Auckland District Health Board

Statement of Intent 2008–11

Status of document

This is the final Statement of Intent for 2008-11 prepared by the Auckland District Health Board, Private Bag 92 189, Auckland, New Zealand.

This document will be available on the Auckland District Health Board's website once approved http://www.adhb.govt.nz

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

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.

This document outlines the intended performance for 2008–09 and two subsequent years. These activities are a summary of the more detailed information 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 2008–11 Statement of Intent is signed for and on behalf of the
AUCKLAND DISTRICT HEALTH BOARD

Pat Snedden
Chairman

Date 19/06/08

Harry Burkhardt
Deputy Chair

Date 19/6/08

Implementing the Treaty of Waitangi

The New Zealand Public Health and Disability Act 2000 requires a DHB to establish and maintain processes to enable Maori to participate in, and contribute towards, strategies for Maori Health improvement. This recognises and respects 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, in this context.

As a Crown entity, Auckland DHB demonstrates how Treaty responsibilities are managed 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 and form the basis of the Auckland DHB bicultural policy. Some of the processes we have established are in the form of partnership agreements and relationships with manawhenua including the formation of the Maori Health Advisory Committee. These relationships and agreements support the overarching and ongoing Crown relationships with Maori that have been established by the Treaty.

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 operational arm Tihi Ora MaPO. This Memorandum of Understanding outlines key principles, processes and protocols for working together at both governance and operational levels.

The role of Tihi Ora MaPO is to support and uphold the kotahitanga, the tino rangatiratanga and manaakitanga responsibilities for the rohe of Ngati Whatua. Tihi Ora will ensure that the Auckland District Health Board delivers a fair share of health resources to meet the needs of Maori.

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

Implementing the principles of the Treaty

Partnership Manawhenua, are partners with Auckland DHB at the governance level	Memorandum of Understanding with Te Runanga o Ngati Whatua and its health operational arm Tihi Ora MaPO Formation of the Auckland DHB Maori Health Advisory Committee Ensure that Ngati Whatua, as manawhenua, is partners with Auckland DHB at the governance level. This health partnership ensures the active protection of Maori interests in health planning and funding Meaningful consultation with Maori and involvement in planning health and disability services. Auckland DHB 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 Maori engagement in planning, development and delivery of health and disability services	Responsible and responsive to Maori communities in our district and those who use our services Active involvement of manawhenua and mataawaka communities in identifying health needs, in providing health services and in our plans to improve health and disability services Maori provider development
Protection	Commitment to the Maori Health Strategy, He Korowai Oranga and other

Maori enjoy the same level of health as non-Maori Safeguard Maori cultural concepts, values and practices Services will meet the rights/ rites, needs, interests and aspirations of Maori	national policy Inequalities framework and the health inequalities impact assessment tool The national prioritisation framework which brings Treaty principles into a decision making tool We recognise the need for equity of participation, access and outcomes for all Maori Adhere to the Auckland DHB Tikanga Best Practice Policy to protect the rights/ rites of Maori, respect the tikanga of manawhenua and practically contribute to providing services that are responsive to Maori needs and interests

He Kamaka Oranga, the Maori Health team is responsible for policy development, planning and funding, provider management, quality, and clinical leadership. The Chief Advisor Tikanga leads the organisation in managing relationships with manawhenua and iwi Maori in tikanga. The team also provides assistance in managing Treaty of Waitangi risks as a result of its monitoring and evaluation processes. All Auckland DHB services are expected to implement their responsibilities towards Maori in our district via performance objectives listed in this plan.

1. Introduction

1.1 About the Statement of Intent

This Auckland DHB Statement of Intent sets out the organisation's objectives for the year ending 30 June 2009. 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, i.e. Treaty Relationship Co Ltd (who has an interest in Northern Region Health Consortium Limited).

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

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

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

Statement of Service Performance

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

The subset of objectives in section five make up our Statement of Service Performance and these cover the financial year 2008–09 and two further years. They are made up of quantitative and qualitative, financial, and timeliness measures, all of which link to our three key organisational goals.

Auckland DHB objectives set out in this Statement of Intent are consistent with our District Strategic Plan 2005 to 2010 and District Annual Plan for 2008–09, Government priorities and the Minister of Health's expectations. The Auditor General will audit the accuracy and reasonableness of Auckland DHB achievements against these measures as recorded in the Statement of Service Performance in the Annual Report.

Statement re Other Arrangements

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

1.2 Reporting to, and Consulting with, 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 2008–09 District Annual Plan will be taken out for public consultation.

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

1.3 Auckland DHB Vision, Goals, and Health Outcomes Planning

Our vision is:

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

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

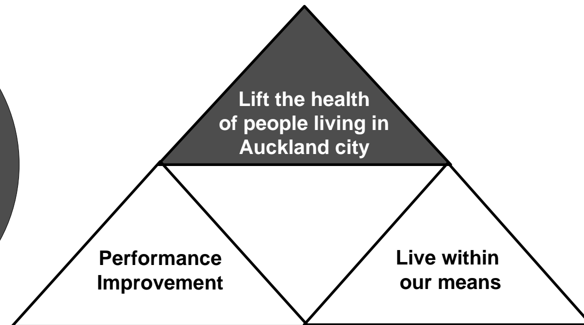
Three goals support the vision.

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

The diagram on the following page shows the logic intervention used to determine priority activities over the long, medium and short term.

Our Health Outcomes Planning Framework

Auckland DHB Vision	Three Goals	Long-Term Outcomes	Medium-Term Outcomes	Short-Term Outcomes
		Healthier communities & environments Equity between groups A whole system approach	Priority health improvement areas: – Improve healthy lifestyles and environments – Reduce inequalities in health outcomes – Reduce the incidence and impact of long-term conditions – Support the appropriate use of hospital services – Achieve the New Zealand Primary Health Care Strategy i.e. system change	Annual health improvement implementation plans
		High quality system Best use of resources	Health improvement plans – Child health – Healthy ageing – Cardiovascular disease, diabetes – Cancer – Mental health – Health inequalities	Annual health implementation plan activities



2. Our Environment

2.1 Our Community – Population, Age and Ethnicity

Auckland city's population is expected to grow at a rate of 1.7% per year until 2011 (medium projection).

Auckland city population, census 2006 and projection

Year	Population	Population increase	Growth from 2006
2006	428,310		
2011	464,296	35,986	8.4%
2016	499,121	34,825	16.5%
2021	533,850	34,729	24.6%
2026	567,844	33,994	32.6%

Auckland DHB census 2006, age group and most deprived (Q4,5)

Age group	2006 population	Group %	Most deprived	Most deprived %
0 to 4	27,710	6%	11,310	41%
5 to 14	51,240	12%	19,694	38%
15 to 24	71,840	17%	27,874	39%
25 to 44	145,410	34%	43,252	30%
45 to 64	91,680	21%	23,023	25%
65 to 74	20,990	5%	5,252	25%
75 to 84	13,630	3%	3,060	22%
85 and over	5,810	1%	905	16%
Total	428,310	100%	134,370	31%

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

Deprivation by ethnicity is shown in the table below. Fifty-seven percent of Maori and 73% of Pacific people are living in the most deprived areas of Auckland city compared to 33% of the others.

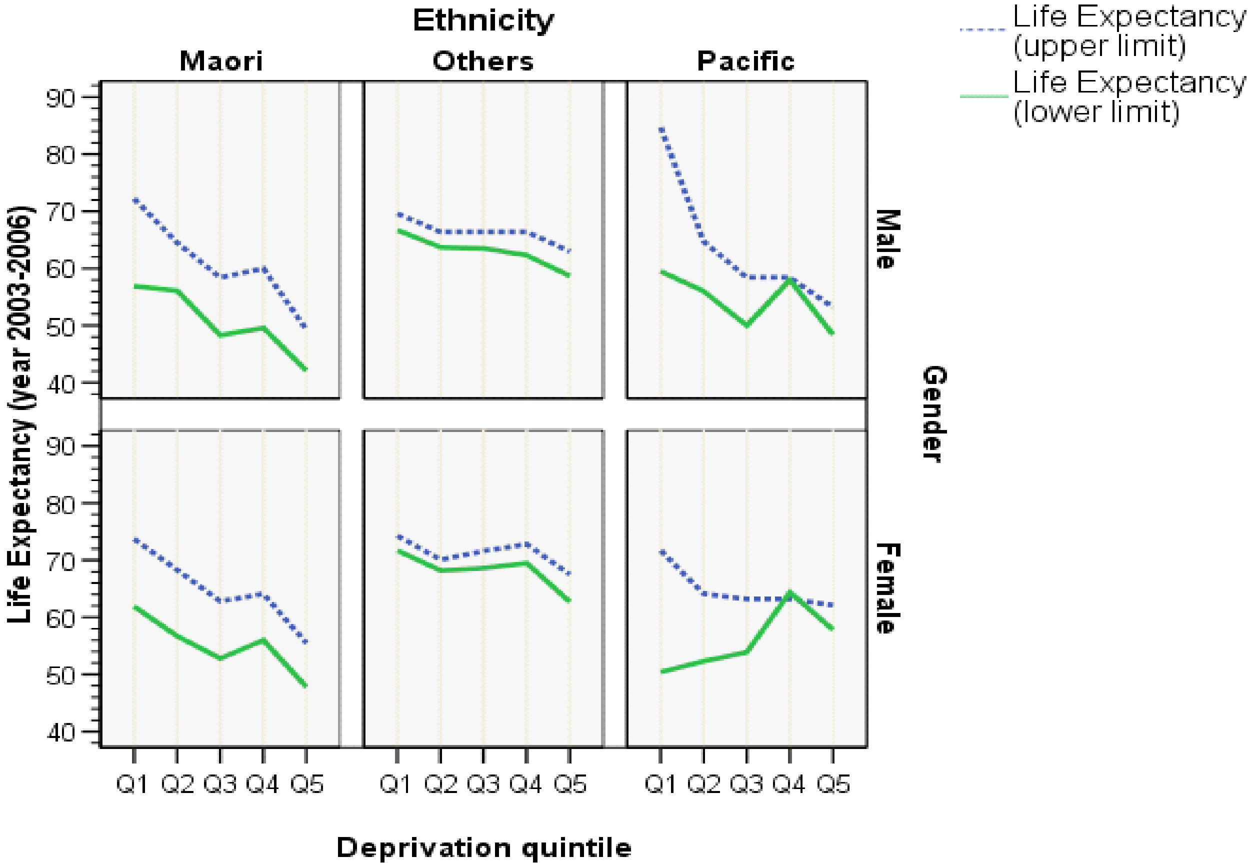
Deprivation by ethnicity

NZ deprivation	Maori	Others	Pacific	Total
Least deprived	9%	22%	3%	19%
Medium deprived	42%	54%	33%	50%
Most deprived	49%	25%	64%	31%
Total	100%	100%	100%	100%
Total number	29,841	347,994	50,184	428,310

The most populated areas in Auckland city are the Tamaki-Maungakiekie and Avondale-Roskill wards – 23% and 22% of Auckland populations respectively. Most Maori and Pacific people live in the Tamaki-Maungakiekie ward – 39% and 46% of their populations respectively. 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.

Our life expectancy is shown in the below graph. The greatest contribution to low life expectancy can be attributed to poverty, however the direction of the slope is also affected by ethnicity and gender.

Auckland DHB life expectancy for years 2003–2006 by ethnicity, gender and deprivation quintile (upper and lower limits)



2.2 Our Health Profile

Aucklanders tend to have a relatively good health status compared to the rest of New Zealand. In 2005, people living in Auckland city had the third lowest mortality rate among all the DHBs. Aucklanders tend to eat healthier food, are slightly less likely to be obese or overweight and we have slightly lower high blood pressure prevalence than the rest of the country. We also smoke less tobacco, are less likely to smoke marijuana, and we have slightly lower hazardous drinking habits.

However there are areas we need to improve. There is a need to reduce inequalities between groups in the city. There are also large differences across social groups in many of the risk indicators. Maori

in Auckland are more likely to smoke tobacco and marijuana, to have higher blood pressure, to be overweight, and to drink alcohol in hazardous manner. Pacific people are far more likely to be obese, smoke tobacco, and have a relatively poor diet. Maori and Pacific men form a very high risk group. At the other end of the spectrum Asian people have lower risks for all the indicators except regular exercise.

In terms of self-assessed health status there is a direct relationship between age, gender, ethnicity and income but for all ethnic groups, except Pacific, self reported health status was higher than the national rates. Those who are poor, Pacific and in age groups 14 to 24 years and those 65 and over have the lowest self rating scores for their health. Females in general self assess their health as better than males, except in the disability and mental scores where females perceive their health as poorer than males.

We also tend to exercise less and have slightly higher cholesterol levels than other areas in New Zealand.

Males tend to have poorer health than females across most of the risks factors observed. Men smoke more tobacco and marijuana, have higher cholesterol levels, are more likely to be overweight and to have a poor diet. Men are much more likely to drink alcohol in a hazardous manner than women; but do tend to exercise more often than females.

Disability is experienced by approximately 22% of the population. The rate of disability increases significantly with age, particularly in the population 65 years and older. The most common types of disability are mobility, agility and hearing.

Inequalities between genders are evident. Males die younger than females by at least nine years though for both genders the rates are improving. For all ethnic groups mortality rates in Auckland DHB are lower than the whole of New Zealand, and are improving faster. However the non-Maori non-Pacific groups had 70% of their deaths after age 75 years compared to only 25% for Maori and 34% for Pacific people.

Premature mortality is measured by the years of life lost (YLL) statistic, which is the sum of the years of life lost annually by people who suffered early deaths. Premature death is defined as death occurring before the age of 65 years. It provides a pure indicator of the impact of mortality that is potentially preventable, i.e. unaffected by mortality in old age. Auckland DHB has a relatively low 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 and only 11% in females. Maori and Pacific ethnic groups have higher YLL rates than non-Maori non-Pacific, however, their decreases were faster overall than for other groups. In general, chronic diseases including cancers encompass nearly 47% of total years of life lost. 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.

Prevalence of major chronic diseases in Auckland

Chronic conditions	Rate %	Number
Asthma	18.5	62,306
Arthritis	12.9	52,196
Ischaemic heart disease	8.4	27,684
Dementia	7.7	3,113
COPD	6.1	19,907
Depression	5.7	18,726
Diabetes	4.2	13,532
Stroke and mild stroke (TIAs)	1.5	5,111
Epilepsy	1.4	5,665
Total cancer since 1994 excluding deaths		7,550
Total		215,790

Three-quarters of all deaths in Auckland city are due to diseases related to the circulatory system (39%), cancer (27%) and the respiratory system (8%).

	Frequency	Percent
Diseases of circulatory system	956	39
Cancer	659	27
Diseases of respiratory system	201	8
Injury, poisoning	121	5
Mental and behavioural disorders	105	4
Diseases of nervous system	104	4
Endocrine, nutrition and metabolic	82	3
Diseases of digestive system	74	3
Diseases of genitourinary system	39	2
Other causes	116	5
Total	2457	

2.3 Our Operating Environment

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

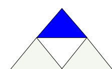
Auckland DHB provides a wide range of services from its Auckland City Hospital and community health services (refer to section 3.3). A wide range of other health services are provided for the people of Auckland, most of which Auckland DHB has a direct funding and monitoring responsibility for, see summary table below.

Five primary health care organisations (PHOs) operate within the Auckland DHB area and are pivotal in population health gain. PHOs and the Regional Public Health Service promote good health, prevent problems and will over time, help to keep people out of hospital. In 2008–09 we will have more specialist clinicians working alongside primary practitioners to provide more health services in the community.

Summarised list of other services (non-hospital)

The type of provider	Number of providers	Number of beds (if applicable)
Community laboratory	1	
Dental	65	
Health of older persons services (residential care)	110	4,225 contracted beds
Health of older persons services (non-residential care)	10	
Carer support	100 (as at 31 December 2007)	
Home-based support	12	
Maori health services	2	
Mental health services	20	212 contracted beds (among other services purchased)
Mental health services (alcohol and other drug services)	6	180 contracted beds (among other services purchased)
Pacific health services	3	
Personal health services	5	
Pharmacy	110	
Pharmacy (wholesalers)	5	
PHOs	6	
Women's and children's health services	19	
		Total beds in the community 4,617

Issues in the operating environment



Lift the health of people in Auckland

In order to achieve substantive health gains with our population, we need to work closely with our primary care partners. Primary Health Organisations (PHOs) are critical to the success of this goal, and it will take time to achieve the full benefits that are possible. We need to do more work with PHOs and GPs and to work collaboratively on primary care improvements.

Prioritisation within health funding is essential to make sure we get the best value from every health dollar available. Competing demands for new money and a very limited pool of new money means only a few new

initiatives can be supported.

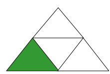
There is potential for tension between access for Auckland DHB residents to core services versus specialist cases from outside our district. Auckland DHB gets more than half its provider arm revenue from other DHBs and this revenue varies with production and in the future will be even more at risk.

The population, particularly South Asian, is changing with far greater numbers of Asian people living in Auckland. The costs associated with this population and other migrants are not adequately reflected in the population based funding formula.

Auckland has an ageing population which is associated with increased burden of disease especially diabetes, cardiovascular disease and cancer.

We purchase home-based support services in a way that provides limited interventions and does not support the older person to live independently.

There are problems in the funding and accountability for disability support services; especially problems ensuring people get the equipment they need to support independence.



Improving performance

Regional structures and decision making are unclear. There needs to be more work done to improve regional governance.

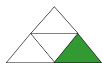
Increasing volumes in the provider arm leads to increase in staff demands and some difficulty in matching resources to the demand.

We need to progress major incident planning to make sure the various efforts across the organisation are co-ordinated.

We need increased stability in our clinical IT systems and ongoing work in production and capacity planning.

Auckland DHB provides specialist and acute aged care services through the Auckland City Hospital and A+ links service. This can be complex to navigate given the multiple points of entry and many different services.

We have difficulty recruiting sufficient staff in mental health, operating rooms and intensive care areas. This compromises our ability to provide services inclusive of carrying out elective surgery.



Living within our means

MECA settlements and staff costs make it hard for us to maintain a break even position. We need to ensure MECA costs are within guidelines, that productivity gains are achievable and inter-district flow pricing and funding lifted in a timely manner.

Asset revaluation and capital charges are similarly hard to cover within budget. We need to ensure that revaluations are adequately funded in a timely manner through discussion with the Ministry of Health.

Auckland DHB is committed to achieving a break even position. There are significant risks to achieving this position arising from factors linked to changes in Ministry of Health funding policy (see finance section).

