

**Counties Manukau District Health Board
2010/11 District Annual Plan**

June 2010



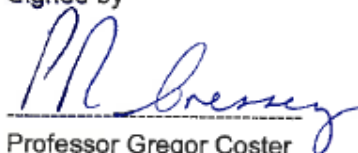
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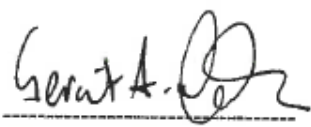
District Annual Plan Dated This _____ Day of _____ 2010.

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

ISSUED BY
Counties Manukau DHB

Signed by

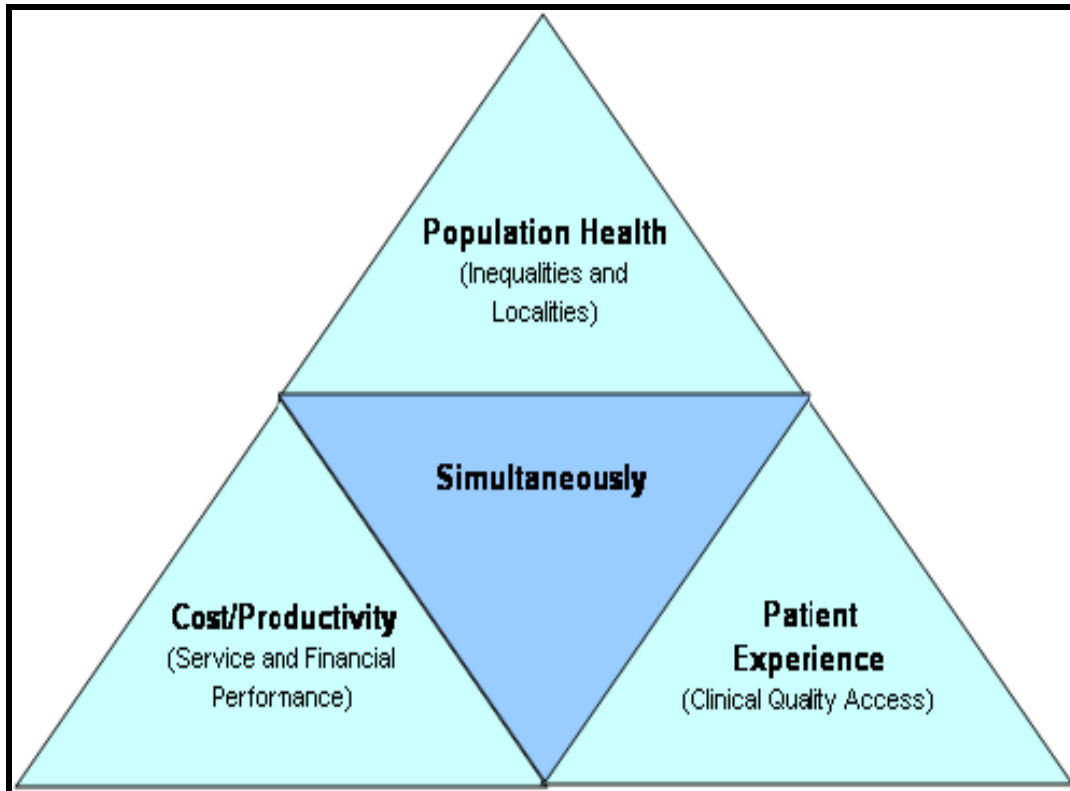

PP Professor Gregor Coster
Chair of Counties Manukau DHB


Geraint A. Martin
Chief Executive of Counties
Manukau DHB

CONSENT GIVEN BY


The Hon Tony Ryall
The Minister of Health

The Triple Aim is our Core Business



The Triple Aim is the core business of Counties Manukau DHB.

The objectives of the Triple Aim encourage us to take an integrated approach to align improvement across the *whole system* by focusing on: *population health*, *cost per capita*, and *patient experience*. These are all objectives of health and provide the basis for our prioritisation process, ensuring that CMDHB delivers safe and high quality services which provide value for money and the best health outcomes for the population.

Our Vision

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



We will do this by leading the development of an improved system of healthcare that is more accessible and better integrated.



We will dedicate ourselves to serving our patients and communities by ensuring the delivery of both quality focused and cost effective healthcare, at the right place, right time and right setting



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

Our Values

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

Commitment to the Treaty of Waitangi

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

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

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

CMDHB will express its commitment to Te Tiriti o Waitangi through the establishment of a number of key initiatives guided by the following principles:

- It is the DHB's intention to continue to develop its Tiriti commitment throughout the organisation. This approach will ensure Tikanga is fully integrated into our processes and indeed help lead our way forward.
- Te Kaahui Ora, the Maaori health team that provides Maaori operational expertise and advice for the whole organisation, will retain a dedicated divisional team, and will establish a matrix framework to planning and organisational delivery as part of a 'whole organisation' approach.
- The DHB is committed to developing an organisation that reflects the diversity of the Counties Manukau population and responds accordingly through its work.

Table of Contents

Our Vision	5
Our Values	5
Commitment to the Treaty of Waitangi	6
1. INTRODUCTION	14
1.1. What we do – the role and function of the DHB	14
1.2. Governance.....	15
1.2.1. The CMDHB Board.....	15
1.3. Organisational Structure.....	16
1.3.1. The Funding Arm - Planning & Purchasing Health and Disability Services 16	
1.3.2. The Provider Arm – Providing Health and Disability Services ..	17
1.4. Shared Approach to Decision Making	17
1.4.1. Clinical Leadership	18
1.5. Partnerships and Collaboration	20
1.5.1. Partnerships with other Health and Disability Providers	20
1.5.2. Partnerships with Primary Health Organisations	21
1.5.3. Partnerships with other sectors and agencies	21
1.5.4. Partnerships with the Community.....	21
1.5.5. Regional DHB Partnerships and Collaboration.....	22
1.5.6. National DHB Partnerships.....	22
2. OUR ENVIRONMENT	23
2.1. Counties Manukau Population Profile and health needs.....	23
2.2. Financial Pressures.....	24
2.3. Workforce Pressures.....	24
3. OUR STRATEGIC DIRECTION.....	25
3.1. CMDHB’s strategic direction	25
3.2. Triple Aim	25
3.3. Quality Improvement	26
3.4. Performance Culture	27
3.5. Transformational Change for Long Term Sustainability	29
3.5.1. Thriving in Difficult Times (TiDT)	29
3.5.2. Working Smarter - the Counties Manukau DHB approach to Productivity	35
4. ACHIEVING NATIONAL PRIORITIES	38
4.1. Minister’s Expectations.....	38
4.2. Performance Improvement Actions (PIAS).....	42
5. REGIONAL PRIORITIES.....	43
5.1. Northern Region Network Strategy	43
5.2. Northern Regional Clinical Service Planning.....	45
5.3. Other Key Regional Initiatives	45
5.3.1. Better Sooner More Convenient Primary Healthcare.....	45
5.3.2. Elective Services	46
5.3.3. Tertiary Eating Disorders.....	47
5.3.4. Northern Region Mental Health and Addictions.....	47

5.3.5.	Northern Region Cancer Network (NCN)	48
5.3.6.	Community Laboratory Services.....	48
5.3.7.	Pharmacy	48
5.3.8.	Procurement.....	49
5.3.9.	Information Systems.....	49
5.3.10.	Workforce development and planning	49
5.3.11.	Regional Asset and Capital Planning	50
5.3.12.	Auckland Regional Public Health Service	50
5.3.13	Auckland Regional Settlement Strategy (ARSS) Migrant Health Activity	51
5.3.14	Oral Health.....	51
6.	KEY RISKS AND ASSUMPTIONS	54
6.1	Key Risks	54
6.2	Service Coverage issues.....	54
7	CMDHB PRIORITIES FOR 2010/11: Actions to Achieve National and Local Priorities	55
7.1	Outcome 1 – Improve Community Wellbeing	55
7.2	Outcome 2 – Improve Child and Youth Health	60
7.3	Outcome 3 – Reduce the incidence and the impact of Priority Conditions	65
7.4	Outcome 4 – Reduce health inequalities.....	71
7.5	Outcome 5 – Improve Health Sector responsiveness to individual and family/ whaanau need	76
7.6	Outcome 6 – Improve the Capacity of the Health Sector to Deliver Quality Services	82
8	MANAGING FINANCIAL RESOURCES	87
8.1	Financial Statements.....	87
8.2	Overview	92
8.2.1	Key Assumptions and Risks	94
8.3	Financial Management.....	98
8.3.1	Specific Cost Pressures – Wage Pressure	98
8.3.2	Capital Planning & Expenditure	99
8.3.3	Banking Covenants	101
8.3.4	Cash Position	102
8.3.5	Capital Charge.....	102
8.3.6	Advance Funding.....	102
8.4	Cost Containment Efficiency Gains	103
8.5	healthAlliance (CMDHB and WDHB Shared Services Organisation)	105
8.6	2010/11 Pharmaceutical Budget	106
8.7	Outlook for 2011/12 and 2012/13 Years.....	106
8.8	Significant Accounting Policies.....	107
	ATTACHMENTS	115
	Attachment 1: Price Volume Schedules	116
	Attachment 2: CMDHB Information Systems Strategic Plan (ISSP).....	118
	Attachment 3: Overview of the Centre for Health Services Innovation Project.....	121
	Attachment 4: Planned Capital Expenditure.....	123

Attachment 5: 2010/11 Metro-Auckland Primary Care <i>Better, Sooner, More Convenient</i> Implementation Plan	124
Attachment 6: Letter from Ministry of Health confirming acceptance of District Annual Plan.....	126

LIST OF TABLES AND FIGURES

Table 1: Summary of Key Areas.	11
Table 2: Objectives and Functions of the DHBs under the New Zealand Public Health & Disability Act, 2000.	13
Table 3: Specific Quality Improvement programmes to improve patient safety in 2010/11.....	25
Table 4: Thriving in Difficult Times Implementation Plan.....	29
Table 5: CMDHB Productivity Initiatives 2010 / 11.....	
Attachment 5: 2010/11 Metro-Auckland Primary Care <i>Better, Sooner, More Convenient</i> Implementation Plan..	38
Table 6: Linking the Minister’s Priorities to CMDHB Long Term Outcomes.	41
Table 7: Counties Manukau DHB Performance Improvement Actions.....	45
Table 8: Summary Regional Table of Activities and Deliverables.....	56
Table 9: Impact of inflation (FFT CCP) short funded over past 5 years.....	103
Table 10: Impact of under-estimated population growth as reported through census / statistics NZ.....	103
Table 11: Towards 20/20 Projects Schedule.....	106
Table 12: Banking Covenants.....	107
Table 13: Management and Admin Resource Levels.....	110
Figure 1: CMDHB Intervention Logic.....	27
Figure 2: Performance relative to average level of access.....	82
Figure 3: CMDHB Provider Arm Outsourced Volumes Summary 2008/09	83

FOREWORD

This District Annual Plan (DAP) 2010/11 describes the operational activity Counties Manukau DHB wishes to undertake to meet the challenges of the oncoming year.

Within the over-arching framework of the Triple Aim, we will continue to deliver quality health and disability services to meet the needs of our complex and rapidly growing community. This will be done by ensuring growth of elective volumes and reducing wait times for emergency care and elective services as well as radiotherapy.

We also remain committed to delivering to both our own as well as the Minister's performance expectations to ensure a balanced budget. Through our Quality Improvement, *Thriving in Difficult Times* projects and our productivity initiatives, our clinicians have worked with us to identify opportunities and lead the resulting implementation programme.

These initiatives will be critical to managing the DHB's cost pressures whilst working with our teams and the population to deliver quality services at a lower cost. There is no intention by the DHB to reduce services, but by focusing on improving efficiency, quality and productivity through ongoing innovation, the DHB will continue to meet demand.

As we come into the 2010/11 fiscal year we are mindful of the challenge of shaping how primary and community services will be delivered within Counties Manukau and across the Northern region. Counties Manukau DHB is committed to being a strong regional partner alongside our neighbouring three DHBs, and it is this clinical/management partnership and the relationships we enjoy within the broader networks that will be integral to the way we work together to implement this transformation.

Phase II of the preparatory work for the Regional Clinical Services plan demonstrates the commitment we share across the Northern region and provides a template for enhancing our regional activities in 2010/11, and the foundation for the Regional Plan development.

Developing, retaining and "growing our workforce" are also key priorities for us and we have a number of critical initiatives underway currently which we will continue implementing in 2010/11. A central plank of our workforce strategy is the Centre for Health Services Innovation project. The Centre will provide much needed infrastructure for the practical training of clinicians and health workers, including support for the significant increase in medical students, already funded by Government, who will require DHB-based training and growth in nursing trainees to meet both current and future needs.

We look forward to the oncoming year as we work with our committed staff, the primary healthcare sector, regional colleagues as well as our community, to continue to lead the sector in the provision of health and disability services for our population.

Gregor Coster
Chairman
Counties Manukau District Health Board

Geraint Martin
Chief Executive
Counties Manukau District Health Board

Table 1: Summary of the key areas that the 2010/11 CMDHB District Annual Plan will address and where to refer to in the document

Key Areas	CMDHB's Focus	Reference
Minister's Priorities - General		
Improving service and reducing waiting times	<ul style="list-style-type: none"> ➤ Emergency Care ➤ Elective services (referral to FSA) ➤ Compliance with Elective Services Patient Flow Indicators (ESPIs) ➤ Quality improvement ➤ Electronic referrals ➤ 	3.3, Quality Improvement 4.1, Minister's Priorities 5.3.9, Regional Information Systems 7.5, CMDHB DSP Outcome 5 7.6, CMDHB DSP Outcome 6
Increase elective volumes year on year	<ul style="list-style-type: none"> ➤ Increase the proportion of elective services which are at or above national access levels ➤ Deliver to SIR targets for base elective contract and elective initiatives ➤ Increase Day of Surgery Admission rates ➤ Improve elective theatre utilisation 	4.1, Minister's Priorities 5.3.2, Regional Electives Planning 7.5, CMDHB DSP Outcome 5
Develop long term relationships with the private sector	<ul style="list-style-type: none"> ➤ Continue relationships with private sector to increase elective volumes. 	7.5, CMDHB DSP Outcome 5
Improve cancer treatment wait times	<ul style="list-style-type: none"> ➤ Regional collaboration by DHBs to work on access, consistent criteria for diagnosis and treatment timeframes ➤ Redesign clinical pathways to reduce waiting times for lung and colorectal cancers ➤ Monitoring and reporting against tumour stream standards and reducing waiting times 	4.1, Minister's Priorities 5.3.5, Northern Cancer Network 7.3, CMDHB DSP Outcome 3
Better, sooner more convenient primary and community health services by:	<ul style="list-style-type: none"> ➤ Delivery of the <i>Better, Sooner, More Convenient</i> primary healthcare implementation plan 	4.1, Minister's Priorities 5.3.1, Better, Sooner, More Convenient Primary Healthcare 7.3, CMDHB DSP Outcome 3 7.5, CMDHB DSP Outcome 5 Attachment 5, 2010/11 Metro-Auckland BSMC Implementation Plan
Foster clinical leadership	<ul style="list-style-type: none"> ➤ Leadership and governance programmes ➤ Clinical Management Executive Committee (CMEC) ➤ Centre for Health Services Innovation (CHSI) ➤ 	1.4.1, Clinical Leadership 4.1, Minister's Priorities 7.6, CMDHB DSP Outcome 6 Attachment 4, Overview of CHSI
Improve clinical staff retention	<ul style="list-style-type: none"> ➤ RMO retention rates ➤ Succession planning ➤ Retention of training roles into full professional roles ➤ Growing our own workforce 	2.3, Workforce Pressures 4.1, Minister's Priorities 5.3.10, Regional Workforce 7.6, CMDHB DSP Outcome 6

Key Areas	CMDHB's Focus	Reference
Greater regional collaboration	➤ Planning and implementation of the Regional Clinical Services Plan	5.2, Regional Clinical Services Planning 5.3, Regional initiatives Table 6: Summary of Regional Activities 7.6, CMDHB DSP Outcome 6
More unified system	➤ National and regional initiatives for greater efficiencies and value for money	5.3.6, Community Laboratories 5.3.7, Pharmacy 5.3.8, Procurement 5.3.9, Information Systems 5.3.10, Workforce development 5.3.11, Regional Asset and Capital Planning 4, National Priorities
Zero Deficit	➤ Thriving in Difficult Times and the Triple Aim strategic review workstreams.	3.5.1, Thriving in Difficult Times 8, Managing Financial Resources
Minister's Priorities - Productivity		
Productivity	<ul style="list-style-type: none"> ➤ Cost per WIES ➤ DNA rates: Maaori and Pacific focus ➤ Referral to procedure time: Electives ➤ Readmission rates for identified sub specialities ➤ End of life planning ➤ Standardised inpatient mortality ➤ POAC rates ➤ Ambulatory sensitive admissions ➤ Cost per immunisation ➤ Theatre utilisation ➤ Productive wards ➤ Staff turnover / sickness absence 	3.5, Transformational Change for Long Term Sustainability 3.5.2, CMDHB approach to Productivity
Minister's Priorities – Performance Improvement Actions		
Performance Improvement Actions	<ul style="list-style-type: none"> ➤ Achieving Financial Security ➤ Improving Productivity and Quality ➤ Enhancing Regional Co-operation 	4.2 Performance Improvement Actions
Minister's Priorities – Inter District Flows		
Reconciliation Auckland Metropolitan	– ➤ Regional discussion in progress regarding any changes that are required to the IDF payment schedule prior to commencement of the new fiscal year	

1. INTRODUCTION

1.1. What we do – the role and function of the DHB

Counties Manukau District Health Board (CDMHB) was established on 1 January 2001 under the provisions of the New Zealand Public Health and Disability (NZPH&D) Act 2000. The DHB comprises the territorial authorities of Manukau City, Papakura District Council and Franklin District Council with a combined population estimated at around 455,000 – or about 11% of the New Zealand population¹.

Working with the funding allocated by Government, the DHB is responsible for working in collaboration with the community, other health and disability organisations and stakeholders in the provision of health and disability services in order to improve, promote and protect the health and independence of the people of Counties Manukau.

The legislative objectives and function of CMDHB under the NZPH&D Act 2000 are summarised in the table below.

Table 2: Objectives and Functions of the DHBs under the New Zealand Public Health & Disability Act 2000

Objectives of DHBs	Functions of DHBs
(a) improve, promote, and protect the health of people and communities	(a) ensure the provision of services as specified in its Crown Funding Agreement
(b) promote the integration of health services, especially primary and secondary health services	(b) develop collaborative arrangements in the health and disability sector
(c) promote personal health services and disability support services	(c) issue information relevant to promoting paragraphs (a) and (b)
(d) promote inclusion, participation and independence of people with disabilities	(d) enable Maori to participate in and contribute to strategies for Maori health improvement
(e) and (f) reduce health disparities	(e) continue to foster the development of Maori capacity
(g) exhibit a sense of social responsibility	(f) provide information relevant promoting paragraphs (d) and (e)
(h) foster community participation	(g) regularly monitor the health status of the population
(i) uphold ethical and quality standards	(h) promote the reduction of adverse social and environmental effects
(j) exhibit a sense of environmental responsibility	(i) monitor the delivery and performance of services
(k) be a good employer	(j) participate in the training of health and disability workers
	(k) provide information to enable the performance of the DHB to be monitored

¹ Impending legislative changes indicated with Auckland boundaries may change this figure

1.2. Governance

CMDHB has a governance and organisational structure as required by the NZPH&D Act 2000.

There is a Board which assumes the governance role and a Funder arm and a Provider arm; the former performs the planning, performance management and purchasing functions of the DHB and the latter, the provision of health and disability services respectively.

1.2.1. The CMDHB Board

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.

CMDHB has seven Board members elected by the community and four appointed by the Minister of Health:

Elected Board members	Ministerial appointments
Mr Paul Cressey (Dep Chairman)	Professor Gregor Coster (Chairman)
Ms Anne Candy	Ms Lope Ginnen
Anae Arthur Anae	Ms Ruth DeSouza
Mr Bob Wichman	Ms Miria Andrews
Ms Colleen Brown	
Mr Donald Barker	
Mr Michael Williams	

The Board has established a number of committees. The following three are required by legislation:

- Hospital Advisory Committee (HAC)
- Community and Public Health Advisory Committee (CPHAC)
- Disability Support Advisory Committee (DiSAC)

In addition, there are five other sub-committees which have been established to assist the Board in meeting its responsibilities. These are

- Maaori Health Advisory Committee (POU)
- Pacific Health Advisory Committee (PHAC)
- Audit, Risk & Finance Committee (ARF)
- Facilities Management & Planning Committee (FMP)
- Remuneration and Appointments Committee (RAC)

POU (Maaori Health Advisory Committee)

The maintenance of POU (Maaori Health Advisory Committee) as the key interaction mechanism with the Board continues. POU provides advice to the Board for Maaori health improvement and continues to play a governance role in overseeing the implementation of the Whaanau Ora Plan (Maaori Health plan).

Pacific Health Advisory Committee (PHAC)

A high proportion of the Counties Manukau population are of Pacific origin and the Pacific Health Advisory Committee (PHAC) is the mechanism which supports the Board and management in ensuring that there is a continued focus on the improvement of health outcomes for Pacific communities and that the health perspectives, views and input of Pacific communities are reflected in the DHB's planning and funding strategies, service delivery, and performance management processes.

1.3. Organisational Structure

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

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

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

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

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

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

1.3.2. The Provider Arm – Providing Health and Disability Services

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 through its provider arm. These specialist services include:

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

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. CMDHB funds these services separately through inter-district flow (IDF) payments to these DHBs.

In summary, CMDHB relates in a variety of different ways to the components of the wider health system. The DHB:

- **provides** secondary (and some tertiary) care;
- **funds through Inter-District Payments** for access to specified secondary and tertiary care services from other DHBs and some Non-Government Organisation (NGO) services;
- **contracts with** PHOs to improve and maintain the health of their enrolled populations and integrate healthcare provision; it contracts with other NGOs to provide residential and support services; and
- **works collaboratively with** communities, local and regional authorities, public health funders and providers, disability support funders and providers, and other agencies and organisations that influence health.

1.4. Shared Approach to Decision Making

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

Business Group members include the Chief Financial Officer, Chief Operational Officer, Chief Medical Officer and the Directors of Planning and Performance, Primary Care, Services Integration, Allied Health, Quality Improvement and Nursing.

Additional support is provided by the Senior Legal Advisor, Communications Manager, the Chief Information Officer for healthAlliance and the General Managers for Maaori Health and Human Resources.

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

1.4.1. Clinical Leadership

Clinical leadership in action - Surgical Services

Clinical leadership is well developed in Surgical Services as each level has a dual Clinical/Management Partnership. This means there is a Clinical Head and a Service Manager for each service, and they report to the Clinical Director and General Manager Surgery respectively. Frontline staff therefore have a direct line of representation, and the relationship between the Clinical Director and the General Manager Surgical Services is such that all major decisions are jointly discussed, and plans formulated which have equal clinical input. The Clinical Director sits on the Clinical Directors forum, CMEC, Asset and Capital, and the Strategic Forum, and is therefore well placed to represent clinicians at decision making meetings. Senior clinicians such as the Clinical Director surgery have been closely involved in new initiatives and projects such as 'Thriving in difficult times, and the 6hr rule in EC, and represent these initiatives to Senior Medical Officers.

The success of these projects is due largely to the role senior clinicians have played. One of the challenges the DHB faces in developing Clinical Leadership is freeing up time for clinicians to be involved, and this is a challenge we have not yet solved, but our commitment is to ensure that the clinician/management partnership is maintained.

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

- Clinical leadership is led by the Chief Medical Officer (CMO), and Directors of Nursing (DoN), Allied Health (DAH), Primary Care and Quality Improvement; through to Clinical Directors, Clinical Nurse Directors, Heads of Department, and formal and informal networks of primary and secondary care clinicians.
- Clinical leaders are represented on the Counties Manukau Board and Board advisory committees like the Community and Public Health Advisory Committee (CPHAC) and the Hospital Advisory Committee (HAC). The CMO reports to the Board monthly and the CMO, DoN and DAH jointly report to HAC monthly.
- Clinicians are well-represented on the Strategic Forum where there are ten clinicians represented alongside the other twenty senior executives of the management team.
- Clinical leaders are a part of advisory committees such as Asset and Capital, and Workforce and are represented on advisory/ steering committees for key projects such as the Emergency Department "6 hours can be ours" campaign and major capital works like the development of the Edmund Hillary Block.

CMDHB also has formal mechanisms for broader based participation from clinical staff through the *Clinical Advisory Group* and the *Clinical Management Executive Committee Secretariat*.

Clinical Advisory Group (CAG)

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

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

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

Clinical Management Executive Committee (CMEC)

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

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

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

1.4.2. Clinical Management Partnership

As described in the case study above, clinical leadership - to be at its most effective - must also involve a partnership with management to ensure processes are in place to design and deliver services. It creates an environment for transformational change. For the clinical/management partnership to become known as the culture of "the way we do things around here" a blend of leadership training and development is used, involving both clinicians and managers along with strong values and relationships between healthcare professionals, the management team and the organisation as a whole.

Emphasis on clear decision making, robust prioritisation and good quality intelligence are key enablers of an effective clinical /management partnership.

1.4.2.1. Decision Making

As a response to the Government's message that the health sector must give priority to improving frontline services whilst operating within the approved financial budget, CMDHB is undertaking – as a part of a wider internal review into organisational enablers (See [Section 3.5.1 Thriving in Difficult Times](#)) – a review of the DHB's decision making framework and prioritisation principles. The framework and its principles guides the DHB in decisions about which competing services or interventions to fund with limited resources, at the same time weighing up what will deliver the best outcome for patients.

The first decision making principle is that processes must reflect CMDHB's commitment to a strong clinical/ management partnership in support of delivering the Triple Aim.

Five further principles of decision making within CMDHB are:

- Decisions are to be made at the lowest possible level in the first instance. This is in recognition of front line staff and their role in determining resource allocation in their daily, clinical capacity.
- Where an individual does not have authority, matters are escalated to the next level as expeditiously as possible.
- Decisions are clearly documented.
- Each group reports all decisions that are made to the next meeting of the tier group above.

- With decision making responsibility comes the accountability for decisions made.

1.4.2.2. Prioritisation

Critical to the success of prioritisation is the clinical/management partnership, consistency with Triple Aim and the CMDHB District Strategic Plan, transparency of process, information and an evidence based methodology.

Counties Manukau DHB has also identified the value of independent facilitation in the prioritisation process and we are being assisted by an external agency using Decision Conferencing. This involves a facilitated and structured workshop approach which uses the proven prioritisation technique of Multi-Criteria Decision Analysis (MCDA), supported by a software tool and group processes to deliver the best value for a limited set of resources. This approach is being trialled to prioritise the Capital Plan for the 2010/11 year.

As we develop the capability to use the software tools in-house, we will reduce our reliance upon an external agency. However we will always retain an independent facilitator to implement decision conferences. We believe this is the most effective method of achieving a robust, transparent approach to prioritisation whilst ensuring our alignment to Triple Aim.

1.4.2.3. Robust Intelligence

In March 2010, CMDHB will launch its Health Intelligence Unit which is being formalised to bring together existing resources and expertise within the organisation and reprioritise the focus of the unit to be consistent with the 2010/11 DAP priorities.

