COUNTIES MANUKAU DISTRICT HEALTH BOARD

A Community Partnership

Statement of Intent

2011/12 – 2013/14

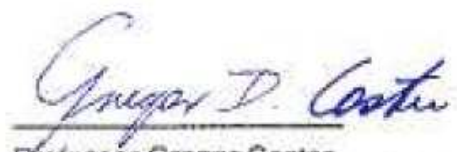
SIGNATORIES –CHAIR / BOARD

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

This document is intended to outline for Parliament and the general public the performance that will be delivered during 2011/12 by Counties Manukau DHB and contains non-financial and financial forecast information for the 2011/12 and 2012/13 years. The agreed performance measures are in the context of the Government's strategic and service priorities for the public health and disability sector and the Northern Region Health Plan.

ISSUED BY
Counties Manukau District Health Board

Signed by



Professor Gregor Coster
Chair of Counties Manukau DHB

Paul Cressey
Counties Manukau DHB Board Member

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Our Vision

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

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 focused and cost effective healthcare, at the right place, right time and right setting

Counties Manukau DHB will be a leader in the delivery of successful secondary and tertiary health care, and supporting primary and community care.

Our 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

Commitment to the 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."

CMDHB has developed an open and inclusive approach towards its engagement with Maaori and is seeking to implement this approach in a manner that focuses on the promotion of healthy lifestyles in this rohe (region). The DHB continues to develop its relationship with Maaori, and this will continue to be reflected in strategic documents, initiatives and actions undertaken by this DHB.

FOREWORD

We are pleased to present our Annual Plan and Statement of Intent for the 2011/12 financial year.

This document reflects our continuing commitment to improve the health and wellbeing of the Counties Manukau population and – in line with government and regional priorities – to reduce health disparities faced by Maaori, Pacific and other communities within the district whilst delivering a safe, patient-centred and cost effective health service.

Whilst our vision for the health of our population has remained steadfast, there are changes in emphasis in our annual planning which reflect the changes to the New Zealand Public Health and Disability Act and the priorities of the Government. Greater regional collaboration in service planning and shared services capabilities, with CMDHB taking a lead role, is all a part of this change of emphasis.

The inaugural *Northern Region Health Plan* launched in June 2011 has now supplanted the DHBs' District Strategic Plans and sets direction of travel for the Northern Region DHBs and wider health sector. The plan which - like our DHB's strategy - is also based on the Triple Aim aspires to:

- Build the safest health care system in Australasia;
- Deliver improvement to health and quality of life of our population and increase life expectancy; and
- Engage patients and their families in decisions about care.

As a first step, diabetes, cardiovascular disease, cancer and health of older people are the key conditions chosen for focus in the Northern Region Health Plan as we and our regional colleagues believe that by getting these areas right, we will be in a better position to assure the sustainability of our health system over the next 10 to 20 years. The next iteration of the plan will extend the scope of focus to include other key areas like child health where regional collaboration is already taking shape and regional mental health services planning. Our annual plans show alignment with these plans and outline the actions the DHB will be undertaking to progress regional goals and the achievement of national health targets.

With the continuing fragility of the global economy, slower domestic growth, and adding to that, the magnitude of the losses from the Christchurch earthquake, we are conscious that the Government will be looking towards the health sector to play its part.

Strong and effective leadership will be needed as we navigate our key challenges for 2011/12 which are:

- Living within our budget;
- *Better, Sooner, More Convenient* primary health care;
- National and regional service configuration;
- An ageing population driving acute demand; and
- Workforce sustainability.

Ko Awatea, our Centre for Health Services Improvement & Innovation will be a key driver of healthcare improvement and innovation for the DHB and the region. The centre will sit at the heart of the DHB's activities to improve value for money and to deliver the transformational change which will be needed to keep apace with the demand for better and more health services whilst managing within tight financial constraints.

Strategic initiatives that the DHB started last financial year such as our patient safety campaigns, our productivity initiatives in surgical and medical services, *Better, Sooner, More Convenient* (BSMC) primary health care business case implementation and our *Thriving in Difficult Times* projects will be even more relevant to the DHB in the new financial year, as

they have been in the last twelve months, if the DHB is to continue focusing on delivering value for money, improving frontline services, and reducing waste.

Continued commitment to our *Toward 20/20* facilities modernisation project is crucial if we are to support the transformation of our health service models and patient pathways and have adequate facilities to support our demographic growth. The DHB's locality based services planning which will progress BSMC goals of integrated care delivered in community based settings nearer to the patient will be paramount to minimising some of the impact for forecast demand for inpatient beds.

This coming year will be one of continuing challenge, both clinically and financially, but also one of quiet confidence - based on our track record - to meet and exceed local and national targets. For this, we thank all our staff, providers and partners who have worked together to contribute towards our success. We look forward to another year of achievement in 2011/12.

Gregor Coster
Chairman

Geraint Martin
Chief Executive

SECTION 1: CONTEXT

1.1 BACKGROUND

Counties Manukau District Health Board (DHB) is one of twenty[1] District Health Boards established on 1 January 2001 in response to government policy and legislation intended to present New Zealanders with the opportunity to exercise greater local influence over the planning, funding and delivery of health and disability services where they lived.

Counties Manukau DHB serves an estimated population of about 500,800 people – about 11 percent of the New Zealand population – within a geographical area covering the areas of the previous Manukau City, Papakura and Franklin districts.

Working with the funding allocated by Government, Counties Manukau DHB is responsible for:

- collaborating with other DHBs, service providers, the community, and other stakeholders to plan the strategic direction for health and disability services in the Northern Region and promote the integration of health services;
- funding the provision of most health and disability services provided in Counties Manukau through service contracts with health and disability providers and non-governmental organisations. The Ministry of Health retains funding responsibility for the remaining health and disability services including the balance of the primary maternity services, public health and national personal health contracts;
- providing hospital based services for the population of Counties Manukau and some access to specialist or highly complex services for people referred from other DHBs;
- promoting, protecting and improving the health of the Counties Manukau population through the provision of health promotion, health education and evidence-based public health initiatives.

Counties Manukau DHB is a major employer in South Auckland with over 5,700 staff employed across hospital and community-based settings.

1.1.1 Population profile

Counties Manukau DHB covers the previous Manukau City, Papakura and Franklin district areas in order to provide health services to an estimated population of 500,800 people. The population composition of Counties Manukau is diverse and includes:

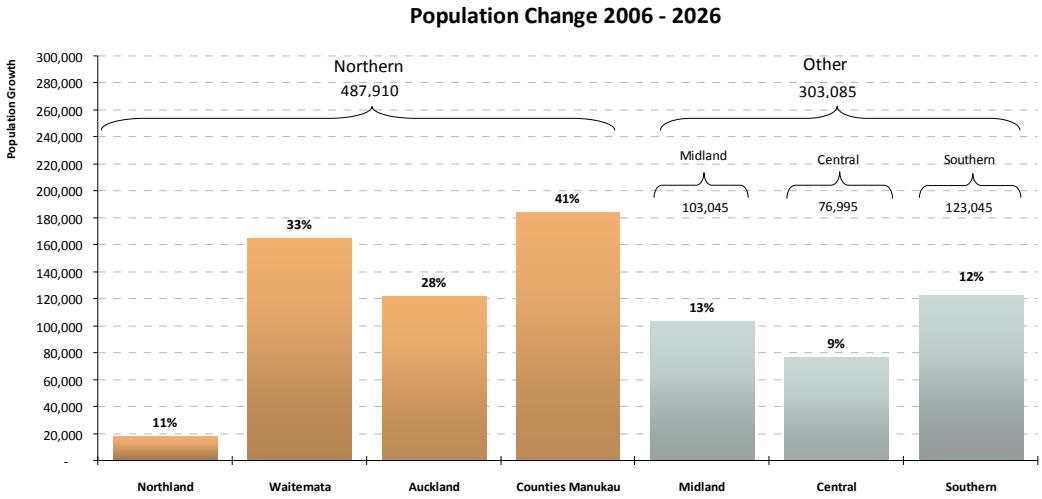
- A high proportion of Maaori. 17% of the Counties Manukau population is Maaori, which is 12% of the New Zealand Maaori population.
- A high proportion of Pacific people at 22%. This is 39% of New Zealand's total Pacific population, a rate which is expected to grow a lot faster compared to overall population growth.
- A high proportion of Asian people at 18% (the term 'Asian' refers to people of ethnic Pakistani and Indian origin, through to Southeast Asia and East Asia, including the Philippines, Indonesia and Japan).
- A relatively young population, with 25% of residents aged 14 and under.

The rate of population growth for the DHB currently sits at 2% to 3% per annum, and although it is due to slow down, the DHB's population is still projected to increase by 41% between 2006 and 2026. [2] See Figure 1.

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

[2] Wang, K & Jackson, G. *The changing demography of Counties Manukau District Health Board.* 2008.Counties Manukau District Health Board.

Figure 1: Population Change 2006 - 2026 - Northern Region DHBs compared to other regions



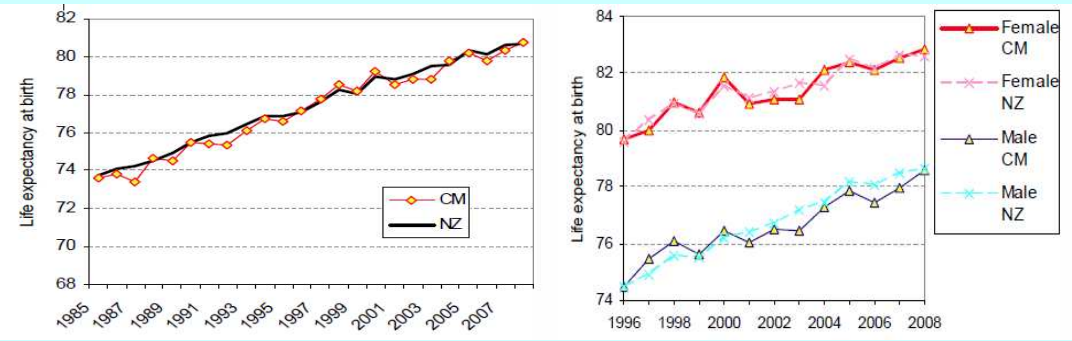
Reference: Northern Region Health Plan

1.1.2 Key health issues and contributing factors for the Counties Manukau Population

The following information has been pulled from the Counties Manukau DHB Health Needs Assessment 2008 and health status reports written by the DHB's Health Intelligence Unit.[3]

Life expectancy:

- As of 2005, life expectancy within Counties Manukau was similar to the New Zealand average of 83 for females and 78 for males despite higher levels of material and socio-economic disadvantage for Counties Manukau.
- However, health disparities remain with males, Maaori and Pacific people and those socio-economically deprived having worse outcomes than their counterparts.
- Maaori have a life expectancy of 73 for females and 70 for males, while Pacific people have a life expectancy of 78 for females and 74 for males.
- The figures below shows life expectancy at birth for the people of Counties Manukau cf. New Zealand, males cf. females, 1996 – 2008[4]



[3] These reports can be downloaded from the following site location:
http://www.cmdhb.org.nz/About_CMDHB/Planning/Health-Status/Health-Status.htm

[4] Smith, J. Jackson, G & Sinclair, S. *Life expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB.* 2008.Counties Manukau District Health Board.

Socio-economic Status:

- Many of Counties Manukau residents live in socio-economic deprivation, with 5% of Counties Manukau households having at least one family member receiving an unemployment benefit as of 2006.
- Lack of adequate income leads to poorer health outcomes and thus contributes to health inequalities.
- A high proportion of children and youth living in the most deprived areas[5] compared to the New Zealand average. 25.9% of children and young people (0-24years) live in decile 10 compared to 12.75 nationally.

Smoking:

- Between 1996 and 2006 the rate of adult smokers within Counties Manukau reduced by 3% to 20% overall. However, this rate is still higher than the New Zealand average.
- Maaori and Pacific people have significantly higher smoking rates than the rest of the population.
- A study looking at the contribution to life expectancy gaps of major disease areas in Counties Manukau found that smoking was a key driver of mortality and health inequity, contributing not only to smoking related lung diseases such as lung cancer, chronic obstructive pulmonary disorder (COPD) but to the other five disease areas identified in the life expectancy study (infant mortality, cardiovascular disease, diabetes, cancers other than lung cancers and all other causes of mortality). Differences in smoking frequency accounted for at least 10% to 20% of the life expectancy gap between Maaori and non-Maaori, non-Pacific in Counties Manukau.[6]

Obesity:

- Counties Manukau has the highest rate of obesity in New Zealand, with more than 110,000 people being classed as obese (BMI >30).
- This is a concern as obesity is a risk factor for several non-communicable diseases such as diabetes, cardiovascular disease and some cancers.

Child Health:

Infectious disease:

- The rate of infectious disease amongst children in Counties Manukau remains high.
- Improving the living conditions of pre-school children continues to be of high priority.

Breast Feeding:

- Counties Manukau breastfeeding rates are lower than the overall New Zealand rate.
- As of December 2009, 42% of infants were exclusively or fully breastfed at 3 months.
- Rates were lower for Maaori, Pacific and Asian babies than European and other populations.

Diabetes:

- Counties Manukau has the largest proportion of people known to have diabetes in New Zealand. In 2009, 31,500 people or 8.4% of the adult population had diabetes.
- The disease is most prevalent amongst the Maaori and Pacific population, with Pacific women having the highest prevalence of any group, with an age standardised prevalence of 15%.[7]

Cardiovascular Disease (CVD):

- Cardiovascular disease is the leading cause of death for people in Counties Manukau.
- As of 2008, there was an estimated 20, 357 people (aged 15 years and over) with cardiovascular disease (CVD) in Counties Manukau.
- Maaori had the highest age standardised CVD prevalence compared to other ethnic groups, with Maaori male prevalence 54% higher than other non-Maaori males. Maaori female prevalence was 120% higher than other non-Maaori females.
- South Asian males had the second highest age standardised CVD prevalence among males at 8%.[8]

[5] NZ Social Deprivation Index deciles 9 and 10

[6] Smith J., Jackson G., Sinclair S., *Life Expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB*, 2008, Counties Manukau District Health Board.

[7] Smith, J. Papa, D & Jackson, G. *Diabetes in CMDHB and Northern Region: Estimation using routinely collected data.* Counties Manukau District Health Board. 2008.

[8] Chan, W.C. Jackson, G & Papa,D. *Healthcare costs related to cardiovascular disease and diabetes in CMDHB.* Counties Manukau District Health Board. 2010.

Avoidable Hospitalisations

- Counties Manukau DHB has an avoidable hospitalisations rate of 4,163 per 100,000 admissions. This is significantly higher than the national rate.
- There are significant differences across ethnic groups, with Maaori having the highest rate of avoidable hospitalisations and Asian people having the lowest.

Avoidable Mortality:

- Counties Manukau has a higher rate of avoidable mortality compared to the rest of New Zealand.
- The leading causes of avoidable mortality were identified as ischaemic heart disease, lung cancer, suicide and self inflicted injury.

Infant Mortality:

- The Counties Manukau infant mortality rate (7.8 per 1000 births) is significantly higher than the rate for all of New Zealand (5.4 per 1000 births).
- Maaori and Pacific infants had a higher mortality rate than Asian infants.

Acute Demand:

- Counties Manukau DHB's adult medical admission rates are amongst the highest in the country.
- The Acute Assessment Team has been able to increase the proportion discharged within 24 hours from 28% to 40%, reducing ALOS to 2.7 days (the lowest in Australasia)
- A large proportion of medical admissions is driven by self-referrals to the Emergency Department and this remains a challenge to the DHB. Closer work between primary and secondary care to reduce demand through greater use of integrated programmes like the Primary Options for Acute Care (POAC) is needed to address this.

Elective Surgery:

- In 2010, Counties Manukau DHB had 14,786 elective surgical discharges. This is a 4.41% increase from 2009, or 625 extra discharges.
- Elective surgery rates in Counties Manukau have had over 40% growth over the past 5 years and age standardised rates are higher than the New Zealand average with improvements in access for Maaori, Pacific and more deprived populations.

1.2 OPERATING ENVIRONMENT

1.2.1 Health Sector Context

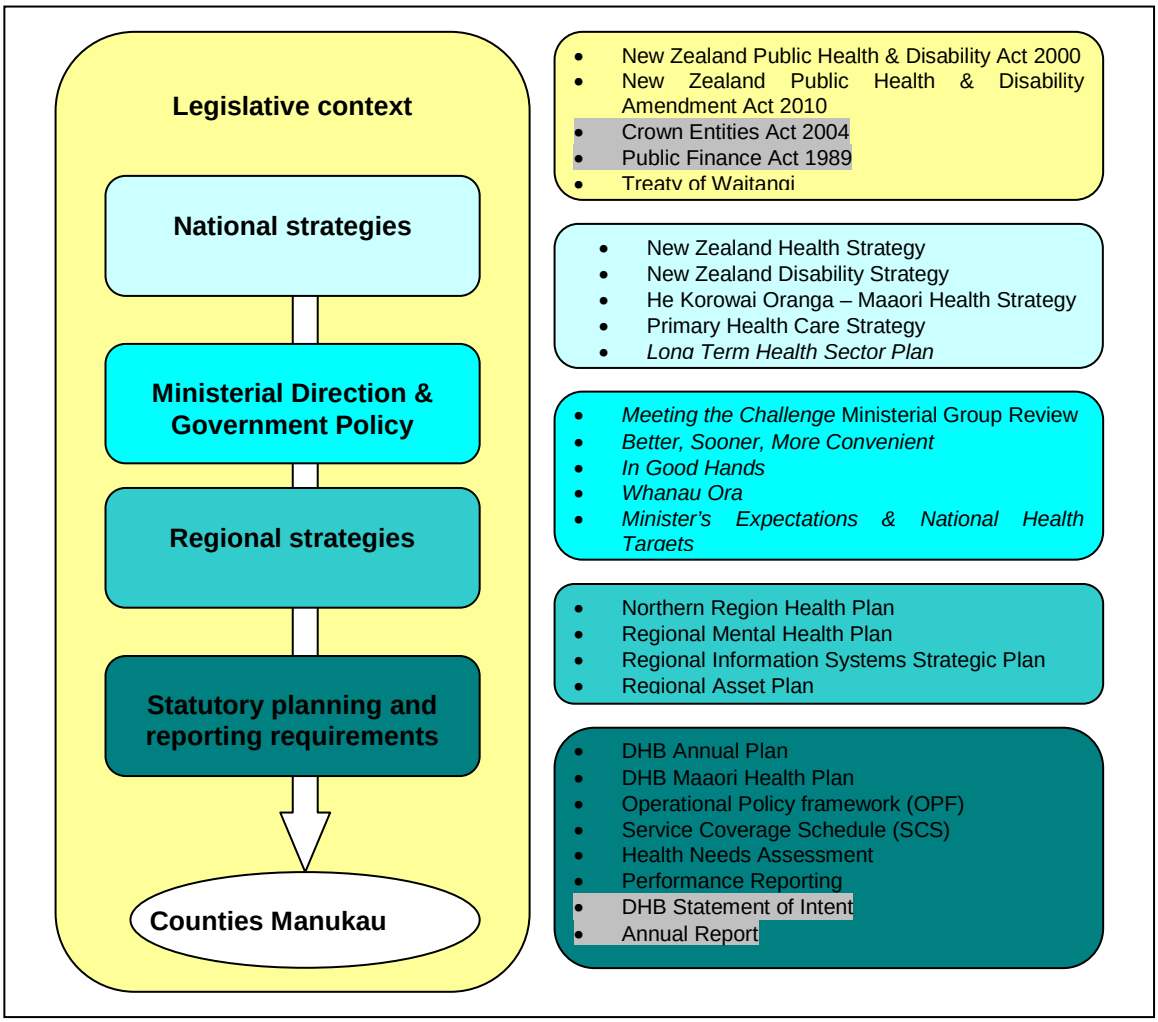
Counties Manukau DHB is accountable to the Minister of Health through his agent, the Ministry of Health, and to Parliament, whose agent is the Office of the Auditor-General.

The DHB operates in an environment governed by key legislation which is brought together in an accountability framework which links national and regional strategies, Ministerial direction, planning and reporting policy and guidelines stipulated by the Ministry of Health.

Figure 2 shows the overarching system context; the legislative environment and the cascade of priorities: national, Governmental and regional; within which the DHB operates.

Section 2 will give a further outline of the national and regional strategies and their influence on the DHB's strategic direction and operations.

Figure 2: Overarching system context that the DHB operates within



1.2.2 Demand Growth

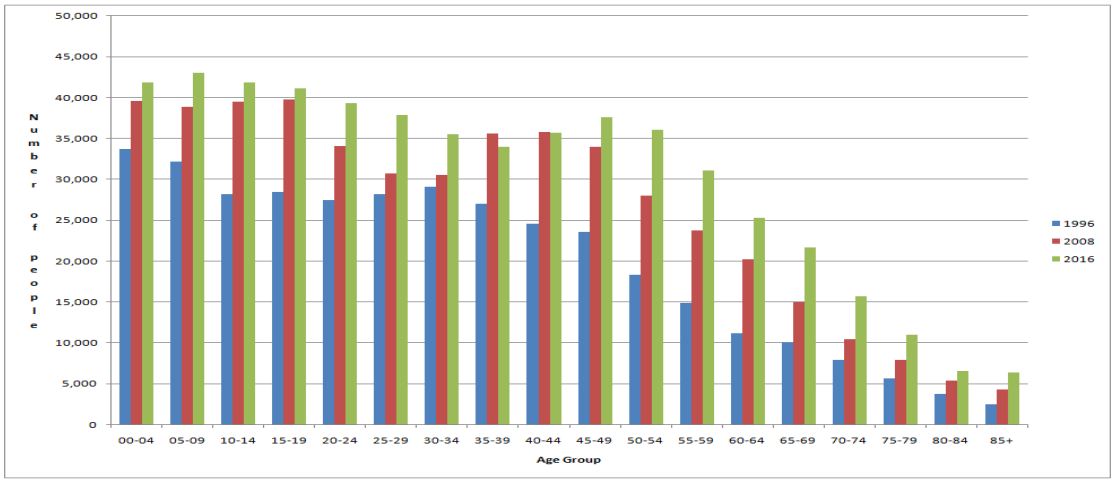
Demographic growth is the key driver of the Northern Region's strategic planning and operations. This is especially the case for Counties Manukau where there is:

- A high proportion of Maaori, Pacific and a growing immigrant population who have significant health needs.
- A significantly higher birth rate than the national average
- High growth in the 65+ age groups

For Counties Manukau, services which are currently experiencing the greatest pressure are those which are focused on providing care for people with chronic diseases such as cancer, diabetes and cardiovascular disease; maternity services; and those services which cater specifically for the elderly.

As pointed out in *Section 1.1.4, Population and Health Profile*, the population is projected to grow by 41% between 2006 and 2026 but more significantly, there will also be greater proportions of older people as seen in Figure 3 (the green columns).

Figure 3: Counties Manukau DHB population structure in 1996, 2008 and 2016 by age groups



The population aged over-65 is projected to more than double from 33,800 in 2001 (48,900 currently in 2011) to 74,700 by 2021.

This is significant because of the demand on services for this age group which includes Aged Residential Care, Home Based Support Services and hospital-based services for age-related chronic conditions. This age group is also strongly associated with high admission rates and longer lengths of stay.

Counties Manukau DHB has been working collaboratively with the Northern Region DHBs to improve regional services provision. This work was given further impetus last year when amendments to the New Zealand Public Health & Disability Act 2000 conferred direct powers to the Minister of Health to direct DHBs to plan collaboratively within their regions.

The Northern Region has developed a Northern Region Health Plan which focuses on long term strategies in the areas of high demand (and high costs) such as diabetes, cardiovascular disease and the health of older people in order to alleviate rising demand for these services.

1.2.3 Workforce

As a result of population growth and increasing demand for health services, Counties Manukau DHB forecasts a need to double the health workforce in the Counties Manukau district over the next twenty years. In the short term, the forecasts estimate that the DHB- employed workforce will need to grow by more than 25% to meet demand for hospital services.

These projections are based on expected growth in patient demand and current ratios of health workers and professionals to patients. The associated workforce growth is not seen as realistic or achievable within the current models, given expected fiscal constraints and the worldwide shortage of health professionals.

Historically it has been possible to meet local workforce shortages by importing health professionals. However, this approach is no longer sustainable due to the increasingly competitive global market for health professionals. In addition, to meet the needs of our local communities, we need a workforce which reflects our population instead of on relying on overseas trained health professionals.

The DHB is faced with a critical business need to work differently, evolve new roles and grow the future health workforce from the local community. There is a continued focus on fostering and supporting clinical leadership and laying the foundations for growing our own workforce through the DHB's *Grow Our Own* initiatives. These will be driven through Ko Awatea, the DHB's Centre for Health Services Innovation and Improvement opened in May 2011.

1.3 NATURE AND SCOPE OF FUNCTIONS

1.3.1 The Funding Arm - Planning & Purchasing Health and Disability Services

Since 2001/02, funding responsibility has been progressively devolved to Counties Manukau DHB for health and disability services.

Services funded by the DHB include:

Personal Health
- Primary, secondary and tertiary care services,
- Maaori health services,
- Pacific health services,
- Primary-referred services
- Oral health services for children and young people and emergency dental care for adults on low incomes

Mental Health
- Adult community mental health services
- Child and adolescent mental health services
- Older adults mental health services

Services for Older People
- Needs Assessment & Service Coordination
- Palliative care
- Rehabilitation
- Aged Residential Care
- Home Based Support Services
- Respite care
- Day services

DHB-provided primary maternity services
- Primary maternity care is provided by Lead Maternity Carers (LMCs), GPs, midwives or specialists, who are independent (not employed by CMDHB) and midwives employed by CMDHB.
- Primary maternity support and education 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 the DHB's geriatricians as close in age and interest), public health and national personal health contracts.

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

In addition, the DHB 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;
- Management of financial and clinical risk;
- Specific funding processes such as needs analysis, prioritisation and provider selection and monitoring service coverage;
- Leading on quality assurance and improvement through audits, reviews,
- Operational relationships between the DHB's funder and provider arms.

1.3.2 The Provider Arm – Providing Health and Disability Services

Counties Manukau DHB provides a wide but not complete range of secondary-level (hospital and specialist) health care, a selected range of community and domiciliary services, as well as a number of niche specialist tertiary services through its provider arm for the Counties Manukau population.

Specialist Tertiary services include:

- Bone tumour surgery
- Plastic, reconstructive and maxillo-facial surgery
- National Burns service
- Spinal cord injury rehabilitation
- National and regional renal dialysis advisory service
- Neonatal intensive care
- Breast reconstruction surgery
- National interventional bronchoscopy (stent and valve placement) service and medical thoracoscopy
- Endoscopic ultrasound and endobronchial ultrasound.

Although not exclusively the case, the majority of services are provided at the following sites:

Inpatient Services	Middlemore Hospital KidzFirst Children's Hospital Pukekohe Hospital Franklin Memorial Hospital
Outpatients Services ***Community Services*** ***Day Surgery***	Ambulatory Care Centres: • Manukau SuperClinic™ • Botany Downs SuperClinic™
Non-intensive care based elective surgery	Manukau Surgery Centre (MSC)
Primary Maternity Services	Botany Maternity Unit Papakura Maternity Unit Pukekohe Maternity Unit

A number of tertiary and other services are not provided directly by the DHB for Counties Manukau residents but are provided by Auckland DHB and Waitemata DHB. The DHB funds these separately through inter-district flow (IDF) payments to both DHBs.

Hospital-based health services provided for our population by neighbouring DHBs

Auckland DHB	• Cardiothoracic surgery, • Neurosurgery, • Oncology, • Emergency dental care for low income adults • Specialist children's surgical and medical services • Clinical genetics • Transplant surgery (liver, renal)
Waitemata DHB	• Forensic Mental Health, • School Oral Health Services for 0 – 17 year olds

SECTION 2: STRATEGIC DIRECTION

This section sets out Counties Manukau DHB's high level strategic direction and will demonstrate how the DHB's strategic objectives align with key national, regional and local health plans to deliver on key Government priorities and targets whilst also meeting the needs of our population.

2.1 COUNTIES MANUKAU DHB VISION

The Counties Manukau vision was developed in consultation with our communities shortly after the time of the health board's establishment in 2000.

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 focused and cost effective healthcare, at the right place, right time and right setting.

- Counties Manukau DHB will be a leader in the delivery of successful secondary and tertiary health care, and supporting primary and community care.

2.2 THE DHB'S STRATEGIC DIRECTION

Legislative changes and implications for DHBs' Strategic Planning

In the past five years, Counties Manukau DHB has been working toward the achievement of six district-level strategic outcomes. These outcomes were articulated in our District Strategic Plan, a statutory plan which was required of the DHB as a Crown Entity, and were influenced by national, regional and local priorities and agreed in consultation with our communities and stakeholders.

The Government passed the New Zealand Public Health and Disability Amendment Bill last year to help meet the many challenges faced by the public health and disability system. The NZPH&D Amendment Act 2010 removes the requirement for DHBs to prepare district strategic plans but instead provides the statutory framework for the National Health Board and DHBs to establish a more deliberate approach to ensure which services should be planned, funded and provided at the national, regional and local levels.

The changes in the Act and its regulations are also designed to put a much stronger emphasis on DHB collaboration to plan health services regionally in order to support better planning across the sector.

2.2.1 Our Transformational Platform

As outlined in the previous section, the challenges facing the DHB of growing demand for healthcare services, an increasingly ageing population and limited funds by which to meet this demand are widely acknowledged. **CMDHB will not have enough in-patient beds to meet the needs of the population it services by 2013, if we do not take radical action now.**

As a DHB, we understand that the health system/health economy is unsustainable and unaffordable in its current configurations and functions and that inaction will lead to system failure. We cannot continue doing what we have done and expect these challenges to be reversed. CMDHB plans bold and concerted action over the next three years to tackle these issues head on. We recognise that we cannot drive change alone and that much collaboration, cooperation and behavioural changes to how we approach health as a system, not a series of silos is vital. We are dependent in many domains on the will and ability of our partner organisations to execute shared ideas and solutions and for a significant portion of our key deliverables.

CMDHB recognises that this is a 2011-12 operating plan however we wish to clearly signal our intention to take a leadership role in the transformation of the health system over the next three years. We plan to guide the system to the next evolutionary phase; the evolution from a dominant focus on doing things right, that is, technical advancement in quality improvement, to also doing the right things, that is, ensuring that each investment and disinvestment decision is based on value added quality improvement criteria around outcomes achieved for each health dollar spent.

At CMDHB, transformational change will be driven by a strong organisational commitment to **healthcare improvement** and **increasing value** from the resources allocated to the DHB.

The Triple Aim concept of focusing on the three bottom lines of population health, patient experience of care and managing per capita cost of health, lies at the heart of the DHB's organisational planning and activities. It reflects the underlying objectives of the Counties Manukau Health System (see Figure 4), which is to:

- Improve the health of the population and reduce inequalities;
- Improve patients and their family/ whaanau's experience of care, and
- Make the best use of our population-based funding.

Primary health care with its Better, Sooner, More Convenient (BSMC) health care focus will be a key strategic platform from which to drive transformational change. CMDHB intends to make significant progress in realising BSMC intent by strengthening and broadening its partnerships with and support of the primary health care sector. CMDHB fully appreciates that strong ownership and accountability from primary health care providers will be key to realising the level of system transformation identified within BSMC.

CMDHB will through its role as health system integrator, over the next 36 months, enable the primary health care sector to configure itself to operate as a key engine room of the health system and show tangible progress at a greater pace on health system provision priorities such as access to services, quality of services, integration of services and the ability of services to positively impact acute demand over time.

Successful, sustainable delivery of activities that impact on acute demand will have a priority focus for us as we understand that activities within this domain are strategically critical for the health sector's ability to meet future demand for public health care services.

