

# statement of intent

MidCentral District Health Board 2006/07

*quality living – healthy lives*

Quality Living – Healthy Lives

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## Introducing MidCentral District Health Board

*Tihei Mauriora*

*E nga waka, e nga iwi katoa o te motu*

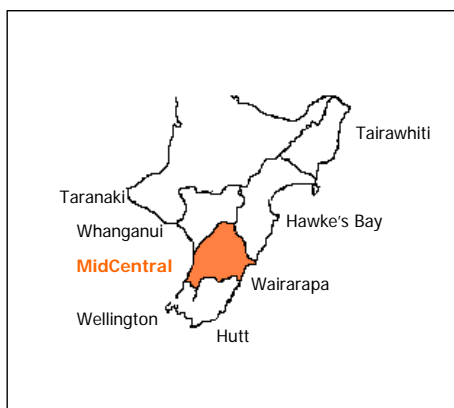
*Tena koutou me nga ahuatanga o te wa*

*ko tenei te mihi whanui ake ki a koutou.*

*Tena koutou katoa.*

MidCentral District Health Board is the organisation responsible for planning and purchasing (funding) most health services for the 155,000 people living in the district. The district covers the following territorial and local authority districts:

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



MidCentral District Health Board was established on 1 January 2001 under the New Zealand Public Health and Disability Act 2000.

As a District Health Board, MidCentral has three key functions (or output classes):

- i. Governing and managing the District Health Board
- ii. Planning and funding health and disability services
- iii. Delivering health and disability care services through Crown owned hospital and associated services.

(Note: Responsibility for the funding and planning of public health and disability supports services for people under 65 years of age currently rests with the Ministry of Health.)

More information about MidCentral District Health Board is contained within the following sections of this document.

## The Purpose of this Document

MidCentral District Health Board is one of 21 DHBs established on 1 January 2001 in accordance with section 19 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act 2000).

MidCentral DHB is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004). This Act (section 49) states that the Board of MidCentral DHB must ensure it acts in a manner consistent with its objectives, functions, and this Statement of Intent.

This Statement of Intent is for the period 2006/07 to 2008/09. The Statement of Intent describes to Parliament and the communities of MidCentral's district, what the DHB intends to achieve over the next three years in terms of promoting, enhancing and facilitating the health and wellbeing of people in the district. This Statement of Intent incorporates the governance (the Board), funder and provider (hospital and associated services) activities of the DHB.

MidCentral District Health Board's achievement of the deliverables specified in this document will be reported through its Annual Report.

The work of MidCentral District Health Board can be broadly categorised as follows:

- long term and annual planning
- systems and processes
- operational performance

The Statement of Intent identifies key deliverables within each category. A description of each category follows.

The key deliverables cover all output classes. They will be measured and reported annually.

### Long Term and Annual Planning

The Board has long term strategies to achieve its vision, "quality living – healthy lives". These are set out in the Board's District Strategic Plan that sets the foundation for the next five to ten years.

This document, the Statement of Intent, outlines how MidCentral will continually measure its progress towards achieving the vision. These measures are long term and need to be reported over a long time frame so that ongoing progress can be monitored.

Each year, MidCentral District Health Board reviews its progress and decides what new initiatives are required to continue moving toward the vision. The annual planning work is detailed in the Board's District Annual Plan. That Plan sets out the financial assumptions on which it is based, including its capital funding requirements.

This Statement of Intent sets out the key short term initiatives to be achieved in 2006/07.

### Operational Performance

The planning, funding and delivery of health and disability services is a complex business, involving annual spending of more than of \$390 million and the direct employment of 2,100 staff (full time equivalents) within the District Health Board.

The Statement of Intent sets out the key operational deliverables (outputs) which MidCentral District Health Board expects to achieve in 2006/07.

### Processes and Systems

There are multiple processes and major resources involved in the planning, funding and delivering health and disability services and it is important to

use them effectively. This requires good systems and processes

Processes include consulting with the local community and partnering arrangements with local Iwi. Systems include corporate support and hospital management.

The Statement of Intent includes measurements for checking the effectiveness of key systems and processes.

#### Other Organisations in Which MidCentral DHB has an Ownership Interest

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

The Board is also a member of District Health Boards' New Zealand (DHBNZ). This is a sector organisation to which all DHBs belong, and it promotes and supports a national DHB perspective on key matters.

Based on the success of these organisations, MidCentral DHB will consider other ventures of a similar nature, as well as alliances with non-government owned entities.

#### *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.

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.

#### *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 the four participating DHBs, being Taranaki, Whanganui, Hawke's Bay and MidCentral Health District Health Boards

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

Allied Laundry Services Limited's key output for 2006/07 is the processing (collection, laundering and delivery) of 2.6m kgs of laundry to its four shareholding DHBs, and Wairarapa DHB.

Further information regarding the financial position and policies of ALSL is set out in Appendices D and E.

#### General

This Statement of Intent is aligned to and consistent with:

- NZ Public Health & Disability Act 2000
- Crown Entities Act 2004
- Public Finance Act 1989 (and subsequent amendment acts)
- MidCentral DHB's District Annual Plan
- MidCentral DHB's District Strategic Plan
- MidCentral DHB's District Crown Funding Agreements
- The NZ Health Strategy (2000)
- The NZ Disability Strategy (2001)
- He Korowai Oranga (Maori Health Strategy, 2002)
- Te Tahuhu: Improving Mental Health 2005-2015 (2005)
- The Health of Older People Strategy (2002)

- The Primary Health Care Strategy (2001)
- The Pacific Health and Disability Action Plan (2002)

This Statement of Intent includes:

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

### Reporting Requirements

MidCentral DHB has an obligation to report to the Minister of Health and Director-General of Health on the following matters (as specified in the Operational Policy Framework, effective from 1 July 2006):

- annual reports and audited financial statements
- quarterly reports re non financial performance
- quarterly reports re hospital benchmark information

- quarterly risk reports
- quarterly reports on service delivery
- monthly financial reports
- ad hoc reports as requested by the Minister
- information for Ministers

It also has reporting requirements in respect of national health information systems, such as:

- ethnicity
- national health index (NHI)
- medical warning system (MWS)
- national minimum dataset (NMDS)
- national booking reporting system (NBRS)
- mental health information national collection (MHINC)
- national immunisation register (NIR)
- standards for data quality and supply of data
- national not-admitted patients collection

MidCentral DHB also has reporting obligations and information requirements for other associations, including HealthPac, ACC, and the Mental Health Commission.

## Measuring the Achievement of Long Term Goals

### *Government's Priorities and Direction*

The Board's strategic plans are closely aligned to the Government's health and disability strategies, which include but are not limited to:

- The New Zealand Health Strategy, December 2000
- The New Zealand Disability Strategy, April 2001
- The Primary Health Care Strategy, February 2001
- The Health of Older Persons Strategy, April 2002
- He Korowai Oranga Maori Health Strategy, November 2002
- The New Zealand Health Workforce, August 2003

The Government has set the following priority areas for 2006/07, and MidCentral's plans are aligned to these:

- Getting "ahead of the curve" on the chronic disease burden, through maintaining and improving an integrated continuum of prevention and intervention services. This includes implementation of the Healthy Eating Healthy Acton Strategic Framework, as well as the Cancer Control Strategy and an ongoing focus on tobacco control.
- Child and Youth Services, including targeted hearing tests for neonates, increasing the scope of well child services for preschoolers, child and adolescent mental health services, improved oral health services, and work towards free primary care services for under six year olds.
- Continued roll-out of the Primary Health Care Strategy, to achieve

reduced costs for more people and to continue the shift towards a population health approach to primary health. Increased PHO focus on prevention and early detection.

- Health of Older Persons, including further development of the continuum of care model to better support people moving between their homes, residential care, assessment, treatment and rehabilitation services, and primary services.
- Health Information Strategy implementation, and health workforce matters.
- Improving cost effectiveness.
- Improving elective services, including orthopaedic and cataract services.

### *MidCentral's Priorities and Direction*

MidCentral District Health Board has a long term strategy for the health of its district. This strategy is closely aligned to the Government's strategic plans and priority areas.

MidCentral District Health Board's vision is, "quality living – healthy lives."

The DHB believes achieving this vision will mean:

- 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.

The vision is a broad view of the future. Following an analysis of the district's current health status (details on following page), MidCentral's projected future health needs, and what will make the greatest impact toward improving the health of the district's population overall, the Board identified ten priority areas on which it will focus:

- Cancer
- Cardiovascular disease
- Diabetes
- Respiratory disease
- Child Health
- Health of Older People
- Maori health
- Mental health
- Oral health
- Rural Health

Cancer is the second most common cause of death within MidCentral's district. At least one third of cancers are preventable and the impact and death rate of cancer can be reduced with early treatment.

Diabetes is increasing significantly and it can increase the risk of a person suffering from other serious illnesses. The main

increase in diabetes is for people with Type II and this is substantially preventable.

Cardiovascular disease is the most common cause of death for MidCentral residents and the leading cause of all hospitalisations (excluding pregnancy and childbirth).

Diseases of the gums and teeth are among the most common health problems experienced by all New Zealanders, and because poor oral health can lead to poor overall health.

Respiratory disease is the third most common cause of death within MidCentral's district and many risk factors are preventable.

Maori have the poorest health status of any ethnic group within MidCentral's district. There is also a local and national commitment to improving Maori health and reducing disparities.

Approximately one in five people will experience a mental illness (including drug and alcohol disorders) of some kind during their lifetime.

MidCentral's population, like that of New Zealand, is aging. Older people experience more illness and disability than any other population group in the district and their needs are more complex.

Poor health in childhood can lead to poorer health in adult years. Therefore a focus on child health is an investment in the future health and wellbeing of the district.

MidCentral has a large rural area, and this creates access issues.

#### *The Health Status of our District*

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

An assessment of the district's health status is regularly undertaken. The latest review was completed in February 2005 and show that:

- According to the New Zealand Health Survey, an estimated 58% of people in MidCentral's district are considered obese or overweight.
- Maori, Pacific Peoples, and Asian children have poorer dental health compared to other ethnicities, including Pakeha. They show lower percentages who are caries free and higher average decayed, missing and filled scores. This is true at both five years of age and at Year 8.
- Circulatory system hospital discharges are increasing for Maori aged 15 to 64. It is already the second most important Major Diagnostic Category in that age group (behind Pregnancy, birth)
- Stroke hospitalisations were increasing for all ethnicities
- Diabetes hospitalisation figures are increasing for all ethnicities, especially for Maori and Pacific Peoples.
- Most other hospital discharge numbers are falling, whether by ethnicity, territorial authority, or socio-economically disadvantaged areas.
- Non-Maori, non-Pacific ethnicities often have lower than expected hospitalisation rates when compared to New Zealand overall.
- The four most common causes of mortality for MidCentral residents from 1999 to 2001 were: circulatory system disease (43%), cancers (27%), respiratory system disease (9%), and injuries (6%).
- MidCentral's mortality rate for all causes combined is 10% higher than New Zealand's all causes mortality rate.
- MidCentral's mortality rate for circulatory system disease is 15% higher than New Zealand's circulatory system disease mortality rate.
- MidCentral Maori mortality rate for all causes combined is 66% higher than New Zealand's all ethnicities mortality rate (1999 to 2001 data). Maori have higher mortality rates for circulatory system diseases, cancers, and respiratory diseases. MidCentral and New Zealand Maori mortality rate for circulatory system disease is twice New Zealand's circulatory diseases mortality rate. MidCentral Maori mortality rate for cancers is almost 40% higher than New Zealand's cancer mortality rate.
- The health status of Horowhenua residents is worse than for MidCentral residents overall. For example, Horowhenua's mortality rate from all causes is 20% higher than MidCentral's mortality rate from all causes.
- Pacific Peoples health disparity probably exists in the MidCentral district. Hospitalisation and mortality numbers for Pacific Peoples were low because the Pacific Peoples population in the district is small. Although this creates difficulty generating statistically stable results, there seems to be a consistent pattern of poorer Pacific Peoples health status across many hospitalisation and mortality parameters. This is consistent with national trends.

