



Auckland District Health Board

Statement of Intent 2009–12

17 June 2009

Status of document

This is the Statement of Intent for 2009-12 prepared by the Auckland District Health Board, Private Bag 92 189, Auckland, New Zealand. This document has been prepared for Ministry of Health review.

The document is also available on the Auckland District Health Board's website <http://www.adhb.govt.nz>

If you require this document in alternative format (e.g. large print or hard copy) please contact:
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Table of Contents

Statement from Auckland DHB Chair and Chief Executive	5
Implementing the Treaty of Waitangi	6
1. Introduction	7
About the Statement of Intent	7
Reporting to the Minister of Health	8
2. The Planning Framework	9
Framework for Planning	9
DHB Intervention Logic	10
Government Priorities	10
Local Priorities	12
3. The Auckland Environment	13
Profile of the Population	13
4. Our Operating Environment	16
DHB Governance and Management	16
5. Auckland DHB Health Care System	20
Funding for Health Services	21
6. Statement of Service Performance	22
Priority Health Outputs	22
7. Output Class: Public Health Services	23
8. Output Class: Primary and Community Services	26
9. Output Class: Hospital Services	32
10. Output Class: Support Services	38
11. Organisation Capability	40
DHB Planning and Funding of Services	40
Clinical Quality and Professional Governance	40
Information Management and Technology Services	42
Workforce Development	42
Collaboration	42
12. Managing our Financial Resources	44
Funding Allocation	44
Financial Management	46
Statement of Accounting Policies	53

E nga mana, e nga reo, e nga karangarangatanga tangata
Ko te Toka Tu Mai O Tamaki Makaurau tenei
E mihi atu nei kia koutou
Tena koutou, tena koutou, tena koutou katoa
Ki wa tatou tini mate, kua tangihia, kua mihia kua ea
Ratou, kia ratou, haere, haere, haere
Ko tatou enei nga kanohi ora kia tatou
Ko tenei te kaupapa, 'Oranga Tika', mo te 'Te Toka Tu Mai' mo te iti me te rahi
Hei huarahi puta hei hapai tahi mo tatou katoa
Hei Oranga mo te Katoa
No reira tena koutou, tena koutou, tena koutou katoa

To the authority, and the voices, of all people within the communities.

This is the message from the Auckland District Health Board.

We send greetings to you all.

We acknowledge the spirituality and wisdom of those who have crossed beyond the veil. We farewell them.

We of today who continue the aspirations of yesterday to ensure a healthy tomorrow. Greetings.

This is the Statement of Intent of the Auckland District Health Board.

Embarking on a journey through a pathway that requires your support to ensure success for all.

Greetings, greetings, greetings

Statement from Auckland DHB Chair and Chief Executive

This Statement of Intent has been prepared by Auckland District Health Board (Auckland DHB) to meet the requirements of section 42 and section 39(8) of the New Zealand Public Health and Disability Act 2000 and section 139(1) of the Crown Entities Act 2004.


Auckland DHB covers the same boundaries as Auckland City. The district borders Waitemata DHB and Counties Manukau DHB with whom we work closely on regional matters and where we can get better efficiency from our resources. The objectives of DHBs are covered by sections 22 and 23 in the NZPHD Act (2000).

This document outlines the intended performance for 2009–10 and two subsequent financial years. These activities are a summary of the more detailed information contained in the District Annual Plan and align closely with our District Strategic Plan and Government's strategic and service priorities for the public health and disability sector. Supplementary documents are available online at www.adhb.govt.nz.

This Statement of Intent for the period 2009 to 2012 is signed for and on behalf of the

AUCKLAND DISTRICT HEALTH BOARD

TE RUNANGA O NGATI WHATUA



Pat Snedden
Chair

Date
17-6-09



Naida Glavish JP.
Chair

Date 17-6-09.



Harry Burkhardt
Deputy Chair

Date
17-6-09.

Implementing the Treaty of Waitangi

The DHB recognises and respects the Treaty of Waitangi as the founding document of New Zealand. The Treaty of Waitangi encapsulates the fundamental relationship between the Crown and Iwi. It provides the framework for Maori development, health and wellbeing. The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes to enable Maori to participate in, and contribute towards, strategies to improve Maori Health outcomes. References to the Treaty of Waitangi in this document derive from, and should therefore be understood in this context. As a Crown Agent, the DHB will demonstrate how Treaty responsibilities are implemented through innovative strategies that apply the principles of Partnership, Participation and Protection. These principles are promoted by the Ministry of Health to provide direction to the health sector. Our commitment is therefore consistent with national Ministry of Health policy within *He Korowai Oranga – Maori Health Strategy*.

The Value of Co-operative Rangatiratanga and Kawanatanga

A Revitalised Iwi/MAPO and DHB Relationship for Equitable Maori Health Outcomes

The DHB and Te Runanga O Ngati Whatua (including its health agent Tihi Ora MaPO) hold a Memorandum of Understanding. The Memorandum outlines key principles, processes and protocols for working together at both governance and operational levels. 2009-2010 signals a new era regarding a revitalised Iwi/MaPO:DHB relationship. The DHB and Te Runanga O Ngati Whatua have agreed that to achieve rapid progress towards equitable Maori health outcomes, both parties need to recognise the Value of Co-operative Rangatiratanga and Kawanatanga in order to realise the extensive opportunities afforded by this unique relationship.

Treaty Principles in Action

<p>Partnership</p> <p>Te Runanga o Ngati Whatua as Maori. Equitable Maori health status.</p> <p>Safeguard Maori cultural concepts, values and practices manawhenua, are partners with Auckland DHB</p>	<p>Memorandum of Understanding with Te Runanga o Ngati Whatua and its health agent Tihi Ora MaPO. Ngati Whatua, as Manawhenua partners with the DHB at governance and operational levels. This actively protects Maori interests in health planning and funding. Auckland DHB has a Maori Health Advisory Committee. There is consultation with Iwi Maori in planning health and disability services and regarding service and other changes</p>
<p>Participation</p> <p>Maori engagement in planning, development and delivery of health and disability services</p>	<p>Responsible and responsive to Maori communities in our district and those who use our services. To develop and implement an innovative Cross-DHB Maori Health Equity Framework linked to Co-operative Rangatiratanga and Kawanatanga. Active involvement of Manawhenua and Mataawaka communities at all levels.</p> <p>There is engagement with Maori regarding the impact service and other changes may have on Maori communities and organisations</p> <p>Assistance to further develop Maori providers in our district</p>
<p>Protection</p> <p>Equity of participation, access and outcomes for all</p>	<p>Adhere to the Auckland DHB Tikanga Best Practice Policy to protect the rites/rights of Maori, respect the tikanga of manawhenua and practically contribute to providing services that are responsive to Maori needs and interests. Services will meet the rights/ rites, needs, interests and aspirations of Maori</p> <p>Commitment to the Maori Health Strategy, He Korowai Oranga and other national policy. Use the national Inequalities Framework, the health inequalities impact assessment tool and the national Prioritisation Framework prioritising whanau ora</p>

1. Introduction

About the Statement of Intent

This Auckland DHB Statement of Intent sets out the organisation's objectives for the year ending 30 June 2010. Some of these will be ongoing for the next three to five years. The Statement of Intent sets the broad parameters under which the Auckland DHB is managed and has been prepared in terms of section 139 of the Crown Entities Act 2004 and sections 39 and 42 of the New Zealand Public Health and Disability Act 2000.

The Auckland District Health Board (Auckland DHB) is a major funder and provider of health care services. The organisation funds and provides community based and secondary services to central Auckland, tertiary services to the Auckland region and tertiary services nationally. Auckland DHB will improve the health of the Auckland city population by focusing on the factors that most influence health and reduce health inequalities between groups.

This Statement of Intent covers the activities of the District Health Board and covers subsidiaries over which it has a joint controlling interest with other DHBs.

The Northern DHBs Support Agency (NDSA) develops its own Statement of Intent. Auckland DHB has a one-third share in Auckland Regional RMO Services Ltd (previously the Northern Clinical Training Network) and this organisation also produces its own Statement of Intent.

Auckland DHB Charitable Trust (A+ Trust) is 100% owned by Auckland DHB. Auckland DHB has no plans to acquire shares or interests in any company, trusts and/or partnerships.

We fulfil our Treaty of Waitangi responsibilities by working in partnership with manawhenua and with the participation of other iwi. We also retain a focus on reducing inequalities to ensure Maori, and other groups where health status is below that of non-Maori, are assisted to improve health status and to address problem areas.

Statement of Service Performance

The targets chosen for inclusion in this Statement of Intent help the Auckland DHB track performance on the longer term goals in our District Strategic Plan. They also reflect national indicators of DHB performance developed by the Ministry of Health and the Minister of Health's expectations for the financial year. The long term goal of Healthy communities, Quality healthcare, *Hei Oranga Tika Mo Te Iti Mei Te Rahi*, is operationalised via yearly objectives which are covered in detail in the District Annual Plan.

The subset of objectives make up our Statement of Service Performance and these cover the financial year 2009–10 and two outyears. They are made up of measures which link to four output classes: Public Health Services, Primary and Community Services, Hospital Services and, Support Services.

Auckland DHB objectives set out in this Statement of Intent are consistent with our District Strategic Plan 2005 to 2010 and District Annual Plan for 2009–10, Government priorities and the Minister of

Health's expectations. The Auditor General will audit the accuracy and reasonableness of Auckland DHB achievements against these measures as recorded in the Statement of Service Performance in the Annual Report.

Statement re Other Arrangements

For the purposes of s25 of the New Zealand Public Health and Disability Act, Auckland DHB is permitted by its annual plan to enter into service agreements, on terms and conditions it considers appropriate for the particular services or outcomes intended to be achieved by that individual service agreement. These service agreements to be in accordance with, and to advance, the strategic objectives and outcomes outlined in the annual plan or be to deliver the services Auckland DHB is required by statute or contract with the Crown or other parties to deliver.

Reporting to the Minister of Health

In addition to the regular reporting outlined below, we will consult with the Minister, via the Ministry of Health on any significant developments not covered in this plan. Any proposed departures from the content of our 2009–10 District Annual Plan will be taken out for public consultation.

Reporting	Frequency
Information requests	Ad hoc
Financial reporting	Monthly
National data collections	Monthly
Risk reporting	Quarterly
Crown funding agreement non-financial reporting and Indicators of DHB performance	Quarterly
Hospital benchmarking information	Quarterly
Annual report	Annually

2. The Planning Framework

Framework for Planning

Our vision is:

Hei Oranga Tika Mo Te Iti Me Te Rahi; Healthy Communities, Quality Healthcare

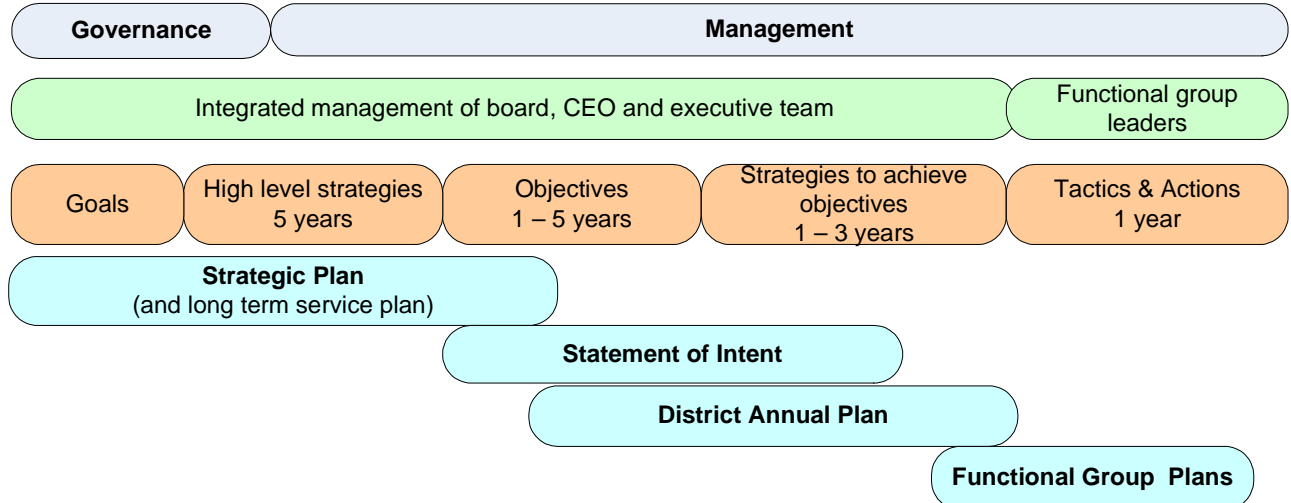
This vision reflects an approach to health that goes well beyond disease states and health service provision. We focus on population health and on the reduction in health inequalities.

Three goals support the vision.

- Lift the health of people living in Auckland city
- Performance improvement
- Live within our means

Auckland DHB Planning Documents

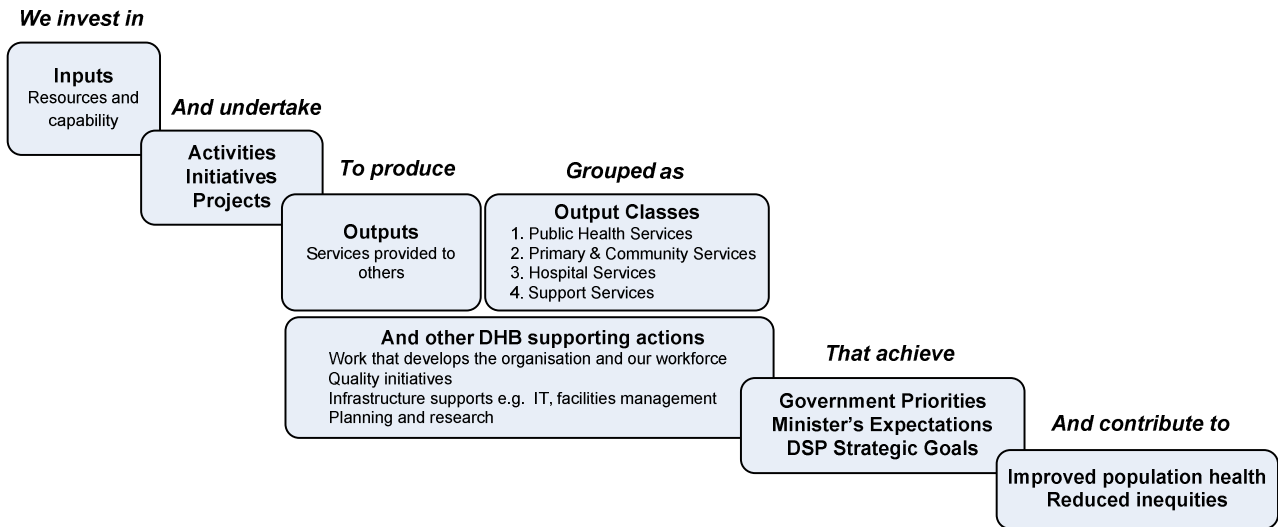
The diagram below shows the suite of documents that make up the planning and accountability environment for the district health board. Additional information to support this Statement of Intent can be found in the other planning documents.



