



Auckland District Health Board

Statement of Intent 2010–13

21 June 2010

Status of document

This is the Statement of Intent for 2010-13 prepared by the Auckland District Health Board, Private Bag 92 189, Auckland, New Zealand.

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

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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).

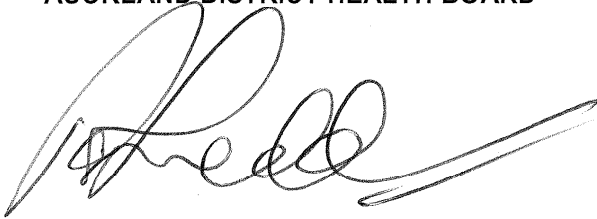
In the current economic environment of increasing fiscal restraint, this Statement of Intent (SOI) sets out the District Health Board (DHB) strategic direction for the next three years. This includes the outcomes we aim to deliver and the investment we will make in our organisation to make this successful. Although, the work within our DHB is diverse, and the links are complex, as an organisation we actively support our population towards achieving healthier and more independent lives. Accordingly, this Statement of Intent has been developed in conjunction with government expectations, local priorities, legislative compliance and public sector accountability.

This document outlines the intended performance for 2010–11 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 2010 to 2013 is signed for and on behalf of the:

AUCKLAND DISTRICT HEALTH BOARD

TE RUNANGA O NGATI WHATUA



Pat Snedden
Chair

Date
29.6.10



R. Naida Glavish JP.
Chair

Date
29.6.10



Harry Burkhardt
Deputy Chair

Date
29/6/10

Implementing Te Tiriti o Waitangi

The DHB recognises and respects Te Tiriti o Waitangi as the founding document of New Zealand. The Te Tiriti o 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 Te Tiriti o 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*.

Co-operative Rangatiratanga and Kawanatanga

The DHB and Te Runanga o Ngati Whatua (including its health arm) hold a Memorandum of Understanding. The Memorandum outlines key principles, processes and protocols for working together at both governance and operational levels. 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 arm. 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. Strategic Context for the Statement of Intent

The Legislative Framework

There are 21 District Health Boards (DHBs) throughout New Zealand. They were set up under the New Zealand Public Health and Disability Act 2000 which set out the roles and functions of the DHBs. Their main responsibility is to provide, or fund the provision of, health and disability services in their district, with the purpose of:

- improving, promoting, and protecting the health of communities;
- promoting the integration of health services, especially primary and secondary care services;
- promoting effective care or support of those in need of personal health services or disability support

Within the responsibility of identifying and providing for the health needs of their district DHB's are required to prepare district strategic (DSP) and annual plans (DAP) that are consistent with New Zealand's health and disability strategies¹. Each year, DHB's also publish a Statement of Intent (SOI), which is a high-level, less detailed statement about how the DHB intends to address the health needs of its district.

During April 2010 the New Zealand Public Health and Disability Amendment Bill 2010 was released, it will progress through Parliamentary processes before being enacted as New Zealand Public Health and Disability Amendment Act 2010. The New Zealand Public Health and Disability Amendment Bill in Section 22 has an additional objective for DHBs, in Section 38 it repeals from the Act the terms and definitions of DAP and DSP and in Section 38 describes the planning framework and requirements. The above cited changes in the Bill are:

Section 22 (1)

(a) seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs

Section 38 Planning framework and requirements

(1) The Minister -

(a) must direct every DHB to prepare a plan for each financial year beginning on or after 1 July 2012; and

(b) may direct a DHB to prepare or contribute to 1 or more other plans.

The New Zealand Public Health and Disability Amendment Bill (pending) lists the requirements of every plan on or after 1 July 2012

¹ The New Zealand Health Strategy (2000), Ministry of Health and The New Zealand Disability Strategy (2001), Ministry of Health overarch a wide range of research based strategies that inform and guide development, provision, and monitoring of services DHBs provide and/or fund (e.g. Primary Health Care Strategy (2001) Ministry of Health, He Korowai Oranga / Maori Health Strategy (2002), Ministry of Health, etc)

About the Statement of Intent

The Auckland DHB Statement of Intent describes the organisation's objectives for the year ending 30 June 2011. 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.

Overview of Forecast Statement of Service Performance

The long term *vision* of Auckland DHB is 'Healthy Communities, Quality Healthcare, *Hei Oranga Tika Mo Te Iti Mei Te Rahi*. Three *goals* overarch and focus all aspects and levels of the Auckland DHB healthcare system. Our eight high level outcomes (also called our vital health outcomes) provide direction for achievement of our goals and enable the *four output classes* to logically group our wide range of healthcare provision to enable us to present a coherent and measurable performance story (appendix 1 provides our performance story in chart form).

Auckland DHB both funds and monitors services provided by a range of non government (NGO) and community providers, and provides a wide range of health services (refer to diagram 3 for detail) community and hospital services for people in Auckland. Auckland DHB is a complex organisation which in its provider arm alone delivers in excess of 80 separate but connected services. Auckland DHB recognises that the Statement of Intent is required to be a high-level, less detailed statement, than the District Strategic Plan (DSP) and District Annual Plan (DAP), about how the DHB intends to address the health needs of its district.

The *Forecast Statement of Service Performance* in this Statement of Intent describes our *intervention logic* used to deliver and monitor across the four output classes, inclusive of the national indicators of DHB performance developed by the Ministry of Health and the Minister of Health's expectations for the financial year. Our District Annual Plan provides detail about how we operationalise and monitor our objectives across the funder and provider arms of Auckland DHB healthcare system.

Using the framework of the four output classes our Forecast Statement of Service Performance identifies our outputs, the measures thereof and our annual targets for the three years: 2010/11, 2011/12, and 2012/13. We have used 2008/09 actual performance as our baseline for the targets, and any significant shifts are described as footnotes on the outputs tables.

Auckland DHB performance story set out in this Statement of Intent is consistent with our District Annual Plan for 2010–11, 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 our 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 2010–11 District Annual Plan will undergo public consultation.

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

Health Sector Requirements

While complying with the Public Health and Disability Act 2000, DHBs also have to meet requirements set by the Ministry of Health and the Minister of Health as detailed below:

Requirement	Explanation	Produced by	Frequency
Operational Policy Framework	"A set of business rules as well as policy and guideline principles that outline the operating functions of DHBs" – essentially how DHBs should carry out their functions	Ministry of Health	Ongoing, updated annually
Service Coverage Schedule	Policy document that describes what services that DHBs must ensure are provided	Ministry of Health	Ongoing, updated annually
National priorities and strategies	Strategic-level expressions of national health priorities and approaches for dealing with them (examples include the Primary Health Care Strategy and the Maori Health Strategy He Korowai Oranga)	Ministry of Health	Various dates, updated every few years
Minister's Letter of Expectations	Describes the Minister's priorities for DHBs for the coming year	Ministry of Health	Annually, during the early stages of each planning round

Whanau Ora – Government Policy

During May 2010 the New Zealand Government announced \$134.3 million funding over four years to enable Te Puni Kokiri, the Ministry of Social Development and the Ministry of Health to jointly implement Whanau Ora, an approach that empowers families to take control of their future.

Government announced the approach will be underpinned by the integration of existing contracts into joint funding arrangements with other agencies. Regional leadership teams will be established across ten regions, with representatives from the community sitting alongside the local agencies ensuring Whanau Ora reflects local priorities and knowledge of each region.

The approach is to support: whanau capability building, strengthening whanau connections, supporting development of whanau leadership, and enhancing best outcomes for whanau. Government seeks to minimise fragmentation, to reduce compliance and transactional costs, to encourage provider collaboration, to establish coherent and integrated services and to be motivated by the goal of positive whanau development.

Whanau Ora Practitioners will act as navigators or champions for the whanau, assisting them to access integrated health and social services, and to focus on opportunities to meet whanau needs.

The measurement of success in Whanau Ora is from outcomes which reflect the aspirations of the people themselves. It is early days in the development of the Whanau Ora Framework. Auckland DHB is participating in the Regional Inter-Sectoral Whanau Ora collaborative, contributing a health perspective.

2. Operating Environment Scan

Government Priorities

This Statement of Intent aligns with national and Government priorities for the health sector. The Minister of Health's 'Letter of Expectations' released in February 2010 specifies the priorities for the coming year.

National health targets help focus the efforts of all DHBs and make more rapid progress against key national priorities. The National Health Targets are included in the output class target tables in the Forecast Statement of Service Performance section of this document, also clearly identified in our Annual Plan.

Government expectations for the 2010–11 year

The public health system will deliver better, sooner, more convenient health care for all New Zealanders. The service priority for 2010-11 will be sharply focused on primary health care with better integration between primary and secondary services.

Improve service and reduce waiting times	Reduce excessive patient waiting times Resources to support frontline services Implement productivity and quality and safety improvements
Increase elective surgical volumes year on year	Both first specialist assessments and surgery Move from reliance on spot purchasing from the private sector Sustainable longer-term relationships to help grow elective surgery
Improve Emergency Department waiting times	Improve performance in line with the 6 hour length of stay target
Improve cancer treatment waiting times	Shorter interval between diagnosis and treatment, particularly radiation treatment
Primary Health Care Strategy	Provide a wider range of services in community settings Services provided at no cost to patients Consolidate PHOs where appropriate, acknowledging provider networks
Clinical Leadership	Strengthen clinical engagement from governance through the organisation
Regional Co-operation	Identify real gains/results from collaborating with neighbouring DHBs
More unified system	Meet national expectations re shared services Make the most of collective procurement and back office rationalisation Work on improvements from the MRG report, such as quality and safety

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 2,000 discharges for the 2010-11
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within four weeks by December 2010
Increased immunisation	90 percent of two year olds will be fully immunised by July 2011; and 95 percent by July 2012
Better help for smokers to quit	90 percent of hospitalised smokers will be provided with advice and help to quit by July 2011; and 95 percent by July 2012 80 percent of patients in primary health care will be provided with advice and help to quit
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

Auckland DHB Population Profile

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.

Auckland city's population of 446,000 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:

In general

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 represent 25% 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

Self reported health status for Auckland is higher than the national rates. In self-assessed health status, there is a direct relationship between age, gender, ethnicity and income for all ethnic groups, except Pacific

However, Aucklanders are also significantly less likely to exercise and have higher cholesterol levels than the rest of the country

In spite of a good overall picture, 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, new migrant and refugee communities, people living on low incomes and disabled people.

Areas of inequity

Poverty

The biggest contributor to low life expectancy is poverty which is also affected by ethnicity and gender

In self-assessed health status, there is a direct relationship between age, gender, ethnicity and income for all ethnic groups, except Pacific

People who are poor, Pacific and those in age groups 14–24 and over 65 years score their health the lowest

49% 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 Tamaki-Maungakiekie and Avondale-Roskill Wards – 25% and 20% of Auckland's population respectively. Most Maori and Pacific people live in the Tamaki-Maungakiekie Ward – 39% and 46% of their populations respectively

41% of all 0–4 year olds live in the most deprived areas of the city

Maori

Maori men in Auckland are a particularly high risk group for health problems

72% of non-Maori die over the age of 75 years of age compared to 16% for Maori

Maori in Auckland are more likely (compared to New Zealand and to local non-Maori) to smoke tobacco and marijuana, to be obese and to drink alcohol in a hazardous manner

Maori have higher Years of Lost Life (YLL) rates than non-Maori

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

Pacific

Pacific men in Auckland are a particularly high risk group for health problems

72% of non-Pacific people die over the age of 75 years of age compared to 32% for Pacific people

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

Pacific people have higher Years of Lost Life (YLL) rates than non-Pacific

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

Asian, new migrant and refugee communities

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

Asian people make up 25% of Auckland's population. 36% of Asians are South Asian and about 80% of this group are Indian

Auckland is one of the highest non-English, non-Maori speaking areas with over 100 different languages spoken

About 13% of our population need some kind of assistant or interpreting when they attend health services

Asians have good health compared to 'Others'. There are lower risks for Asians for all the indicators of health except for regular exercise and vegetables consumption

For South Asian and particularly for Indian people, while there is a lower mortality rate from cardiovascular disease, they have the highest rate of hospitalisation for myocardial infarction and angina. They are the highest users for angioplasty and CABG operations

Disability About one in five Aucklanders live with impairment; the most common being loss of functioning related to mobility, agility and hearing. The rate of disability increases as people age

Poorly informed social attitudes remain the most common barrier for disabled people

Gender Men die younger than women by at least 3-4 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 however, exercise more often than women

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

Source: Multiple data sources, primarily the Ministry of Health, Health Survey and 2010 updates.

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

Prevalence of major chronic diseases with expected no.

Chronic conditions	%	
Arthritis	11.1%	41,400 adults
Asthma	7.7%	28,700 adults
Dementia	7.7%	(varies by age)
Chronic obstructive pulmonary disease	6.1%	
Depression	5.7%	
Diabetes	4.9%	22,100 adults
Ischaemic heart disease	3.8%	14,500 adults
Stroke and TIAs	2.1%	8,000 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%

Auckland DHB cumulative disease burden

Comprises: hospital admissions, case weight per admission, ambulatory sensitive hospitalisations, mortality, years of lost life (YLL), avoidable mortality. 2008 data.

