

MidCentral District Health Board

STATEMENT OF INTENT

2009/10

Contents

Contents	1
1. Executive Summary	2
2. External Environment	2
3. Outcomes Framework	8
4. Output Classes, Outputs & Priorities	14
5. Organisational Capability	26
6. Financial Performance	30
Appendix 1 Financial Statements	33
Appendix 2 Statement of Accounting Policies	37
Appendix 3 Allied Laundry Services Limited	48
Glossary	52

1. Executive Summary

This Statement of Intent (SOI) outlines to Parliament and the general public the performance intentions for MidCentral District Health Board (DHB) during 2009/10 financial forecast information for 2010/11 and 2011/12. This document provides an overview of some of the services we deliver along with our performance targets for the period ahead. We have selected our priority investment areas to discuss in detail. The rationale for selecting these priority areas is detailed in sections 2 and 3.

MidCentral DHB is committed to achieving its vision of:

quality living – healthy lives

In order to improve this accountability document, all 21 DHBs worked with the Ministry of Health and the Office of the Auditor-General to design a consistent approach. This resulted in establishing four new outcome classes to replace the previous three classes. During next year measures for these outcome classes will be developed, enabling greater comparison between each DHB. Work is also being done to link the new outcome classes with financial forecast information.



Ian A Wilson
Chairman



Ann Chapman
Deputy Chair

2. External Environment

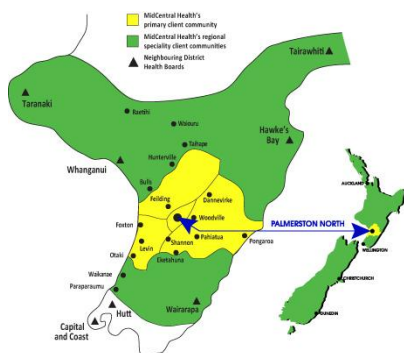
2.1 Population

This section describes our DHB's external environment, including our geographical location and our population profile.

2.2 Geographic Location

MidCentral District Health Board serves a wide geographical district stretching across the North Island from the west to the east coast and is distinguished by the Tararua and Ruahine ranges that traverse the centre of the district. MidCentral DHB's district comprises the following territorial local authority districts:

- Horowhenua district
- Manawatu district
- Palmerston North City
- Tararua district
- The Otaki ward of Kapiti Coast district



Four Iwi have manawhenua status within the district: Muaupoko; Ngati Kahungunu; Ngati Raukawa; and Rangitaane. (Manawhenua status means that the Iwi is recognised as having tribal authority within a region.)

Muaupoko and Ngati Raukawa Iwi are located on the western side of the mountain ranges and Ngati Kahungunu Iwi is located on the eastern side. Rangitaane Iwi covers both sides of the ranges from the Manawatu district (including Palmerston North) across to Pahiatua and Dannevirke areas.

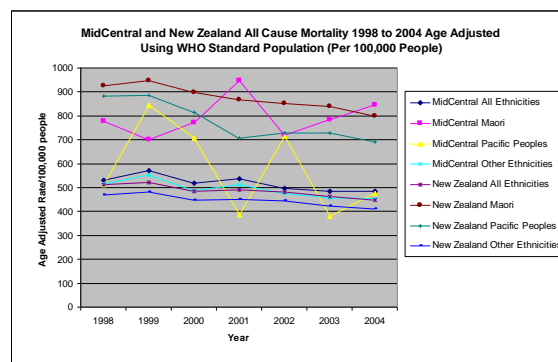
2.3 Health Profile

The planning, purchasing and prioritisation of services is influenced by the district's health status.

An assessment of the district's health status is undertaken regularly. The latest assessment was completed in February 2005 and updated in 2007.

The latest data suggests MidCentral DHB's health status is improving. Mortality rates for most of MidCentral DHB's ethnic groups, and MidCentral DHB overall have been improving. This suggests improving general health status. (NB: Mortality is used as a general indicator of population health status. As health status improves, mortality rates reduce.)

- The five most common causes of mortality are: (1) circulatory diseases, (2) cancer, (3) respiratory diseases, (4) injuries, and (5) endocrine diseases (mostly diabetes). These conditions have the greatest population health impact, when using mortality as a yardstick.



- MidCentral DHB's all cause mortality for 2002 to 2004 data was 6% higher than New Zealand's. This is less than the previous period (1999 to 2001) where it was 10% higher.
- MidCentral DHB's mortality for circulatory diseases mortality from 2002 to 2004 was 11% higher than for New Zealand overall. This is less than

for the 1999 to 2001 period, where MidCentral DHB circulatory diseases mortality was 15% higher than New Zealand overall.

2.3.1 Demographic Patterns

- MidCentral DHB's district's population is growing. The growth is mostly in Palmerston North.
- MidCentral DHB's district's population structure is aging, with increasing proportions aged 65 and over and reducing proportions aged 0 to 14.
- The distribution of people aged 65 years and older is not even across the MidCentral DHB district, it is higher in Horowhenua and MidCentral's portion of Kapiti Coast (Otaki and surrounding areas)
- MidCentral DHB district's proportion of Maori, Pacific, and Asian residents is increasing
- Horowhenua, MidCentral DHB's portion of Kapiti Coast (Otaki and surrounding areas), and Tararua have higher proportions of Maori residents than the rest of MidCentral district

2.3.2 Health Status by Ethnicity

- Maori and Pacific peoples experience disadvantaged health status. This is true for both MidCentral district and New Zealand overall.
- Maori and Pacific health status disadvantage is also reflected in their mortality rates for the five most common causes of mortality.
- There is evidence that Maori and Pacific peoples experience lesser access to health services when compared to health need. This is suggested by comparisons between hospitalisation patterns (service access) to mortality patterns (health need).

- Even though MidCentral DHB Maori are less likely to experience cancer (compared to New Zealanders overall) they are more likely to die from cancer. This pattern was also shown in the 2005 health needs assessment.
- Pacific peoples also have higher cancer mortality, despite lower cancer incidence, compared to New Zealanders overall.

2.3.3 Health Status by Territorial Authority Area

- Mortality (and therefore health status) is improving for all the territorial authorities.
- Horowhenua is still an area of disadvantaged health status, compared to MidCentral overall, although the gap may have narrowed.
- The most common causes of mortality for each of the territorial authorities are the same as for MidCentral DHB overall (already mentioned above).

These findings reinforce MidCentral DHB's priority health areas of cancer, respiratory, diabetes, cardiovascular, oral health, child health, Maori and Mental Health.

2.4 Provider Profile

In 2009/10 MidCentral District Health Board expects to spend \$507.6 million on health services for its population. This is made up of \$504.1 million revenue and \$3.5 million from retained earnings. A breakdown of revenue is shown – see table below. This money will be used for existing services and more initiatives in the DHB's ten priority areas. Investment will also occur in the DHB's workforce, infrastructure, and future planning.

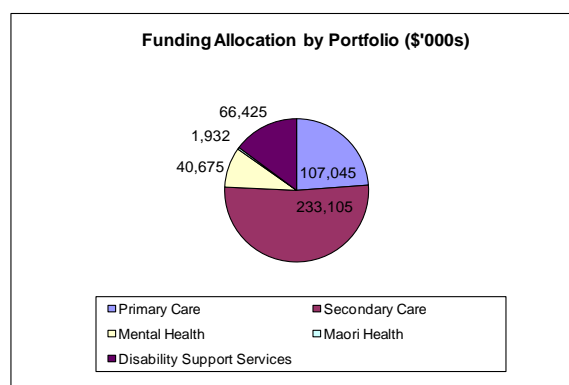
Allocation of Funding by Service - \$m's					
2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Budget	2009/10 Budget	
9.5	10.6	11.6	11.9	12.6	Public health
9.6	9.7	9.2	9.3	9.6	Community laboratories
16.1	17.1	18.7	19.3	20.4	Hospital community, rehabilitation and rural services, eg district nursing
16.6	18.8	20.5	21.1	22.3	Primary Health Organisations / General Practitioners
20.7	15.8	17.3	20.5	21.7	Other (includes in excess of 40 services)
22.1	12.4	0.9	0.3	0.3	Residential services for people with an intellectual disability (NB Kimberley Centre closed 30.10.06)
22.3	23.9	26.1	26.9	28.5	Hospital clinical support (inc x-rays, lab tests, blood products)
26.1	28.9	29.4	33.3	35.3	Regional cancer treatment service
26.2	32.7	35.7	35.5	37.6	Disability information services, needs assessment and service co-ordination
30.3	30.1	34.0	34.5	36.5	Residential care for the elderly
31.4	34.5	37.7	38.9	41.2	Mental health services
31.7	36.3	39.0	39.8	43.9	Community pharmaceuticals
33.0	36.2	37.8	39.7	45.6	Inter district flows
43.8	51.4	52.2	57.0	60.4	Hospital surgical services (inc surgery, orthopaedics, urology, ENT)
67.6	76.6	77.9	86.6	91.7	Hospital medical services (inc cardiology, paediatrics, neurology, renal)
407.0	435.0	448.0	474.6	507.6	TOTAL

Allocation of Funding by Provider Group - \$m's					
9.6	9.7	9.2	9.3	9.6	Laboratories
17.3	19.6	22.2	24.0	24.1	Enable New Zealand
30.3	30.1	34.0	34.5	37.7	Rest Homes
31.7	36.3	39.0	39.8	43.9	Community Pharmacies
33.0	36.2	37.8	39.7	45.6	Other DHBs
58.2	63.4	71.7	75.3	82.4	PHOs, GPs, Non-Govt Owned Providers
226.9	239.7	234.1	252.0	264.3	MidCentral Health
407.0	435.0	448.0	474.6	507.6	TOTAL

The \$3.5 million being spent in 2009/10 from prior years retained earnings will be used for: mental health (\$2.9m), and implementation of the Information Systems Strategic Plan (\$0.6m). The DHB plans to break even over the planning period before incurring the additional expenditure financed from retained earnings.

The receipt and allocation of funding occurs through six health portfolios. These portfolios are: primary health, public health, secondary/tertiary care, Maori health, mental health, and support services for the disabled and older people.

The allocation of funding to each portfolio for 2009/10 is as follows.



2.4.1 Primary Health

MidCentral DHB funds the majority of the primary health care services in the district. The services currently funded include:

- First contact health services provided by general practices (funded on a capitated basis)
- Well child services including immunisation, vision and hearing testing
- Community paediatric services
- Mobile Maori nursing services
- Oral health/dental services for children and adolescents, and emergency dental services for low income adults
- Sexual and reproductive health services
- Community pharmacy services
- Community referred laboratory services
- Community diagnostic imaging services
- Palliative care and hospice/community services
- Youth medical services through the Youth One Stop Shop programme
- Primary maternity services
- Community-based health services such as chronic care teams
- Rural community nursing services
- Regional diabetes co-ordination services

There are still some services funded and some managed centrally by the Ministry of Health. Currently the Ministry is responsible for health promotion services and all health protection services, funding ambulance services, lead maternity carers, Plunket and health camps for MidCentral DHB's district.

Complementary services such as osteopathy, massage therapy and Rongoa Maori are generally not publicly funded.

2.4.2 Secondary Care Services

MidCentral District Health Board will provide access to the following secondary

care services for its population by contracting with health providers:

- Specialist medical and surgical services
- Diagnostic and therapeutic services
- Cancer treatment services
- Maternity services
- Palliative care services
- Transport and accommodation
- Dental services
- Equipment and supplies
- Rural inpatient services
- Public health personal health services
- Mental health services
- Disability support services

Some services are provided by regional providers (ie, they provide services to more than one District Health Board) and some of the contracts with regional providers are managed by a single District Health Board. For example, in the case of emergency transport, the regional provider is St John and Hawke's Bay District Health Board currently manages this contract for the Central Region's District Health Boards. The tertiary needs of MidCentral DHB's population are provided in most part by the larger District Health Boards such as Capital and Coast in Wellington, and A+ in Auckland. Patients access these services on the referral of specialists based at Palmerston North Hospital. Other District Health Boards are funded for providing some non-tertiary services to MidCentral DHB's district, such as fertility services.

2.4.3 Support Services for Disabled and Older People Funding Levels

MidCentral DHB funds services to eligible older people who have been assessed as needing support. The services currently funded cover:

- Needs assessment and service co-ordination services for older people (65 years and older)
- Aged residential care
- Home-based support services

- Assessment, treatment and rehabilitation services.

The majority of services are provided by private providers from small limited liability companies, publicly listed companies, to not-for-profit incorporated societies and trusts. Psychogeriatric and geriatric assessment, treatment and rehabilitation services are provided by MidCentral Health.

In addition to the above a programme for “slow stream rehabilitation” is also funded.

