

Central Region's Technical Advisory Services Limited

Statement of Intent

1 July 2011 – 30 June 2014

Contents

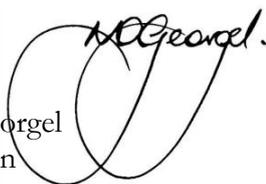
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1. DATE AND AUTHORISATION

This Statement of Intent (1 July 2011 – 30 June 2014) is dated 20 June 2011.

For and on behalf of the Board of Directors who authorise the issue of this Statement of Intent on 20 June 2011.

Murray Georgel
Chairperson



Kevin Snee
Director



STATEMENT OF INTENT

CENTRAL REGION'S TECHNICAL ADVISORY SERVICES LIMITED

2. INTRODUCTION

This Statement of Intent has been prepared in accordance with Section 139 (1) of the Crown Entities Act 2004.

The Statement sets out the intentions and performance objectives of the Central Region's Technical Advisory Services (CRTAS). It covers a three-year period from 1 July 2011 to 30 June 2014.

The financial statements of CRTAS have been prepared in accordance with the requirements of the Companies Act 1993, the Financial Reporting Act 1993, the Public Health Amendment Act 2004 and the Public Finance Act 1989.

3. BACKGROUND

Central Region's Technical Advisory Services Limited (CRTAS), is a multi parent subsidiary company owned by the Central Region DHBs; namely Capital & Coast, Hutt Valley, Wairarapa, MidCentral, Whanganui, and Hawke's Bay DHBs.

The purpose of CRTAS is to support DHBs in improving health services in the Central Region.

Our *vision* is to bring together ideas, information and people in order to create innovative, regional solutions that will lead to lasting improvements in access, quality, sustainability and efficiency of health services. We express this vision as: *Innovation through Collaboration*.

Over the next three years, CRTAS will help Central Region DHBs achieve a regionally coordinated system of health service planning and delivery. To achieve this strategic intent, CRTAS will work to enhance collaboration amongst the Central Region DHBs and enable them to:

- Plan and develop subregional and regional services
- Share knowledge and resources
- Undertake joint service improvement projects
- Continuously improve service delivery throughout the region

The values of CRTAS are:



4. CRTAS GOVERNANCE

CRTAS is a separate entity, established as a limited liability company under the Companies Act 1993. CRTAS has a Board of Directors comprising six members, being the Chief Executive Officers (CEOs) of each of the six shareholding DHBs, one of whom is appointed as the Chairperson. The Board operates with a quorum requirement of two-thirds of all directors and it has full authority to make all decisions and take all actions concerning the Company, other than those that require shareholder approval.

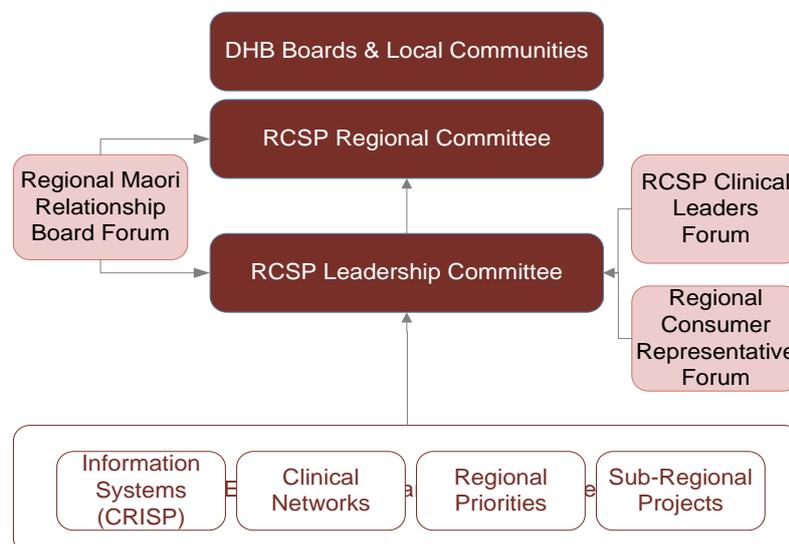
The Board appoints the General Manager who is accountable for the management of the Company in accordance with directions and requirements specified by the Board.

CRTAS has developed a work programme, which has been approved by the CEOs and Directors.

5. CENTRAL REGION GOVERNANCE

The Central Region DHBs have agreed a Regional Decision making structure comprising a Regional Clinical Services Programme (RCSP) Regional Committee and a Regional Clinical Services Programme (RCSP) Leadership Committee.

Figure1: Regional Decision Making Structure



RCSP REGIONAL COMMITTEE (RRC)

The Central Region DHBs have developed a Regional Services Plan. The RCSP Regional Committee (RRC) will provide regional governance and decision making on behalf of the Central Region DHBs to promote the achievement of the RSP.

In signing up to the RSP the six DHB Chairs and Boards have committed to the following:

1. The RSP is the foundation for all Central Region DHBs to agree specific regional health service arrangements that are sustainable and affordable. The approach requires DHBs not to let institutional arrangements impede regional and sub-regional collaboration and to make substantial progress in the key areas of collaborative structures, processes and culture. In the best interests of the greater good of the population of the Central Region, the six DHBs agree to pool part of their planning as part of an ongoing RSP process. As a region, if we cannot make sufficient progress in collaborative arrangements then we accept that change in our institutional arrangements may need to occur.
2. The RSP is the overarching strategy for all Central Region DHB Annual Plans for 2011/12 onwards. This includes agreed common Annual Plan assumptions, clarity about planned inter-district activity flows, changes to service models (including workforce appointments) and capital investment.
3. In recognition of the Treaty of Waitangi, the RSP will be developed in partnership with Māori in areas of service and policy development, and implementation to ensure equal standards of healthcare, equality of access to healthcare and equity of health outcomes for Māori.

RRC membership

The RRC is composed of the following seven members:

- An Independent Chair (currently vacant)
- Either the Chair or the CEO, from each DHB. The other is able to attend as the alternate. In the absence of the Chair or CEO a person acting in the formal capacity of Board Chair or CEO may attend as the alternate.
- The Chairperson of the RCSP Leadership Committee is invited to attend the RRC meetings, but is not be a member of the committee.

RRC responsibilities and decision making

The RRC will make decisions that have material regional implications including:

- Infrastructure investment.
- Changes to clinical services including workforce alignment.

The RRC will take overall responsibility for the implementation of the RSP. DHB Chairs and CEOs will have delegated authority from their Board to act (where permitted in law) and an obligation to regularly report progress against the plan. Decisions will be made by consensus, to reach a decision for the collective good of the Central Region population.

RCSP LEADERSHIP COMMITTEE

RRC decisions will be informed by expert recommendations from the RCSP Leadership Committee (RLC), a group chaired by a clinician, and representative of different disciplines and DHBs. The RLC is a clinical and managerial partnership that will provide direction to the programme and ensure regional proposals are of the highest quality and have undergone rigorous review. As well as clinicians the RLC includes people with expertise in Māori and Pacific Peoples health and health inequalities, and a consumer representative.

