

Statement of Intent
2007/08 – 2009/10
Counties Manukau DHB

June 2007



EXECUTIVE SUMMARY

This Statement of Intent has been prepared by Counties Manukau District Health Board (DHB) to meet the requirements of sections 39 and 42 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 2007/08 by Counties Manukau DHB and contains non-financial and financial forecast information for the 2008/09 and 2009/10 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
(Board Member)

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 CHIEF EXECUTIVE

Counties Manukau DHB strives on achievement and making a difference for the community it serves. 2007/08 will see continued implementation of initiatives and activities towards achieving the DHB's vision. The DHB is on a journey to excellence, and in order to continue to meet our community's expectations of the services they deserve, the DHB will need to make some significant changes in 2007/08.

Our focus on reducing inequalities and the impacts of poverty will continue to be woven through our plans and activities, from a governance level and the implementation of the Whaanau Ora Plan by POU, to community involvement in the development of services via the community panel, and to improved access to specific services through improved information regarding health needs. This focus needs to continue until the discrepancies in health status are negligible within our community.

We have a growing and ever changing population; we need to respond to this with improved ways of delivering health care. We will continue to take a twin track approach, focusing on population health and inequalities on one side, while continuing to ensure the services delivered are efficient and effective on the other.

Importantly this year, we will start moving our focus away from the margins and the net 1% discretionary spending we have each year, to the approximate \$920m already invested in health and disability services in Counties Manukau. It will be hard job reviewing this expenditure and one which we expect to continue for the next couple of years. We will be looking to the outcome of the second of the sustainability conferences, "Paying for Tomorrow's Health' How does New Zealand fund services in the future?", for further opportunities to ensure we are getting value for money from our funding.

We will also be focusing on clinical quality in 2007/08; the business case for quality improvement as underlined by the examples of many other healthcare organisations is that increased quality reduces costs, and therefore provides increased opportunity for investment in priority areas and for the development of services. We will need a more radical approach to quality, one that is very much focussed on patients; it will require re-thinking and redesigning to ensure that care provided is of the highest quality and better placed to meet the needs of patients regardless of cultural background. This is not to say that current services provided by the DHB and other providers in the community are of a poor standard, but that we aspire not just to be good but to excel. In order to continue to meet patients' expectations with the pressures of an increasing population and ever increasing costs, we need to get smarter and more quality-focussed.

To do this we will need strong clinical leadership supported by governance and management structures focussed on achieving our vision. This will require an organisational development programme to deliver and we embarked on this in early 2007.

Working with the other providers in Counties Manukau is essential for achieving our vision. PHOs have been established for a number of years and it is now time we evaluated what works, what doesn't, and how we can create a more effective and efficient overall system. Similarly, we have a major role in alleviating poverty and other determinants which impact health outcomes, and so it is important that we continue to work together with other agencies to improve housing, employment opportunities, education and the general environment. We have a number of joint initiatives with these agencies including healthy housing and PATHS which are extremely important to our DHB and to our community due to their positive impact on health status. Also the Let's Beat Diabetes programme, which the majority of agencies and providers within Counties Manukau are involved, continues to provide the platform for joint initiatives which increase healthy lifestyles through nutrition, physical activity and improved health care services.

In 2007/08 Counties Manukau DHB will continue along the path of previous years, but we also accept that we need to do things differently if we are to continue to meet our community's expectations. We are in a fortunate position in that we are continuing to forecast a break-even financial position in 2007/08 while being confident that we can commit to achieving the outcomes agreed with the Minister of Health as well as embark on this programme of change.

Counties Manukau DHB is a great team to be part of, it is clear that the leadership of the past has provided a strong platform for the future. It is therefore with great heart that we look forward to 2007/08.

Pat Snedden
Chair

Geraint Martin
Chief Executive

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Part 1 INTRODUCTION

1.1 OVERVIEW

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 continues to receive significant support from primary care and community providers, local and national government agencies, and community groups, to achieve its goals and make progress on improving health outcomes for the community of Counties Manukau.

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
- Historically 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
- The capacity of the health and disability sector, ie workforce, facilities, and information systems, is insufficient to respond to the health needs of the community requiring creative and innovative solutions to ensure we get the most out of what is available.

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
- Worked with other agencies to implement programmes which improve housing, employment opportunities and other determinants which can impact health outcomes.

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
- 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).

Counties Manukau DHB also continues to forecast a zero deficit in 2007/08, having successfully turned around its \$50m deficit in 2002/03 to a healthy 'break-even' since then.

What is next?

The DHB is moving into its second year of implementing its revised District Strategic Plan (DSP). 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 describes for 2007/08 the DHB's intentions to continue to advance the strategic direction (refer Part 4) including the DHB resources required (refer Part 6) and how the DHB will measure progress in achieving these intentions (refer Part 5).

The DHB will continue to focus on the ten action areas identified in the 2006/07 plan (refer table below), but will also focus on a number of specific provider arm initiatives including clinical governance, management of acute patients in Emergency Care and quality improvement.

Ten Action Areas

Service development action areas

- Maaori health (refer Outcome 4)
- Pacific health (refer Outcome 4)
- 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 3 & 5)

Enabler action areas

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

Note the references to outcomes in the brackets identifies where the majority of information will be found for the action area in Parts 4 & 5, however for many of the service development areas objectives are also included in other outcomes.

1.2 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 2007/08 to 2009/10. 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 2007/08 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 2007/08 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.

1.3 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.

1.4 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.

1.5 TREATY OF WAITANGI

The Treaty of Waitangi as the founding document of our nation establishes a partnership between Maaori and the Crown to work together. The New Zealand Public Health and Disability Act 2000, Part 1, section 4 identifies that DHBs have a responsibility to improve Maaori health gain through the provision of:

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

This is also further reflected in He Korowai Oranga and Whakataataka Two with the overall aim of whaanau ora;

“Maaori families supported to achieve the maximum health and wellbeing. This requires an approach that recognises and builds on the integral strengths and assets of whaanau.”

While having one of the highest needs profiles of health deprivation in the country, and a major part of that need located in the Maaori population, CMDHB have sought to embody the principles of partnership, protection and participation in the delivery of services to those populations.

Working with the local Maaori communities the Board has changed its approach, and moved into a position where it “will no longer contest your (Maaori community) Rangatiratanga, your collective ability to participate fully in all decisions related to the improvement of 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 plans.”

The transformation in Maaori interaction with the Board has been remarkable and resulted in the formation of POU as a Maaori/ Board advisory partnership group. Made up of six Board members and six members elected by the Maaori community from a fully representative process, this group works in a wholly open and transparent process, to the point where POU are ceded full authority to implement those actions to implement the Whaanau Ora Plan (Maaori Health plan).

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

- The on-going partnership of the Maaori health division of the DHB and Tainui MAPO to work cohesively to identify and implement Maaori health gain strategies on behalf of their constituent Maaori communities
- The on-going development of non-government Maaori health providers so as to allow an equitable choice of services to the community
- The appointment of a General Manager, Maaori Health as part of the Executive Management Team to provide Maaori strategic and operational impetus for the organisation
- The maintenance of a significant Maaori health presence across the Planning and Funding and Provider arms of the organisation. This capacity compliments services delivered to Maaori and ensures increased awareness by our other services of the need to work holistically with Maaori patients and their whaanau

The Whaanau Ora Plan is premised on the vision developed through POU by the community. This is;

Whaanau Ora – Maaori Ora

Kia whai kaha, whai mana painga, ki ngaa kawenga orange Iwi, ki tua o Rangi

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

It identifies six key priorities. They are:

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

1.6 GOOD EMPLOYER

CMDHB is committed to providing a working environment for our committed, skilled workforce which meets "good employer" criteria. This is a key organisational strategy implemented and supported by human resources at an organisational and a service level.

Key components of the strategy include:

- a Harassment Prevention Programme including policy, staff education and training with a commitment to the effective and timely follow up to issues raised by staff
- a yearly Staff Satisfaction Survey which provides an opportunity for the organisation to receive feedback regarding the success of specific interventions within teams and services. The results of this survey are one of the evaluation measures used to evaluate and plan annual activity to support the Harassment Prevention policy
- a focus on Disability Awareness programmes supported by the appointment of a Disability Coordinator. This was identified as part of our Equal Employment Opportunities (EEO) work. Policy and support exists for the employment of people with a disability to be employed within their area of expertise
- access to an Employee Assistance Programme, including self referral, for all staff
- extension of the Occupational Health and Safety Service to include a Return to Work coordination function and a Liten Up programme (to provide training and equipment for manual handling activity)
- an Employee Wellness Programme to support healthy lifestyle change and choice by staff.

The seven key elements identified within the "good employer" model have been used as a base for developing CMDHB's human resource objectives within the Human Resources Strategic Plan. This directly links the Human Resources Strategic Plan with CMDHB's "good employer" obligations.

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 has a continual process of health needs assessment. The following characteristics of the Counties Manukau population are particularly noted (refer Population Profile and Health Indicators 2005 on the DHB's website www.cmdhb.org.nz for further detail):

- 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

- Mortality rates continue to improve for Counties Manukau people. Life expectancy rose 1.4 years from 2000-2005, and currently matches the New Zealand rate. Child mortality remains a concern, with premature birth, SIDS and motor vehicle injury the largest causes.
- The rate of hospitalisation have decreased by 5% since 2002 in children, and remained steady in adults. Of all 2005/06 hospitalisations, 32% might be considered potentially avoidable (35% of Maori, and 38% of Pacific admissions). This compared with 31% 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, respiratory illnesses, cellulitis, otitis media (glue ear), and gastroenteritis. 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 highly successful MeNZB campaign, and the Kidslink programme has seen other childhood immunisation rates go past 90%.
- 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 over-nutrition and inadequate exercise has slowed the decline of cardiovascular disease, still the largest killer in our community. It has also 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. Counties Manukau has a very high number of babies born to teenage mothers. Teenage delivery rates were very high for Maori (91 per 1000 15-19 year olds) and Pacific (48 per 1000) young people in 2005/06, in marked contrast to their European and other (17 per 1000)

counterparts, giving an overall CMDHB rate of 41 per 1000, much higher than the New Zealand rate of 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. Counties Manukau has fewer children caries free at age 5 compared with those living elsewhere in Auckland. Maori and Pacific children have a four-fold higher decayed/missing/filled rate of tooth decay than their Pakeha counterparts.
- 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 the national intervention rate was reached. Given the higher needs in the Counties Manukau population further increases are needed.
- Mental health services continue to expand to meet the needs of the CMDHB community. In 2005 1.9% of the Counties Manukau population used a mental health service, still lower than the NZ rate of 2.2%, or the target of 3%.