The Ministry of Health continues to fund and manage services to younger disabled people, including residential care for people with an intellectual disability.

2.4.4 Maori Health

Annual expenditure on “by Maori, for Maori” services is approximately \$1,932,000 a year. The bulk of this goes toward Tamariki Ora, Maori disability support, Whanau Ora, mobile disease state nursing and mental health (including alcohol and drug) services.

(Note: this funding is additional to the mainstream (general) services which are accessed by Maori.)

Funding decisions by MidCentral DHB are guided by the Ministry of Health’s Health Inequalities Assessment Tool (HEAT) as part of the prioritisation framework and seeks to reduce inequalities and health disparities through good funding decisions and sound purchasing of services to communities.

MidCentral DHB funds “by Maori, for Maori” services throughout the district. There are a range of services available with varying levels of access and eligibility to the Kaupapa Maori funded services. These contracts are funded as fixed dollar amounts and are provided within the Maori health allocation. Kaupapa Maori

mental health services are funded from the mental health “blueprint” funding. There is a very small allocation of Maori health funding for Kaupapa Maori disability support service liaison.

There are four Iwi and three Maori health providers operating within the district. In general, their value centres on tikanga Maori, affiliation to Iwi (local or out of the district), knowledge of, and linkages with, their communities, and promotes a holistic health philosophy, ease of access and ability to deliver appropriate services.

2.4.5 Mental Health

MidCentral DHB will purchase the following mental health services for its client communities (recognising that for some services our client communities include other DHBs):

- Personal mental health services, including acute inpatient services, community-based services, and crisis intervention services cover
- Drug and alcohol services
- Services for children and young people
- Kaupapa Maori mental health services
- Forensic services
- Services for elderly
- Community-based rehabilitation and residential support services
- Community-based day activity services
- Consumer-based services

MidCentral DHB will also provide funds to support the continuing development of the mental health workforce both in terms of capacity and capability.

These outcomes are consistent with the purposes of the Crown Entities Act 2004 (CE Act 2004) and, the New Zealand Public Health and Disability (NZPHD) Act 2000

3. Outcomes Framework

3.1 Role of a DHB

MidCentral DHB is responsible for ensuring the people of its district have access to a wide range of health and disability support services.

It is responsible for “improving, promoting and protecting” the health of its people and the health of the communities in which they live.

This involves assessing the health status of the district, and determining what funds should be directed to preventing illness (via primary health and public health services) while continuing to provide and improve existing hospital and specialist services.

DHBs’ Objective & Outcomes

The objective of MidCentral DHB is to contribute to the outcomes that cover the promotion and provision of health and disability services as set out in the NZ Public Health and Disability Act 2000 (sections 22 & 23). The main way DHBs deliver on the outcomes identified below is through planning and funding, in consultation with stakeholders and our community. We plan the strategic direction, fund and manage the contracts we have with health and disability service providers, to ensure the health needs of our community are met.

These outcomes are:

- to reduce health inequalities by improving health outcomes for Maori and other population groups
- to reduce, with a view to eliminating, health outcome inequalities between various population groups within New Zealand, by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders

- to improve, promote, and protect the health of people and communities
- to improve integration of health services, especially primary and secondary health services
- to promote effective care or support for those in need of personal health services or disability support services
- to promote the inclusion and participation in society and independence of people with disabilities
- to exhibit a sense of social responsibility by having regard to the interests of people to whom it provides, or for whom it arranges the provision of services
- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services
- to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations
- to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations
- to be a good employer.

3.2 Government’s Priorities

The Minister of Health’s annual ‘Letter of Expectations’ is sent to all DHBs and identifies the Minister’s expectations and priorities for the coming year. These expectations, in addition to national health and disability strategies¹ and our strategic priorities (set out in the District Strategic Plan (DSP)), informs our planning and prioritising for 2009/10. The Minister’s priorities for 2009/10 are:

- Increase elective volumes year on year

¹ Available from the Ministry of Health website, www.moh.govt.nz

- Improve emergency department waiting times
- Improve cancer treatment waiting times
- Improve workforce retention, particularly clinical staff retention and leadership.

A set of national Health Targets have been identified to focus the efforts of DHBs toward rapid progress against key national priorities. These Health Targets are included within the selection of performance measures and are also clearly identified in our District Annual Plan 2009/10.

National Health Targets
Shorter stays in Emergency Departments Improved access to elective surgery Shorter waits for cancer treatment Increased immunisation Better help for smokers to quit Better diabetes and cardiovascular services

Our Statement of Intent aligns with national and Government priorities, and our Statement of Forecast Performance includes outputs in these key areas (refer section 4). These priorities are closely aligned with our vision and long term strategy to improve the health and well-being of our community.

Reporting Requirements

MidCentral DHB has an obligation to report to the Minister of Health and Director-General of Health, encompassing national health information management and reporting requirements, national collections requirements and requirements relating to ACC and the Mental Health Commission (as specified in the Operational Policy Framework effective from 1 July 2009 and the DHB Reporting Requirements 2009/10), including:

- annual reports and audited financial statements
- quarterly reports on non financial performance, including health targets and key priorities
- quarterly reports on hospital benchmark information
- quarterly reports on service delivery
- risk reports

- monthly financial reports
- ad hoc reports as requested by the Minister
- information for the Minister/Ministry of Health as required
- information for Ministerial briefings, Parliamentary questions, Select Committee inquiries

The DHB also reports on delivery of service requirements that are funded other than via the Population Based Funding Formula (PBFF), including Crown Funding Agreement variations and direct contracts.

Additionally, the DHB provides information to meet requirements of the national health information collection systems, such as:

- data quality and standards, including changes to standards and audit of data collections and reporting
- privacy and security
- ethnicity reporting
- national health index (NHI)
- health practitioner index (HPI)
- medical warning system (MWS)
- national minimum dataset (NMDS)
- national booking reporting system (NBRS)
- programme for the integration of Mental Health data (PRIMHD)
- national immunisation register (NIR)
- before school checks (B4SC)
- national non-admitted patients collection (NNPAC)
- HealthPac

The DHB is also required to consult and/or notify the Minister of Health of any significant matters (s.141(1)(g) Crown Entities Act), including significant change, risks, or developments in relation to the provision of services, capital and asset management. During 2009/10 MidCentral DHB will be engaging and/or consulting on its District Strategic Plan, including its alliance with Whanganui DHB and the Regional Clinical Services Plan.

3.3 MidCentral DHB's Priorities

Our DHB seeks to achieve the following outcomes for its vision of "Quality Living – Healthy Lives".

- people enjoy healthy lifestyles within a healthy environment
- the healthy will remain well
- health and disability services are accessible and delivered to those most in need
- the health and wellbeing of Maori is improved
- the quality of life is enhanced for people with diabetes, cancer, respiratory illness, cardiovascular disease and other chronic (long duration) conditions
- people experiencing a mental illness receive care that maximises their independence and wellbeing
- the needs of specific age-related groups, eg older people, children/youth, are addressed
- the wider community and family supports and enables older people and the disabled to participate fully in society and enjoy maximum independence
- oral health is improved
- people's journey through the health system is well managed and informed.

To achieve these outcomes the DHB has targeted 10 priority areas for investment. Deciding health priorities is a challenge. Not only must MidCentral DHB focus on making sure a person receives treatment and care when they are ill, injured or disabled, it also needs to focus on helping people to stay healthy and well into the future.

MidCentral DHB's 10 priority areas are:

- Cardiovascular disease - the highest cause of deaths for MDHB's residents, and the leading cause of

hospitalisation (excluding pregnancy & childbirth).

- Cancer - the second most common cause of death within the district.
- Respiratory disease - the third most common cause of death within the district and many risk factors are preventable.
- Diabetes - is growing in prevalence and can increase the risk of a person suffering from other serious illnesses. The main increase is in Type II diabetes and this is substantially preventable.
- Oral health - disease of the gums and teeth are among the most common health problems experienced by all New Zealanders, and can lead to poor overall health.
- Maori have the poorest health status of any ethnic group in the district.
- Mental health - approximately one in five people experience a mental illness (including drug and alcohol disorders) of some kind during their lifetime.
- Child health – poor health in childhood can lead to poorer health in adult years.
- Older people - experience more illness and disability than any other population group in the district, and their needs are more complex.
- Rural health - MidCentral DHB has a large rural area, and this creates access issues.

MidCentral DHB's District Strategic Plan is based on these 10 priority areas and details the high level outcomes we expect to achieve. The District Strategic Plan is a long term strategy (10 years). Each year the Board reviews progress on its vision and long term strategy, and identifies what will be achieved over the next 12 months. This is documented in the District Annual Plan.

A Statement of Intent is also prepared annually and is the formal accountability document between MidCentral DHB and Government. It provides a concise summary of the DHB's intentions for the year ahead, and covers both long term

and annual planning objectives. It also covers the day-to-day operational performance of the DHB.

3.4 Key Mechanisms for Intervention

Our DHB:

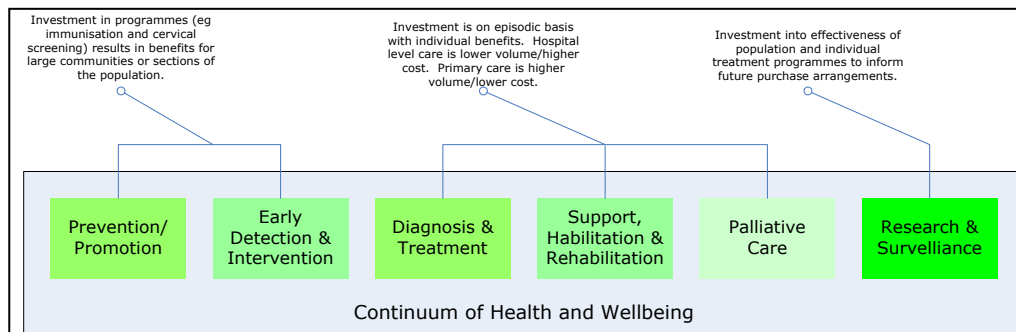
- FUNDS health and disability services through contracts with providers
- PROVIDES hospital and specialist services that covers medical and surgical services, mental health, older person's health
- PROMOTES community health and wellbeing through health promotion,

health education and population health programmes.

- PLANS in consultation with key stakeholders (Iwi, primary health organisations and providers) and our community, the strategic direction for health and disability services within our district
- PLANS in collaboration with other DHBs, regional and national work.

3.5 Intervention Logic

All DHBs follow an intervention logic that encourages cost at the public health end of the models of care, because these interventions are less expensive and cover more of the total population.



Our DHB has identified a number of key interventions, based on our needs. The interventions are:

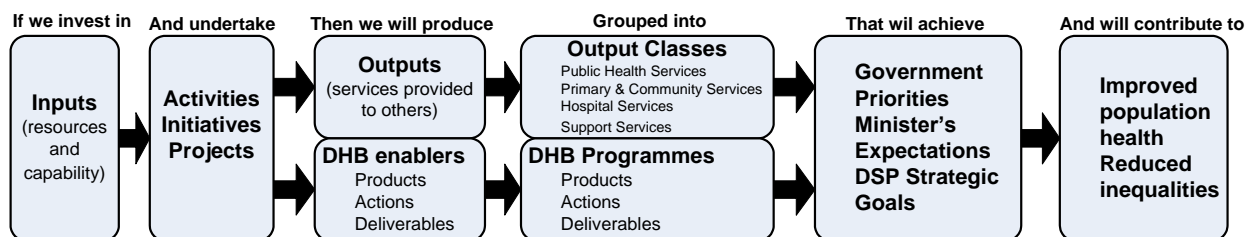
- Invest in the Diabetes Get Checked programme, and undertake free annual checks and eye screening for people with diabetes, this will result in around 60% of diabetics having up-to-date care plans in place. This will further result in those people having blood glucose levels in the target range which is a good indication their diabetes is being effectively managed, thus contributing to improved population health.

The following measures are being used to track the difference our interventions are making:

- Percentage of people estimated to have diabetes accessing free annual checks.
- Percentage of people estimated to have diabetes on the diabetes register who have satisfactory or better diabetes management.

To achieve maximum impact and outcomes, the key aspects of service delivery are quality, quantity or timeliness. For example, effective diabetes management requires timely intervention. Checks must be undertaken regularly to ensure any signs of deterioration are identified early and treatment plans put in place before long term damage occurs, such as blindness.

