

Statement of Intent
2006/07 – 2008/09
Counties Manukau DHB

June 2006



EXECUTIVE SUMMARY

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

This document is intended to outline for Parliament and the general public the performance that will be delivered during 2006/07 by Counties Manukau DHB and contains non-financial and financial forecast information for the 2007/08 and 2008/09 years. The agreed performance measures are in the context of the government's strategic and service priorities for the public health and disability sector and the DHB's District Strategic Plan.

Signature
(Board Chair)

Signature
(Chief Executive)

COUNTIES MANUKAU DHB'S SHARED VISION IS:

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

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

VALUES

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

STATEMENT FROM DHB CHAIR AND CE

This year the Board has made a commitment to address the impacts of poverty on the health of our community. This has determined where we will focus our efforts to get best results. We have for some years now had an overarching vision of reducing health inequalities and so we will be expansive in this goal within the resources available to us.

More than ever the Maori and Pacific communities wish to be in the driving seat of deciding how they will receive these services. This provides us with a big opportunity where we can harness the energy, expertise and local knowledge to ensure services go in the right place and the right time and at the right level. Our Maori committee POU and our Pacific committee provide the intellectual and practical support for these efforts. They are vital to the hoped for success of our strategy.

We are going to be careful with our resources. This new year it is pleasing to be able to forecast a zero deficit for 2006/07 in its operating position. While this has been more of a challenge than previous years due to increasing cost pressures, we are confident that the targets we have set ourselves in the Plan are achievable. This is supported by the significant achievements and performance of the DHB during 2004/05 and the first six months of 2005/06. Further, previous years operating surpluses are being utilised to assist achievement of the DHB's objectives; specifically a commitment to recovering previous years elective volume shortfalls and investment in further priority initiatives aligned with the District Strategic Plan.

Similarly we are able to build forward on the planning undertaken during 2005, particularly the review of the District Strategic Plan, which was developed with considerable input and support from our community, and clearly sets out the outcomes we hope to achieve in the next 5-10 years. Supporting the District Strategic Plan are the plans for the service development action areas the DHB will be focusing on for the next 3 years; Maori health, Pacific health, child and youth health, electives, Let's Beat Diabetes, primary health care and mental health. Supporting the service development action areas are the enablers, service redesign, workforce, and quality and safety, which are wound through all of the key planning documents and are vital to the successful delivery of health services to meet our community's health needs.

In order for the DHB to continue to invest in the priorities identified in the District Strategic Plan the DHB will continue to maintain provider arm costs within the future funding track (inflation), with the exception of those service areas which have significant volume growth and require additional financial input, ie renal and women's health services. The DHB will also continue to have a strong focus on primary health care development which we are hopeful will continue to constrain acute demand in line with previous years.

Focusing on the longer term, the next two years will be critical for clinical service and capital planning out to 2020 to ensure that our building plans are progressed so that the DHB does not fall short of facilities to cope with demand for hospital and related services. The work undertaken to date including demand forecasting and bed

modelling, which have both been independently reviewed, has laid strong foundations for this crucial activity.

The longer term also raises the issue of sustainability and this is of particular interest to the Board. In this regard we are going to prompt some debate on this at a local level with a focus on workforce, capital expenditure and long term service planning and demand management.

While continuing to maintain a zero operating deficit position and continuing investment in priority initiatives, specifically the ten action areas, will be a challenge for CMDHB during 2006/07, we remain confident that this can be achieved while most importantly maintaining our commitment to our community.

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Part 1 INTRODUCTION

1.1 GENERAL

Counties Manukau DHB is one of 21 DHBs established on 1 January 2001 in accordance with section 19 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act 2000). Counties Manukau DHB is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004). The CE Act 2004 (section 49) states that the Board of Counties Manukau DHB must ensure that the DHB acts in a manner consistent with its objectives, functions, and this Statement of Intent (SOI).

This SOI is for the period 2006/07 to 2008/09. The SOI describes to Parliament and the communities of the Counties Manukau District what the DHB intends to achieve over the next three years in terms of promoting, enhancing and facilitating the health, and well-being of the people in our district. This SOI incorporates the governance (the Board), funder and provider (eg, hospitals, clinics) activities of the DHB.

Performance measures and targets are included describing how Counties Manukau DHB will endeavour to improve the health and well-being of our community over the next three financial (1 July to 30 June) years.

This SOI is aligned to and consistent with:

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

This SOI includes:

- a statement of forecasted service performance the DHB will seek to achieve during 2006/07 with non-financial performance measures and targets for one of the three output classes (ie, the governance, funder and provider parts of the DHB) it delivers, and
- financial forecast for 2006/07 and the two subsequent years.

At the end of the year, auditors working on behalf of the Office of the Auditor-General compare the performance planned in the SOI with the actual performance described in the DHB's Annual Report.

1.2 REPORTING TO THE MINISTER OF HEALTH

Counties Manukau DHB will provide the Minister and the Ministry of Health with information that enables monitoring of performance against any agreement between the parties, and providing advice to the Minister in respect to this. This includes routine monitoring against the funding, DHB service delivery, and DHB ownership performance objectives.

Counties Manukau DHB will provide the Minister and the Director-General of Health with the following reports during the year:

- annual reports and audited financial statements
- quarterly reports
- monthly reports
- ad hoc reports.

All reports shall have distinct and separate sections on funding, governance and provider-arm performance.

1.3 RESPONSIBILITIES TO MĀORI

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

1.4 TREATY OF WAITANGI

The New Zealand Public Health and Disability Act 2000, Part 1, section 4 identifies that DHBs must work to improve Maori health gain through the provision of:

“mechanisms to enable Maori to contribute to decision-making on and to participate in the delivery of, health and disability services”.

This is reiterated in the Maori Health Strategy, 'He Korowai Oranga', which states:

“the Government is committed to fulfilling the special relationship between Iwi and the Crown under the Treaty of Waitangi”.

CMDHB has one of the highest needs profiles of health deprivation in the country and a big part of that poverty and need is located within the Maori population. This scale of disparity challenges the fundamentals of fairness, but also provides the DHB with its greatest opportunity.

Maori in the district were clear with the DHB that a change of approach was necessary. In response the Board has decided on a bold move to improve Maori health. The Board went out to the community at the local marae to signal the different approach. The message was simple. “We the Board will no longer contest your rangatiratanga, your collective ability to participate fully in all decisions related

to the improvement of Maori health in this rohe (region). In return we need your recognition of our role and responsibilities as an agent of the Government to meet the health needs of the whole district as described in our strategic plans and annual operating plan.”

This simple message was repeated in every Maori forum for the best part of six months. The impact on both the governing and operating relationship of the Board and Maori has been wholly constructive. The DHB now has a new committee called POU that comprises six members elected by Maori from a fully representative process within the Maori community based on skills matched to the task. This is complemented by six members of the Board including all Board committee chairs, Maori representatives and the Board chair. The Board has delegated to POU the full authority to sign off the Maori Health Plan which is now included in the outcomes of this Plan and is supported by the Maori community at large.

CMDHB has also undertaken to express its commitment to the Treaty of Waitangi through the establishment of a number of key initiatives to support the implementation of the principles of the Treaty. They include:

- The on-going partnership of the Maori health division of the DHB and Tainui MAPO to work cohesively to identify and implement Maori health gain strategies on behalf of the Maori community of Counties Manukau
- The on-going development of non-government Maori health providers so as to allow an equitable choice of services to the community
- The appointment of a General Manager, Maori Health as a part of the Executive Management Team to provide Maori strategic and operational impetus for the organisation
- The maintenance of a significant Maori health presence within the Planning & Funding and Provider arms of the organisation. This capacity is developed to compliment services delivered to Maori in the community.

The Maori Health Plan identifies two groups of priority which will drive Maori Health gain. Group One will focus on:

- Addressing the lifestyle factors associated with obesity, smoking and alcohol and other drug misuse
- Dealing specifically with diabetes and cardiovascular disease
- Improving Tamariki (Child) and Rangatahi (youth) health

Group Two Priorities consist of:

- Improving health and disability services provided to Kaumatua (elder male) and Kuia (elder female) health
- Increasing the delivery of Mental health services to Maori
- Developing the infrastructural supports required to support the provision of services

The commitment of this organisation towards Maori Health gain is best expressed through the DHB’s Maori Health Plan vision:

*“Kia whai kaha, whai mana painga ki nga kawenga oranga iwi, ki tua o Rangi”
Whanau inspired, enabled, resourced and in control of their own health.*

Part 2 COUNTIES MANUKAU POPULATION PROFILE AND HEALTH NEEDS

Counties Manukau has been and remains one of the fastest growing areas in New Zealand. It has a diverse population with complex health needs and service requirements. In developing its funding infrastructure and strategies, CMDHB takes note of the following characteristics of the Counties Manukau population:

- a high proportion of Maori
- a high proportion of Pacific people
- a high proportion of Asian people
- the relative youthfulness of the population
- a high proportion of those who are socio-economically deprived.

2.1 OUR COMMUNITIES' HEALTH NEEDS

- Hospital discharges have increased by 5% per year since 1999. Of all 2004 hospitalisations, 33% might be considered potentially avoidable (37% of Maori, and 39% of Pacific admissions). This compared with 32% for New Zealand. Much of the scope for prevention of these hospital admissions lies in the primary health care sector.
- Infectious disease rates for Counties Manukau people, particularly children, have been very high, for example, meningococcal meningitis, respiratory illnesses, cellulitis, otitis media (glue ear), gastroenteritis, and immunisation preventable disease. Important risk factors for the increased prevalence of these diseases in Counties Manukau include environmental factors such as income/poverty, overcrowding, and access to primary health care. Note the rate for meningococcal meningitis has significantly decreased since the MeNZB campaign
- Lifestyle risk factors for disease are of increasing importance in Counties Manukau and nationally, and include smoking, hazardous drinking, poor nutrition, and inadequate physical activity. In particular, the effect of poor nutrition and inadequate exercise has resulted in a growing epidemic of Type 2 diabetes that is predicted to be socially and economically devastating. Over the next 20 years the number of people with diabetes is forecast to double as a result of population growth, and the ethnic, youthful, and low socio-economic composition of the Counties Manukau population.
- Adolescent health is a key area of concern. Teenage delivery rates were very high for Maori (84 per 1000 16-19 year olds) and Pacific (51 per 1000) young people in 2003/04, in marked contrast to their European and other (16 per 1000) counterparts, and compared with New Zealand rates (27 per 1000). Counties Manukau adolescents also had higher rates of injury and of death due to injury, particularly resulting from motor vehicle crashes.
- Counties Manukau has the highest proportion of working age people on an Invalids' or Sickness Benefit with the most common cause of disability reported as being psychiatric or psychological, followed by musculoskeletal disorders.
- Those people aged 75 years and over, and especially 85+ can be high users of health and disability services. The rapid increase in the over 85 population in the

next 20 years will require additional integrated service provision to meet these needs and facilitate ageing in place. Most people want to remain in their own homes as much as possible. Wider development of community based services including a greater range of supported-housing options are important strategies to assist this.

- Cancer is a leading cause of death in Counties Manukau, accounting for 26% of all deaths. The burden of cancer falls disproportionately on the elderly, Maori, and socio-economically disadvantaged, and thereby continues to contribute to health inequalities. The cancer mortality rate in Maori is highest in Counties Manukau (487/100,000). Prostate and breast cancers are the most common cancers both nationally and in Counties Manukau, followed by lung cancer. High rates of lung cancer in Counties Manukau are due to the high levels of smoking among Maori and Pacific people.
- Children's oral health in Counties Manukau lags behind other DHBs. The 2004 hospitalisation rate for dental conditions in under 5 year-olds in Counties Manukau was twice the rate for the rest of Auckland and higher than the national rate. Counties Manukau has fewer children caries free at age 5 compared with those living elsewhere in Auckland.
- Elective surgery access has been low in Counties Manukau relative to the rest of New Zealand, but increases in provision in the past 3 years mean that by 2004/05 we had reached the national intervention rate.
- A regional needs assessment for people with mental illness and high support needs has been conducted by Auckland University over the past six months. Analysis is under way and results for each DHB are expected later this year.

