



District Annual Plan

for the year ending 30 June 2004



Minister of Health
Minister for Food Safety
MP for Rongotai (incl Chatham Islands)

20 JAN 2004

Mr Wayne Brown
Chair
Auckland District Health Board
Private Bag 92-024
AUCKLAND

Dear Mr Brown

AUCKLAND DISTRICT HEALTH BOARD: 2003/04 DISTRICT ANNUAL PLAN

This is to advise you that I have signed Auckland District Health Board's (ADHB) District Annual Plan (DAP) for 2003/04 and that the Board has my support for the implementation of this plan.

I wish to express my appreciation to the Board, management and staff for all the effort that has gone into producing the plan and the efforts made to manage your services within the funding available.

I have signed and approved ADHB's 2003/04 DAP for three years (including a path to breakeven by 2006/07). I do however appreciate that outyear regionality savings and change programme savings are ambitious and that some of the details have yet to be worked through. As part of the 2004/05 DAP officials will expect to see more detailed plan showing how the savings and efficiencies will be delivered in 2004/05 and 2005/06.

Auckland DHB Chairs will be reporting back to me by the end of February 2004 providing substantial recommendations on better ways of delivering health services to the greater Auckland region with a focus on creating significant savings and improved services. I expect these recommendations and their benefits to inform and be included in the 2004/05 DAP.

I understand it is not ADHB's intention to reduce services available to your population in 2003/04.

Officials will be taking a keen interest in Regional Planning in the New Year to review and monitor planned service transfers and their financial implications and to ensure that service levels across the Auckland region are maintained.

I have noted ADHB's intention for involvement in a number of privately funded services. Please confirm to the Ministry of Health that ADHB meets all of the requirements of the 2003/04 OPF [section 4.2.B, 2] for DHBs to be involved in the provision of privately funded services and that ADHB is compliant with all relevant legal and legislative requirements.

ADHB will be required to report Governance and Provider arm expenses to the Ministry of Health in 2004/05 on a standard basis as set out in the various Ministry guidelines.

The reporting on Mental Health financials to suit ringfence requirements will continue to be an area needing improvement by the DHB and hopefully will build upon the gains made by the DHB this year in understanding what is required.

I note that the DAP omits a statement of projected consolidated cashflows. Please ensure that future DAPs include a statement of cashflows along with the statement of financial performance and the statement of financial position.

Service Coverage Schedule requirements for Mental Health services continue to be developed in line with the funding available and Blueprint expectations. ADHB will continue to be monitored in line with the agreed access targets to ensure the amount of funding that you receive is incrementally moving towards servicing the 3 percent of the population with the most severe mental health needs.

This letter should be attached to the copy of the signed plan held by the Board and a facsimile of the letter should be attached to all copies of the Plan made available to the public or any other third party.

Would you now please forward a copy of your final Statement of Intent 2003/04 to the Ministry within two weeks (ten working days) of receiving this letter.

Yours sincerely



Hon Annette King
MINISTER OF HEALTH

List of Acronyms

| Abbreviation | Description |
|---------------------|---|
| ACC | Accident Compensation Commission |
| ADHB | Auckland District Health Board |
| ALOS | Average Length of Stay |
| BFHI | Baby Friendly Hospital Initiative |
| CEO | Chief Executive Officer |
| CFA | Crown Funding Agreement |
| CIS | Clinical Information System |
| CMDHB | Counties Manukau District Health Board |
| COO | Chief Operating Officer |
| CPHAC | Community & Public Health Advisory Committee |
| CTA | Clinical Training Agency |
| CYFS | Child Youth and Family Service |
| DEAS | Disability Empowerment and Advocacy Service |
| DHB | District Health Board |
| DHBNZ | District Health Boards of New Zealand |
| DiSAC | Disability Services Advisory Committee |
| DNA | Did Not Attend |
| DSP | District Strategic Plan |
| DSS | Disability Support Services |
| FTE | Full Time Equivalent |
| GM | General Manager |
| GP | General Practitioner |
| HealthPac | The national claims processing centre |
| HCA | Health Care Assistant |
| HBO | Hospital Business Organisation |
| HR | Human Resources |
| HSDP | Health Services Delivery Plan (now known as the Building Programme) |
| ICU | Intensive Care Unit |
| IDF | Inter District Flow |
| IPA | Independent Practitioners' Association |
| IS | Information Systems |
| ISLA | Internal Service Level Agreement |
| ISSP | Information Systems Strategic Plan |
| KPI | Key Performance Indicators |
| LOS | Length of Stay |
| LMC | Lead Maternity Care |
| MAC | Multi-Agency Centre |
| MaPO | Maori Purchasing Organisation |
| MF Score | Mean Frequency Score |

| Abbreviation | Description |
|---------------------|--|
| MHINC | Mental Health Information National Collection |
| MoH | Ministry of Health or Ministry |
| NASC | Needs Assessment Service Co-ordination |
| NICU | Neonatal Intensive Care Unit |
| NDSA | Northern District Support Agency |
| NGO | Non Government Organisations |
| NHI | National Health Index |
| NMDS | National Minimum Data Set |
| NZDS | New Zealand Disability Strategy |
| NZHIS | New Zealand Health Information Service |
| NZHS | New Zealand Health Strategy |
| NZPHD Act | New Zealand Public Health and Disability Act |
| OPF | Operational Policy Framework |
| ORL | Ortorhino laryngology |
| OSH | Occupational Health and Safety |
| PBFF | Population Based Funding Formula |
| PBF | Population Based Funding |
| PCO | Primary Care Organisation |
| PHARMAC | Pharmaceutical Management Agency |
| PHO | Primary Health Organisation |
| PICU | Paediatric Intensive Care Unit |
| PSFP | Projected Statement of Financial Performance |
| RAC | Recruitment and Administration Centre |
| RC | Responsibility Code |
| RFF | Regional Funding Forum |
| RFP | Request For Proposal |
| RSP | Regional Service Planning |
| SCBU | Special Care Baby Unit |
| SEAHBC | South East Australasian Hospital Benchmarking Consortium |
| Section 88 | Section providing enabling certain providers to make claim fee for service claims |
| SLA | Service Level Agreement |
| Starship | The children's service within the hospital |
| WAVE Report | Working to Add Value through E-information. MoH Health Information Management and Technology Plan. |
| WDHB | Waitemata District Health Board |
| WMP | Workforce Management Plan |

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List of Strategic Objectives

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1 Executive Summary

1.1 Background

The Auckland District Health Board (ADHB) is an organisation that is working to address an unacceptable level of deficit while managing the healthcare infrastructure for a population of approximately 367,400 people living in the central Auckland district. The ADHB manages over 1000 contracts with non-government organisations (NGOs) which include General Medical practitioners, pharmacies, laboratories and community health workers. The ADHB is also New Zealand's largest public hospital provider with over two million patient contacts annually. Tertiary services are also provided for over 1.3 million people in the Auckland region as well as certain national tertiary services for the whole population of New Zealand. In total the ADHB provides more than 50% of its hospital services to people outside the ADHB area.