6. NATURE AND SCOPE OF ACTIVITIES

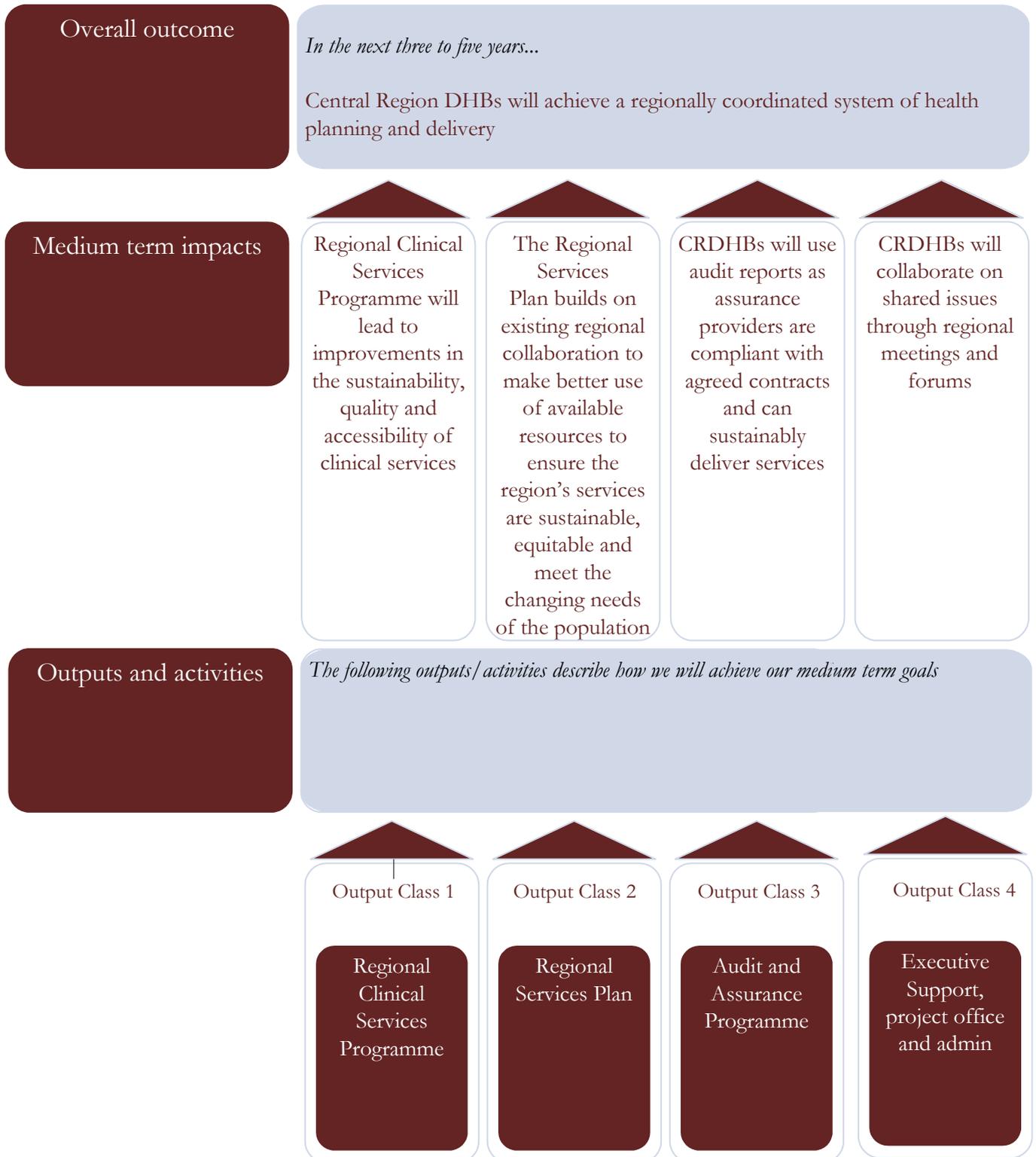
CRTAS has four well-established support service areas and one new area (Regional Services Plan) of support as follows:

1) Regional Clinical Services Programme	Regional Clinical Services Programme; Vulnerable services projects, Clinical networks; and analytical support.
2) Regional Services Plan	Assist in the development, promotion and implementation of the Central Regions' Regional Service Plan
3) Audit and Assurance programme	Management, administration and delivery of the routine audit programme (contractual compliance), special audits, service and organisational reviews of health service providers.
4) Executive Support, Projects and administration	Support for regional executive forums and RCSP Committees; project coordination and administration.
5) Corporate (General Manager's Office)	Support for the internal needs of the organisation including financial, human resources, and IS support.

7. CRTAS OUTCOMES FRAMEWORK

Our outcomes framework (below) based on strategic priorities.

Figure 2: CRTAS Outcomes Framework



8. TAS WORK PROGRAMME

The Central Region DHBs are committed to a regionally coordinated system of health service planning and delivery that will lead to ongoing improvements in the sustainability, quality and accessibility of clinical services in the Central Region. CRTAS has developed a programme of work for 2011/2012 that is aligned with the outcomes framework. A description of the work programme follows:

1. Regional Clinical Services Programme (RCSP)

1.1. Cardiac Network

The goal of the cardiac network is to enhance collaboration and integration of cardiac services throughout the Central Region by improving equity of access for services, supporting improvements for patients through clinical standards and reducing variation in clinical practice, promoting clinical and financial sustainability for services, and providing opportunities for collaborative learning and development. The focus for 2011/12 includes monitoring and reporting on intervention rates for elective cardiac services, including monitoring for ethnic disparities in interventions, promotion of more patient focussed care pathways between primary and secondary care for managing heart failure and atrial fibrillation, and improve provision of ECGs in primary care.

1.2. Mental Health and Addictions Network (MHAN)

The overall goal of the MHAN programme is to develop and implement overarching regional models of care and high level pathways. The intention is to better meet population needs, improve equity of access, reduce inefficiencies and reconfigure regional and local services to improve outcomes and value for money. This will include stock takes of regional and local services and the application of sustainability tools to guide the reconfiguration of services. Specific models of care will be developed and implemented, for the regional rehabilitation services. This will include improved integration with local services and a shift in focus from institutional care to more community based care. The programme of work will also include: the implementation of the regional detoxification model of care; the application of the CRISP project for mental health and addiction and address the Ministry of Health requirement that the region achieves the goal of becoming “co-existing disorders responsive”. This will entail the development of integrated systems and assessment tools and regional capability development.

