to reduce the impact of chronic disease | • >15,500 patients enrolled in CCM programmes (Diabetes/CVD, COPD, CHF, FAMA, Depression) | 30 Jun 09 | Funder (Primary care) |
| | Increase Maaori and Pacific access to CCM Programmes to reduce the impact of chronic | • Fully implement He Puna Oranga nursing contract & set up framework for evaluation completed and | 30 Jun 09 | Funder (Maaori Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | disease on the populations | senior nursing role established<br>• Work with the Primary Care Team to increase uptake for all CCM modules by Maaori and Pacific<br>• Ensure all PHO with large Maaori and Pacific population have agreed and implemented CCM targets for Maaori and Pacific population uptake | 31 Sep 08<br>31 Mar 09 | Funder (Primary Care) |
| | Scope the development of a Care of the Elderly module for the CCM programme | • Scope completed with recommendations around proceeding | 31 Mar 09 | Funder ( ARHOP/Primary Care) |
| | Continue to roll out the CCM tool for Renal disease | • Pilot roll out completed and evaluated<br>• Tool rolled out across all MedTech GP practices | 30 Jun 08<br>30 Jun 09 | Provider (Medicine) |
| | Rollout the Heart Guide Aotearoa programme (community and home based cardiac rehabilitation programme) based on the outcome of the evaluation | • HGA pilot completed and evaluated<br>• Heart Guide Aotearoa expanded to greater numbers and across PHOs (but still targeting Maaori) dependent on the outcome of the evaluation | 30 Sep 08<br>30 Jun 09 | Funder (Maaori Health/Primary Care) |
| | Increase access to evidence based CVD Risk Management | • >2850 patients who have a CVD Risk >15% have received CVD Management based on the NZ Guidelines | 30 Jun 09 | Funder (Primary Care) |
| | Continue the implementation of the CVD tool into all the Medical Wards (this objective is linked to additional CNS Cardiology) | • Roll out in Ward 2 2007/08 & Stroke Unit completed<br>• Roll out to remaining medical wards completed<br>• Implementation evaluated | 31 Jul 08<br>31 Dec 08<br>30 Jun 09 | Provider (Medicine) |
| **Reduce the incidence and impact of diabetes by implementing the Let's Beat Diabetes Plan** | Improve outcomes for women with gestational diabetes by improving co-ordination of midwifery, obstetric and diabetology services and streamlining gestational diabetes clinic | • Review of the gestational diabetes out patient service completed as part of the LBD programme<br>• Recommendations for new model of care developed and implemented | 1 Jul 08<br>30 Jun 09 | Provider (Women's Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | Expand availability of diabetes self-management education (SME) programme | • Capacity of formal enrolments in diabetes self management programmes increased to enable 650 participants per year<br>• All PHOs to be participating in the Self Management Education Programme<br>• Extension of Diabetes SME to a generic programme suitable for most people with a chronic condition but targeting uptake by Maaori and Pacific people | 30 Jun 09<br>30 Sep 08 | Funder (Primary Care) |
| | Increase access of known diabetics to the Diabetes Get Checked Programme | • >15,000 patients have received a Diabetic Get Checked | 30 Jun 09 | Funder (Primary care) |
| | Build Community Retinal Screening Coverage Capacity | • Increased provider capacity confirmed and sustainable price offered<br>• Clinical FTE increased to support DRSS<br>• Management support for Community Retinal Screening Programme increased | 1 Jul 09<br>30 Sep 08<br>31 Jul 08 | Funder (Personal Health)/Provider (Surgical and Ambulatory Care) |
| **Reduce the incidence and impact of cancer** | Continue implementation of the Cancer Control Strategy across CMDHB | • Implementation of local chemotherapy service at CMDHB<br>• Implementation of the Palliative Care Strategy 2006-2011 | Jun 08 plan in place for next year | Provider (Medicine) & Funder (ARHOP) |
| | Support the ongoing development of the Northern Cancer Network | • Regional cancer control strategy developed<br>• Work streams implemented for Lung Cancer and reducing cancer related inequalities | 30 Jun 09<br>30 Jun 09 | Provider (Medicine) |
| | Improve timely access to colposcopy clinics for women with abnormal cytology | • The role of nursing within the colposcopy service to be reviewed with a view to develop a nurse colposcopy role | 30 Jun 09 | Provider (Women's Health) |
| | Review the recommendations from the | • Report from the Advisory Group reviewed | Jun 08 plan in | Provider (Medicine) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | Colorectal Cancer Screening Advisory Group and identify any gaps in the current service and if required develop a plan to address these | • Analysis of CMDHB service gaps to be completed<br>• Plan developed to address potential gaps<br>• This project will go into 2008/09 – potentially 600 additional colonoscopies pa | place for 2008/09 | |
| | Reduce the impact of cancer on Maaori patients and their Whaanau | • Community services scoped and developed to support Maaori and their whaanau affected by Cancer. | 31 Dec 08 | Funder ( Maaori Health) |
| | Improve coverage and access to palliative care provision | • New Palliative Care service specifications implemented along with new funding methodology<br>• Timeline for increase in hospice inpatient beds agreed<br>• Develop CMDHB palliative care plan for people in aged residential care<br>• Implement "Liverpool Care Pathway" in AT&R – Middlemore, Pukekohe and Franklin campuses | 31 Aug 08<br>31 Dec 08<br>30 Jun 09<br>30 Jun 09 | Funder (Personal Health)<br>Funder (ARHOP) |
| **Improve outcomes for people severely affected by mental illness** | Improve the quality of clinical services through audits of provider arm mental health services against agreed standards by the Partnership in Evaluation towards Recovery (PER) team who all have lived experience of mental illness | • Audits completed<br>• Individual service recommendations implemented | 1 Dec 08<br>1 Jun 09 | Provider (Mental Health) |
| | Improve access to effective services for Maaori who experience both mental health and addiction issues | • Maaori focused coexisting service delivery model developed | 28 Feb 09 | Funder (Maaori health/Mental Health) |
| | Support Whaanau to care for family member(s) with Mental health issues | • Mental Health First Aid programme developed for Counties Manukau<br>• Undertake pilot of the First Aid programme completed and programme evaluated | 30 Jun 09 | Funder (Maaori Health) |
| | Ensure: | • Quarterly audit of 75 files for clients over 2 years | 30 Jun 09 | Provider (Mental |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | • 95% of adult long term clients have up-to-date relapse prevention plans in place<br>• 80% of child long term clients have relapse prevention plans in placed | registered pending implementation of electronic clinical record<br>• At least quarterly feedback to teams to review progress and discuss efficacy of actions to date | | Health) |

## National Health Targets

### Reducing cancer waiting times

The Auckland Regional Cancer Centre based at ADHB provides radiotherapy and chemotherapy services for the Counties Manukau population. Waiting times for radiotherapy and chemotherapy are currently at 6 weeks from FSA to treatment for most patients, with exception reporting in place for patients who fall outside of this target.

Radiotherapy - The ADHB linear accelerator replacement programme continues with the successful replacement of a linear accelerator in 2007/08 (operational from 4th February 2008) and there is a further business case to replace the single energy linear accelerator in 2008/09. This improved technology will have benefits for the workforce and the patients in the speed and efficiency of treatment delivery.

Chemotherapy – The establishment of tumour specific groups together with further workforce development is expected to have a positive impact on the chemotherapy treatment waiting times.

With the implementation of the CMDHB Cancer Control Strategy it is anticipated that there will be improved access to treatments and the treatment pathway for cancer patients from CMDHB to the Regional Cancer Centre at ADHB will become more streamlined. Specific actions are included in Outcome 3 above.

The budget for radiotherapy treatments is approximately $5.3m, and $500,000 for radiation oncology first specialist assessments

| Health Target | 2008/09 Target | Responsibility |
|---|---|---|
| All patients wait less than 6 weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D) | CMDHB will work with the provider DHB towards achieving this target. CMDHB has a very strong relationship with the ADHB provider with regular operational meetings held. Where the target is in danger of not being met, CMDHB will discuss this with the provider as soon as possible with a view to looking at feasible solutions. | Provider arm (Medicine) |

**Improving diabetes services**

CMDHB is very pleased with the case detection rates achieved over the last 12 months especially for Maaori. The overall retinal screening rate for CMDHB is 65.4%, lower than the 68% target but an improvement of 1000 people on last year. The rates for Maaori are highest at 67.7 – the only group to meet the target.

Case management rates are of concern although they do reflect the high level of acuity within Counties Manukau eg 8053 (nearly 60%) are enrolled in CCM Diabetes which is skewing the results. CMDHB is working on a number of strategies to reach the targets including:

- launching a Get Checked communication campaign to encourage more people to enrol in the programme. This is likely to result in more people with better managed diabetes being enrolled;
- aligning Get Checked with our Let's Beat Diabetes activities (especially social marketing) to ensure behaviour change messages are getting through to the wider community;
- working with each PHO to identify those practices who do not currently offer Get Checked;
- improving uptake in our diabetes self management programme; and
- working with PHOs through the CCM evaluation process to focus on quality improvement for better control in those patients who currently have HbA1c >8.

The annual budget for Get Checked is $404,000. (Considerably more funds are spent on retinal screening and CCM.)

<table>
<tr><th>Health Target</th><th>2008/09 Target</th><th>Responsibility</th></tr>
<tr>
<td>There will be an increase in the percentage of people in all population groups :<br>• estimated to have diabetes accessing free annual checks<br>• on the diabetes register who have good diabetes management<br>• risk assessment measures</td>
<td>
<table>
<tr><th></th><th>Total</th><th>Maaori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>Detection & Follow-up volumes</td><td>15,041</td><td>2,124</td><td>5,121</td><td>7,795</td></tr>
<tr><td>Diabetes Follow-up %</td><td>65%</td><td>63%</td><td>65%</td><td>65%</td></tr>
<tr><td>Diabetes Management %</td><td>68%</td><td>60%</td><td>52%</td><td>80%</td></tr>
</table>
Note the Ministry has updated the prevalence rates for 2008/09 - resulting in a 75% increase for CMDHB. The Ministry has advised there will be no baseline for 2008/09 so both the volumes and percentage have been included for detection and follow-up.
</td>
<td>Funder (Primary Care)</td>
</tr>
</table>

**Improving mental health services**

Relapse prevention plans for long term clients, assist clinicians with the client and their family/whaanau to understand the range of clinical and support needs required and to provide active management in order to minimise the risk of relapse and reduce hospitalisation. The provision of information regarding rationale followed by audit and feedback to clinicians improves both compliance and quality.

| Health Target | 2008/09 Target | Responsibility |
|---|---|---|
| At least 90% of long-term clients have up to date relapse prevention plans (NMHSS criteria 16.4) | Children 90%<br>Adults and Older People 90%<br>DHB Total 90% | Provider (Mental Health) |

## Indicators of DHB Performance

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| **Outcome 3: Reduce the incidence and impact of priority conditions** | | | | | |
| **Increase access to structured programmes to reduce the impact of disease** | Care Plus enrolled population<br>Numerator: The number of each PHO's Care Plus enrolled population.<br>Denominator:<br>Each PHO's expected Care Plus enrolled population. | | 70% | IDP – SER-02 | Funder (Primary Care) |
| **Reduce the incidence and impact of cardiovascular disease** | Cardiac Rehabilitation Programme<br>Numerator: The number of people who have suffered an acute coronary syndrome event who attend a cardiac rehabilitation outpatient programme as defined below.<br>Denominator: The number of people who have suffered an acute coronary syndrome | No Baseline data available | CMDHB is currently developing systems and processes to be able to identify baseline data and establish a target for 2008/09. At the time of writing neither baseline nor target information was available. | IDP – POP-02 | Provider (Medicine) |

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| | event who were admitted and discharged from hospital.<br>Acute Myocardial infarction/unstable angina. (2002 NZGG cardiac rehabilitation guidelines) [ICD 10 – 120-125]. | | | | |
| **Reduce the incidence and impact of cardiovascular disease** | Organised Stroke Services<br>Numerator: The number of people who have suffered a stroke event who have been admitted to organised stroke services and remain there for their entire hospital stay.<br>Denominator: The number of people who have suffered a stroke event.<br>Stroke event is defined as 'a clinical syndrome typified by rapidly developing signs of focal or global disturbance of cerebral function, lasting more than 24 hours or leading to death, with no apparent cause other than of vascular origin'. (Stroke Guidelines Nov 2003) [ICD 10 – 161, 163, 164]. | 58.1% | 65% | IDP – POP-03 | Provider (Medicine/ARHOP) |

<table>
<tr><th>Outcome/Objective</th><th>Description</th><th>Baseline</th><th>2008/09 Target</th><th>Reference (IDP, HBI etc)</th><th>Responsibility</th></tr>
<tr><td>Improve outcomes for people severely affected by mental illness</td><td>Access to mental health services<br>Numerator: The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for:<br>• child and youth aged 0-19, specified for each of the three categories: Maaori, other, and in total.<br>• adults aged 20-64, specified for each of the three categories: Maaori, other, and in total.<br>• older people aged 65+, specified for each of the three categories: Maaori, other, and in total.<br>Denominator: Projected population of DHB region by age and ethnicity</td><td><table><tr><th>Ages</th><th>Total</th><th>Maaori</th><th>Other</th></tr><tr><td>0-19</td><td>1.78%</td><td>1.78%</td><td>1.78%</td></tr><tr><td>20-64</td><td>2.6%</td><td>2.6%</td><td>2.6%</td></tr><tr><td>>64</td><td>2.45%</td><td>2.45%</td><td>2.45%</td></tr></table><table><tr><th>Data Source: 2007/08 CMDHB DAPAges</th><th>Total</th><th>Maaori</th><th>Other</th></tr><tr><td>0-19</td><td>1.78%</td><td>1.78%</td><td>1.78%</td></tr><tr><td>20-64</td><td>2.6%</td><td>2.6%</td><td>2.6%</td></tr><tr><td>>64</td><td>2.45%</td><td>2.45%</td><td>2.45%</td></tr></table>Data Source: 2007/08 CMDHB DAP</td><td><table><tr><td>Ages</td><td>0-19</td><td>20-64</td><td>65+</td></tr><tr><td>Maaori</td><td>2.2%</td><td>2.8%</td><td>2.4%</td></tr><tr><td>Other</td><td>2.2%</td><td>2.8%</td><td>2.4%</td></tr><tr><td>Total</td><td>2.2%</td><td>2.8%</td><td>2.4%</td></tr></table></td><td>IDP - POP-06</td><td>Provider (Mental Health)</td></tr>
<tr><td>Reduce the incidence and impact of cancer</td><td>Radiation oncology and chemotherapy treatment waiting times<br>Data is supplied monthly for both chemotherapy and radiation oncology,</td><td></td><td>CMDHB will work with the provider DHB (ADHB) towards achieving the provision of complete data and nationally agreed treatment standards for patients in priority categories A and B. CMDHB has a very strong relationship with the ADHB provider with regular operational meetings held. Where</td><td>IDP – POP-10</td><td>ADHB / Funder (Hospital & Specialist Services)</td></tr>
</table>