DHB Intervention Logic



An example of intervention logic for diabetes:

Investing an Additional \$3.1 million per annum in Diabetes & Evaluating Value for Money

Initiatives implemented across continuum	
Health Promotion & Prevention \$0.4m	<ul style="list-style-type: none"> - Healthy Eating, Healthy Action Programme - Green prescription programme - Fruit in Schools
Early Detection & Intervention \$1.9m	<ul style="list-style-type: none"> - Chronic Care Teams established in community - Get checked programme
Diagnosis & Treatment \$0.3m	<ul style="list-style-type: none"> - Capacity of renal unit increased - Diabetes nursing services established - Pump trial funded for 10 children/youth with Type 1 Diabetes - Rural podiatry & retinal screening services established
Support, Habilitation & Rehabilitation \$0.4m	<ul style="list-style-type: none"> - Adolescent Diabetes Camp established - Diabetes Co-ordinator position funded - Subsidised sharps container service established - Psychological support service established for chronic
Palliative Care \$0.2m	<ul style="list-style-type: none"> - Liverpool care of the dying programme implemented
Research & Surveillance \$0.1m	<ul style="list-style-type: none"> - Three-yearly health needs assessment - Report card established as part of Diabetes Plan - Long term measures monitored via District Strategy Plan

Note: dollars quoted are 2008/09 budget.
Palliative care funding sourced from Cancer Service Plan budget.
Psychological support services goes across multiple disease state plans.

Diabetes Report Card Long Term Measures

% retinopathy (eye screening) by ethnicity
% case detection by ethnicity
% annual checks for registered people with diabetes

% of people with Type 2 Diabetes with HbA1C levels in target range

No of education sessions (diet, physical exercise)

No. of referrals to Liverpool Care for the Dying

Health outcome changes as a result of research
No. of research papers published
\$ spend from innovation funding pool
No of new innovations published

Needs Analysis Measures

Diabetes hospital discharges by age and location

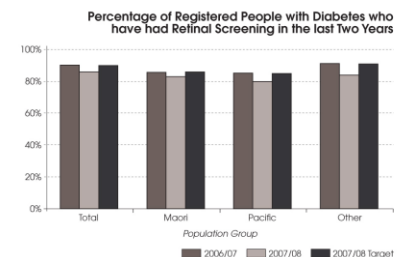
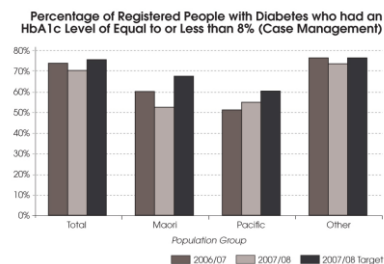
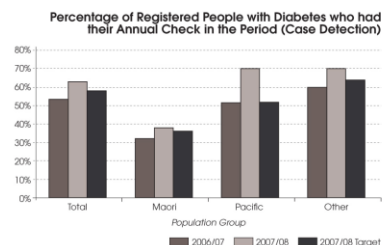
District Strategic Plan Measure

Diabetes prevalence, age standardised %
Obesity, age standardised percentage
Overweight, age standardised percentage
Current smoker, age standardised percentage
Physically active <150 mins/week
Fruit consumption at least 2 servings per day

Note: measures identified to determine success of initiatives, and their impact on the district's health status. MDHB is expecting a positive impact in all measures as a result of its additional investment.

Results to Date

The results to date show steady improvement in getting people on the Diabetes Get Checked Register and having annual check-ups. The percentage of people checked whose blood glucose level is in the target range showing their diabetes is well managed, has reduced as a result of the surge in enrolments. Retinal screening rates have also fallen as a result of the increase in the number of people on the Get Checked Register. The PHOs are working in this area and the results for 2008/09 are positive.



4. Output Classes, Outputs & Priorities

Our DHB ensures the promotion, provision, monitoring and evaluation of health and disability support services in line with national health and disability strategies and local population health needs. The role of a DHB is complex and covers planning, funding, promotion and service provision.

Planning and funding role involves contracting with organisations including our own hospital services (Palmerston North Hospital and Horowhenua Health Centre). Our DHB also contracts services from other providers (such as GPs and pharmacists), and other DHBs who often provide more specialist services. Some services are still purchased directly by the Ministry, eg breast and cervical screening as well as the provision of disability support services for people aged less than 65 years. Our DHB is responsible for monitoring and evaluating service delivery, including audits of the full range of funded services.

The role of our DHB involves most of the health and disability services provided in the district. In this section we detail our agreed priority areas. Many of the services that are not mentioned, such as maternity care, pharmacist services and emergency care are positively impacted by good primary health care in our communities. Other services not mentioned in detail will continue to be planned, funded and provided to a high standard. Although these services do not have outcomes attributed to them and may not be included in the outputs in section 4, we report quarterly to the Ministry of Health on our performance in these services. This reporting, either

through the reporting against Indicators of DHB Performance or through the Hospital Benchmark Information, ensures our progress in these services is documented and improvements are tracked. (NB: reports accessible from Ministry of Health's website: www.moh.govt.nz.)

There are four output classes that are applicable to all DHBs.

- Public Health Services
- Primary and Community Services
- Hospital Services
- Support Services

For each output class there are agreed national performance measures and targets for the desired outcomes and objectives. These measures and targets will be subject to an annual audit by auditors appointed by the Office of the Auditor General. The performance measures chosen are not a comprehensive list and do not cover all the activity of the DHB, but they do reflect a picture of our activity against local and national strategies and priorities. Where possible, we have included past performance (baseline data) along with each performance target to give context of what we are trying to achieve and to better evaluate our performance.

One of the functions of this SOI, and in particular the following section, the Forecast of Service Performance is to show how the DHB will evaluate and assess what services and products we deliver to others in 2009/10.

4.1 Statement of Forecast Service Performance

4.1.1 Public Health Services

Public health services are the domain of many organisations across the region:

- Ministry of Health, principally as a funder of public health services, and also a regulator and planner
- Regional Public Health, as a provider of services
- District Health Boards, in both funding and provision
- Primary Health Organisations, mainly in the area of provision of primary health care services, but with some public health functions
- A significant array of private and non-government organisations, including Maori and Pacific providers
- Regional Sports Trusts
- Local and regional government

A Regional Public Health Services is owned and operated from its base at MidCentral DHB. The remaining are delivered by other providers. These services include environmental health, communicable disease control, tobacco control and health promotion programmes.

Twelve public health units (PHUs) provide more than half the country's public health services.

Primary health care includes a broad range of first-level services (although not all of these are government funded), including: "health improvement and preventive services, such as screening.

Local Priorities and Strategies

Fundamental to the DHB's plans in its 10 priority areas is "healthy lifestyles", and the DHB is committed to supporting individuals to take simple steps which will improve their health and reduce diseases that are largely preventable. Things like exercising regularly, eating a healthier diet, quitting smoking, and getting regular health checks. Maori, children, and people with long term chronic conditions, are

priority population groups. MidCentral DHB has a "healthy eating, healthy action" plan which is implementing, which includes things such as green prescriptions, smoking cessation, and working through workplaces, health providers and education settings to create environments which support healthy choices and wellbeing.

A key focus of MidCentral DHB's plans for child and oral health is immunisation and improved oral hygiene.

Immunisation aims to prevent the spread of vaccine preventable diseases in a community and protect children against a range of serious diseases, such as measles, mumps and rubella. MidCentral DHB aims to achieve the national target of 95% of two year old children being fully up to date with their immunisation by 2010, and we are making good progress in this regard.

The other key area of focus is a reducing in the number of children/youth with dental caries. Diseases of the gums and teeth are among the most common health problems experienced by New Zealanders, and poor oral health can lead to poor overall health. Encouraging children to have good dental hygiene and preventative dental care will promote good oral health for life. Measuring the number of children who are caries-free, and those who have decayed, missing or filled teeth is a good indicator of oral health.

MidCentral DHB believes its investment in child immunisation and oral health, and healthy lifestyles will help it achieve the following six of its 10 long term outcomes:

- People enjoy healthy lifestyles within a healthy environment.
- The healthy remain well.
- Health and disability services are accessible and delivered to those in need.
- The health and wellbeing of Iwi Maori is improved.
- The needs of specific age-related groups, eg older people, children/youth are addressed.

- Oral health is improved for people within MidCentral's district.

Statement of Forecast Service Performance for Public Health Services

This section outlines the Public Health services we intend to deliver our population. These outputs are aggregated into: Health Promotion Services and Immunisation Services.

Measures	Baseline	2009/10	2010/11	2011/12
<p><i>Output:</i> <i>Health Promotion Services</i></p> <p>Percentage of children examined by the DHB School Dental Service who are caries free at the first examination after the child has turned five years, but before their sixth birthday, in the year to which reporting relates. By ethnic group.</p>	<p>Total: 65% Maori: 38% Pacific: 40% Other: 61%</p>	<p>Fluoridated: Total >65% Maori >42% Pacific >20% Other >70%</p> <p>Non-Fluoridated: Total >49% Maori >31% Pacific >34% Other >58%</p>	<p>Fluoridated: Total >65% Maori >42% Pacific >20% Other >70%</p> <p>Non-Fluoridated: Total >49% Maori >31% Pacific >34% Other >58%</p>	<p>Fluoridated: Total >65% Maori >42% Pacific >20% Other >70%</p> <p>Non-Fluoridated: Total >49% Maori >31% Pacific >34% Other >58%</p>
<p>Mean score of decayed, missing and filled teeth of Year 8 (Form 2) children at the last dental examination before the child leaves the DHB School Dental Service.</p>	<p>Total: 1.6 Maori: 2.1 Pacific: 3.3 Other: 1.4</p>	<p>Fluoridated: Total <1.6 Maori <2.0 Pacific <2.7 Other <1.3</p> <p>Non-Fluoridated: Total <1.6 Maori <2.1 Pacific <1.6 Other <1.4</p>	<p>Fluoridated: Total <1.6 Maori <2.0 Pacific <2.7 Other <1.3</p> <p>Non-Fluoridated: Total <1.6 Maori <2.1 Pacific <1.6 Other <1.4</p>	<p>Fluoridated: Total <1.6 Maori <2.0 Pacific <2.7 Other <1.3</p> <p>Non-Fluoridated: Total <1.6 Maori <2.1 Pacific <1.6 Other <1.4</p>
<p><i>Output:</i> <i>Healthy Lifestyles</i></p> <p>Proportion of hospitalised smokers who are provided with advice and help to quit</p>	<p>NA</p>	<p>80%</p>	<p>>80%</p>	<p>>80%</p>
<p>Number of schools registered as a Health Promoting School/Centre</p>	<p>11</p>	<p>20</p>	<p>30</p>	<p>40</p>
<p><i>Output:</i> <i>Immunisation Services</i></p> <p>Progress towards 95% of two year olds fully immunised</p>	<p>73%</p>	<p>85%</p>	<p>90%</p>	<p>95%</p>

4.1.2 Primary and Community Services

A strong primary health care system (as outlined in the Primary Health Care Strategy) is central to improving New Zealanders' overall health, and to reducing health inequalities between different groups. New Zealand is experiencing a growing prevalence of long-term conditions including diabetes and cardiovascular disease. Some groups of New Zealanders suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. Long-term conditions require an increased focus across the primary/secondary interface to ensure that they are recognised early and managed effectively.

The three key goals from the national Primary Health Care Strategy are:

- Transparent national priorities – DHBs, Primary Health Organisations (PHO) and the Ministry focused on national health priorities and working collaboratively to improve sector performance.
- Collective stewardship and governance – Communities and PHOs engaged to identify population needs and target responses consistent with national priorities.
- Enhanced delivery – A continuum of accessible services focused on reducing the incidence and impact of chronic conditions.

Locally, the primary health sector has developed well over the last four years.

Significant additions to the clinical workforce and the benefits of these are now being seen, such as a rise in the number of people on the Diabetes Get Checked Programme.

Many new services are now available in the community, focusing on identifying and managing chronic (long term) conditions such as diabetes, cardiovascular disease and cancer. These include a number of services previously provided in a hospital setting.

The district has four geographically based Primary Health Organisations (PHOs). These are well established and generally working well, supported by a shared Management Services Organisation.

Government initiatives have reduced the cost of accessing general practice and utilisation rates have improved.

MidCentral DHB's primary health care nursing development programme is a real strength and has supported primary nurses in taking on new responsibilities

Local Priorities and Strategies

MidCentral DHB's health needs assessment identifies four chronic (long term) conditions which are having a detrimental impact on the district's health:

- Cardiovascular disease is the highest cause of deaths for MDHB's residents, and the leading cause of hospitalisation (excluding pregnancy and childbirth).
- Cancer is the second most common cause of death within the district.
- Respiratory disease is the third most common cause of death within the district and many risk factors are preventable.
- The prevalence of diabetes is growing and it can increase the risk of a person suffering from other serious illnesses. The main increase is in Type II diabetes and this is substantially preventable.