2.2 KEY ISSUES AND RISKS

In addition to the health needs of the Counties Manukau population there are a number of key issues for services and population groups within the district, which underpin both strategic and annual planning. These include:

- the lack of capacity of health and disability services to meet the community's needs, particularly Maori and Pacific peoples and other communities with health disparities
- the need for improved co-ordination between hospital based and community based services, including those provided by NGOs
- the need for improved co-ordination with public health, disability and other services funded directly by the Ministry of Health
- variation in clinical practice and resource use unrelated to patient need
- the need for improved data collection, health surveillance, health research and programme evaluation particularly with regard to Maori
- the greater focus of the primary health sector on population health, and on the goals and priorities of the New Zealand Health Strategy
- the implementation of population-based funding which has an impact on pricing of services, equity of access, and inter-district flows.

There are also a number of risks inherent in the DHB's responsibilities. These include:

- meeting the Minister's and Government's expectations regarding a break-even financial result (zero deficit) and compliance with Government strategies and policies

- meeting the communities' expectations now that the DHB has been moved to equity from a population based funding perspective and with regard to community participation in decision-making
- the financial risks associated with demand driven services, in which volume growth outstrips funding. Also, risks arise from poor historical data, assumed savings being built into the forecast, poor data and information systems, price pressures, and pricing inequalities between providers
- workforce skills, capacity and availability, which impact on service delivery and patient outcomes
- inability to manage, assess or influence the quality of non-DHB providers to the same extent as the DHB's provider arm.

Refer Part 6 for specific financial risks and mitigation strategies.

Strategies to minimise the impact of these issues and risks include:

- continuing collaboration with other DHBs within the region regarding planning, funding and providing health services to ensure services are delivered in the most financial efficient and safe environment for both the district and at a regional level
- continuing investment in prevention, primary and community initiatives to reduce the need for more specialist health and disability services
- implementation of the DHB's District Strategic Plan
- development and implementation of workforce, recruitment and succession planning strategies
- working with other DHB's in the region to align DAP objectives and maximise resources
- working with other providers and sectors to ensure a co-ordinated approach to service development and provision
- regular discussion between clinical leaders and management
- careful planning and scoping of new programmes to allow for early identification of issues and development of solutions.

Part 3 NATURE AND SCOPE OF ACTIVITIES

The activities of our DHB fall into three groups (or “output classes”):

- Governance
- Planning and Funding
- Provision of Services.

3.1 GOVERNANCE

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

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

The elections for the current DHB Board members took place on 9 October 2004.

Each DHB has seven members elected for a 3 year term. For CMDHB the elected Board members (until November 2007) are:

- Arthur Anae
- Don Barker
- David Collings
- Paul Cressey
- Jillian Dooley
- William Mudgway
- Bob Wichman.

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

- Pat Snedden (chair)
- Ross Keenan (regional deputy chair)
- Airini Tukerangi
- Miria Andrews.

There are a number of sub committees to the Board and these are made up of Board members, DHB staff and community representatives. The Board is required to publish when and where it, or any of its subcommittees, is meeting. Three are required by legislation:

- the *Community & Public Health Advisory Committee*: provides advice to the Board on the mix and range of services that will best meet local health improvement and independence objectives, recognising both resource constraints and the requirements of national policy and strategy, and taking into account the diverse and unique needs of Maori
- the *Hospital Advisory Committee*: provides advice to the Board on the performance of DHB provider arm services

- the *Disability Support Advisory Committee*: advises the Board on issues facing people with disabilities, and how these can best be addressed (in the context of the DHB not being the funder of disability support services for people aged under 65)

In addition, the Board has established three other committees:

- *POU*: provides strategic and governance advice to the Board on Maori health gain issues. It is a partnership committee made up from 50% Board members and 50% nominated Maori community/health experts.
- the *Pacific Health Advisory Committee*: provides advice on strategies to reduce disparities in health status for Pacific people
- the *Finance & Audit Committee*: reviews the annual financial statements, manages the relationship with external auditors, ensures compliance with statutory financial requirements, and approves annual budgets.

3.2 PLANNING AND FUNDING

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

Service Devolved to CMDHB	Key activities and initiatives
<p>Primary Health Care</p> <ul style="list-style-type: none"> • Services provided by primary health organisations (PHOs) • Other primary care services such as pharmacy, oral health and community laboratory services • A wide range of community health services providing first point of contact, primary health care related services 	<ul style="list-style-type: none"> • Working with PHOs to deliver health promotion and services to improve access to primary care (refer to Section 4.3 Outcome 1) • Implementation of strategies to increase the number of patients with chronic conditions whose care is managed through structured programmes refer to Section 4.3 Outcome 3 • Implementation of the recommendations of the oral health plan • Also refer to Section 4.3 Outcome 5 regarding key strategies to improve primary care utilisation and Outcome 6 regarding workforce development
<p>Maori Health Funding of 'by Maori for Maori' services including:</p> <ul style="list-style-type: none"> • Chronic Care Management 	<ul style="list-style-type: none"> • Implementation of the revised Maori Health Plan (refer Section 4.3 Outcome 4)

Service Devolved to CMDHB	Key activities and initiatives
<ul style="list-style-type: none"> • Primary Health Care • Well child services including Outreach Immunisation • Breastfeeding support • Smoking Cessation • Public Health promotion • Sexual Health services 	
<p>Pacific Health</p> <ul style="list-style-type: none"> • Funding of 'by Pacific for Pacific' services and targeted Pacific services 	<ul style="list-style-type: none"> • Implementation of the Pacific Health and Disability Action Plan (refer Section 4.3 Outcome 4)
<p>Mental Health and addiction services</p> <ul style="list-style-type: none"> • Services focused on supporting people with the most serious mental health needs to achieve recovery of a full life within the community. The services are primarily delivered in the community, with access to inpatient services where this is deemed necessary. • Providers of mental health services include the DHB, NGOs and by other DHBs (ie regional services) 	<ul style="list-style-type: none"> • Improve the outcomes for people severely affected by mental illness (refer Section 4.3 Outcome 3)
<p>Services for older people</p> <ul style="list-style-type: none"> • Private hospitals, rest homes, respite and day care • Home based support • Community health • Information services, assessment, treatment and rehabilitation • Needs assessment and service co-ordination. 	<ul style="list-style-type: none"> • Implementation of the Health of Older People plan • Specific initiatives to improve the continuum of care for services provided to older people refer Section 4.3 Outcome 5
<p>Secondary / Tertiary services (ie hospital and related services)</p> <ul style="list-style-type: none"> • All of the services provided by the DHB's provider arm with the exception of those services directly funded by the Ministry of Health or funded by other DHBs (inter-district flows) 	<ul style="list-style-type: none"> • Implementation of strategies to increase access to services so they align with national levels (refer Section 4.3 Outcome 5) • Continued focus on elective services (refer section 4.3 Outcome 5) • Continued focus on the delivery of programmes and initiatives to reduce the number of people admitted to hospital who could have been cared for in the community (refer Section 4.3 Outcome 5) • Implementation of strategies to improve the capacity of the health sector to deliver quality services (refer Section 4.3 Outcome 6)

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

- payment of providers
- monitoring and audit of provider performance
- management of relationships with providers
- re-negotiation of service agreements that expire
- identification of where the agreements fit into the district's priorities.

In addition, CMDHB is responsible for core ongoing business, including:

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

3.3 PROVISION OF HEALTH AND DISABILITY SERVICES

Through its provider arm CMDHB provides a wide but not complete range of specialist secondary services, a selected range of community services, as well as a number of niche specialist tertiary services, including:

- Orthopaedic surgery
- Plastic, reconstructive and maxillo-facial surgery
- National Burns service
- Spinal injury rehabilitation
- Renal dialysis
- Neonatal intensive care
- Breast surgery
- Specialist youth health services (this service provides a national youth suicide prevention framework in conjunction with the Mental Health Foundation).

The majority of inpatient services continue to be provided at the Middlemore Hospital site, with the majority of outpatients, community, and day surgery services being provided at our two *SuperClinics*[™] (ambulatory care centres at Manukau and Botany Downs). Non-intensive care based elective surgery has been progressively transferred to the Manukau Surgery Centre (MSC) which is located on the same site as the Manukau *SuperClinic*[™]. This transfer will continue during 2006/07.

A number of tertiary and other services are not provided directly by CMDHB, most of which are provide by Auckland DHB, for example cardiothoracic surgery, neurosurgery, oncology; and forensic mental health and school dental services by Waitemata DHB. This requires that CMDHB purchases these services separately and these are termed inter-district flows (IDFs).

Part 4 OUTCOMES AND OBJECTIVES

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

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

4.1 OBJECTIVES FOR DHBs FROM THE NZPHD ACT 2000

Counties Manukau DHB's statutory objectives are:

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

4.2 NATIONAL PRIORITIES FOR 2006/07

The Minister of Health sent all DHBs a 'Letter of Expectations for 2006/07' which identified priorities for 2006/07. This will be used, in addition to health and disability strategies and our DSP to plan what we do in 2006/07:

- Continued progress, with emphasis on quality, safety and reducing inequalities, on following :
 - Elective surgery
 - Breast screening

- Community mental health services
- Meningococcal B Immunisation Programme
- Māori health service provision
- Pacific health service provision
- The 'Get Checked' programme for Diabetes Mellitus
- Pandemic preparedness
- Working within budget
- Ensuring Board members have the requisite governance skills
- The New Zealand Health Strategy (2000)
- The New Zealand Disability Strategy (2001)
- He Korowai Oranga (Māori Health Strategy, 2002)
- Te Tāhuhu: Improving Mental Health 2005-2015 (2005)
- The Health of Older People Strategy (2002)
- The Primary Health Care Strategy (2001)

(the Strategies listed above are available through the Ministry of Health website www.moh.govt.nz)

- Relationships with other DHBs and relevant organisations to achieve developments such as: improved services, reduced transaction costs and further gains in areas relating to staff such as human resources/industrial relations, procurement and/or new interventions. Increased trust by ensuring financial transparency.
- Reducing the chronic disease burden, including the Healthy Eating Healthy Action Strategic Framework, the Cancer Control Strategy and tobacco control.
- Child and Youth services including hearing tests for neonates, increasing the scope of well child services for preschoolers, child and adolescent mental health services, improved oral health services, work towards free primary care services for under six year olds.
- Primary Health Care including reduced costs for more people, continued shift towards a population approach to primary health care, increased PHO focus on prevention and early detection, broadening the range of health professionals involved in the management and co-ordination of a person's care.
- The health of older people including support for them to remain at home for longer, support people when moving between their homes, residential care, assessment treatment and rehabilitation services, and primary services.
- The Health Information Strategy is to be progressed and the findings from work streams on health workforce need to be progressed.
- Opportunities to improve cost effectiveness should be taken.

4.3 COUNTIES MANUKAU DHB'S STRATEGIC DIRECTION

STRATEGIC DIRECTION

Counties Manukau DHB, and its predecessor South Auckland Health, has a strong history of striving to “making a difference” for the community it serves. The DHB’s strategic direction has been developed based on many years of innovative activity with primary and community providers, local and national government agencies, and community groups, which has provided a strong foundation for the DHB moving forward.

CMDHB is committed to working in partnership with our communities and health professionals to provide services that meet the needs of people at the right time and in the right place, whether that be in hospital, in the community or at home.

Whilst we will always strive to ensure excellent hospital services are available for people who are sick or injured, we are increasingly shifting our focus to support people to keep healthy, and access services earlier and in community settings. This shift in focus is reflected in our priorities. Increased investment in primary care and community services is already resulting in reduced hospital admissions when compared with population growth and historical demand. Investment in our priorities has been assisted by the movement to funding equity compared with the rest of New Zealand, based on the population based formula used to distribute funds to DHBs.

Counties Manukau faces some unique health challenges:

- Our population has high deprivation, is ethnically diverse with high health needs, and is growing faster than anywhere else in New Zealand
- The historic focus of health services investment and delivery has been on hospital (secondary) care. Demand for acute services (such as emergency and medical care) was growing by an average of 9% per year, an unsustainable rate.

In response to these challenges, CMDHB has:

- Invested in new or improved facilities, including the SuperClinics, Kidz First, Emergency Care and Manukau Surgery Centre
- Invested in development of mental health services, with particular emphasis on community-based early intervention and support services
- Invested in primary health care to support integration with specialist services, lower fees for patients, and new services to promote wellbeing and improved access
- Begun investment in home-based and community services for older people, to support ‘ageing in place’
- Maintained funding increases to hospital services to below inflation rates to increase productivity and allow investment in high priority primary and community services.

What are the results?