The longer term objectives for Auckland District health Board (Auckland DHB) are covered in our Strategic Plan. These determine the high level direction through to 2010. The strategic direction will be reviewed in 2009 and may be amended.

Our annual plan concentrates on activities during the 2009–10 year that puts the strategic priorities into action. The annual plan therefore has a direct links to our strategic plan and to our foundation vision and goals.

DHB Intervention Logic



Our Strategic Direction

This Statement of Intent is devoted to key outputs collated under four output classes. More information on areas of priority and specific changes proposed for the 2009–10 year. Further detail is contained in our District Annual Plan 2009–10.

Government Priorities

This Statement of Intent aligns with national and Government priorities for the health sector. These priorities are closely aligned with our vision and long term strategy to improve the health and well-being of our community.

The Minister of Health's annual 'Letter of Expectations' specifies the Minister's priorities for the coming year. These expectations, in addition to national health and disability strategies and our strategic priorities (set out in the District Strategic Plan 2006), enable Auckland DHB to plan and prioritise activity for the 2009-10 year.

A set of national Health Targets help focus the efforts of all DHBs and make more rapid progress against key national priorities. These Health Targets are included within the selection of performance measures and are also clearly identified in our Annual Plan for 2009-10.

The Minister of Health's expectations for the 2009–10 year

The public health system will deliver better, sooner, more convenient healthcare for all New Zealanders. The service priority for 2009-10 will be sharply focused on hospital services.

Key expectations from Government

Frontline services	Improved patient outcomes and satisfaction Increased elective volumes year on year Improved emergency department waiting times Improved cancer treatment waiting times
Primary health care	Commitment to the Primary Health Care Strategy Shifting some secondary services to more convenient settings Establishing multi-disciplinary Integrated Family Health Centres
Workforce	Less bureaucracy A trusted and motivated workforce Improve workforce retention and clinical retention Foster clinical leadership
Value for money	Strong financial discipline Improving productivity and performance Increased regional co-operation

National targets for health

Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours
Improved access to surgery	The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1,400 per year)
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010
Increased immunisation	85 percent of two year olds will be fully immunised by July 2010; 90 percent by July 2011; and 95 percent by July 2012
Better help for smokers to quit	80 percent of hospitalised smokers will be re provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95 percent by July 2012 Similar target for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme
Better diabetes and cardiovascular services	Increased percent of: a) the eligible adult population will have had their CVD risk assessed in the last 5 years b) people with diabetes will attend free annual checks c) people with diabetes will have satisfactory or better diabetes management

3. The Auckland Environment

Profile of the Population

The population of Auckland city is young with more than half the population in the 15–44 year age group. Many of our children (41% of all 0–4 year olds) live in the most deprived areas of the city.

Forty-nine percent of Maori and 64% of Pacific people live in the most deprived areas of Auckland city compared to 25% of the 'Others'. Most Indians and Asians live in the Avondale-Roskill Ward – 46% and 33% of their populations respectively. The 'Other' populations are fairly evenly distributed across all Auckland wards.

The most populated areas in Auckland city are the Tamaki-Maungakiekie (25%) and Avondale-Roskill Wards (20%). Most Maori (39%) and Pacific people (46%) live in the Tamaki-Maungakiekie Ward.

About one in five people live with an impairment; the most common being loss of functioning related to mobility, agility and hearing. The rate of disability increases as people age. Support services assist disabled people and older people to live as independently as possible and to participate in their community. Poorly informed social attitudes remain the most common barrier for disabled people.

Auckland city's population is expected to grow at a rate of 1.4% per year until 2011 using a medium projection.

Aucklanders have relatively good health compared to the rest of the country:

- People living in Auckland city have the 4th lowest mortality rate among all the DHBs (in 2007)
- For all ethnic groups, mortality rates in Auckland DHB are lower than the rest of the country and are improving faster
- Although Aucklanders eat less healthy food, they do have slightly lower obesity and overweight prevalence and slightly lower rates of high blood pressure compared to the rest of the country
- Aucklanders smoke significantly less tobacco and are less likely to smoke marijuana and have slightly lower hazardous drinking habits
- The Auckland population is better than the national level in all indicators of health except high blood cholesterol and low physical activity which are significantly worse than the national level
- Auckland DHB has a relatively low years of life lost (YLL) age standardised rate. Since 1996 YLL has decreased by about 32%, or 6.4% a year. Twenty-one percent of that decrease was in males compared to 11% in females
- Asian people represents 23% of Auckland's population. 36% of Asians are South Asian and about 80% of those are Indian. Although Asians, as a general grouping, have good health compared to 'Others' there are sub-groups that have high need

There are areas of inequity

There are still unacceptable differences in health status between groups of people living in the city. Achieving better equity between groups is our priority for the future. We are especially focused on better health for Maori, Pacific, South Asian communities, people living on low incomes and disabled people. Maori and Pacific men in Auckland are a particularly high risk group for health problems.

- The biggest contributor to low life expectancy is poverty which is affected by ethnicity and gender
- 72% of non-Maori and non-Pacific people die over the age of 75 years of age compared to 16% for Maori and to 32% for Pacific people
- Maori in Auckland DHB are more likely (compared to NZ and to local non-Maori) to smoke tobacco and marijuana, to be obese and to drink alcohol in hazardous manner
- Pacific people are far more likely (compared to NZ Pacific and to local non-Pacific) to be obese, smoke tobacco, and have a poor diet
- Maori and Pacific ethnic groups have higher Years of Lost Life (YLL) rates than non-Maori, non-Pacific
- Aucklanders are significantly less likely to exercise and have higher cholesterol levels than the rest of NZ
- Men die younger than women by at least nine years (although the rates are improving for both genders)
- Men have poorer health than women: they smoke more tobacco and marijuana, have higher cholesterol, are more likely to be overweight and to have a poor diet. Men are more likely to drink alcohol in a hazardous manner. Men do however exercise more often than women
- For South Asian and precisely for Indian, the picture varies enormously; despite a lower mortality rate from cardiovascular disease they have the highest rate of hospitalisation for myocardial infarction and angina. They are also the highest users for angioplasty and CABG operations
- Auckland DHB is one of the highest non-English, non-Maori speaking areas in NZ with about 100 different languages spoken. About 13% of our population need some kind of assistant or interpreting when they attend health services
- Asian people have lower risks for all the indicators of poor health except for regular exercise and lower vegetables consumption.
- In self-assessed health status, there is a direct relationship between age, gender, ethnicity and income for all ethnic groups, except Pacific
- Self reported health status for Auckland is higher than the national rates
- People who are poor, Pacific and those in age groups 14–24 and over 65 years score their health the lowest
- Men assess their health as better than women except in the general health perceptions scores. In this area men assess their health as poorer than women

Health problems

- Chronic diseases including cancers encompass nearly 47% of total Years of Lost Life (YLL)
- The second most common cause is injuries and poisoning (33%), followed by congenital and perinatal diseases (20%)
- Asthma, arthritis and ischemic heart disease are the most major contributors to 'long term conditions' seen in the Auckland city population
- Three-quarters of all deaths in Auckland city are due to diseases related to the circulatory system, cancer and the respiratory system

Auckland Population

Prevalence of major chronic diseases with expected no.

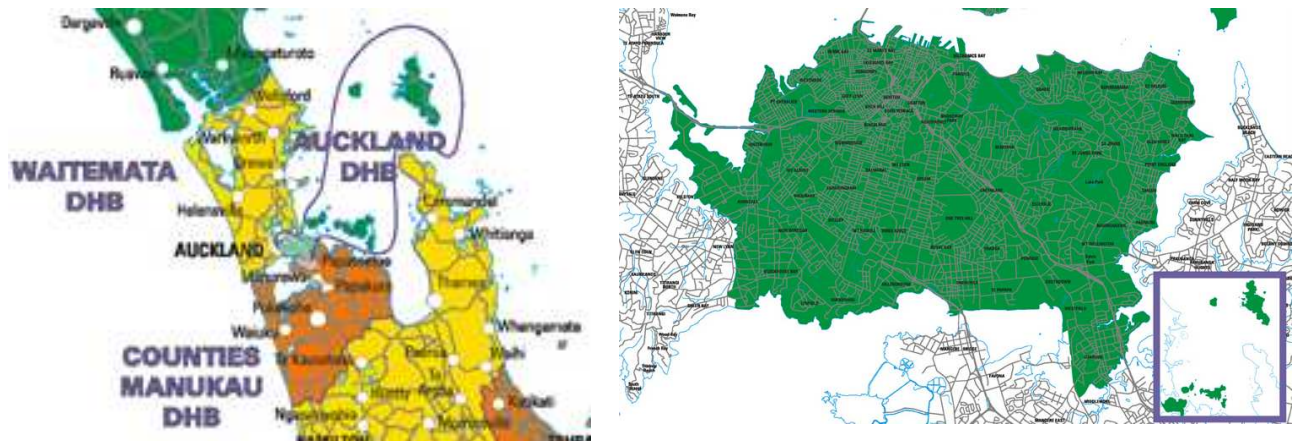
Chronic conditions	%
Asthma	13.3 (8.5-18.0) 24,800 adults
Arthritis	12.9%
Ischaemic heart disease	3.8 (2.5-5.0) 12,100 adults
Dementia	7.7% (varies by age)
Chronic obstructive pulmonary disease	6.1%
Depression	5.7%
Diabetes	4.9 (3.4-6.3) 15,600 adults
Stroke and TIAs	2.1 (1.2-3.5) 6,900 adults
Epilepsy	1.4%
Total cancer since 1994 excluding deaths	7,550 adults

Causes of death	%
Diseases of circulatory system	39%
Cancer	27%
Diseases of respiratory system	8%
Injury, poisoning	5%
Mental and behavioural disorders	4%
Diseases of nervous system	4%
Endocrine, nutrition and metabolic	3%
Diseases of digestive system	3%
Diseases of genitourinary system	2%
Other causes	5%

4. Our Operating Environment

Although Auckland DHB is the biggest DHB by turnover, according to population it is the fourth largest and covers the boundaries and same population of people as Auckland City Council. As well as providing health and disability support services for Auckland city, Auckland DHB manages the flow of people into our area for treatment. Over half the work carried out in the provider arm (our hospital and related services) is for people living in other parts of New Zealand (most are from the other two DHBs in the metro Auckland area).

Auckland DHB provides a wide range of services from its Auckland City Hospital and community health services. A wide range of other health services are provided for the people of Auckland, most of which Auckland DHB has a direct funding and monitoring responsibility for, see summary table page 20.



DHB Governance and Management

Governance

The following activities cover Governance and Management. This activity supports all four output classes.

The New Zealand Public Health and Disability Act 2000 established District Health Boards and statutory advisory committees to ensure that the community has a voice in health and disability service planning and funding. Boards have eleven members, seven of which are elected during the three-yearly local body elections. The Minister of Health appoints four additional members and the Board's Chair. Boards are required to have two Maori representatives and in general should reflect the diversity of people and interests within the Auckland DHB area.

Pat Snedden (Chair)
Jo Agnew
Susan Buckland
Harry Burkhardt (Deputy Chair)
Chris Chambers

Rob Cooper
 Brian Fergus
 Ian Scott
 Bob Tizard
 Seiuli Juliet Walker
 Ian Ward

The Board is responsible for funding health and disability support services and for reducing health disparities by improving health outcomes for Maori. The Minister of Health approves these activities and approaches through DHB Strategic and Annual Plans, the Statement of Intent and Crown Funding Agreement.

The Board plans across a wide range of health and non-health sectors to influence the broader determinants of health. This is achieved through the following activities:

- population health needs analysis
- planning and funding for services that meet the principles and priorities of the New Zealand Health Strategy and the New Zealand Disability Strategy
- collaboration with other DHBs, government agencies and non-government entities
- contribution to the development of good public health policy
- strengthening community participation in health
- building capability within the Auckland DHB and community
- improving access, appropriateness and effectiveness of the services for Maori and Pacific people in order to reduce health inequalities
- provision of public health services in collaboration with other Auckland DHBs and the Auckland Regional Public Health Service.

The Board has three permanent advisory committees, each of which must provide for Maori representation.

Community and Public Health Advisory Committee	<p>This committee (CPHAC) provides advice on health gains and how to manage the interface between primary and secondary care. It advises on service option issues focused on 'what is best for the community'. The role of the committee is to provide advice to the Board:</p> <ul style="list-style-type: none"> • on the health status of the Auckland DHB population • to prioritise the use of health funding provided • to ensure the overall health gain of the population is maximised. <p>This advice must be consistent with the New Zealand Health Strategy.</p>
Disability Support Advisory Committee	<p>This committee (DSAC) advises the Board on issues facing disabled people and the priorities for use of disability support funding provided.</p>
Hospital Advisory Committee	<p>The role of the Hospital Advisory Committee (HAC) is to assess strategic issues and monitor the financial and operational performance of the hospitals and related services of the Auckland DHB.</p>

The Board has established other committees to provide advice.

Finance Committee	Monitors the financial performance of the Auckland DHB, liaises with external auditors and receives reports for the internal auditor.
Quality, Risk and Audit Committee	Monitors clinical quality, patient satisfaction and accreditation of services.
Maori Health Advisory Committee	Consists of Board and Ngati Whatua representatives and monitors Auckland DHB obligations under the Treaty of Waitangi and the delivery of health services to Maori as well as tikanga best practice within services.
Pacific Health Advisory Committee	Pacific representatives provide advice to the Board and CEO on matters relating to Pacific health improvement

Board and statutory committee meetings are open to the public and are notified in the New Zealand Herald. Meeting details are listed on the website www.adhb.govt.nz or are available on request from Ian Bell, Board Administrator (630 9943 extension 8077, or lbell@adhb.govt.nz).

The Integrated Management Structure

The management structure has been designed to attract and retain the right people for achieving organisational success. It is based on a matrix of functional teams working with operational teams.

A Senior Leadership Team assists the CEO with leadership on major organisational issues. This ensures that matters requiring input from governance or that require formal sign off are taken to the Board. This team includes representation from the Primary Health Organisations (PHOs).

The Senior Leadership Team

Garry Smith	Chief Executive
Ann Yates	Midwifery Leader
Barbara Stevens	CEO, Auckland PHO
Bernie Twomey	Nurse Leader - Women & Child Health
Brent Wiseman	Chief Financial Officer
Dr Celia Palmer	Clinical Leader Planning & Funding
Dr Clive Bensemman	Director Mental Health Services.
Dr David Sage	Chief Medical Officer
Dr Denis Jury	Chief Planning and Funding Officer
Dr Denys Court	Clinical Leader – Women’s Health
Fionnagh Dougan	General Manager (Blood & Cancer, Ambulatory, Mental Health)
Dr Glennis Mafi	Clinical Leader, Tongan Health
Greg Balla	Director Performance and Innovation
Dr Guy Naden	Clinical Leader, Auckpac PHO
Hilda Faasalele	General Manager – Pacific Health (Acting)
Mr. Ian Civil	Director of Surgery
Janice Mueller	Director of Allied Health, Scientific & Technical
Johan Vendrig	Chief Information Officer
Jude Keys	CEO, Procure PHO
Kay Hyman	General Manager (Women’s & Children’s Health, Cardiac, Genetics, Operating Rooms & Anaesthesia.)