2.2 KEY ISSUES AND RISKS

There continue to be a number of underlying issues and risks the DHB faces which will take long term solutions to resolve. These include:

- the capacity of the health and disability sector to meet the community's health needs
- the need for improved co-ordination and communication between health providers to ensure continuity of care for patients
- the need to meet the community's expectations including access to health services and the quality of health services, to ensure they have confidence in the health and disability sector
- the need to meet the Minister's and Government's expectations regarding a break-even financial result (zero deficit) and compliance with Government strategies and policies
- the need for improved data collection, health surveillance, health research and programme evaluation

- 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, wage pressures and pricing inequalities between providers
- the need for workforce skills, capacity and availability, which impact on service delivery and patient outcomes.

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

- continuing collaboration with other DHBs within the region and nationally 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
- lifting our game with respect to quality improvement
- development and implementation of workforce, recruitment and succession planning strategies
- 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 and the next election) 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, Maaori health, Pacific health, primary referred services and oral health), mental health, and services for older people, and from 1 July 2007 DHB provided primary maternity services. The Ministry of Health retains funding responsibility for the remaining health and disability services including the balance of the primary maternity services, disability services for those under 65 years of age, (except for those clinically assessed by CMDHB geriatricians as close in age and interest), public health and national personal health contracts.

Service Devolved to CMDHB	Key activities and initiatives
Primary Health Care <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 • Implementation of strategies to increase primary care utilisation and increase the number of patients with chronic conditions whose care is managed through structured programmes • Implementation of the recommendations of the oral health plan • Implementation of strategies to increase immunisation coverage • Implementation of strategies to support workforce development
Maori Health Funding of 'by Maori for Maori' services including: <ul style="list-style-type: none"> • Chronic Care Management • Primary Health Care • Well child services including Outreach 	<ul style="list-style-type: none"> • Implementation of Whaanau Ora Plan (Maaori Health Plan)

Service Devolved to CMDHB	Key activities and initiatives
Immunisation <ul style="list-style-type: none"> • Breastfeeding support • Smoking Cessation • Public Health promotion • Sexual Health services 	
Pacific Health <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 Tupu Ola Moui (Pacific Health and Disability Action Plan)
Mental Health and addiction services <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"> • Implementation of the Mental Health Plans to improve the outcomes for people severely affected by mental illness • Implementation of primary care mental health initiatives including the expansion of the CCM programme to include a depression module
Services for older people <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
Secondary / Tertiary services (ie hospital and related services) <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 • Continued focus on elective services • 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 • Implementation of strategies to improve the capacity of the health sector to deliver quality services

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*[™].

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

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 2007/08

The Minister of Health sent all DHBs a 'Letter of Expectations' which identified priorities for 2007/08. This has been used, in addition to the New Zealand Health and Disability strategies and our District Strategic Plan (DSP), to plan what we do in 2007/08: Key priorities identified in the Minister's letters include:

- Chronic disease
- Child and youth services
- Primary health
- Health of older people
- Infrastructure, particularly information and workforce
- Value for money.

4.3 COUNTIES MANUKAU DHB'S STRATEGIC DIRECTION

The District Strategic Plan 2006-2011 uses as its framework six outcome areas that will be the focus for CMDHB 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/whaanau need** – a commitment to improving our community's access to timely and appropriate health and disability services in line with the rest of New Zealand; focussing on hospital and specialist services, elective services, primary care, services for older people and the integration between community based and hospital services.
6. **Improve the capacity of the health sector to deliver quality services** – to achieve the above 5 outcomes the DHB needs to ensure the appropriate infrastructure is in place, particularly workforce, facilities, information and quality systems, that all resources are efficiently applied, and all services provided from our hospital and by other contracted providers are safe.

The overarching direction of the District Strategic Plan (DSP) 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, and thereby enabling funding to be directed towards primary and community strategies in line with the DSP. 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). Also the DHB is placing an increasing emphasis on quality improvement this year with the establishment of the quality improvement team and the increased focus on improving clinical quality.

Work is underway to develop a Counties Manukau Health Services Plan (HSP) which translates the DSP into a 20 year view of health services delivery, including

models and locations of care. The first stage of HSP development will be completed in June 2007, with the second stage to be completed by June 2008.

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	Whaanau Ora Plan Tupu Ola Moui Regional Maori Mental Health Plan	Primary Health Care Plan Chronic Care Management Plan	Health Services Plan Facilities Modernisation Plan Long Term Financial Plan Workforce Plan Quality Plan

Part 5 FORECAST SERVICE PERFORMANCE: MEASURES AND STANDARDS

One of the functions of the SOI, in particular the Performance Measures and Targets, and Statement of Forecast Service Performance, is to show how we will measure our organisational performance against our commitments for 2007/08. 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 used current performance as our baseline data against which progress will be measured. The performance measures included in the SOI have been chosen based on their link to key priorities and are outlined in the District Strategic Plan. The DHB recognises that some of these measures will not perfectly measure progress towards achieving the longer term outcomes but, at the time of writing, are the most reliable measures available.

The performance measure tables on the following pages include national measures (which are consistent across all DHBs) together with local measures and targets. This section is structured along the six long-term outcomes outlined in the District Strategic Plan. We have included 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. CMDHB has identified 6 headline indicators, ie one per outcome, to annually monitor progress against the District Strategic Plan as part of the Sol. These are high level non-financial measures which will give the DHB an indication of how the implementation of the DSP is impacting health outcomes. These headline indicators are supported by other measures and objectives to provide a broad perspective of the DHB's activities.

For each measure, detail is provided on:

- The objective of the measure, ie what we are trying to achieve
- The performance measure itself, ie what is being measured
- Baseline/current performance figures and target performance figures for the next three years.

The measures are a reflection of how well the DHB is carrying out its main three functions or outputs of governance, planning and funding of health and disability services, and the provision of these services, against budgeted costs. The budgeted cost of these outputs for 2007/08 is as follows:

	Budget 2006/07 (\$m)	Forecast 2006/07 (\$m)	Budget 2007/08 (\$m)
Governance & Funding Administration*	7.7	8.1	10.4
Funder**	423.0	423.8	475.1
Provider Arm (Hospital)	493.2	483.2	529.8
TOTAL	923.9	915.1	1,015.2

* 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.

5.1 NATIONAL HEALTH TARGETS

As referenced in the Minister of Health's 2007/08 'Letter of Expectations', the 2007/08 year sees the introduction of ten health targets aligned to national strategic priorities. One target is to reduce the percentage of the health budget spent on the Ministry of Health and DHBs are not expected to provide direct contribution to achieving this. Two further targets; improving HEHA, and improving tobacco control are health sector targets, but it is expected that DHB activity will support achievement of each target. DHBs are expected to directly contribute to the achievement of the remaining seven targets and these are summarised in the following table alongside the local CMDHB targets:

Health Measure		CMDHB Target																				
Improving immunisation coverage	95% of two year olds are fully immunised with at least 4 to 6 percent point increase on 2005 national immunisation coverage survey baseline	2007/08 CMDHB target 75% Note: This target is set against the 2005 National Immunisation Coverage Survey (NICS) results, and progress for the 2007/08 year will be measured by a similar survey or an equivalent methodology agreed between CMDHB and MoH. CMDHB do not expect monitoring of progress to be against the NIR reporting for the 2007/08 year and hence we will not be providing quarterly narrative on the discrepancies between our target and the NIR Datamart quarterly reports.																				
Improving oral health	Progress is made towards 85% adolescent oral health utilisation	2007/08 CMDHB target 52%																				
Improving elective services	Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs). Each DHB will set an agreed increase in the number of elective service discharges, and will provide the amount of service agreed	2007/08 CMDHB targets ESPI 1 – 97% ESPI 2 – <2% ESPI 3 – <5% ESPI 4 – NA ESPI 5 – 3.0% ESPI 6 – 10% ESPI 7 – 3.0% ESPI 8 – 97% <table border="1"> <thead> <tr> <th></th> <th>Base</th> <th>Add.</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>E. CWD</td> <td>12292.13</td> <td>1315</td> <td>13607.13</td> </tr> <tr> <td>Est. E Discharges</td> <td>15650</td> <td>1979</td> <td>17629</td> </tr> </tbody> </table>		Base	Add.	Total	E. CWD	12292.13	1315	13607.13	Est. E Discharges	15650	1979	17629								
	Base	Add.	Total																			
E. CWD	12292.13	1315	13607.13																			
Est. E Discharges	15650	1979	17629																			
Reducing cancer waiting times	All patients wait less than 8 weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D)	The DHB acknowledges that the Health Target that all patients (100%) to wait less than 8 weeks between first specialist assessment and the start of radiation oncology treatment and will work with the provider DHB towards achieving this target. The Auckland region has a very strong relationship with the ADHB provider with regular operational meetings held with issues discussed. Where the target is in danger of not being met, the DHB will discuss this with the provider as soon as possible with a view to looking at feasible solutions.																				
Reducing ambulatory sensitive (avoidable) admissions (ASH)	There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0 - 74 across all population groups	2007/08 CMDHB Target Reduction in ASH Admissions <table border="1"> <thead> <tr> <th></th> <th>Total</th> <th>Maaori</th> <th>Pacific</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>0-4</td> <td>12</td> <td>0</td> <td>12</td> <td>0</td> </tr> <tr> <td>45-64</td> <td>72</td> <td>32</td> <td>0</td> <td>40</td> </tr> <tr> <td>Total</td> <td>109</td> <td>65</td> <td>44</td> <td>0</td> </tr> </tbody> </table> Targets based on NDMDS 12 month data to 30 September 2006 and MoH expectations		Total	Maaori	Pacific	Other	0-4	12	0	12	0	45-64	72	32	0	40	Total	109	65	44	0
	Total	Maaori	Pacific	Other																		
0-4	12	0	12	0																		
45-64	72	32	0	40																		
Total	109	65	44	0																		