1.3. Renal Network

The goal of the Renal Network is to recommend, communicate and give effect to the initiatives outlined in the *Renal Services in the Central Region: Strategic Direction and Opportunities for Regional Action* (November 2007). The Renal Network commenced in May 2008 with the implementation plan (5 project scopes) agreed in November 2008. The focus in 2011/2012 is to recommend and implement a renal IT solution for the Central Region, to investigate and recommend potential opportunities to

contain rising costs of Chronic Kidney Disease; develop sub- regional business cases for the implementation of satellite haemodialysis units and commence planning; to implement policy recommendations designed to provide support to patients and their families and to monitor improvements to access to renal transplantation in the Central Region.

2. Regional Services Plan

The aim of the RSP is to build on existing regional collaboration to make better use of available resources to ensure the regions services are sustainable, equitable and met the changing needs of the population. The Central Region has agreed on 11 priority areas for action in 2011/12 which are aligned with the Ministers letter of expectations. System linkages are reflected in the DHB local plans, and are strengthened by each of the Chief Executives taking a lead sponsorship role for a regional implementation plan on behalf of the other DHBs. The following are the regional priorities for action on 2011/12:

- **Meeting the National Health Targets:** improving services and reducing waiting times through improved access to elective services and shorter waiting times for cancer services,
- **Strengthening Vulnerable Services:** including Regional Radiology and Older Adults and Rehabilitation,
- **Key Regional Enablers:** strengthening clinical leadership and clinical governance in partnership with consumer involvement as a fundamental driver of improved patient care, the Central Region Information Systems Plan (CRISP), capital asset management, shared support services (non – clinical), and transport and accommodation,
- **Sub – Regional Activity:** for Capital & Coast, Hutt Valley and Wairarapa DHBs, and the Central Alliance between MidCentral and Whanganui DHBs. This is being delivered by sub regional teams.

2.1. Strengthening Services Projects

2.1.1. Radiology

The radiology services in the Central Region are a vulnerable service due to workforce issues, poor IT infrastructure and excessive wait times. The goal of the service is to provide a consumer focussed radiology service that is high quality, timely, affordable and therefore sustainable. The focus in 2011/12 seeks to improve the quality of service by developing and applying regional standardising prioritisation criteria and key performance indicator monitoring; work towards improving the region's IT infrastructure by procuring and deploying a regional Picture Archiving Communication System (PACS) archive and Radiology

Information System (RIS); developing and applying regional evidence based referral guidelines and undertake work to improve the regional radiology workforce.

2.1.2. Older Adults and Rehabilitation

The overarching strategy for Older Adults in 2011/2012 is to develop and implement a model of care for an ageing population which is planned regionally and implemented locally, which reduces reliance on hospital based and residential care services.

Key work streams supporting the strategy for Older Adults are:

- Investigate and pilot an outreach model of care to support clinical decision making for remote providers or provide specialist input into care planning, including through the use of technology to support service delivery
- Develop and pilot shared care plans which promote cross sector communication and care planning, to reduce unnecessary hospital admissions for complex patients
- Develop sub-regional work streams to review prescribing patterns with a view to reducing unnecessary pharmaceutical intake and develop a better understanding of the key drivers for frequent readmissions for complex patients
- Implementation of the Dementia Behaviour Support Advisory Service to support clinicians to develop skills in early assessment and treatment of dementia and up skill the rest home sector in the management of clients with dementia
- Investigate at a local and regional level why Māori and Pacific Islanders are not accessing aged residential care and explore if there are opportunities for improvement

2.2. Key Regional Enablers

2.2.1. Strengthening Clinical Leadership and Clinical Governance

The Central Region is facing key challenges, with an ageing population, increasing expectations on the quality and safety of clinical services, a continued shift of services to different settings, increasing use of technology and ongoing constraints to funding. Clinical Governance is the oversight of clinical systems and processes, with monitoring and alteration where required, in order to ensure and improve the quality of health services. Clinical Leadership is integral to Clinical Governance but extends further into all aspects of the governance of health services. Clinical Leadership is well proven to be a fundamental driver of improved health services.

The focus of this plan is to:

- Improve quality and effectiveness of care for patients, their whānau and family, and the wider community by aligning clinical governance systems across the Central Region DHBs to provide greater support to sole practitioners, applying credentialing to two services and taking opportunities for joint appointments
- Develop strong Clinical Leadership and Clinical Governance supported by a Regional Clinical Board

2.2.2. Capital Asset Management

The goal of the Central Region is to develop a more coordinated and affordable approach to capital and asset management across the region through the establishment of a regional capital committee with the aim of reducing duplication and waste and freeing up resources.

A regional approach to capital investment is more likely to secure a sustainable approach to service and capacity development. This is especially relevant for any future service changes. Capital and asset planning will be undertaken within the context of service planning with a regional and national overview to ensure that expenditure plans will:

- address regional requirements and health needs
- ensure future investments are coordinated
- maximise the health dollars available to the region to spend.

All of the projects comprising the regional work programme utilise best practice project management methodology. CRTAS support for each of the projects includes project management and project facilitation. Each RSP project, Clinical Network and Forum has a CEO sponsor.

A communications plan has been drafted to facilitate communication of the RSP and other work programmes across the region.

Work programmes included in the RSP but not allocated to TAS at the time of writing are the Central Region Information Systems Plan (CRISP) and non clinical shared support services. TAS is currently scoping the Transport and Accommodation and improving access to Elective services projects for the region. After the scoping exercise resources for each of these work programmes will be allocated.

Preliminary discussions have also commenced to establish if TAS should host the core functions of DHBNZ. Financial resources and consequences have not been factored into the SOI at this time.

3. Audit and Assurance Programme

Since 2002, CRTAS has undertaken the region's routine audit programme and a range of ad hoc special audits, service and organisation reviews. The programme is limited to auditing of DHB contracted providers in the health sector. An annual list of providers is determined by the Planning and Funding divisions in each of the respective DHBs. The DHBs utilise a risk based process for the selection of the providers into the routine programme, which includes an annual reassessment using the agreed tools developed by CRTAS. Routine audits and PHO reviews comprise a standardised approach for providers based on internationally recognised auditing standards. However, the content of special or focussed audits will vary based on the issues raised and range from forensic financial or clinical reviews, to complaints investigations and benchmarking reviews. The annual routine

(and follow-up) audit programme comprises 65-weighted audits. The objectives of the routine reports are;

- to provide the relevant DHB and provider organisation with findings on how the provider is complying with the DHB contract(s) and other relevant criteria and recommendations for improvement in any areas of non-compliance
- to ensure that audit findings accurately reflect current practice at the provider
- to advise the relevant DHB of any requirement for special audits or follow-up audits for the provider
- to ensure that the audit occurs within set timeframes and budgets as specified by the Project Sponsor and Programme Manager
- to ensure a robust audit process is followed

At a Programme level CRTAS aims to offer DHBs;

- Advice on good practice in contract management
- Trends in Planning and Funding, provider and sector performance
- Identification of specific issues or risks to DHBs within this group of providers.

4. Executive Support, Project and Administration

CRTAS has historically supported a range of Executive groups and project-related committees with secretarial and project administration support. These include: The RCSP Regional Committee, The RCSP Leadership Committee, the Clinical Leaders Forum, and other groups such as the Central Region DHB Māori Relationship Board Forum and the Consumers Representative Forum; all of which are supported through CRTAS.