Margaret Dotchin	General Manager, Clinical Services and Nurse Director, Adult Health Services
Dr Margaret Wilsher	Deputy Chief Medical Officer and Medical Director Adult Health
Matire Harwood	Clinical Leader, PHO
Naida Glavish	Chief Advisor Tikanga and General Manager Maori Health
Dr Neil Hefford	Clinical Leader, PHO
Ngaire Buchanan	General Manager – Operations
Paul Lavulo	CEO, Tongan Health PHO
Dr Richard Aickin	Director of Child Health
Dr Rick Franklin	Clinical Leader – Ambulatory
Dr Russell Smart	Clinical Leader, Auckland PHO
Taima Campbell	Executive Director of Nursing
Tereki Stewart	CEO, Tamaki PHO
Dr Vanessa Beavis	Director – ADHB Operating Rooms and Anaesthesia
Vivienne Rawlings	General Manager Human Resources
Winston Timaloa	CEO, Auckpac PHO

5. Auckland DHB Health Care System

Auckland DHB provides or contracts for health and disability services across a continuum from health promotion and problem to primary care, hospital services and support services.

Our approach places a strong emphasis on primary health care in the knowledge that more can be done in community settings to prevent problems at an early stage and to provide ongoing care for more chronic conditions. Clinical leadership, quality and the integration of services are critical factors in the development of Auckland DHB's healthcare system.

For the purposes of this Statement of Intent, the services provided are amalgamated under four output classes. The activities below show a selection of priority activities. This is not the full description of the Auckland DHB activities but those that are considered high priority for the 2009-10 year. The full detailing of Auckland DHB activities are included in the Annual Plan for 2009-10 and the five functional group plans that sit alongside that document.

Activities across the continuum of care				
	Public health	Primary/community	Hospital	Support services
Child & youth	Immunisation B4 school checks Nutrition (HEHA & tobacco)	Immunisation Oral health Health assessments Primary birthing	Family violence Post-natal stays	Disability Support Services
Women	Breast & cervical screening	Family violence prevention	Extended postnatal stays Cancer treatment Herceptin Family violence	
Older people		NASC Home based care Management of long-term conditions	Assessment and Rehabilitation TIA/Stroke Unit Palliative care	Respite care Aged Residential care Palliative care
People with a mental health disorder		Primary mental health	Eating disorders	Residential rehabilitation
Adult	HEHA and lifestyle coaching Health protection Emergency planning	Get Checked for diabetes PREDICT POAK Long term conditions management Some secondary services available in the community	Devolution of services to primary care Elective surgery Cancer treatment Clinical networks and leadership Quality improvement Workforce development	Palliative care Long term conditions management

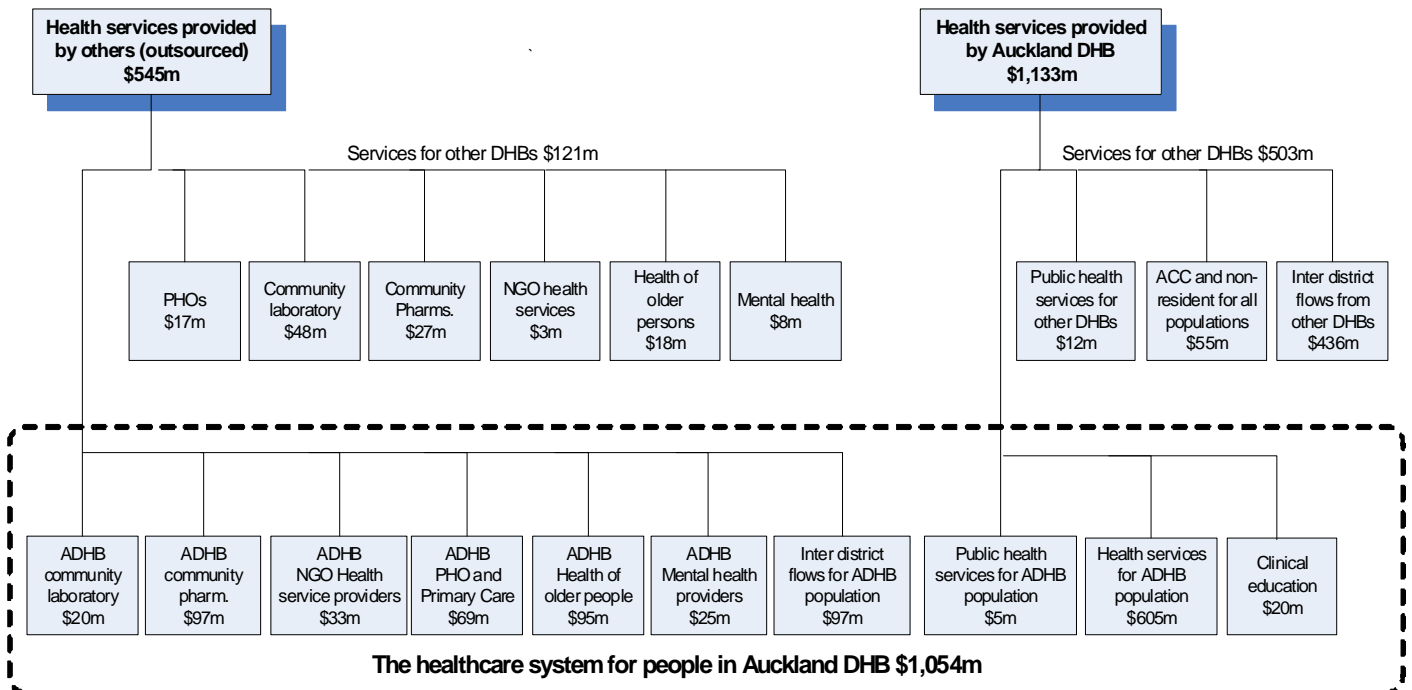
Specific activities for Maori, for Pacific, new migrant, Asian and refugee groups sit within these activities, especially where targeted activities are required to reduce inequities. Our population health needs assessment indicates where we have unacceptable differences in health status between groups.

Funding for Health Services

The total value of services is approximately \$1,054 million for the Auckland DHB population. Some funding for services comes directly from the Ministry of Health, e.g. public health services. Auckland DHB also provides services for other DHBs to the value of \$624 million.

In the diagram below, the left component covers services provided to the Auckland population and to people from other DHBs that are contracted from various non government organisations (NGOs) and community providers (outsourced health services). The right component of the figure shows the services that are provided by the Auckland DHB provider (hospital and related community services) for the Auckland population and to other DHBs.

The area in dotted lines at the bottom shows the range of services across the continuum of care that make up the package of services available for people living in Auckland.



Mechanisms for Intervention

Auckland DHB:

FUNDS health and disability services through the contracts we have with providers

PROVIDES hospital and specialist services that cover medical and surgical services, mental health, older person's health

PROMOTES community health and wellbeing through health promotion, health education and population health programmes.

Ensures our interventions are relevant to our communities, coordinated and deliver best value for money by:

- PLANNING in consultation with key stakeholders (Iwi, PHOs and NGOs) and our community
- PLANNING in collaboration with other DHBs via regional and national work

6. Statement of Service Performance

Priority Health Outputs

Our DHB ensures the promotion, provision, monitoring and evaluation of health and disability support services in line with national health and disability strategies and local population health needs.

The services provided by our DHB are many and varied. The DHB's planning and funding role is responsible for planning, promoting and undertaking service contracting with organisations including our own hospital services. However, we do not deliver all services ourselves within our own hospitals. Our DHB also contracts services from other providers; including other DHBs who often provide more specialist services e.g. the treatment of burns takes place at Counties Manukau DHB. Some services are funded and contracted directly by the Ministry for example breast and cervical screening as well as the provision of disability support services for people under 65 years of age. Our DHB is responsible for monitoring and evaluating service delivery, including audits of the full range of funded services.

The role of our DHB covers most of the health and disability services provided in our district. This section details our agreed priority areas. The areas of focus are based on the directions identified in our District Strategic Plan and on findings from our Health Needs Analysis. For example, we have prioritised primary health care as an area that influences the health of people living in Auckland city.

The performance of all services is reported quarterly to the Ministry of Health, based on indicators of DHB Performance or through the Hospital Benchmark Information. These reports can be accessed on the Ministry of Health website (www.moh.govt.nz).

With a medium term outlook of 5 to 10 years, Auckland DHB is focused on achieving a vital few health outcomes. These relate to areas of highest need and those problems responsible for the greatest burden of disease. Having a vital few outcome areas means we can focus attention and resources on priority areas. The statement of service performance is made up from several cornerstone activities:

Our price volume schedule	This sets the contracted level of service to be delivered by a hospital provider. Delivery against these volumes is closely monitored
Four output classes	<p>These are: Public Health Services; Primary and Community Services; Hospital Services; and Support Services. They include the relevant Government Commitments and Minister of Health's expectations as well as any agreed national health targets.</p> <p>We also describe how the DHB organises the delivery of services. These are not outputs but demonstrate that the organisation is well managed to meet future needs and to deliver clinician led, high quality, safe, and efficient services and programmes.</p>

Section 7 details the Auckland DHB output measures within each of the four output classes.

These measures and targets will be subject to an annual audit by auditors appointed by the Office of the Auditor General.

7. Output Class: Public Health Services

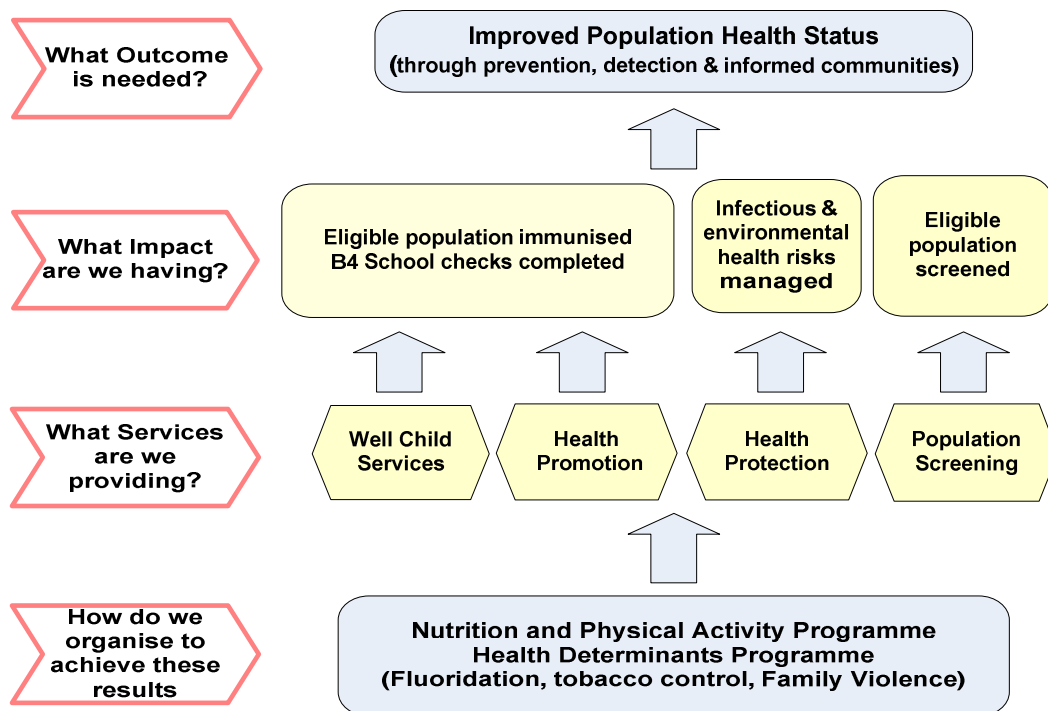
Health promotion, prevention and protection

Dedicated public health activity for Auckland city is primarily undertaken by the Auckland Regional Public Health Service (ARPHS) however other public health service providers also contribute to the delivery of these services including NGOs. The Auckland Regional Public Health Service is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau DHB, Waitemata DHB under contract from the Ministry of Health. The service is responsible for improving population health outcomes and reducing inequalities.

Auckland Regional Public Health Service strategic priorities:

Excellence in Core Delivery	Deliver effective, efficient and economic public health services Respond to district health board and key stakeholder priorities Develop and strengthen the public health workforce
Leadership and Advocacy	Provide innovative leadership in public health Work collaboratively to address inequalities in health status
Future Focused	Influence the sustainable development of the Auckland region Respond to emerging public health challenges

The following section outlines the Public Health services we intend to deliver to the Auckland city population although it is important to note that the figures are for the Auckland region. These outputs include: health protection services, health promotion, population screening services, and immunisation services. The logic model for the output class Public health sits below.