Auckland City Hospital provides a range of specialist services for other districts and acts as a hospital of last resort for the country. Viability is compromised as other DHBs establish similar services, thereby reducing the critical mass needed to support specialties.

We have significant changes in revenue as a result of industrial action with the cost to Auckland DHB well exceeding the settlements contemplated. For most DHBs a strike may actually improve short term DHB position, but Auckland DHB is only paid for the actual production of its provider arm by its funders.

There are a disproportionate number of rest home beds in Auckland city and these attract people from other areas. This commits Auckland DHB to increased laboratory and pharmacy costs not covered in the current funding formula.

Funding changes mean increased national inter-district flow prices but a potential reduction in the tertiary adjuster and volumes as work is repatriated.

Collective employment (MECA) settlements for employees are outstripping the funding increases available through the Future Funding Track (FFT).

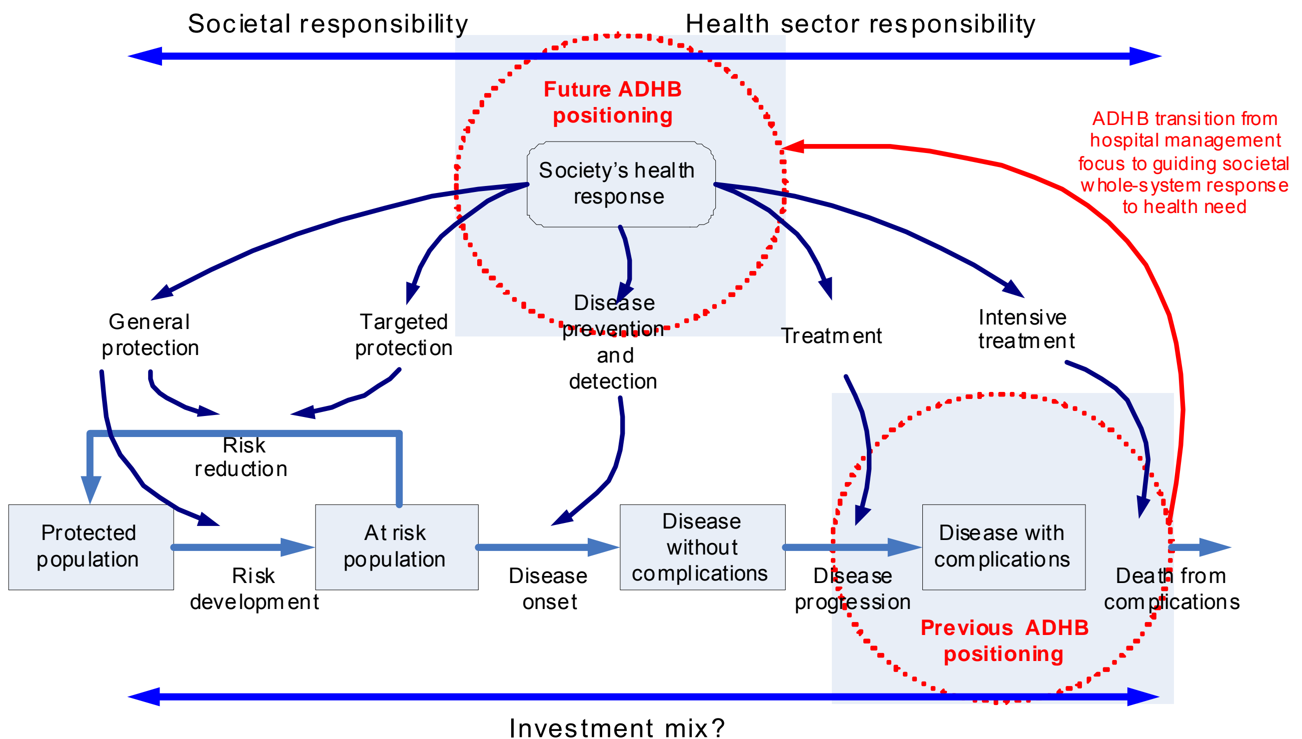
There are costs associated with medical device registration through new Therapeutic Goods Administration (TGA) which Medsafe agency is merging with. Costs are estimated to increase between 1% and 4%.

We need to ensure the adequacy of funding for devolved maternity services as a result of the change in funding methodology.

2.4 Our Health Care System

In order to function as a "real DHB" and to achieve its goal of *Lifting the Health of the People of Auckland City* Auckland DHB takes a wide view of health care. This encompasses population health including prevention, managing populations at risk, treatment and management of early stage disease as well as a range of hospital services. Our approach places a strong emphasis on primary health care in the knowledge that more can be done in community settings to prevent problems at an early stage and to provide ongoing care for more chronic conditions.

To be cost effective and to maximise the quality of health the Auckland DHB health care system must have ongoing access to the best health care practice, provide a continuum of care, and co-ordinate its use. This means that individuals in our population, based on their risks, must have available health care planning and, as needed, a full range of services from prevention and health promotion, all the way through to hospice care (below). Access to the system will be based on rational planning based on need from their care giver and provider team.



The figure above shows how we are developing the Auckland DHB healthcare system. It shows how we are moving from a focus on hospital treatment to a whole-system response to health need.

Many components are already in place. We have high level hospital care, specialty care, emergency and intensive care, greatly increased ability to deliver primary care (and reduced access barriers), public health, a range of community delivered services, home care, rehabilitation, a range of institutional, community and home based care in both mental health and older people and hospice care.

Clinical and operational integration of the continuum of care is extremely important and a critical success factor in the ongoing development of Auckland DHB's health care system. The approach Auckland DHB will take is to use the development of systems for the management of care for people with long-term conditions as a means of achieving increased clinical and operational integration of the overall system.

In order to achieve the goals outlined in the graphic above, Auckland DHB must shift from being simply a provider of care to a co-ordinator of care in a very complex system of care involving a broad range of services and providers. We also need to educate health care providers to be able to work across this continuum and to have the expertise to work further upstream where there are opportunities to prevent problems.

As Auckland DHB focuses on the creation of healthy environments and the prevention and early detection of disease, we increasingly operate in an environment where many services along the continuum are provided by others. We have contracts for some of these services, but in many cases we do not and thus have less influence over the shape and design of the delivery system than is necessary to have the maximum effect possible in the total system.

We must now take on a leadership role in partnership with community-based providers of care and other stakeholders for overall performance of the system. As Auckland DHB focuses further "upstream" (towards prevention etc) the greater the reliance on other organisations and often other funding sources. In this regard other sectors and their related agencies such as housing, employment, social development and education have a major impact on determinants of health outcomes.

The Auckland DHB healthcare system includes more than traditional healthcare providers and health funding sources. The system depends on a wide range of services from health promotion and problem prevention work through to those secondary and specialist services provided within our hospital. The total dollar value of these services for Auckland city is approximately one billion dollars although some of this comes directly from the Ministry of Health, e.g. the contract for public health services.

3. The Nature and Scope of our Activity

Auckland DHB has three groups of activities, known as output classes. These are: Governance, Funder, and Provider, and are described below.

3.1 DHB Governance and Management

Governance

The following activities cover the output class, Governance and Management. This has a funding value of approximately $3 million.

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

Pat Snedden (Chair)
Jo Agnew*
Susan Buckland*
Harry Burkhardt (Deputy Chair)
Chris Chambers*
Rob Cooper
Brian Fergus*
Ian Scott*
Bob Tizard*
Seiuli Juliet Walker
Ian Ward*

* Elected members October 2007

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

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

- population health needs analysis
- planning and funding for services that meet the principles and priorities of the New Zealand Health Strategy and the New Zealand Disability Strategy
- collaboration with other DHBs, government agencies and non-government entities
- contribution to the development of good public health policy
- strengthening community participation in health

- building capability within the Auckland DHB and community
- improving access, appropriateness and effectiveness of the services for Maori and Pacific people in order to reduce health inequalities
- provision of public health services in collaboration with other Auckland DHBs and the Auckland Regional Public Health Service.

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

Community and Public Health Advisory Committee	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: • 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.

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

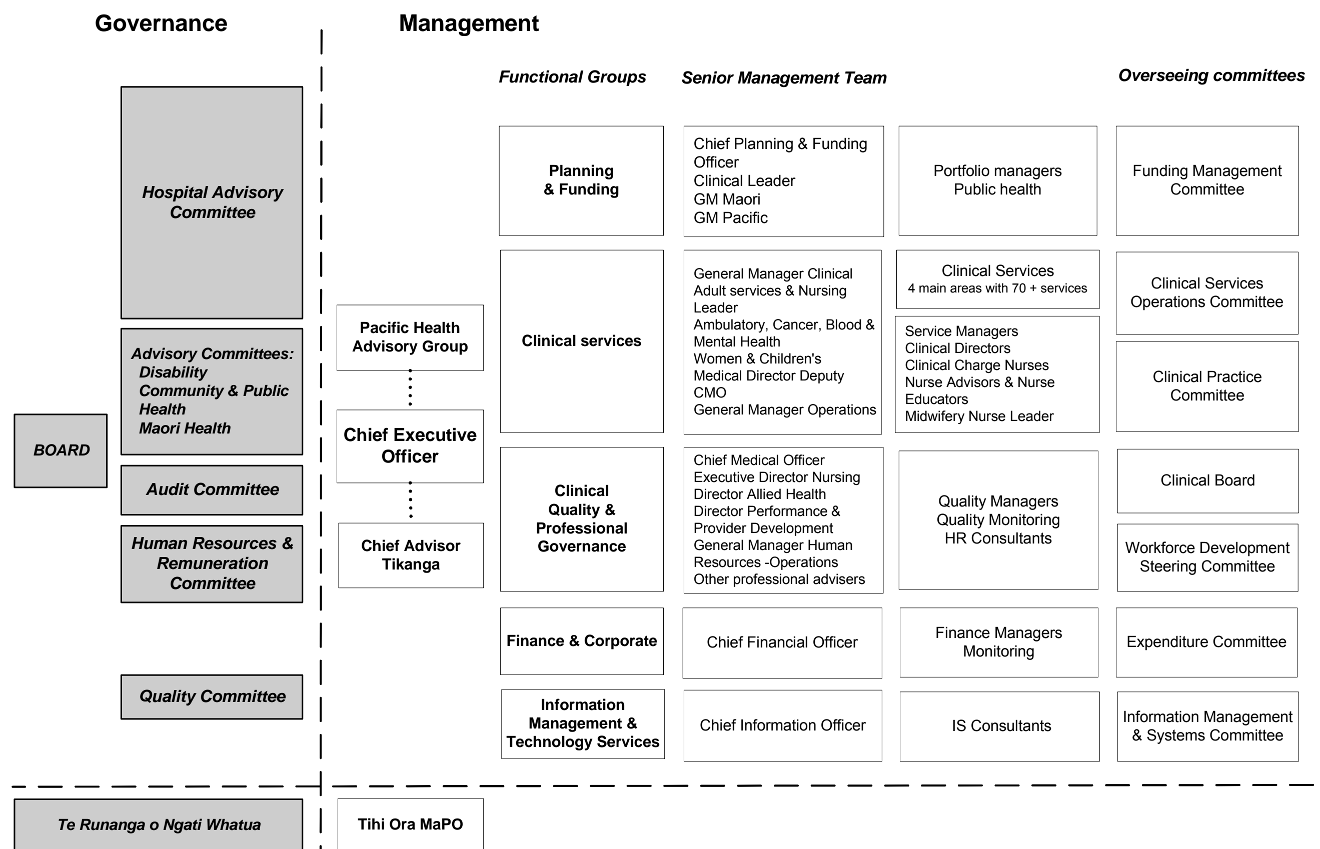
Board and statutory committee meetings are open to the public and are notified in the New Zealand Herald. Meeting details are listed on the website www.adhb.govt.nz or are available on request from Ian Bell, Board Administrator (630 9943 extension 8077, or Ibell@adhb.govt.nz).

The Integrated Management Structure

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

Auckland DHB is committed to being a values-based organisation and reflecting our values in our behaviours, actions and communication with staff, patients and the wider public. To be a preferred employer we also need to:

- implement EEO and whanau/ family friendly programme recommendations
- implement healthy workplace guidelines including standards for safe staffing
- develop a policy and programme to minimise the harm to staff from violence in the workplace
- collect data on disciplinary, formal performance management processes and harassment complaints
- work with the Pay and Equity Taskforce to identify issues and barriers that inhibit employment equity and develop solutions to those issues and barriers.



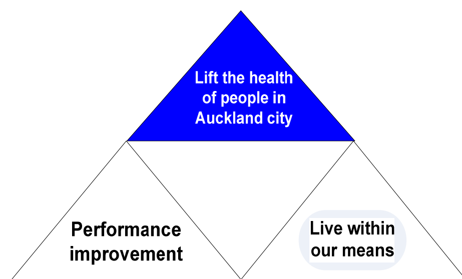
A Senior Management Team assists the CEO with leadership on major organisational issues. This ensures that matters requiring input from governance or that require formal sign off are taken to the Board. In carrying out its functions, the senior management team is expected to reflect:

- evidence-based management
- values based leadership
- using simple policies and processes
- manager/clinical leader partnerships
- managers/clinical leaders clear about their accountabilities and authorities.

The Senior Management Team

Garry Smith	Chief Executive
Greg Balla	Director Performance and Provider Development
Ngaire Buchanan	General Manager Operations
Taima Campbell	Executive Director of Nursing
Margaret Dotchin	General Manager and Nurse Leader Adult Services
Fionnagh Dougan	General Manager Ambulatory, Blood and Cancer Services and Mental Health Services
Naida Glavish	Chief Advisor Tikanga and General Manager Maori Health
Kay Hyman	General Manager Women, Children's, Cardiac and Genetic Services
Roger Jarrold	Chief Financial Officer
Denis Jury	Chief Planning and Funding Officer
Janice Mueller	Director Allied Health
Celia Palmer	Clinical Leader Planning and Funding
Vivienne Rawlings	General Manager Human Resource Operations
Aseta Redican	General Manager Pacific Health
David Sage	Chief Medical Officer
Johan Vendrig	Chief Information Officer
Margaret Wilsher	Deputy Chief Medical Officer and Medical Director Adult Health Services

3.2 DHB Planning and Funding of Services



This activity is undertaken within the output class Planning and Funding. It has a funding value of approximately $447 million.

Funding is devolved from the Ministry of Health to the Auckland DHB for most services although public health and some disability services are funded directly from the Ministry of Health.

Funding for the people living in our district must comply with the Crown Funding Agreement, Ministry of Health national strategic plans, the New Zealand Health Strategy and the New Zealand Disability Strategy.

Planning and Funding is responsible for funding health services for its resident population 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.

Being a true DHB means focusing on the people who live in Auckland city and on their health needs. We want to achieve a vital few health outcomes in areas of highest need and problems responsible for the greatest burden of disease. These priority areas are taken from our analysis of the local population, particularly areas of high need and inequality.

The health problems responsible for the greatest burden of disease in our area	Priority areas for local health gain
Cancer Cardiovascular disease (includes congestive heart failure) Diabetes Respiratory tract diseases Stroke Injuries (intentional and unintentional) Nervous system disease Mental health Cellulitis	Cardiovascular disease/diabetes Cancer control Child health Mental health The health of older people Reducing inequalities for groups with high need (Maori, Pacific, disabled people, refugee communities, people living in poverty)

These priorities address the needs of high needs groups: Maori, Pacific, disabled people, refugees, other migrant groups and people living in poverty. Data about health needs from the profile of our population and from community consultation ensures the right mix of services is available to people in the city, and that the services reduce inequalities between groups over time.

The planning and funding team ensures that services meet these needs, future demands, and makes the best use of the funding available. This is being progressed through 'Our Health 2020', an umbrella which focuses on a few vital outcomes for the longer term.

Health Improvement Plans sit under the Our Health 2020 umbrella:

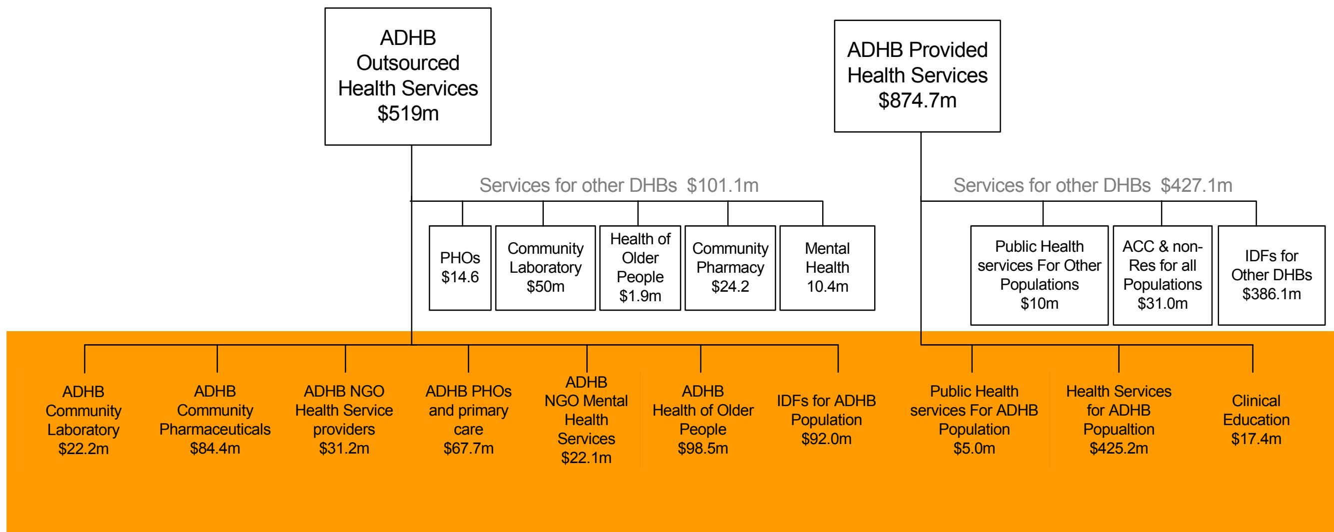
- Child Health Improvement Plan, 2006 - 2011
- Healthy Ageing 2020
- Improving Outcomes for Cardiovascular Disease and Diabetes Plan, 2006 -2011
- Improving Cancer Control For Auckland City, 2007
- Mental Health and Addiction Plan, 2006 – 2011

Each of the Health Improvement Plan has five medium term outcomes, these are:

- Improve healthy lifestyles and environments
- Reduce the incidence and impact of long-term conditions
- Reduce inequalities in health outcomes
- Achieve New Zealand Primary Health Care Strategy system change
- Support the appropriate use of hospital services

The scope of activity covered by the Auckland DHB

The following diagram, the top row of the diagram, the left hand arm shows the services provided to people from other DHBs that are contracted from various non government organisations (NGOs) and community providers (outsourced health services). The right hand arm shows those services provided by Auckland DHB provider (hospital and related community services) for other DHBs.