The Regional Executive Groups, RCSP committees, project related committees, and forums require secretariat services and project management and facilitation where appropriate. Importantly, the working papers of all groups need to be aligned with the regional decision making framework in a timely and logical sequence to ensure duplication is minimised, and that actions and decisions are clearly documented and communicated to key stakeholders.

Meeting schedules for all relevant Executive groups, RCSP Committees, and project committees have been established for 2011/12 to expedite decision making. CRTAS provides secretariat support for many of the following DHB groupings:

- Chairs and CEOs – supported by CRTAS
- CEOs – supported by CRTAS
- General Manager’s Planning and Funding – supported by CRTAS
- Chief Operating Officers- supported by CRTAS
- Chief Medical Officers and Directors of Nursing – supported by CRTAS
- Chief Financial Officers

- Chief Information Officers
- General Manager's Māori Health
- General Manager's Human Resources

CRTAS in addition provides support to the RCSP Regional Committee and RCSP Leadership Committee, and for the Central Region DHB Māori Relationship Board Forum and Consumers Representative Forum.

Each Executive group has a CEO sponsor as follows:

Executive Group	CEO Sponsor
Chief Financial Officers	Graham Dyer
Chief Information Officers	Tracey Adamson
Chief Medical Officers / Directors of Nursing	Murray Georgel
Chief Operating Officers	Kevin Snee
GMs Human Resources	Julie Patterson
GMs Māori	Julie Patterson
GMs Planning and Funding	Julie Patterson

5. Corporate (General Manager's Office)

The Corporate (General Manager's Office) seeks to support CRTAS employees and DHBs to successfully deliver the regional work programme with the most effective tools, systems and processes. Various internal projects include communications and website review, office refurbishment, performance management framework, review of operational procedures and policies, and building a better workplace.

9. PERFORMANCE AND MONITORING FRAMEWORK

The monitoring and evaluation of the RSP and other work programmes will be undertaken using a regional performance framework. The approach to improvement will emphasise optimising performance, delivery of high quality services, improving consumer experiences and achieving value for money. Performance will be monitored and reported through the regional governance mechanisms that are in place, and:

- lead CEOs will be responsible for the delivery of their regional work plans
- assurance of progress against milestones will be reported quarterly to the Regional Leadership Committee and RCSP Regional Committee
- any mitigating actions required will be detailed to maintain or improve our performance
- we will monitor our plans for their impact on our Māori, Pacific People and other high needs groups to ensure equity in access to treatment or interventions, and improved outcomes
- we will explore developing consumer experience indicators as part of putting consumers at the centre of services and pathways.

10. STATEMENT OF FORCAST SERVICE PERFORMANCE

CRTAS does not directly provide health services but rather supports the DHBs to enable them to focus on service delivery. As a consequence the activity undertaken by CRTAS does not readily map to the output classes proposed for DHB SOI reporting. We have used the output classes of Regional Clinical Services Programme (RCSP), Regional Services Plan, Audit and Assurance Programme, and Executive support, project and administration which guide the work programme. It is planned to develop the base line measures for all key priority areas.

Statement of Service Performance			
Output class	Impacts / Objectives <i>What are we trying to achieve?</i>	Outputs / Activities <i>How are we going to achieve it?</i>	Key Performance Measures <i>How will we know it's been achieved?</i>
1. Regional Clinical Services Programme	<p>Work programmes will be developed that enhance the patient care experience for people in the Central Region, in some or all of the following ways:</p> <ul style="list-style-type: none"> • Improved access to services • Improved quality of services delivered/received • Improved sustainability of services • Improved efficiency of services delivered/received 	Refer to work programmes detailed below	All projects will show evidence on completion of improvements to some or all of: access, quality, sustainability and efficiency
1.1. Cardiac network programme			
1.1.1. Standardised Intervention Rates for cardiac Procedures	SIR for cardiac procedures in the central region achieve the national average	Investigate varying SIR rates for cardiac procedures and where appropriate recommend changes for service delivery to best practice standards	SIR measured quarterly in KPI dashboard and to DHBs via regional Framework

Statement of Service Performance			
Output class	Impacts / Objectives <i>What are we trying to achieve?</i>	Outputs / Activities <i>How are we going to achieve it?</i>	Key Performance Measures <i>How will we know it's been achieved?</i>
1.1.2. Maori inequalities project	To action research why inequalities in revascularisation are prevalent in the region	Implement phase 2 of the Maori inequalities project. Work with 1 DHB to action research in the light of the research to understand factors driving disparities	Ongoing monitoring of Maori health indicators in KPI dashboard reported through Regional Framework
1.1.3. Heart Failure and Atrial Fibrillation	Improved management of heart failure and atrial fibrillation across primary secondary interface resulting in reduced hospitalisations	Focus on 2 pathways of care – primary/ secondary care a) heart failure b) atrial fibrillation	Delivery of two collaborative care workshops
1.1.4. Acute Coronary Syndrome	Improved management of ACS across the region in line with evidence based practice	Audit data of ACS management	Complete audit of management of ACS across the region by June 2012
1.1.5. Cardiac Technician Training	Standardise Cardiac technician training into Private hospitals/facilities	Expand cardiac tech training to private clinics/ hospitals	Number of training sessions delivered in private clinics/ hospitals
1.2. Mental health network (MHAN) programme			
1.2.1. Regional addiction residential services	To improve service delivery, service quality, service user outcomes and potentially achieve efficiency gains	Implementation of standardised pathways to regional addiction services to improve equity of access, collaborative review and throughput	Implementation of a Regional model of care and pathways.
1.2.2. Regional detoxification clinical advisory group	To improve the integration, capacity and quality of detoxification services in the Central Region	Implementation of a regional detoxification model of care and a matrix of local and regional services and pathways	National detoxification guidelines implemented. This will lead to a reconfiguration of services in 2012

Statement of Service Performance			
Output class	Impacts / Objectives <i>What are we trying to achieve?</i>	Outputs / Activities <i>How are we going to achieve it?</i>	Key Performance Measures <i>How will we know it's been achieved?</i>
1.3. Renal network programme			
1.3.1. Service models and workforce	To develop an overarching regional renal dialysis service model and feasibility study, and to support service sustainability through development of a workforce plan	Completed a feasibility study on the development of sub-regional satellite renal units. The feasibility study examined projected growth of renal patient need in a sub-regional context to identify potential and requirements for sub-regional satellite units. Work has begun on developing business cases for the implementation of sub-regional satellite units	Further development of sub-regional business cases for the implementation of satellite haemodialysis units, and commencement of planning for this implementation. A review of regional renal workforce is due to be completed in October 2011 and a regional workforce strategy by December 2011
1.3.2. Support for patients and their families	To identify improvements in service or policies designed to provide support for patients and their families that will enhance a renal patients' experience across the continuum of care, and improve their ability to live as normal a life as possible, attaining Whānau Ora, while appropriately managing their renal disease	A regional transport survey for renal patients has been completed. In addition, a scope document has been developed identifying priorities and making recommendations for the next phase of this area of work	Implementation of the recommendations outlined in the scope document titled ' <i>Support for Patients and their Families, Scoping Document, February 2011</i> '.
1.3.3. Information technology system	To investigate, recommend and procure a regional renal IT solution for the Central Region	Development of a business case for the implementation of the solution is underway	Implementation of a regional solution, by December 2011
1.3.4. Cost containment	To broadly quantify and scope the potential savings value if current clinical practice were to change significantly from the present, in	A speculative cost containment analysis report was completed, to assess the potential to achieve savings, especially regarding renal replacement therapy costs	Development of a scope document investigating and defining service delivery requirements for improving more home base therapies long term.