- Growth rates in acute hospital admissions at Middlemore Hospital and Kidz First have reduced to levels the same as, or below, population growth
- Cost growth has been contained within the DHB's provider arm, and the DHB overall has achieved a break-even or better financial position in 2004/05 and 2005/06, and is forecasting to maintain this in 2006/07
- Improved access to mental health services
- Improved access to primary health care services
- Improved health outcomes for people with chronic conditions enrolled in our chronic care management programme
- Improved processes to ensure that elective services are provided to those most in need, and for the first time the level of elective services provided to our community is in line with national averages. Previously CMDHB was well below the national average
- Multi-agency, 'whole community' action to improve community well-being (such as the Let's Beat Diabetes, Healthy Housing, AIMHI and PATHS programmes).

What is next?

The DHB revised its District Strategic Plan (DSP) in 2005, based on the health issues identified, achievements to date and initiatives currently underway. The revised DSP uses as its framework six outcome areas that will be the focus for health sector activities over the next 5-10 years (refer to the table following this section for the detailed framework). These are:

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

systems, that all resources are efficiently applied, and all services provided from our hospital and by other contracted providers are safe.

This strategic direction – an emphasis on prevention, and primary and community services, focused within the six outcome areas - is reflected in resource allocation within the 2006/07 District Annual Plan. In general terms, our distribution of funding within this District Annual Plan / Statement of Intent is based on the following approach:

- Existing services receive an annual increase to partially compensate for inflation. In 2006/07, this increase, which for many providers is considerably less than their actual cost increases, means they must pursue efficiency gains
- New funds – demographic funding and any other remaining unallocated funds - are targeted to development of new services in the action areas that support our District Strategic Plan, including any volume increase in existing services required to meet increased health needs or population increases.

We are now starting to see clear evidence that this strategic approach is making a difference for the people of Counties Manukau. The District Annual Plan and Statement of Intent describe for 2006/07 the DHB's intentions to continue to advance the strategic direction including the DHB resources required (refer Part 6) and how the DHB will measure progress in achieving these intentions (refer Part 5).

SUMMARY OF CMDHB'S OBJECTIVES FOR 2006/07

CMDHB's revised District Strategic Plan provides the DHB with a clear outcomes framework, which is supported by detailed 5-year plans (including Maori Health Plan, Primary Health Care Plan and Let's Beat Diabetes Plan) and a long term financial plan that allows a more strategic investment approach.

The overarching direction of the District Strategic Plan is towards community wellbeing and preventative health strategies. While the DHB is continuing to maintain hospital and related services at a level that meets the needs of the growing population, the emphasis is on containing growth within these services so that service growth does not exceed population growth. Therefore enabling funding (operational funding) to be re-directed towards prevention strategies in line with District Strategic Plan. However it should be noted that capital expenditure is still required to continue to maintain and build hospital and related facilities to meet the needs of the growing population, refer to Outcome 6 of the District Strategic Plan and within this Plan.

The 2006/07 District Annual Plan moves the emphasis from short term, one-year, projects to a multi-year 'programme' approach for a small number of action areas, each with:

- a multi-year action plan and key performance indicators
- a multi-year funding commitment
- an annual operational plan linked to the DAP.

The **ten action areas**, or programmes, CMDHB will focus on for the next 3 years are categorised as 'service development' and 'enablers' and are drawn from the six outcome areas in the District Strategic Plan.

1. Improve community wellbeing
2. Improve child and youth health
3. Reduce the incidence and impact of priority conditions
4. Reduce health inequalities
5. Improve health sector responsiveness to individual and family/whanau need
6. Improve the capacity of health sector to deliver quality services.

Service development action areas are focussed on improving services to meet the needs of the community, whereas the enablers are the key aspects of infrastructure needed to support the organisation achieve its outcomes.

Note the references to outcomes below identifies where the majority of information will be found for the action area, however for many of the service development areas objectives are also included in other outcomes.

Service development action areas

- Maori health (refer Outcome 3)
- Pacific health (refer Outcome 3)
- Child & youth health (refer Outcome 2)
- Electives (refer Outcome 5)
- Let's Beat Diabetes (refer Outcome 1)
- Mental health (refer Outcome 3)
- Primary health care (refer Outcome 5)

Enabler action areas

- Service redesign (including facilities and clinical planning) (refer Outcome 6)
- Workforce (refer Outcome 6)
- Quality & safety (refer Outcome 6).

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

Long term outcomes	Outcome 1 Improve community wellbeing	Outcome 2 Improve child and youth health	Outcome 3 Reduce the incidence and impact of priority conditions	Outcome 4 Reduce health inequalities	Outcome 5 Improve health sector responsiveness to individual and family/whanau need	Outcome 6 Improve the capacity of the health sector to deliver quality services
Medium term outcomes	Achieve the outcomes in the Let's Beat Diabetes Plan	Improve maternal wellbeing	Increase access to structured programmes to reduce the impact of disease for the priority conditions	Address the systemic origins of inequalities	Increase access to services so they align with national levels	Ensure the health workforce meets the community's need for services
	Increase levels of physical activity	Improve health outcomes for infants and pre-school children	Reduce the incidence and impact of diabetes by implementing the Let's Beat Diabetes Plan	Implement specific initiatives to reduce inequalities	Improve access to and management of elective services	Improve health professionals communication skills in their dealings with patients and their families/whanau
	Increase healthy school environments	Improve weight management in children and young people	Reduce the incidence and impact of cancer	Improve the capacity of all providers to deliver services to the populations they serve	Increase primary care utilisation	Ensure that services and facilities are planned to meet the future needs of the community
	Increase smokefree environments	Decrease the incidence and impact of risk taking actions by young people	Improve outcomes for people severely affected by mental illness	Improve ethnicity data collection	Improve the continuum of care for services provided to older people	Support information exchange amongst health professionals
	Develop healthy communities by working intersectorally				Reduce the number of people admitted to hospital who could have been cared for in the community	Ensure the delivery of safe and effective services
	Improve access to information to enable the community to make informed choices					Ensure the efficient use of resources
A set of measures for 2006/07 is described in Part 5: Forecast Service Performance: Measures And Standards.						
Health sector strategic inputs – existing detailed plans	District Annual Plan Statement of Intent Let's Beat Diabetes Plan	Youth Health Plan Child Health Plan Sexual & Reproductive Health Plan Let's Beat Diabetes Plan Oral Health Plan	Let's Beat Diabetes Plan Primary Health Care Plan Mental Health and Addictions Plan Chronic Care Management Plan	Maori Health Plan Pacific Health Plan Regional Maori Mental Health Plan	Primary Health Care Plan Chronic Care Management Plan	Clinical Services Plan Facilities Modernisation Plan Long Term Financial Plan Workforce Plan Quality Plan

OUTCOME 1 - IMPROVE COMMUNITY WELLBEING

Health outcomes for the Counties Manukau population can be significantly improved only by a 'whole society' approach. CMDHB will work with our communities (in particular the Maori and Pacific communities) and other agencies (in particular Manukau City Council through Tomorrow's Manukau, and Franklin and Papakura district councils; the Ministry of Social Development; and Housing New Zealand) to encourage healthy behaviours, and to improve the environments in which people live, work and play. CMDHB also works closely with the Ministry of Health, a major funder of services in this area, through the regional Public Health Service Alignment Group to ensure alignment of CMDHB and Ministry of Health priorities and outcomes.

A number of the initiatives and strategies included in this outcome area could also be included in other outcome areas, but have only been included here to avoid duplication.

Implementation of the Let's Beat Diabetes Plan is a key focus for this outcome area and has been identified as one of the ten action areas. The Let's Beat Diabetes (LBD) Plan addresses many of the goals of the Healthy Eating Healthy Action strategy and includes wide-ranging initiatives to improve nutrition and physical activity, and reduce obesity (refer to the table below for more detail).

Key strategies for 2006/07

Medium Term Outcome	Key strategies
Achieve the outcomes in the Let's Beat Diabetes Plan	<ul style="list-style-type: none"> • Support community leadership and action • Promote behaviour change through social marketing • Change urban design to support healthy lifestyles • Support a healthy environment through a Food Industry Accord • Strengthen health promotion co-ordination and activity • Enhance well child services to reduce childhood obesity • Develop a Schools Accord to support 'fit and healthy' schools • Support primary care-based prevention and early intervention • Enable families to make healthy choices • Improve service integration and care for advanced disease
Increase levels of physical activity	<ul style="list-style-type: none"> • Successful implementation and evaluation of community nutrition project • Improved nutrition and physical activity in LotuMoui churches • Family centred interventions developed for obese and overweight people • Develop and pilot the Whare Oranga concept
Increase healthy school	<ul style="list-style-type: none"> • Schools and communities in areas of high need are

Medium Term Outcome	Key strategies
environments	able to foster healthy eating through implementation of the Fruit in Schools programme.
Increase smokefree environments	<ul style="list-style-type: none"> • Work with district-wide smoking cessation to reduce adult smoking in Maori and Pacific populations, targeting those with children • Through LotuMoui 90% of Pacific churches will have a trained smokefree health promoter • Ensure contracted and non contract dental practices are aware of referral services for smoking cessation • Rollout of new maternity booklet with smoke-free messages
Develop healthy communities by working intersectorally	<ul style="list-style-type: none"> • Implement the PATHS programme with Ministry of Social Development to improve employment opportunities for people in receipt of either the Sickness or Invalids benefit • Improve housing in Counties Manukau by working in partnership with Housing New Zealand to continue implementing the Healthy Housing Programme • Access facilitated to Housing New Zealand Corporation homes for 20 additional mental health clients. • Identification of the current stock of housing options for older adults in Counties Manukau to identify an array of potential strategies to improve the options • Work with Ministry of Social Development, Work and Income and primary care to improve the uptake of the Child Disability Allowance in Counties Manukau • Training courses on family violence for primary care practitioners (including community health workers) available bi-monthly.
Improve access to information to enable the community to make informed choices	<ul style="list-style-type: none"> • Communication and information available in the community on health and disability services. • Optimise transport to health and disability services in Counties Manukau

OUTCOME 2 - IMPROVE CHILD AND YOUTH HEALTH

The population of Counties Manukau has a high proportion of children and young people, a significant number of whom live in areas of high deprivation. CMDHB will meet the health needs of children and young people through improving their access to health care services and by developing and implementing policies, programmes and initiatives which improve their health status.

Child and youth health has been identified as one of the ten action areas. The focus for 2006/07 will be on continuing initiatives progressed during 2005/06, including Baby Friendly Hospital Initiative, Kidslink and implementation of the Youth Health Plan. This will be supported by the implementation of initiatives from the Child Health Plan developed during 2005/06. Other DHB plans, including the Maori

Health, Pacific Health and Oral Health plans also include strategies and initiatives to improve child and youth health.

Key strategies for 2006/07

Medium Term Outcome	Key strategies
Improve maternal wellbeing	<ul style="list-style-type: none"> • Implement proposed Antenatal Best Practice Guidelines • Improve maternal oral health • Increase the number of breastfed Maori and Pacific babies
Improve health outcomes for infants and pre-school children	<ul style="list-style-type: none"> • Work towards Baby Friendly Hospital Initiative requirements for the Middlemore site • Maintain the Kidslink/NIR programme to ensure high coverage rates for immunisation services and well child checks, including hearing and vision checks • Support oral health education and training as part of regular well child health assessments. • Increased engagement of Maori and Pacific preschoolers in the school dental scheme • Review and update guidelines recently reviewed by the New Zealand Paediatric Society: <ul style="list-style-type: none"> • Enuresis • Cough and wheeze • Asthma • Improve the outcomes of children with disabilities by establishing a snapshot of children with disabilities and reviewing models of care.
Improve weight management in children and young people	<ul style="list-style-type: none"> • Develop overweight and obesity action plan for Pacific children
Decrease the incidence and impact of risk taking actions by young people	<ul style="list-style-type: none"> • Implement the sexual health model for schools • Extend the clinical wraparound service to Alternative Education students • Develop a project plan for enhancing resiliency and minimising risk • Extend clinical services to the students at Teen Parent Units • Develop youth specific Alcohol and Other Drug (AOD) Services • Support mobile dental services to service low decile high schools • Scope and establish a Pacific youth one stop shop pilot • Develop a youth advisory group to advise the DHB

OUTCOME 3 - REDUCE THE INCIDENCE AND IMPACT OF PRIORITY CONDITIONS

CMDHB has identified the following priority conditions for focus as they are the leading causes of death and illness for our population, and particularly for Maori and Pacific people in Counties Manukau. Strengthened delivery of primary and community-based care, and improved linkage to specialist services are key to reducing the adverse impact of these and associated conditions, and reducing reliance on hospital-based care:

- Diabetes
- Cardiovascular disease
- Chronic respiratory disease
- Cancer
- Mental health.