Contracts for Auckland City Hospital are managed as two distinct businesses:

- one associated with the work for the Auckland DHB population which will be managed with regard to population-based funding and a focus on population health outcomes
- one associated with the work done for people living in other districts (inter-district flows).

The external work component of the business (inter-district flows) is managed from a price/volume view with a focus on structuring the organisation to deliver the volumes required by external customers and only undertaking work that is paid for.

The organisation has to carefully manage the volume of patients it sees and especially the flow of patients into Auckland DHB services from other DHBs. We aim to provide the level of service that has been contracted for and have all our costs managed within budget, i.e. inter-district flow volumes at 100% of contract and costs within budget.

To deliver the outcomes of healthier communities, equity between groups and environments, high quality services and best use of resources Auckland DHB is committed to continuous performance improvement. This section defines the local (by functional group) regional and national activities that will be undertaken to achieve improvement in Auckland DHB performance.

The national component demonstrates our commitment to work collaboratively with the other DHBs, the Quality Improvement Committee (QIC) and the Ministry to implement the five QIC programmes. Auckland DHB is the lead DHB for the programme on infection prevention and control and will oversee the work done nationally in this area.

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.

3.3 DHB Provision of Services

The Auckland DHB provider arm is made up of the Auckland City Hospital and the Greenlane Clinical Centre and a number of community-based services. Auckland City Hospital includes services provided by Starship Children's Health and National Women's Health services. The Greenlane Clinical Centre provides advanced outpatient, ambulatory services, and short-stay surgical care.

Auckland DHB operates New Zealand's largest public hospital with the following characteristics:

- almost two million patient contacts annually
- local hospital and outpatient services for more than 439,355 Aucklanders
- provides tertiary services for the northern region (about 1.5 million people)
- over 50% of Auckland services are provided to people living outside the city
- we provide a number of tertiary services (e.g. clinical genetics and paediatric oncology) for people in the Northern, Midland and Central regions
- we provide specialist services for New Zealand including:
  - organ transplant (heart, lung and liver)
  - acute massive pulmonary embolism transferred for thrombarterectomy or extra corporeal membrane oxygenation (ECMO)
  - acute respiratory distress syndrome (ARDS) in adults or children requiring extra corporeal membrane oxygenation (ECMO)
  - 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
  - high-risk obstetrics
  - National Forensic Pathology Service (contract with Ministry of Justice)
  - National Newborn Screening Service (contract with National Screening Unit)
- we have over 8,000 staff or approximately 7,300 full-time equivalent (FTE) positions including bureau staff
- we are the largest trainer of doctors in the country with approximately 1,000 medical staff of whom about 460 FTE are in various stages of training
- we are the largest clinical research facility in New Zealand, engaging in work that attracts funding and participation here and overseas
- major efficiency programmes are in progress within the Auckland DHB Hospital:
  - elective services planning and management
  - operational efficiency programmes including surgical review process, after hours model of care, and production planning
  - regional services planning with Counties Manukau, Waitemata and Northland DHBs

- we are integrating hospital services with services provided by primary health care, e.g.
  - streamlining referrals and discharge processes
  - reducing waiting times for cancer patients
  - introduced an integrated heart failure project for diabetes and vascular services
  - introduced a cardiac rehabilitation programme
  - reducing admissions and readmissions for older people
  - reducing waiting times for mental health patients
  - implementing the booking system that creates certainty for patients needing elective surgery and manages their condition during the waiting time.

More information on all of Auckland DHB hospital and related services is available at http://www.healthpoint.co.nz. The summarised price volume schedule below shows the type and level of services provided by the hospital.

Service reviews to improve performance

Auckland DHB continues to identify the steps needed to bring Auckland DHB back into a more stable and predictable financial position. This process started with the introduction of service reviews. Reviews of each service on the provider arm have evolved into a "business as usual" Annual Service Plan. This plan focuses on revenue streams, labour costs and direct treatment costs, relevant to what the Auckland DHB funder and other DHBs contract to purchase.

A key feature of these service plans and reporting against them, is that revenue is paid on national prices for actual volumes produced each month. There are no top-ups, thus each service is essentially "in business". Auckland DHB will achieve efficiencies where we can and will hold managers and clinicians accountable for these.

Productivity measurement and performance against production plans (based on contracted volumes) are now two key activities. Along with pricing gains, the gains in Auckland DHB performance have come from improvements in productivity, i.e. growing volumes of contracted work being done with a less than proportionate increase in staff numbers.

Auckland DHB has proven over two years that given good planning and rostering, we are capable of quite extraordinary production levels, which must be taken into account when the sector considers capital expansion, particularly in the region.

Indicative 2008–09 contracted outputs for hospital and specialist services by case weighted discharges (in summary)

The following information is summarised from the price volume schedule. The complete price volume schedule is contained within the District Annual Plan.

Price volume schedule

Portfolio	Subspecialty	For Auckland residents		For other populations (IDFs)	
		Acute	Elective	Acute	Elective
		Proposed volume	Proposed volume	Proposed volume	Proposed volume
Emergency Department, APU, DCCM, air ambulance	Emergency medicine	2,289	–	315	–
Ambulatory health services	Dermatology	34	30	58	18
	Endocrinology	67	0	16	0
	Immunology	91	0	161	0
	Oral health	24	346	30	881
	Rheumatology	23	0	2	0
Cancer and blood services	Haematology	612	0	1,170	0
	Oncology	752	0	1,681	0
Cardiac services	Cardiology	2,504	742	2,789	1,567
	Cardiothoracic	1,794	1,041	4,674	2,930
	Vascular surgery	753	374	1,280	825
General medicine, A+ links, ID, NASC	General medicine	9,214	0	370	0
	Infectious diseases	195	0	86	0
General surgery, trauma, gastro, respiratory	Gastroenterology	542	0	146	0
	General surgery	4,292	3,156	1,182	685
	Liver resections	227	0	512	39
	Respiratory medicine	1,274	0	895	0
Medical and community services	General paediatrics	1,174	0	1,921	0
	Paediatric emergency department	996	–	711	–
	Paediatric endocrinology	39	–	98	–
	Paediatric gastroenterology	46	–	398	–
	Paediatric haematology/oncology	276	–	1,180	–
	Paediatric infectious diseases	89	–	217	–
	Paediatric neurology	114	–	399	–
	Paediatric renal medicine	72	–	303	–
	Paediatric respiratory medicine	187	–	881	–
Ophthalmology	Ophthalmology	273	981	772	1,263
Orthopaedics adults	Orthopaedics	4,538	3,221	822	210
Paediatric cardiac and Intensive Care Units	Newborn services	2,142	0	2,313	0
	Paediatric cardiac	247	306	1,379	1,834
Surgical and community services	Paediatric neurosurgery	100	52	610	195
	Paediatric ORL	114	518	386	462
	Paediatric orthopaedics	711	309	1,239	599
	Paediatric surgery	401	275	1,376	802
Transplant, renal, urology, ORL, neurology	Neurology	546	–	451	–
	Neurosurgery	895	397	2,513	1,043
	ORL	477	851	687	803
	Renal medicine	1,030	0	830	0
	Renal transplant	148	0	536	0
	Urology	583	753	1,192	845
Women's health	Gynaecology	1,126	1,346	216	499
Total		41,011	14,698	36,796	15,499

Clinical quality and professional governance

Four areas which comprise clinical quality and professional governance, each underpinned by organisational values of integrity, respect, innovation and effectiveness. Each area depends on openness and transparency, and a "no blame" culture. This encourages public scrutiny and facilitates continuing quality and process improvement.

This work:

- is a part of the organisation-wide quality framework
- applies to all aspects of service delivery that relate to care for patients and their carers
- influences all functions of the organisation that affect the delivery of care
- links the quality of the service delivered and identifies and values the issues for clinicians who deliver these services, while providing a professional practice and risk management support structure

Professional governance	Professional standards and development: • setting clinical and cultural competency requirements and ethical standards • performance monitoring • compliance with credentialing standards and processes • professional development through ongoing education and training • workforce development
Quality/clinical effectiveness cycle	Clinical quality, efficiency, safety, and value for money: • 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: • 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: • 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.

Information management and technology services

Information management and technology services make sure that systems and information are available at the right time, at the right place and to the right person to help with timely and informed decision-making. Clinical and financial data is drawn together to help with decision-making about health services and about financial and clinical outcomes.

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

A review of the 'Regional Information Strategic Plan' is underway. The new 'Northern Regional Information Strategic Plan' will be completed by the end of 2008. Accordingly the Auckland DHB Information Management Framework (v 5.2) reflects priorities at a national, regional, and local level across both primary and secondary care.

Workforce Development

Auckland DHB Workforce Development strategy and initiatives span the whole health care system. We focus on delivering a quality patient journey in order to continuously improve the quality of service and safeguard high standards of care. This requires systems and processes that extend beyond the hospital. It requires collaboration with primary care, community based services, and other sectors.

We place strong emphasis on:

- professional governance and clinical quality systems and processes that meet current and future workforce requirements
- Health and Disability Safety Standards
- professional standards such as accreditation, credentialing, and re-certification.

These activities improve performance, efficiency and productivity, quality and safety. They enhance the patient's journey through the health care system.

We also place a strong emphasis on having healthy workplace environments, they are prerequisite for successful workforce development. Teamwork, commitment to innovation, continuing professional development and education, shared learning and career development are all features of a healthy workplace. Workplaces where everyone's contribution is important, diversity is valued along with ideas and innovations are more likely to attract and retain staff. Part of a positive culture is having ways of doing things (systems and practices) that are known to everyone and which encourage participation.

4. Advancing our Strategic Direction

This Statement of Intent is devoted to areas where we propose to make changes during the 2008–09 year. Further detail is contained in our District Annual Plan 2008–09. Changes involve health improvement or greater efficiency and better use of the funding we get. Changes can be via new services or programmes, expanding services that are performing well, stopping activity where we are not getting results or where the results should be achieved with better value for money. All significant changes have to go through consultation so that affected parties have a chance to have a say. Definitions of significant change are covered in the New Zealand Public Health and Disability Act 2000 and in the Operational Policy Framework.

4.1 National Strategic Objectives for DHBs

The core documents for determining national health sector policies remain the New Zealand Public Health and Disability Act, 2000, the New Zealand Health Strategy, 2000 and the New Zealand Disability Strategy, 2001. The priorities outlined in these strategic documents are refined each year via the Minister of Health's letter of expectation which provides a short term focus on areas of improvement.

The Minister of Health's expectations for the 2008–09 year

Better value for money	So we provide more health care for more New Zealanders
Getting ahead of chronic conditions	Maintain the pace of programme implementation
Reducing health disparities	Especially for Maori and Pasifika populations
Child and youth health	Implement programmes and build on the well child review
Primary health	Improve the interface, through planning and working together with PHOs
Infrastructure	Especially workforce development and co-ordinated information systems
Health of older people	Continue to give priority to new service models

In addition there are a number of national strategies developed by the Ministry of Health which provide national direction in specific areas, for example:

Looking Upstream, Causes of death cross-classified by risk and condition 1997
Making a Pacific Difference: Strategic initiatives for the health of Pacific peoples, 1997
Primary Health Care Strategy, 2001
Sexual and Reproductive Health Strategy, 2001
The Primary Health Care Strategy, 2001 and companion documents
New Zealand Palliative Care Strategy, 2001
Blueprint for Mental Health Services In NZ, 1997
Mental Health DHB Toolkit to improve the mental health status of people with severe mental illness, 2001
He Korowai Oranga, Maori Health Strategy, 2002
Reducing Inequalities in Health, 2002
Health of Older People Strategy, 2002

Mental Health (Alcohol and Other Drugs) Workforce Development Framework, 2002
Tauawhitia te Wero – Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan 2006-2009
The Pacific Health and Disability Action Plan, 2002
Achieving Health For All People: A framework for public health action for the New Zealand Health, 2003
Te Tāhuhu: Improving Mental Health 2005-2015: The Second New Zealand National Mental Health and Addiction Plan
Clearing the Smoke: A five-year plan for tobacco control in New Zealand 2004-2009
Decades of Disparity: Ethnic mortality trends in New Zealand 1980 – 1999
The New Zealand Cancer Control Strategy, 2003
Improve the Health of Young People, 2004
Pacific Health and Disability Action Plan, 2004
Health Information Strategy for New Zealand, 2005
Strategic Vision for Oral Health in New Zealand, 2006
Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau, Implementation Plan: 2004–2010
Healthy Eating Healthy Action – Progress on implementing the HEHA Strategy 2007
Family Violence Intervention Guidelines, 2007

4.2. Local Priorities

Auckland DHB Strategic Priorities for 2008–09 and beyond

Strategic priorities are drawn from the District Strategic Plan, 2006. These are based on our assessment of population health need and from public consultation. These priorities will be reviewed in 2009.

Focus on the health of people living in Auckland city first and foremost
Focus on health outcomes
Take a whole system approach
Improve the links between primary and secondary care
Strengthen relationships and communication
Protect basic rights
Work more efficiently and effectively
Continuously improve the quality of service, safeguard high standards of care
Decision making is fair, consistent and transparent
Workforce development, teaching, and training
Develop a culture based on a deeper understanding of our activities
Emphasise productivity, clinical effectiveness and strong management
Meet budget targets for the treatment of people living in Auckland city
Contain expenses related to the treatment of people from other districts within the provider arm
Manage labour costs and the clinical workforce
Plan for what’s best across the region
Address the problems related to the funding formula

5. Forecast Service Performance Measures

5.1 Priority Health Improvement Areas

With a medium term outlook of 5 to 10 years, Auckland DHB is focused on achieving a vital few health outcomes. These relate to areas of highest need and those problems responsible for the greatest burden of disease. Having a vital few outcome areas means we can focus attention and resources on priority areas. This section covers improvements in the medium term, these are in addition to business-as-usual activities.

Our intervention logic (Health Outcomes Planning Framework, page 9) spans the continuum of care but with an increased focus on population disease prevention, and early intervention with individuals.

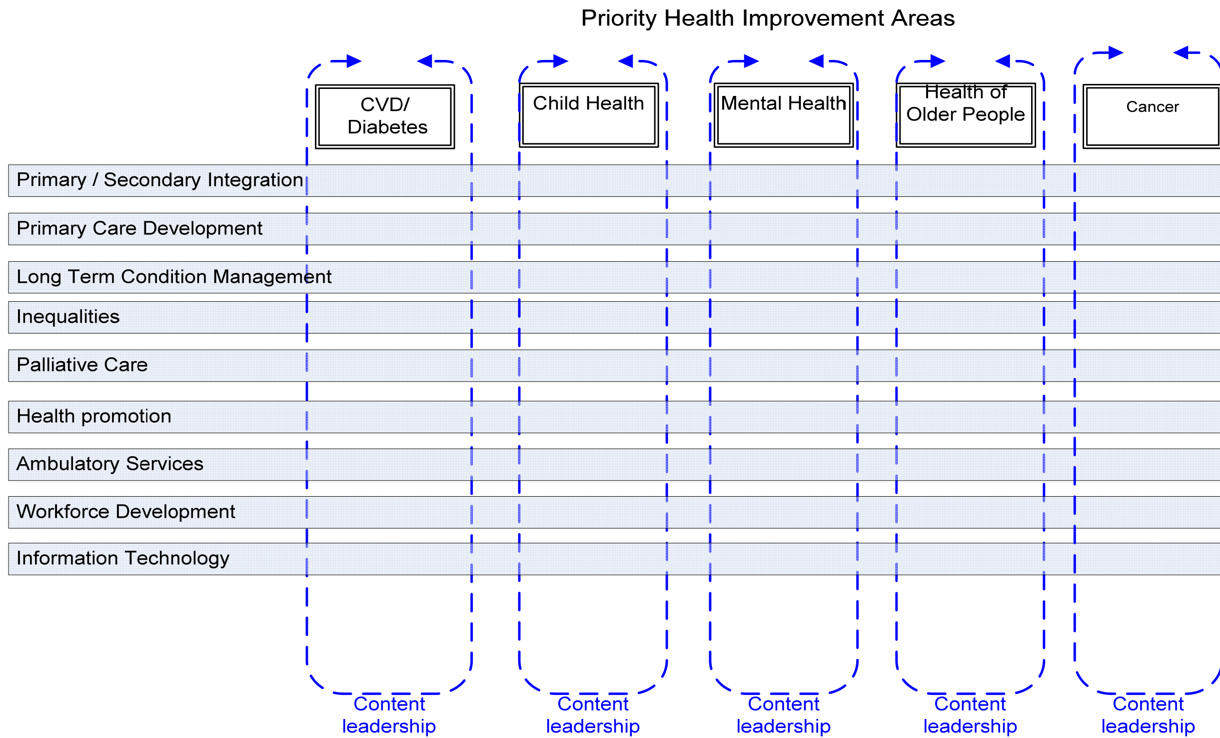
Prevention actions may take many years (20 - 30 years or more) to deliver statistically relevant decreases in the incidence or prevalence in the targeted disease / condition. Targeted prevention and early intervention strategies can result in significant increases in the number of previously undiagnosed cases being diagnosed (e.g. individuals who have had no symptoms, or had previously recognised the symptoms but thought them unimportant, or worried about the symptoms but trying to ignore them). The newly diagnosed cases will span the spectrum of need from primary care low level intervention through to those needing a complex mix of primary, secondary and maybe even tertiary level health care. This pattern of increased incidence and mortality from the start of a screening / assessment programme normally persists for a number of years, causing an artificial bulge in demand for services for a variable period of time.

Our long-term aim is to decrease the morbidity and mortality from preventable or amenable conditions. We will increase access for diagnosis at an early stage of disease so that early intervention and building patient self-management abilities can prevent or slow progression of the disease or condition. The key to self management is to enhance the patients understanding of their condition, how to prevent it worsening, and how to identify and act on early warning signs of deterioration, to either prevent or slow the progression of disease. Our emphasis is on a whole system approach, spanning the continuum of care. This is critically important for enabling the already heavily loaded health care system to cope with the increased demand for services that will occur if we do not better manage some key long term conditions from worsening.

Our outputs in the following tables deliver on our medium-term outcomes, they span: prevention of disease / illness outputs; detection and early intervention outputs, and management of disease / illness outputs. In all instances we have entered our planned outputs into the section that is leading the activity, however the reality is we are and need to continue to strengthen integration across the continuum of care in order to effect long-term population health gain.