Maori feature highly in these disease groups and are a specific area of focus for MidCentral DHB.

MidCentral DHB's is investing in these chronic conditions as a means of improving the district's overall health status. It has established chronic care teams and other community-based services. These new services are linked strongly to, and supported, by specialist hospital based services.

This work is expected to result in long term benefits in the health of the district as the incidence and impact of these diseases is reduced.

For example, diabetes is a condition that requires constant attention, and if well managed people can lead a healthy life. Measuring the number of people who have an annual check and regular eye screening, and their blood glucose levels gives a good indication of the effectiveness of diabetes management.

Another example is early identification and treatment of cardiovascular disease. MidCentral has provided GPs with “Best Practice” decision support software, which works hand-in-hand with patient record systems that are used by each GP. The Risk Assessment module calculates the absolute risk that any individual will have a “cardiovascular event”, such as a heart attack, in the next 5 years. It then provides information about treatment that research has shown to be the most effective to reduce that level of risk. People found to have increased risk of heart disease can be referred, free of charge, to teams in each district who provide free dietary, smoking cessation, and physical activity advice. People with other diseases that may accelerate heart disease, such as diabetes, can receive help from community-based diabetes nurse specialists. MidCentral DHB’s Health Needs Assessment has shown that people in outlying areas (Tararua, Horowhenua, Otaki) that have difficulty accessing hospital-based services, have poorer health outcomes than people living close to the hospital. Those areas have been provided with improved access to diagnostic tests, including ECGs, Exercise Treadmill Tests, and access to portable Echocardiograph tests. Cardiologist appointments have also been introduced in these areas, piloted first to good effect in the Tararua district where the waiting list has been almost eliminated.

In addition to chronic disease management, the DHB is focused on easy and early access to primary health care services, particularly in rural areas.

MDHB is investing in its primary care capacity and capability, particularly the establishment of large family practices which offer a “one stop shop” service for the community. Redeveloped general practice infrastructure will not only provide excellence in General Practice, but will also entice new graduates to the discipline, provide teaching facilities, and improve collaboration with community, district, chronic illness nurses and specialist outpatient clinics. They will also provide accessible and timely access to community diagnostics (lab, radiology, Ultra Sound, echocardiography, spirometry, and audiology).

Through MidCentral DHB’s investment in priority areas, approximately 70 additional positions have been created in nursing, medical and allied health professional groups.

The bulk of the new investment has been in primary care and most of the new positions have been created through the Primary Health Organisations (PHOs).

MidCentral DHB believes its investment in chronic diseases and primary health capacity will help it achieve the following five of its 10 long term outcomes:

- Quality of life is enhanced for people with diabetes, cancer, respiratory illness, cardiovascular disease and other chronic (long duration) diseases.
- Health and disability services are accessible and delivered to those in need.
- The health and wellbeing of Iwi Maori is improved.
- The healthy remain well.
- People’s transition through the health and wellbeing continuum is well managed and informed.

Statement of Forecast Service Performance for Primary and Community Health Services

This section outlines the Primary and Community services we intend to deliver to our population. Some of these services are provided by us while others are funded by us through a range of contracts and provided by PHOs and other providers. These services include personal health services, mental health services, Maori and Pacific health services and disability support services

These outputs are aggregated into: DHB Primary and Community services and PHO capitated services.

Measures	Baseline	2009/10	2010/11	2011/12
<p><i>Output:</i> <i>Primary Community Services</i></p> <p>CVD risk assessment: fasting lipids and glucose test</p> <p>Eligible population:</p> <ul style="list-style-type: none"> • Maori/Pacific/Indian men aged 35-79 • Maori/Pacific/Indian women aged 45-79 • New Zealand European & Other men aged 45-79 • New Zealand European & Other women aged 55-79 	<p>All age groups: Total: 76.5% Maori: 66.8% Other: 79.1%</p>	<p>All age groups: Total: $\geq 78.5\%$ Maori: $\geq 70.3\%$ Other: $\geq 81.1\%$</p>	<p>All age groups: Total: $\geq 78.5\%$ Maori: $\geq 70.3\%$ Other: $\geq 81.1\%$</p>	<p>All age groups: Total: $\geq 78.5\%$ Maori: $\geq 70.3\%$ Other: $\geq 81.1\%$</p>
Percentage of people estimated to have diabetes accessing free annual checks	<p>Total: 59.3% Maori: 49.4% Other: 61.2%</p> <p>(Estimated 08/09 year end)</p>	<p>Total: 62% Maori: 54% Other: 63%</p>	<p>Total: >62% Maori: > 54% Other: > 63%</p>	<p>Total: >62% Maori: >54% Other: >63%</p>
Percentage of people with Type 1 or Type II diabetes mellitus on a diabetes register that had an HbA1c level of equal to or less than 8%	<p>Total: 80.8% Maori: 68% Other: 82.8%</p> <p>(Estimated 08/09 year end)</p>	<p>Total: 78% Maori: 70% Other: 79%</p>	<p>Total: >78% Maori: >70% Other: >79%</p>	<p>Total: >78% Maori: >70% Other: >79%</p>
A reduction in rate of admissions to hospital which are avoidable or preventable by primary health care for 0-74 years, under 5 years and 45-64 years across all population groups	<p>0-74yrs: 87.5% 0-4yrs: 89.5% 45-64yrs: 86.5%</p> <p>(12 months to September 2008)</p>	<p>0-74yrs: $\leq 95\%$ 0-4yrs: $\leq 95\%$ 45-64yrs: $\leq 95\%$</p>	<p>0-74yrs: $\leq 95\%$ 0-4yrs: $\leq 95\%$ 45-64yrs: $\leq 95\%$</p>	<p>0-74yrs: $\leq 95\%$ 0-4yrs: $\leq 95\%$ 45-64yrs: $\leq 95\%$</p>
<p><i>Output:</i> <i>PHO Capitated Services</i></p> <p>Ratio of age-standardised rate of GP consultations per high need person to non-high need person</p>	1.06	≥ 1.0	≥ 1.0	≥ 1.0

4.1.3 Hospital Services

The DHB's provider arm, MidCentral Health, is the key provider of secondary care (hospital) services in the district. These are provided from two key facilities, being Palmerston North Hospital and Horowhenua Health Centre. Palmerston North Hospital is a Level 5/6 facility, providing full range of secondary care services (including diagnostic support), emergency and ICU care, and some tertiary level services. It has 259 beds. Horowhenua Health Centre has 24 assessment, treatment & rehabilitation beds and four primary maternity beds. MidCentral Health also provides a regional cancer treatment service, and the DHB has three linear accelerators (linac) to provide radiation therapy. (NB: currently utilising fourth linac which is to be reviewed for decommissioning in the near future.) These, together with the three linear accelerators at Wellington Hospital, serve the Central Region and beyond.

MidCentral DHB has already made substantial investments in secondary care services through initiatives in the diabetes, cardiovascular, respiratory and cancer service plans. Developments have mainly focussed on delivery of secondary services in the community setting, particularly in outlying and high-needs areas; and on integration of primary and secondary care delivery. A notable exception was stroke, for which service enhancements were delivered within the hospital.

Local Priorities and Strategies

MidCentral DHB investment in public and community health services will help people remain well, and reduce the incidence and impact of disease. However, no matter how well this is done people will require access to hospital services. The DHB is committed to ensuring it can provide timely access to hospital care.

The DHB has a Clinical Services Plan which sets out the investment required in hospital models of care, buildings, workforce and information systems to meet future demand. Work on models of care and information systems is underway, and building plans will commence in 2009/10. Workforce requirements are

discussed under the workforce section of this Plan.

Concurrent with the development of the Clinical Services Plan is the establishment of a regional clinical services plan. All DHBs in the Central Region are facing increased demand for hospital services. The regional plan looks at how collectively all DHBs can ensure their populations have access to secondary care services, and, the sustainability of these services in face of workforce shortages and cost pressures.

Elective (non-urgent) services are hospital services for people who do not need immediate medical treatment, such as a hip replacement or cataract operation. Acute (urgent) services refers to conditions that, if left untreated, may result in death or considerable disability, eg head trauma, certain cardiac conditions.

MidCentral DHB is experiencing constant growth in acute cases. This is impacting its ability to carry out elective services. It is now focusing on managing hospital inflows, particularly through the emergency department, to ensure the appropriate use of this facility. This work is being in conjunction with general practice teams, St John's, and primary health organisations.

MidCentral DHB's investment in primary care services is aimed at reducing the level of acute demand on hospital services.

(NB: Acute services are for illnesses that have an abrupt onset. It is usually of short duration, rapidly progressive, and in need of urgent care.

Elective services (booked surgery) are for patients who do not require immediate hospital treatment. "Acute-arranged", which means hospital services can be booked are classified as electives.)

Concurrent with this, it is also looking at how it can maximise the use of its capacity (staff, beds, and equipment), and its discharge practices.

The shortage of resourced beds is a key issues, particularly the shortage of surgical beds as these are required for acute medical patients. Medical services are implementing new systems so they can

more effectively manage higher levels of acute demand. For example, a medical assessment unit is being established.

By increasing the level of access to elective services, more people will be treated. Early treatment of elective conditions reduces the likelihood of people developing more serious and/or acute conditions.

The DHB is responsible for ensuring mental health services are in place to care for the 3% of the population who are diagnosed as having a severe mental illness. These services go across the full continuum of care, including health promotion, early detection/intervention, diagnosis/treatment, support/habilitation/rehabilitation, and research. MidCentral DHB's plans aim to ensure people with an experience of mental health and addiction maintain their own wellbeing and participate in society and in the everyday life of their communities and whanau. Timely access

to mental health service is fundamental, and MidCentral DHB focus is on enhancing local crisis respite services, implementing a new model of care for sub-acute mental health services, and, reconfiguring and developing child, adolescent and family mental health services to prepare for planned growth in this area. It is also focused on kaupapa Maori mental health services.

MidCentral DHB believes its investment in hospital and mental health services will help it achieve the following three of its 10 long term outcomes:

- Health and disability services are accessible and delivered to those in need.
- People experiencing a mental illness receive care that maximises their independence and wellbeing.
- People's transition through the health and wellbeing continuum is well managed and informed.

Statement of Forecast Service Performance for Hospital Services

This section outlines the hospital-based services we intend to deliver to our population. It also outlines those hospital services we intend to fund others to provide for our population. Hospital services include all personal health services, mental health services, Maori health services, services for older people and disability support services provided through MidCentral DHB's hospital provider and through other DHBs via interdistrict flows (IDFs).

These outputs are aggregated into: Acute (those services that are unplanned) and Elective, Acute and Emergency Department Attendances for the purposes of this SOI.

Measures	Baseline	2009/10	2010/11	2011/12
<i>Output: Elective Services</i>				
Elective discharges (MCH, ex IDFs)	4,040	4,525	4,675	4,829
Elective daycase procedures at 55%	2,343	2,488	2,571	2,656
All patients wait less than 6 weeks between first specialist assessment and start of radiation oncology treatment (excluding category D)	83.32%	100%	100%	100%
<i>Output: Emergency Department Attendances</i>				
The proportion of patients admitted, discharged or transferred from an Emergency Department within six hours	New measure	95% <small>(around 34,048 per annum, based on 35,840 presentations)</small>	95% <small>(around 34,048 per annum, based on retaining 35,840 presentations)</small>	95%
Triage wait times	Triage 1: 100% Triage 2: 87% Triage 3: 71%	100% ≥80% ≥75%	100% ≥80% ≥75%	100% ≥80% ≥75%
<i>Output: Acute Inpatient Services</i>				
Acute readmissions within 7 days of previous discharge	4.4% <small>(average 66 per month)</small>	<4.5% <small>(average <70 per month)</small>	<4.5% <small>(average <70 per month)</small>	<4.5% <small>(average <70 per month)</small>
<i>Output: Mental Health Services</i>				
Mental Health Access rates: proportion of projected domiciled population seen on average (annual)				
• 0-19 years				
· Total	1.7%	2.2%	>2.2%	>2.2%
· Maori	1.3%	1.8%	>1.8%	>1.8%
· Other	1.9%	2.4%	>2.4%	>2.4%
• 20-64 years				
· Total	2.5%	2.9%	>2.9%	>2.9%
· Maori	3.1%	3.6%	>3.6%	>3.6%
· Other	2.3%	2.7%	>3.0%	>3.0%
• 65+ years				
· Total	0.4%	0.5%	>0.5%	>0.5%
· Maori	0.6%	0.6%	>0.6%	>0.6%
· Other	0.4%	0.5%	>0.5%	>0.5%

4.1.4 Support Services

The district has a large number of aged residential care facilities that provide rest home care (general care, hospital level continuing care, psycho-geriatric continuing care, and dementia services, as well as respite and day care). The providers generally operate good quality facilities and the standard of their care is subject to regular audit.