Statement of Service Performance			
Output class	Impacts / Objectives <i>What are we trying to achieve?</i>	Outputs / Activities <i>How are we going to achieve it?</i>	Key Performance Measures <i>How will we know it's been achieved?</i>
	order to stimulate thinking around cost effectiveness and to encourage open discussion and discovery going forward		Also to consider options for increasing live renal donor transplantation
1.3.5. Improving access to dialysis related surgery	Improve the access to dialysis related surgery for renal patients, including fistula, Tenckhoff catheter and parathyroidectomy operations	Development of an options analysis report on improving access to dialysis related surgery	Analysis report on improving access to dialysis related surgery completed in December 2011
1.3.6. Joint procurement	<ul style="list-style-type: none"> Reduction in regional contracting duplication. Alignment of sub-regional and regional renal contracts to improve supply delivery and reduce expenditure 	To review current contracts for renal dialysis consumables, and alignment with Health Benefits Limited	Current contracts for renal dialysis consumables, reviewed and aligned with Health Benefits Limited, by December 2011 with a view to create a regional collective consumables and products contract by 2014
2. Regional services plan	Develop a Central Region Regional Services Plan per National Health Board's (NHB) scope	Consultation meeting with key stakeholders on priority areas for RSP	Central Region Regional Services Plan completed and submitted to National Health Board at a time advised by NHB
2.1. Vulnerable services - Radiology			
2.1.1. Improve regional radiology IT infrastructure by procuring and deploying a regional Picture Archiving and Communications System (PACS) and disaster recovery programme	Improved access to radiology imaging and reports at point of care to enable improved patient care	Develop a suitable region PACS solution	Suitable regional PACS solution installed and migrated January- March 2012

Statement of Service Performance			
Output class	Impacts / Objectives <i>What are we trying to achieve?</i>	Outputs / Activities <i>How are we going to achieve it?</i>	Key Performance Measures <i>How will we know it's been achieved?</i>
2.1.2. Complete a review of the current radiology service with a view to the following: <ul style="list-style-type: none"> Developing a regional radiology after-hours service including application of regional standardised RIS codes and regional RIS system Developing a regional radiology service 	Developing a regional radiology after hours service including application of regional standardised RIS codes and regional RIS system Develop a regional radiology service	Complete a review of the current radiology service and summarise outcomes in a report	Report completed with recommendations by June 2012 A viable out of hours service is in place. Common RIS codes used in preparation for implementation of a common RIS system by December 2012 Milestones for developing a regional radiology service are met by June 2013
2.1.3. Make the best use of clinical radiology services by: <ul style="list-style-type: none"> Developing and applying regional evidence-based referral guidelines. Application of standardised prioritisation codes & KPI monitoring 	Standardised prioritisation of MRI, CT and Ultrasound referrals, and ability to standardise reading times through the use of the regional PACS system	Establish working party with key personnel	Standardised prioritisation for CT, MRI and Ultrasound by December 2011.
2.1.4. Regional radiology workforce	Undertake review to improve regional radiology workforce	<ul style="list-style-type: none"> Increase in registrar training by 2 per year Commencement of a regional Fellowship training programme Develop extensions to roles: Radiographic and MRT assistants. Increase SMO workforce	In 2011 and 2012: <ul style="list-style-type: none"> Fellowship training programme up and running by December 2012 Roles extended for Radiographic and MRT assistants by June 2012 No of FTE in SMO workforce

Statement of Service Performance			
Output class	Impacts / Objectives <i>What are we trying to achieve?</i>	Outputs / Activities <i>How are we going to achieve it?</i>	Key Performance Measures <i>How will we know it's been achieved?</i>
2.2. Vulnerable Services- Older Adults and Rehabilitation			
2.2.1. Integrated Model of Care	Support increased treatment and management of older adults in primary care thereby reducing acute hospital admissions	Framework for Regional model of care developed Model piloted	Framework for Regional model of care developed by June 2012: <ul style="list-style-type: none"> • Patient centred response service model for older adults with multiple co-morbidities
2.2.2. Outreach Model of care	Support clinical decision making for remote providers or provide specialist input into care planning	Model of outreach developed and piloted Technology to support service delivery identified and implemented during a pilot Develop & report indicators that measure readmissions to hospital from a home environment	By June 2012: <ul style="list-style-type: none"> • Earlier recognition, diagnosis and treatment of dementia related issues • Technology such as telemedicine will ensure a smoother transition between services for patients • More service provision at home, within community and rest home enabling clients to be managed without needing admission to secondary services
2.2.3. Shared Care Plans	Promote cross sector communication and care planning, to reduce unnecessary hospital admissions for complex patients	Shared care plan template developed Pilot of care plan	By June 2012: <ul style="list-style-type: none"> • Ethnic monitoring tool in the pathway that will address barrier to service access • Increased utilisation and sharing of

Statement of Service Performance			
Output class	Impacts / Objectives <i>What are we trying to achieve?</i>	Outputs / Activities <i>How are we going to achieve it?</i>	Key Performance Measures <i>How will we know it's been achieved?</i>
			<p>clinical records and care plans across the care continuum</p> <ul style="list-style-type: none"> • Development of integrated health care through shared care planning across services • For a designated cohort of patients, a higher proportion of older people will still be at home (91) days after discharge from rehabilitation services
2.2.4. Prescribing Patterns	Reduce unnecessary pharmaceutical intake for a designated cohort of patients	<p>Sub-regional audit report informing the integrated pathway and shared care plan work streams</p> <p>National benchmarking (if possible)</p>	<p>By June 2012:</p> <ul style="list-style-type: none"> • Report outlining drivers for medication prescribing behaviour
2.2.5. Frequent readmissions for complex patients	Develop a better understanding of the key drivers for frequent readmissions for complex patients to inform the older adults integrated pathway	<p>Sub-regional audit report informing the integrated pathway and shared care plan work streams</p> <p>Develop regional reporting that enables an understanding of the drivers for readmissions of complex older patients across the region.</p>	<p>By June 2012:</p> <ul style="list-style-type: none"> • Acute readmission within 28 days for a designated cohort of clients is reduced
2.2.6. Access by Maori and Pacific Peoples to Aged Residential Care	Investigate at a local and regional level why Maori and Pacific Islanders are not accessing aged residential care and explore if there are	<p>Qualitative interviews</p> <p>Review of national datasets and reports</p>	<p>By June 2012:</p> <ul style="list-style-type: none"> • Discussion paper to Older Adults and Rehabilitation Steering group