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

An assessment of the support needs for older people (people aged 65 years and older) identified the health of older persons as another priority area for MidCentral DHB. The assessment was undertaken in two strands, one focusing on Maori (with an age range of 50 – 64 years to take account of Maori encountering age related support needs earlier than non-Maori) and one on the general population. The assessment estimated that 32,135 people within the district have a disability, of whom 4,801 will be Maori and 500 Pacific peoples. The majority of people with a disability report that they have more than one disability. The estimated number of adults by

disability type residing households as at 2001 is as follows:

Disability Type	Number
Sensory	11,035
Physical	17,468
Intellectual	1,194
Psychiatric/psychological	3,909
Other	10,328
Total*	26,644

\*an individual may appear in the table more than once. Therefore, the column will not sum to the given total.

## Measures

The measures in place to determine the achievement of the Board's vision and associated outcomes follow. They are long term in nature, having a 5-10 year time horizon. Over this time, significant progress is expected to occur. The measures will be reported annually, enabling trend information to be available.

The measures are linked, and each measure should not be viewed in isolation. Each measure reports on an aspect of the organisation's success, but it is only when they are viewed together that the full picture can be seen.

The information used to report the measures will be derived from a variety of sources. Details of how they are calculated are provided in Appendix C.

The measures have been selected as they will show how successful MidCentral DHB has been in implementing its priority health plans. A summary of the activities the Board intends to do in 2006/07 to advance these priority health plans is set out below. Full details can be sourced from the Plans and MidCentral's District Annual Plan for 2006/07.

## Cancer

- Establish community cancer nursing services
- Establish psycho-oncology services
- Regional Cancer Treatment Service will continue to meet radiation oncology wait times
- Regional Cancer Treatment Network will meet regularly (NB: regional cancer treatment network comprises MDHB and the DHBs to which it provides services)
- Implement key priorities outlined in the regional cancer network plan
- Adopt the Liverpool care of the dying programme
- Increase capacity of screening programmes for breast and cervical cancer

## Cardiovascular Disease

- Establish screening programmes through primary health care providers
- Utilisation of community defibrillators
- Establish community based nurse-led clinics for cardiovascular disease
- Establish cardiac rehabilitation clinics.
- Develop integrated clinical guidelines for cardiovascular service by primary health care nursing development programme

## Diabetes

- Increase the number of people on the "get checked" programmes through primary health care providers
- Establish screening programmes through primary health care providers
- Develop integrated clinical guidelines for diabetes by primary health care nursing development programme

## Respiratory Disease

- Establish community respiratory nurse-led clinic
- Increase usage of sleep apnoea clinic
- Increase the number of influenza immunisations for the elderly
- Develop integrated clinical guidelines for respiratory services by primary health care nursing development programme

## Child Health

- Promote smoking cessation for parents (precursor for glue ear)
- Increase in parenting programmes
- Hold district-wide community child health forum
- Develop a youth health strategy
- Encourage Health Promoting Schools

## Health of Older Persons

- Develop Maori disability provider strategy
- Enhance and improve information sharing and links between service providers and older people
- Develop a psycho geriatric strategy
- Work with providers and other agencies to increase awareness of older people in the community
- Increase the use of elder abuse family violence intervention guidelines by providers and other agencies
- Minimise discharge delays for elder persons through AT&R expertise being available in emergency department and acute services of MCH
- Develop a brand strategy for the Care Industry workforce
- Develop a mental health/age related disability strategy

## Maori Health

- Develop recruitment and retention policies for Maori health workforce within the district
- Develop coaching and mentoring frameworks for Maori health workforce within district
- Stocktake of Maori health providers re service capacity and capability
- Establish a network database of key Maori community groups/agencies supporting whanau in the community
- Stocktake of whanau, hapu and iwi and Maori community development
- Implement Kaupapa Tuatahi review findings
- Review PHO Maori health action plans
- Increase Maori health service expenditure in line with target

## Mental Health

- Establish consumer run Wellness Recovery Action Plan workshops
- Make available training courses for identifying depression for front line staff
- Increase in specialist clinician support for PHOs
- Introduce new residential service in outlying or rural areas to cater for rehabilitation needs of younger adults, and, one for older adults.
- Place additional staff in Child Adolescent and Family services
- Establish access to home-based acute treatment services as an option for consumers
- Develop an internship programme for allied health staff

#### Oral Health

- Establish “teeth 4 keeps” programme

#### Rural Health

- Develop a rural health strategy
- Establish nurse-led clinics in areas with GP shortages
- Commence mobile surgical bus service by June 2007 in Horowhenua and Dannevirke
- Establish mental health residential services for young adults, and, older adults, in rural/outlying areas
- Implement maternity services plan

#### Lifestyle Programmes (across all 10 priority areas)

- Place primary chronic care teams through Primary Health Organisations operational by December 2006
- Health promoting schools working toward healthy food policy
- Develop community wide physical activity plan

Measures: annual and long term by desired outcome

	<i>Output Classes 2 and 3</i>	<i>YTD Actual to 31.12.05 or latest available data</i>	<i>Target 2006/07</i>	<i>2007/08 Indicative</i>	<i>2008/09 Indicative</i>
Cancer	<b>Outcome One: An increase in cervical screening and breast screening rates</b>				
	<ul style="list-style-type: none"> <li>Proportion of eligible (target) BSCC population screened for breast cancer</li> </ul>	100.6%	100%	100%	100%
	<ul style="list-style-type: none"> <li>Proportion of eligible population screened for cervical cancer (coverage rate – Manawatu-Wanganui)</li> </ul>		>67%	75%	80%
	<b>Outcome Two: Increased access to, and effectiveness of, regional cancer treatment services.</b>				
<ul style="list-style-type: none"> <li>A reduction in delay to start of radiation oncology treatment Average wait time from assessment to treatment (weeks)</li> </ul>					
<ul style="list-style-type: none"> <li>Priority A</li> <li>Priority B</li> <li>Priority C</li> <li>Priority D</li> </ul>	0 2.8 2.0 10.7	0 ≤2.8 ≤2.0 ≤10.7	0 ≤2.8 ≤2.0 ≤10.7	0 ≤2.8 ≤2.0 ≤10.7	
Cardiovascular	<b>Outcome Three: An increase in the early recognition of individuals at risk of cardiovascular disease/stroke</b>				
<ul style="list-style-type: none"> <li>The proportion of people in each target group who have had their five-year absolute CVD risk recorded in the last five years..</li> </ul>	New indicator – not available	All population groups: ≥50%	All population groups: 75%	All population groups: 100%	
<ul style="list-style-type: none"> <li>Maori/Pacific and Indian subcontinent men &gt; 35 years of age.</li> <li>Maori/Pacific and Indian subcontinent women &gt; 45 years of age.</li> <li>European and other men &gt; 45 years of age.</li> </ul>					

	<i>Output Classes 2 and 3</i>	<i>YTD Actual to 31.12.05 or latest available data</i>	<i>Target 2006/07</i>	<i>2007/08 Indicative</i>	<i>2008/09 Indicative</i>
	<ul style="list-style-type: none"> <li>European and other women &gt; 55 years of age. (Note: subject to PHO monitoring framework; capability to measure.)</li> </ul>				
<b>Diabetes</b>	<p><b>Outcome Four: To increase case detection and case management rates for diabetes</b></p> <ul style="list-style-type: none"> <li>Percentage of expected number of people with type I or II diabetes mellitus on a diabetes register, whose date of their free annual check is during the reporting period.</li> <li>Percentage of people with type I or II diabetes mellitus on a diabetes register, that had an HBA1c of equal to or less than 8% and at their free annual check is during the reporting period.</li> <li>Percentage of people with type I or type II diabetes mellitus on a diabetes register that have had retinal screening or an ophthalmologist examination in the last two years, and the date of the free annual check during the reporting period.</li> </ul>	Not yet available	Total: >65% Maori: >60% Pacific: >60% Other: >66%	Total: 78% Maori: 75% Pacific: 75% Other: 85%	Total: 88% Maori: 85% Pacific: 85% Other: 95%
<b>Respiratory</b>	<p><b>Outcome Five: An increase in access to, and update of effective asthma prevention and self-management strategies</b></p> <ul style="list-style-type: none"> <li>The proportion of children and young people in our district who have been discharged from hospital with a diagnosis of asthma           <ul style="list-style-type: none"> <li>Discharge rate per 1,000 population, aged under five years</li> </ul> </li> <li>Discharge rate per 1,000 population, aged five to 14 years</li> </ul>	Total: 5.8 Maori: 7.1 Pacific: -- Other: 5.1	5.8 – 8.1 7.1 – 11.2 -- 5.1 – 5.9	99% confidence interval – total NZ rate	99% confidence interval – total NZ rate

	<b>Output Classes 2 and 3</b>	YTD Actual to 31.12.05 or latest available data	Target 2006/07	2007/08 Indicative	2008/09 Indicative
Child Health	<b>Outcome Six: Improved immunisation cover</b>				
	<ul style="list-style-type: none"> <li>Percent of eligible newborns born and enrolled on the NIR in reporting period</li> </ul>	Not yet available	92%	95%	95%
	<ul style="list-style-type: none"> <li>NIR immunisation coverage at 6, 12 and 24 months of age</li> </ul>				
	<ul style="list-style-type: none"> <li>% of children on the NIR up-to-date with immunisation on the day they turned a specific age (6, 12, 18, 24 months) during the reporting period</li> </ul>	89%	92%	95%	95%
	<ul style="list-style-type: none"> <li>% of children on the NIR up-to-date with MMR immunisation on the day they turned 18 months during the reporting period.</li> </ul>	82%	90%	95%	95%
Older People	<b>Outcome Seven: Ensuring information sharing and needs assessment and service co-ordination with other services is improved</b> <ul style="list-style-type: none"> <li>Ratio of expenditure on subsidised home-based support services, carer support, and respite care to expenditure on subsidised care in rest homes, dementia units and long-stay hospitals. (Note: measuring system being developed by MoH. Reporting against this scheduled for 2006/07 accordingly.)</li> </ul>			Target to be determined once baseline data available	Target to be determined once baseline data available