Health Measure		CMDHB Target				
		This translates to the following target percentage difference from the national average.				
			Maaori	Pacific	Other	
		0-4	Remain below	7.6% above	Remain below	
		45-64	20.5% above	Remain below	8.6% above	
		Total	8.1% above	5.9% above	Remain below	
Improving diabetes services	<p>There will be an increase in the percentage of people in all population groups :</p> <ul style="list-style-type: none"> estimated to have diabetes accessing free annual checks on the diabetes register who have good diabetes management on the diabetes register who have had retinal screening in the past two years <p>There will be improved equity for all population groups in relation to diabetes management</p>	2007/08 CMDHB targets				
			Total	Maaori	Pacific	Other
		Detection & Follow-up volumes	11,866	1,934	4,306	5,626
		Diabetes Follow-up %	83%	60%	118%	75%
		Diabetes Management %	68%	60%	54%	82%
		Diabetic retinopathy screening	68%	68%	68%	68%
Improving mental health services	At least 90% of long-term clients have up to date relapse prevention plans (NMHSS criteria 16.4)	<p>2007/08 CMDHB Target</p> <p>90% of long-term clients have up to date relapse prevention plans</p> <p>75 client files audited per quarter for clients over two years registered. The DHB has defined 'up to date' as input made within a 3 month period.</p> <p>Note: CMDHB does not currently have the electronic information systems in place to capture the data required to support this indicator and will need to do this by way of a manual audit until such a system is in place.</p>				
<p>Improve nutrition</p> <p>Increase physical activity</p> <p>Reduce obesity</p>	<p>DHB activity supports achievement of these health sector targets</p> <p>Proportion (percent) of infants exclusively and fully breastfed:</p> <p>- 74% at six weeks; 57% at three months; 27% at six months.</p> <p>Proportion (percent) of adults (15+ years) consuming at least three servings vegetables per day, and proportion (percent) of adults (15+ years) consuming at least two servings fruit per day:</p> <p>- 70% for vegetable consumption; 62% for fruit consumption</p>	<p>CMDHB is committed to improving nutrition, increasing physical activity and reducing obesity as outlined in the District Strategic Plan. Specific objectives for 2007/08 are included in Part II Outcome 1 Improve community wellbeing and Outcome 2 Improve child & youth health.</p>				

Health Measure		CMDHB Target
Reduce the harm caused by tobacco	DHB activity supports achievement of health sector targets – <ul style="list-style-type: none"> • to increase the proportion of “never smokers” among Year 10 students by at least 2% (absolute increase) over 2007/2008 • to increase the proportion of smokefree homes with one or more smoker and one or more children to over 75% in 2007/2008 	CMDHB is committed to reducing the harm caused by tobacco. Specific objectives for 2007/08 are included in Part II Outcome 1 Improve Community Wellbeing, including the implementation of the Counties Manukau Tobacco Control Plan.
Reduce the percentage of the health budget spent on the Ministry of Health		

5.2 CMDHB DISTRICT STRATEGIC PLAN MEDIUM TERM OUTCOMES

OUTCOME 1 - IMPROVE COMMUNITY WELLBEING

Why is this important to Counties Manukau DHB?

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 public health services in this area, through the regional Public Health Service Alignment Group to ensure alignment of CMDHB and Ministry of Health priorities and outcomes.

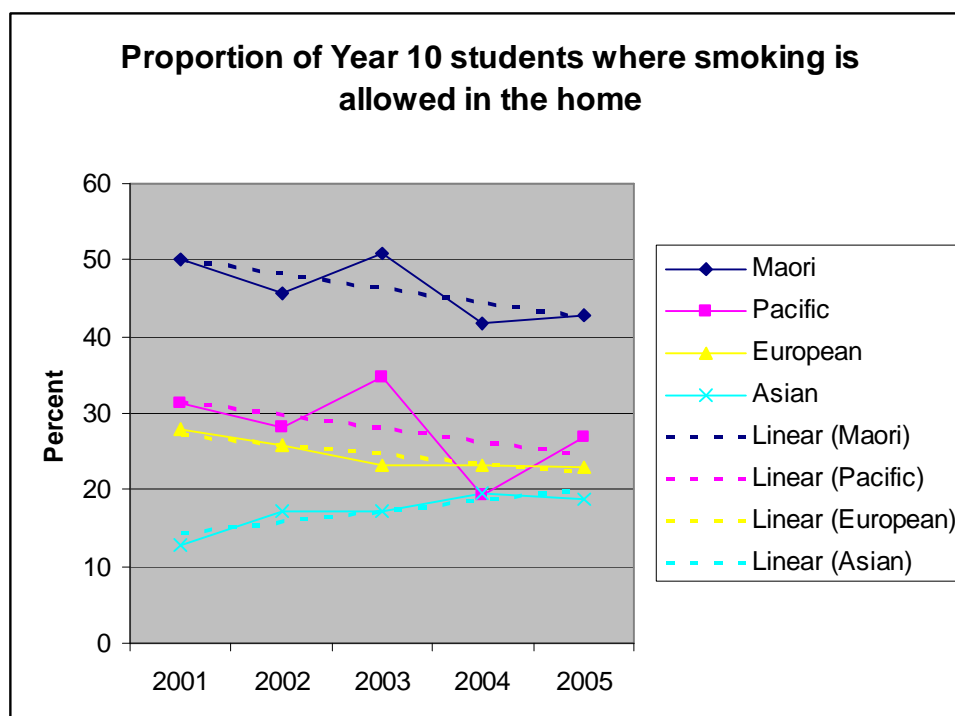
Implementation of the Let's Beat Diabetes Plan is a key focus for this outcome area and has been identified as one of the ten action areas. The Let's Beat Diabetes (LBD) Plan addresses many of the goals of the Healthy Eating Healthy Action strategy and includes wide-ranging initiatives to improve nutrition and increase physical activity, and reduce obesity. Further detail on LBD is available in the LBD 5-year and operational plans, including analysis of how funding applied to diabetes prevention and services will impact on outcomes, outputs and quality.

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards improving community wellbeing (Outcome 1).

- 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

Headline Indicator: Decrease the percentage of year 10 students from homes where smoking is allowed in the home



Baseline Data 05/06	Performance Targets		
	07/08	08/09	09/10
Maori 42.8%	41%	39%	37%
Pacific 27.0%	23%	21%	19%
Asian 18.8%	19%	18%	18%
Other 22.9%	21%	20%	18%

Other measures

Objective	Performance Measure	Baseline Data	Performance Targets			
			07/08	08/09	09/10	
Increase the proportion of adults who do at least 2.5 hours physical activity per week. (SPARC survey)	Percentage of adults who do at least 2.5 hours of physical activity per week	Maori	62%	No survey	68%	No Survey
		Pacific	63%		68%	
		European	70%		74%	
		Other	43%		52%	
		Total	65%		70%	
Increase the proportion of schools that are health promoting schools	Number of health promoting schools within the DHB	80/185	100/185	120/185	140/185	
Complete the target number of joint health and housing assessments done in the Healthy Housing Programme	Number of health and housing assessments done in calendar year	498 assessments done/ 300 target	450	300	300	

2007/08 Annual Objectives

Objective	Deliverable	Timeframe
Promote behaviour change through social marketing	Implement coordinated social marketing activities across Counties Manukau	30/06/08
Develop a Schools Accord to support 'fit and healthy' schools	Extension of Healthy Tuck Shop model to 8 other Counties Manukau schools	30/06/08
Using LotuMoui churches as health promoting environments to the Pacific community	250 church members to complete physical activity module	30/06/08
Develop and pilot the Whare Oranga concept	Implement the Whare Oranga pilot in two venues	30/06/08
Community liaison role contributes to distribution of DHB information including: <ul style="list-style-type: none"> o Regular attendance at public fora o Communication on specific plans 	Summary report outlining: <ul style="list-style-type: none"> • Public fora attended • Community liaison, engagement and consultation activities • Specific plans communicated. 	30/06/08

Output Class

The measures for Outcome 1 are included in the Funder and Provider Output classes.

OUTCOME 2. IMPROVE CHILD AND YOUTH HEALTH

Why is this important to Counties Manukau DHB?

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.

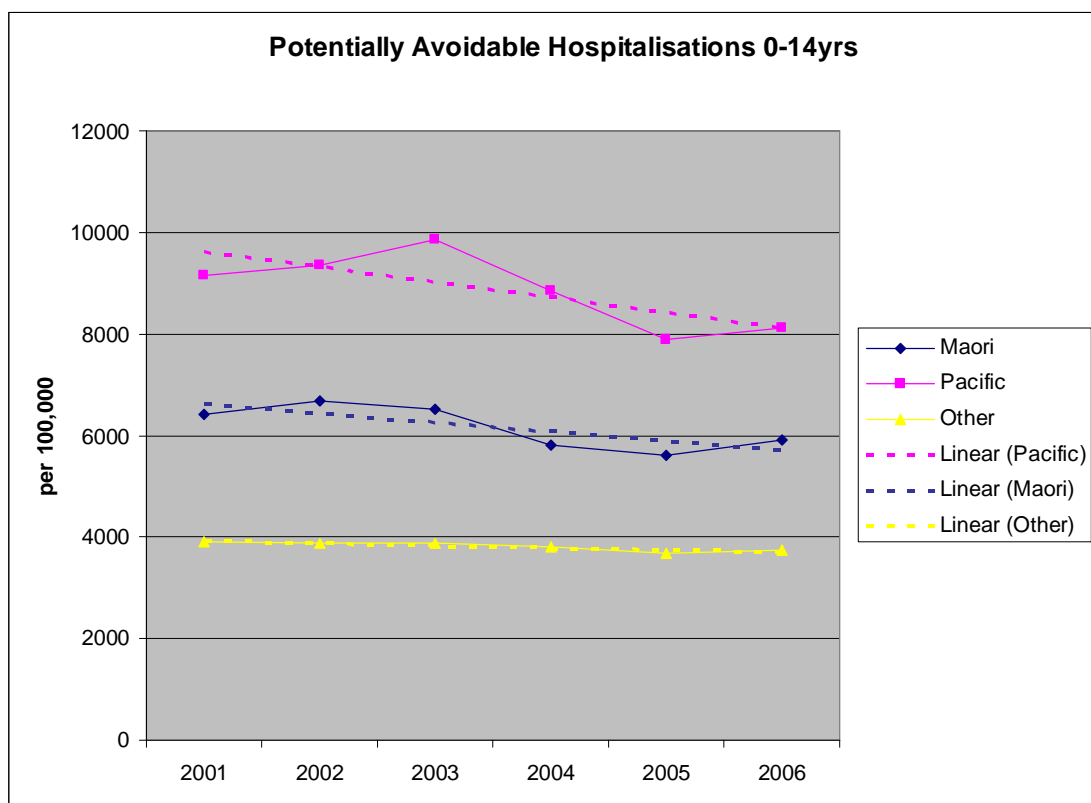
Child and youth health has been identified as one of the ten action areas. The focus for 2007/08 will be on continuing existing initiatives, including Baby Friendly Hospitals, Kidslink and NIR, and the implementation of the Child Health and Youth Health plans. The Whaanau Ora (Maori Health), Tupu Ola Moui (Pacific Health) and Oral Health plans also include strategies and initiatives to improve child and youth health.