Statement of Service Performance			
Output class	Impacts / Objectives <i>What are we trying to achieve?</i>	Outputs / Activities <i>How are we going to achieve it?</i>	Key Performance Measures <i>How will we know it's been achieved?</i>
	opportunities for improvement		
2.3. Strengthening Clinical Leadership and Clinical Governance	To improve quality of care and enhanced safety for consumers receiving health care across the region, including primary care, through the development of robust Clinical Governance systems under the leadership of a Central Region Clinical Governance Board	Establishment of Regional Clinical Board. Scope to include: <ul style="list-style-type: none"> • Credentialing of facilities, SMOs and advanced scope Practitioners • Single Policies in important areas e.g. informed consent, reportable events, open disclosure • Regional approach to medicines and national drug chart • Alignment with Health Quality and safety Commission recommendations • Review/collate/support practice change from major Health and Disability Commissioner and Coroner recommendations • Regional research opportunities • Regional leadership supporting regional service development, especially to increase Māori and Pacific leadership capacity and capability • Regional Health Passport • Review of inter-DHB complaints and reportable events 	Establishment of a Regional Clinical Board, with Terms of Reference and participation from all DHBs

Statement of Service Performance			
Output class	Impacts / Objectives <i>What are we trying to achieve?</i>	Outputs / Activities <i>How are we going to achieve it?</i>	Key Performance Measures <i>How will we know it's been achieved?</i>
		<ul style="list-style-type: none"> • Development of Consumer responsiveness as a region • Oversight of regional Training Hub • Linkage and support to PHO clinical governance systems <p>All sole practitioners have formal links with neighbouring DHBs</p>	
3. Audit and assurance programme	CRDHBs use audit reports: as assurance providers are compliant with agreed contracts and have capability to deliver contracted services to address discrepancies in provider service delivery against agreed contracts	Refer to work programmes detailed below	Feedback from providers and CRDHBs on effectiveness and value of the audit and assurance programme
3.1.Routine audit programme	Routine audit service for CR DHBs providing assurance to them that providers are compliant with agreed contracts and have the capability and capacity to deliver contracted services	Annual (financial year) schedule of DHB prioritised routine audits	Routine audits completed on schedule and reports delivered as per the agreed schedule
3.2.Special audits	Special audit service for CR DHBs allowing them to investigate or review issues related to provider performance	Complete ad hoc special (issue-based) audits on request	Special audits completed on schedule and reports delivered

<p>4. Executive support, project and administration</p>	<p>CRDHBs will collaborate on shared issues through regional meetings for each executive group and other major forums e.g. RCSP committees and clinical network meetings</p>	<p>Refer to work programmes detailed below</p>	<p>Evidence of annual schedule of meetings</p> <p>All meetings held have agendas and minutes</p> <p>Regional decisions will show evidence of following the agreed decision-making framework</p> <p>Each project has an approved scope which clearly describes how the project will achieve the desired outcomes</p>
<p>4.1.Executive group and regional committee secretariat support</p>	<p>DHB executive groups, RCSP committees and the Central Region Maori Relationship Board Forum will be supported to progress with their regional work programmes</p>	<p>Schedule an annual calendar of meetings for each group/committee</p> <p>Provide dedicated secretariat support to each group/committee</p>	<p>All meetings scheduled</p> <p>All meetings held have agendas and minutes</p>
<p>4.2.Project office</p>	<p>Support an integrated approach to delivery of the regional work programmes</p>	<p>Dashboard detailing all projects including monthly status updates</p> <p>Project scopes will describe how each project will achieve the desired outcomes</p>	<p>Dashboard includes all projects and status fields are no older than 3-months</p> <p>Each project has an approved scope and project plan</p>

11. ORGANISATIONAL INFORMATION

CRTAS has 27 employees and permanent contractors (23.63 FTE) organised into four service teams:

Regional Clinical Services Programme	8.7 FTE
Audit and Assurance Programme	5.8 FTE
Executive Support, Projects and Administration	4.13 FTE
Corporate (General Manager's Office)	5.0 FTE
Total FTE	23.63 FTE

12. ALIGNMENT WITH GOVERNMENT PRIORITIES

The CRTAS work programme is aligned to the Governments priorities.

In 2000, the 'New Zealand Health Strategy' set the platform for health action, identifying the Government's health priorities. This was to ensure health services were directed at those areas that would provide the highest benefits to our population, with a particular focus on tackling inequalities in health. At the core of this strategy (and the many that flow from this e.g. He Korowai Oranga: Māori Health Strategy, 2002, Primary Health Care Strategy, 2001) is a population based approach that "puts the needs of communities at the forefront of health services" (the Minister of Health, Health Targets, 2007/08).

In November 2009 Cabinet endorsed the recommendations of the Ministerial Review Group. 'Meeting the Challenge' containing 170 recommendations on how to reduce bureaucracy, improve frontline health services, and improve value in the public health and disability sector.

Annually DHBs receive guidance from the Minister and Ministry of Health to support them in their District Annual Planning process and preparation of their annual Statements of Intent¹. In 2011/12, there is clear expectation for the Central Region to achieve the following through the RSP and local annual plans:

- Improve service and reduce waiting times by achieving the Health Targets
- Strengthen Clinical Leadership as a fundamental driver of improved patient care
- Develop services closer to home and closer integration of services
- Focus on the health of older people, especially mental health (dementia)
- Greater regional collaboration including regional plans to focus on priorities and vulnerable services, development of shared back office functions, and regional IT solutions.

¹ Letter of Expectations for District Health boards and their subsidiary entities for the 2011/12 year.

13. GOOD EMPLOYER AND EQUAL OPPORTUNITY PRACTICES

CRTAS is committed to being a good employer and maintaining a well-qualified and motivated team. CRTAS operates a human resources policy that treats all employees fairly and properly in all aspects of their recruitment, retention and employment. HR policies are EEO compliant and operate in accordance with relevant governing legislation.

14. CONSULTATION AND REPORTING TO THE MINISTER

CRTAS does not report directly to the Minister on any issues, and any relationship the organisation has with the Minister will normally be through the DHBs.

15. FINANCIAL INFORMATION

STATEMENT OF ACCOUNTING POLICIES FOR THE YEAR ENDING 30 JUNE 2012

REPORTING ENTITY

Central Region's Technical Advisory Services Limited (CRTAS) was incorporated on 6 June 2001 under the Companies Act 1993. It is wholly owned by the six central region District Health Boards (DHB) – Capital and Coast DHB, Hutt Valley DHB, Wairarapa DHB, MidCentral DHB, Whanganui DHB and Hawkes Bay DHB.