	<b>Output Classes 2 and 3</b>	YTD Actual to 31.12.05 or latest available data	Target 2006/07	2007/08 Indicative	2008/09 Indicative
Maori Health	<p><b>Outcome Eight: Increase the capacity and capability of the Maori workforce and Iwi/Maori providers</b></p> <ul style="list-style-type: none"> <li>Maori health and disability service expenditure increased in line with targets set. (NB: figures stated are total budget.)</li> </ul>	\$4,468,376	\$4,677,579	\$4,779,9857	\$4,769,186
	<p><b>Outcome Nine: Improved access to, and effectiveness of, mainstream services for Maori</b></p> <ul style="list-style-type: none"> <li>Maori targets for diabetes achieved. Refer "diabetes" measures</li> <li>Percentage of (access funded) PHO effectively collecting ethnicity data</li> </ul>	0%	50%	75%	100%
Mental Health	<p><b>Outcome Ten: Increased access to mental health services</b></p> <ul style="list-style-type: none"> <li>Proportion of projected domiciled population seen on average (annual) <ul style="list-style-type: none"> <li>0 – 19 years</li> <li>20 – 64 years</li> <li>65+ years</li> </ul> </li> </ul>	Total: 1.69% Maori: 1.36% Other: 2.03%	Total: 1.81% Maori: 1.81% Other: 1.81%	Total: >1.81% Maori: >1.81% Other: >1.81%	Total: 2.0% Maori: 2.0% Other: 2.0%
Oral Health	<p><b>Outcome Eleven: A reduction in the number of dental caries in our district's child and youth populations</b></p> <ul style="list-style-type: none"> <li>% children caries free at the commencement of dental care, in the year to which the reporting relates, examined by the DHB School Dental Service (SDS), by ethnic group</li> </ul>	Total: 53.9% Maori: 37.6% Pacific: 40.0% Other: 61.4%	Total: 55% Maori: 40% Pacific: 42% Other: 62%	Total: 56% Maori: 42% Pacific: 45% Other: 62%	Total: 58% Maori: 45% Pacific: 48% Other: 62%

	<ul style="list-style-type: none"> <li>Mean Decayed, Missing and Filled teeth score of Year 8 (Form 2) children at the commencement of dental care, at the last dental examination, before the child leaves the DHB SDS</li> </ul>	Total: 1.6 Maori: 2.1 Pacific: 3.3 Other: 1.4	Total: 1.7 Maori: 2.0 Pacific: 3.0 Other: 1.4	Total: 1.6 Maori: 2.0 Pacific: 2.8 Other: 1.2	Total: ≤1.6 Maori: ≤1.8 Pacific: ≤2.5 Other: ≤1.2
Rural Health	<b>Outcome Twelve: Enhance capability and capacity requirements of the district's primary sector</b>				
	<ul style="list-style-type: none"> <li>Five new nurse-led initiatives are introduced inline with service plans in health priority areas by 30 June 2008.</li> </ul>	Narrative	Narrative	Narrative	Narrative
	<b>Outcome Thirteen: Service coverage for MidCentral's district maintained</b>				
	<ul style="list-style-type: none"> <li>Rural health strategy developed for MidCentral DHB by year end</li> </ul>	Narrative	Narrative	N/a	N/a
	<ul style="list-style-type: none"> <li>After-hours Accident and Medical Plan developed for district by end February 2007.</li> </ul>	Narrative	Narrative		

## Measuring Systems and Processes

The planning and funding of health and disability services requires robust systems around determining the health and disability needs of the community, and prioritising the various needs against available funding. It is also important that the right level of services are purchased, at the right place, and that the community can have confidence that these services will be available and appropriate. This requires sound audit and monitoring systems.

The provision of health and disability services requires the right service to be provided at the right time and by the right person. Services must adhere to agreed clinical standards, and the funding provided must be used in the most effective way.

The governance/corporate function of a District Health Board requires sound decision-making systems, with consultation and engagement with various stakeholders.

The Board must ensure that the principles of the Treaty of Waitangi are upheld within the framework of the NZ Public Health and Disability Act 2000. The Board must also be able to account for the funding it receives, and that its employment of staff is appropriate and in line with legislative requirements.

The Board is required to publicly advise its accounting policies, and these are outlined in Appendix B.

In addition to these policies, MidCentral District Health Board states that in the event it seeks shares or an interest in a body corporate or association of persons, it will seek the consent of the Minister of Health as required by the NZ Public Health and Disability Act 2000 and using the process set out in Cabinet Minute 00 32/2A (1).

MidCentral District Health Board will actively look to identify and dispose of all surplus assets, including land, not required for core business. Any disposal of land will be in accordance with Clause 43, Schedule 3 of the NZ Public Health and Disability Act 2000.

### Measures

The measures that determine the effectiveness of the Board's processes and systems closely linked to the organisation's performance measures. As such, these measures are listed together. It is through good systems and processes that MidCentral can deliver on its operational responsibilities, and to the standard required.

The measures cover the three output classes as defined by legislation. Details of how they are calculated are provided in Appendix C.

## Measuring Operational Performance

To carry out its functions MidCentral District Health Board established three divisions:

- i. Funding Division
- ii. Provider Division
- iii. Governance and Corporate Division

Each of these three organisational divisions has its own distinct role. Resources have been assigned to each Division to enable it to carry out its responsibilities.

### Governance/Corporate

#### *Governance*

A Board of eleven members is responsible for the governance of MidCentral District Health Board. Seven members are elected alongside the triennial local authority election process (last held in 2004). The Minister of Health appoints four members by notice in the Gazette.

The Board's mandate is stated in the New Zealand Public Health and Disability Act 2000. The Board is responsible to the Minister of Health.

Its key responsibilities are:

- Setting the strategic direction and developing policy that is consistent with the statutory framework
- Appointing the Chief Executive
- Monitoring the performance of the organisation and its Chief Executive
- Ensuring compliance with legal requirements, the Government's accountability framework and the Crown's expectations
- Maintaining appropriate relationships with the Minister, Parliament and the public

Accountability for the performance and management of the organisation

The Board has all powers necessary for the governance of the District Health Board and has a delegation policy, approved by the Minister of Health, to delegate decisions on management matters to the Chief Executive. It has the following sub-committees, the first three of which are statutory committees under sections 34 – 36 of the NZ Public Health and Disability Act. In accordance with schedule 4 of this Act, public notice of the date, time and venue of Board and statutory committee meetings must be provided.

In accordance with good business practice and to meet the requirements of the Public Finance Act, separate audit committees have been established for the Board and Corporate Services Division, the Funding Division and the Provider Division.

The Board also appoints, where necessary, external experts to its three advisory committees and the Enable NZ Governance Group to ensure that the membership has the skills necessary to undertake their role.

Each Committee has its own terms of reference and these are reviewed regularly. It also has an annual work programme. This is established by the Board on an annual basis, and includes monitoring arrangements for the District Annual Plan.

#### *Committees of the Board*

- Hospital Advisory Committee: This statutory committee monitors the financial and operational performance of the board's Provider Division, MidCentral Health. It also assesses strategic issues relating to the provision of hospital services by or through the District Health Board. The committee meets 11 times per

year, and comprises seven board members, and three external members.

- **Community & Public Health Advisory Committee:** The role of this statutory committee is to provide advice on the needs, and any factors that the committee believes may adversely affect the health status of the resident population of the District Health Board. It also provides advice on priorities for the use of the health funding provided. The committee comprises six board members, and three external members. It meets 11 times per year.
- **Disability Support Advisory Committee:** This statutory committee provides advice on the disability support needs of the resident population of the region, and priorities for the use of disability support funding provided. The committee meets quarterly, and comprises five board members, and three external members.
- **Enable New Zealand Governance Group:** This committee monitors the financial and operational performance of Enable New Zealand. The committee meets four times per year, and comprises three board members, the CEO, and two external members.
- **Group Audit Committee:** This committee meets quarterly, and comprises seven board members. It considers the adequacy of financial statements, accounting policies, and financial controls. It also co-ordinates the development of a risk profile for the organisation, and an associated internal audit plan. It monitors the implementation of the internal audit function in relation to the corporate/governance section.
- **Hospital Audit Sub-Committee:** This committee ensures that management reporting and decision-making process used within the Provider Division is sound, and monitors the delivery of quality health services. It develops a

risk profile for this Division, and monitors the implementation of the associated internal audit programme. The committee meets quarterly, and comprises four board members.

- **Funding Audit Sub-Committee:** This committee ensures that management reporting and decision-making process used within the Funding Division is sound. It also ensures that contract payment processes are adequate, and that funding received from Vote Health is appropriately accounted for. It develops a risk profile for this Division, and monitors the implementation of the associated internal audit programme. The committee meets quarterly, and comprises four board members.
- **Remuneration Committee:** This committee monitors the individual performance of the Chief Executive Officer and associated remuneration. It comprises three board members and meets at least quarterly.

To ensure the cohesiveness of the governance function, the Chair and Deputy Chair of the Board meet regularly with the chairs of various Committees. In general, all meetings where the Board or any of its Statutory Committees make decisions are open to the public to attend, as observers. Certain discussions may be held without public presence as outlined within the NZ Public Health and Disabilities Act. Details of Board and Committee meetings (order paper, minutes, membership) are publicly available on the DHB's website, [www.midcentral.co.nz](http://www.midcentral.co.nz).

In respect of all issues related to Maori health, MidCentral District Health Board observes the Treaty Principles within the framework of the New Zealand Public Health and Disability Act 2000. The principles are:

- **Partnership**  
We are committed to a framework that enables Maori to engage and contribute to decisions at the highest

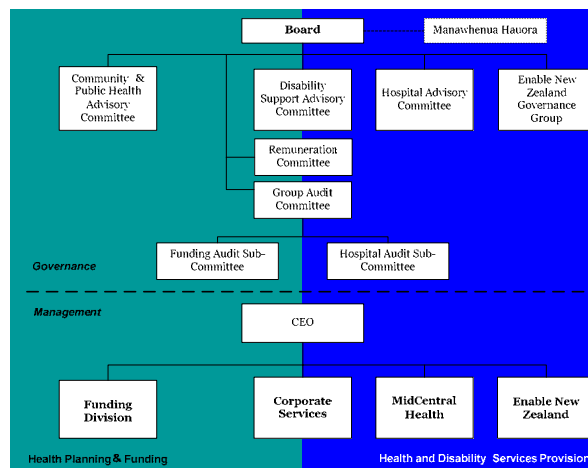
strategic level based on mutual understanding and co-operation.

- **Participation**  
We recognise our role as a joint partner in identifying priority areas for Maori health within MidCentral's district. Maori are involved in overall strategic, operational, planning and consultation processes.
- **Protection**  
We are committed to a bi-cultural approach in our delivery of health and disability services and the utilisation of tikanga Maori. We will work with Maori to ensure the protection of Maori cultural concepts, values, practices and other taonga.

To give effect to these principles, the Board has established a formal relationship with Manawhenua Hauora, a consortium of the four Iwi who have manawhenua status in the Manawatu, Horowhenua, Tararua and Otaki districts. This relationship is at a governance level and is underpinned by a Memorandum of Understanding. The purpose of this relationship is to provide leadership and guidance to MidCentral District Health Board on the health and disability needs and priorities of Iwi/Maori within the district, together with advice on strategies to improve Maori health outcomes. Representatives of Manawhenua Hauora sit on each statutory committee.