The Unit will consist of senior Public Health consultants and registrars, data and statistical analysts as well as a leading expert in case mix and Health Round Table data. The purpose of the Unit is to support the clinical/ management partnership across the entire health sector within Counties Manukau to utilise the wealth of information available and support decision making at all levels; clinicians, provider organisations/divisions, planners, funders and in time, consumers of health services.

The Unit will develop strong linkages with other agencies within the region and nationally. It has formed a strategic alliance with a public health observatory in England and is actively developing another similar relationship in Wales.

1.5. Partnerships and Collaboration

1.5.1. Partnerships with other Health and Disability Providers

Counties Manukau DHB contracts with other health and disability providers to provide services to the local population. These include: non-governmental mental health and addiction services, Well Child providers, children and adolescents' oral health services, lead maternity providers, residential support and rest home services, Maaori and Pacific health service providers, and hospital and specialist services which the DHB does not provide.

Counties Manukau DHB works with these providers as one health system so that patients receive continuity of care. The DHB also supports the development of capacity and capability within this sector to ensure that population needs are able to be met.

1.5.2. Partnerships with Primary Health Organisations

Counties Manukau DHB contracts with PHOs for the provision of primary healthcare services to the population. PHOs provide the structure by which the population has access to low cost primary health care when needed and after hours care. In line with Ministerial direction for *Better, Sooner, More Convenient Primary Healthcare*, the primary healthcare sector is redefining what this partnership will look like. Priorities include working towards a road map for greater consolidation of PHOs, improved clinical networks leading to improved pathways of care and integrated services.

The DHB is working actively in partnership with the other metro-Auckland DHBs and the three coalitions of PHOs who have developed implementation plans for delivering '*Better, Sooner, More Convenient*' primary care. They are:

- The Greater Auckland Integrated Health Network (3 DHBs and 11 PHOs) covering 1.2 million Aucklanders
- Alliance Health+ (AH+) – A Pacific-led alliance covering 72,000 people across three PHOs
- National Maaori PHO Coalition (NMPC) which in the Northland region currently has four PHOs

The DHB is committed to working with the three Auckland business case coalitions to implement their plans and to continue to work with other PHOs in transition.

See Section, [5.3.1](#), for information on what the metro-Auckland DHBs and primary healthcare sector will be delivering in terms of *Better, Sooner, More Convenient primary healthcare healthcare*.

1.5.3. Partnerships with other sectors and agencies

Environmental and social determinants of health play a large part in shaping our population's health, and arguably have a greater impact on improving or reducing the health of our population than health determinants alone.

Partnerships with other sectors are important to help create policies and social and physical environments which reduce the risk of ill health. CMDHB's partnership with Housing New Zealand in delivering the Healthy Housing programme and the Let's Beat Diabetes partnership with the food industry introducing healthier food and drink options are an example of how inter-sectoral partnerships can result in positive changes to support community wellbeing.

CMDHB is a partner organisation and a member of the Strategic Steering Group for Tomorrow's Manukau which is a 10 year framework for meeting Manukau City residents' aspirations for their environment, economic, social and health wellbeing. The forum is made up of over 70 Manukau organisations and provides the DHB with a platform for developing working relationships with other sectors.

1.5.4. Partnerships with the Community

The diversity of the Counties Manukau population with its high proportion of Maaori, Pacific and Asian people gives the district a unique cultural perspective which influences the way the DHB works with local communities. Partnerships with the community are therefore vital to achieving the DHB's strategic vision and direction.

The DHB partners with Maaori and Pacific peoples and communities with high need to provide programmes which help equip them with knowledge and resources to manage their

own health. These include community based self management and train-the-trainer programmes as well as health promotion.

The DHB's partnership with the Mangere Health Community Trust/ Mangere Integrated Health Care is an example of positive partnering with the community where the community has actively participated and determined the way they want their health services delivered.

1.5.5. Regional DHB Partnerships and Collaboration

The Northern DHBs have been working regionally for some time through:

- Formally established fora with delegated decision making authorities (for example, Regional Governance Group, Regional CEO Forum and the Regional Funding Forum, Regional Capital Group)
- A range of clinical networks and regional clinical services (Network North for Mental Health and Addiction Services, the Northern Region Cancer Network, Auckland Regional Public Health Service, Auckland Region Dental Service)
- Shared support agencies (Northern DHB Support Agency (all four DHBS), healthAlliance (Waitemata and Counties Manukau DHBs) and Auckland Regional Resident Medical Officers Service (metro Auckland)).

Regional collaboration and the range of regionally delivered services and initiatives are outlined in more detail in [Section 5](#).

1.5.6. National DHB Partnerships

The 21 DHBs work in partnership to progress common issues and initiatives and have established District Health Board New Zealand (DHBNZ) to provide coordination of activities at a national level. DHBNZ supports the 21 DHBs in a range of areas including: primary health, workforce development, industrial relations, pricing, procurement, and information systems. This collaboration happens across all levels of professional groupings such as Chief Executives, Medical Directors, Nursing Directors, Planning and Funding Managers, Chief Financial Officers, Human Resource Management, Quality and Information Services.

2. OUR ENVIRONMENT

2.1. Counties Manukau Population Profile and health needs

Counties Manukau has one of the fastest growing populations in New Zealand. It has a diverse population with complex health needs and service requirements. Key features of the CMDHB population are described on the website: www.cmdhb.org.nz/About_CMDHB/Overview/population-profile.html. They include:

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

Detailed analyses of the health of Counties Manukau residents are provided at www.cmdhb.org.nz/About_CMDHB/Planning/Health-Status/Health-Status.htm and www.cmdhb.org.nz/About_CMDHB/Overview/Our-Localities/default.htm. Key themes are:

- CMDHB residents' health is improving. For example, average life expectancy at birth is similar to the New Zealand average despite material and socio-economic disadvantage in Counties Manukau.
- However, health disparities remain a concern. Males, Maaori and Pacific people and those socio-economically deprived all do worse than their counterparts.
- For Maaori, a quarter of the life expectancy gap is due to tobacco. Smoking remains the single largest preventable cause of disease and death in our communities.
- A third of all hospitalisations for CMDHB people are considered potentially avoidable. Much of the scope for prevention of these lie in the population health and primary care sectors.
- Although adult medical admission rates are among the highest in the country, an acute assessment team has increased the proportion discharged within 24 hours from 28% to 40% with consequential reduction in ALOS to 2.7 days (the lowest in Australasia). Further improvements in ambulatory care and an Acute Assessment Unit would be expected to lead to further reductions in ALOS. However, the largest driver for medical admissions arises from self referrals to the ED and this will require innovative solutions as well as a much closer working relationship between the primary and secondary sectors.
- Infectious disease rates for Counties Manukau people, particularly children, remain high. Improving the living conditions of pre-school children remains a priority.
- CMDHB has the largest number of people with diabetes in NZ (29,000, or 8.3% of the adult population in 2008). Diabetes prevalence is likely to double in Counties Manukau by 2021.
- CMDHB has the highest rate of obesity in NZ, with 33% of the adult population considered obese (BMI>30). For morbid obesity, BMI>40, CMDHB was estimated to have 17,500 people in 2006/07 – 5.7% of the adult population. Modelled increases of 1,700 people per year reaching a BMI >40 increase the urgency of population approaches to reduce the rate of growth and stem the rising tide of associated morbidity and mortality.
- Teenage pregnancy rates are very high for Maaori and Pacific young people.
- Elective surgery rates are up 6% over the past year, with a 44% growth over the past 5 years. Counties Manukau has age-standardised rates higher than the New Zealand average with improvements in access for Maaori, Pacific and more deprived populations.

2.2. Financial Pressures

It is well recognised that we are at a global financial “low” and whilst the New Zealand economy has not been as severely impacted as Europe and the US, New Zealanders are faced with the realisation that we are living beyond our means. This must be reined in, not least in the health sector and the first indication of this came in the reduced funding package Counties Manukau DHB received from the Crown in 2009/10 which meant a loss of revenue of \$24.0 million.

This comes at a time when we are experiencing the impact of the ageing population in Counties Manukau with costs for Aged Residential Care rising at approximately 9% per annum, industrial agreements being settled at a level greater than the rate of inflation, demand pressure for pharmaceutical and acute hospital services, and the continuing challenge of reducing health inequalities in our district.

To ensure that Counties Manukau DHB is able to retain current levels of service and access over time the DHB is challenged with looking at new ways of doing things to ensure it can sustain in the future. The DHB is required to make material new savings and actions to meet expectations, national targets and manage within a tighter funding path.

Counties Manukau DHB is responding to these challenges and has implemented a range of initiatives and projects to ensure we are able to continue our commitment to delivering high quality and efficient hospital, primary and community services. These form the basis of our DAP 2010 / 2011.

2.3. Workforce Pressures

As a result of population growth and increasing demand for health services, Counties Manukau DHB forecasts a need to double the health workforce in the Counties Manukau district over the next 20 years. In the short term, the forecasts estimate that the Counties Manukau DHB employed workforce will need to grow by more than 25% over the next five years to meet demand for hospital services.

These projections are based on expected growth in patient demand and current ratios of health workers and professionals to patients.

While Counties Manukau DHB has confidence in patient demand projections, the associated workforce growth is not seen as realistic or achievable given expected fiscal constraints and the worldwide shortage of health professionals. Simply put: CMDHB does not believe it will have access to a traditionally structured health workforce which is double the current size.

Historically it has been possible to meet local workforce shortages by importing health professionals. However, this approach is no longer sustainable due to the increasingly competitive global market for health professionals.

In addition, to meet the needs of our local communities, we need a workforce which reflects our population instead of on relying on overseas trained health professionals. As outlined in the organisation’s Health Service Plan, we also need to support individuals and families in our communities to become more actively involved in their own self-care.

Counties Manukau DHB is faced with a critical business need to work differently, evolve new roles and grow the future health workforce from the local community. Labour demand forecasts highlight the urgent need to address workforce pressures now to ensure that the building blocks are put in place to create a sustainable and skilled health workforce for the future.

3 OUR STRATEGIC DIRECTION

This chapter summarises the DHB's strategic vision and direction and outlines the key drivers: Triple Aim, Quality Improvement and Performance Management; which enable the DHB to be in a position to deliver on national priorities as well as strategic priorities outlined in the District Strategic Plan.

3.1. CMDHB's strategic direction

Counties Manukau DHB's strategic direction focuses on six long term outcomes articulated in the *CMDHB District Strategic Plan 2006-11*. The current District Strategic Plan was developed in 2005/06. It responds to the national and policy context of the time, local needs, and reflects our ways of working here at CMDHB. It is the product of extended conversations with our communities, health professionals, and partner agencies - working together to make a difference.

The overarching direction of the DSP is towards community wellbeing and preventative strategies, while maintaining and improving the quality of existing health services. These outcomes have been determined based on the community's health needs whilst balancing national health priorities with the need to remain a sustainable organisation.

It is a statutory requirement that the DHB reviews the DSP every three years. The next review will be undertaken in 2010/11 with the intention that the DHB will have a reviewed strategic plan by November 2010.

3.2. Triple Aim

Counties Manukau DHB's strategic direction will continue to be underpinned by the Triple Aim which the DHB adopted in 2008 as its core business. This is a concept which the Institute for Healthcare Improvement developed and the key tenet of this concept is that in order for a healthcare organisation to be successful, the organisation needs to be simultaneously looking at three business "bottom lines". These are:

- Improving population health;
- Improving the patient experience of care;
- Managing per capita cost of health.

The Triple Aim is consistent with CMDHB's strategic direction and has been adopted and adapted to reflect the underlying objectives of the Counties Manukau health system, that is:

- Improving the health of the population and reducing inequalities;
- Improving patients and their whaanau's experience of care, and
- Making the best use of our population-based funding.

The objectives for Counties Manukau DHB in the 2010/11 District Annual Plan are all framed within the Triple Aim.

3.3. Quality Improvement

With the Triple Aim underpinning the DHB's overall direction, a key driver of achieving our goals is the organisational commitment to Quality Improvement. The "6 hours can be ours" campaign has demonstrated what the organisation can achieve when attention is paid to the drivers of quality like timeliness, patient safety and patient centred care, supported by enablers such as our strong clinical management partnership and a comprehensive communication campaign.

The DHB will continue as an organisation to focus on planning and delivering health care services which reflect the six care dimensions which define healthcare quality. These are:

- Safe care
- Effective care
- Patient-centred care
- Timely care
- Clinically efficient care
- Equitable care

These same dimensions are reflected in the Ministry of Health's "Improving Quality Strategy".

The major workstreams which were mapped out in the CMDHB QI Secondary Care Action Plan 2008 – 2011 will continue to be progressed in 2010/11 (see Table 2 below). The primary focus of quality improvement remains improving patient safety, which will be measured through implementation of the Institute for Healthcare Improvement Global Trigger Tool (GTT), and continuation of the Adverse Drug Event (ADE) Trigger Tool (ADE TT). A baseline measure has already been established using the ADE TT; the GTT baseline will be established by the start of the new financial year.

Table 3: Specific quality improvement programmes to improve patient safety in 2010/11

Improving medication safety	<ul style="list-style-type: none"> ➤ Improved communication between primary and secondary care through medication reconciliation and effective discharge medication records ➤ Standardisation of management of medications on wards by the use of Pyxis© technology ➤ Improved management of IV medications through the introduction of Guardrail© technology
Reducing Hospital Acquired Infections	<ul style="list-style-type: none"> ➤ Compliance with Hand Hygiene practices ➤ Reduction in Central Line Associated Bacteraemia
Perfecting Patient Care	<ul style="list-style-type: none"> ➤ Reduction in patient falls causing injury ➤ Reduction in hospital acquired pressure injuries
Creating efficient patient flow	<ul style="list-style-type: none"> ➤ Patients discharged from EC within 6 hours
Creating safer surgery	<ul style="list-style-type: none"> ➤ Implementation of the World Health Organisation Surgical Checklist

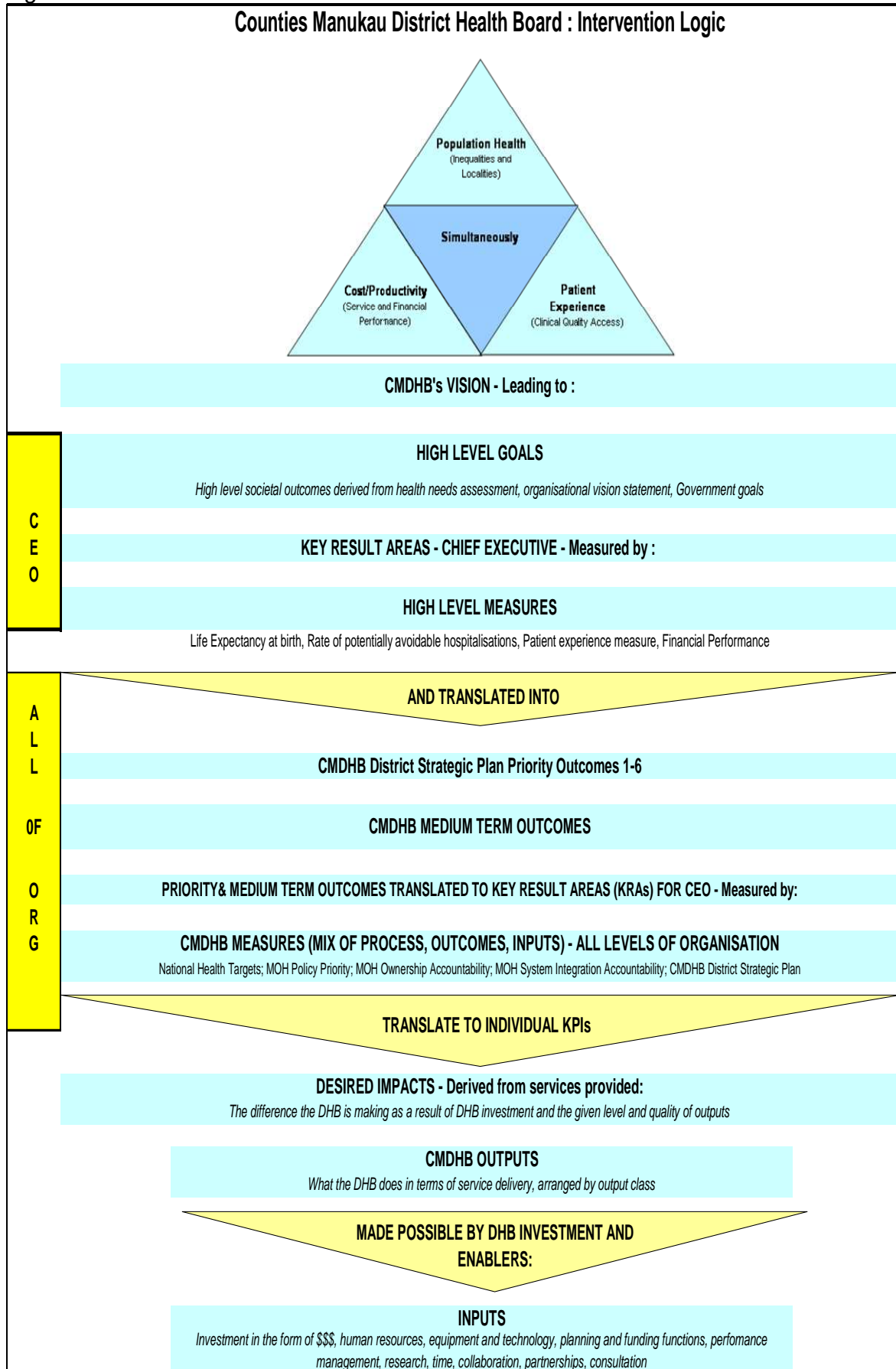
3.4. Performance Culture

In order to realise the DHB's strategic objectives, Counties Manukau DHB is actively cultivating a performance culture which complements the Triple Aim and will help drive the DHB to improve quality of patient care, patient safety and productivity. Examples of our approach are the Thriving in Difficult Times and Quality Improvement initiatives where robust analysis of the problems has been undertaken, deliberate actions put in place to minimise or eliminate barriers to performance and progress being measured.

It is the executive and senior management's role through leadership to ensure the organisation's strategic integrity and alignment with its goals. For this reason, CMDHB makes a significant investment in leadership training and support. It is critical that every employee, whatever their role, shares a desire to continually improve performance and not only meet expectations but exceed them.

At the date of writing this plan, CMDHB is developing an enhanced performance framework which has specific indicators for achieving organisational goals at each level of the organisation. The organisational goals translate into Key Result Areas for the Chief Executive and these cascade down through all management levels to the front line and convert to meaningful and measurable Key Performance Indicators (KPIs) for each staff member. The objective of this structure is to ensure each employee has a clear understanding of how their work directly contributes to the achievement of the organisation's strategic goals.

Figure 1:



3.5 Transformational Change for Long Term Sustainability

3.5.1. Thriving in Difficult Times (TiDT)

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

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

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

Two main activities have emerged from the scoping work: A *Saver* workstream and an *Enabler* workstream - the implementation of which will be clinically led.

The CMDHB Board has given its endorsement and support to the TiDT plan which outlines how the workstreams are going to contribute to the zero deficit position and future savings.

These plans are tabled below in [Table 4](#).

Implementation of the core actions from the TiDT workstreams will form the 2010/11 *Achieving Financial Security* and *Improving Productivity and Quality* Performance Improvement Actions (PIAs) for the DHB, as outlined in [Section 4.2](#).

Table 4: Thriving in Difficult Times Implementation Plan

WASTE REDUCTION WORKSTREAM				
Sub-Groups	Action taken	Time frame	Responsibility	Monitoring
Clinical Practice Reducing Variation in Clinical Practice	Top ten Diagnostic Related Groups (DRGs) to be identified within Medicine and Surgical; three DRGs within each service to be selected for closer analysis of variation and integrated pathways developed for the episode of hospital care. The CMDHB work to develop integrated pathways for the hospital episode will be complementary to the Auckland Metro Better, Sooner, More Convenient Primary Healthcare workstream, development of clinical pathways, taking a whole of systems approach and integrating primary, secondary and tertiary care.	Ongoing It is intended that 15 care pathways will be developed by December 2010	GM-Medicine & Clinical Support, CDs – Medicine, Surgical and Health of Older People	To be monitored on a regular basis and reported to Business Group.
Laboratory - blood products	Clinically lead project to reduce the number of small volume transfusion.	Reporting start - 1 August Clinician engagement process to be worked out by Sep 10.	1. Transfusion Committee. 2. Transfusion Review Nurse 3. CD - Laboratories 4. Lab Service Mgr	To be monitored on a regular basis and reported to Business Group.

WASTE REDUCTION WORKSTREAM				
Sub-Groups	Action taken	Time frame	Responsibility	Monitoring
Pharmacy - drug (generic) Substitution - Formulary Management - DUE Guidelines - Antibiotic initiatives	Pharmaceutical expenditure management a) Expenditure reporting – information on pharmaceutical expenditure provided to services on a regular basis, reporting expenditure against budget and analysis of variance. b) Stewardship of appropriate pharmaceutical use – clinician engagement and creation of a culture of accountability for cost effective use. c) Active cost management – including: i. Cost containment (Formulary management) – identification of top 10-20 drugs by cost and volume and monitoring and managing their utilisation. ii. Cost minimisation – Exploring cheaper alternatives or brand switches iii. Cost effective use – DUE programmes and IV antibiotic switch initiatives	a) Jun 10 and ongoing b) Start July 10 c) Start Jun 10	Pharmacy Service Manager and Pharmacists	To be monitored on a regular basis and reported to Business Group.
Single use v Multiuse items (theatres)	Use of single use laryngeal masks will be trialled in Anaesthetics in June 2010. Expect to achieve savings through rollout post trial.	Ongoing	GM – Surgical & Ambulatory Care	To be monitored on a regular basis and reported to Business Group.

WASTE REDUCTION WORKSTREAM				
Sub-Groups	Action taken	Time frame	Responsibility	Monitoring
Environmental & Site				
Switching off PCs	Implement automatic shut down and wake up software for PCs (Standby mode)	Start June 2010 on confirmation by HA	GM – Facilities, HealthAlliance	To be monitored on a regular basis and reported to Business Group.
Reduce wastage from medical gases leaks at bed head	Medical gas leak points identified and rectified	Completed	GM – Facilities	
Vehicle Usage/Car Fleet	Vehicle fleet optimisation review	Ongoing	GM – Facilities	
Incomplete sets of instruments	New processes put in place in Surgical Services Unit to track instruments during cleaning process to ensure they are not lost. Savings may arise from the following: - reduced capex requests in the future for instrument replacements - reduced delays in theatre will allow additional theatre throughput	Ongoing	GM- Surgical & Ambulatory Care	
Supply Chain/Kanban	Kanban Steering Group investigating the best options for ward-based imprest stock levels	Ongoing	GM – Revenue & Business Development	

HUMAN RESOURCES WORKSTREAM				
Sub-Groups	Action taken	Time frame	Owners	Monitoring
Sick Leave Reduce the organisation average sickness absence by 1 day from 3.5% to 2.7% (8 days to 7 days) by 30 June 2011	Organisational wide training programme for managers delivered jointly with the Unions for existing Managers, reinforced in orientation programmes and management development programmes for new Managers	Quarterly, ongoing and individually as required Monthly	GMHR and delegated responsibility to HRMs in partnership with Service Managers	To be monitored on a regular basis and reported to Business Group.
Payment of Sick Leave Ensure all sick leave is paid at the correct rate as per Holidays Act	Regular monitoring based on monthly reporting of variations to agreed sick leave usage levels Ensure Payroll Leader system is changed in order that only the first 5 days of sick leave is paid at average daily rate	November 2010	GMHR / health Alliance Business Solutions	To be monitored on a regular basis and reported to Business Group.
Annual Leave To actively manage annual leave and expectations across the organisation by monitoring excessive annual leave accruals and ensuring that no staff have more than two years entitlement at any one time	Regular interaction with all Operational Managers to ensure annual leave is being managed within established guidelines Individual coaching and follow up for Managers where variances are evident Regular monitoring based on monthly reporting of variations to agreed annual leave usage levels	Monthly As required Monthly	GMHR and delegated responsibility to HRMs in partnership with Service Managers	To be monitored on a regular basis and reported to Business Group.
Recruitment Reduce recruitment budget by 10% effective 1.7.10 Centralise organisational budget for all agency spend from 1.7.10	Budget holding for recruitment & agency spend centralised for the organisation effective beginning financial year 2010/11	Ongoing	GMHR and delegated responsibility to Recruitment Manager	To be monitored on a regular basis and reported to Business Group.

HUMAN RESOURCES WORKSTREAM				
Sub-Groups	Action taken	Time frame	Owners	Monitoring
Resident Medical Officers (RMO) Meal Entitlement	Formalise and manage agreed RMO meal guidelines to ensure reduction of costs and Mulit-Employer Collective Agreement (MECA) compliance	Ongoing	GMHR	To be monitored on a regular basis and reported to Business Group.
PATIENT SAFETY AND QUALITY IMPROVEMENT				
Central Line Associated Bacteraemia (CLAB)	CLAB programme will be rolled out to the rest of the hospital as part of the new patient safety programme.	Ongoing	Patient Safety Governance Group	To be monitored on a regular basis and reported to Business Group.
Medication Safety	Pyxis roll-out , Five rights education, medication reconciliation, and ADE monitoring	Ongoing	Patient Safety Governance Group	To be monitored on a regular basis and reported to Business Group.
Multi Resistant Organism (MRO) rate (hand hygiene programme)	The hand hygiene programme will be expanded as part of the patient safety programme	Ongoing	Patient Safety Governance Group	To be monitored on a regular basis and reported to Business Group.
Pressure Injuries	Hourly rounding has been rolled out to all surgery wards from the initial Medicine pilot. Costing mechanism to be determined.	Ongoing	Patient Safety Governance Group	To be monitored on a regular basis and reported to Business Group.
Falls Causing Harm	Hourly rounding has been rolled out to all surgery wards from the initial Medicine pilot. Costing mechanism to be determined.	Ongoing	Patient Safety Governance Group	To be monitored on a regular basis and reported to Business Group.
Venous Thronboembolism (VTE) Prevention	The programme will be part of the patient safety programme	Start July 2010	Patient Safety Governance Group	To be monitored on a regular basis and reported to Business Group.
Catheter Related Urinary Tract Infection (UTI)	The programme will be part of the patient safety programme	Start July 2010	Patient Safety Governance Group	To be monitored on a regular basis and reported to Business Group.
Surgical Safety	Work has started in Plastics The programme will be expanded as part of the patient safety programme	Ongoing	Patient Safety Governance Group	To be monitored on a regular basis and reported to Business Group.
TOTAL	\$12,003,000			

3.5.2. Working Smarter - the Counties Manukau DHB approach to Productivity

High levels of efficiency or productivity is one of several key dimensions that make up a successful and sustainable organisation. Efficiency or productivity is one of six key dimensions across the Triple Aim, and is looked at within the broader context to the other key components that contribute to a successful health system. An isolated focus on productivity without awareness of the broader system and effectiveness of interventions may produce a poor understanding of the issue and/or unintended consequences. These potentially include detrimental impacts on quality or areas that are not measured.

Counties Manukau DHB's approach is that in order to improve its costs per case, it also needs to simultaneously focus on the other dimensions of quality, patient experience and population health.