Each output listed is linked to the DHBs output class (i.e. Governance, Funder, Provider) that takes the lead in progressing the actual output. There are instances where the lead is shared, especially between the funder and provider working closely together.

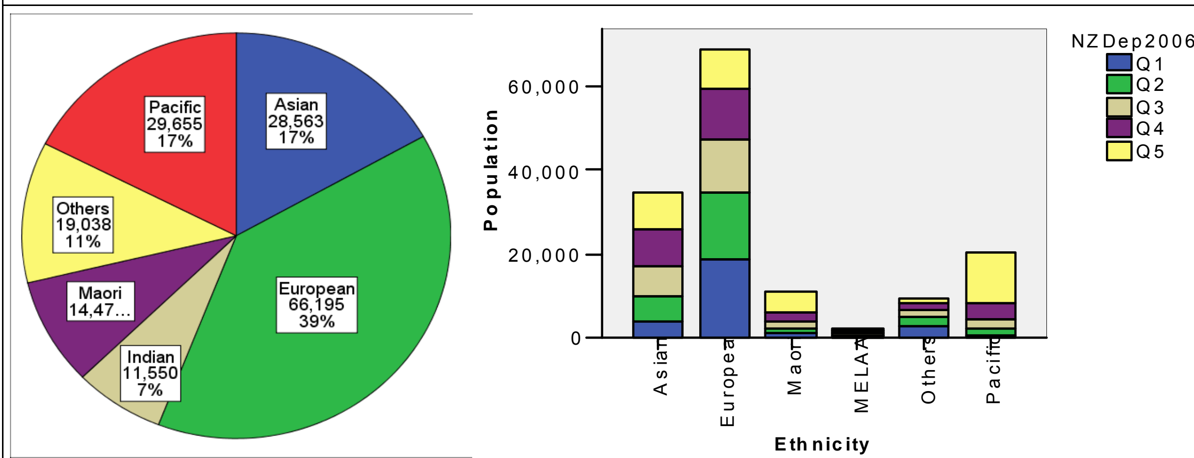
Our local priorities



5.1.1 Better outcomes in child health

<table>
<tr><th colspan="2">Child health (0–14 years)</th></tr>
<tr><td colspan="2">Long-term objective: Our vision of Auckland city is a place that builds healthy children. A place with clean air and water, good food, quality physical activity, less disease and safer environments, and where:
• children are supported by a health system that helps families / whanau to help themselves and nurture their children to achieve their full potential
• children and their families / whanau are supported by universally available health services which are accessible and co-ordinated
• children from vulnerable families / whanau receive targeted support so their health is not disadvantaged by their economic and social situation
• children who suffer illness and accidents are treated promptly with quality care. Health and social services work closely together to help those children with complex and long-term conditions
• children with disabilities have the help they and their families / whanau need to have quality of life and to participate in, and contribute to, society
• children enjoy better health as a foundation for successful lives.
During 2008–09 Auckland DHB will begin implementing a youth health plan. Existing programmes focus on smoking, sexual health, teenage pregnancy, injury, suicide, child abuse, violence, drug and alcohol abuse. Well co-ordinated school-based health programmes are especially important.</td></tr>
<tr><td>Achieve better outcomes in child health</td><td>In April 2006 Auckland DHB published ‘Our Healthy Children – Auckland City Child Health Improvement Plan 2006–2011’. The development of the plan included policy review, needs analysis, review of evidence, stocktake of current child health services, a child’s journey approach to reviewing health systems, and expert input from clinical and community representatives.
Implementation of ‘Our Healthy Children’ is managed and monitored through annual implementation plans and championed by a Child Health Advisory Group comprised of clinical and community representatives.</td></tr>
</table>

At the time of the 2006 Census there were 150,790 children usually resident within the Auckland DHB boundaries. The graphs below show Auckland has comparatively high numbers and proportions of both Pacific and Asian / Indian children, with lower proportions of European and Maori children. However 70% of Pacific children live in NZDep deciles 8–10 along with 56% of Maori children. For 'other' ethnicity children 23% live in the three highest deprivation deciles.



Medium-term outcomes		Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
Work towards the national target of 95% of two-year-olds fully immunised	Maori Pacific Total	Not relevant as birth cohort just at 2yrs	70% 77% 83%[1]	76% 83% 90%	79% 86% 93%	Improving immunisation coverage is a national priority and contributes to Auckland DHB medium term outcomes of: reducing the incidence and impact of long-term conditions, and reducing inequalities in health outcomes
Infants exclusively and fully breastfed (by Maori, Pacific, Other)	6 weeks 3 months 6 months		74% 57% 27%	Set targets in 2008/09	Targets to be set	Reducing chronic disease is a national priority. International evidence identifies infants breastfed for at least the first 6 months of life have reduced incidence and impact from long-term conditions inclusive of asthma and diabetes
Proportion of 5–14-year-olds eating the recommended at least two servings of fruit/day and three servings of vegetables/day		Data available only for > 15yrs	No targets yet as per MoH advice	Xx	xx	Improving nutrition is a national priority and contributes to Auckland DHB medium-term outcomes of: improving healthy lifestyles, reducing the incidence and impact of long-term conditions, and reducing inequalities in health outcomes
% smoking prevalence in Year 10 children (MoH target to increase the % of 'never smokers' among Year 10 students by ≥ 3%		65.4%	At least 3 % increase	No targets yet as per MoH advice	No targets yet as per MoH advice	Reducing the harm caused by tobacco use is a national priority and contributes to Auckland DHB medium-term outcomes of: improving

[1] These figures are based on Ministry of Health projections.

Medium-term outcomes		Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
[absolute] over 2007/08 An increase for both Māori Year 10 'never smokers' and Pacific Year 10 'never smokers' that is greater than that for European Year 10 'never smokers' N.B. Also directly impacts on Sections: 5.1.3 Cardiovascular Disease and 5.1.4: Reducing the Impact of Cancer			Subject to data being available to monitor targets			healthy lifestyles, reducing the incidence and impact of long-term conditions, and reducing inequalities in health outcomes
Reduce the prevalence of exposure of non-smokers to SHS inside the home to less than 5% (baseline 2006 12.5%, 2007 7.5%) and Reduction in the exposure of non-smokers to SHS inside the home for Māori is greater than that for European N.B. Also directly impacts on Sections: 5.1.3 Cardiovascular Disease and 5.1.4: Reducing the Impact of Cancer		MoH targets not yet available	< 5%	< 5%	< 5%	Reducing the harm caused by tobacco use is a national priority and contributes to Auckland DHB medium-term outcomes of: improving healthy lifestyles, reducing the incidence and impact of long-term conditions, and reducing inequalities in health outcomes
% of children caries free at 5 years (oral health)	Maori Pacific Asian European Other Total	45.4% 29.7% 58.1% 78.9% 65.6% 59.7%	44% 35% 59% 80% 80% 60%	To be set	5% improvement for Maori and Pacific	Improving oral health is a national priority and contributes to Auckland DHB medium-term outcomes of: reducing the incidence and impact of long-term conditions and reducing inequalities in health outcomes
Teeth of 8-year-olds decayed, missing, or filled (DMFT)	Maori Pacific Asian European Other Total	1.6 1.61 0.87 0.67 0.97 1.01	1.5 1.8 1.1 0.8 1.1 1.1	To be set	1.1 for Maori and Pacific	Improving oral health is a national priority and contributes to Auckland DHB medium-term outcomes of: reducing the incidence and impact of long-term conditions and reducing inequalities in health outcomes
Progress towards 85% adolescent oral health utilisation (N.B. Maori and Pacific data not collected)		49%	Establish baseline target over 2008/09	To be set	52%	Improving oral health is a national priority and contributes to Auckland DHB medium-term outcomes of: reducing the incidence and impact of long-term conditions and reducing inequalities in health outcomes
All children have access to primary care		99.3%	100% under 5yr olds enrolled			This contributes toward Auckland DHB medium term outcomes of : reduce inequalities in health

Medium-term outcomes	Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
		in a PHO			outcomes and achieve NZ Primary Health Care Strategy system change
Work with primary care to reduce below the national average unnecessary hospital admissions for all children (N.B. Under 5yrs)	Achieved, below national average	Under 5 yrs < 95	Less than national average	Less than national average	Reducing ambulatory sensitive hospitalisations is a national priority and contributes to Auckland DHB medium term outcomes of: achieve NZ Primary Health Care Strategy system change, and supporting the appropriate use of hospital services
Manage target rates of acute admissions, within 28 days of previous discharge date, to the same speciality that discharged them their previous admission	2.11%	1.98%	To be set	To be set	This contributes to Auckland DHB medium term goal of supporting the appropriate use of hospital services

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Continue to undertake across the continuum of care the full range of Auckland DHB contracted child health work underpinned by our goal for continuous quality improvement	–	–	Auckland DHB contract reporting
Undertake the range of 2008–09 Implementation Plans developed as part of 'Our Healthy Children', inclusive of planned evaluations and development of the 2009–10 Implementation Plans. The priority child health improvement actions for 2008–09 are as follow:			
Prevention of disease / illness outputs			
Enable Auckland DHB well child providers to increase the % of children enrolled with a GP and a well child provider and to enhance consistency and compliance with the Well Child Framework requirements inclusive of the reporting requirements	-	100% 5-year-olds	Funder & Provider
Progress toward 95% of 2 year olds fully immunised	-	84%[2]	Funder
Increase the number of enrolments with oral health providers and increase in the numbers of children caries free at milestone ages	Refer to outcome targets	As per outcome targets	Funder
Develop and implement with other Auckland region DHBs an integrated Well Child Information System	-	Milestones report	Funder & Provider
Implement Ministry Approved Healthy Eating Healthy Action Plan	Approved 2007-08	Milestones report	Funder & Provider
In collaboration with other agencies work to improve housing, reduce neglect and non accidental injuries, reduce family violence, and advocate on issues affecting families / whanau	–	Milestones report	Funder and Provider
Develop Auckland DHB Youth Health Plan	–	Milestones report	Funder and Provider

[2] The Ministry of Health target for Auckland DHB is a minimum of 84% coverage in 2008/09, however Auckland DHB has concerns whether this is achievable

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Detection and early intervention outputs			
Implement the universal newborn hearing screening programme across Auckland DHB	–	No. of infants screened	Provider
Implement the national programme to assess the health of children before they commence schooling: *'B4 School Checks'*	–	No. children checked	Provider
Continue to implement a programme to assess the health of children (0–14 years) in the care of the Child, Youth and Families Service	New initiative 08/09	No assessed	Funder
Extend the programme to assess the health of 15–17-year-olds in the care of the Child, Youth and Families Service	–	No assessed	Funder
Management of disease / illness outputs			
Tertiary paediatric services will work with primary care to expand community-based expertise in the care of serious illness and chronic conditions	New initiative 2007 - 09	Milestones report	Provider
Work to ensure children and young people with disabilities get the assistance they need	-	Milestones report	Funder and provider
Improve patient outcomes oncology / haematology, renal and endocrinology clinics by implementing joint clinics for children and young people who undergo treatment for cancer and have long-term late effects on their health	New initiative 08/09	No. of joint clinics	Provider
Increase access to surgery for children and young people through refurbishment and additional theatre facilities at Starship Children's Health	New initiative 08/09	Milestones report	Funder & Provider
Create defined spaces in Starship Hospital services for adolescents; and processes for improved transition from paediatric to youth to adult services for young people with chronic health care needs	New initiative 08/09	No. of adolescent spaces	Provider
Establish a Child & Youth Mortality Review Group for Auckland	New initiative 08/09	Milestones report	Provider

5.1.2 Better outcomes in the health of older people

Older people

Long-term objective: Auckland DHB aligns with the Ministry of Health (April 2002) 'Health of Older People Strategy'. The national vision reflects our long-term objective, *'older people participate to their fullest ability in decisions about their health and wellbeing and in family, whanau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes'.*

Achieve better outcomes in the health of older people	In December 2006 Auckland DHB published 'Healthy Ageing 2020 – the Auckland DHB plan to improve the health of people 65 years and older in Auckland city'. Development of the plan included extensive consultation with service users and service providers via public meetings, focus groups, agency discussions, and community of interest discussions. Consultation with Maori identified the needs of Kaumatua and Kuia in the central Auckland area. We also studied national policy and direction, the research on the health of older people, international best practice, alternative models of care and a workshop on the patient journey through the health system. Auckland DHB Disability Support Advisory Committee was a key stakeholder in development of the plan. Improving the quality of health services for older people will focus on comprehensive assessment, support services and flexible 'packages of care' so older people can stay at home longer and with increased independence.

Auckland DHB is moving to implement over the next few years InteRAI (a multi disciplinary single assessment tool) that can streamline, co-ordinate, and prevent duplication of assessments older people currently experience. New Zealand pilot sites of InterRai report it directly increases multisector collaboration, increases responsiveness to older persons' needs and ultimately improved health outcomes for older people.

This new model of needs assessment and service co-ordination may change the way services are delivered to older people, it may require a reallocation of some staffing roles to improve services, funding and support.

		Number	% of total sum	CW	% of total CW sum
		Sum	Sum	Sum	Sum
Agegroup	00-00	9090	12	4980	7
	01-14	7234	10	4359	6
	15-24	7506	10	6026	8
	25-44	21052	28	18229	24
	45-64	12590	17	15116	20
	65-74	6215	8	8764	12
	75+	10829	15	18131	24

Source: NZHIS data, ADHB, Year 2005, Hospital discharge

Medium-term outcomes	Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
Increase in the number of people ≥ 85 years who are able to remain in their own homes	-	Set baseline target 2008/09	5% increase from 2008/09	5% increase from 2009/10	The majority of our eligible population do not access Health of Older Persons services until much later in life. The average age of entry into rest homes is 82 years.
Reduction in number of assessments/person aged ≥ 65 years and requiring help	-	10% reduction in number sessions / person	Target to be set	4% reduction in number assessments / person	Disability is experienced by approximately 22% of the population. The rate of disability increases significantly with age, particularly in the population 65 years and older. The most common types of disability are mobility, agility, and hearing.
Work with primary care to reduce the numbers of unnecessary hospital admissions for 65–74-year-olds	-	National average or lower	Further reduce	Further reduce	In Auckland DHB non-Maori non-Pacific groups have 70% of their deaths after age 75 years compared to only 25% for Maori and 34% for Pacific people.
Improve the national contract negotiation process, agreeing a regional default position	-	Begin discussion with providers re local solutions to improve outcomes	Local amendme nts to national contracts	Refinement of local variation to national agreement and improved monitoring of outcomes	Flexibility within national agreements to ensure the contract intent and content does not disadvantage any areas

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Continue to undertake across the continuum of care the full range of Auckland DHB contracted older persons work underpinned by our goal for continuous quality improvement	–	–	Auckland DHB contract reporting
Undertake the range of 2008–09 Implementation Plans developed as part of '*Healthy Ageing 2020*', inclusive of planned evaluations and development of the 2009–10 Implementation Plans. The priority older persons health improvement actions for 2008–09 are as follow:			
Prevention of disease / illness outputs	-		
Provide alternatives for low to medium need clients e.g. GPs allocating services rather than referring for comprehensive assessment	-	Milestones report	Funder
Expand the regional residential care line into a communication / call centre with language skills, information on all residential care facilities, current vacancies, policies. Procedures etc	-	Milestones report	Funder
Assist home-based support service providers to become budget holders	-	Milestones report	Funder
Agree regional rules around licence to occupy arrangements	-	Milestones report	Funder
Detection and early intervention outputs			
Evaluate clients being supported in their own homes under the ageing in place initiatives	-	4,000	Funder

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Implement the web-based performance monitoring system with training available within the sector	-	Milestones report	Funder
Train providers to implement restorative home care, with a new contracting and monitoring	-	Milestones report	Funder
New Clinical Nurse Specialist positions will complete training needs analysis in the residential care, implement training programmes inclusive of clinical mentorship and advice	-	Milestones report	Funder
Management of disease / illness outputs			
Finalise the polypharmacy research pilot & circulate results	-	Report circulated	Funder
Commence implementation of standardised assessment and referral pathways, 'individual client care packages' older persons' self-management of support services and increased access to information – all deliverables identified from the Community and Home-Based Service Review	-	Milestones report	Funder & Providers
Develop enhanced home support capacity to address ethnic diversity among older people, with particular focus on South Asian communities	-	Milestones report	Funder & Providers
Develop specific plans and provider relationships relevant for each of the three acuity levels	-	Milestones report	Funder & Providers

5.1.3 Reduce the impact of cardiovascular disease and diabetes

Diabetes and cardiovascular disease

Long-term objective: Auckland DHB is using a four pronged approach to achieve its goal of reducing the impact of cardiovascular disease (CVD) and diabetes, specifically these are:

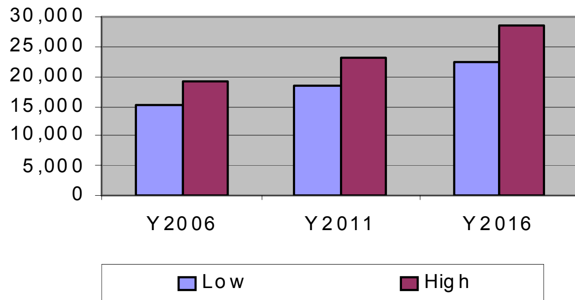
- Prevention of disease, approaches include: education and social marketing; nutrition and food supply; physical activity and urban design; the environment we live in; smoking; community development and leadership
- Management of disease, approaches include: detection and evidence based management of disease; managing care in the community; secondary care enhancements
- Improved health system design and integration, approaches include: workforce, Auckland DHB structure and funding; information systems
- Reducing inequalities in health outcomes, approaches include: health improvement for high risk / high needs groups; health improvements for Maori; health improvements for Pacific peoples; access; measurement and reporting

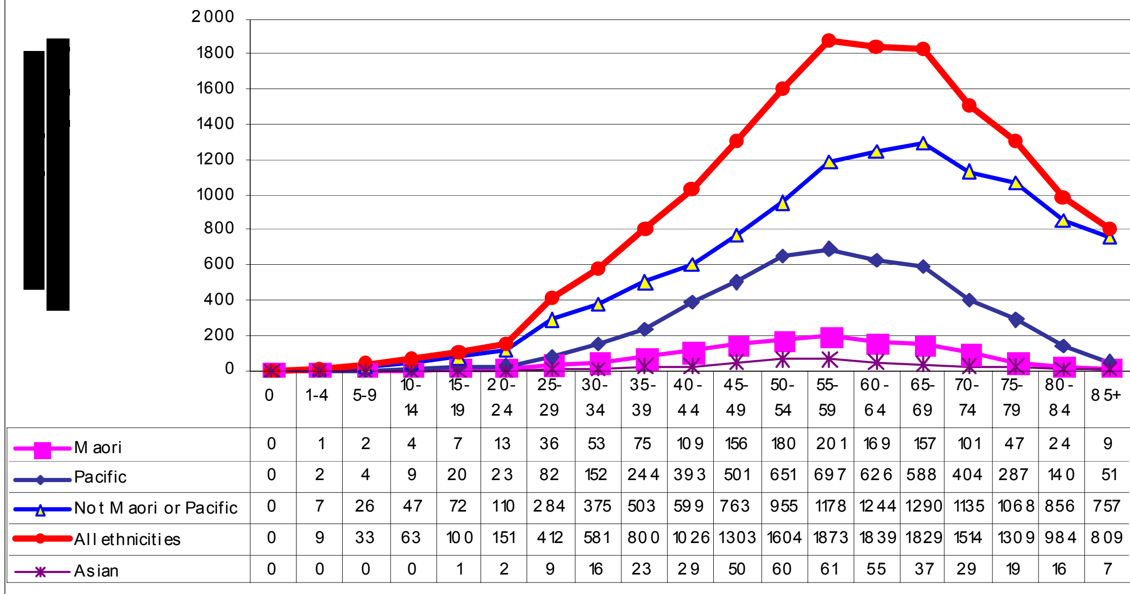
Cardiovascular disease and diabetes are combined in our plan because of the commonalities in addressing risk factors and complications. It is important to note that where the Ministry of Health uses the terminology chronic conditions Auckland DHB uses long term conditions.