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| | and nationally agreed treatment standards for patients in priority categories A and B are met. | | the target is in danger of not being met, CMDHB will discuss this with the provider as soon as possible with a view to looking at feasible solutions. | | |
| **Improve outcomes for people severely affected by mental illness** | Alcohol and other drug service waiting times - waiting times are measured from the time of referral for treatment to the date the client is admitted to treatment, following assessment for the following service types: Inpatient Detoxification, Specialist Prescribing, Structured Counselling, Day Programmes and Residential Rehabilitation. | | Alcohol & other drug services are provided for the region by WDHB. These targets will be agreed between WDHB and the Ministry. | IDP - POP-07 | WDHB/Ministry |
| **Improve outcomes for people severely affected by mental illness** | 1. The number (and percentage) of long-term clients in full time work (> 30 hours).<br>2. The number (and percentage) of long-term clients with no paid work.<br>3. The number (and percentage) of long-term clients undertaking some form of education eg University, Polytechnic. | Baseline data not available | Electronic clinical recording planned in 2008/09 to enable collection of QUA 02 information | IDP - QUA-02 | Provider (Mental Health) |

# Outcome 4 - Reduce health inequalities

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

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

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

## Key Objectives and Milestones

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **Address the systemic origins of inequalities** | Develop environments which promote, improve and protect community health and well being, and reduce inequalities | • Regional Maaori public health plan implemented in collaboration with the other metro-Auckland DHBs, ARPHS, Hapai Te Hauora Tapui, Tainui MAPO and Tihi Ora MAPO | 28 Feb 09 | Funder (Maaori Health) |
| | Increase community involvement in governance and decision making for locality planning for health services | • Governance training with LotuMoui health committees and Ministers forum implemented<br>• Kaitiaki group established in Mangere, conforming to a Treaty Framework with strong governance by Maaori and Pacific people<br>• Scoping of implementation of similar model for next high-needs area completed | 30 Jun 09<br>30 Sep 08<br>31 Mar 09 | Funder (Pacific Health)<br>Funder (Primary Care) |
| | Continue to implement the Maaori | • Tikanga Best Practice Training Programme | 30 Jun 09 | Funder (Maaori |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | Responsiveness Programme within CMDHB and primary health care services | delivered to 700 CMDHB staff<br>• Tikanga In Practice implemented to specific wards in alignment with the Releasing Time to Care programme<br>• Maaori quality measures developed and piloted to gauge effectiveness of Tikanga in Practice<br>• Tikanga Best Practice Programme delivered to 25% of the Primary Care Practices with Maaori ESU's exceeding 10% | 30 Jun 09<br>30 Jun 09<br>30 Jun 09 | Health) |
| | Ensure use of an appropriate reducing inequalities tool for Counties Manukau in all planning processes | • Reducing Inequalities working group established<br>• Content of the HEAT tool reviewed and an appropriate assessment tool developed for consistent use across the organisation | 31 Aug 08<br>30 Jun 09 | Funder (Maaori Health) |
| | Develop a Maaori Research Action Plan that identifies priority areas for research where Maaori needs are significant | • Draft Maaori research action plan ready for consultation<br>• Consultation undertaken and action plan finalised | 31 Dec 08<br>30 Jun 09 | Funder ( Maaori Health) |
| | Ensure all research proposals presented to the Maaori Research Review Committee meet the standards expected | • Community base research group maintained and work with CCRep and other researchers to facilitate improved cultural responsiveness of research planning (eg Tikanga Best Practice training for research staff) supported | 30 Jun 09 | Funder (Maaori Health) |
| | Support the implementation of cultural services to enhance secondary care services | • Key target areas within secondary care services targeted for cultural support for 2008/09 | 30 Jun 09 | Funder (Maaori Health/Pacific Health) |
| **Implement specific initiatives to reduce inequalities** | Implement cultural responsiveness action within the DHB | • Did Not Attend (DNA) programme evaluated based on DNA seen by Cultural Support team<br>• The role and the capacity of cultural staff at the Emergency Department scoped | 31 Sep 08<br>30 Jun 09 | Funder (Pacific Health/Maaori Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | • Scope the need and build business case to extend Maaori and Pacific cultural support services to the clinics at MSC | 30 Jun 09 | |
| | | • Whaanau Hui processes and information improved and discharge information developed as per 2007/08 plan | 31 Mar 09 | Funder (ARHOP) |
| | | • Cultural support services scoped and established in AT&R (subject to funding) | 30 Jun 09 | Funder (Maaori Health) |
| | Increase options for Maaori community support and advocacy services for older people | • Additional day services and advocacy services provision developed in Franklin | 30 Jun 09 | Funder (ARHOP) |
| | Reduce health inequalities for Maaori and Pacific families that require maternity services | • Role for Community Support workers in antenatal and postnatal services scoped | 31 Sep 08 | Funder (Maaori & Pacific Health) & Provider (Women's Health) |
| | Improve access to effective services for Maaori and Pacific with a disability and their whaanau/families | • Recommendations from Maaori Disability Advisory group implemented | 30 Jun 09 | Funder (Maaori Health/Pacific Health) |
| | | • Relevant actions from the Lui Ola Plan implemented | 30 Jun 09 | |
| | Increase the capacity of Maaori and Pacific mental health services | • Funds allocated to Provider Arm for Maaori and Pacific Child and Adolescent Mental Health Services and Maaori Community Mental Health Centre | 1 Jul 08 | Funder(Mental Health)/Provider (Mental Health) |
| | | • Vacancies to targeted at < 10% | 1 Dec 08 | |
| | Develop a Maaori specific satisfaction survey | • Steering committee established to guide the development of a Maaori specific satisfaction survey | 30 Sep 08 | Funder (Maaori Health) |
| | | • Maaori specific satisfaction survey drafted, piloted and finalised for use | 30 Jun 09 | |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **Improve the capacity of all providers to deliver services to the populations they serve** | Support PHOs to deliver Tikanga/Pacific cultural competency training practices where there is greater than 10% enrolment of Maaori and Pacific | • Tikanga Best Practice training and Pacific Culture Competency training made available to PHOs<br>• KPIs agreed with PHOs for demonstrating cultural responsiveness to Maaori and Pacific | 30 Jun 09 | Funder (Maaori Health/Pacific Health/Primary Care)<br>Subject to funding |
| | Support the development of the Tainui Health Plan and establishment of a Tainui PHO | • Implement the Raukura Hauora o Tainui transition to the Tainui PHO in conjunction with Waikato DHB | 30 Jun 09 | Funder ( Maaori Health) |
| | Ensure the CMDHB health workforce reflects the local community | • Review the processes and systems to capture workforce ethnicity data. HR selection and recruitment policy reviewed.<br>• Identify recommendations to improve the data collection<br>• Implementation of recommendations to commence 09/10 | 31 Dec 08<br>30 Jun 09 | Funder ( Maaori Health)/Workforce Development Team |
| | Develop formal processes to collect, analyse and monitor performance data appropriate for Counties Manukau | • Develop and pilot Maaori quality measures/tools and IT support that will measure effectiveness of change<br>• Quality measures in place for Whai Manaaki | 30 Jun 09<br>30 Sep 08 | Funder ( Maaori Health) |

## Indicators of DHB Performance

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| **Outcome 4: Reduce health inequalities** | | | | | |
| **Address the systemic origins of inequalities** | Percentage of PHOs with Maaori Health Plans (MHP) that have been agreed to by the DHB<br>Numerator = Total number of agreed PHO MHPs<br>Denominator = Total number of established PHOs | 7/8 PHOs (YTD 31/12/05)<br>6/7 = 86% (YTD 31/12/2007) | 100% | IDP - HKO-01 | Funder (Maaori Health) |

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| **Address the systemic origins of inequalities** | Percentage of District Health Board members who have undertaken Treaty of Waitangi training<br>Numerator = Total number of District Health Board members who have undertaken Treaty of Waitangi training<br>Denominator = Total number of District Health Board members | 7/12 = 58% as at 31/12/06<br>7/11 = 63% as at 31/12/07<br><br>Note: This number is based on self confirmed numbers of those who have undertaken previous Treaty training. Board members are also to be invited to attend the Tikanga responsiveness training to be supplied by the organisation | 100% | IDP - HKO-01 | Funder (Maaori Health) |
| **Address the systemic origins of inequalities** | Percentage of DHB strategies and plans on which Pacific communities or representatives were consulted<br>Numerator = Total number of strategies and plans developed by the DHB during the year whose development involved consultation/fono with Pacific communities or representatives<br>Denominator = Total number of strategies and plans developed by the DHB during the year | New measure in 2008/09 | 90% | IDP – PAC-01 | Funder (Pacific Health) |
| **Address the systemic origins of inequalities** | Percentage of DHB working groups and steering groups that included representation for Pacific communities<br>Numerator = Total number of working groups and steering groups run by the DHB during the year that included representation from Pacific communities<br>Denominator = Total | New measure in 2008/09 | 90% | IDP – PAC-01 | Funder (Pacific Health) |

<table>
<tr><th>Outcome/Objective</th><th>Description</th><th>Baseline</th><th>2008/09 Target</th><th>Reference (IDP, HBI etc)</th><th>Responsibility</th></tr>
<tr><td></td><td>number of working groups and steering groups run by the DHB during the year</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Implement specific initiatives to reduce inequalities</td><td>Actual expenditure on Maaori Health Providers by GL code</td><td>
<table>
<tr><th></th><th>$000s 2007/08 bud</th></tr>
<tr><td>Maaori Health External Providers</td><td>12,390</td></tr>
<tr><td>Specific Maaori Services (Provider arm)</td><td>4,576</td></tr>
<tr><td>Maaori Health Governance</td><td>1328</td></tr>
<tr><td>Specific Maaori Services (inc. Governance)</td><td></td></tr>
<tr><td>Iwi/Maaori led PHOs (TKOH)</td><td>871</td></tr>
<tr><td>Workforce</td><td>200</td></tr>
<tr><td>Total Benchmark</td><td>19,365</td></tr>
<tr><td>Percentage Inc applied</td><td>26%</td></tr>
</table>
Note:<br>Subsequent to the finalisation of the 2007/08 DAP it was identified that the Maaori Health budget had been overstated by $300k.</td><td>
<table>
<tr><th></th><th>$000s 2008/09bud</th></tr>
<tr><td>Maaori Health External Providers</td><td>10,966</td></tr>
<tr><td>Specific Maaori Services (Provider arm)</td><td>5,458</td></tr>
<tr><td>Maaori Health Governance</td><td>2,098</td></tr>
<tr><td>Specific Maaori Services (inc. Governance)</td><td></td></tr>
<tr><td>Iwi/Maaori led PHOs (TKOH)</td><td>1,119</td></tr>
<tr><td>Workforce</td><td>220</td></tr>
<tr><td>Total Benchmark</td><td>19,861</td></tr>
<tr><td>Percentage Inc applied</td><td>4.2%</td></tr>
</table>
Notes:<br>The 2008/09 budget is currently being reviewed to ensure alignment with the Whaanau Ora Plan and will be confirmed once the final 2007/08 financial results are available in August 2008.<br>When compared to the original 2007/08 budget figure the increase between the 2 years is 2.6%.</td><td>IDP – HKO-04</td><td>Funder (Maaori Health)</td></tr>
</table>