This District Annual Plan (DAP) is aligned with the priorities and objectives set out in the ADHB District Strategic Plan (DSP). It provides an overview of the significant change processes that are currently being implemented to manage deficit levels and to enable the organisation to move into its new hospital facilities within the next 12 months.

The plan also identifies how the ADHB will achieve the Government's priorities for health within the funding available over the next three years. It reflects our commitment to reporting requirements of the Ministry of Health (MoH) and demonstrates our appreciation of the broader policy setting with which we operate. It has been prepared in accordance with the requirements of the Public Finance Act 1989 and the New Zealand Public Health and Disability Act 2000 (NZPHD Act). It is also guided by the New Zealand Public Health and Disabilities (NZPHD) Act, the New Zealand Health Strategy, the New Zealand Disability Strategy and the Minister of Health's expectations.

The ADHB vision remains *'Hei Oranga Tika Mo Te Iti Me Te Rahi, Healthy Communities, Quality Healthcare'* which reflects a focus on the health of our population. This focus includes working with other agencies, organisations, Iwi and community leaders to achieve our goals. The benefits of this work will be realised in the medium to long term, not the immediate future.

We will meet our Treaty of Waitangi obligations to ensure Maori in our district experience good health. The Memorandum of Understanding ADHB has with Te Runanga o Ngati Whatua outlines partnership principles, processes for engagement and protocols. These protocols have been implemented across the organisation at Board, planning, funding and provider levels. This plan reflects the ADHB's close relationship with Tihi Ora MaPO and proactive engagement with our local communities.

1.2 Our four goals

The ADHB has selected four key goals to provide focus for its planning processes.

| | |
|---|---|
| Improve our business performance | <ul style="list-style-type: none"> • Get control of our finances and reduce the current level of deficit |
| Make the change programme happen | <ul style="list-style-type: none"> • Standardise, consolidate, and integrate our services • Collaborate across all health services to streamline care and to secure more cost effective health gain |
| Finish the building programme | <ul style="list-style-type: none"> • So gains from the change programme can work to maximum effect in our new and efficient hospital |
| Lift the health of Aucklanders | <ul style="list-style-type: none"> • Reflect our Treaty of Waitangi responsibilities within the framework of the NZPHD Act • Focus on population health • Reduce inequalities • Manage continuums of care • Strengthen the primary care sector • Improve quality and safety of services |

The work programmes planned to achieve these goals are set out in the body of this plan and reflect a commitment to pursuing the best health outcomes for our population within the available funding. The plan recognises 2003–04 will be a complex and challenging year for ADHB. We recognise that our deficit levels are at unacceptable levels and we are working to resolve this issue. Whilst addressing the breakeven issue this does not mean that other key initiatives have been ignored and our plan confirms our intention to pursue continued success in a large number of areas. These include completion of the building and change programmes on time and within budget, the continued commitment to the regional collaboration processes and PHO development to name but a few. It should also be noted that the funder arm of the ADHB is budgeted to break even in each of the plan years.

To manage our deficit levels towards breakeven we have developed a comprehensive plan to reach breakeven by 2006–07. We have not been able to meet Crown initial requirements for a \$35 million deficit for the 2003–04 year (\$25 million plus \$10 million allowance for migration costs) but the Crown has agreed to support a higher initial deficit as part of the four year pathway to breakeven.

Our plan to break even by 2006–07 is contained in two parts:

- The first part includes a wide range of initiatives that the Board and management fully endorse and are in the process of implementing.
- The second part reflects further regional initiatives recommended by independent reviews including the review commissioned by the Minister. The Board and management support these initiatives subject to verification of their accuracy, and the development of appropriate processes for their implementation and gaining Crown support.

A third level of FTE related savings to meet the anticipated excess of cost of wage settlements over the maximum permitted cost increase levels will only be actioned if the ADHB is in danger of not meeting its overall budget targets.

The first part of the plan confirms we will:

- take the price component of new funding directly to the bottom to reduce the deficit
- control FTE numbers to ensure they return to the freeze levels set in March 2002
- reduce FTE levels to deliver on the commitments we have made around the Change Programme
- set volumes to no more than historical levels and with the intention of absorbing growth in demand, with the exception of critical areas such as oncology, renal and diabetes where appropriate increases are planned for 2003–04

- manage the impact of regional service planning changes
- in line with the Building and Change Programmes, and Regional Service Planning reduced resourced bed numbers from 1077 (current) to 946 following the move into the new Auckland City Hospital
- absorb any allowed volumes increases within the existing cost structure
- recognise the maximum potential for property sales in each year with some major sales achieved by the fourth quarter of the 2003–04 year
- progressively reduce debt levels with surplus cash being proceeds from asset sales and the excess of depreciation over capital expenditure.

The second part comprises the potential for further regional initiatives to improve our operational performance. These have been incorporated into the plan on the basis that they are fully implemented by 2006–07. They will require both Crown support and appropriate validation and project scoping:

- assessment of the best means of simplifying the governance structures of the three Auckland DHBs
- streamlining of the management structures through collaboration and shared roles
- rationalisation of the management of laboratory expenditure
- further integration of the regional management of radiology services and capital expenditure planning
- integration of information technology resources and management
- adoption of a single Human Resources management structure and policy
- a high level of co-operation and integration for clinical services
- common policies and processes for the efficient management of clinical resources
- efficient management of equipment purchasing and operation
- service initiatives to improve access whilst avoiding unnecessary duplication.

The table below illustrates the impact of the reduction in FTEs arising from the plan.

| FTE's | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|--------------------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Base FTE | 6,932 | 7,014 | 6,678 | 6,292 | 6,131 | 6,163 |
| Mental Health | 17 | 17 | 17 | 17 | 17 | 17 |
| Public Health | 15 | 15 | 15 | 15 | 15 | 15 |
| Approved FTE's | 28 | 0 | 0 | 0 | 0 | 0 |
| Other increases | 117 | (117) | 0 | 0 | 0 | 0 |
| Sub total | 7,109 | 6,929 | 6,710 | 6,324 | 6,163 | 6,195 |
| Change programme savings | (95) | (251) | (330) | (110) | 0 | 0 |
| Regionality savings | 0 | 0 | (88) | (83) | 0 | 0 |
| Total | 7,014 | 6,678 | 6,292 | 6,131 | 6,163 | 6,195 |

FTE's if staff reductions are required to meet cost guidelines*

| FTE's | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|--|--------------|--------------|--------------|--------------|--------------|--------------|
| Base FTE | 6,932 | 7,014 | 6,550 | 6,044 | 5,770 | 5,696 |
| Mental Health | 17 | 17 | 17 | 17 | 17 | 17 |
| Public Health | 15 | 15 | 15 | 15 | 15 | 15 |
| Approved FTE's | 28 | 0 | 0 | 0 | 0 | 0 |
| Other increases | 117 | (117) | 0 | 0 | 0 | 0 |
| Sub total | 7,109 | 6,929 | 6,582 | 6,076 | 5,802 | 5,728 |
| Change programme savings | (95) | (251) | (330) | (110) | 0 | 0 |
| Regionality savings | 0 | 0 | (88) | (83) | 0 | 0 |
| Staff reductions due to cost guidelines* | | (128) | (120) | (113) | (106) | (99) |
| Total | 7,014 | 6,550 | 6,044 | 5,770 | 5,696 | 5,629 |

*The ADHB is charged to maintain overall cost increase limits of no more than 2%, 3% and 3% in the next three years. This is anticipated to be insufficient to cover the cost of likely wage settlements as the wage settlements will be outside its control when determined by national bargaining. FTE reductions to offset these costs will only be actioned if the ADHB is in danger of not meeting its overall budget targets.