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

A key strategy within the primary health care programme is to increase the number of people enrolled in structured programmes, the first outcome area in the table below. The priority conditions CMDHB will be continuing to focus on in 2006/07 as part of the structured programmes are: cardiovascular disease; diabetes; congestive heart failure; chronic obstructive lung disease and depression. CMDHB will also scope, as an addition to the Chronic Care Management (CCM) diabetes module, a renal disease programme. CMDHB will continue to support and empower primary care through the CCM programme which provides:

- structured care
- additional support from secondary care
- electronic clinical decision support incorporating the NZGG guidelines
- feedback on progress and performance.

In addition to CCM CMDHB is building new capacity in patient self management and education; taking a family based approach to caring for those with chronic conditions; as well as introducing brief opportunistic intervention (lifestyle advice re exercise nutrition and smoking cessation). These programmes link to PHO Health Promotion plans and national campaigns such as HEHA and Cancer Control Strategy. Specifically the Community Nutrition Project (as part of Let's Beat Diabetes) is increasing the availability of consistent and reliable advice on nutrition and lifestyle interventions to lose weight. This builds on the PHO driven prevention activities that the DHB is encouraging via Services for Increased Access and Health Promotion plans, and the health promotion programmes funded by the Ministry of Health public health directorate.

Key strategies for 2006/07

Medium Term Outcome	Key strategies
Increase access to structured programmes to reduce the impact of disease for the priority conditions	<ul style="list-style-type: none"> • Increase the number of patients in the CCM, FAMA and Care Plus programmes • Ensure Care Plus services are effective and meet the needs of individuals • Introduce pharmacist support services to CCM • Implement targeted CVD risk management programme • Pilot the Heart Guide Aotearoa • Implement a pilot diabetes and cardiovascular screening programme for Pacific populations • Implement CCM for renal patients • Review the provision of services for children with bronchiectasis through regional project
Reduce the incidence and impact of diabetes by implementing the Let's Beat Diabetes Plan	<ul style="list-style-type: none"> • Refer to all objectives under LBD implementation in Outcome 1 • Review model of care for women with gestational diabetes • Improve Get Checked detection and management
Reduce the incidence and impact of cancer	<ul style="list-style-type: none"> • Reduce the incidence of cancer through primary prevention • Ensure effective screening and early detection to reduce cancer incidence and mortality • Ensure effective diagnosis and treatment of cancer to reduce morbidity and mortality • Improve the quality of life for those with cancer, their family and whanau through support rehabilitation and palliative care • Improve the delivery of services across the continuum of cancer control through effective planning, coordination and integration of resources and activity, monitoring and evaluation. • Review palliative care services provided for children with cancer (especially brain tumours) and ensure they meet clinical criteria as well as the special needs of children and their families
Improve outcomes for people severely affected by mental illness	<ul style="list-style-type: none"> • Increase NGO accountability for service delivery to ensure it is equivalent to funded levels • Review NGO services and contracts to increase consistency, decrease fragmentation and tailor funded service to need • Additional peer support specialist services funded • Routine use of NHI based information to evaluate NGO and DHB service delivery and outcomes achieved • Complete the CCM primary mental health pilot • Improve child and youth mental health

OUTCOME 4 - REDUCE HEALTH INEQUALITIES

A key indicator of health status is life expectancy at birth. People living in Counties Manukau can on average expect to live one year less than the rest of New Zealand based on this measure. Maori people living in Counties Manukau have a life expectancy at birth 8 years less than their European and other counterparts, and for Pacific peoples in Counties Manukau the difference is 5 years. Similar differences are seen in other measures that the DHB monitors including immunisation rates, use of hospital services and breastfeeding rates. Other groups with high health needs include refugees and migrants and those living in areas of high deprivation (decile 9 and 10). CMDHB will strive to lift life expectancy for our people to the level enjoyed by the rest of New Zealand.

Many of the whole society approaches included in Outcome 1 Improve Community Wellbeing could also be considered as part of this outcome area but have not been included here to avoid duplication, eg implementation of the Let's Beat Diabetes Plan.

Key areas of focus for 2006/07, (ie from the ten action areas) to reduce health inequalities include service development in Maori, Pacific, and child and youth health (refer Outcome 2), and workforce development (refer Outcome 6). During 2005/06 CMDHB revised the Maori Health Plan and developed a Pacific Health and Disability Action, key strategies from each of these plans will be implemented during 2006/07 and have been included in the table below.

Key Strategies for 2006/07

Medium Term Outcome	Key strategies
Address the systemic origins of inequalities	<ul style="list-style-type: none"> • Increase involvement in strategic decisionmaking processes • Build community engagement structures and processes
Implement specific initiatives to reduce inequalities	<ul style="list-style-type: none"> • Implement recommendations from CMDHB Review of Services to Improve Access funded programmes • Increase Maori access to primary health care services • Develop service measures and targets to reduce health inequalities across the organisation • Reduce non attendance at outpatient clinics for Maori and Pacific populations • Review and develop specific advocacy and information services for older Maori and Pacific Island people • Ensure consistent quality input into research projects undertaken in Counties Manukau
Improve ethnicity data collection	<ul style="list-style-type: none"> • Full roll-out of Healthware clinical applications • Track completeness of PHO ethnicity coding

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

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

During 2006/07 CMDHB will focus on access to elective surgery, and progressing the implementation of the Primary Health Care Strategy, two of the ten action areas. The DHB will also continue to progress the initiatives underway to improve services for older people.

Key Strategies for 2006/07

Medium Term Outcome	Key strategies
Increase access to services so they align with national levels	<ul style="list-style-type: none"> • Improve access and appropriateness of diagnostic services • Improve acute surgical patient management • Pilot an integrated Community Dental Clinic to improve access to and visibility of a range of oral health services in high needs communities
Improve access to and management of elective services	<ul style="list-style-type: none"> • Maintain compliance with the national Elective Services Strategy • Maintain access to elective services so they align with national levels • Improve paediatric access to elective services
Increase primary care utilisation	<ul style="list-style-type: none"> • Develop services that provide advice and support for Primary Care to meet mental health needs • Improve integration between primary care and elective services • Ensure low copayment environment is sustained • Ensure an acceptable level of access to after hours services • Improve responsiveness of primary health care services regarding sexual health
Improve the continuum of care for services provided to older people	<ul style="list-style-type: none"> • Develop/expand mental health community treatment for older people • Prepare a service development plan for older people with dementia • Ensure appropriate support services are available on hospital discharge and during recovery • Enhance NASC and carer support services • Further develop the Community Based Rehabilitation Team including widening eligibility criteria for additional diagnostic groups • Continue the Franklin Integration Project • Implement pilot PHO based case management of

Medium Term Outcome	Key strategies
	<p>the medically multiple and complex older patient</p> <ul style="list-style-type: none"> • Implement home based support services workforce development activities • Implement the orthogeriatric review • Implement best practice guidelines
<p>Reduce the number of people admitted to hospital who could have been cared for in the community</p>	<ul style="list-style-type: none"> • Maintain Primary Options for Acute Care (POAC) programme • Manage acute demand over winter • Continue to develop alternatives to mental health admission in peoples' own homes and environments that maximise a person's responsibility for their own recovery • Integrate community and acute inpatient mental health services • Review Early Pregnancy Service to ensure appropriate inpatient/daypatient/ outpatient model of care and environment is implemented • Encouraging integration between PHOs, community organisations and DHB community services to ensure treatment, follow-up and after-care is co-ordinated. • Enhancing continuum of care support through DHB provided community based service delivery, and partnerships with other primary care providers, non government organisations, and DHB services provided by other metro-Auckland DHBs • Continue repatriation of agreed services from Auckland DHB

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

The people who work in the health sector are the DHB's biggest and most valued resource. To be successful in the delivery of quality health services to our community, CMDHB must attract and retain health professionals by fostering an environment which is supportive of effective service delivery. Similarly the infrastructure that supports this environment must meet the capacity needs of the community it serves, including:

- adequate facilities to safely treat people
- information systems to assist with the delivery and planning of health services
- quality systems and processes including the key quality dimensions of people centred, access and equity, safety, effectiveness and efficiency which underpin CMDHB's Quality Framework and Quality Plans
- workforce development activities including employee and wellness concepts and involvement in regional and national workforce initiatives.

In addition the resources that are applied to the health sector in Counties Manukau must be used efficiently. CMDHB will continue to focus on productivity and efficient use of resources during 2006/07, as well as the enablers of the 10 action areas, service re-design, workforce and quality and safety. Regional collaboration with the other metro-Auckland DHBs, including regional services planning, will be important to ensure progress in these key areas.

Key Strategies for 2006/07

Medium Term Outcome	Key strategies
Ensure the health workforce meets the community's need for services	<ul style="list-style-type: none"> • Develop and implement sustainable workforce management plans across the organisation • Develop and implement plans in priority service areas • Improve workforce training opportunities / experience in the district for oral health • Promote health careers as a choice for entry level students • Continue implementation of Employee Wellness Programme • Develop and implement training packages for staff awareness of disability are available via the learning and development training centre
Improve health professionals communication skills in their dealings with patients and their families/whanau	<ul style="list-style-type: none"> • Cultural responsiveness training is developed for all health providers • Provider arm Maori Health services are responsive to patient and whanau needs • Pharmacist workforce development programme • Build and develop individual and team learning opportunities • Active encouragement of the participation between DHB Funder, Provider, Consumers and Health Professionals
Ensure that services and facilities are planned to meet the future needs of the community	<ul style="list-style-type: none"> • Completion of Project Excel in accordance with the business case • Development and implementation of the Clinical Services Plan • Ensure all current work areas are accessible to people with disabilities
Support information exchange amongst health professionals	<ul style="list-style-type: none"> • Enhance patient clinical records through ongoing improvement of core systems • Review information management standards • Implement systems to improve patient outcomes • Further development of Chronic Care Management system • Improve organisational web content and structure • Improving payroll systems
Ensure the delivery of safe and effective services	<ul style="list-style-type: none"> • Implement medication safety initiative • Implement Save 100 Lives project

Medium Term Outcome	Key strategies
	<ul style="list-style-type: none"> • Implement Physiologically Unstable Patient Project • Reduce number of patient falls and associated injuries that occur within the organisation • Implement programmes to encourage quality improvement in the health sector eg Open Disclosure Policy and Just Culture Policy Implemented, and PHO Performance Management
Ensure the efficient use of resources	<ul style="list-style-type: none"> • Improving performance and efficiency through regional collaboration • Obtain and use key information to improve planning and delivery of mental health services • Use Blueprint underspend to develop infrastructure that will enhance service delivery • Implement MoH Pacific Provider Purchasing Strategy • HRMS procedures embedded in business practice. • Implement Onestaff for all CMDHB staff. • Consolidate the regional RMO administration and payroll structure. • IEA job sizing completed • Continue with the work of regional and national alignment of collective employment agreement negotiations

Part 5 FORECAST SERVICE PERFORMANCE: MEASURES AND STANDARDS

One of the functions of this SOI, and in particular, the Performance Measures and Targets, and Statement of Forecast Service Performance, is to show how what we do in 2006/07 will be measured. These measures and standards will be subject to an annual audit by auditors appointed by the Office of the Auditor General.

Where possible, we have included past performance (baseline data) along with each performance target to give context. The performance measures included in the SOI have been chosen based on their link to key priorities, inclusion in the District Strategic Plan and data availability. The DHB recognises that some of these measures are imperfect, with regard to measuring progress towards achieving the longer term outcomes, but at the time of writing are the most reliable measures available. Note: progress against the medium term outcomes (2005-2010) described at the beginning of each outcome are monitored as part of the District Strategic Plan reporting; the DHB's expectation is that the medium outcomes will either remain the same or improve.

The Performance Measure tables on the following pages include national measures, which are consistent across DHBs together with local measures and targets. The structure of this section is based on the District Strategic Plan structure, ie the six long term outcomes to achieve the DHB's strategic vision. Note only those performance measures from the District Strategic Plan which are measured annually, or where there is an expectation that the measure will change within a year have been included in the SOI.

For each measure detail is provided on:

- Why the measure is important to the DHB
- The objective of the measure, ie generally to increase or decrease a ratio
- The performance measure itself, ie what is being measured. Generally the measures are described using both the numerator and denominator, as the majority of the measures are impacted by changes to both the numerator and denominator
- Baseline and target information for the next 3 years.

The measures reflect the three output classes:

- Governance
- Planning and Funding
- Provision of Services.