In addition to this formal Iwi partnership, the various divisions of MidCentral DHB have links with both Iwi health and independent Maori health providers.

The following chart provides a diagrammatic representation of the organisational structure at Board (governance) level.



### Corporate Services

Corporate Services supports the governance and management activities for the District Health Board's activities. It has two distinct areas:

- Chief Executive's department
- The Corporate service function.

Approximately 105 people (ftes) work in these areas. They provide the following services to all divisions of the organisation.

- Organisational leadership
- Information systems
- Financial management and systems
- Risk management
- Health service contracting, and health statistics
- Human resource and workforce development
- Payroll
- Clinical records and central patient administration services
- Corporate communication service
- Commercial services

In addition, Corporate Services has a major part in responding to statutory requirements and the requirements of

external stakeholders, such as the Ministry of Health and the community.

Strategic documents have been developed to guide:

- information systems development
- workforce development
- asset management

## Funding Division

The Funding Division employs people to plan and purchase (fund) health and disability services for the residents of the MidCentral District, including primary care, hospital and specialist services, mental health services, support services for people with disability (including residential services), and Maori health. For some services (eg Public Health and Disability Support Services for people under 65 years of age) the planning and purchasing is still undertaken by the Ministry of Health.

The Funding Division is a small unit, employing around 16 staff members (or 14 full time equivalents).

The Funding Division has responsibility for planning and purchasing health services and monitoring contracts valued at around \$345 million per annum. Its core activities are:

- determining the health and disability needs of the community
- operationalising national health and disability strategies in relation to local need
- funding health and disability services in the district
- involving the community through consultation and participation
- identifying service gaps and developing services accordingly
- undertaking service contracting and monitoring and evaluation of service delivery, including audits

The Funding Division is also responsible for arranging access to specialist services which are not delivered in the district. Government policies and priorities guide the planning and funding of health and disability services. Funding is also carried out within national policies, such as the Nationwide Service Framework. This framework sets out the criteria for access.

In funding services, MidCentral DHB strives to maintain and improve the health of its resident population within the constraints of the funding allocated.

Details of the services purchased by the Funding Division (including the volume schedule for the DHB's Provider Division) are outlined with MidCentral DHB's District Annual Plan which is published annually.

The Funding Division has developed a range of service plans which it is implementing. These include:

- Cancer Services Plan
- Cardiovascular Service Plan
- Child Health Plan
- Diabetes Strategy
- Health of Older Persons Plan
- Management of Depression Plan
- Maori Health Strategy
- Maori Health Workforce Strategy
- Maternity Services Strategy
- Mental Health and Addictions Service Strategy
- Oral Health Service Plan
- Primary Care Strategy
- Referred Services Management Strategy
- Respiratory Service Plan
- Secondary Care Strategy

## Provider Division

In addition to planning and funding most health services, MidCentral District Health Board also provides some services.

MidCentral District Health Board, through its provider division, operates both Enable New Zealand, a provider of disability information, support and assessment services, and, MidCentral Health – the district’s publicly owned provider of specialist hospital and associated health services.

The role of these two provider units is covered below.

### *MidCentral Health*

MidCentral Health provides specialist hospital and associated services.

It currently employs approximately 2,000 fte staff directly who work alongside staff employed via commercial contracts with other organisations (outsourced services such as catering).

Hospital inpatient and residential beds are currently available in three facilities: Palmerston North Hospital, Horowhenua Hospital (Levin), and Kimberley Centre (Levin). Outpatient and community services are also provided from these sites, as well as several other sites throughout the district, such as Feilding, Pahiatua and Dannevirke, where facilities are shared with local general practitioners.

Hospital and associated services costing around \$220 million per annum are provided by the DHB’s hospital service, MidCentral Health.

MidCentral Health’s prime purpose is to provide specialist:

- medical and surgical services
- maternity services
- child health services
- mental health and alcohol and drug services
- oncology services

- disability support services
- public health services
- associated clinical support and community-based services

These broad categories include a range of services.

MidCentral Health serves the Manawatu, Palmerston North, Horowhenua, Tararua districts, and the Otaki Ward of the Kapiti Coast district. Some specialist health services and public health services are also provided to neighbouring districts such as Whanganui and Taranaki. The Palmerston North based Regional Cancer Treatment Service provides medical oncology, haematology and radiation oncology services to people who live in a wide geographical area, including the bottom half of the North Island (except Wellington).

More than half of the District Health Board’s resident population live outside Palmerston North city, and therefore some distance from the district’s base hospital in Palmerston North. MidCentral Health recognises its responsibilities by providing visiting specialist and outreach community-based services to its rural communities and by establishing strategic alliances with rural-based primary providers, supported by access to centralised inpatient treatment and care at Palmerston North Hospital.

MidCentral Health is committed to meeting the government’s expectations around elective services, particularly in the three key policy areas of:

- patient flow management, which includes compliance with all Elective Services Patient Flow Indicators (ESPIs)
- level of service, ie achievement of contracted volumes, including those purchased as part of the national orthopaedic and cataract initiatives.
- order of service (prioritisation), ie assessment and prioritisation of people for surgery on a consistent basis, and

scheduling surgery according to patients' priority status.

#### *Enable New Zealand*

The District Health Board also owns, Enable New Zealand – a national provider of disability information services and the larger of the two providers of the Ministry of Health's Environmental Support Services (including funding for equipment, housing modifications and vehicles) for disabled people.

Enable New Zealand's core business is to manage the provision of:

- Environmental Support Services including equipment and housing modifications
- Generic Disability Information
- Information of disabilities and disability support services
- Management of Rehabilitation Equipment for ACC
- Needs Assessments for people with disabilities and older persons
- Co-ordination of, and referral to, a range of residential, community and disability support services

Enable New Zealand is contracted by the Disability Services Directorate, Ministry Of Health and ACC to provide a range of services to disabled people throughout New Zealand. These contracts include: provision of access to disability information and research, access to funding for long-term loan equipment, housing alterations, vehicle purchase and modifications, and in the MidCentral district, Supportlinks provides needs assessment and service coordination for disabled people.

Enable New Zealand, including SupportLinks, employs 94.5 staff across six sites.

#### Working Collaboratively

MidCentral DHB, on its own, cannot do everything to achieve health gains in these areas. It will take a combined effort - because everyone in the district has a part to play in creating a healthier community.

At an individual level, simple steps can be taken to improve health and avoid diseases that are largely preventable – things like exercising regularly, eating a healthier diet, quitting smoking and getting regular health checks. Self-responsibility for these lifestyle choices is essential, and will be encouraged by MidCentral District Health Board.

At a societal level, there are many factors which impact on the community's health and wellbeing, such as clean air and water, adequate housing, employment and the environment. Local councils, housing and social agencies, community groups, schools, businesses and many others also have a role in addressing the wider social, cultural, economic and environmental determinants of health. MidCentral DHB will therefore be working on an intersectoral basis with a variety of people and groups to advance health status in these priority areas.

MidCentral DHB will also be working closely with other providers of health and disability services, Primary Health Organisations and health professionals. Of particular importance will be ensuring new services are sustainable and adequately resourced. Some of the initiatives implemented to health the communities health status will result in increased demand for local providers and health professionals in the short to medium term, eg screening and early detection initiatives, management of chronic diseases (particularly in the primary sector). Implementation planning will ensure a phased, and progressive approach. It will also ensure care is provided across the continuum of health and wellbeing, and is delivered from the most appropriate setting(s).

### *DHB Partnerships*

MidCentral District Health Board works closely with other district health boards, particularly those within the central region.

- National DHB Collaboration  
Collaboration between DHBs occurs at all levels and across all Divisions, including CEOs, Chief Financial Officers, Human Resource, Quality and Information Systems management, as well as Medical Directors, Nursing Directors, and Chief Operating Officers.

New Zealand's 21 District Health Boards work together to progress common issues and projects. They have created an organisation, District Health Boards' New Zealand (DHBNZ), and it has an annual work programme. This is developed in conjunction with all DHBs and the Ministry of Health.

DHBNZ exists to support all district health boards and provide coordination of activity at a national level. DHBNZ maintains links with central agencies and works to confirm sector priorities through the Health Sector Workplan and the DHBNZ Annual Plan. DHBNZ is active in a range of areas including primary health, workforce development, industrial relations, funding and accountability, service frameworks, pricing and prioritisation tools, and information.

During 2006/07 MidCentral DHB will continue to support national DHB initiatives, including:

- service improvement project
- workforce development
- employee relations
- service framework development
- pay equity and employment project

- performance assessment and management framework

During 2004/05, a tripartite agreement between all DHBs, the Ministry of Health and the Combined Trade Unions is in place in respect of employment matters. MidCentral DHB is a partner to this agreement.

National multi-employer collective agreements (MECA) are in place for major occupational groups, such as nurses, and both junior and senior medical staff. MidCentral DHB is a party to these agreements.

- Regional DHB Collaboration  
The central region comprises six district health boards, including MidCentral, Capital and Coast (Wellington), Hawke's Bay, Wairarapa, Hutt Valley and Whanganui. Together, we are endeavouring to ensure that our respective communities enjoy not only a district approach to health care, but also a supportive regional configuration.

The six district health boards work collaboratively in a variety of ways, and they have developed principles for regional collaboration. Collaboration occurs in a number of ways, including:

- Regular scheduled meetings between the various staff groups of the DHB including the Chief Executives, Chief operating Officers and funding managers.
- A joint venture company – The Central Region Technical Advisory Service (TAS) – established by the five regional DHB's as an impartial advisory service specifically for the regions DHBs. It often undertakes project work that potentially affects the operations of one or more DHB's.
- Establishment of regional networks, such as the Central Regional Mental Health and Addictions Network, which

provide grassroots input into the DHBs' decision making

- A regional capital committee comprising the Chairpersons and CEOs of each DHB.
- A central health region Emergency Management Committee.

During 2006/07 MidCentral DHB will continue to support regional DHB initiatives, including:

- service development in respect of cardiology and renal services
- service planning for mental health through the Central Region's Mental Health and Addictions Network
- workforce development, including the establishment of a common web portal for recruitment, development of a regional brand, policy development, e-learning opportunities, and a regional Resident Medical Officer Unit
- establishment of a secure broadband network, which will link up all regional DHBs and enable sharing of key clinical and administrative information

- regional audit and quality improvement framework
- further development of a regional emergency management plan, with particular focus on pandemics (through the central regions Emergency Management Group)
- three-yearly health needs assessment
- continue to support regional service planning for mental health

### Annual Operating Measures

The measures put in place to determine the achievement of the annual operational activities cover all Divisions of the District Health Board, and all output classes.

Details of how they are calculated are provided in Appendix C.

A key annual operating goal is to achieve financial sustainability. The planning period covered by this document presents some challenges to achieving a break-even result for the Provider Division. A number of initiatives are planned to achieve financial sustainability for the Provider, and these are detailed in the Board's District Annual Plan 2006/07.