**FTE numbers in 2004-05 and subsequent years do not reflect unallocated costs related to regional services planning and demographic growth that have been included in employee costs in the statement of financial performance. FTE numbers may increase in the outer years depending on volume decisions taken in these areas.

The four year timeframe to breakeven recognises that major redevelopment and organisational change of the magnitude we are undergoing with our Building and Change Programmes requires more than one year after completion to deliver the full benefits and eliminate short-term costs associated with these programmes. The four-year timeframe establishes a sustainable financial position and avoids the need to consider service cuts. It allows the full benefits of the Change Programme to be realised with a return to a viable and sustainable business.

It is important to note that the plan does not include a number of areas that should provide some benefit to ADHB but are as yet unknown factors. This includes the national review of pricing.

The table below illustrates the budget position for a five-year period. A full set of financial tables for the first three years of the plan is included in section four.

Consolidated Projected Statement of Financial Performance

| | 2002-03 Actual \$000 | 2003-04 Budget \$000 | 2004-05 Budget \$000 | 2005-06 Budget \$000 | 2006-07 Budget \$000 | 2007-08 Budget \$000 |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Total revenue | 891,856 | 1,090,718 | 1,136,795 | 1,164,101 | 1,150,398 | 1,184,221 |
| Employee Costs | 469,363 | 481,502 | 473,222 | 478,303 | 478,720 | 493,082 |
| Other Costs (including funder) | 426,752 | 584,488 | 595,291 | 603,726 | 566,874 | 581,430 |
| Regionality Savings | 0 | 0 | (10,000) | (20,000) | (20,000) | (20,000) |
| Total Operating Costs | 896,115 | 1,065,990 | 1,058,513 | 1,062,029 | 1,025,594 | 1,054,512 |
| Operating Surplus (Deficit) | (4,259) | 24,728 | 78,282 | 102,072 | 124,804 | 129,709 |
| Depreciation, Interest, Capital charge | (45,893) | (84,669) | (120,458) | (122,249) | (128,451) | (130,379) |
| Other Contributions | 446 | 20,555 | 16,100 | 2,650 | 3,600 | 3,650 |
| Migration costs | 0 | (9,404) | (1,000) | 0 | 0 | 0 |
| Total Surplus (Deficit) | (49,706) | (48,790) | (27,076) | (17,527) | (47) | 2,980 |

1.3 Putting the goals into action

While the deficit levels will remain a significant challenge the ADHB continues to work towards addressing the health needs of its population and completing the building and change programmes. These challenges are aligned with our strategic plan objectives. We have also adopted the Ministers "Start Here" list in preparing this plan together with a focus on reducing inequalities of, and access to services where appropriate.

1.3.1 Building Programme

The building programme will provide the new Auckland City Hospital for combined acute and elective services. The Greenlane site is being converted into an advanced day-care surgical hospital and comprehensive medical centre focusing on outpatient services. Migration to the

new facilities will involve the physical move of staff, equipment and furniture from their current locations to their new locations. There will be close control of bed numbers and volumes to ensure there is efficient use of resources and that contract volumes are met in spite of the disruption inherent in moving 200 services. The migration programme will follow the timetable set out below.

- Auckland Hospital within the Grafton site 25 October 2003.
- Women's Services from the Greenlane site April 2004.
- Cardiac Services from the Greenlane site 23 December 2003.
- Greenlane Clinical Centre – initial October 2003, remainder March–December 2004.
- All other moves by March 2005.

Each service has a detailed move plan that itemises every activity that must occur from three months out to hour-by-hour on the day of the move. There are significant costs associated with migration in the 2003–04 year (\$10 million) and these have been included in the budget and forecast for out years. The need to meet these costs has not led to any reduction in access to services. The costs are separately identified in the projected statement of financial performance.

1.3.2 Change Programme

The Change Programme's objectives are to assist the organisation to review its systems and processes. There is a substantial body of work to complete in the 2003–04 year. This will enable ADHB to:

- provide effective and safe services to its patients with the right staffing levels and supported through the introduction of appropriate clinical information systems
- manage effectively and efficiently in a new hospital with less beds than currently available
- reduce operating costs through the elimination of duplicated processes or those that do not add value to the patient or the organisation.

The five key projects include:

- admission, discharge, transfer – redesigning the patient continuum of care from the point of admission to discharge and adding clinical information technology
- surgical project – redesigning the surgical processes from time of referral, through to the postoperative period. Also includes implementation of a theatre information system
- outpatient and administration project – which establishes the new off site outpatient and day surgical centre (staffing, schedules, equipment, technology) and redesigns the clerical staff roles to support the new facilities. In addition we are implementing digital dictation and clinical document management systems
- 24-hour centre and clinician rosters – establishes a single point of co-ordination across the organisation for day to day operational management 24 hours, seven days per week. In addition it involves redesigning clinicians' rosters so that they are able to work across two sites without schedule conflicts
- roles and responsibilities – the redesign of the nursing model of care to address staff shortages and to improve the quality of care.

1.3.3 Managing our population's health

The funder arm of the ADHB will continue to implement a wide ranging work plan in the 2003–04 year including participation in a number of national processes including:

- further development of the implementation of population based funding in preparation for the 2004–05 year

- a review of pricing – to update prices based on current cost structures in the sector. This will be an important update as the current pricing schedule has not been reviewed at this level detail for several years
- management of inter district flows and their impact on funding allocations. This will help inform service capacity and patient access decision making for future years
- the planned devolution of disability support services for older people.

At a local level there are also important developments in approach to funding and managing services. Recently Women's Health, Maternity Services agreed that a further 1400 primary maternity women per annum will be accommodated at Birthcare Auckland Ltd facilities for their post natal stay as part of the plan to reduce maternity beds within the ADHB maternity service from 99 inpatient beds to 82. Birthcare Auckland Ltd is a private provider with an existing public contract and the arrangement will result in both financial savings for the ADHB and a continuing high quality service for birth mothers.