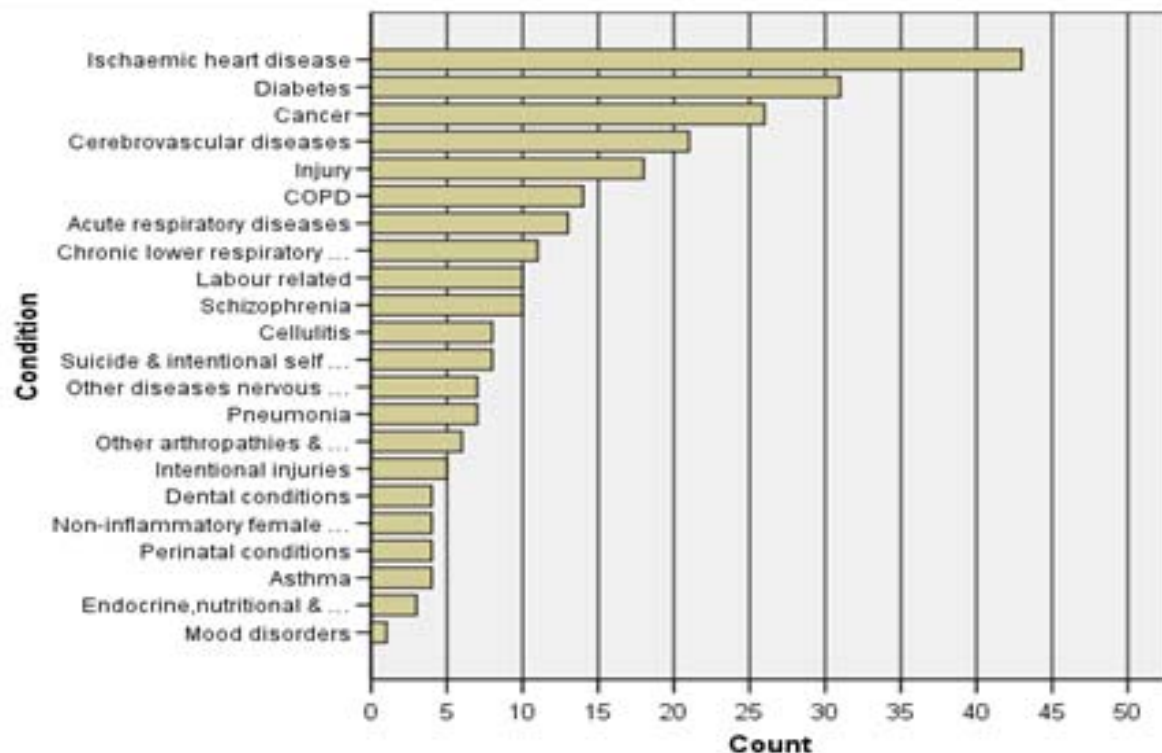


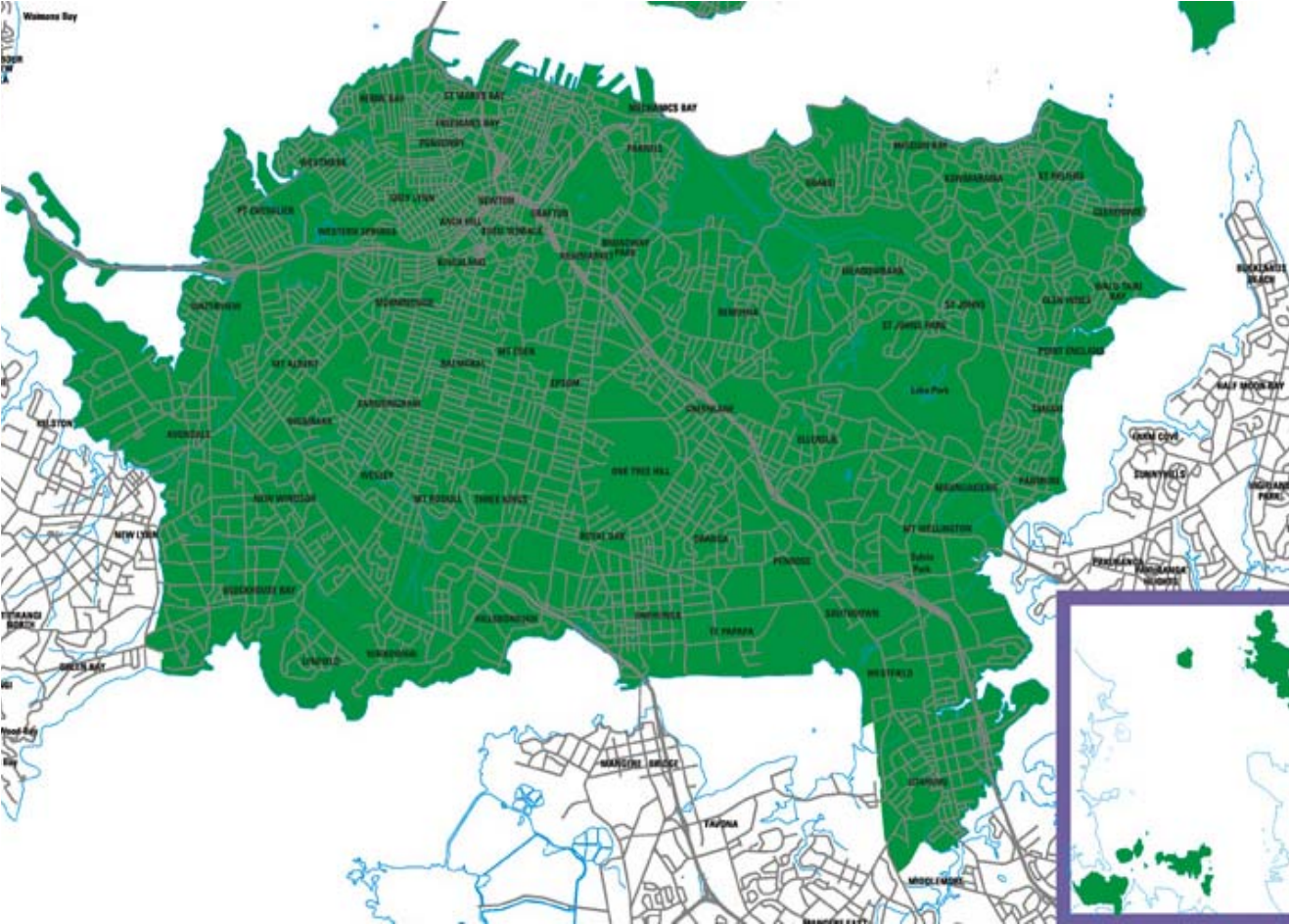
Diagram 1: Cumulative Burden of Disease for Auckland District Health Board Population

Structure and Function of Auckland DHB

Although Auckland DHB is the biggest DHB in New Zealand by turnover, population wise it is the fourth largest, covering the same boundaries and population as the existing Auckland City Council. The formation of the supercity in the 2010 local body elections will allow for a greater regional focus on health by creating the potential to link with local government on common priorities. The 2010-11 year will also see the three district health boards in the greater Auckland area working more closely. This involves sharing some functions where this makes the best use of resources.

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). Long term health services planning at the national, regional and local level will make sure that we have a planned approach to population health need and especially the development and location of health services. This work is already underway for primary health care, as part of the Government strategy for *'Better, Sooner, More Convenient Primary Health Care.'*

Auckland DHB provides 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.





Auckland DHB Planning and Accountability Environment

Auckland DHB health planning aligns with national health strategy

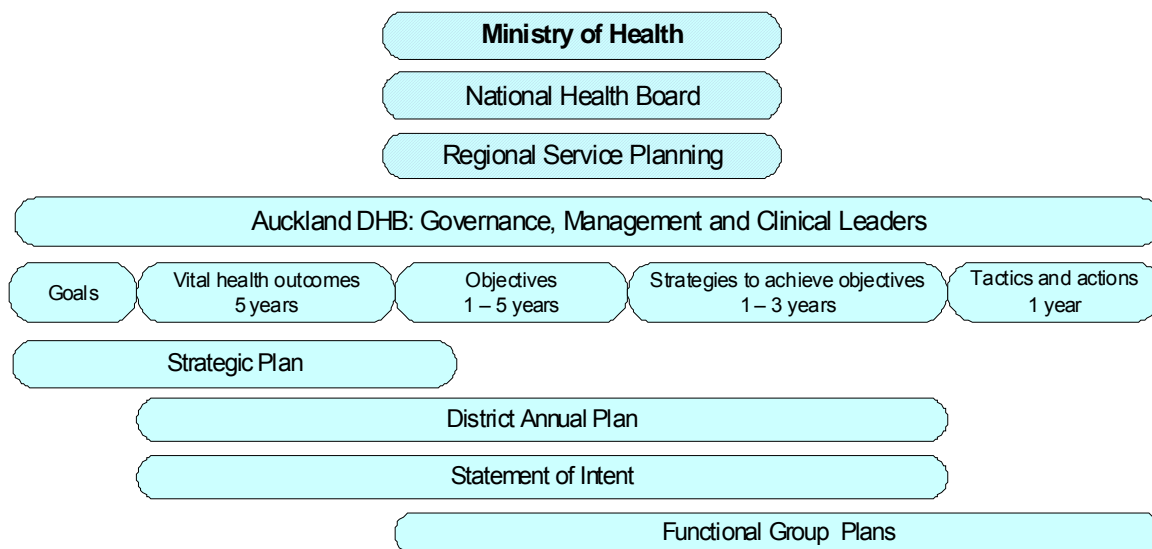


Diagram 2: ADHB Planning & Accountability Environment

The Auckland District Health Board vision is:

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

This 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

The strategic priorities for the District Health Board reflect assessment of population health status, common problems and unmet needs as described in the District Strategic Plan (DSP). Our District Annual Plan (DAP) concentrates on activities during the 2010–11 year that are strategic priorities and which are over and above our business as usual. Our detailed work activities are covered in five functional group plans:

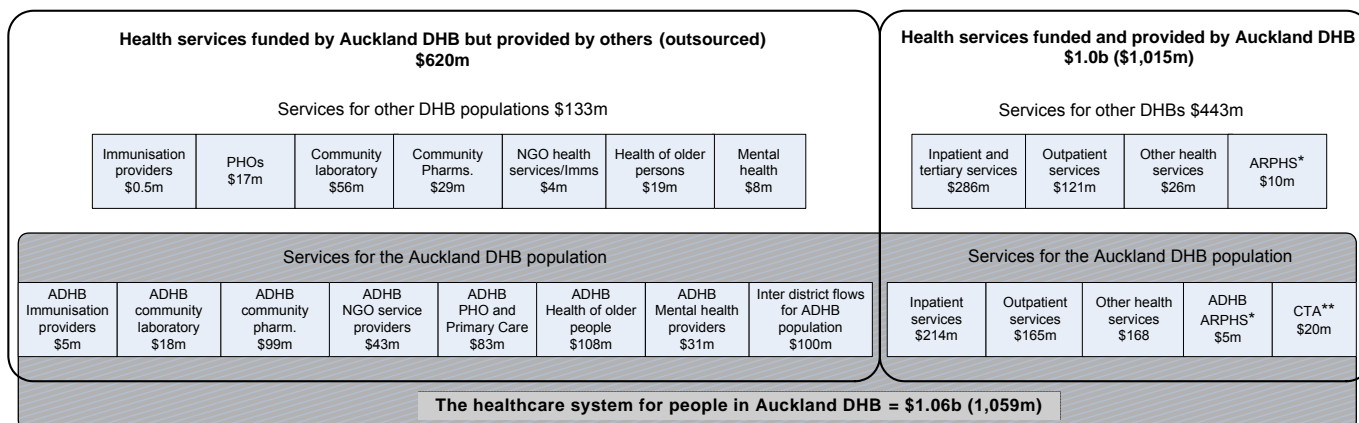
- Planning and Funding
- Clinical Quality and professional Governance
- Health Care System Improvement
- Operational Functional Group (Clinical Services)
- Corporate Services (Information Management and Technology Services, Human Resources, Finance and Corporate).

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).

Funding for Auckland DHB Health Services

Auckland DHB's health care system includes a wide range of services from health promotion and prevention work through to the secondary and specialist services provided by our hospital. The total value of services is approximately 1 billion dollars for the Auckland DHB population. Some funding for services comes directly from the Ministry of Health, e.g. public health services and from the Clinical Training Agency to cover costs associated with junior medical training. Auckland DHB also provides services for other DHBs to the value of \$576 million.

The left component of the following diagram covers services provided to the Auckland population and to people from other DHBs that are contracted by Auckland DHB from various non government organisations (NGOs) and community providers (outsourced health services). The right component 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 shaded area 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.



* ARPHS is the Auckland Regional Public Health Service; provided by ARPHS for the region

** CTA is the Clinical Training Agency

Diagram 3: The Auckland DHB Healthcare System: funding breakdown

DHB Governance and Management

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.

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 provide for Maori representation.

Community and Public Health Advisory Committee	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: <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 • This advice must be consistent with the New Zealand Health Strategy.
Disability Support Advisory Committee	This committee (DSAC) advises the Board on issues facing disabled people and the priorities for use of disability support funding provided.
Hospital Advisory Committee	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.