Reduce the impact of cardiovascular disease and diabetes	In December 2006 Auckland DHB published 'Improving Outcomes for Cardiovascular Disease and Diabetes in Auckland City – A Health Improvement Plan 2006 – 2011.' The development of the plan included policy review, review of evidence and input from many stakeholder groups to identify the issues with existing services and to design service improvements. The Plan takes a 20 year vision but is focused over a 5 year timeframe, inclusive of detailed annual plans with measurable actions.

Cardiovascular disease is the leading cause of death in the Auckland DHB area and is responsible for over $100 million of direct costs each year. Diabetes affects 14,000 Aucklanders with the prevalence rising at a significant rate. The burden of cardiovascular disease and diabetes fall heavily on Maori and Pacific peoples with mortality rates ranging from 2 – 4 times the average.

Ethnicity
Maori
Non Maori Non Pacific
Pacific People
Category
Cancer
Ischaemic heart disease
COPD
CVA
Diabetes
Other heart disease
Transport accidents
Cellulitis
Asthma
Perinatal conditions
0 2 4 6 8 10 12 14 16 18 20 22 24 26
Count





	0	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Maori	0	1	2	4	7	13	36	53	75	109	156	180	201	169	157	101	47	24	9
Pacific	0	2	4	9	20	23	82	152	244	393	501	651	697	626	588	404	287	140	51
Not Maori or Pacific	0	7	26	47	72	110	284	375	503	599	763	955	1178	1244	1290	1135	1068	856	757
All ethnicities	0	9	33	63	100	151	412	581	800	1026	1303	1604	1873	1839	1829	1514	1309	984	809
Asian	0	0	0	0	1	2	9	16	23	29	50	60	61	55	37	29	19	16	7

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

Medium-term outcomes	Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
Refer to Section 5.1 Child Health Breastfeeding Outcomes	-	-	-	-	There is evidence that infants who are exclusively breastfed for at least the first 6 months of life have significantly reduced later life risk factors for CVD and Diabetes, as well as other lifespan health advantages

Medium-term outcomes	Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
% of adults (15+ years) consuming ≥ 3 vegetable servings/day	HEHA – MAP approved 07/08	Initiatives identified in HEHA -MAP	Initiatives identified in HEHA -MAP	Initiatives identified in HEHA -MAP	Improving nutrition is a national priority and contributes to Auckland DHB medium term outcomes of: improve healthy lifestyles, reduce the incidence and impact of long-term conditions, and reduce inequalities in health
Improve PHO enrolment rates in Care Plus	69.2%	≥ 70% of eligible patients enrolled	To be set	To be set	Care Plus contributes to the national priorities of: reducing the burden of chronic disease , improving diabetes services, improving nutrition and increasing physical activity and reducing the harm caused by tobacco use; and to Auckland DHBs medium term outcomes noted in the introduction to section 5.1
Increase from 2007/08 the prevalence of 'never smokers' among Year 10 students. N.B. Also directly impacts on Sections: 5.1.1 Child Health and 5.1.4: Reducing the Impact of Cancer	MoH targets not yet available	≥ 2% from 07/08 (absolute increase)	MoH advise no targets yet	MoH advise no targets yet	Auckland DHB is smokefree. Patients that smoke are offered smoking cessation information and assistance. We are making particular effort to develop smokefree environments and smoking cessation available in mental health non government organisations (NGOs)
Increase % of homes with a children that have a smokefree policy when there are smokers who live at / visit the home. N.B. Also directly impacts on Sections: 5.1.3 Child Health and 5.1.4: Reducing the Impact of Cancer	MoH targets not yet available	≥ 78%	MoH advise no targets yet	MoH advise no targets yet	Reducing the harm caused by tobacco use is a national priority and contributes to Auckland DHB medium-term outcomes of: improving healthy lifestyles, reducing the incidence and impact of long-term conditions, and reducing inequalities in health outcomes

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Continue to undertake across the continuum of care the full range of Auckland DHB contracted CVD and Diabetes work underpinned by our goal for continuous quality improvement	–	–	Auckland DHB contract reporting
Undertake the range of 2008–09 Implementation Plans developed as part of *'Improving Outcomes for Cardiovascular Disease and Diabetes in Auckland City',* inclusive of planned evaluations and development of the 2009–10 Implementation Plans. The priority CVD and Diabetes health improvement actions for 2008–09 are as follow:			
Prevention of disease / illness outputs			
Establish a community breastfeeding support, promotion and advocacy service to increase breastfeeding rates in Maori, Pacific and Asian populations	New initiative 08/09	Milestones report	Funder

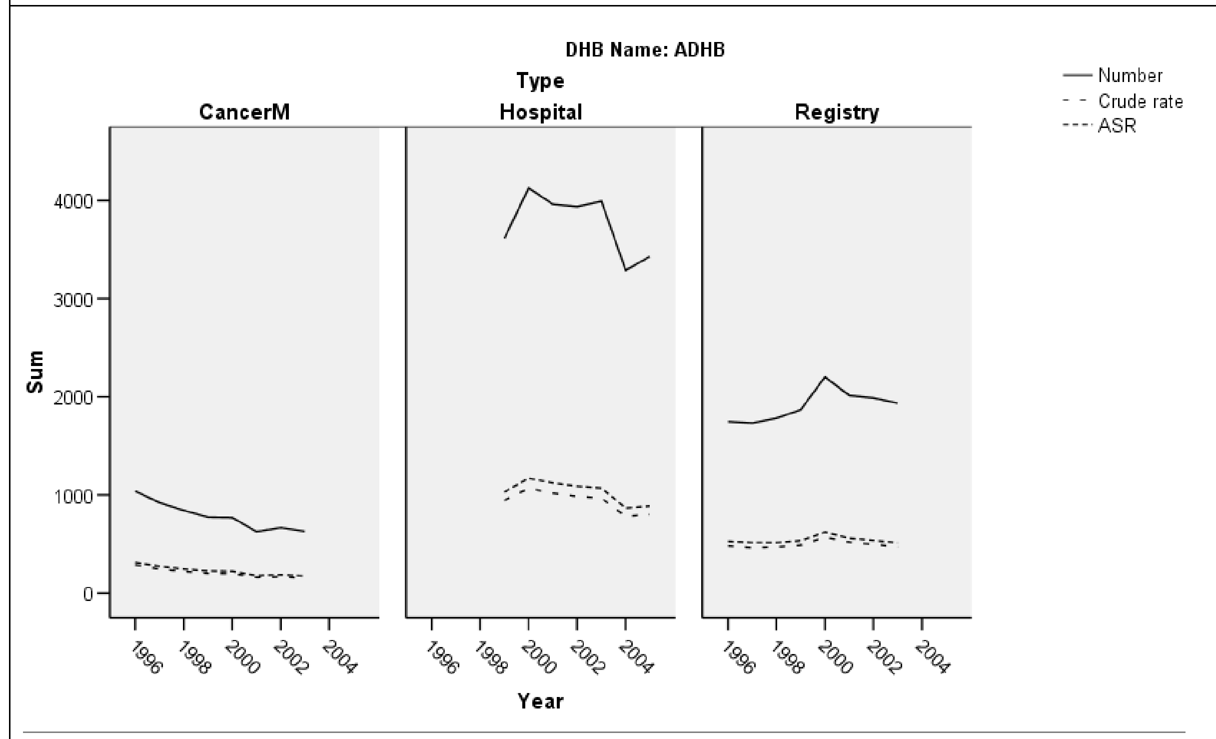
2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Establish a database to monitor progress towards improving nutrition environments in schools and early childhood centres	-	Accurate targets set for 09/10	Funder
Implement government led initiatives to reduce CVD and / or Diabetes via improved nutrition, increased physical activity, reducing obesity, reducing harmful effect of tobacco	HEHA – MAP approved 07/08	All agreed deliverables met	Funder
In partnership with the respective communities develop separate Maori and Pacific Healthy Eating Healthy Action Plans (HEHA) to identify priorities and solutions for reducing obesity, improving nutrition and increasing physical activity	New initiative 08/09	Milestones report	Funder
Plan and secure funding for a HEHA programme that addresses the environmental causes of obesity for the people of South Central Asian ethnicities	New initiative 08/09	Milestones report	Funder
Implement the actions in the Auckland DHB tobacco control plan (N.B also directly relevant output for 5.1.4: Reduce the Impact of Cancer)	New initiative 08/09	Achieve MoH agreed targets	Funder & Providers
Develop a long-term conditions framework for Auckland DHB	New initiative 08/09	Milestones report	Funder & Providers
Detection and early intervention outputs			
Implement the separate but connected CVD & Diabetes Plans focusing on improving primary care services and workforce capacity	8853 'Get Checked' Consults	10,035 Get Checked Consults	Funder & Providers
Expand systematic cardiovascular risk screening by general practice including screening for people with diabetes	-	75% of Get Checked consults have Hba1c < 8	Providers
Pilot telehealth options for people with long term conditions Heart Failure	New initiative 08/09	Milestones report	Funder
Implement the Diabetes Plan focusing on improving primary care services and workforce capacity	-	Milestones report	Funder & Providers
More diabetes education and self management programmes	-	Milestones report	Providers
Increase the capacity of diabetic retinal screening to improve access for Maori, Pacific and other populations	-	Milestones report	Providers
Pilot the Type 1 Diabetes programme run by Diabetes Auckland	-	Milestones report	Funder & Providers
Develop the workforce to provide evidence–based community care for diabetes and associated conditions	-	Milestones report	Providers
Use pathways of care that allow a nursing model of care shared between community and hospital	-	Milestones report	Providers
Implement pilots for long term conditions management services (primary care based)	-	Milestones report	Provider
Management of disease / illness outputs			
Strengthen the integrated heart failure project by working with primary care and out hospitals to reduce variation in treatment	New initiative 07/08	Milestones report	Providers
Increase cardio-surgical treatment and maintain the expert workforce needed to deliver this	-	Milestones report	Providers

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Increase available programmes and options for cardiac rehabilitation including home-based and community services integrated with PHOs and GPs programmes	New initiative 07/08	Milestones report	Providers
Strengthen Auckland City Hospital Stroke Unit treatment / rehabilitation options for stroke	New initiative 08-09	Milestones report	Provider

5.1.4 Reduce the incidence and impact of cancer

<table>
<tr><th colspan="2">Cancer</th></tr>
<tr><td colspan="2">Long-term objective: To reduce the incidence and impact of cancer for the people of Auckland DHB and as a member of the Northern Cancer Network to achieve the same goals across the northern region.</td></tr>
<tr><td>Reduce the impact of cancer</td><td>Auckland DHB is committed to the ongoing development of the Northern Cancer Network and its Regional Cancer Control Plan. This work aims to improve cancer control through increased regional collaboration not constrained by organisational or professional boundaries. The Northern Cancer Network comprises the DHBs from Auckland, Counties Manukau, Waitemata, and Northland.

The Network will facilitate the goals of the National Cancer Control Strategy to reduce the incidence and impact of cancer in the Northern region; and to reduce inequalities with respect to cancer in the region. Regional collaboration will improve the patient journey and outcomes, while also supporting regional integration across traditional silos.</td></tr>
<tr><td colspan="2">In Auckland DHB cancer is the second leading cause of death (27%). Cancer is a major cause of hospitalisation (7%) in New Zealand, approximately 50% of those diagnosed with cancer will die from it (NZ Health Strategy). Early detection and diagnosis improve the survival time with good quality of life. These better outcomes are especially likely with cancers detectable by screening. In Auckland DHB compared to adult cancer incidence, paediatric cancer incidence may seem low (on average 140 cases /year) but the cure rate is high (about 70%) with good health outcomes over a normal life expectancy in the majority of survivors. Overall cancer mortality rates have increased over time among Maori compared to a steady decrease among non-Maori and non Pacific people.

Palliative care is recognized by Auckland DHB to be a very important aspect of Cancer Control. Because palliative care is not limited to cancer it is a separate strategy with key intersecting points with Auckland DHB Cancer Control Plan. The World Health Organisation (2002) defines palliative care as: ‘an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.’</td></tr>
<tr><td colspan="2">
</td></tr>
</table>

Medium-term outcomes	Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
All patients wait 6 wks between 1st Specialist Assessment (FSA) and start of radiation oncology treatment		Treatment within 6wks for 100% of patients	Maintain 6wk wait	Maintain 6wk wait	Reducing cancer waiting times is a national priority and contributes to Auckland DHB medium term outcomes of reducing inequalities in health outcomes, and supports the appropriate use of hospital services
Increase the prevalence of 'never smokers' among yr 10 students. N.B: This action also directly impacts on Sections: 5.1.1: Child Health and 5.1.3: Reduce the impact of Cardiovascular Disease	MoH targets not yet availabl e	≥ 3% absolute over 07/08	MoH advise no targets yet	MoH advise no targets yet	Reducing the harm caused by tobacco is a national priority and contributes to Auckland DHB medium term outcomes of: reducing the incidence and impact of long term conditions, reduce inequalities in health outcomes, and improve healthy lifestyles and environments
Increase % of homes with children that have a smokefree policy when there are smokers who live at / visit the home. N.B: This action also directly impacts on Sections: 5.1.1: Child Health and 5.1.3: Reduce the impact of Cardiovascular Disease	MoH targets not yet available	MoH advise no targets yet	MoH advise no targets yet	MoH advise no targets yet	Reducing the harm caused by tobacco use is a national priority and contributes to Auckland DHB medium-term outcomes of: improving healthy lifestyles, reducing the incidence and impact of long-term conditions, and reducing inequalities in health outcomes

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Continue to undertake across the continuum of care the full range of Auckland DHB contracted Cancer Control work underpinned by our goal for continuous quality improvement	–	–	Auckland DHB contract reporting
Undertake the range of 2008–09 Implementation Plans developed as part of *'Auckland DHB Cancer Control Health Improvement Plan',* inclusive of planned evaluations and development of the 2009–10 Implementation Plans. The priority Cancer Control health improvement actions for 2008–09 are as follow:			
Prevention of disease / illness outputs			
Implement the actions in the Auckland DHB tobacco control plan (N.B. also a directly relevant output for 5.1.3: Reduce the impact of Cardiovascular Disease and Diabetes)	MoH targets achieved	Achieve MoH agreed targets	Funder & Providers
Ministry Approved Healthy Eating Healthy Action Plan implemented (N.B. also a directly relevant output for 5.1.1: Child Health and for 5.1.3: Reduce the impact of Cardiovascular Disease and Diabetes)	HEHA – MAP approved 07/08	Achieve MoH agreed targets	Funder & Providers
Increase access to cervical screening within primary care and to specialist services within Auckland City Hospital for woman with disabilities	See coverage rates below	Milestones report	Funder
Detection and early intervention outputs			
Develop the regional cancer network policy, protocols and governance structures	Planning 06/07	Milestones report	Governance
Regional Oncology Operational Group continues to oversee collaborative delivery of regional cancer services	Planning 06/07	Milestones report	Providers

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Improve participation in the National Breast Screening Programme by eligible women (*2 year coverage rate for 50 -64 yr old women at 31.12.07)	*42.9%	Contract Targets met	Funder & Providers
Improve participation in the National Cervical Screening Programme by eligible women, particularly: Maori, Pacific and Asian women (**3yr coverage rate for 20 – 65 yr women at 31.12.07)	**65%	Contract Targets met	Funder & Providers
Management of disease / illness outputs			
Introduce Site Specific Tumor Groups in Oncology with patient navigators appointed	New initiative 08/09	Milestones report	Provider
Evaluate radiation oncology intervention rates	New initiative 08/09	Milestones report	Provider
Investigate the feasibility of an electronic patient management system (PMS) tailored to medical and radiation oncology	New initiative 08/09	Milestones report	Provider
Improve data collection, analysis, and reporting to meet Ministry of Health requirements and to inform regional planning	New initiative 08/09	Milestones report	Provider
Ensure equipment is replaced in a timely manner to prevent patient delays (e.g. linear accelerator replacement plan is followed)	Equipment targets met	Milestones report	Funder
Develop a Palliative Care model of care for future service development (for adults), including the human resource requirements of specialist and generalist roles	New initiative 08/09	Milestones report	Provider
Develop a Palliative Care education strategy and establish partnerships with education agencies	New initiative 08/09	Milestones report	Provider
Co-ordinate general practice, other community palliative care providers and specialist palliative care providers	New initiative 08/09	All providers have access electronic to screening & diagnostic information	Provider
Develop an after-hours palliative care service policy	New initiative 08/09	Milestones report	Provider

5.1.5 Better outcomes in mental health

<table>
<tr><th colspan="2">Mental health</th></tr>
<tr><td colspan="2">Long-term objective: Our vision is that environments and services promote mental wellness and recovery and work towards reducing mental illness and addiction.