# Outcome 5 – Improve health sector responsiveness to individual and family/whaanau need

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

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

## Key Objectives and Milestones

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **Increase access to services so they align with National levels** | Improve access to first clinical assessment by Paediatric Medicine Outpatients | • Local acceptance criteria guidelines for Kidz First Outpatient Care developed<br>• GP referral guidelines inclusive of Health Point electronic access developed<br>• New clinics and structures implemented<br>• Compliance with targeted waiting times (Priority 1 < 2 weeks , Priority 2 < 6 weeks, Priority 3 < 12 weeks) met | 30 Jun 09<br>30 Jun 09<br>30 Apr 09<br>30 Jun 09 | Provider (Kidz First) |
| | Continue repatriation of secondary care services from ADHB | • Business case for the implantable cardiac defibrillator (ICD) service developed and service repatriated during 2008/09<br>• Transfer of repatriated services evaluated | 31 Jul 08<br>31 Mar 09 | Provider (Medicine) |
| | Improve access to diagnostic services, particularly related to Ultrasound and CT services | • Identify roadblocks and solutions<br>• Implement change | 31 Dec 08 | Provider (Radiology)<br>Funder |
| **Improve access to and** | Reduce average length of stay through improved system and | • Target of 5% reduction in caseweight adjusted length of stay for elective surgery patients (excluding Ophthalmology) met | Ongoing | Provider (Surgical and Ambulatory Care) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **management of elective services** | process management, increased day of surgery rates, changes in models of care, improved discharge planning | | | |
| | Ensure that modality of service provided is aligned with best practice | • % Eligible Day of Surgery Rates >90% for specified conditions by service<br>• % Day of Surgery Admission rates > 95% by service | Monthly ongoing | Provider (Surgical and Ambulatory Care) |
| | Implement findings of Plastic and Reconstruction Services Regional Service Planning process | • Implementation plan agreed by metro-Auckland Region Chief Executives | Ongoing | Provider (Surgical and Ambulatory Care) |
| | Increase local provision of elective service volumes for people of CMDHB through IDF | • Implementation of agreed plan to repatriate elective secondary care volumes currently being provided at ADHB in Ophthalmology, General Surgery and Vascular Surgery | 30 Jun 08 | Provider (Surgical and Ambulatory Care) |
| | Implement findings of Ophthalmology RSP process | • Implementation plan agreed by metro-Auckland Region Chief Executives | Ongoing | Provider (Surgical and Ambulatory Care) |
| | Increase internal capacity to achieve elective services provision at CMDHB | • Internal capacity for the delivery of 1100 elective surgery WIES per month (including gynaecology) developed | 31 Dec 08 | Provider (Surgical and Ambulatory Care) |
| **Increase primary care utilisation** | Work with primary care to deliver first setting assessments for tubal ligations in primary health care and improve access to sterilisation/family planning services | • PHO involvement in the implementation of first setting assessment for tubal ligations in primary care increased<br>• Volumes of GP Provided Tubal Ligation consultations and numbers of GPs trained to provide consultations increased | 31 Dec 08 | Funder (Personal Health) & Provider (Women's Health) |
| | Prioritise PHO/SIA/HP planning process to meet Pacific health needs appropriately | • Appropriate plans developed and implemented for PHOs with large Pacific populations to address Pacific health needs<br>• SIA/HP and PHO plans reviewed to address Pacific health needs | 31 Sep 08<br>31 Mar 09 | Funder (Pacific Health) |
| | Maintain and improve the Primary Options to Acute Care programme (POAC) | • Action plans implemented to address the POAC review findings<br>• At least 5000 avoided admissions achieved, with Maaori and Pacific referral rates at greater than their population share<br>• POAC appropriately targeted to reduce ASH rates | 30 Sep 08<br>30 Jun 09<br>30 Jun 09 | Funder (Primary Care) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | • Extension of POAC to Rest Homes piloted and rolled out if successful | 30 Jun 09 | |
| | Support the increased utilisation of primary care units in maternity services | • Recommendations developed and required referral processes implemented<br>• Role development for social workers in community maternity services scoped and implemented<br>• Service evaluated and recommendations for future service requirements developed | 30 Jun 08<br>31 Aug 08<br>30 Jun 09 | Provider (Women's Health) |
| | Reduce the re-admission rates of Maaori through Emergency Care. | • Pilot group of high risk Maaori who re-admit through Emergency Care identified for follow up and support into primary health services<br>• Pilot group evaluated for improvements to accessing Primary Health Services. | 30 Jun 09 | Funder (Maaori Health) |
| | Increase access to primary mental health Initiatives | • CCM Depression module available in 75% of CMDHB PHO's (subject to resourcing) | 31 Mar 09 | Funder (Primary Care/Mental Health) |
| **Improve the continuum of care for services provided to older people** | Provide a range of therapeutic and assessment services to rural communities | • Contribution of community CNS/Nurse Practitioner to rural delivery scoped<br>• "Meals for Independence" Pukekohe project completed | 30 Jun 09 | Funder & Provider (ARHOP) |
| | Establish Memory clinics to reduce the impact of cognitive impairment | • Service model and business case developed<br>• Service model developed and cognitive/memory screening piloted in primary care settings | 30 Jun 09<br>30 Jun 09 | Funder & Provider (ARHOP) |
| | Assist older people and their family/carers to access DHB services including increasing access to services for older Maaori and Pacific people | • Options for a single Health of Older People and Community Services referral, reception and call centre investigated and report completed<br>• Specific advocacy and information services for older Pacific people developed | 30 Jun 09<br>31 Dec 08 | Funder & Provider (ARHOP)<br>Funder (Pacific Health)<br>Funder (Maaori Health/Pacific Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | • Current health programmes within CMDHB suitable for Kaumaatua/Kuia and older Pacific people identified and database that collates all available services developed<br>• Information and referral access to community health services provided to Kaumaatua/Kuia and older Pacific people | 30 Jun 09 | |
| | Support older people with long term illness/disability by reviewing continence/urology services | • Issues scoped and position paper developed<br>• Recommendations implemented | 30 Jun 09 | Funder(ARHOP) |
| | Support older people with long term illness/disability by improving the provision of respite care | • Contract and capacity for residential respite care developed | 30 Jun 09 | Funder (ARHOP) |
| | Build opportunities for health promotion, disability prevention and rehabilitation through the expansion of community geriatric services and developing links with primary care | • Proposal for closer linkages with PHO NASC and HHC developed<br>• Community geriatric service with PHO and residential care providers extended as per staged implementation plan<br>• Primary care support role for shared clinical care model developed | 30 Jun 09 | Funder (ARHOP)/Provider |
| | Investigate electronic options for care assessment provision and monitoring | • Telemedicine opportunities identified and scoped<br>• InterRAI position paper completed and proposals developed | 30 Jun 09 | Funder( ARHOP)/Provider |
| | Expand MHSOP capacity to support people with dementia-related mental health needs and better address needs of Maaori and Pacific peoples | • Funds for 4 FTE allocated to Provider Arm<br>• Vacancies reduced to less than 10%<br>• Maaori Kaumaatua/Kuia access to mental health services established | 1 Jul 08<br>1 Dec 08<br>30 Jun 09 | Funder (Mental Health)<br>Funder (Maaori Health) |
| | Support Carers (family and informal) in their role | • CMDHB carer strategy action plan developed following participation in the development of the national carer strategy document<br>• Agreed criteria processes for funded carer support finalised and new funding implemented | 30 Jun 09 | Funder & Provider (ARHOP) |
| | Capacity and range of | • Dementia and Alzheimer's Disease service capacity expanded | 30 Jun 09 | Funder (ARHOP) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | community support services are increased | • Day care options including Asian day care increased | | |
| | Provide support for safe care and management of heavy patients | • Options to support staff and carers developed and recommendations implemented | 30 Jun 09 | Funder & Provider (ARHOP) |
| | Provide end of life planning for older people across the primary and secondary sectors | • Care of older people pilot evaluated<br>• End of life planning across the primary and secondary sectors implemented | 30 Jun 09 | Provider(Medicine & ARHOP) |
| **Improve hospital services responsiveness to family/whaanau need** | Improved access to regular medication review for dialysis patients | • Medication Reviews by additional clinical pharmacist (0.5 FTE) in Dialysis clinic to start<br>• Evaluation completed | Starts Aug 08<br>30 Sep 08 | Provider (Medicine) |
| | Increase the number of CMDHB patients on the transplant waiting list by ensuring all patients have a transplantation (kidney) workup and are presented to the ADHB transplant group in a timely manner | • Business case for a transplant nurse specialist to manage the work up of patient developed and transplant nurse specialist employed<br>• Improvement in number and time taken to work patients up for transplant evaluated | Jul 08 – Aug 08<br>31 Mar 09 | Provider (Medicine) |
| | Further develop ortho-geriatric service to meet demand for acute services | • Additional Ortho- Geriatric 0.5 FTE RMO support funded and recruited | 30 Jun 09 | Funder (ARHOP)/Provider |
| | Improve the management of chest pain through the Chest Pain Pathway | • Capital and operational resources identified<br>• New service implemented and results monitored (depending on resource availability)<br>• Set up of a discharge lounge for low risk chest pain patients assessed | Jul – Dec 2008 | Provider (Medicine) |
| | Medication reconciliation within 24 hours of admission for all newly admitted patients | • Plan for medication reconciliation for all admitted patients implemented and roll out underway | 31 Dec 08 | Provider(Medicine) |
| | Enable identification | • Action plan for dietetics initiative (Weigh in, Weigh out scheme) for | 30 Jun 09 | Provider (ARHOP) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | and/quantifying of obesity and malnourishment in hospital population through the dietetics initiative for in patients | inpatients developed and approval to proceed gained | | |
| | Promote early discharge and prevent unnecessary discharge delays | • "Patient flow projects" in AT&R, HHC and NASC implemented<br>• Allied Health FTE requirements scoped | 30 Jun 09 | Provider (ARHOP) |
| | Implement the Renal Replacement Therapy policy - for both pre-dialysis and existing patients | • Issues identified and resolved in relation to implementing the policy<br>• Policy reviewed | 31 Dec 08 | Provider (Renal) |
| | Develop a policy for providing financial support for those patients who dialyse at home | • Policy to financially support home haemodialysis patients developed with the Renal Advisory Board<br>• Plan developed and implemented at CMDHB following approval | 31 Jul 08<br>2008/09 | Provider (Renal) |
| | Utilise best practice guidelines in Stroke service development to achieve best practice | • Stroke Care Coordinator appointed to facilitate care continuum<br>• SLT "Aphasia friendly" resources services established | 30 Jun 09 | Provider (ARHOP) |
| | Improvement in the quality of food services to patients across the metro-Auckland DHBs by developing a robust future state model for the delivery of food services to patients (including Meals on Wheels) | • Potential future state food service models evaluated<br>• Business case with recommended future state food service model presented to DHBs | 1 Jul 08<br>31 Jul 08 | Provider (Medicine) |
| **Reduce the number of people admitted to hospital who could have been cared for in the community** | Implement a Medicines Compliance Support Service for community pharmacy providers to ensure a culture of continuous quality improvement and appropriate access for people with priority conditions | • Quality programme for Medicines Compliance Support implemented<br>• Review of phase 1 completed | 31 Aug 08<br>30 Apr 09 | Funder (Pharmacy) |
| | Anticipate and manage Interim Funding Pool<br>• Devolution February 2009 | • Management processes/interfaces set up<br>• Scope and resources developed for additional structure in NASC services | 30 Jun 09 | Funder (ARHOP) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | • Ministry determine capability/capacity | | | |
| | Support people with long term illness/disability with the "Advance Care Planning" initiative | • Advance care planning model developed and application expanded and piloted within residential care setting | 30 Jun 09 | Funder(ARHOP)/Provider (Medicine) |

## National Health Targets

### Improving elective services

CMDHB has a robust elective services strategy for delivering elective services according to agreed contract volumes and for meeting Ministry ESPI requirements. During 2008/09, CMDHB will have significantly increased capability and capacity to produce elective services using internal resources with minimal reliance on subcontracting. Through delivering contracted volumes, CMDHB will meet national Standardised Discharge Rates. Ongoing service reconfiguration will ensure that services are of a high quality, meets clinical standards and achieve high patient satisfaction. The budget for electives will be confirmed once the price volume schedule is agreed.

<table>
<tr><th>Health Target</th><th>2008/09 Target</th><th>Responsibility</th></tr>
<tr><td>Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs).</td><td>2008/09 CMDHB targets<br><br>ESPI 1 – 97%<br>ESPI 2 – 1.6%<br>ESPI 3 – 4.0%<br>ESPI 4 – NA<br>ESPI 5 – 3.0%<br>ESPI 6 – 10%<br>ESPI 7 – 3.0%<br>ESPI 8 – 97%</td><td>Provider (Electives)</td></tr>
<tr><td>Each DHB will set an agreed increase in the number of elective service discharges, and will provide the amount of service agreed</td><td><table><tr><td></td><td>Base</td><td>Add.</td><td>Total</td></tr><tr><td>Est. E Discharges</td><td>13052</td><td>1305</td><td>14357</td></tr></table><br>Note: These discharge exclude the 2907 scopes which are included in the personal health volume schedule</td><td>Provider (Electives)</td></tr>
</table>

**Reducing ambulatory sensitive hospitalisations**

CMDHB generally has higher ASH rates than elsewhere due to its population being one of the most deprived in New Zealand. The district's ethnically diverse population also presents challenges around issues of access and health seeking behaviour. However, CMDHB is confident that the planned actions described below will ultimately impact on avoidable admissions and will improve the timeliness of reporting locally so that this indicator can be tracked in a more meaningful way.

CMDHB has comprehensive strategies in place to address the underlying drivers for health inequality but has not managed to reduce ASH rates to the extent desired, particularly for Maaori. Because of this, CMDHB has set targets at the same level as last year. Although some progress has been made, these remain very challenging targets for the DHB.

The main strategies CMDHB has employed are expected to start showing benefit over the coming year. To be specific, CMDHB has:

- Targeted general practices with high Maaori enrolments and referral rates and updated them on cellulitis management including the clinical pathway available through the Primary Option for Acute Care (POAC) programme which funds intravenous therapy in the community;
- Targeted CVD, Diabetes and CHF for these and other practices as part of the Chronic Care Management (CCM) programme;
- Nearly completed an integrated IT platform that will enable CMDHB to collect data on funded annual checks for people with high cardiovascular risk. This coupled with PHO funded CVD Risk screening programmes, will ensure that people are appropriately managed with aspirin and statin and will eventually impact on ischaemic heart disease rates.

Providing resources allow, CMDHB will be re-launching the Frequent Adult Medical Admissions (FAMA) programme in time to impact acute demand before winter. Targeting these 'frequent fliers' should provide a high yield in terms of reduction in ASH rates; the original campaign in 2002 had a 48% bed day reduction and reduced re-admission rates.

CMDHB cultural support units through the various programmes within the Whaanau Ora (Maaori Health) Plan and Tupuola Moui Pacific Health Plan are targeting families of high need and ensuring that they are well connected with primary care. These plans will support the extension of the cardiac rehabilitation process (Heart Guide Aotearoa) and case management nurses (He Punua Oranga) to manage complex and high need Maaori clients with chronic disease.

CMDHBs health promotion and prevention strategies (Let's Beat Diabetes,HEHA, LBD, district-wide PHO health promotion plan, and tobacco control strategy) are all designed to prevent cardiovascular disease, obesity, and diabetes, and there are signs of some success.

If new resources are approved, the "Acute Care Team" and 'outreach' nurses from Middlemore Hospital Emergency Care will be expanded as well as teams of nurses employed at a PHO level to specifically target proactive management of the six most common diseases on the ASH list.

Finally, the DHB is exploring the use of the PARR (Patients At Risk of Rehospitalisation) tool from the NHS and intends to pilot its use if possible.

<table>
<tr><th>Health Target</th><th>2008/09 Target</th><th>Responsibility</th></tr>
<tr><td>Reducing ambulatory sensitive (avoidable) admissions (ASH): There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0 - 74 across all population groups.</td><td>2008/09 CMDHB Target standardised discharge ratios for the year ending 30th June 2008.<br><br>
<table>
<tr><th></th><th>Maaori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>0-4</td><td><95</td><td><=107.9</td><td><95</td></tr>
<tr><td>45-64</td><td><=122.1</td><td><=104.5</td><td><=109.3</td></tr>
<tr><td>0-74</td><td><=111.4</td><td><=105.4</td><td><=101.4</td></tr>
</table>
<br>This translates to the following number of admissions based on 2007 population data.<br><br>
<table>
<tr><th>2008-09 Target</th><th>Maaori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>0-4</td><td>695</td><td>1,157</td><td>822</td></tr>
<tr><td>Expected if SDR = 100</td><td>732</td><td>1,073</td><td>865</td></tr>
<tr><td>45-64</td><td>757</td><td>1,008</td><td>1,997</td></tr>
<tr><td>Expected if SDR = 100</td><td>620</td><td>965</td><td>1,827</td></tr>
<tr><td>0-74</td><td>3,219</td><td>4,369</td><td>6,196</td></tr>
<tr><td>Expected if SDR = 100</td><td>2,890</td><td>4,146</td><td>6,111</td></tr>
</table>
</td><td>Funder (Primary Care)</td></tr>
</table>

## Indicators of DHB Performance

<table>
<tr><th>Outcome/Objective</th><th>Description</th><th>Baseline</th><th>2008/09 Target</th><th>Reference (IDP, HBI etc)</th><th>Responsibility</th></tr>
<tr><td colspan="6">Outcome 5: Improve health sector responsiveness to individual and family/whaanau need</td></tr>
<tr><td></td><td>Service Coverage<br>DHBs to report providing the following information:<br><br>Report progress achieved during the quarter towards resolution of gaps in service coverage identified in the DAP and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through:<br>• analysis of explanatory indicators<br>• media reporting<br>• risk reporting<br>• formal audit outcomes<br>• complaints mechanisms<br>• sector intelligence.</td><td>Not applicable – qualitative measure</td><td>The DHB will report progress against any service coverage gaps identified.</td><td>RIS-01</td><td>Funder & Provider</td></tr>
<tr><td>Improve access to and management of elective services</td><td>Continuous Quality Improvement – Elective services<br>Standardised Discharge Ratios (SDRs) for 11 elective procedures as published on the Ministry of Health website each quarter (excluding hip and knee replacements and cataracts covered by separate initiatives).</td><td>Data from NZHIS at 15 February 2008<br><br><table><tr><th>Surgical Procedure</th><th>Discharge ratio Jul – Dec 2007</th></tr><tr><td>Coronary Artery Bypass Graft (CABG)</td><td>0.95</td></tr><tr><td>Angioplasty</td><td>0.90</td></tr><tr><td>Prostatectomy</td><td>0.97</td></tr><tr><td>Grommets</td><td>0.89</td></tr><tr><td>Repairs of Hernia</td><td>1.26</td></tr><tr><td>Tubal Ligation</td><td>1.17</td></tr><tr><td>Hysterectomy</td><td>0.78</td></tr><tr><td>Cholecystectomy</td><td>1.18</td></tr><tr><td>Tonsils and Adenoids</td><td>0.87</td></tr><tr><td>Carpal Tunnel Procedures</td><td>1.14</td></tr></table></td><td>Rate > 0.95</td><td>IDP – SER-04</td><td>Provider (Surgical and Ambulatory Care)</td></tr>
</table>