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards improving child and youth health (Outcome 2).

- 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

Performance Measures

Headline Indicator: Decrease the number of preventable hospitalisations of children aged 0-14 years.



Baseline Data 2006		Performance Targets		
		07/08	08/09	09/10
Maori	5915	5713	5535	5356
Pacific	8138	8134	7835	7536
Other	3742	3709	3667	3625

Other Measures

Objective	Performance Measure	Baseline Data	Performance Targets		
			07/08	08/09	09/10
Decrease the admission and readmission rate for infants.	Percentage of babies born in the year who are admitted to hospital in their first year of life (other than at delivery)	Maori 25%	24%	23%	23%
		Pacific 29%	28%	27%	25%
		Other 15%	15%	15%	15%
		Total 23%	22%	21%	20%
Decrease the mean number of Decay, Missing or Filled (DMF) teeth in 5 year olds	Number of decayed, missing or filled teeth of children enrolled with the Dental Service in CMDHB	Maori 2.99	3	3	2.8
		Pacific 3.11	3.1	3.1	2.8
		Asian 2.05	2	2	1.9
		European 1.02	1	1	0.9
		Total 2.1	2.1	2.1	2
Reduce the number of births to teenage mothers (15-19 years)	Number of babies born to women 15-19 years old who reside in CMDHB	(Per 1,000)			
		Maori 90.6	87	84	81
		Pacific 47.9	50	48	46
		Other 16.8	16	16	15
		Total 40.8	40	39	38

2007/08 Annual Objectives

Objective	Deliverable	Timeframe
Implement the new Ministry of Health Service Specifications for Primary Maternity	• Sign off on service specifications	30/06/08
	• Develop new models of care particularly with regards to antenatal Shared Care (shared responsibility of named midwife and GP)	30/06/08
Baby Friendly Hospital accreditation for all three Community Maternity Units	• Gain accreditation for all 3 Units	30/09/07
Review the current outreach immunisation strategies and scope additional services to reach Maaori and Pacific children < 5 years of age	• New vaccination pilot for hard to reach implemented	30/06/08
Support initiatives that aim to reduce substance abuse and promote good sexual health	• Develop a primary healthcare training package with sexual health team	30/06/08

Output Class

The measures for Outcome 2 are included in the Funder and Provider Output classes.

OUTCOME 3. REDUCE THE INCIDENCE AND IMPACT OF PRIORITY CONDITIONS

Why is this important to Counties Manukau DHB?

CMDHB has identified the following priority conditions for focus as they are the leading causes of death and illness for our population, particularly 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 key areas (of the ten action areas) for priority. 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 like 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 like the chronic care management (CCM) programme. The priority conditions CMDHB will be continuing to focus on in 2007/08 are: cardiovascular disease, diabetes, congestive heart failure; chronic obstructive lung disease; depression; and renal disease. 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.

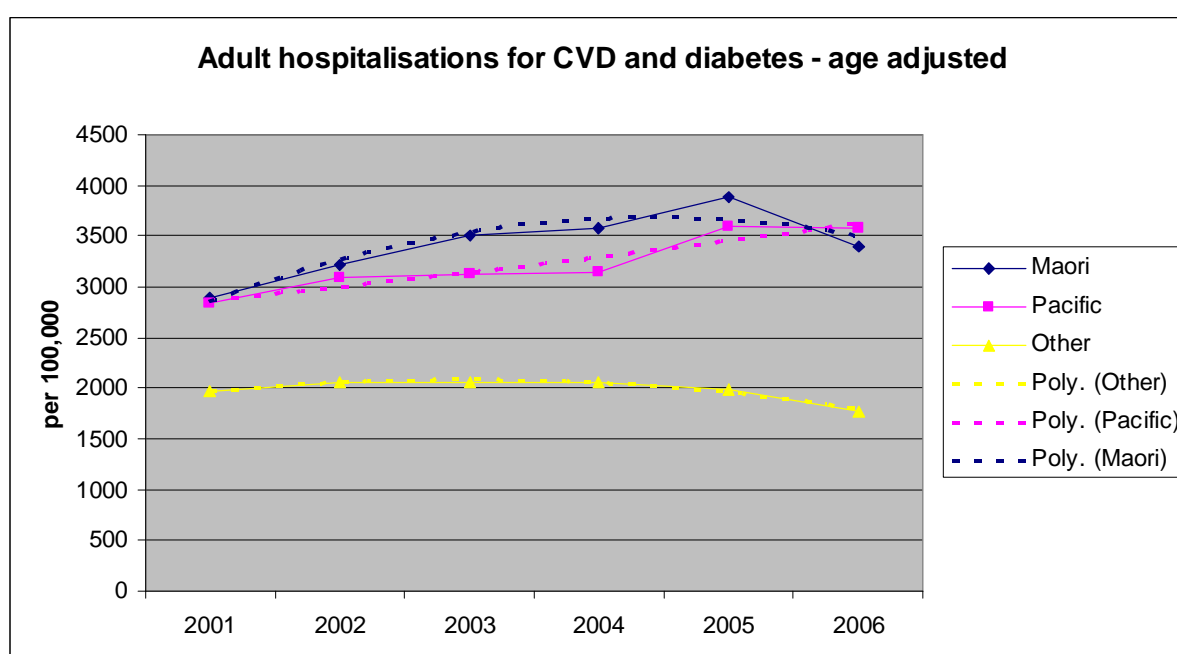
Within CCM there has been an increased focus on building capacity for patient self management and education; taking a family based approach to caring for those with chronic conditions; as well as introducing brief opportunistic intervention (lifestyle advice re exercise nutrition and smoking cessation). These programmes link to PHO Health Promotion plans and national campaigns such as HEHA and the Cancer Control Strategy. We will use the learnings from the Community Nutrition Project (as part of Let's Beat Diabetes) to inform the way self management is implemented so that the availability of consistent and reliable advice on nutrition and lifestyle interventions is readily available. 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.

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards reducing the incidence and impact of priority conditions (Outcome 3).

- 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

Performance Measures

Headline Indicator: Decrease the hospital admission rate for CVD and diabetes (adults).



	Baseline Data 2006 (per 100,000)	Performance Targets		
		07/08	08/09	09/10
Maori	3400	3400	3300	3200
Pacific	3585	3600	3600	3600
Other	1778	1800	1800	1800

Other Measures

Objective	Performance Measure	Baseline Data	Performance Targets		
			07/08	08/09	09/10
Increase the numbers of CCM enrolments for all five modules	Total enrolments in CCM programme (All enrolments minus disenrolments)	7250	9150	10000	11000
Increase the proportion of	Percentage of individuals with	Maori 53%	60%	62%	64%
		Pacific 125%	118%	100%*	100%*

Objective	Performance Measure	Baseline Data	Performance Targets		
			07/08	08/09	09/10
estimated number of people with diabetes who had an annual Get Checked free check	diabetes who have an annual free annual check * Target likely to be greater than 100% in line with baseline	Other 73%	75%	77%	79%
		Total 81%	83%	85%	86%
Increase the 2 year breast screening coverage for women aged 50-64	Percentage of women aged 50-64 who have had a breast screen in the last 24 months	Maori 50.4%	54%	56%	58%
		Pacific 45.5%	50%	52%	54%
		Other 55.1%	60%	62%	64%
		Total 53.8%	56%	58%	60%
Increase the proportion of the Counties-Manukau population with severe mental illness accessing mental health services	Percentage of people aged 20-64 seen by mental health services each month for the three months	0-19 years 1.6%	1.78		
		20-64 years 2.4%	2.6		
		65+ years 2.3%	2.46		
		Total 2.1%	2.31		
Note: the achievement of these targets is contingent upon the amount of additional Blueprint funding available each year.					

2007/08 Annual Objectives

Objective	Deliverable	Timeframe
Rollout of pharmacist services for CCM patients	<ul style="list-style-type: none"> 20% of pharmacies have services available to CCM patients 	30/06/08
Ongoing support of the primary mental health initiatives in 3 PHOs	<ul style="list-style-type: none"> Increase the number of patients enrolled in CCM depression by 500 via ongoing support for CCM depression pilot to June 2008 	30/06/08
Support initiatives that reduce the impact of cardiovascular disease	<ul style="list-style-type: none"> Pilot CVD risk assessment screening programme targeting 5% of eligible population Implement the CVD tool into 3 medical wards 	30/6/08

Output Class

The measures for Outcome 3 are included in the Funder and Provider Output classes.

OUTCOME 4. REDUCE HEALTH INEQUALITIES

Why is this important to Counties Manukau DHB?

A key indicator of health status is life expectancy at birth. Maori people living in Counties Manukau have a life expectancy ten years less than their European and other counterparts, and for Pacific peoples in Counties Manukau, the difference is five 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 with high levels of 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 a part of this outcome area but have not been included here to avoid duplication, e.g. implementation of the Let's Beat Diabetes Plan.