It is important that the mental health of our society is seen as everyone's responsibility, 'there is no health without mental health.'</td></tr>
<tr><td>To achieve better outcomes in mental health</td><td>Auckland DHB entitled 'Mental Health and Addiction Plan 2008 – 2011.' This plan was developed by Auckland DHB working with Mental Health, Addiction and related sectors in the Northern region. This involved sector wide consultation in the development of the Plan. This Plan focuses on improved outcomes across the continuum of wellness and illness, it takes a whole-system view of mental health and addiction need and service. The Plan has 6 goals:
• Services across the continuum
• Services responsive to population need
• Supports that sustain mental health
• Improved quality of service
• Focus on outcomes while building capacity
• Improved services for children and young people

An associated Action Plan is in the final stages of development, and this includes more specific examples of how the strategic direction will be achieved. This also involved significant stakeholder input.</td></tr>
<tr><td colspan="2">Our Health Needs Assessment reviewed disease risk factors, death and hospitalisations for the period 2001 – 2004 for the Auckland population (www.adhb.govt.nz/healthneeds). Mental health problems are included amongst the most significant health priorities for Auckland DHB. Younger and older age groups are high consumers of health services. Overall percentages of age groupings are projected to remain similar but mental health services are required to meet an increasing level of absolute demand in 'dependency' age groups (19,000 people). A regional analysis of the needs of people with significant mental illness has been undertaken to inform the development of additional secondary mental health services.

The major challenge in the current level of service availability is in the area of child and youth services. Greater numbers of people are living to older age, with a corresponding growth in mental health and addiction needs estimated at about twice the rate of the increase in the potential workforce. We need to continue to develop regional specialist services in collaboration with other Northern region DHBs in order to meet current need and plan to meet future need.

There is also a need to explore what capacity is required for intensive rehabilitation options and respite. International studies suggest that different population groups generally have similar levels of serious mental illness. Local service use shows that Maori use secondary mental health and addiction services (particularly at the acute end) considerably more often than their non-Maori counterparts. However both Maori and Pacific groups access primary health services (PHOs) at lower rates than the general population.</td></tr>
</table>

12 months prevalence Mental health				
Age group	16-24	25-44	45-64	65 and over
Maori	2,307	3,682	1,332	109
Pacific	2,738	4,089	1,434	464
Others	15,496	28,725	13,188	2,297
Total Number	20,541	36,495	15,954	2,870
Total Population > 15	71,820	145,400	91,690	40,420

Medium-term outcomes	Actual 2007/08	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
Clients have up to date relapse prevention plans: Maori Pacific Other Total	57%[3]	90% for all groups	90%	90%	Improving mental health services is a national priority and contributes to Auckland DHB medium term outcomes of: improving healthy lifestyles and environments, reducing the incidence and impact of long-term conditions, reducing inequalities in health outcomes, achieving NZ primary health care strategy system change, supporting the appropriate use of hospital services
Increased % of people with enduring mental illness in paid work or education or appropriate discharges	10.9%[4]	5% increase from 07/08	5% increase from 08/09	5% increase from 09/10	
Reduced waiting times for alcohol and other drug services and clients engaged with services for longer periods	This data is prepared by Waitemata DHB for the region.				
Audit of mental health providers	30% of providers audited	30%[5] of providers audited	30% of providers audited	30% of providers audited	

2008/09 priority outputs toward medium-term outcomes	Actual 2007/08	Target 2008/09	Output class
Continue to undertake across the continuum of care the full range of Auckland DHB contracted mental health and addictions work underpinned by our goal for continuous quality improvement	–	–	Auckland DHB contract reporting
Undertake the range of 2008–09 Actions developed as part of 'Auckland DHB 'Mental Health and Addiction Plan 2008 – 2011, Action Plan for this period. The priority mental health and addictions health improvement actions for 2008–09 are as follow:			
Detection and early intervention outputs			
Build workforce via an internship programme	Internship programmes operational via A+ Trust	Milestones report	Providers
Collaboration between primary and secondary care staff to enable services responsive to client need	Provider Arm project	¼rly audit a sample of relapse plans	Funder & Providers
Within Auckland DHB Youth Action Plan work with other portfolios to develop youth initiatives that include mental health	Planned work underway	Milestones report	Funder & Providers
Progress the service changes required as services are devolved	Service agreement being	Milestones report	Funder & Providers

[3] This figure is at Quarter 3 (31March 2008) as reported via Health Target. This is a significant increase from Quarter 2 and service managers are confident of their ability to reach 90%

[4] This figure is via QUA-02 (Quarter 2 at 31 December 2007). This figure is for consumers in paid work (fulltime or part-time). Note1: the employment status of 16.8% of consumers is unknown. Note 2: The % of consumers in some form of education was unknown at Quarter 2.

[5] The target is for 30% of providers to be audited each year, with a 3 year target of approximately 100%. By 30 June 2009 all NGO providers will have been audited.

2008/09 priority outputs toward medium-term outcomes	Actual 2007/08	Target 2008/09	Output class
	developed with Provider		
Management of disease / illness outputs			
Work with residential service providers to provide recovery based accommodation services which are well integrated with clinical services and the community	Review of level 3 & 4 residential services currently underway	By 30.06.09 all contracted NGO providers audited	Funder
Improve responsiveness to consumers with high end diagnosis issues (e.g. address service gaps for improved access to forensic resources)	Working regionally on forensic strategy	Milestones report of ADHB action	Providers
Via Regional Services planning address the gaps in services for children and young people with eating disorders	Regional project underway	Milestones report of ADHB action	Funder & Providers
Clinical and NGO services meet quality and accreditation standards	-	Milestones report	Providers
Agreed service delivery specific to Blueprint funding	Blueprint services developed for 07/08 in line with prioritisation process	Milestones report	Providers

5.1.6 Improve equity of health outcomes between groups

Reduce inequalities in health status between groups	
Long-term objective: Equality in health status between population groups	
Reduce inequalities for groups with high need	Reducing inequalities between groups is a key organisation wide area of work. In order to effect shifts in health status Auckland DHB is currently concentrating this effort on the following population groups: • Maori (8.1 % of Auckland DHB population) • Pacific (12.53 % of Auckland DHB population) • People with disabilities (17 % of NZ population have a disability, it is estimated that Auckland DHB rate will be similar) • People from refugee and refugee-like backgrounds (it is estimated that 20,000 people or ½ of the Auckland Region refugee population live in Auckland DHB) • People living in poverty[6] (15.9 % of Auckland DHB population)
Refer to Our Environment, Section 2 of this document for detailed information about Auckland DHB: population, age, ethnicity, health profile, and our operating environment.	

Medium-term outcomes	Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
Optimum use of the 'Improve Access (SIA)' funding tagged for high needs groups to make better use of primary care	Planned activities achieved	Milestones Report	To be set	To be set	Reducing inequalities in health status is a national priority, it is an overarching medium term outcome for Auckland DHB that influences the remaining four medium term outcomes, namely: improving healthy lifestyles and environments; reducing the incidence and impact of long-term conditions; achieving NZ primary care strategy system change, and supporting the appropriate use of hospital services
Local Iwi / Maori engaged and participate in Auckland DHB decision-making and development of strategies and plans for Maori health gain	Maori Health Advisory Committe oversee. 06/07 result achieved	Implement Maori Health Plan & complete 2 actions by 07/09	To be set	To be set	
Pacific peoples are engaged and participate in Auckland DHB decision-making and development of strategies and plans for Pacific health gain	Pacific Health Advisory Group oversee. 06/07 result achieved	Implement the Pacific Health 5 Priority Areas	To be set	To be set	
All planning, funding, service development and service delivery work reflects a disability perspective	Disability Support Advisory Committe oversee. 06/07 result achieved	Complete needs analysis & gap analysis	To be set	To be set	

[6] The proportion of people living in households with gross real income less than 60% of the median equivalent national income benchmark at 2001

Medium-term outcomes	Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
Provide input to the Health Work-strand of the Auckland Regional Settlement Strategy Steering Group	-	Milestones Report of ADHB action	To be set	To be set	A strong health input to this project is critical for impacting on short, medium, and long term health and social integration needs of these particularly high needs groups
Provide input to the Housing NZ led multi-agency Tamaki Transformation Project (an identified area of deprivation)	-	Milestones Report of ADHB action	To be set	To be set	A strong health input to this project is critical for impacting on short, medium, and long term health inequalities of the people who live in this area of Auckland

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Continue to undertake across the continuum of care the full range of Auckland DHB contracted reducing inequalities work underpinned by our goal for continuous quality improvement	–	–	Auckland DHB contract reporting
Undertake the range of 2008–09 Implementation Plans developed as part of 'reducing inequalities', inclusive of planned evaluations and development of the 2009–10 Implementation Plans. The priority reducing inequalities health improvement actions for 2008–09 are as follow:			
Prevention of disease / illness outputs			
Refer to Sections 5.1.1, 5.1.2, 5.1.3, 5.1.4,5.1.5 as initiatives to improve nutrition, increase physical activity, and reduce smoking and obesity rates include specific emphasis for Maori, Pacific and other disadvantaged peoples	Refer to 5.1.:1,2,3,4, & 5	Refer to 5.1.:1,2,3,4,& 5	Refer to 5.1.:1,2,3,4,& 5
Research the needs and aspirations of the disability community as a joint project with other government agencies, organisations and the disabled community	-	Report by Dec 08	Funder & Providers
Assist disabled people to participate more in planning, including help to provide planning material in accessible formats	-	Milestones report	Funder & Providers
Develop and maintain systems and processes responsive to the health needs of people from refugee and refugee-like backgrounds resettling in Auckland city, such as: • Pilot use of interpreter services in general practice • Identify the required cultural competencies for primary, secondary, disability and NGO workforce particular to people from refugee and migrant backgrounds	-	Milestones report	Funder & Providers
In conjunction with Auckland city Mission and senior leaders across sectors the goal is to get and keep our homeless off the street	-	Milestones report of ADHB role	Governance
Work with other agencies to foster job growth for older people migrating to Auckland (e.g. mentoring for migrants, internships, and business leadership)	-	Milestones report	Funder
Detection and early intervention outputs			
Increase funding targets for Maori health and disability initiatives within current Maori health expenditure by 8% in total compared to 2007-08	Not achieved but 5% increase	8% Increase	Funder

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Each Auckland DHB owned service will introduce at least 2 initiatives linked to the Maori Health Plan and which: • Improve clinical and cultural partnerships • Improve discharge planning • Promote whanau support	-	2 initiatives / service	Funder & Provider
Implement findings from the national evaluation of the Maori provider development scheme and support Maori providers through this process	-	Milestones report	Funder &Providers
Refer to 5.1.3 and 5.1.4 – the primary care based long-term conditions case management initiatives include specific emphasis for Maori and Pacific peoples and other disadvantaged peoples	Refer 5.1.3 & 5.1.4	Refer 5.1.3 & 5.1.4	Refer 5.1.3 & 5.1.4
Implement the Maori Health Workforce Plan within primary and secondary services	-	Milestones report	Funder & Providers
Action the Pacific Health 5 Priority Areas: • Increase the capacity and capability of the Pacific Health and Disability Workforce • Mainstream responsiveness • Build Health Pacific communities • Pacific provider and workforce development • Performance improvement	Achieved as per 06/07 Annual Report	Milestones report	Funder
Management of disease / illness outputs			
Outputs described in the above section 'Detection and Early Intervention' apply to this section too	--	-	-

5.2 Improved Performance

5.2.1 Productivity and efficiency

<table>
<tr><th colspan="2">Auckland DHB health care system</th></tr>
<tr><td colspan="2">Long-term objective: That Auckland DHB provides value for money for the taxpayer</td></tr>
<tr><td>To align the flow of patients / consumers through the contracted continuum of care with the provision of high quality services delivered within budget</td><td>Auckland DHB health care system funds and provides a wide range of services from health promotion and problem prevention work through to secondary and tertiary level specialist services provided within our hospital. The total dollar value of these services is approximately $865.7 million, some of this is funded directly from the Ministry of Health (e.g. the contract for public health services). In addition Auckland DHB provides services for other DHBs to the value of $528.2 million.

As detailed in section 2.3 of this document Auckland DHB is increasingly broadening its focus, with emphasis on the creation of healthy environments and the prevention and early detection of disease. Auckland DHB recognizes this requires collaboration and co-operation with other organisations, other funding sources, and indeed other sectors such as housing, employment, social development and education, for their work has major impact on determining health outcome.

At the same time of proactively working upstream to impact on improved health outcomes Auckland DHB must continue to achieve improved clinical outcomes and be cost effective. This requires Auckland DHB health care system to co-ordinate for its constituency access to an integrated and appropriate continuum of quality care that is grounded in evidence based best practice. As well we need to use our clinical and managerial capacity to support population and personal health developments in primary care and with other community based providers of care.</td></tr>
<tr><td colspan="2">Auckland DHB as a funder of health services for Auckland city has relationships with a wide range of community based non government organisations (see summary table in section 2.3) and primary care providers. General Practitioners (GPs) and their practice teams are significant providers of primary care services. Auckland has a high rate of GP fulltime equivalents (83 per 100,000 population) compared to the national rate (70 per 100,000). Around 400 GPs work fulltime in Auckland city caring for an enrolled population of 431,615 (N.B. 95,551 of these people are not residents of Auckland city, most being residents of neighbouring Counties Manukau or Waitemata). Primary care practices align to one of five Primary Health Organisations (PHOs), each PHO has its own philosophy and enrolled population.

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 includes services provided by Adult services, Starship Children's Health and National Women's Health services. The Greenlane Clinical Centre provides inpatient Ophthalmology, advanced outpatient, ambulatory services, and short –stay surgical care. Auckland DHB also provides a number of community based services: Rehab Plus, Community Mental Health Services, Community Child Health and Disability Services.</td></tr>
<tr><td colspan="2">Auckland DHB operates NZ's largest public hospital, Auckland City Hospital, with the following characteristics:
• Almost 2 million patient contacts annually
• Local hospital & outpatient services for more than 439,355 Aucklanders
• Tertiary services for the northern region, about 1.5 million people
• Over 50% of Auckland City Hospital services are provided to people outside the city
• Provide a number of tertiary services (e.g. clinical genetics and paediatric oncology) for people in the Northern, Midland and Central regions
• Provide a range of services for NZ (e.g. heart, lung and liver transplants; acute respiratory distress syndrome [ARDS] in adults or children requiring extra corporeal membrane oxygenation [ECMO], high –risk obstetrics; epilepsy surgery etc)
• NZ's largest trainer of doctors, with approximately 1,000 medical staff of whom 460 fulltime equivalents (FTE) are in various stages of training
• NZ's largest clinical research facility, engaging work that attracts funding and participation here and overseas
• Auckland DHB has over 8,000 staff or approximately 7,300 FTE positions (inclusive of bureau contracted staff)</td></tr>
</table>

Medium-term outcomes	Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
Achieve an integrated quality patient journey through primary and secondary care services	Implemented production planning and after hours project	Projects proceed to plan	Projects proceed to plan	Projects proceed to plan	Planned projects include: • Streamline referral & discharge processes • Reduce waiting times for cancer patients • Introduce an integrated heart failure project for diabetes & vascular services • Introduce a cardiac rehabilitation programme • Reduce admissions & re-admissions for older people • Reduce waiting times for mental health patients • Implement an elective surgery booking system that creates certainty for patients & manages their condition while on the wait list • Surgical review process • After-hours model of care project • Production planning project
Clinical quality and professional governance model that creates an environment of openness, transparency and a no blame culture that invites public scrutiny and facilitates continuing quality and process improvement	Policy, systems & processes upheld at all times	Policy, systems & processes upheld at all times	Policy, systems & processe s upheld at all times	Policy, systems & processes upheld at all times	The four cornerstones of Auckland DHB clinical quality and professional governance are: • Professional governance • Quality / clinical effectiveness cycle • Policy and risk management • Research and development
Organisation vision, values, and goals cascade through Auckland DHB: Strategic Plan, Annual Plan, Service Contracts, Functional Group Business Plans and Staff Performance Management Plans	Workforce Developmen t Plan Adopted	Deliverable s according to plan	Accordin g to plan	Deliverables according to plan	Auckland DHB Workforce Development plan has 5 strands of activity: • Workforce Development Infrastructure • Healthy Workplaces • Recruitment and Retention • Teaching and Learning • Research and Innovation
Provide *fit for purpose* facilities and infrastructure that support and enable operational efficiency and	Purchase, maintenance , and development on time, within	Purchase maintenan ce, and developme nt on time, within	Purchase maintena nce, and develop ment on time,	Purchase, maintenance and development on time, within	Facilities and Infrastructure includes but is not limited to: • Governance and Management , Finance & Treasury inclusive of intra-

Medium-term outcomes	Actual 2006/07	Target 2008/09	Target 2009/10	Target 2010/11	National & Auckland DHB Outcomes
effectiveness	budget and according to plan	budget and according to plan	within budget and accordin g to plan	budget and according to plan	district flows management • Legal • Facilities management • Materials management and procurement • Information and communication technology and management
Implement recommendations from Auckland DHB Information and Communications Technology Architecture Plan, 2008	Plan developed	Achieve agreed milestones	Achieve agreed milestone	Achieve agreed milestones	The plan has several strands of work given , due to the complexity the size of Auckland DHB

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Continue to undertake across the continuum of care the full range of Auckland DHB contracted work underpinned by our goal for continuous quality improvement	–	–	Auckland DHB contract reporting
Undertake the range of 2008–09 Implementation Plans developed as part of *'Auckland DHB Health Care System Planning',* inclusive of planned evaluations and development of the 2009–10 Implementation Plans. The DHB targets for national performance measures can demonstrate our commitment to medium term productivity and efficiency improvements, and long-term toward health improvement , our 2008-09 targets are:			
Primary Health Organisations (PHO) Performance			
Percent valid NHI on patient register	99.2%	99.5%	Funder
Ratio utilisation by high needs enrolee (GP and nurse consults)		1	Funder
Percentage of Auckland DHB residents enrolled in PHOs		100%	Funder
Percentage of under 5-year-olds enrolled in PHOs		100%	Funder
Percentage of high needs enrolled in PHOs	106%	100%	Funder
Percentage of PHOs committing to performance management project targets		100%	Funder
Quality and Patient Outcome			
% triage 1 patients seen immediately	100%	100%	Provider
% triage 2 patients seen within 10 minutes	65%	80%	Provider
% triage 3 patients seen within 30 minutes	52%	75%	Provider
Readmissions per 1000 discharges	43 per 1,000	30 per 1,000	Provider
% score overall satisfaction	89%	88%	Provider
Aggregated % for respect dimension	86%	84.8%	Provider
Aggregated % score for information dimension	82%	80.7%	Provider
Aggregated % score for physical dimension	83%	82.0%	Provider
Bloodstream infections per 1000 bed days	1.67	0.2 BSI	Provider