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| | | Heart Valve Replacements and repairs: 1.09 | | | |
| **Increase primary care utilisation** | Accessible and appropriate services in Primary Health Organisations<br>Numerator: The age-standardised rate of General Practitioner consultations per high need person.<br>Denominator: The age-standardised rate of General Practitioner consultations per non-high need person. | Data at 6 months ending 30 June 2007 showed that all organisations met the target of a rate greater or equal to 1.0. | Rate > 1.0 | IDP – SER-01 | Funder (Personal Health) |
| **Increase primary care utilisation** | Lower or reduced cost access to first level primary care services<br>Numerator: The number of PHO practices that demonstrate that all increased subsidies translate into low or reduced cost access for eligible patients.<br>Denominator: The number of PHO practices in a DHB region. | 100% as at 31/12/07 | 100% | IDP – SER-07 | Funder (Personal Health) |

## Outcome 6 - Improve the capacity of the health sector to deliver quality services

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

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

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

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

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

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

## Key Objectives and Milestones

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **Ensure the delivery of safe and effective services** | Improve management of access to acute surgery | • Improved "Time to theatre" compliance:<br>o category 1 & 2 from 83-95%;<br>o category 3, 4 & 5 from 81-90% | 31 Dec 08 | Provider (Surgical & Ambulatory Care) |
| | Renew and develop clinical indicators at service and divisional level and develop a strategy for coordinated clinical audit activity across services | • Clinical indicators development & compliance collation completed<br>• Current systems audited and recommendations implemented | 30 Jun 09<br>31 Dec 08 | Provider |
| | Re-design of theatre processes to improve safety and service delivery | • Systems and process redesign, and implementation of theatre processes for both intra-operative and pre-operative processes completed | 30 Jun 09 | Provider (Surgical & Ambulatory Care) |
| | Improve performance of DHB on Emergency Care related targets through the Patient Flow Programme | • Triage times in EC reduced to target levels<br>• Number of patients discharged from Emergency Care within 6 hours increased to target levels<br>o >90% of patients discharged from Emergency Departments < 6 hours from presentation<br>o Patients are seen within their triage times and have an average length of stay of < 6 hrs within Emergency Care | 30 Apr 09 | Provider |
| | Improve Patient Safety | • Physiologically Unstable Patient Programme implemented<br>• ICU bundles in place and used on all appropriate patients | 31 Oct 08<br>30 Jun 09 | Provider |
| | Improve performance within the ward environment through the Releasing Time to Care programme | • Programme completed for 4 wards each quarter until April 2009 | 30 Apr 09 | Provider (Quality Improvement) |
| | Development of CMDHB Trauma Services | • Service Development and Quality Improvement Plan developed and actioned | 31 Dec 08 | Provider ( Surgical and Ambulatory Care) |
| | Improve capacity and quality of National Burns | • Service plan for improving capacity and quality of | 31 Dec 08 | Provider ( Surgical |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | Service | National/Regional Burns Service implemented | | and Ambulatory Care) |
| | Support the implementation of the national Quality Improvement Committee (QIC) work programme | • Leadership is provided on the QIC initiative Optimising the Patient Journey starting with the joint Ministry/CMDHB-led workshop "Achieving quality in our emergency departments" scheduled for May 2008. During 2008/09 CMDHB will lead the "national collaboratives" focusing on Optimising the Patient Journey<br>• CMDHB contributes to regional quality improvement collaboration fora and activities including the development of a regional strategic plan and work programme<br>• CMDHB is in a position to start implementing outputs on other QIC initiatives | 30 Jun 09 | Provider (Quality) |
| | Support continuous clinical quality improvement in primary care | • National health targets achieved<br>• Targets set in annual PHO Performance Programme achieved by PHOs<br>• Support culture of Continuous Quality Improvement and accountability for population health outcomes by sponsoring Clinical Governance Forum for PHOs | 30 Jun 09 | Funder (Primary Care) |
| | Support for initiatives that improve medication knowledge and adherence | • Medications compliance support project piloted in 20 pharmacies<br>• Pilot evaluated and report completed on recommendations for roll out | 31 Dec 08<br>31 Mar 09 | Funder (Primary Care) |
| | Establish Pacific Complementary and Alternative Medicine (CAM) Self Regulatory Governance Group | • Governance group comprising individual groups of traditional medicines (eg herbalists, masseurs) formed<br>• Governance group's terms of reference developed | 31 Dec 08<br>30 Jun 09 | Funder (Pacific Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | To implement a system that identifies and prioritises new technology and material changes in clinical practice within the division – this includes new drug therapies | • Agree and implement a forum and process to manage and appropriately prioritise new technologies organisation wide (but particularly for Medicine) | 30 Jun 09 | Provider (Medicine) |
| | Revise and develop health and safety risk management system and processes to achieve organisation-wide formalised process with injury prevention focus | • Revised Health and Safety Policy Statement signed off<br>• Revised Hazard Management Policy and Procedure signed off<br>• Injury Prevention Plans to address organisation-wide risk factors developed | 30 Jun 09 | Provider (Occupational Health and Safety Service) |
| | Lead co-ordinated action to address organisation-wide risks of patient and visitor aggressive behaviours towards CMDHB staff. | • DHB staff policies around staff support reviewed with Human Resources<br>• Project plan designed<br>• Key party sign off for organisational policy achieved and work as per project plan commenced<br>• Health plan which includes the promotion of violence free initiatives focusing on staff developed | 30 Jun 09 | Provider (Occupational Health and Safety Service) |
| | Develop quality in the home based support service (HBSS) sector | • Current sector standard achieved by providers<br>• HBSS contract changed to ensure that sector standard is mandatory requirement for providers | 30 Jun 09 | Funder (ARHOP) |
| **Ensure that services and facilities are planned to meet the future needs of the community** | Develop facilities, based on the Health Services Plan, for existing community teams to maintain sufficient geographical spread and office space | • New base in East Manukau to be developed | 30 Jun 09 | Funder (ARHOP) |
| | Provide clarity re future Service Definition, Scope and Configuration of PHOs in Counties Manukau | • Future role of PHOs in Counties Manukau including with respect to Primary & Community Health Centres and locality based plans for health improvement clarified, setting a clear direction for future PHO configuration | 30 Jun 09 | Funder (Primary Care) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | Identify and implement a development programme that supports the Mangere community to take charge of its health and wellbeing with the support of health professionals, NGOs and Government agencies | • Work programme established and implemented including the following:<br>o Development of community capacity;<br>o Review and enhancement of services, including the development of integrated Primary Health Care Teams and innovative models of care;<br>o Review of provider and inter-sector working;<br>o Review of facilities requirements<br>• Business case for new and enhanced primary & community health services, in Mangere, including facility requirements, developed | 30 Sep 08<br>31 Mar 09 | Funder (Primary Care) |
| | Increase numbers of primary healthcare clinics in communities with high Maaori populations | • Increase in primary healthcare clinics scoped in partnership with Te Kupenga o Hoturoa (TKOH) | 30 Jun 09 | Funder (Maaori Health) |
| | Identify the needs of Maaori and Pacific providers and develop and implement initiatives that will help them deliver quality services to the community | • Provider development needs from the Provider Development Needs Analysis (PDNA) identified and projects implemented following allocations<br>• Fit for Purpose (FFP) CMDHB/Tainui MAPO project scoped<br>• Pacific Provider Development plan implemented and evaluated | 31 Dec 08<br>30 Jun 09<br>30 Jun 09 | Funder (Maaori Health)<br>Funder (Pacific Health) |
| | Develop plans to meet community health needs in defined localities | • Commencement of Locality Planning across different health organisations in at least two areas<br>• Draft plan completed in at least one area | 30 Sep 08<br>30 Jun 09 | Funder (Primary Care) |
| | Improve utilisation of the Manukau Surgery Centre | • Physical occupancy increased from 38% to 50% | 30 Jun 09 | Provider (Surgical and Ambulatory Care) |
| | Expand the ICU/HDU service to ensure capacity meets service needs | • Staged ICU/HDU capacity expansion is delivered<br>• Surgical cancellations due to ICU/HDU bed shortages <5% of booked ICU beds | 31 Dec 08<br>31 Dec 08 | Provider (Surgical and Ambulatory Care) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | • Major burn referrals not accepted due to ICU shortage less than 1 per annum | 30 Jun 09 | |
| | Commence process for development of Aortic Abdominal Aneurysm Screening | • Proposal for implementation of AAA screening developed | 30 Jun 09 | Provider (Surgical and Ambulatory Care) |
| | Improve access to affordable dental care for older adults | • New subsidised dental hygiene services developed with AUT and HOP staff<br>• Potential residential care support or triage scoped | 31 Mar 09<br>31 May 09 | Funder (Personal Health/ARHOP) |
| | Improve access to emergency dental for low income | • IDF Relief Of Pain volumes increased for new Buckland Road (ADHB) chairs | 31 Dec 08 | Funder (Personal Health) |
| | Review the current model of care of the centre for youth health | • Evaluate current model of care evaluated and current community requirements established<br>• Recommendations for future model of care developed and implemented | 31 Jan 09<br>01 Dec 09 | Provider (Kidz First) |
| | Work with facilities management to progress the development/commissioning of the new Gynaeology Outpatient module at Manukau SuperClinics™ site | • Detailed design, construction and commissioning as per facilities building schedule | TBC | Provider (Women's Health) |
| | Develop capacity in the HBSS and psycho geriatric aged residential care (ARC) facilities | • Need and requirements for additional HBSS providers and psycho-geriatric ARC providers scoped | 30 Jun 09 | Funder (ARHOP) |
| | Prepare for Rehabilitation Campus at Manukau Site | • Model of Care for the new context developed to prepare for new Campus<br>• Additional medical rehabilitation specialist (SMO) 1.0 FTE recruited | 30 Jun 09<br>31 Jul 08 | Provider (ARHOP) |
| | Preparation for new rehabilitation wards within AMC building, and other building development on Middlemore campus | • Impact on location and delivery for acute allied health (AAH) and outpatient services identified<br>• Model of Care for the new context developed | 30 Jun 09 | Provider (ARHOP) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | New Adult Medical Centre (AMC) building available in 2009 | • One AT&R ward moved to new AMC building<br>• AAH teams relocated as per building schedule | 30 Jun 09 | Provider (ARHOP) |
| **Ensure the health workforce meets the community's need for services** | Continue "Employer of Choice" initiatives | • Employer Branding exercise completed<br>• In-house careers advisory service established<br>• Retention project Ageing Workforce implemented | 31 Mar 09<br>30 Jun 09 | Provider (Human Resources/Workforce Development) |
| | Develop new Nursing roles in Outpatient services | • Appropriate nursing support and enhancement for children with dermatological conditions established | 31 Dec 08 | Provider (Kidz First) |
| | Review the model of care of the public health Nursing service | • Current model of care evaluated<br>• Recommendations for future model of care developed and implemented | 31 Jan 09<br>1 Dec 09 | Provider (Kidz First) |
| | Further develop primary care nursing (subject to CMDHB funding) | • Additional primary care nursing roles investigated and established where feasible:<br>  • Community Nursing Case Management services for FAMA and CCM<br>  • Clinical Nurse Educator to work across PHOs and support uptake of new graduate programme<br>  • Rural outreach nursing service for Franklin<br>  • Additional nursing resource with a link to the Community Geriatric team to target rest home care<br>  • Framework and support developed for Nurse Practitioner roles based in primary care funding | 31 Dec 08 | Funder (Primary Care) & Provider (Nursing) |
| | Support tertiary training in primary health care sector | • Fund students (who meet criteria) to undertake the Community Health Worker Training at MIT<br>• Run a return to Nursing course with specific focus on primary care and mentoring to support candidates through the training | 30 Jun 09 | Funder (Primary Care) & Provider (Nursing) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | • Build capacity of PHC nursing uptake of Post Graduate education via CTA funding increase | 31 Mar 09 | |
| | Further develop Registered Midwifery and Registered Nursing (RN) workforce in maternity services | • Required education programme for RN's implemented within the maternity service<br>• Model of care for Women's Health inpatient service re-evaluated<br>• Continue the Midwifery development and education service in partnership with Auckland University of Technology | 31 Dec 08<br>30 Jun 09<br>31 Dec 08 | Provider (Women's Health) |
| | Respond to increasing demand (Inpatient and community) for allied health services in any development of initiatives and Models of Care | • Model of care for Allied Health in acute settings developed and workforce and skill requirements aligned to the Model of Care | 30 Jun 09 | Funder (ARHOP) & Provider (Allied Health) |
| | Support PHO training and professional development needs | • Training in the use of PMS systems to optimise population health provided<br>• Support and training specific to chronic disease management provided to PHOs and their providers<br>• On-going training provided for PHO's in Supported Self Care and Self Management Education<br>• PHO development supported specifically in the areas of change management skills, communication and strategic planning | 30 Jun 09<br>30 Jun 09<br>30 Jun 09<br>30 Jun 09 | Funder (Primary Care) |
| | Accurate data about the primary care workforce is available to assist workforce planning | • Robust quarterly reporting of workforce numbers (FTEs) in Counties Manukau consolidated as yardstick to measure progress and to enable change in plans if insufficient progress is made | 30 Jun 09 | Funder (Primary Health) |
| | Implement the CMDHB workforce development plan for mental health | • Infrastructure established within CMDHB and Mental Health Partnership Group<br>• One-off funding needs identified and funding | 1 Sep 08<br>1 Oct 08 | Funder (Mental Health)/Provider (Mental Health) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | allocated | | |
| | Develop and implement workforce plans across the organisation | • Medical workforce plan including investigation of new roles developed<br>• Nursing workforce plan developed including new ways of working with undergraduates<br>• Corporate/Management Workforce Plan developed<br>• Staff satisfaction survey completed and action plans at organisational and service levels developed and implemented | 31 Dec 08<br>31 Sep 08<br>31 Sep 08<br>31 May 09 | Provider (CMO)<br>Provider (Nursing)<br>Human Resources |
| | Ensure the youth health workforce meets the community's needs for services | • Strategies developed to address the workforce issues for youth health | 30 Jun 09 | Youth Health Funder |
| | Recruit and retain Maaori and Pacific health staff across all levels and roles both internally and across providers | • CMDHB Maaori workforce development plan implemented<br>• Pu ora Matatini nursing initiative with Te Kupenga O Hoturoa/MSD/MIT supported<br>• Maaori specific nurse graduate placements developed<br>• Pacific Workforce Development Plan's first year actions and innovations evaluated and reported. (Subject to available funding) | 30 Jun 09<br>31 Dec 08<br>30 Jun 09<br>31 Dec 08 | Funder ( Maaori Health)<br>Funder (Pacific Health) |
| | Promote health careers as a choice for entry level students | • Health careers promotion programme with local secondary schools implemented<br>• Incubator Programme Year 1 implemented (Hawkes Bay DHB)<br>• Scholarships awarded in 2009 academic year, through South Auckland Health Foundation, with emphasis on: Midwifery, Oral health, Maaori/Pacific | 30 Jun 09<br>31 Dec 08<br>30 Mar 09 | Workforce Development Committee |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | students, Primary health care, Technical roles<br>• Schools Maaori workforce programme implemented to increase the number of local Maaori students enrolled in health related tertiary study | 30 Jun 09 | Funder ( Maaori Health) |
| | Promote health careers as a choice for mid-career people | • Implications of Mid-careers market research translated into actions with respect to recruitment and other workforce activity. Resources developed and rolled out to community venues and audiences | 31 Dec 08 | Funder (Primary Health Care)/Workforce Development Committee |
| | Implement plans in priority service areas | • Organisation-wide Leadership and Management Development Programme implemented | 31 Dec 08 | Human Resources |
| **Improve health professionals communication skills in their dealings with patients and their families/whaanau** | Deliver Pacific cultural competency and awareness training for metro-Auckland | • The metro-Auckland regional Pacific cultural competency working group re-convened<br>• Regional plan of action scoped | 31 Dec 08<br>30 Jun 09 | Funder (Pacific Health) |
| | Enhance staff-patient communication | • Coaching and mentoring programme reviewed and implemented<br>• Patient-focused communication modules to support building a culture of quality developed and implemented | 31 Dec 08<br>Ongoing | Human Resources/Provider (Nursing) |
| **Ensure the efficient use of resources** | Embed clinical accountability for efficient and effective utilisation of theatre resources | • Resourced theatre utilisation across - increased from 80-82% | 31 Dec 08 | Provider (Surgical & Ambulatory Care) |
| | Improve performance and efficiency through regional collaboration with the other metro-Auckland DHBs | Key initiatives for 2008/09 year:<br>• Regional Medical Officer Systems<br>• Regional services planning<br>• Regional workforce planning<br>• Regional quality improvement planning & collaboration<br>• Senior Medical Officer Alignment | 30 Jun 09 | Funder and Provider |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | Initiate Quality and Efficiency programme in one major high cost support service | • Improvements in efficiency and waste reduction initiated in one major high cost area | 30 Jun 09 | Provider (Quality Improvement) |
| | Develop Nurse Lead Initiatives that improve access and quality of cost-effective service | • 4 new nurse-led initiatives identified and initiatives implemented | 30 Jun 09 | Provider (Surgical & Ambulatory Care) |
| **Support information exchange amongst health professionals** | Integrate health information from secondary services to primary care | • Capture community pharmacy dispensing records in regional Éclair for sharing with secondary and primary care | 30 Jun 09 | Provider (Information Services) |
| | Develop a Health Information Strategy for Primary Health Care in Counties Manukau | • PHOs and Primary Care Providers engaged as key stakeholders and a framework developed to support future models of care and health information needs, under the umbrella of the Auckland Regional IS Strategic Plan | 31 Dec 08 | Funder (Primary Care)/Provider (Information Services) |
| | Lead the regional development of a Kidslink-NIR compatible Child Health Integrated Information system (Kidslink+) that incorporates outcomes in all priority areas of Well Child and screening, including immunisation | • Kidslink+ solution definition | 31 Jul 08 | Funder (Well Child) |
| | Improve delivery of care and support to mental health clients across the region between secondary, community and acute care settings | • Auckland regional Mental Health Clinical Information (ARMHIT) System implemented and supporting MH Smart and MHINC reporting requirements<br>• Requirements agreed for NGO and client information sharing | 30 Jun 09<br>30 Jun 09 | Funder (Mental Health)/Provider (Mental Health/Information Services) |
| | Support community services multidisciplinary care between services and with primary and secondary care providers | • 100% of community pharmacies have access to NHI lookup<br>• 100% of pharmacies have access to a Pharmaceutical Data Repository – date dependant on the implementation of the repository (yet to be identified)<br>• Implement Community Online and NASC Online project plan - stage one | 30 Jun 09<br>TBC<br>30 Jun 09 | Funder (Pharmacy)<br>Provider (Information Services/Quality Improvement)<br>Provider (Kidz First/ARHOP/Information Services) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | | | |
| | Provide a regionally standardised drug database and reference source for all IT medication and prescribing software<br>Provide an electronic repository of community dispensed medicines | • Universal Data Model (UDM) installed at CMDHB<br>• Business case developed and approved | 31 Jul 08<br>31 Mar 09 | Funder (Secondary and Primary Care) |