Overall then, productivity in Counties Manukau will focus on:

- Quality improvement;
- Its context within the broader health system;
- Health gain outcomes; and
- Value for money with a focus on efficiency and effectiveness at both the individual and population levels

Table 5 describes the specific productivity measures and targets CMDHB will monitor in 2010/11.

Table 5: 2010/11 CMDHB Productivity Initiatives

	Initiative	Description	Target
Hospital services	Improve hospital productivity: Inpatient	Tackling Cost per WIES to national price for significant outliers and key focus areas: <ul style="list-style-type: none"> ➤ Acute hands ➤ Bronchiolitis ➤ Chest pain, Deep Vein Thrombosis, Transient Ischaemic Attack (TIA)/Stroke, Chronic Obstructive Pulmonary Disease, pneumonia, collapse clinical pathways ➤ Theatre utilisation ➤ Day of Surgery Admission ➤ IV at home 	Cost per WEIS relative to national price: Medicine ≤ 2% Surgery ≤ 9% Acute Care ≤ 3%
	Improve time from referral to procedure for elective services	<ul style="list-style-type: none"> ➤ Improving time from referral to first specialist assessment (FSA) for medical specialities. 	<ul style="list-style-type: none"> ➤ Less than 3 months.
	Improve Hospital Productivity: Outpatient	<ul style="list-style-type: none"> ➤ Focus on Did Not Attend (DNA) rates for specialities with high DNA rates as well as rates for Maori and Pacific ➤ For Division of Medicine achieve targets for prioritisation criteria 1 to 3 agreed to between the MoH and subspecialty societies in the 1990s. 	<ul style="list-style-type: none"> ➤ CMDHB to achieve < or = national level DNA rates ➤ 80% of priority 1 patients seen within 2 weeks and 100% within 4 weeks of receipt of referral ➤ 80% of priority 2 patients seen within 6 weeks and 100% within 3 months ➤ 70% of priority 3 within 3 months and 100% within 6 months
	Improve readmission rate	<ul style="list-style-type: none"> ➤ Review each speciality and particular sub-specialities with high readmission rates ➤ Track acute readmissions rate 	<ul style="list-style-type: none"> ➤ 7 day unplanned acute readmissions to hospital rate to be monitored for specialities with high readmission rates ➤ As per MOH measure OS8: 28 day unplanned acute readmissions to hospital rate to be maintained at the current rate or lower
	Improve the use of appropriate interventions and end of life quality	<ul style="list-style-type: none"> ➤ Advance Care Planning-pilot standardised approach in primary Health care (Pukekohe Health Centre), COPD, Congestive Cardiac Failure, palliative care, ward 7 medical inpatients ➤ Liverpool Pathway 	<ul style="list-style-type: none"> ➤ Review results of Pilot by December 2010 ➤ Audit uptake at regular intervals
	Standardised acute inpatient mortality rate	Institute for Healthcare Improvement defined <i>Numerator: Number of in-hospital deaths in acute care inpatient population</i> <i>Denominator Number of inpatient discharges</i>	To be agreed on with our clinical partners

	Initiative	Description	Target																
		Expressed as %																	
	Ward productivity	Whai Manaaki Programme (Optimising the Patients Journey): Applying Problem Solving methodologies in wards to remove waste from the care process. The current focus is on Patient Safety and ward teams are being encouraged to measure their practice relating to Medication safety, Infection Prevention & Control, and Improving Patient Care	➤ Targets relating to Medication Safety, Infection Prevention & Control, and Improving Patient Care are outlined in Section 7.6 , under Outcome 6 Performance Indicators																
Workforce	Staff Turnover	<i>Numerator: Full time equivalent (FTE) leavers within six months</i> <i>Denominator : Average number of FTE staff in post for the time period</i> Expressed as %	Current rate is 0.9% Target to aim for 0.7%																
	Sickness absence	<i>Numerator: Number of full time equivalent staff days lost to sickness</i> <i>Denominator : Total all staff in post for the time period</i>	Current rate is 6 days per person per year Target is < 5 days per person per year																
Population Health	Costs per immunisation	Increase coverage so need to pair with overall immunisation rates particularly for Maaori and Pacific	To decrease the ratio over 2010/11																
	Immunisation rates	Link with above	Coverage 95%																
Primary care	Primary Options for Acute Care (POAC) prevented admissions	Impact of POAC on Emergency Care	> 6,800 attendances at E.C. avoided via POAC																
	Ambulatory Sensitive Admissions	<i>Numerator : Number of acute admissions to the inpatient service designated as ambulatory sensitive</i> <i>Denominator : Total number of acute admissions to the inpatient service in the time period</i>	<table border="1"> <thead> <tr> <th>Age</th> <th>Maaori</th> <th>Pacific</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>0-4</td> <td>95</td> <td>113.0</td> <td>95</td> </tr> <tr> <td>45-64</td> <td>139</td> <td>132.7</td> <td>113.4</td> </tr> <tr> <td>0-74</td> <td>117.0</td> <td>125.2</td> <td>103.0</td> </tr> </tbody> </table>	Age	Maaori	Pacific	Other	0-4	95	113.0	95	45-64	139	132.7	113.4	0-74	117.0	125.2	103.0
Age	Maaori	Pacific	Other																
0-4	95	113.0	95																
45-64	139	132.7	113.4																
0-74	117.0	125.2	103.0																
Enhancing Regional Cooperation		See Table 8: Summary Regional Table of Activity and Deliverables																	

4. ACHIEVING NATIONAL PRIORITIES

This section demonstrates how the priorities identified by CMDHB in the District Strategic Plan and this District Annual Plan are aligned with national priorities and the Minister of Health's expectations.

4.1. Minister's Expectations

The Minister of Health's 'Letter of Expectations', sent on 11th February 2010 identifies what he expects to see DHB's deliver for the 2010/11 financial year.

The letter states that the new Government wants the public health system to deliver "**Better, Sooner, More Convenient primary healthcare** for all New Zealanders", and to give priority to improving frontline services whilst operating within the DHB's financial budget.

The following table outlines the Minister's priorities alongside the relevant District Strategic Plan outcome area for CMDHB, showing how the DHB will organise to deliver healthcare that will meet the Minister's and the public's expectations.

Table 6: Linking the Minister's Priorities to CMDHB Long Term Outcomes

Minister's Priorities	CMDHB Actions 2010/11	CMDHB Target 2010/11	CMDHB DSP Priority
Improving service and reducing waiting times	<ul style="list-style-type: none"> ➤ Improve the time from referral to first specialist assessment (FSA) for medical patients through: <ul style="list-style-type: none"> ● Using electronic referrals ● Ensuring adequate FSA slots ● Improving processes for grading of referrals ● Regular performance reporting ➤ Maintaining compliance with MOH Elective Services Patient Flow indicators (ESPIs) ➤ Implementation of quality improvement reviews like Whai Manaaki to free up staff time and target wastage. 	<ul style="list-style-type: none"> ➤ Compliance with MOH ESPI targets ➤ > 80% of FSA medical patients to be seen within their designated timeframe ➤ Outpatient Hospital Productivity Rate: 80% of priority 1 patients seen within 2 weeks and 100% within 4 weeks of receipt of referral. 80% of priority 2 patients seen within 6 weeks and 100% within 3 months. 70% of priority 3 patients seen within 3 months and 100% within 6 months. 	Outcome 5: Improve health sector responsiveness to individual and family/whaanau need
Increase elective volumes year on year	<ul style="list-style-type: none"> ➤ Increase the proportion of elective services which are at or above national access levels ➤ Deliver to Standardised Intervention Rate (SIR) targets for base elective contract and elective initiatives ➤ Plan to increase Day of Surgery Admission (DOSA) rates ➤ Improve elective theatre utilisation ➤ Continuing relationship with the Manukau Health Trust (private provider) and other private providers to provide additional elective surgery 	<ul style="list-style-type: none"> ➤ An additional 41 discharges annually as CMDHB contribution to Ministers expectation of 2000 nationally. ➤ DOSA rate 90% ➤ Elective theatre utilisation rate 82.5% ➤ Cataract and other procedures delivered in partnership with private sector 	Outcome 5: Improve health sector responsiveness to individual and family/whaanau need
Improve emergency department (ED) waiting times	<ul style="list-style-type: none"> ➤ Implementation of agreed ED Delivery Plan ➤ Improve processes within ED and the wider organisation ➤ Development of Adult Observation Unit (AOU) ➤ Implement Charge Nurse Specialist (CNS) role in ED to support seen by times within ED ➤ Continue with communication strategy "6 hours can be ours" ➤ Continue implementation of Whai Manaaki to free up staff time for patient care 	95% of patients admitted, discharged or transferred from an Emergency Department within 6 hours	Outcome 6: Improve the capacity of the health sector to deliver quality services

Minister's Priorities	CMDHB Actions 2010/11	CMDHB Target 2010/11	CMDHB DSP Priority
<p>Improve cancer treatment wait times</p>	<ul style="list-style-type: none"> ➤ Regional collaboration by DHBs to work on access, consistent criteria for diagnosis and treatment timeframes as defined by tumour streams ➤ Redesign clinical pathways to reduce waiting times for lung and colorectal cancers ➤ Improve monitoring and reporting against tumour stream standards and reducing waiting times 	<p>100% of patients in category A, B, C wait less than 4 weeks between first specialist assessment and the start of radiation oncology treatment</p>	<p>Outcome 3: Reduce the incidence and impact of priority conditions</p>
<p>Better, sooner more convenient primary and community health services by:</p>	<ul style="list-style-type: none"> ➤ Improve access to radiology ➤ Increase minor surgery in the community ➤ Reduce impact of acute demand on hospitals through increased referrals to the Primary Options for Acute Care (POAC) ➤ Co-ordinate metro-Auckland approach to affordable after hours care ➤ Develop primary secondary clinical pathways ➤ Improve prescribing and safer use of medicines in community pharmacy ➤ Increase Maaori provider capability to support implementation of Whanau Ora ➤ Support regional health targets for immunisation, diabetes, cardio vascular disease (CVD) risk management and smoking to improve performance on national health targets <p><i>See Attachment 5 for the 2010/11 metro-Auckland BSMC Implementation Plan</i></p> <ul style="list-style-type: none"> ➤ Applying the 2% increase in First Contact funding as agreed nationally. ➤ Commitment to work with Auckland coalitions in the implementation of their business cases. 	<p>Targets being developed currently and will be confirmed by commencement of 2010/11 year</p>	<p>Outcome 3: Reduce the incidence and impact of priority conditions</p> <p>Outcome 5: Improve health sector responsiveness to individual and family/whaanau need</p>
<p>Foster clinical leadership</p>	<ul style="list-style-type: none"> ➤ Continue strengthening and supporting nursing leadership and governance ➤ Continue strengthening the Clinical/ Management Partnership and maintaining high levels of clinical involvement in decision making forums like Business Group, Clinical Management Executive Committee, Clinical Advisory Group, Strategic Forum ➤ Developing the Centre for Health Services Innovation. <i>See Attachment 3: Overview of the Centre for Health Services Innovation Project.</i> 	<ul style="list-style-type: none"> ➤ 100% of charge nurse managers to undertake coaching and mentoring 	<p>Outcome 6: Improve the capacity of the health sector to deliver quality services</p>

Minister's Priorities	CMDHB Actions 2010/11	CMDHB Target 2010/11	CMDHB DSP Priority
<p>Improve clinical staff retention</p>	<ul style="list-style-type: none"> ➤ Working regionally on Resident Medical Officers retention rates ➤ Succession planning for senior nursing roles ➤ Improving the experience of allied health trainees undertaking their final training and/or transitioning into their first post-qualification role at CMDHB to support retention of training roles into full professional roles 	<ul style="list-style-type: none"> ➤ Reducing RMO vacancy rates from 10% to 5% by 2013 ➤ increasing RMO retention rates by improving run evaluation results (a measure of workforce satisfaction) to a minimum score of 4/5 from the current 3.5/5 ➤ Senior nursing succession ➤ Midwifery vacancies reduced by 15 FTE from Dec 09 levels 	<p>Outcome 6: Improve the capacity of the health sector to deliver quality services</p>
<p>Greater collaboration and a more unified system</p>	<ul style="list-style-type: none"> ➤ National and regional initiatives for greater efficiencies and value for money ➤ Regional Clinical Services Planning ➤ See Section 5 for the range of regional initiatives and the Regional Clinical Services Planning 	<ul style="list-style-type: none"> ➤ Delivery of the Regional Clinical Services Plan 	<p>Outcome 6: Improve the capacity of the health sector to deliver quality services</p>

4.2 Performance Improvement Actions (PIAS)

For the 2010/11 DAP process, the Ministry of Health introduced a new planning and accountability requirement which expects DHBs to outline a few vital actions which they will take over the next one to five years to improve efficiency, effectiveness and alignment with Government priorities. These PIAs are intended to have a material effect on improving the performance of the funding administered.

DHBs are expected to focus their PIAs on the 3 objectives of:

- Achieving financial security – by ensuring delivery on Minister agreed financial forecasts within available funding, through active cost management and achieved planned productivity savings;
- Improving productivity and quality – with a focus on hospital wards, theatre utilisation, increasing day surgery and emergency departments; and
- Enhancing regional co-operation – through development of clinical regional service plans and greater regionalisation of shared services and back-office functions.

Counties Manukau DHB's PIAs are derived from several areas of ongoing areas of work which the DHB started in the last year in response to the Government's expectations around health sector productivity, the Thriving in Difficult Times work streams, and the ongoing Quality Improvement work of the DHB. As a result, CMDHB has extended its specific improvement actions to also focus on two other areas: Growing Our Own Workforce and improving population health via effective interventions

PIA OBJECTIVE	IMPACT
Achieving Financial Security	Targeted savings of \$19.5m over three years
Improving Quality & Productivity	Targeted savings of \$15m over three years
Enhancing Regional Co-operation	No new material initiatives as we already have healthAlliance and their benefits incorporated from 5/6 years establishment. Gains would be more advantageous to the other DHB's joining healthAlliance or an expanding Northern Shared Service; significant work in this direction is already underway but not yet quantified.

5. REGIONAL PRIORITIES

There is a compelling case for stepping up the level and pace of regional activity. The drivers for this change include:

- Improving equity of access particularly for at risk population groups
- Addressing the challenges the region is facing around high population growth, ageing and changing trends
- Utilising the region's scarce resources (workforce and assets) effectively and ensuring service sustainability
- Meeting efficiency and affordability pressures within a constrained funding environment

5.1. Northern Region Network Strategy

The proposed scale of regional activity needs to be supported by a more effective regional framework than currently exists. The DHBs have agreed an overall Northern Region Network (NRN) framework and will work with the Ministry of Health, National Health Board and Shared Services Establishment Board to ensure appropriate alignment. During 2010/11 the DHBs will progressively work to implement the recommendations outlined in the NRN Strategy.

Detailed implementation planning is underway around clinical services and business services with early work indicating that key activities in 2010/11 will include:

- Clinical Services activity will include:
 - Reviewing, aligning and clarifying the roles and mandates of the Northern Cancer Network, ROOG and the Regional Oncology Service
 - Establishing three new networks
 - Cardiac/Heart disease
 - Radiology
 - Regional Elective Services Network
 - Strengthening the governance and management of 3-4 key regional services
 - Reviewing and agreeing the future direction for Public Health Services and School Dental services
 - Clinical leadership – developing a regional plan to strengthen clinical leadership capability across the region and to better leverage clinical leadership across clinical disciplines with small and vulnerable FTE
 - Innovation and research – determining how best to share systems and information to support innovation and research at a regional level that will be of benefit to all DHBs
 - Planning support – review planning support activities undertaken at a DHB level and regionally with a view to agreeing how best to undertake this work moving forward.

- Business Services activity will include:
 - Completing implementation planning to align the following functions across the region
 - Information Services
 - Finance
 - Business Solutions
 - Procurement and Supply Chain
 - Payroll
 - Internal Audit
 - ARRMOS
 - Focusing on key initiatives in the following areas as the first of three planned wave of implementation:
 - IS Strategy and Planning for core systems
 - Procurement for non clinical items
 - Financial, Procurement and Supply Chain financial software systems
 - Transactional reporting (Finance)
 - IS Project delivery and IS Service delivery
 - Internal Audit
 - ARRMOS

The key principles underpinning the NRN are:

- The proposed framework and supporting operating model must provide a delivery vehicle which presents an investment in better health for the whole Northern Region and supports the autonomy of the four DHBs
- Any regional support organisation(s) proposed will provide the right level of support based on simple structures and make effective use of existing regional resources
- The future collaboration framework and supporting operating model will not increase overall costs across the Northern DHBs and administrative costs will decrease, with demonstrable savings beginning to occur within the first 12 months of implementation
- Collaboration will include sharing of DHB operational resources for 'back-office' transactional functions and agreed regional services where there is clear benefit to do so
- DHBs will retain key strategic roles and capability to allow them to continue to meet their statutory accountabilities effectively
- Each DHB will work collaboratively based on shared values, using transparent processes, recognising regional contributions, respecting other DHB's individual needs and views so that no one DHB is dominant
- In some instances regional collaboration initiatives will apply only to a subset of all four DHBs

The DHBs have agreed an overall framework and will work with the Ministry of Health, National Health Board and Shared Services Establishment Board to ensure appropriate alignment. During 2010/11 the DHBs will progressively work to implement the recommendations outlined in the NRN Strategy.

5.2. Northern Regional Clinical Service Planning

Over the recent past, the Northern DHBs have undertaken the foundation work required to develop a long term Regional Clinical Service Plan. This includes:

- Work undertaken in each DHB around clinical service planning and patient pathway redesign and quality improvement
- Detailed reviews of individual services that have been undertaken regionally
- An initial assessment of services which are vulnerable across the region (this work will be updated on completion of the Regional Clinical Services Plan)
- Two phases of work that have been undertaken regionally in respect to long term regional service planning:
 - Phase 1 which focused on developing a joint statement of demand and supply of health services and generated an agreed regional picture of current and future inpatient bed requirements, current bed and theatre capacity and population forecasts
 - Phase 2 with the over riding objective being to develop a focused plan that will further shape the strategic direction for service planning in the region, identify the changes needed to meet the new health targets and support the 2009 and subsequent business cases for capital expenditure. Rather than trying to develop a comprehensive plan for all services, Phase 2 focused around 5 key work streams, clinical networks and regional services, urgent and acute care, planned and elective care, health of older people and radiology.

This work will now be leveraged to develop the first Regional Clinical Service Plan by October 2010. The Ministry is seeking plans that will describe the future configuration of services across the region that will best ensure clinical viability and financial affordability from a regional perspective, and to inform resource allocation and service provision decisions at the regional and district level.

5.3. Other Key Regional Initiatives

In addition the region is also undertaking a range of work that is linked to the work outlined above, and is focused around the drive towards meeting the health targets and the wider initiatives associated with *Better, Sooner, More Convenient primary healthcare*. Key initiatives are summarised below.

5.3.1. Better Sooner More Convenient Primary HealthCare

The implementation of the *Better, Sooner, More Convenient* primary health care objectives is largely focused on a more personalised primary healthcare system where services are provided closer to the home. Downstream this will make our populations healthier and reduce the demand on public hospitals. More specifically the government is keen to see the development of integrated family health centres, greater convenience through extended opening hours and walk in clinics, a greater role for nurses (e.g. nurse clinics) to deliver a broader range of services and a level of consolidation across general practice and PHOs.

Across the Northern Region there is also a common objective to maintain a focus on reducing inequalities and have a neighbourhood or locality dimension to primary and community services. This is to improve co-ordination and navigation, drive quality improvement, increase services connection with communities and shift some traditionally secondary services to these localities for more convenience.

The DHBs will continue to work closely with BSMC consortia in 2010/11 to implement their business cases. The focus of work in 2010/11 will be around the following key workstreams:

- new packages of care for mama, pepi, and tamariki to support whanau ora
- clinical pathways across primary and secondary care
- IFHCs and whanau ora centres
- locality networks and approaches
- a more efficient and effective management and commissioning layer across PHOs and three DHBs

Regional approach to PHO consolidation:

Across metro-Auckland there is a common objective to have a locality or neighbourhood approach (ref: GAIHN, NMPC and AH+ Business Plans as well as the WDHB, ADHB and CMDHB Primary Care Plans). This is to improve local access to services, co-ordination and integration, drive quality improvement, be responsive to community needs and shift some secondary services to local settings.

The metro-Auckland DHBs will be looking to support models and structures that:

1. support the locality/neighbourhood approach to be responsive to community needs
2. are of sufficient scale and capacity to drive change, and
3. meet the Minister's goal of reducing the number of PHOs

Some PHOs have already made progress through amalgamations (e.g. TKOH and The People's Centre Trust) and proposed amalgamations (e.g. the incorporation of three PHOs in the Alliance Health+). There are other PHO mergers also in progress although at this stage none within the Waitemata DHB. It is likely there will be at least a 20% reduction in the number of PHOs across metro-Auckland by 31 December 2010.

Each DHB is canvassing the views of various stakeholders on the best approach to meet these goals over May and June 2010 and will have a regionally agreed approach for review by the Ministry by 30 June 2010. The approach will be developed into a more formal plan with associated policies (e.g. cross boundary PHO policies and contracting) in consultation with key stakeholders over July to October with implementation by December 2010.

See [Attachment 5 for the 2010/11 metro-Auckland BSMC Implementation Plan](#)

5.3.2. Elective Services

In 2009 work was undertaken to determine the best regional response to meet the Minister's objectives for Elective Surgical Units (ESUs) and improved access to elective services, recognising the wider DHB objectives in terms of sustainable delivery of clinical services in a financially constrained environment. Based on this work Northern Region has developed a proposal which encompasses:

- The establishment of the Regional Elective Services Network (RESN) which will support the development and design of regional referral pathways, workforce development and training, service delivery models, and intervention and demand analysis.
- Progressively moving to equitable intervention rates across the region, underpinned by a streamlined model of care with distributed ESUs playing a key role in the delivery.

The elective workstream will increasingly be separated from the acute workstream, with the exception of the most complex cases. The implications for each DHB are:

- *Northland DHB* will adopt a range of local strategies to ensure delivery of elective volumes but will not establish a dedicated ESU as there is not sufficient scale
- *Auckland DHB* will extend the Greenlane Short Stay Unit into the Greenlane Surgical Centre (GSC) which will include 4 additional theatres, 25-30 inpatient beds, a new endoscopy suite and an extended Clinical Sterile Services Department (CSSD). This development will be staged with the first phase completed in April 2010 and all phases completed by April 2011.

- *Waitemata DHB* will develop a dedicated purpose built elective facility on the North Shore Hospital campus that will comprise 4 theatres, 4 outpatient clinics and 40 additional inpatient beds. This development will be completed in December 2011 and could be open for the first patients in February 2012
- *Counties Manukau DHB* will expand the current Manukau Surgical Centre by 4 theatres, and extend the CSSD and bring a blood bank on site to support the additional theatres. Indicative timing for this extension is 2014/15.

The ESUs will undertake a mix of additional electives, repatriated publicly funded volumes currently being undertaken in private facilities and volumes that are decanted from the main acute/elective theatres to the ESU. In all cases (apart from acute eyes) the ESUs will be dedicated to elective service delivery.

The regional electronic referrals (GP to ambulatory services) project is on track and has achieved the same referral criteria for each subspecialty service for each of the 3 DHBs and identifies the provider for services that are only provided for the region out of a single DHB (see below).

5.3.3. Tertiary Eating Disorders

Implementation of the Northern Region Eating Disorders Services Plan 2008-2013, covering the Northern and Midland regions. Key elements of this plan include:

- Services for People Aged 15 Years and Under will be provided by Starship Hospital, involving the establishment of 5 specialist beds
- Services for People Aged over 15 Years with the intention that this will be provided from a residential treatment facility with the clinical services provided by the existing Regional Eating Disorders Service. The final configuration for this service will be dependent on receipt of an acceptable response to RFP. In addition, new funding will be available to supplement Regional Eating Disorders Services, and the establishment of FTE within DHBs to increase local capacity.

5.3.4. Northern Region Mental Health and Addictions

The Mental Health and Addiction sector (DHBs) is engaged in regional strategic planning and collaboration to result in improved outcomes for Northern region residents with mental health and addictions needs. This work aligns with the full range of national and regional Mental Health and Addictions Plans.

Regional Services Planning and Governance Groups are supported by the NDSA Mental Health and Addiction Services team.

The Regional Services work programme for 2010/11 will be informed by a service coverage document that has identified the priorities for activity, but will include:

- Implementation of the Northern Region Eating Disorders Services Plan 2008-2013 with recourse to the Northern Region Eating Disorders Services Governance Group.
- Implementation of agreed changes to the delivery of Alcohol & Other Drug services by the Non-government Organisation sector.
- Ongoing implementation of the Strategic Review of District Health Board provided Community Alcohol & Drug Services.
- Increasing the capacity of Regional Forensic Psychiatry Services through application of new Mental Health funds available from 2009.
- Establishment of a new Regional Dementia Advisory service through application of new Mental Health funds available from 2009
- Implementation of the Regional Child & Adolescent Mental Health Inpatient unit service delivery model reconfiguration.

5.3.5. Northern Region Cancer Network (NCN)

The Northern Cancer Network (NCN) will assist northern DHB's to address the national cancer priorities. Through regional collaboration the Network and DHBs will work towards meeting consistent timeliness targets for patients with lung and bowel cancer, and standardised models of care. Tumour streams will be the main mechanism through which these improvements will be realised in 2010/11.

- The region will work to improve cancer wait times as defined by lung and bowel tumour streams. CMDHB targets are outlined in [7.5, CMDHB Priority Outcome 5](#)

Standards for lung cancer

- Patients discussed in Thoracic Multidisciplinary Meeting (TMDM) within 28 days of referral
- Patients have thoracic surgery within 14 days of the TMDM
- Patients that have FSA Medical Oncology within 14 days of the TMDM
- Patients that have First Specialist Assessment (FSA) for Radiation Oncology within 14 days of the TMDM

Standards for bowel cancer to be developed.

- Standardise the model of care for cancer care coordination within the Northern region.
- Everyone needing public radiation treatment will have this within 6 weeks by July 2010 and 4 weeks by December 2010.
- Work towards achieving regional radiotherapy intervention rate of 46% by 2014/15

5.3.6. Community Laboratory Services

The three Auckland Region DHBs will continue to work collaboratively and collectively on the management of the community laboratory service to ensure a quality service is provided that meets expectations. This will consist of ongoing monitoring and management of the contracts that are in place with Labtests and Diagnostic Medlab. In addition, a strategic review of the future provision of histopathology services will also be undertaken that encompasses both community and hospital laboratory services.

5.3.7. Pharmacy

The four northern DHBs will continue to work collaboratively and collectively on community pharmacy in three key areas:

- Contract Review - The four northern region DHBs will continue to provide support and input in to the national contract review. The current agreement with community pharmacies has an expiry date of 30th June 2011. The national review will inform options for agreement options from 1 July 2011.
- e-prescribing - The four northern region DHBs will undertake an initial scoping of the potential to develop and implement an e-prescribing model for the region that can then be picked up by other DHBs/Regions. After the initial scoping, a decision will be made as to progressing the development and implementation or not.
- Relationship development – A Regional Advisory Group will provide advice on the contract review and e-prescribing and will enable local groups to leverage learning and explore common opportunities.