Measures: systems and processes, and operational performance

<i>Measure</i>	<i>Report Type</i>	<i>YTD Actual to 31.12.05 or latest data available</i>	<i>2006/07 Target</i>	<i>2007/08 Indicative</i>	<i>2008/09 Indicative</i>
<i>Governance/Corporate Function (Output class one)</i>					
1. Annual workplan with Manawhenua Hauora in place, and achieved	Narrative	N/a	N/a	N/a	N/a
2. Manawhenua Hauora representation on all Statutory Committees of Board	Narrative	N/a	N/a	N/a	N/a
3. Self review of governance processes undertaken annually and no issues of significance identified	Narrative	N/a	N/a	N/a	N/a
4. Annual external audit review ratings are satisfactory or above	Narrative	N/a	N/a	N/a	N/a
5. Achievement of organisation-wide budgets (as detailed in Appendix A)	Narrative	N/a	N/a	N/a	N/a
<i>Funding and Planning Function (Output class two)</i>					
6. Funding Division's prioritisation process is maintained and applied in a robust manner	Narrative	N/a	N/a	N/a	N/a
7. Service coverage gaps identified during annual planning round are addressed by year end.	Narrative	N/a	N/a	N/a	N/a

<i>Measure</i>	<i>Report Type</i>	<i>YTD Actual to 31.12.05 or latest data available</i>	<i>2006/07 Target</i>	<i>2007/08 Indicative</i>	<i>2008/09 Indicative</i>
8. Proportion of planned routine service provider audits completed by due date	Quantitative	100% (June 05)	100% (June 07)	100% (June 08)	100% (June 09)
<i>Provider Function (Output class three)</i>					
9. Reduced proportion of people waiting greater than six months for a first specialist assessment for medical and surgical services	Quantitative	21.4%	10%	0%	0%
10. Reduced proportion of people given certainty waiting greater than six months for surgery (post FSA)	Quantitative	20.1%	10%	0%	0%
11. Improved triage wait times:	Quantitative				
• Triage 1: % patients seen immediately		100%	100%	100%	100%
• Triage 2: % patients seen within 10 minutes		74.6%	80%	80%	80%
• Triage 3: % patients seen within 30 minutes		69.0%	75%	75%	75%
12. Sustained proportion of elective surgery undertaken as a day case	Quantitative	55.9%	≥55%	≥55%	≥55%
13. MidCentral Health's purchase unit volumes delivered, as detailed in provider arm volume schedule	Quantitative	99%	98% - 102%	98% - 102%	98% - 102%
14. Service development activities of Enable New Zealand have input from independent disability sector advisory groups	Quantitative	N/a	N/a	N/a	N/a

## Risks

MidCentral DHB continuously identifies its risks – both current and emerging – and implements strategies to minimise those risks. Some risks can be completely mitigated (ie controlled) and some are more difficult to mitigate. Many of the risks in the more difficult mitigation category are imposed from an external source, eg national wage settlements. Listed below are the high level risks that have been identified by the Board as a part of the planning process. The predominant source of these risks is external in the form of signalled (or potential) Government Policy shifts.

This risk assessment included potential barriers to the successful implementation of the many deliverables outlined in this document, and the Board's District Annual Plan for the same period. For each risk identified, the likelihood of it occurring has been assessed, together with the consequence, giving a risk rating. Means of mitigating or reducing each risk has also been considered.

### *Risk 1:*

The cost of delivering health and disability services increases at a greater rate than funding increases (future funding track).

Costs within MidCentral Health have risen at a rate of around 9% per annum over the last three years. At the same time, prices have increased at around 3% pa.

This situation is compounded by the closure of Kimberley Centre in June 2006, with the associated loss of revenue and overhead contribution.

The health sector has experienced a significant increase in personnel costs as a result of wage negotiations, and indications are that demand for further increases will continue across the sector.

The need for fiscal restraints in the health sector may impact MidCentral Health's

ability to provide services within its funding package, and to meet employer demands. As a result, MidCentral Health may be unable to deliver its contracted volumes. Industrial unrest may also result.

- Mitigation
  - The DHB has increased cost controls. In addition, a financial management plan has been established to reduce the cost structure of the provider division.
  - The fiscal restraints facing the health sector are being communicated to all stakeholders and the public at all levels.
  - Production levels will be closely monitored.
  - Industrial negotiating strategies will be developed to support wage negotiations.
  - Management of change processes will be used.
- Risk Rating: extreme

### *Risk Two*

Future service capability and capacity will be negatively impacted by delaying capital expenditure.

- Mitigation
  - MidCentral DHB will apply prioritisation criteria to planned capital expenditure.
  - A robust business case process will be used for capital expenditure proposals.
- Risk Rating: High

*Risk Three:*

Optimum staffing mix and levels are not achievable

- Mitigation
  - MidCentral DHB will implement its Workforce Plan, and participate in national workforce projects. It has developed a comprehensive Recruitment Strategy. Nurse Practitioner roles are being developed. MidCentral DHB also collaborates with other DHBs to ensure service coverage.
- Risk Rating: High

*Risk Four:*

Changes in population based funding results in a lesser share of total funding for MDHB

- Mitigation
  - MidCentral DHB participates in national funding and pricing projects. MidCentral DHB will determine the impact of any amendments to PBFF, and may need to change services, if appropriate, to offset any shortfall.
- Risk Rating: High

*Risk Five:*

Competition for capital investment funding restricts MidCentral DHB's ability to fund new initiatives.

- Mitigation
  - MidCentral DHB will attempt to self-fund capital projects where practical. All capital projects are prioritised to enable funds to be directed appropriately. An asset plan is in place, and supporting service plans are now being developed.
- Risk Rating: Moderate

*Risk Six:*

The Primary Health Organisation model is not able to deliver the primary health strategy.

- Mitigation
  - MidCentral DHB supports its Primary Health Organisations, and is investing in primary health care capacity and infrastructure for its district. New community-based services have been contracted to enable PHOs to shift toward a population health focus.
- Risk Rating: High

*Risk Seven*

Workforce shortages restrict our ability to fully utilise mental health blueprint funding.

- Mitigation
  - A workforce plan, and a district Mental Health Plan is in place.
- Risk Rating: High

*Risk Eight:*

Deinstitutionalisation of Kimberley Centre takes longer than planned.

- Mitigation
  - Contractual arrangements are in place to ensure the financial impact is cost neutral for MidCentral DHB and service delivery can continue as required. The DHB is collaborating closely with providers of community-based care to ensure a smooth transition.
- Risk Rating: High

*Risk Nine:*

Increasing inter district outflows.

- Mitigation
  - Strict monitoring of IDFs is in place within MidCentral DHB.
- Risk Rating: High

*Risk Ten:*

Insufficient primary care capacity impedes the implementation of the disease state plans.

- Mitigation
  - New funding directed at primary sector to support disease state implementation, including funding for new community-based positions.
- Risk Rating: High

*Risk Eleven:*

Capital cost escalation at Horowhenua Health Centre.

- Mitigation
  - Value management workshops have been held to ensure best value for money. Strong project management is in place. MidCentral DHB's risk exposure has been minimised through the contractual arrangements put in place.
- Risk Rating: High

*Risk Twelve:*

Expenditure related to disability support services is redirected to DHBs without revenue transfer

- Mitigation
  - MidCentral DHB is closely monitoring this issue, and maintaining dialogue with the Ministry of Health.
- Risk Rating: High

*Risk Thirteen*

Capital and Coast District Health Board's building programme disrupts access to its services.

- Mitigation
  - MidCentral DHB is liaising closely with CCDHB in this regard.
- Risk Rating: Moderate

*Risk Fourteen*

Inability to achieve Government's waiting time targets due to secondary care capacity restrictions.

- Mitigation
  - Additional funding allocated in 2004/05 and 2005/06 for spot purchasing.
  - Clinical Service Plan being developed for MidCentral Health aligning resources to service needs.
  - Regular monitoring and review of waiting lists and times.
  - Service provision aligned to resourced capacity.
- Risk Rating: High

*Risk Fifteen:*

Investment in new services or financial efficiencies do not produce the expected benefits/savings.

- Mitigation
  - Good project planning will be used to manage implementation, with milestones and monitoring arrangements, plus risk mitigation.
  - When monitoring identifies a project is not successful in achieving the benefits, it will be reviewed.
- Risk Rating: High

*Risk Sixteen:*

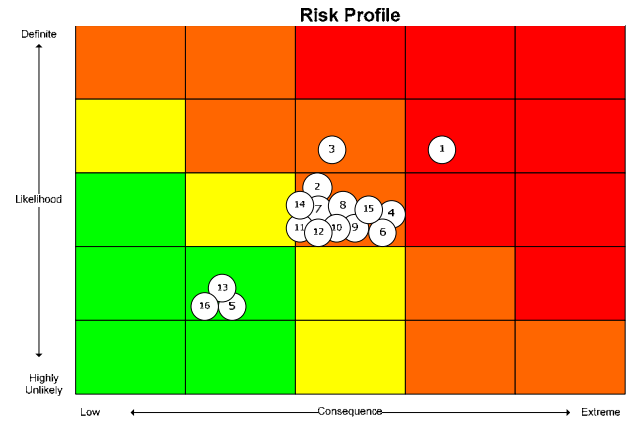
Failure of MidCentral DHB to respond/readiness to a pandemic episode.

- Mitigation
  - Pandemic plan being developed, and training provided to staff.
  - Local, regional and national collaborative initiatives underway.

- Risk Rating: Moderate

*Organisational Risk Profile*

The organisation's risk profile is as follows:



## Signatories

Signed on behalf of MidCentral District Health Board by:



.....  
Ian A Wilson  
Chairman



.....  
Murray Georgel  
Chief Executive Officer

30.6.06

## Appendix A, Financial Forecasts

The financial forecasts are based on maintaining a breakeven position. The move to population based funding has been beneficial for MidCentral District Health Board, providing funds for investment in new or enhanced services. This investment will occur in priority areas, such as primary health and disease state management. Controlling cost growth at or around the cost of inflation will require constant monitoring, as well as a number of cost saving initiatives.

Capital expenditure will – over time – remain within the annual level of depreciation. The long-term aim is maintain a breakeven situation over time, with continued new investment in priority areas. All capital expenditure planned is normal maintenance of capital assets and service capacity.

Capital expenditure will be funded from asset sales and internal resources (including retained earnings), with the exception of the Horowhenua Health Centre Project. Loan funding of \$9.7 million will be secured from the Crown Health Funding Authority for this project.