Outputs	Measures	Baseline	Targets		
			2009-10	2010-11	2011-12
Health protection	Number of health assessments done of Early Childhood Education Centres*	60	Up to 70	Up to 70	Up to 70
	Investigations to monitor/improve the quality of drinking water	130	Between 100-130	Between 100-130	Between 100-130
	Emergency investigations on hazardous substances and new organisms*	100%	100%	100%	100%
Health promotion	Prevalence of exposure of year ten students to second hand smoke inside the home	28%	< 25%	< 25%	< 25%
	Percentage of 'never smokers' among Year 10 students	66.9%	69%	No targets yet	No target
	Pacific smoking cessation programmes in Auckland DHB*	New initiative	240 enrolled	240 enrolled	N/A
	Healthy Housing project: *				
	Assessments	200	200	200	200
	Referred to insulation provider	80%	80%	80%	80%
	Infants exclusively and fully breastfed:				
6 weeks	66.6%	68.6%	69.6%	70.6%	
3 months	57.3%	59.3%	60.3%	61.3%	
6 months	27%	29%	30%	31%	
Communicable Disease Control	Receive notifications of disease, investigations as required, case management and contact tracing	400 TB cases 900 other disease investigations	100%	100%	100%
Immunisation	Immunisation status of babies, support GPs in submitting data to the NIR and follow-up children not immunised	1000-1300 referrals to immunisation outreach services	Up to 1300 referrals	Up to 1300 referrals	Up to 1300 referrals
	Percentage of two-year-olds immunised (target 85%)	74%	85%	88%	95%
	Percentage of children completing the year 7 vaccination, of those eligible and who have consented	New initiative	67%	80%	90%
Screening	Participation in the National Breast Screening Programme by eligible women (2 year coverage rate for 50 -64 yr old women)	42.9%	Contract Targets met	Contract Targets met	Contract Targets met
	Participation in the National Cervical Screening Programme by eligible women, particularly: Maori, Pacific and Asian women (3yr coverage rate for 20 – 65 yr women)	65%	Contract Targets met	Contract Targets met	Contract Targets met
	B4 School Checks carried out	1800	3600	3600	3600

* ARPHS performance measures

How we are organising to achieve results

The priority public health initiatives for 2009-10 are:

- Over the longer term we will reduce inequities in health. To achieve this we ensure that Maori, Pacific and other groups with high needs e.g. South Asian, are involved in decision making and in the development of strategies. The Maori Health Advisory Committee and the Pacific Health Advisory Group oversee progress against health plans for these populations.
- We work with Local Authorities on improvements to air and water quality, tobacco smoking in open places, cycle and walking pathways, contaminated sites; sale of alcohol issues; urban design; safe environments.
- We work with other agencies that have a key impact on the major determinants of health to improve community well-being. Examples include:
 - healthy and accessible housing
 - strategic advocacy to influence social and health policy.
 - input into the multi-agency Tamaki Transformation Project (an area of deprivation)
 - working with Auckland City Mission and sector leaders on the homeless project
 - reducing neglect and non accidental injuries, reducing family violence, and advocating on issues affecting families / whanau
- Reduce cardiovascular disease and diabetes via improved nutrition, increased physical activity, with dedicated efforts for Pacific via the Health Village Action Zones (Church groups providing health promotion)
- There is a Maori immunisation initiative underway to increase cover for this group

8. Output Class: Primary and Community Services

Primary healthcare

A strong primary health care system is central to improving health and reducing health inequalities between different groups. New Zealand has a growing prevalence of long-term conditions including diabetes and cardiovascular disease, with some groups particularly affected: Maori and Pacific people, older people and those on lower incomes. Long-term conditions require good management across primary and secondary care to ensure they are recognised early and treatment managed effectively.

The approach relies on primary health care services, the delivery of health care programmes in various community settings and multi-disciplinary health care teams. Our clinical and management expertise supports primary care and community-based providers of care.

Five primary health care organisations (PHOs) operate within the Auckland DHB area.

Primary health organisation (PHO)	% Maori	% Pacific	% Other	Total no. enrolled	% of Total	No of full time doctors
Auckland PHO limited	11%	9%	10%	45,467	10%	41
AuckPAC Health Trust Board	13%	23%	7%	42,591	10%	20
ProcCare Network Auckland Limited	53%	46%	75%	310,250	70%	272
Tongan Health Society Incorporated	0%	7%	0%	4,766	1%	5
Tamaki Healthcare Charitable Trust	23%	15%	8%	42,347	10%	55
Total enrolled population: Auckland DHB	25,475	63,264	356,682	445,421	100%	393
Auckland city residents enrolled with an ADHB PHOs	52%	70%	79%	336,064	76%	
Total non-Aucklanders enrolled with an Auckland DHB PHO	6,869	30%	21%	95,551	22%	
Auckland city residents enrolled with a 'non-ADHB' PHO	6,986	17,186	41,536	65,708		
Auckland city residents enrolled with a 'non-ADHB' PHO	20%	33%	12%	65,708	15%	
Total percentage of Aucklanders enrolled in any PHO (regardless of the DHB that funds it)	72%	110%	90%		91%	

Community services

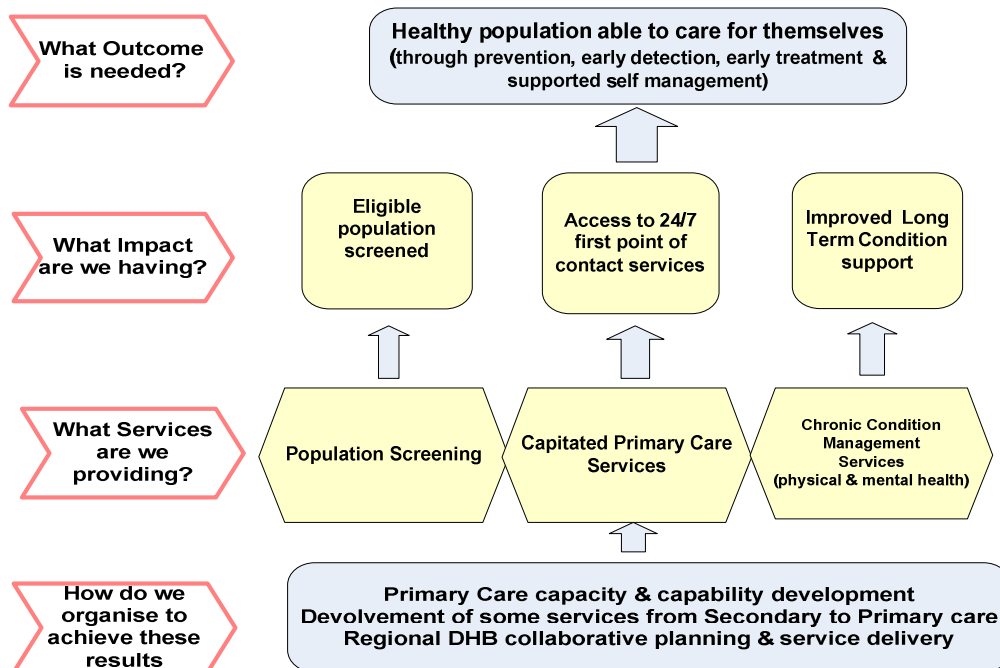
Auckland DHB contracts with a range of non government organisations (NGOs) to provide health and disability support services for people living in Auckland city. These services range from primary health services such as those provided via General Practice through to supported accommodation for people with severe mental illness. The Auckland DHB also provides community services: Rehab Plus, community mental health services, community child health and disability services

Summarised list of other services (non-hospital)

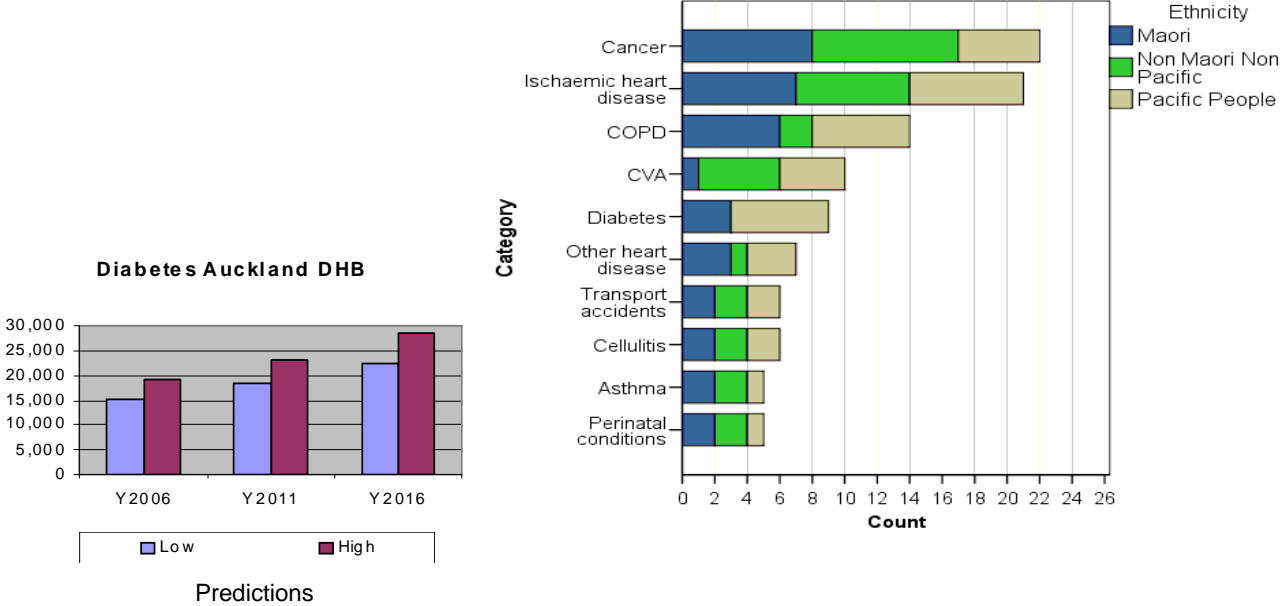
The type of provider	Number of providers	Total value of services	Number of beds (if applicable)
Community laboratory (includes Lab Plus).	2	\$69,300,000.00	
Dental	64 (as at January 2009)	\$3,774,832	
Health of older persons services - residential care	64 (total facilities 81)	\$85,700,000	4,206 contracted beds (at Sept 08)
Health of older persons services (inter district flows)		\$8,843,232	
Health of older persons services -non-residential care	11	\$8,321,996	
Home-based support	10	\$17,700,000	
Maori health services	2	\$1,400,000	
Mental health services	24	\$25,423,351	195 contracted beds (among other services purchased)
Mental health (inter district flows)		\$17,801,304	
Mental health services - alcohol and other drug services	6	\$9,075,367	180 contracted beds (among other services purchased)
Pacific health services	3	\$1,000,000	
Primary Care Organisation (PCO)	1	\$1,100,000	
Personal health services (includes Lifting the Health of Aucklanders, Miscellaneous Services and National Travel Assistance)	10	\$25,666,045	
Personal health services (inter district flows)		\$70,469,100	
Pharmacy	127	\$109,233,144	
Pharmacy (wholesalers)	4	\$4,300,000	
Primary Healthcare Organisation (PHOs)	5	\$83,033,434	
Women's and children's health services	17	\$6,500,000	
		\$548,641,805	Total beds in the community 4,581

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

These outputs are aggregated into: DHB Primary and Community services; PHO capitated services; other PHO services; NGO services

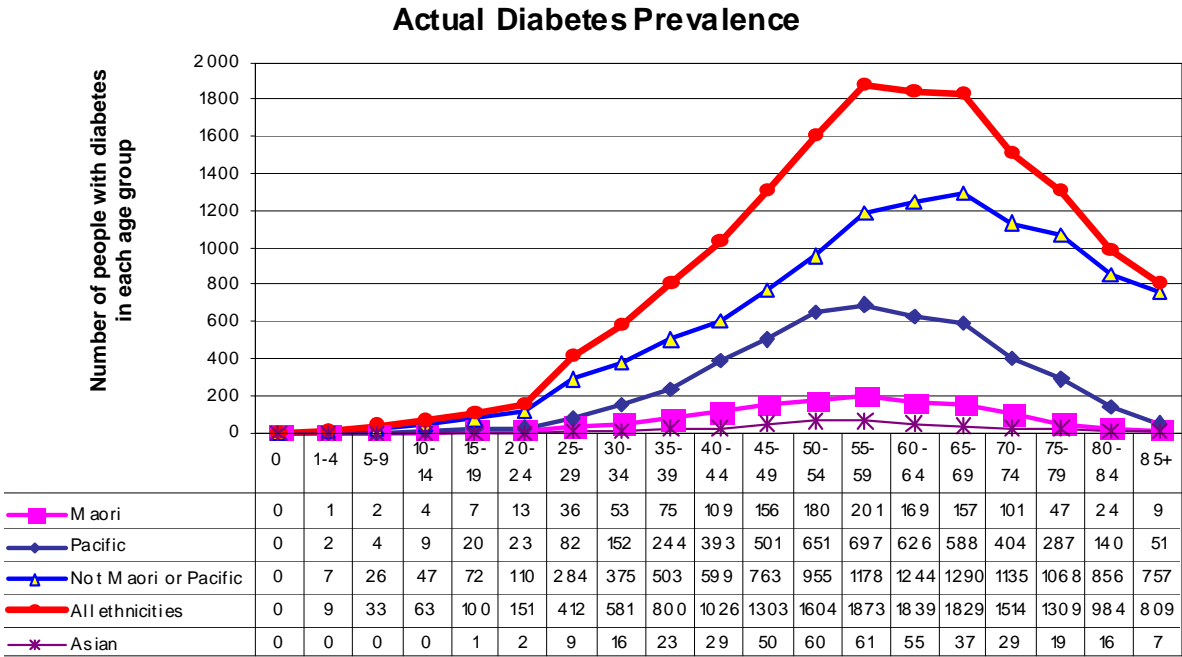


The following graphs show that cancer, diabetes and heart disease are the dominant health problems for people in Auckland city. Our efforts as a district health board are directed at activities that prevent these problems and provide treatment across a continuum of care. There is considerable work underway to boost the efforts of primary care in early intervention work and in managing the long term conditions which may arise.



Diagnosed diabetes in Auckland DHB for year 2008/9

	Total	Maori	Pacific	Other
Actual diabetes 2007	20,931	1,439	5,176	14,316
Free annual diabetes check in 2007	8,853	555	2,368	5,930
Expected diabetes for 2008/9	18,797	1,409	5,119	12,270



Outputs	Measures	Baseline	Targets		
			2009-10	2010-11	2011-12
Diabetes	Diabetes annual check	9,328	11,991	13,081	14,171
		consults	consults	consults	consults
	Maori	44%	46%	48%	50%
	Pacific	56%	58%	60%	62%
	Total	50%	52%	54%	56%
	Get Checked patients with an HbA1c<8				
	Maori	65%	67%	69%	71%
	Pacific	66%	68%	70%	72%
	Total	75%	77%	78%	79%
	Diabetic retinal screening for people with diabetes:				
Maori	61%	64%	69%	72%	
Pacific	64%	67%	70%	73%	
Total	68%	71%	74%	77%	
Cardiovascular disease	Cardiovascular risk screening (lipid and glucose or HbA1c)				
	Maori	69%	71%	73%	75%
	Pacific	70%	72%	74%	76%
	Other	76%	78%	80%	80%
	Total	75%	77%	79%	80%
	Programmes and options for cardiac rehabilitation	New initiative	5% increase for all groups	5% increase from previous year or maintenance if 85% achieved	5% increase from previous year or maintenance if 85% achieved
PHO services	Percent valid NHI on patient register	97%	98%	99%	99.5%
	Maori enrolment in PHOs	85%	95%	97%	100%
	All children under 5 years of age are enrolled with a PHO	98%	99%	99.5%	100%
	Care plus enrolled population (baseline 2008)	69.2%	≥ 70% of eligible patients enrolled	To be set	To be set
	Palliative client in receipt of PHO services	New initiative	15% of clients	17% of clients	20% of clients
Ambulatory Sensitive Admissions (ASH)	Admissions to hospital for children under 5 that are avoidable or preventable by primary health (by other, Maori and Pacific)	< 95%	Remain below 95% of the national average	Remain below 95% of the national average	Remain below 95% of the national average
	Unnecessary hospital admissions for Maori,	National average	Other (45-64) at or	Other (45-64) at or	Other (45-64) at or