As a DHB, we will be focusing on:

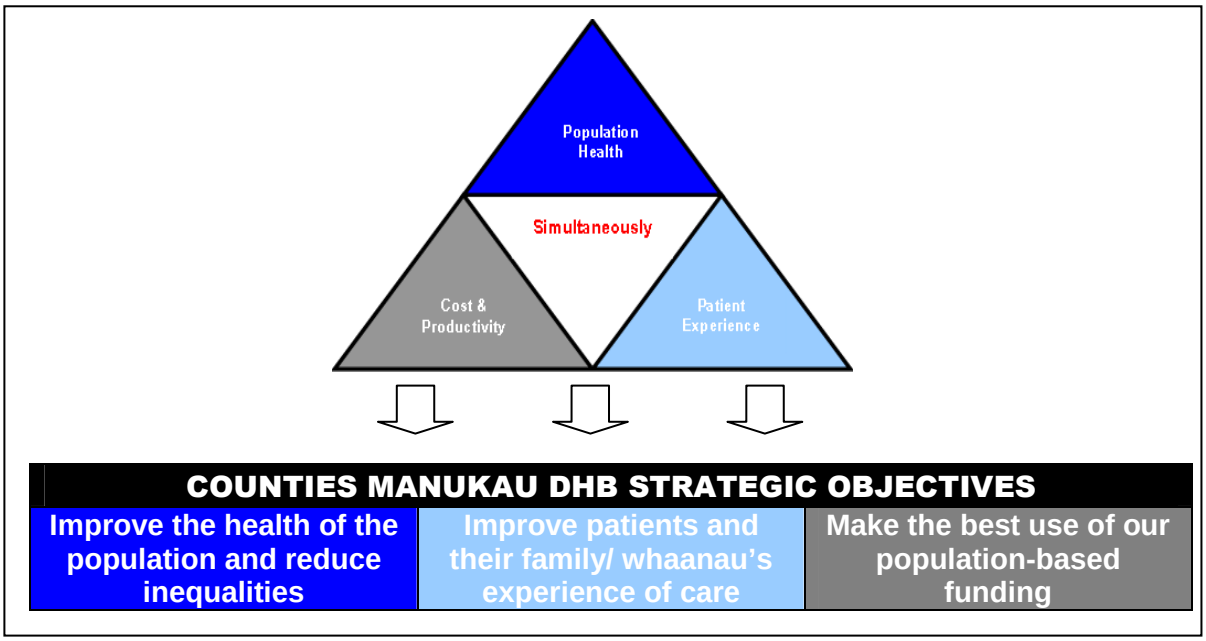
- Reducing disparities in personal health access and outcome and population health status of our Maaori and Pacific populations and other populations experiencing health disparity
- Reducing acute demand for health services through primary and secondary prevention by providing our population with high quality, affordable, integrated, equitable and readily accessible services that meet their needs
- Improving service and reducing waiting times for patient access to important services
- Ensuring our focus on Child, Youth and Maternity health and well being remains sharp and delivers on the provision of a Child and Youth Health Plan by December 2011 which will be aligned with the localities, mental health and Maaori Health plans. Focusing on reducing the incidence of communicable disease with the aim that our children are less likely to acquire chronic diseases in later life.
- Reducing risk taking behaviours (sexual health, smoking and suicide prevention) and improving youth engagement with health services
- Strengthening clinical leadership "from bedside to boardroom" and supporting clinical engagement and regional clinical networks
- Delivering more services in community-based settings which are closer to the patient and improving integration of services across hospitals and the community
- Meeting the health and support needs of older people, particularly in the areas of dementia, disease and injury prevention
- Collaborating regionally in shared services planning and development of back office functions and regionalisation of key enablers like information systems and workforce development
- Budgeting and operating within the allocated funding and improving financial performance
- Working to reduce the incidence and impact of chronic disease and collaborating regionally and locally to deliver 'best designed' (cost, efficient, quality) systems and interventions with a particular focus on reducing the health disparities of our Maaori, Pacific and high needs populations in those key health areas of: diabetes, cardiovascular disease, cancer, child health, elective surgery, emergency care, health of older people, mental health

- Ensuring people affected by mental ill health have access to mental health services and mental health clients have fewer acute episodes
- Ensuring increased availability and access to health and disability services in primary and community settings

This will be enabled by:

- Continuing with our commitment to support the three Auckland Business Cases; Greater Auckland Integrated Health Network (GAIHN), Nation Hauora Coalition (NHC) and Alliance Health + (AH+) to implement their business cases and deliver on their stated objectives
- Continuing to build on shared regional approaches to increasing efficiency and improving relationship management under Host and Partner DHB functions as defined in the collaborative agreement between DHBs and PHOs and Business Case entities
- Achieving the final consolidation of PHOs and supporting 4 large capable organisations linked with the BSMC business cases
- Delivering on our objectives identified in the Regional Primary Care Annual Plan with our partner DHBs with a focus on after hours and other acute demand activities, primary care quality, and defining key performance indicators, clinical leadership, patient centred decision making and service shift
- Continuing to work with the opportunities offered within the BSMC environment via the constructive, collaborative and transparent working philosophy inherent in an "Alliancing approach"
- Implementing a locality based approach with a focus on approximately 6 localities based on geography and health need rather than organisational boundaries and utilising this approach to identify and implement solutions to system challenges.
- Building collaborative local health networks at various levels focused on delivering new and innovative models of care that positively impact on acute demand management particularly ED attendances; and improve integrated management of long term conditions particularly diabetes and cardio vascular disease
- Supporting the implementation of Integrated Family Health Centres (IFHCs) and Whanau Ora Centres (WOCs) in our district which will be delivered through public-private partnerships. These centres are key deliverables and mechanisms in primary care reconfiguration to build capacity and capability for better integrated services and service shifts. We will work to enable IFHCs/WoCs to provide a wide range of services including specialist assessments by GPs, extended and after hours services, walk in access and an increased focus on nursing, allied and social services
- CMDHB working in support of clinical and social movement activities required to support the Regional Health Plan and associated campaigns
- Progressing work on an Atlas of Healthcare Variation to identify variation in clinical outcomes, processes, spending, and value, and to use this information to drive healthcare improvement.

Figure 4: The Triple Aim and Counties Manukau DHB's Strategic Objectives



2.2.2 Our Strategic Objectives

<table>
<tr><th colspan="2">Improve patients and their family/ whaanau's experience of care</th></tr>
<tr><td>Why is this important?</td><td>
Counties Manukau DHB is cognisant of the fact that we do not yet have a health care system which is sufficiently patient-centred.

Consider the findings from this study by Peter Davis et al[9] of 6,579 records from 13 hospitals.
• 12.9% had adverse events,
• 15.0% of those were permanent or fatal,
• 20% occurred outside the hospital environment, and
• 33.0% could have been avoided.

Avoidable serious adverse events totalled 4,600 admissions which translates to 276,000 bed days. At a cost of approximately NZ$13,000 per adverse event, the cost of preventable adverse events is $573 million.

A culture of quality improvement needs to be grafted into all aspects of the DHB's operations and processes if the DHB is to deliver safe and high quality health care services which patients and their families can trust and use with confidence. QI will also drive the reduction of waste in the system so that resources can be re-directed to other areas.

A high quality healthcare system is marked by these six dimensions[10]
<table>
<tr><th>Quality Dimensions</th><th>What this means for our services</th></tr>
<tr><td>Safe</td><td>No unnecessary harm</td></tr>
<tr><td>Patient-centred</td><td>Involve patients in their care and in system improvements</td></tr>
<tr><td>Efficient</td><td>Reduce waste</td></tr>
<tr><td>Timely</td><td>No unnecessary waiting</td></tr>
<tr><td>Equitable</td><td>Services matched to the level of social and health need to provide equal opportunity of health outcomes</td></tr>
<tr><td>Effective</td><td>Doing things which are evidence based</td></tr>
</table>

The DHB launched the Aiming for Zero Patient Harm campaign in September 2010 (See Section 2.3.4 for more information on our Aiming for Zero Patient Harm Campaign) and is taking what we have learnt through our quality improvement initiatives out to the region, with the aim of developing a consistent regional structure and methodology for addressing patient safety.

Patient centred care is also about:
• Improving patient literacy about their health
• Better communication with patients about their management plans and involving patients and their families in the development of their care plans
• Advance care planning with patient and families to reduce inappropriate intervention at the end of life
</td></tr>
</table>

[9] Davis, P. Lay-Yee, R. Briant, R. Schus, S. Scott, A. Johnson,S & Bingley, W. *Adverse events in New Zealand Public Hospitals: Principal findings from a national survey.* 2001. Ministry of Health.

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

Improve patients and their family/ whaanau's experience of care

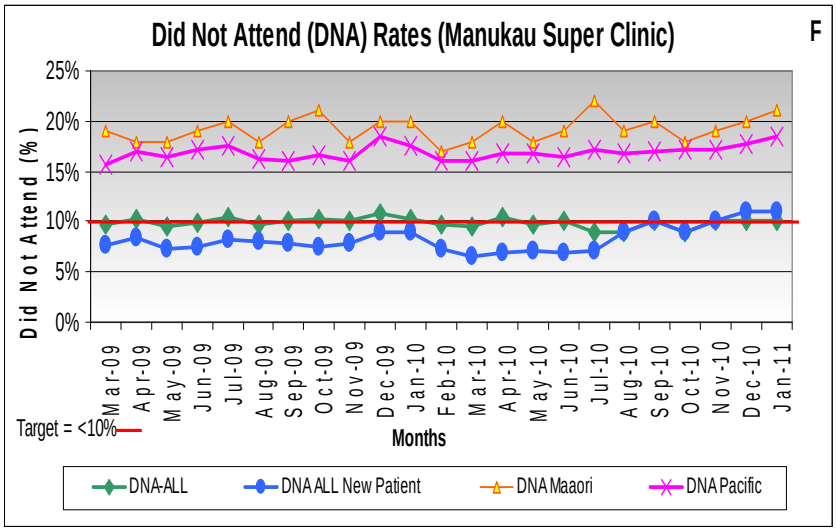
What is the current picture?

At Counties Manukau, harm is occurring in the following areas:

- Preventable Patient Falls: On average 80-90 patients fall each month at the DHB. Of these approximately 20 are harmed. 11 are Serious and Sentinel events.
- Preventable Pressure Injuries: Survey of all patients in 2009 showed 169 patients had 287 pressure injuries, 50% developed in the DHB's care.
- Patient harm does not just occur in our hospitals, for example up to 50% of preventable pressure injuries occur before the patient reaches secondary care.
- Preventable Central Line Acquired Bacteremia (CLAB): In 2009 there were 51 preventable CLAB events hospital wide. These lead to increased costs, morbidity and potential mortality.

The outpatient Did Not Attend (DNA) rates for Maaori and Pacific remain high with rates in the last three years remaining between the 15% to 20% band. This signifies a significant amount of waste remains in the system and the DHB needs to continue with initiatives to address this issue including: ensuring Maaori and Pacific patients have the cultural support they need, that there is sufficient information given to patients and to referrers, and ensuring patients are given First Specialist Assessments and certainty of treatment within acceptable time frames.

DHB Outpatient Did Not Attend (DNA) rates[11]



Our priority as a DHB is to:

- Deliver patient and family/whanau-centred care by focusing on the six healthcare quality dimensions: safe, patient-centred, equitable, timely, efficient, and effective
- Develop and build capacity and capability in:
  - Quality
  - Workforce,
  - Health intelligence,
  - Health systems research and innovation,
  - Clinical leadership.

We will know we are making an impact on this objective when we have:

- Improved waiting times for services
- Improved patient satisfaction with services
- Fewer adverse clinical events
- Improved engagement of Maaori and Pacific with health services

This will be measured by our progress on the following key measures

- Patient satisfaction with services (rating it Good or Very Good) improve
- Acute readmissions rate decreases

Other measures contributing to this objective are outlined in Section 3

[11] *CMDHB Board Dashboard*

Improve the health of the population and reduce inequalities	
Why is this important?	The commitment to improving the health of our population and reducing health inequalities is clearly stated in the Counties Manukau DHB vision. Whilst life expectancy as a whole has improved across the Counties Manukau population, the life expectancy gap between Maaori and non-Maaori and non-Pacific population remains in excess of 10 years while the gap between Pacific and non-Maaori and non-Pacific is 5 to 7 years[12]. Many other markers of ill-health show similar disparities.[13] Therefore, if the DHB is to improve the health status of the population it is important that we focus on reducing some of the disparities in health outcomes faced by our Maaori and Pacific populations; a high proportion of whom live in relative social and economic deprivation compared to the rest of the population. The DHB has a Health Equity Working Group who provide support for clinicians and managers to systematically consider equity as part of 'business as usual', and to capture and disseminate the organisational lessons so as to increase DHB capacity for addressing health disparities. Non Communicable Diseases like diabetes, lung disease and cardiovascular disease (CVD) in particular are key contributors to our mortality rates and affect our Maaori and Pacific population disproportionately. Increasing obesity, smoking prevalence and demographic changes in our population mean that the numbers of people with non-communicable disease like diabetes, CVD and cancers will increase. The burden of these diseases is not only one which has to be borne by the afflicted individual and their family but it affects all of society as the cost of management and treatment of these long term conditions account for a substantial proportion of health care expenditure, along with wider societal costs related to impacts on employment and related welfare expenditure. The implication for the DHB is that there needs to be continued focus and investment in interventions and programmes aimed at primary (before disease has been diagnosed) and secondary (reducing the impact of non-communicable disease after diagnosis) prevention which are evidence-based and effective. The Northern Region Health Plan will serve as a starting point for the coordination of a regionally consistent framework around issues relating to prevention, care and treatment of people who are either at risk of developing non-communicable disease or have non-communicable disease. Local implementations of these strategies are outlined in our Annual Plan 2011/12 and also our Maaori Health Plan 2011/12. This will be the key document outlining priority areas for Maaori health and the activities which the DHB will be undertaking in relation to improving Maaori health outcomes. Locally, our *Creating a Better Future* programme is the vehicle for the DHB to work across sectors and with the community to address the growing burden of disease created through tobacco use, poor nutrition, inactivity and hazardous alcohol consumption. Improving the health and wellbeing of children and young people living in Counties Manukau is a priority for CMDHB as we have a young population – 40% under the age of 25 years. Hospitalisation rates for children and young people residing in CMDHB are above the national average for many diseases, the main ones being: lower respiratory infections, rheumatic fever and meningococcal disease. Continuing to advocate for improved housing and smokefree living environments are central to decreasing the risk of these infectious diseases and giving children a good start to life. The high prevalence of mental health and addiction issues is also of major importance for service planning and intersectoral action is particularly important to address these needs.

[12] Smith, J. Jackson, G & Sinclair, S. 2008. *Life expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB.* Counties Manukau District Health Board.
[13] Health and Disability Intelligence Unit. 2008. *Counties Manukau DHB Health Needs Assessment September 2008*. Manukau: Counties Manukau District Health Board.

Improve the health of the population and reduce inequalities

What is the current picture?

Major disease areas contributing to life expectancy gaps in CMDHB in 2005 and proportional contribution of each area[14]

Cause of death (disease area)	Maaori	Pacific
Infant mortality	5%	10%
Cardiovascular disease	16%	35%
Smoking-related lung disease	20%	9%
Cancer (non-lung)	17%	6%
Diabetes	7%	13%
Remainder	37%	27%

Our priority as a DHB is to:

- Reduce demand for health services through primary and secondary prevention
- Deliver more services in primary care and community based settings
- Collaborate regionally and locally to deliver 'best designed' (cost, efficient, quality) systems and interventions in key health areas
    - Diabetes
    - Cardiovascular
    - Cancer
    - Child health
    - Elective surgery
    - Emergency care
    - Health of older people
    - Mental Health
- Increase availability and access to health and disability services in primary and community settings

We will know we are making an impact on this objective when we have:

- Reduced incidence and impact of chronic disease
- Older people are supported and receive services appropriate to their needs
- People affected by mental ill health have access to mental health services and mental health clients have fewer acute episodes
- Children are healthier and safer

This will be measured by our progress on the following key measures:

- Life expectancy gaps between Maaori and Pacific and non-Maaori and non-Pacific reduce
- Proportion of the adult population who are smokers decrease
- Acute hospitalisation rates for cardiovascular disease and diabetes decrease
- Number of patient admissions avoided at Emergency Care through the Primary Options for Acute Care (POAC) programme increase
- Access rates to Mental health services increase
- The ratio of older people in Home Based Support Services compared to Aged Residential Care improves
- The number of 65+ year olds presenting at the Emergency Department decrease
- Rate of children's acute hospitalisation decrease

Other measures contributing to this objective are outlined in Section 3

[14] Smith, J. Jackson, G & Sinclair, S. 2008. *Life expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB.* Counties Manukau District Health Board.

Make the best use of our population-based funding

Why is this important?

The DHB faces significant demands on its funding due to a growing and ageing population. With the current constraints on the Government's fiscal position, it is unlikely that the health sector will receive much new funding over the next few years and DHBs will be expected to manage on lower levels of funding.

Whilst we are working hard to ensure that we are able to manage within our given budget to meet present need, measures are also being taken to future proof our current investment so that we are able to meet future health demands.

Our *Thriving in Difficult Times* programme which was launched in December 2009 is helping the organisation increase the value we get from our resources and free up funding for re-investment in other areas . This is done by focusing on improving patient safety, reducing inappropriate clinical variation and removing duplication and waste from our operations and processes.

All these actions are being made in the context of the Triple Aim so that whilst there is a focus on managing costs, the expectation is that there is also a simultaneous focus on population health outcomes and improved services.

Making the best use of our population-based funding also means working with the other Northern Region DHBs to ensure that our support and back room functions and key DHB enablers like information systems, workforce and facilities are planned in a collaborative manner which maximises value for money and reduces waste and duplication.

Growing Our Own Workforce is a key strategic workforce initiative for the DHB which aims to build a local workforce for the DHB and the wider health sector which will reflect our community and their needs.

What is the current picture?

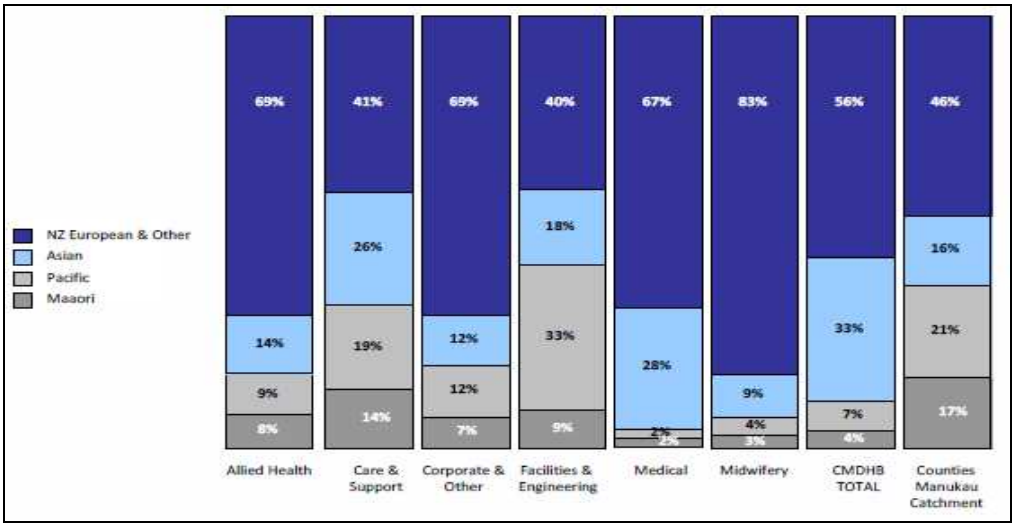
CMDHB's Financial Performance[15]

Actual Net result Combined Operating Arm c/f against budget net result ($000)

ANNUAL: Cost/Productivity	GOAL	Annual FY07	Annual FY08	Annual FY09	Annual FY10
Financial Performance	>=0	6435	8575	101	3018

CMDHB Workforce ethnicity by workgroup and Counties Manukau population[16]

FTE is shown here with n = 4931, on 30 September 2010



<table>
<tr><th colspan="4">Make the best use of our population-based funding</th></tr>
<tr><td>Our priority as a DHB is to:</td><td colspan="3">• 'Work smarter' to free up resources for re-investment in other areas
• Reduce inappropriate variation in clinical practice
• Reduce duplication and waste by working in a more unified manner within the organisation and with our regional colleagues
• Build a workforce which reflects our own communities and their needs</td></tr>
<tr><td>We will know we are making an impact on this objective when we have:</td><td>• Increased value from the resources allocated to the DHB
• Services delivered efficiently with minimal wastage and duplication
• Increased participation of Maaori and Pacific people from Counties Manukau in the health sector workforce</td><td>This will be measured by our progress on the following key measures:</td><td>• Zero deficit
• Proportion of Maaori and Pacific staff in DHBs by occupation class to increase
Other measures contributing to this objective are outlined in Section 3</td></tr>
</table>

2.3 OUR STRATEGIC OBJECTIVES IN THE NATIONAL, REGIONAL AND LOCAL CONTEXT

Counties Manukau DHB's strategic direction and planning has been shaped and influenced within a strategic context of national, regional and local plans and priorities. These include:

- The New Zealand Health and New Zealand Disability Strategies
- The Maaori Health Strategy (He Korowai Oranga) and Whanau Ora
- The Primary Health Strategy
- The Long Term Health Sector Plan
- Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014
- The Northern Region Health Plan
- The regional *Better, Sooner, More Convenient* primary health care business plans
- The Minister of Health's Expectations
- National Health Targets
- Other regional service plans and priorities (which are not covered in this first iteration of the NRHP but will be in subsequent years) for example, mental health, child and youth health,
- National and regional strategies for key DHB enablers like workforce development and information systems
- Local DHB priorities like the development of Ko Awatea (Centre for Health Services Innovation and Improvement), the *Thriving in Difficult Times* initiative, and the *Aiming for Zero Patient Harm* campaign.
- Local plans like the Maaori Health Plan and the DHB's Health Services Plans.

A brief summary of some of these key plans and strategies and how they shape the DHB's strategic objectives are outlined below.

2.3.1 At the National Level

At the national level, the *New Zealand Health Strategy* and the *New Zealand Disability Strategy* currently sets the strategic direction for all health services in New Zealand. The former establishes a vision for health services, principles for planning and provision of services and it outlines objectives for the health of the population, with a focus on tracking inequalities in health. The latter aims to improve the ability of people experiencing disability to participate in community life and is intended to move New Zealand towards becoming an inclusive society.

These strategies are supported by other national level strategies like the *Maaori Health Strategy* (*He Korowai Oranga*), the *Primary Health Care Strategy* and *Whaanau Ora.*

The *Maaori Health Strategy (He Korowai Oranga)* sets the basis for reducing health inequalities for Maaori by establishing the need to work with whaanau/ families as opposed to just individual patients. In particular the key pathways for better outcomes for Maaori include development of whaanau, hapu and Iwi, greater participation in development, delivery and evaluation of health services, delivery of effective services and the provision of services which work across sectors.

This in turn has led to the development of the *Whaanau Ora* policy framework which sets out the need to develop services which work alongside whaanau within communities and seeks to bring together all relevant services together to enable whaanau.

A *Long Term Health Sector Plan* (LTHSP) is currently being drafted by the National Health Board (with expected delivery of the final plan in June 2011). The LTHSP will outline the future direction for public health services, focusing on service planning and new models of care. It will provide high-level direction over the next 20 years and describe the challenges the sector faces and options for models of care that offer solutions and implications for the way services are configured in the future.

After the LTHSP is finalised by the NHB, it will guide future decisions about service configuration and investment at all levels of the system and support the DHB in their long term local and regional planning. The NHB will use the LTHSP to inform their review of national, regional, and district plans.

The Minister of Health's Expectations and the National Health Targets

The Minister of Health's annual *Letter of Expectations* sets out what DHBs are expected to deliver for the upcoming financial year. Together with the national health targets, they provide a clear focus for DHBs to plan for service and system improvements.

The Minister's expectations for 2011/12 are that DHBs will focus on:

- Improving service and reducing waiting times for patient access to important services
- Strengthening clinical leadership and supporting clinical engagement and regional clinical networks
- Delivering more services in community-based settings which are closer to the patient and improving integration of services across hospitals and the community
- Meeting the health and support needs of older people, particularly in the areas of dementia, disease and injury prevention
- Collaborating regionally in services planning and development of back office functions and regionalisation of key enablers like IS and Workforce Development
- Budgeting and operating within the allocated funding and improve financial performance

National Health Targets for 2011/12 are as follows:

- 95% of all people will be admitted, transferred or discharged within 6 hours of presenting at the Emergency Department
- 4,000 more elective procedures will be delivered to the population nationally
- 100% of all cancer patients awaiting radiotherapy treatment are treated within 4 weeks
- 95% of all children are fully immunised at the age of 2 years
- 95% of all hospitalised smokers are given advice and support to quit
- 90% of all enrolled primary care clients who are smokers and seen in general practice are given advice and support to quit by their GP
- People who are eligible will have had their cardiovascular disease risk assessed in the last 5 years
- People who are diabetic will attend free annual checks and have satisfactory or better diabetes management

2.3.2 At the Regional Level

The Northern Region Health Plan (NRHP)

Under the New Zealand Public Health & Disablity Amendment Act 2010, the requirement for the DHB to have a district-level strategic plan has been removed and as directed by the Minister of Health, the Northern Region DHBs have collaborated to develop the first Northern Region Health Plan.

The challenges the DHB is facing are by no means unique to us. This is why we have sought to find a common strategic platform with our neighbouring DHBs in the Northern Region through the Northern Region Health Plan.

This whole-of-system regional health plan is expected to outline common regional outcomes, strategic goals and high level implementation plans in a few key areas of high priority and vulnerable services for DHBs and other stakeholders.

The NRHP has an intervention logic (*See Appendix 4*) framed by the Triple Aim concepts of: *Patient Experience*, *Population Health* and *Cost/ Value*, with a high level vision of:

Adding value through better health and healthcare to 1.6 million New Zealanders

The long term mission of the NRHP is to improve health outcomes and reduce health disparities by delivering better, sooner, more convenient services in a way which is financially sustainable.

In line with Ministerial expectations, Counties Manukau DHB's strategic direction will align with regional direction and the DHB's annual priorities for 2011/12 will include local implementation of regional objectives which will be evident in this Annual Plan and in the Counties Manukau Maaori Health Plan 2011/12.

Figure 5 shows the alignment of Counties Manukau's strategic objectives with the region's strategic goals within the Triple Aim framework.

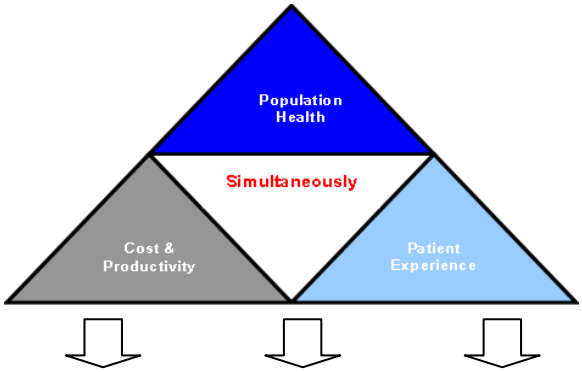
Alignment of our local priorities with regional and national direction

The DHB's strategic priorities are pulled together in Figure 6 in an intervention logic framework which establishes the links between Government/national priorities and regional priorities and the DHB's strategic objectives.

The framework also shows the key local strategies and plans that the DHB will undertake to progress regional and national outcomes and the desired impacts (or intermediate outcomes) which these strategies and plans will deliver, including key performance measures – medium term measures - which will tell us whether we are progressing towards our outcomes and ultimately achievement of our goals. In our *Statement of Forecast Service Performance* in Section 3 we outline in further detail why these measures are important markers of our performance.

The broad output classes which our activities fall within are presented in the framework but it is only in Section 3 that we will look at the specific outputs within each output class, the impacts that it is hoped these outputs will deliver, and the performance that we forecast to deliver for the financial year.

Figure 5: Alignment of Counties Manukau DHB Strategic Priorities with the Northern Region Health Plan Strategic Vision and Goals



REGIONAL GOALS

POPULATION HEALTH	PATIENT EXPERIENCE	COST/ PRODUCTIVITY
Adding to and increasing the productive life of people in the Northern Region	**Delivering better services by Aiming for Zero Patient Harm, Performance Improvement and Informed Patient Choice**	**The region's health resources are efficiently and sustainably managed to meet present and future health needs**

REGIONAL PRIORITIES

"Life & Years" • *Adding Life to Years*: To focus on a set of conditions which if "best designed" would deliver a significant improvement to health of the population, keeping citizens productive, reducing demand on hospital services • *Adding Years to Life*: To increase the number of years of life in the Northern Region by reducing risks of **diabetes** and **cardiovascular disease** This priority will also include: **Health of Older People**, **Cancer** and **Radiology**	**"First, Do No Harm"** • To be the safest healthcare system in Australasia through the systematic application of evidence based interventions which will save lives, prevent harm to patients, save money, free up capacity and improve productivity. **"Informed Patient Choice"** • *Advance Care Planning* To involve our patients in the decisions that impact their lives, their families/whanau	• Affordability • Asset Management • Workforce • Information Systems

COUNTIES MANUKAU DHB STRATEGIC OBJECTIVES

Improve the health of the population and reduce inequalities	Improve patients and their family/ whaanau's experience of care	Make the best use of our population-based funding

WE WILL ACHIEVE OUR STRATEGIC OBJECTIVES BY

• Reducing demand for health services through primary and secondary prevention
• Delivering more services in primary care and community based settings
• Collaborating regionally and locally to deliver 'best designed' systems and interventions in key health areas: diabetes, cardiovascular disease, cancer, child health, elective surgery, emergency care, health of older people, mental health
	• Delivering patient and family/whanau-centred care which is safe, patient-centred, equitable, timely, efficient, and effective
	• Developing and building capacity and capability in:
	  • Quality
	  • Workforce,
	  • Health intelligence,
	  • Health systems research and innovation,
	  • Clinical leadership.
		• 'Working smarter' to free up resources for re-investment in other areas
		• Reducing inappropriate variation in clinical practice
		• Reduce duplication and waste by working in a more unified manner within the organisation and with our regional colleagues
		• Building a workforce which reflects our own communities and their needs

Figure 6: Counties Manukau DHB Strategic Framework and Intervention Logic

High Level Outcomes	**All New Zealanders lead longer, healthier and more independent lives.**		
Regional Mission	**To improve health outcomes and reduce health disparities by delivering better, sooner, more convenient services. We will do this in a way that meets future demand whilst living within our means.**		
Regional Goals	**Population Health** **Adding to and increasing the productive life of people in the northern region**	**Patient Experience** **Delivering safe and good quality healthcare which is patient and family/ Whaanau centred**	**Cost / Productivity** The region's health resources are efficiently and sustainably managed to meet present and future health needs.
DHB Strategic Objectives	**Improved health of the population and reduced inequalities**	**Improved patients and their family / whaanau's experience of care.**	**Make the best use of our population based funding.**
We will do this in order to achieve our strategic objectives *NB: Linkage to the NRHP intervention logic in between brackets*	• Reducing demand for health services through prevention and delivering more services in primary care and community based settings (NRHP 1.1, 1.2, 1.3, 1.4). • Collaborating regionally and locally to deliver 'best designed (cost, efficient, quality) systems and interventions in key health areas including; - Diabetes - Cardiovascular - Cancer - Child Health - Elective Surgery - Health of Older People - Emergency Care - Mental Health (NRHP 1.1, 1.2, 1.3, 2.1) • Increasing availability and access to health and disability services in primary and community settings.	• Developing patient and family/ whanau centred care by focusing on the six healthcare quality dimensions: safe, patient centred, equitable, timely, efficient and effective. • Developing and building strategic capacity and capability in; - Workforce - Health systems research and innovation - Clinical leadership - Quality - Health Intelligence (NRHP 2.1, 2.2, 2.3)	• 'Working Smarter' to free up resources for re-investment in other areas (NRHP 3.1) • Reducing inappropriate variation in clinical practice (NRHP 3.1) • Reducing duplication and waste by taking a more unified systems approach (NRHP 3.4, 3.5, 3.6) • Building a workforce which reflects our own communities and their needs (NRHP 3.2)
High Level Impact sought	• Reduced incidence and impact of chronic disease. • Older people are supported and receive services appropriate to their needs. • People affected by mental ill health have access to mental health services and mental health clients have fewer acute episodes. • Healthier and safer children.	• Improved waiting times for services. • Improved patient satisfaction with services • Fewer adverse clinical events • Improved engagement of Maaori and Pacific with health services.	• Increased value from the resources allocated to the DHB. • Services delivered efficiently with minimal wastage and duplication. • Increased participation of Maaori and Pacific people from Counties Manukau in the health sector workforce.
Key Performance Measures	• Acute hospitalisation rates for Diabetes and Cardiovascular disease decrease (1 a) • Number of POAC patient admissions avoided at Emergency Care increase (1 b) • Life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific decreases (I c) • Proportion of adults in the population who are regular smokers decrease (1 d) • Rate of acute hospitalisations for children (0-14 years) decrease (2 a) • The ratio of older people in HBSS compared to ARC improves (3 a) • Proportion of people aged 65 years and above presenting to ED decreases (3 b) • Mental Health service access rates improve (4 a)	• Rate of acute readmissions within 28 days is maintained or reduced (5 b) • Patient Satisfaction with services (rated Good or Very Good) improves (5 a).	• Zero deficit • Proportion of Maaori and Pacific staff in DHBs by occupation class increases.
Key Strategies and Plans	• Better, Sooner, More Convenient Primary Health Care. • Creating a Better Future • Healthy Housing Programme • Whanau Ora • Lotu Moui *Northern Regional Health Plan* • Diabetes • Cardiovascular Disease • Cancer • Health of Older People *Regional services Plan:* • Child and Youth Health • Mental Health *Maaori Health Plan*	• Northern Regional Health Plan: First Do no Harm • Aiming for Zero Patient Harm • Ko Awatea • Innovation Hub	• Thriving in Difficult Times • Productivity Initiatives: *Electives Productivity* • Growing Our Own workforce • Regional Information Systems Plan • Regional Workforce Plan • Regional Asset Planning • Northern Regional Shared Services Organisation establishment
The DHB will achieve this through the delivery of the following services (grouped by Output Class)	**Prevention** • Health Promotion and Education • Statutory Regulation • Population Based Screening • Immunisation • Well Child Services	**Early Detection and Management** • Primary Health Care • Oral Health • Primary Community Care Programmes • Pharmacist • Community Referred Testing and Diagnostic • Mental Health	**Intensive Assessment and Treatment** • Mental Health • Elective (Inpatient / Outpatient) • Acute (Emergency Department / Inpatient / Outpatient) • Maternity Services	**Rehabilitation and Support** • Assessment, Treatment and Rehabilitation • Needs Assessment and Service Co-Ordination • Palliative Care • Rehabilitation • Aged Related Residential Care • Home Based Support • Life Long Disability • Respite Care • Day Services.