The continued implementation of the government's Primary Health Care Strategy will also support these activities by improving access to primary health care services for populations with high health needs. Improved service co-ordination and resolution of more health problems in the primary sector will complement our drive for efficiency within the hospital setting. We want to make the most of this nationwide opportunity.

Locally, doctors and related primary care services have been encouraged to work in high need locations to reduce the level of co-payment required of patients, and to work closely with other health workers. The focus is to ensure the right services are delivered at the right time, in the right place, in the right setting, and by the right people using culturally appropriate management tools for service delivery (whanau ora). Community interests served will also need to be addressed by PHOs collaborating across boundaries with Waitemata and Counties Manukau DHBs where appropriate.

ADHB has allocated \$1 million of provider arm funding to the funder arm for investment in primary health care services and the Board has just approved a further \$500,000 in principle for 2003–04. These funds will be applied to support improvements in primary health care services in high need areas that will ultimately reduce utilisation of secondary services. Diabetes, parish nursing and the Glen Innes project were selected priority projects for ADHB in 2002–03 and remain key initiatives.

1.3.4 Working with other DHBs

Regional Service Planning involves the ADHB working with the other two Auckland DHBs to identify which DHBs will provide which services in 2003/04, including when any changes in responsibility between DHBs for service provision will occur. Some of the detail associated with Regional Service Planning is still being finalised. It is the ADHB's intention to work collaboratively with the other two Auckland DHBs to ensure that in total, the volume of secondary and tertiary services available to the population encompassed by the three Auckland DHBs is not reduced compared to service volumes available in 2002-03.

The complexity and uncertainty surrounding these decision processes indicates careful monitoring and management will be essential throughout the 2003–04 year as capacity within our hospital will be less than in the past. With fewer beds there will be a reduced capability to manage unexpected demand from the other DHBs.

The three Auckland DHBs are collaborating in a wide range of areas. The work plan for 2003–04 is reflected in this plan with the following areas targeted.

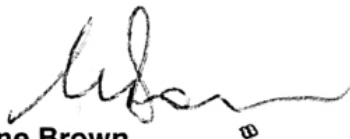
- Inter-district flows – agree service levels/volumes and management processes.
- Regional capital planning – coordination of capital expenditure planning.
- Oral health – common strategies and service review.
- Shared services – developing common operational processes.

- Regional service planning – ensuring best use of resources and local provision of services where practicable.
- Pricing and funding – sharing information and developing a joint view of pricing and funding issues in support of national led processes (e.g. tertiary services and site specific adjuster).
- Mental health – alignment/co-ordination of the funding, planning and delivery functions of mental health services.
- PHOs – collaboration on cross boundary PHO development.
- Referred services – developing strategies to contain expenditure whilst maintaining appropriate service levels.
- Monitoring and audit systems for contract management – to ensure common approaches.
- Regional IT solutions for pharmacy, primary health care – to provide savings and better exchange of information.
- DSS devolution – to develop a regional model for implementing DSS devolution.
- Prioritisation – to ensure that decision making within the region is consistent.

In addition there are other important opportunities for greater regional efficiency that have been already been discussed briefly in the financial commentary above.

The ADHB will meet these challenges in the coming year by applying the tools and processes it has been developing for the purpose. This plan provides a detailed view of this work programme. This will be one of the most important years of this organisation's history as it works to manage issues and change processes in all areas of its business.

Signed for and on behalf of the
AUCKLAND DISTRICT HEALTH BOARD



Wayne Brown
Chairman

Signed on behalf of the
CROWN



Hon Annette King
Minister of Health

2 Introduction

2.1 Vision statement and values

Our vision statement: *Hei Oranga Tika Mo Te Iti Me Te Rahi, Healthy Communities, Quality Healthcare* is our commitment to the NZ Health and Disability Strategies and to achieving the best possible health and independence for the district within the available resources.

ADHB role

- Uphold the Treaty of Waitangi by working in partnership with Ngati Whatua to ensure the protection and participation of Maori at all levels.
- Address inequalities, reduce barriers to access and ensure Maori, Pacific people, New Migrant¹ and other disadvantaged groups have specific responses to their needs.
- Promote, improve and protect the health of our local communities and promote the inclusion and participation in society, and independence of, people with disabilities.
- Provide safe, effective, innovative and comprehensive health and disability support services, including community, public, primary, secondary, tertiary, and national tertiary health services.
- Undertake and support research, training and education, in conjunction with Auckland University and other research partners.
- Assess needs, prioritise and allocate resources to meet population demands.
- Provide leadership of change within the sector.
- Work collaboratively and co-operatively within and across the sector.
- Develop our workforce so staff are able and willing to meet demands and help achieve our vision.
- Engage with the communities of interest within Auckland City.

Principles

- Honouring the special relationship between Maori and the Crown under the Treaty of Waitangi.
- Improve health status for those currently disadvantaged.
- Collaborative health promotion and disease and injury prevention by all sectors.
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.
- Good health and wellbeing for all New Zealanders throughout their lives.
- A high-performing system in which people have confidence.
- Innovation around partnerships and collaboration so people have greater choice.
- Valuing all tiers and disciplines and participants within the health and disability support sector.
- Providing an integrated, co-ordinated continuum of care.
- Evidential based decision making to make best use of the available resources.
- The development of the health workforce for an integrated health and disability support service.
- Active involvement of consumers and communities at all levels.

¹ New migrant includes refugee communities.

Values

- Integrity; we are open, honest, direct and transparent in our communications and dealings with others.
- Collegiality; to understand diversity and differences, to value people and staff, to work well in teams.
- Humanity; we deal with others with compassion, and take risks and act with courage in our roles and work so we can achieve our vision.
- Innovation; we value challenging current ways of working to find better ways for achieving outcomes.
- Research and development; we aim to be well informed as a base for decisions and actions.
- Excellence; we strive for high standards of quality in our service delivery, that embraces a spirit of pride that reflects our public service orientation.
- Access; we strive to find ways that enhance engagement of others and maximise our contribution, so we fulfil our responsibilities as a publicly funded organisation.
- Fun; we create a positive stimulating environment that balances informality and discipline.

ADHB manages its activities in a manner that is consistent with the four strategic goals, particularly the underpinning vision and values. There are a number of forums for managing performance. These include the regular monthly review, Building and Change Programme processes and a programme called Leadership and Action. Leadership and Action provides a basis for senior management and level three managers and clinical leaders (a group of almost 200 people in total) to consider and monitor the strategies and initiatives in this plan.

2.2 The Treaty of Waitangi

ADHB recognises and respects the Treaty of Waitangi as the founding document of New Zealand. The Treaty of Waitangi is the fundamental relationship between the Crown and Iwi and as such, provides the framework for Maori development, health and wellbeing.

The NZ Public Health and Disability Act requires a DHB to establish and maintain processes to enable Maori to participate in, and contribute towards, strategies for Maori Health improvement. This is in order to recognise and respect the principles of the Treaty of Waitangi in order to improve health outcomes for Maori. References to the Treaty of Waitangi in this document derive from, and should therefore be understood, with a Maori intent in this context.