5.3.8. Procurement

The Northern DHBs intend to work closely with the newly established Shared Services Establishment Board (SSEB) to ensure that procurement continues to meet the DHB's needs. In support of this work the Northern DHBs will improve their collaborative procurement work in 2010-11 through a number of initiatives, including:

- Establish joint procurement clinical governance arrangements
- Develop a joint procurement plan
- Continue to align systems and processes
- Reduce duplication of effort

5.3.9. Information Systems

In 2009, the Northern DHBs together with a wide range of sector stakeholders developed the Regional Information Strategy for 2010 to 2020 (RIS10-20). The strategy supports the transformation to new models of care and underpins the development of a person centred model to achieve Better, Sooner, More Convenient primary healthcare. In 2010-2011 the Northern Region DHBs will establish an enhanced regional governance structure to oversee and progress the implementation of the new regional strategy. In addition, the DHBs will engage in some smaller initiatives to start the implementation of this new strategy, as well as progress and complete some significant regional projects that have already been started under the previous strategy. Priority deliverables for the 2010-2011 year include:

- Shared Care Planning - In partnership with PHOs and GPs, DHBs will implement a number of pilot projects which are clinically lead and enable the use of shared care plans between providers
- Electronic Referrals - Implementation of a regional electronic Referrals solution between primary and secondary care providers (eReferrals phase 1). In addition planning for enhancements to allow faster turnaround and improved response to referrals (eReferrals phase 2 & 3) will also start this year.
- Enhancement of the regionally shared clinical data repository: The DHBs will expand the use and content of the regional clinical data repository for sharing of pharmaceutical dispensing information between Pharmacies, GPs and DHBs (TestSafe Pharmacy project), sharing of outpatient letters between DHBs and GPs (Regional Clinical Documents project) and sharing of various additional diagnostic test results between DHBs and GPs (Regional Éclair Enhancement projects)

5.3.10. Workforce development and planning

A Northern Region DHBs Human Resource Management Systems Strategy 2009-2013 has been developed. This document aligns with the RIS 10-120 but may require review depending on the direction taken nationally regarding the scope of this strategy.

The Northern DHBs will continue to work together on in depth regional reporting on a range of established recruitment KPIs and collaboration around the negotiation of regional external partnership agreements which have resulted in substantive cost savings.

National strategy in the area of Employment Relations will drive the regional ER activity in the coming year. Relationships and consultative and communication mechanisms are in place to manage these processes along with the inherent and potential risks of industrial negotiations including management of settlement costs.

Key projects in 2010/11 will include:

- The SMO Job sizing project is developing an agreed Service Size for each speciality, job sizing each SMO (1400 in the region) to that Service Size, aligning their remuneration to the MECA and implementing regional remuneration relativity strategies across like specialities.
- Auckland Regional RMO Services Ltd (ARRMOS) focus for 2010/11 is to work closely with the CTAB, DHBZ etc on developing a model for nationally consistent RMO administration in line with the recommendations of the 2009 RMO Commission report.
- Physician Assistant Pilot. The four Northern Region DHBs and the University of Auckland Faculty of Medical and Health Sciences are collaborating to undertake a pilot of the USA trained, medical model of the Physician Assistant (PA) role. The first stage is to be a pilot of two PAs in surgery (including elective surgery) at CMDHB for a period of 12 months commencing in mid 2010. Once the pilot at CMDHB is established, the DHBs will give consideration to further pilots in other specialities and at other DHBs.

Work is ongoing to get recruitment, education and workforce plans regionally aligned. Schools based programmes are a key element in the different organisations plans to prepare more Maaori and Pacific young people for tertiary studies in health related courses and ongoing employment within our sector. Better health outcomes are a desired result of more Maaori and Pacific being in education and in good jobs earning a higher income.

5.3.11. Regional Asset and Capital Planning

The first Northern Region Asset Management Plan was developed in 2009 in line with Ministry timelines. It was essentially a roll up of the individual DHB plans. It is recognised that the region is unlikely to be able to afford the investments proposed in this plan and that there will increasingly be strong 'competition' for Health Capital Budget funding which will put at risk a number of strategic investment proposals. Moving forward there is scope to improve asset management both locally and regionally. In 2010/11 it is envisaged that this will occur at a number of levels:

- Alignment with the Regional Clinical Services Plan (when it is completed in October, 2010)
- Improve information about the asset base
- Improve the capital budgeting process
- Strengthen the linkages between service planning and asset management planning, including affordability analysis
- Develop a transparent decision making framework for use in challenging investment requests and to help the region to make some of the tough decisions that are likely to be required in the medium term

The DHBs have signalled specific improvement initiatives in their individual plans. At a regional level the focus will be on the latter two areas outlined above.

5.3.12. Auckland Regional Public Health Service

ARPHS provides public health services for the people within the three DHBs in the Auckland region and aims to keep people well through preventing disease, prolonging life and promoting health. ARPHS focuses on those public health services that are most effectively and efficiently undertaken at the regional level. The focus for 2010 – 2011 will be on:

- Consolidate inter-agency regional emergency planning.
- Work with other sectors to ensure that decisions outside the health sector consider health and health inequalities consequences.
- Work with the inaugural Auckland council to try and influence the development of strategies, policies and operational practices.

5.3.13 Auckland Regional Settlement Strategy (ARSS) Migrant Health Activity

The ARSS is a region-wide approach to improving the health of Asian, refugee and migrant populations. Improving access for these groups to health and disability services, and improving the cultural responsiveness of the services provided is vital to the improvement of their health outcomes. Regional activities include:

- Primary Health Interpreting Pilots.
- Cultural competency training for the DHB primary and secondary workforce.
- Culturally responsive child services.
- South Asian CVD, Diabetes and obesity prevention projects.
- Auckland Region Middle Eastern / Latin American / African Health Needs Assessment.
-

5.3.14 Oral Health

Regional priorities for oral health include reducing inequalities, improving child and adolescent oral health and ensuring efficient resource utilisation and distribution. In order to address these priorities, regional initiatives include:

- Implementation of the Oral Health Business case.
- Establishment of Community Based Workers to target preschool populations in Auckland Regional Dental Service (ARDS).
- Track preschool enrolments / examinations and effectively communicate with primary care providers and DHBs.

Table 8 below shows the summary of regional activities and deliverables for 2010/11.

Table 8: Summary Regional Table of Activities and Deliverables:

	Deliverables/Milestones	Q1	Q2	Q3	Q4
Northern Regional Network Strategy	<p>Progressively implement the Northern Regional Network Strategy Priority areas include:</p> <ul style="list-style-type: none"> ➤ Clinical Networks ➤ Strengthening the governance/management of regional services ➤ Better sooner more convenient primary care <ul style="list-style-type: none"> ➤ Clinical leadership ➤ Innovation and research ➤ Planning support ➤ IS Strategy and Planning for core services ➤ Procurement for non clinical items ➤ Financial, procurement and supply chain software systems ➤ Transactional reporting (finance) ➤ IS Project delivery and IS service delivery <p>Implementation planning is still progressing but where specific actions and performance measure have been agreed these are specified below.</p>	✓	✓	✓	✓

Clinical Service Planning	Regional Clinical Services Plan completed Monitoring of progress against RCSP implementation plan (further milestones will be specified on completion of the RCP in Q2)		✓		✓	✓
	Deliverables/Milestones	Q1	Q2	Q3	Q4	
Establish New Clinical Networks	Establish new clinical networks: <ul style="list-style-type: none"> ➤ Cardiac/Heart ➤ Regional Elective Services ➤ Radiology 		✓	✓		✓
Cancer	Radiotherapy <ul style="list-style-type: none"> ➤ Meet 6 week waiting time target ➤ Meet 4 week waiting time target Lung: <ul style="list-style-type: none"> ➤ Increase from 43 per cent to 50 per cent the patients discussed in Thoracic Multidisciplinary Meeting (TMDM) within 28 days of referral ➤ Increase from 30 per cent to 50 per cent the Patients that have thoracic surgery within 14 days of the TMDM ➤ Increase from 36 per cent to 50 per cent the patients that have First Specialist Assessment (FSA) Medical Oncology within 14 days of the TMDM ➤ Increase from 7 per cent to 50 per cent the patients that have FSA Radiation Oncology within 14 days of the TMDM Bowel: <ul style="list-style-type: none"> ➤ Baseline performance against regional timeliness standards will be established ➤ Regional prioritisation criteria established for colonoscopies 	✓	✓	✓	✓	✓
Tertiary Eating Disorders	Dedicated service for People Aged 15 Years and Under will be provided by Starship Hospital, involving the establishment of 5 specialist beds Residential treatment service (potentially comprising 8 beds for Northern DHBs and 1 for Midland region) established for people aged over 15 Year. (final configuration for this service will be dependent on receipt of an acceptable response to RFP). FTE appointed within DHBs to supplement Regional Eating Disorders Services and increase local capacity	✓		✓	✓	
Forensic Mental Health	Establishment of additional regional forensic services – court liaison services (1.0 FTE), forensic community team (1.0FTE), forensic prison mental health team (5.0FTE)	✓				

Community Pharmacy	New agreement for community pharmacy completed				✓
Procurement	<p>The Northern DHBs are working closely with the Shared Services Establishment Board (SSEB) to determine procurement priorities for delivery in 2010/11. This work will be completed in time to add specificity into the May DAP but initiatives are expected to include:</p> <ul style="list-style-type: none"> ➤ Establishment of joint procurement clinical governance arrangements ➤ Development of a joint procurement plan ➤ Progressive alignment of systems and processes and reduction of duplication of effort ➤ Implementation of initiatives aimed at reducing costs 				
Information Systems	<p>Shared Care Planning - In partnership with PHOs and GPs, DHBs will implement a number of pilot projects which are clinically lead and enable the use of shared care plans between providers</p> <p>Phase 1 of Regional electronic referrals solution between primary and secondary care providers implemented</p> <p>Regionally shared clinical data repository expanded to include pharmaceutical dispensing information between Pharmacies, GPs and DHBs, sharing of outpatient letters between DHBs and GPs and sharing of various additional diagnostic test results between DHBs and GPs</p> <p>Phase 2 of Mental Health electronic patient record system</p>		✓	✓	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>
Workforce	<p>Progressive implementation of the Regional Human Resource Management Systems Strategy</p> <p>Progress SMO job sizing work to align remuneration to MECA and implement regional remuneration strategies across like specialties</p> <p>Nationally consistent RMO administration processes aligned with RMO Commission Report in place</p> <p>Initiate the Physician Assistant Pilot (2 FTEs)</p>			<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>
Regional Asset Management and Capital Planning	Regional Asset Management Plan 2011/12 that is aligned with Regional Clinical Service Plan (timing may need to alter to meet NHB timelines when they are determined)				✓

6. KEY RISKS AND ASSUMPTIONS

6.1 Key Risks

Refer to [8.3 Key Risks and Assumptions](#).

For Financial Risks refer to [Section 8](#)

6.2 Service Coverage issues

No service coverage issues are anticipated by CMDHB in 2010/11.

7 CMDHB PRIORITIES FOR 2010/11: Actions to Achieve National and Local Priorities

7.1 Outcome 1 – Improve Community Wellbeing

Why is this important?

Tackling lifestyle risk factors and health behaviours like smoking, obesity, lack of physical activity and poor nutrition are some of the biggest challenges faced by CMDHB.

There are four main categories of noncommunicable disease responsible for a substantial proportion of deaths, long term illness or disability and reduced quality of life within Counties Manukau; they are diabetes, cardiovascular disease (CVD), cancers and chronic respiratory disease. These diseases are largely preventable through eliminating the shared risk factors, mainly tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol.

Obesity and smoking are amongst two of the most preventable causes of death and diseases attributable to both include cardiovascular disease, Type 2 diabetes, and some cancers. Both these risk factors impact on our Maaori and Pacific populations disproportionately. The effect of poor nutrition and inadequate exercise intake has also contributed to a growing rate of Type 2 diabetes amongst the Counties Manukau population. The number of people with Type 2 diabetes is anticipated to increase very significantly over the next 20 years - which if not controlled - will not only have a major impact on health services in Counties Manukau but will also be devastating for the social and economic wellbeing of the local population.

CMDHB has a large proportion of individuals and families living in crowded conditions and poor quality housing; a reflection of the relatively high proportion of the Counties Manukau population who are affected by social and economic deprivation. The resultant effect is poor health status amongst these individuals, with the Counties Manukau Maaori and Pacific population affected disproportionately. Risks associated with poor quality housing and crowding include conditions like tuberculosis, rheumatic fever, gastroenteritis and skin infections.

How are we going to do this?

<p>“Creating a Better Future”</p>	<p>In 2005, CMDHB launched the Let’s Beat Diabetes (LBD) 5 year programme to set up the long-term infrastructure for preventing and/or delaying the onset of diabetes, slowing disease progression, and increasing the quality of life for people with diabetes. The LBD programme has since concluded with good gains made in the area of cross-sector cooperation and social marketing.</p> <p>In 2010/11, CMDHB will continue to work on the foundation laid by LBD through the “Creating a Better Future” plan which will see the DHB take a long term view of creating healthier communities by reducing the burden of non-communicable diseases (NCD).</p> <p>This Plan aims to prevent or delay the onset of NCD and to improve health outcomes and quality of life for those with disease and to reduce health inequalities. This will be achieved through:</p> <ul style="list-style-type: none"> ➤ Strong clinical leadership; ➤ Supporting structural change to ensure responsiveness to the need for prevention and improved management of NCD; ➤ Developing new or building on existing effective initiatives that promote active engagement in being healthy; ➤ Reducing risk factors and improving the identification and management of NCD;
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	<ul style="list-style-type: none"> ➤ Working in partnership across sectors to create environments that support active engagement in being healthy; and ➤ Consolidating and further developing a knowledge base for action.
<p>Intersectoral partnerships to develop healthy environments</p>	<p>CMDHB will continue to work collaboratively and in partnership with other agencies, in particular, schools, Manukau City Council, the Ministry of Social Development, and Housing New Zealand, to bring about the social and environmental changes which are needed to bring about better health outcomes for the population.</p> <p><i>Healthy Housing</i></p> <ul style="list-style-type: none"> ➤ CMDHB will continue to deliver joint health and housing assessments in partnership with Housing New Zealand as a part of the Healthy Housing programme. This programme which is entering its 9th year is having a positive impact on housing related hospitalisations and participants utilisation of primary healthcare services and outpatient services. ➤ CMDHB will also run programmes to retrofit insulation into the homes of low income households, prioritising those with children under 14 years old and older people over 65+ with respiratory problems. <p><i>Healthy Schools</i></p> <ul style="list-style-type: none"> ➤ Using the Tipu Ka Rea – 3-step – model, CMDHB will continue to work with schools in the district to be self-sustaining health promoting schools. A Health Promoting School is defined by the World Health Organisation as, “one that is characterised by constantly strengthening its capacity as a healthy setting for living, learning and working”. 60% of schools in deciles 1-3 are targeted for this work. <p><i>Family Violence Prevention (FVP)</i></p> <p>CMDHB will:</p> <ul style="list-style-type: none"> ➤ continue to maintain intersectoral links with agencies working to address family violence and identify opportunities to work collaboratively with stakeholders. ➤ support the Family Violence Prevention Policy and promote the implementation of the FVP programme action plan for staff at CMDHB ➤ identify and respond to remedial actions arriving from the annual service audit and service specification will identify opportunities to work collaboratively with key stakeholders and community groups
<p>Creating Smokefree Environments</p>	<p>Secondary Care</p> <p>In the past year, the CMDHB has developed systems and provided training to support the achievement of this target. These include:</p> <ul style="list-style-type: none"> ➤ Development of the Patient Smokefree Assessment sticker to support easy and standard documentation of patient interventions ➤ Smokefree Best Practice training for clinicians (now mandatory for nurses) ➤ Nicotine Replacement Therapy (NRT) Standing orders for Nurses ➤ Train the trainer – to develop capacity within the hospital to deliver the Smokefree Best Practice Training ➤ As of May 2010, having smoking information as a mandatory field in the Electronic Discharge Summary <p>The 2010/11 year will see continued development of the training including:</p> <ul style="list-style-type: none"> ➤ An e-learning module for all doctors on prescribing NRT (and other cessation medication) and charting the medication for patients. ➤ Increasing the capacity of trainers within the hospital with more Train the Trainer courses ➤ Encouraging more Nurses and Allied health professionals to become Standing Order trained

	<ul style="list-style-type: none">➤ Support the on-going mandatory training for all Nurses and encourage Midwives also to include the training as part of their mandatory requirement <p>Achievement of the hospital smokefree target will be championed by the Hospital Smokefree Leadership Group, a group consisting of the Chief Operating Officer, various senior management and clinical leaders.</p> <p>Primary Care</p> <p>All PHOs have agreed to report to a standard set of indicators, with reporting on the first quarter due in October 2010. DHBNZ will be working with patient Management System (PMS) vendors and CMDHB will be offering training and support including:</p> <ul style="list-style-type: none">➤ Providing GP and Practice Nurse training and Train the Trainer courses for PHO/Primary Care Nurses➤ Providing resources for both practitioner and patient➤ Providing on-going feedback and communication to PHOs➤ Providing funding for PHOs for having 75% of doctors and nurses trained in the <i>Smokefree ABCs</i> and showing improved results.
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How we will measure our progress

- An increase in the availability of smoking cessation advice and support for the community
- A decrease in the proportion of inpatient smokers
- A decrease in the proportion of students living in homes where there is smoking
- An increase in the proportion of adults who are regularly physically active
- A reduction in the proportion of adults who are classified as obese
- An increase in the proportion of adults who eat at least 3 portions of vegetables and 2 portions of fruits a day
- An increase in the number of schools which are health promoting schools
- An increase in hospital responsiveness to Family Violence, Child and Adult Abuse
- A increase in joint health and housing assessments
- An increase in homes in Counties Manukau retrofitted with insulation

Outcome 1 Performance Indicators

Ref column definitions:

HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan, DAP = District Annual Plan, P = Productivity Initiative

Measure	Ref	CMDHB Target/ Deliverable	Responsibility
Proportion of hospitalised smokers provided with advice and help to quit National Target: <i>90% of hospitalised smokers can access advice and help to quit by July 2011</i>	HT5	90%	Provider Arm with the support of Service Integration – Healthy Lifestyles
Proportion of primary care patients provided with advice and help to quit National Target: <i>80% of primary care patients provided with advice and help to quit by July 2011</i>	HT5	50%	Primary Care with the support of Service Integration – Healthy Lifestyles
Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit Score	PP14	Family Violence: 70/100 Child Protection: 70/100 Total: 140/ 200	Service Integration – Child, Youth & Maternity
Number of physical activity opportunities to be created in the community	DAP	≥ 48	Service Integration – Healthy Lifestyles
Number of people in the community who will be equipped to be physical activity leaders	DAP	≥ 40	Service Integration – Healthy Lifestyles
Number of eligible schools who are health promoting schools	DSP/ DAP	110	Kidz First
Number of joint health and housing assessments completed	DSP/ DAP	480	Service Integration - Intersectoral
Number of low income homes retrofitted with insulation (Warm up Counties Manukau)	DAP	500	Service Integration - Intersectoral
Number of low income homes retrofitted with insulation (Snug Homes Counties Manukau)	DAP	500	Service Integration - Intersectoral

7.2 Outcome 2 – Improve Child and Youth Health

Why is this important?

Counties Manukau has a relatively youthful population, with 13% of the nation’s children living in the district, and 25% of the Counties Manukau population being aged 14 years and under. Children have the right to good health care, safe and clean environments, nutritious food, clean drinking water, and information to help them stay healthy². Good child health is also important as it lays the foundation for good adult health. In Counties Manukau, a significant proportion of children live in areas of high deprivation and many are at risk of poor health outcomes due to a combination of social and economic factors like poor quality housing, parental employment and incomes.

How are we going to do this?

<p>Immunisation</p>	<p>Immunisation is considered one of the most cost effective and successful public health interventions by which to maintain and protect the health of the population via the reduction, and ideally the eradication, of preventable communicable diseases. CMDHB will be looking at ways of working more innovatively and cost effectively to improve the immunisation rates for the population. This will include working with the Northern region DHBs to share resources on a range of initiatives which will foster regional collaboration in working towards the newly established regional target.</p> <p>The local CMDHB initiatives are documented in our immunisation delivery framework 2009-2012, which is aimed at steadily increasing our overall coverage rates to achieve 95% by 2012. The strategies included in the framework are aimed specifically at Maaori and Pacific Tamariki, and Whaanau. Our ethnic providers have requested outreach immunisation services that are equipped to immunise tamariki in their homes, therefore outreach models will be amended to enable service delivery. Pacific churches have requested immunisation opportunities within the churches therefore we will pilot immunisation and well child services within a church setting. Our strategy has been formulated using evidence based methods and in response to requests from our local communities.</p>
<p>Community-based health services</p>	<p>CMDHB will continue to work with communities and partner agencies to ensure that the health needs of children and young people are met by improving access to health care services and by developing and implementing child and family-centred policies, programmes and initiatives to bring about improved health outcomes.</p> <p>Central to this work is the movement from a treatment-based model of care to a preventative model of care and also the development of community-based health services - like the outreach immunisation programme, mobile vision and hearing services, mobile oral health clinics, preschool brushing programmes and <i>B4 School Checks</i> delivered by Well Child and community providers - which are delivered to where people live, makes access to health services possible for a wider group of people and also enables the delivery of health information to these groups.</p>

² Article 24 of the United Nations Convention on the Rights of the Child

<p>Maternal and infant health</p>	<p>CMDHB has been working toward achieving <i>Baby Friendly Hospital</i> accreditation for Middlemore Hospital. All three community maternity units have achieved accreditation and continue to maintain this. Work is ongoing at the Maternity Unit on the Middlemore campus to achieve accreditation and the DHB will be entering year 3 of the 3-4 year work project in 2010/11. In the meantime, maternity services including Maternity providers are focused on the national objectives of supporting more mothers to breastfeed and optimising the postnatal length of stay, particularly for first time Maori and Pacific mothers.</p> <p>Infant mental health is also a focus for the DHB and resources have been developed for the community which will now be extended to resources to support health professionals working with mothers.</p>
<p>Youth Health</p>	<p>Youth health services are provided to 12-24 year olds and include school based health services like the Year 9 health assessments and the human papillomavirus (HPV) vaccination programme (the latter is also provided via primary care).</p> <p>The DHB also provides health assessments for young people who are in the care of Children, Youth & Family Services (CYFS), alternative education, teen parent units, or those who are incarcerated.</p> <p>2010/11 priorities for youth health include enhancing health assessments for Year 9s, youth in teen parent units and youth in alternative education to include follow ups.</p> <p>Youth in alternative education will also have youth advisory groups set up, post intervention support in the event of a traumatic incident and breakfast clubs.</p> <p>Young people aged 12 – 17 (up to their 18th birthday) are also eligible for free oral health services provided via contracted dentists in the community including the school-based mobile oral health service.</p>

How we will measure our progress

- An increase in the proportion of two year olds fully immunised
- A reduction in the admission and readmission to hospital rates for infants in their first year of life
- A reduction in ambulatory sensitive (avoidable) hospitalisations for children aged 0- 4 years
- An improvement in the proportion of preschool children enrolled in DHB-funded oral health services consistent with the focus on early intervention
- An improvement in the caries free rate and mean Decayed, Missing, Filled Teeth (DMFT) teeth score for children aged from 0 years to year 8 (12 /13 years).
- An improvement in the utilisation of oral health services by adolescents aged from 12 – 17 years.
- An improvement in breastfeeding rates
- A reduction in the rate of alcohol-related hospitalisations for 15 – 19 year olds

Outcome 2 Performance Indicators

Ref column definitions:

HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan, DAP = District Annual Plan, P = Productivity Initiative

Measure	Ref	CMDHB Target/ Deliverable	Responsibility
Proportion of 2 year olds fully immunised <i>National Target: 90% of two year olds are fully immunised by July 2011</i>	HT4	Maaori: 83 % Pacific: 90% Total: 90%	Service Integration – Child, Youth and Maternity
Proportion of children referred to outreach immunisation service who are then immunised.	DAP	50%	Service Integration – Child, Youth and Maternity
Proportion of over due/ un-immunised children under 5 years registered with Lotu Moui churches immunised	DAP	50%	Service Integration – Child, Youth and Maternity
Ambulatory sensitive (avoidable) hospitalisations for 0 – 4 year olds	SI 1	See Outcome 5 Performance Indicators	Service Integration – Primary Care
Mean Decayed, Missing or Filled Teeth (DMFT) Score at Year 8	PP10	Maaori 1.50 Pacific 1.30 Other 0.88 Total 1.10 Fluoridated 1.10 Non Fluoridated 1.10 All areas 1.10	Service Integration – Child, Youth and Maternity
Proportion of children who are caries-free at 5 years old	PP11/ DSP	Maori 40.0% Pacific 35.0% Other 68.0% All 52.0% Fluoridated 52.0% Non-Fluoridated 60.0% All Areas 52.0%	Service Integration – Child, Youth and Maternity
Mean decayed, missing or filled teeth (DMFT) score at 5 years old	DAP	Maori 3.00 Pacific 3.00 Other 1.40 All 2.25 Fluoridated 2.12 Non Fluoridated 1.70 All areas 2.25	Service Integration – Child, Youth and Maternity
Proportion of adolescents utilising DHB-funded dental services	PP12	60%	Service Integration – Child, Youth and Maternity
Proportion of Year 8 children transferred to the Adolescent Dental Service	DAP	>95%	Service Integration – Child, Youth and Maternity
Proportion of children enrolled in DHB-funded oral health services Measure 1: Proportion of children under 5 years old enrolled in DHB-funded oral health services Measure 2: Proportion of preschool and primary school children enrolled with DHB funded oral health services who have not been examined according to their planned recall	PP13	Measure 1: 0 – 2 years 50% 3 – 4 years 85% Measure 2: 15%	Service Integration – Child, Youth and Maternity

Measure	Ref	CMDHB Target/ Deliverable	Responsibility
Oral Health Did Not Attend rate.	DAP	≤10%	Service Integration – Child, Youth and Maternity
Proportion of CMDHB maternity facilities with newborn hearing screening facilities including a mop-up programme for babies discharged before screening has been completed	DAP	100%	Kidz First
Proportion of infants exclusively and fully breastfed at 6 weeks, 3 months and 6 months <i>National Target: 74% at 6 weeks 57% at 3 months 27% at 6 months</i>	SI7	6 weeksMaaori: 50% Pacific: 50% Other: 60% Total: 55% 3 months: Maaori: 48% Pacific: 40% Other: 57% Total: 50% 6 months: Maaori: 27% Pacific: 27% Other: 27% Total: 27%	Service Integration
Proportion of infants exclusively breastfed at discharge from hospital.	DAP	> 75%	Women's' Health
Proportion of eligible young women who have completed the full human papillomavirus (HPV) vaccination course through the school-based programme	DAP	Dose 3 completion – 55% Dose 2 completion – 60% Dose 1 completion – 65%	Kidz First
Number of Year 9 assessments with follow up	DAP	2000	Service Integration – Child, Youth and Maternity
Number of assessments with follow up for young people in alternative education	DAP	500	Service Integration – Child, Youth and Maternity
Proportion of assessments for teen mothers with follow up	DAP	100%	Service Integration – Child, Youth and Maternity

7.3 Outcome 3 – Reduce the incidence and the impact of Priority Conditions

Why is this important?

Diabetes, cardiovascular disease, chronic respiratory disease, cancer and mental health are leading causes of death and illness for our population, particularly for Maaori and Pacific people. Reducing the incidence and impact of these priority conditions is necessary in order for the DHB to be in the position to better manage long term conditions and reduce acute demand and unnecessary hospital admissions.