2.4 KEY RISKS

All of these risks are existing, known and managed as much as possible currently, but remain critical to the organisation in terms of either meeting our community's health needs, remaining financially viable, or adequately planning for the future. There is no particular order of ranking to the list below.

Risk Description	Mitigation Strategies
Growing Acute Demand Growth in acute medical admissions has been rising faster than population growth since 2007. Between 2008 and 2009 there was an 8% increase in acute adult medical admissions; this is 5% above expectations based on population growth. Ambulatory Sensitive Hospital (ASH) rates and Emergency Care (EC) rates have also trended upwards since 2007. The majority of the increased admissions to Middlemore Hospital are avoidable admissions which are sensitive to timely primary care intervention.[17] Chronic and long term conditions like diabetes and cardiovascular disease (as outlined below) and respiratory conditions like chronic obstructive pulmonary disease (COPD) are the biggest contributors to acute demand. Given that our population will be growing by more than 40% over the next 20 years and we will be more than doubling the proportion of our population aged over 65 years (See *Section 1.2.2, Demand Growth*), acute demand and the burden of chronic disease will only be trending upwards. The pressure on facilities, workforce and resources is showing no signs of letting up. Current hospital bed demand is already in excess of what we forecasted for 2013 and last year, our outpatient services saw an unprecedented **299,412** patients attended to – about a 9% increase from the previous year.	• Continued focus and investment in interventions and programmes aimed at primary and secondary prevention which are evidence-based and effective. • At the primary prevention end: reduce the burden of disease through community-based interventions and programmes aimed at smoking cessation, improving maternal and child health (breastfeeding, immunisations, well child checks, oral health, infant and maternal mental health), healthier eating and a more active lifestyle. Regional collaboration across DHBs and PHOs to implement initiatives to reduce/ manage acute demand: • Continued investment in community and primary care based programmes to reduce the burden of chronic disease and growing acute demand: Chronic Care Management (CCM), Get Checked Diabetes programme, Care Plus and Primary Options for Acute Care (POAC). • Ensuring more equitable access to an integrated after-hours primary health care service • After hours care is made more affordable with standard co-payments across the network for high needs patients.
Cardiovascular disease (CVD) and diabetes Counties Manukau has the highest rate of diabetes in the country, with 8.4% of the adult population afflicted with this disease. This rate is due to double by 2021. People with Cardiovascular disease and/or diabetes account for 13% of the adult population in Counties Manukau. The cost of management and treatment of these diseases account for a substantial proportion of health care expenditure for the DHB. Some figures: • On average, each person with CVD and/or diabetes had healthcare costs of $2,400 more per head compared to a person without CVD or diabetes[18] • In 2008, 46% of the total in-hospitalisation costs (equivalent to $101million) were spent on patients with CVD and/or diabetes	• Continued focus and investment in interventions and programmes aimed at primary and secondary prevention which are evidence-based and effective. • At the primary prevention end: reduce the burden of disease through community-based interventions and programmes aimed at smoking cessation, improving maternal and child health (breastfeeding, immunisations, oral health, well child checks), healthier eating and a more active lifestyle. • Work with the Auckland Regional Public Health Service and across sectors to create greater awareness of diabetes in the region in order to influence policy settings Regional collaboration across DHBs and PHOs, primary and secondary care providers to: • Increase assessments of CVD risk particularly for eligible Maaori • Improve management of high risk CVD patients

Risk Description	Mitigation Strategies
• In 2009, 24% ($133million) of the costs allocated to the hospital, pharmaceuticals, and labs provision in Counties Manukau DHB were attributed to people with diabetes[19] The cost of treating and managing diabetes and CVD-related conditions is already incurring a disproportionate amount of the health spend. If no action is taken to curb the uptake of lifestyle factors like smoking, poor nutrition, inactivity and alcohol consumption, our ageing population profile means that the actual number of people with diabetes and CVD will increase significantly in the next 10 to 20 years, putting immense pressure on DHB resources.	• Increase the use of retinal screening as a preventative strategy for diabetes • Develop a clinical pathway for diabetes to improve primary and secondary integration of care • Develop a sustainable workforce to provide prevention, education, diagnosis, treatment and management activities for diabetes and CVD • Involve patients and their families in their management plans and improve patient health literacy by using care plans
Growing Demand for Cancer Services Significant volume growth is forecast for both radiation oncology and medical oncology for the next 10 years within the Northern Region. In addition to this there is the additional cost of excess capacity required to sustainably meet the Minister's health target. There is a risk that funders will not be able to reprioritise from other areas of health spend to meet this cost.	Work with the Northern Cancer Network on the following: • Regional Cancer Care Planning to identify the key priority areas for improvement in cancer care and what is needed to support future prioritisation and service delivery • Movement to a radiation therapy intervention rate which reflects appropriate clinical practice. • Management of access to medical oncology services and the implementation of national prioritisation criteria • Improve access to diagnosis and treatment of cancers through implementation of the cancer tumour streams so that cancers are diagnosed and treated early • Continued development of palliative care services
Growing Demand for Health of Older People Services The proportion of those aged 65 years and over in Counties Manukau is projected to increase by 131% from 2006 to 2026. For those aged 85+, the projected growth is 162%. Currently, about 29% of HOP clients are in residential care, accounting for more than 85% of the total HOP services funding. More than half the residential care clients are in age related hospital care. Overall, client numbers have increased in the last few years for many HOP services. These include: age-related hospital care, dementia rest home care, day care and carer support. If the current rate of intervention for HOP services remains the same, the rate of growth in the 65+ population will determine the rate of growth in HOP services. These projections also signal an urgent need to develop workforce capacity in both home-based care and residential care services. Failure to invest in workforce capacity development may result in	• Enhancing NASC capacity to ensure provision of equitable assessment and service coordination • Continue to develop the Community Geriatric Service with specialist input and promotion of services in the community to support positive ageing. • Improving the continuum and quality of care for people in residential care by ensuring there are internal audits, ongoing training for staff, and clinical support • Limit unnecessary medical intervention by increasing Advance Care Planning for older people as per NRHP implementation plan

Risk Description	Mitigation Strategies
compromised quality of care and patient safety issues.	
Managing the Cost of Wages and Salaries Within the provider arm, wage increases have been built in at the estimated level of settlements, as almost all awards have or are about to currently expire. Over and above these base salary and wage movements which in themselves are higher than the core FFT/CCP reimbursement level, Counties Manukau DHB is, along with all other DHBs experiencing very significant levels of oncosts. These include increasing step functions, additional leave, allowances and superannuation (Kiwisaver), primarily around medical and nursing staff entitlements. In many cases wage staff are entitled to move up a step virtually automatically after each year of service (step function increases) which result in an average of 2 – 2.5% (net) increases. The step function increases have to be absorbed by direct funding or by way of continuously increasing efficiencies. Actual changes in leave entitlements over the past three years, some related to the implementation of the Holidays Act, are already having both a material financial and resourcing impact on the organisation with particular challenges around the impact of observing the extra leave entitlement and then filling the consequent vacancies this is causing. The provision for the cashing up of the fourth weeks leave will present a significant cash flow challenge for the sector if all parties take full advantage of the change.	• Manage growing demand for services as outlined in the risks above on managing diabetes, CVD and acute demand • Taking a sector-wide approach to collective bargaining negotiations with different workforce groups. • The Auckland Region is due to complete the Senior Medical Officer (SMO) Regional Job Sizing exercise which will ensure there is regional wage comparability and establish safe clinical levels (full time equivalents) • Regular review of job vacancies
Implementation of Regional Primary Care business cases Regional business case activity fails to achieve promised improvements	DHBs are committed to ensuring the success of the three Primary Care business cases operating in the Auckland region and will continue to resource them to succeed. In addition, DHBs recognise that a shared understanding and approach to locality based health planning & delivery are key to achievement of the promised improvements and are working toward this.

SECTION 3: DHB PERFORMANCE (Module 4 in Annual Plan)

The DHB is required under Section 142 of the Crown Entities Act 2004 to provide a Statement of Forecast Service Performance. The measures in the Statement of Forecast Service Performance are non financial measures and consist of key outputs which the DHB is planning to deliver through its planned activities/ actions for 2011/12 and also expected performance on key performance measures over the time period of the Statement of Intent, that is, 2011/12 to 2013/14.

Figure 6 in Section 2 shows the DHB's strategic framework and how our strategic objectives - influenced by national and regional priorities - guide the DHB's decisions around what level of **input** (that is, resources) and mix of services best meets our population's health needs, how they are to be delivered and to what level.

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

These are measured against health quality measures like timeliness, access, patient safety, efficiency, effectiveness and equity.[20]

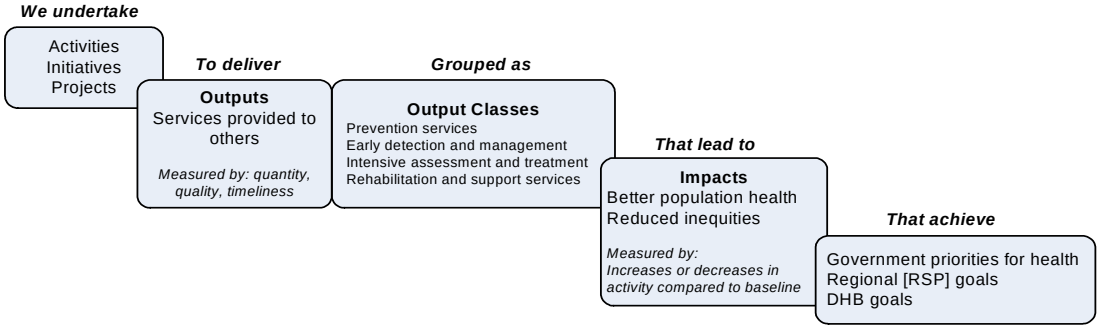
Where possible, we have included past performance (baseline data) along with each performance target to give some context of what we are trying to achieve and to better evaluate our performance.

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

The reader will note that for expediency, we have chosen only the key few measures of output and impact for each output class which best describes the activities that will contribute to the DHB's achievement of key strategic objectives and improved outcomes for our population.

The actual results of our service performance will be published in our 2011/12 Annual Report.

The intervention logic that underpins this Statement of Intent



3.1. High Level Impact - what we are trying to achieve for our population

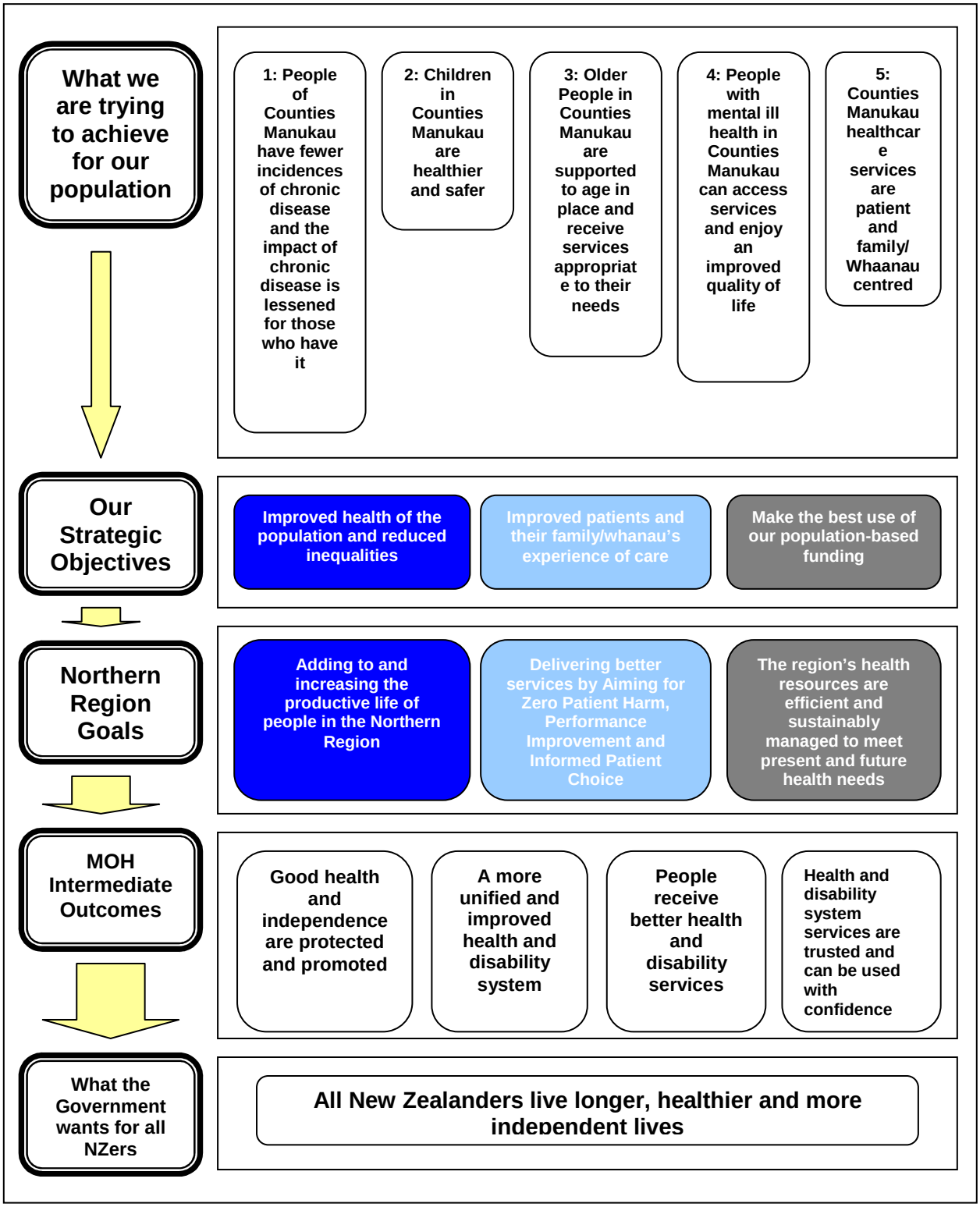
Figure 8 below shows the five key impacts that we are trying to achieve for our population through the DHB's role as planner, funder and provider of health services. These impacts are consistent with our strategic objectives, the regional vision for a healthier Northern Region and the government's desire for the health sector to contribute toward New Zealanders living longer, healthier and more independent lives.

The first four key impacts are *population health* impacts, achievement of which will bring about a healthier Counties Manukau with fewer health inequities between different population groups.

The fifth key impact is a *patient experience* impact which aims to provide patient and family/whaanau centred care which in Counties Manukau is care which is safe, patient centred, equitable, timely, efficient and effective.[21]

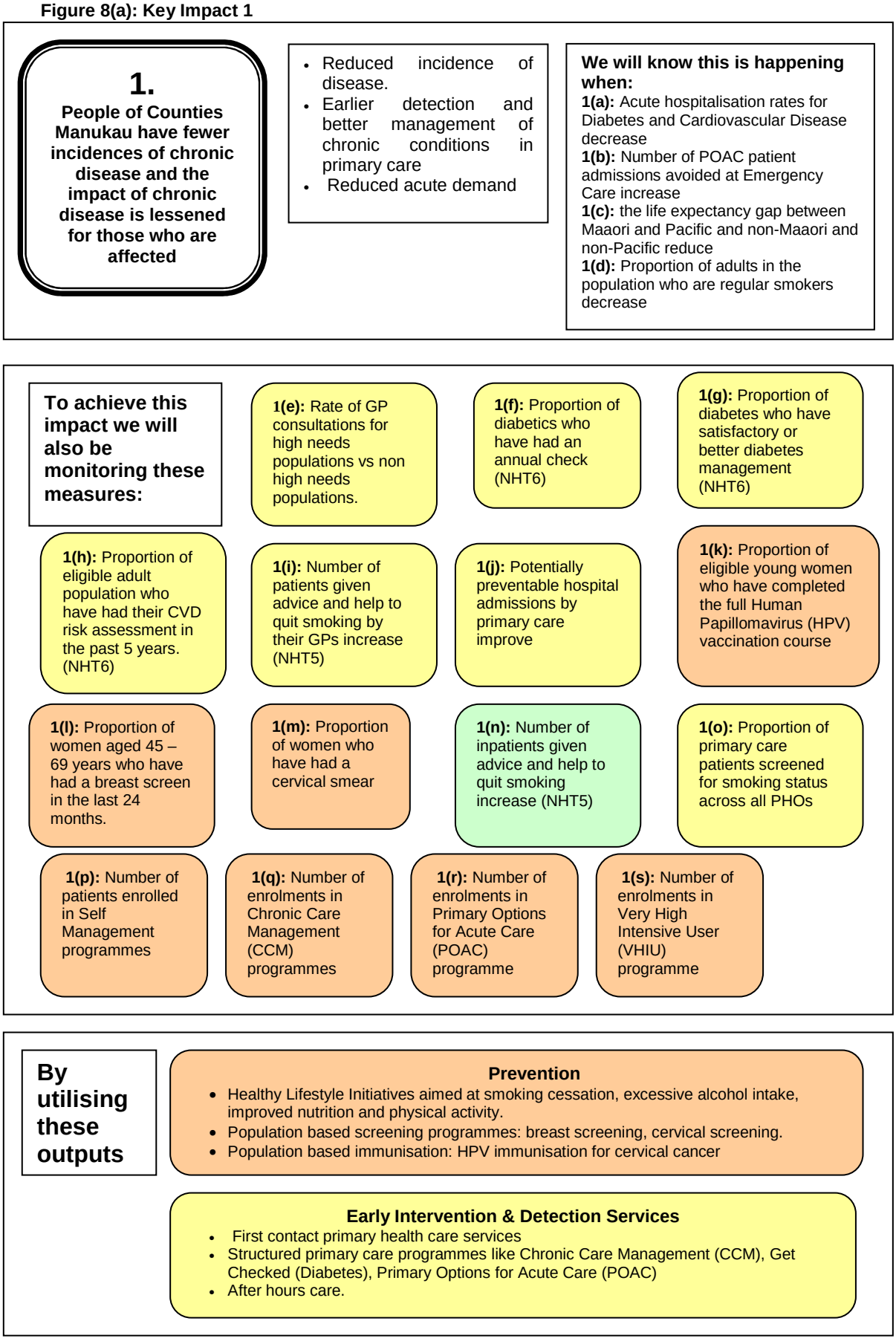
Each impact has measures which have been chosen as main measures relating to the full period of this Statement of Intent and information has been provided alongside each impact (Figures 8(a), 8(b), 8(c), 8(d), 8(e)) explaining why this measure is important and an indication of what our current picture is and the expected performance over the next three years.

Figure 8: What Counties Manukau DHB is trying to achieve for its population



3.1.2 Key Impact 1 – Reducing the incidence and impact of chronic disease

Figure 8(a): Key Impact 1



Key Measure

1(a): Acute hospitalisation rates for Diabetes and Cardiovascular Disease

Expected Performance

Baseline (2007)		July 2012 Target	Expected performance
Maaori	3300	The impact of primary care initiatives will lead to a reduction in diabetes and CVD hospitalisations.	
Pacific	3735		
Other	1841		

Rationale

Cardiovascular disease and diabetes as noted in previous *Sections 1.1.2, 2.2.2*, and *2.4* are leading causes of illness and death in Counties Manukau and account for a substantial proportion of healthcare expenditure. Reducing the impact of cardiovascular disease and diabetes requires an integrated response from both primary and secondary care.

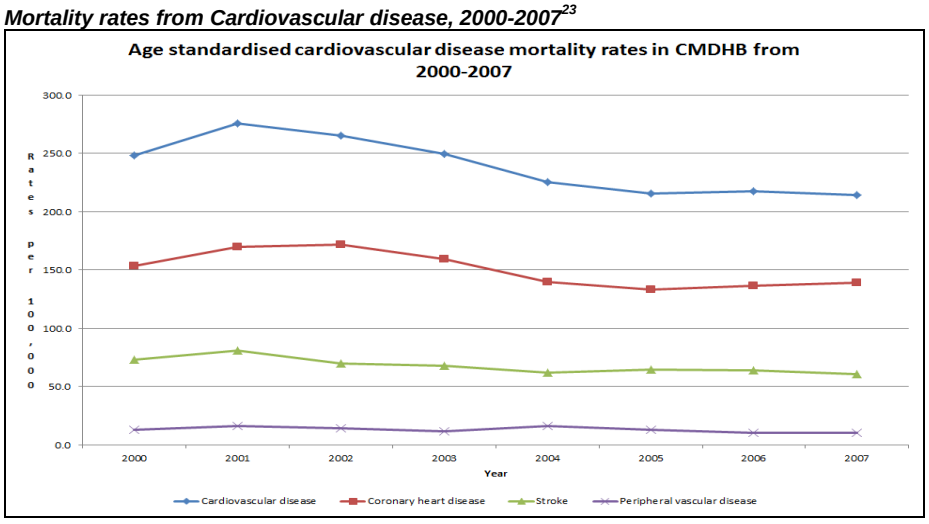
There are currently 35,000 people with diabetes in Counties Manukau (9,000 of these undiagnosed). On the current trajectory, this is expected to **double to over 72,000 by 2027**.

Diabetes Prevalence by DHB, 2010[22]

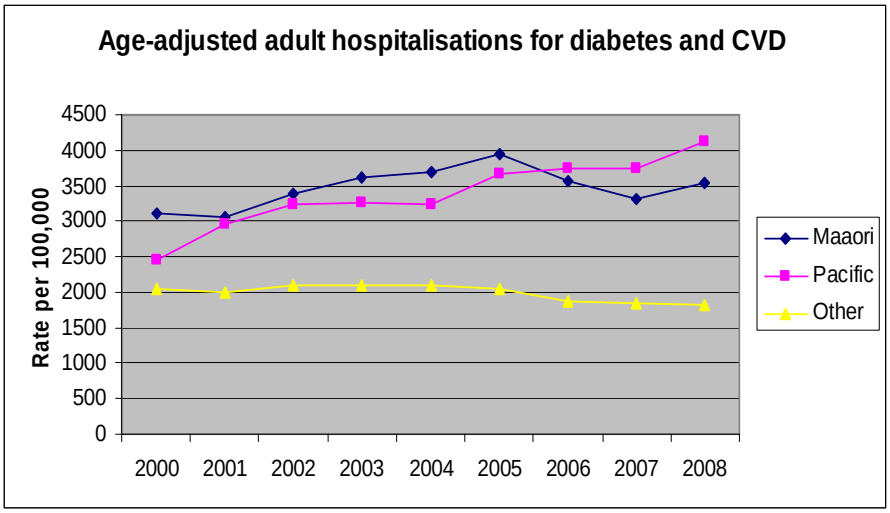
DHB area	Prevalence (95% CI)	Number of adults
Northland / Tairawhiti / Hawke's Bay / Lakes / Whanganui	4.5 (3.4–5.7)	17000
Waitemata	4.0 (2.8–5.2)	15200
Auckland	4.9 (3.4–6.3)	15600
Counties Manukau	8.2 (6.4–9.9) +	26400
Waikato	5.6 (4.2–7.0)	14400
Bay of Plenty / Taranaki / MidCentral	4.8 (3.5–6.1)	16900
Wairarapa / Hutt Valley / Capital and Coast	5.1 (3.6–6.7)	17700
Canterbury	4.4 (2.7–6.1)	16500
Nelson Marlborough / West Coast / South Canterbury / Otago / Southland	4.4 (3.0–5.8)	17400
New Zealand total	5.0 (4.6–5.5)	157100

Cardiovascular disease is the leading cause of death for people in Counties Manukau. As of 2008, there was an estimated 20, 357 people (aged 15 years and over) with cardiovascular disease (CVD) in Counties Manukau.

Mortality rates from Cardiovascular disease, 2000-2007[23]



Designing better health systems and interventions to tackle diabetes and cardiovascular disease is a key priority for the Northern Region DHBs and primary care partners and will be a major focus for the health sector for the foreseeable. In selecting a measure for this area, we recognise that evidence suggests that it is unlikely that there will be early savings for the health sector but if done correctly, there is the opportunity for reducing morbidity and premature mortality. A measure of the efficacy of the work in this area is the hospital admission rate for diabetes and CVD which we will be aiming to reduce in the long term.



Source: CMDHB Annual Report 2008/09

Key Measure	**1(b): Number of POAC patient admissions avoided at Emergency Care**

Expected Performance

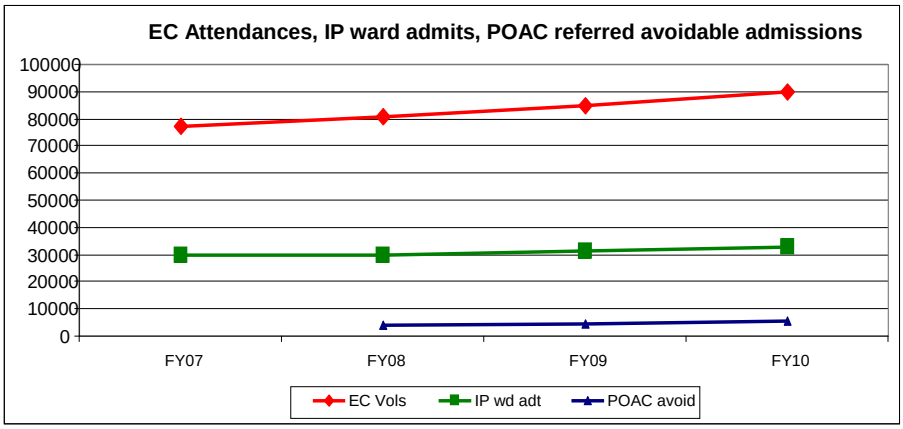
Baseline	July 2012 Target	Expected performance
6375	7650	The number of POAC patient admissions avoided at EC will *increase*.

Rationale

The challenges facing the DHB are that of growing demand in acute hospital admissions which has been rising faster than population growth since 2007. If the status quo remains, the DHB is in the position of not being able to have enough inpatient beds to meet the needs of the population it services by 2013. See *Key Risks, Section 2.4*.

The Primary Options for Acute Care (POAC) programme is one of our key strategies for reducing the demand on hospital-based care and the expansion of POAC will be one of the key areas undertaken by our primary care partners, the Greater Auckland Integrated Health Network (GAIHN).

The figure below shows the DHB's rising EC attendances (red line) and the inpatient hospital admissions (green line) against our POAC attendances avoided (blue line). We can infer that the red and green lines would be much steeper if there was no investment in POAC.



Source: CMDHB Board Dashboard

<table>
<tr><th>Key Measure</th><td colspan="2">1(c): The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific</td></tr>
<tr><th>Expected Performance</th><td colspan="2">
<table>
<tr><th colspan="2">Baseline</th><th>July 2012 Target</th><th>Expected performance</th></tr>
<tr><td>Maaori</td><td>8 years</td><td rowspan="2">Reduce current rate</td><td rowspan="2">The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific will reduce</td></tr>
<tr><td>Pacific</td><td>5 years</td></tr>
</table>
</td></tr>
<tr><th>Rationale</th><td colspan="2">Life expectancy at birth is a key indicator of health status. As outlined in Section 1.1.2, Maaori people living in Counties Manukau have a life expectancy at birth of 8 years less than their European and Other Counties Manukau residents whilst Pacific people in Counties Manukau have a life expectancy at birth of 5 years less than their European and Other Counties Manukau residents.

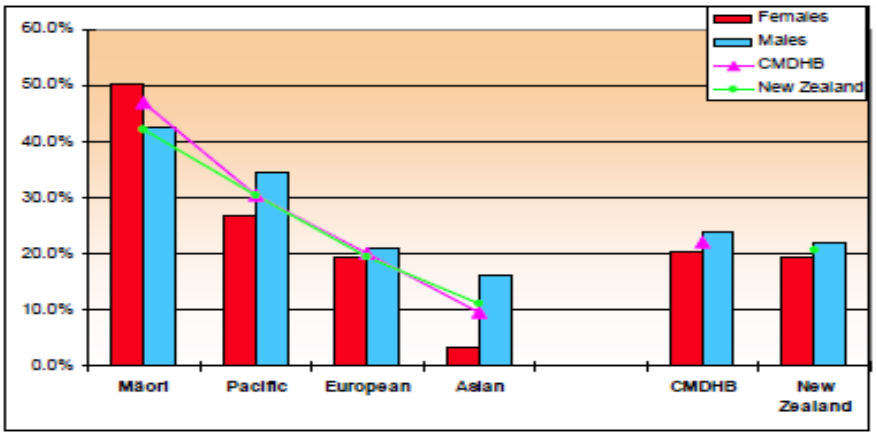
These disparities are mirrored in many other markers of ill health. If the DHB is to improve the health status of the population it is important that we focus on reducing some of the disparities in health outcomes faced by our Maaori and Pacific populations. As such, the life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific is an important point of focus for the DHB as a marker of the impact we are making in reducing health inequalities.