As a Crown Agency ADHB demonstrates how Treaty responsibilities are managed within the health sector by our commitment to the principles of Partnership, Participation and Protection. These principles are outlined by the Ministry of Health to provide direction to the health sector. Some of the processes we have established are in the form of Partnership agreements and relationships with local Iwi. These relationships and agreements support the overarching and ongoing Crown relationships with Maori that have been established by the Treaty.

Each principle contains a significant provision that relates to health and these are incorporated in all aspects of this plan. Our commitment is consistent with the Ministry of Health, He Korowai Oranga – Maori Health Strategy and the Memorandum of Understanding we hold with Te Runanga o Ngati Whatua and its health operational arm Tihi Ora MaPO. This Memorandum of Understanding outlines key principles, processes and protocols for working together at both governance and operational levels.

Alongside our relationship with Ngati Whatua as manawhenua is our responsibility to the Maori communities in our district and those who use our services. ADHB works together with Maori communities to develop strategies for Maori health gain and appropriate health and disability services.

- **Partnership:** Working in accord with our Memorandum of Understanding with Te Runanga o Ngati Whatua to ensure that Ngati Whatua, as manawhenua, are partners with ADHB at the governance level. This health partnership ensures the active protection of Maori interests in health planning and funding. With regard to public funding and provision of health and disability services, this means meaningful consultation with Maori and involvement in planning health and disability services. ADHB as an agent of the Crown will continue to engage with Maori regarding the impact service changes may have on Maori communities and organisations.
- **Participation:** Involving Maori at all levels of the sector in planning, development and delivery of health and disability services. ADHB recognises this by actively involving manawhenua and mataawaka communities in defining health needs, and involving them in the implementation and provision of health services which will improve health and disability services and health outcomes for Maori. Once again this commits our organisation to ongoing engagement with Maori.
- **Protection:** ADHB aims to ensure that Maori enjoy the same level of health as non-Maori and will safeguard Maori cultural concepts, values and practices. This includes the right of equity between Maori and other New Zealanders to health services and the expectation that these services will meet the rights/rites, needs, interests and aspirations of Maori. ADHB recognises the need for equity of participation, access and outcomes for all Maori and that there is still some way to go to achieve these goals. ADHB acknowledges the need to preserve and protect the rites of Maori including te reo, carvings, waiata, tukutuku and karakia according to tikanga of manawhenua and other Maori living in our district.

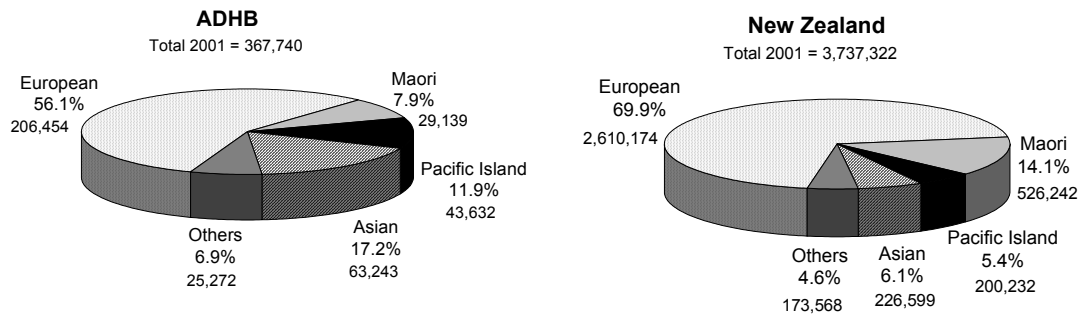
He Kamaka Oranga (the Maori Health team) within ADHB takes responsibility for policy development, planning and funding, provider management, quality, clinical leadership and Tikanga Maori. The team also provides assistance in managing Treaty of Waitangi risks as a result of its monitoring and evaluation processes. With this leadership in place, all ADHB services are expected to proactively implement their responsibilities towards Maori in our district. This translates into specific performance objectives for mainstream providers to lift the health of Maori in our area and reduce inequalities.

Maori Health will seek to consolidate current Maori health initiatives within the secondary and tertiary sector of the ADHB on a business as usual basis while driving initiatives in primary health care, public health, integration and co-ordination and intersectoral strategies including Maori population health strategies.

2.3 Population profile

ADHB is the third largest DHB in the country with approximately 367,400 people (March 2001) usually living in this area. Of these: 56% European, 8% Maori, 12% Pacific people and 17.2% Asian. Twenty percent of the population are children (aged 0–14 years), 15.3% are aged 15–24 and 10% are older people (aged 65+ years). It is estimated that there will be 414,800 people living in this district by 30 June 2003, an increase of 47,400 people or 12.8% increase from 2001.

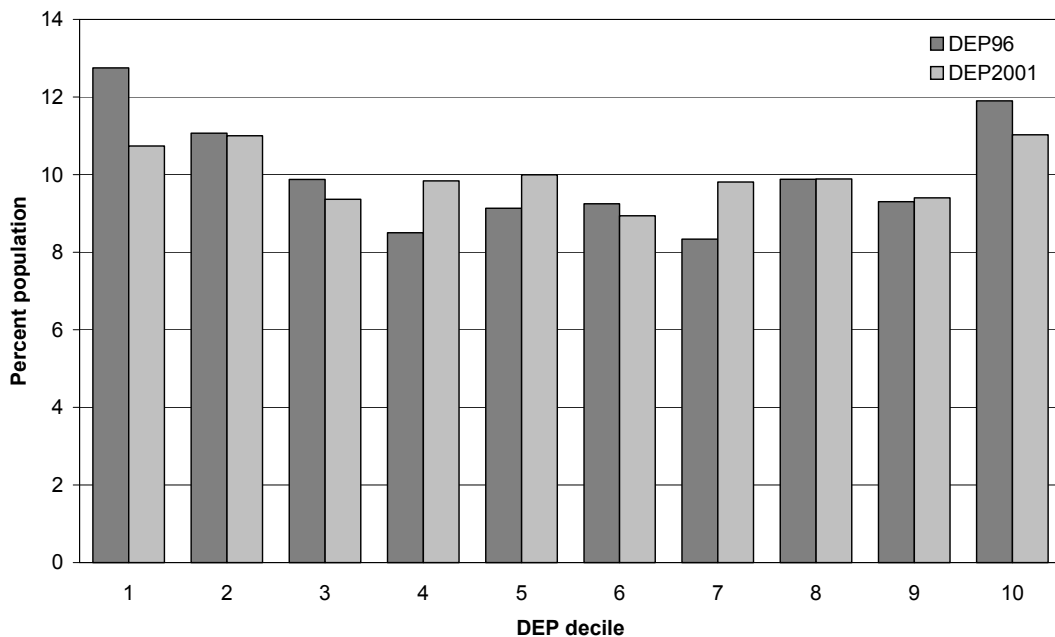
New Zealand and ADHB populations by ethnic group (%), 2001