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 Te Tiriti o Waitangi and the delivery of health services to Maori as well as tikanga best practice within services.
Pacific Health Advisory Group	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).

Auckland DHB 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. Many members of our Senior Leadership Team are clinicians (i.e. Doctors, Nurses, Allied Health Professionals) with several years clinical and management experience. The team includes representation from the Primary Health Organisations (PHOs).

3. Auckland DHB Intervention Logic

Auckland DHB provides, or contracts for, health and disability services across a continuum from health promotion, disease prevention and primary care, to hospital services and support services. We place 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 long term conditions. Clinical leadership, quality and the integration of services are critical factors in the development of Auckland DHB’s healthcare system.

An over-riding stressor on the health system is aging of the baby boomer population bulge and the consequent constantly increasing demands placed on all points of the health continuum for better sooner more convenient health care. This combined with scientific advances that increase survival and advanced quality of life at both ends of the age spectrum and all points between are major drivers for system wide performance improvement to enable the DHB to continually live within its means.

Mechanisms for Intervention

Auckland DHB:

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

Provides child and adult 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

DHB Intervention Logic

Our overarching intervention logic is described by this diagram.

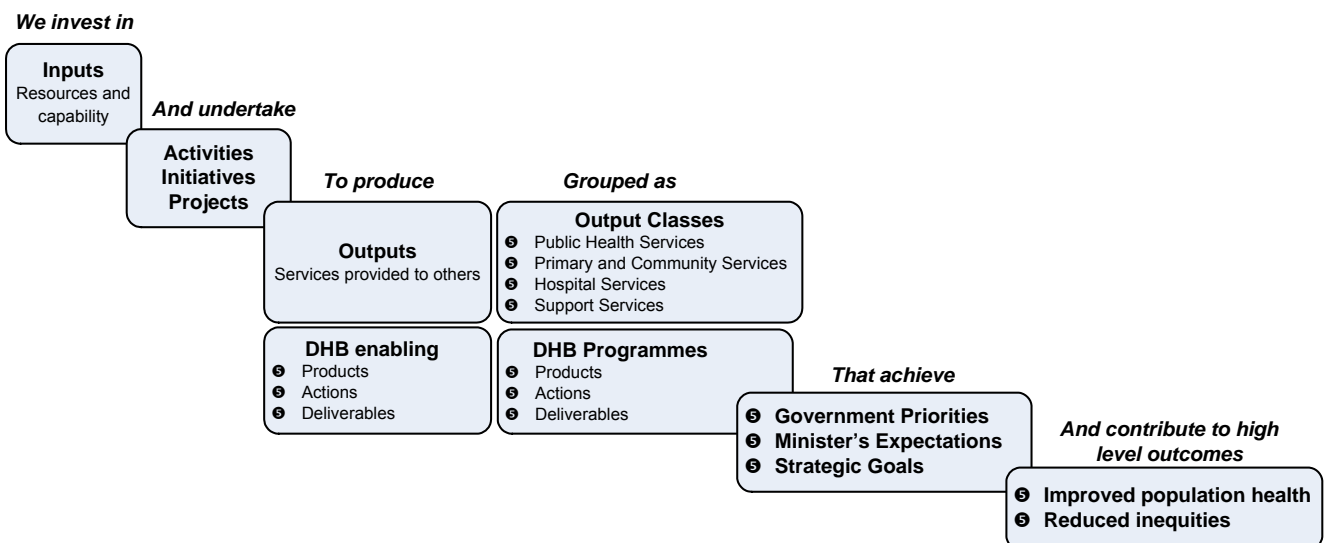


Diagram 4: Auckland District Health Board Intervention Logic

Auckland DHB High Level Outcomes Framework

The link between the four output classes and our high level outcomes is demonstrated on the following table and diagrammatically shown in appendix 2

Auckland DHB Vision	Auckland DHB Goals	High Level Outcomes	High Level Measures	Impacts	Output Class			
					1	2	3	4
Health Communities, Quality Healthcare <i>Hei Oranga Tika Mo Te Iti Me Te Rahi</i>	Lift the health of people living in Auckland	Impacts from cancer, diabetes, and cardiovascular disease are minimised	↓ morbidity & mortality from cancer, diabetes, and cardiovascular disease	Amelioration of cancer, diabetes, and cardiovascular disease symptoms and / or delay in their onset	√	√	√	
		Improved quality of life for people with mental health and / or addiction issues and their family / whanau	↓ in mental health & addiction problems	Environments & services promote mental wellness and recovery			√	√
		Improved quality of life for people with disabilities and their family / whanau	↑ independence for people with disabilities and those who need support services	Continual reduction of barriers to progressing in society for people with disabilities				√
		Improved quality of life for older people and their family / whanau	↑ rates of 85+ yrs able to live independently	More older people are able to age in the environment of their choice				√
		Healthier safer children	↓ rates of ambulatory sensitive hospital admissions (ASH) for children	Earlier identification and appropriate interventions with vulnerable children and their family/whanau	√	√		
	Performance improvement	Improve primary and secondary care integration	↑ the number of primary options for acute care (POAC)	Improved access and efficiency of service delivery		√		
		Improve quality of hospital care while improving productivity	↑ service throughput and productivity	Improved patient / client experience and outcomes			√	
	Live within our means	People of New Zealand continue to have confidence in the levels of care available from Auckland DHB	Break-even position is maintained	Auckland DHB continues to meet the needs of its population and the advanced levels of intervention required by the sector	√	√	√	√

Key:

Output Class 1: Public & Population Services

Output Class 2: Primary & Community Services

Output Class 3: Hospital Services

Output Class 4: Support Services

Output classes

Our intervention logic clusters the DHBs health care system into four main areas (output classes) which cover the spectrum of activities from health promotion and disease prevention through to support services.

The health continuum is another way of describing the points at which individual's, their family / whanau and population groups or communities of people interact with the health system, from health promotion and disease prevention services through to end of life support services.

Showing the continuum of care on the horizontal axis and the four output classes on the vertical axis the below diagram illustrates the stages of the patient journey that people typically interact with the healthcare system.

In reality the interaction is not linear, because people may interact with different output classes concurrently for the same or different health conditions they and/or their family/whanau are experiencing.

Auckland DHB is a complex organisation, across the output classes it provides services at primary, secondary, tertiary and in many instances is the sole national provider. As discussed earlier, the Auckland DHB hospital and related services encompass 87 separate but connected services. The four output classes shown on the below diagram and the High Level Outcomes Framework on the previous page have been combined on Appendix 2 to tell the story of the Auckland DHB's planned performance. Appendix 2 shows how the four output classes individually and collectively make high level impacts toward achievement of our high level outcomes. The inter-relationships are many, varied and complex, they are bound by a wide range of compliance imperatives inclusive of cultural, clinical, professional, contractual, financial, and legislative to name just a few.

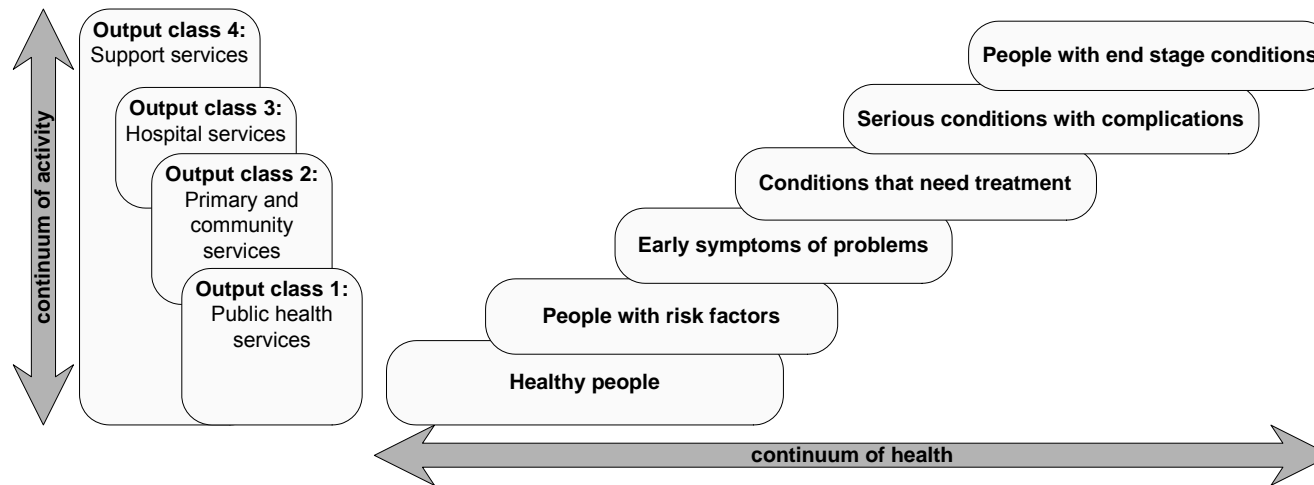


Diagram 5: Health Continuum Intersection with the Four Output Classes

4. Forecast Statement of Service Performance

The following Forecast Statement of Service Performance does not list all Auckland DHB activities. It describes the priority focus for the 2010-11 year. The full description of our activities for 2010-11 are referenced within our District Annual Plan 2010-11 and monitored by the range of internal and contractual processes.

Setting Auckland DHB priorities

Priorities for the year ahead are drawn from:

- Government priorities and the Minister's letter of Expectations,
- Our ongoing assessment of population health need,
- Constant monitoring of our own DHB performance, and
- Underpinned by the strategic priorities set in our District Strategic Plan, 2006

Major considerations for Auckland DHB

As a district health board our emphasis is on population health using a whole system approach that spans the continuum of care. We will do more outside of the hospital to manage long term conditions and prevent them from worsening. This will enable an already heavily loaded health care system to cope with the increased demand for services. We will do more to make front line services better for patients especially around waiting times for essential hospital services.

A population health focus

Lifting the health of people in Auckland city requires a broad view of health. A population health approach includes prevention, helping populations at risk, treatment and management of early-stage disease, as well as a range of hospital and support services. Population health means intervening at the earliest possible stage of a health problem, especially those such as cardiovascular disease and diabetes which can have long term and serious health impacts.

We are especially concerned that children get the best start in life and are protected from adverse events such as communicable disease and domestic violence. Our Board members continue to express a determination to see infant, child and family/whanau health improved in Auckland city.

There is also considerable attention to health inequities. Our population health needs assessment indicates where we have unacceptable differences in health status between groups. Special and remedial actions are required for groups in our city, via tools like the Ministry of Health HEAT assessment that ensures every service innovation and change is of direct benefit to the groups living with the greatest disadvantage.

A continuum of service

People living in Auckland city have access to the full range of services along a continuum from prevention and health promotion, to specialist treatments and, when needed, hospice or palliative care.

The challenge is to achieve better integration of these services. Health care providers receive the training and support needed to work across this continuum. We are also doing more to enhance patient feedback systems and to respond to suggestions made by advisory groups, consumer panels and via consultation.

Primary health care

Primary care services reach people close to their homes and in the settings that work best for them. *Sooner, Better, More Convenient Primary Care* is a priority of Government with significant changes underway in relation to Primary Health Organisations (PHOs).

Three primary care business cases for the Auckland region population are progressing toward implementation phase, the collective aim is to integrate services for patients and to allow for more clinical leadership in health decision making. In future, there will be more hospital based clinical and management expertise supporting primary care and other community-based providers.

Working with our PHO partners we continue our emphasis on NZ Royal College of General Practice Cornerstone quality accreditation and quality improvement. We are committed to working with the new national quality standards and our PHOs in the new environment.

The new regional service developments in primary care also make a commitment to Whanau Ora, focusing on integrated care that addresses the range of factors that influence individuals and family / whanau health and wellbeing.

Acute Services

The Price Volume Schedule for acute services for the Auckland DHB population has been set and monitored by the DHBs quarterly contract reporting with a volume increase to meet estimated demand based on:

- i) the projected population growth over 2010-11
- ii) additional increase for specific service development (e.g. Haematology Bone Marrow Transplants, Infectious Diseases, and Oncology/Radiotherapy services)

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

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 10,227 discharges (monitored by the DHBs quarterly contract reporting)

Inter District Flows

For services provided to other DHB populations (Inter District Flows), negotiated agreement has been reached with the nineteen 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.

Collaboration

The success of the continuum of care in meeting patient needs rests in its ability to work across services. Integration is critical. The whole health care system depends on educational systems, the rapid introduction of improved therapies to improve the level of care over time, research and the support of information systems that tie the system together.

We work in partnership with community-based providers of care and other stakeholders for overall performance of the system. We also try to address the wider determinants of health by working with other sectors such as local government, housing, employment, social development and education.

2010-11 will see the three DHBs domiciled in the greater Auckland area working more closely together. This allows for a better use of resources available in the region and recognises that Aucklanders are mobile and like to use health services across the various city boundaries.

Cost effective

As in previous years, there is a focus on improving productivity and value for money. In order to breakeven we need to ensure that every dollar available to the DHB is well spent. Strong financial discipline will ensure that resources are available to meet the expectations of our local population as well as the expectations on us as a Crown Entity.

For example, more attention will be paid to the contracts we hold with providers including our own hospital and related services. Through a contract review process we will assess if the funding can be better allocated, or if there is some way to achieve health gain more effectively.