The district has a robust needs assessment and service co-ordination service (NASC), and a range of home based support organisations.

It also has a comprehensive palliative care service throughout the district, with all providers adopting the Liverpool Care of the Dying Pathway, to ensure consistent support to those who are imminently dying.

Local Plans & Strategies

MidCentral DHB aims to improve and support independence and choices for older people, fostering their ability to live at home or in their place of choice longer.

A key to achieving MDHB's aims is a robust needs assessment and service co-ordination process. MidCentral DHB is investing in a new information management tool, InterRAI, to assist with the assessment process. Linked to this is a need to review the configuration and resourcing of the local NASC service.

Through the timely turnaround of need assessments the DHB can ensure early identification of older peoples' level and type of functional loss and need for support or services in the community and/or entry to residential care, is identified early. This will result in older persons maintaining maximum independence and quality of life.

In line with the Government's priorities, MidCentral DHB aims to improve the quality of nursing care within aged residential care facilities. Additional funding is being provided to age residential care providers for this purpose. Through improved nursing care, residents' health will be regularly reviewed and treatment plans adjusted,

resulting in maximum independence and quality of life. All providers of aged residential care must be certified by the Ministry of Health that they meet the NZ Health & Disability Standards 2008. Providers cannot operate nor receive funding subsidies unless certified. All providers are required to undergo a surveillance audit 18 month's post certification, and a further routine audit takes place three year's post certification. In addition to this process, MidCentral DHB intends to undertake up to six special audits (20% of providers) per year.

MidCentral DHB has invested in a comprehensive palliative care service to support people with chronic conditions as appropriate, and those in the final stages of their life. One component is the Liverpool Care of the Dying Pathway which aims to ensure people can receive consistent specialist palliative care regardless of their location (home, hospital, hospice, community or rest home). MidCentral DHB has funded specialist palliative care practitioners, a clinical pharmacist, and training programme, with the aim that all primary, secondary and aged residential care facilities are capable of delivering the LCP. (NB: There are approximately 90 facilities in the district.) It is expected this will result in more people being able to receive community care within a community setting of their choice.

MidCentral DHB believes its investment in support health services will help it achieve the following four of its 10 long term outcomes:

- Health and disability services are accessible and delivered to those in need.
- The needs of specific age-related groups, eg older people, children/youth are addressed.
- The wider community and family supports and enables older people and the disabled to participate fully in society and enjoy maximum independence.
- People's transition through the health and wellbeing continuum is well managed and informed.

Statement of Forecast Service Performance for Support Services

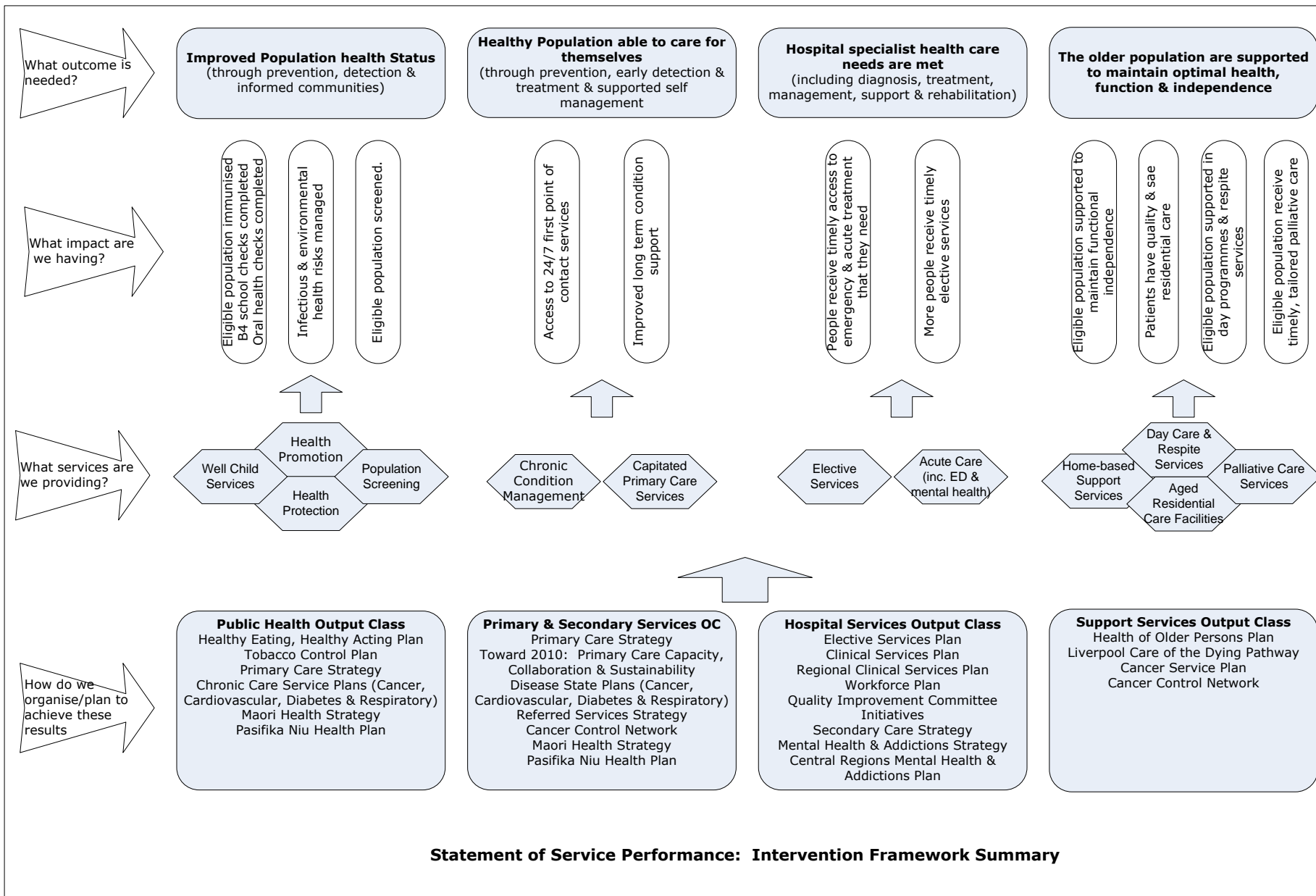
This section outlines the Support services we intend to deliver to our population. Each aggregate includes people with long-term disabilities; people with mental health problems and people who have age-related disabilities.

These outputs are aggregated into: assessment services; residential care support services; and palliative care services.

Measures	Baseline	2009/10	2010/11	2011/12
<p><i>Output:</i> <i>Assessment Services</i></p> <p>Proportion of support needs assessments for persons aged 65+ years completed within the specified target working days of referral from MidCentral Health providers: 3 days</p>	28% (end June 2008)	100%	100%	100%
<p><i>Output:</i> <i>Residential Care Services</i></p> <p>% of MDHB special routine audits of aged residential care providers with 80% compliance with the Health & Disability Sector Standards.</p>	80%	80%	85%	90%
<p><i>Output:</i> <i>Palliative Care Services</i></p> <p>Percentage of facilities within the district where the Liverpool Care of the Dying Pathway has been implemented.</p>	35%	100%	100%	100%

4.2 Statement of Service Performance: Intervention Framework Summary

The schematic diagram on the following page shows the links between the desired outcomes for each Output Class and MidCentral DHB's plans and services.



5. Organisational Capability

5.1 Accountability

A Board of eleven is responsible for the governance of MidCentral DHB. Seven members are elected alongside the triennial local authority elective process (last held in 2007). The Minister of Health appoints four members by notice in the Gazette.

The public are welcome to observe the meetings of the board and statutory committees. The meetings are usually held monthly (except January) and details of the meetings (such as agendas, minutes, membership of the committee, people who attended a meeting) are publicly available on our website www.midcentraldhb.govt.nz. Occasionally these groups have discussions where it is best if the public does not attend, and this is allowed for in the NZPHD Act 2000.

5.2 National and Regional Collaboration, and cross-sector Collaboration

Working collaboratively with others, both across the sector and with other health and social service providers is integral to the success of MidCentral DHB in achieving the goals set out in our District Strategic Plan. We are committed to sharing resources with regional DHBs and providers as well as collaboration with the Ministry, DHBNZ, and providers in order to achieve specific outcomes.

All DHBs within the central region recognise the need for greater collaboration and have established a Regional Clinical Services Plan. This is a conceptual document setting out the vision for the future to the year 2020 and provides the framework for the region's future service development and investment. The Plan looks at how the region can ensure access to secondary care services, and, the sustainability of these in face of workforce shortages. The

implementation of the Regional Clinical Services Plan will get underway in 2009/10 and will see the establishment of more clinical networks.

A regional Asset Management Plan and a Regional Information Strategic Plan are to be developed.

MidCentral DHB has established an alliance with Whanganui DHB. The aim of this initiative, called the centralAlliance, is to develop a consistent, combined districts approach to health and disability service planning which will result in health gains for our populations.

Under the alliance we will remain autonomous organisations, but will collaborate further on an integrated approach to common strategic and operational responsibilities. An example is our current joint project around women's and children health services. We are also currently working on shared corporate and commercial support services.

As part of its district strategic planning process, MidCentral DHB will be engaging and/or consulting with key stakeholders and the community about the centralAlliance and the Regional Clinical Services Plan, and that they mean for the district.

5.3 Workforce Development and Organisational Health

The provision of effective health care across the MidCentral district depends, inter alia, on an appropriately skilled workforce of the right size. MidCentral DHB takes its role as a good employer seriously, as is evidenced by the implementation of its workforce development strategy. The Board ensures a comprehensive range of human resource policies are in place including, but not restricted to: appointment, code of conduct, orientation, recruitment leave, continuing education, credentialing, performance management, disciplinary procedures, whistle-blowing, harassment

and bullying prevention, health and safety, impaired staff, work and family, workplace rehabilitation, and equal employment opportunities.

The DHB is a member of the ACC Partnership Programme and has been accorded tertiary status – the highest level possible.

MidCentral DHB employs 2,100 staff (full time equivalents). Over half are of NZ European ethnicity, and 6% are Maori. The majority of staff employed are health professionals:

MDHB	2008/09 Budget	2009/10 Budget	Change
Medical	233	259	26
Nursing & Midwifery	926	901	-25
Allied Health	364	363	-1
Support	45	45	0
Mgm /Admin	539	521	-18
TOTAL	2,107	2,089	-18

Within MidCentral Health, the DHB's provider arm, the staff turnover and staff stability rates are very good, averaging 10.19% and 97.06% per year respectively:

Staff Group	Staff Turnover	Staff Stability
Medical*	8.33%	97.50%
Nursing & Midwifery	9.2%	97.21%
Allied Health	9.44%	97.64%
Support	25.93%	88.89%
Management/ Administration	13.73%	96.48%
Total	10.19%	97.06%
<i>*Excludes junior medical staff. Their national training programmes requires them to move between DHBs to complete their curriculum.</i>		

Within MidCentral Health a clinical:management partnership exists, with each major service line being led by a Clinical Director, Group Manager and the Director of Nursing. For most specialities within a service line, there is a Medical Head. MidCentral DHB has a strong professional nursing structure. A professional advisory function is in place for medicine, nursing, allied health, and clerical. This includes professional advisor roles and reference groups. Clinical

governance within MidCentral Health is led by its Clinical Board.

Within the secondary care (hospital) health services, the workforce is ageing. The average age of MidCentral DHB's workforce is 45.2 years. (December 2007: 43.8 years.) There are international workforce shortages for appropriately skilled health professionals, including medical specialists, nursing staff, and allied health staff. DHBs in the Central Region have developed a Regional Clinical Services Plan which looks at ensuring sustainability of services into the future, including workforce arrangements. This will require MidCentral DHB to forecast its future workforce requirements in light of new regional arrangements and local demand, and plan, recruit and train accordingly.

In addition to the DHB staff there is many other people working in primary health care, aged residential facilities, and other non-government owned health organisations. Information regarding this non-DHB workforce is not detailed, but there are around 150 practice nurses, 30 Maori health nurses working for Maori providers, 256 people working in residential care facilities, and 100 general practitioners.

Clinical governance within the primary sector is led by the combined PHOs Clinical Board. A professional development nursing team also works with general practice.

General Practitioners are currently the critical professional group in terms of primary health care services. They need to be present in sufficient numbers, they need to possess an appropriate range of skills, and they need to be distributed in such a way that they are accessible to the people who need their help.