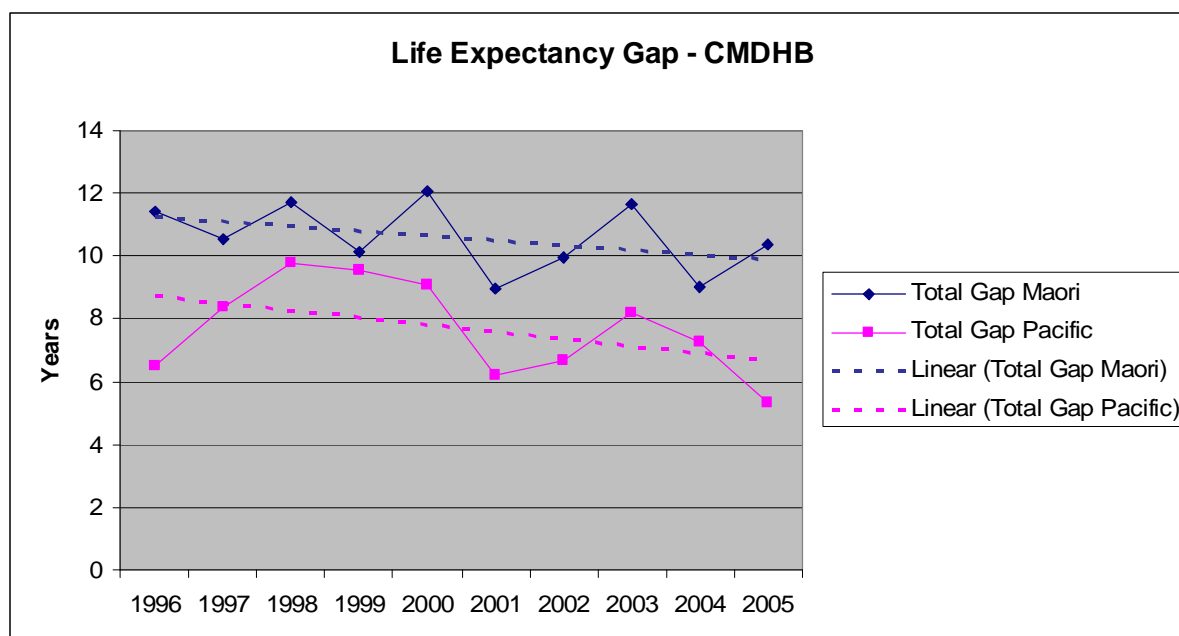
Key areas of focus for 2007/08, (ie from the ten action areas) to reduce health inequalities include service development in Maori, Pacific, and child and youth health (refer Outcome 2), and workforce development (refer Outcome 6). During 2005/06 CMDHB revised the Maori Health Plan (Whaanau Ora Plan) and developed Tupu Ola Moui (Pacific Health and Disability Action Plan), key strategies from each of these plans will continue to be implemented during 2007/08.

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards reducing health inequalities (Outcome 4).

- Address the systemic origins of inequalities
- Implement specific initiatives to reduce inequalities
- Improve ethnicity data collection

Performance Measures

Headline Indicator: Decrease the life expectancy gap.



Baseline Data 2005		Performance Targets		
		07/08	08/09	09/10
Maori	10.37	9.9	9.8	9.6
Pacific	5.33	6.7	6.4	6.2

Other Measures

Objective	Performance Measure	Baseline Data	Performance Targets			
			07/08	08/09	09/10	
Reduce the rate of potentially avoidable hospitalisations for adults	Number of adult hospital discharges considered potentially avoidable	(per 100,000)				
		Maori	8887	8750	8600	8400
		Pacific	9009	8900	8700	8500
		Other	4675	4650	4600	4550
		Total	5742	5700	5600	5500
Reduce the mortality rate for Maori and Pacific men aged 45-64 years	Number of deaths of male CMDHB residents aged 45-64	(per 100,000)				
		Maori	1062	1050	1000	950
		Pacific	762	750	725	700
		Other	419	400	390	380
		Total	533	520	520	510
Ethnicity data is collected accurately and completely in secondary care	Percentage of patients seen as inpatients who have ethnicity recorded as Not stated or Not defined	1.3%	<3% (national target)	<3%	<3%	

2007/08 Annual Objectives

Objective	Deliverable	Timeframe
Reduce non attendance at outpatient clinics for Maaori and Pacific populations	<ul style="list-style-type: none"> Review booking and scheduling processes and attendance of Maaori and Pacific populations at outpatient clinics 	30/06/08
Review and develop specific advocacy and information services for older Maaori and Pacific Island people	<ul style="list-style-type: none"> Develop and implement community engagement guidelines Implement advocacy services 	30/06/08
Support the development of high performing PHOs in improving outcomes for high needs groups	<ul style="list-style-type: none"> Establishment of a SIA/HP Innovation Award that recognises excellence in initiatives from PHOs that increase access and improve outcomes for high needs groups 	30/06/08

Output Class

The measures for Outcome 4 are included in the Governance, Funder and Provider Output classes.

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

Why is this important to Counties Manukau DHB?

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.

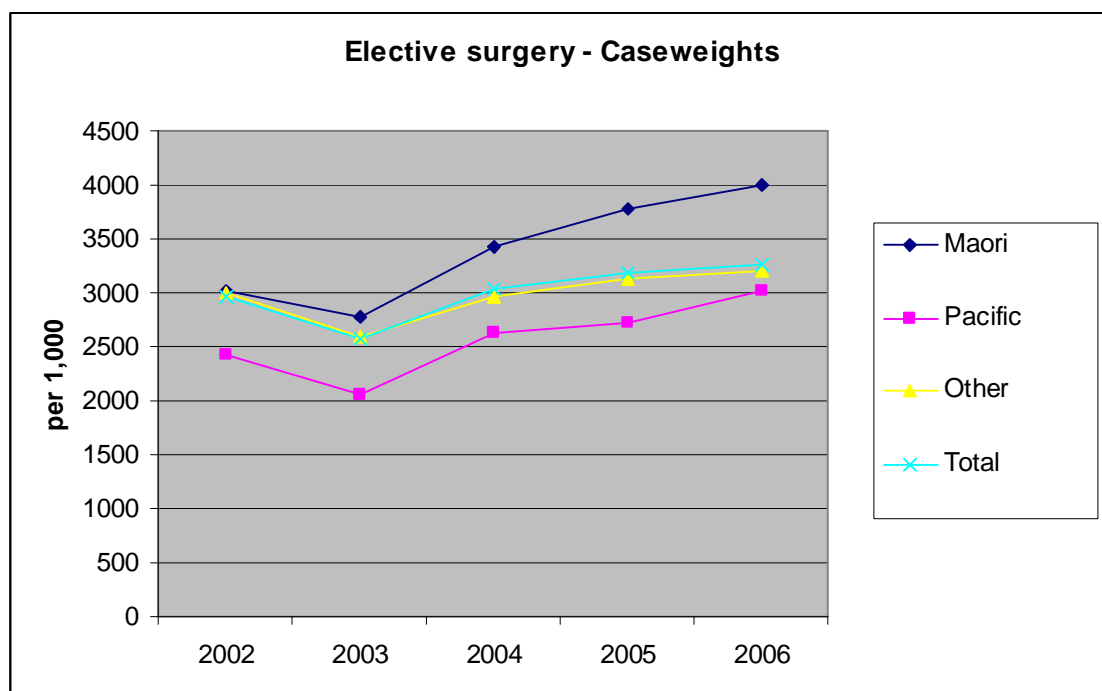
During 2007/08 CMDHB will focus on access to elective surgery, and will be progressing the implementation of the Primary Health Care Strategy. The DHB will also continue to progress initiatives to improve services for older people.

Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards improving health sector responsiveness to individual and family/whanau need (Outcome 5).

- Increase access to services so they align with national levels
- Improve access to and management of elective services
- Increase primary care utilisation
- 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.

Performance Measures

Headline Indicator: Increase the caseweight adjusted utilisation for elective surgery.



Baseline Data		Performance Targets		
		07/08	08/09	09/10
Maori	4005	4000	4050	4100
Pacific	3025	3100	3150	3200
Other	3197	3200	3200	3200
Total	3262	3300	3350	3400

Other Measures

Objective	Performance Measure	Baseline Data	Performance Targets		
			07/08	08/09	09/10
Increase the proportion of elective services which are at or above national access levels	Number of service groups (e.g. orthopaedics) where access is below the NZ average	5/13	3/13	3/13	3/13
Decrease the number of patients who have not been managed according to their assigned status and who should have received treatment	Percentage of patients with a priority score above the treatment threshold who have not received treatment within 6 months, or have been placed on active review but have not received a clinical assessment within the last 6 months	0.75%	<5.0%	<5.0%	<5.0%
Increase rate of GP consultations for high needs (Maori, Pacific, or living in decile 9 or 10 area) compared with non-high needs populations	Rate of GP consultations per high needs person	1.16	>1	>1	>1
Increase the ratio of expenditure on home based care to expenditure on residential care	Home based care expenditure as a percentage of residential care expenditure	28%	29%	30%	31%

2007/08 Annual Objectives

Objective	Deliverable	Timeframe
Deliver to base elective contract, orthopaedic and cataract initiative, and new elective surgery funding targets	<ul style="list-style-type: none"> Delivery against agreed contract schedule 	Monthly ongoing
Ensure all elective patients are seen and managed in a timely manner, consistent with Ministry	<ul style="list-style-type: none"> Green ESPI compliance is maintained on a monthly basis, and where a service 	Monthly ongoing

Objective	Deliverable	Timeframe
of Health guidelines	moves out of compliance it is returned within three months	
Develop comprehensive assessment guidelines for older people	<ul style="list-style-type: none"> Develop and implement cultural component in all clinical and support needs assessment and care planning 	30/06/08
Manage Acute Demand over winter Campaign to promote uptake of Flu Vaccines	<ul style="list-style-type: none"> Aim for 70% district coverage in over 65 year olds 	31/03/08

Output Class

The measures for Outcome 5 are included in the Funder and Provider Output classes.

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

Why is this important to Counties Manukau DHB?

Growing and retaining a workforce that serves the needs of our community and reflects its diversity is critically important. Having a sustainable workforce also represents a significant contribution CMDHB can make to the economic and social wellbeing of its local community.