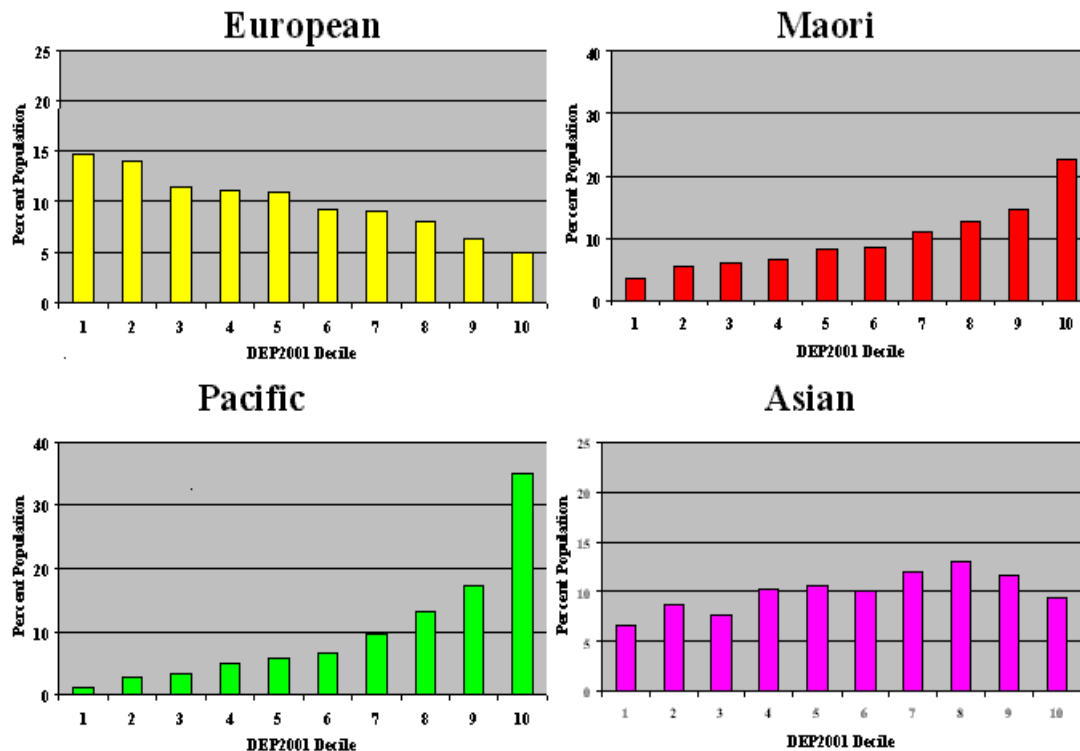
There were on average about 5900 live births per year in ADHB. Life expectancy at birth for females in this district is 82.9 years compared with 77.4 years for males.

DEP2001 is the index of deprivation from 2001 Census. The scale of deprivation ranges from 1 to 10 where 1 represents the least deprived areas and 10 the most deprived areas. An analysis of DEP2001 compared with DEP1996 for the ADHB district is shown below. There was a slight decrease in the percentage of the population living in the high deprived areas. 31% of ADHB population in 1996 compared with 30% in 2001 lived in deciles 8–10.

Percent population by DEP96 and DEP 2001, Auckland DHB



When broken down by ethnic groups, higher proportions of Pacific and Maori people live in the more deprived areas, compared with the other groups (see chart below).



It is expected that there will be 561,500 people living in ADHB by the year 2026, about 172,700 more people or 40% increase from 2001. There will be a decrease in the percentage of the younger population (0–14 years) and an increase in the percentage of older people aged 65+ years in the next 23 years. The percentage of the younger population will decrease from 20% in 2001 to 16.3 while the proportion of older people in this district will increase from 10% to 13.6% in the year 2026.

The Population Health Needs Assessment 2001 highlighted major health problems and areas where there are inequalities in health status:

- Cardiovascular disease and cancer are the leading causes of death.
- Diabetes is predicted to increase markedly over the next 10 years, especially among Maori and Pacific peoples.
- Maori and Pacific children within the district have poor oral health compared to others.
- There are disturbing increases in the incidence of disease among young children (tuberculosis, rheumatic fever, meningitis, cellulitis and gastro-enteritis) especially among Maori, Pacific peoples and people from refugee backgrounds.
- About 20% of our population have a disability, and 3% have a severe disability.
- Alcohol and illicit drug use is increasing with concerns about the use of these substances among young people, Maori and Pacific peoples.
- Concern for the high youth suicide rates among males, particularly young Maori men.
- Family violence (including domestic violence and child abuse) is recognised as a key social and health issue in society.

Maori and Pacific all-cause mortality rates are high in comparison to the rates for other groups in Auckland and the total New Zealand population. The overall health status for Pacific people in Auckland is however similar to that of Pacific people living in other parts of the country, while the all-cause mortality rate for Maori in Auckland is substantially less than the national rate for Maori. Therefore the health of Maori is not as high as that of other cultures in Auckland, but local Maori do have better health than those Maori living in other parts of the country.

Standardised all-cause mortality (100,000 population) Auckland and New Zealand, 1996–98

| | Auckland | New Zealand |
|---------|----------|-------------|
| Pacific | 1040.8 | 1041.0 |
| Maori | 995.5 | 1155.4 |
| Other | 678.5 | 692.0 |

Data source: NZHIS: 1 Standardised to New Zealand population.

Perinatal mortality (rates per 1000 live births) for Auckland and New Zealand, 1996–98

| | Auckland | New Zealand |
|-----------|----------|-------------|
| Maori | 10.9 | 7.7 |
| Non-Maori | 6.8 | 7.0 |

Data source: NZHIS

Cancer and ischaemic heart disease are leading causes of death for all ethnic groups in Auckland. There are however, significant variations in other leading causes of deaths between ethnic groups (e.g. injury and poisoning, perinatal conditions and diabetes featured more strongly in Maori and Pacific people than for other groups). Maori in New Zealand have higher perinatal mortality rates of than non-Maori but this disparity appears to be more pronounced for Auckland Maori.

The marked differences in ethnic discharge proportions between the Auckland and New Zealand populations, especially among Maori, Pacific and Asian peoples are to a large extent due to the difference in the ethnic composition of the populations of interest. For instance, a greater proportion of the Auckland population identifies as Pacific (12%), compared to the New Zealand population (5.6%) and therefore Pacific people comprised a greater proportion of all ADHB public hospital discharges (15% in 1999–00), compared to the proportion for all New Zealand (6%).

Profiling the local population continues as we engage more with communities of interest. Additional information on the health of Auckland communities will be undertaken with other agencies, to monitor trends in health status over time, and most importantly, to ensure that this informs our decisions. Intersectoral working parties and joint plans are underway to help establish the relationships needed to build good profiles of the communities in Auckland and processes to address the social issues we have identified for our area.