4.1 Output Class 1: Public Health Services

Health promotion, prevention and protection

The Auckland Regional Public Health Service is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau DHB and Waitemata DHB areas under contract from the Ministry of Health. The service is responsible for improving population health outcomes and reducing inequalities. This work helps to reduce downstream demands on DHBs for personal health services.

The Auckland Regional Public Health Service delivers evidence and regulation based public health services which can be broadly grouped as follows:

Notifiable and communicable disease control

Investigating the source of notifiable diseases and outbreaks and limiting the spread of infection
This is a mandatory function performed by the Auckland Regional Public Health Service across the region and will be delivered according to legislation and using evidence based protocols

Regulatory functions

Including:

- physical environment regulatory functions, e.g., drinking water quality, biosecurity (exotic mosquito surveillance), hazardous substances, recreational water quality, lead poisoning, and all other public risks associated with environmental hazards
- implementation of the International Health Regulations 2005
- alcohol and tobacco regulatory functions and harm minimisation
- emergency management – responding to local, national and international public health emergencies, e.g. the ‘keep it out, stamp it out’ response to the H1N1 novel influenza pandemic
- health promotion targeted at discrete populations or sectors in the region to achieve overall improvements in health and reduced health inequalities.

Population Screening

The principle roles for Auckland Regional Public Health Service are:

- provision of Public Health advice to District Health Boards on screening
- provision of management and oversight of the National Immunisation Register (NIR) and the National Cervical Screening Programme (NCSP) Register

Output Class 1: Public Health Services

Outputs	Measures	Baseline (08/09 actual)	Targets			Trend data
			2010-11	2011-12	2012-13	
1a) Health protection	<p>1ai) Number of Early Childhood Education Centres health assessed (therefore required corrections identified & monitored) (Δ baseline & targets across Auckland region)</p> <p>1aii) *Number of drinking water investigations to monitor/improve the quality (planned & demand driven activity) (Δ baseline & targets across Auckland region)</p> <p>1aiii) *Hazardous substances and new organisms emergency investigations (demand driven) (Δ baseline & targets across Auckland region)</p>	60	100%	100%	100%	<p>√ Has been part of quarterly reporting for some years.</p> <p>√ Has been part of quarterly reporting for some years.</p> <p>√ Has been part of quarterly reporting for some years.</p>
1b) Health promotion	<p>1bi) *Number enrolled on Pacific smoking cessation programmes in Auckland DHB (direct impact on reducing cancer & cardiovascular disease) (◇ baseline & target for ADHB & WDHB)</p> <p>Healthy Housing project:</p> <p>1bii) *Number of Assessments</p> <p>1biii) Percentage referred to insulation provider (◇ baseline & targets for Auckland DHB & Waitemata DHB)</p> <p>1biv) *Infants exclusively and fully breastfed (total):</p> <p>6 weeks</p> <p>3 months</p> <p>6 months</p> <p>(breast fed ≥ 6mths of age ↓ lifetime risk of type 2 diabetes)</p>	<p>New initiative</p> <p>200</p> <p>80%</p> <p>66.6%</p> <p>57.3%</p> <p>27%</p>	<p>240 enrolled</p> <p>500</p> <p>80%</p> <p>74.0%</p> <p>57.0%</p> <p>27%</p>	<p>240 enrolled</p> <p>500</p> <p>80%</p> <p>To be agreed</p>	<p>N/A</p> <p>nil</p> <p>80%</p> <p>To be agreed</p>	<p>New initiative</p> <p>√ Has been part of quarterly reporting over recent years.</p>
1c) Communicable Disease Control	<p>*Disease notifications: investigations as required; case management and contact tracing (demand driven)</p> <p>1ci) Number TB cases</p> <p>1cii) Number of other disease investigations</p>	<p>400 TB cases</p>	100%	100%	100%	<p>√ Has been part of quarterly reporting for some years</p>

Outputs	Measures	Baseline (08/09 actual)	Targets			Trend data
			2010-11	2011-12	2012-13	
	(△ baseline & targets across Auck region)	900 other disease investigations				
1d) Immunisation	1di) *Support GPs in submitting data to the National Immunisation Register (NIR) and follow-up babies / children not immunised 1dii) *Percentage of two-year-olds fully immunised for age 1diii) *Percentage of eligible and consented children completing the year 7 vaccination	1000-1300 referrals to immunisation outreach services 74% 57%	Up to 1300 referrals 90% 63%	Up to 1300 referrals 95% 65%	Up to 1300 referrals 95% 68%	√ Has been part of quarterly reporting for some years √ Has been part of quarterly reporting for some years √ Has been part of quarterly reporting for some years
1e) Screening	1ei) *Eligible women participating in the National Cervical Screening Programme, particularly: Maori, Pacific and Asian women (3yr coverage rate for 20 – 65 yr women) (◇ baseline & targets for ADHB & WDHB) 1eii) *B4 School Checks completed	65% 1800	Contract Targets met 3600	Contract Targets met 3600	Contract Targets met 3600	√ Has been part of quarterly reporting for some years √ Has been part of quarterly reporting over recent years.

* Activities that Auckland DHB performance is dependent on an external provider and / or external factors

Key:

- △ Regional activity that covers all three Auckland Metropolitan District Health Boards
- ◇ Activities specific to Auckland and Waitemata District Health Boards

Note: All stated measures are subject to Clinical Quality and/or Professional Governance requirements that comprise the process to achieve the measure. Clinical Quality and Professional Governance as described in Section 5 of this document include the following requirements: professional standards and development; quality / clinical effectiveness cycle; policy and risk management; research and development. For example, Drinking Water Investigations have a number of quality steps that must be undertaken at each phase within the process described as 'Drinking Water Investigation.'

4.2. Output Class 2: Primary and Community Services

Primary healthcare

Sooner, Better, More Convenient Primary Health Care is a priority of government with significant changes underway in relation to Primary Health Organisations (PHOs). Working with our PHO partners our emphasis is on ensuring the population of Auckland DHB has easy access to the general practice health services they require.

Community services

Auckland DHB contracts with a range of non government organisations (NGOs) and other community based providers to provide health and disability support services for people living in Auckland city. Diagram 3 – The Auckland DHB Healthcare System: funding breakdown, illustrates that services provided by others for Auckland DHB population range from primary health services inclusive of general practice through to home based or residential health and disability support services for older people and people with mental health conditions (these are included in Output Class 4).

The range of community health services includes a number of Maori and Pacific providers who focus on interventions to reduce health inequalities, in particular child health and reduction in rates of their respective morbidity and mortality from cancer, diabetes, and cardiovascular disease – these non residential services feature in Output Class 2 table that follows.

Output Class 2: Primary and Community Services

Outputs	Measures	Baseline (08/09 actual)	Targets			Trend data
			2010-11	2011-12	2012-13	
2a) Diabetes	2ai)* Percentage eligible patients having Diabetes annual check	11,571 consults				This material is under development will be available in the outyears
	Maori	50%	55%	58%	62%	
	Pacific	50%	55%	58%	62%	
	Total	55%	57%	60%	65%	
	2aii) * Percentage 'Get Checked' patients with an HbA1c<8:					
	Maori	70%	72%	75%	78%	
	Pacific	70%	72%	75%	78%	
	Total	79%	84%	86%	88%	
	2aiii) *Percentage patients with diabetes retinal screened (N.B. service provided by ADHB and an external provider):					
	Maori	75%	77%	80%	82%	
	Pacific	75%	77%	80%	82%	
	Total	75%	77%	85%	85%	
2b) Cardiovascular disease	2bi) * Percentage eligible patients cardiovascular risk screened (lipid and glucose or HbA1c):					
	Maori	71%	70%	73%	75%	
	Pacific	71%	70%	73%	75%	
	Other	78%	80%	84%	86%	
	Total	77%	79%	80%	82%	
	2bii) * Percentage increase in programmes and options available for cardiac rehabilitation	55%	5% increase for all groups	5% increase from previous year or maintenance if 85%	5% increase from previous year or maintenance if 85%	

Outputs	Measures	Baseline (08/09 actual)	Targets			Trend data
			2010-11	2011-12	2012-13	
				achieved	achieved	
2c) PHO services	<p>2ci) * Percent valid NHI on patient register</p> <p>2cii) * Percentage of Maori enrolment in PHOs</p> <p>2ciii) * Percentage of eligible enrolled patients enrolled on Care Plus (baseline 2008)</p> <p>2civ) * Percentage of palliative care clients in receipt of PHO services</p>	<p>97%</p> <p>72.4%</p> <p>69.2%</p> <p>1,200 deaths per year</p>	<p>98%</p> <p>80%</p> <p>≥ 70% of eligible patients enrolled</p> <p>15% of clients (cumulative)</p>	<p>99%</p> <p>85%</p> <p>To be set</p> <p>17% of clients (cumulative)</p>	<p>99.5%</p> <p>TBA</p> <p>To be set</p> <p>20% of clients (cumulative)</p>	
2d) Ambulatory Sensitive Admissions (ASH)	<p>2di) * Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health (by other, Maori and Pacific)</p> <p>2dii) * Percentage of unnecessary hospital admissions for Maori, Pacific and Other (45 to 64)</p> <p>2diii) * Percentage of unnecessary hospital admissions for Maori, Pacific and Other (0–74 age)</p>	<p>< 95%</p> <p>National average</p> <p>National average</p>	<p>Remain below 95% of the national average</p> <p>Remain below the national average</p> <p>Remain below the national average</p>	<p>Remain below 95% of the national average</p> <p>Remain below the national average</p> <p>Remain below the national average</p>	<p>Remain below 95% of the national average</p> <p>Remain below the national average</p> <p>Remain below the national average</p>	
2e) Oral health (N.B. caries free teeth directly impacts on ↑ child health outcomes)	<p>2ei) * Percentage of adolescent oral health use</p> <p>2eii) * Percentage of children caries free at 5 years</p> <p>Maori</p> <p>Pacific</p> <p>Other</p> <p>Total</p>	<p>64.3%</p> <p>45.60%</p> <p>36.20%</p> <p>71.50%</p> <p>61%</p>	<p>68%</p> <p>50%</p> <p>38%</p> <p>80%</p> <p>66%</p>	<p>70%</p> <p>To be set</p>	<p>75%</p> <p>To be set</p>	

Outputs	Measures	Baseline (08/09 actual)	Targets			Trend data
			2010-11	2011-12	2012-13	
	2eiii) * Number of teeth of 8-year-olds decayed, missing, or filled (DMFT)					
	Maori	1.21	1.00	To be set	To be set	
	Pacific	1.69	1.15			
	Other	0.65	0.55			
	Total	0.96	0.73			

* Activities that Auckland DHB performance is dependent on an external provider and / or external factors

Note: All stated measures are subject to Clinical Quality and/or Professional Governance requirements that comprise the process to achieve the measure. Clinical Quality and Professional Governance as described in Section 5 of this document include the following requirements: professional standards and development; quality / clinical effectiveness cycle; policy and risk management; research and development. For example, the percentage of children caries free at 5 years and the average number of DMFT teeth of 8 year olds have a number of quality control steps that must be undertaken at each phase to be reported as such. International evidence identifies both these measures as significant markers for assessing the status of child health and therefore child health outcomes from a range of interventions.

4.3. Output Class 3: Hospital Services

The Auckland DHB provider arm is made up of the Auckland City Hospital, the Greenlane Clinical Centre and a number of community-based services.

Auckland City Hospital	Acute adult medical, surgical and older people's health services Acute mental health services including the Child and Family Unit Child health services provided by Starship Children's Health Women's health and maternity services provided by National Women's Health
Greenlane Clinical Centre	Provides advanced outpatient, ambulatory services, and short-stay surgical care
Community-based services	Rehab Plus, older people's community based services, home health, community mental health services, community child health and disability services

The Auckland DHB provider arm operates New Zealand's largest public hospital. Over half the work done is for people who live outside the city. Auckland City Hospital has the following characteristics:

- Almost two million patient contacts each year
- Over half the work done within the provider arm is for people who live outside Auckland DHB catchment
- Inpatient and outpatient services are provided for 446,000 Aucklanders
- The largest elective surgery delivery system in New Zealand with 30,000 elective procedures (approximately 50% of which are for other DHB populations)
- Approximately 10,000 staff or a little over 7,700 full-time equivalent positions (FTE)
- The largest trainer of doctors in the country with approximately 1,477 medical staff of whom about 685 are in various stages of training
- The largest clinical research facility in New Zealand, engaging in work that attracts funding and participation here and overseas
- National Forensic Pathology Service (contract with Ministry of Justice)
- National Newborn Screening Service (contract with National Screening Unit)
- A specialist centre for the region and the rest of the country

- Provide tertiary services for the northern region (about 1.6 million people)
- Some tertiary services (e.g., clinical genetics and paediatric oncology) are provided for people in the Northern, Midland and Central regions
- Specialist services for the whole of New Zealand include:
 - organ transplant (heart, lung and liver)
 - acute major airway obstruction transferred for laser or stent placement
 - massive haemoptysis transferred for surgery or bronchial arterial embolisation
 - hepatic laceration requiring acute hepatic surgery
 - paediatric Intensive Care Unit transfers
 - paediatric cardiac services
 - epilepsy surgery
 - deep brain stimulation
 - high-risk obstetrics

More information on all of Auckland DHB hospital and related services is available at <http://www.healthpoint.co.nz>

The following table contains the priority focus for the 2010-13 hospital and related services that Auckland DHB delivers. The ultimate priority is on improving patient outcomes, with specific targets set for emergency department waiting times, additional elective surgery and reduced waiting times for cancer treatment. The following table does not list the full activity for this complex provider. The critical inputs required to ensure the provision of high quality hospital services such as workforce development, leadership networks, clinical quality and information technology are discussed in the Organisation Capability section of this document (Section 5).