With competition increasing to recruit and retain health professionals significant change needs to occur. It is not just about increasing workforce supply but also “how we work”. The current model is not sustainable and we need to design better models of care across both the hospital and community/ primary health care settings.

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

In terms of models of care there is a need to review existing roles and look at introducing new roles where appropriate. All this activity needs to take place in the context of continued regional and national collaboration and action (consistent with “*Future Workforce 2005:2010*”, DHBNZ 2005).

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

- adequate facilities to safely treat people
- information systems to assist with the delivery and planning of health services
- quality systems and processes which are people-centred, focusing on access and equity, safety, effectiveness and efficiency.

2007/08 will see the establishment of a quality improvement team, initially focussed on the delivery of hospital and related services, but in the medium term expanded to include community services such as residential care and primary care. Key projects for this team include:

- patient safety campaign
- Save 100 lives
- Physiologically unstable patients
- Patient flow.

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, value for money and efficient use of resources during 2007/08, as well as the enablers of the 10 action areas: service re-design, workforce and quality and safety. Regional

collaboration with the other metro-Auckland DHBs will be important to ensure progress in these key areas.

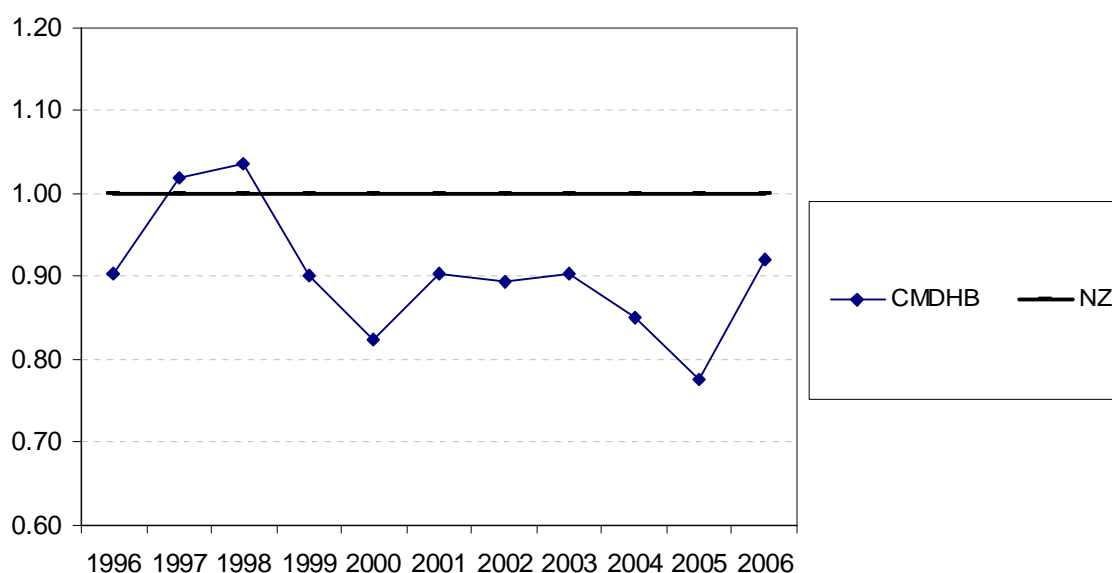
Counties Manukau DHB will continue to focus on the following medium term outcomes to work towards improving the capacity of the health sector to deliver quality services (Outcome 6).

- 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.

Performance Measures

Headline Indicator: Maintain a low in hospital mortality standardised rate

Overall in-hospital mortality standardised rates



Baseline Data 2006	Performance Targets		
	07/08	08/09	09/10
0.92	≤0.9	≤0.9	≤0.9

Other Measures

Objective	Performance Measure	Baseline Data	Performance Targets		
			07/08	08/09	09/10
Reduce the percentage of employees who voluntarily resign (Staff turnover – FTE)	Percentage of employees who resigned in the year	2.9%	<3.5%	<3.5%	<3.5%

Objective	Performance Measure	Baseline Data	Performance Targets		
			07/08	08/09	09/10
Reduce the ratio of communication patient complaints to the number of admissions	Proportion of communication complaints received to the number of admissions	0.21%	0.3%	0.3%	0.3%
Reduce the number of days where occupancy is greater than 90% (85%) in CMDHB facilities	Number of days in a financial year when more than 90% and 85% of beds in CMDHB facilities are occupied	90% - 19	90% - 30	90% - 30	90% - 30
		85% - 120	85% - 135	85% - 135	85% - 135
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					
Reduce unplanned readmissions within 1 month of discharge (the definition of this indicator is likely to be changed soon)	Percentage of patients admitted acutely within 30 days of discharge from the same specialty	7.22%	6.5%	6.5%	6.5%
The percentage of laboratory test and pharmaceutical transactions with a valid NHI	<i>Pharmaceuticals:</i> Percentage of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted. <i>Laboratory tests:</i> Percentage of tests carried out by community laboratories in the DHB district with a valid NHI submitted.	<i>Pharmaceuticals:</i> 92%	92%	94%	95%
		<i>Laboratory:</i> 92.8%	93%	94%	95%

2007/08 Annual Objectives

Objective	Deliverable	Timeframe
Health service planning is integrated across care settings	<ul style="list-style-type: none"> Stage 2 development of HSP using established system/process and framework with medium to long term horizon Roll out of agreed models of care changes from HSP Stage One completed in June 2007 	30/06/08
Improvements in EC triage times as a result of systems redesign and GP after hours/EC project	<ul style="list-style-type: none"> Redesign EC processes Staged introduction of national EC disposition tool to primary care 	30/06/08
Services provided by CMDHB are safe and effective	<ul style="list-style-type: none"> Implement the CMDHB 2007/08 Quality & Risk 	30/06/08

Objective	Deliverable	Timeframe
	Action Plan	
Implement a health research strategy which is aligned with the DHB's strategic direction and encourages the undertaking and participation in health research and clinical audit to deliver benefits to patients	<ul style="list-style-type: none"> Finalise five year Research and Audit Strategic plan focusing initially on building CMDHB capability (infrastructure, facilities and staff resources) to undertake research and clinical audit 	30/06/08
Recruit and retain staff	<ul style="list-style-type: none"> Implement the CMDHB workforce development plan 	30/06/08

Output Class

The measures for Outcome 6 are included in the Funder and Provider Output classes.

Part 6 STATEMENTS OF FINANCIAL PERFORMANCE

6.1 FINANCIAL STATEMENTS

Statement of Financial Performance						
\$000	2005/06	2006/07	2006/07	2007/08	2008/09	2009/10
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Revenue	862,670	921,059	917,951	1,013,884	1,044,227	1,075,477
Operating Costs	824,354	873,624	871,307	964,350	991,742	1,020,211
EBITDA	38,316	47,435	46,644	49,534	52,485	55,265
Depreciation	20,861	25,778	20,663	22,774	24,274	25,524
Interest	5,805	9,004	7,077	11,056	12,556	14,056
Operating Results before Capital Charge	11,650	12,653	18,904	15,704	15,655	15,685
Capital Charge	7,207	12,634	12,623	15,585	15,631	15,633
Operating Surplus	4,443	19	6,281	119	24	52
Carried Forward costs	(3,051)	(6,000)	(3,500)	(1,500)	(1,500)	
Surplus / (Deficit)	\$1,392	\$(5,981)	\$2,781	\$(1,381)	\$(1,476)	\$52

Allocation of Retained Earnings

\$000	2005/06	2006/07	2006/07	2007/08	2008/09	2009/10
	Actual	Budget	Forecast	Budget	Estimate	Estimate
Opening Balance c/fwd	6,289	7,681	7,681	10,462	6,295	4,819
Operating Surplus	4,443	19	6,281	119	24	52
Allowable spending C/fwd	(3,051)	(6,000)	(3,500)	(1,500)	(1,500)	-
NZIFRS adjustment				(2,786)		
Closing Balance	7,681	1,700	10,462	6,295	4,819	4,871

Summary by Output Source						
\$000	2005/06	2006/07	2006/07	2007/08	2008/09	2009/10
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Funder - Arm						
Revenue	795,832	840,338	840,338	945,152	973,510	1,002,715
Expenses	796,862	843,662	844,843	945,340	974,568	998,901
Surplus / (Deficit)	(1,030)	(3,324)	(4,505)	(188)	(1,058)	3,814
Governance - Arm						
Revenue	8,109	6,297	6,784	8,998	9,376	9,758
Expenses	9,066	7,659	8,129	10,392	10,802	11,226
Surplus / (Deficit)	(957)	(1,362)	(1,345)	(1,394)	(1,426)	(1,469)
Provider - Arm						
Revenue	457,360	491,916	491,916	529,994	545,819	562,119
Expenses	453,980	493,211	483,285	529,794	544,811	564,412
Surplus / (Deficit)	3,380	(1,295)	8,631	201	1,008	(2,293)
Eliminations						
Revenue	(406,048)	(420,587)	(421,087)	(470,260)	(484,478)	(499,115)
Expenses	(406,048)	(420,587)	(421,087)	(470,260)	(484,478)	(499,115)
Surplus / (Deficit)	-	-	-	-	-	-
DHB – Total	\$1,392	\$(5,981)	\$2,781	\$(1,381)	\$(1,476)	\$52

Statement of Financial Position						
\$000	2005/06	2006/07	2006/07	2007/08	2008/09	2009/10
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Current Assets	29,718	49,717	24,473	27,624	28,585	31,835
Current Liabilities	149,794	169,235	162,295	205,644	191,615	200,924
Working Capital	(120,076)	(119,518)	(137,822)	(178,020)	(163,030)	(169,089)
Non-Current Assets	371,311	398,903	412,557	447,163	468,994	455,670 ¹
Net Funds Employed	\$251,235	\$279,385	\$274,735	\$269,143	\$305,964	\$286,581
Total Non-Current Liabilities	78,621	122,267	79,384	77,990	116,337	96,952 ¹
Crown Equity	172,614	157,118	195,351	191,153	189,627	189,630
Net Funds Employed	\$251,235	\$279,385	\$274,735	\$269,143	\$305,964	\$286,582