CRTAS is a joint venture company owned by DHBs as crown entities in terms of the Public Finance Act 1989, Public Finance Amendment Act 2004 and the New Zealand Public Health and Disability Act 2000. The share capital of CRTAS consists of 600 shares owned by each of the six DHB shareholders in equal proportion of a 100 shares each.

CRTAS is also a public benefit entity, as defined under NZIAS 1.

CRTAS's primary objective is to provide technical services to its six shareholder District Health Boards, as opposed to making a financial return.

BASIS OF PREPARATION

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

MEASUREMENT BASE/FUNCTIONAL AND PRESENTATION CURRENCY

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The functional currency of CRTAS is New Zealand Dollars. The financial statements are prepared on the historical cost basis.

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

SIGNIFICANT ACCOUNTING POLICIES

The following particular accounting policies which materially affect the measurement of results and financial position are applied:

BUDGETS

The budget figures are those presented in the Statement of Intent and approved by the shareholders. The budget figures have been prepared in accordance with the New Zealand Generally Accepted Accounting Practice (NZ GAAP). They comply with NZ IFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Central Region Technical Advisory Service Limited in the preparation of the financial statements.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

In preparing these financial statements CRTAS has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

At each balance date CRTAS reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires CRTAS to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by CRTAS and the expected disposal proceeds from the future sale of the asset. An incorrect estimate of useful life or residual value will impact the depreciation expense recognised in the Statement of Comprehensive Income, and carrying amount of the asset in the statement of financial

position. CRTAS has not made significant changes to past assumptions concerning useful lives and residual values.

REVENUE

DHB Funding

The majority of revenue is provided by the DHBs. Revenue is recognised monthly in accordance with the annual service level funding agreement of CRTAS with the DHBs.

Services Rendered

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to CRTAS and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by CRTAS.

Interest

Interest income is recognised using the effective interest method. Interest income on an impaired financial asset is recognised using the original effective interest rate.

LEASES

Operating Leases

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

CASH AND CASH EQUIVALENTS

Cash and cash equivalents includes cash in hand and deposits with original maturities less than three months held with banks.

INVESTMENTS

At each balance sheet date CRTAS assesses whether there is any objective evidence that an investment is impaired.

Bank deposits

Investments in bank deposits are initially measured at fair value plus transaction costs.

After initial recognition investments in bank deposits are measured at amortised cost using the effective interest method.

For bank deposits, impairment is established when there is objective evidence that the CRTAS will not be able to collect amounts due according to the original terms of the deposit. Significant financial difficulties of the bank, probability that the bank will enter into bankruptcy, and default in payments are considered indicators that the deposit is impaired.

GOODS AND SERVICES TAX

All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position. The net GST paid to, or received from IRD; including GST relating to investing and financing activities is classified as an operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed exclusive of GST.

EMPLOYEE ENTITLEMENTS

Short-term employee entitlements

Employee entitlements that CRTAS expects to be settled within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay. These include salaries and wages up to balance date, annual leave earned but not yet taken at balance date, retiring and long service entitlements expected to be settled within 12 months, and sick leave. CRTAS recognises a liability and expense for bonuses where it is contractually obliged to pay them, or where there is a past practice that has created a constructive obligation.

DEBTORS AND OTHER RECEIVABLES

Accounts receivable are stated at expected realisable value after providing for doubtful and un-collectable debts.

Impairment of a receivable is established when there is objective evidence that CRTAS will not be able to collect amounts due according to the original terms of the receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted using the original effective interest rate. The carrying amount of the asset is reduced through the use of a provision for impairment account, and the amount of the loss is recognised in the surplus or deficit. Overdue receivables that are renegotiated are reclassified as current (that is, not past due).

PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consists of leasehold improvements, information technology and office equipment. Property plant and equipment is measured at cost, less accumulated depreciation. Property, plant and equipment are recorded at their cost of acquisition including applicable installation costs such as materials, labour, direct overheads and transport costs.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to CRTAS and the cost of the item can be measured reliably.

Disposals

Gains and losses on disposal are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposal are included in the Statement of Comprehensive Income.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to CRTAS and the cost of the item can be measured reliably. The cost of day-to-day servicing of property, plant and equipment are recognised in the Statement of Comprehensive Income as they are incurred.

DEPRECIATION

Depreciation is provided on a straight line basis on all property, plant and equipment at rates that will write off the cost of the assets, to their estimated residual value, over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Information Technology	10.5% - 40%	2.5 – 9.5 years
Office Equipment	6.5% - 80.4%	1.2 – 15.4 years
Leasehold Improvement	8.4% - 25%	4 – 11.9 years

Gains and losses on disposal of fixed assets are taken into account in determining the net operating result for the year.

INTANGIBLE ASSETS

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring into use the specific software. Costs associated with maintaining computer software are recognised as an expense when incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date the asset is derecognised. The useful life and associated amortisation rate of major classes of intangible assets have been estimated as follows:

Computer software – useful life 3-4 years, amortisation rate 30%

INCOME TAX

CRTAS is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CW38 of the Income Tax Act 2007. Accordingly, no charge for income tax has been provided for.

CREDITORS AND OTHER PAYABLES

Creditors and other payables are initially measured at fair values and subsequently measured at amortised using the effective interest method.

STATEMENT OF CASH FLOWS

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the company invests as part of its day-to-day cash management, net of bank loan facilities.

Operating activities include all transactions and other events that are not investing or financing activities.

Investing activities are those activities relating to the acquisition and disposal of non-current assets.

Financing activities comprise the change in equity and debt capital structure of CRTAS.

FINANCIAL INSTRUMENTS

Central Region Technical Advisory Service Limited is risk averse and seeks to minimise exposure arising from its treasury activity.

Financial instruments reflected in the statement of financial position include cash and bank balances, investments, receivables and trade creditors. These instruments are, generally, carried at their estimated fair value. For example, receivables are carried net of the estimated doubtful receivables. The particular recognition methods adopted are disclosed in the individual policy statements associated with each item.

CHANGES IN ACCOUNTING POLICIES

There have been no changes in the accounting policies since the date of the last audited financial statements, and the accounting policies have been applied on a basis consistent with the previous year.

NEW STANDARDS ADOPTED & INTERPRETATIONS NOT YET ADOPTED

CRTAS has adopted the following revisions to accounting standards during the financial year, which have had only a presentational or disclosure effect. The adoption of the following standards is not expected to have a material impact on CRTAS's financial statements.

NZ IAS 1 Presentation of Financial Statements (Revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (issued 2004). The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. Items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes equity.

Amendments to NZ IFRS 7 Financial Instruments: Disclosures. The amendments introduce a three-level fair value disclosure hierarchy that distinguishes fair value measurements by the significance of valuation inputs used, and requires the maturity analysis of derivative liabilities

to be presented separately from non-derivative financial liability contractual maturity analysis. This disclosure requirement is not applicable to CRTAS. The transitional provisions of the amendments do not require disclosure of comparative information in the first year of application. CRTAS has elected to disclose comparative information if applicable.