2.4 Key issues

We expect there will be about 561,500 people living in the district by 2026, an increase of 40% from 2001. Significant demographic shifts are expected to occur over this period, with changes to the ethnic composition (increasing in Asian population) and age structure of the resident population with an increasing proportion for the older population.

The new migrant and refugee population has high unmet needs that span health and other service areas. Specific plans exist in this area as well as a range of intersectoral initiatives via Strengthening Families that ensure local agencies responses and resources are well co-ordinated.

The Asian population also has distinct health needs that ADHB need to incorporate into planning. A regional plan for Asian Public Health has been completed by the Ministry of Health working with the ADHB Public Health team and the Asian Steering Group. This report identifies areas for further health service planning and intersectoral work.

ADHB identified diabetes as a special focus area in the District Strategic Plan and subsequent to that there has been a major growth in volumes relating to diabetes. The

Planning and Funding team are working in collaboration with providers in the sector to develop an action/implementation plan. This will detail the types of activities required to achieve the goals and strategies, the resource requirements and timelines.

ADHB provides over 55% of its services to people outside of the ADHB area. Project work continues on inter district flows in order to gauge the volume of work flowing between DHBs and the costing for these.

The provision of national tertiary services exposes ADHB to risks associated with high cost treatments that are not fully covered within the funding envelope. Transplant work (kidney in particular), blood products associated with haemophilia treatment, and some high cost pharmaceuticals continue to expose the organisation to ongoing losses that cannot be retrieved through the population based funding (PBF) or inter district flows (IDF) projects.

Services provided to the rest of the country necessarily involve some trade-offs that may impact on the local population and our locally determined priorities. We constantly balance the demand for specialist services against our aim to contribute to health communities and provide quality healthcare to all the people in our area, with a special focus on the reduction of inequalities in health status.

The three regional DHBs work closely together given the issues in common and the mobility of the greater Auckland population. Regional projects of high importance for the 2003–04 year include:

- population based funding
- PHO development and investigation of cross boundary PHO development where this services community interest
- prioritisation approaches – regional work is co-ordinated and links into the national process led by Ministry of Health and DHBNZ
- site specific adjuster – a mechanism to compensate DHBs for their varying capital structures
- inter-district flows – the working group continues on regional issues and links to the national work underway
- regional provider configuration/RSP – since 1996 the three DHBs have been planning on the basis of the delivery of secondary services locally and regional services by one provider
- ACC revenue – a project is underway to manage the costs associated with services provided to clients under ACC
- community pharmacy and laboratory growth – continued growth in pharmaceuticals including wastage from non-compliance. The demographic adjuster for the district is used to absorb the overspend on demand driven laboratory and pharmaceutical services. Pharmacy project underway to reconfigure the spend in this area. The large private sector market in Auckland drives up laboratory and initial pharmaceutical costs
- non-resident bad debts.

2.5 Organisational structure

2.5.1 Governance

The following organisational chart shows the basic governance structure with the funding and hospital (and related services) arms of the organisation and key relationships with Treaty partners and providers. The Memorandum of Understanding with Te Runanga o Ngati Whatua is operationalised to ensure that Ngati Whatua, as manawhenua, are our partners at the governance level. This health partnership ensures that we actively protect Maori interests in our health planning and funding activities.

This develops a regionally and nationally consistent approach to issues such as Population Based Funding (PBF), Inter District Flows (IDFs), prioritisation approaches and the National Service Framework. It also ensures that developments in one area of health do not create problems for others. We also work in conjunction with a wide range of educational facilities and third parties in relation to research.

2.5.2 Ownership

The ADHB is a Crown owned entity. It owns a number of interests in other entities that comprise:

- LabPlus Limited – a non-trading name protection company
- Green Lane Hospital Limited – a non-trading name protection company
- Auckland Hospital Limited – a non-trading name protection company
- National Women's Hospital Limited – a non-trading name protection company
- Auckland Healthcare Charitable Trust (not a subsidiary but controlled by ADHB).

ADHB also has significant influence (holding up to and equal to a 50% shareholding) over the operating and financial policies of the following interests:

- The Treaty Relationship Company Limited – a holding company for the relationship with Ngati Whatua
- Westkids Limited – providing paediatric services
- Northern Clinical Training Network Limited – a training services company
- Biomed Investments Limited (in liquidation)
- Biomed Trading Limited (formerly Health Support Limited) – a holding company owned with Waitemata DHB.

The organisation provides tertiary services for a population of about 1.3 million in the northern region, supports other tertiary hospitals around the country and takes referrals for some specialist services from all over the country. ADHB has the only paediatric intensive care unit in the country that is used by all DHBs. We also perform major organ transplants such as heart, lungs and livers for people all over New Zealand. A number of tertiary services (e.g. neurosurgery, clinical genetics and paediatric oncology) are available for patients in the northern and midland regions.

ADHB provides disability services for Assessment, Treatment and Rehabilitation services, Community services, Needs Assessment and Service Co-ordination services (65+ years), Child Development services, and Therapy services. The organisation manages over 1000 contracts for community health care.

2.5.3 The Building and Change Programmes

The organisation is undergoing a period of extensive change with a \$447 million building redevelopment involving the construction of the new Auckland City Hospital for combined acute services. The Greenlane site is being converted into an advanced day-care surgical hospital and comprehensive medical centre focusing on outpatient service, rehabilitation and hospital in the home services.

Migration involves the physical move of staff, equipment and furniture from their current locations to their end-state location or in some cases temporary locations as building refurbishment is undertaken. Planning is already at the detailed level for services moving in the first half of the year. Each service moving has a detailed move plan which itemises every activity that must occur from three months out to hour-by-hour on the day of the move.

The complexity of migration plans vary considerably, from for example a patient ward moving between the existing Auckland Hospital and Auckland City Hospital to an area such as Cardiothoracic Service who are moving from Green Lane Hospital to Auckland City Hospital. Macro plans for the migration of hotel and clinical support services are also being developed.

The move plan is supplemented by:

- a detailed Communications Plan that identifies key stakeholders and the information that needs to be communicated to them
- an Information Services plan that details the requirements of all computers and clinical equipment that interfaces with the building network infrastructure
- an equipment plan that details how specific items of equipment will be moved, set-up and recalibrated for use
- a service continuity plan that outlines how patient care will be provided pre, during and post move including agreed service volume reductions, transfers to other wards, services or hospitals and also details the key clinical inter-relationships of services to ensure patient care is not compromised.