Statement of Movement in Equity						
\$000	2005/06	2006/07	2006/07	2007/08	2008/09	2009/10
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Opening Balance	88,402	163,063	172,614	195,351	191,153	189,627
Surplus / (Deficit)	1,392	(5,981)	2,781	(1,381)	(1,476)	52
Transfer of restricted funds		36	(44)	(30)	(50)	(49)
NZIFRS adjustment				(2,786)		
Revaluation Assets	82,820		20,000			
Closing Balance	172,614	\$157,118	195,351	191,153	189,627	189,630

Statement of Movement in Cash Flow						
\$000	2005/06	2006/07	2006/07	2007/08	2008/09	2009/10
	Actual	Budget	Forecast	Draft Budget	Estimate	Estimate
Operating	30,142	19,828	35,519	23,135	24,717	26,358
Capital Expenditure	(46,070)	(59,000)	(41,909)	(57,380)	(46,105)	(12,200) ¹
Financing	17,412	47,000	(702)	34,245	21,388	(14,158) ¹
Net Cash Flow	1,484	7,828	(7,092)	-	-	-
Opening Cash	6,123	(13,552)	7,607	515	515	515
Closing Cash	\$7,607	\$(5,724)	\$515	515	515	515

1. Excludes \$30.0m (estimate) of non-approved strategic facility investment.

6.2 OVERVIEW

Counties Manukau DHB is continuing to forecast a zero operating deficit following the trend of previous years. This is despite significantly increased cost pressures (particularly wage and salary growth which continues to be in excess of FFT) combined with a Board commitment to increased investment in District Strategic Plan priorities, while maintaining the standard of service delivery set in the previous four years. The forecast small operating surplus of \$119k is at the operating financial position level and excludes either the revenue or cost impact of any ministerial elective initiatives, or the carrying forward of any surgical elective volumes and priority initiatives under spent in the 2006/07 year. Further it is proposed, that the balance of previous years operating surpluses continue to be utilised to assist the achievement of the DHB's objectives; specifically a commitment to recovering elective volumes shortfalls and investments in further priority initiatives aligned with the District Strategic Plan. Provisionally \$1.5m has been formally included in the first two years of the DAP. However it is likely that the Board will seek to lift the investment level in these areas, within the limits of the carried forward earnings.

The 2007/08 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 recognition of the full costs of the recent MECA settlements, as referred to later, as well as the impact of the very significant IDF outflow and pricing adjustments.

We have continued to put considerable pressure and demand on the financial position of the organisation in order to meet the Board's requirement to identify and "ring fence" 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 \$15million annually, up from \$10million in the previous year.

As previously, to achieve the District Annual Plan operating position in 2007/08, 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:

- § There is an increasing likelihood that there will be a need for an asset revaluating to be carried out during the future financial years (2007/08, 2008/09, 2009/10) due to increased land and building costs. At the current point in time we have budgeted for a revaluation of \$20.0m in June 07. However this will depend on whether or not the valuation has a material impact on the financial statements. If this did occur, then there would be related depreciation and interest costs which are unlikely to be reimbursed by Ministry of Health on a yearly basis
- § funding for the Health of Older People income and asset testing recalculation is sufficient to match our forecast level. Reconciliation and resolution of this issue is still outstanding.
- § PHO Top-Up reimbursements continue from the Ministry of Health as previously
- § all mental health funds, including "Blue-Print", continue to be "ring-fenced", with a neutral impact on the consolidated position.

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 2.6 percent (net) funded level, specifically:
 - significant national wage settlements, with flow on-costs, well in excess of the MoH funded levels (including recognition of the automatic ongoing step function on-cost implications)
 - the introduction of the Holiday Act extra week funding
 - 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 in 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 renal growth volumes, albeit at a growth level slightly below the extremes of previous years

- § the absorption of significant pricing adjustments to inter-district flows (IDFs) and the volume of IDF outflows.

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, particularly in the two outer years of this DAP
- § meeting the communities' expectations now that the DHB has been moved to equity from a population based funding perspective and with regard to community participation in decision-making
- § the financial risks associated with demand driven services, in which volume growth outstrips funding. Also, risks arise from poor historical data, assumed savings being built into the forecast, price pressures, and pricing inequalities between providers
- § wage price pressure continuing to emanate from union expectations and the increasing international nature of the health labour market, leading to clinical staff shortages. There are also potential relativity flow on risks associated with the current Police wages settlement which would directly impact on nursing salary/wage levels.

Risk mitigation strategies (refer also Part I), 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 maximising the benefits of the recently established 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.

6.3 FINANCIAL MANAGEMENT

6.3.1 Specific Cost Pressures – Wage pressure

Within the Provider arm, basic wage increases are built in at the levels of actual settlements either finalised or indicative settlement levels, most of which are now MECA based. Over and above those base salary and wage movements, CMDHB is, along with other DHBs, experiencing very significant levels of on-costs, including ever-increasing step functions, allowances and superannuation, primarily around medical and nursing staff entitlements. Of note is the flow on of the nursing-related jolt payments to other non-reimbursed groups, which is occurring in award claims with potential consequent impact on all DHBs. As well there is a likelihood of further relativity claims for nursing (and related activities) given the recent Police wages settlement of 4%+4%+1% over the next three years..

Step increases: In most cases staff are entitled to move up a step after each year of service, which results in an average 2.5% (net) increase. The step function increases have to be absorbed by direct funding or by way of efficiencies. In a number of cases the minimum step has been increased, e.g. 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. At the level of current step function increases, it is becoming impossible for any DHB to simply absorb this and this is now having to be funded, at least in part, given these are national settlements and agreed to on this basis.

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.

6.3.2 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 initially under the general heading of Facilities Modernisation Programme and more latterly as a completely separate development phase 2 has been renamed "Towards 20:20".

- Phase 0 has been completed in the last 12 months and included the complete radiology refurbishment and Middlemore-wide site infrastructure upgrade.
- Phase 1 is similarly now virtually completed including Neonatal Intensive Care Unit, the National Burn Unit, the Catheterisation Laboratory, fit out of Manukau Surgical upper floor and the extension to the Adult Medical Centre. These are now all fully operational.

- Towards 20:20 (previously Phase 2) involves the development of a wider more comprehensive CMDHB service delivery strategy across both Middlemore and Manukau sites.

As part of “Towards 20:20” we are now well advanced in determining the medium to long term organisational requirements (15-20 year horizon). This is being driven by extensive internal and external consultation, the roll out of the Clinical Services Plan (primarily Provider focused) to the Health Services Plan (community-wide focus) and coordinated with the Asset Management Plan as supported by the Ministry of Health.

We have now received Ministerial sign-off for Stage 3 of the Core Consolidation encompassing the building of a new ward and clinical services block on the Middlemore site and the full refurbishment/upgrade of the gynaecology and early pregnancy service on the same site. The capital cost of this is \$36.5m of which funding support of \$25m had been requested. National Capital Committee supported the Business Case in December 2006 and the formal Ministerial approval letter was received in March 2007.

To date CMDHB has been able to fully fund all capital requirements through either internal cash generation or available debt facilities, whereas “Towards 20:20” as described above is seeking Ministerial financial support of \$25m against the total cost of projects undertaken to date of almost \$300m i.e. CMDHB has, through its existing free cashflow or debt facilities, contributed \$275m of the required funding.

It is anticipated that strong growth requirements for CMDHB will continue and as such outstrip the ability for CMDHB to fund either internally or from existing debt facilities. Ongoing discussions continue with Ministry and Treasury officials in regard to these requirements and the very clear need of further ministerial support in future “Towards 20.20” phases, given the anticipated significant overall capital requirement outlined in the Asset Management Plan and the current Core Consolidation Business Case. While there may be some fine tuning (driven by the benefits of primary care initiatives or other rationalisations) of these requirements, nonetheless the underlying forecast continuing significant growth of CMDHB will have to be met through improved or additional facilities incorporating substantial clinical equipment purchase or replacement.

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

Towards 20.20 involves the development a wider and more comprehensive CMDHB service delivery strategy reflecting future growth requirements. The Business Case for the first step in Project Excel was to be presented at the October 2006 National Capital Committee meeting.

Note: Beyond the “Towards 20:20”, no business cases have been completed for years 4 to 20. Therefore, for the purposes of capital expenditure no strategic capital

has been included. 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 is that a forecasted total of \$535 million will be required in incremental capital spend 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 and Health 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. Further, CMDHB has initiated a series of national sustainability conferences in recognition of the wider national issues arising from these forecasts. The first of these addressed workforce planning, the second (to be held in June 2007) to address "Funding Tomorrow's Health" i.e. fundability and affordability and the third (planned for November/December 2007) to consider and challenge current models of care/change management. While these funding issues within this DAP relate specifically to CMDHB, nonetheless there are clear indications that our challenges would be mirrored ultimately through the public health sector.

It is important to note, however, that a significant proportion of the forecast capital requirements for "Towards 20:20" can be internally funded i.e. free cashflow. In the current forecast to the period 2010, CMDHB requires only \$100m, 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. This is slightly down on the previous forecast as a result of further maximising cashflow management and reassessment of asset lives and depreciation

6.3.3 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 has transitioned all bank debt facilities to the Crown Health Financing Agency, the institutional bonds will remain in place until maturity. In addition the Board maintains 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 be completed with the transference of the existing bonds of \$70m which mature in September 2007.

Facilities	Existing
CHFA	\$127.0m
Commonwealth Bank (working capital)	\$45.0m
Westpac (lease agreement)	\$10.0m
Bonds (to be replaced by CHFA funding)	\$70.0m

Covenants

	2005/06	2006/07	2007/08	2008/09	2009/10
Debt/Equity + Debt <65% <i>Long Term + Current Private Debt / Total Equity</i>	36.3%	33.3%	41.0%	44.9%	42.7%
Cash Interest Cover (Times) >2.5 <i>EBIDA (excl Cap Chge) / Interest Expense</i>	6.6	6.6	4.5	4.2	3.9

6.3.4 Cash Position

The forecast cash position of CMDHB assumes effectively a cash neutral position through full utilisation of free cash flow and available approved debt facilities to match the level of capital all expenditure requirements in 2007/08 including both new and replacement assets. Although we have still to complete the final review of all capital expenditure requests (and therefore confirm the associated depreciation levels), capital expenditure related to the 2007/08 year will be limited to \$57.4m, increased by the existing approved Towards 20.20 projects relating to current and future years.