Output Class 1:  
Governing and Managing the District Health Board

<b>Statement of Financial Performance</b>					
<b>MidCentral DHB</b>					
(S'000's)	Actual 2004/05	Forecast 2005/06	Budget 2006/07	Budget 2007/08	Budget 2008/09
<b>Revenue</b>	<b>372,231</b>	<b>392,310</b>	<b>395,992</b>	<b>409,208</b>	<b>420,135</b>
% change		5.39%	0.94%	3.34%	2.67%
<b>less Expenditure</b>					
Personnel	129,447	131,491	127,791	131,978	136,161
Outsourced Services	13,412	14,495	14,958	15,463	15,939
Clinical Supplies	33,033	32,792	33,363	34,495	35,561
Infrastructure & Non-Clinical	47,577	45,343	44,426	44,229	45,285
Financing Charges	10,527	9,426	13,355	13,808	14,235
External Provider Payments	99,871	123,023	127,481	131,791	135,843
Inter-District Payments	29,763	34,597	36,076	37,301	38,456
Corporate costs	-	-	-	-	-
	<b>363,630</b>	<b>391,167</b>	<b>397,450</b>	<b>409,065</b>	<b>421,480</b>
% change		7.57%	1.61%	2.92%	3.03%
<b>Operating Surplus / (Deficit)</b>	<b>8,601</b>	<b>1,143</b>	<b>(1,458)</b>	<b>143</b>	<b>(1,345)</b>

<b>Statement of Financial Position</b>					
<b>MidCentral DHB</b>					
(S'000's)	Actual 2004/05	Forecast 2005/06	Budget 2006/07	Budget 2007/08	Budget 2008/09
Current Assets	55,615	61,927	59,855	61,954	64,028
Current Liabilities	55,200	56,012	57,075	58,164	59,281
Working Capital	415	5,915	2,780	3,790	4,747
Non current assets	108,196	147,777	153,844	152,617	149,955
Assets Employed	<b>108,611</b>	<b>153,692</b>	<b>156,624</b>	<b>156,407</b>	<b>154,702</b>
Non Current Liabilities	47,028	51,778	56,168	55,808	55,448
Equity	61,583	101,914	100,456	100,599	99,254
Funds Employed	<b>108,611</b>	<b>153,692</b>	<b>156,624</b>	<b>156,407</b>	<b>154,702</b>

**Statement of Cashflows**  
**MidCentral DHB**

(\$'000's)	Actual 2004/05	Forecast 2005/06	Budget 2006/07	Budget 2007/08	Budget 2008/09
Total Receipts	372,390	390,219	395,354	408,184	419,102
Total Payments	(343,153)	(382,329)	(386,171)	(396,366)	(408,653)
Operating Cash flow	29,237	7,890	9,183	11,818	10,449
Investing Cashflow	(4,468)	(19,030)	(16,908)	(10,448)	(9,131)
Financing Cashflow	(23,189)	5,886	4,590	(360)	(360)
Net Capital Cashflow	(27,657)	(13,144)	(12,318)	(10,808)	(9,491)
Net Cashflow	1,580	(5,254)	(3,135)	1,010	958
Opening Cash	1,277	2,857	(2,397)	(5,532)	(4,522)
Closing Cash	2,857	(2,397)	(5,532)	(4,522)	(3,564)

**Statement of Debt & Equity**  
**MidCentral DHB**

(\$'000's)	Actual 2004/05	Forecast 2005/06	Budget 2006/07	Budget 2007/08	Budget 2008/09
<b>Debt:</b>					
Facility Utilised:					
Working Capital	-	-	-	-	-
Long-Term Debt	47,098	51,848	56,438	56,078	55,718
	47,098	51,848	56,438	56,078	55,718
Facility Available:					
Crown	47,000	50,700	56,700	56,700	56,700
Private Sector	15,000	15,000	15,000	15,000	15,000
	62,000	65,700	71,700	71,700	71,700
Unused Facility	14,902	13,852	15,262	15,622	15,982
<b>Equity:</b>					
Opening	51,642	61,583	101,914	100,456	100,599
Net Surplus/(Deficit)	8,601	1,143	(1,458)	143	(1,345)
Revaluation Reserve	-	40,528	-	-	-
Movement in Trust Funds	1,340	(1,340)	-	-	-
Equity Injection	-	-	-	-	-
	61,583	101,914	100,456	100,599	99,254
Debt / Debt plus Equity ratio:	43.34%	33.72%	35.97%	35.79%	35.95%
YTD Interest Cover	5.42	4.30	3.41	3.87	3.49

**Statement of Contingent Liabilities****MidCentral DHB**

(S'000's)	Actual 2004/05	Forecast 2005/06	Budget 2006/07	Budget 2007/08	Budget 2008/09
Legal proceedings and disputes	-	-	-	-	-

**Statement of Commitments****MidCentral DHB**

(S'000's)	Actual 2004/05	Forecast 2005/06	Budget 2006/07	Budget 2007/08	Budget 2008/09
Capital Commitments	15,470	-	-	-	-
Operating Commitments					
Less than one year	25,773	25,773	25,773	25,773	25,773
One to two years	5,182	5,182	5,182	5,182	5,182
Two to five years	8,217	8,217	8,217	8,217	8,217
Over five years	-	-	-	-	-
	<b>39,172</b>	<b>39,172</b>	<b>39,172</b>	<b>39,172</b>	<b>39,172</b>
Total Commitments	<b>54,642</b>	<b>39,172</b>	<b>39,172</b>	<b>39,172</b>	<b>39,172</b>

**Statement of Financial Performance****Governance**

(S'000's)	Actual 2004/05	Forecast 2005/06	Budget 2006/07	Budget 2007/08	Budget 2008/09
<b>Revenue</b>	<b>4,079</b>	<b>5,217</b>	<b>4,275</b>	<b>4,415</b>	<b>4,553</b>
% change		<b>27.90%</b>	<b>-18.06%</b>	<b>3.27%</b>	<b>3.13%</b>
<b>less Expenditure</b>					
Personnel	6,626	6,901	7,045	7,284	7,509
Outsourced Services	324	695	571	589	606
Clinical Supplies	1	4	3	3	3
Infrastructure & Non-Clinical	5,416	5,044	4,300	4,443	4,578
Financing Charges	1,551	2,458	1,840	1,902	1,960
Corporate costs	(9,138)	(9,222)	(9,484)	(9,807)	(10,112)
	<b>4,780</b>	<b>5,880</b>	<b>4,275</b>	<b>4,414</b>	<b>4,544</b>
% change		<b>23.01%</b>	<b>-27.30%</b>	<b>3.25%</b>	<b>2.95%</b>
<b>Operating Surplus / (Deficit)</b>	<b>(701)</b>	<b>(663)</b>	<b>-</b>	<b>1</b>	<b>9</b>

Output Class 2:

Planning and Funding Health and Disability Services

<b>Statement of Financial Performance</b>					
<b>Funder</b>					
(S'000's)	Actual 2004/05	Forecast 2005/06	Budget 2006/07	Budget 2007/08	Budget 2008/09
<b>Revenue</b>	<b>305,271</b>	<b>332,635</b>	<b>345,921</b>	<b>359,248</b>	<b>368,774</b>
% change		<b>8.96%</b>	<b>3.99%</b>	<b>3.85%</b>	<b>2.65%</b>
<b>less Expenditure</b>					
Provider and Governance Division's	163,885	171,522	183,364	191,163	195,478
External Providers	99,871	123,023	127,481	131,791	135,843
Inter-District Outflows	29,763	34,597	36,076	37,301	38,456
	<b>293,519</b>	<b>329,142</b>	<b>346,921</b>	<b>360,255</b>	<b>369,777</b>
% change		<b>12.14%</b>	<b>5.40%</b>	<b>3.84%</b>	<b>2.64%</b>
<b>Operating Surplus / (Deficit)</b>	<b>11,752</b>	<b>3,493</b>	<b>(1,000)</b>	<b>(1,007)</b>	<b>(1,003)</b>

Output Class 3:

Delivery Health and Disability Services through Crown owned Hospital and Associated Services

<b>Statement of Financial Performance</b>					
<b>Provider</b>					
(S'000's)	Actual 2004/05	Forecast 2005/06	Budget 2006/07	Budget 2007/08	Budget 2008/09
<b>Revenue</b>	<b>226,766</b>	<b>225,980</b>	<b>229,160</b>	<b>236,708</b>	<b>242,286</b>
% change		<b>-0.35%</b>	<b>1.41%</b>	<b>3.29%</b>	<b>2.36%</b>
<b>less Expenditure</b>					
Personnel	122,821	124,590	120,746	124,694	128,652
Outsourced Services	13,088	13,800	14,387	14,874	15,333
Clinical Supplies	33,032	32,788	33,360	34,492	35,558
Infrastructure & Non-Clinical	42,161	40,299	40,126	39,786	40,707
Financing Charges	8,976	6,968	11,515	11,906	12,275
Corporate costs	9,138	9,222	9,484	9,807	10,112
	<b>229,216</b>	<b>227,667</b>	<b>229,618</b>	<b>235,559</b>	<b>242,637</b>
% change		<b>-0.68%</b>	<b>0.86%</b>	<b>2.59%</b>	<b>3.00%</b>
<b>Operating Surplus / (Deficit)</b>	<b>(2,450)</b>	<b>(1,687)</b>	<b>(458)</b>	<b>1,149</b>	<b>(351)</b>

## Appendix B, Statement of Accounting Policies

### Introduction

MidCentral District Health Board will comply with the accounting principles and policies promulgated by the Institute of Chartered Accountants of New Zealand and meet the requirements of the Financial Reporting Act 1993, the Public Finance Act 1989 and the New Zealand Public Health and Disability Act 2000. The Operational Policy Framework, disseminated from time to time by the Ministry of Health, sets out additional quasi-regulatory rules, including aspects pertaining to the financial operating environment, by which MidCentral District Health Board must also comply.

### Policy

A set of accounting policies shall be established that comply with the requirements of the Financial Reporting Act 1993; the Public Finance Act 1989 and Financial Reporting Standards promulgated by the Institute of Chartered Accountants of New Zealand.

### Purpose

To ensure that MidCentral District Health Board consistently adopts commonly accepted accounting principles and complies with legislative requirements.

### Statement of Accounting Policies:

#### *Reporting Entity*

MidCentral District Health Board is a Crown entity in terms of the Public

Finance Act 1989. 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 District Health Board, and associated entities, being Central Region's Technical Advisory Service Limited (TAS) (16.7% owned), and, Allied Laundry Services Limited (25% owned).

The financial statements of MidCentral District Health Board have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Public Financial Act 1989.

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

#### *Measurement Base*

The financial statements are prepared on an historical cost basis, modified by the revaluation of certain fixed assets.

MidCentral District Health Board follows the general accounting principles recognised as appropriate for the measurement and reporting of financial performance, financial position and cash flows. Reliance is placed on the fact that MidCentral District Health Board is a going concern.

#### *Accounting Policies*

The following accounting policies, which materially affect the measurement of financial performance, financial position and cash flows, are applied:

- Associate Companies  
MidCentral District Health Board holds

a 1/6 shareholding in TAS and participates in its commercial and financial policy decisions. Five other District Health Boards in the lower North Island hold the balance of the shareholding.

MidCentral District Health Board holds a 1/4 interest in Allied Laundry Services Limited. The principal activity of Allied Laundry Services Limited is providing laundry services to the MidCentral, Whanganui, Taranaki, and Hawke's Bay District Health Boards.