The cost of the outputs

The Forecast of Service Performance comprises three main output classes, reflecting the DHB's three main functions: governance and funding administration, funding of health services, and provision of health and disability services. The budgeted cost of these outputs for 2006/07 is as follows:

	Budget 2005/06 (\$m)	Forecast 2005/06 (\$m)	Budget 2006/07 (\$m)
Governance & Funding Administration*	7.0	7.0	7.7
Funder**	394.6	394.3	423.0
Provider Arm (Hospital)	444.2	445.9	493.2
TOTAL	845.8	847.2	923.9

* 2005/06 budget includes the transfer of the Maori and Pacific units previously included in the provider arm.

** Priority initiatives included in the funder budget.

OUTCOME 1 - IMPROVE COMMUNITY WELLBEING

Medium Term Outcomes (2005-2010)					
<ul style="list-style-type: none"> • Achieve the outcomes in the Let's Beat Diabetes Plan • Increase levels of physical activity • Increase healthy school environments • Increase smokefree environments • Develop healthy communities by working intersectorally • Improve access to information to enable the community to make informed choices 					
Performance Measures					
<i>Achieve the outcomes in the Let's Beat Diabetes Plan</i>					
<p>LBD is a community wide plan that aims to prevent and manage diabetes. Its success will be indicated by other indicators listed, namely:</p> <ul style="list-style-type: none"> • Increase levels of physical activity (Outcome 1) • Increase healthy schools environment (Outcome 1) • Increase the numbers of CCM enrolments for all five modules (Outcome 3) • Increase the proportion of estimated number of people with diabetes who had an annual Get Checked free check (Outcome 3) 					
<i>Increase levels of physical activity</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • Physical activity protects people from obesity, diabetes and cardiovascular disease • Physical activity levels are decreasing in NZ 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Increase the proportion of adults who do at least 2.5 hours physical activity per week. (SPARC survey)	<i>Numerator</i> number of adults surveyed in CMDHB <i>Denominator</i> number of adults who do at least 2.5 hours of physical activity per week	Maori 62%	65%	No survey	68%
		Pacific 63%	65%		68%
		European 70%	72%		74%
		Other 43%	48%		52%
		Total 65%	67%		70%
<i>Increase healthy school environments</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • Overweight and obesity is common and increasing in schools • Lifestyle patterns developed in childhood affect adult behaviour 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Increase the proportion of schools that are health promoting	<i>Numerator</i> The number of health promoting schools	20/232	70/232	100/232	120/232
	<i>Denominator</i> The total number of				

schools	schools within the DHB				
<i>Increase smokefree environments</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> Smoking is the single most important preventable cause of death Passive smoking leads to 300 deaths per year in NZ Children exposed to smoking in the home are more likely to smoke themselves Smokefree homes is seen as the next priority in the Smokefree campaign 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Reduce the proportion of year 10 students where smoking is allowed in the in the house.	<i>Numerator</i> Number of students where smoking is allowed within the house	Maori 41.8%	40%	30%	25%
		Pacific 19.4%	19%	17%	15%
		Asian 19.6%	19%	17%	15%
		Other 23.6%	23%	20%	17%
		Total 24.9%	24%	22%	19%
	<i>Denominator</i> Number of year 10 students surveyed in CMDHB schools				
<i>Develop healthy communities by working intersectorally</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> Housing has a significant effect on health, particularly infectious and respiratory disease Poor housing is a significant issue for CMDHB's population, particularly for our Maori and Pacific populations There is evidence of effectiveness of this type of intervention 			
Objective	Performance Measure	Baseline Data &/ or Previous Target	Performance Targets 2006/07, 07/08, 08/09		
Complete the target number of joint health and housing assessments done in the Healthy Housing Programme	<i>Numerator</i> Number of health and housing assessments done in calendar year <i>Denominator</i> Target number of assessments for the year	498 assessments done/ 300 target	450	450	300
<i>Improve access to information to enable the community to make informed choices</i>					

Why is this measure important to CMDHB?		<ul style="list-style-type: none"> Information on health choices is a consumer right Informed consumers achieve better health outcomes Informed consumers lead to a more efficient health service 			
Objective	Performance Measure	Baseline Data &/ or Previous Target	Performance Targets 2006/07, 07/08, 08/09		
Increase the community's awareness of DHB activities and services available	<ul style="list-style-type: none"> Connect newsletter published at least bi-monthly GP newsletter published at least bi-monthly Community panel meets a minimum of ten times per year Community liaison role contributes to distribution of DHB information including: <ul style="list-style-type: none"> Regular attendance at public fora Communication on specific plans 	6 publications	6	6	6
		6 publications	6	6	6
		10 meetings	10	10	10
		Summary report outlining: <ul style="list-style-type: none"> Public fora attended Community liaison, engagement and consultation activities Specific plans communicated. 			

OUTCOME 2. IMPROVE CHILD AND YOUTH HEALTH

Medium Term Outcomes					
<ul style="list-style-type: none"> • Improve maternal wellbeing • Improve health outcomes for infants and pre-school children • Improve weight management in children and young people • Decrease the incidence and impact of risk taking actions by young people 					
<i>Improve maternal wellbeing</i>					
Why are these measures important to CMDHB?		<ul style="list-style-type: none"> • Low birth weight has significant short term and long term health consequences • Low birth weight is preventable by smoking prevention and prenatal and antenatal care • Maori have significantly higher rates of low birth weight pregnancies 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Decrease the percentage of babies born who have a low birth weight (<2500g).	<i>Numerator</i> Number of babies with birth weight <2500g <i>Denominator</i> Total number of births to CMDHB residents	Maori 51.9 per 1,000	50	48	45
		Pacific 20.8	20	20	20
		Other 36.0	35	34	33
		Total 34.7	35	34	33
<i>Improve health outcomes for infants and preschool children</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • CMDHB has a significant higher infant admission rate than NZ as a whole • There are significant ethnic disparities • Infant admission rate is an indicator of infant health • Outcomes are affected by antenatal, natal and postnatal care, parenting skills, social conditions and access to primary care • Oral health has a significant lifelong impact on health • Early enrolment with dental service and health promotion is important to ensuring oral health 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		

Decrease the admission and readmission rate for infants.	<i>Numerator</i> Number of these babies who are admitted to hospital in their first year of life (other than at delivery) <i>Denominator</i> Total number of babies born at CMDHB born in one year	Maori 26%	24%	23	23
		Pacific 30%	28%	27	25
		Other 17%	15%	15	15
		Total 23%	22%	21	20
Decrease the mean number of Decay, Missing or Filled (DMF) teeth in 5 year olds	<i>Numerator</i> Total number of DMF teeth <i>Denominator</i> Total number of children enrolled with the Dental Service in CMDHB	Maori 2.32	2.2	NA	NA
		Pacific 2.29	2.3	NA	NA
		Asian 1.80	1.8	NA	NA
		European 0.69	0.7	NA	NA
		Total 1.56	1.55	NA	NA
Currently methodology for collection of data on oral health is being reconsidered and therefore 07/08 and 08/09 targets are not given					
Improve weight management in children and young people					
We are currently uncertain about our ability to collect or accurately report on data for this outcome.					
Increase the incidence and impact of risk taking actions by young people					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • Teenage births may limit opportunities for both mother and child • Rates amongst Maori and Pacific are much higher than other groups • Teen pregnancy can be prevented by education and access to primary care 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Reduce the number of births to teenage mothers (15-19 years)	<i>Numerator</i> Total number of babies born to women 15-19 years old who reside in CMDHB <i>Denominator</i> Total number of women 15-19 in CMDHB	Maori 93 per 1,000	90	87	84
		Pacific 58	56	54	52
		Other 17	17	17	17
		Total 43	42	41	40

OUTCOME 3. REDUCE THE INCIDENCE AND IMPACT OF PRIORITY CONDITIONS

Medium Term Outcomes (2005-2010)					
<ul style="list-style-type: none"> • Increase access to structured programmes to reduce the impact of disease for the priority conditions • Reduce the incidence and impact of diabetes by implementing the Let's Beat Diabetes Plan • Reduce the incidence and impact of cancer • Improve outcomes for people severely affected by mental illness 					
<i>Increase access to structured programmes to reduce the impact of disease</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • Chronic conditions are becoming increasingly prevalent • Structured chronic care can lead to reduced mortality and morbidity, improved function and decreased hospitalisation 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Increase the numbers of CCM enrolments for all five modules	Total enrolments in CCM programme (All enrolments minus disenrolments)	5150 (22% Maori, 47% Pacific, 31% Other)	8750	10000	11000
<i>Reduce the incidence and impact of diabetes</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • The prevalence of type 2 diabetes is rapidly increasing particularly in Maori and Pacific people • Diabetes causes significant morbidity and mortality • Most diabetes needs to be managed primarily in primary care • There is a significant gap between recommended and in practice care 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Increase the proportion of estimated number of people with diabetes who had an annual Get Checked free check	<i>Numerator</i> The number of individuals with diabetes who have an annual free annual check <i>Denominator</i> The estimated number of individuals with diabetes	Maori 52%	63%	66%	68%
		Pacific 110%	100%	100%	100%
		Other 58%	62%	63%	64%
		Total 70%	72%	73%	74%

Reduce the incidence and impact of cancer					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • CMDHB has recently become provider of this service • Breast cancer is the leading cause of cancer mortality for women • Coverage rates are well below national targets of 70% 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Increase the 2 year breast screening coverage for women aged 50-64	<i>Numerator</i> Number of women aged 50-64 who have had a breast screen in the last 24 months <i>Denominator</i> Number of women aged 50-64 living in Counties-Manukau	Maori 50.4%	56%	58%	60%
		Pacific 45.5%	50%	52%	54%
		Other 55.1%	61%	63%	65%
		Total 53.8%	60%	62%	64%
Improve outcomes for people severely affected by mental illness					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • Serious mental illness is a leading cause of morbidity • There is currently poor access to mental health services 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Increase the proportion of the Counties-Manukau population with severe mental illness accessing mental health services	<i>Numerator</i> The average number of people seen each month for the three months <i>Denominator</i> Number of CMDHB residents aged 20-64	0-19 years 1.4%	1.4	1.6	1.8
		20-64 years 2.3%	2.6	2.8	3.0
		65+ years 1.9%	2.3	2.4	2.5
		Total 1.9%	2.2	2.4	2.6
Note: the achievement of these targets is contingent upon the amount of additional Blueprint funding available each year. Actual funding levels for 07/08 and 08/09 are yet to be determined.					

OUTCOME 4. REDUCE HEALTH INEQUALITIES

Medium Term Outcomes (2005-2010)					
<ul style="list-style-type: none"> • Address the systemic origins of inequalities • Implement specific initiatives to reduce inequalities • Improve ethnicity data collection 					
Address the systemic origins of inequalities					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • Potentially avoidable hospitalisations are an indicator of morbidly avoidable by social change, public health measures and primary care • It is a very sensitive measure of health inequalities 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Reduce the rate of potentially avoidable hospitalisations for adults	<i>Numerator</i> The total number of hospital discharges considered potentially avoidable <i>Denominator</i> Total number of adult residents in CMDHB	Maori 8884 (per 100,000)	8500	8250	8000
		Pacific 8022	7750	7550	7350
		Asian 3262	3250	3240	3225
		Other 4572	4500	4450	4400
		Total 5298	5200	5050	4900
Address the systemic origins of inequalities					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • Inequalities in ethnic mortality is extreme in this group and therefore should be a sensitive marker of progress • Maori men of this age are often regarded as difficult to access and influence 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Reduce the mortality rate for Maori and Pacific men aged 45-64 years	<i>Numerator</i> Total number of deaths of male CMDHB residents aged 45-64 <i>Denominator</i> Total number of men in CMDHB aged 45-64	Maori 1242 (per 100,000)	1200	1150	1100
		Pacific 1145	1100	1050	1000
		Other 355	350	340	330
		Total 545	520	500	480
Improve ethnicity data collection					
Why is this measure important to CMDHB?		Inequalities cannot be effectively analysed, addressed or evaluated unless ethnicity data is accurately collected			

Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Ethnicity data is collected accurately and completely in secondary care	<i>Numerator</i> Number of patients who have ethnicity recorded as Not stated or Not defined <i>Denominator</i> Number of patients seen as an inpatient	1.5%	1.5%	1.5%	1.5%