Overall we are therefore confident of meeting all reasonably anticipated cash outflows for 2007/08 through both the achievement of the zero deficit operating position and utilisation for capital purposes of the existing unutilised/approved debt facilities.

However, the forecast cash position is anticipated to improve as referred to under the later paragraph 'Outlook for 2008/9 year and 2009/10 year'. This position is anticipated given the removal of non approved strategic capital in the 2009/10 year.

6.3.5 Capital Charge

The District Annual Plan continues to include the matching of cost and revenue on the higher capital charge arising from the anticipated asset revaluation on a three yearly cycle.

6.3.6 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, implementation of new services for breast screening, catheterisation laboratory and MRI. 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.

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

Women's health cost pressures continue particularly relating to Section 88 maternity compliance costs, as well as a birth rate well in excess of national averages (over 4%) and growing beyond population based funding levels.

With the exception of the areas identified above, there has been some very encouraging stability around hospital acute growth levels overall. At February 2007, WIES volumes on the base MoH contracts are only up 0-1% on the previous year. The District Annual Plan has been based on absorption of any increases in acute growth levels within overall funding limitations.

CMDHB remains committed to recovering the anticipated shortfall in carried forward elective volumes that may result in 2006/07. This will be achieved through a combination of both internal and external resources in 2007/08. Please also note this is currently excluded from all financial analyses as it is currently uncertain as to what the magnitude of this carried forward shortfall will be. Please note that CMDHB remains confident of fully achieving its contracted volumes for the 2006/07 year. If there is a shortfall in achievement of the carried forward volumes, then these would, as previously, be funded through the utilisation of the remaining part of the surplus forecast to be carried forward at 30 June 2007.

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 0.5% (or approximately \$3m) to be

able to contribute to the significant investment in new and existing priority initiatives. These initiatives, aligned with the District Strategic Plan, are focused 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, capacity planning tool utilisation, regional benchmarking, change management/model of care reviews and continuing healthAlliance efficiency reviews.

For the third consecutive year CMDHB expresses concern around forecast increases in utility costs in the areas of gas, electricity, fuel costs and water following on from similar increases over the last two years. Again as previously there appears to be little and probably no financial advantage in metro-Auckland 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 continue to be a major focus for CMDHB within the District Annual Plan and are essential to offset both volume cost growth and to fund essential investment in primary care initiatives to ultimately minimise secondary care volume impacts and improve health outcomes for the Counties Manukau community.

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

New resourcing models within theatres are improving both clinical efficiency and reducing costs as anticipated 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 services and 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 only by new services, funded services or clinical safety drivers. It is notable that within the FTE trend analysis virtually all growth is within the clinical areas or direct clinical support, other than those directly associated with primary care initiatives in the funder arm. As previously, FTE increases are subject to regular 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, an earlier external review highlighted the potential need for increased investment, relative to shareholders very high level of expectation. Further reviews of previous cost benefit analysis work will be done in this regard over the next six to twelve months, but it is likely that investment will be necessary to maintain the momentum required by the provider arm as well as the very significant needs around the capture of primary care and community level information.

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

There have continued to be 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 each use the same payroll software and can thus share and learn from each others experiences.

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

A particular risk for hA, which will directly impact on CMDHB, WDHB and ultimately all DHBs, is the position being indicated that will be taken by the Inland Revenue Department around the taxability of recruitment costs. CMDHB, given the international shortage of health professionals, is forced to recruit extensively overseas with associated recruitment and relocation costs. The position being taken by the IRD, if successful, could increase our employee-related recruitment costs by 64% relating to the “grossing up” of relocation costs. This is a material potential exposure for all DHBs and is the subject of a formal submission to IRD from CMDHB on behalf of the sector.

6.5 MAAORI HEALTH

The Maaori health budget for 2007/8 is a continuation of the work carried out during the previous financial year to embed the Whaanau Ora Plan. The budget is in line with the six priority areas, they being:

- 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 Maaori
- Developing the infrastructural supports required to support the provision of services

Significant injection will occur in the areas of lifestyle risk factors, infrastructure development and Tamariki and Rangatahi health as look to increase proactive engagement with the Maaori community.

The budget reflects the refining of our approach to work more collaboratively with our Maaori communities. To this end we will be investing up front in the engagement of Maaori communities in new and existing activities. We do not underestimate the resource required to achieve this, but see its alignment with the Whaanau Ora vision, **Whaanau Ora – Maaori Ora**.

Once again, Maaori 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 Maaori Health consolidated internal budget for 2007/8 totals \$6,918,207 and is made up of \$5 218 207 being the internal operational budget (this includes both the provider arm, funding and planning governance and administration budget) plus \$1,700,000 being the additional component to operationalise the Whaanau Ora Plan. This represents a target percentage increase for Maaori health for 07/08 of 36%, a significant increase and a 15% increase when you include Mental Health, DSS Maaori spend. For 08/09 and 09/10 the projected target increases are 14.2% and 2.50% respectively. This is indicative of the three year process the Board has implemented with regards to implementation of the Whaanau Ora Plan, which started in 06/07 through to 08/09, at which point further investment decisions will be made.

The funding and planning arm increase for the upcoming year is reflective of the growth in new services committed by the DHB as part of implementing the Whaanau Ora Plan. This has also been signalled above. Further infrastructure within the team will also be a part of this implementation process. The provider arm services amalgamate this year, to refine further service delivery on the hospital grounds.

The external provider budget increase of 2.4% is in line with FFT increases and does not include the committed extra funding needed to implement the Whaanau Ora plan. There is significant funding increases for the provision of 'by Maaori, for Maaori' services, which is reflective of the priority area identified in the Maaori health plan.

This pathway of increased commitment to Maaori health initiatives is forecast to continue in 2008/9 with it to be reviewed at the end of that year.

The Maaori Provider Development Scheme will continue to be administered through Tainui MAPO with the assistance of CMDHB and will reflect the increasing Maaori population for Counties Manukau.

6.6 OUTLOOK FOR 2008/09 AND 2009/10

We have completed the two outer years of the DAP based on the indicative funding levels advised by MoH/Treasury. We have, however, calculated at a higher level, the anticipated cost increases in those outer years at realistic levels based on both current or anticipated wage settlements, general cost increases and specific calculations around financing costs of depreciation, interest and capital charge.

As a result, a small operating surplus is forecast for the years 2008/09 and 2009/10. Note however that the year 2009/10, while showing a small operating surplus, makes no allowance for the cost impacts (depreciation, interest, operating costs) of unapproved strategic capital expenditure.

6.7 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.

The years 2005, 2006, and 2007 are produced under GAAP and the future years 2008, 2009, 2010 are produced under New Zealand International Financial Reporting Standards (NZIFRS).

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 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. Each year the Land and Buildings are subject to a review for any material variation. 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 2006.

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%)
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

- *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 2007 there are expected to be 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

The only change in accounting polices has been the introduction of New Zealand International Financial Reporting Standards with effect from 1 July 2007. Counties Manukau DHB is fully compliant with all requirements.

6.8 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 Admissions
AUT	Auckland University Technology
BSA	Breast Screening Aotearoa
BSI	Blood Stream Infections
CAG	Clinical Advisory Group
CCM	Chronic Care Management
*CFA	Crown Funding Agency (future debt funder)
CHF	Congestive Heart Failure
CIU	Cardiac Investigation Unit
CLS	Community Living Skills
CMDHB	Counties Manukau District Health Board
CME	Continuing Medical Education
COPD	Chronic Obstructive Pulmonary Disease
CPHAC	Community and Primary Health Advisory Committee
CQI	Clinical Quality Improvement
CTA	Clinical Training Agency
CVD	Cardio Vascular Disease
CWD	Case Weighted Discharges
CYFH	Children, Young People and Family Health Services
DAP	District Annual Plan
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DiSAC	Disability Support Advisory Committee
DNA	Did Not Attend
DOSA	Day of Surgery Admission
DRGs	Diagnostic Related Groups
DSP	District Strategic Plan
DSS	Disability Support Services
ECLAOP	Emergency Care Local Anaesthetic Operative Procedure
EMT	Executive Management Team
ESPI	Elective Service Performance Indicator
FAMA	Frequent Adult Medical Admissions
FMP	Facilities Modernisation Project
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full-time equivalent (Employees)
GAAP	Generally Accepted Accounting Principles
GL	General Ledger

Acronyms	Description
GP	General Practitioner
hA	healthAlliance
HBI	Hospital Benchmark Information
HNA	Health Needs Analysis
HOP	Health of Older People
HR	Human Resources
HSP	Health Services Plan
ICU	Intensive Care Unit
IDF	Inter District Flows
IDP	Indicator of DHB Performance
IFRS	International Financial Reporting Standards
IS	Information Systems or Services
ISSP	Information Services Strategic Plan
IT	Information Technology
KF	Kidz First
KPIs	Key Performance Indicators
LOS	Length of Stay
MACS	Medicine, Acute Care and Clinical Support Services
MAPO	Maaori Advisory Purchasing Organisation
MECA	Multi Employment Collective Agreement
MeNZB	Meningococcal B Vaccine New Zealand
MHAC	Maaori Health Advisory Committee
MHINC	Mental Health Information National Collection
MIT	Manukau Institute Technology
MMH	Middlemore Hospital
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 Admissions
PAM	Performance, Assessment and Management
PCD	Primary Care Development
PHAC	Pacific Health Advisory Committee
PHO	Primary Health Organisations
POAC	Primary Options to Acute Care

Acronyms	Description
RC	Responsibility Centre
RISSP	Regional Information Services Strategic Plan
SAC	Surgical and Ambulatory Care Services
SIA	Services to Improved Access
SLA	Service Level Agreement
TBC	To Be Confirmed
TLA	Territorial Local Authority
WDHB	Waitemata District Health Board
WIES	Weighted Inlier Equivalent Separation = Weighted Relative Value Purchasing Unit for medical and surgical Inpatient services
YJN	Youth Justice North
YTD	Year to Date