Output Class 3: Hospital Services

Outputs	Measures	Baseline (08/09 actual)	Targets			Trend data
			2010-11	2011-12	2012-13	
3a) Cancer patients	3ai) Patients requiring radiation treatment will receive this within four weeks (target by December 2010)	100%	100%	100%	100%	√ Waiting time has been part of quarterly reporting for some years
3b) Emergency Department patients	3bi) Percentage of Emergency Department patients who are admitted, discharged or transferred within 6 hrs	76%	95%	95%	95%	√ Has been part of quarterly reporting for some years
3c) Patient journey	3ci) Reduce the average length of stay (ALOS) for elective and arranged inpatients	4.25	4.15	4.15	4.15	√ Has been part of quarterly reporting for some years
	3cii) Acute Inpatient ALOS	4.25	4.15	4.05	3.92	√ Has been part of quarterly reporting for some years
	3ciii) Elective and Arranged Day of Surgery Admission (DOSA)	56%	60%	60%	60%	√ Has been part of quarterly reporting for some years
	3civ) Percentage of non attendance (DNA) for specialist appointments	9.2%	8.5%	7.8%	7%	√ Has been part of quarterly reporting for some years
	3cv) Percentage Maori patients DNA rates in hospital services	9.6%	9%	8%	7%	√ Has been part of quarterly reporting for some years
3d) Mental health clients	3di) At least 90% of long-term clients have up to date relapse prevention plans by July 2011	57%	90%	95%	95%	√ Has been part of quarterly reporting for some years
	3dii) Percentage improved access to mental health services	2.8%	3.30% (adult)	To be determined	To be determined	√ Has been part of quarterly reporting for some years
3e) Patient throughput	3ei) Volume acute (all populations)	79,761	100% of total contract	100% of total contract	100% of total contract	√ Has been part of quarterly reporting for some years
	3eii) Volume elective (all populations)	24,881	100% of contract	100% of total contract	100% of total contract	√ Has been part of quarterly reporting for some years
3f) Smoking patients	3fi) Percentage of hospitalised smokers provided with advice and help to quit (N.B. stopping smoking can ↓ rates of cancer & cardiovascular disease and ↑ outcomes for patients with type 2 diabetes)	13%	90%	90%	95%	√ Has been part of quarterly reporting for some years

Outputs	Measures	Baseline (08/09 actual)	Targets			Trend data
			2010-11	2011-12	2012-13	
3g) Patient discharges	3gi) Number of elective services discharges	9,425	10,227	Increase in line with demographic growth	Increase in line with demographic growth	√ Has been part of quarterly reporting for some years
3h) Patient outcome	3hi) Number of hospital in-patient deaths within 30 days of admission as a proportion of all discharges including day cases	1.39	1.39	1.39	1.39	√ Has been part of quarterly reporting for some years
	3hii) Percentage of unplanned acute readmissions within 28 days of discharge	10.40%	10.40%	10.40%	10.40%	√ Has been part of quarterly reporting for some years

* Activities that Auckland DHB performance is dependent on an external provider and / or external factors

Note: All stated measures are subject to Clinical Quality and / or Professional Governance requirements that comprise the process to achieve the measure. Clinical Quality and Professional Governance as described in Section 5 of this document include the following requirements: professional standards and development; quality / clinical effectiveness cycle; policy and risk management; research and development. For example, management of hospital admissions, average length of stay and discharges have a very large number of quality control steps that must be undertaken at each phase within each of those steps on the patient journey.

4.4. Output Class 4: 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. The Output table outlines the support services that Auckland DHB delivers for its local population. These are particularly relevant for people with long-term disabilities; people with mental health problems and people who have age-related disabilities. Outputs that relate to the provision of support are aggregated into: home-based support services; residential care support services; day services; and palliative care services.

Outputs	Measures	Targets				Trend data
		Baseline (08/09 actual)	2010-11	2011-12	2012-13	
4a) People receiving services in their homes	4ai) * Number of people ≥ 85 years who are able to remain in their own homes with support	800 ☉	5% increase (cumulative)	10% increase (cumulative)	15% increase (cumulative)	√ Has been part of quarterly reporting for some years.
	4aia) * Number of low level clients self managing on support packages with input from key workers	New programme ^Δ	150	175	200	New programme
	4aiii) * Number of reassessments for clients receiving home based support services	Annual (1 per year)	25% increase (cumulative)	30% increase (cumulative)	35% Increase (cumulative)	√ Has been part of quarterly reporting for some years.
4b) Residential care clients	4bi) * Number of complaints	51	25% reduction (cumulative)	25% reduction (cumulative)	25% reduction (cumulative)	√ Has been part of quarterly reporting for some years.
4c) Palliative care patients	4ci) * Number of palliative clients accessing primary care under the subsidised DHB/PHO partnership	60	Increase to 100	Increase to 150	Maintain at 150	√ Has been part of quarterly reporting for some years.
4d) Mental Health Clients	4di) * Percentage of residential mental health providers audited	30%	30% ∞	30%	30%	
	4dii) * Percentage of people with enduring mental illness in paid work, or education, or appropriate discharges	10.9%	15%	15%	15%	

* Activities that Auckland DHB performance is dependent on an external provider and / or external factors

Key:

- ⊗ 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%

Note: All stated measures are subject to Clinical Quality and/or Professional Governance requirements that comprise the process to achieve the measure. Clinical Quality and Professional Governance as described in Section 5 of this document include the following requirements: professional standards and development; quality / clinical effectiveness cycle; policy and risk management; research and development. For example, the measure for number of complaints about a residential care facility involves a number of quality control steps that must be undertaken at each phase of the management of each complaint.

5. Organisation Capability – Inputs

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.

Planning documents are in place for most of our areas of activity although these are constantly being updated to reflect: changes in government policy, of new knowledge about the health status of our population, and research and quality advances in health care (e.g. best practice guidelines updates).

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.

The specific 2010-11 targets for planning are:

- Complete the updated District Strategic Plan to Ministry of Health requirements and deadlines
- Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030:
 - description of future models of care across the continuum of care
 - plan the shape, size, setting, and location for future services and inter district flow patients
 - provide the strategic context for major future developments and business cases
 - develop workforce response to current and long term service plans via regional and the national workforce planning
- Increase regional planning and collaboration with the regional primary care business cases
- Any potential service and/or funding changes arising from implementation of the National Health Board are identified and responded to

Clinical Quality and Professional Governance

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

Professional governance	Professional standards and development: <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
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Quality/clinical effectiveness cycle	Clinical quality, efficiency, safety, and value for money: <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	Patient, staff and organisational risk management: <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	Best practice based on evidence: <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 specific 2010-11 targets for quality and professional governance are:

- Provide leadership in cancer and cardiac clinical networks
- Support the development of clinical networks needed to integrate hospital and primary care
- Continue to implement the national quality improvement projects: medication safety, infection, prevention and control, mortality review, incident management
- Implement an Early Warning System for the physiologically unstable patients in all clinical areas
- Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process
- 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for people under 65s
- Implement Senior Leadership Team 'Walk-around' safety programme i.e. growth and training in clinical leadership
- Establish Consumer Council to increase consumer engagement in quality improvement
- Evaluation against Health Excellence Framework
- Continue roll out of Cornerstone accreditation across primary care
- Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System
- Research strategy developed and approved by Board with annual report on activity

Information Management and Technology

The Northern DHBs are collaborating to implement the Information Strategy for 2010 to 2020. The strategy supports the transformation to new models of care and underpins the development of a person-centred model to achieve better, sooner, more convenient health care. In 2010-2011 the Northern DHBs will undertake smaller initiatives to start the strategy, as well as progress and complete some significant regional projects already underway.

The focus of regional Information Systems projects is to improve the integration of primary and secondary care services. This benefits patients through improving continuity and safety of the health services they receive.

Deliverables for 2010-2011 include:

Shared Care Planning	In partnership with PHOs and GPs, DHBs will implement pilot projects which are clinically led and enable the use of shared care plans between providers
Electronic Referrals	Regional electronic Referrals solution between primary and secondary care providers (eReferrals phase 1) Plan for enhancements that allow faster turnaround and improved responses to referrals (eReferrals phase 2 and 3)
Clinical data repository	DHBs will expand the use and content of the regional clinical data repository for sharing of pharmaceutical dispensing information between Pharmacies, GPs and DHBs: <ul style="list-style-type: none"> • TestSafe Pharmacy project • sharing of outpatient letters between DHBs and GPs (Regional Clinical Documents project) • sharing of various additional diagnostic test results between DHBs and GPs (Regional Éclair Enhancement projects). <p>These initiatives support the outcomes of the national and regional primary care initiatives, including the establishment of integrated family health centres.</p>

The DHBs will look for opportunities to improve efficiency through joint procurement of IT equipment and services, regional hosting of information systems and implementation of shared IT services as appropriate.

Alongside the regional work are specific Auckland 2010-11 targets for information technology:

- resilience improvement plan Phase 3 and 4 delivered on time
- KPI reporting for end-to-end application performance in place
- IMTS user satisfaction increases by >10% against previous year
- unplanned system outages reduce from >20 to <5 per month
- Tier 1 system availability increases to >99.95%
- manage corporate information – achieve level 1 with Public Records Act compliance
- manage Scanned Clinical Records (replace solution for management of scanned clinical records)
- Ministry of Health data quality targets met

Workforce Development

The four DHBs in the Northern Region collaborate around employment relations; recruitment; workforce development; special projects; HR infrastructure and systems development; and shared services including the Auckland Regional Resident Medical Officers Service (ARRMOS).

Existing regional objectives will be extended in 2010-11

Regional reporting	Regional reporting on established recruitment KPIs, collaboration to negotiate regional external partnership agreements, and greater collaboration with DHB workforce development activity.
National strategy around Employment Relations	Relationships, consultative and communication mechanisms are in place to manage Employment Relations processes along with the inherent and potential risks of industrial negotiations, including management of settlement costs.
SMO job sizing project	Senior Medical Officer job sizing project will complete an agreed Service Size for each speciality, job sizing each SMO to that Service Size, aligning remuneration to the MECA and implementing regional remuneration relativity strategies across like specialities.
Auckland Regional RMO Services Ltd (ARRMOS)	ARRMOS provides recruitment, allocation, rostering, daily operations, workforce development and general administration support to the three DHBs. The focus is for nationally consistent RMO administration in line with the recommendations of the 2009 RMO Commission report. Regionally the focus is on achieving the KPIs in its three strategic plans: i.e. reducing vacancy rates and increasing RMO retention rates. DHBs are committed to restoring the balance between supply of medical graduates with demand for training positions. Additional demand for delivery of medical services will be diverted into growth of alternative workforces.
Physician Assistant role	A pilot of Physician Assistant role involves two Physician Assistants in surgery (including elective surgery) at Counties Manukau DHB. DHBs will consider further pilots in other specialities and at other DHBs. The pilot will determine whether Physician Assistant have a role to play in the future of surgery in NZ (with a particular emphasis on elective surgery).
Workforce Development plans	Recruitment, education and workforce plans are being aligned across the region. Regional approaches to new models of care and workforce redesign are included in long term sector planning. This includes a regional approach to new roles in Operating rooms and elective surgical services.
Schools-based programmes	Schools-based programmes across the region aim to recruit and retain more Maori and Pacific young people in tertiary studies in health related courses and ongoing employment within our sector. Better health outcomes are a desired result of more Maori and Pacific being in education and in good jobs earning a higher income.

The specific Auckland DHB targets for workforce development are:

- Targeted recruitment of 'hard to staff' clinical roles/ workforces
- Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme
- Increase the percentage of Maori in the workforce via the Tamaki project
- At least two Maori nurse graduates in each Auckland DHB NETP programme
- Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%
- Staff engagement survey conducted and strategies to promote positive workplace culture implemented

National and Regional 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 partner, Te Runanga o Ngati Whatua.

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.

National work

- Advance the five national quality improvement projects (Auckland DHB to lead the project on hospital infection prevention and control)
- National services underway to evaluate new technologies
- Implement the donation after cardiac death as a project to be rolled out across the country
- Leading a national programme for the Ministry of Health on Maori nursing and midwifery workforce development

Work within the region

- Implement Better, Sooner, More Convenient Primary Health Care (per business cases)
- The Northern Region Network Strategy
- Northern Region Clinical Services Planning
- Cancer services
- Elective Services
- Cardiology
- Mental health (includes Eating Disorder Service and Forensics)
- Northern Region Oral Health - Regional Services/Networks
- Regional Nutrition and Food Service
- Auckland Regional Public Health Service (ARPHS)
- Auckland Regional Settlement Strategy Migrant Health Activity
- Community laboratories
- Community pharmacy
- Regional Workforce and Human Resource
- Information systems (including RISP)
- Procurement
- Work with Waitemata DHB e.g. the repatriation of renal services
- Regional Asset and Capital Planning

6. Managing our Financial Resources

Population-based Funding Formula (PBF)

The Ministry of Health uses a Population Based Formula (PBF) to distribute funding to each of the 21 DHBs on a proportionate basis relative to the national population and specific socio-economic factors and deprivation classification. Each District's population is 'adjusted' for gender, ethnicity and social-deprivation status and age. While Auckland's district population is growing to nearly half a million people, our rate of increase is lower than neighbouring DHBs. This means a lowered share of national PBF funding for Auckland DHB relative to others.