How are we going to do this?

Management of Long Term Conditions	<p>In 2010/11, CMDHB will work towards key deliverables including:</p> <ul style="list-style-type: none"> ➤ Increasing Maaori (22%), Pacific (38%) and Asian (11%) enrolments into the Chronic Care Management (CCM) programme to ensure equitable coverage for those with long term conditions by June, 2011. Counties Manukau DHB will continue to work with PHOs with target populations to ensure that CCM enrolments are targeted to the highest group of clinical need. ➤ Measuring improved engagement and self management perception for people with Long Term Conditions by ensuring at least 450 patients have completed the pre and post intervention questionnaire by June, 2011. The results will continue to be used as part of our quality improvement cycle to ensure consistency in the way programmes are delivered to target populations. ➤ Increasing awareness of Primary Options for Acute Care, CCM, Get Checked, Frequent Adult Medical Admissions (FAMA), Very High Intensive Users (VHIU) and Care Plus to nurses and undergraduate nursing students throughout 2010 and 2011. The Primary Health Care Nurse specialists will continue to increase post graduate awareness of the Long Term Conditions paper via the CTA funding. The PHO nurse leaders are also engaged and will work with providers to identify people to complete further study. ➤ Increasing access to evidence-based CVD risk management for 3000 patients who have a CVD risk of > 15% by June, 2011. ➤ Reducing the impact of chronic diseases for Maaori through the continuing development of Heart Guide Aotearoa as part of the CCM programme by June, 2010. ➤ More consistent utilisation of the POAC programme across CMDHB while focusing on those practices with nil/ low POAC utilisations and high hospital admissions by June, 2011. ➤ Development of an agreed Quality Improvement framework in order to provide clinical governance to the diabetes and CVD care provided across Counties Manukau by December, 2010. The Diabetes Cardiovascular Clinical Governance Group is continuing to support the clinical governance of these priority conditions. The quality improvement framework will ensure we are making clinical improvements at a system level as well as an individual health outcome level. ➤ Continue with the establishment of collaborative clinical networks for quality improvement within two localities that will work on evolving the model of CCM. ➤ Evaluation of Clinical Networks with recommendations provided by
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	<p>30th June, 2011.</p> <ul style="list-style-type: none"> ➤ Improvement of CCM indicators within primary care, both process and clinical, by December, 2010. ➤ Good clinical engagement through regular meeting attendance. ➤ Clinical networks have completed their second quarterly PDSA cycle. ➤ Improved agreement of CCM key performance indicators by 5% of baseline <p>Clinical Networks (also known as Local health Networks) will focus on health outcomes and variability at a local level. Synthesised data from the CCM programme, admission data, and demographic population data will be used by the clinical network to develop a 'population plan' for a group of practices. The plan will include what they will target, and strategies used to target those changes. The plan will also identify resource and skill issues that need to be addressed. The members of the collaborative will then work over the next 3 months by focusing on the targets they have identified. These members will receive ongoing support, including monthly visits, to support the quality improvement plan.</p> <p>Furthermore, CMDHB will continue to work with its regional counterparts in support of increasing referrals to the POAC programme as identified in the 2010/11 metro-Auckland Better, Sooner, More Convenient Implementation Plan (<i>Attachment 5</i>).</p> <p>CMDHB's targets for Diabetes Get Checked will appear to be lower than the 2009/10 targets. This is due to the increase in the expected number of unique individuals with diabetes across the Counties Manukau population from 2009/10.</p> <p>The 13% increase means that while it appears that our detection rate has decreased from 68% in 2009/10 to 62% for 2010/11, the DHB has in fact increased actual detection by 4.5%.</p> <p>The actual expected number of Pacific within the Counties Manukau area has increased by 26.7% for the 2010/11 target alongside a substantial increase in "Other", which includes Asian prevalence rates. It is well established that Pacific have higher levels of HbA1c when detected. These factors have therefore reduced our overall 2010/11 target for case management by 1%.</p>
<p>Cancer Control</p>	<p>Regional collaboration through the Northern Cancer Network (NCN) will be pivotal to CMDHB and the other northern DHBs improving cancer treatment waiting times.</p> <ul style="list-style-type: none"> ➤ Tumour streams and multidisciplinary working groups will be the main mechanisms by which these improvements will be achieved. DHBs are working to achieve consistent criteria, diagnosis and treatment timeframe targets for lung and bowel cancer. Specific standards have been regionally agreed in order to reduce wait times and improve the pathway of care from first diagnosis to treatment. Waiting time standards for lung and colorectal cancers will be implemented in 2010/11. ➤ A referral pathway to improve access of Maaori patients to the Maaori Community Cancer Support Services will be developed in collaboration with the Regional Blood and Cancer service.

	<ul style="list-style-type: none"> ➤ With regards to improving on Chemotherapy wait times, CMDHB will be exploring the development of an outreach chemotherapy treatment service at Middlemore Hospital. Should this proceed, the earliest time this service will become available to patients will be in the 2011/12 financial year. In the interim, chemotherapy services for CMDHB patients will continue to be purchased from Auckland DHB. <p>To ensure that CMDHB is reaching its targets for cancer treatment waiting times, active monitoring systems have been established. Monthly and quarterly reports, produced by Auckland DHB, detail the provision of radiotherapy and medical oncology services for CMDHB patients and track patient waiting times including reasons for delay where treatment waiting times are greater than target (6 weeks or 4 weeks) CMDHB monitors the latter, working with ADHB where necessary to address these delays.</p>
Mental health	<ul style="list-style-type: none"> ➤ The CMDHB Mental Health Service is moving towards a more restorative model of care with a shift away from hospital-based care towards community-based care where people are encouraged to actively manage their own recovery, backed up by specialist services. These include increasing Peer Support Specialist Services both in the community and in the hospital, and supporting family/ whaanau to care for family members with mental health issues via the Mental Health First Aid programme ➤ Access to primary mental health services will be further developed in 2010/11 where PHOs with more than 20,000 patients enrolled will be able to offer the CCM Depression module. This will enable people to access lower-level mental health services at a primary service level which is in line with the <i>“Better, Sooner, More Convenient Primary Healthcare”</i> national objective. ➤ Services for youth with moderate to severe mental health will be reconfigured to improve access for this group.

How we will measure our progress

- An increase in the proportion of people with diabetes who have had an annual check
- An increase in the proportion of people with diabetes have satisfactory or better diabetes management
- An increase in the proportion of eligible adult population have had their CVD risk assessed in the last 5 years
- A reduction in adult hospital discharge rates for cardiovascular disease and diabetes
- An increase in the proportion of women aged 45-69 who have had a breast screen in the last 24 months
- All people needing radiation oncology treatment will have this within 6 weeks of their first specialist assessment
- An increase in the proportion of Counties Manukau people with severe mental health accessing mental health services

Outcome 3 Performance Indicators

Ref column definitions:

HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan, DAP = District Annual Plan

Measure	Ref	CMDHB Target/ Deliverable	Responsibility
Proportion of people with diabetes who have had an annual check <i>National Target:</i>	HT6	Maaori: 80% Pacific: 69% Other: 54% Total > 62%	Service Integration – Primary Care
Proportion of people with diabetes have satisfactory or better diabetes management <i>National Target:</i>	HT6	Maaori 53% Pacific 48% Other 70% Total > 60%	Service Integration – Primary Care
Proportion of the eligible adult population who have had their cardiovascular disease (CVD) risk assessed in the last 5 years <i>National Target:</i>	HT6	Maaori: 74% Pacific: 75% Other: 82% Total : 79%	Service Integration – Primary Care
Number of patients who receive a Get Checked visit	DAP	> 16,900	Service Integration – Primary Care
Number of enrolments in the Chronic Care Management Programme	DSP	> 17,500	Service Integration – Primary Care
CCM Depression module available in CMDHB PHOs with enrolled populations > 20,000	DAP	100%	Service Integration – Primary Care
Number of additional patients enrolled in Self Management programmes	DAP	> 850	Service Integration – Primary Care
Proportion of patients attending cardiac rehabilitation	DAP	20% increase from baseline	Medicine & Clinical Support
Compliance with Transient Ischaemic Attack (TIA)/ Stroke pathway	DAP	>70%	Medicine & Clinical Support
Proportion of patients in category A, B, C wait less than 4 weeks between first specialist assessment and the start of radiation oncology treatment National Target: <i>100% of patients in category A, B, C wait less than 4 weeks between first specialist assessment and the start of radiation oncology treatment</i>	HT3	100%	This service is delivered by ADHB
Proportion of patients waiting less than 6 weeks between first specialist assessment and the start of chemotherapy treatment National Target: <i>100% patients waiting less than 6 weeks between first specialist assessment and the start of chemotherapy treatment</i>	PP5	100%	This service is delivered by ADHB

Measure	Ref	CMDHB Target/ Deliverable	Responsibility																
Proportion of women aged 45-69 who have had a breast screen in the last 24 months	DSP	67%	Medicine & Clinical Support																
Proportion lung cancer patients discussed in Thoracic Multidisciplinary Meeting (TMDM) within 28 days of referral.	DAP	43% to 50%	Medicine & Clinical Support																
Proportion of lung cancer outpatients who are treated within 4 weeks of FSA	DAP	80%	Medicine & Clinical Support																
Proportion of lung cancer outpatients discussed at the Thoracic Multidisciplinary Meeting (TMDM) within 4 weeks of GP referral	DAP	≥ 50%	Medicine & Clinical Support																
Proportion of lung cancer patients who start radiation oncology treatment within 14 days of FSA (after TMDM)	DAP	36% to 50%	Medicine & Clinical Support																
Proportion of lung cancer patients who start chemotherapy (medical oncology) within 14 days of FSA (after TMDM)	DAP	7% to 50%	Medicine & Clinical Support																
Proportion of lung cancer patients who have thoracic surgery within 14 days (after TMDM)	DAP	30% to 50%	Medicine & Clinical Support																
Proportion of cancer patients who have radiotherapy intervention at ADHB	DAP	37.6% to 40%	Medicine & Clinical Support																
Proportion of people (0-19, 20-64, 65+ years) domiciled in the DHB region accessing mental health services.	PP6	Represented as a percentage <table border="1" data-bbox="1339 746 1738 852"> <thead> <tr> <th>Ages</th> <th>Maaori</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>0 - 19</td> <td>3.00</td> <td>1.99</td> <td>2.20</td> </tr> <tr> <td>20 – 64</td> <td>5.58</td> <td>2.43</td> <td>2.88</td> </tr> <tr> <td>> 64</td> <td></td> <td></td> <td>1.98</td> </tr> </tbody> </table>	Ages	Maaori	Other	Total	0 - 19	3.00	1.99	2.20	20 – 64	5.58	2.43	2.88	> 64			1.98	Mental Health
Ages	Maaori	Other	Total																
0 - 19	3.00	1.99	2.20																
20 – 64	5.58	2.43	2.88																
> 64			1.98																
Proportion of long term mental health service clients (in contact for 2 years or more) with current relapse prevention plans National Target: <i>95% of long term clients (in contact for 2 years or more) have relapse prevention plans</i>	PP7	95%	Mental Health																
Alcohol and drug service waiting times and waiting lists	PP8	These will be reported 6 monthly by WDHB on our behalf.	Mental Health																
Delivery of Te Kokiri: the mental health and addiction action plan	PP9	This will be reported annually by the DHB	Mental Health																

7.4 Outcome 4 – Reduce health inequalities

Why is this important?

The commitment to reducing health disparities is clearly stated in the CMDHB vision and highlighted as one of the key outcome areas in the current Counties Manukau DHB *District Strategic Plan 2006 - 2011*.

This is important to CMDHB as there is a high proportion of Maaori and Pacific people in Counties Manukau who live in relative social and economic deprivation compared to the rest of the population and are disproportionately affected by poor health outcomes.

Whilst life expectancy as a whole has improved across the Counties Manukau population, the life expectancy gap between Maaori and non-Maaori and non-Pacific population remains in excess of 10 years while the gap between Pacific and non-Maaori and non-Pacific is 5 - 7 years. Mortality rates and potentially avoidable hospitalisations show similar disparities.

In response to growing health disparities amongst Asian communities, the DHB has taken the step to develop an Asian Health Plan which identifies the key risks and disease burden for Asian sub-groups and outlines the DHB's approach to addressing Asian Health. Asians in total comprise 18% of the total Counties Manukau District Health Board (CMDHB) population and of the Asian sub-population groups in CMDHB the largest group is Indian followed by Chinese. Over 20% of all Asians in New Zealand live in Counties Manukau region.

How are we going to do this?

<p>The Triple Aim and Health Equity</p>	<p>Equity has been identified as a key central component that relates to all three components of the Triple Aim. The DHB's pursuit of quality improvement, value for money and population health must be mindful of the needs of the population. CMDHB aims to address health equity through a systematic process.</p> <p>A Health Equity Working Party has been established in order to further increase CMDHB's commitment to ensure equity is a key value of the organisation. The key deliverables of this working party include the development of:</p> <ul style="list-style-type: none"> ➤ An organisational definition and understanding of health equity. ➤ A Health Equity framework and the appropriate infrastructure to drive a Health Equity approach. ➤ A detailed communications plan to assist in the provision of key messages associated with the development and implementation of a Health Equity approach. <p>The Health Equity Approach will be implemented from July 2010.</p>
<p>Priority Actions</p>	<p>CMDHB has three work plans which specifically outline what initiatives are being taken across the organisation to reduce inequalities for their targeted populations. These actions span the continuum of care from primary and community healthcare services to secondary and specialist services provided at the hospital.</p>
<p>Whaanau Ora</p>	<p>The Whaanau Ora Plan, as the key Maaori strategic document, sets out the parameters of the DHB/Maaori community relationship.</p>

	<p>The aspiration of this document is: Whaanau Ora – Maaori Ora <i>Kia whai kaha, whai mana painga, ki ngaa kawenga orange Iwi, ki tua o Rangī Whaanau inspired, enabled, resourced and in control of their own health</i></p> <p>The six key priorities of the Whaanau Ora plan are:</p> <ul style="list-style-type: none"> ➤ Addressing the lifestyle risk factors that affect Maaori in Counties Manukau; ➤ 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.
<p>Tupu Ola Moui (Pacific Health Plan)</p>	<p>The Tupu Ola Moui outlines how the DHB will implement the CMDHB District Strategic Plan for Pacific people who live in the Counties Manukau District. The plan identifies priority areas for Pacific Health in CMDHB and describe the actions that will be undertaken to progress those priority areas.</p> <p>The priority areas are:</p> <ul style="list-style-type: none"> ➤ Workforce Development ➤ Well Child – Immunisation/Oral Health ➤ Pacific Community Obesity Initiatives ➤ Cultural Competency Training ➤ Capacity and Capability building for Pacific Churches ➤ Reduce Ambulatory Sensitive Admissions
<p>Asian Health Plan</p>	<p>CMDHB has completed the Integrated Asian Health Strategic Action Plan - Collective Action Towards' Health Equity (CATHE) 2010-2015. The DHB is currently working on developing an outcome framework that underpins the Asian plan. The vision for Asian Health is: “Collective action towards ensuring equity and reducing health disparities among Asian people, their families and communities”</p> <p>Priorities for Asians have been identified through measures such as utilisation, prevalence, and incidence data.</p> <p>Some of the key health issues identified in the Asian health plan are:</p> <ul style="list-style-type: none"> ➤ High incidence of cardiovascular disease, diabetes and stroke among South Asians. ➤ High prevalence of obesity in the Indian population. ➤ Sexually transmitted diseases - are a major concern for Chinese and other South East Asian populations. Both Indian and Chinese have high rates of pregnancy terminations. ➤ Mental health - Suicide is high among Indian men and Asian youth. Self harm is high among all Asian women. ➤ Family violence ➤ Low uptake of cervical and breast screening by Asian women. ➤ Low utilisation of health services by Asian peoples, particularly recent migrants <p>An action plan will be developed for 2010/11 with the intention that interventions identified will be delivered through existing services and initiatives.</p>

How we will measure our progress

- A reduction in the rate of potentially avoidable hospitalisations
- A reduction in Ambulatory Sensitive Hospital (ASH) admission rates
- A reduction in outpatient Did Not Attend (DNA) rates
- A closing of the gap in life expectancy between Maaori and Pacific with non-Maaori and non-Pacific
- A reduction in the mortality rate for Maaori and Pacific men aged 45-64 years
- An increase in the referral rates to cardiac rehabilitation for the Maaori, Pacific and South Indian population

Outcome 4 Performance Indicators

Ref column definitions:

HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan, DAP = District Annual Plan, P = Productivity Initiative

Measure	Ref	CMDHB Target/ Deliverable	Responsibility
<p>Local Iwi/ Maaori engagement and participation in DHB decision making</p> <p>Measure 1: Proportion of PHOs with Maaori Health Plans that have been agreed to by the DHB Measure 2: Proportion of DHB members that have undertaken Treaty of Waitangi training Measure 3: Achievements against the MoU between CMDHB and its local Iwi/ Maaori health relationship partner, initiatives achieved as a result of engagement between the parties in the year. Measure 4: Local Iwi/ Maaori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring and evaluation (include a section on PHOs) Measure 5: How MHPs are being implemented by the PHOs and monitored by the DHB. Measure 6: Treaty of Waitangi training (including any facilitated by the Ministry) that has or will take place for Board members. Measure 7: 2 milestones from the MHP</p> <p>1(a) Work with the primary care team to ensure at least 22% of total CCM enrolments are Maaori and are enrolled on either Diabetes/CVD/Congestive Heart Failure/Chronic Obstructive Pulmonary Disease module 1(b) At least 70% of Maaori enrolled on CCM have been seen in the last 17 weeks (known as up to date). 2 Increase proportion of Maaori two year olds who are fully immunised to 83%</p>	PP3	<p>Measure 1: 100%</p> <p>Measure 2: 100%</p> <p>Measures 3, 4, 5 and 6 will be reported 6 monthly by the DHB</p> <p>Measure 7 milestones</p>	Service Integration – Maaori Health
<p>Mainstream effectiveness of DHB provider arm pathways of care for Maaori</p> <p>Measure 1: Reviews of pathways of care undertaken in the last 12 months which focused on improving health outcomes and reducing health inequalities for Maaori Measure 2: Outline of actions taken to address issues identified in the reviews</p>	PP4	This will be reported 6 monthly by the DHB	Service Integration – Maaori Health
<p>Agreed funding for Maaori Health and Disability initiatives</p> <p>Measure 1: Actual expenditure on Maaori Health Providers by General Ledger (GL) code Measure 2: Actual expenditure for specific Maaori Services provided within mainstream services targeted to improving Maaori health by Purchase Unit (PU) Measure 3: DHB predicted expenditure for Maaori Health in the 2009/10 DAP in comparison to actual expenditure</p>	SI5	This will be reported annually by the DHB	Service Integration – Maaori Health
Ambulatory sensitive (avoidable) hospitalisations	SI1	See Outcome 5 Performance Indicators	Service Integration – Primary Care
Proportion of Maaori enrolments in the He Puna Oranga services per quarter.	DAP	80%	Service Integration – Maaori Health
Proportion of Lotu Moui churches with a smokefree policy	DAP	85%	Service Integration – Pacific Health
Proportion of Lotu Moui churches whose participants in health train the trainer have completed their course	DAP	50%	Service Integration – Pacific Health
Proportion of Lotu Moui churches who have a nutrition policy.	DAP	90%	Service Integration – Pacific Health
Proportion of Lotu Moui churches with more than 1 physical activity per week.	DAP	100%	Service Integration – Pacific Health

Measure	Ref	CMDHB Target/ Deliverable	Responsibility
Where Lotu Moui churches have physical activity, the number of churches with more than 10% of the congregation attending the activity.	DAP	100%	Service Integration – Pacific Health
Proportion of patients enrolled in Self Management programmes that are Maaori, Pacific or South Asian	DAP	60%	Service Integration – Primary Care
Proportion of high needs (≥ 3 times in last 6 months) Maaori patients seen by a support worker	DAP	> 70%	Service Integration - Maaori Health
Proportion of high needs (≥ 3 times in last 6 months) Pacific patients seen by a support worker	DAP	≥ 80%	Service Integration - Pacific Health
Proportion of referrals to the Pacific Cultural Unit to be seen within 24 hours	DAP	90%	Service Integration – Pacific Health
Did Not Attend Rates for Maaori and Pacific Outpatient Clinics.	DAP / P	Maaori < 10% Pacific < 18%	Service Integration – Maaori Health. Service Integration – Pacific Health
Number of smokefree champions within Maaori communities	DAP	10	Service Integration – Maaori Health
Number of CMDHB staff trained in Tikanga Best Practice	DAP	1500	Service Integration – Maaori Health
Proportion of staff trained as champions in Tikanga Best Practice	DAP	5%	Service Integration – Maaori Health
Proportion of students enrolled in the Kiaroa Hauora Maaori Workforce programme at the start of the 2010 academic year who are still in the programme	DAP	≥ 70%	Service Integration – Maaori Health

7.5 Outcome 5 – Improve Health Sector responsiveness to individual and family/ whaanau need

Why is this important?

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 in line with the Minister's priorities for *Better, Sooner, More Convenient primary healthcare* care.

How are we going to do this?

Electives

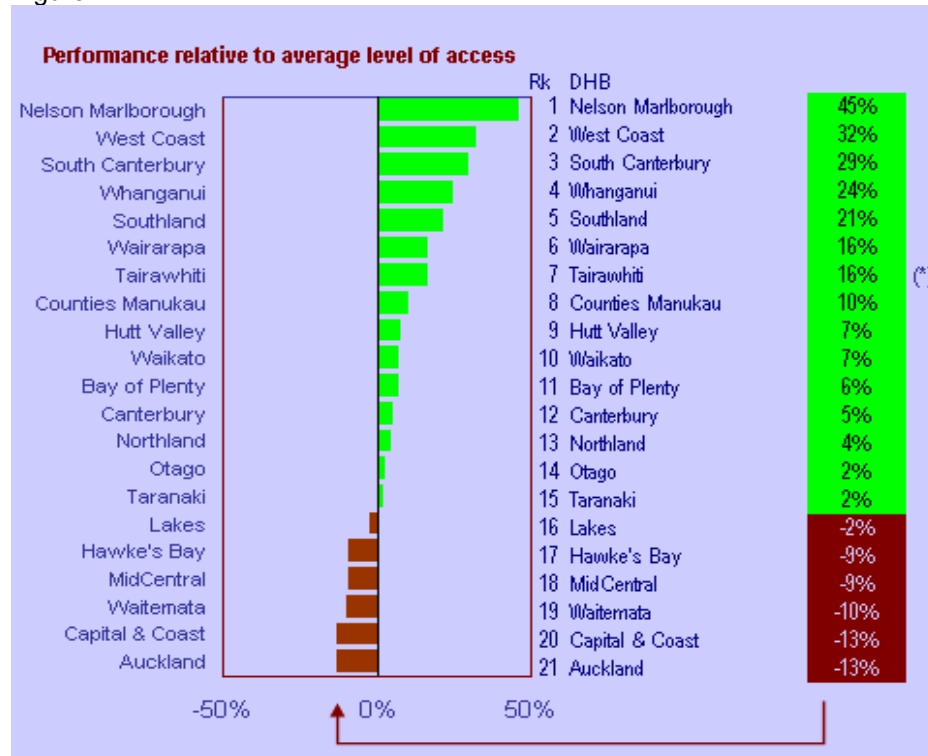
In line with the Minister's expectations, CMDHB will continue to focus on improving access to elective surgery. The DHB continues to exceed the national targets for elective surgery volumes and is delivering more elective surgery procedures to the population.

At the end of the 2008/09 financial year the Elective Standardised Discharge Rate for the Counties Manukau population was 1.07 or 7% above national average. Since 2003/04 - and including the forecast volumes for 2009/10 - Counties Manukau DHB will have provided 8498 extra procedures for our population, to contribute to an intervention rate which we anticipate will be beyond 1.07% for 2009/10.

At Quarter 2, 2009/10 our production was at 106% of contract and access rates for our population at 10% was the highest of the major district health boards.

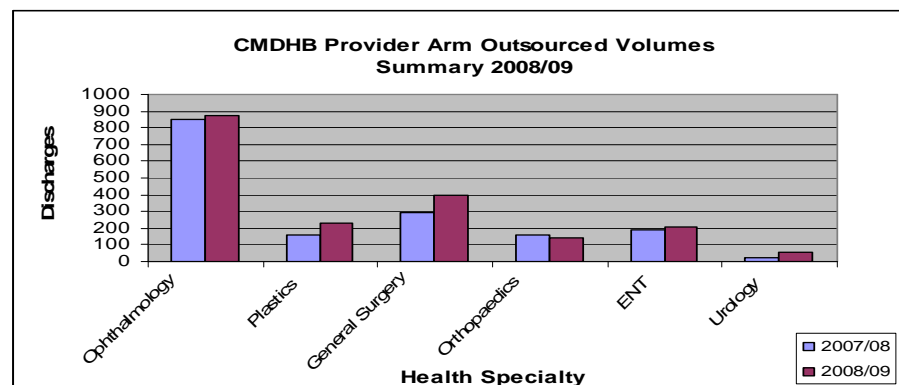
Figure

2:



In 2010/11, the DHB will be increasing elective surgical discharges in line with the national health target and will also be focusing on improving service quality and productivity within elective surgical services. Key actions include:

- *Maintaining the DHB's contractual relationships with the private sector*
 CMDHB has actively worked with a number of providers over the last 3 years to support the provision of surgery in order to meet and exceed surgical discharge health target requirements. Approximately 15% of our elective surgery has been performed by the private sector in the last two years. Figure 3 below shows the outsourced volumes summary for 2008/09. In 2010/11, a tender process will be entered into which will invite Expressions of Interest to contribute to 10/11 volume production. The tender process for potential providers will be opened in July 2010.
- *Implementing a change in clinical practice for the Ophthalmology service to support an increase in the number of minor eye procedures undertaken*
 The model of care for nominated procedures will be updated to reflect change of practice and will be overseen by a clinical champion. 1400 minor eye procedures will be provided in an ambulatory setting in 2010/11. The development of Ophthalmology Ambulatory Care Facilities has created the opportunity to move some eye procedures undertaken as a theatre-based procedure to an ambulatory clinic-based procedure. Trials for selected patients in 09/10 have been successful, thus supporting the extension and increase in planned volumes for 10/11. Freed up theatre capacity will be shared between other surgical services to ensure surgical discharge Health target volumes met.
- *Exploring options for providing elective urology services through a private provider*
 In 2010/11, the DHB will be exploring options for providing elective urology services through a private provider, with the aim of having a definitive, revised programme in place in the next 12 months. Currently these services are provided predominantly through Auckland DHB.
- *Improving theatre utilisation*
 A theatre preadmission project focusing on reviewing and reducing day of surgery cancellations will be rolled out in 2010
- *Increasing Day of Surgery Admission and day surgery rates*
 A preadmission project will be implemented which will include undertaking a review of models of care for DOSA. This will commence with Orthopaedics.
 Day of Surgery cancellations will be analysed to see what the reasons for cancellations are, e.g. Nil by mouth instructions, transport issues.