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

Medium Term Outcomes (2005-2010)					
<ul style="list-style-type: none"> • Increase access to services so they align with national levels • Improve access to and management of elective services • Increase primary care utilization • Improve the continuum of care for services provided to older people • Reduce the number of people admitted to hospital who could have been cared for in the community 					
<i>Increase access to services so they align with national levels</i>					
Why is this measure important to CMDHB?			<ul style="list-style-type: none"> • CMDHB wishes to provide elective services to its population at national access rates as a minimum 		
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Increase the proportion of services which are at or above national access levels	<i>Numerator</i> The number of service groups (e.g. orthopaedics) where CMDHB is below the NZ average <i>Denominator</i> The number of service groups analysed	5/14	3/14	3/14	3/14
<i>Improve access to and management of elective services</i>					
Why is this measure important to CMDHB?			<ul style="list-style-type: none"> • It is important to give certainty to patients as to their treatment and then provide treatment within specified timeframes 		
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Decrease the number of patients who have not been managed according to their assigned status and who should have received treatment	<i>Numerator</i> Those patients have not received treatment within 6 months, and for those place on active review have not received a clinical assessment within the last 6 months <i>Denominator</i> Patients, irrespective of their	7.4%	<5.0%	<5.0%	<5.0%

	assigned status, who have a priority score above the treatment threshold				
<i>Increase primary care utilization</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> High needs populations have higher health needs but face barriers to access to primary care 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Increase rate of GP consultations for high needs (Maori, Pacific, or living in decile 9 or 10 area) compared with non-high needs populations	<i>Numerator</i> The rate of GP consultations per high needs person <i>Denominator</i> The rate of GP consultations per non-high needs person	1.13	1.13	1.13	1.13
<i>Improve the continuum of care for services provided to older people</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> Older people should be maintain independence in their own homes whenever this is possible 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Increase the ratio of expenditure on home based care to expenditure on residential care		28%	29%	30%	31%
<i>Reduce the number of people admitted to hospital who could have been cared for in the community</i>					
Refer to the indicator in Outcome 3 "Increase the numbers of CCM enrolments for all five modules"					

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

Medium Term Outcomes (2005-2010)					
<ul style="list-style-type: none"> • Ensure the health workforce meets the community's need for services • Improve health professionals communication skills in their dealings with patients and their families/whanau • Ensure that services and facilities are planned to meet the future needs of the community • Support information exchange amongst health professionals • Ensure the delivery of safe and effective services • Ensure the efficient use of resources 					
<i>Ensure the health workforce meets the community's need for services</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • High staff turnover indicates an unhappy staff base • High staff turnover will lead to poorer service delivery 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Reduce the percentage of employees who voluntarily resign (Staff turnover – FTE)	<i>Numerator</i> The number of employees who resign <i>Denominator</i> The total number of employees in the organisation	2.9%	3.5%	3.5%	3.5%
<i>Improve health professionals communication skills in their dealings with patients and their families/whanau</i>					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> • Communication is essential to achieving good health outcomes 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Reduce the ratio of communication patient complaints to the number of admissions	<i>Numerator</i> Number of communication complaints received <i>Denominator</i> Total number of admission	0.32%	0.3%	0.28%	0.28%
<i>Ensure that services and facilities are planned to meet the future needs of the community</i>					

Why is this measure important to CMDHB?		<ul style="list-style-type: none"> When facilities are overfull it reduces the quality and efficiency of delivery of services to patients 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Reduce the number of days where occupancy is greater than 90% (85%) in CMDHB facilities	The number of days in a financial year when DHB the number of beds is more than 90% (85%) of the total physical occupancy	90% - 27, 85% - 135	90% - 30, 85% - 135	90% - 30, 85% - 135	90% - 30, 85% - 135
<p>Note: this is a new indicator, the target reflects the tradeoff between having adequate facilities for peaks and an efficient use of capital resources so at this stage they are estimates only. In addition CMDHB is in the middle of a building programme with wards being commissioned and decommissioned which will mean achieving the target this year is less certain</p>					
Ensure the delivery of safe and effective services					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> Unplanned readmissions can be a reflection of the quality of discharge planning, and primary and community support processes 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		
Reduce unplanned readmissions within 1 month of discharge (the definition of this indicator is likely to be changed soon)	<i>Numerator</i> The number of patients admitted acutely whose admission occurred within 30 days after a discharge from the same specialty <i>Denominator</i> The number of patients discharged	6.38%	6.5%	6.5	6.5
Ensure the efficient use of resources					
Why is this measure important to CMDHB?		<ul style="list-style-type: none"> Having valid NHIs on pharmaceutical and laboratory test transactions will enable tracking of expenditure and usage by the DHB's resident population. This allows for more accurate analysis of expenditure against population-based budgets. 			
Objective	Performance Measure	Baseline Data	Performance Targets 2006/07, 07/08, 08/09		

<p>The percentage of laboratory test and pharmaceutical transactions with a valid NHI</p>	<p><i>Numerator</i> Pharmaceuticals: the number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted. Laboratory tests: The number of tests carried out by community laboratories in the DHB district with a valid NHI submitted.</p> <p><i>Denominator</i> Pharmaceuticals: the total number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district. Laboratory: The total number of tests carried out by community laboratories in the DHB district.</p>	Pharmaceuticals: 90% Laboratory: 92%	90% 92%	90% 92%	90% 92%
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Part 6 STATEMENTS OF FINANCIAL PERFORMANCE

6.1 FINANCIAL STATEMENTS

Statement of Financial Performance						
\$000	2004/05	2005/06	2005/06	2006/07	2007/08	2008/09
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Revenue	807,465	670,794	851,086	917,964	961,699	1,004,912
Operating Costs	771,245	631,035	811,383	870,527	909,049	948,185
EBITDA	36,220	39,759	39,703	47,437	52,650	56,727
Depreciation	19,798	22,205	22,282	25,780	28,286	31,986
Interest	6,612	8,145	6,345	9,004	11,155	11,589
Operating Results before Capital Charge	9,810	9,408	11,076	12,653	13,209	13,152
Capital Charge	9,499	9,292	7,189	12,634	12,928	13,079
Operating Surplus	311	116	3,887	19	281	73
Carried Forward costs			(3,052)	(6,000)		
Surplus / (Deficit)	\$ 311	\$ 116	\$ 835	\$(5,981)	\$ 281	\$ 73
Summary by Output						
Funder- Arm	163	1,008	(1,686)	(3,325)	(708)	(923)
Governance	(657)	(973)	(998)	(1,361)	(907)	(870)
Provider-Arm	805	81	3,519	(1,295)	1,896	1,866
DHB	\$ 311	\$ 116	\$ 835	\$(5,981)	\$ 281	\$ 73

Movement over last three years	June 2004	June 2005	June 2006	Total
Operating surplus	413	2,825	3,887	7,125
Moh additional funding	5,565	(2,514)	(3,052)	-
Net Surplus/(deficit)	\$ 5,978	\$ 311	\$ 835	\$ 7,125
Movement in 2006/07	Carried Forward	Electives	Priority Initiatives	Balance
	\$ 7,125	(3,000)	(3,000)	\$ 1,125

Key Drivers of Change						
\$000	2004/05	2005/06	2005/06	2006/07	2007/08	2008/09
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Staff Costs %	31.6%	32.6%	32.8%	33.4%	32.8%	32.3%
Change		1.0%	1.1%	0.7%	(0.6)%	(0.5)%
FTEs	3,859	3,837	3,833	3,996	3,997	3,997
Medical supplies	60,094	62,703	63,563	64,813	67,961	69,996
Volume growth						
Capital Expenditure						
Buildings	9,420	59,242	45,096	49,500	35,000	10,000
Equipment	8,759	5,898	5,898	9,500	12,000	9,500
IS	3,992	2,666	2,666	-	-	-
Motor Vehicles	19		-	-	-	-
Total	\$ 22,190	\$ 67,806	\$ 53,660	\$ 59,000	\$ 47,000	\$ 19,500
Strategic Initiatives		7,780	7,780	13,943	10,169	10,371

Statement of Financial Position						
\$000	2004/05	2005/06	2005/06	2006/07	2007/08	2008/09
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Current Assets	27,009	18,481	49,679	49,717	49,781	49,735
Current Liabilities	124,634	117,865	178,084	175,987	176,484	174,379
Working Capital	(97,625)	(99,384)	(128,405)	(126,270)	(126,703)	(124,644)
Non-Current Assets	263,537	385,149	365,683	398,903	417,617	405,131
Net Funds Employed	165,912	\$285,764	\$237,278	\$272,633	\$290,914	\$280,487
Total Non-Current Liabilities	77,517	128,768	77,267	118,567	136,567	126,067
Crown Equity	88,395	156,996	160,011	154,066	154,347	154,420
Net Funds Employed	\$165,912	\$285,764	\$237,278	\$272,633	\$290,914	\$280,487

Statement of Movement in Equity						
\$000	2004/05	2005/06	2005/06	2006/07	2007/08	2008/09
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Opening Balance	88,055	86,112	88,395	160,011	154,066	154,347
Surplus / (Deficit)	311	116	835	(5,981)	281	73
Transfer of restricted funds	29		13	36		
Revaluation Assets		70,768	70,768			
Closing Balance	88,395	\$156,996	\$160,011	\$154,066	\$154,347	\$154,419

Summary of Cash Flow						
\$000	2004/05	2005/06	2005/06	2006/07	2007/08	2008/09
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Net Cash flow from Operating	34,755	22,322	23,985	19,828	28,503	32,105
Net Capital Expenditure	(25,883)	(69,600)	(49,960)	(59,000)	(47,000)	(19,500)
Net Cash flow from Financing	(31,608)	45,407	10,000	47,000	18,433	(10,500)
Net Cash flow	(22,736)	(1,871)	(15,975)	10,880	(497)	2,104
Plus Opening Cash (Bank Account)	25,159	2,423	2,423	(13,552)	(5,724)	(5,788)
Equals Closing Cash (Bank account)	\$ 2,423	\$ 552	\$(13,552)	\$(5,724)	\$ (2,788)	\$ (3,683)

6.2 OVERVIEW

2006/07 will see CMDHB continue to forecast a zero deficit in its Operating Financial Position despite significantly increased cost pressures combined with a Board commitment to increased investment in reducing health inequalities, maintaining the standard set in the previous three years. While CMDHB is showing a deficit of \$5,981k, it is more importantly achieving an operating surplus of \$19k. The variance of \$6,000k is due to surgical elective volumes and priority initiatives under spent in the previous year. Further, previous years operating surpluses are being utilised to assist achievement of the DHB's objectives; specifically a commitment to recovering previous year's elective volume shortfalls and investment in further priority initiatives aligned with the District Strategic Plan.

The 2006/07 District Annual Plan continues to focus on strong financial management and fiscal control, assisted by the FFT (or inflationary) adjustment and demographic growth adjuster. However, CMDHB has been left in a far more challenging position than at the same time last year due to the impact of the very significant IDF outflow and pricing adjustments, acute growth within the Provider Arm, and the transfer/establishment of new services such as National Burn Unit, Neonatal Intensive Care Unit, Breastscreening, and the Catheterisation Laboratory.

Compounding the pressure on the financial position, has been the Board's requirement to identify and "ringfence" significant investment in initiatives aimed at improving primary and community health services. These are particularly focussed on those areas where there is the greatest health need, as identified in the District

Strategic Plan. These initiatives and investment in the future health of CMDHB's community now total well over \$10million annually.

To achieve the District Annual Plan operating position in 2006/07, we have "capped" the allowable and fundable growth within the Provider Arm. This will present a challenge to contain the growth and related cost within these parameters, but we remain confident of achieving targets.

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

- § Partial funding from the Crown for Assets revaluation
- § Funding for the Health of Older People income and asset testing has been estimated but is not yet finalised with Ministry of Health.
- § PHO Top-Up reimbursements continue from the Ministry of Health as previously
- § Nursing jolt payments will be reimbursed by the Ministry of Health relative to the PACT settlement in accordance with CMDHB's forecasts of the gap between the total cost and the DHB's contribution.

It is particularly important to note that the zero deficit position has been reached after:

- § absorbing anticipated wage and salary settlements well in excess of the 2.93 percent funded level, specifically:
 - significant national wage settlements, with flow on-costs, well in excess of the MoH funded levels (including recognition of the automatic ongoing step function on-cost implications)
 - increasing roster and compliance costs around RMO's terms of employment
- § the continuing investment in priority initiatives aligned with the District Strategic Plan, including those focussed on lessening the growth on hospital services
- § the ongoing internal efficiencies being generated, including those within healthAlliance, to offset these very significant cost increases
- § the absorption of increasing Pharmaceutical demand, reflecting greater access and usage by our community
- § the absorption of continuing strong renal growth volumes
- § the benefit of the lower depreciation levels arising from the longer lives based on the revaluation of June 2002. Note that while a further revaluation is planned for June 2006 as required, there is no anticipated financial impact, positive or negative, included within these forecasts. It is assumed (and still subject to MoH/Treasury consideration and confirmation) that these costs will be fully reimbursed.