## Indicators of DHB Performance

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| **Outcome 6: Improve the capacity of the health sector to deliver quality services** | | | | | |
| **Ensure the health workforce meets the community's needs** | Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Maaori out of the total numbers of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs in the DHB respectively. | NA | Data is available to report against this indicator however the accuracy of the data is questionable. CMDHB does not currently have the processes in place to capture the data required to support this set of indicators, eg ethnicity is not automatically captured at time of recruitment. The process is currently reliant on self reporting. A review of the current process for workforce ethnicity data collection is to be undertaken and included as a DAP objective for 2008/09 | IDP – HKO-02 | Funder (Maaori Health) |
| **Ensure the health workforce meets the community's needs** | Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Pacific out of the total numbers of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs in the DHB respectively. | NA | CMDHB is putting in place a process to collect the data/information required for target setting. A questionnaire will be circulated to relevant CMDHB service and provider groups to complete. The questionnaire will ask for information in the areas of (i) Pacific representation at governance, steering and planning groups and (ii) number of Pacific roles/employees in the planning, service and provider groups. The questionnaire will be collected similar to the census | IDP – PAC-01 | Funder (Pacific Health) |

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| | | | collection process (ie) information collected on a nominated date. At this time we anticipate the collection date will be in sometime in mid April | | |
| **Support information exchange amongst health professionals** | Improving the quality of data provided to National Collections Systems (NCS)<br>Measure 1: National Health Index (NHI) duplications<br>Measure 2: Non-specific NHI Ethnicity<br>Measure 3: Non-specific NMDS Ethnicity<br>Measure 4: Standard versus specific descriptors in the National Minimum Data Set (NMDS)<br>Measure 5: Error Diagnostic Related Group (DRG)<br>Measure 6: Percentage of DHB sourced records able to be successfully loaded into the national collections data marts | Measure 1: 4%<br><br>Measure 2: No baseline data available<br><br>Measure 3: *New measure*<br><br>Measure 4: No baseline data available<br><br>Measure 5: No baseline data available<br><br>Measure 6: *New measure* | Measure 1: 3.5%<br>Note: While this is less than the Ministry target of less than 2%, CMDHB believes that this is a realistic target considering the number of patients who present to EC who are unable to provide their demographic details and a temporary NHI number is given to them so that treatment can start.<br><br>Measure 2: The NZHIS is regularly collecting data relating to Measure 2, and a 3% target is realistic.<br><br>Measure 3: Ratio greater than 2 and less than 3<br><br>Measure 4: Greater than 4% and less than or equal to 7%<br><br>Measure 5: 100%<br><br>Measure 6: Mental Health is expected to comply with PRIMHED reporting requirements with effect from 1st July 2008. CMDHB expects to achieve a target of 90% by June 2009 | IDP – QUA-03 | Provider (Surgical and Ambulatory Services) |
| **Ensure the delivery of safe and effective services through the implementation of the CMDHB quality plan** | Percentage of mental health providers with audits completed in the period<br>Numerator: Total provider audits completed in the 12 month period<br>Denominator: Total number of mental health provider contracts | New measure in 2008/09 | 17 providers on the MH audit programme.<br>6 will be audited in the 2008/09 year. | QUA-04 | Funder (Mental Health) |

| Outcome/Objective | Description | Baseline | 2008/09 Target | Reference (IDP, HBI etc) | Responsibility |
|---|---|---|---|---|---|
| | Quality systems<br>The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting:<br><br>A high level summary (list) of key quality improvement and clinical audit initiatives and results, focusing on those that are effective and/or ineffective against the Goals in *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector*. | Not applicable - Qualitative Measure | A high level summary of quality activities will be provided | QUA-01 | Provider (Quality) |
| **Ensure the efficient use of resources** | The proportion of laboratory test and pharmaceutical transactions with a valid NHI<br>Numerator: Pharmaceuticals: the number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted.<br>Laboratory tests: The number of tests carried out by community laboratories in the DHB district with a valid NHI submitted.<br>Denominator: Pharmaceuticals: the total number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district.<br>Laboratory: The total number of tests carried out by community laboratories in the DHB district. | Laboratory 92%%<br>Pharmaceuticals 92.8% | Pharmaceuticals: 94%<br>Laboratory: 94% | IDP – SER-03 | Funder (Personal Health) |

## Additional Objectives for 2008/09

This section includes DHB objectives for 2008/09 which are in addition to those aligned to the District Strategic Plan. Generally they relate to activities the DHB is involved in at a national level or with the Pacific nations.

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| **Work with Pacific nations under NZAID Pacific programmes** | Manage the demand for specialist health services that are not provided within the Pacific islands<br><br>Support and work with the Pacific islands to grow their capacity to provide quality health services | For Niue, Cook Islands and Samoa:<br>• Clinical Referral Committees on islands are able to prioritise referrals in a timely way<br>• CMDHB provides a single contact person to triage and accept and manage referrals<br>• CMDHB to identify provider(s) of services to accommodate referrals<br>• CMDHB recovers costs from NZAID in a timely way<br>• CMDHB to look at developing a strategic business unit to manage the future development and requirements<br>For Niue:<br>• Continue the Halavaka agreement (ends November 2009)<br>For the Cook Islands:<br>• Continue MoU until review in June 2009<br>For Samoa:<br>• MoU to be signed | 30 Jun 09<br><br>30 Nov 09<br><br>1 Jul 09<br><br>1 Jul 08 | Funder (Pacific Health/NZAID) |
| **Effective use of Health Information, with particular reference to progressing the HISNZ, and its specific Action Zones** | Action Zone 1 Health Network | • Continue to promote use of health network for all strategic projects involving connectivity with primary and community, including TestSafe, mental health, community system, chronic care system, community pharmacy dispensing | 30 Jun 09 | Funder (Primary Care)/Provider (Information Services) |
| | Action Zone 2 NHI promotion | • Continue to encourage increasing use of the NHI in primary care, particularly for the pharmacy dispensing project | 30 Jun 09 | Funder (Primary Care)/Provider (Information Services) |

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| | | • NHI used in regional alerts project combining with national systems such as MWS | | |
| | Action Zone 3 HPI Implementation | • New projects will endeavour to use the HPI whenever a provider directory service is required | 30 Jun 09 | Provider (Information Services) |
| | Action Zone 4 e-Pharmacy | • Community pharmacy dispensing records captured in regional Éclair for sharing with secondary and primary care | 30 Jun 09 | Funder/Provider (Information Services) |
| | Action Zone 5 e-Labs: | • Clinician Order Strategy promoted and implemented | 30 Jun 09 | Provider (Information Services) |
| | Action Zone 6 Hospital discharge summaries | • HISAC e discharge/referral standard implemented | 31 Dec 08 | Information Services |
| | Action Zone 7 Chronic Care & Disease Management | • Use of Predict and inhouse decision support tools replaced with a fully hosted service from Enigma<br>• Primary and secondary care data combined to provide a more complete patient record | 30 Jun 09 | Funder (Primary Care)/Provider (Information Services) |
| | Action Zone 8 e-Referrals | • Electronic referral information system implemented | 30 Jun 09 | Provider (Information Services) |
| | Action Zone 9 National outpatient collection | • CMDHB will continue to comply with the data extract requirements for the Ministry | 30 Jun 09 | Provider (Decision Support) |
| | Action Zone 10 National primary care & community care collection | • CMDHB will comply with the requirements of this national project | 30 Jun 09 | Provider (Information Services) |
| | Action Zone 11 National system access | • CMDHB will comply with the requirements of this national project | 30 Jun 09 | Provider (Information Services) |
| | Action Zone 12 Anchoring framework | • CMDHB will comply with the requirements of this national project | 30 Jun 09 | Provider (Information Services) |
| **Implement on-line claiming systems for community pharmacy and facilitate the provision of information in a more timely manner.** | Ensure all pharmacy providers are connected to the Health Network and are capable of claiming electronically | • 100% of pharmacies connected to the Health Network<br>• 100% of pharmacies on-line claiming | 31 Dec 08<br>30 Jun 09 | Funder (Pharmacy) |

# Part III MANAGING FINANCIAL RESOURCES

## 6.1 FINANCIAL STATEMENTS

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

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

| Summary by Output Source | | | | | | |
|---|---|---|---|---|---|---|
| **$000** | **2006/07** | **2007/08** | **2007/08** | **2008/09** | **2009/10** | **2010/11** |
| | **Actual** | **Budget** | **Forecast** | **Draft Budget** | **Estimate** | **Estimate** |
| **Funder - Arm** | | | | | | |
| Government & Crown | 803,683 | 870,389 | 886,004 | 954999 | 1,003,704 | 1,088,798 |
| Non Government and Crown Agency | | 625 | 54 | 1,566 | 1,566 | 1,566 |
| Inter DHB & Internal | 65,663 | 80,513 | 80,513 | 73,264 | 71,107 | 68,580 |
| **Revenue** | **869,346** | **951,527** | **966,571** | **1,029,829** | **1,076,377** | **1,158,944** |
| Expenditure | | | | | | |
| Personal Health | 676,728 | 747,286 | 754,998 | 802,929 | 838,309 | 904,590 |
| Mental Health | 109,644 | 109,950 | 109,312 | 114,525 | 121,398 | 128,680 |
| DSS | 71,818 | 80,175 | 80,494 | 96,432 | 102,219 | 108,353 |
| Public Health | 1,161 | 1,021 | 727 | 216 | 229 | 243 |
| Maori | 3,948 | 4,904 | 7,572 | 7,101 | 7,279 | 7,460 |
| DHB Governance | 9,303 | 7,728 | 7,719 | 8,573 | 8,980 | 9,407 |
| **Expenses** | **872,602** | **951,064** | **960,969** | **1,029,776** | **1,078,414** | **1,158,733** |
| **Surplus / (Deficit)** | **(3,256)** | **463** | **5,602** | **53** | **(2,037)** | **211** |
| **Governance - Arm** | | | | | | |
| **Revenue** | | | | | | |
| Government & Crown | 10,801 | 7,978 | 7,947 | 8,573 | 8,980 | 9,407 |
| **Total Revenue** | **10,801** | **7,978** | **7,947** | **8,573** | **8,980** | **9,407** |
| Personnel | 6,903 | 6,425 | 6,177 | 7,483 | 7,932 | 8,407 |
| Outsourced Service | 427 | 112 | 17 | (72) | (122) | (181) |
| Infrastructure | 4,812 | 3,640 | 3,905 | 3,902 | 4,054 | 4,217 |
| **Total Expenses** | **12,142** | **10,177** | **10,099** | **11,313** | **11,864** | **12,443** |
| **Surplus / (Deficit)** | **(1,341)** | **(2,199)** | **(2,152)** | **(2,740)** | **(2,884)** | **(3,036)** |

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

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

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

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

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

## 6.2 OVERVIEW

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

The key drivers of this change in financial position are:

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

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

- The continuing significant IDF outflow and pricing adjustments.