Outputs	Measures	Baseline	Targets		
			2009-10	2010-11	2011-12
	Pacific and Other (45 to 64) Numbers of unnecessary hospital admissions for Maori, Pacific and Other (0-74 age)	National average	below 106 Maori (45-64) at or below 116 Pacific (45-64) at or below 98 Remain below 95% of the national average At or below 98% for Maori	below 106 Maori (45-64) at or below 116 Pacific (45-64) at or below 98 Remain below 95% of the national average	below 106 Maori (45-64) at or below 116 Pacific (45-64) at or below 98 Remain below 95% of the national average
Oral health	85% adolescent oral health utilisation Percentage of children caries free at 5 years Maori Pacific Asian European Other Total Number of teeth of 8-year-olds decayed, missing, or filled (DMFT) Maori Pacific Asian European Other Total	57% 45% 34% 60% 79% 62% 61%	60% 47% 36% 62% 80% 62% 62%	63% To be set To be set	66% To be set To be set

How we are organising to achieve results

The priority primary health and community health initiatives for 2009-10 are:

- PHOs committing to performance management targets with the aim to involve all local PHOs.
- Focus on improved self-management for patients with long term conditions. This involves more work being done via primary health care to help patients manage their condition and prevent problems from escalating into hospitalisations
- Increase the input of primary care teams in palliative care
- Improved IT systems so that Clinicians and GPs have access to clinic letters, discharge summaries and operation notes through the Regional HES Repository. This also involves outpatient letters being sent electronically to GPs as well as GP Referrals

- New services will devolve from hospital to primary care. This is a new initiative which will start with 3 services being devolved in the first instance. A plan is underway to manage this process.
- Assess the health of children before they commence schooling: 'B4 School Checks'.
- Assess the health of children and young people (0–17 years) in the care of the Child, Youth and Families Service.
- Universal newborn hearing screening programme across Auckland DHB

Indicative 2009–10 contracted outputs for hospital and specialist services by case weighted discharges (summary outline)

- Acute Services** The Price Volume Schedule for acute services for the Auckland DHB population has been set with a volume increase to meet estimated demand based on:
- i) the projected population growth over 2009-10, leading to an increase of 1.8% overall
 - ii) additional increase for specific service development (e.g. Haematology Bone Marrow Transplants, Infectious Diseases, and Oncology/Radiotherapy services)
- Elective Services** Elective services for the Auckland DHB population have shown strong growth over the 3 years since 2005-06. Auckland DHB is expecting to maintain this strong level of elective increases during the 2009-10 year
- The health target for elective surgery for Auckland DHB is 9,425
- Inter District Flows** For services provided to other DHB populations (Inter District Flows), negotiated agreement has been reached with the 20 DHBs on the level of referrals, and/or treatments and assessments, as well as payment schedules for the estimated acute workload that will be undertaken at Auckland DHB. Given that the estimated workloads are based on forecasts of previous years' activity, 'wash-up arrangements at the end of the year' are generally agreed

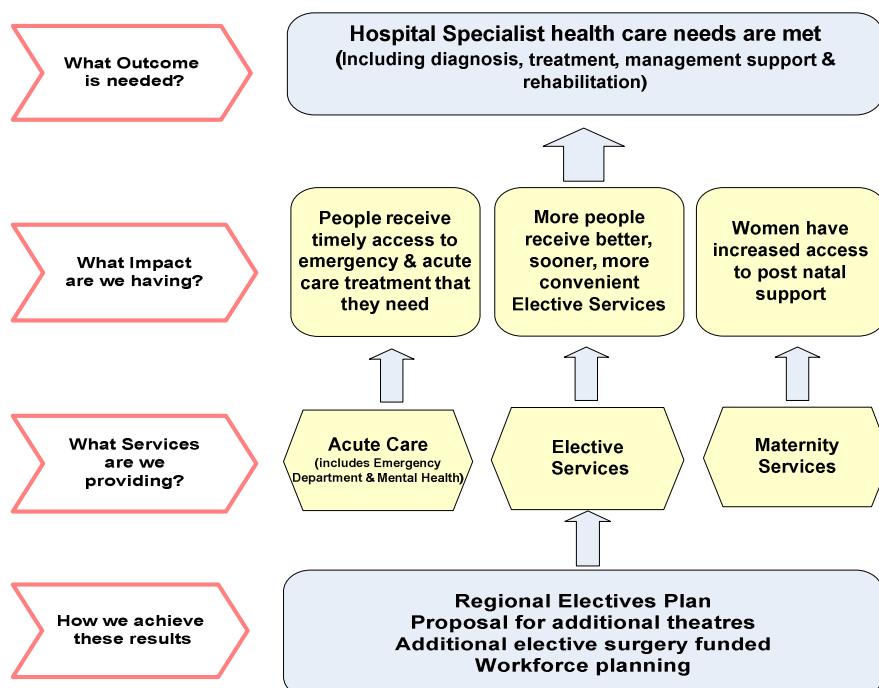
The price volume schedule below details the type and level of services provided by the hospital.

Portfolio	Subspeciality	Cost weighted discharge			
		For Auckland population		For other populations	
		Acute	Elective	Acute	Elective
Adult Emergency Department	Emergency Medicine	2,652.15		674.75	
Ambulatory Health Services	Dermatology	70.00	30.24	38.18	9.00
	Endocrinology	66.42		78.94	
	Immunology	150.00		201.07	
	Oral Health	23.10	303.75	71.13	698.24
	Rheumatology	24.70		11.12	
Cancer and Blood services	Haematology	958.01		1,421.48	
	Oncology	800.00		1,764.20	
Cardiac Services	Cardiology	2,416.14	817.36	2,830.01	1,030.66
	Cardiothoracic	1,500.00	1,032.18	4,397.49	3,174.75
	Vascular Surgery	929.29	288.93	1,467.69	697.07
Gen Med	General Medicine	9,347.62		391.47	
	Infectious Diseases	250.00		130.20	
General Surgery, Trauma, Gastro, Respiratory	Gastroenterology	547.14		185.78	
	General Surgery	4,630.03	3,188.27	1,932.37	707.97
	Liver Resections	0.00	0.00	0.00	0.00
	Respiratory Medicine	1,287.60		915.48	
Paediatric Medical & Community services	General Paediatrics	1,191.81		1,511.06	
	Paediatric Emergency department	1,013.78		995.11	
	Paediatric Endocrinology	28.00		129.51	
	Paediatric Gastroenterology	46.35		505.38	
	Paediatric Haem/Onc	303.16		1,296.63	
	Paediatric Infectious Diseases	57.84		166.86	
	Paediatric Neurology	114.92		418.01	

Portfolio	Subspecialty	Cost weighted discharge			
		For Auckland population		For other populations	
		Acute	Elective	Acute	Elective
	Paediatric Renal Medicine	72.88		323.78	
	Paediatric Respiratory Medicine	188.63		1,039.40	
	Paediatric Rheumatology	47.79		12.00	
Ophthalmology	Ophthalmology	382.64	997.03	720.49	1,497.01
Orthopaedics Adult	Orthopaedics	4,877.51	3,375.10	846.92	322.51
Paediatric Cardiac & ICU's	Newborn Services	2,500.00		2,031.40	
	Paediatric Cardiac	300.00	350.00	1,793.48	1,948.74
Surgical and Community services	Paediatric Neurosurgery	100.86	53.70	782.57	192.67
	Paediatric ORL	115.63	531.60	336.64	512.75
	Paediatric Orthopaedics	736.48	323.50	1,195.75	909.57
	Paediatric Pain Service	0.00		0.00	
	Paediatric Surgery	611.19	285.11	1,547.92	844.81
Transplant, Renal, Uro, ORL, Neuro	Neurology	600.00	0.00	463.00	0.00
	Neurosurgery	902.17	413.21	2,570.80	958.12
	ORL	483.75	873.70	742.39	892.42
	Renal Medicine	950.00		942.64	
	Renal Transplant	149.17		572.31	
	Urology	593.62	760.63	1,197.68	790.30
Women's Health	Gynaecology	1,177.64	1,360.58	206.71	457.95
	Obstetrics	5,173.46		2,638.85	
Total		48,371.45	14,984.91	41,498.65	15,644.57

The full Price Volume Schedule is included in the District Annual Plan.

The model below shows how hospital specialist services are developed and how national commitments regarding reduced waiting times for elective services are managed in the medium term.



The following section outlines the hospital and related services that Auckland DHB delivers for its local population. The focus for the 2009-10 year is on improving the quality of frontline health services with specific targets set for emergency department waiting times, additional elective surgery and reduced waiting times for cancer treatment. This is not the full list of activity proposed for 2009-10, nor does it cover workforce development, leadership networks, clinical quality and information technology that are required to ensure the provision of high quality hospital services.

Outputs	Measures	Baseline	Targets		
			2009-10	2010-11	2011-12
Quality and patient outcome	Percentage of Triage-2 patients seen within 10 minutes	65%	80%	80%	80%
	Percentage of Triage-3 patients seen within 30 minutes	42%	50%	52%	55%
	Percentage of Triage-2 children seen within 10 minutes	40%	55%	60%	65%
	Percentage of Triage-3 children seen within 30 minutes	65%	70%	75%	75%
	Adverse events causing significant harm	5	3	1	0
	Bloodstream infections per 1000 bed days adult	1.67	1.2	1	0.2
	Bloodstream infections per 1000 bed days children	2.0	1.0	0.5	0.2
Process and efficiency ¹	Raw average length of stay	3.30	3.30	3.30	3.30
	Day cases as a % of all elective procedures	52.1%	52%	52%	52%
	Median acute time to theatre for all suites (decimal hours)	4.1	4	4	4
	Percentage of non attendance (DNA) for specialist appointments	9.2%	8.5%	7.8%	7%
	Reduce Maori DNA rates in hospital services	16%	11%	9%	7%
Overall productivity	Volume acute (all populations)	79,761	100% of total contract	100% of total contract	100% of total contract
	Volume elective (all populations)	24,881	100% of contract	100% of total contract	100% of total contract
	Theatre utilisation (elective)	80%	80%	80%	80%
	Bed utilisation	87%	85%	85%	85%

¹ Measure definitions as per Ministry of Health HBI Report

Outputs	Measures	Baseline	Targets		
			2009-10	2010-11	2011-12
Improve the rate of Elective Services	Number of elective service discharges	8,042	9,425	To the level of service agreed	To the level of service agreed
	Intervention rate per 1000 (standard discharge rate)	0.85	0.94	0.96	1.00
	Elective day of surgery admission rate	67%	70%	72%	75%
Stroke	Patients cared for a stroke unit for treatment / rehabilitation	No dedicated stroke beds	50% of patients cared for within stroke unit (12 dedicated beds)	50% of patients cared for within stroke unit	50% of patients cared for within stroke unit
Cancer treatment	100% of eligible cancer patients, except for Category D, receive radiotherapy treatment within six weeks of FSA/decision to treat	100%	100%	100%	100%
	Radiotherapy intervention rate	37%	40%	43%	46%
Emergency Department attendances	Emergency Department length of stay (% of all ED patients who are admitted, discharged or transferred within 6 hrs)	64%	95%	95%	95%
Mental health	At least 90% of long-term clients have up to date relapse prevention plans	57%	90%	90%	90%
Smoking prevention	80% of hospitalised smokers will be provided with advice and help to quit	Not available	80%	90%	95%

How we are organising to achieve results

The priority hospital initiatives for 2009-10 are:

- Ensure the acute emergency and acute inpatient services comply with national targets re waiting times
- Meet the national targets for elective services
- Reduce waiting times for radiation oncology and medical oncology via better use of day stays and patient centred scheduling
- Enhanced clinical leadership to engage clinicians in planning. Increased focus on succession planning, mentoring, leadership development and integrated management systems
- Improve the safety and quality of care by participating in the national Quality Improvement Programme; taking the lead in project work and driving improvements to the quality of hospital care

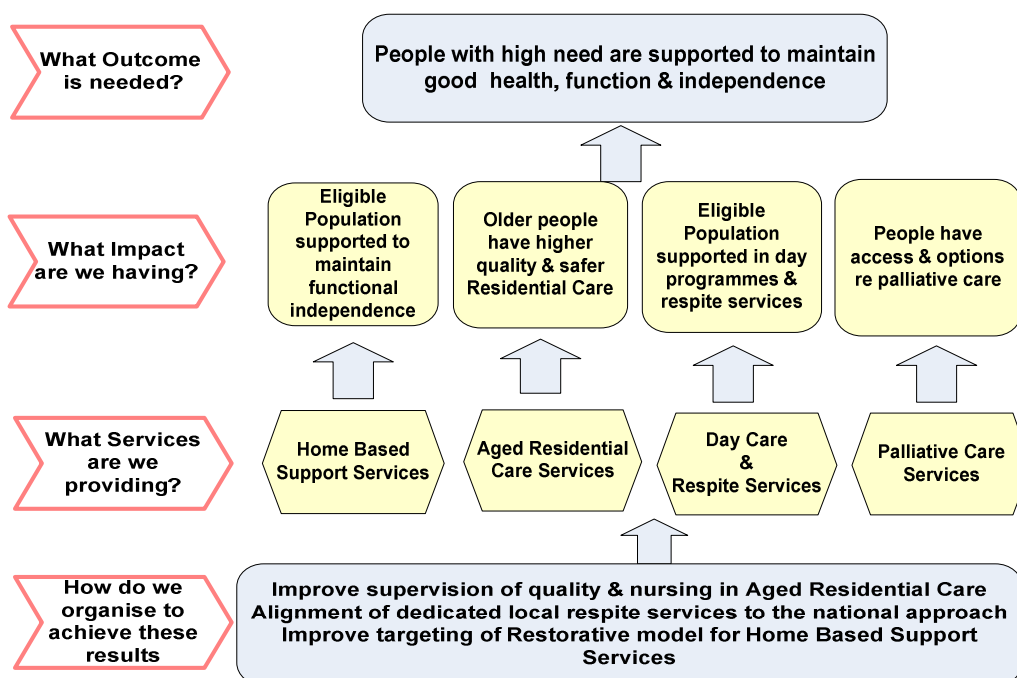
- Implement the plan to devolve relevant hospital services to community settings and make sure the success factors are in place to support this service change
- Intensive support for people with high needs including case management, cardiac rehabilitation for Maori and telemedicine options
- Provide certainty for better, more convenient access to elective services through local and regional planning. Increase the capacity of Greenlane to a full elective service centre
- Work with neighbouring District Health Boards to plan and implement regional solutions to more, better, higher quality hospital care delivery through long term service planning
- Regional planning for new elective services centres
- Make sure our facilities are fit-for-purpose and support operational efficiency and effectiveness. Purchase, maintain and develop these facilities within budget
- Mental health services will deliver to Blueprint funding expectations. The services developed will be in line with regional plans and in line with the Auckland DHB prioritisation process
- Tertiary eating disorder service established according to plan
- Reconfiguration of services in two areas: Maori mental health services and the current levels 3 and 4 for residential rehabilitation
- Post natal stays will be extended in line with national expectations re maternity service improvements. Indicators will be used to determine the criteria for longer stays as contained in the service specification with average length of stay monitored. We will ensure the maximum use of bed capacity across primary and secondary facilities to support a longer length of stay

10. Output Class: Support Services

Auckland DHB aims to have a fully inclusive community, where people are supported to live with independence and can participate in their communities.