Maintaining an adequate GP workforce is a challenge nationally and is particularly difficult in the MidCentral district because there are already too few GPs. At the national average of 74.9 GPs per 100,000 population it is expected there be about 120 GPs for the MidCentral DHB's district, an increase of 20 on current levels.

On a district-wide basis, two key mechanisms have been established to ensure clinical involvement in decision making. One is a Clinical Council for the DHB which covers both primary and secondary health professionals, a lay person, and a Maori representative. For each of MDHB's priority health areas a district management group exists, comprising representatives from primary and secondary care, consumers, and providers. These oversee the implementation of these service plans. Regionally, clinical networks continue to be established – refer Regional Collaboration section.

All DHBs work together regarding workforce issues, particularly determining current and future workforce trends and requirements, recruitment, and negotiation of multi-employer collective agreements.

5.4 Building Capability

The district's public health, primary and secondary care services are supported by a robust infrastructure, including information technology, buildings and equipment. MidCentral DHB has an Asset Plan, and will be working with other DHBs in the central region to develop a Regional Asset Plan during 2009/10.

Significant investment and development work has taken place over the last five years.

The DHB's building stock is in good repair. The main facility, Palmerston North Hospital, is scheduled for reconfiguration over the next three years so that it can meet further growth.

The DHB has a robust capital expenditure programme which enables new and replacement equipment to be purchased as required.

5.5 Information Systems

The DHB's Information Systems Strategic Plan (ISSP) is being progressively implemented. One of the key systems is the patient management information system and this is scheduled for a major upgrade in 2010. Supporting (feeder) systems have been upgraded in readiness.

The investment in information technology has included the primary sector, with funding provided for disease-state decision software. Funding has also been provided for general practices to look at the feasibility of larger, collective primary care practices.

Work on establishing a regional Information Systems Strategic Plan will get underway in 2009/10.

5.6 Subsidiaries

MidCentral District Health Board has a part ownership in the Central Region's Technical Advisory Service (TAS) and Allied Laundry Services.

5.6.1 Central Region's Technical Advisory Service Limited

The Central Region's Technical Advisory Service Limited (TAS) was established with Ministerial approval in 2001 as a limited liability company under the Companies Act 1993 and is jointly and equally owned by the six District Health Boards in the Central region. Each District Health Board participates in its governance through the board structure.

The purpose of TAS is to provide the central region's District Health Boards with expert advisory services through health information, service planning and external service audit functions to support local District Health Board decision-making. It does not have a mandate to make purchasing decisions. TAS also undertakes audit services for District Health Boards - reviewing and monitoring the contract performance of service providers, with the emphasis on quality and patient/community outcomes.

TAS issues its own Statement of Intent each year.

5.6.2 Allied Laundry Services Limited

MidCentral District Health Board is part owner of Allied Laundry Services Limited, a limited liability company established in 2002 under the Companies Act 1993. The company is equally owned by four participating DHBs, being Taranaki, Whanganui, Hawke's Bay and MidCentral Health District Health Boards

The purpose of Allied Laundry Services Limited is to provide laundry services in this region. The regional laundry facility is based on Palmerston North Hospital campus.

Allied Laundry Services Limited's key output for 2009/10 is the processing (collection, laundering and delivery) of 2,901,109 kgs of laundry to its four shareholding DHBs, and Wairarapa DHB.

Details of this company's financial forecasts and accounting statements are contained in this document – refer Appendix 3.

5.7 Quality and Safety

MidCentral DHB's quality plan is closely aligned to the national Quality Improvement Committee's (QIC) programme which is in year two of its implementation. MidCentral DHB will work at both the national collective level and at the DHB level to deliver the QIC programme over the next 2-3 years. It is implementing a component of the "optimising the patient journey" project and is also doing the training component of the new incident management database.

MidCentral DHB participates in the NZ health accreditation programme. This is an independent review of the DHB's systems and processes. In addition, it is reviewed by the Ministry of Health to ensure compliance (certification) under the

Health & Disability Sector (Safety) Act 2000.

The National Service Framework provides nationally consistent service specifications, quality specifications, purchase units (including purchase unit definitions) and prices. It aligns with the Service Coverage Schedule and Operational Policy Framework documents, which, together, define the baseline services which District Health Boards must make sure are available to their populations. All District Health Boards use the National Service Framework, and it is maintained through the collaborative efforts of the Ministry of Health, District Health Boards' New Zealand, and the District Health Boards.

MidCentral District Health Board is committed to participating in the development and maintenance of the National Service Framework and using it to structure the services the District Health Board funds. Providers will be contracted under the National Service Framework wherever there are suitable service specifications and purchase units. All providers are expected to comply with the quality specifications in the Operational Policy Framework.

Many primary health care providers are paid under regulatory arrangements based on national frameworks. These are typically fee for service arrangements. The DHB monitors service performance in these areas through statistical reports, many of which are produced by Central Region's Technical Advisory Service (TAS), on behalf of MidCentral DHB. The performance of DHB-owned providers (such as MidCentral Health) is monitored through an internal reporting framework.

In addition to routine contract monitoring, the DHB also has a formal audit programme which is managed by TAS using a team of auditors who are qualified to carry out service-based, financial or cultural audits. Audits are of two types: routine audits which are expected to occur at least every three years and Special and Issues based audits which occur at the request of the DHB, usually in response to an emerging issue.

6. Financial Performance

6.1 Financial Statements

MidCentral DHB is planning for a small deficit of \$3.5 million in 2009/10 before the use of retained earnings, followed by break-even in 2010/11 and 2011/12. Of the deficit in 2009/10 \$2.9m relates to the ring-fence mental health surplus and the balance is for implementation of the DHB's Information Systems Strategic Plan.

	Actual 2007/08	Forecast 2008/09	Budget 2009/10	Budget 2010/11	Budget 2011/12
Operating surplus/(deficit)	(4,089)	(4,682)	(3,539)	8	6
Use of previous surpluses	4,089	4,682	3,539	-	-
Surplus/(deficit) after the use of previous surpluses	-	-	-	8	6

For detailed financial statements refer Appendix 2.

6.2 Capital Expenditure

The majority of MDHB's capital expenditure programme relates to its provider division, including investment in information systems.

MCH has an extensive capital program planned over the next few years excluding the possible hospital redevelopment. The retained earnings will be used to supplement funding from depreciation to make the program affordable.

In 2008/09 planning work will commence regarding the implementation of MidCentral Health's Clinical Service Plan, which includes the redevelopment of hospital facilities.

MidCentral DHB will work with six other DHBs, including Wairarapa and Whanganui, on a replacement patient management information systems.

6.3 Disposal of Land

The DHB is required to seek the Minister of Health's approval regarding proposed disposal of property. At the time of writing this Statement of Intent, MidCentral DHB expected to be consulting the Minister in 2009/10 regarding the sale of surplus land, such as portion of the Horowhenua Hospital campus, and possibly Clevely Centre. (NB: Clevely Centre may be retained depending upon the outcome of a primary care initiative.)

6.4 Financial Assumptions

General Assumptions

- No external deficit funding will be required during the planning period.
- Capital expenditure of \$16 million is planned for 2009/10.
- Work is underway to scope a building redevelopment project for MidCentral Health. It is too early to signal any capital expenditure requirements at this stage.
- MidCentral DHB's land and buildings are revalued every three years. The last revaluation occurred on 30 June 2006. The next one will take place on 30 June 2009. For the purposes of this Plan, it has been assumed the revaluation will be cost neutral.
- No new ownership investments in other businesses are included in this Plan.
- Early payment of funding from the Ministry of Health will continue.
- Changes to the value of the Provider Arm Volume Schedule (refer Appendix C) will be accommodated within the application of the service level agreement (SLA) rules with the Funding Division. Any new or additional costs will be offset by

equivalent cost reductions elsewhere in MidCentral Health.

- Interest rate fluctuations are assumed to be significant during the planning period, falling from around 9% (90 day bill rate) to 4% in 2009 and 2010, rising to around 6% in 2011.
- Exchange rate fluctuations may materially impact the cost of supplies and will be offset by clinical supply saving initiatives, and the use of hedging contracts by suppliers.
- MidCentral DHB's share of the national population based funding formula will be 4.16%, 4.15% and 4.5% in 2009/10, 2010/11 and 2011/12 respectively.
- No change in capital charge rate of 8%.
- Expenditure incurred in the planning period for the Information Systems Strategic Plan project will increase governance costs. This additional expenditure may need to be accommodated from prior year's retained earnings.
- Additional compliance costs eg Archives Act changes may be met out of retained earnings.
- There will be marginal changes to intervention rates and inter-district flows, with no significant impact on net costs.
- No material costs have been included for a pandemic.
- Allied Laundry will not require any funding in the 2009/10 year.
- Any collaborative regional initiatives will be cost-neutral.

Personnel

- Personnel cost increases will be in accordance with nationally agreed financial assumptions. Any increases above these levels must be accompanied by an agreed funding mechanism.
- Any restructuring costs incurred in implementing the deliverables contained in this Plan will be met from retained earnings.

- Administration/management numbers will not exceed the cap established in January 2009, ie 560 ftes except by agreement of the Minister of Health.
- Provision has been made for the employer's contribution to Kiwisaver at the level of 2% throughout the planning period.

Demand for Hospital & Associated Services

- MidCentral Health will live within its budget.
- Overall acute demand will be similar to that of 2008/09, thus allowing planned levels of elective procedures to be undertaken.
- Elective throughput will be in accordance with the Elective Services Plan, April 2009.

National Policy

- Government policy settings will not vary significantly.
- The impact of changes to the income and asset testing regime will be cost neutral, with revenue equating to current costs.
- Revenue for capital and operating costs, as detailed in MDHB's business case for Child & Adolescent Oral Health Services, will be provided from national funds. This funding has not been included in our financial forecasts.
- The impact of changes to the national Travel & Accommodation Policy (announced March 2009) will be cost neutral to MidCentral DHB.

Contracted Providers: Pricing

- Price increases for contracted providers will be within the future funding track provision, including technology adjuster, ie 3.116%.
- A maximum of future funding track is assumed for primary health providers and Primary Health Organisations
- Price increases for pharmaceuticals (community pharmaceuticals and pharmaceutical cancer treatment) have

been assumed at future funding track, including technology adjuster. The base dispensing fee will be as per the agreement reached for the period 1 October 2008 to 28 February 2010, ie 2.798% increase.

- 3.116% increase for blood services, being future funding track, including technology adjuster.

- The government's additional funding for improving quality of care in aged residential care facilities will be passed across in total as a price increase.

Appendix 1

Financial Statements

The DHB (and its three output classes) is planning to breakeven before incurring planned expenditure funded from prior year surpluses (including mental health ring-fenced funds). Therefore all deficits appearing in the tables below are to be funded internally from retained earnings or mental health ring-fence monies.

Consolidated Position

Statement of Financial Performance					
MidCentral DHB					
	Actual	Forecast	Budget	Budget	Budget
(\$'000's)	2007/08	2008/09	2009/10	2010/11	2011/12
Revenue	452,122	483,339	504,022	523,318	542,679
% change		6.90%	4.28%	3.83%	3.70%
less Expenditure					
Personnel	147,225	157,199	161,726	167,709	173,916
Outsourced Services	22,949	22,149	16,754	17,375	18,017
Clinical Supplies	37,281	39,201	44,127	45,759	47,452
Infrastructure & Non-Clinical	55,934	59,659	61,119	63,380	65,725
Financing Charges	10,848	11,039	10,135	10,510	10,899
External Provider Payments	142,391	157,921	168,102	171,292	177,629
Inter-District Payments	39,583	40,853	45,598	47,285	49,035
Corporate costs	-	-	-	-	-
	456,211	488,021	507,561	523,310	542,673
% change		6.97%	4.00%	3.10%	3.70%
Operating Surplus / (Deficit)	(4,089)	(4,682)	(3,539)	8	6
Use of Previous Surpluses	4,089	4,682	3,539	-	-
Surplus / (Deficit) After Use of Previous Surpluses	-	-	-	8	6

Statement of Financial Position**MidCentral DHB**

(\$'000's)	Actual 2007/08	Forecast 2008/09	Budget 2009/10	Budget 2010/11	Budget 2011/12
Current Assets	48,911	45,321	39,870	36,837	36,843
Current Liabilities	54,741	53,221	49,121	61,168	60,668
Working Capital	(5,830)	(7,900)	(9,251)	(24,331)	(23,825)
Non current assets	144,480	144,766	148,227	150,702	150,702
Assets Employed	<u>138,650</u>	<u>136,866</u>	<u>138,976</u>	<u>126,371</u>	<u>126,877</u>
Non Current Liabilities	49,030	51,930	56,030	41,700	42,200
Equity	89,620	84,936	82,946	84,671	84,677
Funds Employed	<u>138,650</u>	<u>136,866</u>	<u>138,976</u>	<u>126,371</u>	<u>126,877</u>