For trend graphs see Section 1.1.2 under Life Expectancy.</td></tr>
</table>

<table>
<tr><th>Key Measure</th><td colspan="2">1(d): Proportion of adults in the population who are regular smokers</td></tr>
<tr><th>Expected Performance</th><td colspan="2">
<table>
<tr><th colspan="2">Baseline</th><th>July 2012 Target</th><th>Expected performance</th></tr>
<tr><td>Maaori</td><td>47%</td><td>37%</td><td rowspan="3">The proportion of adults in the population who are regular smokers will decrease</td></tr>
<tr><td>Pacific</td><td>30%</td><td>25%</td></tr>
<tr><td>European</td><td>20%</td><td>18%</td></tr>
</table>
</td></tr>
<tr><th>Rationale</th><td colspan="2">Smoking is the ‘big ticket item’ contributing to not only smoking related lung diseases such as lung cancer but also to the major disease areas: diabetes, CVD, infant mortality and all other causes of mortality as outlined in Section 1.1.2.

This measure has been chosen as a key measure because smoking is the single most important preventable cause of death and therefore, strategies to decrease the number of smokers in the community and/or to reduce the number initiating smoking has the ability to make an impact on the community’s health and well being and also on reducing health inequities between Maaori and Pacific with non-Maaori and non-Pacific in Counties Manukau.

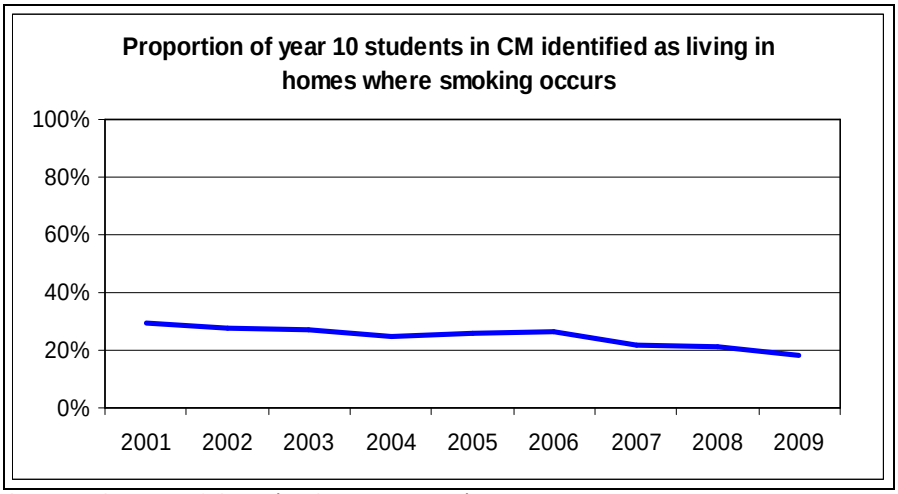
Counties Manukau has the highest smoking rates in New Zealand. 12% of the total smokers in the country are in the district.

Prevalence of regular smokers, aged 15+, by gender and ethnicity, 2006²⁴
 

Source: CMDHB Board Dashboard

CMDHB is also committed to addressing high maternal smoking rates in order to improve child health outcomes in Counties Manukau and reducing the initiation of smoking amongst high school students.</td></tr>
</table>

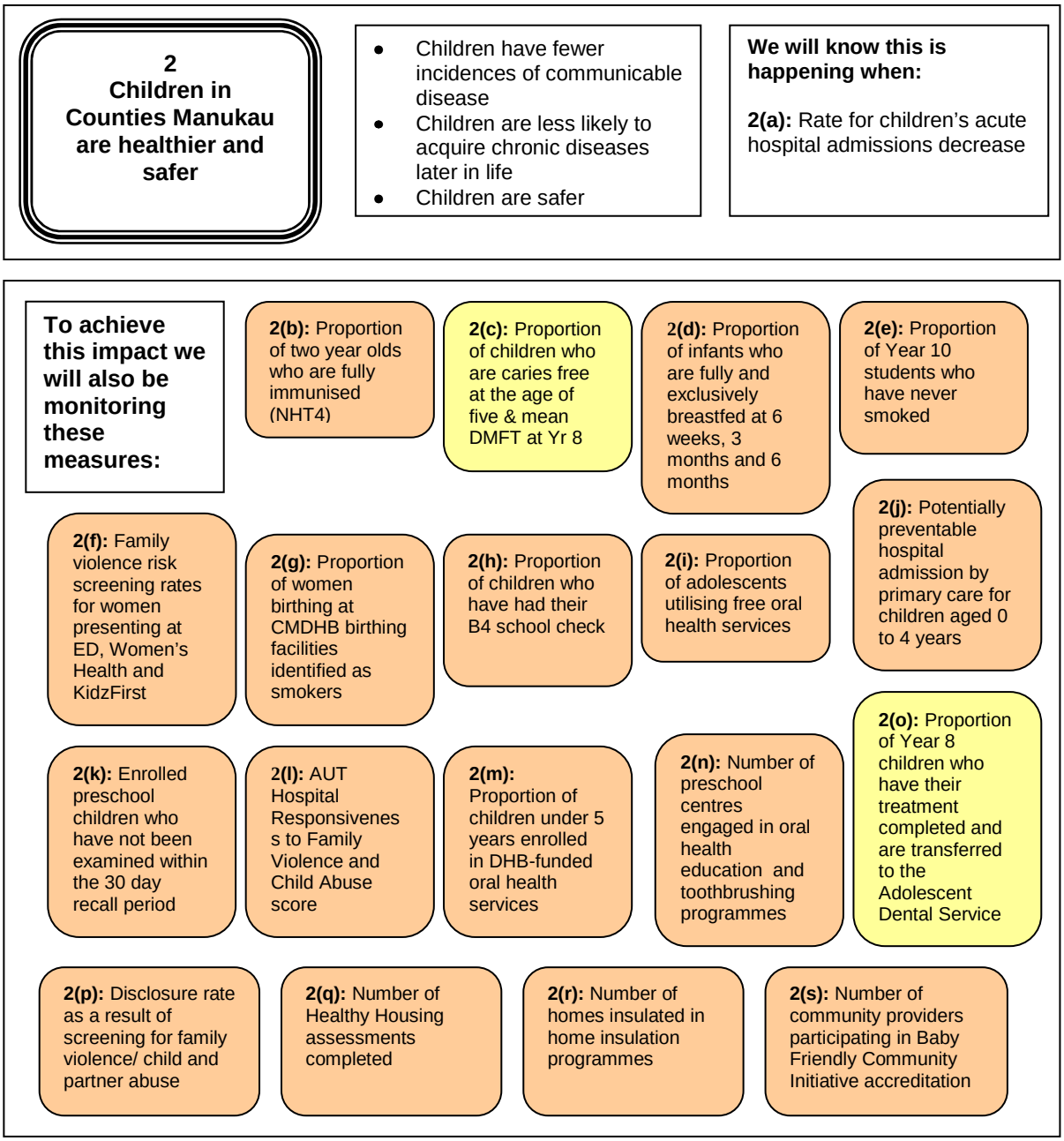
Ensuring that children grow up in a smokefree environment is important in preventing lower respiratory tract infection and smoke exposure is a significant risk factor for Sudden Unexplained Infant Death (SUDI). *See Key Impact 2 – Children in Counties Manukau are healthier and safer*



Source: ASH Year 10 Snapshot Survey, www.ash.org.nz

3.1.3 Key Impact 2 – Healthier and Safer Children

Figure 8(b): Key Impact 2



Key Measure	2(a): Rates for children's acute hospital admissions

Expected Performance

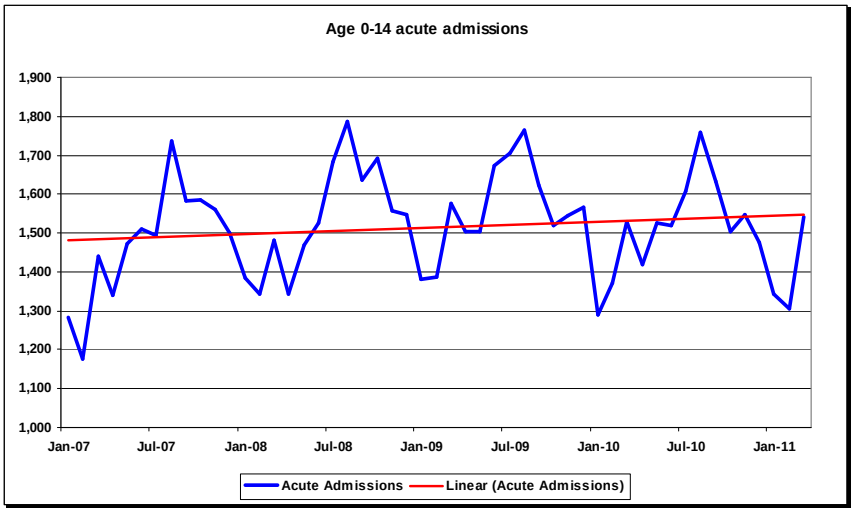
Baseline		July 2012 Target	Expected performance
Maaori	3,402	Maintain or lower current rate	Rates for children's acute hospital admissions will *decrease*
Pacific	6,045		
Other	5,188		

Rationale

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

The linear trend for child acute admissions has been on the rise over the past few years. This is due to an increase in child Emergency admissions, and birthing admissions.

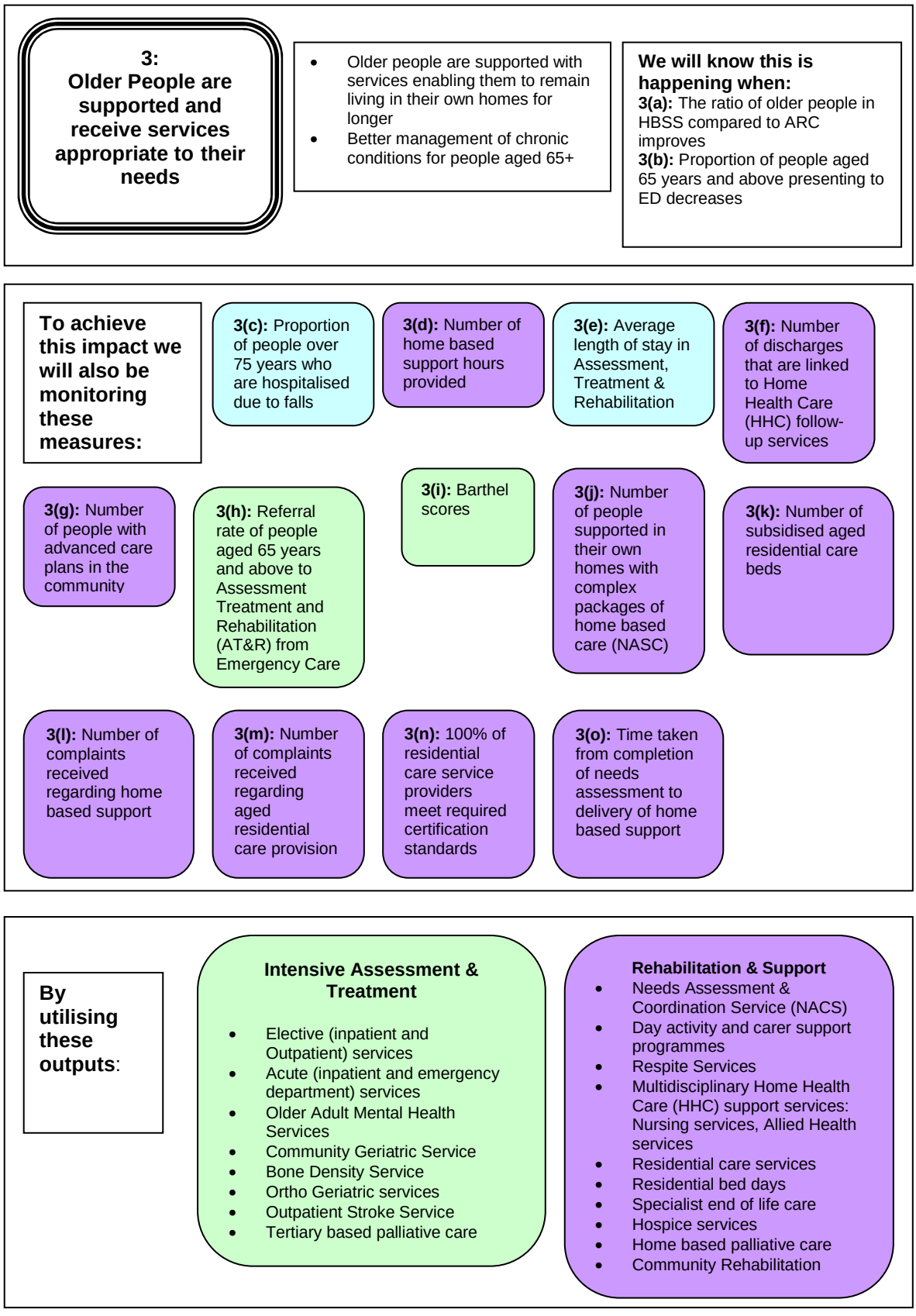
Overall hospitalisation rates for children and young people residing in CMDHB are above the national average for infectious diseases such as lower respiratory infections, with the quality of housing being recognised as a risk factor.



Source: Counties Manukau DHB Decision Support Service

3.1.4 Key Impact 3 – Older People

Figure 8(c): Key Impact 3



Key Measure

3(a): The ratio of older people in home based support services (HBSS) compared to aged residential care (ARC)

Expected Performance

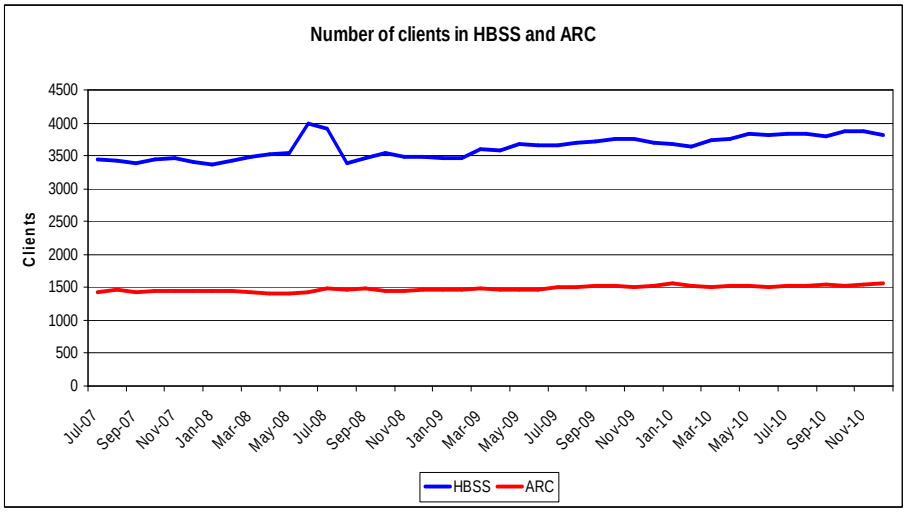
Baseline		July 2012 Target	Expected performance
HBSS	71%	Increase rate	The proportion of people receiving HBSS will *increase*, thereby *reducing* the number of people in ARC.
ARC	29%	Decrease rate	

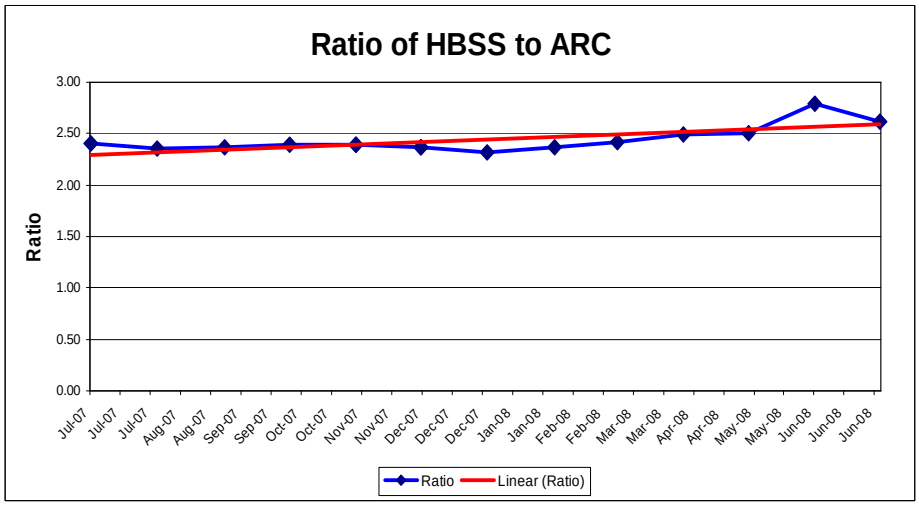
Rationale

We support the Government goal for older people of 'ageing in place' and that older people are supported to help them maintain independence in their own homes where this is appropriate and possible.

As such, we want to increase the ratio of the number of older people receiving Home Based Support Services to the number of older people receiving Aged Residential Care. This is supported by our strategic direction for older people which seeks to improve and expand the range of home and community based services available for supporting our older population, whilst also ensuring that we have enough beds for older people who need to be in long term residential care.

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





Source: Counties Manukau DHB Health of Older People Service

Key Measure	**3(b): Proportion of ED presentations by 65+ year olds**

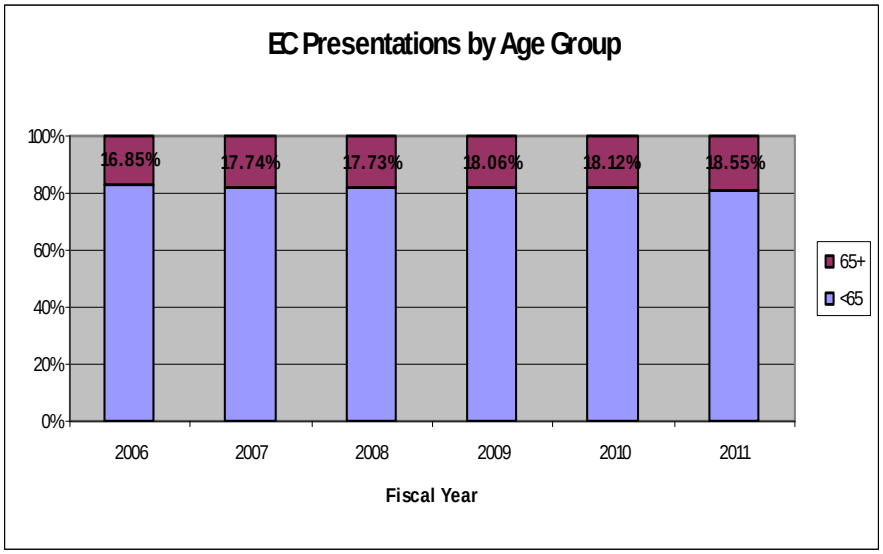
Expected Performance

Baseline	July 2012 Target	Expected performance
18.32%	Decrease current rate	The proportion of ED presentations by 65+ year olds will *decrease*

Rationale

A key objective for the DHB is to reduce demand for our hospital services. With our increasingly ageing population, the burden of chronic conditions like cardiovascular disease, Chronic Obstructive Pulmonary disease (COPD) and co-morbidities will inevitably increase leading to more presentations at ED, more hospital admissions and thus, placing huge stress on the health infrastructure and resources.

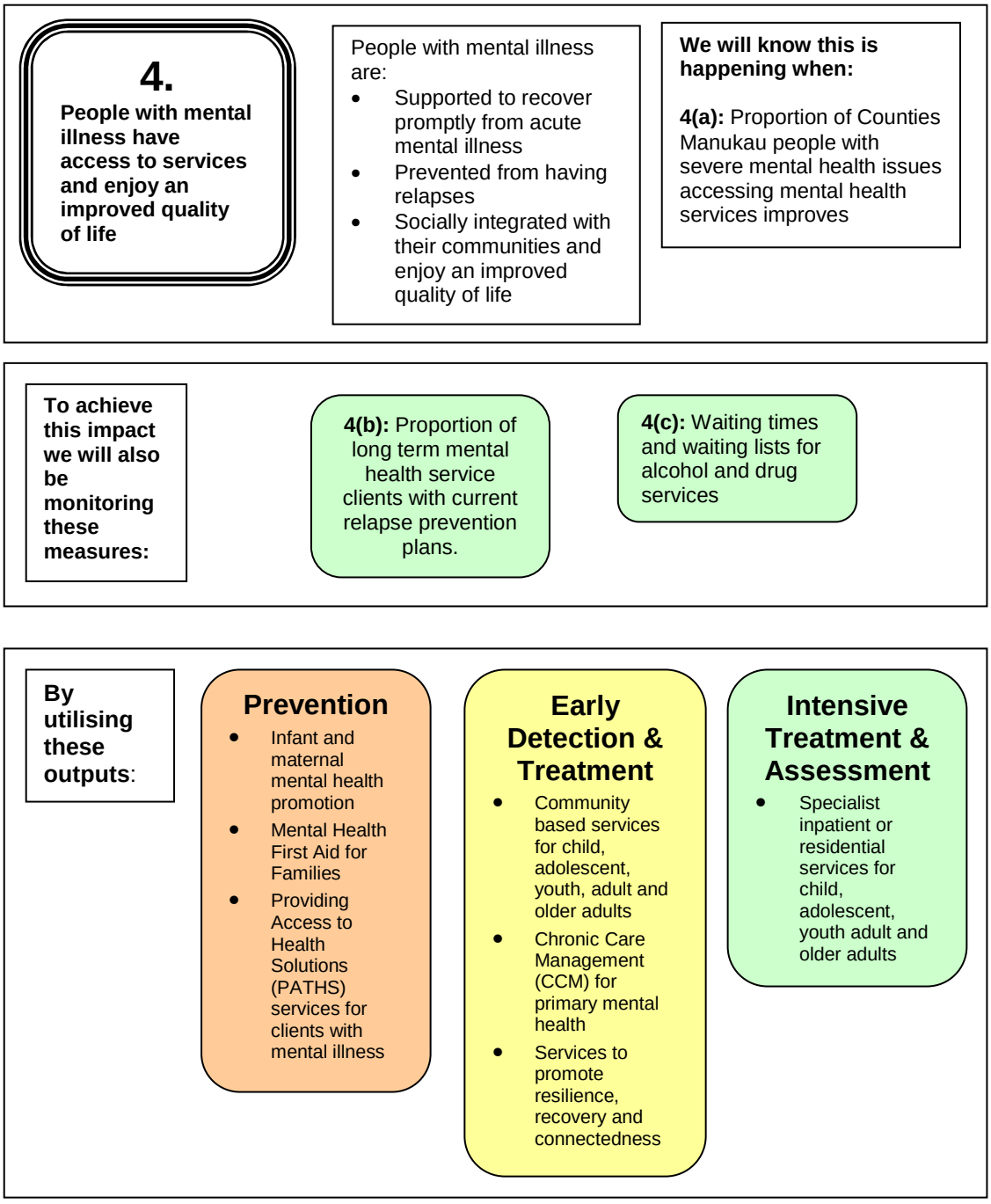
Counties Manukau DHB is actively working with regional primary care partners and with local residential care providers and health of older people services to ensure that there is better management of chronic conditions for older people in primary care so that there are fewer presentations at ED.



Source: Counties Manukau DHB Decision Support Service

3.1.5 Key Impact 4 – Mental Health

Figure 8(d): Key Impact 4



Key Measure

4(a): Rate of people with severe mental illness accessing mental health services

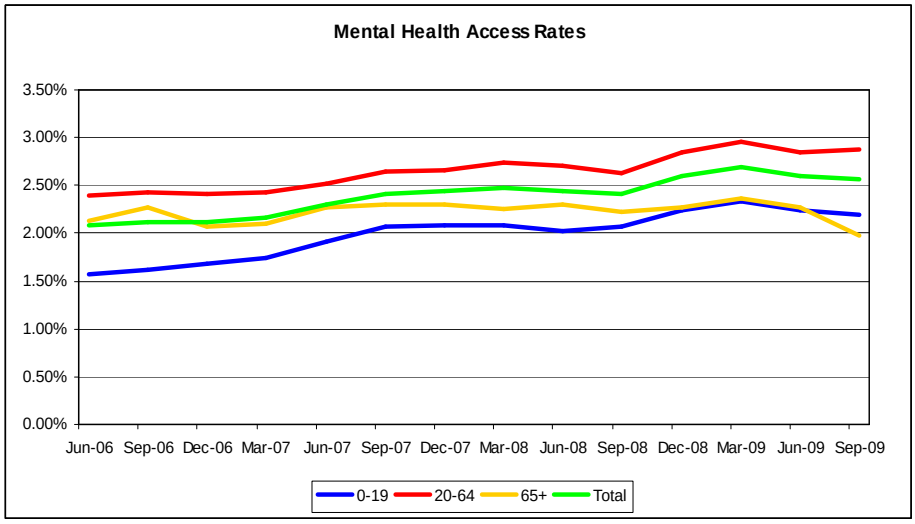
Expected Performance

Baseline			July 2012 Target	Expected performance
Age 0 -19	Māori	3.95%	4.00%	Mental health access rates will *increase*.
	Other	2.65%	2.67%	
	Total	2.96%	2.98%	
Age 20 - 64	Māori	6.66%	6.66%	
	Other	2.89%	2.89%	
	Total	3.43%	3.43%	
Age 65+	Total	2.63%	2.63%	

Rationale

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

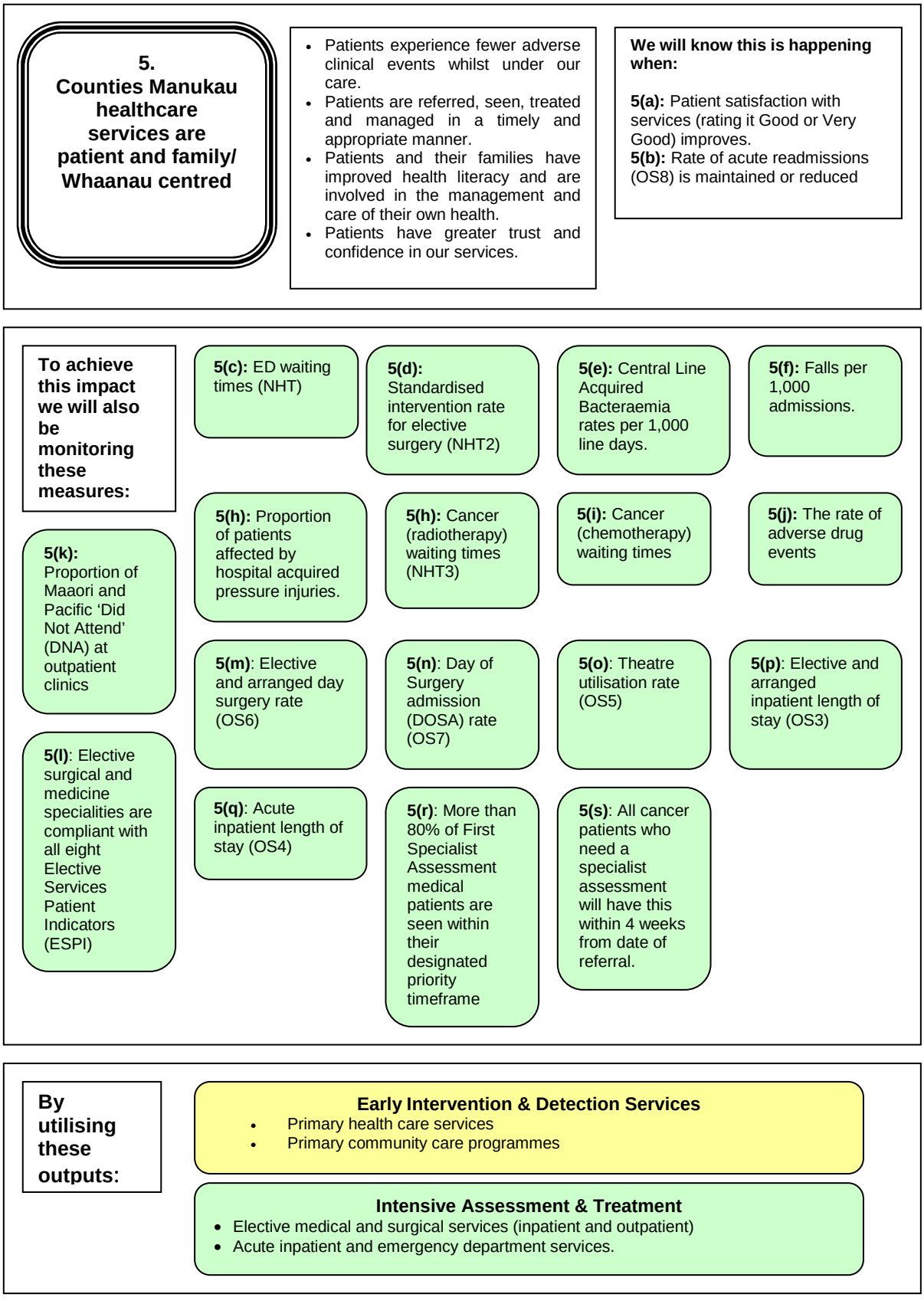
Mental health access rates have been gradually increasing in the district for all age groups with the exception of the 65+ age group which decreased in the last financial year. The access rate across all age groups for the DHB's Mental Health Services was 3.04% for the reporting period ending 31 March 2010. The New Zealand average for the same period was 2.46%.



Source: Counties Manukau DHB Mental Health Services

3.1.6 Key Impact 5 – Patient and Family/ Whaanau-centredness

Figure 8(e): Key Impact 5



Key Measure	5(a): Patient satisfaction with services (rating it Good or Very Good)

Expected Performance

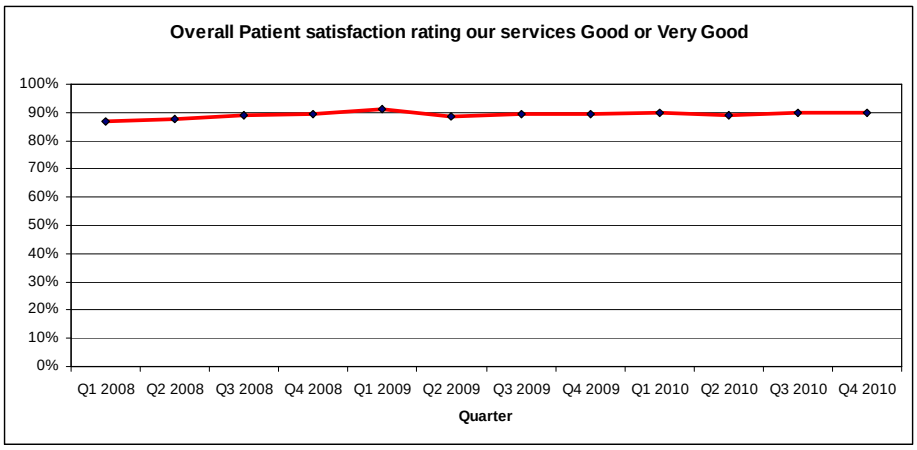
Baseline	July 2012 Target	Expected performance
90%	> 90%	Patient satisfaction with services will *improve*

Rationale

Overall patient satisfaction with hospital inpatient and outpatient services remain high with more than 83% of patients rating our services 'Good or Very Good' in the last two years.

Outpatient satisfaction with services has had smaller levels of variance over the years and remained higher than inpatient satisfaction, reaching the target of 90% satisfaction. Overall, inpatient satisfaction has been increasing though variance between quarters remains large. While still not at the 90% target level of patient satisfaction, CMDHB is confident this will be achieved in the upcoming year.