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

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

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

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

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

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

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

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

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

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

- It is likely that an asset revaluation will need to be carried out during the future financial years (2008/09 and likely, 2009/10, 2010/11) due to increasing land and building costs. At the current point in time we have budgeted for a relatively small revaluation in June 2008 on the basis that commercial values appear to have steadied and stabilised and therefore the exposure is slightly diminished. However this will ultimately depend on whether or not the valuation has a material impact on the financial statements. If this did occur, then there would be related depreciation and capital charge costs, which based on advice previously received, are unlikely to be reimbursed by Ministry of Health on a yearly basis.
- Funding for the Health of Older People income and asset testing recalculation is sufficient to match our forecast level, with the "irony" that if house prices fall, Health of Older People accessibility levels will drop, entitling more people to claim. Reconciliation and resolution of this issue is still outstanding.
- PHO Top-Up reimbursements continue from the Ministry of Health as previously.
- All mental health funds, including "Blue-Print", continue to be "ring-fenced", with a neutral impact on the consolidated position. Note Mental Health is being instructed to absorb its related excess wage settlement within its ring fence on the basis it has its own 'ring fenced' FFT and demographic growth and must operate within those parameters.

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

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

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

- The significantly increased difficulty in meeting the Minister's and Government's expectations regarding a break-even financial result (zero deficit) and compliance with Government strategies and policies, in all years of this DAP.
- Meeting the communities' expectations, now that the DHB has been moved to equity from a population based funding perspective and with regard to community participation in decision-making.

- The financial risks associated with demand driven services, in which volume growth continues to outstrip funding in many areas. Also, risks arise from poor historical data, assumed targeted savings being built into the forecast, price pressures, and pricing inequalities between providers.
- Wage price pressure continuing to emanate from union expectations and the increasing international nature of the health labour market, leading to both significantly higher wages and clinical staff shortages arising from a much more mobile workforce. There are also potential relativity flow-on risks associated with the recent nursing wages settlement which will directly impact on other salary/wage levels initially within the Provider Arm. Ultimately these will almost certainly flow through to the NGO Sector with huge potential financial ramifications for the sector.

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

- An organisation wide, commitment to quality and quality improvement. This initiative, led by the CEO, has resulted in the formation of a formal quality unit within the organisation. The quality initiative will ultimately lead to financial benefit and be self funding or better, but initially requires considerable financial commitment.
- Continued development of audit, evaluation and monitoring systems to ensure that CMDHB is receiving value for money.
- Significantly lifting the level and frequency of all internal and external audit reviews. Increasing emphasis is currently being placed on widening the audits in the NGO/PHO areas, with notable results to date. The primary focus here has been around ensuring full delivery of contracted services, as well as ensuring appropriate health outcomes. Further strategies include maximising the benefits of the now well established regional internal audit function across the three metro-Auckland DHB's which is expected to lead to ensuring best value for services.
- Continued application/utilisation of a robust expenditure and long term forecasting monitoring tool.
- Continued very strong focus on efficiency and cost opportunities, particularly through the use of healthAlliance, but increasingly through regional collaboration. The latter will ensure a consistent approach and common policy and also ensure appropriate benchmarking is regularly carried out to maximise efficiencies. Note the absolute dollar level of cost reduction opportunities is lessening in many areas with an increasing focus around consistency of regional purchasing and common systems development.
- Working with the unions to realise the efficiency benefits included in the MECA settlements.
- Support of national initiatives that will lead to cost reductions, subject to the perceived risks being manageable such as the Procurement and Value for Money projects.
- Continuing to place very high emphasis on robust, regular monthly performance reviews at all levels of the organisation to ensure that CMDHB meets or this year exceed both its financial and operational targets.

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

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

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

Note: Data not available for 2008 year

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

| Estimation made in | Estimate 2006 pop | Est growth | % undercount | error in growth | % to inflate growth | Annual error |
|---|---|---|---|---|---|---|
| 2001 | 418,000 | 30,000 | 9% | 31,000 | 103% | 6,200 |
| 2002 | 436,000 | 42,000 | 4% | 19,000 | 45% | 4,750 |
| 2003 | 440,000 | 46,000 | 3% | 15,000 | 33% | 5,000 |
| 2004 | 441,000 | 47,000 | 3% | 14,000 | 30% | 7,000 |
| 2005 | 441,000 | 47,000 | 3% | 14,000 | 30% | 14,000 |
| 2006 | 443,000 | 49,000 | 3% | 12,000 | 24% | 12,000 |
| **Actual Census '06** | **454,800** | **61,100** | | | **average:** | **8,158** |

| | | |
|---|---|---|
| Value of understated Revenue | at PBFF | $ 14,954,225 |
| | at $1,000 | $ 8,158,333 |

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

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

## 6.3 FINANCIAL MANAGEMENT

### 6.3.1 Specific Cost Pressures – Wage pressure

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

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

Actual and anticipated changes in leave entitlement, due to the implementation of the Holidays Act, are already having both a material financial and resourcing impact on the organisation with particular challenges around the impact of both observing the extra leave entitlement and filling the consequent vacancies this is causing. In setting the DAP, the DHB has fully reviewed current vacancy levels. At a service level the opportunity to continue to maintain vacancy levels have been severely restricted due to volume, and most importantly, safety constraints.

## 6.3.2 Capital Planning and Expenditure

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

We are, and will continue to, work closely with all other Auckland Region DHB’s to ensure non-duplication or under utilisation of asset investment. However CMDHB’s independently reviewed growth and bed projections are such that this planned investment is essential simply to meet our communities current and forecast health needs.

Over the past few years, CMDHB has very successfully completed all phases of its building programme under the auspice of FMP. This will total over $300M on completion and will have been almost totally funded from CMDHB free cash flow or existing debt facilities. It will have come in ‘on time’, under budget, and within specification – an almost unique occurrence in the public health sector.

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

Having received Ministerial sign-off for Stage 3 of the Core Consolidation, encompassing the building of a new ward and clinical services block on the Middlemore site and the full refurbishment/upgrade of the gynaecology and early pregnancy service on the same site, we are now well advanced in implementing this project. This has a non moveable completion date of May 2009 given a severe shortage of in-patient beds at that stage if not achieved. The capital cost of this is $36.5m of which funding support of $25m has been agreed although nothing drawn down to date. The National Capital Committee supported the Business Case in December 2006 and the formal Ministerial approval letter was received in March 2007.

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

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

It is anticipated that strong demographic growth requirements for CMDHB will continue and as such outstrip the ability for CMDHB to fund either internally or from existing debt facilities. Ongoing discussions continue with Ministry and Treasury officials in regard to these requirements. There is a very clear need for significant further ministerial support in future "Towards 20:20" phases, given the anticipated significant overall capital requirement outlined in the Asset Management Plan and the current Business Case. While there may be some fine tuning (driven by the benefits of primary care initiatives or other rationalisations) of these requirements, nonetheless the underlying forecast continuing significant growth of CMDHB will have to be met through improved or additional facilities, incorporating substantial clinical equipment purchase or replacement.

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

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

It is well recognised that the future funding requirements for CMDHB are large and will present a national funding issue. CMDHB has fully reviewed and updated its Health Services Plan, re-run the bed model forecasts, aggressively considered new models of care, and re-assessed community based health solutions, forecast growth, facility timing and other options in order to lessen this forecast demand and related impact on capital requirements. Extensive resource has been applied to this exercise, including significant independent external input and a very high level of regional collaboration to ensure non duplication and aligned timing of new facilities and capacities. Further, CMDHB initiated a series of national sustainability conferences in recognition of the wider national issues arising from these forecasts. The first of these addressed workforce planning, the second "Funding Tomorrow's Health" ie fundability and affordability and the third (planned for August 2008) to consider and challenge current models of care/change management. While the funding issues within this DAP relate specifically to CMDHB, nonetheless there are clear indications that our challenges will be mirrored ultimately throughout the public health sector.

## 6.3.3 Banking Covenants

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

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

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

## 6.3.4 Cash Position

The forecast cash position of CMDHB assumes effectively a cash neutral position through full utilisation of free cash flow and available approved debt facilities to match the level of capital expenditure requirements in 2008/09 including both new and replacement assets. Although we have still to complete the final review of all capital expenditure requests (and therefore confirm the associated depreciation levels), capital expenditure related to the 2008/09 year will be limited to $46.1m, increased by the existing approved Towards 20:20 projects relating to current and future years.

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

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

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

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

### 6.3.5 Capital Charge

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

### 6.3.6 Advance Funding

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

## 6.4 COST CONTAINMENT & EFFICIENCY GAINS

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

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

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

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

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

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

In achieving the desired zero deficit operating target, we have placed even greater emphasis on containing our costs and achieving further efficiency gains, with all areas of the organisation expected to build into their plans continuing and significant but achievable efficiency targets. As would be expected many of these are the same areas targeted in the

2006/07 and 2007/08 District Annual Plans. In order to achieve this we have effectively "short funded" both the Funder and the Provider Arm by 0.5% (or approximately $3m each) to be able to contribute to the significant investment in new and existing District Strategic Plan initiatives.

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

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

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

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

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

CMDHB continues to maintain a very close focus on FTE management given that salary and wage costs are two thirds of the Provider budget. As a result there is a relatively modest increase in overall approved FTE levels. However as noted previously, there is significant clinical pressure to fill existing vacancies to cope with demand and clinical safety pressures. These are primarily driven by new services, funded services or clinical safety drivers. It is notable that within the FTE trend analysis virtually all growth is within the clinical areas or direct clinical support, other than those directly associated with primary care initiatives in the funder arm. As previously, FTE increases are subject to regular close scrutiny to ensure justification.

## 6.5 HEALTHALLIANCE (CMDHB & WDHB SHARED SERVICE ORGANISATION)

healthAlliance continues to perform well as a shared support service for Information Services, Accounting/Finance, Human Resource Support, Procurement and Payroll. Cost savings, particularly within procurement, as well as reduced human resource recruitment costs, are again expected to significantly benefit CMDHB and WDHB. These achievements are expected to continue, but as noted last year the level of savings cannot be expected to be as high as previously achieved. Further, there is increasing cost pressure on

healthAlliance as a result of shareholder expectations, particularly in regard to information technology opportunities. While costs have been managed in this area over the last three years, an earlier external review highlighted the potential need for increased investment, relative to shareholders very high level of expectation. Further reviews of previous cost benefit analysis work will be done in this regard over the next six months. It is likely that investment will be necessary to maintain the momentum required by the provider arm as well as the very significant needs around the capture of primary care and community level information.

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

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

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

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

## 6.6 OUTLOOK FOR 2009/10 AND 2010/11 YEARS

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

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

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

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

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

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

# Part IV REFERENCES

The following documents are referred to in the District Annual Plan and are available on the DHBs website www.cmdhb.org.nz or from the DHBs office telephone (09) 262 9500:

- Counties Manukau Health Profile
- Counties Manukau Health Indicators 2005
- Counties Manukau Primary Health Care Plan
- Disability Action Plan
- District Strategic Plan
- Health of Older People Action Plan
- 'Let's Beat Diabetes' Plans www.letsbeatdiabetes.org.nz
- Mental Health plans
- Oral Health Plan
- Primary Health Care Workforce Action Plan
- Sexual & Reproductive Health Plan
- Tupu Ola Moui (Pacific Health & Disability Action Plan)
- Whaanau Ora Plan (Maaori Health Plan)
- Workforce Development Reports
- Youth Health Plan.

In addition, the following plans are under development, and their availability can be advised by the DHB office:

- Cancer Control Plan
- Child Health Plan

# Part V ATTACHMENTS

## 1.0 VOLUME SCHEDULE

Provided Separately

# 2.0 OPERATIONAL POLICY FRAMEWORK REQUIREMENTS

<table>
<tr><th colspan="2">Operational Policy Framework Requirements</th></tr>
<tr><td colspan="2">Service Coverage Gaps<br>CMDHB is accountable for managing the service delivery aspects of service coverage including monitoring and resolution of delivery/compliance issues for those responsibilities and contracts, which have been transferred with funding to the DHB.</td></tr>
<tr><th>Gap</th><th>Resolution Plan</th></tr>
<tr><td>Workforce</td><td>Work to support the HBSS and residential care workforce development<br>Utilisation of Ministry HBSS Funds</td></tr>
<tr><td>Residential care bed availability, in particular dementia and pschogeriatric beds</td><td>Development of a service mix model to target appropriate capacity growth</td></tr>
<tr><td>Clinical Nurse Specialist (CNS) Cardiac Rehabilitation – we are not meeting the Ministry target of 95% of patients who suffer a CVD event are enrolled in a rehabilitation program</td><td>Business Case developed to support additional CNS FTE for Cardiac Rehabilitation</td></tr>
<tr><td colspan="2">Service Reconfigurations</td></tr>
<tr><td colspan="2">CMDHB does not plan to implement any significant or material service changes during 2008/09. As Middlemore Hospital is the largest acute trauma hospital in Australasia it will be necessary from time to time, based on acute demand, to reprioritise volumes at an operational level.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Co-operative Agreements</td></tr>
<tr><td colspan="2">CMDHB has established the following co-operative agreements:<br>National<br>• District Health Boards New Zealand – with the other 20 DHBs<br>• Memorandum of Understanding with HealthPAC and New Zealand Health Information Service (NZHIS)<br><br>Regional<br>• Northern DHB Support Agency – with Waitemata, Auckland and Northland DHBs<br>• healthAlliance – with Waitemata DHB<br>• Northern Clinical Training Agency – with Auckland, Waitemata, Waikato and Northland DHBs and the Auckland University School of Medicine<br><br>Let's Beat Diabetes<br>• Schools – ongoing expansion of Schools Accord with aim of including all schools in Counties Manukau<br>• Food industry– Progression of Food Industry Accord and joint work programme<br>• Manukau City Council, Papakura District Council, Franklin District Council<br>• Auckland Regional Public Health Services<br>• Ministry of Social Development<br>• Housing New Zealand Corporation<br><br>Intersectoral<br>• Housing New Zealand Corporation<br>• Ministry of Social Development and Work and Income<br>• Manukau City Council<br>• Prison Service - Service Level Agreement<br>• Tomorrow's Manukau<br>• Police, Victim Support, SafePin – Family violence memorandum of understanding</td></tr>
</table>