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Process and Efficiency[7]			
Average length of stay per discharged inpatient	4.2	4.1	Provider
Actual length of stay vs. expected length of stay (casemix adjusted)	-	100%	Provider
Day cases as a % of all elective procedures	52.1%	52%	Provider
Actual day cases as % of expected day cases (casemix adjusted)	-	100%	Provider
Day of surgery admissions (DOSA) as % of all inpatient surgery	62%	41%	Provider
Actual DOSA as % of expected DOSA (casemix adjusted)	-	100%	Provider
Did not attends % of non attendance for specialist appointments	9.2%	8.5%	Provider
Organisational Health			
Staff turnover resignations for quarter as % of total head count	3.0%	3.1%	Provider
Sick leave hours as % of accrued FTE hours	3.9%	3.5%	Provider
Injury/illnesses per 1,000,000 hours worked	7.5	7.5	Provider
Finance			
Debt at quarter end as % of (debt + equity)	43%	78.03%	Funder & Provider
Ratio of 12 months revenue to fixed assets at quarter end	1.39	1.72	Funder & Provider
Ratio of capital expenditure to depreciation over the quarter	1.56	1.33	Funder & Provider
Staff costs (in 1000s) divided by workforce FTE (for medical personnel)	154	143.514	Funder & Provider
Staff costs (in 1000s) divided by workforce FTE (for nursing personnel)	65	72.037	Funder & Provider
Staff costs (in 1000s) divided by workforce FTE (for allied health personnel)	56	66.495	Funder & Provider
Staff costs (in 1000s) divided by workforce FTE (for support personnel)	38	35.835	Funder & Provider
Staff costs (in 1000s) divided by workforce FTE (for managers and administrators)	55	68.996	Funder & Provider
Staff costs (in 1000s) divided by workforce FTE (for total provider arm personnel)	72	82.084	Funder & Provider
Improve the Rate of Elective Services			
Auckland DHB agrees an increase in the number of elective service discharges, and will provide the level of service agreed (N.B ADHB Population)	Electives 06/07 10,542	CWDs: Base 10,670 Add 1,067 Total 11,737 Elect Discharges Base 8.581 Add 858 Total 9,439	Provider Provider
Overall Productivity			
Volume acute (N.B. All Populations)	79,761	100% of total contract	Provider

[7] Measure definitions as per Ministry of Health HBI Report

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Volume elective (N.B. All Populations)	24,881	100% of contract	Provider
WIES equivalent per FTE	34.5	36.67	Provider
Theatre utilisation8	-	85%	Provider
Bed utilisation9	-	85%	Provider
Waiting times for acute surgery	-	10% to 07-08 results	Provider
Surgical cancellations	-	10% to 07-08 results	Provider

[8] Theatre utilisation: % utilisation of resourced elective operating time (by minute)

[9] Bed utilisation: % at 12 midnight occupancy of resourced beds for Auckland City Hospital, excludes adult emergency department/ assessment planning unit beds, labour and birthing and WOW beds

5.2.2 National and regional health services planning

<table>
<tr><th colspan="2">National and regional planning</th></tr>
<tr><td colspan="2">Long-term objective: DHBs collaborating to mutual advantage and across the system as a whole to improve the health of New Zealander's, reduce disparities between population groups, and deliver a value for money New Zealand health system</td></tr>
<tr><td>To enhance continuity of care and equitable health outcomes irrespective of where people live in the northern region and indeed within New Zealand</td><td>As the provider of the largest hospital in NZ we provide some specialist services for the Northern region, and some for the whole of NZ. Auckland DHB has a strong commitment to strengthening clinical quality, systems and processes , and the infrastructure thereof to enable a timely and quality patient journey for all patients / consumers who interact with our wide range of services.

This requires collaboration across the range of providers our services work with, inclusive of the 20 other DHBs and collectively with: DHBNZ, Ministry of Health, other funders, professional organisations and representative agencies, indeed the whole health sector.

Currently Auckland DHB actively supports a range of national and regional projects, inclusive of those listed below in the outputs table.</td></tr>
<tr><td colspan="2">Auckland DHB has proven over the past two years that given good planning and rostering, it is capable of quite extraordinary production levels, which must be taken into consideration when the sector considers expansion, particularly in the region.

Over 50% of Auckland DHB services are provided to people outside our DHB population. This presents a major funding issue for us in relation to inter-district flow (IDF) prices and tertiary adjuster payments. We have been a very active member of the national pricing project, which is tasked with recommending inter-district flow (IDF) prices and tertiary adjuster payments.

A major funding issue remains for us around inter district flows. No data envelopment analysis adjuster is applied to population-based formula funding, which means inter district flow providers are cross-subsidising inter-district flow payers. This costs between $6 - $7 million per annum.

It is critical to Auckland DHB to get these funding issues sorted as these fundamentals cannot be allowed to negatively influence the commitment of Auckland DHB clinicians and management to provision of a quality journey for all patients / consumers who come into the organisation. This commitment extends to providing expertise, input and leadership as required to develop knowledge and skill across the sector, thus contributing to enhancement of the consistency of quality for the patient journey across the region and across New Zealand.</td></tr>
</table>

<table>
<tr><th>Medium-term outcomes</th><th>Actual 2006/07</th><th>Target 2008/09</th><th>Target 2009/10</th><th>Target 2010/11</th><th>National & Auckland DHB Outcomes</th></tr>
<tr><td>Auckland DHB uses its strengths to add value to national and regional developments</td><td>Nationally & Regionally reported</td><td>Nationally & Regionally reported</td><td>Nationally & Regionally reported</td><td>Nationally & Regionally reported</td><td rowspan="3">Auckland DHB is committed to:
• The greatest possible health gain for its population
• The most efficient and effective use of health resources
• Equitable and appropriate access to provided & funded health services
• Robust forum for long-term planning of health services at regional and national levels</td></tr>
<tr><td>The Northern Regional Collaboration delivers according to its action plan</td><td>Nationally & Regionally reported</td><td>Nationally & Regionally reported</td><td>Nationally & Regionally reported</td><td>Nationally & Regionally reported</td></tr>
<tr><td>Auckland DHB maintains its contracted service delivery targets</td><td>As per DHB Contract Reporting</td><td>As per DHB Contract Reporting</td><td>As per DHB Contract Reporting</td><td>As per DHB Contract Reporting</td></tr>
</table>

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Auckland DHB is committed to health outcome, process and system efficiencies and effectiveness. In addition to its contracted work Auckland DHB governance, management, clinical leaders and specialists give their expertise, time and effort to a range of national and regional quality improvement projects, inclusive of the following lists.			
National Projects Auckland DHB is actively involved with			
National pricing projects	-	Reported progress in line with annual project objectives	Funding
Quality Improvement Programme, Auckland DHB directly involved in 5 projects:	-	Report on progress	Provider and funder
Management of health care incidents	-	Report on progress	
National mortality review	-	Report on progress	
Safe medicines management	-	Report on progress	
Infection prevention and control	MoH targets met	Report on progress	
Midwifery models of care	New project 07/08	Report on progress	Provider and funder
Ways to manage the introduction and impact of new technologies	-	Report on progress	Provider arm
National Health Emergency Plan (under construction)	Plan due 08/09	Report on progress	Governance and provider arm
National Health Emergency Plan for infectious diseases (Pandemic Planning)	MoH target met-	Report on progress	Governance and provider arm
Northern Regional Collaboration Projects			
Employee Relations and Multi Employer Collective Agreements (MECA) *'one-voice'* project	-	Progress in line with timelines included in CEO endorsed regional services planning workplan	Provider arm
Regional Funding Forum	-	Progress in line with key deliverables in 0809 operational plan	
Regional Recruitment Strategy Project	-	Progress in line with key deliverables in 0809 operational plan	Provider arm

2008/09 priority outputs toward medium-term outcomes	Actual 2006/07	Target 2008/09	Output class
Northern Cancer Network	Planned 07/08	Progress in line with key deliverables in 0809 operational plan	Funder
Regional Service Reviews Underway / Planned:	-	Progress against workplan	Provider arm
• Renal	Planned 07/08	Regionally reported	Provider arm
• Plastics and Reconstructive Surgery	Planned 07/08	Regionally reported	Provider arm
• Opthalmology	Planned 07/08	Regionally reported	Provider arm
• Chronic Pain Services (TARPS)	Planned 07/08	Regionally reported	Provider arm
• Sexual Health	Planned 07/08	Regionally reported	Provider arm
• Major Trauma	Planned 08/09	Regionally reported	Provider arm
• Urology	Planned 08/09	Regionally reported	Provider arm
• Oral Health	Planned 08/09	Regionally reported	Provider arm
• ORL / Head and Neck	Planned 08/09	Regionally reported	Provider arm
• Vascular	Planned 08/09	Regionally reported	Provider arm
• Interventional Radiology	Planned 08/09	Regionally reported	Provider arm
• Mental Health (initial review and additional projects)	Planned 08/09	Regionally reported	Provider arm

6. Managing our Financial Resources

6.1 Population-Based Funding

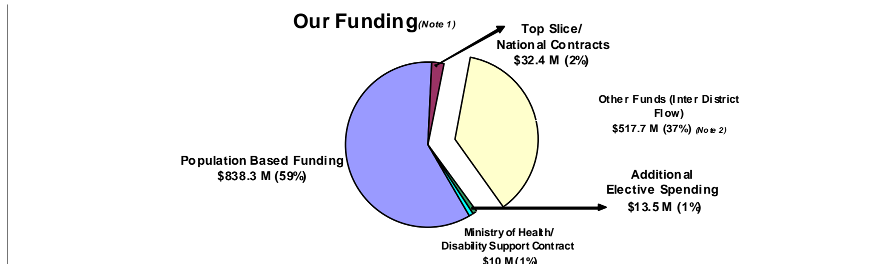
The district-wide allocation of the funding envelope is as follows. The funding available to Auckland District Health Board is calculated each year on a population-based funding formula.

Funding envelope allocation	Proportion of the funding	
	Auckland DHB provider	NGOs
Personal health	62.5	
Additional electives	0.5	
Pharmaceuticals		7.2
Laboratory		1.8
Primary health organisations (PHOs)		5.5
Mental health	6.6	2.2
Health of older people/residential care and home support	2.2	7.7
Other	1.6	2.2
Total	73.4	26.6
Funding envelope ($1.232 million)	100%	

Comparison of funding 2007–08 to 2008–09

	2007–08	2008–09	Percentage funding change 2008–09
Population-based funding	$782 million	$836 million	+4.1%
Top slice/national contracts	$26 million	$35 million	+0.7%
Additional elective spending	$11 million	$14 million	+1%
Other funds (inter-district flows)	$414 million	$426 million	+0.2%
Total	$1,232 million	$1,310 million	

Outline of 2008–09 funding



Our Allocation Across the Auckland District *(Note 4)*

IDF Outflow $91.6 M

NGOs $433.6 M

DHB Hospital and Specialist Providers $887 M

Hospital and Specialist Services With Mental Health

IDF's and Other $421.3 M (47%)

Auckland DHB Provider $465.7 M (53%)

NGO Funding *(Note 3)*

Auckland NGOs $318.9 M (74%)

IDF NGOs $114.7 M (26%)

NGOs

Maori and Other Services $0.1 M (0%)

Home Support $24.4 M (7.7%)

Mental Health $21.9 M (6.9%)

GP/PHOs $61.1 M (19.2%)

Residential Ca $67.9 M (21.3

Pharmaceuticals $77.7 M (24.3%)

Other Services $32 M (10%)

Community and Support $15.6 M (4.9%)

Laboratory $18.2 M (5.7%)

Hospital and Specialist Services for ADHB Population By ADHB

Women Health $33.9 M (7.3%)

Adult Health $274.2 M (58.9%)

Tertiary and Other Adjuster $14.2 M (3%)

Operations $7.3 M (1.6%)

Child Health $51.4 M (11%)

Ambulatory Services $12.9 M (2.8%)

Mental Health $71.8 M (15.4%)

Hospital and Specialist IDF and Other Services for Other Populations Provided By ADHB

Womens Health $19.2 M (4.5%)

National Contracts and Other $24.2 M (5.7%)

Tertiary and Other Adjuster $50.6 M (12%)

Operations $12 M (2.9%)

Adult Health $203.8 M (48.4%)

Child Health $85.5 M (20.3%)

Mental Health $11.3 M (2.7%)

Ambulatory Services $14.6 M (3.5%)

Note:

1. This is based on 12 December 2007 MoH advice; and excludes any other funding through Crown Funding Agreements for supplementary services (e.g. regional public health).

2. This figure includes community based, non-DHB services.

3. Services are also purchased from various non-direct regional providers (e.g. Pacific Health Centre).

6.2 Financial Management

Auckland DHB has continued along the path started with the introduction of service reviews which were used to identify, by service, the steps needed to bring Auckland DHB back into a more stable and predictable financial position. These service reviews have evolved into a "business as usual" annual Service Plan which focuses on revenue streams, labour costs and direct treatment costs, relevant to what the Auckland DHB funder and other DHBs contract to purchase.

A key feature of these service plans and reporting against them, is that revenue is paid, on national prices, for actual volumes produced each month. There are no top-ups, thus each service is essentially "in business".

Productivity measurement and performance against production plans (based on contracted volumes) are now two key activities. It would be fair to say that the recent gains in Auckland DHB have, along with pricing gains, come from improvements in productivity with the growing volumes contracted being produced with a less than proportionate increase in staff numbers.

Auckland DHB has proven over two years that given good planning and rostering, it is capable of quite extraordinary production levels, which must be taken into account when the sector considers capital expansion, particularly in the region.

Growth and inter-district flows

For the first time since the new hospital has been completed, volumes as per the Funding Envelope, have not been budgeted to increase in 2008–09. The growth from Auckland DHB population demographics has been largely offset by reductions in inter-district flow work. Growth is estimated to be less than 1%.

This has important implications as previously, growing production while holding staff increases to a minimum has been a key feature of Auckland DHB's improving performance. The importance of growth and being able to produce at a margin cannot be underestimated in an environment where the cost structure is fixed at very high levels and the key resources (skilled medical and nursing staff) are not easily increased or decreased. Bringing on additional theatre capacity, surgeons and theatre staff, is not done quickly. Equally, downsizing scarce national resources is not easily recommended. The key is very strong regional collaboration in governance, service planning and capital expenditure developments.

Salary increases from national agreements (MECAs)

The settlements early in the 2007–08 year largely settled within agreed future funding track (FFT) constrained guidelines.

The nurses' settlement however, and probably the PSA settlement, were considerably in excess of FFT, both for 2007–08 and 2008–09. The resident medical officers and senior medical officer multi-employer agreements (MECAs) are currently being accrued at higher than FFT levels, but this may well prove to be too low.

It appears that, on current information, the full cost of most of the MECAs will be 2% ahead of FFT. This is approximately a $12 million unfunded cost to Auckland DHB.

Every effort is being made to offset this with procurement gains, but this has to be in the context that our direct treatment costs are in total $120 million and a 10% saving is not practical.

The affordability of these increases will therefore lie with the services and staff groups to achieve, on a service by service level, productivity gains of at least 1%. This will be a challenge, particularly within the constraints of MECA staffing rules and professional association staffing rules. However Auckland DHB, through volume growth has achieved productivity gains of 1% per annum. Without revenue growth, the trend can easily swing to a loss of productivity.

National pricing

Auckland DHB has been a very active member of the national pricing project, which is tasked with recommending inter-district flow (IDF) prices and tertiary adjuster payments.

Auckland DHB is pleased with the increasing transparency and progress made each year, but there is still some way to go, particularly in identifying what constitutes a tertiary service and how this should be reimbursed to cover both capacity and capability issues.

The second major issue Auckland DHB has is the application of a data envelopment analysis adjuster to the nationally derived average prices. This effectively ensures that inter-district flow payers receive a discount from the average price. This is largely historical and has no relevance to today's governance regime of 21 DHBs which are population-based formula funded. There is no data envelopment analysis adjuster applied to population-based formula funding, thus IDF providers are cross-subsidising inter-district flow payers. This is costing Auckland DHB between $6 million and $7 million per annum.

It was requested that this be removed in 2008–09, but it appears that the combined CEOs have deferred this correction until 2009–10.

The third major issue with the inter-district flow price process is that it lags too far behind the impact of real cost increases.

The impact of the nurses' MECA will not begin to feed into national prices until 2009–10. The cost increases were (backdated) effective January 2007 and again, inter-district flow providers are effectively cross-subsidising inter-district flow payers through until 1 July 2009.

The inter-district flow prices can be easily uplifted for such increases in a timely manner. The real impediment is that the CEO's group, that on one hand approves an above average future funding track MECA settlement by a majority vote, can equally vote not to uplift the inter-district flow prices to at least compensate for the increase they, by a majority vote, approved. The approvers thus award themselves a deferment, through restraining inter-district flow prices of these settlements for 1½ years in the case of the nurses, resident medical officers, senior medical officers and PSA increases.

This is being challenged at a CEO/DHBNZ level, but the Ministry of Health needs to show leadership also as, in the attempt to have all DHBs break even, such inequitable pricing ensures that the impact of wage jolts becomes evident in the financials of the major inter-district flow providers at least a year ahead of all other DHBs. It disconnects the responsibility for approving settlements and the paying for them. The impact of this on Auckland DHB is a shortfall of $6 - $7 million per annum.

National service funding

The now-named "Tier II" pricing, predominantly for paediatric services, was completed successfully and has been carried forward from 2006–07 into 2007–08 and 2008–09. Auckland DHB has established an effective clinical costing system and is eager to use its experts to further enhance these capabilities and provide continued leadership in this area in the coming year.

There is some remaining work to do on service specifications.

Long Term Sector Planning is a focus for Auckland DHB. Population growth and distribution, population health needs and patterns of disease, clinical and technological developments, available workforce and funding all influence demand for and supply of health services. These factors are key drivers for Auckland DHB's Long Term Sector Planning, a critical exercise that requires two parallel and collaborative strands of work.

One strand will focus on the requirements for the Auckland DHB population. This will be based on population health needs analysis, ongoing development of models of care informed by research and technology advances, and health workforce planning and projections. The deliverable will be a forecast of what and how the DHB can deliver its continuum of care over the next 10 – 20 years.

The other strand requires the three Auckland region DHBs and Northland DHB to take a regional perspective to determine: the best utilisation of health funding, the best clinical outcomes for the population, and the required models of care. The four DHBs need to reach common understanding about their respective 20 year service and asset requirements, and their respective intra district funding expenditure and repatriations thereof.