The overall socio-economic status of the Auckland population, relative to the national population, is viewed as 'less worse off' based on socio-economic factors and deprivation classification. Auckland district does however have other emerging ethnic populations with high health needs that are yet to be recognised in the funding formula, e.g. South Indian for diabetes/cardiovascular and African communities for maternity/reproductive health.

Auckland DHB is expected to restrain cost growth, reduce waste and improve productivity over 2010-11. The Minister of Health expects that:

- Auckland DHB will continue to maintain its provision of 'core services' (in line with the national Quality Policy Framework, National Service Coverage and Service Schedules)
- Auckland DHB must also 'demonstrate' health services growth that is in line with demographic trends
- Per capita expenditure on community pharmaceuticals will be maintained at the current level
- 'First contact patient care' should be adequate to meet population growth and demographic demand
- Savings will need to be achieved from PHO management fees and others
- Oncology services are a national priority; and there will be increased pressure to reduce further wait times for treatment and follow ups

Auckland DHB Funding Principles

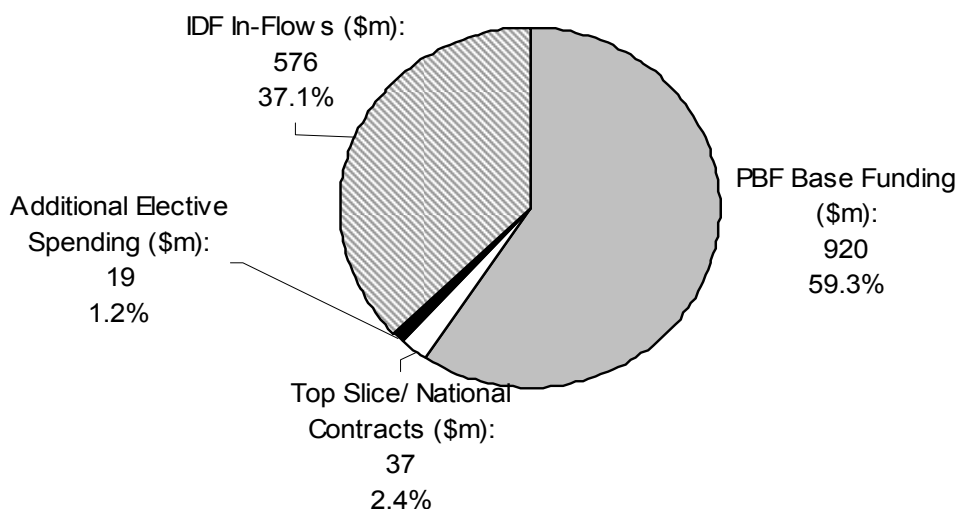
Nationally, Auckland DHB's revenue is fixed and therefore our cost structures need to be less or equal to the budget cost target. There will be a real fiscal risk to Auckland DHB if we deliver services beyond those we can afford. This includes work for other DHBs for which it has not been contracted for or where there is no 'wash-up agreement'. The key funding allocation principles are as follows:

- Acutes and electives service will be separately monitored, with little scope of 'transferring monies' across the service types to offset overproduction in one or the other
- Acute emergency and urgent services funding for 2010-11 will be set by annualising the 2009-10 YTD production and adding an averaged growth factor of 0.85% per month (to cover over the year, the projected population growth of 1.53%). The impact of this increased service provision means compromises in the funding and development of new and innovative service programmes

- Community pharmacy is based on national agreement between CEOs and PHARMAC; which has forecasted population growth and higher utilization due to greater primary care access and screening programmes
- A 2% increase in First Contact funding will be applied in 2010-2011 as part of the primary healthcare funding
- Community laboratory budget reflects the regional contracts
- Services such as Health of Older People that received a heavy reduction in the current year's budget have a compensatory step up in funding. This is also the case for PHO funding where a 'catch up' is proposed
- The majority of NGO contracts are demand driven (often driven by primary on-referrals) and these need to be funded to the forecast demographic demand levels
- Auckland DHB will apply a price increase in the Aged Residential Care Contract. The increase includes cost implications (if any) on providers from changes to the new audit regime and any funding implications that may arise out of the A21 Review for 2010-11. With the implementation of unannounced spot audits from 1 January 2010 there may be a cost increase to providers for such audits due to increased time taken to conduct the audits

A review of all contracts is underway to ensure that the funding available to the Auckland DHB is allocated to best effect. This prioritisation work will cover the provider arm and contracts with providers outside the Auckland DHB owned services. NGOs will be expected to operate on the revenue as per existing funding arrangements with Auckland DHB funder.

Breakdown of Auckland DHB funding received



2010–11 Ministry of Health and IDF* funding compared to 2009–10

	2009–10 Forecast \$m	2010–11 Plan \$m	% change
Population-based funding (PBF)	930.8	956.4	2.7%
Additional sector capability initiatives	12.1	10.3	(1.4)%
Additional elective spending	18.6	20.3	9.1%
Other side contracts	60.1	66.9	11.3%
Inter District Flows	558.7	574.7	2.9%
Total	1,580.3	1,628.6	3.0%

* IDF= inter district flows, where people come into the Auckland DHB area for treatment or for services

The district-wide allocation of funding

	Services for Auckland Population \$m			
	By Auckland DHB provider	Provided by other DHBs & funded by ADHB	ADHB community NGO providers	Total \$ by Auckland DHB
Hospital personal health services	\$316	\$51	-	\$367
Additional electives	\$18	\$3	\$6	\$27
Pharmaceuticals	\$82	\$10	\$89	\$181
Laboratory services	\$27	\$1	\$19	\$47
PHOs and related services e.g. GMSS		\$11	\$72	\$83
Mental health services	\$92	\$18	\$33	\$125
Health of Older People, Aged Residential Care, and Home Based Support Services	\$35	\$8	\$101	\$144
Public Health (regional)	\$15	-	\$2	\$17
Radiology services	\$33	-	\$1	\$34
Other hospital-based services				-
Other community-based services	-	\$2	\$8	\$10
Other-miscellaneous	\$5		\$1	\$6
Total	\$623m	\$104m	\$332m	\$1,041m

Capital expenditure projects planned for 2010-11

Greenlane Clinic Centre elective surgical facility	Commenced work on stage one of a multistage development
Car park at Auckland City Hospital	Pending Ministerial approval, we propose to build the new car park building at the Auckland City Hospital site starting in 2010-11 \$11 million included in the 2010-11 capital plan (unapproved)
Building 10 exit and site development	Building 10 is a two storey, early 1900s structure on the Greenlane site. The building covers a key future development area on the Greenlane site. The Building 10 Exit Plan is releasing this area for the development of future clinical facilities. Ministry of Health bed modelling for Auckland DHB indicates such facilities may be required within the next five to ten years. In combination with the gradual exit of occupants, sections of the building will be demolished.
Starship Theatres Upgrade	A \$15 million project to upgrade the theatres in Starship with \$7m budgeted for build commencement in 2010-11

Financing for the above projects in the 2010-11 year is to be provided from Auckland DHB cashflows and existing debt facilities.

Financial Management

The Minister's Letter of Expectations requires the organisation to achieve a break even position within the allocated funding. This requires reprioritisation and reallocation of resources and investment in tools such as lean thinking in order to enable new ways of working, reduce variation and ensure avoidance of waste.

The significant pressure on costs and cost growth, arising from increased service delivery requirements and the expectations of the labour market, means our drive to identify and implement new ways of working throughout the organisation is an imperative. This District Annual Plan incorporates a number of initiatives to avoid waste and improve productivity, including clinical resource utilisation and practice change, reduced administrative costs and procurement savings. This includes maintaining management and administration FTE numbers below the Minister's December 2008 cap levels, with the processes and rules for managing below this cap now well established.

Key assumptions within the financial plans include:

- There is significantly reduced interest income compared with earlier years due to lower interest rates. This reflects the impacts of the world economic crisis which has also increased 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 has also increased uncertainty and risk regarding the future levels of donation income that will be received and the collection of payments from non-residents
- Inflation is generally assumed at 2.3 percent. The potential future impact of the forex rate movements is also inherently uncertain in a small economy such as New Zealand operating in a global environment. 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, including agreed MECA settlements through to their expiry date and step increases within the MECA documents. There is an uncertain impact arising from job sizing which will need to be absorbed within the overall budget. A one percent variation in employee costs equates to approximately \$7 million at Auckland DHB
- There is uncertainty in property market values, particularly since 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 the same level as 2010-11 year to 2012-13.

Board policy is to revalue land and buildings to fair value, as determined by a registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every 3 years. The latest revaluation was completed on 30 June 2009. We do not anticipate a revaluation of property assets during the Annual Planning horizon. A +/- 5% change in the valuation of

land and buildings would result in a change in asset values of \$40m, and impact on the Statement of Financial Performance by approximately \$4.0m per annum.

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.

Finances mapped against output classes (refer table 8)

The Statement of Financial Performance has been recast to provide a summary of results by Output Class. The Health Sector has worked together with the Office of the Auditor General and Audit New Zealand to develop an approach to assigning revenue and expenditure in a first attempt at deriving a financial summary in Output Class format.

It is important to note that the majority of revenue is not received in a manner which can be easily related to Output Classes. It is therefore the responsibility of District Health Boards to determine the allocation of resources in accordance with the needs of the population it serves and Government Health Priorities. By following the allocation of expenditure, the best demonstration of the allocation of resources by output class is achieved. As a consequence the current allocation of revenue does not necessarily relate to the allocation of resources by output class.

Efficiency Related Activity

Auckland DHB contributes to national health goals, notably to get the best out of the sector funding available. Auckland DHB will improve the efficiency, effectiveness and alignment with the government’s priorities of the funding we administer, through innovation and cost effective delivery of services. Efficiencies will be achieved through performance improvement actions, which will be monitored monthly. We contribute information on expected and actual performance against the indicators to the Ministry of Health, especially those regarding price, quantity and standards, so results can be measured across the sector.

Ministry of Health performance improvement actions

Short term impact across Vote Health	<p>Stronger funding framework to drive improvements across Vote Health</p> <p>Improved purchasing and prioritisation identified by rolling in-depth spending reviews, including options for funding devolution that optimise purchasing power</p> <p>Stronger accountability with monitoring & enforcement based on support plans, streamlined reporting and rapid intervention when performance issues arise</p>
Short term impact across DHBs	<p>Improved hospital productivity and quality – focus on hospital wards, theatre utilisation, increasing day surgery and emergency departments</p> <p>Primary Care Implementation Plan – strengthen focus on chronic disease management and reducing avoidable hospitalisation</p> <p>Work with the sector to improve purchasing, including: smarter contracting, collective procurement & shared back-office services</p> <p>Contain rate of employment cost growth</p> <p>Maximum use of settings to enforce plans and deliver improved value against price, quantity and standards</p>
Medium term impact across sector	<p>Support sector to achieve all government health targets on time</p> <p>New models of care, focus on innovative use of workforce</p> <p>Service planning to define national and regional services</p> <p>Accelerated quality improvements including reductions and then elimination of avoidable variations and adverse events</p>

The Financial Plan 2010–13

Table 1: Statement of financial performance

STATEMENT OF FINANCIAL PERFORMANCE	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
REVENUE					
Base Funding					
Population Based	899,155	930,832	956,414	983,194	1,010,723
Inter District Flows	524,323	558,675	574,688	597,100	620,387
	1,423,479	1,489,507	1,531,102	1,580,294	1,631,111
Side Contracts with Ministry of Health					
Additional Electives	19,176	18,611	20,358	20,358	20,358
Sector Capability & Innovation	-	12,122	10,253	10,253	10,253
Other Side Contracts	60,417	60,037	66,863	66,863	66,863
	79,593	90,770	97,474	97,474	97,474
Other Revenue					
Other Patient Care	35,755	33,584	32,951	33,643	34,316
External	99,427	86,437	82,091	83,933	85,593
	135,182	120,022	115,043	117,576	119,909
TOTAL REVENUE	1,638,253	1,700,299	1,743,618	1,795,344	1,848,493
OPERATING COSTS					
Employee Costs	686,971	720,008	734,414	758,319	783,696
Treatment Costs	254,627	257,152	249,067	254,298	259,384
Funder Payments	521,457	550,560	573,934	590,848	608,269
Property & Equipment Maintenance	51,098	49,809	50,839	51,890	52,928
Administration	20,382	18,444	24,225	24,734	25,228
TOTAL OPERATING COSTS	1,534,536	1,595,973	1,632,480	1,680,089	1,729,505
OPERATING SURPLUS/(DEFICIT)	103,717	104,326	111,138	115,256	118,989
NON OPERATING COSTS					
Depreciation	42,810	48,182	54,310	59,140	63,552
Interest	20,904	20,346	20,154	19,406	18,876
Capital Charge	39,678	35,586	36,617	36,650	36,500
TOTAL NON OPERATING COSTS	103,392	104,114	111,081	115,196	118,928
SURPLUS/(DEFICIT) FOR THE YEAR	325	212	58	60	61