There are also a number of financial risks inherent in the DHB's responsibilities. These include:

- § meeting the Minister's and Government's expectations regarding a break-even financial result (zero deficit) and compliance with Government strategies and policies
- § meeting the communities' expectations now that the DHB has been moved to equity from a population based funding perspective and with regard to community participation in decision-making

- § the financial risks associated with demand driven services, in which volume growth outstrips funding. Also, risks arise from poor historical data, assumed savings being built into the forecast, poor data and information systems, price pressures, and pricing inequalities between providers
- § wage price pressure emanating from union expectations and the increasing international nature of the health labour market, leading to clinical staff shortages.

6.3 FINANCIAL MANAGEMENT

3.1 Capital Planning and Expenditure

The Board remains committed to a number of major capital projects which will utilise a significant proportion of available cash funds, sourced from either current or accumulated depreciation or available debt funding. These projects to date have been under the general heading of Facilities Modernisation Programme and contained three distinct phases;

- Phase 0 currently nearing completion includes the complete radiology refurbishment and Middlemore-wide site infrastructure upgrade
- Phase 1 consisting of the upgraded and expanded Neonatal Intensive Care Unit, establishment of the National Burn Unit, establishment of the Catheterisation Laboratory, fit out of Manukau Surgical upper floor and the extension to the Adult Medical Centre. These projects are well advanced and other than Adult Medical Centre will be fully operational by June 2006
- Phase 2 involves the development of a wider more comprehensive CMDHB service delivery strategy across both Middlemore and Manukau sites.

As part of Phase 2 we are now initiating work around the medium to long term organisational requirements (15-20 year horizon) under the project heading Project Excel-Towards 20.20. This will be driven by extensive internal and external consultation, aligned with the next iteration of the Clinical Services Plan and coordinated with the Asset Management Plan currently being considered by the Ministry of Health.

To date CMDHB has been able to fully fund all capital requirements through either internal cash generation or available debt facilities, whereas Phase 2 as described above is expected to require Ministerial financial support of approximately \$27m against the total cost of projects funded to date of almost \$300m. As a result there are currently extensive discussions with Ministry and Treasury officials relating to both this requirement and the need for further Ministerial support on the "Towards 20.20" next phase, given the anticipated significant overall capital requirement over an extended period.

Facility Modernisation Programme/Project Excel-Towards 20.20

Forecasted population growth and the associated increase in requirements for health services means CMDHB will need to significantly increase capacity at both its major sites. This will be achieved through the upgrade of existing assets and the development of new capital stock as part of the Facilities Modernisation Programme

(FMP). CMDHB has already completed \$174 million of projects over the last 5 years associated with the first stage of the FMP. However, over \$680 million of capital (inclusive of all the stages detailed below) is still required over the next 20 years to orientate service delivery to meet future health service needs, based on current population growth forecasts. The current status of the facilities renewal is summarised as follows:

1. \$2 million **Breast Screening** to implement the Breast Screen Counties Manukau national initiative in 2005/06.
2. \$7 million **FMP 2 Phase 0** in 2005/06 associated with the completion of the upgrade of Middlemore Hospital's radiology services.
3. \$42 million design and construction of **FMP 2 Phase 1** in 2005/06 providing an increase in inpatient beds from 765 to a total of 878, and the establishment of the National Burn Unit.
4. \$95 million **FMP 2 Phase 2** associated with core consolidation projects to be implemented over 2005/06 to 2008/09. This has been submitted to National Capital Committee who have considered this in three stages based on Ministry of Health recommendation; an initial stage of \$42m for replacement of Middlemore facilities, a second stage encompassing Middlemore additional mental health beds and initial Browns Road site expansion, and a third stage of \$27m covering the first steps in future growth requirements on the Middlemore site. The National Capital Committee has fully supported the initial stage and we are currently awaiting Ministerial sign off. Preliminary work has commenced in advance of the formal approval from the Minister, with the support of National Capital Committee and Ministry of Health. An updated business case will be presented to National Capital Committee at its April 2006 meeting, further supporting the second and third stages of the core consolidation project.
5. **Project Excel – Towards 20.20** involves the development a wider and more comprehensive CMDHB service delivery strategy reflecting future growth requirements. The Business Case for Project Excel is to be presented at the October 2006 National Capital Committee meeting.

Note: Beyond the FMP 2 Phase 2, no business cases have been completed for years 4 to 20. Therefore, for the purposes of capital expenditure Project Excel is assumed to cycle as per the 3 year capital spend associated with FMP2, phase 2. This assumption is consistent with CMDHB's long term strategic plan including forecast population growth, bed modelling requirements and a reflection of the anticipated impact of primary care and community intervention strategies. This totals \$535 million over years 4 to 20.

It is well recognised that the future funding requirements for CMDHB are large and may well present a national funding issue. CMDHB is actively reviewing and updating its clinical services plan, and re-assessing community based health solutions, forecast growth, facility timing and other options in order to lessen this forecast demand and associated impact on capital requirements.

Extensive resource is being applied to this exercise, including significant independent external input and a very high level of regional collaboration to ensure non duplication and aligned timing of new facilities and capacities.

However a significant proportion of the forecast capital requirements for Project Excel can be internally funded. Over the period to 2021 CMDHB requires only \$186m, approximately, in total from the Crown (debt or equity) of the total capital funding requirement of \$1.2b, with the balance being generated from either depreciation, utilisation of existing available debt facilities or internal efficiencies.

3.3 Banking Covenants

CMDHB continues to operate under existing banking covenants with both its remaining major New Zealand bank and institutional bond holders. While the organisation is currently transitioning all bank debt facilities to the Crown Health Financing Agency, the bonds will remain in place until maturity, also the Board continues to maintain a working capital facility with ASB Bank/Commonwealth Bank which continues to fall under the existing covenant requirements. Despite the fact that the covenants were re-negotiated to more favourable requirements, over the past two years the DHB has fully complied with the original covenants and, based on forward zero deficit operating projections, expects to remain compliant over the District Annual Plan period. The shift of debt facilities to the Crown Health Financing Agency will not presently impact on existing bonds of \$70m which do not mature until 2007.

The Crown Health Funding Agency, excluding the bonds, have now replaced all but the final \$60m which has been formally approved, around which we are still negotiating final covenant/reporting requirements.

3.4 Cash Position

The forecast cash position of CMDHB assumes effectively a cash neutral position through full utilisation of free cash flow to match the level of capital expenditure requirements. Although we have still to complete the final review all capital expenditure requests (and therefore confirm the associated depreciation levels), capital expenditure related to the 2006/07 year will total \$22-24m, increased by the capital under spend being carried forward from 2005/06 relating primarily to committed but not fully spent facilities projects.

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

3.5 Capital Charge

The District Annual Plan continues to include the matching of cost and revenue on the higher capital charge arising from the anticipated asset revaluation. This reimbursement is still subject to Ministry of Health and Treasury confirmation.

3.6 Advance Funding

The District Annual Plan continues to incorporate the fiscal benefit of the one month advance funding, based on the tabling of the zero deficit operating position, and maintenance of the other Ministry of Health requirements necessary to access this benefit.

6.4 COST CONTAINMENT & EFFICIENCY GAINS

As in previous years the District Annual Plan reflects continuing growth containment within the organisation but particularly within the provider arm. The only exceptions within the provider are within renal, women's health, roll out costs related to the significant expansion and refurbishment of radiology, and implementation of new services for breast screening and catheterisation laboratory. In many of these cases demand continues to significantly outstrip projections and therefore levels of funded growth, which has required even tighter cost containment in order to achieve the zero operating deficit.

Renal dialysis outpatient volumes are growing at over 8% compounded annually – a level which is both clinically and financially unsustainable and which, in current financial terms, incurs \$0.7m per year unfunded operating cost growth and a further million dollars of capital/facility requirements for every new 12 bed module required to meet this demand.

Women's health cost pressures continue particularly relating to Section 88 maternity compliance costs as well as a birth rate well in excess of national averages (over 6%) and growing beyond population based funding levels.

With the exception of the areas identified above, there has been some stability around hospital acute growth levels overall. The District Annual Plan has been based on absorption of any increases in acute growth levels within existing cost structures.

Also, CMDHB is committed to recovering the anticipated shortfall in contracted elective volumes in 2005/06, through a combination of both internal and external resources in 2006/07. This is being funded through utilisation of part of the surplus forecast to be carried forward at 30 June 2006; this is being shown within the District Annual Plan as "below the line" following the principles previously agreed with the Ministry of Health. The forecast surplus in the provider arm within the 2005/06 year has arisen primarily through lower than budgeted costs directly related to lower than budgeted elective volumes.

In order to achieve the desired zero deficit operating target, we have placed even greater emphasis on containing our costs and achieving further efficiency gains, with all areas of the organisation expected to build into their plans continuing and significant efficiency targets. As would be expected many of these are the same areas targeted in the 2005/06 District Annual Plan. In order to achieve this we have effectively "short funded" the Provider Arm by 0.4% (or approximately \$2m) to be able to contribute to the significant investment in new and existing priority initiatives.

These initiatives, aligned with the District Strategic Plan, are focussed on both reducing health inequalities and placing increasing emphasis on primary care solutions as opposed to continuing unchecked growth in the provider arm. Given the extremely tight and demanding budget, we are committed to actively pursuing further cost efficiencies within the provider arm in particular, ongoing nursing cost structure reviews (including regional collaboration and alignment) and continuing healthAlliance efficiency reviews.

The DHB's concern around forecast increases in utility costs raised in last year's DAP is expected to continue in 2006/07. While not yet finalised there is expected to be a significant increase in the areas of gas, electricity and fuel costs following on from similar increases over the last two years. This follows the move away by suppliers from medium term contracts to one year only contracts with resultant subsequent price increases. Again as previously there appears to be little and probably no financial advantage in metro-Auckland regional negotiations as these prices are primarily geographical site-related, rather than collectively related. These forecast increases are expected to be above the funded inflation and population growth adjustments.

Efficiency Gains

Efficiency gains within the District Annual Plan are identified at well over \$10m (in excess of Ministry of Health targets) and are essential to offset both volume cost growth and to fund essential investment in primary care initiatives to ultimately minimise secondary care volume impacts and improve health outcomes for the Counties Manukau community.

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

New resourcing models within theatres are improving both clinical efficiency and reducing costs as anticipated within last year's Plan.

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

CMDHB continues to maintain a very close focus on FTE management given that salary and wage costs are two thirds of the provider budget. As a result there is a relatively modest increase in overall FTEs, primarily driven by new services (ie National Burns Centre, Neonatal Intensive Care Unit, catheterisation laboratory,

Mental Health Blueprint etc.) or funded services (ie. Agreed growth areas – mental health, renal, births etc.). It is notable that within the FTE trend analysis virtually all growth is within the clinical areas or direct clinical support. As previously, FTE increases are subject to regular scrutiny to ensure justification.

healthAlliance

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

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

There have continued to be numerous discussions with Auckland DHB in regard to formally joining healthAlliance, or shared services, particularly in the areas of information services and procurement but to date this has not eventuated. However it is very pleasing to confirm that all parties are working very closely together to maximise benefits without Auckland DHB formally being part of healthAlliance. This is particularly the case with regional information technology development and payroll where all three metro-Auckland DHBs now have a common payroll system and can thus share and learn from each others experiences.

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

Wage Cost Pressure

As discussed above, within the provider arm, basic wage increases are built in at the levels of funding provided by the Ministry of Health. However, over and above those basic salary and wage movements, CMDHB is, along with most other DHBs, absorbing very significant levels of on-costs, including step functions, allowances and superannuation, primarily around medical and nursing staff entitlements. As referred to elsewhere it is anticipated that the nursing jolt payment, net of FFT funded levels, will be reimbursed by the Ministry of Health relative to the PACT settlement and is sufficient to match the actual cost increases ultimately incurred. Of

note is the flow on of these jolt payments to other non-reimbursed groups, which is occurring in award claims with potential consequent impact on all DHBs.

In calculating wage and salary movement, there have been a number of other financial impacts from the award settlements.