Statement of Cashflows**MidCentral DHB**

(\$'000's)	Actual 2007/08	Forecast 2008/09	Budget 2009/10	Budget 2010/11	Budget 2011/12
Total Receipts	445,894	477,719	502,319	521,552	540,848
Total Payments	(447,165)	(475,464)	(494,414)	(512,292)	(529,028)
Operating Cash flow	(1,271)	2,255	7,905	9,260	11,820
Investing Cashflow	(20,554)	8,955	(14,905)	(14,010)	(11,814)
Financing Cashflow	5,119	(47)	1,549	1,717	-
Net Capital Cashflow	(15,435)	8,908	(13,356)	(12,293)	(11,814)
Net Cashflow	(16,706)	11,163	(5,451)	(3,033)	6
Opening Cash	37,321	20,615	31,778	26,327	23,294
Closing Cash	20,615	31,778	26,327	23,294	23,300

Statement of Debt & Equity
MidCentral DHB

(\$'000's)	Actual 2007/08	Forecast 2008/09	Budget 2009/10	Budget 2010/11	Budget 2011/12
Debt:					
Facility Utilised:					
Working Capital	-	-	-	-	-
Long-Term Debt	54,700	54,700	54,700	54,700	54,700
	<u>54,700</u>	<u>54,700</u>	<u>54,700</u>	<u>54,700</u>	<u>54,700</u>
Facility Available:					
Crown	56,700	56,700	56,700	56,700	56,700
Private Sector	15,000	15,000	15,000	15,000	15,000
	<u>71,700</u>	<u>71,700</u>	<u>71,700</u>	<u>71,700</u>	<u>71,700</u>
Unused Facility	<u>17,000</u>	<u>17,000</u>	<u>17,000</u>	<u>17,000</u>	<u>17,000</u>
Equity:					
Opening	94,421	89,620	84,936	82,946	84,671
Net Surplus/(Deficit)	(4,089)	(4,682)	(3,539)	8	6
Revaluation Reserve	(45)	-	-	-	-
Movement in Trust Funds	(79)	-	-	-	-
Equity Injection	(588)	(2)	1,549	1,717	-
	<u>89,620</u>	<u>84,936</u>	<u>82,946</u>	<u>84,671</u>	<u>84,677</u>

Funding Division

Statement of Financial Performance

Funder

(\$'000's)	Actual 2007/08	Forecast 2008/09	Budget 2009/10	Budget 2010/11	Budget 2011/12
Revenue	396,186	419,905	448,646	465,245	482,458
% change		5.99%	6.84%	3.70%	3.70%
less Expenditure					
Provider and Governance Divisions	210,613	222,298	237,866	246,667	255,793
External Providers	142,391	157,921	168,102	171,292	177,629
Inter-District Outflows	39,583	40,853	45,598	47,285	49,035
	<u>392,587</u>	<u>421,072</u>	<u>451,566</u>	<u>465,244</u>	<u>482,457</u>
% change		7.26%	7.24%	3.03%	3.70%
Operating Surplus / (Deficit)	3,599	(1,167)	(2,920)	1	1

Provider Division

Statement of Financial Performance					
Provider					
(\$'000's)	Actual 2007/08	Forecast 2008/09	Budget 2009/10	Budget 2010/11	Budget 2011/12
Revenue	259,673	277,811	288,393	299,063	310,128
% change		6.98%	3.81%	3.70%	3.70%
less Expenditure					
Personnel	139,178	148,228	152,641	158,288	164,146
Outsourced Services	22,432	21,590	16,174	16,773	17,393
Clinical Supplies	37,280	39,196	44,123	45,755	47,448
Infrastructure & Non-Clinical	51,526	55,014	56,714	58,812	60,988
Financing Charges	8,966	8,544	9,060	9,395	9,743
Corporate costs	7,956	9,339	9,677	10,035	10,406
	267,338	281,911	288,389	299,058	310,124
% change		5.45%	2.30%	3.70%	3.70%
Operating Surplus / (Deficit)	(7,665)	(4,100)	4	5	4

Governance Division

Statement of Financial Performance					
Governance					
(\$'000's)	Actual 2007/08	Forecast 2008/09	Budget 2009/10	Budget 2010/11	Budget 2011/12
Revenue	6,876	7,921	4,849	5,677	5,886
% change		15.20%	-38.78%	17.08%	3.68%
less Expenditure					
Personnel	8,047	8,971	9,085	9,421	9,770
Outsourced Services	517	559	580	602	624
Clinical Supplies	1	5	4	4	4
Infrastructure & Non-Clinical	4,408	4,645	4,405	4,568	4,737
Financing Charges	1,882	2,495	1,075	1,115	1,156
Corporate costs	(7,956)	(9,339)	(9,677)	(10,035)	(10,406)
	6,899	7,336	5,472	5,675	5,885
% change		6.33%	-25.41%	3.71%	3.70%
Operating Surplus / (Deficit)	(23)	585	(623)	2	1

Appendix 2

Statement of Accounting Policies

Reporting Entity

MidCentral District Health Board (MidCentral DHB) is a Crown entity in terms of the Crown Entities Act 2004, is owned by the Crown, and is domiciled in New Zealand. MidCentral District Health Board was created under the New Zealand Public Health and Disability Act 2000, effective 1 January 2001.

The group consists of MidCentral DHB, associated entity Allied Laundry Services Limited (Allied Laundry) (25.0% owned) and an investment in Central Region's Technical Advisory Service Limited (TAS) (16.7% owned). In addition, the group includes wholly owned subsidiary Enable New Zealand Limited, which is non-trading. As of November 2002 all the assets, liabilities and activities of Enable New Zealand Ltd were vested in the MidCentral District Health Board.

The financial statements and group financial statements of MidCentral DHB have been prepared in accordance with the requirements of New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989, and the Crown Entities Act, 2004.

MidCentral DHB is a public benefit entity, as defined under NZ IAS 1 - Presentation of Financial Statements.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

MidCentral 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 16 September 2008.

Statement of Compliance and Basis of Preparation

The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). They comply with the New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards as appropriate for Public Benefit Entities.

These are MidCentral DHB's first NZ IFRS financial statements and NZ IFRS 1, First Time Adoption of New Zealand Equivalents to International Financial Reporting Standards, has been applied. An explanation of how the transition to NZ IFRS has affected the reported financial position and financial performance of MidCentral DHB is provided in note 28.

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: land and buildings, and derivative financial instruments (foreign exchange contract).

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value less costs to sell.

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements and in preparing an opening NZ IFRS Statement of Financial Position at 1 July 2006 for the purposes of the transition to NZ IFRS.

The preparation of financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the

application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

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

Judgements made by management in the application of NZ IFRS that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 26.

Basis for Consolidation

Associates

Associates are those entities in which MidCentral District Health Board has significant influence, but not control, over the financial and operating policies. Allied laundry is an associate company of MidCentral DHB.

The consolidated financial statements include MidCentral DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When MidCentral DHB's share of losses exceeds its interest in an associate, MidCentral DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that MidCentral DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Transactions Eliminated on Consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates and jointly controlled entities are eliminated to the extent of MidCentral DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign Currency Transactions

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to New Zealand dollars at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the Statement of Financial Performance. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to New Zealand Dollars at foreign exchange rates ruling at the dates the fair value was determined. The associated foreign exchange gains or losses follow the fair value gains or losses to either the Statement of Financial Performance or directly to equity.

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 NZ GAAP. They comply with NZ IFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by MidCentral DHB for the preparation of these financial statements.

Property, Plant and Equipment

Classes of Property, Plant and Equipment

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

- Freehold land
- Freehold buildings
- Plant, equipment and vehicles
- Fixtures and fittings
- Work in progress.

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 every three years. Valuations undertaken in accordance with standards issued by the New Zealand Property Institute are used where available. Otherwise, valuations are conducted in accordance with the Rating Valuation Act 1998, which have been confirmed by an independent valuer. Any increase in value of a class of land and buildings is recognised directly in 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.

Rental property is included in property, plant and equipment in accordance with NZ IFRS as the rental property is held for strategic and social purposes rather than for rental income, capital appreciation or both.

Disposal of Property, Plant and Equipment

Where an item of 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 MidCentral DHB 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. The capitalised values are depreciated over the period in which the DHB expects to receive benefits from their use. Operating leases, where the lessor substantially retains the risks and rewards of ownership, are recognised in a systematic manner over the term of the lease. Leasehold improvements are capitalised and the cost is depreciated over the lease or the estimated useful life of the improvements, whichever is the shorter.

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 MidCentral DHB. 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
Freehold Buildings	1 - 80 years
Plant, Equipment and Motor Vehicles	3 - 20 years
Fixtures and Fittings	3 - 25 years

The residual value of assets are 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.

Accumulated depreciation at revaluation date will be eliminated against the gross carrying amount so that the carrying amount after revaluation equals the revalued amount.

For each property, plant and equipment project, borrowing costs incurred during the period required to complete and prepare the asset for its intended use are expensed.

Intangible Assets

Intangible assets that are acquired by MidCentral DHB 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 unless such lives are indefinite. Intangible assets with indefinite useful lives are tested for impairment at least annually to determine if there is any indication of impairment. 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
Software	6 - 10 years

Realised gains and losses arising from disposal of intangible assets are recognised in the Statement of Financial Performance in the period in which the transaction occurs.

Financial Assets and Liabilities

Financial Assets

Financial assets are classified into the following specified categories. Financial assets 'at fair value through profit or loss', 'held to maturity, investments, 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. At balance date MidCentral DHB had 'held to maturity investments' and 'loans and receivables'.

Effective Interest Method

The effective interest method is a method of calculating the amortised cost of a financial asset and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, or where appropriate, a shorter period, to the net carrying amount of the financial asset.

Loans and Receivables

Cash, short term deposits and trade and other receivables with fixed or

determinable payments that are not quoted in an active market are classified as loans and receivables. Loans and receivables are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method, less any impairment. Interest income is recognised by applying the effective interest rate method.

Held to Maturity Investments

Term deposits with fixed or determinable payments and maturity dates that the group has the positive intent and ability to hold to maturity are classified as held to maturity investments. Held to maturity investments are initially recorded at fair value and subsequently measured at amortised cost using the effective interest method, less any impairment, with revenue recognised on an effective interest method. Investments are classified as 'held to maturity' investments.

Investments in Equity Securities

Investments in associates and subsidiaries are measured at cost.

Impairment of Financial Assets

Financial assets other than those at fair value through profit or loss are assessed for indicators of impairment at each balance sheet date. Financial assets are impaired where there is objective evidence that as a result of one or more events that occurred after the initial recognition of the financial asset the estimated future cash flows of the asset have been impacted. For financial assets carried at amortised cost, the amount of the impairment is the difference between carrying amount and the present value of the estimated future cash flows, discounted at the original effective interest rate.

The carrying amount of the financial asset is reduced by the impairment loss directly for all financial assets with the exception of trade receivables where the carrying amount is reduced through the use of an allowance account. Subsequent recoveries of amounts previously written off are credited against the allowance account. Changes in the carrying amount of the allowance account are recognised in profit or loss.

If in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through profit or loss to the extent that the carrying amount of the investment at the date of impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Other Financial Liabilities

Other financial liabilities including trade and other payables and interest bearing loans and borrowings are initially measured at fair values, net of transaction costs. Other financial liabilities are subsequently measured at amortised cost using the effective interest rate method, with interest expense recognised on an effective yield basis.

The effective interest method is a method of calculating the amortised cost of a financial liability and of allocating interest expense over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash payments through the expected life of the financial liability, or, where appropriate a shorter period, to the net carrying amount of the financial liability.

Derivative Financial Instruments

MidCentral DHB uses foreign exchange contracts to hedge its exposure to foreign exchange risks arising from investing activities.

Derivatives that do not qualify for hedge accounting are accounted for as trading instruments.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are stated at fair value. The gain or loss on remeasurement to fair value is recognised immediately in the Statement of Financial Performance.

The fair value of forward exchange contracts is their quoted market price at the balance date, being the present value of the quoted forward price.

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.

Cost is based on weighted average cost.

Inventories Held for Distribution

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

Cash and Cash Equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of MidCentral DHB's cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flows.

Impairment of Other Tangible Assets

The carrying amounts of MidCentral DHB's assets other than 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.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance sheet date.

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.

The recoverable amount of MidCentral DHB's receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at the original effective interest rate (i.e., the effective interest rate computed at initial recognition of these financial assets). Receivables with a short duration are not discounted.

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

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not.

For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

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.