This section below outlines the hospital and related services that Auckland DHB delivers for its local population. Each aggregate includes people with long-term disabilities; people with mental health problems and people who have age-related disabilities.

These outputs are aggregated into: Home-based support services; Residential care support services; Day Services; and Palliative Care services.



Outputs	Measures	Targets			
		Baseline	2009-10	2010-11	2011-12
Home-based support services	Number of people ≥ 85 years who are able to remain in their own homes	3,097 *	5% increase	10% increase	15% increase
	Number of low level clients self managing on support packages with input from key workers	2,352 per year	10%	15%	20%
	Number of reassessments for clients receiving home based support services	Annual (1 per year)	25% increase	30% increase	35% increase
Residential care support services	Number of complaints from residential care	51	20% reduction	25% reduction	25% reduction
Palliative care services	Number of palliative clients accessing primary care under the subsidised DHB/PHO partnership	New initiative	20	25	30

Outputs	Measures	Targets			
		Baseline	2009-10	2010-11	2011-12
	Education sessions delivered by specialist providers to aged care facilities	6	10	12	12
Mental Health	Audit of residential mental health providers	30%	30% ***	30%	30%
	Percentage of people with enduring mental illness in paid work or education or appropriate discharges	10.9%	15%	15%	15%

* Based on 5, 679 total population of 85+ 2006 Census, and 2,582 clients in ARC at January 2009 (pre Inter District Flows)

** Based on 4,200 Home Based Support Service clients per year, where statistics indicate that 56% are Low Need

*** The target is for 30% of providers to be audited each year, with a 3 year target of approximately 100%

How we are organising to achieve results

The priority support services for 2009-10 are:

- Streamlined access to older people's services via a single point of entry to services and direct referral to community support
- Standardised assessment and referral pathways, 'individual client care packages' older persons' self-management of support services and increased access to information
- Web-based performance monitoring system to be introduced with training available within the sector
- Improvements to the quality of supervision and nursing in rest homes by directing new government funding to support and retain rest home staff
- Additional respite beds so older people can stay in their own homes and to support carers
- Enhanced home support capacity to address diversity among older people, with focus on South Asian communities
- Providers trained to implement restorative home care via a new contracting and monitoring system
- New Clinical Nurse Specialist positions will complete training in needs analysis in residential care. Training programmes include clinical mentorship and advice
- Residential rehab services for people with a mental illness will be reconfigured across levels 3 and 4 residential rehabilitation, consistent with the wider continuum of services
- Changes to palliative care will ensure that equipment is available for clients who choose to die at home and that an increasing number of patients will come under the care of a district nurse
- Develop after-hours services

11. Organisation Capability

DHB Planning and Funding of Services

Planning and Funding is responsible for funding most health services for the resident population of Auckland as well as a number of regional and national services. This involves funding for almost 1,000 providers including primary health care, mental health services, Maori and Pacific community based providers, and disability support services for older people. The total value of health service provided for people living in Auckland city (by our own Auckland DHB providers or from other providers) amounts to \$940 million.

Our key planning documents include:

- Child Health Improvement Plan, 2006 - 2011
- Healthy Ageing 2020
- Improving Outcomes for Cardiovascular Disease and Diabetes Plan, 2006 -2011
- Improving Cancer Control For Auckland City, 2007
- Mental Health and Addiction Plan, 2006 – 2011
- Maori Health Plan, 2007
- Primary care Plan, 2008

The three regional DHBs work closely together on issues in common, recognising the mobility of the greater Auckland population. Working regionally ensures that developments in one area of health do not create problems for others.

Clinical Quality and Professional Governance

The following four components comprise the Auckland DHB clinical quality and professional governance framework.

Professional governance	<p>Professional standards and development:</p> <ul style="list-style-type: none"> • setting clinical and cultural competency requirements and ethical standards • performance monitoring • compliance with credentialing standards and processes • professional development through ongoing education and training • workforce development
Quality/clinical effectiveness cycle	<p>Clinical quality, efficiency, safety, and value for money:</p> <ul style="list-style-type: none"> • clinical audit management, planning and monitoring • measuring efficiency, safety and value for money of clinical interventions • learning through research and audit • teaching/collaboration with academic institutions to support evidence-based clinical practice • integrated information management and technology services.
Policy and risk management	<p>Patient, staff and organisational risk management:</p>

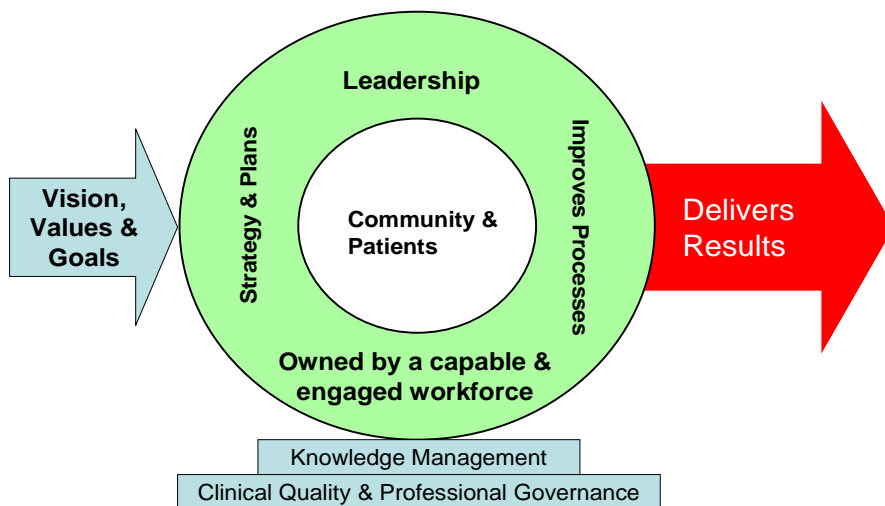
	<ul style="list-style-type: none"> • statutory regulation and compliance • ensuring safe work environments • high quality employment practices • consumer involvement • ongoing review of policy, systems, processes and guidelines • service contracts, specifications and accreditation.
Research and development	<p>Best practice based on evidence:</p> <ul style="list-style-type: none"> • research guidelines • transparent research governance and financing • integrated approach to the learning and clinical effectiveness cycle • health service research.

Accountability for clinical and professional governance lies with the Chief Executive, the Chief Medical Officer, the Executive Director of Nursing and the Director Allied Health, however the model applies to all clinicians and to all staff who interact with, and provide direct care to, patients.

The Auckland DHB system wide approach to quality (the Baldrige model)

Auckland DHB is now using the Baldrige model to get the best transfer of knowledge and skills. This helps our health system to better manage change in the future by solving our own problems and keeping attention and resources focused on key goals.

Our success factors are high performance (including financial performance, quality products and services, high productivity), continuous improvement, and a high quality of work life.



Information Management and Technology Services

A Regional Information Systems Strategic Plan (aligned with the Health Information Strategy for NZ) is aimed at improving continuity of care and health outcomes for patients through the exchange of information between health care providers. The top priorities are: improvements in information management support for chronic care management, child health, and generic improvements to sharing health event summaries across the region.

A review of the 'Regional Information Strategic Plan' is underway. The new 'Northern Regional Information Strategic Plan' will be completed by the end of 2008. Accordingly the Auckland DHB Information Management Framework reflects priorities at a national, regional, and local level across both primary and secondary care.

We are also progressing regional information technology projects including additional regionally shared and hosted systems such as eReferrals, Health Event Summaries, Endoscopy, Mental Health IS, Pacemaker management, etc. The Northern Region DHBs are collaborating on IT architecture and facilities design and a number of IT and telecommunications procurement initiatives.

Workforce Development

Auckland DHB Workforce Development strategy and initiatives span the whole health care system. We place a strong emphasis on having a healthy workplace because this is a prerequisite for successful workforce development. Teamwork, commitment to innovation, continuing professional development and education, shared learning and career development are all features of Auckland DHB's workforce development approach.

Collaboration

Working collaboratively with others, both across the sector and with other health and social service providers is integral to the success of Auckland DHB in achieving the goals set out in our District Strategic Plan. We are committed to sharing resources with regional DHBs and providers as well as collaborating with the Ministry, DHBNZ, NGOs and other service providers in order to achieve specific outcomes. We work closely with our Treaty partners, Tihi Ora MaPO.

Regional collaboration is outlined in the 'Northern Regional Network Strategy' which has been endorsed in principle by the CEOs and Boards. The strategy proposes a framework encompassing: Long term regional planning, employee relations and workforce, capital planning, information management, quality and innovation, and corporate support (i.e. back office, transactional activity).

The Northern Regional Network Strategy covers the implementation planning. Phase 2 of the Regional Plan will focus on secondary and tertiary services which have significant regional impact (with primary care inter-linkages acknowledged). Key work streams include clinical networks, regional services and clinical leadership, elective surgery and planned care, and urgent and emergency care.

Auckland DHB works with Waitemata DHB to:

- develop the required capacity to support the transfer of agreed renal services by June 2010
- define the scope and timing of Ophthalmology services and Chronic pain services
- develop an agreed service change plan between Auckland DHB and Waitemata DHBs for the next five years, by December 2009

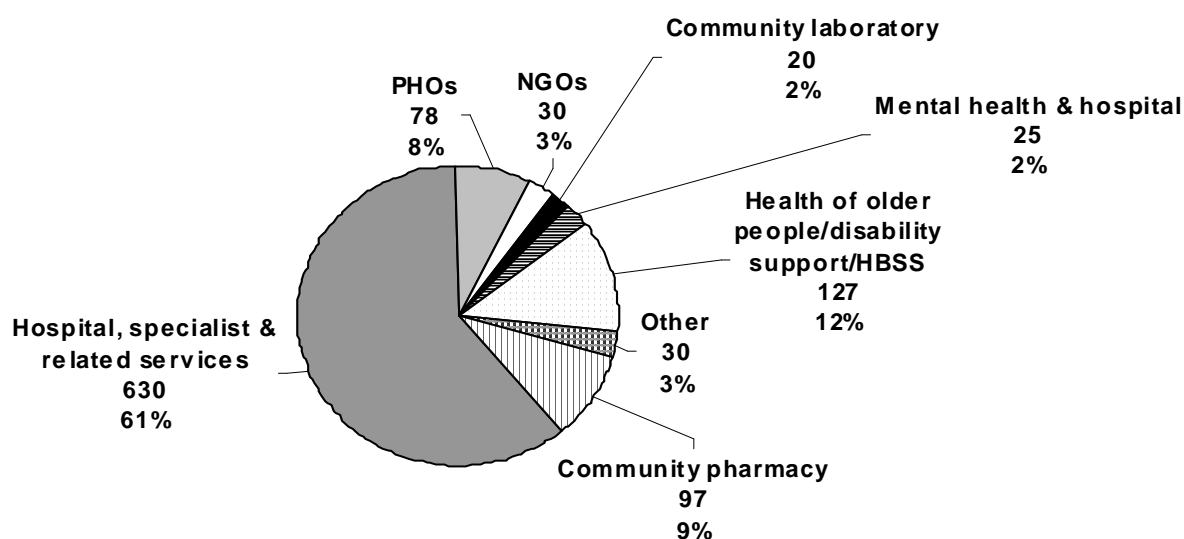
Work within the region	National work
<p>Long term health services planning</p> <p>Eating disorder service</p> <p>Northern Cancer Network and related activities</p> <p>The Northern Regional Collaboration</p> <p>Regional plastic service review</p> <p>Regional service planning work programme</p> <p>Transition of community laboratory services to the new provider</p> <p>Long Term Pharmacy Strategy</p> <p>Regional planning for elective services centres</p> <p>Progress the three key joint agency projects and support the action required: Tamaki project, disability work, Homelessness taskforce</p>	<p>Advance the five national quality improvement projects</p> <p>Auckland DHB is taking the lead in the national project to improve hospital infection prevention and control</p> <p>Assess the health of children in the care of Child Youth and Families Services</p> <p>Universal newborn hearing screening</p> <p>“Donation After Cardiac Death” initiative</p> <p>B4 School Checks</p> <p>National services underway to evaluate new technologies</p> <p>Rollout of HPV Vaccination for 13-18 years</p> <p>Auckland DHB in partnership with Hutt DHB re a national rheumatology service</p> <p>Introduction of casemix funding for maternity services</p> <p>Auckland DHB taking the lead role in Maternal Fetal Medicine (funded by Ministry of Health)</p>

12. Managing our Financial Resources

Funding Allocation

The district-wide allocation of the funding envelope is as follows. The funding available to Auckland District Health Board is calculated each year on a population-based funding formula. For the Auckland district health board population, funding has been allocated across health services in the following manner.

Funding allocation in dollars (m) and percentages for 2009-10



For 2009-10, the district-wide allocation of the funding envelope (non-IDF) will be as follows:

Funding allocation for the Auckland DHB population	Proportion of the funding	
	Auckland DHB provider	Non-Auckland DHB provider
Personal health	\$329m	\$20m
Additional electives	\$18m	\$9.2
Pharmaceuticals	\$50m	\$97m
Laboratory services	\$26m	\$20m
Primary health organisations & related GP services e.g. GMS & PNS	0	\$78m
Mental health	\$88m	\$25m
Health of older people/residential care & home support	\$32m	\$95m
Other:		
public health	\$5m	
clinical education	\$20m	\$28m
Total	\$568m*	\$372.2m

* includes \$97 million of IDF outflows and finance costs/depreciation

2009–10 funding compared to 2008–09

	2008–09	2009–10
Population-based funding	\$847 million	\$893 million*
Top slice/ national contracts	\$26.2 million	\$36.9 million**
Additional elective spending	\$17.7 million	\$18.6 million
Other funds (inter-district in flows)	\$518 million	\$569 million
Total	\$1.41 billion	\$1.52 billion (ADHB funder revenue 2009-10)

* This figure includes additional funding, such as the caveat loan income for ARC (\$3 million)

** This figure is for national services – Auckland DHB has population rated proportionate 'share' = \$3.3m (at 9% relative population)

Funded new initiatives that support implementation of our strategic direction

Project	2009–10	Sustainable	Source of funds
Implementing the Auckland DHB Tobacco Control Plan	\$492,920	\$492,920	Ministry of Health
Specialist Pregnancy Smoking Cessation Service	\$338,698	\$338,698	Ministry of Health
Increased access to diagnostics in primary care	\$400,000	\$400,000	Auckland DHB
Clinical Nurse Specialist to support residential care	\$90,000	\$90,000	Auckland DHB
Improved access to Primary Care for Palliative patients	\$298,000	\$298,000	Auckland DHB

Capital expenditure

For the three years covered by this plan the following significant capital expenditure projects are planned.