Patient Satisfaction Survey



Source: CMDHB Board Dashboard

Key Measure	5(b): Rate of acute readmissions

Expected Performance

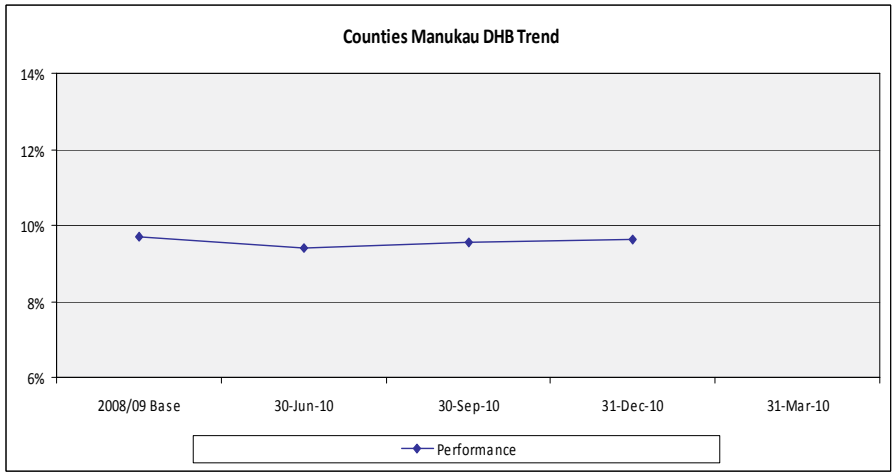
Baseline	July 2012 Target	Expected performance
10.37%	9.55%	The rate of acute readmissions will *improve*

Rationale

Monitoring acute readmission rates allows the DHB to determine an average rate for readmissions due to unforeseen medical circumstance. Unplanned acute readmissions above this average rate may indicate short comings in quality of care such as early discharge, inadequate home support and efficiency of hospital care. Furthermore, acute readmissions to hospital are correlated to shorter lengths of stay.

Acute readmissions are measured as a standardised acute readmission rate. This means the readmission rate is adjusted to account for case mix and different population composition between DHBs to allow for comparison.

CMDHB's acute readmissions rate is better than the national average and has remained relatively unchanged over the last two years but overall is trending downwards.



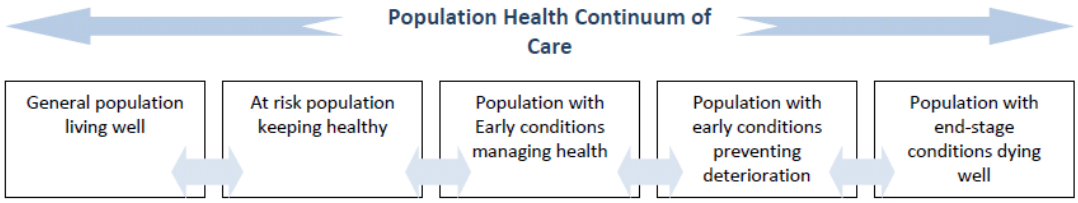
3.2 OUTPUT CLASS

To provide further structure to the outputs, they have been organised into four **Output Class** categories:

- Prevention Services
- Early Detection and Management
- Intensive Assessment and Treatment
- Rehabilitation and Support

Figure 7 below sets out the relationship between Output Classes and specific stages within the Population Health Continuum of Care, that is, the range of states of health that is to be found amongst the population.

Figure 7: Relationship between output classes and specific stages within the Population Health Continuum of Care



Output Class 1: Prevention Services
Prevention services are those used to support healthy living, educate communities on health issues and services and safe-guard against preventable diseases.

Output Class 2: Early Detection and Management
Early detection and Management services support those with health problems to promote better quality of life and, if possible, resolve these health issues.

Output Class 3: Intensive Assessment and Treatment
Intensive assessment and treatment services are those which cannot be provided within a community setting due to the severity of health condition and subsequent treatment required.

Output Class 4: Rehabilitation and Support
Rehabilitation and support services are delivered following a needs assessment process and coordination input by Needs Assessment and Service Coordination (NASC) services for a range of services including palliative care services, home based support services and residential care services.

3.2.1 Input Levels Against The Four Output Classes 2009/10 – 2013

Level of input against all four output classes

Total	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**1,216,354**	**1,277,653**	**1,328,957**	**1,395,344**	**1,465,047**
Personnel costs	427,485	451,327	479,325	503,269	528,409
Outsourced Services	50,273	52,674	50,028	52,527	55,151
Clinical Supplies	94,442	101,702	98,975	103,938	116,764
Infrastructure & Non-Clinical Supplies	95,178	95,867	100,697	105,729	126,295
Other	548,813	573,134	599,889	629,857	661,322
Total costs	**1,216,191**	**1,274,704**	**1,328,914**	**1,395,320**	**1,487,941**
Surplus (Deficit)	**163**	**2,949**	**43**	**24**	**(22,894)**

Level of input for Prevention Services

Prevention	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**22,834**	**20,860**	**18,801**	**19,742**	**20,729**
Personnel costs	3,049	3,251	3,295	3,460	3,633
Outsourced Services	2,584	1,843	1,938	2,035	2,137
Clinical Supplies	941	1,631	1,792	1,882	1,976
Infrastructure & Non-Clinical Supplies	2,119	2,321	1,615	1,696	1,781
Other	14,141	11,814	10,161	10,669	11,202
Total costs	**22,834**	**20,860**	**18,801**	**19,742**	**20,729**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Level of input for Early Detection and Management services

Early Detection	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**207,374**	**207,208**	**177,150**	**186,008**	**195,308**
Personnel costs	-	-	-	-	-
Outsourced Services	-	-	-	-	-
Clinical Supplies	-	-	-	-	-
Infrastructure & Non-Clinical Supplies	-	-	-	-	-
Other	207,374	207,208	177,150	186,008	195,308
Total costs	**207,374**	**207,208**	**177,150**	**186,008**	**195,308**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Level of input for Intensive Assessment and Treatment services

Intensive	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**900,847**	**962,092**	**1,036,348**	**1,088,103**	**1,142,444**
Personnel costs	424,436	448,076	476,030	499,809	524,776
Outsourced Services	47,689	50,831	48,090	50,492	53,014
Clinical Supplies	93,501	100,071	97,183	102,056	114,788
Infrastructure & Non-Clinical Supplies	93,059	93,546	99,082	104,033	124,514
Other	241,999	266,619	315,920	331,689	348,246
Total costs	**900,684**	**959,143**	**1,036,305**	**1,088,079**	**1,165,338**
Surplus (Deficit)	**163**	**2,949**	**43**	**24**	**(22,894)**

Level of input for Rehabilitation and Support services

Rehabilitation	2009/10	2010/11	2011/12	2012/13	2013/14
Revenue	**85,299**	**87,493**	**96,658**	**101,491**	**106,566**
Personnel costs					
Outsourced Services					
Clinical Supplies					
Infrastructure & Non-Clinical Supplies					
Other	85,299	87,493	96,658	101,491	106,566
Total costs	**85,299**	**87,493**	**96,658**	**101,491**	**106,566**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

3.2.2 Statement of Forecast Service Performance by Output Class

Key for the 'Reference' column in the Output Class tables:

NHT	National Health Target (1 = ED length of stay, 2 = Electives, 3 = Cancer waiting times, 4 = Immunisations, 5 = Smoking cessation, 6 = Diabetes and Cardiovascular disease detection and management)
OS	Ownership Dimension (Indicator of DHB Performance)
PP	Policy Priority (Indicator of DHB Performance)
SI	Systems Integration (Indicator of DHB Performance)
MHP	Maaori Health Plan
NRHP	Northern Region Health Plan outcome indicator (numbers link to the NRHP intervention logic, see Appendix 4)

Output Class: Prevention Services

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

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these activities	**To deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**To achieve this outcome**
Smoking Cessation					
Provide smoking cessation advice and support for hospitalised patients and primary care patients. (NRHP 1.18) Train clinical staff to deliver smoke-free interventions. (NRHP 1.18) Fund community-based programmes to support people living smoke-free and reduce smoking initiation (NRHP 1.18) Support smoking cessation programmes in primary care and community-based settings (NRHP 1.18)	**Smoking cessation advice and support delivered by health professionals in secondary and primary care** *Quality:* Proportion of hospitalised smokers provided with advice and help to quit Baseline (Q2, 2010/11): 66% — Target 2011/12: 95% Proportion of enrolled primary care patients who smoke and are seen in General Practice provided with advice and help to quit Baseline (Q2, 2010/11): 17% — Target 2011/12: 90% **Smokefree training and support to community health services and providers** *Quality:* Proportion of primary care patients screened for smoking status across all PHOs Baseline (2010): 52% — Target 2011/12: 80%	NHT5 1(n) NHT5 1(i) 1(o)	**These outputs will lead to a reduced proportion of smokers in the population and reduced incidence and impact of smoking related harm. These are measured by:** Percentage of adult smokers in the population: Maaori: Baseline 47% — By July 2012: 37% Pacific: Baseline 30% — By July 2012: 25% European: Baseline 20% — By July 2012: 18% Percentage of Year 10 students who never smoked: Maaori: Baseline (2008) 30.7% Pacific: Baseline (2008) 52.1% European: Baseline (2008) 65.1% By July 2012: Maintain or lower current rate.	NRHP 1.8 MHP 1(d) 2(e) 2(g)	Improved health of the population and reduced inequalities

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>To achieve this outcome</th></tr>
<tr><td></td><td>Programmes for pregnant women and Maaori and Pacific people.

One region wide comprehensive cessation service for each of the following:
• Pregnant women and their whaanau (additional to the MOH funded service)
• Maaori people (additional to current Aukati Kai Paipa service)
• Pacific people</td><td></td><td>Percentage of women birthing at a CMDHB birthing facility identified as currently smoking.<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>System to measure baseline currently under development.</td><td>Average of 15% across all ethnicities</td></tr></table></td><td></td><td></td></tr>
<tr><td colspan="6">Infant Health</td></tr>
<tr><td>Breastfeeding

Collaborate with local providers and fund initiatives to encourage and promote breastfeeding.
(NRHP 1.4)</td><td>Breastfeeding and promotion services:

Quantity:
Number of community providers participating in Baby Friendly Community Initiative accreditation<table><tr><td>Baseline</td><td>2011/12</td></tr><tr><td colspan="2">This is a new initiative and we are aiming to get 3 community providers participating in BFCI accreditation this financial year</td></tr></table>
The Baby Friendly Community Initiative (BFCI) aims to protect, promote and support breastfeeding for healthy mothers and babies</td><td>2(s)</td><td>Child health will be improved thus reducing the risk of chronic disease, obesity and promoting healthy growth. This will be measured by:

Infants exclusively and fully breastfed at:<table><tr><td></td><td></td><td>By July 2012</td></tr><tr><td rowspan="4">6 weeks</td><td>Māori</td><td>62%</td></tr><tr><td>Pacific</td><td>67%</td></tr><tr><td>Other</td><td>70%</td></tr><tr><td>Total</td><td>67%</td></tr><tr><td rowspan="4">3 Months</td><td>Māori</td><td>46%</td></tr><tr><td>Pacific</td><td>51%</td></tr><tr><td>Other</td><td>59%</td></tr><tr><td>Total</td><td>55%</td></tr><tr><td rowspan="4">6 Months</td><td>Māori</td><td>18%</td></tr><tr><td>Pacific</td><td>22%</td></tr><tr><td>Other</td><td>29%</td></tr><tr><td>Total</td><td>26%</td></tr></table></td><td>NRHP 1.4
MHP

SI7
2(d)</td><td>Improved health of the population and reduced inequalities</td></tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>To achieve this outcome</th></tr>
<tr>
<td>Immunisation

Fund a range of providers to deliver immunisation services through general practice, outreach, school and other community setting (NRHP 1.4)</td>
<td>Immunisation services (through general practice, outreach, school and other community settings).

Proportion of two year olds fully vaccinated:
<table>
<tr><th></th><th>Baseline</th><th>2011/12 Target</th></tr>
<tr><td>Maaori</td><td>80%</td><td>95%</td></tr>
<tr><td>Pacific</td><td>90%</td><td>95%</td></tr>
<tr><td>Total</td><td>87%</td><td>95%</td></tr>
</table>
</td>
<td>NHT 4
2(b)</td>
<td rowspan="3">Immunisation will reduce the incidence of vaccine preventable and prophylaxis preventable diseases among children.

Well child services promote the early detection and resolution of health issues.

Improving living conditions leads to a reduction in health conditions caused by poor housing.

These impacts will be measured by:

Acute hospitalisation rates for children aged 0 to 4 year
<table>
<tr><th></th><th>Baseline</th><th>July 2011/12</th></tr>
<tr><td>Maaori</td><td>3,402</td><td rowspan="3">Maintain or lower current rate</td></tr>
<tr><td>Pacific</td><td>6,045</td></tr>
<tr><td>Other</td><td>5,188</td></tr>
</table>

Ambulatory Sensitive Hospitalisation rate[25] for children aged 0 to 4 years
<table>
<tr><th></th><th>Baseline</th><th>July 2011/12</th></tr>
<tr><td>Maaori</td><td>96.0</td><td>95.0</td></tr>
<tr><td>Pacific</td><td>98.4</td><td>95.0</td></tr>
<tr><td>Other</td><td>74.5</td><td>95.0</td></tr>
</table>
</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Child/ Tamariki Ora

Fund Well Child/ Tamariki Ora services to support new mothers and their infants (NRHP 1.4)</td>
<td>Well child checks and home visits

Quantity:
B4 School Checks
<table>
<tr><th></th><th>Baseline</th><th>By July 2012</th></tr>
<tr><td>Vision and Hearing (2 components)</td><td>722</td><td rowspan="3">7076 combined</td></tr>
<tr><td>Nurse (Well child – 6 components)</td><td>2213</td></tr>
<tr><td>Children who have 1 component missing from their check</td><td>100</td></tr>
</table>
</td>
<td>2(h)</td>
</tr>
<tr>
<td>Living Conditions

Work with Housing New Zealand and other non-governmental agencies to improve the housing conditions in the community[26]</td>
<td>Joint assessments with Housing NZ

Quantity:
Completed health and housing assessments
<table>
<tr><th>Baseline (YTD March 2011)</th><th>By July 2012</th></tr>
<tr><td>540</td><td>320</td></tr>
</table>

Home insulation programmes
Number of homes insulated
<table>
<tr><th>Programme</th><th>By July 2012</th></tr>
<tr><td>Snug Homes</td><td>500</td></tr>
<tr><td>Warn Up CM</td><td>1000</td></tr>
</table>
</td>
<td>2(q)

2(r)</td>
</tr>
</table>

<table>
<tr><th colspan="2">OUTPUTS</th><th></th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>To achieve this outcome</th></tr>
<tr><td colspan="6">Family Violence Prevention</td></tr>
<tr><td>Deliver family violence prevention (VIP) programme</td><td>Training of staff in designated areas (Women's Health, KidzFirst and Emergency Department) to screen for VIP risk
Proportion of women presenting in Emergency Care who are screened for VIP risk
<table><tr><td></td><td>Baseline</td><td>By July 2012</td></tr><tr><td>EC</td><td>19%</td><td>100%</td></tr></table>
AUT Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit Score:
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>173/200</td><td>140/200</td></tr></table></td><td>2(f)

PP14
2(l)</td><td>Early intervention for families and children in situations of domestic violence or child abuse, measured by:

Increase in disclosures as a result of screening
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>14%</td><td>Increase current rate</td></tr></table></td><td></td><td>Improved health of the population and reduced inequalities</td></tr>
<tr><td colspan="6">Population based screening</td></tr>
<tr><td>Provide breast screening services.</td><td>Breast screening for women aged 45 – 69 years

Quantity:
Women aged 45 – 69 years who have had a breast screen in the last 24 months
<table><tr><td></td><td>Baseline Q2, 2010/11</td><td>By July 2012</td></tr><tr><td>Maaori</td><td>55.5%</td><td rowspan="3">Total: 70%</td></tr><tr><td>Pacific</td><td>62.5%</td></tr><tr><td>Total</td><td>62.9%</td></tr></table></td><td>1(l)</td><td>Improved outcomes for women through earlier detection of breast cancer. This is measured by:

Breast cancer mortality:
<table><tr><td colspan="2">Baseline (2003- 2005, 25+ years, age standardised rate per 100,000)</td></tr><tr><td>Maaori</td><td>66.3</td></tr><tr><td>Pacific</td><td>41.8</td></tr><tr><td>Asian</td><td>16.3</td></tr><tr><td>European/Other</td><td>30.0</td></tr></table>Source: CMDHB Health Needs Assessment, 2008</td><td></td><td>Improved health of the population and reduced inequalities</td></tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>To achieve this outcome</th></tr>
<tr><td>Fund primary care providers to deliver cervical screening (MHP)</td><td>Cervical smears for women aged 20 – 70 years

Quantity:
Women aged 20 - 70 years who have had a cervical smear in the last three years.<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>67%</td><td>>75%</td></tr></table></td><td>1(m)</td><td>Improved outcomes for women through earlier detection of cervical abnormalities. Measured by:
Cervical cancer rates<table><tr><td colspan="2">Baseline (2003- 2005, 25+ years, age standardised rate per 100,000)</td></tr><tr><td>Maaori</td><td>10.4</td></tr><tr><td>Pacific</td><td>12.8</td></tr><tr><td>European/Other</td><td>2.0</td></tr></table>Source: CMDHB Health Needs Assessment, 2008</td><td></td><td></td></tr>
<tr><td colspan="6">HPV immunisation</td></tr>
<tr><td>Fund school based HPV vaccination programme. (NRHP 1.4)</td><td>Schools providing the HPV vaccination programme.

Proportion of eligible young women who have completed the full human papillomavirus (HPV) vaccination course through the school based programme<table><tr><td></td><td>Year to Date, Dec2010</td><td>By July 2012</td></tr><tr><td>Dose 3</td><td>45%</td><td>60%</td></tr></table></td><td>1(k)</td><td>Reduced incidence of cervical cancer measured by:

Cervical cancer rates (see above)</td><td></td><td>Improved health of the population and reduced inequalities</td></tr>
</table>

Output Class: Early Detection and Management services.

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

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Leading to these Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr><td colspan="6">Primary Care</td></tr>
<tr>
<td>Create greater access to primary care for high needs patients.

Provide early detection services for chronic conditions. (National Health Target) (NRHP 1.16, 1.17)

Fund education programmes to support patients with long term conditions. (NRHP 1.16, 1.17)</td>
<td>Increased consults for high needs patients.
Rate of GP consultations for high needs population compared with non-high needs population
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>1.03</td><td>> 1</td></tr>
</table>
After hours care
The implementation of ARAHN (Auckland Regional After Hours Network) including a number of clinics open until 10pm with lower maximum co-pays for CSC and HUHC holders

CVD risk assessments.
Proportion of the eligible adult population who have had their CVD risk assessment in the past 5 years
<table>
<tr><td></td><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>75%</td><td>90%</td></tr>
<tr><td>Pacific</td><td>76%</td><td>90%</td></tr>
<tr><td>Other</td><td>83%</td><td>90%</td></tr>
<tr><td>Total</td><td>79%</td><td>90%</td></tr>
</table>
</td>
<td>1(e)

NHT6
1(h)</td>
<td>Reduced avoidable admissions and acute demand for conditions that can be effectively managed in general practice. This will be measured by:

Ambulatory Sensitive (Avoidable) Hospitalisations: 0-74 years
<table>
<tr><td></td><td>Baseline</td><td>Target</td></tr>
<tr><td>Maaori</td><td>112</td><td>103</td></tr>
<tr><td>Pacific</td><td>110</td><td>96</td></tr>
<tr><td>Other</td><td>106</td><td>100</td></tr>
</table>
45-64 years:
<table>
<tr><td></td><td>Baseline</td><td>Target</td></tr>
<tr><td>Maaori</td><td>117</td><td>119</td></tr>
<tr><td>Pacific</td><td>151.5</td><td>98</td></tr>
<tr><td>Other</td><td>134.6</td><td>115</td></tr>
</table>
0-4 years: See previous section

Number of Primary Options for Acute Care (POAC) patient admissions avoided
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>6375</td><td>7650</td></tr>
</table>
</td>
<td>SI1
1(j)

1(b)</td>
<td>Improved health of the population and reduced inequalities</td>
</tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Leading to these Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr>
<td>Fund services to provide structured evidence based care to people with Chronic Conditions (NRHP 1.14, 1.16, 1.17).

Fund services and programmes to reduce acute demand (NRHP 2.1)</td>
<td>
Self Management (SM) Programmes.

Quantity:
Number of additional patients enrolled in SM programme.
<table>
<tr><td>Baseline (YTD Jan 2011)</td><td>By July 2012</td></tr>
<tr><td>513</td><td>850</td></tr>
</table>
Structured primary care programmes for management of chronic conditions

Uptake of programmes aimed at managing people with chronic conditions in primary care and reducing reliance on hospital based services

Chronic Care Management (CCM) Programmes.
- Diabetes
- Depression
- CVD
- COPD
- CHF
Quantity:
Number of enrolments in all CCM programmes
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>18,500</td><td>>19,500</td></tr>
</table>
Diabetes management

Timeliness:
Proportion of people with diabetes who have had an annual check
<table>
<tr><td></td><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>78.5%</td><td>96%</td></tr>
<tr><td>Pacific</td><td>68.4%</td><td>87%</td></tr>
<tr><td>Other</td><td>52%</td><td>68%</td></tr>
<tr><td>Total</td><td>60.6%</td><td>78%</td></tr>
</table>
</td>
<td>1(p)

1(q)

NHT6
1(f)</td>
<td>
Hospitalisation rate for diabetes and cardiovascular disease (aged adjusted).
<table>
<tr><td></td><td>Baseline (2007)</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>3300</td><td rowspan="3">The impact of primary care initiatives will lead to a reduction in diabetes and CVD hospitalisations .</td></tr>
<tr><td>Pacific</td><td>3735</td></tr>
<tr><td>Other</td><td>1841</td></tr>
</table>
</td>
<td>1(a)</td>
<td></td>
</tr>
</table>

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Leading to these Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr><td></td><td>Proportion of people with diabetes who have satisfactory or better diabetes management.
<table><tr><td></td><td>Baseline</td><td>By July 2012</td></tr><tr><td>Maaori</td><td>53%</td><td>54%</td></tr><tr><td>Pacific</td><td>45%</td><td>49%</td></tr><tr><td>Other</td><td>70%</td><td>71%</td></tr><tr><td>Total</td><td>58%</td><td>60%</td></tr></table>
Primary Options for Acute Care (POAC) programme and Very High Intensive User (VHIU) programme.

Number of enrolments in POAC
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>7,500</td><td>9,000</td></tr></table>
Number of referrals to VHIU:
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>450</td><td>800</td></tr></table></td><td>NHT6
1(g)

1(r)

1(s)</td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Oral Health</td></tr>
<tr><td>Support the improvement of child and adolescent oral health status (NRHP 1.4)

Providing targeted oral health promotion and tooth brushing programmes for under 5 year olds (NRHP 1.4)

Facilitating adolescent access to free oral health services. (NRHP 1.4)</td><td>Oral health services for children aged 0 years to School year 8 (12/13 years).

Proportion of children under 5 years enrolled in DHB-funded oral health services
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>45%</td><td>65%</td></tr></table>
Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)
<table><tr><td>Baseline</td><td>By July 2012</td></tr><tr><td>42%</td><td>10%</td></tr></table>
Oral health education and tooth brushing programmes targeting Māori, Pacific, and children from High Deprivation communities</td><td>2(m)

2(k)</td><td>Improved oral health outcomes for preschool children (0-4 years) and school aged children though:
- Reduction in arrears.
- Increased dental services enrolment.
Measured by:

Proportion of children aged 5 years who are caries free
<table><tr><td></td><td>Base line</td><td>By July 2012</td></tr><tr><td>Maaori</td><td>38%</td><td>43%</td></tr><tr><td>Pacific</td><td>28%</td><td>35%</td></tr><tr><td>Other</td><td>62%</td><td>65%</td></tr><tr><td>Total</td><td>45%</td><td>52%</td></tr><tr><td>Fluoridated</td><td>44%</td><td>45%</td></tr><tr><td>Non-Fluoridated</td><td>57%</td><td>58%</td></tr></table></td><td>PP11
2(c)</td><td>Improved health of the population and reduced inequalities</td></tr>
</table>

<table>
<tr><th colspan="2">OUTPUTS</th><th></th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>To deliver these Outputs with these Measures</th><th>Reference</th><th>Leading to these Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr>
<td></td>
<td>Number of preschool centres engaged in the oral health education and tooth brushing programme.
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>40</td><td>150</td></tr>
</table>
Increased access to adolescent services for all adolescents from School year 9 up to and including 17 years.

Quality:
Proportion of Year 8 children who have their treatment completed and are transferred to the Adolescent dental service
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>99%</td><td>100%</td></tr>
</table>
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services.
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>56%</td><td>80%</td></tr>
</table>
</td>
<td>2(n)

2(o)

2(i)</td>
<td>Mean, Decayed, Missing or Filled (DMFT) at Year 8
<table>
<tr><td></td><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>Maaori</td><td>1.59</td><td>1.50</td></tr>
<tr><td>Pacific</td><td>1.72</td><td>1.63</td></tr>
<tr><td>Other</td><td>0.90</td><td>0.88</td></tr>
<tr><td>Total</td><td>1.29</td><td>1.20</td></tr>
<tr><td>Fluoridated</td><td>1.31</td><td>1.30</td></tr>
<tr><td>Non-Fluoridated</td><td>0.87</td><td>0.86</td></tr>
</table>
</td>
<td>PP10
2(c)</td>
<td></td>
</tr>
</table>

Output Class: Intensive Treatment and Assessment services.

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

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

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

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these initiatives/activities	**Deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**Toward delivering these outcomes**
Mental Health					
Provide and/or contract mental health inpatient, outpatient, community, residential, rehabilitation, support and liaison services	**A matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health & Addiction services covering Child, Adolescent & Youth; Adult; and Older Adult Age bands.** **The matrix of services comprise** - **Acute & Intensive services;** - **Community based clinical treatment & therapy services; and** **Services to promote resilience, recovery and connectedness**		**Mental Health initiatives will lead to the prompt recovery from acute mental illness, the prevention of mental illness relapses and further social integration and improved quality of life.** **The Mental Health Regional Services Planning Group will be looking into developing measures in the future.**	PP6 PP7	Improved health of the population and reduced inequalities

<table>
<tr><th colspan="2">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>Deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr><td></td><td>Access Rates for total and specific population groups (defined as the proportion of the population utilising MH&A services in the last year). The population groups for which this indicator is measured are:

<table>
<tr><th></th><th></th><th>Baseline</th><th>By July 2012</th></tr>
<tr><td rowspan="3">Age 0-19</td><td>Māori</td><td>3.95%</td><td>4.00%</td></tr>
<tr><td>Other</td><td>2.65%</td><td>2.67%</td></tr>
<tr><td>Total</td><td>2.96%</td><td>2.98%</td></tr>
<tr><td rowspan="3">Age 20-64</td><td>Māori</td><td>6.66%</td><td>6.66%</td></tr>
<tr><td>Other</td><td>2.89%</td><td>2.89%</td></tr>
<tr><td>Total</td><td>3.43%</td><td>3.43%</td></tr>
<tr><td>Age 65+</td><td>Total</td><td>2.63%</td><td>2.63%</td></tr>
</table>

Quality
Proportion of long term clients with Relapse Prevention Plan (RPP) in the above population groups
<table>
<tr><td>Baseline</td><td>By July 2012</td></tr>
<tr><td>56%</td><td>95%</td></tr>
</table>

Quality
Alcohol and drug service waiting times
<table>
<tr><td>Baseline</td><td>By July 212</td></tr>
<tr><td>24.5 days (NGOs)</td><td>Decrease current rate</td></tr>
</table>
</td><td>PP6
4(a)

PP7
4(b)

PP8
4(c)</td><td></td><td></td><td></td></tr>
</table>

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these initiatives/activities	**Deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**Toward delivering these outcomes**
Elective (Inpatient/ Outpatient)					
Provide and purchase elective inpatient and outpatient services (NRHP 2.32)	**Elective inpatient services.** **Elective outpatient services.** *Quantity:* Delivering agreed elective surgery discharge volume Baseline: 100% — By July 2012: 100% *Quality:* Elective and arranged inpatient Average Length of Stay: Baseline: 4.21 — By July 2012: 3.92 *Timeliness:* ESPI compliance Baseline: 100% — By July 2012: 100% >80% of FSA patients to be seen within designated priority timeframes. Elective and Arranged Day of Surgery Rate: Baseline: 55% — Target 2011/12: 60% Elective Theatre Utilisation Rate Baseline: 81.5% — Target 2011/12: 82.5%	NHT2 5(d) OS3 5(p) 5(l) 5(r) OS6 5(m) OS5 5(o)	**Elective services ensure the restoration of functional independence and longer life for patients.**	NRHP 2.3	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these initiatives/activities	**Deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**Toward delivering these outcomes**
Acute Inpatient Services					
Provide an acute care service with the following characteristics: • timely access to all service components (including diagnostics) and appropriate timely discharge. • capacity to meet needs • right treatment in the right place • good access to support services in the community or primary care level to support patient recovery. (NRHP 2.1, 2.3)	**Acute inpatient services** *Quality:* Acute readmissions to hospital Baseline: 10.37% — 2011/12: 9.55% Acute Inpatient Length of Stay: Baseline: 4.19 — By July 2012: 3.96	OS8 5(b) OS4 5(q)	**Acute services provide timely assessment and treatment to support patient's recovery and prevent deterioration and reduce mortality.**	NRHP 2.3	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care
Emergency Department					
Provide an emergency and acute care service with the following characteristics: • timely access to all service components (including diagnostics) and appropriate timely discharge. • capacity to meet needs • right treatment in the right place • timely patient transfer to appropriate services from Emergency Department. • good access to support services in the community or primary care level to support patient recovery. (NRHP 2.1, 2.31)	**Emergency department services:** • **Referral** • **Assessment** • **Treatment**		**Timely referral, assessment and treatment for acute conditions, measured by** 95% of admitted patients discharged or transferred from the Emergency Department within six hours: Baseline: 97% — By July 2012: 95%	NHT1 5(c)	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these initiatives/activities	**Deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**Toward delivering these outcomes**
Assessment Treatment and Rehabilitation					
Provision of ambulatory and inpatient rehabilitative services. (NRHP 2.3)	**Bone Density Service** **Community Based Rehabilitation** **Community Geriatric Service** **Inpatient/ Outpatient HOP services** **Ortho Geriatric service** **Outpatient** **Stroke Service** *Quality:* Number of falls per month Baseline: 23 — By July 2012: < 15 Proportion of pressure areas acquired during ARHOP admissions Baseline: 5% — By July 2012: 5%	5(f) 5(g)	**Improved mobility and daily functioning for inpatients, measured by:** Barthel score improvement [27] Baseline: 74% — By July 2012: Continue to maintain a rate > 60% Referral rate to ATR from EC Baseline: 26% — By July 2012: Continue to maintain a rate > 15% Average length of stay in AT&R Baseline: 23.57 days — By July 2012: < 15 days	3(i) 3(h) 3(e)	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care
Maternity Services					
Provide readily accessible maternity, obstetric and neonatal care services. (NRHP 1.4, 2.3)	**Non-specialist antenatal consultations** **Obstetric antenatal consultations** **Postnatal inpatient and outpatient care.** **Delivery Services** **Specialist neo-natal inpatient and outpatient care.** **Amniocentesis** MOH ESPI compliance reports for gynaecology Baseline: 100% — By July 2012: 100%	5(l)	**Improved maternity services will lead to safer pregnancies with reduced complications and safer childbirth, thus ensuring healthier infants.** Proportion of women who have not been managed according to their assigned status (ESPI). Baseline: 2.7% — By July 2012: 0%	MHP 5(l)	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>Deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr><td colspan="6">Quality and Safety</td></tr>
<tr>
<td>Implement Quality Improvement Initiatives which focus on reducing clinical risks, improving patient safety, minimising wastage, improving workflows</td>
<td>Quality systems improvement and waste minimisation
- Aiming for Zero Patient Harm programme
- Safe Medication Management Programme
- Hand Hygiene Programme
- Whai Manaaki (searching for a better way to provide care)
- Did Not Attend</td>
<td></td>
<td>Quality systems contribute to enhancing patients and their families experience of care

Rate of adverse drug events (per 100 patient admissions)
Baseline | By July 2012
48.7% | 0%

Number of total CLAB (hospital wide per month)
Baseline | By July 2012
8 | 0

Patient satisfaction with services (rating it Good or Very Good) improves
Baseline | By July 2012
90% | > 90%

Outpatient Did Not Attend (DNA) rates for Maaori and Pacific
| Baseline | By July 2012
Maaori | 19% | < 10%
Pacific | 16% | < 15%</td>
<td>5(j)

5(e)

5(a)

5(k)</td>
<td></td>
</tr>
</table>

Output Class: Rehabilitation and Support Services

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

OUTPUTS			IMPACTS		OUTCOMES
We will undertake these initiatives/activities	**Deliver these Outputs with these Measures**	**Reference**	**Impacts and Measures**	**Reference**	**Toward delivering these outcomes**
Palliative Care					
Contract with Hospice services to provide care. Provide specialist palliative care services. Fund Home based palliative care services. (NRHP 1.2, 2.2, 2.3)	**Specialist end of life care.** **Advance Care Planning in aged residential care and secondary care** *Quality:* Number of people with advance care plans in the community Baseline: Currently being established — By July 212: Increase current rate	3(g)	**Reduced inappropriate admissions / demand on acute hospitals**		Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care
Aged Residential Care Beds (ARC)					
Provide access to subsidised beds based on assessed need. Fund a sufficient supply of contracted beds available to people assessed as requiring long term residential care. (NRHP 1.2)	**Residential care services.** **Residential bed days** *Quantity:* Total number of subsidised aged residential care bed days. Baseline: 1,043 — By July 212: Increase to accommodate population growth *Quality* Proportion of residential care service providers who meet required certification standards. Baseline: 100% — By July 212: 100%	3(k) 3(n)	**Better management of chronic conditions for those aged 65 years and over.**	NRHP 1.2	Improved health of the population and reduced inequalities Improved patients and their family/ whaanau's experience of care

<table>
<tr><th colspan="3">OUTPUTS</th><th colspan="2">IMPACTS</th><th>OUTCOMES</th></tr>
<tr><th>We will undertake these initiatives/activities</th><th>Deliver these Outputs with these Measures</th><th>Reference</th><th>Impacts and Measures</th><th>Reference</th><th>Toward delivering these outcomes</th></tr>
<tr><td></td><td>Number of complaints received regarding residential care service
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>10</td><td>Reduce current rate</td></tr></table></td><td>3(m)</td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Home Based Support</td></tr>
<tr><td>Use of the InterRAI tool to ensure people who need home based support services receive them in a consistent way. Provide timely access to assessment, treatment and support services for older people with complex health problems (NRHP 1.2, 2.3).