Standards, Amendments, and Interpretations Issued That Are Not Yet Effective and Have Not Been Early Adopted

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to CRTAS, are:

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit.

The new standard is required to be adopted for the year ended 30 June 2014. CRTAS has not yet assessed the effect of the new standard and expects it will not be early adopted.

16. FORECAST FINANCIAL STATEMENTS

Central Region Technical Advisory Service Ltd					
Statement of Comprehensive Income					
For the Year Ended 30 June					
	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Income					
Total income from DHBs	2,935	2,788	2,788	2,788	2,788
Interest income	14	12	15	15	15
Other income	105	90	70	70	70
Total Income	3,054	2,890	2,873	2,873	2,873
Expenditure					
Personnel costs	1,893	2,000	2,166	2,166	2,166
Depreciation and amortisation expense	84	107	90	90	90
Other operating expenses	929	780	615	615	615
Total Expenditure	2,906	2,887	2,871	2,871	2,871
Surplus/(Deficit)	148	3	2	2	2
Other comprehensive income	0	0	0	0	0
Total comprehensive income	148	3	2	2	2

Central Region Technical Advisory Service Ltd					
Statement of Changes in Equity					
For the Year Ended 30 June					
	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Balance at 1 July	467	615	618	620	622
Total comprehensive income	148	3	2	2	2
Balance at 30 June	615	618	620	622	624

Central Region Technical Advisory Service Ltd					
Statement of Financial Position					
As at 30 June					
	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Assets					
Current Assets					
Cash and cash equivalents	442	487	487	487	487
Investments	80	82	84	86	88
Debtors and other receivables	217	217	217	217	217
Prepayments	2	2	2	2	2
<i>Total Current Assets</i>	741	788	790	792	794
Non-Current Assets					
Property plant and equipment	197	188	188	188	188
Intangibles	33	25	25	25	25
<i>Total Non-Current Assets</i>	230	213	213	213	213
Total Assets	971	1,001	1,003	1,005	1,007
Liabilities					
Current Liabilities					
Creditors and other payables	-158	-158	-158	-158	-158
GST payable	-44	-68	-68	-68	-68
Income received in advance	-33	-36	-36	-36	-36
Employee entitlements	-121	-121	-121	-121	-121
<i>Total current Liabilities</i>	-356	-383	-383	-383	-383
Non-Current Liabilities					
Borrowings	0	0	0	0	0
Employee Entitlements	0	0	0	0	0
<i>Total Non-Current Liabilities</i>	0	0	0	0	0
Total Liabilities	-356	-383	-383	-383	-383
Net Assets	615	618	620	622	624
Equity					
Share Capital	0	0	0	0	0
General funds	615	618	620	622	624
Total Equity	615	618	620	622	624

Central Region Technical Advisory Service Ltd					
Statement of Cash Flows					
For the Year Ended 30 June					
	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Operating Activities					
Receipt from customers	3,053	2,881	2,858	2,858	2,858
Interest received	14	12	15	15	15
Payment to employees	-1,900	-2,000	-2,166	-2,166	-2,166
Payment to suppliers	-991	-780	-615	-615	-615
GST (net)	-10	24	0	0	0
Net Cash Flow from Operating Activities	166	137	92	92	92
Investing Activities					
Purchase of fixed assets	-153	-90	-90	-90	-90
Net Cash Flow from Investing Activities	-153	-90	-90	-90	-90
Net Cash Flow	13	47	2	2	2
Opening cash balance	509	522	569	571	573
Closing Cash Balance	522	569	571	573	575
Represented by:					
Funds in bank	522	569	571	573	575
Bank overdraft	0	0	0	0	0
Cash and Cash Equivalents	522	569	571	573	575

17. FORECAST COST OF SERVICE STATEMENT

Cost of Service Statement for Output Class: Regional Clinical Services Programme	2010/2011	2011/2012	2012/2013	2013/2014
	(\$000)	(\$000)	(\$000)	(\$000)
Revenue				
DHB Revenue	1,431	1,466	1,466	1,466
Interest Revenue	6	8	8	8
Other Revenue	90	70	70	70
Total Revenue	1,527	1,544	1,544	1,544
Expenditure				
Personnel Costs	1,014	1,127	1,127	1,127
Depreciation Costs	54	47	47	47
Other Operating Costs	395	320	320	320
Total Operating Costs	1,463	1,494	1,494	1,494
Net surplus/deficit	64	50	50	50
Cost of Service Statement for Output Class: Audit and Assurance Programme	2010/2011	2011/2012	2012/2013	2013/2014
	(\$000)	(\$000)	(\$000)	(\$000)
Revenue				
DHB Revenue	1,025	932	932	932
Interest Revenue	4	5	5	5
Other Revenue	0	0	0	0
Total Revenue	1,029	937	937	937
Expenditure				
Personnel Costs	725	706	706	706
Depreciation Costs	39	29	29	29
Other Operating Costs	283	201	201	201
Total Operating Costs	1,047	936	936	936
Net surplus/deficit	-18	1	1	1
Cost of Service Statement for Output Class: Executive Support, Projects & Admin	2010/2011	2011/2012	2012/2013	2013/2014
	(\$000)	(\$000)	(\$000)	(\$000)
Revenue				
DHB Revenue	333	391	391	391
Interest Revenue	2	2	2	2
Other Revenue	0	0	0	0
Total Revenue	335	393	393	393
Expenditure				
Personnel Costs	261	332	332	332
Depreciation Costs	14	14	14	14
Other Operating Costs	102	94	94	94
Total Operating Costs	377	440	440	440
Net surplus/deficit	-42	-47	-47	-47

NOTE: Total net surplus of the three output class has a difference of 1 due to rounding.

KEY ASSUMPTIONS

The following key assumptions were made:

1. The revenue is charged on a monthly basis in advance and all revenue is received in the same month.
2. SLA revenue is not expected to increase in future years.
3. Employee costs are incurred and paid in the same month. Employee costs are expected to be flat in the years ahead. The TAS FTE is capped at 25 and no further FTE rise is expected after 2011/2012.
4. Capital expenditure will be funded from cash flows. The capital expenditure programme for 2011/12 is estimated at \$90K with the main components of this being an information technology update (computers and software).
5. Regional work such as the CRISP Programme Office that is hosted at CRTAS and financially managed by CRTAS but does not contribute to the income of CRTAS will be regarded as pass-through funds. These projects will have an impact on the financial statements if projects are extended over the financial year.

CAUTIONARY NOTE

Actual results achieved for the period are likely to vary from the information presented.

There are no specific fiscal risks relating to the possible variations. Any possible changes to the work programme and the related revenue streams will be carefully managed and offset by commensurate changes to the costing structure of CRTAS.