Table 2: Statement of comprehensive income

STATEMENT OF COMPREHENSIVE INCOME	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
SURPLUS/(DEFICIT) FOR THE YEAR	325	212	58	60	61
OTHER COMPREHENSIVE INCOME					
Gains/Losses on Property Revaluations	(35,739)	-	-	-	-
TOTAL COMPREHENSIVE INCOME	(35,414)	212	58	60	61

Table 3: Cost of service statement

COST OF SERVICE STATEMENT	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
Governance & Funding Administration					
Revenue	3,245	6,628	4,892	5,029	5,170
Expenses	(11,815)	(12,077)	(5,789)	(6,024)	(6,262)
Net Surplus/(Deficit) - Governance & Funding Administration	(8,570)	(5,449)	(897)	(995)	(1,092)
Provider					
Revenue	1,076,717	1,137,922	1,162,210	1,192,841	1,224,062
Expenses	(1,102,462)	(1,135,465)	(1,162,154)	(1,193,838)	(1,230,819)
Net Surplus/(Deficit) - Provider	(25,745)	2,457	56	(997)	(6,757)
Funder					
Revenue	1,463,505	1,536,164	1,585,022	1,634,218	1,685,034
Expenses	(1,428,865)	(1,532,960)	(1,584,123)	(1,632,166)	(1,677,124)
Net Surplus/(Deficit) - Funder	34,640	3,204	899	2,052	7,910
Elimination					
Revenue	(905,214)	(980,415)	(1,008,506)	(1,036,744)	(1,065,773)
Expenses	905,214	980,415	1,008,506	1,036,744	1,065,773
Net Surplus/(Deficit) - Elimination	-	-	-	-	-
Total					
Revenue	1,638,253	1,700,299	1,743,618	1,795,344	1,848,493
Expenses	(1,637,928)	(1,700,087)	(1,743,560)	(1,795,284)	(1,848,432)
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	325	212	58	60	61

Table 4: Statement of changes in equity

STATEMENT OF CHANGES IN EQUITY	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
Balance as at 1 July	549,131	478,717	482,144	486,260	489,462
Total Comprehensive Income	(35,414)	212	58	60	61
Capital Contributions from the Crown	-	3,215	4,058	3,143	-
Capital Repayments to the Crown	(35,000)	-	-	-	-
Balance as at 30 June	478,717	482,144	486,260	489,462	489,523

Table 5: Statement of financial position

STATEMENT OF FINANCIAL POSITION	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
ASSETS					
CURRENT ASSETS					
Cash, Bank Balances & Investment bonds	35,287	30,030	13,293	11,695	16,074
Financing Cash Deposit	-	10,500	21,000	31,500	42,000
Restricted Trust Funds	11,780	11,508	11,508	11,508	11,508
Receivables and Prepayments	63,416	63,719	58,435	59,419	60,518
Inventories	11,717	11,717	12,106	12,445	12,794
	122,200	127,474	116,342	126,567	142,893
NON CURRENT ASSETS					
Restricted Trust Funds	8,000	8,000	8,000	8,000	8,000
Property, Plant and Equipment	888,803	896,986	915,566	915,041	909,056
Intangible Assets	12,766	19,970	24,607	25,992	26,425
Derivatives in Gain	8,227	5,052	4,399	3,463	2,440
Investment in Associates	386	386	386	386	386
	918,182	930,394	952,958	952,881	946,307
TOTAL ASSETS	1,040,382	1,057,868	1,069,300	1,079,449	1,089,200
LIABILITIES					
CURRENT LIABILITIES					
Trade and Other Payables	133,129	134,652	137,189	139,145	141,785
Employee Benefits	118,013	121,568	124,900	127,773	131,350
Borrowings	18,375	85,564	25,836	27,642	30,218
Funds held in Trust	1,038	1,054	1,126	1,198	1,270
Derivatives in Loss	1,273	(0)	-	-	-
	271,827	342,837	289,051	295,757	304,623
NON - CURRENT LIABILITIES					
Employee Benefits	20,673	20,673	20,880	20,880	21,464
Borrowings	269,167	212,213	273,109	273,349	273,589
	289,840	232,886	293,989	294,229	295,053
TOTAL LIABILITIES	561,666	575,723	583,040	589,986	599,676
EQUITY					
Public Equity	566,090	569,304	573,362	576,505	576,505
Accumulated Deficit	(477,657)	(477,444)	(477,386)	(477,327)	(477,266)
Revaluation Reserve	381,277	381,277	381,277	381,277	381,277
Trust/Special Funds	9,007	9,007	9,007	9,007	9,007
TOTAL EQUITY	478,716	482,144	486,260	489,462	489,523
NET ASSETS	1,040,383	1,057,867	1,069,300	1,079,449	1,089,200

Table 6: Statement of cash flows

STATEMENT OF CASH FLOWS	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
<u>CASH FLOWS FROM OPERATING ACTIVITIES</u>					
Cash was provided from					
Provision of Health Services	1,592,646	1,700,738	1,744,507	1,790,113	1,842,618
Repayment of Major Debtors by the Crown	36,957	-	-	-	-
Interest Received	11,356	5,217	4,436	4,793	5,411
	1,640,959	1,705,955	1,748,944	1,794,906	1,848,028
Cash was applied to					
Employee Costs	(657,814)	(716,453)	(730,875)	(755,446)	(779,533)
Other Operating Costs	(917,172)	(911,339)	(931,907)	(956,412)	(979,628)
Interest Paid	(21,065)	(21,458)	(19,910)	(17,360)	(16,060)
	(1,596,051)	(1,649,251)	(1,682,693)	(1,729,218)	(1,775,222)
Net Cash Flow from Operating Activities	44,908	56,704	66,251	65,687	72,807
<u>INVESTING ACTIVITIES</u>					
Cash was provided from					
Proceeds from Sale of Fixed Assets	83	22	(16)	-	-
Decrease/(Increase) in Restricted Trust & Financing Funds	(1,042)	(10,212)	(10,428)	(10,428)	(10,428)
	(959)	(10,190)	(10,444)	(10,428)	(10,428)
Cash was applied to					
Purchase of Fixed Assets and Intangibles	(42,344)	(65,063)	(77,527)	(60,000)	(58,000)
Net cash (Outflow) from Investing Activities	(43,303)	(75,253)	(87,971)	(70,428)	(68,428)
<u>FINANCING ACTIVITIES</u>					
Proceeds from Capital Raised/(Repaid)	(35,000)	3,215	4,058	3,143	-
Proceeds from Loans Raised	0	20,575	11,425	10,500	10,500
Loans Repaid	(10,500)	(10,500)	(10,500)	(10,500)	(10,500)
Net cash (Outflow) from Financing Activities	(45,500)	13,290	4,983	3,143	-
OPENING BANK BALANCE	79,181	35,287	30,029	13,291	11,694
NET CASH INFLOW/(OUTFLOW)	(43,895)	(5,259)	(16,737)	(1,598)	4,379
CLOSING BANK BALANCE	35,287	30,028	13,291	11,694	16,072

RECONCILIATION OF OPERATING DEFICIT WITH CASH FLOWS FROM OPERATING ACTIVITIES	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
Total Surplus/(Deficit) for the Year	325	212	58	60	61
Non - Cash Items					
Depreciation and Impairment Losses	42,811	48,182	54,310	59,140	63,552
(Gains)/Losses on Financial Instruments	(5,228)	1,902	653	936	1,023
Amortisation of Borrowing Costs	239	172	173	336	240
	37,822	50,256	55,136	60,413	64,815
Items Classified as Investing Activities					
Gain on Sale of Property Plant and Equipment	339	1,472	16	-	-
Movements in Working Capital					
(Increase)/Decrease in Receivables	14,180	(303)	5,284	(984)	(1,098)
(Increase)/Decrease in Inventories	(955)	0	(389)	(339)	(348)
Increase/(Decrease) in Payables	(6,803)	5,067	6,146	6,538	9,378
	6,422	4,764	11,041	5,215	7,931
Net Cash Flow from Operating Activities	44,908	56,704	66,251	65,687	72,807

Table 7: Balance sheet equity ratio

BALANCE SHEET EQUITY RATIO	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
Equity Position					
Crown Equity	(468,671)	(472,084)	(476,127)	(479,258)	(479,247)
Trust Equity	(10,045)	(10,061)	(10,133)	(10,205)	(10,277)
Total Equity	(478,716)	(482,144)	(486,260)	(489,462)	(489,523)
Total Debt					
Bank	-	-	-	-	-
Bonds	(120,000)	(120,000)	(50,000)	(50,000)	(50,000)
Crown Funding Authority	(163,500)	(173,200)	(244,500)	(244,500)	(244,500)
	(283,500)	(293,200)	(294,500)	(294,500)	(294,500)
Total Debt	(283,500)	(293,200)	(294,500)	(294,500)	(294,500)
Total Debt + Equity	(762,216)	(775,344)	(780,760)	(783,962)	(784,023)
Equity Ratio - to be less than 65%	37.2%	37.8%	37.7%	37.6%	37.6%
	4,041	4,577	4,445	6,491	9,307

Table 8: Summary of Results by Output Class

Output Class Service	Actual 2009 \$'000	Forecast 2010 \$'000	Plan 2011 \$'000	Estimate 2012 \$'000	Estimate 2013 \$'000
Primary					
Revenue	424,079	407,740	413,352	425,614	438,214
Expenditure	(405,149)	(425,132)	(433,780)	(446,560)	(461,641)
Surplus/(Deficit)	18,930	(17,392)	(20,428)	(20,946)	(23,427)
Hospital					
Revenue	1,060,747	1,133,020	1,164,688	1,199,239	1,234,741
Expenditure	(1,069,560)	(1,103,758)	(1,134,715)	(1,168,497)	(1,200,563)
Surplus/(Deficit)	(8,813)	29,262	29,973	30,743	34,178
Support					
Revenue	130,295	137,285	146,102	150,437	154,890
Expenditure	(139,505)	(148,239)	(155,546)	(160,131)	(165,492)
Surplus/(Deficit)	(9,210)	(10,954)	(9,444)	(9,695)	(10,602)
Public Health					
Revenue	23,132	22,254	19,476	20,053	20,647
Expenditure	(23,715)	(22,958)	(19,519)	(20,096)	(20,735)
Surplus/(Deficit)	(583)	(704)	(43)	(42)	(87)
Total					
Revenue	1,638,253	1,700,299	1,743,618	1,795,344	1,848,493
Expenditure	(1,637,928)	(1,700,087)	(1,743,560)	(1,795,284)	(1,848,432)
Surplus/(Deficit)	325	212	58	60	61

Statement of Accounting Policies

The following is a summarised description of the accounting policies used in the preparation of this District Annual Plan. A full description of accounting policies used by Auckland DHB for financial reporting, budgeting and forecasting can be found in the 2009 Annual Report on the website at www.adhb.govt.nz/publications.

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 reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, and the Public Finance Act 1989 and the Crown Entities Act 2004.

Auckland DHB is a public benefit entity (PBE), as defined under NZ IAS 1.

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 for the district.

Accounting policies remain unchanged from the previous year.

Basis of preparation

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

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that the following asset and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swaps), financial instruments and land and buildings.

The preparation of financial statements in conformity with NZ IFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about the 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.

Associates

Associates are those entities in which Auckland DHB has the power to exert significant influence, but not control, over the financial and operating policies. Auckland DHB holds shareholdings in the following associates: Auckland Regional RMO Services Limited (previously The Northern Clinical Training Network Limited) (33% owned) and Northern DHB Support Agency Limited (33% owned).

Auckland Regional RMO Services Limited is a joint venture company with Counties-Manukau and Waitemata DHBs, which exists to support and facilitate employment and training for Resident Medical Officers across the three Auckland regional DHBs.

Northern DHB Support Agency Limited with Counties-Manukau and Waitemata DHB exists to provide a shared services agency to the three Auckland regional DHB boards in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution.

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 in 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 balance date are translated to NZD at the rate ruling at that date.

Equity

Equity comprises contributions from the Crown, accumulated surpluses/deficits and reserves. Crown contributions are recognised at the amount received, accumulated surpluses/deficits in accordance with the financial results using generally accepted accounting principles, and reserves from changes in the value of land and buildings.

Property, plant and equipment (PPE)

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

- Freehold land
- Freehold buildings and fitouts
- Plant, equipment and vehicles
- Leased assets
- Work in progress

Owned assets

Except for land and buildings, items of PPE are stated at cost, less accumulated depreciation and impairment losses.

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 2009.

Additions to PPE between valuations are recorded at cost.

Disposal of property, plant and equipment

Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the Statement of Financial Performance is calculated as the difference between the net sales price and the carrying amount of the asset.

Leased assets

Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases.

Operating lease payments are recorded as an expense in the Statement of Financial Performance on a straight-line basis over the lease term.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the future economic benefit embodied within the item will flow to Auckland DHB. All other costs are recognised in the Statement of Financial Performance as an expense as incurred.