Provide information and support to older people and their carers about community support options (NRHP 1.2, 1.25)

Provide Home and Clinic based specialist Nursing services and allied health services to support community care (NRHP 1.2, 2.3).</td><td>Home based support services
Home based Nursing services
Wound care
Continence/ Ostomy
Lymphodema
Home IV
Home based Allied Health services

Quantity:
Number of home based support hours provided.
<table><tr><td>Baseline (2010)</td><td>By July 212</td></tr><tr><td>484,146</td><td>Increase current rate</td></tr></table>Number of complaints received regarding home based support.
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>0</td><td>Maintain current rate</td></tr></table>Quality / Timeliness:
Time taken from completion of initial needs assessment to delivery of service.
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>Currently being established</td><td>80% of cases within 10 working days
20% of cases within 20 working days.</td></tr></table></td><td>3(d)

3(l)

3(o)</td><td>Older people with complex needs are able to remain living in their home for longer periods (living to their ‘functional ability’). This is measured by:

Proportion of elderly receiving health of older people services in residential care or via HBSS
<table><tr><td></td><td>Baseline</td><td>By July 2012</td></tr><tr><td>HBSS</td><td>71%</td><td>Increase current rate</td></tr><tr><td>RC</td><td>29%</td><td>Decrease current rate</td></tr></table>Number of people supported in their own homes with complex packages of home-based care (NASC)
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>332</td><td>Increase current rate</td></tr></table>Proportion of ED attendances by 65+ year olds
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>18.32%</td><td>Decrease current rate</td></tr></table>Proportion of people over 75 years who are hospitalised due to falls
<table><tr><td>Baseline</td><td>By July 212</td></tr><tr><td>14.02%</td><td>Decrease current rate</td></tr></table></td><td>NRHP 1.2

3(a)

3(j)

3(b)

3(c)</td><td>Improved health of the population and reduced inequalities

Improved patients and their family/ whaanau’s experience of care</td></tr>
</table>

SECTION 4: STEWARDSHIP (Module 5 in Annual Plan)

Every week in CMDHB

- **110** people are admitted to hospital due to cardiovascular disease.
- **160** people are admitted to hospital due to respiratory conditions.
- **250** people with diabetes will be admitted to hospital.
- **860** free annual checks for diabetes.
- **40** patients receiving radiation therapy treatment
- **1,600** attendances in the emergency department
- **4,300** people are seen in outpatients.
- **23,700** adult and **7,900** child GP visits
- **37,600** prescriptions dispensed
- **54,300** lab tests ordered
- **3,440** people received **51,600** hours of home based care
- **610** immunisation visits for children under 2 years.

The scale of our **Capacity:**

- **1057** inpatient hospital beds
- **21** surgical theatres
- **73** school dental clinics / mobile dental facilities
- **6590** full time equivalent staff including **2680** nurses and **830** doctors

This section details how the organisation manages its business effectively and efficiently to deliver on the priorities described in Section 2 and 3. It shows how the DHB's high level strategic planning translates into action in an organisational sense within the DHB and details the supportive infrastructure requirements to achieve this. As both funder and deliverer of health services, the DHB must operate in a fiscally responsible manner and be accountable for the assets it owns and manages.

4.1 GOVERNANCE AND ORGANISATIONAL STRUCTURE

CMDHB has a governance and organisational structure as required by the New Zealand Public Health & Disability Act 2000.

The CMDHB Board assumes the governance role and is responsible to the Minister of Health for the overall performance and management of the DHB.

Responsibilities of the Board include:	• Setting strategic direction and policies which are in line with Government objectives and priorities; • 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 CMDHB Board has seven Board members elected by the community and four appointed by the Minister of Health.

Three statutory advisory committees and five non-statutory committees have been established to help the Board meet its responsibilities.

Membership of these committees is a mix of Board members and community representatives including Maaori, Pacific, mana whenua and clinicians.

See Figure 8 for the DHB's governance structure and key functions of the Board committees.

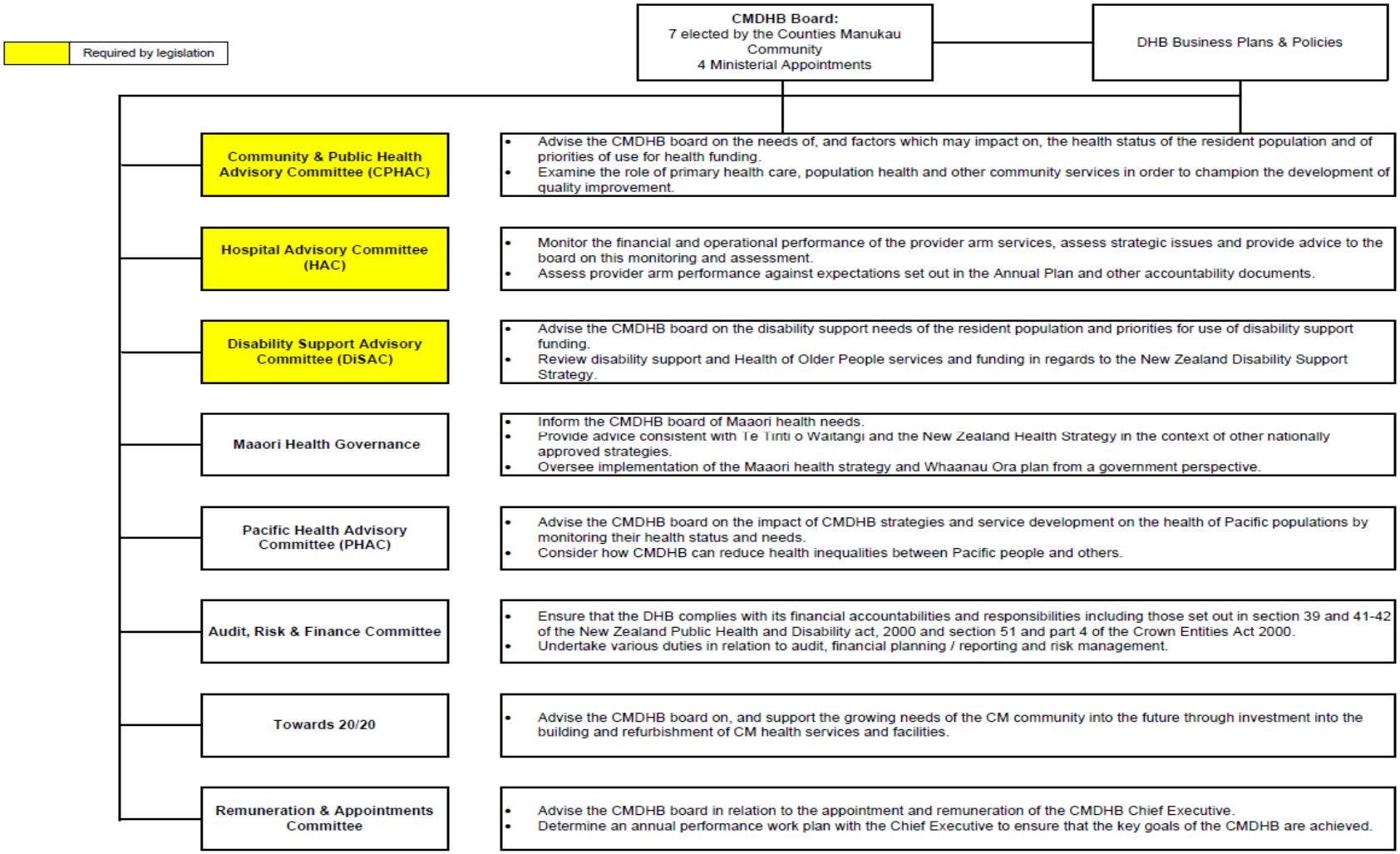
4.1.1 Management Structure

Whilst the Board is responsible for the DHB's overall performance, operational and management matters are assigned to the Chief Executive who is supported by the Business Group and Strategic Forum.

Strategic Forum consists of Business Group members as well as the General Managers and Clinical Directors from all the divisions across the organisation.

Business Group membership	• Finance Director • Chief Operational Officer • Chief Medical Officer • Director of Nursing • Director of Allied health • Director of Planning & Performance • Director of Services Integration • Director of Primary Care • Director of Quality Improvement • Director of Ko Awatea Additional support is provided by: • Senior Legal Advisor • Communications Manager • Chief Information Officer for healthAlliance • General Manager, Human Resources • General Manager, Maaori Health

Figure 8: Counties Manukau DHB Governance Structure



4.1.2 Clinical Engagement and Leadership

Counties Manukau DHB is committed to the philosophy and practice of clinical leadership where clinicians are accountable for outcomes they have the ability to affect. To facilitate this, CMDHB has a governance structure that ensures active, robust decision making and partnership between clinicians and management.

- Clinical leadership is led by the Chief Medical Officer (CMO), and Directors of Nursing (DoN), Allied Health (DAH), Primary Care and Quality Improvement; through to Clinical Directors, Clinical Nurse Directors, Heads of Department, and formal and informal networks of primary and secondary care clinicians.
- Clinical leaders are represented on the Counties Manukau Board and Board advisory committees like the Community and Public Health Advisory Committee (CPHAC) and the Hospital Advisory Committee (HAC). The CMO reports to the Board monthly and the CMO, DoN and DAH jointly report to HAC monthly.
- Clinicians are well-represented on the Strategic Forum where there are ten clinicians represented alongside the other twenty senior executives of the management team.
- Clinical leaders are a part of advisory committees such as Asset and Capital, and Workforce and are represented on advisory/ steering committees for key projects such as the Emergency Department *"6 Hours Can Be Ours*" campaign and major capital works like the development of the Edmund Hillary Block.
- The current work undertaken to develop the Northern Region Health Plan is an example of close collaboration between clinicians and health sector administrators. All the workstream groups are lead by a clinical leader and consist of a mix of senior clinicians, managers and other key stakeholders.

CMDHB also has formal mechanisms for broader based participation from clinical staff through the Clinical Advisory Group and the Clinical Management Executive Committee (CMEC) Secretariat. *See Appendix 2 for more detail about these structures.*

4.2 FUNDER INTERESTS

4.2.1 How the DHB ensures value for money

The concept of value for money is evident is all phases of the procurement life cycle. Our funding processes follow closely the Office of the auditor General's procurement guidelines which includes contestable provider selection. This allows the DHB to compare proposals from a number of providers, including pricing, in order to find the most effective provider for the services sought. There are some circumstances where a contestable provider selection process may not be appropriate. Management of funding agreements includes formal performance monitoring and auditing by external organisations as well as continuing an informal relationship to ensure accountability for service value.

4.2.2 Funding and financial management

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

4.2.3 Risks

The management of risk in funding arrangements is one of measured mitigation, balancing the application of appropriate mitigation strategy/cost to the degree and size of risk. CMDHB risk management is managed centrally via a formalised process using specific risk management technology to assist and record the various DHB risks. At a micro level we apply the same principles of high level contractual rigour for high value complex funding agreements to simple letters of agreement for low cost "one off" arrangements. The continued approach of using a combination of informal relationship monitoring with external resourced audit and monitoring ensure risks are managed prudently.

4.2.4 Quality assurance and improvement

Quality Assurance

To help ensure that contracts are prepared to an acceptable standard, all CMDHB Funder Arm agreements are reviewed internally before they are released to the providers. Funder Arm personnel involved in this internal review process include General Managers, the Finance Manager, the Director Service Integration, the Senior Legal Advisor (and/or the Procurement & Accountability Coordinator). To facilitate ongoing improvement in Funder Arm contracts, the CMDHB Procurement Guidelines for Funder Arm services requires that all service agreements are reviewed at least on an annual basis.

Improvement

In 2010, the CMDHB Funder Arm commenced a 'Procurement Improvement Project'. The four main components of the project were as follows:

- **Formally define the roles and responsibilities** of all persons involved in the Procurement Process;
- **Review procurement processes** used in the CMDHB Funder Arm, investigate ways to improve the processes as required, and ensure implementation of new processes;
- **Clearly document all policies and procedures relating to the procurement process**, incorporating any process improvements developed; and
- **Develop and ensure the implementation of a comprehensive training programme** to educate all staff involved in procurement about CMDHB Procurement Policies and Processes, as well as their roles and responsibilities at each stage of the Procurement Process.

In addition to the above, one of the main objectives of the project was to ensure CMDHB Funder Arm staff procurement activities and practices comply with OAG guidelines.

The new procurement processes developed through this project are described in the DHB's '*Procurement Guidelines for Funder Arm Services'* which were also developed as part of the project. Changes are currently being made to the guidelines, based on feedback received from staff during the Procurement Training. Formally, the Procurement Guidelines, and the processes contained within them, will be reviewed at least on an annual basis.

4.2.5 Audit and review

Audit

The CMDHB Funder Arm coordinates a Routine Audit Programme to assess the extent to which Personal Health, Maaori Health and Pacific Health NGO providers are complying with terms of their contract with the DHB. Additional issues based audits can be commissioned if there are particular concerns about a provider's performance.

The NDSA coordinates the Routine Audit Programme for Mental Health services.

In addition to the Routine Audit Programmes, Audit & Compliance (Sector Services) and MedSafe provide additional audit and investigation services on behalf of CMDHB.

Wherever possible, CMDHB will endeavour to coordinate audit activity with other District Health Boards and the Sector Services teams.

Contract Review

The Procurement Guidelines for Funder Arm Services require that service agreements are reviewed at least on an annual basis. This is an opportunity for CMDHB to assess how well a provider has performed over the term of an agreement, review the services that we have purchased, and review and improve our contract documentation.

4.3 PROVIDER INTERESTS

4.3.1 How the DHB ensures value for money

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

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

CMDHB together with WDHB established healthAlliance, a non clinical shared services agency some ten years ago as an early commitment to ensuring a value for money approach to health .This has been extremely successful in all areas of activity in both consistently achieving considerable savings and ensuring a standardisation of approach wherever possible. It has recently [1st April 2011] been expanded to include ADHB and NDHB and will be working in close alignment with HBL to build on these gains for national benefit

4.3.2 Funding and financial management

CMDHB apply industry and public sector standard practices that ensure best practice financial management at both the macro and micro level. At a macro level there are robust budget, forecasting and reporting processes that link in all levels of management in a structured framework accountable to the Chief Executive and Board. Clear documented management, operational and financial delegations combined with the current IT applications ensures the highest level of financial accountability resulting in the DHB's consistency in achieving zero deficit results in recent years despite extraordinary clinical and fiscal pressures. At a micro level funding for clinical services requires a commercial approach which is based on nationally based Price / Volume (P/V) schedules. Where PV funding is deemed to be inadequate, additional funding is provided where justified to ensure quality delivery of core and high profile services. A continuing tight fiscal environment continues to put pressure on increased reliance on financial management and our clinical services to deliver sustainable value for money health services.

4.3.3 Risks

The management of risk in ongoing operations is one of measured mitigation, balancing the application of appropriate mitigation strategy/cost to the degree and size of risk. CMDHB risk management is managed centrally via a formalised process using specific risk management technology to assist and record the various DHB risks. High organisation risks are reviewed by CMDHB's Board monthly, and at Audit, Risk & Finance Committee quarterly, to ensure that appropriate attention is given to these risks. At a micro level the Providers' operational risk is determined by population related pressures, with mitigation strategies developed which centre around bed modelling, models of care, and capital planning. The continued approach of using a combination of informal relationship monitoring with external resourced audit and monitoring ensure risks are managed prudently.

4.3.4 Quality assurance and improvement

Quality Assurance

To help ensure that services are delivered to an acceptable standard, CMDHB Provider Arm clinical results are reported on by the Health Intelligence Unit and reviewed internally by the Quality Improvement team as well as each Services internal quality team. There is also a Clinical Management Executive Committee and various clinical committees involved in internally reviewing quality results and processes. Committee members include the COO, General Managers, Finance Manager, Directors of Nursing and Allied Health, CMO, clinical and service directors.

4.3.5 Audit and review

Audit

The CMDHB Provider Arm is actively involved in regular programmed internal audits as well as CMDHB's annual audit to ensure the accuracy and integrity of its financial results. Additionally, there are certification and assurance audits carried out to verify the hospital's ability to perform to acceptable standards.

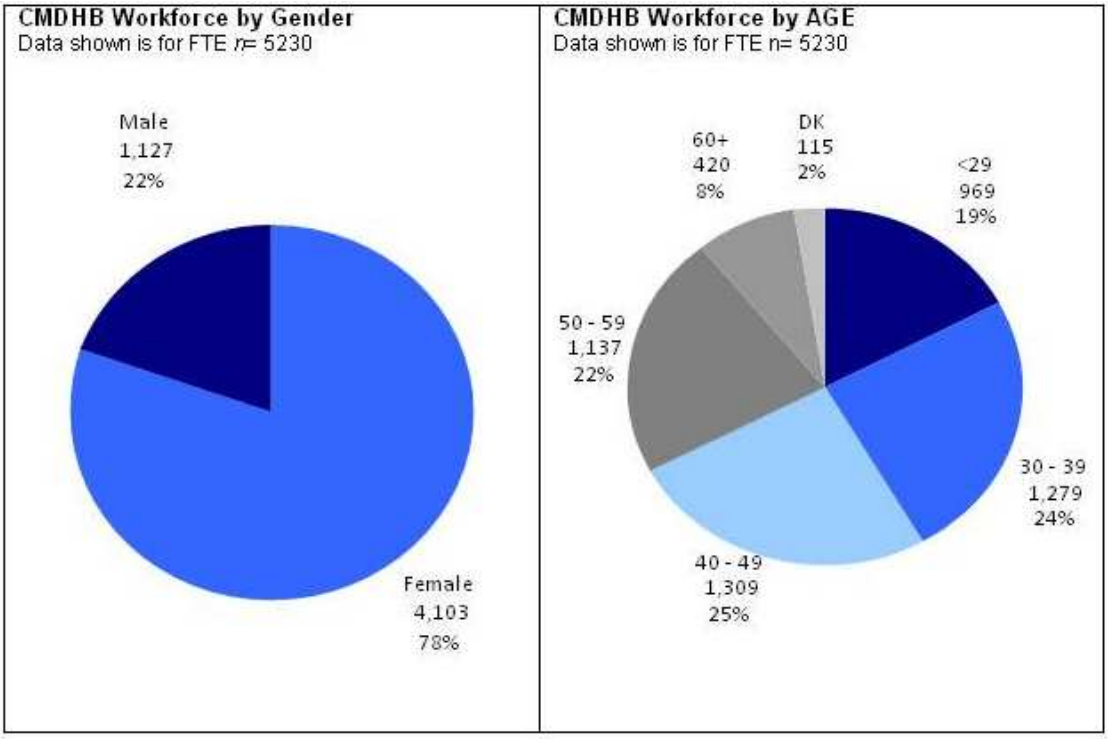
Wherever possible, CMDHB will endeavour to coordinate audit activity with other District Health Boards. An example of this is the Regional Internal Audit team which services the four Northern DHB's. CMDHB's Finance Director acts as lead CFO over this activity, coordinating both CMDHB Board and management requirements with those of the other three DHB's to ensure a consistent approach, value for money as a shared service and a sharing of outcomes.

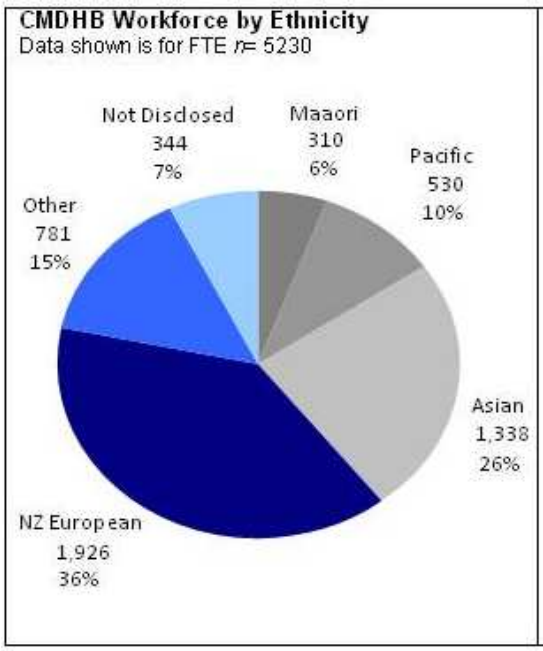
4.4 ORGANISATIONAL HEALTH

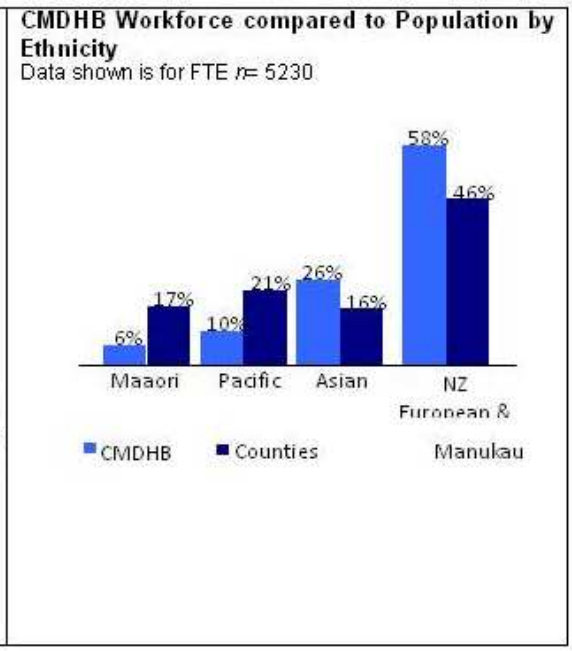
4.4.1 Good Employer

Counties Manukau DHB is a major employer in South Auckland with over 5,700 staff employed across hospital and community-based settings.

A snapshot of our workforce profile at 30 March 2010 is shown below.







Principle

CMDHB discharges its Good Employer obligations by operating under a Human Resources policy containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment.

CMDHB is committed to this principle and will actively seek to uphold any legislative requirements in this regard.

4.4.2 Good Employer principles in practice

Provisions which reflect the General Principles include:

- **Good and safe working conditions**
  CMDHB is an approved Accredited Employer within the ACC Partnership Programme at Tertiary Level. This decision reflects tertiary standards of both health and safety systems and processes and work injury management processes.

  OHSS roll out of a safety cannula device to all clinical workplaces. Introduction of this device was as result of OHSS injury prevention project aimed at reducing needlestick injuries and workplace blood/body fluid exposures. Since roll out, there have been nil needlestick injuries reported resulting from cannulation activity. OHSS continues to carry out injury prevention project work which aims to improve workplace safety, therefore demonstrating CMDHB commitment to acting as a good employer.

  Development and publication of de-escalation and restraint minimisation e-learning modules now available for all staff. Future goal is to achieve roll out of de-escalation training to all clinical workplaces.

- **An equal opportunities programme**
  CMDHB has revised its Good Employer Policy to ensure it is more inclusive of EEO principles and practices relevant for this DHB. An EEO Action Plan is currently in development which will identify a stage implementation approach from awareness to practice across the organisation which both celebrates diversity to activity influencing recruitment and retention. The Plan identifies a range of activities and links existing networks to foster a cohesive approach to equal opportunities practice.

- **The impartial selection of suitably qualified persons for employment**
  CMDHB uses a variety of selection processes comprehensively linked to competencies. Behavioural based interviews and or assessment centres are conducted linking applicant ability to deliver the functions and purpose of each position we hire into. Panels are utilised to cover both clinical and management representation – with specific cultural participation and support factored into our hiring process. Post interview CMDHB managers also conduct thorough reference checks.

- **Recognition of the aims, aspirations and employment requirements of Maaori people**
- **Recognition of the aims, aspirations cultural differences and employment requirements of Pacific peoples, and people from other ethnic or minority groups**
  CMDHB has established cultural diversity programmes focused both on service delivery for a culturally diverse and improving the employment environment for staff from diverse ethnic groups. An expected outcome of this programme is to enhance the ethnic diversity of staffing by providing an environment which is rewarding and engaging for a diverse workforce.

  CMDHB has a specific management programme for managers about managing within a culturally diverse workforce which is part of a compulsory orientation for managers and all new managers undertake a comprehensive training programme which includes a specific module on diversity and inclusion.

  CMDHB is also focusing resources on encouraging students from groups under-represented in tertiary qualified roles within the organisation, such as Pacific peoples to participate in advanced qualifications to improve the representation Pacific peoples in the clinical roles in the DHB (and across the broader sector workforce), and to encourage existing staff to undertake further qualifications to enable career advancement.

  CMDHB is running a Language, Literacy and Numeracy programme to enhance the career opportunities and long term workforce participation of staff who currently have limited skills in these areas.

  CMDHB has established an Aspiring Leaders programme specifically to build the leadership capacity and capability of CMDHB's Maaori, Pacific and Asian staff, to provide opportunity career advancement and improved representation of these groups at higher levels in the organisation, and also the broader sector workforce.

- **Opportunities for the enhancement of the abilities of individual employees**
  A range of services are provided throughout CMDHB in primary, secondary and planning & funding. This takes many forms and includes leadership and management training and development, career development consultancy, customised in-service programmes for individual, teams and managers, e-learning and the provision of internal and external courses and training over a range of skills and knowledge.

- **Recognition of the employment requirements of women**
  CMDHB provides opportunities for flexible employment in almost all roles; employment agreements for female dominated workforces provide better provisions for parental leave and extended absence for childcare beyond the statutory requirements. Dedicated breastfeeding facilities are provided on the larger campuses.

  CMDHB has dedicated career development resources to encourage career planning for all staff and a significant programme of learning and development opportunities, and has plans to further extend the programmes and development opportunities available on-site.

- **Recognition of the employment requirements of men**
  CMDHB has dedicated career development resources to encourage career planning for all staff and a significant programme of learning and development opportunities and has plans to further extend the programmes and development opportunities available on-site.

- **Recognition of the employment requirements of persons with disabilities.**
  CMDHB Disability Support Services are here to help assist staff and patients by implementing the NZ Disability strategy which is to eliminate barriers for disabled people and to promote a more inclusive society. CMDHB will measure this by assessing how staff and consumers with

disabilities are provided for, in terms of environmental access, support, employment and inclusion, with particular reference to CMDHB policies.

Standards

CMDHB shall ensure that employees maintain proper standards of integrity and conduct, in keeping with the "Vision and Values" of CMDHB.

Complaints and appeals

CMDHB supports the right of all employees to pursue resolution of any complaint through the procedures contained in the relevant legislation (e.g. Human Rights Act, Race Relations Act, and Employment Relations Act). In the first instance, an employee can obtain assistance in the pursuit of a complaint or appeal, by contacting the Human Resources Service Manager.

4.4.3 Equal Employment Opportunities (EEO)

Principles

Discrimination in employment occurs whenever factors or personal characteristics which are not relevant to the job are used. Discrimination can be direct (e.g. by refusing to hire people with certain characteristics) or, more often, indirect (e.g. when people appear to be treated in the same way but are in fact denied equal opportunity).

CMDHB believes that by ensuring our workplaces reflect and value the differences within our workforce, we will be able to deliver quality health services more efficiently, effectively, and appropriately.

CMDHB believes that by removing seen and unseen barriers which prevent people from reaching their full potential, we can deliver top performance at every level of the organisation.

Equal Employment Opportunities (EEO) is an integral part of being a good employer.

Policy

CMDHB is committed to the concept of EEO and will work towards the elimination of all forms of unfair discrimination in employment evidenced by:

- inclusive, respectful and responsible organisational culture which enable access to work, equitable career opportunities and maximum participation for members of designated groups and all employees
- procedural fairness as a feature of all human resource strategies, systems, and practices
- employment of EEO groups at all levels in the workplace

CMDHB's Human Resource policies and practices will be free from any discriminatory element that has the potential to deny a person equal opportunity.

In the past year CMDHB has joined the Equal Employment Opportunity(EEO) trust. This assists the organisation to champion our EEO goals.

Over the next year EEO initiatives will continue to develop as we grow and celebrate our diverse workforce.

EEO Benefits for Counties Manukau DHB

EEO will help CMDHB develop a more united and diverse workforce which is responsive to change, is more flexible and has a richer workplace culture.

EEO is a way of honouring our obligations under the Treaty of Waitangi.

EEO will assist CMDHB to:

- deliver improved customer service by better matching our services with our clients
- improve its productivity through valuing its employees and treating them fairly

EEO can improve staff relations and morale, lower absenteeism and reduce staff turnover. CMDHB has one of the lowest staff turnover rates within the public health sector.

4.5 BUILDING CAPABILITY

The capabilities that the DHB needs over the next three to five years are outlined here.

4.5.1 Thriving in Difficult Times

Thriving in Difficult Times (TiDT) was initiated by CMDHB in November 2009 as a response to the challenge of having to post a zero deficit position for 2009/10, 2010/11 and into the future years.

The TiDT project is a clinically led programme to review the DHB's plans, processes and identify opportunities for improvement in what the DHB currently does. The scope specifically refers to:

- identifying what services and processes can be improved/ changed to deliver better care, without compromising patient safety or quality or investment in staff and facilities, whilst achieving value for money;
- identifying areas where value could be added;
- identifying and eliminating duplication of effort and wastage;
- identifying those activities which do not deliver to the DHB's core business and stopping them.

Two main activities were scoped in 2010/11: A *Saver* workstream and an *Enabler* workstream. The CMDHB Board gave its endorsement and support to the TiDT plan in 2009 which outlines how the workstreams are going to contribute to the zero deficit position and future savings.

The workstreams are now in various stages of implementation, with some having been completed and savings achieved. Some of the initiatives like the patient safety initiatives, quality improvement activities targeting waste, reducing variation in clinical practice will require ongoing effort so that these are not just one off imperatives but a way of life for the DHB.