<p>Better, sooner more convenient primary and community health</p>	<p>In 2010/11, CMDHB will be applying the 2% increase in First Contact funding as nationally agreed.</p> <p>The key focus for primary health care will be to work closely with BSMC consortia in 2010/11 to implement their business cases. The focus of work in 2010/11 will be around the following key workstreams:</p> <ul style="list-style-type: none"> ➤ Improve access to radiology ➤ Increase minor surgery in the community ➤ Reduce impact on hospitals through increased referrals to the Primary Options for Acute Care (POAC) ➤ Co-ordinate metro-Auckland approach to affordable after hours care ➤ Develop primary secondary clinical pathways ➤ Improve prescribing and safer use of medicines in community pharmacy ➤ Increase Maaori provider capability to support implementation of Whanau Ora ➤ Support regional health targets for immunisation, diabetes, CVD risk management and smoking to improve performance on national health targets <p><i>See Attachment 5 for the 2010/11 metro-Auckland BSMC Implementation Plan</i></p>
<p>Health of Older People</p>	<ul style="list-style-type: none"> ➤ CMDHB will continue to progress the initiatives underway to improve the continuum of care for older people. The DHB is supporting older people to maintain their independence in the community for as long as it is appropriate and will continue to: <ul style="list-style-type: none"> - Develop the Community Geriatric Service; - Raise the profile of specialist rehabilitation services and community support services like community respite care. ➤ InterRAI which is a nationally consistent assessment tool for older people requiring community and long term support services will be rolled out in 2010/11 via a regional implementation.

How we will measure our progress

- Increased access to elective surgery for the population
- A decrease in the number of elective patients who have not been managed according to their assigned status and who should have received treatment
- Improved clinical pathways across primary and secondary care contributing to improved utilisation of primary health care and appropriate referral to secondary services when needed
- An increase in GP consultations for high needs people compared with non-high needs people
- A reduction in ambulatory sensitive hospital (ASH) admission rates
- An increase in the numbers of older people receiving home-based care where it is appropriate to do so

Outcome 5 Performance Indicators

Ref column definitions:

HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan, DAP = District Annual Plan, P = Productivity Initiative

Measure	Ref	CMDHB Target				Responsibility
Improved access to elective surgery National Target: Increase of elective surgery volumes by an average of 4,000 discharges per year	HT2	14,469				Surgical and Ambulatory Care / Women's Health
Implementation of Better, Sooner, More Convenient primary health care	PP2	This will be reported annually by the DHB				Service Integration – Primary Care
Ambulatory sensitive (avoidable) hospitalisations	SI 1	Age	Maaori	Pacific	Other	Service Integration – Primary Care
		0-4	95	113.0	95	
		45-64	139	132.7	113.4	
		0-74	117.0	125.2	103.0	
Elective services Standardised Intervention Rates National Targets: Intervention rate of at least 292 per 10,000 Major joint - 21 per 10,000 (10.5 for each knee and hip) Cataract – 27 per 10,000 Cardiac – 6.23 per 10,000	SI 4	Electives Intervention rate – 292 per 10,000 (number of)Major joint – 812 Cataract – 1147 Cardiac - 273				Surgical and Ambulatory Care/ Women's Health
Theatre productivity	OS5	Measure yet to be determined by MOH				Surgical and Ambulatory Care / Women's Health
Proportion of elective and arranged surgical patients undertaken on a day surgery basis	OS6	60% standardised				Surgical and Ambulatory Care / Women's Health
Proportion of elective and arranged surgical patients on a day of surgery admissions (DOSA) basis National Target: 90%	OS7	90%				Surgical and Ambulatory Care / Women's Health
Elective Theatre utilisation rate	DAP	82.5%				Surgical and Ambulatory Care / Women's Health
Number of day of surgery cancellations (Elective Services only)	DAP	≤ 1100				Surgical and Ambulatory Care / Women's Health
Time from referral to first specialist assessment (FSA) for medical electives	P	≤ 3 months				Medicine and Clinical Support
Proportion of Priority 1 – Priority 3 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	DAP	< 3%				Medicine & Clinical Support
Proportion of FSA patients seen within their designated priority timeframe for all medical specialities	DAP / P	> 80%				Medicine & Clinical Support
Rate of GP consultations for high needs population compared with non-high needs population	DSP	> 1				Service Integration – Primary Care

Measure	Ref	CMDHB Target	Responsibility
Number of enrolments in the Very High Intensive User (VHIU) programme	DAP	> 400	Service Integration – Primary Care
Number of Primary Options for Acute Care (POAC) patient attendances at EC avoided	DSP / P	> 6,800 attendances at E.C. avoided via POAC	Service Integration – Primary Care.
Ratio of the number of people receiving home-based support services to the number of people receiving aged residential care	DSP	2.6	Health of Older People
Number of community respite bed days used for the 65+ year olds	DAP	208 bed days / month	Health of Older People
Cost per WIES relative to national price.	P	Medicine ≤ 2% Surgery ≤ 9% Acute care ≤ 3%	Provider Arm

7.6 Outcome 6 – Improve the Capacity of the Health Sector to Deliver Quality Services

Why is this important?

Growing and retaining a workforce that serves the needs of our community and reflects its diversity is critically important. With increasing competition to recruit and retain health professionals, the DHB is focusing investment on developing the infrastructure that needs to be in place to support the workforce in meeting the needs of the community it serves. This includes having:

- adequate facilities to safely treat people;
- information systems to assist with the delivery and planning of health services;
- maintenance of professional standards as defined by respective Colleges and Subspecialty Societies; and
- quality systems and processes including the key quality dimensions of people centred, access and equity, safety, effectiveness and efficiency which underpin CMDHBs Quality Framework and Quality Plans.

How are we going to do this?

Workforce Development	<ul style="list-style-type: none"> ➤ The DHB's focus is on " Growing our own", that is, attracting young people in our district, particularly Maaori and Pacific youth, to take up health-related studies, and to encourage those in other sectors of the workforce to consider a change to a career in health. The DHB offers scholarships in health training programmes to local people with the intention of offering them employment at the completion of their studies. ➤ The DHB positions itself as an "employer of choice" and there is a strong focus on learning and development within the organisation to support employees in their work and to reach their full potential. E-learning which CMDHB rolled out in partnership with WDHB in 2009 will continue to be developed in 2010/11 with more learning materials available. ➤ The DHB recognises the increasingly diverse composition of the health sector workforce, many of whom are not New Zealand born, and has courses which facilitate the building of better communication and working relationships amongst our diverse staff. There are also cultural acclimatisation programmes like the, Tikanga Best Practice and Pacific Cultural Competency courses, which aim to support staff in delivering culturally safe services to a predominantly Maaori and Pacific patient population. ➤ Regional collaboration on recruitment and workforce development initiatives remain strong. One of the regional workforce development initiatives CMDHB is trialling as a pilot site in 2010/11 is the Physician Assistant role. <i>This is outlined in the Regional Workforce Development initiatives in Section 5.3.10.</i> ➤ CMDHB's long term vision for "growing our own" workforce - the Centre for Health Services Innovation project. <i>See Attachment 5: Overview of the Centre for Health Services Innovation Project.</i>
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<p>Quality Improvement and Patient Safety</p>	<p>➤ CMDHB is committed to the improvement of patient safety and the delivery of efficient services. The quality improvement team will initially focus on the delivery of hospital and related services but will be expanded in the medium term to include community services such as residential care and primary care.</p> <p><i>The 2010/11 objectives for Quality Improvement and Patient Safety are outlined in Section 3.3, and targets for the Quality initiatives are presented under Outcome 6 Performance Measures.</i></p>
<p>Emergency Department</p>	<p>The whole focus of the Emergency Department '6 Hours Can be Ours' initiative has been a hospital-wide response to deliver against the target. The initiative has been led by the Chief Executive and fully supported by the CMDHB Board through regular updating of progress to the Board. The initiative has involved all staff groups in the hospital including medical, nursing, allied health staff across all specialties, orderly and cleaning staff and management. A comprehensive communication plan was - and continues to be - in place.</p> <p>In 2010/11, CMDHB will continue on the "6 hours can be ours" initiatives with focus on the following actions:</p> <ul style="list-style-type: none"> ➤ Maintaining the Governance Group to oversee the initiative ➤ Maintaining the Operational Group to drive and monitor the ongoing workstreams ➤ Maintaining Bed Management workstream to focus on bed management and responding to variations in demand ➤ Identification of the factors that contribute to the remaining 5% of patients who do not meet the target ➤ Maintaining the communication workstream to communicate progress against the 6 hour goal to staff ➤ Development of a 15-bed Acute Observation Unit ("AOU") ➤ Implementing the Clinical Nurse Specialist role in ED to support seen by times.
<p>Information Systems</p>	<p>➤ The Northern region DHB's Metro Auckland Regional IS Strategic Plan was replaced last year with the Northern Regional Information Strategic Plan (RISP 10-20). The RISP 10-20, which is also CMDHB's Information Systems Strategic Plan (ISSP), outlines the five year vision for information management and technology to support the delivery of healthcare services in the Northern Region. The plan is closely aligned to the Health Information Systems New Zealand (HISNZ) objectives and national activities.</p> <p>➤ Key IS activities which will be delivered in 2010/11 include:</p> <ul style="list-style-type: none"> • eReferrals – Electronic referrals which will improve patient safety and reduce the amount of manual processing required • Single hosted Radiology information system (RIS) – which will be available across the Auckland region and will allow for Metro Auckland DHB clinicians to share shared patient radiology information • Phase 2 of the Mental Health electronic patient records (EPR) system - which will extend the benefits of a shared system to the wider clinical team, including NGOs, primary care and their clients and whaanau. • Regional Clinical Records – which will create one location where key clinical documents can be stored and made available to all clinicians involved in patient care across the region. <p><i>The RISP 10-20 is available at: http://www.healthpoint.co.nz/default,157023.sm and the CMDHB ISSP is attached as Attachment 4 of this document.</i></p>

How we will measure our progress

- Maintaining or improving on the national target for shorter stays in Emergency Departments
- A reduction in the turnover rate of staff
- Increase number of Maaori and Pacific candidates entering health training programmes and employment at CMDHB.
- Greater patient satisfaction with the care they receive and communication with staff
- A reduction in the number of unplanned readmissions
- A reduction in the number of incidents related to patient safety and quality of care
- Assessment of performance against published Standards of Care
- Improved financial management

Outcome 6 Performance Indicators

Ref column definitions:

HT = National Health Target; PP= Policy Priority (MOH Accountability), OS= Ownership (MOH Accountability), SI= System Integration (MOH Accountability), DSP = District Strategic Plan, DAP = District Annual Plan, P = Productivity Initiative, QIP = Quality Improvement Plan, PIA = Performance Improvement Action

Measure	Ref	CMDHB Target/ Deliverable	Responsibility
Proportion of patients admitted, discharged or transferred from an Emergency Department within 6 hours National Target: 95%	HT1	95%	Medicine and Clinical Support
Clinical Leadership self assessment	PP1	This will be reported annually by the DHB	Clinical Board
Regional Service Planning	SI 2	This will be reported 6 monthly by the DHB	Planning & Performance
Service coverage	SI 3	This will be reported 6 monthly by the DHB	All CMDHB
Risk Reporting	SI 6	This will be reported 6 monthly by the DHB	Quality Improvement Unit
Staff turnover by major professional group	OS1	This will be reported quarterly by the DHB	Human Resources
Capital Expenditure in line with plan	OS2	See attachment 5	
Elective and arranged inpatient length of stay	OS3	3.92 days	Provider Arm
Acute inpatient length of stay	OS4	4.01 days	Provider Arm
28 day unplanned acute readmissions to hospital rate	OS8	9.70	Provider Arm
30 Day mortality	OS9	Maintain current rate or lower	Provider Arm
Standardised acute inpatient mortality rate	P	This will be tracked monthly as a part of productivity initiatives	Provider Arm
National Patient Satisfaction measure	OS12	Place holder measure - no measure defined by the MOH as yet	
Improving the quality of data provided to national collection systems Measure 1: Timeliness of NMDS data Measure 2: NMHI Duplications Measure 3: Ethnicity not stated in NHI Measure 4: Start versus specific descriptors in the NMDS	OS10	Measure 1: > 2% and ≤ 5% Measure 2: > 2% and ≤ 5% Measure 3: > 2% and ≤ 4% Measure 4: > 50% and ≤ 59%	Provider Arm
All hospital outputs are delivered to plan	OS11	This will be reported via the PVS every quarter by the DHB	Performance & Planning

Measure	Ref	CMDHB Target/ Deliverable	Responsibility
Midwifery vacancies	DAP	15 FTE decrease on Dec 09 vacancy numbers	Women's Health
Number of year 12 and 13 Maaori and Pacific students per year enrolled in the <i>Health could be 4 U</i> training programme	DAP/ PIA	150	Human Resources
Number of health training scholarships granted to community members for the 2011 academic year	DAP/ PIA	75	Human Resources
Proportion of scholarship recipients to be employed within CMDHB or other CM health organisation	DAP/ PIA	50%	Human Resources
Proportion of new starts and internal transfers to have complete pre-employment health screening	DAP	100%	Human Resources
Staff turnover rate (FTE leavers within 6 months)	P	Current rate: 0.9%. Target rate : 0.7%	Human Resources
Average number of days of sick leave per person per year	DAP	<5 days per person per year	Human Resources
Staff lost time related to patient handling injuries	DAP	30% reduction from baseline	Human Resources
Improved communication between primary and secondary care through medication reconciliation and effective discharge medication records.	DAP/ QIP	Reduction to 9% ADE rate (per patients admitted).	Quality Improvement
Standardisation of management of medications on wards by the use of Pyxis© technology	DAP/ QIP	Reduction to 9% ADE rate (per patients admitted).	Quality Improvement
Improved management of IV medications through the introduction of Guardrail© technology	DAP/ QIP	Reduction to 9% ADE rate (per patients admitted).	Quality Improvement
Compliance with Hand Hygiene practices	DAP/ QIP	80% of staff comply with WHO hand hygiene guidelines.	Quality Improvement
Reduction in Central Line Associated Bacteraemia	DAP/ QIP	Reduction in CLAB to 4.5 per 1000 line days.	Quality Improvement
Reduction in the number of patient falls which cause harm.	DAP/ QIP	Reduction to 18 patient falls causing harm per month	Quality Improvement
Reduction in the number of patients with hospital acquired pressure injuries.	DAP/ QIP	Reduction to 8% of inpatients affected (measured by annual 'whole hospital' audit)	Quality Improvement
Patients discharged from EC within 6 hours	DAP/ QIP	95% of all patients attending Emergency Department discharged or transferred within 6 hours.	Quality Improvement
Implementation of the World Health Organisational Surgical Checklist	DAP/ QIP	80% of patients receiving surgery receive WHO checklist	Quality Improvement

8 MANAGING FINANCIAL RESOURCES

8.1 Financial Statements

Summary by Funding Arm	2008/09	2009/10	2010/11	2011/12	2012/13
	Audited Actual	Forecast	Plan	Plan	Plan
Provider	(378)	6,166	5	5	5
Governance	(2,564)	(3,052)	(2,005)	(2,095)	(2,186)
Funder	2,949	(3,077)	2,028	2,488	2,725
Operating Surplus	7	37	28	399	544
Below the Line	(3,000)	(3,000)			
Surplus (Deficit)	(2,993)	(2,963)	28	399	544

Statement of Comprehensive Income

Net Result \$000	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Crown	1,121,892	1,211,366	1,242,566	1,298,730	1,354,965
Other	16,635	14,186	12,083	12,736	13,416
Total Revenue	1,138,527	1,225,552	1,254,649	1,311,466	1,368,381
Expenses					
Personnel	393,775	435,077	445,471	465,440	485,435
Outsourced	49,494	42,296	44,250	46,250	48,253
ISP	509,961	570,840	572,844	598,475	624,388
Clinical Sup.	79,950	81,838	85,398	89,120	92,847
Infrastructure	62,847	50,668	57,053	60,467	64,084
Operating Exp	1,096,027	1,180,719	1,205,016	1,259,751	1,315,006
Operating surplus	42,500	44,833	49,633	51,715	53,375
Depn.	23,346	25,604	27,081	27,581	28,081
Interest	7,831	8,192	8,520	9,735	10,750
Capital Chg.	14,316	14,000	14,004	14,000	14,000
Net Surplus	(2,993)	(2,963)	28	399	544

Funder	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Crown	969,021	1,051,964	1,106,232	1,156,234	1,206,299
Other	74,587	83,484	82,536	86,373	90,242
Total	1,043,608	1,135,448	1,188,768	1,242,607	1,296,541
Personnel	-	-	-	-	-
Depreciation	-	-	-	-	-
Capital Charge	-	-	-	-	-
Other	1,043,659	1,141,525	1,186,740	1,240,119	1,293,816
Total Expenditure	1,043,659	1,141,525	1,186,740	1,240,119	1,293,816
Net Surplus	(51)	(6,077)	2,028	2,488	2,725

Eliminations	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Crown	(533,698)	(570,685)	(613,896)	(641,644)	(669,427)
Other					
Total	(533,698)	(570,685)	(613,896)	(641,644)	(669,427)
Personnel					
Depreciation					
Capital Charge					
Other	(533,698)	(570,685)	(613,896)	(641,644)	(669,427)
Total Expenditure	(533,698)	(570,685)	(613,896)	(641,644)	(669,427)
Net Surplus	-	-	-	-	-

Provider	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Crown	594,050	630,654	653,222	682,748	712,311
Other	24,497	20,850	18,563	19,402	20,242
Total	618,547	651,504	671,785	702,150	732,553
Personnel	386,917	428,984	439,266	459,121	479,001
Depreciation	23,346	25,604	27,081	27,581	28,081
Capital Charge	14,316	14,000	14,004	14,000	14,000
Other	194,346	176,750	191,429	201,443	211,466
Total Expenditure	618,925	645,338	671,780	702,144	732,547
Net Surplus	(378)	6,166	5	5	5

Governance	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Crown	10,070	9,091	7,968	8,328	8,689
Other	-	194	24	25	26
Total	10,070	9,285	7,992	8,353	8,715
Personnel	6,858	6,093	6,205	6,319	6,434
Depreciation					
Capital Charge					
Other	5,776	6,244	3,792	4,129	4,467
Total Expenditure	12,634	12,337	9,997	10,448	10,901
Net Surplus	(2,564)	(3,052)	(2,005)	(2,095)	(2,186)

Total	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Revenue					
Crown	1,039,443	1,121,024	1,153,526	1,205,665	1,257,871
Other	99,084	104,528	101,123	105,801	110,511
Total	1,138,527	1,225,552	1,254,649	1,311,466	1,368,381
	-	-	-	-	-
Personnel	393,775	435,077	445,471	465,440	485,435
Depreciation	23,346	25,604	27,081	27,581	28,081
Capital Charge	14,316	14,000	14,004	14,000	14,000
Other	710,083	753,834	768,065	804,046	840,321
Total Expenditure	1,141,520	1,228,515	1,254,621	1,311,067	1,367,837
Net Surplus	(2,993)	(2,963)	28	399	544

Balance Sheet	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Assets					
Fixed Assets					
Property, plant and equipment	433,531	457,662	486,808	527,885	579,677
Intangibles	1,196	762	1,562	2,362	3,162
Total Non current assets	434,727	458,424	488,370	530,247	582,839
Current Assets					
Inventories	493	493	493	493	493
Trade and other receivables	51,063	62,150	73,650	73,650	73,650
Cash	1,128	1,012	1,012	1,012	1,012
Trust / Special funds	834	858	882	882	882
Total Current Assets	53,518	64,513	76,037	76,037	76,037
Total Assets	488,245	522,937	564,407	606,284	658,876
Equity					
Crown equity	118,368	118,985	119,602	120,219	120,836
Revaluation Reserves	119,073	119,073	119,073	119,073	119,073
Retained Earnings	(77,786)	(80,749)	(80,721)	(80,322)	(79,778)
Trust / Special funds	834	834	834	834	834
Total Equity	160,489	158,143	158,788	159,804	160,965
Liabilities					
Borrowings	70,000	120,000	144,000	184,286	217,840
Employee benefits	62,982	36,103	52,389	45,657	52,318
Total non-current liabilities	132,982	156,103	196,389	229,943	270,158
Current Liabilities					
Borrowings	18,500	29,196	39,396	44,396	49,396
Trade and other payables	89,323	95,544	85,296	84,396	87,412
Employee benefits	86,951	83,951	84,538	87,745	90,945
Total Current Liabilities	194,774	208,691	209,230	216,537	227,753
Total Liabilities	327,756	364,794	405,619	446,480	497,911
Total Equity and Liabilities	488,245	522,937	564,407	606,284	658,876

Movement of Equity	2008/09	2009/10	2010/11	2011/12	2012/13
	Audited Actual	Forecast	Plan	Plan	Plan
Total Equity at beginning of period	181,486	160,489	158,143	158,788	159,804
Surplus / (Loss) for period	(2,994)	(2,963)	28	399	544
Interest received from Restricted funds	24				
Crown Equity injection	1,037	1,037	1,037	1,037	1,037
Crown Equity withdrawal	(419)	(420)	(420)	(420)	(420)
Revaluation of Fixed Assets	(18,645)				
Total Equity at beginning of period	160,489	158,143	158,788	159,804	160,965

Cash flows from operating activities	2008/09 Audited Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Cash receipts from Ministry of Health and patients	1,129,586	1,225,552	1,254,649	1,311,466	1,368,381
Cash paid to suppliers	707,983	745,857	751,749	783,447	814,842
Cash paid to employees	381,689	435,808	445,471	465,440	485,435
Cash generated from operations	39,914	43,887	57,429	62,579	68,104
Net taxes refunded/(paid) (goods and services tax)	767	9,803	9,600	9,600	9,600
Capital charge paid	11,883	14,000	14,000	14,000	14,000
Net cash flows from operating activities	27,264	20,084	33,829	38,979	44,504
Cash flows from investing activities					
Interest received	1,771	2,004	996	1,041	1,086
Acquisition of property, plant and equipment	61,850	49,301	57,027	69,458	80,673
Net appropriation from trust funds					
Net cash flows from investing activities	(60,079)	(47,297)	(56,031)	(68,417)	(79,587)
Cash flows from financing activities					
Proceeds from/(Repayment of) equity injection	618	618	618	618	618
Borrowings raised	39,500	34,696	30,128	38,554	45,215
Interest Paid	7,598	8,192	8,520	9,735	10,750
Other Movements	24				
Net cash flows from financing activities	32,544	27,122	22,226	29,437	35,083
Net increase in cash and cash equivalents	(271)	(91)	24	(1)	0
Cash and cash equivalents at beginning of year	2,233	1,962	1,871	1,895	1,894
Cash and cash equivalents at end of year	1,962	1,871	1,895	1,894	1,894

Capital Expenditure	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Baseline Capital				
Clinical Equipment	1,251	1,251	1,250	1,248
Other Equipment	600	600	600	600
Information Technology	975	975	975	975
Intangible Assets (Software)	450	450	450	450
Motor Vehicles	225	225	225	225
Subtotal	3,501	3,501	3,500	3,498
Strategic Capital				
Clinical Services Block	12,423	5,998	8,041	6,615
CHSI	800	6,000	3,150	-
Subtotal	13,223	11,998	11,191	6,615
Total	16,724	15,499	14,691	10,113

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

8.2 Overview

The early indications from the Minister and Ministry of Health of lower funding levels from 2010/11 onwards resulted in Counties Manukau DHB taking similarly early action through its Thriving in Difficult Times and Productivity initiatives in order to achieve a DAP reflecting a zero deficit operating position. Compounding this challenge has been the requirement that the final DAP be presented virtually two months ahead of previous year's timeframes. Despite these challenges, a full consolidated breakeven position has been achieved without any reduction in front line clinical services, as required both by management and the Board.

However, as this has meant a reduction in support staff, this has put the organisation in a position of higher clinical and financial risk as a result, which we acknowledge must be managed, despite the continuing escalating pressures.

While the nationally consistent application of the PBF formula would have significantly benefited the financial position by almost \$24m and allowed CMDHB to continue to self fund the significant number of initiatives around primary care and hospitalisation avoidance, the reality is that this is not available under the lowered MoH capped percentage funding envelope. Previously the MoH cap increase was limited to 7% in total funding. This has now been reduced in the 2010/11 year to 5%, with CMDHB the only DHB negatively impacted by this. Consequently CMDHB has achieved breakeven through further very intensive reviews of its existing investments and structures. We highlight however that it is anticipated that the benefit of the Population Based Formula (PBF) formula will accrue to CMDHB in future years. This is a very fundamental and important assumption to highlight, as without this recognition, the financial position of CMDHB would be at risk, particularly given the increasing cost impact as the new facility investments come on stream in later years.

The key drivers of this change in financial position are:

- Despite the international economic position, the anticipated continuing relatively high level of clinical wage settlements will continue, primarily in the Provider Arm. These are expected to be settled at levels around double the general inflationary levels, on an all up basis, i.e. base and step function increases.
- The continuing significant IDF outflows and pricing adjustments primarily related to ADHB provision of tertiary services.
- The continuing population growth in excess of the census projections used to calculate the population based formula revenue, albeit this gap is diminishing gradually.
- The annualised impact of operating costs relating primarily to the opening of Stage One of the new Edmund Hillary Ward block on the Middlemore site. Of future critical importance will be the impact of the \$208m Clinical Services Block Stage 1 which is anticipated to come on stream in the year after this DAP period, i.e. 2013/14
- The need to achieve Government health targets/priorities around ED waiting times, Electives, Cancer waiting times, ESPIs and the increased costs, primarily FTE related, associated with those targets within the forthcoming constrained budget.
- The annualisation of commitments made in 2009/10, including the very significant continuing investment in all quality related areas, with significant initial "hump" funding. This is expected to start producing a return on investment in the coming year and forms a very significant and important part of our Thriving in Difficult Times targets.
- Acute demand growth is again increasing, particularly in the Department of Medicine, Provider Arm, after a period of relatively lower growth.

While the 2009/10 financial result is forecast to achieve a breakeven position, this result could be perceived as misleading in comparison to the forecast 2010/11 position, without further analysis. There are a number of current year gains that are, from a timing perspective, "one off". Depreciation and interest costs are anticipated to be significantly lower than budget for 2009/10 reflecting both the timing issues of the new facility developments and lower depreciation levels on assets reaching the end of their economic lives. These benefits offset the very significant demand driven cost increases occurring within the Funder Arm, particularly Health of Older People, and Pharmaceutical costs. In addition, the anticipated unfunded

capital charge revaluation cost did not occur, which has also helped offset other cost increases.

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

This forecast financial position, particularly for the first year of the DAP (but also obviously impacting on the outer years) has severely limited CMDHB’s ability to continue to invest in and achieve many of its wide-ranging objectives. CMDHB remains absolutely committed to achieving its Triple Aim objectives, but in order to do so has implemented a process of organisational wide review under the project “Thriving in Difficult Times” which highlighted initially five key areas of focus. The funding constraints CMDHB will be under to achieve breakeven will be of critical concern in determining where and how these impact on the Triple Aim objectives. It is important to note, as referred to elsewhere, that there is not and cannot be at this stage, any recognition with confidence in CMDHB’s DAP of the impact of external initiatives being taken whether jointly by the DHBs or by Government, i.e. regionalisation, national procurement, shared services initiatives, integrated family health centres. While clearly these initiatives are intended to produce ultimate clinical and financial gain, it is impossible to confidently quantify such at this stage.