Depreciation

Depreciation is charged to the Statement of Financial Performance using the straight line method. Land 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, as follows:

Asset class	Useful lives
Freehold buildings and fitouts	1–89 years
Plant, equipment and vehicles	2–20 years
Lease assets	4–8 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 less accumulated amortisation and impairment losses.

Interest-bearing loans and borrowings

Interest-bearing capital bonds 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.

Crown Health Financing Agency borrowings are recorded at nominal or “face” value.

Derivative financial instruments

Auckland DHB uses foreign exchange and interest rate swap contracts to manage its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities. Such derivatives are accounted for as trading instruments, and are stated at fair value.

Trade and other receivables

Trade and other receivables are recognised and carried at original invoice amount less impairment. 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 net realisable value. A provision for slow moving or obsolete stock is made.

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

Cash and cash equivalents

Cash and cash equivalents comprise cash and call deposits with an original maturity of less than three months. 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.

Impairment

The carrying amounts of Auckland assets are reviewed at balance date to determine whether there is any indication of impairment. Impairment losses are recognised in the Statement of Financial Performance.

Financial instruments

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

Employee benefits

Defined Contribution Plan (DCP)

Obligations for contributions to DCPs are recognised as an expense in the Statement of Financial Performance 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.

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.

Revenue

The majority of revenue is provided through an appropriation in association 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 Auckland DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Auckland DHB.

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 such revenue, with the agreement of the funder, 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.

Interest income is recognised using the effective interest method.

Expenses

Payments made under operating leases are recognised in the Statement of Financial Performance on a straight-line basis over the term of the lease.

Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases.

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.

Borrowing costs

Borrowing costs are recognised as an expense when incurred.

Cost allocation

Auckland DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below:

Cost allocation policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Criteria for direct and indirect costs

Direct costs are those costs directly attributable to an output class. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is held in central overhead pools, for example, the cost of building accommodation. The exceptions to this are ring-fenced services Mental Health and Public Health where an allocation of overheads is made, and some services that sell to third parties, for example LabPlus.

Other Provisions

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.

Schedule of arrangements

Under section 24 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.

Below are some examples of the co-operative agreements or arrangements Auckland DHB is authorised by this plan to enter into in the future. Auckland DHB may also enter into any other co-operative agreements or arrangements which, in the opinion of its Chief Executive, will assist in meeting its objectives, or will enhance health or disability outcomes for people, or enhance efficiencies in the health sector.

Co operative arrangements are in place to achieve the following objectives

- Meet public health objectives for the region
- Improve public health outcomes for Maori across the region
- Advance healthy housing development strategy
- Work regionally and nationally with other DHBs, DHBNZ, tertiary education institutions and the Crown in respect health education and work force development
- Work regionally and nationally with other DHBs and DHBNZ in relation to procurement

Achieve regional collaboration in the recruitment of staff

Maintain the multi-agency centre, Puawaitahi, where various agencies case-manage specialist investigation and treatment for abused children

Allow staff of other entities to access Auckland DHB facilities for research, training or to work with Auckland DHB staff

Undertake initiatives with tertiary education institutions to promote public health, research, evidence-based practice and clinical effectiveness

Clinical trial agreements, via the ADHB Charitable Trust to develop better treatment options and quality measures

Enable Auckland DHB to assist ACC in the treatment of injuries and provision of care

Occupation licences to allow early childhood education and care services on Auckland DHB sites for children of Auckland DHB staff

Occupation licences to provide premises for organisations who assist Auckland DHB in meeting its objectives or to enhance health or disability outcomes for people, for example Starship Foundation and Ronald McDonald House

Assist with the treatment of inmates in the care of the Department of Corrections

Support community health initiatives

Implement a regional Drinking Water Incident Co operation Plan

Co ordinate with other sectors in Strengthening Families, the joint sector project to improve case management for children and families with high need

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%
Bonds	<i>\$120 million:</i> <i>\$70 million to mature 2010*</i> <i>\$50 million to mature 2015</i> <i>* Commitment by Crown Health Funding Agency to fund</i>
Crown Health Funding Agency	<i>\$184.5 million * increasing to \$254.5 million when bonds repaid</i>
Commonwealth Bank of Australia	<i>\$65 million working capital facility</i>

Appendix 1: Commonly used acronyms and abbreviations

A&D	Alcohol and Drug
ADHB	Auckland District Health Board
ALOS	Average Length of Stay
ARDS	Auckland Regional Dental Service
ARMHIT	Auckland Regional Mental Health Information Technology
ARPHS	Auckland Regional Public Health Service
ARRMOS	Auckland Regional Resident Medical Officers Services Ltd (replaces NCTN)
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment and Rehabilitation
BFH	Baby Friendly Hospital
BSI	Blood Stream Infections
BSMC	Better Sooner More Convenient (Government Health Policy)
C&F	Child & Family
CE	Crown Entity
CFA	Crown Funding Agreement
CFO	Chief Financial Officer
CHFA	Crown Health Financing Agency
CMHC	Community Mental Health Centre
COPD	Chronic Obstructive Pulmonary Disease
CPHAC	Community & Public Health Advisory Committee (committee of the ADHB Board)
CTA	Clinical Training Agency
CVD	Cardiovascular Disease
CWD	Case Weighted Discharges
DAP	District Annual Plan (DHB)
DHB	District Health Board
DSAC	Disability Support Advisory Committee (committee of the ADHB Board)
DMFT	Decayed/Missing/Filled Teeth
DNA	Did not attend
DSP	District Strategic Plan (DHB)
ED	Emergency Department
EOI	Expression of Interest
eReferrals	Electronic Referrals
FFT	Future funding track
FSA	First Specialist Assessment (Hospital Out-patient visit)
FTE	Full-time equivalent (staff)
GAIHN	Greater Auckland Integrated Health Network
Get Checked	Free annual diabetes check from a GP / Practice Nurse for people with diabetes
HAC	Hospital Advisory Committee (committee of the Board)
HBI	Hospital Benchmark Information (previously the Balanced Score Card (BSC))
HEHA	Healthy Eating Healthy Action
HOP	Health of Older People
HR	Human Resources
IDF	Inter District Flows (services provided by one DHB for residents of another DHB)
IFHC	Integrated Family Health Centres
IT	Information Technology
InterRai	Older Persons Health Assessment System
ISSP	Information Systems Strategic Plan
KPIs	Key Performance Indicators
LOS	Length of Stay
MECA	Multi Employer Collective Agreement

MoH	Ministry of Health
MoU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
NASC	Needs Assessment and Service Coordination
NCN	Northern Cancer Network
NCTN	Northern Clinical Training Network (became ARRMOS in March 2007)
NDSA	Northern DHB Support Agency
NGO	Non-Government Organisation
NHB	National Health Board
NHI	National Health Index (unique health identifier for every individual)
NMDS	National Minimum Data Set (national collection of hospital discharge data)
NZHS	New Zealand Health Strategy
NZDS	New Zealand Disability Strategy
NZNO	New Zealand Nurses Association
NZQF	New Zealand Quality Foundation
OPF	Operating Policy Framework - part of the Crown Funding Agreement (for DHBs)
PBFF	Population Based Funding Formula
PHO	Primary Healthcare Organisation
PIA	Performance Improvement Actions
POAC	Primary Options for Acute Care
RMO	Resident Medical Officer
RN	Registered Nurse
RSP	Regional Service Plan
SCS	Service Coverage Schedule - part of the Crown Funding Agreement (for DHBs)
SMO	Senior Medical Officer
SOI	Statement of Intent (DHB Accountability Document)
WDHB	Waitemata District Health Board
WIES	System for comparing the relative costs of Medical and Surgical admissions
YTD	Year to date

Appendix 2: Auckland DHB Intervention Logic Framework - Summarised

Vision	Hei Oranga Tika Mo Te Iti Me Te Rahi: Healthy Communities, Quality Healthcare							
Goals	Lift the health of people living in Auckland city					Performance Improvement		Live within our means
High Level Outcomes	Impacts from cancer, diabetes, & cardiovascular disease are minimised	Improved quality of life for people with mental health and addiction problems & their family / whanau	Improved quality of life for people with disabilities and their family / whanau	Improved quality of life for older people and their family / whanau	Healthier, safer children	Improve primary and secondary care integration	Improve quality of hospital care while also improving productivity	NZ'ers have confidence in the levels of care available from Auckland DHB
High Level Measures	↓ morbidity and mortality from cancer, diabetes, and cardiovascular disease	↓ in mental health and addiction problems	↑ independence for people with disabilities & those needing support services	↑ rates of 85+yrs able to live independently	↓ the rates of Ambulatory Sensitive Hospital (ASH) Admissions for children	↑ number of primary options for acute care (POAC)	↑ service throughput and productivity	Break-even position is maintained
High Level Impacts	Chronic Conditions Ameliorate impacts of cancer, diabetes, and cardiovascular symptoms, and/or delay in their onset	Mental Health Environments and services support mental wellness and recovery	Disabilities Continual reduction in barriers for people with disabilities progressing in society	Older People More older people are able to age in the environment of their choice	Child Health Earlier identification and interventions with vulnerable children and their family / whanau	Primary & Community Care Improved access of service delivery	Secondary Care Improved patient / client experience and outcomes	Viability ADHB meets local health needs & provides specialist care as required by the sector

Output Classes	1: Public and Population Health					2: Primary and Community Services				
Outputs	1a) Health Protection	1b) Health Promotion	1c) Communicable Disease Control	1d) Immunisation	1e) Screening	2a) Diabetes	2b) Cardiovascular disease	2c) PHO Services	2d) Ambulatory Sensitive Admissions (ASH)	2e) Oral health
Output Measures	1ai) No. of Early Childhood Centres health assessed 1aii) No. of drinking water investigations to monitor/improve quality 1aiii) Hazardous substances & new organisms emergency investigations	1bi) No. on Pacific smoking programmes in Auckland ADHB 1bii) No. of Healthy Housing Assessments 1biii) % of 1bii) referred to insulation provider 1biv) % of infants exclusively & fully breast fed until: 6 wks, 3 mths, 6mths	Disease notifications: investigated as required; case management & contact tracing: 1ci) No. TB cases 1cii) No. other disease investigations	1di) No. of referrals to immunisation outreach services 1dii) % of 2 yr olds fully immunised for age 1diii) % eligible consented children completing year 7 vaccination	1ei) No. eligible 20 – 65 yr women participating in National Cervical Screening programme in accordance with the 3 yr coverage rate: Maori, Pacific, Asian, Other 1eii) No. B4 School Checks completed	2ai) % eligible patients Diabetes annual check: Maori, Pacific, Total 2aii) % Get Checked pts with HbA1c<8: Maori, Pacific, Total 2aiii) % people with diabetes retinal screened: Maori, Pacific, Total	2bi) % eligible people cardiovascular screened: Maori, Pacific, Other 2bii) % increase in programmes & options available for cardiac rehabilitation	2ci) % of valid NHI on patient register 2cii) % Maori enrolment in PHOs 2ciii) % eligible enrolled patients 2civ) % palliative care patients in receipt of PHO services	2di) % admissions < 5yr olds - avoid or prevent: Maori, Pacific, Other 2dii) % unnecessary hospital admissions for 45 – 64 yr olds: Maori, Pacific, Other 2diii) % unnecessary hospital admissions for 0 – 74 yr olds: Maori, Pacific, Other	2ei) % of adolescent oral health utilisation 2eii) % of children caries free at 5 yrs old: Maori, Pacific, Other, Total 2eiii) Average number of teeth of 8 yr olds – DMFT: Maori, Pacific, Other, Total

Output Classes	3: Secondary Services							4: Support Services				
Outputs	3a) Cancer Patients	3b) Emergency Department Patients	3c) Patient Journey	3d) Mental Health Clients	3e) Patient Throughput	3f) Smoking Patients	3g) Patient Discharges	3h) Patient Outcomes	4a) People Receiving Services In Their Homes	4b) Residential Care Patients	4c) Palliative Care Patients	4d) Mental Health Clients
Output Measures	3ai) Patients requiring radiation treatment & receive this within 4 weeks (target by December 2010)	3bi) % of ED patients admitted, discharged, or transferred within 6 hrs	3ci) ↓ ALOS for elective & arranged inpatients 3cii) Acute inpatient ALOS 3ciii) Elective & arranged DOSA 3civ) % DNA for specialist appointments 3cv) % Maori patients DNA rates	3di) ≥ 90% long-term clients have up to date relapse prevention plans 3dii) % improved access for clients to mental health services	3ei) Volume of acute cases 3eii) Volume of elective cases	3fi) % of hospitalised smokers provided with advice & help to quit	3gi) Number of elective service discharges	3hi) Mortality rate (30 days) 3hii) % of unplanned acute re-admissions within 28 days of discharge	4ai) No. people ≥ 85yrs able to remain in their own homes with support 4aii) No. low level clients self managing with support 4aiii) No. of re-assessments - home based support clients	4bi) Number of complaints	4ci) No. palliative care patients accessing primary care under the subsidised DHB/PHO partnership	4di) % of residential mental health providers audited 4dii) % of people with enduring mental illness in work, or education, or appropriate discharges