| **Operational Policy Framework Requirements** |
|---|
| *Maaori*<br>• Memorandum of Understanding with Manawhenua/Tamaki Makarau<br><br>*Pacific*<br>• Cook Islands Memorandum of Understanding<br>• Tonga Memorandum of Understanding<br>• Niue Memorandum of Understanding |
| ***Collaborative Activities*** |
| *Regional*<br>• CEOs/Chairs Forum<br>• Northern Region CEOs Forum<br>• Regional Funding Forum (RFF) made up of the four Funding GMs; and GM Maaori and GM Pacific Health delegates<br>• Regional Services Planning<br>• Regional Capital Group<br>• Regional Public Health Service Alignment Group<br>• Regional Network-Network North Coalition (mental health)<br>• In addition there are a number of other service related regional advisory groups.<br><br>*Information Services*<br>• Shared common Regional ISSP (RISSP) with Waitemata DHB and with Auckland DHB<br>• Shared RISSP Governance Group with Waitemata DHB and with Auckland DHB<br>• Shared Auckland Regional Privacy Advisory Group<br>• Shared IS services with Waitemata DHB<br>• All key information services strategic initiatives are explored for opportunities for regional collaboration<br><br>*Maternity*<br>• Ministry/CMDHB Maternity Work plan<br><br>*Local Government*<br>• Papakura District Council<br>• Franklin District Council<br>• Strategic Co-ordination Group |
| |
| ***Outsourcing*** |
| The DHBs Provider Arm outsources a number of support services these include:<br>• linen services<br>• catering and cleaning services<br>• waste management services<br>• orderly services.<br><br>The DHB continues to review other services as to their suitability for outsourcing where there is suitable financial and clinical benefit arising.<br><br>Where internal capacity is not available, the Provider Arm also outsources some elective procedures. |
| |
| ***Alternative Sources of Funding*** |
| CMDHB has entered into a number of service agreements, to provide health and disability services, in addition to those with the Ministry of Health. These include:<br>• ACC – elective surgery, burns, rehabilitation services (including spinal), allied health and high technology imaging services<br>• Tahitian government – burns services |

| **Operational Policy Framework Requirements** |
|---|
| • Northland DHB - rheumatology services<br>• AIMHI Consortium– Healthy Community Schools project<br>• Manukau Institute of Technology, Auckland University of Technology and Unitec - student nurse, midwifery and allied health experience<br>• Centre for Clinical Research and effective practice (CCREP) - site and services, and secondment of staff<br>• South Auckland Clinical School/University of Auckland – site and services, and the provision of clinical staff for teaching purposes<br>• Ministry of Education - play and recreation projects<br>• Ministry of Social Development - Providing Access to Health Solutions (PATHS)<br>• Ministry of Foreign Affairs and Trade<br>• NZAID<br>• Auckland DHB - renal services including home haemodialysis<br>• Various private organisations - research projects and sponsorship etc.<br>• Inter-district flows (IDFs)<br>CMDHB will have arrangements with each of the other 20 DHBs to cover treatment of their residents by CMDHB.<br>Services for which CMDHB will have IDFs include:<br>◦ Personal Health case weighted services<br>◦ Personal Health non-case weighted services<br>◦ General medical subsidies<br>◦ Laboratory tests<br>◦ Pharmaceuticals<br>◦ Tertiary adjuster<br>◦ NGOs paid through HealthPAC's Contract Management System for Personal Health contracts<br>◦ Mental health services<br>◦ Disability support services for over 65 years.<br><br>The Manukau Health Trust currently provides private health services at the Manukau SuperClinics™ and Surgical Centre. This occurs within spare capacity, and at times which does not impact on public health service delivery. |

# 3.0 NATIONAL HEALTH TARGETS

<table>
<tr><th>Health Target</th><th>2008/09 Target</th><th>Responsibility</th></tr>
<tr><td>95% of two year olds are fully immunised</td><td><table><tr><td>CMDHB Total</td><td>80%</td></tr><tr><td>Maaori</td><td>72%</td></tr><tr><td>Pacific</td><td>77%</td></tr></table><br>Note: This target is 5% above our 2007/08 target which was set against the 2005 National Immunisation Coverage Survey (NICS) results. To date our results using the NIR reporting have not achieved this level and are tracking approximately 5% behind the survey target. While the DHB is very committed to achieving a coverage rate above 80%, this is going to be very challenging using the NIR reporting and existing processes, systems and resources.</td><td>Funder (Well Child)</td></tr>
<tr><td>Progress is made towards 85% adolescent oral health utilisation</td><td>The 2008/09 target for CMDHB adolescent utilisation of oral health services is 57% Note this is dependent on the final results for 2007 which have not yet been received.</td><td>Funder (Oral Health)</td></tr>
<tr><td>Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs).</td><td>2008/09 CMDHB targets<br><br>ESPI 1 – 97%<br>ESPI 2 – 1.6%<br>ESPI 3 – 4.0%<br>ESPI 4 – NA<br>ESPI 5 – 3.0%<br>ESPI 6 – 10%<br>ESPI 7 – 3.0%<br>ESPI 8 – 97%</td><td>Provider (Electives)</td></tr>
<tr><td>Each DHB will set an agreed increase in the number of elective service discharges, and will provide the amount of service agreed</td><td><table><tr><td></td><td>Base</td><td>Add.</td><td>Total</td></tr><tr><td>Est. E Discharges</td><td>13535</td><td>1209</td><td>14744</td></tr></table><br>Note: These discharge exclude the 2907 scopes which are included in the personal health volume schedule</td><td>Provider (Electives)</td></tr>
<tr><td>All patients wait less than 6 weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D)</td><td>CMDHB will work with the provider DHB towards achieving this target. CMDHB has a very strong relationship with the ADHB provider with regular operational meetings held. Where the target is in danger of not being met, CMDHB will discuss this with the provider as soon as possible with a view to looking at feasible solutions.</td><td>Provider arm (Medicine)</td></tr>
</table>

<table>
<tr><th>Health Target</th><th>2008/09 Target</th><th>Responsibility</th></tr>
<tr><td>Reducing ambulatory sensitive (avoidable) admissions (ASH): There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0 - 74 across all population groups.</td><td>2008/09 CMDHB Target standardised discharge ratios for the year ending 30th June 2008.<br><br>
<table>
<tr><th></th><th>Maaori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>0-4</td><td><95</td><td><=107.9</td><td><95</td></tr>
<tr><td>45-64</td><td><=122.1</td><td><=104.5</td><td><=109.3</td></tr>
<tr><td>0-74</td><td><=111.4</td><td><=105.4</td><td><=101.4</td></tr>
</table>
<br>This translates to the following number of admissions based on 2007 population data.<br><br>
<table>
<tr><th>2008-09 Target</th><th>Maaori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>0-4</td><td>695</td><td>1,157</td><td>822</td></tr>
<tr><td>Expected if SDR = 100</td><td>732</td><td>1,073</td><td>865</td></tr>
<tr><td>45-64</td><td>757</td><td>1,008</td><td>1,997</td></tr>
<tr><td>Expected if SDR = 100</td><td>620</td><td>965</td><td>1,827</td></tr>
<tr><td>0-74</td><td>3,219</td><td>4,369</td><td>6,196</td></tr>
<tr><td>Expected if SDR = 100</td><td>2,890</td><td>4,146</td><td>6,111</td></tr>
</table></td><td>Funder (Primary Care)</td></tr>
<tr><td>There will be an increase in the percentage of people in all population groups :<br>• estimated to have diabetes accessing free annual checks<br>• on the diabetes register who have good diabetes management<br>• risk assessment measures</td><td>
<table>
<tr><th></th><th>Total</th><th>Maaori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>Detection & Follow-up volumes</td><td>15,041</td><td>2,124</td><td>5,121</td><td>7,795</td></tr>
<tr><td>Diabetes Follow-up %</td><td>65%</td><td>63%</td><td>65%</td><td>65%</td></tr>
<tr><td>Diabetes Management %</td><td>68%</td><td>60%</td><td>52%</td><td>80%</td></tr>
</table>
<br>Note the Ministry has updated the prevalence rates for 2008/09 - resulting in a 75% increase for CMDHB. The Ministry has advised there will be no baseline for 2008/09 so both the volumes and percentage have been included for detection and follow-up.</td><td>Funder (Primary Care)</td></tr>
<tr><td>At least 90% of long-term clients have up to date relapse prevention plans (NMHSS criteria 16.4)</td><td>Children 90%<br><br>Adults and Older People 90%<br><br>DHB Total 90%</td><td>Provider (Mental Health)</td></tr>
<tr><td>DHB activity supports achievement of these health sector targets:<br>• Proportion (percent) of infants exclusively and fully breastfed:<br>  • 74% at six weeks; 57% at three months; 27% at six months.<br>• Proportion (percent) of adults (15+ years) consuming at least three servings vegetables per day, and proportion (percent) of adults (15+ years) consuming at least two servings fruit per day:<br>  • 70% for vegetable consumption; 62% for fruit consumption</td><td>CMDHB is committed to improving nutrition, increasing physical activity and reducing obesity. Specific objectives for 2008/09 are included in Part II Outcome 1 Improve community wellbeing and Outcome 2 Improve child & youth health.</td><td>Funder (Let's Beat Diabetes)</td></tr>
</table>

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

# 4.0 ACCOUNTING POLICIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Property, Plant and Equipment**
*Fixed assets vested from the Hospital and Health Service*
Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Counties Manukau Health Ltd (a Hospital and Health Service) vested in Counties Manukau District Health Board on 1 January 2001. Accordingly, assets were transferred to the Board at their net book value as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost, and accumulated depreciation

amounts from the Hospital and Health Service. The vested assets have since been re-valued and will be depreciated over their remaining useful lives.

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

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

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

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

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

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

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

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

**Restructuring**
A provision for restructuring is recognised when Counties Manukau District Health Board has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

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

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

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

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

**Statement of Cash Flows**

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

**Operating activities** include cash received from all income sources of Counties Manukau District Health Board and records the cash payments made for the supply of goods and services.

**Investing activities** are those activities relating to the acquisition and disposal of non-current assets.

**Financial activities** comprise the change in equity and debt capital structure.

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

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

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

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

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

***Reconciliation of taxpayers funds***

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

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

# 5.0 JARGON & ACRONYMS

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

| Acronyms | Description |
|---|---|
| IDP | Indicator of DHB Performance |
| IFRS | International Financial Reporting Standards |
| IS | Information Systems or Services |
| ISSP | Information Services Strategic Plan |
| IT | Information Technology |
| KF | Kidz First |
| KPIs | Key Performance Indicators |
| LOS | Length of Stay |
| MACS | Medicine, Acute Care and Clinical Support Services |
| MAPO | Maaori Advisory Purchasing Organisation |
| MECA | Multi Employment Collective Agreement |
| MeNZB | Meningococcal B Vaccine New Zealand |
| MHAC | Maaori Health Advisory Committee |
| MHINC | Mental Health Information National Collection |
| MIT | Manukau Institute Technology |
| MMH | Middlemore Hospital |
| Ministry | Ministry of Health |
| MOU | Memorandum of Understanding |
| MSC | Manukau Surgical Centre |
| MVS | Meningococcal Vaccine Strategy |
| NASC | Needs Assessment and Service Co-ordination |
| NCTN | Northern Clinical Training Network |
| NDSA | Northern DHB Support Agency (DHB Shared Services) |
| NGO | Non-Governmental Organisation |
| NHI | National Health Index |
| NICU | Neonatal Intensive Care Unit |
| NIR | National Immunisation Register |
| NMDS | National Minimum Data Set |
| NNU | Neonatal Unit |
| NZIER | New Zealand Institute of Economic Research |
| NZIFRS | New Zealand International Financial Reporting Standards |
| P&L | Profit and Loss |
| PAH | Potentially Avoidable Hospital Admissions |
| PAM | Performance, Assessment and Management |
| PCD | Primary Care Development |
| PHAC | Pacific Health Advisory Committee |
| PHO | Primary Health Organisations |
| POAC | Primary Options to Acute Care |
| RC | Responsibility Centre |
| RISSP | Regional Information Services Strategic Plan |
| SAC | Surgical and Ambulatory Care Services |
| SIA | Services to Improved Access |
| SLA | Service Level Agreement |
| SOI | Statement of Intent |
| TBC | To Be Confirmed |
| TLA | Territorial Local Authority |
| TPU | Teen Parent Unit |
| WDHB | Waitemata District Health Board |
| WIES | Weighted Inlier Equivalent Separation = Weighted Relative Value Purchasing Unit for medical and surgical Inpatient services |
| YJN | Youth Justice North |
| YTD | Year to Date |

# 6.0 ADDITIONAL OBJECTIVES FOR 2008/09: IMPROVING MENTAL HEALTH

**Ringfenced Mental Health Funding**
The following table gives the breakdown of the planned ringfenced mental health expenditure for 2008/09. The detail of use of this funding is described below. Planned expenditure and projects have been included in earlier sections aligning planned expenditure with this DHBs organisational strategic outcomes framework. Appendix 2 describes the relationship between the services to be funded and Te Kokiri and Appendix 3 describes the relationship between the services to be funded and the Minister's priorities.
*Note - may be modified in light of recent advice from Ministry of Health.*

| Mental Health Funding | 2008/09 | Annual thereafter |
|---|---|---|
| Provider Arm 2007/08 | $59,392,768 | |
| Less maternal respite (moved to funder arm) | -$93,307 | |
| Plus 2007/08 additional Blueprint (infant mental health) | $96,699 | |
| Provider Arm Blueprint/Demog | 1,984,939 | |
| Pricing increase FRS3 | $0 | |
| Pricing increase Provider Arm FFT | $1,958,885 | |
| **Provider Arm Total** | **$63,339,984** | **$63,339,984** |
| Funder Arm 2007/08 | $31,467,612 | $34,757,490 |
| Less ADHB funding for Richmond Fellowship included in error | -$1,018,517 | |
| Devolved Contracts | $403,208 | |
| Plus maternal respite (moved from provider arm) | $93,307 | |
| Less 2007/08 additional Blueprint (infant mental health) | -$96,699 | |
| NDSA Regional Director, Monitoring | $125,821 | $125,821 |
| Older people supports (transfer to HOP) | $300,000 | $300,000 |
| Mental Health Development Projects | $956,272 | $0 |
| Funder Arm BP/Demog | $1,889,328 | |
| Funder Arm FFT | $1,062,979 | |
| **Funder Arm Total** | **$35,183,311** | **$35,183,311** |
| | **$98,523,295** | **$98,523,295** |

**BLUEPRINT/DEMOGRAPHIC FUNDING: PLANNED EXPENDITURE**

**Breakdown of planned expenditure:**
Additional 2008/09 Blueprint Funding and Demographic funding will be allocated between DHB Provider Arm, DHB Governance, NGOs and regional services.