The 2010/11 year becomes a difficult balancing act as the focus moves to ensuring financial stability and potentially diverts away from enhancing the District Strategic Plan objectives and our clinical and quality imperatives. If the financial pressures continue as forecast, even greater efficiencies and increased innovation become more important as the primary drivers to addressing the organisation’s strategic objectives and meeting its financial obligations. These increased financial constraints and targets are imposed at the same time as the initial costs of the new facilities investments are being incurred, i.e. CMDHB is being asked to absorb long term capital investment costs in the initial years of occurrence in order to breakeven, as opposed to a normal commercial model where the norm would be over a period of time, probably for many years. This challenge will compound as the facility investment grows significantly both in capital and consequent increased operating cost over the next five years. What also needs to be considered are the huge clinical pressures already imposed on CMDHB staff who are severely stretched given the continuing growth pressures, resulting in increasing clinical risk.

The forecast DAP position shows a current deficit of \$Nil. In a change from previous years, we are now looking to retain and maintain carry forward surpluses of \$10m. This is in order to build up a reserve to offset any future likely investment related deficits in order to achieve a continuing zero deficit return. With regard to the targeted national and DHB objectives, these would be around investment in priority initiatives aligned with our District Strategic Plan and Ministerial areas of emphasis and change such as Chronic Care Management (CCM) and Maaori Health. Again as previously, it is likely that the Board will continue to seek to review the investment levels in these areas within the limits of the carried forward earnings. It also includes recognition of the Minister’s “tagged” funding and costs related to the specific tags.

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

In order to reduce our deficit to \$Nil for the organisation, we have already had to cap the allowable and fundable growth, both within the provider and the funder arms. This continues to present a huge challenge to contain the growth, related costs and quality investment throughout the organisation within these parameters. However the organisation recognises that CMDHB will have to further constrain these areas in order to achieve the zero deficit budget position. It should be noted very clearly that we have maintained our Lets Beat Diabetes (LBD) investment at existing investment levels (\$2m per annum), increased our investment in Primary Options for Acute Care (POAC) by a further \$0.8m per annum and lifted our investment in Oral Health through significant volume increases costing over \$1.7m per annum. These investments are seen as critical and unavoidable, despite the intense financial constraints, with even more significant clinical and financial downside, if not addressed now.

8.2.1 Key Assumptions and Risks

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

- A mandatory asset revaluation was carried out last 30 June 2009 under the 3 year minimum asset revaluation period requirement. As a result, devaluation occurred reversing some of the very significant revaluations of previous years. A further high level review is required annually to ensure there are no material variations. Given the much earlier deadline for this DAP finalisation and based on current market conditions, it is expected that there will be no material change in asset valuations and therefore no related change in the capital charge.
- All mental health funding, including existing “blueprint”, continues to be “ring fenced”. At the time of writing, there has been no indication of any further blueprint funding for 2010/11. As in previous years, mental health has been instructed to absorb its related excess wage settlements within its own ring fence, on the basis it has its own “ring fenced” FFT equivalent (CCP) and demographic growth and must operate within those parameters without top up from any other source.
- No PHO top up reimbursements are anticipated as continuing from the Ministry of Health
- Funding for Health of Older People income and asset testing recalculation is insufficient to match our forecast level, given that as house prices stabilise or fall (as is currently happening), health of older people accessibility levels will drop, entitling more people to claim. This needs to be offset by savings elsewhere.
- That the current ACC arrangements both in regard to revenue levels and cost recoveries are maintained at current levels. Publicly ACC has indicated a tighter fiscal affordability envelope and as well, a tightening of their payment parameters. While this is difficult to quantify currently, CMDHB expects to offset any downside by further opportunities or enhancement of existing contracts.
- That all revenue allocated to CMDHB, other than ministerially tagged funding, remains at CMDHB’s discretion to allocate and contractually commit. This is a very important and fundamental assumption, as there appears to be increasing consideration from the Centre around potential claw back of untagged funds.

It is important to note that the forecast zero deficit position has been reached after recognising anticipated wage and salary settlements well in excess of the 1.73% funded level, specifically:

- The flow on effects of significant national three year wage settlements agreed in previous years, with the flow on costs well in excess of the MoH funded levels. These are driven primarily by additional leave entitlements, automatic ongoing step function on-cost implications, a doubling of CME entitlements, significantly enhanced call out charges and the resultant increase in back-filling.
- As earlier noted, this DAP has been prepared based on the latest information available around likely wage settlements. It is anticipated based on this, that there will be an “across the board” agreed settlement rate for all CTU related unions, with the exception of specifically junior doctors, and under separate award, senior doctors.

The likely base settlements are in excess of the funded levels which together with the add on costs and automatic step functions applicable to most awards, continues to present a huge challenge to all DHBs.

- There is no evidence of any material quantifiable efficiency benefits arising from previous MECA settlements or likely in current negotiations. Thus the onus is on the DHBs to manage these costs.
- Increased roster and compliance costs around RMOs terms of employment from previous settlements.
- Generally increased, more demanding terms and conditions of employment across earlier MECAs which significantly lessens flexibility.
- Note that in regard to previous historical financial comparisons, CMDHB has from December 2008 brought Cleaners and Orderlies back onto its payroll from the previous outsourced classification.
- The continuing committed (albeit constrained) investment in priority initiatives aligned with the District Strategic Plan, including those focused on lessening the growth of hospital services and improving quality clinical outcomes.
- The ongoing internal efficiencies being generated including those within healthAlliance. Again, while there are national procurement and shared services initiatives well under way as a result of recent government initiatives, we have reviewed the likely outcome of these as they impact on this year's DAP. It appears extremely difficult to identify and therefore quantify any current additional material financial benefit arising from these given the level of efficiency in these targeted areas already being achieved by healthAlliance. We do not believe it is appropriate to build into the DAP a potentially very risky "unspecified lump sum" saving when there appears to be a high likelihood that we will be unable to achieve this.
- The absorption of increasing pharmaceutical demand, reflecting greater access and usage by our community.
- The absorption of the very significant and increasingly unfavourable costs around Health of Older People, specifically around private hospital funding. This is a national trend reflecting the ageing population shift, growing at a rate which by itself is completely unsustainable financially. It is only through savings in other unrelated areas that this level can at least be managed.
- The absorption of continuing renal growth volumes, albeit it at a growth level below the extremes of previous years.
- The absorption of continuing price adjustments to inter-district flows (IDFs) and to a lesser extent the volume of IDF outflows. These relate primarily to provision of services by ADHB with recent upward changes in prices far in excess of FFT and requiring strong challenge as to the level of efficiency built into tertiary pricing and the perpetuation of a 'cost plus' mentality. Much firmer disciplines have been put in place to enable both principles agreement and management of volumes and costs with IDF partners to minimise this significant exposure.
- The combined impact of meeting the Ministerial ED 6 Hour target and the absorption of increasing ED volumes with consequent flow-on bed impact. The international financial crisis and flow-on impact to our community is likely to have an even greater as yet, un-quantified impact on these volumes and the consequent pressure on CMDHB.

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

- The increasing challenge in both meeting the Minister's and government's health targets/priorities of a breakeven financial result (zero deficit) while complying with all government strategies and policies and investing in and opening significant new facilities, through all years of this DAP and beyond.
- Meeting the community's expectations, now that CMDHB has moved (relatively speaking) to equity from a population based funding perspective, despite the restrictive financial constraints.
- The financial risks associated with demand driven services, in which volume growth continues to far outstrip funding in many areas.

- As above, the outcome of earlier wage price pressure and settlements has led to significantly higher wages and clinical staff shortages arising from a much more mobile workforce. Despite the world wide financial crisis, we still remain exposed to “relativity” flow on risks from these wage settlements. This risk is also relative to the likelihood of flow through to the NGO sector with huge potential ramifications for the overall sector.

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

- An organisational wide commitment to clinical safety and quality improvement. This initiative led by the CEO, and now picked up on a national basis, has resulted in the formation of a formal quality unit within the organisation, but working across and within each area of CMDHB. The quality initiatives will ultimately lead to significant clinical and thus financial benefit and will ultimately be self funding. It is anticipated that these benefits will begin to arise during this financial year through focused action under the Thriving in Difficult Times initiative, but will still remain a challenging financial target despite the significant resource commitment.
- As mentioned earlier, in recognition of the continually tightening fiscal constraints and capped funding CMDHB management, with full Board support, initiated a series of efficiency projects under the general heading “Thriving in Difficult Times”. The overall objective of the projects is around cost reduction and efficiency improvement with a deliberate avoidance of any negative clinical impact or where possible, material redundancies. The core principles of the project are a commitment to a transformational culture change, a disciplined methodology, a commitment to the Triple Aim, investment in effective and disinvestment in ineffective and reshape, resize, rather than restructure and redundancies. Further (medium to longer term) focus will be around the critical area of service configuration and also capital affordability.
- A significant lift in emphasis and focus around continued development of evaluation, monitoring and auditing processes and systems to ensure that CMDHB is receiving Value For Money (VFM) in all key areas of its operations. While there is increasing emphasis from the centre around VFM, it should be recognised and acknowledged that CMDHB has for many years applied the VFM principles, albeit in a less formalised manner. We will continue to apply a VFM methodology in all areas of the organisation; from procurement through quality, clinical enhancement, etc.
- An increased commitment, which is already occurring, to lifting the level and frequency of all internal and external audit reviews. Increasing emphasis has been placed on widening the audits in the NGO/PHO areas with solid results to date. The primary focus here is around ensuring appropriate contracting of services, full delivery of those contracted services, as well as ensuring appropriate health outcomes.
- As referred to elsewhere in the DAP, considerable effort and development of appropriate strategies are occurring relative to maximising and increasing the benefits of the existing regional or quasi regional functions to ensure significantly greater regional benefit. While there are potential savings to be made through this “roll out”, CMDHB (and WDHB) are already benefiting significantly from their existing formal relationship and it would be fiscally imprudent to anticipate further un-quantified national benefits that may fundamentally change the financial viability of any of the participating organisations.
- CMDHB is continuing to focus around maximising the benefits of the now well established Regional Internal Audit function which is leading to ensuring best value for services.

Therefore, when any assessment of efficiencies being achieved is made, there needs to be acknowledgement and recognition that CMDHB is already absorbing between \$18m and \$25m per year through effective revenue or cost recognition under-funding. This represents a huge challenge from a clinical or health perspective. While this represents a very solid financial absorption which could be argued is simply “getting rid of existing inefficiency”, to do so would be ignoring reality.

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

8.3 Financial Management

8.3.1 Specific Cost Pressures – Wage Pressure

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

In many cases wage staff are entitled to move up a step virtually automatically after each year of service (step function increases) which result in an average of 2 – 2.5% (net) increases. The step function increases have to be absorbed by direct funding (none available) or by way of continuously increasing efficiencies.

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

Actual changes in leave entitlements over the past three years, some related to the implementation of the Holidays Act, are already having both a material financial and resourcing impact on the organisation with particular challenges around the impact of observing the extra leave entitlement and then filling the consequent vacancies this is causing.

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

IEA Wage/Salary Freeze

CMDHB, along with all DHBs took a very prudent and responsible approach to this over the past year with a total salary freeze across all IEAs. However, it is unrealistic to expect this to continue into the 2010/11 year and we are thus anticipating wage settlements in this area similar to the general MECA settlements.

Regional Job Sizing

As part of an Auckland regional approach, CMDHB has previously agreed to participate and abide by SMO regional job sizing standardisation. While some specialties are known and budgeted, there remains significant financial exposure to those specialties not yet finalised.

Almost all regional job sizing quantifications are now complete, but have still to be rolled out and include in many cases, back dating of the adjustments. This has been a costly but necessary, exercise for CMDHB, both in regard to ensuring strict regional wage comparability, but also actual safe clinical establishment levels (FTEs).

8.3.2 Capital Planning & Expenditure

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

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

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

Over the past few years, CMDHB has successfully completed all phases of its building programme under the auspice of FMP. This investment totalled over \$300m and was fully funded from CMDHB free-cashflow or existing approved debt facilities. It has come in "on time", "under budget" and "within specifications" – an almost unique occurrence in the public health sector.

We have recently completed the final stage (3) of the Core Consolidation Project encompassing the building of a new stand alone ward block on the Middlemore site (Edmund Hillary Block) which has provided a significant number of in-patient beds. This facility incorporates significant improvement in models of care through both layout changes and staffing structures. These beds have been immediately utilised, reflecting the existing severe shortage of in-patient beds, but have equally assisted in helping achieve the 6 Hour ED target. As noted following, the "shelled" levels of the Edmund Hillary Block are currently being fitted out as part of the subsequently approved "Clinical Services Block Project Stage 1".

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

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

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

In recognising these challenges, CMDHB initiated a series of three national Sustainability Conferences over earlier years to address the wider national issues arising from these forecasts. These consisted initially of “workforce planning”, “funding and affordability” and more recently, “future models of care/building tomorrow’s health services”. These conferences were recognised as very successful and there was a high degree of mutual agreement around the issues. However, the underlying drivers have not changed and those challenges are still facing the whole public health sector.

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

Simplistically, this project, albeit that it has technically been split into two stages, proposed a new Clinical Services Block encompassing a completely new replacement suite of theatres, High Dependency Unit (HDU) and Assessment and Observation Unit (AOU) facilities at Middlemore and the fit out of the remaining incomplete (shelled) wards in the Edmund Hillary Block. It is envisaged that completion of this new CSB, Stage 1, will be followed by the relocation of support services to the Manukau Health Park (Browns Road), Stage 1a.

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

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

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

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

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

A comprehensive presentation of all aspects of the proposal was recently given by the proposed partners to senior management of the National Health Board ([See Attachment 4](#)). While originally this was proposed as a form of public private partnership (PPP), given that the intent of the project was a “whole of life” financial risk management/mitigation concept, the indications have been that this is either inappropriate or would not meet government requirements as such in the constrained timeframe available.

As a result of further discussions with NHB, particularly around severe short term capital funding constraints, CMDHB (and its partners) have formulated an interim or modular solution. This will be internally funded and neutral in overall cost amongst the interested partners. However, the requirement of a permanent solution will be needed by the latest 2013 (for completion 2015 /16), given the cost of the interim solution.

Table 11: Towards 20/20 Projects Schedule

Project	Budgeted Approval	Projected finish date	Value	Status
Middlemore (Clinical Services Block Stage 1)	Late May 09	Jan 2013	\$208m	Underway (\$108m internal funded)
Centre for Health Services Innovation	June 10	Jan 2013	\$9.95mm	Approved by Board.
Maternity theatres.			\$10m	Staged 2010- 2013
Manukau Health Park (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre) Stage 1a	Nov 2012	2016	\$122m	Staged 2010 - 2013
Middlemore (Clinical Services Block stage 2) Manukau Health Park (SuperClinic and Surgery Centre)	Nov 2013	2017	\$75m	As above
Middlemore (Clinic Services Block Radiology and Laboratory C Pod Kidz First) Manukau Health Park (SuperClinic, Rehab Centre, Mental Health Campus) Satellite Sites	Nov 2015	2019	\$100m	As above
Middlemore (Inpatient Replacement & Expansion) Manukau Health Park (SuperClinic, Rehab Centre, Mental Health Campus and Surgery Centre)	Nov 2017	2021	\$70m	Unknown
Middlemore (Decommission Galbraith, New Entrance)	Nov 2023	2027	\$50m	Unknown
Grand Total			\$644.95m	

8.3.3 Banking Covenants

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

Clearly our existing banking relationships in these times are more important than ever. We have, over the past year communicated regularly with the external banks and CHFA of our likely tighter position for 2009/10 which we have managed through without any major issues but are now indicating that significant tightening is increasingly likely to occur in 2010/11.

Table 12: Banking Covenants

Facilities (\$m)	Existing Limit	Utilisation @ 30 June 2010	Available Facility @ 1 July 2010
CHFA	197	120	53
Commonwealth Bank (working capital)	45	29.1	15.9
Commonwealth Bank (lease facility)	10	-	10.0
Westpac (lease facility)	10	1.6	8.4

Note: The above CHFA limit INCLUDES the funding approved for the CSB Stage 1, but EXCLUDES any facility relating to MHP Stage 1a and MMH WH Theatres which are still under consideration at the time of writing.

8.3.4 Cash Position

The forecast cash position of CMDHB assumes effectively a cash neutral position through full utilisation of free cash flow and available approved debt facilities to match the level of capital expenditure requirements in 2010/11, including both new and replacement assets. Although we have still to complete the final review of all capital expenditure requests, (and therefore confirm the final associated depreciation levels), capital expenditure related to 2010/11 will be limited to \$56.0m. We have not included within the cash flow forecast any capital requirements still requiring MoH/Minister approval, therefore specifically the MHP Stage 1a and MMH WH Theatres.

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2010/11 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing unutilised/approved debt facilities.

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

Covenants

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

Asset Sales

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

8.3.5 Capital Charge

The District Annual Plan continues to include the matching of cost and revenue on any higher capital charge that may arise from asset revaluations on a three yearly cycle. While this DAP for 2010/11 is immediately following the 30 June 2009 three year requirement, as earlier, CMDHB is not anticipating any material valuation change. Rather, there is a likelihood of either a nil or devaluation given the current financial environment.

8.3.6 Advance Funding

The 2010/11 District Annual Plan continues to incorporate the fiscal benefit of the one month advance funding, based on achieving an breakeven operating position and the maintenance of the other Ministry of Health requirements necessary to access this benefit.

8.4 Cost Containment Efficiency Gains

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

As a result of this, CMDHB has, as part of the preparation of this 2010/11 DAP and the early low funding indications, taken immediate formal action to address the need for cost containment and clinical improvement. As earlier indicated, we have formally recognised these challenges through the initiation of the Thriving in Difficult Times projects, and further roll out of productivity initiatives essentially aimed at thinking differently about cost and quality, while still committed to achieving our core objectives around the Triple Aim. The DHB recognises the overarching expectation that core clinical services cannot be cut. In fact, despite the financial pressures, the expectation is that they will be enhanced. However, in order to achieve the financial target facing CMDHB, it has been absolutely essential that we address, and correct as necessary, the level of investment in certain marginal areas and refocus our efforts in proven areas.

Generally throughout the organisation, demand continues to significantly outstrip projections and therefore levels of funded growth. Where there were signs of the steepness of growth slightly flattening over recent years, there are now indications of those growth pressures escalating again. This will require even tighter cost containment than ever to ultimately achieve zero operating deficit, but will in itself put very considerable clinical strain on an organisation experiencing these growth pressures and increase the focus on risk management and minimisation.

Women's health cost pressures continue, particularly relating to meeting service coverage requirements and higher ministerial expectations of bed availability, as well as birth rates (while slightly lower over previous years) still continuing at levels well in excess of national averages and well beyond current population based funding levels.

As noted earlier in the financial narrative, the previous signs of stability around hospital acute growth levels appear to have been temporary as these volumes grow again and are likely to worsen as a result of health and poverty issues potentially increasing through the effects of the international financial crisis. The DAP has been based on realistic levels of increase in acute growth levels, but there remains significant risk that these will exceed funded levels and therefore put further pressure on the organisation.

CMDHB remains committed to maintaining and exceeding in 2010/11, its existing very high level of access and elective volumes that are forecast for 2009/10. These levels have been achieved previously through a combination of both internal and external resources and, while a year later than planned, many of these elective volumes are proposed to be provided primarily within internal resourcing capacity and capability in 2010/11. However, where financially or clinically appropriate, in order to continue the strong reduction in waiting lists, we will access third party providers through formal longer term contracts.

In previous years CMDHB has quite deliberately "short funded" both the funder and provider arms by 0.5% of the demographic growth funding allocation to be able to contribute to the significant investment in new and existing District Strategic Plan initiatives. This has proved impossible in this year's DAP given the very significant growth and financial pressures imposed to reach a zero deficit operating position.

CMDHB continues to express concern around the forecast level of increases in utility costs in the areas of gas, electricity, fuel costs and particularly again indications of high waste water and water increases following on from similar increases over the last 2 years. The latter area is forecast to sustain significant high increases as Watercare takes full responsibility under the Auckland 'Super City' concept. As previously, there appears to be little or no financial advantage from metro Auckland DHB regional negotiations as these prices are primarily geographically site related, rather than collectively related, or they are flat non-negotiable equally applied prices in the case of water/waste water. These forecast increases are well above funded inflation and population growth adjustments and represent in some of the cases, the need for very significant infrastructure investment (and subsequent cost recovery) for the greater Auckland region.

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

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

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

CMDHB has and always will continue to maintain a very close focus on FTE management, given that salary and wage costs are 2/3rds of the provider budget. These are monitored and managed on a monthly basis, both in terms of absolute head count and cost per FTE by division, by RC.

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

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

Table 13: Management and Admin resource levels.

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

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

8.5 healthAlliance (CMDHB and WDHB Shared Services Organisation)

healthAlliance continues to perform very well as a shared support service for information services, accounting/finance/human resource support, procurement and materials management and payroll. Cost savings particularly within procurement as well as reduced Human Resource recruitment costs are again expected to significantly benefit CMDHB and WDHB, albeit at a lower level than achieved over previous years. This is occurring as healthAlliance's procurement focus becomes more about tackling the difficult costs negotiations. These achievements are expected to continue but CMDHB cannot expect the level of savings to be as high as previously achieved. CMDHB is working very closely with and contributing to, the national procurement objective although the current assessment is that neither CMDHB nor WDHB can currently have any material expectations around additional national savings over levels currently being achieved.

The current financial constraints imposed on all DHBs have meant we have had to restrict healthAlliance activities for the current year in order to enable them to live within the overall funding package. Regrettably this means a year (or possibly a number of years) of consolidation and in some cases, reduced ability to meet the needs and expectations of its shareholders as a shared services organisation. These cost pressures have meant that focus on areas such as information technology and management opportunities that are seen as essential by all parties, have had to be deferred or in fact reduced for fiscal compliance at a time when both organisations should be investing in this area given the shareholders very high level of expectations and needs. This increased investment, particularly in IS, is necessary to recapture the momentum previously given to the provider arm as well as the very significant needs around the capture and integration within one system of primary care and community level information. This is seen as a critical area for both DHBs and essential to the future development of both.

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

While CMDHB is working towards a more formal regional structure, all northern region DHBs continue to work very closely together to maximise benefits, without ADHB and Northland DHB formally being part of healthAlliance. This is particularly the case with regional information technology development and payroll where all three Auckland metro DHBs now use the same payroll software and thus can share and learn from each other's experiences.

8.6 2010/11 Pharmaceutical Budget

CMDHB is committed to the Government's medicines boost initiative by engaging with Pharmac via our representations on SIG and the GMs' Planning and Funding forums. Pharmac's CMDHB 2010 forecast (January) on 10/2/2010 describes an increase of \$3M or 2.9% increase at "reimbursement cost" (drug cost plus dispensing less rebates and co-payments). This forms the base budget to which is added local and regional initiatives. The base budget includes the continued investment of Pharmaceutical Cancer Treatments and the Ministry's funding of 12 month Herceptin treatments. Locally/Regionally the pharmaceutical budget allows for initiatives in the areas of gout, patient drug switching incentives, regional pharmacy development and the continuation of pharmacy quality audits.

8.7 Outlook for 2011/12 and 2012/13 Years

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

1. As a result of the budgeted forecast of a zero deficit position for 2010/11 financial year, the outer years "base" positions have improved significantly, based on the continuing revenue and cost assumptions. We are therefore anticipating that the outer 2 years of the Plan, can be maintained at a nil deficit level.
 - Years 2 and 3 of the CMDHB DAP will benefit from the assumption that PBF funding will continue at the current levels, thus assuming the reduced 5% maximum increase cap in any one year continues to be applied.
 - Within all years of the DAP, the full impact of the cost relating to the opening of the Stage 1 Edmund Hillary Block at Middlemore is recognised at almost \$6m per year as detailed in the original Business Case.
 - The outer years of the DAP assume a continuing level of wage and salary settlements at the current proposed settlement levels, which means CMDHB will have to continue to absorb settlements at virtually twice the funded levels. This remains a huge challenge for any organisation to absorb, while still continuing to provide both essential and increasing clinical services in a constrained fiscal environment. It is expected that there will be even greater pressure from medical staff for parity with Australian terms and conditions, given the significant easing/accessibility of New Zealand medical staff to Australia from April of this year.

This is similarly likely to put even greater pressure around workforce levels, recruitment and training, underlining the criticality of the need for early resolution of, and support for, the Centre for Health Services Innovation.
 - The DAP does NOT include the cash flow impact and initial operating expense impacts of any current or future, but as yet unapproved Business Cases, OTHER THAN the capital cost of the approved current \$208m Clinical Services Block Business Case and the Operating costs of the fitted out additional wards in the Edmund Hillary Block.
2. The challenges as described above are anticipated to be significantly offset by recognition of the continuing benefits of the rollout of the Thriving in Difficult Times project, thus underlining how important the achievement of the project outcomes is, both clinically and financially, to the organisation.

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

8.8 Significant Accounting Policies

<p>Reporting entity</p> <p>Counties Manukau District Health Board (“CMDHB”) is a Health Board established by the New Zealand Public Health and Disability Act 2000. Counties Manukau DHB is a crown entity in terms of the Crown Entities Act 2004 owned by the Crown and domiciled in New Zealand.</p> <p>The CMDHB group consists of the ultimate parent, Counties Manukau District Health Board and its “deemed” subsidiaries, Manukau Health Trust (0% owned), and South Auckland Health Foundation (0% owned) - these are not considered to be material and have not been consolidated into the accounts. Its associate companies are healthAlliance Ltd (50%), Auckland Regional RMO Services Ltd (33%) and the Northern DHB Support Agency (33.3%) – these entities are not equity accounted as they are not considered material to CMDHB. All CMDHB subsidiaries and associates are incorporated and domiciled in New Zealand. Counties Manukau DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Public Finance Act 1989 and the Crown Entities Act 2004.</p> <p>Counties Manukau DHB is a public benefit entity, as defined under NZIAS 1. Counties Manukau DHB’s activities involve delivering health and disability services and mental health services in a variety of ways to the community. The financial statements were authorised for issue by the Board on 20/10/09.</p>
<p>Statement of compliance</p> <p>The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.</p>
<p>Standards, amendments and interpretations issued that are not yet effective and have not been early adopted</p> <p>Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to CMDHB include:</p> <ul style="list-style-type: none"> □ NZ IAS 1 <i>Presentation of Financial Statements (revised 2007)</i> replaces NZ IAS 1 <i>Presentation of Financial Statements (issued 2004)</i> and is effective for reporting periods beginning on or after 1 January 2009. <p>The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. The revised standard gives CMDHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). CMDHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.</p> <ul style="list-style-type: none"> □ NZ IAS 23 <i>Borrowing Costs (revised 2007)</i> replaces NZ IAS 23 <i>Borrowing Costs (issued 2004)</i> and is effective for reporting periods beginning on or after 1 January 2009. <p>The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. The revised standard will also require borrowing costs to be considered when revaluing property, plant and equipment to fair value based on depreciated replacement cost. Any necessary adjustments to depreciated replacement cost carrying values will have flow on effects to depreciation expense. CMDHB intends to adopt this standard for the year ending 30 June 2010 and has not yet quantified the potential impact of the new standard.</p>

Basis of preparation

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (interest rate swap contracts) and financial instruments classified as available-for-sale and land and buildings.

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements the DHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Refer to note 1 for the treatment of income in-advance

Management discussed with the Audit Risk & Finance Committee, the development, selection and disclosure of CMDHB's critical accounting policies and estimates and the application of these policies and estimates.