4.5.2 Workforce and Human Resource

For 2011/12 the four DHBs in the Northern Region will strengthen and build on the cooperative and collaborative activity already undertaken across a range of human resource (HR) functions over past years. This work provides an enabling platform on which to progress regional activity in line with health policy and ministerial expectation of greater collaboration and sharing of resources across support services. The establishment of the shared services Health Benefits Ltd at a national level and the Northern Regional Shared Services organisation (now incorporated as healthAlliance Limited) including all four Northern Region DHB's locally provides the organisational mechanisms for the formalisation of ongoing planning and implementation of shared strategies and projects within the greater human resource field.

The regional collaboration work is maturing in a range of speciality areas of human resource activity. This includes work in the areas of Employment Relations, Recruitment, Workforce Development, Learning and Development, Occupational Health and Safety, special projects, HR infrastructure and systems development and shared services. .

A key objective is for the DHBs to have common systems and organisational structures that enable them to better plan for and manage the HR issues across the spectrum of the employment relationship of our large and diverse workforces. Previously this has only been achieved where DHB specific strategic objectives and local and regional contexts have aligned. It is expected and valued that in the current environment this alignment will be more overt and supported by other regional planning in the areas of systems and organisational infrastructure and clinical service planning.

The Northern Region DHBs Human Resource Management Strategy 2009-2013 is developed. It incorporates findings from research, meetings and stakeholders at ADHB, CMDHB, NDHB, WDHB and healthAlliance. It includes the strategy and problem definition, prioritisation criteria and principles for applying resources to HRMS and the steps and high level action plan for implementation of the strategy. This document aligns with the Regional Information Strategy 2010 - 2020 and will be reviewed depending on the direction taken nationally regarding the scope of this strategy. The achievement of this strategic document and agreement confirms the existence of significant regional competency and commitment to the process of planning and moving towards the implementation of HR systems and processes which enhance the recruitment and retention of our workforce whilst effectively managing the costs of that workforce.

It is critical that our talent is retained within our region or sector so that service delivery goals can be achieved.

4.5.3 Information Systems

The *Northern Region Information Systems Implementation Plan (NRISIP)* outlines the programme of work required to achieve the objectives of the *National IT Plan 2010* and the *Regional Information Strategy 2010 -2020* for the next 3 to 5 years. Due to challenges around resourcing, complexity and governance the programme may need to be spread over a longer timeframe.

As agreed by the regional Chief Medical Officers, the main clinical driver is to improve the continuity of care for patients in our region across the continuum of services through providing consistent and reliable access to core clinical documents and facts for all clinicians involved in a patient's care.

A significant technical driver is the need to ensure that basic aspects of IS development and functioning are both resilient and comparable across the four DHBs. This will provide a platform from which all can continue to develop regional information systems in a coordinated fashion. A key business driver is the need to replace Northland's legacy systems, as identified in the Readiness Assessment produced by the National IT Board. It will likely be necessary to delay progress on some projects in some, if not all, DHBs during the period of catch-up required to establish a more uniform regional platform.

Two key processes will require active, strong leadership by senior management:

1. The development of regionally agreed and consistent business and clinical processes, which the regional technical information systems will underpin and enable.
2. The reprioritisation required within each DHB to match IS developments to available resources and to ensure that the order in which projects are undertaken takes account of crucial interdependencies and the need for regional consistency.

The January 2011 Minister's Letter of Expectations requires regional plans which focus on a small number of high priorities and regionalisation of IT platforms and IT support. The 16 February 2011 letter to DHB CEOs from the Chair of the DHB Information Group and from the Director of the National Health IT Board states that each DHB will need to significantly reduce the number of local health IT projects and focus on regional clinical projects. Furthermore, replacing legacy applications must be a priority so that each region has a common and standard regional IT platform. In this context the Chief Information Officers and Chief Medical Officers have identified a shortlist of key foundation projects in the attached table which need to be planned, funded and implemented regionally.

Other priorities

Regional project teams will be established over the next few months to plan these programmes of work and project the necessary funding for the coming years. These programmes of work should be the key focus for regional investment and activity and should be "protected" in local DHB capital and operational expenditure prioritisation processes.

Some investment will also be possible and required in other regional projects that underpin the delivery of key clinical priorities in the short to medium term. Other regional priorities that have been identified include:

- E Referrals Phase 2
- E Discharges implemented to national standards
- E Medicines including e medicines reconciliation, community & hospital e prescribing
- Shared Care Plan Phase 2
- E Rostering
- establishment of NRSSO including network integration, single sign-on and single service desk
- shared financial management systems
- IS support for Better Sooner More Convenient business case workstreams

4.5.4 Capital planning and infrastructure development

See Section 5.3.2 for our capital planning and expenditure priorities for 2011/12

4.5.5 Innovation

Ko Awatea – Counties Manukau DHB's Centre for Health System Innovation and Improvement

Ko Awatea	*(First Light)* A light to ignite energy and illuminate knowledge to enable health system change.

To help achieve the DHB's aim of being the best performing health system in Asia-Pacific by 2015, the organisation is establishing a new capability - Ko Awatea.

Ko Awatea is an education and innovation centre, located at Middlemore Hospital, which brings together expertise and relationships to improve the effective and efficient application of healthcare.

Its goal is to help the DHB move from successful individual projects to sustainability and spread of best and new practice which will enable better care, better population health and lower cost.

Ko Awatea's core functions are capacity building and knowledge development, management and dissemination to increase capability and deliver whole of health system improvement. The majority of Ko Awatea's $2.35 million budget in 2011/12 is directed towards capacity building.

The capacity building aspects of Ko Awatea link to partnerships with the Institute of Healthcare Improvement, the Oxford Centre for Healthcare Transformation, and three tertiary education organisations – University of Auckland, AUT University and Manukau Institute of Technology to jointly develop and grow a future workforce that meets the needs of our community.

This partnership approach is reflected in the recent joint appointment of Ko Awatea's Director, Professor Jonathon Gray with the University of Auckland where he is the Stevenson Professor of Health Improvement.

Ko Awatea opened in June 2011.

To find out more about Ko Awatea, go to: http://koawatea.co.nz/home/index.html

NZ Health Innovation Hub

Subject to pending approvals, the four largest District Health Boards (Counties Manukau, Auckland, Waitemata and Canterbury) plan to establish a national Health Innovation Hub to grow New Zealand's health innovation sector by engaging clinicians, facilities and patients with industry in the commercialisation of product and service innovations.

The Hub's goals are to improve healthcare for our communities, retain and attract clinical and technical expertise and generate economic benefits for NZ in this high value, export focussed sector.

The Hub will work in policy alignment with central and local government agencies - in health, research and development, and economic development - and be supported in its formative period by their funding, with partner DHBs contributing financial and in-kind support. Counties Manukau DHB's contribution in the 2011/12 year will be $300,000 and the equivalent of one full time in-kind resource.

4.6 LEGISLATIVE REQUIREMENTS

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

- Significant changes to services (as per MOH Service Change Guidelines);
- Entering into new arrangements such as the changes in shareholding with healthAlliance NZ Limited, and Ko Awatea and the Innovation Hub.

In this regard, the DHB is presently finalising arrangements that may require Ministerial approval to either the changes or new investment.

- Expansion of healthAlliance NZ Limited to encompass Auckland DHB, Northern DHB and Health Benefits Limited alongside the existing shareholding of Counties Manukau DHB and Waitemata DHB. This approval request is presently with the Minister.
- The establishment of the Innovation Hub which, for Counties Manukau DHB, sits under the umbrella of Ko Awatea. The Hub will be a partnership owned by the DHBs of Auckland, Waitemata, Canterbury and Counties Manukau. All of this will be fully documented in a Section 28 request to the Minister (expected in early May).
- The establishment of Ko Awatea has also necessitated an unincorporated joint venture which will function through a limited liability nominee company incorporating the four shareholders (Counties Manukau DHB, University of Auckland Faculty of Medicine & Health Sciences, Manukau Institute of Technology and AUT University) to hold the shared educational assets related to Ko Awatea.
- The likely establishment of a special purposes vehicle (SPV) for Integrated Family Health Care / Whanau Ora Centre, in conjunction with Tainui on land owned by CMDHB at the Manukau Health Park.

SECTION 5: FINANCIAL PERFORMANCE (Module 8 in Annual Plan)

5.1 FINANCIAL STATEMENTS

Summary by Funding Arm	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Forecast	2013/14 Plan
Provider	7,584	(55)	(4,235)	(4,465)	(27,606)
Governance	(2,577)	(2,174)	(24)	(27)	(29)
Funder	(4,844)	5,178	4,302	4,516	4,741
Operating Surplus	**163**	**2,949**	**43**	**24**	**(22,894)**
Other Comprehensive Income	(8,775)	-	-	-	-
Surplus (Deficit)	**(8,612)**	**2,949**	**43**	**24**	**(22,894)**

Statement of Comprehensive Income

Net Result $000	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Forecast	2013/14 Plan
Revenue					
Crown	1,188,368	1,249,078	1,303,616	1,368,737	1,437,111
Other	27,986	28,575	25,341	26,607	27,936
Total Revenue	**1,216,354**	**1,277,653**	**1,328,957**	**1,395,344**	**1,465,047**
Expenses					
Personnel	427,485	451,327	479,325	503,269	528,409
Outsourced	50,273	52,674	50,028	52,527	55,151
ISP	548,813	573,134	599,889	629,857	661,322
Clinical Sup.	86,376	93,702	90,475	95,898	108,724
Infrastructure	59,662	56,660	60,866	58,938	64,219
Operating Exp	**1,172,609**	**1,227,497**	**1,280,583**	**1,340,489**	**1,417,825**
Operating surplus	**43,745**	**50,156**	**48,374**	**54,855**	**47,222**
Depn.	23,283	26,361	23,831	25,331	31,601
Interest	7,713	8,681	12,500	17,500	26,014
Capital Chg.	12,586	12,165	12,000	12,000	12,501
Operating Surplus	**163**	**2,949**	**43**	**24**	**(22,894)**
Other Comprehensive Income	(8,775)	-	-	-	-
Surplus (Deficit)	**(8,612)**	**2,949**	**43**	**24**	**(22,894)**

Funder	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	1,143,863	1,190,890	1,255,812	1,318,545	1,384,412
Other	52	-	-	-	-
Total	**1,143,915**	**1,190,890**	**1,255,812**	**1,318,545**	**1,384,412**
Personnel	-	-	-	-	-
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	1,148,759	1,185,712	1,251,510	1,314,029	1,379,671
Total Expenditure	1,148,759	1,185,712	1,251,510	1,314,029	1,379,671
Net Surplus	**(4,844)**	**5,178**	**4,302**	**4,516**	**4,741**

Eliminations	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	(599,946)	(612,578)	(651,621)	(684,172)	(718,349)
Other					
Total	(599,946)	(612,578)	(651,621)	(684,172)	(718,349)
Personnel	-	-	-	-	-
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	(599,946)	(612,578)	(651,621)	(684,172)	(718,349)
Total Expenditure	(599,946)	(612,578)	(651,621)	(684,172)	(718,349)
Net Surplus	**-**	**-**	**-**	**-**	**-**

Provider	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	636,021	662,803	689,261	723,692	759,843
Other	27,564	28,522	25,341	26,607	27,936
Total	**663,585**	**691,325**	**714,602**	**750,299**	**787,779**
Personnel	421,174	444,958	472,689	496,301	521,093
Depreciation	23,283	26,361	23,831	25,331	31,601
Capital Charge	7,713	8,681	12,500	17,500	26,014
Other	203,831	211,380	209,817	215,632	236,677
Total Expenditure	**656,001**	**691,380**	**718,837**	**754,764**	**815,385**
Net Surplus	**7,584**	**(55)**	**(4,235)**	**(4,465)**	**(27,606)**
Other Comprehensive Income	(8,775)	-	-	-	-
Surplus (Deficit)	**(1,191)**	**(55)**	**(4,235)**	**(4,465)**	**(27,606)**

Governance	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	8,430	7,963	10,164	10,672	11,205
Other	370	53	-	-	-
Total	**8,800**	**8,016**	**10,164**	**10,672**	**11,205**
Personnel	6,311	6,369	6,636	6,968	7,316
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	5,066	3,821	3,552	3,731	3,918
Total Expenditure	**11,377**	**10,190**	**10,188**	**10,699**	**11,234**
Net Surplus	**(2,577)**	**(2,174)**	**(24)**	**(27)**	**(29)**

Total	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
Revenue	**Audited Actual**	**Forecast**	**Plan**	**Plan**	**Plan**
Crown	1,188,368	1,249,078	1,303,616	1,368,737	1,437,111
Other	27,986	28,575	25,341	26,607	27,936
Total	**1,216,354**	**1,277,653**	**1,328,957**	**1,395,344**	**1,465,047**
Personnel	427,485	451,327	479,325	503,269	528,409
Depreciation	23,283	26,361	23,831	25,331	31,601
Capital Charge	7,713	8,681	12,500	17,500	26,014
Other	757,710	788,335	813,258	849,220	901,917
Total Expenditure	**1,216,191**	**1,274,704**	**1,328,914**	**1,395,320**	**1,487,941**
Net Surplus	**163**	**2,949**	**43**	**24**	**(22,894)**
Other Comprehensive Income	(8,775)	-	-	-	-
Surplus (Deficit)	**(8,612)**	**2,949**	**43**	**24**	**(22,894)**

Balance Sheet

$000	2009/10	2010/11	2011/12	2012/13	2013/14
Current Assets					
Cash and Bank	1,577	1,866	1,878	1,888	1,898
Debtors	46,738	48,618	50,558	52,582	54,543
Inventory	613	613	613	613	613
Current Assets total	**48,928**	**51,097**	**53,049**	**55,083**	**57,054**
Non Current Assets	449,085	476,875	511,431	585,686	597,914
Total Assets	**498,013**	**527,972**	**564,480**	**640,769**	**654,968**
Current Liabilities					
Creditors	82,914	76,859	78,270	77,675	74,049
Loans *(Working Capital)*	7,500	21,600	33,600	35,000	40,000
Employee Provisions *(current)*	89,186	94,459	97,807	99,894	102,822
Total Current Liabilities	**179,600**	**192,918**	**209,677**	**212,569**	**216,871**
Working capital	**(130,672)**	**(141,821)**	**(156,628)**	**(157,486)**	**(159,817)**
Net Funds Employed	**318,413**	**335,054**	**354,803**	**428,200**	**438,097**
Non Current Liabilities					
Employee Provision *(Long term)*	13,938	14,290	14,622	14,725	14,795
Term Loans	150,000	160,741	177,514	248,185	278,307
Restricted funds	844	854	866	876	886
Total Non Current Liabilities	**164,782**	**175,885**	**193,002**	**263,786**	**293,988**
Crown Equity	**153,631**	**159,169**	**161,801**	**164,414**	**144,109**
Net Funds Employed	**318,413**	**335,054**	**354,803**	**428,200**	**438,097**

Movement of Equity	**2009/10 Audited Actual**	**2010/11 Forecast**	**2011/12 Plan**	**2012/13 Plan**	**2013/14 Plan**
Total Equity at beginning of period	**159,655**	**153,631**	**159,169**	**161,801**	**164,414**
Surplus / (Loss) for period	(8,612)	2,949	43	24	(22,894)
Crown Equity injection	3,009	3,009	3,009	3,009	3,009
Crown Equity withdrawal	(421)	(420)	(420)	(420)	(420)
Total Equity at beginning of period	**153,631**	**159,169**	**161,801**	**164,414**	**144,109**

Cash flows from operating activities	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Operating Activities					
Crown Revenue	1,173,903	1,243,218	1,309,890	1,375,424	1,444,152
Other	45,786	13,720	16,487	17,135	18,181
Interest rec.	647	1,000	1,000	1,050	1,102
Suppliers	749,766	763,756	805,772	840,098	893,251
Employees	424,327	446,767	475,713	501,259	525,557
Interest paid	8,737	8,681	12,500	17,500	26,014
Capital charge	13,404	12,165	12,011	11,889	12,401
GST (Net)	317	95	96	95	90
Net cash from Operations	**23,785**	**26,474**	**21,285**	**22,768**	**6,122**
Investing activities					
Fixed assets					
Baseline	(16,502)	(14,000)	(14,500)	(14,500)	(14,500)
Strategic	(29,268)	(40,151)	(38,147)	(82,926)	(29,329)
Total Fixed Assets	**(45,770)**	**(54,151)**	**(52,647)**	**(97,426)**	**(43,829)**
Restricted & Trust Funds	10	10	12	10	10
Net cash from Investing	**(45,760)**	**(54,141)**	**(52,635)**	**(97,416)**	**(43,819)**
Financing					
Private Debt	500	14,100	12,000	1,400	5,000
Crown Debt	18,500	11,267	16,773	70,669	30,118
Equity - Capital	2,590	2,589	2,589	2,589	2,589
Net cash from Financing	**21,590**	**27,956**	**31,362**	**74,658**	**37,707**
Net increase / (decrease)	(385)	289	12	10	10
Opening cash	1,962	1,577	1,866	1,878	1,888
Closing cash	**1,577**	**1,866**	**1,878**	**1,888**	**1,898**

Capital Expenditure	2009/10 Audited Actual	2010/11 Forecast	2011/12 Plan	2012/13 Plan	2013/14 Plan
Baseline Capital					
Clinical Equipment	9,085	5,000	5,500	5,500	5,500
Other Equipment	613	2,400	2,400	2,400	2,400
Information Technology	3,170	3,900	3,900	3,900	3,900
Intangible Assets (Software)	3,198	1,800	1,800	1,800	1,800
Motor Vehicles	436	900	900	900	900
Subtotal	**16,502**	**14,000**	**14,500**	**14,500**	**14,500**
Strategic Capital					
Clinical Services Block	29,268	40,151	38,147	82,926	29,329
Total	**45,770**	**54,151**	**52,647**	**97,426**	**43,829**

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

5.2 OVERVIEW

The early indications from the Minister and Ministry of Health of continuing constrained funding levels from 2011/12 onwards resulted in CMDHB taking similarly early action through its *Thriving in Difficult Times* and Productivity Initiatives initially established in 2010/11 in order to achieve an Annual Plan reflecting a zero deficit operating position.

Despite the challenges, a budgeted full consolidated breakeven position has been achieved without any reduction in front line clinical services, as required both by management and the Board. However, as this has meant a reduction in support staff, the organisation has been put in a position of higher clinical and financial risk as a result, which we acknowledge must be managed despite the continuing escalating pressures.

While a nationally consistent application of the PBF formula would have significantly benefited CMDHB's financial position by a minimum of $12m, and allowed CMDHB to continue to self fund the significant number of initiatives around primary care and hospitalisation avoidance, this is not available under the MoH capped percentage funding envelope.

Previously the MoH cap increase was limited to 7% (2009/10) in total funding. This was reduced in the 2010/11 year to 5%, and maintained at the same capped level for 2011/12. CMDHB was the only DHB negatively impacted by this. Consequently CMDHB has achieved breakeven through further very intensive reviews of its existing investments and structures.

We highlight however that it is anticipated that the benefit of the Population Based Formula (PBF) formula will accrue to CMDHB in future years albeit at the current capped level. This is a very fundamental and important assumption to highlight, as without this recognition the financial position of CMDHB would be at risk (as highlighted later in this document), particularly given the increasing cost impact as the new facility investments come on stream in later years.

The key drivers of this change in financial position are:

- Despite the international economic position, the anticipated continuing relatively high level of clinical wage settlements will continue, primarily in the Provider Arm. These are expected to be settled at levels around double the general inflationary levels, on an all up basis, i.e. base and step function increases.
- The continuing significant IDF outflows and pricing adjustments primarily related to provision of tertiary services.
- The continuing population growth in excess of the census projections used to calculate the population based formula revenue, albeit this gap is diminishing gradually.
- The full annualised impact of operating costs relating primarily to the full opening of the new Edmund Hillary Ward block on the Middlemore site. Of future critical importance will be the impact of the $208m Clinical Services Block Stage 1 which is anticipated to come on stream with significant cost impacts in the third year of this Annual Plan, i.e. 2013/14
- Middlemore hospital bed capacity is expected to be reached in 2013, which will cause other constraint related issues and which will be compounded by the opening of CSB Stage 1. The reaching of capacity is two years ahead of earlier forecasts on bed capacity.
- The need to achieve Government health targets/priorities around ED waiting times, Electives, Cancer waiting times, Elective Services Patient Indicators and the increased costs, primarily FTE related, associated with those targets within the forthcoming constrained budget.
- The annualisation of commitments made in 2010/11, including the very significant continuing investment in all quality related areas, with significant initial "hump" funding. This is expected to start producing a return on investment in the coming years and forms a very significant and important part of our *Thriving in Difficult Times* targets.
- Acute demand growth is increasing, particularly in the Department of Medicine, Provider Arm, after a period of relatively lower growth.

While the 2010/11 financial result is forecast to achieve a surplus position, this result could be perceived as misleading in comparison to the forecast 2011/12 position, without further analysis. There are a number of current year gains that are, from a timing perspective, "one off". Depreciation and interest costs are anticipated to be significantly lower than budget for 2010/11 reflecting both the timing issues of the new facility developments and lower depreciation levels on assets reaching the end of their economic lives.

We are also forecasting in 2010/11 a "surplus" within the ring fenced Mental Health spend which is essentially a timing issue rather than a permanent underspend. These benefits offset the demand driven

cost increases occurring within the Funder Arm, particularly Health of Older People, and Pharmaceutical costs.

In previous years, CMDHB has benefited from the PBF formula specifically through the demographic growth component of the funding which is additional to CCP. This has allowed CMDHB the opportunity to invest in areas directed towards primary health care and early intervention, which would result in a lessening in hospital demand. Both the "capping" of the PBF and the anticipated wage increases allow no opportunity for such continuing additional investment, although the core investment of previous years continues.

This forecast financial position, particularly for the first year of the Annual Plan (but also obviously impacting on the outer years) has severely limited CMDHB's ability to continue to invest in and achieve many of its wide-ranging objectives at the level it seeks. CMDHB remains committed to achieving its Triple Aim objectives. In order to do so we implemented a process of organisational wide review last financial year under the project "*Thriving in Difficult Times*" which highlighted initially five key areas of focus. The funding constraints CMDHB will be under to achieve breakeven will be of critical concern in determining where and how these impact on the Triple Aim objectives.

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

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

The 2011/12 year will be a difficult balancing act as the focus moves to ensuring financial stability and potentially diluting efforts to deliver on the Northern Region Health Plan objectives and our clinical and quality imperatives. If the financial pressures continue as forecast, greater efficiencies and increased innovation will become more important as the primary drivers to addressing the organisation's strategic objectives and meeting its financial obligations.

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

The 2011/12 Annual Plan shows a breakeven position. In a change from previous years, we are now looking to retain and maintain the existing carried forward surpluses of $15.5m. This is to build up a reserve to offset any future likely investment related deficits in order to achieve a continuing zero deficit return. With regard to the targeted national and DHB objectives, these would be around investment in priority initiatives aligned with the Northern Region Health Plan and Ministerial areas of emphasis and change such as Chronic Care Management (CCM) and Maaori Health. It is likely that the Board will continue to seek to review the investment levels in these areas within the limits of the carried forward earnings. The Annual Plan also includes recognition of the Minister's "tagged" funding and costs related to the specific tags.

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

In order to reduce our deficit to $Nil for the organisation, we have already had to financially cap the level of allowable and fundable growth as well as initiatives, both within the provider and the funder arms. This continues to present a huge challenge to contain the growth, related costs and quality investment throughout the organisation within these parameters. However, management and Board recognise that CMDHB will have to further constrain these areas in order to achieve the zero deficit budget position.

It should be noted very clearly that we have maintained our Lets Beat Diabetes (LBD) investment at existing investment levels ($1m-$2m per annum), increased our investment in Primary Options for Acute Care (POAC) by a further $0.6m per annum and lifted our investment in Oral Health through significant volume increases costing over $1.7m per annum. These investments are seen as critical and unavoidable, despite the intense financial constraints, with even more significant clinical and financial downside, if not addressed now.

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

5.2.1 Key Assumptions and Risks

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

- A mandatory asset revaluation was carried out June 30th, 2009 under the 3 year minimum asset revaluation period requirement. As a result, devaluation occurred reversing some of the very significant revaluations of previous years. A further high level review is required annually to ensure there are no material variations. Based on current market conditions, it is expected that there will be no material change in asset valuations and therefore no related change in the capital charge.
- All mental health funding continues to be "ring fenced". As in previous years, mental health has been instructed to absorb its related excess wage settlements within its own ring fence, on the basis it has its own "ring fenced" FFT equivalent (CCP) and demographic growth and must operate within those parameters without top up from any other source.
- Funding for Health of Older People income and asset testing recalculation is insufficient to match our forecast level, given that as house prices stabilise or fall (as is currently happening), health of older people accessibility levels will drop, entitling more people to claim. This needs to be offset by savings elsewhere.
- That the current ACC arrangements both in regard to revenue levels and cost recoveries are maintained at current levels. Publicly ACC has indicated a tighter fiscal affordability envelope and as well, a tightening of their payment parameters. While this is difficult to quantify currently, CMDHB expects to offset any downside by further opportunities or enhancement of existing contracts.
- That all revenue allocated to CMDHB, other than ministerially tagged funding, remains at CMDHB's discretion to allocate and contractually commit. This is a very important and fundamental assumption, as there appears to be increasing consideration from the MOH around potential claw back of untagged funds.

It is important to note that the forecast zero deficit position has been reached after recognising anticipated wage and salary settlements well in excess of the 1.72% funded level, specifically:

- The flow on effects of significant national three year wage settlements agreed in previous years, with the flow on costs well in excess of the MoH funded levels. These are driven primarily by additional leave entitlements, automatic ongoing step function on–cost implications, a doubling of CME entitlements, significantly enhanced call out charges and the resultant increase in back-filling.
- This Annual Plan has been prepared based on the latest information available around existing and likely wage settlements. It is anticipated based on this, that there will be an "across the board" agreed settlement rate for all CTU related unions, with the exception of specifically junior doctors, and under separate award, senior doctors at very similar levels. The base settlements are in excess of the funded levels which, together with the add on costs and automatic step functions applicable to most awards, continues to present a huge challenge to all DHBs.
- There is no evidence of any material quantifiable efficiency benefits arising from previous MECA settlements or likely in current negotiations. Thus the onus is on the DHBs to manage these costs.
- Increased roster and compliance costs around RMOs terms of employment from previous settlements.
- Generally increased, more demanding terms and conditions of employment across earlier MECAs which significantly lessens flexibility.

- The significant annual financial impact, particularly this coming year, of the formal introduction in the Auckland region of SMO job sizing
- The continuing committed (albeit constrained) investment in priority initiatives aligned with the Northern Region Health Plan, including those focused on lessening the growth of hospital services and improving quality clinical outcomes.
- The ongoing internal efficiencies being generated including those within the expanded healthAlliance, now covering the full Northern Region. Again, while there are national procurement and shared services initiatives well under way via HBL as a result of recent government initiatives, we have reviewed the likely outcome of these as they impact on this year's Annual Plan. They appear extremely difficult to identify and therefore quantify any current additional material financial benefit arising from these given the level of efficiency in these targeted areas already being achieved by the "old" healthAlliance. We do not believe it is appropriate to build into the Annual Plan a potentially very risky "unspecified lump sum" saving when there appears to be a high likelihood that we will be unable to achieve this.
- The absorption of increasing pharmaceutical demand, reflecting greater access and usage by our community.
- The absorption of the very significant and increasingly unfavourable costs around Health of Older People, specifically around private hospital funding. This is a national trend reflecting the ageing population shift, growing at a rate which by itself is completely unsustainable financially. It is only through savings in other unrelated areas that this level can at least be managed.
- The absorption of continuing renal growth volumes, albeit it at a growth level below the extremes of previous years.
- The absorption of continuing price adjustments to inter-district flows (IDFs) and to a lesser extent the volume of IDF outflows. These relate primarily to provision of services by ADHB with recent upward changes in prices far in excess of CCP and requiring strong challenge as to the level of efficiency built into tertiary pricing and the perpetuation of a 'cost plus' mentality. Much firmer disciplines have been put in place to enable both principles agreement and management of volumes and costs with IDF partners to minimise this significant exposure.
- The combined impact of meeting and maintaining the Ministerial ED 6 Hour target and the absorption of increasing ED volumes with consequent flow-on bed impact. The international financial crisis and flow-on impact to our community is clearly having a negative impact on these volumes and the consequent pressure on CMDHB.
- Minister's expectation that each DHB pick up their share of Christchurch Elective volumes. This may cause capacity issues in Auckland which could adversely affect third party prices, which CMDHB will have to access to achieve these volumes given our current capacity constraints.

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

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

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

- An organisational wide commitment to clinical safety and quality improvement. This initiative led by the CEO, and now picked up on a national basis, resulted in the formation of a formal quality unit within the organisation, but working across and within each area of CMDHB. The quality initiatives will ultimately lead to significant clinical and thus financial benefit and will ultimately be self funding. It is anticipated that these benefits will continue to impact CMDHB during this and next financial year through focussed action under the *Thriving in Difficult Times* initiative, but will still remain a challenging financial target despite the significant resource commitment.

- In recognition of the continuingly tightening fiscal constraints and capped funding CMDHB management, with full Board support, last year initiated a series of efficiency projects under the general heading *Thriving in Difficult Times*. Those same initiatives together with newly identified areas of opportunity are reflected in the three year Plan. The overall objectives of the projects are around cost reduction and efficiency improvement with a deliberate avoidance of any negative clinical impact or where possible, material redundancies. The core principles of the project are a commitment to a transformational culture change, a disciplined methodology, a commitment to the Triple Aim, investment in effective and disinvestment in ineffective and reshape, resize, rather than restructure and redundancies. One of the positive outcomes of Quality initiatives has been a reduction in ALOS which has enabled CMDHB to absorb some of the volume growth with existing capacity. Further (medium to longer term) focus will be around the critical area of service configuration and related capital affordability, as well as extending Quality initiatives into the Primary sector.

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

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

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

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

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

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

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

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

Finally, it is important to highlight within this Annual Plan, that CMDHB has over the past 6 years now, fully absorbed the impact of CCP [previously FFT] and demographic growth funding levels being understated as per the following two tables:

Table 9: Impact of Inflation (FFT/CCP) Short Funded Over Past 6 Years

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

Table 10: Impact of Under-estimated Population Growth as Reported through Census/Statistics NZ

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

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

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

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

Therefore, when any assessment of efficiencies being achieved is made, there needs to be acknowledgement and recognition that CMDHB is already absorbing between $18m and $26m per year through effective revenue or cost recognition under-funding. This represents a huge challenge from a clinical or health perspective. While this represents a very solid financial absorption which could be argued is simply "getting rid of existing inefficiency", to do so would be ignoring reality.

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

5.3 FINANCIAL MANAGEMENT

5.3.1 Specific Cost Pressures – Wage Pressure

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

In many cases wage staff are entitled to move up a step virtually automatically after each year of service (step function increases) which result in an average of 2 – 2.5% (net) increases. The step function

increases have to be absorbed by direct funding (none available) or by way of continuously increasing efficiencies.

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

Actual changes in leave entitlements over the past three years, some related to the implementation of the Holidays Act, are already having both a material financial and resourcing impact on the organisation with particular challenges around the impact of observing the extra leave entitlement and then filling the consequent vacancies this is causing. The provision for the cashing up of the fourth weeks leave will present a significant cash flow challenge for the sector if all parties take full advantage of the change.

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

Regional Job Sizing

As part of an Auckland regional standard approach, CMDHB has previously agreed to participate and abide by SMO regional job sizing standardisation. While most specialties are known and budgeted, there remains significant financial exposure to those specialties not yet finalised. Further, the costs of the existing settlements are at levels somewhat higher than anticipated.

5.3.2 Capital Planning & Expenditure

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

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

Extensive resource has been applied to this exercise on numerous occasions including significant independent external input as well as the achievement of a very high level of regional collaboration to ensure non-duplication and aligned timing of new facilities and capacities.