Year Ending 2010

Expenditure

\$000

GCC New Elective Surgery Facility	9,100 unapproved
Car Park –Auckland City	6,900 unapproved
Oral Health Clinics	3,609
Relocation of IMTS, Finance and Quality from Building 10	1,900
Cogen steam generators	1,900
New wards ACH Support Building level 14	7,000
Child & Family unit ex Starship	250
Starship MRI	4,500
Replacement Linear accelerators Bldg 8	3,920
Total	39,079

Funding

\$000

Internal from depreciation	14,970
Ministry approved equity	3,609
Crown Health Funding Agency	16,000
Donations	4,500
	39,079

Year Ending 2011

Expenditure

\$000

GCC New Elective Surgery Facility	9,100 unapproved
Balance of new Carp park Auckland City	16,100 unapproved
Oral Health	3,404
Child & Family unit ex Starship	13,750
Balance of New wards ACH Support Building level 14	800
Replacement Linear accelerators Bldg 8	3,800
Eating Disorders inpatient unit	3,520
Total	50,474

Funding

\$000

Internal depreciation	21,870
Ministry approved equity	3,404
Crown Health Funding Agency	25,200
Total	50,474

Year Ending 2012

Expenditure

\$000

GCC New Elective Surgery Facility	13,800 unapproved
Future Regional Electronic Patient Records & Patient Management System	7,940
Oral Health	3,404
Replacement Linear accelerators Bldg 8	4,000
Replacement of MRI Suite Level 5 Bldg 32	5,800
Starship Theatres redevelopment	7,300
	42,244

Funding

\$000

Internal depreciation	25,040
Crown Health Funding Agency	13,800
Ministry approved equity	3,404
	42,244

Financial Management

The Letter of Expectation requires the organisation to achieve a break even position within the allocated funding. This will require reprioritisation and reallocation of resources.

The significant pressure on costs and cost growth, arising from increased service delivery requirements and the labour market, means our drive to reduce 'transaction cost' throughout the organisation is an imperative. Our District Annual Plan incorporates a number of initiatives to reduce costs, including requirements for improved productivity, clinical resource utilisation and practice change, reduced administrative costs and procurement savings. This includes reducing management and administration FTE numbers below the Minister's December 2008 cap levels, with the processes and rules for managing this cap now in place.

Key assumptions within the financial plans include:

- There is significantly reduced interest income in 2009-10 due to lower interest rates. This reflects the impacts of the world economic crisis which also causes uncertainty in terms of there being a new world paradigm in which established historical practices and expectations may no longer apply
- The world economic recession also creates uncertainty and risk regarding the future levels of donation income that will be received.
- Inflation is generally assumed at 2.7%. The potential future impact of the forex rate movements is uncertain, particularly in times of a worldwide recession. A one percent inflationary movement in the cost of goods and services equates to approximately \$8 million at Auckland DHB
- Employee terms and conditions are subject to negotiation and interpretation. The impact of employee wage rate settlements have been estimated for inclusion in the financial plans based on agreed MECA settlements through to their expiry date. There is an uncertain impact arising from job sizing which will need to be absorbed within the overall budget. A 1% variation in employee costs equates to approximately \$7m at Auckland DHB
- There is uncertainty in property market values, particularly under the new world economic environment. Accordingly it is assumed that there will be no change in the revaluation reserve. It is assumed that funding arrangements in relation to depreciation and capital charges arising from the revaluation reserve will not change.
- As advised in the Crown funding letter, the future funding track is assumed to grow at 3.6% and 3.7% for 2010-11 and 2011-12 respectively
- Blueprint funding for mental health is not confirmed for the 2009-10 year and this revenue is not included in our assumptions. If received, the blueprint funding will be targeted to specific Mental Health priorities
- There are set criteria to determine the application of Future Funding Track (FFT) to specified Health of Older Persons and Personal Health Agreements. The Service Agreements included within this process are those excluded from nationally or regionally negotiated pricing increases. The criteria aim to achieve consistency between the prices of similar services at a local, regional and national level - based on affordability.

As assumptions are made due to there being uncertain or unknown future events, they inherently represent a risk in that actual events may vary from the assumption. Similarly, actions which require a change from current processes and activities inherently represent a risk due to the need for a change in established practices and behaviours.

The Financial Plan 2009–12

Table 1: Statement of financial performance

	2007–08 Actual \$000	2008–09 Forecast \$000	2009–10 Plan \$000	2010–11 Estimate \$000	2011–12 Estimate \$000
REVENUE					
Base funding					
Population based	850,347	913,002	941,661	975,560	1,011,656
Inter-district flows	503,515	511,341	563,869	584,169	605,783
Adjustments to base funding					
Inter-district flows – additional price allowance	-	6,150	-	-	-
Asset revaluation	-	-	-	-	-
	1,353,862	1,430,493	1,505,530	1,559,729	1,617,439
Side contracts with Ministry of Health					
Additional electives	17,151	17,456	18,611	19,281	19,995
Public health	16,656	15,759	16,253	16,838	17,461
Other side contracts	22,234	31,096	29,601	30,666	31,801
	56,041	64,311	64,465	66,786	69,257
Other revenue					
Other patient care	34,508	35,460	36,009	37,306	38,686
External	85,901	98,747	87,521	87,459	92,865
	120,409	134,207	123,531	124,765	131,551
TOTAL REVENUE	1,530,312	1,629,011	1,693,526	1,751,279	1,818,247
OPERATING COSTS					
Employee costs	640,017	679,498	719,323	742,366	772,389
Treatment costs	223,214	246,438	248,627	257,577	267,108
Funder payments	489,308	520,788	543,114	562,667	583,485
Property and equipment maintenance	51,115	51,294	53,100	54,990	57,025
Administration	19,192	20,355	18,709	19,383	20,100
TOTAL OPERATING COSTS	1,422,846	1,518,373	1,582,873	1,636,983	1,700,107
OPERATING SURPLUS/(DEFICIT)	107,466	110,638	110,652	114,296	118,139
NON-OPERATING COSTS					
Depreciation	44,650	48,302	50,824	55,274	59,647
Interest	22,018	20,923	20,311	19,406	18,876
Capital charge	38,405	41,413	39,501	39,600	39,600
TOTAL NON-OPERATING COSTS	105,073	110,638	110,636	114,280	118,123
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	2,393	(0)	16	16	17

Table 2: Statement of financial performance by output class

	2007–08 Actual \$000	2008–09 Forecast \$000	2009–10 Plan \$000	2010–11 Estimate \$000	2011–12 Estimate \$000
Governance					
Total Revenue	3,006	3,214	4,952	5,130	5,320
Employee costs	(5,538)	(6,404)	(7,698)	(7,975)	(8,270)
Other operating costs	(4,982)	(5,562)	(5,122)	(5,306)	(5,503)
Operating costs	(10,520)	(11,966)	(12,820)	(13,282)	(13,773)
Operating margin	(7,514)	(8,752)	(7,868)	(8,151)	(8,453)
Non-operating costs					
Depreciation, interest and capital charge	(14)	(13)	(11)	(11)	(11)
Net surplus/(deficit) – governance	(7,528)	(8,765)	(7,879)	(8,162)	(8,464)
Provider					
Total Revenue	1,011,393	1,066,362	1,137,946	1,175,698	1,221,369
Employee costs	(634,479)	(673,094)	(711,625)	(734,392)	(763,382)
Treatment costs	(223,046)	(246,329)	(242,526)	(251,257)	(260,553)
Property and equipment maintenance	(50,219)	(48,623)	(50,573)	(52,394)	(54,332)
Administration	(12,759)	(13,811)	(19,812)	(20,503)	(21,999)
Operating costs	(920,503)	(981,857)	(1,024,536)	(1,058,545)	(1,100,267)
Operating margin	90,890	84,505	113,410	117,153	121,102
Non-operating costs					
Depreciation, interest and capital charge	(105,059)	(110,625)	(110,625)	(114,269)	(118,112)
Net surplus/(deficit) – provider	(14,169)	(26,120)	2,785	2,885	2,991
Funder					
Total Revenue	515,913	559,435	550,628	570,451	591,557
Funder payments					
Personal health	(287,573)	(313,915)	(324,442)	(336,122)	(348,558)
Medical/surgical	(45,803)	(45,636)	(48,864)	(50,623)	(52,496)
Mental health	(47,941)	(47,910)	(50,826)	(52,656)	(54,604)
Public health	(1,090)	(1,011)	(245)	(254)	(263)
Disability support	(109,118)	(115,775)	(120,780)	(125,128)	(129,758)
For Maori by Maori	(298)	(303)	(361)	(374)	(388)
Operating costs	(491,823)	(524,550)	(545,518)	(565,157)	(586,067)
Operating margin	24,090	34,885	5,110	5,294	5,490
Net surplus/(deficit) – funder	24,090	34,885	5,110	5,294	5,490
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	2,393	(0)	16	16	17

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Table 3: Employee costs and FTE

	2007-08 Actual \$000	2008-09 Forecast \$000	2009-10 Plan \$000	2010-11 Estimate \$000	2011-12 Estimate \$000
Medical	194,530	203,443	221,712	229,694	238,192
Nursing	202,876	221,121	236,551	245,067	254,134
Technical	103,504	110,097	119,364	123,661	128,237
Hotel services	9,399	9,222	9,743	10,094	10,467
Administration and stores	89,253	92,149	88,748	91,943	95,345
	599,562	636,032	676,118	700,458	726,375
% increase over prior year	6.8%	6.1%	6.3%	3.6%	3.7%
Other employee-related expenses	40,445	43,466	43,205	44,760	46,417
% increase over prior year	23.0%	7.4%	(0.6%)	3.6%	3.7%
Auckland DHB issues – savings required	-	-	-	(2,852)	(402)
	40,455	43,466	43,205	41,908	46,015
	640,017	679,498	719,323	742,367	772,390
% increase over prior year	7.7%	6.2%	5.9%	3.2%	4.0%

FTE measurement basis	Accrued FTE	Accrued FTE	Accrued FTE	Accrued FTE	Accrued FTE
Average FTE numbers FY 30 June – including additional MH FTE	7,423	7,679	7,759	7,875	7,994
Average salary	\$80,771	\$82,827	\$87,140	\$88,943	\$90,871
% increase	7.4%	2.5%	5.2%	2.1%	2.2%

Capping Growth in Management & Administration FTE (Note – FTE numbers are as at 31 Dec 2008 & 2009 respectively for comparative purposes)	Advised 28 April- 2009	Plan Year 2009-10	Variance
FTE per Monthly Template	1,444.03	1,370.00	(74.03)
Vacancies			
Advertised not Filled	48.69		(48.69)
Advertised Filled Subsequently	13.80		(13.80)
Not advertised as yet	29.00		(29.00)
Covered by Contractors	60.10		(60.10)
Covered by Consultants	5.92		(5.92)
	157.51	-	(157.51)
Temporary Cover for Annual Leave in Essential Risks	48.00	36.34	(11.66)
Demand Driven Projects			
Covered by Contractors	38.80		(38.80)
Covered by Consultants	3.37	21.04	17.67
	42.17	21.04	(21.13)
Allowance for National Programmes	12.70		(12.70)
Total Management & Administration FTE	1,704.41	1,427.38	(277.03)

Table 4: Statement of financial position

	2007–08 Actual \$000	2008–09 Forecast \$000	2009–10 Plan \$000	2010–11 Estimate \$000	2011–12 Estimate \$000
ASSETS					
Current assets					
Cash, bank balances and investment bonds	79,181	62,222	62,396	79,240	74,644
Restricted trust funds	13,889	15,264	15,264	15,264	15,264
Receivables and prepayments	78,553	43,602	45,934	47,344	48,902
Inventories	10,762	10,896	11,348	11,756	12,191
Property intended for resale	100	-	-	-	-
	182,485	131,984	134,942	153,604	151,002
Non-current assets					
Restricted trust funds	4,850	5,500	5,500	5,500	5,500
Property, plant and equipment	928,186	921,820	930,128	943,064	941,222
Intangible assets	10,596	9,317	11,185	11,975	11,671
Derivatives in gain	1,727	5,571	2,823	73	73
Investment in associates	366	366	366	366	366
	945,725	942,574	950,002	960,978	958,831
TOTAL ASSETS	1,128,210	1,074,558	1,084,944	1,114,582	1,109,833
LIABILITIES					
Current liabilities					
Bank overdraft	-	-	-	-	-
Payables and accruals	259,018	247,041	256,181	274,957	274,870
Borrowings	15,584	18,373	18,253	15,978	17,096
Funds held in trust	983	1,028	1,100	1,172	1,244
Derivatives in loss	-	-	-	-	-
	275,585	266,442	275,533	292,106	293,210
Non-current liabilities					
Payables and accruals	21,063	24,790	25,818	26,623	27,608
Borrowings	282,430	269,193	265,834	274,675	264,416
	303,493	293,983	291,652	301,297	292,023
TOTAL LIABILITIES	579,078	560,425	567,185	593,404	585,233
EQUITY					
General funds					
Opening balance	129,618	132,117	97,118	100,743	104,163
Net surplus/(deficit)	2,393	1	16	16	17
Capital contributions	106	(35,000)	3,609	3,404	3,404
Capital withdrawals	-	-	-	-	-
Closing balance	132,117	97,118	100,743	104,163	107,584
Revaluation reserve					
Opening balance	417,016	417,016	417,016	417,016	417,016
Movement in revaluation reserve					
– Land	-	-	-	-	-
– Buildings	-	-	-	-	-
Total movement in revaluation reserve	-	-	-	-	-
Closing balance	417,016	417,016	417,016	417,016	417,016
TOTAL EQUITY	549,133	514,134	517,759	521,179	524,600
NET ASSETS	1,128,211	1,074,559	1,084,944	1,114,583	1,109,833

Table 5: Statement of cash flows

	2007-08 Actual \$000	2008-09 Forecast \$000	2009-10 Plan \$000	2010-11 Estimate \$000	2011-12 Estimate \$000
CASH FLOWS FROM OPERATING ACTIVITIES					
Cash was provided from					
Provision of health services	1,525,555	1,611,700	1,688,973	1,747,146	1,810,603
Repayment of debtors by the Crown	41,931	36,957	-	-	-
Interest received	10,612	12,567	4,459	5,111	5,729
	1,578,098	1,661,224	1,693,432	1,752,257	1,816,332
Cash was applied to					
Employee costs	(587,525)	(682,507)	(711,478)	(725,268)	(774,701)
Other operating costs	(840,515)	(886,390)	(900,650)	(931,781)	(964,186)
Interest paid	(22,041)	(20,871)	(20,190)	(18,440)	(17,517)
	(1,450,081)	(1,589,768)	(1,632,318)	(1,675,489)	(1,756,404)
Net cash flow from operating activities	128,017	71,456	61,113	76,768	59,928
INVESTING ACTIVITIES					
Cash provided from					
Proceeds from sale of fixed assets	165	67	(21)	-	-
Proceeds from sale of financial instruments	-	-	-	-	-
Decrease(increase) in restricted trust funds	(1,719)	(1,980)	72	72	72
	(1,554)	(1,913)	51	72	72
Cash was applied to					
Purchase of fixed assets and intangibles	(33,550)	(41,000)	(61,000)	(69,000)	(57,500)
Net cash (outflow) from investing activities	(35,104)	(42,913)	(60,949)	(68,928)	(57,428)
FINANCING ACTIVITIES					
Cash provided from					
Proceeds from capital raised/(repaid)	106	(35,000)	3,609	3,404	3,404
Proceeds from loans raised	13	-	6,900	16,100	-
Loans Repaid	(10,500)	(10,500)	(10,500)	(10,500)	(10,500)
Net cash (outflow) from financing activities	(10,381)	(45,500)	9	9,004	(7,096)
OPENING BANK BALANCE	(3,351)	79,181	62,222	62,396	79,240
NET CASH INFLOW(OUTFLOW)	82,532	(16,958)	(173)	16,844	(4,596)
CLOSING BALANCE	79,181	62,223	62,396	79,240	74,644