- The interest in associate companies is reflected in the financial statements on an equity accounting basis, to show the share of surpluses/deficits in the consolidated statement of financial performance and the share of post-acquisition increases/decreases in net assets in the consolidated statement of financial position.
- Goods and Services Tax  
The financial statements are prepared on a GST exclusive basis. Accounts Receivable and Payable are stated with GST included. Where GST is irrecoverable as an input tax, then this is recognised as part of the related asset or expense.
- Income Tax  
For the purposes of the Inland Revenue Act, District Health Boards are classified as public authorities under the New Zealand Public Health and Disability Act 2000. MidCentral District Health Board is therefore, as a deemed public authority, exempt from income tax under section CB 3 of the Income Tax Act 1994.
- Bequests and Special Funds  
Bequests and special funds received by the District Health Board are treated as revenue in the statement of financial performance. Subsequently, they are appropriated to Special Funds that form part of the owner's equity.
- Accounts Receivable  
Accounts receivable are stated at their estimated realisable value after providing for doubtful and uncollectable debts.
- Inventories  
Inventories are valued at weighted average cost price or net realisable value, whichever is lower.
- Investments  
Investments are stated at the lower of cost and net realisable value.
- Fixed Assets  
Following enactment of the New Zealand Public Health and Disability Act 2000, the assets of MidCentral Health Limited were vested in MidCentral District Health Board on 1 January 2001. The assets so vested are stated on the same measurement base as the former entity – original cost less accumulated depreciation (with the exception of certain land and buildings that had previously been re-valued to reflect service delivery decisions). The vested assets will continue to be depreciated over their remaining useful lives.
- Fixed assets purchased after 1 January 2001 are recorded at cost less accumulated depreciation. Cost includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.
- Crown accounting policies require that land and buildings be re-valued every three years to their fair value, as determined by an independent registered valuer by reference to their highest and best use, with additions between revaluation's recorded at cost. The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

- When a fixed asset is disposed of, any gain or loss is recognised in the Statement of Financial Performance and is calculated as the difference between the sale price and the carrying value of the fixed asset.
- Properties intended for sale are classified as current assets and are stated at net book value.
- Individual Fixed Assets with a cost less than \$1000 in value are expensed in the year of purchase.
- Any aids or appliances purchased by the District Health Board's Funding Division are expensed in the year of purchase. The Board has limited control over these assets as they are issued to individuals for as long as they require them.
- Depreciation of Fixed Assets  
Depreciation is provided on a straight line basis for all fixed assets other than freehold land, at rates calculated to allocate the asset's cost or valuation, less estimated residual value, over their estimated useful lives.

The useful lives of the major classes of assets are estimated as follows:

- Buildings: 1 - 80 years
- Building fit-out: 10-25 years
- Plant Equipment and Motor Vehicles: 3 - 20 years
- Information technology items: 3 – 8 years

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

- Employee Entitlements  
Provision is made in the statements of financial performance and financial position for the benefits due to staff under existing employment agreements for annual, long service

and conference leave on the basis of actual entitlements, and, additional long service leave and retirement gratuities on the basis of an actuarial assessment.

- Leases  
Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset are transferred to MidCentral District Health Board, are classified as finance leases and capitalised at the present value of the minimum lease payment. The leased assets and corresponding liabilities are disclosed and the leased assets are depreciated over the period MidCentral District Health Board or its subsidiary company are expected to benefit from their use.

Operating Lease payments, where the lessors effectively retain substantially all the risks and benefits of ownership of the leased items, are included in the determination of financial performance at equal instalments over the lease term.

- Financial Instruments  
Dealings in financial instruments are categorised as follows:

- On-Balance Sheet  
The organisation is party to financial instruments as part of its normal operations. These include Bills, Deposits and Bonds, which, at balance date, are valued at market value. Income and gains or losses on such are recognised in the Statement of Financial Performance.
- Off-Balance Sheet  
The organisation may enter into foreign currency forward exchange contracts to hedge foreign currency transactions. Any gains or losses arising from exposure to these contracts are offset against the related losses or gains on the assets or liabilities being hedged.

- **Foreign Currency Transactions**  
Transactions denominated in foreign currencies (other than forward contracts) are translated at the rate of exchange ruling as at the transaction date.  
Short term transactions covered by forward exchange contracts are measured and reported at the forward rates specified in the contracts.  
At balance date, foreign monetary assets and liabilities are translated at the closing rate and exchange differences arising from the translations are recognised in the Statement of Financial Performance.
- **Statement of Cash Flows**
  - “Cash” means the cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the organisation may invest as part of its day to day cash management.
  - “Investing activities” means those activities that relate to the acquisition and disposal of non current assets.
  - “Financing activities” comprises the change in equity and debt structure of the organisation.  
“Operating activities” includes cash received from all income sources of the organisation and records the cash payments made for the supply of goods and services.
- "The financial reporting standard about preparing prospective financial statements (FRS-42) says that the (prospective) forecast statements for an

upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

- **International Financial Reporting Standards**  
The prospective (forecast) financial statements in this SOI have been prepared in accordance with NZ GAAP. However, from 1 July 2007 a new set of accounting standards will be used in New Zealand called the New Zealand Equivalents to International Financial Reporting Standards (NZIFRS). This means that the financial statements at the end of the financial years 2007/08 and 2008/09 will be prepared in accordance with the new NZIFRS but the prospective (forecast) statements in this document are prepared using the previous standards (NZ GAAP).  
The prospective statements for 2007/08 and 2008/09 in this SOI do not comply with FRS-42 because the full impact of the NZIFRS has not yet been determined.

#### Changes in Accounting Policies

Changes in Accounting Policies will be submitted to and approved by the Board as and when deemed necessary.

## Appendix C, Performance Indicator Definitions

### **Eligible (target) Breast Screen Coast to Coast population screened**

*Rationale:* A key objective of the NZ Cancer Control Strategy, and MidCentral's Cancer Services' Plan, is to ensure effective screening and early detection to reduce cancer incidence and mortality. MidCentral Health is a lead provider of breast screening services for eligible women (aged 49 – 65 years), which promotes the programme and educates about breast cancer, as well as providing screening mammography, follow-up multidisciplinary assessment, counselling and support, and an information system to support the national BreastScreen Aotearoa programme. There is a need to increase the coverage rate for women in the North Island, and in particular Maori and Pacific women.

*Numerator:* Number of unique women screened during the year

*Denominator:* Total agreed target volume of women to be screened during the year

### **Eligible population screened (coverage rate) for cervical cancer**

*Rationale:* Cancer of the cervix is one of the most preventable of all cancers. It is estimated that about 90 per cent of cases of the most common form of cervical cancer could be prevented if women had smear tests every three years. MidCentral aims to reduce the incidence of, and mortality from, cervical cancer among women in the Manawatu-Wanganui district through its cervical screening programme. A high coverage rate of the target population is desirable.

*Numerator:* Number of women aged 20 -69 years who have had at least one cervical smear test

*Denominator:* Projected (2007) population of women aged 20-69 years

### **Radiation oncology treatment waiting times (Ref: POP-14)**

*Rationale:* Inclusion of this measure supports Implementing the New Zealand Cancer Control Strategy – a Government implementation priority for 2006/07. Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Waiting times for radiation oncology treatment have been chosen as a representative indicator of specialist treatment, and is an area with waiting time issues for patients. Radiotherapy is of proven effectiveness in reducing the impact of a range of cancers, and delay to radiotherapy is likely to lead to poorer outcomes of treatment.

Average waiting time from assessment to start of treatment (Four Patient Priority Categories)

*Numerator:* Total number of weeks between first specialist assessment and start of radiation oncology treatment for all patients commencing treatment during the period (by each Priority Category)

*Denominator:* Total number of patients who commenced radiation oncology treatment during

the period (by each Priority Category)

**Diabetes case detection (Ref: POP-01)**

*Rationale:* Identifying and registering people with diabetes enhance the ability to target services towards those at most need. This indicator measures the effectiveness of the healthcare system in identifying the population with diabetes.

*Numerator:* The number of unique individuals with type I or type II diabetes mellitus on a diabetes register, whose date of their free annual check is during the reporting period.

*Denominator:* The expected number of unique individuals to have type I or type II diabetes mellitus, as at the end of the reporting period.

**Diabetes management (Ref: POP-01)**

*Rationale:* The Diabetes Guideline states that target HbA1c levels should be preferably less than 7%, and tailored to the individual.

*Numerator:* The number of people with type I or type II diabetes mellitus on a diabetes register that had an HbA1c of equal to or less than 8% and at their free annual check during the reporting period.

*Denominator:* The number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period.

**Diabetic retinopathy screening (Ref: POP-01)**

*Rationale:* Diabetes is the most common cause of avoidable loss of vision of people of working age in developed countries. It is reliably detected by screening, and there are effective treatments.

*Numerator:* The number of people with type I or type II diabetes mellitus on a diabetes register that have had retinal screening or an ophthalmologist examination in the last two years, and the date of the free annual check is during the reporting period.

*Denominator:* The number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period.

**Discharge rate for asthma – children**

*Rationale:* Asthma is a common cause of admission of children to hospital. Approximately one-third of all asthma admissions are of children aged less than five years and one-quarter of all admissions in the five to 14 years age group. The prevalence of child asthma is similar across ethnicities, although Maori and Pacific children and children from lower socioeconomic families are over-represented in hospital admissions. The asthma prevalence rate is thought to be increasing by approximately 5 percent per year. While the indicator shows a steadily decreasing rate in asthma admission rates for European/Other children, it shows widening disparities between different population groups of children requiring hospitalisation with asthma – particularly for those under five years of age.

*Numerator:* Number of children aged 0 – 4 years who have been discharged from hospital with a diagnosis of asthma (by ethnicity)

*Denominator:* Projected population (2007) of DHB region aged under 5 years, by ethnicity  
Expressed as a rate per 1,000

*Numerator:* Number of children aged 5 – 14 years who have been discharged from hospital

with a diagnosis of asthma (by ethnicity)

*Denominator:* Projected population (2007) of DHB region aged 5 – 14 years, by ethnicity

Expressed as a rate per 1,000

Discharges are for people of each DHB region of domicile

### **Immunisation coverage rates (Ref: POP-12)**

*Rationale:* Improving immunisation coverage is a key component of the NZ Health Strategy: “to improve child health”. High immunisation coverage is necessary to prevent vaccine preventable diseases in individual children, and in the general population. The national immunisation target is 95% of children fully immunised at two years of age.

(1) Eligible newborns enrolled on the National Immunisation Register

*Numerator:* number of newborns born and enrolled during reporting period.

*Denominator:* number of children born during the reporting period.

(2) Immunisation rate of children up to 2 years

*Numerator:* number of children on the National Immunisation Register (NIR) up-to-date with immunisation on the day they turned a specified age (6, 12, 18, 24 months) during the reporting period.

*Denominator:* Number of children on the NIR who turned a specified age (6, 12, 18, 24 months) during the reporting period

(3) MMR immunisation rate of children aged 18 months

*Numerator:* number of children on the National Immunisation Register (NIR) up-to-date with MMR immunisation on the day they turned 18 months during the reporting period.