While acknowledging the Regional Annual Plan position, CMDHB with full Board support, must remain committed to the major capital projects currently under construction and nearing completion as previously approved by MoH or NCC/Minister, or those presently under consideration/application with MoH, the NCC replacement or the Minister. As we have indicated in the separate capital submissions, these capital projects, given their magnitude and continuing growth demand within CMDHB will, with the CSB Stage 1 project, fully utilise all existing available cash funding, sourced from either current or accumulated depreciation or remaining available approved debt funding or approved equity/debt. It is therefore critical that CMDHB receives its equitable portion of funding under PBF in order to ensure affordability of these future projects, thus ensuring all DHBs are on a fair level playing field in terms of capital requests.

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

Over the past few years, CMDHB has successfully completed all phases of its building programme under the auspice of FMP. This investment totalled over $400m and was almost all fully funded from

CMDHB free-cashflow or existing approved debt facilities. They have come in “on time”, “under budget” and “within specifications” – an almost unique occurrence in the public health sector.

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

The Clinical Services Block [CSB] Stage 1 [$208m] is now progressing well with the main contract for construction due to be finalised shortly .We continue to refine and improve the original concept as the design is finalised. We remain very confident around the outcomes both clinical and financial

As part of *Towards 20/20* the DHB is well advanced in determining the medium to long term organisational requirements (15 – 20 year horizon). This has been driven earlier by extensive internal and external consultation, the roll out of the Clinical Services Plan (primarily provider or hospital focused) to the Health Services Plan (community wide focus), co-ordinated with the earlier Asset Management Plan as supported by the Ministry of Health. The Business Case encompassing the first stage of the long term plan (CSB Stage 1) was approved by the Minister with initial construction well advanced and completion date commencement 2013 calendar year.

Simplistically, this project, albeit that it has technically been split into two stages, proposed a new Clinical Services Block encompassing a completely new replacement suite of theatres, High Dependency Unit (HDU) and Assessment and Observation Unit (AOU) facilities at Middlemore and the [now complete and occupied] fit out of the remaining (shelled) wards in the Edmund Hillary Block. It is envisaged that completion of this new CSB, Stage 1, will be followed by the relocation of support services to the Manukau Health Park [MHP] (Browns Road), Stage 1a. In this regard an amended Business case is currently awaiting Ministerial consideration and approval The original MHP stage 1 has at MOH’s request, been split into smaller more financially affordable stages, but is seen as essential in regard to establishing the infrastructure necessary to developing the Health Park concept. Ultimately this health park concept is seen as a true public private alignment and utilisation of health facilities on a single easily accessible site .

It is anticipated that the strong demographic growth requirements for CMDHB will continue and as such, outstrip the ability for CMDHB to fund future facility development, either internally or from existing debt facilities. Ongoing discussions continue with Ministry of Health and Treasury officials in regard to these requirements and the financial implications.

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

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

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

As highlighted in Section 4, CMDHB as lead partner, together with Auckland University School of Medicine, MIT and AUT, has opened a modular interim educational facility [Ko Awatea] aimed at addressing both current and short term health workforce planning requirements, as well as replacing existing teaching and learning facilities that are being demolished as part of the redevelopment described above. This is a very significant and critical project to ensure that there is adequate and appropriate clinical workforce, given both CMDHB’s and the greater Auckland’s population growth and ageing populations.

A much larger concept for Ko Awatea was originally presented to senior management of the National Health Board in April last year but severe short term capital funding constraints and the urgent need to address the workforce requirements has resulted in CMDHB scaling back the physical size but not the objectives of Ko Awatea to ensure affordability and accessibility.

As a result of further discussions with NHB an interim or modular solution was agreed. This is being internally funded and neutral in overall cost amongst the interested partners. However, the requirement of a permanent solution will be needed by the latest 2013 (for completion 2015 /16), given the limited growth capacity of the interim solution.

Table 11: Towards 20/20 Projects Schedule – Current Projects

Current Projects	Budgeted Approval	Projected finish date	Value	Status
Middlemore, Clinical Services Block Stage 1	Late May 09	Jan 2013	$208m	Underway ($108m internal funded)
Centre for Health Services Innovation	June 10	May 2011	$9.95mm	Approved by Board.

Table 12: Towards 20/20 Projects Schedule – Future Projects

Future Projects	Budgeted Approval	Projected finish date	Value	Status
Manukau Health Park, Stage 1a (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre) Now programmed into 3 phases as per MOH discussions	April 2011 April 2012 April 2013	Nov 2012 Nov 2013 Nov 2014	$33.1m $32.4m $57.0m ($122.5m)	Staged 2011 - 2014
Manukau Health Park, Stage 1b (Mental Health Unit, Mental Health Services for Older People, site infrastructure)	April 2013	Nov 2014	$49.4m	
Women's Health Building (replacing Galbraith, NICU, delivery suites, ante and postnatal wards and gynaecology wards)	April 2014	2018	$80m	
Manukau Health Park, Stage 2 (theatre expansion – 4 elective theatres, MICU, biomed, endoscopy, surgical wards - 40 beds, Women's Health primary maternity unit - 36 beds, community midwives, oncology – haematology unit)	April 2015	2018-2020	$71m	
Middlemore, Clinical Services Block Stage 2 (Radiology service fitout, laboratory service fitout, emergency department expansion, C-Pod Kidz First refurb)	April 2012	2015	$108m	
Middlemore Stage 3 (Inpatient Replacement & Expansion) **Manukau Health Park** (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre)	Nov 2015	2018	$80m	
Middlemore Stage 4 (decommission old ARHOP wards) **Manukau Health Park** (Outpatient expansion, ARHOP expansion - 25 beds, Mental Health Services for Older People expansion – 5 beds, surgical wards and theatre expansion)	2016	2017-2018	$55m	
Middlemore, Stage 5 (Decommission Galbraith, new entrance)	Nov 2017	2018-2020	$50m	
Ko Awatea replacement	Mid 2013	Mid 2015	$80m	PPP or equivalent
Staff Carpark	Mid 2013	Mid 2015	~$25m	PPP or equivalent
Integrated Family Healthcare Centre/ Whanau Ora Centre/Tainui	2011/2012	2013/2014		3rd party/SPV
Grand Total			**$615.9m Excluding last 3 items above**	

5.3.3 Banking Covenants

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

Clearly our existing banking relationships in these times are more important than ever. We have, over the past year communicated regularly with the external banks and CHFA of our likely tighter position for 2011/12 which we have managed through without any major issues but are now indicating that further significant tightening is increasingly likely to occur in 2012/13.

Table 12: Banking Covenants

Facilities ($m)	**Existing Limit**	**Utilisation @ 30 June 2011**	**Available Facility @ 1 July 2011**
CHFA	297.0	150.0	147.0
Commonwealth Bank (working capital)	50.0	7.5	42.5
Commonwealth Bank (lease facility)	10	-	10.0
Westpac (lease facility)	10	1.6	8.4

Note: The above CHFA limit INCLUDES the funding approved for the CSB Stage 1.

5.3.4 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 2011/12, including both new and replacement assets. Although we have still to complete the final review of all capital expenditure requests, (and therefore confirm the final associated depreciation levels), capital expenditure related to 2011/12 will be limited to $53.0m. We have not included within the cash flow forecast any capital requirements still requiring MoH/Minister approval, therefore specifically exclude the MHP Stage 1a and MMH WH Theatres.

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2011/12 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing unutilised/approved debt facilities.

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

Covenants

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

Asset Sales

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

5.3.5 Capital Charge

The Annual Plan continues to include the matching of cost and revenue on any higher capital charge that may arise from asset revaluations on a three yearly cycle. While this Annual Plan for 2011/12 is immediately following the June 30th 2009 three year requirement, as earlier, CMDHB is not anticipating any material valuation change. Rather, there is a likelihood of either a nil or devaluation given the current financial environment.

5.3.6 Advance Funding

The 2011/12 Annual Plan continues to incorporate the fiscal benefit of the one month advance funding, based on achieving an breakeven operating position and the maintenance of the other Ministry of Health requirements necessary to access this benefit.

5.4 COST CONTAINMENT EFFICIENCY GAINS

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

As a result of this, CMDHB has, as part of the preparation of this 2011/12 Annual Plan and the early low funding indications, taken immediate formal action to address the need for cost containment and clinical improvement. As earlier indicated, we have formally recognised these challenges through the initiation and then continuance of the *Thriving in Difficult Times* projects, and further roll out of productivity initiatives essentially aimed at thinking differently about cost and quality, while still committed to achieving our core objectives around the Triple Aim. The DHB recognises the overarching expectation that core clinical services cannot be cut. In fact, despite the financial pressures, the expectation is that they will be enhanced. However, in order to achieve the financial target facing CMDHB, it has been absolutely essential that we address, and correct as necessary, the level of investment in certain marginal areas and refocus our efforts in proven areas.

CMDHB remains committed to maintaining and exceeding in 2011/12, its existing very high level of access and elective volumes that are forecast for 2010/11. These levels have been achieved previously through a combination of both internal and external resources and, while a year later than planned, many of these elective volumes are proposed to be provided primarily within internal resourcing capacity and capability in 2011/12. However, where financially or clinically appropriate, in order to continue the strong reduction in waiting lists, we will access third party providers through formal longer term contracts.

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

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

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

CMDHB has and always will continue to maintain a very close focus on FTE management, given that salary and wage costs are two thirds of the provider budget. These are monitored and managed on a monthly basis, both in terms of absolute head count and cost per FTE by division, by RC.

We continue to administer and comply with the Minister's requirement around the freeze on management and admin FTEs. As noted previously, we had already implemented an equivalent

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

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

Table 13: Management and Admin resource levels.

Objective	**Deliverables**	**Target** **(Actual as at 31/12/08)**		**Timeframe**
Contain the level of investment in Management and Administration resourcing	Manage the FTE's categorised as Management and Administration within the District Health Board within the target FTE cap		Number	Monthly
		FTEs employed (Accrued)	833.8	Compliance
		+ contractors	17.90	
		+ advertised vacancies	35.80	
		+ subsidiaries	-	
		+ other	-	
		= TOTAL	887.5	

The total above does not include CMDHB's share of healthAlliance, NDSA, ARMOS or DHBNZ which are reported separately.

These caps will require adjustment relative to the expansion of hA and the transfer of ADHB and NDHB staff to the enlarged hA.

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

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

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

The current financial constraints imposed on all DHBs have meant DHBs have had to restrict healthAlliance activities for the past year in order to enable them to live within the overall funding package. Regrettably this meant a year of consolidation and in some cases, reduced ability to meet the needs and expectations of its shareholders as a shared services organisation. These cost pressures have meant that focus on areas such as information technology and management opportunities that are

seen as essential by all parties, have had to be deferred or in fact reduced for fiscal compliance at a time when both organisations should be investing in this area given the shareholders very high level of expectations and needs. This increased investment, particularly in IS, is necessary to recapture the momentum previously given to the provider arm as well as the very significant needs around the capture and integration within one system of primary care and community level information. This is seen as a critical area for all the new DHB shareholders and essential to the future development of the region.

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

5.6 2011/12 PHARMACEUTICAL BUDGET

CMDHB is committed to the Government's medicines boost initiative by engaging with Pharmac via our representations on SIG and the GMs' Planning and Funding forums. Pharmac's CMDHB 2011 "October" forecast describes an increase of $4m or 4.3% increase at "reimbursement cost" (drug cost plus dispensing less rebates and co-payments). This forms the base budget to which is added local and regional initiatives. The base budget includes the continued investment of Pharmaceutical Cancer Treatments and the Ministry's funding of 12 month Herceptin treatments. Locally/Regionally the pharmaceutical budget allows for initiatives in the areas of gout, patient drug switching incentives, regional pharmacy development and the continuation of pharmacy quality audits.

At time of writing, Pharmac is seeking DHB response to its amended budget bid. CMDHB with the Northern Region, support Option A - a reduction in the current level of investment. This will provide greater ability to fund the huge growth in dispensing cost, outside of Pharmac's control.

5.7 OUTLOOK FOR 2012/13 AND 2013/14 YEARS

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

1. As a result of the budgeted forecast of a zero deficit position for 2011/12 financial year, the outer years "base" positions have relatively speaking, improved significantly, based on the continuing revenue and cost assumptions. We are therefore anticipating that the 2012/13 of the Plan can be maintained at a nil deficit level. The 2013/14 year of the plan however includes the part year impact of the new Clinical Services Block coming on stream with increasing material impact on our operating financial position. While the incremental costs of the CSB Stage 1 is, as forecast in the original Business case, expected to be in excess of $40m per annum much of this has been absorbed. What remains is the shortfall in PBF funding over that anticipated and the net original deficit forecast resulting from this investment.

   - Years 2 and 3 of the CMDHB Annual Plan will benefit from the assumption that PBF funding will continue at the current levels, thus assuming the reduced 5% maximum increase cap in any one year continues to be applied.

   - Within all years of the Annual Plan, the full impact of the cost relating to the opening of Edmund Hillary Block at Middlemore is recognised at almost $6m per year as detailed in the original Business Case and has been fully absorbed.

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

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

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

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

5.8 SIGNIFICANT ACCOUNTING POLICIES

Cash and cash equivalents
Cash and cash equivalents includes cash on hand, deposits held at call with the banks, other short term highly liquid investments with original maturities of three months or less, and bank overdrafts.

Bank overdrafts are shown within borrowings as a current liability in the statement of financial position.

Instruments at fair value through surplus or loss
An instrument is classified as at fair value through **surplus** or loss if it is held for trading or is designated as such upon initial recognition. Financial instruments (interest rate swaps) are designated at fair value through comprehensive income if CMDHB manages such investments and makes purchase and sale decisions based on their fair value. Upon initial recognition, attributable transaction costs are recognised in comprehensive income when incurred. Subsequent to initial recognition, financial instruments at fair value through comprehensive income are measured at fair value, and changes therein are recognised in the surplus or loss.

Other non derivative financial instruments
Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment losses.

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

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

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

Derivative financial instruments
CMDHB uses foreign exchange and interest rate swap contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities.
Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments that do not qualify for hedge accounting are stated at fair value. The gain or loss on re-measurement to fair value is recognised immediately in the surplus or loss. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

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

Property, plant and equipment

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

- freehold land
- freehold buildings
- plant and equipment
- clinical equipment
- motor vehicles
- other equipment

Owned assets
Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.
Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised in other comprehensive income unless it offsets a previous decrease in value recognised in the surplus or loss. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of comprehensive income.

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

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

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

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

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

An operating lease is a lease that does not transfer substantially all risks and rewards incidental to ownership of an asset.

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

Depreciation

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

- **Class of asset Estimated life Depreciation rate**

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

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

Intangible assets

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

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

Amortisation
Amortisation is recognised as an expense on a straight-line basis over the estimated useful lives of intangible assets. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
• Software	2 - 5 years	20% - 50%

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

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

Impairment
The carrying amounts of CMDHB's assets, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.
If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of comprehensive income.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.
When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive income is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of comprehensive income.

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

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

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

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

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

Employee benefits

Defined contribution plans
Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive income as incurred.

Long service leave, sabbatical leave and retirement gratuities
CMDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

Annual leave, conference leave, sick leave and medical education leave
Annual leave, conference leave, sick leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount CMDHB expects to pay. CMDHB accrues the obligation for paid absences when the obligation relates to employees' past services.

Provisions
A provision is recognised when CMDHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation

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

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

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

Revenue

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

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

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

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

Mental Health Ring Fenced Revenue

In accordance with Generally Accepted Accounting Practice and NZIFRS, surpluses of Income over expenditure are reported through the Statement of comprehensive income. Where such surpluses are in respect of Mental Health Ring Fenced Revenue, the unspent portion of the revenue is only available to be spent on Mental Health Services in subsequent accounting periods. For year end 30 June 2011 there is estimated to be $3.5M unspent in respect of Mental Health Ring Fenced Revenue (as at 30 June 2010 $4.4 m).

Expenses

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

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

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

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

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

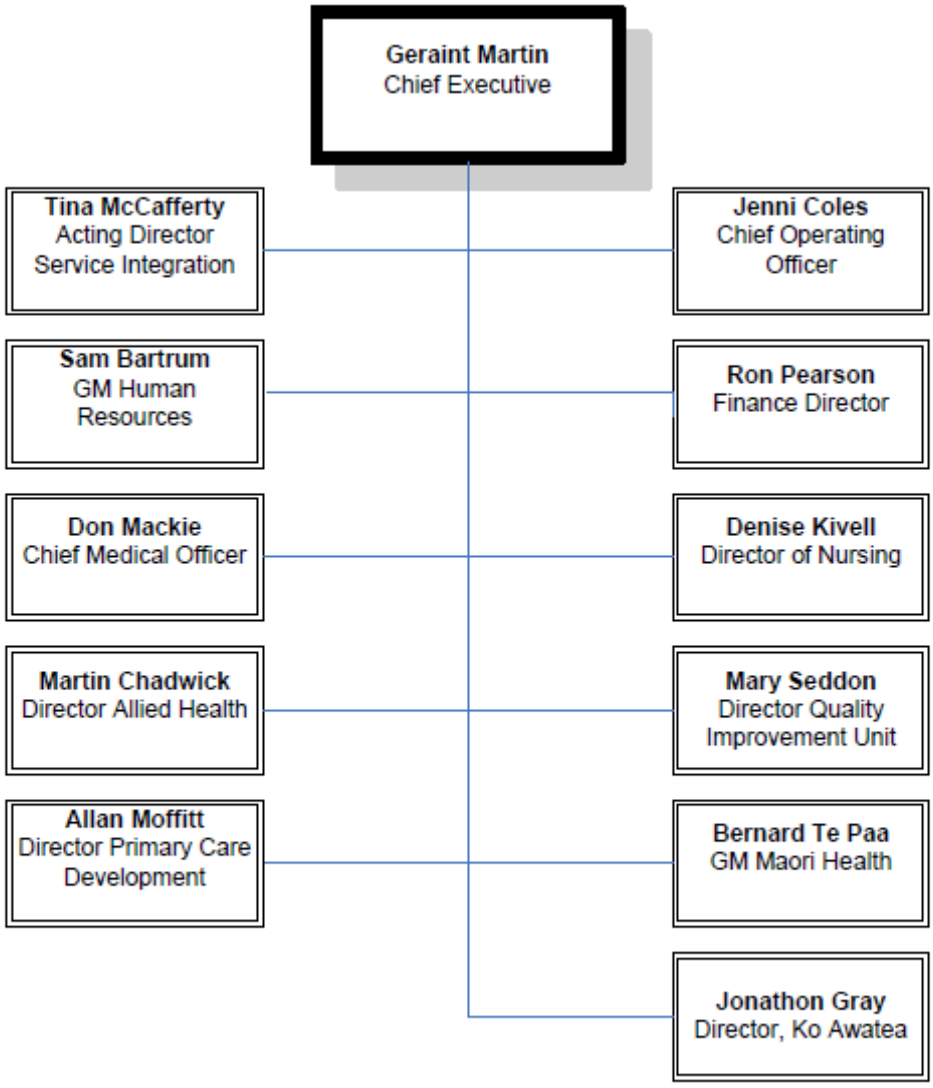
Cost Allocation Policy
Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

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

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

SECTION 6: APPENDICES (Module 9 in Annual Plan)

APPENDIX 1: CMDHB ORGANISATIONAL STRUCTURE CHART



APPENDIX 2: CLINICAL LEADERSHIP STRUCTURES AT CMDHB

Clinical Advisory Group (CAG)

The Clinical Advisory Group provides overarching clinical governance of the health sector in Counties Manukau, with particular emphasis on the interface issues and to assist CMDHB achieve service integration. The forum provides advice on matters of clinical quality and clinical risk management and escalation of clinical risks where there is no other appropriate forum for cross-sector issues.

The forum will also advise on clinical and patient safety issues, for example, issues relating to clinical quality between primary, secondary and tertiary care interfaces; accountability for hand-over between primary and secondary care; and, the implementation of appropriate systems to support clinical governance in provider services.

Other functions of CAG include informing the development of, and monitoring the progress of, whole of sector performance indicators; providing provider feedback, and, informing the development of clinical services.

Clinical Management Executive Committee (CMEC)

The Clinical Management Executive Committee Secretariat is responsible for the entire patient journey, including horizontal integration across the sector and across primary and secondary/tertiary services.

The roles and functions of the Clinical Management Executive Committee include:

- Responsibility for setting policies and guidelines on clinical and ethical issues; Monitoring the outcomes of the policies it defines and clinical quality throughout the organisation;
- Commissioning of audits or specific investigations and to make recommendations to the Executive Management Team, Clinical Directors and Service Managers;
- Resolving disagreements about clinical and ethical standards;
- Monitoring credentialing processes;
- Encouraging good practice and the introduction of good practice; and
- Investigating patient safety issues.

APPENDIX 3: GLOSSARY OF TERMS

Activity	What an agency does to convert inputs to **Outputs**.
Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve the Government's goals.
Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister. One of the three types of statutory entities (see also Crown entity; autonomous Crown entity and independent Crown entity)
Crown entity	A generic term for a diverse range of entities within 1 of the 5 categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
Impact	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. E.g. The change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations. (Public Finance Act 1989)
Impact measures	Impact measures are attributed to agency (DHBs) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can be measured after delivery, promoting timely decisions; reveal specific ways in which managers can remedy performance shortfalls. (http://www.ssc.govt.nz/upload/downloadable_files/performance-measurement.pdf)
Input	The resources such as labour, materials, money, people, information technology used by departments to produce outputs, that will achieve the Government's stated outcomes. (http://www.ssc.govt.nz/glossary/)
Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group. (Refer (http://www.ssc.govt.nz/glossary/)
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes (Refer State Services Commission 'Performance Measurement – Advice and examples on how to develop effective frameworks: www.ssc.govt.nz)
Intermediate outcome	See **Outcome**
Management systems	Are the supporting systems and policies used by the DHB in conducting its business.
Measure	A measure identifies the focus for measurement: it specifies what is to be measured
Objectives	Is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve "outputs" . E.g. Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving Governance…etc are 'internal to the organisation and enable the achievement of 'outputs'.

Outcome

Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to a end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. (Refer http://www.ssc.govt.nz/glossary/)

A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).

Output agreement

Output agreement/output plan - See **Purchase agreement** (refer to http://www.ssc.govt.nz/glossary/)

An output agreement is to assist a Minister and a Crown entity (DHB) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs (see s170 (2) CE Act 2004.

Output classes

Are an aggregation of outputs. (Public Finance Act 1989)
Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures (s 142 (2) (b) CE Act 2004). Are groups of similar outputs (Public Finance Act 1989).

Outputs

Are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).

Ownership

The Crown's core interests as 'owner' can be thought of as:
Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown;

Capability - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future;

Performance - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively. (Refer http://www.ssc.govt.nz/glossary/)

Performance measures

Selected measures must align with the DHBs DSP and DAP. The use four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year (2010/11) and show intended results for the two subsequent financial years. (Refer to www.ssc.govt.nz/performance-info-measures)

Priorities

Statements of medium term policy priorities.

Purchase agreement

A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs. Some departments piloting new accountability and reporting arrangements now prepare an output agreement. An output agreement extends a purchase agreement to include any outputs paid for by third parties where the Minister still has some responsibility for setting fee levels or service specifications. The Review of the Centre has recommended the development of output plans to replace departmental purchase and output agreements. (Refer http://www.ssc.govt.nz/glossary/)

Regional collaboration

Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist.

- Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB
- Midland: Bay of Plenty DHB, Lakes DHB, Tairawhiti, Taranaki, Waikato DHB,
- Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB, Whanganui DHB
- Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB

Regional collaboration for some clinical networks may vary slightly. For example Central Cancer Network contains eight DHBs, Taranaki DHB and Tairawhiti DHB in addition to the Central Region DHBs.

Results

Sometimes used as a synonym for ' **Outcome** '; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once. (http://www.ssc.govt.nz/glossary/)

Standards of Service Measures

Measures of the quality of service to clients focus on aspects such as client satisfaction with the way they are treated; comparison of current standards of service with past standards; and appropriateness of the standard of service to client needs.

Statement of service performance (SSP)

Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year. (http://www.ssc.govt.nz/glossary/)

Strategy

See **Ownership**
(http://www.ssc.govt.nz/glossary/)

Sub regional collaboration

Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping. Typically this is groupings of two or three DHBs and may be formalized with an agreement e.g. Memorandum of Understanding. Examples include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (centralAlliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.

Targets

Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.

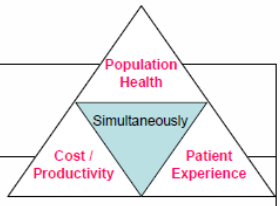
Values

The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. (http://www.ssc.govt.nz/glossary/)

APPENDIX 4: NORTHERN REGION HEALTH PLAN OUTCOMES FRAMEWORK

Northern Region Health Service Plan

Our Mission:
"To Improve **health outcomes** and reduce disparities by delivering **better** sooner more convenient **services**. We will do this in a way that **meets** future **demand** whilst living **within our means**"



Our Region's Strategic Challenges
- Inequalities in health status and health outcomes linked to ethnicity and socio-economic deprivation
- Demand for health care services, and particularly acute care, is predicted to exceed the level of health care resources
- The cost of providing publicly funded health services is growing at an unsustainable rate, influenced by demand pressures, new technologies and labour costs
- Delivery of care is fragmented between primary and secondary services and is based around an episodic model of care which does not work well for people with long term and complex conditions.
- There are substantial human and financial costs to our community associated with failures in health and disability services.

Our Strategic Goals

	1. Population Health: Lift Health Outcomes of Northern Region Population; Life and years (Longer, healthier, more independent lives); and reduce health inequalities	2. Patient Experience: Better Services; First do no harm; Informed choice; and performance improvement	3. Cost / Productivity: Ensure capacity to meet demand whilst living within our means
Objectives and expected outcomes	1.1 Minimise impacts from diabetes and cardiovascular disease evidenced by • Improved outcomes for patients and reduced inequality gap • Reduced incidence of disease • Regionally consistent response and methodology to prevention, care and treatment of those at risk of, or with disease. • Development and support of workforce to meet demand 1.2 Improve outcomes for older people and have a regionally consistent approach to best ensure the alignment of capacity and demand, by: • Reducing the need for older people to enter residential care • Reducing older people acute demand on hospital through development and implementation of alternative care settings and care processes • Ensuring dementia care needs are met by consistent regional co-ordination and care pathways • Improving the safety and quality of care for older patients in hospital and aged residential care • **Development and support of workforce to meet demand** 1.3 Minimise impacts from cancer and improve quality of cancer care by ensuring regional equity of access to care, improved treatment times and appropriate screening mechanisms, these approaches evidenced by: • **Further develop/ improve lung cancer and bowel cancer pathways for the region** • **Improved early diagnosis and management of bowel cancer** • Partnering with private sector to increase region capacity • **Reducing wait times for care** 1.4 Healthier safer children evidenced by : • Increased immunisation	2.1 Improve safety and quality of Regions health care across the whole sector • Ensure fewer adverse clinical events result from patient care • Understand what harm is occurring (also where and how it is occurring) • Raise patient satisfaction with their care • Implement regionally consistent methodologies to address regional issues • Implement a structured regional collaboration approach to drive progress of safety and quality priorities 2.2 Informed patient choice to ensure patients get appropriate care that best suits their context • Develop and promote consistent Advanced Care Planning (ACP) • **Implement Whanau Ora Assessments** 2.3 Appropriate health and disability services are able to be accessed in a timely manner when needed • Rapid access for patients with acute needs • Improved access to elective services to restore/ maintain peoples' functional independence • Maintain / reduce target wait times for patients accessing the hospital system	3.1 Regional resources are used effectively and services delivered efficiently with minimal wastage 3.2 Improve Regional radiology services by: • Improving access to, and timeliness of, radiology diagnostics 3.3 Manage infrastructure and assets to ensure safe, efficient and effective services evident by • Regional collaboration on spatial planning to inform capital planning • Delivering major infrastructure developments on time within budget 3.4 Work in partnership to effectively influence health and wellbeing outcomes evident by • Improving involvement of internal and external partners in the planning and provision of health services 3.5 Ensure a consistent region wide service investment-mix prioritisation process to help each DHB determine the optimum service mix 3.6 Invest in information systems and technology in five priority areas • Common PAS with standard processes and improved data quality related to patient registration • Provide a consistent user experience, improve clinical communication options and reduce the complexity of integration and audit functions • Meet the requirements of continuity of care • Create a single source of truth for regional population health information • Maintain current capability and support ongoing development
Expanded Outcomes / High Level Measures (short, medium and long term)	1.11 Develop and implement an auditable clinical pathway for Diabetes 1.12 Develop and implement a GP mentoring system and nurse practitioner model supported by training as required 1.13 Develop outcomes based framework 1.14 Improve data capture and information quality with regard to diabetes and CVD. 1.15 Align Diabetes / CVD workforce to meet demand 1.16 Reduce morbidity and mortality from Diabetes and Cardiovascular disease (including inequalities between different population rates) 1.17 Better diabetes and cardiovascular services [HT6] 1.18 Better Help for smokers to quit [HT5] 1.19 Appointment of a Diabetes and a Cardiology Clinical Network with supporting resource 1.21 Understand and manage drivers for admission to ARC 1.22 promote Aging in Place in line with national strategy 1.23 Expand implementation of community gerontology model 1.24 Development of regional strategies to: reduce ASH rates for older people; manage hospital acute demand from ARC 1.25 Better support older people with cognitive decline - mental health issues 1.26 Reduce falls and pressure injuries in hospitals and ARC facilities 1.27 Appointment of an Older People Clinical Network with supporting resource 1.28 engage in workforce modeling and development 1.31 Improved lung cancer and Bowel cancer pathways 1.32 Implemented Northern Region prioritisation criteria for colonoscopy 1.33 Deliver a successful bowel screening pilot at Waitemata DHB 1.34 Source a long term, sustainable RT solution 1.35 Monitor time from date of waitlist to colonoscopy 1.41 Increased Immunisation rates [HT4]	2.11 Develop a safety and quality outcomes based framework with performance indicators, measures and targets 2.12 Develop 'how to' guides for areas of focus (inc falls, pressure injuries CLABs, care transfer and patient ID) 2.13 Establish pilot site for medication safety 2.14 Complete 50 deaths audit in each DHB 2.15 Implement 'Trigger Tool' across the Region 2.16 Establish a campaign with collaborative structure and resource. 2.21 Stock take existing ACP activities especially in relation to ARC 2.22 Develop capacity of staff to undertake ACP 2.23 Increase number of people having an advanced care plan 2.22 Number of Whanau Ora Assessments with agreed goal oriented plans 2.31 Shorter stays in emergency departments [HT1] 2.32 Elective surgical services to be increased in line with elective service Health Target [HT2] 2.33 Shorter waits for treatment - maintain 4 week radiotherapy [HT3] - reduce wait time for chemotherapy - meet door to cath- lab target time	3.11 Maximise gains through regional provision of back office shared services 3.12 Minimal Region delivery variation once good clinical practice is identified 3.21 Develop a Radiology Clinical Network and agree regional workplan with priorities likely to encompass: models of care; workforce; IS and capital expenditure 3.31 Develop Regional Spatial and Asset Plan 3.41 Clinicians engaged in development and management activities 3.42 Number of planned clinical networks successfully established across Region 3.43 Number of public/ private partnerships explored and converted to successful implementation 3.44 Number of IFHC's implemented with social service solutions and implementation of Whanau Ora 3.51 Prioritisation process developed and agreed for implementation 3.61 Improved regional alignment of Patient Administration System [PAS] and PAS processes 3.62 Improved data quality (consistency of identification & event data) 3.63 Improved clinician satisfaction with access to clinical information

For next level of detail (Outcomes / Measures / Primary accountabilities) refer :
1 - Regional Goal Matrices (Appendix xxxx)
2 – District Annual Plans incorporating Statement of Intent 2011/14

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