Reconciliation of operating deficit with cash flows from operating activities	2007-08 Actual \$000	2008-09 Forecast \$000	2009-10 Plan \$000	2010-11 Estimate \$000	2011-12 Estimate \$000
Total surplus/(deficit) for the year	2,393	(0)	16	16	17
Non-cash items					
Depreciation and impairment losses	44,659	48,302	50,824	55,274	59,647
(Gains)/Losses on Financial Instruments	(2,128)	(3,844)	2,748	2,750	-
Amortisation of borrowing costs	221	239	240	240	240
	42,752	44,697	53,812	58,264	59,887
Items classified as investing activities					
Gain on sale of property, plant and equipment	106	378	21	-	-
Movement in working capital					
(Increase)/decrease in receivables	47,148	34,952	(2,333)	(1,410)	(1,558)
(Increase)/decrease in inventories	(355)	(134)	(452)	(409)	(435)
(Increase)/decrease in payables	35,973	(8,437)	10,049	20,306	2,018
	82,766	26,381	7,264	18,488	24
Net cash flow from operating activities	128,017	71,456	61,113	76,768	59,928

Table 6: Balance sheet equity ratio

	2007–08 Actual \$000	2008–09 Forecast \$000	2009–10 Plan \$000	2010–11 Estimate \$000	2011–12 Estimate \$000
Equity position					
Crown equity	(539,143)	(504,099)	(507,652)	(511,000)	(514,349)
Trust equity	(9,990)	(10,035)	(10,107)	(10,179)	(10,251)
Total equity	(549,133)	(514,134)	(517,759)	(521,179)	(524,600)
Total debt					
Bank	-	-	-	-	-
Bonds	(120,000)	(120,000)	(120,000)	(50,000)	(50,000)
Crown funding authority	(174,000)	(163,500)	(159,900)	(235,500)	(225,000)
	(294,000)	(283,500)	(279,900)	(285,500)	(275,000)
Total debt	(294,000)	(283,500)	(279,900)	(285,500)	(275,000)
Total debt + equity	(843,133)	(797,634)	(797,659)	(806,679)	(799,600)
Equity ratio – to be less than 65%	34.9%	35.5%	35.1%	35.4%	34.4%

Statement of Accounting Policies

The reporting entity is the Auckland District Health Board which was created by the New Zealand Public Health and Disability Act 2000. Auckland DHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

Auckland DHB's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions, e.g. laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services of the regions, and Maori health.

Accounting policies remain unchanged from the previous year.

Basis of preparation

The consolidated financial statements in this plan have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). In line with other District Health Boards, Auckland DHB has adopted International Financial Reporting Standards (IFRS). The first set of financial reports using IFRS was completed for the financial year ended 30 June 2008.

Auckland DHB is a public benefit entity, as defined under New Zealand equivalent to International Accounting Standard Number 1 (NZ IAS 1). Auckland DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, Public Finance Act 1989 and Crown Entities Act 2004.

Balance sheet values in this plan are prepared on the historical cost basis except that the following assets and liabilities are stated at their revalued amount and fair value respectively – certain land and buildings and financial assets and liabilities.

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

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by Auckland DHB. Control exists when Auckland DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. Auckland DHB is the main beneficiary of the Auckland District Health Board Charitable Trust. Accordingly, the assets and liabilities of the Auckland DHB Charitable Trust are consolidated into the balance sheet of Auckland DHB. Consistent accounting policies have been used for both parent and subsidiary.

Associates/Joint Ventures

Associates are those entities in which Auckland DHB has significant influence, but not control, over the financial and operating policies. A joint venture is an entity over whose activities Auckland DHB has joint control, established by contractual agreement. Auckland DHB has shareholdings in the following associates: Auckland Regional RMO Services Ltd (33% owned) and Northern DHB Support Agency Limited (33% owned).

Associates and joint ventures are accounted for at the original cost of the investment plus Auckland DHB's share of the change in the net assets of the associate or joint venture on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When Auckland DHB's share of losses exceeds its interest in an associate or joint venture, the carrying amount is reduced to nil and recognition of further losses is discontinued, except to the extent that Auckland DHB has incurred legal or constructive obligations or made payments on their behalf. There are no differences in accounting policies between the parent and associate or joint venture entities.

Transactions eliminated on consolidation

All inter-entity transactions are eliminated on consolidation.

Foreign currency

Both the functional and presentation currency of Auckland DHB and Group is New Zealand dollars (NZD). Transactions in foreign currencies are translated at the exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the rate ruling at that date. Foreign exchange differences arising on translation and settlement are recognised in the income statement. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Property, plant and equipment (PPE)

The major classes of property, plant and equipment	Freehold land Land improvements Plant and equipment Freehold buildings Building fitout and services Leasehold improvements Work in progress Leased plant and equipment						
Owned assets	<p>Except for land and buildings (as well as the assets vested from the hospital and health service – see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.</p> <p>Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. The latest revaluation was done on 30 June 2008.</p> <p>Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the income statement in which case the increase is recognised in the income statement.</p> <p>Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the income statement.</p> <p>Additions to property, plant and equipment between valuations are recorded at cost.</p> <p>Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for separately.</p>						
Property, plant and equipment vested from the hospital and health service	<p>Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Auckland Healthcare Services Limited (a hospital and health service) vested in Auckland DHB on 1 January 2001. Accordingly, assets were transferred to Auckland DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.</p>						
Disposal of property, plant and equipment	<p>Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the income statement is calculated as the difference between the net sales price and the carrying amount of the asset.</p>						
Leased assets	<p>Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at the inception of the lease, less accumulated depreciation and impairment losses. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.</p> <p>Operating lease payments are recorded as an expense in the income statement on a straight-line basis over the lease term.</p>						
Subsequent costs	<p>Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the future economic benefit embodied within the item will flow to Auckland DHB. All other costs are recognised in the income statement as an expense as incurred.</p>						
Depreciation	<p>Depreciation is charged to the income statement using the straight line method. Land is not depreciated. Depreciation is set at rates that write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:</p> <table border="1" data-bbox="432 1890 1214 2009"> <thead> <tr> <th data-bbox="432 1890 970 1935">Asset class</th> <th data-bbox="970 1890 1214 1935">Useful lives</th> </tr> </thead> <tbody> <tr> <td data-bbox="432 1935 970 1980">Freehold buildings</td> <td data-bbox="970 1935 1214 1980">1–89 years</td> </tr> <tr> <td data-bbox="432 1980 970 2009">Plant and equipment</td> <td data-bbox="970 1980 1214 2009">2–20 years</td> </tr> </tbody> </table>	Asset class	Useful lives	Freehold buildings	1–89 years	Plant and equipment	2–20 years
Asset class	Useful lives						
Freehold buildings	1–89 years						
Plant and equipment	2–20 years						

	Building fit-out and services Leased plant and equipment Leasehold improvements	1–45 years 4–8 years 6–8 years	
	The residual value, useful life and depreciation method of assets is reassessed annually. Work-in progress is not depreciated. The total cost of a project is transferred to property, plant and equipment on its completion and then depreciated.		
Intangible assets	Computer software not an integral part of the related hardware is treated as an intangible asset. Such intangible assets are acquired separately and are capitalised at cost. The useful lives are assessed as finite and amortisation expense is taken to the income statement. Intangible assets are tested for impairment where an indicator of impairment exists. Useful lives and amortisation methods are also examined on an annual basis and adjustments, where applicable, are made on a prospective basis.		

Interest-bearing borrowings

All interest-bearing borrowings are initially recognised at fair value net of transaction costs that are directly attributable to the issue. After initial recognition, borrowings are measured at amortised cost using the effective interest method. Amortised cost is calculated by taking into account any issue costs, and any discount or premium on settlement.

Derivative financial instruments

Auckland DHB uses interest rate swaps to hedge its exposure to interest rate risks arising from financing activities. Such derivatives are accounted for as trading instruments, and are stated at fair value. The fair value of interest rate swaps is the estimated amount that Auckland DHB would receive or pay to terminate the swaps at balance date taking into account the current interest rates and the current creditworthiness of the counterparty.

Trade and other receivables

Trade and other receivables are recognised and carried at original invoice amount less an allowance for any uncollectible amounts. An estimate for doubtful debts is made in accordance with the Board's credit management policy. Bad debts are written off during the period in which they are identified.

Inventories

All items are valued at the lower of cost, determined on a first-in first-out basis, and current replacement cost. Current replacement cost is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses. Standard costs are reviewed at least once a year and revised in the light of current conditions as required. A provision for slow moving or obsolete stock is made.

Cash and cash equivalents

Cash and cash equivalents comprise cash balances and call deposits. Bank overdrafts that are repayable on demand and form an integral part of Auckland DHB's cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flows.

Non-current assets classified as held for sale

Properties intended for sale are measured at the lower of carrying amount or fair value less costs to sell.

Impairment

The carrying amounts of Auckland DHB's assets are reviewed at balance date to determine whether there is any indication of impairment. If such an indication exists, the assets' recoverable amounts are estimated. If the estimated recoverable amount of an asset is less than its carrying value, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the income statement.

Calculation of recoverable amount

The estimated recoverable amount of assets other than trade debtors above is the greater of their fair value less costs to sell and value in use. In assessing value in use, the estimated future cash flows are discounted to their present value using a discount rate that reflects market assessments of the time value of money and the risks specific to the asset. For non-cash generating assets that are not part of a cash generating unit, e.g. land and buildings, value in use is based on depreciated replacement cost (DRC). Impairment losses and reversals of impairment losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount. An impairment loss on items of property, plant and equipment carried at revalued amounts is reversed through the relevant reserve to the extent that the impairment loss was previously recognised directly against any revaluation surplus. All other impairment losses are reversed through the income statement. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Investments

Restricted trust funds are initially recognised at cost, being the fair value of the consideration given. After initial recognition, these investments are classified at fair value through profit and loss and are measured at fair value. Gains or losses on restricted trust funds are recognised in the income statement.

Employee benefits

Defined contribution plans (DCP)	Obligations for contributions to defined contribution plans are recognised as an expense in the income statement as incurred.
Retiring gratuities and long service leave	Auckland DHB's net obligation in respect of retiring gratuities and long service leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods calculated on an actuarial basis.
Annual leave, sick leave, continuing medical education leave and expenses	Annual leave is a short-term obligation and is calculated on an actual basis at the amount Auckland DHB expects to pay when staff take leave or resign. Sick leave is a short-term obligation which represents the estimated future cost of sick leave attributable to the entitlement not used at balance date calculated as the amount expected to be paid. Continuing medical education leave and expenses are calculated based on a discounted valuation of the estimated three years non-vesting entitlement under the current collective agreement with senior medical officers based on current leave patterns.

Provisions

A provision is recognised when Auckland DHB has a present obligation (legal or constructive) as a result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation and a reliable estimate can be made. If the time-value of money is material the obligation is discounted to its present value, at a rate that reflects the current market assessment of the time value of money and the risks specific to the liability.

Restructuring

A provision for restructuring is recognised when Auckland DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Revenue recognition

The majority of revenue is provided through an appropriation with a Crown Funding Agreement. Revenue is received monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

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

Auckland DHB is required to recognise and expend all monies appropriated within certain contracts, e.g. the mental health ring-fence on mental health services, during the year in which it was appropriated. Should this not be done, Auckland DHB may be required to repay the money or, with the agreement of the funder, to expend it on health services in subsequent years. Such revenue is included in Payables and Accruals in the Statement of Financial Position until the time this obligation is discharged.

Trust and special fund donations received are treated as revenue on receipt, in the Statement of Financial Performance. These funds are administered by the Auckland District Health Board Charitable Trust. Trust and special funds from third party trusts are recognised as revenue only when actually receipted. Interest income is recognised using the effective interest method.

Income tax

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

Goods and Services Tax (GST)

All amounts are shown exclusive of GST, except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Borrowing costs

Borrowing costs are recognised as an expense when incurred.

Statement re other arrangements

For the purposes of s25 of the New Zealand Public Health and Disability Act, Auckland DHB is permitted by this annual plan to enter into service agreements, on terms and conditions it considers appropriate for the particular services or outcomes intended to be achieved by that individual service agreement. These service agreements are in accordance with, and to advance, the strategic objectives and outcomes outlined in this annual plan or are to deliver the services Auckland DHB is required by statute or contract with the Crown or other parties to deliver.

Under s24 of the New Zealand Public Health and Disability Act, Auckland DHB is permitted to enter into co-operative agreements or arrangements with any person in order to assist in meeting its objectives or to enhance health or disability outcomes for people or to enhance efficiencies in the health sector where that agreement or arrangement is authorised by its annual plan.

Other Provisions

Capital expenditure

Our normal capital expenditure will be some \$10 million less than depreciation, reflecting the Board's desire to repay debt. The precise list of projects within the capital budget has yet to be finalised, all projects will be subject to normal business case and Board approvals and, where required, regional and Ministerial approvals.

Surplus land

The procedure for disposal of Surplus land is subject to due process with regard to the New Zealand Public Health and Disabilities Act 2000, including Ministerial approval, Public Works Act 1981, S.40, the mechanism for protection of Maori interests in Crown owned land and any other interests registered on the title or under any other applicable legislation (e.g. Reserves Act 1977), is held at cost as property intended for resale. There are no plans to sell assets in 2009–10 or the outer years.

Key lenders and arrangements

Bonds	\$120 million: \$70 million to mature 2010* \$50 million to mature 2015 * Commitment by Crown Health Funding Agency to fund
Crown Health Funding Agency	\$184.5 million reducing by \$10.5 million per annum
Commonwealth Bank of Australia	\$65 million working capital facility

Key lenders and applicable covenants

Key lenders	Covenants to all lenders
Commercial Bank of Australia Crown Health Financing Agency Bonds on issue	Cashflow from operations greater than zero Debt to debt + equity less than 65%