Borrowing Costs

Borrowing costs are recognised in profit or loss in the period in which they are incurred.

Employee benefits

Defined Contribution Plans

Obligations for contributions to defined contribution plans are recognised as an expense in the Statement of Financial Performance as incurred.

There are a small number of employees that are part of a state defined benefit superannuation plan. The DHB has no legal or constructive obligation to pay future benefits, the Crown guarantees these benefits and as a result the plans are accounted for as a defined contribution plan.

Long Service Leave, Sabbatical Leave and Retirement Gratuities

MidCentral DHB'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 MidCentral DHB expects to pay. MidCentral DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Termination Payments

Termination Payments are recognised in the Statement of Financial Performance only where there is a demonstrable commitment to either terminate employment prior to normal retirement date or to provide such benefits as a result of an offer to encourage voluntary redundancy. Termination benefits settled in 12 months are reported as the amount expected to be paid, otherwise they are reported as the present value of the estimated future cash flows.

Provisions

A provision is recognised when MidCentral DHB 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. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Restructuring

A provision for restructuring is recognised when MidCentral DHB 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.

Revenue Relating to Service Contracts

MidCentral DHB 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 MidCentral DHB, 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 where there is sufficient certainty of a specific obligation to repay.

Other Liabilities and Provisions

Other liabilities and provisions are recorded at the best estimate of the expenditure required to settle the obligation. Liabilities and provisions to be settled beyond 12 months are recorded at their present value.

Insurance Contracts

MidCentral belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme MidCentral is liable for all its claims costs for a period of two years up to a specified maximum. At the end of the two year period, MidCentral pays a

premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC. The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Taxation

Income Tax

MidCentral DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

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. Revenue from the supply of goods and services is measured at the fair value of consideration received.

Goods Sold and Services Rendered

Revenue from goods sold is recognised when MidCentral DHB has transferred to

the buyer the significant risks and rewards of ownership of the goods and MidCentral DHB 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 MidCentral DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by MidCentral DHB.

Rental Income

Rental income from strategic assets / assets held for social benefit is recognised in the Statement of Financial Performance on a straight line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term on a straight line basis.

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 on a straight line basis.

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.

Financing Costs

Financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method.

The interest expense component of finance lease payments is recognised in the Statement of Financial Performance using the effective interest rate method.

Non-Current Assets held for Sale and Discontinued Operations

Immediately before classification as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable NZ IFRS. Then, on initial classification as held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

Impairment losses on initial classification as held for sale are included in the Statement of Financial Performance, even when the asset was previously revalued. The same applies to gains and losses on subsequent remeasurement.

A discontinued operation is a component of MidCentral DHB's business that represents a separate major line of business or geographical area of operations or is a subsidiary acquired exclusively with a view to resale.

Classification as a discontinued operation occurs upon disposal or when the operation meets the criteria to be classified as held for sale, if earlier.

Contingent Assets and Contingent Liabilities

Contingent liabilities and contingent assets are recorded in the Statement of Contingent Liabilities and Contingent Assets at the point at which the contingency is evident. Contingent liabilities are disclosed if the possibility that they will crystallise is not remote. Contingent assets are disclosed if it is probable that the benefits will be realised.

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 MidCentral DHB and are represented by the cost of providing the

output less all the revenue that can be allocated to these activities.

Cost Allocation

MidCentral DHB 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.

Statement of Cash Flows

The statement of cash flows is prepared exclusive of GST, which is consistent with the method used in the statement of financial performance.

GST inflows and GST outflows in the Cash Flow Statement have been shown net as the Board does not believe that showing gross cash flows provides more useful information given that GST is paid net each month.

Definitions of the terms used in the statement of cash flows are:

- Cash includes coins and notes, demand deposits and other highly liquid investments readily convertible

into cash and includes all call borrowings such as bank overdrafts used by the organisation.

- Operating activities include all transactions and other events that are not investing or financing activities.
- Investing activities are those activities relating to the acquisition and disposal of current and non current investments and any other non-current assets.
- Financing activities are those activities relating to changes in the equity and debt capital structure of the organisation and those relating to the cost of servicing the organisation's equity capital.

New Standards and Interpretations Approved but not yet Adopted

Certain new standards, amendments and interpretations to existing standards have been published that are not yet effective for the year ended 30 June 2008, and have not been applied in preparing these financial statements. The adoption of the following standards is not expected to have a material impact on MidCentral DHB's financial statements.

- NZ IAS 1, Presentation of Financial Statements (revised 2007) - (effective from annual periods beginning on or after 1 January 2009).
- NZ IAS 23, Borrowing Costs (revised) - (effective from annual periods beginning on or after 1 January 2009).
- NZ IAS 27, Consolidated and Separate financial statements (revised 2008) - (effective from annual periods beginning on or after 1 July 2009).
- NZ IFRS 3, Business Combinations (revised 2008) - (effective from annual periods beginning on or after 1 July 2009).
- Improvements to New Zealand Equivalents to International Financial Reporting Standards 2008 - (effective various^).

Other standards/interpretations that are not relevant to MidCentral DHB have been reviewed and are not applicable.

The effective date and transitional provisions vary by Standard. Most of the improvements are effective for annual periods beginning on or after 1 January 2009, with earlier adoption permitted, and they are to be applied retrospectively.

Appendix 3

Allied Laundry Services Limited

Financial Statements

Allied Laundry Services Ltd			
<u>Statement of Financial Performance</u>	Actual 2007/08 \$000	Forecast 2008/09 \$000	Budget 2009/10 \$000
Revenue	6,097	6,423	6,522
<u>Expenditure</u>			
Processing	4,246	4,209	4,214
Service Items	678	573	667
Delivery	669	669	689
Selling / Administration	226	214	213
Overhead Allocation	274	235	238
Total Linen Supply Expenditure	6,093	5,900	6,021
Linen Supply Surplus	4	523	501
Non-operating Expenditure	4	48	104
Net Surplus / (Deficit)	0	475	397

Allied Laundry Services Ltd			
Statement of Financial Position	Actual 2007/08 \$000	Forecast 2008/09 \$000	Budget 2009/10 \$000
Current Assets	928	1,402	1,860
Current Liabilities	949	977	1,007
Working Capital	-21	424	853
Non current assets	3,138	3,624	3,548
Assets Employed	<u>3,117</u>	<u>4,048</u>	<u>4,401</u>
Non Current Liabilities	88	544	500
Equity	3,029	3,504	3,901
Funds Employed	<u>3,117</u>	<u>4,048</u>	<u>4,401</u>

Allied Laundry Services Ltd			
Cash Flow	Actual 2007/08 \$000	Forecast 2008/09 \$000	Budget 2009/10 \$000
Total Receipts	6,342	6,423	6,522
Total Payments	-4,945	-4,948	-5,125
Operating Cashflow	<u>1,397</u>	<u>1,475</u>	<u>1,397</u>
Investing Cashflow	-1,345	-1,942	-880
Financing Cashflow	118	456	-44
Net Capital Cashflow	<u>-1,227</u>	<u>-1,486</u>	<u>-924</u>
Net Cashflow	<u>170</u>	<u>-11</u>	<u>473</u>
Opening Cash	<u>65</u>	<u>235</u>	<u>224</u>
Closing Cash	<u>235</u>	<u>224</u>	<u>697</u>

Statement of Accounting Policy

General Accounting Policies

The general accounting policies recognised as appropriate for the measurement and reporting of results, cashflows and financial position, under the historical cost

method, have been followed in the preparation of these financial statements.

Differential Reporting

The company qualifies for differential reporting as it is not publicly accountable and there is no separation between the owners and the governing body. The company has taken advantage of all differential reporting exemptions with the exception of FRS-10 Statement of Cash Flows.

Particular Accounting Policies

The following particular accounting policies, which materially affect the measurement of profit and financial position, have been applied.

Revenue

Revenue shown in the Statement of Financial Performance comprise the amounts received and receivable by the business for goods and services supplied to customers in the ordinary course of business.

Depreciation

Depreciation is calculated at the maximum rates approved for taxation purposes. The rates are as follows:

Category	Rate	Method
Linen	50%	Diminishing Value
Plan	10-40%	Diminishing Value
Office Equipment	18.6%	Diminishing Value

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

Taxation

The Company is exempt from income tax under Section CW31(2) of the Income Tax Act 2004.

Inventories

Inventory is stated at the lower of cost or market selling value. Cost is determined on a first in, first out basis.

Accounts Receivable

Accounts receivable are stated at estimated realistic value, after due allowance for amounts which are not considered recoverable.

Goods and Services Tax (GST)

All revenue and expense transactions are recorded exclusive of GST. Where applicable, all assets and liabilities have been stated exclusive of GST with the exception of receivables and payables which are stated inclusive of GST.

Property, Plant and Equipment

The cost of purchased assets is the value of consideration given to acquire the assets and the value of other directly attributable costs which have been incurred in bringing the assets to the location and condition necessary for their intended service. Costs include financing costs that are directly attributable to the purchase of those assets.

Impairment

All items of property, plant and equipment are assessed for impairment at each reporting date. Where the carrying amount is assessed to be greater than its recoverable amount, the item is written down. The writedown is recognised in the Statement of Financial Performance.

Provisions

All provisions are recorded at the best estimate of the expenditure required to settle the obligation at balance sheet date. Where the effect is material, the expected expenditure are discounted to their present value using pre-tax discount rates.

Leased Assets

Operating lease payments are representative of the pattern of benefits derived from the leased assets and accordingly are charged to the Statement of Financial Performance in the periods in which they occur.

Leases under which the entity assumes substantially all the risks and rewards incidental to ownership have been classified as finance leases and are capitalised. The asset and corresponding

liability are recorded at inception of the lease at the fair value of the leased asset, at amounts equivalent to the discounted present value of the minimum lease payments including residual values.

Finance charges are apportioned over the terms of the respective leases using the rule of 78 method.

Capitalised leased assets are depreciated over their expected lives in accordance with rates established for other similar assets of the entity.

Statement of Cash Flows

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

- Cash is considered to be cash on hand, current account in banks, and other highly liquid investments in which the entity invests as part of its day to day cash management. Cash includes borrowings from financial institutions such as bank overdrafts, where such borrowings are at call and are used as part of day to day cash management.
- Investing activities are those activities relating to the acquisition, holding and disposal of fixed assets and of investments. Investments can include securities not falling within the definition of cash.
- Financing activities are those activities which result in changes in the size and composition of the capital structure of the group. This includes both equity and debt not falling within the definition of cash. Dividends paid in relation to the capital structure are included in financing activities.
- Operating activities includes all transactions and other events that are not financing or investing activities.

- The reconciliation of the surplus (deficit) after tax with the net cash flow from operating activities is set out in the Statement of Cash Flows.

Comparative Figures

Where necessary, comparative information has been reclassified to achieve consistency in disclosure with the current year.

International Financial Reporting Standards

Allied Laundry Services Limited is not required to prepare financial statements under New Zealand International Financial Reporting Standards (NZIFRS) for the year ending 30 June 2008, as it satisfies all of the following criteria per Release 9:

- The Company is not an issuer, as defined by the Act, in either the current or preceding accounting period;
- The Company is not required by section 19 of the Act to file its financial statements with the Register of Companies;
- The Company is not large, as defined by section 19A of the Act.

Changes in Accounting Policies

There has been no material changes in the accounting policies applied during the period covered by these financial statements. All policies have been applied on a basis consistent with the previous year.

Glossary

Impact	means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. E.g. The change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations (Public Finance Act 1989)
Inputs	are the resources used to produce the goods and services (outputs) of the DHB. They include personnel, travel, motor vehicles, and land and buildings Input information provides information about what the DHB has spent money on but not what the entity has produced.
Internal outputs	also referred to as intermediate or management outputs) are: goods or services processed by one part of the DHB and delivered to another part of the same DHB; or steps along the way in the DHB's processes which contribute directly to the delivery of another output.
Management systems	are the supporting systems and policies used by the DHB in conducting its business. Management systems, internal outputs and processes are needed to support the delivery of outputs to external parties. Although they are not outputs, information on them is needed for internal management purposes and may be useful for readers of general purpose financial statements.
Objectives	is not defined in the legislation but use recognises that not all outputs and activities are intended to achieve "outcomes" . E.g. Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving relationships; improving Governance...etc.
Outcome	means a state or condition of society, the economy or the environment and includes a change in that state or condition. It normally describes a state or condition that is influenced by many different factors which may operate independently and where attributing change to the activities of one agency is very difficult. E.g. The life expectancy of infants at birth and at age one (Public Finance Act 1989)
Output classes	are groups of similar outputs
Outputs	are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group
Processes	are the way the DHB converts inputs into outputs.