**Summary of planned expenditure (detail follows)**

| | | |
|---|---|---|
| **DHB Provider Arm** | | 1,984,939 |
| **DHB Governance** | | 120,000 |
| **NGO/undecided** | | 1,267,774 |
| **Regional/Specialist Services** | | 501,554 |
| **TOTAL** | **DHB Provider Arm, DHB Governance and NGO** | **3,874,267** |

**Provider Arm**

| PU Code | Service Description | Volume Type | Volume | Price | 2008/09 |
|---|---|---|---|---|---|
| MHCS08A | Clinical youth integrated service | FTE | 3 | 99,888.04 | 299,664 |
| MHCS08A | Child and Youth Service (Interagency Wraparound | FTE | 2 | 99,888.04 | 199,776 |
| MHCS08A | Pacific clinical child and youth service | FTE | 4 | 99,888.04 | 399,552 |
| MHCS18 | MHSOP clinical service | FTE | 2 | 119,730.76 | 239,462 |
| MHCS18A | Maaori MHSOP | FTE | 1 | 119,730.76 | 119,731 |
| MHCS18A | Pacific MHSOP | FTE | 1 | 119,730.76 | 119,731 |
| MHCS19 | Maaori CMHC | FTE | 2 | 108,722.74 | 217,445 |
| MHCS39 | Maaori clinical child and youth service | FTE | 2 | 99,888.04 | 199,776 |
| MHCS39 | Maaori clinical child and youth service (infant mental health) | FTE | 1 | 99,888.04 | 99,888 |
| MHCS46 | Maaori child and youth kaumatua/kuia | FTE | 1 | 89,913.73 | 89,914 |
| **TOTAL** | | | | | 1,984,939 |

**Governance**

CMDHBs mental health funder arm budget has grown from $13.6M in 2002/03 to a planned $35.1M in 2008/09. It has more than doubled (after allowing for FFT). Over that time the planning and funding workforce has remained constant (at 2 FTE plus NDSA support and CMDHB contracting team support) and all new Funder Arm funding has been applied to paying for mental health and addictions services. CMDHB plans to increase its planning and funding workforce to keep pace with the rate of expansion, beginning in 2008/09 with recruiting a new Assistant Programme Manager MH (AOD) using demographic funding.

| | | | |
|---|---|---|---|
| AOD planning and funding | FTE | 1 | 120,000 |

**Funder Arm**

| | Provider | PU Code | Service Description | Volume Type | Volume | Price | 2008/09 |
|---|---|---|---|---|---|---|---|
| Adult Services | HOP NGO | | Older peoples' supports for Maaori (transfer to HOP) | | | | 50,000 |
| Adult Services | HOP NGO | | Older peoples' supports for Pacific (transfer to HOP) | | | | 50,000 |
| Adult Services | DHB/NGO | MHCS21 | Peer support specialists | FTE | 4 | 80,081.88 | 320,328 |
| AOD Pacific | RFP | MHCS01C | Pacific AOD | FTE | 2 | 90,611.19 | 181,222 |
| AOD Mainstream | Odyssey House | MHCS01C | Stand Up! Roll out | FTE | 3 | 90,611.19 | 271,834 |
| AOD to be determined | RFP | MHCS01C | 1 AOD FTE for integrated youth service | FTE | 1 | 90,611.19 | 90,611 |
| Maternal MH | RFP | MHRE03 | Maternal respite | | | | 143,616 |
| Information sharing with sector | RFP | MHQI01 | Service linkage | | | | 160,164 |
| Regional services | To be determined collaboratively | | | | | | 501,554 |
| **TOTAL** | | | | | | | 1,769,328 |

In 2008/09 any underspend from delayed start of NGO services or Provider Arm vacancies will be used to fund a range of Mental Health Development Projects. For some projects, detail is given in the narrative for the DAP. Others are yet to be fully scoped and are listed below. These projects are:

- Physical health needs of people with mental illnesses
- Review of service configuration with a view to enhancing integration
- Access to/configuration of supports for older people with mental illness
- Asian responsiveness/cultural competency
- Kaumatua/Kuia spread/coverage
- Evaluation of new initiatives
- Workforce Development

Underspend may also be used to support the early start of some 2009/10 services, subject to approval from the Ministry of Health.

**Meeting ringfence requirements**

See DAP financials

No prior year underspend from prior to 2007/08 anticipated, but should there be any small underspend, this will increase the sum to be applied to the mental health development projects described above.

**CMDHB Mental Health Audit Activity** **NGO Audit & Monitoring**

| Outcome | Objectives | Milestones/Contracted Targets | Target completion date | Responsibility |
|---|---|---|---|---|
| Auditing & Monitoring of NGO providers continues for CMDHBs contracted NGOs and the audit outcomes is utilised in service planning & development | ▪ Surveillance Audits of 5 NGO's are completed | First two audit and remedial actions completed<br>Second audit and remedial actions completed<br>Third audit and remedial actions completed<br>Fourth audit and remedial actions completed | End of quarter one<br>End of quarter two<br>End of quarter three<br>End of quarter four | Funder & Planner (MH)<br>Funder & Planner (MH)<br>Funder & Planner (MH)<br>Funder & Planner (MH) |

# 7.0 ADDRESSING LEADING CHALLENGES AS DESCRIBED IN TE KOKIRI

| **Leading Challenge**: **Promotion & Prevention** | **Related objectives 2008/09** | **Prior activities** |
|---|---|---|
| ▪ Develop a plan that sets out MH promotion policy & service delivery | No action 2008/09 | |
| ▪ Infant MH/Social inclusion/Inter-sectorial approaches | Maaori Infant Mental Health development (Outcome 2, new funding)<br>Maternal mental health respite RFP (Outcome 2, new funding) | Earlier work on infant mental health<br>Community Living Services for social inclusion |
| **Leading Challenge: Building Better Mental Health Service** | | |
| ▪ Locally agreed pathways btw specialist MHS & A, Primary Care inc. info sharing | Continuation of previous initiatives | 2006 07 – Primary Care Liaison funded with this brief<br>Agreements/protocols in place between Primary Care and Secondary MHS<br>Primary Care Liaison function<br>Primary Mental Health Coordinator Initiatives |
| ▪ DHB specialist services to improve links with Primary Care | Primary Care Liaison fully implemented<br>Vacancies at under 10% | 2006 07 – Primary Care Liaison funded |
| ▪ Development of protocols for TOC btw and across service age groups & services inc. Primary Care & AOD | Continued work with CADS teams | Internal/regional TOC protocols developed.<br>Provision of service information to primary care practices in CMDHB.<br>Referral pathway CMDHB MHS and WDHB AOD<br>Agreement in place between CMDHB secondary MHS & the CADS Dual Diagnosis Team |
| ▪ Demonstrate a range of effective & integrated services | Consumer governed organisation/Peer Support (new funding)/Integrated Service Delivery Developments continue | Peer Support<br>Community Living Services<br>Alternatives to admission<br>Home based treatment Integrated service delivery<br>DBT Services |

| **Leading Challenge**: **Promotion & Prevention** | **Related objectives 2008/09** | **Prior activities** |
|---|---|---|
| | | All developments over last three years require integration and reporting to enable measurement of effectiveness |
| ▪ Demonstrate communication btw multiple services involved in consumers care | Continue to implement Organisational Development/Community of Learning (commenced in 2007/08) to guide future DHB and NGO services | CMMHAP-established – Multi agency collaborative group established<br>CLS/Clinical Team partnerships<br>Devolution of RCS to local rehabilitation coordination.<br>Redevelopment of CSW referral and interface protocols. |
| ▪ Demonstrate involvement in intersectorial that promote recovery | Watch House Pilot (with NZ Police – See Outcome 1)<br>Evaluate the MH Employment project | Intersectoral approaches to housing and work |
| ▪ Seamless delivery to consumers that supports informed choices | CMDHB Service Linkage/Service Directory (Outcome 1, new funding) | Integrated service delivery<br>Community Living Services<br>Peer support specialist developments within CMHCs<br>Webhealth<br>Support work register |
| ▪ Increase access to specialist mental health and addiction services for children and youth | Integrated Transition Age Youth AOD/MH Service (Outcome 2, new funding) | Parenting pilot<br>Early intervention project |
| ▪ MH to support 'aging in place' | Establishment of two geographically aligned MHSOP community teams – deferred from 2007/08 | Funded mental health supports for older people |
| ▪ Increase access to MH & A for Older People | Expand MHSOP capacity to support people with dementia-related mental health needs, particularly Maaori and Pacific people (Outcome 5, new funding) | |
| ▪ Increase capacity, quality and capacity of services for people with high & complex needs | Benchmark services to improve value for money (Outcome 6) | |
| ▪ Increase access to MH & A for Adults (inc acute emergency services) | Roll-out of Stand Up! Programme (new funding) | New AOD services |
| ▪ Meet the physical health needs of people with SMI | Provide access to dietician (subject to one-off funding) | Physical Health Project 2006 07<br>Implementation of recommendations |

| **Leading Challenge**: **Promotion & Prevention** | **Related objectives 2008/09** | **Prior activities** |
|---|---|---|
| | | from Physical Health Project across Adult MHS |
| **Leading Challenge:**<br>**Responsiveness to unique populations needs** | | |
| ▪ Pacific | Pacific AOD (new funding)<br>Pacific child and youth clinical service (Outcome 4, new funding)<br>Pacific expertise in MHSOP (Outcome 5, new funding) | Pacific AOD (youth)<br>Pacific MH Plan |
| ▪ Asian | | Asian coordinator (Blueprint funding) |
| ▪ Refugees & Migrants | | Asian Mental Health Coordinator & Development of Refugees and Migrants handbook for clinicians |
| ▪ People with Disabilities | | Dual disability, Intensive CLS New Funding |
| ▪ Family & Whaanau | Whaanau Mental Health First Aid (Maaori mental health) | Peer Support Family/Whaanau (New Funding) |
| ▪ Maaori | As below under Leading Challenge (Maaori) | |
| **Leading Challenge: Workforce & Culture for Recovery** | | |
| ▪ Local Plan development | Continue to implement the CMDHB workforce development plan (Outcome 6)<br>Continue Organisational Recovery and Development/Community of Learning initiative | |
| **Leading Challenge: Maaori MH** | | |
| ▪ Implement Te Puawaitanga | Continued implementation of CMDHB Maaori Mental Health and Addictions Plan 2005-2009 | |
| ▪ Implement He Korowai Oranga | | Maaori Workforce Project |
| ▪ Increase number of Maaori MH services | Maaori Child and Adolescent Mental Health Service (including wrap around and infant mental health – Outcome 4, new funding) | New Youth AOD Services |

| **Leading Challenge**: **Promotion & Prevention** | **Related objectives 2008/09** | **Prior activities** |
|---|---|---|
| | Child and youth Kaumatua/kuia (new funding)<br>Maaori Community Mental Health Centre (Outcome 4 – new funding)<br>Maaori expertise in MHSOP (Outcome 5, new funding) | |
| ▪ TWO choice | | |
| ▪ Cultural training and clinical competency | | Tikanga Best Practice training rolled out across MHS |
| ▪ Early intervention strategies | | Funded Kaupapa Maaori Early Intervention Service |
| ▪ Increased access | Meet access targets | |
| ▪ Pathways to ensure continuity of care | DHB Clinical Information System (Outcome 6) | |
| **Leading Challenge: Primary Health Care** | | |
| ▪ PHO's demonstrate of service dev. Toolkits | CCM Depression Roll Out (subject to availability of new primary care funding, Outcome 5) | CCM Depression Pilot |
| ▪ Meet the physical health needs | | Physical Health Project, Implement recommendations of Physical Health Project in Adult MHS |
| ▪ Pathways protocols btw Primary/Secondary Care | | Noted in Building Better MHS |
| ▪ Specialist service linkages to primary care | | Noted in Building Better MHS Primary Care Liaison |
| ▪ Promotion & prevention | Nil in 2008/09 | |
| **Leading Challenge: Addiction** | | |
| ▪ Improve access | Stand up! roll out<br>Pacific AOD (new funding) | Stand Up pilot project |
| ▪ Develop a local plan covering all of the areas | | Mental Health and Addiction Plan<br>AOD Plan completed 2007/08 |
| **Leading Challenge: Funding Mechanisms for Recovery** | | |
| ▪ Core funding capacity required is identified | Expansion of 1 FTE noted for 2008/09 with subsequent expansion planned to reflect increased funder workload<br>Participation in the national MH funder & planner training when available | Recruit assistant programme manager to build capacity and sustainability of funder role |

| **Leading Challenge**: **Promotion & Prevention** | **Related objectives 2008/09** | **Prior activities** |
|---|---|---|
| ▪ Pilot two alternative funding models | Integrated Service Delivery – pilot of new funding mechanisms continues | |
| **Leading Challenge: Transparency & Trust** | | |
| ▪ Changes in F&P of services based on reviews | Planning based on Blueprint, Survey and Needs Assessment | Mental Health Needs Assessment<br>Annual review of Progress against Blueprint |
| ▪ Compliance with MH sector standards | | Routine Provider Audits in place |
| ▪ Bench marking | Benchmark services to improve value for money (Outcome 6) | Use of NGO and Provider Arm reporting to internally benchmark services<br>Lead in provider arm benchmarking |
| ▪ Evaluation processes | All new services evaluated<br>Routine use of information to improve service delivery | |
| ▪ Recovery plans in place | Audits to establish % care plans including relapse prevention plans | Regular audit of client participation in care plans. |
| ▪ Complaint processes and feedback mechanisms | Routine service audit by consumer led evaluation (PER) team across the provider arm (Outcome 3). | Formalised process for SIRPs |
| **Leading Challenge: Working together** | | |
| ▪ Partnerships btw DHB MHS | As in previous years | Lead in provider arm benchmarking<br>Involvement in regional service planning<br>Participation in regional mental health planning and funding |
| ▪ Sector development | Further implementation of Community of Learning initiative | Collaborative development of five year action plan<br>Mental Health and Addiction Stakeholder Network input into district annual planning |
| ▪ Intersectorial initiatives | | Housing initiative with Housing NZ<br>Employment initiative<br>PATHS (Mental Health) |
| ▪ TLA/DHBs | | |

# 8.0 ADDRESSING MINISTER'S PRIORITIES – MENTAL HEALTH

| Minister's Priority | Actions in 2008/09 |
|---|---|
| *Value for money – better value for money provides more health care for more New Zealanders* | • Integrated service delivery pilot programme to improve value for money<br>• Benchmarking initiative using information to improve service quality and value for money |
| *Getting ahead of chronic conditions – maintain the pace of programme implementation* | • CCM depression roll-out<br>• Peer Support initiative expansion |
| *Reducing disparities, especially for Maaori and Pasifika populations* | Pasifika:<br>• Pacific clinical child and youth service,<br>• specific expertise in MHSOP<br>• older peoples' supports tailored for Pacific peoples<br>• Expanded AOD service<br>Maaori:<br>• Maaori clinical child and youth service expansion, including infant mental health and interagency wrap-around<br>• specific expertise in MHSOP<br>• older peoples' supports tailored for Maaori peoples<br>• expansion of Maaori CMHC |
| *Child and youth health – implement current programmes and build on the well child review* | • youth integrated service<br>• pacific child and youth clinical service and Maaori clinical service expansion |
| *Primary health – improve the interface, through planning and working together with PHOs* | • continuation of primary care liaison within provider arm and primary care coordination pilots |
| *Infrastructure – especially workforce development and coordinated information systems* | • CMDHB-wide workforce development programme<br>• NGO reporting project (to integrate information between NGOs and the DHB), to be enhanced to incorporate PRIMHED reporting requirements<br>• ARMHIT implementation (region-wide clinical information system, with capacity to interface with NGOs and provide access to service users) |
| *Health of older people – continue to give priority to new service models.* | • expanded MHSOP community team including Maaori expertise and Pacific expertise<br>• expanding supports for older people with mental disorders to include supports tailored to the needs of Maaori and Pacific peoples |