The schedule of migration activities is as follows.

| | |
|---|--|
| Auckland City Hospital, Main Building | Children's Emergency Department, the first department to occupy, moves into the new Auckland City Hospital (ACH) in June 2003, with Auckland Hospital Services moving in October 2003. Services at Green Lane Hospital move across in December 2003, with National Women's Hospital June/July 2004. |
| Auckland City Hospital, Support Building | Once Auckland Hospital moves out, the building is then refurbished to the endstate and departments are progressively moved in during 2004, once their space has been completed. |
| Greenlane Clinical Centre | At the same time as we move Auckland Hospital into Auckland City Hospital, the Outpatients Clinics move to the Greenlane Clinical Centre, Building One. With progressive moves into the rest of the complex, Buildings Four and Seven, during 2004 as space is refurbished in the current buildings. |

By February 2004 both Auckland and Greenlane Hospitals will be in the new Auckland City Hospital, along with Children's Health Services. Some services will also have occupied the new Greenlane Clinical Centre.

2.5.4 The workforce

ADHB employs a large workforce as shown in the table below. This workforce comprises clinical, management and support staff in the four hospitals, the community and mental health services, clinical support services, and governance and support functions. The table below identifies the total FTE numbers and the reduction in each of the first three years to achieve breakeven by the fourth year.

| FTE's (see note #) | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|--------------------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Base FTE | 6,932 | 7,014 | 6,678 | 6,292 | 6,131 | 6,163 |
| Mental Health | 17 | 17 | 17 | 17 | 17 | 17 |
| Public Health | 15 | 15 | 15 | 15 | 15 | 15 |
| Approved FTE's | 28 | 0 | 0 | 0 | 0 | 0 |
| Other increases | 117 | (117) | 0 | 0 | 0 | 0 |
| Sub total | 7,109 | 6,929 | 6,710 | 6,324 | 6,163 | 6,195 |
| Change programme savings | (95) | (251) | (330) | (110) | 0 | 0 |
| Regionality savings | 0 | 0 | (88) | (83) | 0 | 0 |
| Total | 7,014 | 6,678 | 6,292 | 6,131 | 6,163 | 6,195 |

FTE's if staff reductions are required to meet cost guidelines*

| FTE's (see note #) | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|--|--------------|--------------|--------------|--------------|--------------|--------------|
| Base FTE | 6,932 | 7,014 | 6,550 | 6,044 | 5,770 | 5,696 |
| Mental Health | 17 | 17 | 17 | 17 | 17 | 17 |
| Public Health | 15 | 15 | 15 | 15 | 15 | 15 |
| Approved FTE's | 28 | 0 | 0 | 0 | 0 | 0 |
| Other increases | 117 | (117) | 0 | 0 | 0 | 0 |
| Sub total | 7,109 | 6,929 | 6,582 | 6,076 | 5,802 | 5,728 |
| Change programme savings | (95) | (251) | (330) | (110) | 0 | 0 |
| Regionality savings | 0 | 0 | (88) | (83) | 0 | 0 |
| Staff reductions due to cost guidelines* | | (128) | (120) | (113) | (106) | (99) |
| Total | 7,014 | 6,550 | 6,044 | 5,770 | 5,696 | 5,629 |

*The ADHB is charged to maintain overall cost increase limits of no more than 2%, 3% and 3% in the next three years. This is anticipated to be insufficient to cover the cost of likely wage settlements as the wage settlements will be outside its control when determined by national bargaining. FTE reductions to offset these costs will only be actioned if the ADHB is in danger of not meeting its overall budget targets.

#The definition of paid FTEs is standard worked hours plus paid leave taken (e.g. annual, sick, conference, etc) plus bureau staff and School of Medicine appointments.

**FTE numbers in 2004-05 and subsequent years do not reflect unallocated costs related to regional services planning and demographic growth that have been included in employee costs in the statement of financial performance. FTE numbers may increase in the outer years depending on volume decisions taken in these areas.

Our FTE management plan is contained in two parts. The first part includes a wide range of initiatives that the Board and management fully endorse and are in the process of implementing:

- controlling FTE numbers to ensure they return to the freeze levels set in March 2002
- reduce FTE levels to deliver on the commitments we have made around the Change Programme.

The second part reflects further regional initiatives recommended by independent reviews including the review commissioned by the Minister. The Board and management support these initiatives subject to verification of their accuracy, and the development of appropriate processes for their implementation and gaining Crown support. The savings will result from:

- assessment of the best means of simplifying the governance structures of the three Auckland DHBs
- streamlining of the management structures through collaboration and shared roles

- further integration of the regional management of radiology services and capital expenditure planning
- integration of information technology resources and management
- adoption of a single human resources management structure and policy
- a high level of co-operation and integration for clinical services
- common policies and processes for the efficient management of clinical resources.

A third level of FTE related savings to meet the anticipated excess of cost of wage settlements over the maximum permitted cost increase levels will only be actioned if the ADHB is in danger of not meeting its overall budget targets.

The four year timeframe to breakeven recognises that major redevelopment and organisational change of the magnitude we are undergoing with our Building and Change Programmes requires more than one year after completion to deliver the full benefits and eliminate short-term costs associated with these programmes. The four-year timeframe establishes a sustainable financial position and avoids the need to consider service cuts. It allows the full benefits of the Change Programme to be realised with a return to a viable and sustainable business.

Additionally the Workforce Management Plan (WMP) scheduled for 2002–03 (see section 3) has been rescheduled to follow after the Change Programme's implementation of the new models of care and the revised systems and processes that will be operationalised in the new facilities.

2.5.5 Developments in Allied Health

The ADHB recently appointed an Allied Health Director and a review has been undertaken of the structure and operation of this service area. There are approximately 650 health care professionals from nine different professional disciplines working in Allied Health at ADHB:

- Dieticians
- Needs Assessment and Service Coordinators (NASC)
- Occupational Therapists
- Physiotherapists
- Play Specialists
- Psychologists
- Psychotherapists
- Social Workers and Speech Language Therapists.

These services are represented in all HBOs across the organisation, with 70 percent of the work occurring in Physical Health and 30 percent in Mental Health. Community service provision accounts for 56 percent of the work, with the remaining 44 percent occurring in the various hospital environments.

The operational review identified five key issues with the need to:

- profile the current workforce
- improve the organisational structure and reporting lines for some Allied Health staff
- ensure opening requirements of the Auckland City Hospital (ACH) are met
- improve the relationship between ADHB and the PSA union
- better leadership and communication on clinical practice matters

Work on the profiling and organisation structure has been completed in the 2002-03 year with respect to the ADHB provider arm activities and will be progressively expanded in future to cover community allied health services. The focus for 2003-04 will be on maintaining a close alignment with the building and change programmes to ensure good support for the

opening of the new hospital facilities and the further development of the relationship with union representatives to support these change processes. These activities will require progressive improvement in the leadership and communication processes. This will be managed partly through the improved technology and processes introduced by the change programme and also through the leadership of the Director of Allied Health.

Other areas that will be addressed include improving the way interdisciplinary teams work, better recruitment processes and addressing the impact of new legislation. The initiatives associated with this are contained within the strategies and initiatives in this plan and will also form part of the Allied Health work plan that will be progressively developed and implemented during the 2003-04 year.