Basis for consolidation**Subsidiaries**

Counties Manukau District Health Board is required under the Crown Entities Act, to consolidate into its statutory Accounts those entities "deemed" subsidiaries under this Act. The definition of subsidiaries extends to those entities, whose sole or primary purpose gives "benefit to Counties Manukau District Health Board. This is irrespective of legal ownership.

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 Board.

The South Auckland Health Foundation operates as a registered Charitable Trust controlled by a group of trustees and includes three nominees from Counties Manukau District Health Board. Counties Manukau District Health Board has no legal right or equally, obligation in respect of SAHF. This entity is not consolidated as it is not material to Counties Manukau District Health Board.

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.

Budget figures

The budget figures are those approved by the health board in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by CMDHB for the preparation of these financial statements.

Financial instruments**Non-derivative financial instruments**

Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

Non-derivative financial instruments are recognised initially at fair value plus, for instruments not at fair value through profit or loss, any directly attributable transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.

A financial instrument is recognised if CMDHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if CMDHB's contractual rights to the cash flows from the financial assets expire or if CMDHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset

Cash and cash equivalents

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

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

Instruments at fair value through profit or loss

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

Other

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

Trade and other receivables

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

Interest-bearing loans and borrowings

Interest-bearing loans and borrowings are classified as other non-derivative financial instruments.

Trade and other payables

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

Derivative financial instruments

CMDHB uses foreign exchange and interest rate swap contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments that do not qualify for hedge accounting are stated at fair value. The gain or loss on remeasurement to fair value is recognised immediately in the statement of financial performance. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

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

Hedging**Cash flow hedges**

The Board has no financial instruments by way of interest rate options or foreign currency hedges, although it has entered into these in prior years.

Hedge of monetary assets and liabilities

Where a derivative financial instrument is used to hedge economically the foreign exchange exposure of a recognised monetary asset or liability, no hedge accounting is applied and any gain or loss on the hedging instrument is recognised in the statement of financial performance.

Property, plant and equipment
Classes of property, plant and equipment
The major classes of property, plant and equipment are as follows: <ul style="list-style-type: none"> ➤ freehold land ➤ freehold buildings ➤ plant and equipment ➤ clinical equipment ➤ motor vehicles ➤ other equipment
Owned assets
Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.
Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance.
Additions to property, plant and equipment between valuations are recorded at cost.
Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.
Property, Plant and Equipment Vested from the Hospital and Health Service
Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Counties Manukau Health Ltd (a hospital and health service company) vested in COUNTIES MANUKAU DHB on 1 January 2001. Accordingly, assets were transferred to COUNTIES MANUKAU DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets continue to be depreciated over their remaining useful lives.
Disposal of Property, Plant and Equipment
Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance is calculated as the difference between the net sales price and the carrying amount of the asset.
Leased assets
Leases where CMDHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.
Operating Leases
An operating lease is a lease that does not transfer substantially all risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.
Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.

Subsequent costs		
Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to CMDHB. All other costs are recognised in the statement of financial performance as an expense as incurred.		
Depreciation		
Depreciation is charged to the statement of financial performance using the straight line method. Land and Work in Progress are not depreciated. Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:		
Class of asset Estimated life Depreciation rate		
➤ - Structure/Envelope	10 - 50 years	2% - 10%
➤ - Electrical Services	10 – 15 years	6% - 10%
➤ - Other Services	15 – 25 years	4% - 6%
➤ - Fit out	5 – 10 years	10% - 20%
➤ Plant and equipment	5 - 10 years	10% - 20%
➤ Clinical Equipment	3 - 25 years	4% - 33%
➤ Information Technology	3 – 5 years	20% - 33%
➤ Vehicles	4 years	25%
➤ Other Equipment	3 - 25 years	4% - 33%
The residual value of assets is reassessed annually. Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.		
Intangible assets		
Other intangibles		
Intangible assets comprise software that is acquired by CMDHB are stated at cost less accumulated amortisation and impairment losses.		
Subsequent expenditure		
Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.		
Amortisation		
Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:		
Type of asset Estimated life Amortisation rate		
➤ Software	2 - 5 years	20% - 50%
Inventories		
Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.		
Inventories held for distribution		
Inventories held for distribution are stated at the lower of cost and current replacement cost.		

Impairment
The carrying amounts of CMDHB's assets, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.
If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.
An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.
When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance.
Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on numbers of days overdue, and taking into account the historical loss experience in portfolios with a similar amount of days overdue.
Calculation of recoverable amount
Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.
Reversals of impairment
Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.
An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of financial performance.
An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.
Interest-bearing borrowings
Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

Employee benefits
Defined contribution plans
Long service leave, sabbatical leave and retirement gratuities
CMDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.
Annual leave, conference leave, sick leave and medical education leave
Annual leave, conference leave, sick leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount CMDHB expects to pay. CMDHB accrues the obligation for paid absences when the obligation relates to employees' past services.
Provisions
A provision is recognised when CMDHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation
Restructuring
A provision for restructuring is recognised when CMDHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.
Income tax
CMDHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for
Goods and services tax
All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.
Revenue
Crown funding
The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.
Goods sold and services rendered
Revenue from goods sold is recognised when CMDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and CMDHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.
Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to CMDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by CMDHB.
Rental income
Rental income is recognised in the statement of financial performance on a straight-line basis over the term of the lease.

Revenue relating to service contracts
CMDHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or CMDHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.
Mental Health Ring Fenced Revenue
In accordance with Generally Accepted Accounting Practice and NZIFRS, surpluses of Income over expenditure are reported through the Statement of 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 2009 there were no unspent amounts in respect of Mental Health Ring Fenced Revenue (as at 30 June 2008 - nil)
Expenses
Operating lease payments
Payments made under operating leases are recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.
Finance lease payments
Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.
Interest Expense
The interest expense component of finance lease payments is recognised in the statement of financial performance using the effective interest rate method.
Cost of Service (Statement of Service Performance)
The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of CMDHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.
Cost Allocation
CMDHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.
Cost Allocation Policy
Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.
Criteria for Direct and Indirect Costs
Direct costs are those costs directly attributable to an output class. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.
Cost Drivers for Allocation of Indirect Costs
The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

ATTACHMENTS

- Attachment 1: Price Volume Schedules
- Attachment 2: CMDHB Information Systems Strategic Plan (ISSP)
- Attachment 3: Overview of the Centre for Health Services Innovation Project
- Attachment 4: Planned Capital Expenditure
- Attachment 5: 2010/11 Metro-Auckland *Better, Sooner, More Convenient* Implementation Plan

Attachment 1: Price Volume Schedules

Provider Arm Schedule.

Counties Manukau DHB has concerns with the summary tables provided in the Price Volume Schedules which the DHB believes does not adequately reflect the planning activity that has occurred within the DHB to arrive at the 2010/11 volumes. The DHB disagrees with the underlying assumption that a planned volume which is not in line with current forecast volumes is inappropriate.

Of particular concern is the conversion of Outpatient Volumes to WIES. We believe the methodology is flawed and the conversion does not reflect true volumes, thus being of little use in interpreting our planned volumes and assumptions.

The planning assumptions underpinning our PVS are outlined below:

- Inter District Flows into Counties Manukau DHB from Auckland and Waitemata DHBs have been discussed and a more appropriate schedule, reflecting demand, has been prepared. This is based on trend data as well as planning and other personnel from Auckland and Waitemata DHBs. Although there has not yet been formal signoff on these volumes, there has been verbal agreement and these have been built into the Volume Schedules. This includes recognition of services where previous level of service is no longer required. The remaining DHB volumes have been left at December 2009 Release Funding Envelope Volumes
- Acute inpatients have been planned utilising actuals and past year trends on a service by service basis, with clinical input, to inform appropriate levels for the coming Financial Year.
- The 2010/11 Elective volumes also reflect changes in clinical practice where patients who have been historically treated in the inpatient setting are now being treated in a procedural outpatient setting and therefore will no longer count as part of traditional elective surgery counts. Examples of these are Avastin injections for macular degeneration and insertion of the Mirena© inter-uterine device instead of a hysterectomy.
- Outpatient volumes have been planned to be reflective of demand. FSA volumes will enable us to remain ESPI compliant. Follow up volumes have been planned in line with improving FSA to FU ratios.

Electives Schedule: Population View.

Base case-weighted discharges have been increased from Ministry expectation in two specialties (Plastic Surgery and Urology) to enable us to meet the required discharge target within both the confines of the additional funding, and the need to redistribute this based on change in practice. Need has been identified in both specialties and is achievable. Paediatric surgical specialties have decreased by 15 WIES. This does not decrease the level of service currently being provided which appears to be meeting demand.

Please note that a substantial number of procedures that were previously captured as inpatient elective discharges are now being treated as outpatient day procedures. This will make attaining the required discharge target for financial year 2011/12 more challenging as the change in practice means we are unable to count these against our discharge totals.

Most FSA and procedural volumes have been altered from original populated volumes. In most cases these have been increased to reflect more appropriate levels of service for our population. Services that have been decreased have only been where demand is being currently being met at the stated level.

Attachment 2: CMDHB Information Systems Strategic Plan (ISSP)

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	Project rank/priority	DHB Project Reference #	Planned Start (Month/Yr)	Expected Completion (Month/Yr)	HIS-NZ Action Zone #	Project Type	Significance: National? Regional? Local?	Approx Capital Cost (\$000)	Funding Source	Identify Project reference in DAP. State how project aligns to specific DHB Objectives	Brief Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved

Column 2: Project Ranking	Column 6: HISAC Action Zone	Column 7: Project type	Column 8: Project significance	Column 10: Project Funding Source
1: Must Do in 2010/2011	1: National Network Strategy	N: New	N: National	I: Internal (in approved DAP)
2: Should Do in 2010/2011 - Probable Do in 2011/2012	2: NHI Promotion	U: Upgrade	R: Regional	M: MoH New Funding
3: Nice to Do in 2010/2011 - Should Do in 2011/2012	3: HPI Implementation	R: Replacement	L: Local	P: Third Party
4: Non-urgent-Requested by Clinicians	4: ePharmacy			N: Not yet determined
5: Non-urgent-Requested by Board/Staff	5: eLabs			
6: Non-urgent-Requested by Ministry	6: Discharge Summaries			
7: Early Warning-upcoming work-probable future Rank 1	7: Clinical Care and Disease Management'			
8: Early Warning-upcoming work-probable future Rank 2	8: Electronic Referrals			
9: Early Warning-upcoming work-probable future Rank 3	9: National Outpatient Collection			
	10: National Primary Care Collection			
	11: National Systems Access			
	12: Anchoring Framework			

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	Project rank/priority	Project Reference #	Planned Start (Month/Yr)	Expected Completion (Month/Yr)	HIS-NZ Action Zone #	Project Type	Significance: National? Regional? Local?	Approx Capital Cost (\$000)	Funding Source	Identify Project reference in DAP. State how project aligns to specific DHB Objectives	Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved
Regional eReferrals Phase 1	1		Jan10	Jun11	8	N	R L	460	I	In DAP IS plan Project provides increased ability for DHB to meet HISNZ targets	Install eReferrals application. 1) Improved patient safety from Electronic Referrals 2) less manual resource applied to exception processing
Electronic Medicines Reconciliation (EMR)	1		Jan10	Jun12	4	N	R L	369	I	In DAP IS plan Project provides increased ability for DHB to meet HISNZ targets	Electronic Medicines Reconciliation system 1) Improved patient safety from Safe Medications 2) Improved quality and communication of medication information between secondary and primary care reducing the incidence of medication errors and adverse drug events inherent in the current system.
Regional Clinical documents	1		Jan10	Dec11	7	N	R L		I	In DAP IS plan Project provides increased ability for DHB to meet HISNZ targets	To create a single location where key clinical documents can be stored and made available to all clinicians involved in patient care across the region. 1) Key information from any DHB in the region is available to clinicians caring for the patient in a single view 2) Outpatient clinic letters stored and accessed in Eclair
IT support for devolution of services & IFHC centres	1		Jan10	Mar10	7	N	R L	23	I	In DAP IS plan Project provides increased ability for DHB to meet HISNZ targets	Scoping of a shared care system 1) Real time clinical information available to enable coordinated care for

											patients and whanau across multiple providers 2) Improved coordination of care
Single hosted regional PACS/RIS	1		Jan10	Jun11	12	R	R L	3,900	I	In DAP IS plan Project replaces high risk end of life RIS and moves to single regional RIS & PACS	A single hosted Radiology information system (RIS) available across the Auckland region Current RIS not supported 1) Metro Auckland DHB clinicians able to share shared patient radiology information 2) Expected move to regional system
Mental Health Phase 2	1		Jul10	Dec11	7	N	R L		I	In DAP IS plan Project builds upon Phase 1 DHB shared mental health EPR to deliver benefit to wider shared care community	Phase 2 is extending the benefits of a shared system to the wider clinical team to include NGOs and Primary care and to the clients and their whanau 1) Greater involvement of the client and whanau in their care planning and recovery 2) Collaborate clinical process leading to improved clinical safety, reduced relapse incidents
Regional data centre	1		Jan07	Dec13	12	N	R L	Not known yet	N	In DAP IS plan Essential infrastructure without which DHB growth and initiatives will not be able to proceed.	The new regional data centre will overcome limits to current capacity in terms of power and physical space, and thereby provide capacity for future growth in DHB initiatives and systems.
Regional data storage	1		Jun07	Jun11	12	N	R L	1,500	I	In DAP IS plan Essential infrastructure without which DHB growth and initiatives will not be able to proceed.	The new data storage system will overcome limits to current capacity and enable the DHB to comply with new data storage requirements such as the Public Records Act.

Attachment 3: Overview of the Centre for Health Services Innovation Project

1.1 History

Counties Manukau is the fastest growing DHB in New Zealand, with an additional 170,000 people projected to be resident in the district within the next 15 or so years. This growth, combined with population ageing and the prevalence of long term health conditions, particularly in the Pacific and Maaori communities, will increase demand for services, health professionals and health workers – and will require new models of service delivery and workforce deployment across the medical, nursing and allied health workforce

These workforce requirements mirror some of the challenges identified in national workforce planning undertaken by the Ministry, as well as Treasury's concerns about long term sustainability.

As part of addressing workforce requirements, CMDHB intends to build a workforce which reflects local communities by increasing access and training opportunities for Maaori and Pacific. A significant step in achieving this has been made possible through the Tindall Foundation's announcement that it will annually fund 150+ scholarships for Maaori and Pacific in the district.

As recognised by Government following the review undertaken by the Medical Training Board, there is an urgent need to increase medical student intakes. The University Of Auckland School for Medicine has had a presence at Middlemore Hospital for over 40 years, with the South Auckland Clinical School today providing applied training for more than 135 students each year. A significant increase in student numbers is expected following increased Government funding, requiring additional infrastructure and support.

This growth is occurring at the same time that CMHB is undertaking major redevelopment of its Middlemore site, which will result in the demolition of existing academic facilities.

Recognising these opportunities and challenges, CMDHB and the University of Auckland, together with AUT University and Manukau Institute of Technology developed a proposal to establish a Centre for Health Services Innovation which will act as a catalyst for integrating training programmes across nursing, medical and allied health disciplines and a close industry/ provider link to address looming workforce issues, and provide a focus for quality improvement, leadership development and research and innovation activities in the district and beyond.

1.2 Centre Activities & Focus

The Centre for Health Services Innovation will provide much needed infrastructure for the practical training of clinicians and health workers, including support for the significant increase in medical students, already funded by Government, who will require DHB-based training as well as growth in nursing trainees to meet both current and future needs.

In addition to helping address immediate workforce issues, the Centre will enable CMDHB to lead the health sector in piloting new roles and introducing changes in training models and workforce mix, aimed at evolving a workforce from our local community which can meet projected growth in demand and is financially sustainable for the sector.

The joint venture (JV) will enable applied health education, learning and research in the district by providing facilities, infrastructure and support services at a new facility which has a primary objective of being built on CMDHB land adjacent to Middlemore Hospital or as part of an integrated solution with replacement Maternity facilities on the main Middlemore campus.

The Centre will be the base for health-related education & learning undertaken by CMDHB & education partners in the district and will be linked to the community via a 'hub and spoke' model.

Activities will span:

- Applied learning for undergraduates (medical, nursing, allied health)
- Foundation programmes for entry level health workers
- Mentoring and support for trainees
- Continuing clinical and non-clinical education programmes
- Leadership and management programmes
- Patient, family and community education programmes

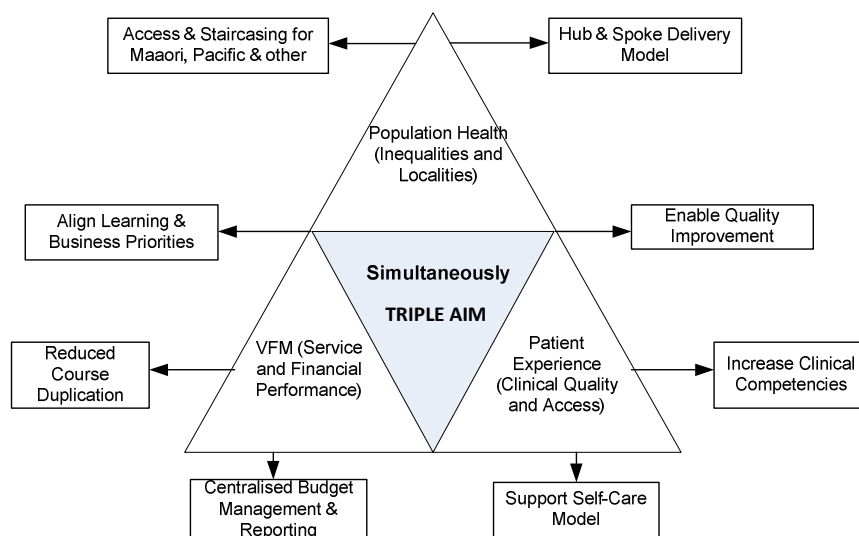
It will also support research, innovation and quality improvement activities, including a proposed regional health technologies innovation hub being developed with Ministry of Economic Development support.

Education, research and innovation activities will link regionally and the intention is that activities based at Counties Manukau will complement those of other DHBs. In particular, CMDHB and WDHB have been in discussions with regards to potential areas of synergy. CMDHB also intends to share learnings related to workforce initiatives with other DHBs

Over recent years, CMDHB has been taking a national leadership role in quality improvement. Canterbury DHB also has a strategic focus on quality. To further quality and patient safety initiatives, CMDHB and Canterbury DHB have established a formal collaboration agreement at a senior clinical and management level.

The JV partnership with key tertiary providers is expected to enable CMDHB to have greater input to the development of curricula and training programmes. Similarly, tertiary providers will be better positioned to respond to health sector needs if they can share health labour market intelligence and CMDHB's strategic vision of growing a future workforce from local communities.

The activities within the Centre will support CMDHB's strategic Triple Aim:



The Centre's facilities will be shared by the foundation partners and also available to other users.

The facility requirements have been specified based on actual current learning & training volumes and the design future-proofed for projected growth, including planned growth in both medical and nursing student numbers:

It will also provide office accommodation for resident and visiting academics and researchers from each tertiary education institution, CMDHB educators and researchers, as well as CMDHB's executive, funding & planning team (which is currently located offsite in commercially rented premises).

Attachment 4: Planned Capital Expenditure

This table sets out the breakdown of the DHB's planned capital expenditure for 2010/11, by quarter. Capital expenditure is subject to timing of equipment and projects, sign off, purchase, lead times, charges, weather and other variations (best estimates have been made on timing).

Capital Expenditure	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Baseline Capital				
Clinical Equipment	1,251	1,251	1,250	1,248
Other Equipment	600	600	600	600
Information Technology	975	975	975	975
Intangible Assets (Software)	450	450	450	450
Motor Vehicles	225	225	225	225
Subtotal	3,501	3,501	3,500	3,498
Strategic Capital				
Clinical Services Block	12,423	5,998	8,041	6,615
CHSI	800	6,000	3,150	-
Subtotal	13,223	11,998	11,191	6,615
Total	16,724	15,499	14,691	10,113

Attachment 5: 2010/11 Metro-Auckland Primary Care *Better, Sooner, More Convenient* Implementation Plan

Service Area	Key Result Area	Key Performance Indicator	Implemented By
Access To Diagnostics	Software development	ProExtra Demand Management tool and web based triage tools complete and ready for installation	30 Jun 2010
	Regional acceptability and feasibility	Regional impact assessment complete	31 Jul 2010
	Software implementation	Installation & training complete for all 100 ADHB practices	31 Dec 2010
	Community access	Community providers contracted for direct GP referrals	31 Dec 2010
	Regional expansion	Through local clinical engagement and support, roll out to up to another 100 practices in Greater Auckland	30 Jun 2011
Access to minor surgery/skin lesions	Minor surgery within primary care	100% increase in publicly funded minor skin lesion procedures in primary care over 08/09 volumes	30 Sep 2011
Clinical Pathways	Phase 1 : Clinical Pathway: Dyspepsia Commence Re-Implementation of Pathway for Gastroenterology:	<ul style="list-style-type: none"> ➢ Reduction in all Secondary care FSAs for Dyspepsia for all those participating in programme ➢ Reduction in unnecessary Gastroscopies in Secondary Care by up to 30% for referrers participating in programme ➢ Reduction in time to wait for a Gastroscopy in secondary care to clinically appropriate timeframe 	30 Jun 2010 with 30% implementation by 30 Jun 2010
	Regional Clinical Pathways Working Group across the care continuum	Establish with Terms of Reference and Scope to include regional process to be undertaken to solve the problem	31 May 2010
	Phase 2 : Areas for regional Clinical Pathways	<ul style="list-style-type: none"> ➢ A minimum of five prioritised, selected and agreed across GAIHN ➢ Clinical Pathway development completed for each of five areas ➢ Key performance indicators developed ➢ Processes implemented and tested ➢ Commencement of minimum of five Clinical Pathways 	30 Jun 2010 31 Mar 2011 30 April 2011 15 June 2011 30 June 2011
Pharmaceuticals	Resource Management - Pharmaceuticals	Reduction of \$1.5million actual verses budgeted pharmaceutical expenditure (including drug cost and dispensing fees) for the Pilot Programme GPs in the 2010 / 2011 financial year	30 June 2011
	Quality use of medicines	<ul style="list-style-type: none"> ➢ Conduct medication reviews within a sample of residential care facilities. ➢ Evaluate the impact of the medication reviews 	30 September 2010 March 2011
Acute Demand /POAC	Reducing Acute Demand through POAC	50% increase in budgeted POAC volumes (i.e. over 5,000 additional referrals)	30 June 2011
After Hours/ Extended Hours	After Hours Network Phase One	<ul style="list-style-type: none"> ➢ Development of a regional after hours plan ➢ A minimum of 10 operational clinics until 10pm across region ➢ Increased availability of regional triage and disposition 	1 July 2010

Service Area	Key Result Area	Key Performance Indicator	Implemented By
		<ul style="list-style-type: none"> ➤ Availability of essential medicines ➤ Measurable reduction in inappropriate presentations to emergency departments across the region within 12 months 	
Pharmaceuticals	Resource Management - Pharmaceuticals	Reduction of \$1.5million actual verses budgeted pharmaceutical expenditure (including drug cost and dispensing fees) for the Pilot Programme GPs in the 2010 / 2011 financial year	30 June 2011
Maori Services Devolution	Phase One Devolve all non core Maori specific services currently provided by DHBs to Iwi / Community	<ul style="list-style-type: none"> ➤ Potential devolution of following services ➤ Delivery of Well child services in community in accordance with current contract deliverables ➤ Delivery of Parenting programmes in community setting, in accordance with current contract deliverables ➤ Delivery of Healthy Lifestyle planning in community setting, in accordance with current contract deliverables ➤ Delivery CAYADS- Drug and Alcohol services, in community setting, in accordance with current contract deliverables 	30 June 2011
	Phase Two- Review of DHB services that have high Maori service utilisation, or services of high priority for Maori that are under utilised	<ul style="list-style-type: none"> ➤ Identification of services for devolution ➤ Development of a regional devolution template ➤ Literature review to identify evidenced for Indigenous community service models ➤ Assessment of Provider capacity ➤ Development of service devolution implementation plan, to include change management strategy, and risk management contingencies ➤ Key stakeholder engagement process ➤ Sign off for Iwi / MOU 	3 Dec 2010 Board Recommendation February 2011
	Phase Three Implementation of service review recommendations for service devolution across three DHBs	Contract negotiations- DHB / MOH Implementation of service devolution	30 June 2012

Attachment 6: Letter from Ministry of Health, confirming acceptance of District Annual Plan.



Office of Hon Tony Ryall

Minister of Health
Minister of State Services

21 SEP 2010

Professor Gregor Coster
Chair
Counties Manukau District Health Board
Private Bag 94-052
South Auckland Mail Centre
AUCKLAND



Dear Professor Coster

Counties Manukau District Health Board: 2010/11 District Annual Plan

This letter advises you that I have signed Counties Manukau District Health Board's (DHB) 2010/11 District Annual Plan (DAP) for three years.

Clinical and Financial Sustainability

I appreciate the efforts your Board and management have put in over the past year to manage your DHB in a sustainable manner. More work lies ahead to achieve long lasting sustainability, while ensuring that New Zealanders get an improved delivery of services. The challenge for us all is to achieve this.

All DHBs must budget within their allocations and improve financial performance. I note your planned financial position which incorporates performance improvement actions and efficiencies in 2010/11. The DHB's actions to achieve efficiencies and control costs will be important in the current fiscal environment in 2010/11 and out years. I note that the DHB is anticipating significant capital works in the medium term, and it would be appropriate for you to actively seek greater efficiencies to improve the DHB's ability to fund those projects. My approval of your DAP does not mean acceptance of your assumptions in out years.

Health Targets and Priorities

I am encouraged that your plan is underpinned by the Triple Aim framework, creating a strong quality and value for money theme throughout the plan. I appreciate the DHB's emphasis on the Government's health targets and priority areas.

The Ministry of Health has advised that it considers there are heightened risks associated with your achievement of the agreed health target for Shorter waits for Cancer Treatment. I expect that your DHB remains focused on improving performance in this and other health target areas, and that it will work closely with the Ministry of Health, and in particular, the Health Target Champions, to deliver concrete actions to ensure good progress is made.

New Zealanders want better access to a wider range of services closer to home. I expect your DHB to make substantial progress with implementing the Government's primary health care policy. I note your strong commitment to doing so. Success in this area will require you to work increasingly closely and collaboratively with your Northern region colleagues. The DHB will need to keep the Ministry of Health and National Health Board well informed of its progress in this priority area, including through a quarterly report.

I note that your Board plans to work closely with other Northern DHBs, building on promising regional actions from 2009/10. I will be particularly interested to review your Regional Clinical Services Plan and to see how the Northern Region will collaborate in ways which improve the financial and clinical viability of specific services.

DAP Approval

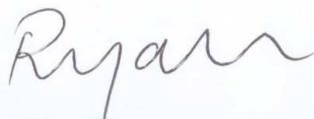
The approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry of Health where any proposals may require my approval.

My approval of your DAP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependant on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I wish you, your Board and management every success with the implementation of your 2010/11 DAP, and thank you for your contribution and efforts towards a unified health system.

Finally, please ensure that a copy of this letter is attached to the copy of your signed DAP held by the Board and to all copies of the DAP made available to the public.

Yours sincerely



Hon Tony Ryall
Minister of Health