*Denominator:* number of children on the NIR who turned 18 months during the reporting period

### **Ethnicity data collection - PHOs**

*Rationale:* The Ethnicity Data Protocols for the Health and Disability Sector describes procedures for the standardised collection, recording and output of ethnicity data for the New Zealand health and disability sector. The protocols have been developed with input from a wide range of sector and government organisations. It is intended that the promotion of the Ethnicity Data Protocols and their adoption by the health and disability sector will improve the accuracy and consistency of ethnicity data over time, and across the different collections of data and various uses of data analysis within the sector. MidCentral DHB seeks to support PHOs in its district to implement these protocols to:

Help to measure how health services and policies are doing for specific populations

To improve relevant information to improve decision-making

Help to plan for policies, services and programmes for people who need them

*Numerator:* The number of PHOs collecting ethnicity data

*Denominator:* Total number of access funded PHOs in MidCentral’s district

**Maori health and disability service expenditure (Ref: HKO-04)**

*Rationale:* Referred to in the Operational Policy Framework (OPF) and as an action from He Korowai Oranga (Maori Health Strategy), Action 0.1.2 of Whakatataka. DHBs are expected to set targets to increase funding for Maori health and disability initiatives, taking into account their population profiles, needs assessments and the services currently available.

Measures:

- Actual expenditure on Maori Health Providers by GL code.
- Actual expenditure for Specific Maori Services provided within mainstream services targeted to improving Maori health by Purchase Unit (PU).
- Total actual expenditure for Iwi/Maori-led PHOs.
- Actual expenditure for mainstream PHO services targeted at improving Maori health.
- Total actual expenditure on DHB Maori Workforce or Provider Maori Workforce Development initiatives, which are not funded through the Maori Provider Development Scheme.

**Mental health access rates – Maori, Other and Total population groups (Ref: POP-08[a])**

*Rationale:* Improving the health status of people with severe mental illness is a population priority identified in the New Zealand Health Strategy. The New Zealand Mental Health Strategy documents set targets for access to treatment and support services for people of different age groups with severe mental illness. There is a need to measure progress towards the targets for access to treatment and support services identified in the New Zealand Health Strategy. There is a specific focus on Maori access rates. It is expected that setting explicit access targets and formally monitoring and managing the achievement of these targets will ensure improvements in access to mental health services, in line with funding increases.

*Numerator:* The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for:

child and youth aged 0-19, specified for each of the three population groups

adults aged 20-64, specified for each of the three population groups

older people aged 65+, specified for each of the three population groups

*Denominator:* Projected population (2007) of DHB region by age and ethnicity.

**Caries free children, aged 5 years (Ref: POP-05)**

*Rationale:* This outcome indicator measures the oral health status of children, in line with the NZHS population priority objective of improving oral health; to evaluate how health promotion programmes, and services such as Well Child and the School Dental Service (SDS), are influencing oral health status. The data itemised by ethnicity and fluoridation status enable DHBs to identify and target the pockets of disadvantage in their district where children's oral health status is poorest.

*Numerator:* The total number of caries free children at the first examination after the child has turned five years, but before their sixth birthday, examined by the DHB School Dental Service.

*Denominator:* The total number of children who have been examined in the age five group, in the year to which the reporting relates. This data should be collected at unit level, on first

examination after the child has turned five years of age, but before their sixth birthday.

*Reporting period:* Calendar year

**DMFT rates of Year 8 children (Ref: POP-06)**

*Rationale:* This outcome indicator measures the oral health status of children, in line with the NZHS population priority objective of improving oral health; to evaluate how health promotion programmes, and services such as Well Child and the School Dental Service (SDS), are influencing oral health status. The data itemised by ethnicity and fluoridation status enable DHBs to identify and target the pockets of disadvantage in their district where children's oral health status is poorest.

*Numerator:* The total number of permanent teeth of Year eight children, Decayed, Missing (due to caries) or Filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB SDS.

*Denominator:* The total number of children who have been examined in the Year eight group, in the year to which the reporting relates. Data on Decayed, Missing (due to caries) and Filled teeth should be collected at unit level.

*Reporting period:* Calendar year

**Completion of Service provider routine audits**

*Rationale:* The Funding Division of the DHB is required to undertake a programme of routine audits of service providers against Service Specifications for the services they are contracted to provide. A three-year programme has been established and is undertaken by an independent agency on behalf of the DHB.

*Numerator:* Number of Service Provider organisations who have been audited during the year

*Denominator:* Number of planned Service Provider organisations to be audited by year ended June 2007

**First specialist assessments waiting greater than 6 months (Ref: ESPI 2)**

*Rationale:* One of the 8 Elective Services Patient Flow Indicators (ESPIs) used to monitor how patients are managed while awaiting an elective (non-urgent) service. As a patient moves through the system there are a number of key decision points — from when people are first referred as outpatients through to when decisions are made as to whether or not treatment is appropriate and/or available. The ESPIs demonstrate the extent to which Government's targets in respect of patient flow processes are being met.

All patients accepted for an FSA should be seen within six months of the date of referral. The goal is to have no patients waiting more than six months for an FSA.

A First Specialist Assessment is the assessment undertaken by a hospital specialist following referral by a patient's primary care practitioner, usually a general practitioner (GP).

*Numerator:* Number of patients seen for their FSA within 6 months of their referral date (all specialities)

*Denominator:* Number of patients referred for a FSA (all specialities)

**People given certainty of treatment waiting greater than 6 months (Ref: ESPI 5)**

*Rationale:* All patients given a commitment to treatment should receive it within six months. The goal is to ensure no patients with this status remain untreated after six months.

Certainty means that the patient is told that they will receive treatment within the next six months and that the treatment date will be provided closer to the time.

*Numerator:* Number of patients who have had their surgical procedure within 6 months of the date of being given certainty (all surgical specialties)

*Denominator:* Number of patients who have been given certainty of (surgical) treatment (all surgical specialties)

**Triage wait times (Ref: Hospital Benchmark Information)**

*Rationale:* Waiting time relative to triage category is an important performance indicator for an Emergency Department. Where Emergency Department resources are chronically restricted, or during periods of transient patient overload, staff should be deployed so that performance is maintained in the most urgent categories. The Australasian Triage Scale (ATS) is used for rating clinical urgency; whilst the ATS is primarily a clinical tool for ensuring that patients are seen in a timely manner, commensurate with their clinical urgency, it also a useful casemix tool. Whilst there are 5 triage categories, the measures here focus on Triage categories 1, 2 and 3. Waiting time is the difference between the time of arrival and the time of initial medical assessment and treatment.

- Triage 1

*Numerator:* Number of patients allocated ATS Triage Category 1 who are attended to immediately

*Denominator:* Total number of patients attending the Emergency Department triaged to ATS Category 1

- Triage 2

*Numerator:* Number of patients allocated ATS Triage Category 2 who are attended to within 10 minutes

*Denominator:* Total number of patients attending the Emergency Department triaged to ATS Category 2

- Triage 3

*Numerator:* Number of patients allocated ATS Triage Category 3 who are attended to within 30 minutes

*Denominator:* Total number of patients attending the Emergency Department triaged to ATS Category 3

**Day case elective surgery**

*Rationale:* Elective surgical procedures undertaken on a day-case basis are generally more cost efficient than the same procedures undertaken on an inpatient basis. The costs of holding a patient overnight mean that procedures should be undertaken on a day-case basis wherever possible.

*Numerator:* Number of elective procedures undertaken on a day case basis during the period

*Denominator:* Number of total elective procedures undertaken during the period

**Delivery of purchase unit volumes**

*Rationale:* An indicator for monitoring and managing output production against contracted target volumes, purchased on an annual basis, as identified in the Provider Arm Volume Schedule. This is consistent with the expectation that DHB Providers deliver services to meet contract specifications; providing a measure of actual activity compared to expected activity. In this case it is assumed that the sum of all contracts is the DHB Provider Arm's (MidCentral Health's) expected and budgeted activity level.

*Numerator:* Total dollar value of actual outputs for all contract types produced during the year

*Denominator:* Total dollar value of contracted outputs, during the year.

## Appendix D, Allied Laundry Services Limited's Statement of Accounting Policies

### A. 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.

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

#### *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.

#### *Taxation*

In accordance with the Financial Reporting Order 1994, the company follows the taxes payable method for accounting for income tax.

### B. Particular Accounting Policies

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

#### *Inventories*

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

#### *Sales*

Sales 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.

#### *Accounts Receivable*

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

#### *Depreciation*

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

#### *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.

### *Fixed Assets*

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.

### *Statement of Cash Flows*

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

- a. 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.
- b. 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.
- c. 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.
- d. Operating activities includes all transactions and other events that are not financing or investing activities.
- e. 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.

### *Financial Reporting Standards*

The financial reporting standard about preparing prospective financial statements (FRS-42) says that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

### *International Financial Reporting Standards*

The prospective (forecast) financial statements in this SOI have been prepared in accordance with NZ GAAP. However, from 1 July 2007 a new set of accounting standards will be used in New Zealand called the New Zealand Equivalents to International Financial Reporting Standards (NZIFRS). This means that the financial statements at the end of the financial years 2007/08 and 2008/09 will be prepared in accordance with the new NZIFRS but the prospective (forecast) statements in this document are prepared using the previous standards (NZ GAAP). The prospective statements for 2007/08 and 2008/09 in this SOI do not comply with FRS-42 because the full impact of the NZIFRS has not yet been determined

### C. Changes in Accounting Policies

There has been no material changes in the accounting policies applied during the period covered by these financial statements.

## Appendix E, Allied Laundry Services Limited's Financial Statements

Based on proposed budget for 2006/07

### **Allied Laundry Services Ltd**

<b><u>Statement of Financial Performance</u></b>	<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
Revenue	6,080	5,762	5,814
<b><u>Expenditure</u></b>			
Processing	-3,799	-3,663	-3,684
Service Items	-994	-881	-919
Delivery	-700	-676	-653
Selling / Administration	-196	-209	-206
Overhead Allocation	-325	-325	-325
Total Linen Supply Expenditure	-6,014	-5,754	-5,787
Linen Supply Surplus	66	8	27
Product Sales	20	38	23
Cost of Sales	-11	-36	-11
Product Sales Surplus	9	2	12
Non-operating Expenditure	-75	-8	-10
Net Surplus Before Tax	0	2	29
Income Tax Benefit	177	0	0
Net Surplus After Tax	177	2	29

**Allied Laundry Services Ltd****Statement of Financial Position**

	<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
Current Assets	620	1,001	1,213
Current Liabilities	633	757	780
Working Capital	-13	244	433
Non current assets	3,333	2,953	2,693
Assets Employed	<u>3,320</u>	<u>3,197</u>	<u>3,126</u>
Non Current Liabilities	415	290	190
Equity	2,905	2,907	2,936
Funds Employed	<u>3,320</u>	<u>3,197</u>	<u>3,126</u>

**Allied Laundry Services Ltd****Cash Flow**

	<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
Total Receipts	7,689	6,291	5,837
Total Payments	-5,133	-4,967	-4,699
Operating Cash flow	<u>2,556</u>	<u>1,324</u>	<u>1,138</u>
Investing Cashflow	-1,044	-770	-849
Financing Cashflow	-1,285	-150	-100
Net Capital Cashflow	<u>-2,329</u>	<u>-920</u>	<u>-949</u>
Net Cashflow	<u>227</u>	<u>404</u>	<u>189</u>
Opening Cash	<u>-222</u>	<u>5</u>	<u>409</u>
Closing Cash	<u>5</u>	<u>409</u>	<u>598</u>