Step increases: in most cases staff are entitled to move up a step after each year of service, on average this equals to a 3% increase. The step function increases have been absorbed by way of efficiencies. In a number of cases the minimum step has been increased, eg allied health workers, this has not been compensated for in any pay jolt. Note: step functions for clinical personnel, are automatically applied and can almost double the base increases which in turn are further compounded by equivalent changes to related terms and conditions.

Anticipated changes in leave entitlement, due to the implementation of the Holidays Act, will also have a material financial impact and will present a challenge to all DHBs to resist flow-on claims from other wage and salary areas. In setting the budget, the DHB has fully reviewed current vacancies; at a service level vacancy levels have been agreed to be maintained on a case by case basis but clearly filled where possible in critical skilled areas.

Maori Health

The Maori health budget for 2006/07 reflects the intensive planning that has taken place by the organisation over the previous year. This planning was required to ensure organisational commitment and community buy-in to implementing the Maori health Plan. The budget builds on the consistent approaches of the past years, with significant injections in new and existing areas where Maori health gain needs to be prioritised. As part of its commitment to improving Maori health and access to services, the Board has committed \$1.3m for specifically targeted projects including:

- Development of Maori providers and workforce to enable better health outcomes for Maori
- Concerted effort to address Maori health issues associated with chronic diseases including diabetes and cardiovascular disease
- Development and/or implementation of strategies to increase healthy lifestyle options for Maori.

Once again, Maori Health has contributed to the organisation achieving a zero deficit target. This is a strategic direction adjustment that will be implemented over the next three to five years.

The Maori Health consolidated internal budget for 2006/7 is \$1,092,358. This amount includes both the provider arm as well as the funding and planning governance and administration budget. The funding and planning arm increase is consistent with the increased workload for non-DHB providers for the year, with that part of the service increasing by 4.5 FTE's. While the provider arm remains static, including the priority initiative programmes, Matapuna Rapuora and Hauora Whanau teams. The two latter mentioned projects reach their conclusion this year, with an evaluation required to ascertain their on-going viability.

The external provider budget increases by 4.2%. This is due to the commitment by the Board to increase the development of Maori services and Maori providers. This figure is not inclusive of FFT percentage increase. There is significant funding increases for the provision of 'by Maori, for Maori' services, which is reflective of the priority area identified in the Maori health plan. Those priority areas are:

- Addressing the lifestyle factors associated with obesity, smoking and alcohol and other drug misuse
- Dealing specifically with diabetes and cardiovascular disease
- Improving Tamariki (Child) and Rangatahi (youth) health
- Improving health and disability services provided to Kaumatua (elder male) and Kuia (elder female) health
- Increasing the delivery of Mental health services to maori
- Developing the infrastructural supports required to support the provision of services

In the outer year 2007/8, a minimum budget increase of 3.3% has been allowed for, with the 2008/9 spend subject to confirmation by POU (Maori Advisory Committee).

The Maori Provider Development Scheme will continue to be administered through Tainui MAPO with the assistance of CMDHB.

6.5 RISK MITIGATION STRATEGIES

Risk mitigation strategies (refer also Part 2.2 Key Issues and Risks), to minimise the negative impact of any changes to the base assumptions, will include:

- Continued development of audit, evaluation and monitoring systems to ensure that CMDHB is receiving value for money
- Significantly lifting the level and frequency of all internal and external audit reviews. Increasing emphasis is currently being placed on widening the audits of the NGO/PHO areas, with notable results to date. The primary focus here has been around ensuring full delivery of contracted services, as well as ensuring appropriate health outcomes. Further strategies include the planned establishment of a regional internal audit function across the three metro-Auckland DHBs which is expected to lead to ensuring best value for services.
- Continued development of a robust expenditure and long term forecasting monitoring tool
- Continued focus on efficiency and cost opportunities, particularly through the use of healthAlliance, but increasingly through regional collaboration. The latter will ensure a consistent approach and common policy and also ensure appropriate benchmarking is regularly carried out to maximise efficiencies
- Support of national initiatives that will lead to cost reductions, subject to the perceived risks being manageable. For example the current national insurance project, specifically motor vehicle insurance. Overall, the policy of increased self insurance will reduce costs, as long as the risks of such are recognised and indemnified as the DHB cannot be in the position of speculating around risk, given the Board's governance accountabilities.
- Continuing to place very high emphasis on robust, regular monthly performance reviews at all levels of the organisation to ensure that CMDHB meets both its financial and operational targets.

6.6 ACCOUNTING POLICIES

Reporting Entity

Counties Manukau District Health Board is a Crown entity in terms of the Public Finance Act 1989.

The organisation is wholly owned on behalf of the Crown by the two stakeholding ministers, the Minister of Health and the Minister of Finance.

In the preparation of its financial statements, the Board follows the recommendations of the Statements of Standard Accounting Practice and Financial Reporting Standards issued by the Institute of Chartered Accountants of New Zealand.

Measurement Base

The general accounting principles recognised as appropriate for the measurement and reporting of results and financial position on an historical cost basis have been applied. The financial statements have been prepared on an historical cost basis, modified by the revaluation of certain fixed assets.

Accounting Policies

The following particular accounting policies that materially affect the measurement of results and financial position have been applied:

- *Future Years*

These are stated under current Generally Accepted Accounting Principles (GAAP) and not under New Zealand International Financial Reporting Standards (NZIFRS).

- *Leases*

Operating lease payments, where the lessors effectively retain substantially all the risks and benefits of ownership of the leased items are charged as expenses in the periods in which they are incurred.

- *Employee Entitlements*

Provision is made in respect of the Board's liability for annual leave, long service leave, retirement entitlements and continuing medical education (CME). Annual leave and CME have been calculated on an actual basis whilst the other provisions have been calculated on an actuarial basis.

- *Accounts Receivable*

Accounts Receivables are stated at expected realisable value after providing for doubtful and uncollectable debts.

- *Inventories*

Inventories are valued at the lower of cost, determined on a first-in, first-out basis, and net realisable value. This valuation includes allowances for slow moving items. Obsolete inventories are written off.

- *Investments*

Investments are stated at the lower of cost and net realisable value. Any decreases are recognised in the Statement of Financial Performance.

- *Fixed Assets*

Fixed assets vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Counties Manukau Health Limited (a Hospital and Health Service) were vested in Counties Manukau District Health Board on 1 January 2001. Accordingly, assets were transferred to Counties Manukau District Health Board at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed assets acquired since the establishment of the District Health Board

Assets acquired by the Board since its establishment, other than those vested from the Hospital and Health Service, are recorded at cost less accumulated depreciation. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

Revaluation of fixed assets

Land and buildings are revalued at least every three years to their fair value as determined by an independent registered valuer. Additions between revaluations are recorded at cost. The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance. The most recent revaluation was performed by independent Registered Valuers, Telfer Young in June 2002 and a further valuation is now planned for June 2006. An assessment was carried out at June 2005 but deemed not material, relative to operating performance. However CMDHB is committed to completing a revaluation in 2005/2006 in line with most of the health sector.

Disposal of fixed assets

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

Land and Buildings intended for sale in the next financial period are transferred to current assets at lower of cost less accumulated depreciation and net realisable value.

- *Depreciation of Fixed Assets*

Depreciation is charged on a straight-line basis on all tangible fixed assets other than freehold land, at rates calculated to allocate the cost over their estimated economic lives, as follows:

Buildings	33 or 50 years (2%-3%)
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Plant	3-25 years (4%-33%)
Clinical Equipment	3-25 years (4%-33%)
Information Technology Equipment	3-5 years (20%-33%)
Motor Vehicles	4 years (25%)
Other Equipment	3-25 years (4%-33%)

Work in progress is not depreciated. The total cost of a project is transferred to freehold buildings and/or plant and equipment on its completion and then depreciated.

- *Restricted and Bequest Funds*

Donations and bequests received are treated as revenue on receipt in the Statement of Financial Performance. When expenditure is subsequently incurred in respect of these funds it is recognised in the Statement of Financial Performance.

Disbursements from restricted funds accumulated prior to 1993 are not recognised in the Statement of Financial Performance but are directly debited to the Restricted Funds component of Equity

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- *Joint Ventures*

Counties Manukau District Health Board was a party to a small number of joint venture arrangements. These interests have not been reflected in these financial statements using the proportionate method as they are not material to Counties Manukau District Health Board.

- *In-substance Subsidiaries*

The Manukau Health Trust Board which is operated by a group of trustees, includes nominees from Counties Manukau District Health Board. This entity is not consolidated as it is not material to Counties Manukau District Health.

- *Associates*

The Board holds share holdings in associate companies. The interests in these associates are not accounted for as they are not material to Counties Manukau District Health Board.

- *Statement of Cash Flows*

The following are the definitions of the terms used in the Statement of Cash Flows:

- a) Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the Board invests as part of its day-to-day cash management.
- b) Operating activities include cash received from all income sources of the Board and records the cash payments made for the supply of goods and services
- c) Investing activities are those activities relating to the acquisition and disposal of non-current assets.

d) Financing activities comprise the change in equity and debt capital structure of the Board.

- *Financial Instruments*

As a guardian of public money, Counties Manukau District Health Board must be risk averse and seek to minimise exposure arising from its treasury activities. The Board is not authorised by its Treasury Policy to enter into any transaction that is speculative in nature.

Contracts have been entered into with various counter parties having such credit ratings and in accordance with such dollar limits as set forth by the Board. The Board does not require any collateral or security to support financial instruments subject to credit risk.

The Board's dealings in financial instruments come under the following categories:

a. *On-Balance Sheet*

The Board is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short-term deposits, investments, debtors, creditors and loans. All financial instruments are recognised in the Statement of Financial Position and all revenues and expenses in relation to financial instruments are recognised in the Statement of Financial Performance.

Except for loans, which are recorded at cost, and those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

b. *Off-Balance Sheet*

The Board has entered into financial instruments by way of interest rate options and foreign currency hedges which give rise to off-balance sheet exposures, in order to reduce exposure to fluctuations in interest rates and foreign currencies. Any gains or losses arising from exposure to these instruments are offset against the related losses or gains on the assets or liabilities being hedged. Any premiums paid on interest rate options are amortised over the period to maturity.

- *Mental Health Ring Fenced Revenue*

In accordance with Generally Accepted Accounting Principles, surpluses of income over expenditure are reported through the Statement of Financial Performance. 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. As at 30 June 2005 there were no unspent amounts in respect of Mental Health Ring Fenced Revenue

Budget figures

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

Goods and Services Tax (GST)

All items in the financial statements are exclusive of Goods and Services Tax (GST) with the exception of receivables and payables that are stated with GST included

Taxation

Counties Manukau District Health Board is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 1994.

Changes in Accounting Policies

There has been no change in accounting policies. All policies have been applied on a basis consistent with the previous period.

6.7 DISPOSAL OF LAND

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

Part 7 JARGON & ACRONYMS

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

Acronyms	Description
HNA	Health Needs Analysis
HR	Human Resources
ICU	Intensive Care Unit
IDF	Inter District Flows
IS	Information Systems
IT	Information Technology
KF	Kidz First
KPIs	Key Performance Indicators
LOS	Length of Stay
MAPO	Maori Advisory Purchasing Organisation
MECA	Multi Employment Collective Agreement
MeNZB	Meningococcal B Vaccine New Zealand
MHAC	Maori Health Advisory Committee
MHINC	Mental Health Information National Collection
MIT	Manukau Institute Technology
MMH	Middlemore Hospital
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSC	Manukau Surgical Centre
MVS	Meningococcal Vaccine Strategy
NASC	Needs Assessment and Service Co-ordination
NCTN	Northern Clinical Training Network
NDSA	Northern DHB Support Agency (DHB Shared Services)
NGO	Non-Governmental Organisation
NHI	National Health Index
NICU	Neonatal Intensive Care Unit
NIR	National Immunisation Register
NMDS	National Minimum Data Set
NNU	Neonatal Unit
NZIER	New Zealand Institute of Economic Research
NZIFRS	New Zealand International Financial Reporting Standards
P&L	Profit and Loss
PAH	Potentially Avoidable Hospital Admission
PHAC	Pacific Health Advisory Committee
PHO	Primary Health Organisations
POAC	Primary Options to Acute Care
RC	Responsibility Centre
SIA	Services to Improved Access
SLA	Service Level Agreement
TB	To Be Confirmed
WDHB	Waitemata District Health Board
WIES	Weighted Inlier Equivalent Separation = Weighted Relative Value Purchasing Unit for medical and surgical Inpatient services
YTD	Year to Date