These two strands of work will inform Auckland DHB's short, medium, and long term plans for facilities, infrastructure and the range of required enablers such as Information Technology.

The success of this paves the way for this approach to be followed for all tertiary adjuster work, as it relies on a clear definition of services rather than a "self-nominated" mechanism applied to cost differentials.

There is, however, a growing concern at a recent trend for new service technologies to be granted approval by the National Service and Technology Review Group with funding being recommended to be taken from already established national funding pools.

Certainly for Auckland DHB to be close to break-even based on current pricing and funding mechanisms, to have additional costs, no matter how valid, added in on the basis that a "national" cost pool exists, only leads down an inevitable path of costs exceeding funding. The national pool, and the purpose of each, needs clearer definition and the funding of the technologies needs to be established and agreed upon by the sector and DHB of service, rather than a simple recommendation of applying

the costs to a national pool. It again avoids the responsibility of the "approved" funding, cost increases.

Revaluation

Background

Auckland DHB is required to prepare its financial statements in accordance with International Finance Reporting Standards, applied to New Zealand.

One of these standards – Financial Reporting Standard 3 – requires reporting entities to revalue fixed assets to a 'fair value' periodically. Previously the Board has resolved that for certain land owned by the Board, a 'fair value' valuation is not appropriate because of restrictions on the subsequent use by new owner. These restrictions reduce the potential sale proceeds and make the valuation methodology of 'fair value' inappropriate.

Auckland DHB's annual accounts have been "qualified" in successive years, based on Ernst & Young's view on one of the pieces of legal advice pertaining to the ability of the Board to sell land at full commercial value, i.e. the land was used for its maximum reasonable value (probably mixed commercial).

Auckland DHB, for the purposes of the District Annual Plan, has revalued because the funding envelope has included revenue uplifts and to exclude this given the timetable was impractical.

The issue has been to the Board and it is recommended that no revaluation be undertaken for those assets which the Board had previously decided, based on legal advice, were not able to be sold readily for full commercial value.

Comment

Nothing has changed since the original advice was given and accepted, other than to note that following the recent experience in selling a surplus piece of land, with a residence of historic interest on it, the full significance of the (a) special zoning conferred on all Auckland DHB land by the Auckland City Council, and (b) the new sensitive land process has become very apparent.

To be utilised as commercial land, the underlying zoning must be changed. Crown Health Finance is currently working through this process with one piece of land previously declared surplus and the hurdles are formidable, with the process by no means certain. This is controlled by the Auckland City Council District Plan.

The new sensitive land process raises the threshold on selling public land considerably, and it could not categorically be said that a government will readily now approve the sale of a large and visible part of the Greenlane Hospital site into private hands.

Flow-on effects

While not directly related to the question of valuation, the implications of the national pricing and funding mechanism has an impact on Auckland DHB's accounts following a full revaluation.

Essentially the Ministry will cover the costs by way of a special top up for the 2008–09 year ($8 million), but will not and indeed cannot, because of its annual Vote Health mechanism, guarantee payment of this top-up for 2009–10 and 2010–11 (an oddity of the annual Vote Health system versus three-year District Annual Plan process).

The full revaluation will push Auckland DHB's property holding costs well beyond the average New Zealand/DHB cost structure on which funding is devolved to DHBs. Thus Auckland DHB, following 2008–09 will incur a $20 million cost for which there is only certainty of $12 million income through the national pricing and funding regime into the future.

The Board is required to sign off on a three-year District Annual Plan, in which two years will have significant costs with no certain funding streams.

In is considered preferable to face the public, Auditor General and profession with clearly tagged accounts, alerting the reader to an issue, which for creditors, bankers and rating agencies is of little consequence, rather than sign off on a forecast of future performance knowing that a large liability (capital charges) has no certain funding stream. The results, in the context of a possible break-even, could be deemed misleading.

The rationale for revaluing such land as hospital land to commercial values is rooted in Accountancy Standards IFRS, which the Auditor General recently publicly questioned in the Accounting Journal.

It is our view that the Ministry has no clear rationale as to why it insists on revaluations of land, nor has it thought through deeply enough, the implications in incorporating them into its pricing / funding model.

Auckland is a significant influence in the models, the impact of including such costs from Auckland lifts the overall health cost structure (and in doing so, lifts the health of no-one), ironically ensuring that Southland or West Coast will pay more in inter-district flow prices to Otago and Canterbury, while at the same time driving Auckland towards a deepening mismatch between revenue and costs, leading it once again into the infamous "outlier" status in cost per unit of output, compared to the average.

Property is revalued for many reasons, to advise investors, lenders, core shareholders, etc, of the value of their asset and ensuring a fair reward is paid for the inherent risks of the investment or loans to finance those assets.

The yield from the assets, revalued, is intrinsic – yield determines value in the long run. There is no opportunity for Auckland to derive a true market income for its revalued assets – it simply receives the New Zealand average cost structure (cost = price in the sector).

The sector is caught between market driven accountancy rules and public-good service delivery. It needs to complete the move from the previous market model to a pure public sector cost = price model, without regard to yields and other private sector drivers (risk and return, etc) on such assets as land.

Auckland, being the only DHB "in business", with significant customers other than its own population, is caught in the worst of both worlds at present.

There might be some logic to revaluing if:

1. the Auckland region operated as one unit
2. all land/buildings were aggregated and considered available for sale, if surplus to joint regional needs
3. inter-district flow prices were based on market values of land, thus leading to rational "investment" decisions on where to build and so derive the maximum yields.

The public health sector, quite pragmatically, is not really about absolute yields, but is about public good, with other measures of outputs, health gains, etc to determine success. The break-even target is one part of this. Signing a forecast in this environment, without certainty of income, is a serious issue. Standard & Poors are interested in our net cash flows, not the value of land which they know will, for the vast majority of the next 50 years, be delivering public-good health services.

6.3 Major Assumptions and Risks

1. We have assumed that additional electives funding, spread across a range of services, where we have capacity, of $10 million will be provided, in addition to the funding envelope issued in December. This is an important assumption, as without revenue growth Auckland DHB is unable to hold the "status quo" in terms of cost structures with wage inflation outstripping the future funding track. Growth, with our ability to produce at, in some areas, marginal cost, delivers an improved financial result while delivering a significant benefit to taxpayers and patients.

2. We have assumed a lift in inter-district flow (IDF) prices of $6–$7 million to compensate Auckland DHB for the failure of the IDF prices, based on uplifted 2005–06 costs, to properly reflect the significant labour cost increases in excess of future funding track that the sector agreed to. Auckland DHB only agreed to such increases contingent on IDF prices being adjusted effective 1 July 2007 to compensate IDF providers who are otherwise cross-subsidising the rest of the sector from their local PBF funding.

3. Revaluation and the 2009–10 and 2010–11 outyears: We have, for the basis of 2008–09 Plan, assumed a further revaluation based on a desktop analysis of $222 million at June 2007, at a depreciation and interest cost of $20 million. We note this is funded via the population-based formula, $12 million and a top-up of $8 million, for 2008–09.

   Subject to discussions with our Auditors and the Office of the Auditor General, we believe this will be sufficient to avoid the accounts being tagged for June 2008, with increases in value to June 2008 being below a 10% materiality threshold.

   A full revaluation is required by June 2010 adding a further estimated $218 million in value. A revenue stream of $8 million has been assumed for 2009–10 and a further revenue stream of $29 million assumed for 2010–11. <u>Note that we have now labelled the outyears as estimates.</u> They are indicative only while the Ministry of Health cannot, through the Vote Health process, commit to outyear projections other than on an indicative / estimated basis and Auckland DHB's funding is from, ultimately, Vote Health.

We believe that rather than enter into a discourse about how such matters as revaluations should be handled and funded, it is better to show readers, on an indicative basis, the impacts of complying with legislation and the consequent funding streams that may be required, in the future, for planning purposes from Vote Health.

The assumption that must be made by the reader is that it will be very difficult for the Auckland DHB to break even should it revalue without separate funding.

4. Blueprint money not in the funding envelope, of $2.6 million, has been assumed as Ministry of Health income for 2008–09.

5. Co-payments on non NHI issued prescriptions will be reduced from $15 to $3 saving $1 million.

6. Co-payments for after hours clinics will be reduced by $1 million (see section on issues, risks and mitigation).

7. The laboratories contract will have an increase commensurate with FFT effective 1 January 2009.

8. Health of older people – A23 additional costs have been assumed to settle at FFT as included in the A21 review. If this is not the case, there is an indicative risk of $5 million.

9. Health of older people – It is assumed the A21 annual review settles for FFT.

10. The senior medical officers and resident medical officer wage settlements have been assumed to settle at the last published offers to the respective unions (since rejected). The amounts accrued to date have been based on these offers. Should (as is becoming more likely) they settle for more than the CEO-mandated offers, then Auckland DHB will require additional Ministry of Health and IDF revenues to maintain a close to break-even position.

    <u>This is a very high risk for the Auckland DHB and sector</u> as, with Auckland DHB employing 20% of the sector's senior medical officers, many on higher steps, the impact will be for every 1% above the current offer, approximately $2 million per annum in additional costs to Auckland DHB, plus the accrual impact on outstanding leave balances.

11. The value-for-money procurement savings realised will offset cost increases in power, gas, petrol, water, ACC (residual levies), food, dairy products and building costs that are in excess of "inflation". Auckland DHB is confident of this, having a good track record of holding direct and indirect treatment costs at a fixed percentage of income over several years.

12. The full FFT of 3.298% is assumed as being received in its entirety for the full year.

13. Nurses' MECA – the increase in leave, sick leave, study leave, discretionary leave and long service leave, is estimated to require an extra 120 staff to cover existing rostering requirements. Management is committed through the Partnership Agreement process to absorbing this $8.4 million cost through productivity gains. We have further assumed that on top of the basic MECA increase, that the creep in rates will be limited to a very low 1%.

14. Ringfenced electives – it is assumed that all ringfenced Ministry of Health elective work is delivered and paid for, both for Auckland DHB and IDF population work, and that reasonable

advice of funding increases is given to enable to gear up to deliver such volumes, with respect to staff and facilities.

15. All funding (population-based and inter-district flows) is received in advance as with other DHBs.

16. Inter-district flow prices/tertiary adjusters for 2009–10 are no lower than 2008–09 in aggregate after allowing for reasonable FFT uplifts.

17. Pharmaceutical cancer treatment drug cost exercise leaves Auckland DHB in a no worse position than as at December 2007 funding advice. This is uncertain, as with all the pricing and PCT changes we appear to be missing $2–$3 million in the price volume schedule and further reductions re WIES calculations have been mooted. There is too much uncertainty in the cancer price volume schedule. The uplift for PCT pricing, received in December 2007, is difficult to trace through the various WIES / pricing adjustments made in national pricing and requires further investigation.

18. KiwiSaver contributions (including 2% for nursing) are fully funded by Inland Revenue.

19. Future revenue streams – as noted, Auckland DHB is susceptible, favourably, to upswings in revenues and, unfavourably, to decreases in revenue. Given the cost increases in the health sector, flexible MECA arrangements to deliver productivity gains and continuing volume growth are important to Auckland DHB to cover any cost growth in excess of FFT.

    There is no certainty regarding outyear Ministry of Health funding. Several large MECAs are unsettled and national pricing structures continue to evolve. There is growing evidence that IDF suppliers, in embarking on both cost saving (insourcing) and building programmes, will repatriate volumes which could significantly impact Auckland DHB's financial position. It appears, at current volumes, that Auckland DHB's largely fixed, in the near term, cost structure, is relatively well balanced to deliver at marginal cost, but will lose, at full cost per unit, if volumes decrease in the near term.

    These outyears must be treated as best endeavours estimates only and are presented only on this basis by Auckland DHB's Board and management.

6.4 The Financial Plan 2008–09

Table 1: Statement of financial performance

	2006–07 Actual $000	2007–08 Forecast $000	2008–09 Plan $000	2009–10 Estimate $000	2010–11 Estimate $000
REVENUE					
Base funding					
Population based	789,459	820,340	884,054	915,880	953,431
Inter-district flows	429,343	500,280	515,851	534,421	556,333
Adjustments to base funding					
Inter-district flows – additional price allowance	–	–	6,150	6,371	6,633
Asset revaluation	19,641	–	–	–	29,192
	1,238,443	1,320,620	1,406,055	1,456,762	1,545,589
Side contracts with Ministry of Health					
Additional electives	7,031	8,275	17,711	18,348	19,100
Public health	15,080	15,782	15,771	16,339	17,009
Other side contracts	33,846	21,503	25,079	25,982	27,047
	55,957	45,560	58,561	60,669	63,156
Other revenue					
Other patient care	33,343	32,202	37,211	38,551	40,131
External	75,928	83,104	98,603	92,428	94,884
	109,271	115,306	135,814	130,979	135,015
TOTAL REVENUE	**1,403,671**	**1,481,486**	**1,600,430**	**1,648,320**	**1,743,760**
OPERATING COSTS					
Employee costs	594,322	622,975	674,379	704,726	736,438
Treatment costs	203,399	212,268	228,772	237,008	246,725
Funder payments	471,069	490,047	517,202	535,821	557,790
Property and equipment maintenance	49,116	50,649	52,861	54,725	56,969
Administration	16,446	18,362	20,969	21,724	22,615
TOTAL OPERATING COSTS	1,334,352	1,394,301	1,494,183	1,554,004	1,620,537
SECTOR ISSUES				13,175	9,600
OPERATING SURPLUS/(DEFICIT)	69,319	87,185	106,247	107,491	132,823
NON-OPERATING COSTS					
Depreciation	44,307	44,460	47,840	52,142	61,849
Interest	19,899	22,427	21,168	19,906	18,323
Capital charge	21,559	20,272	37,239	35,400	52,600
TOTAL NON-OPERATING COSTS	85,765	87,159	106,247	107,448	132,772
NET SURPLUS/(DEFICIT) FOR YEAR	(16,446)	26	(0)	43	51
OTHER CONTRIBUTIONS					
Surplus on sale of assets	2,138	–	–	–	–
	2,138	–	–	–	–
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	**(14,308)**	**26**	**(0)**	**43**	**51**

Table 2: Statement of financial performance by output class

	2006–07 Actual $000	2007–08 Forecast $000	2008–09 Plan $000	2009–10 Estimate $000	2010–11 Estimate $000
Governance					
Total Revenue	2,920	2,997	3,336	3,456	3,598
Employee costs	(4,419)	(5,190)	(6,948)	(7,260)	(7,588)
Other operating costs	(3,600)	(5,326)	(4,401)	(4,497)	(4,652)
Operating costs	(8,019)	(10,516)	(11,349)	(11,757)	(12,240)
Operating margin	(5,099)	(7,519)	(8,013)	(8,301)	(8,642)
Non-operating costs					
Depreciation, interest and capital charge	(15)	(14)	(10)	(10)	(10)
Net surplus/(deficit) – governance	(5,114)	(7,533)	(8,023)	(8,311)	(8,652)
Provider					
Total Revenue	888,989	974,360	1,053,366	1,081,563	1,153,765
Employee costs	(589,903)	(617,785)	(667,431)	(697,466)	(728,852)
Sector issues				13,175	9,600
Treatment costs	(201,278)	(212,132)	(228,645)	(236,876)	(246,588)
Property and equipment maintenance	(48,387)	(49,899)	(52,069)	(53,943)	(56,155)
Administration	(11,555)	(11,978)	(15,349)	(15,925)	(16,607)
Operating costs	(851,123)	(891,794)	(963,494)	(991,035)	(1,038,602)
Operating margin	37,866	82,566	89,872	90,528	115,163
Non-operating costs					
Depreciation, interest and capital charge	(85,750)	(87,145)	(106,236)	(107,438)	(132,762)
Surplus on sale of land	2,138	–	–	–	–
Net surplus/(deficit) – provider	**(45,746)**	**(4,579)**	**(16,364)**	**(16,910)**	**(17,598)**
Funder					
Total Revenue	511,762	504,129	543,727	563,301	586,397
Funder payments					
Personal health	(281,936)	(288,962)	(312,001)	(323,233)	(336,486)
Medical/surgical	(36,319)	(45,970)	(47,173)	(48,871)	(50,875)
Mental health	(56,597)	(47,872)	(46,278)	(47,944)	(49,910)
Disability support	(97,688)	(108,709)	(113,773)	(117,869)	(122,701)
For Maori by Maori	(2,670)	(478)	(115)	(119)	(124)
Operating costs	(475,210)	(491,991)	(519,340)	(538,036)	(560,096)
Operating margin	36,552	12,138	24,387	25,265	26,301
Net surplus/(deficit) – funder	**36,552**	**12,138**	**24,387**	**25,265**	**26,301**
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	**(14,308)**	**26**	**(0)**	**43**	**51**

Table 3: Employee costs and FTE

	2006–07 Actual $000	2007–08 Forecast $000	2008–09 Plan $000	2009–10 Estimate $000	2010–11 Estimate $000
Medical	174,357	182,363	202,321	211,425	220,939
Nursing	196,697	209,407	221,777	231,757	242,186
Technical	96,965	103,594	114,332	119,477	124,854
Hotel services	9,049	9,147	10,324	10,788	11,274
Administration and stores	84,355	89,453	95,281	99,569	104,049
	561,423	593,964	644,035	673,016	703,302
% increase over prior year	9.5%	5.8%	8.4%	4.5%	4.5%
Other employee-related expenses	32,899	29,011	36,817	38,474	40,206
% increase over prior year	4.9%	(11.8)%	26.9%	4.5%	4.5%
Auckland DHB issues – savings required	–	–	(6,474)	(6,766)	(7,069)
	32,899	29,011	30,344	31,710	33,136
	594,322	**622,975**	**674,379**	**704,726**	**736,438**
% increase over prior year		4.8%	8.3%	4.5%	4.5%

FTE measurement basis	Accrued FTE	Accrued FTE	Accrued FTE	Accrued FTE	Accrued FTE
Average FTE numbers FY 30 June – including additional MH FTE	7,680	7,762	8,074	8,120	8,213
Average salary	$73,102	$76,522	$79,767	$82,884	$85,630
% increase	7.4%	4.7%	4.2%	3.9%	3.3%

Table 4: Statement of financial position

	2006–07 Actual $000	2007–08 Forecast $000	2008–09 Plan $000	2009–10 Estimate $000	2010–11 Estimate $000
ASSETS					
Current assets					
Cash, bank balances and investment bonds	–	48,756	18,615	19,748	32,523
Restricted trust funds	10,981	12,341	12,341	12,341	12,341
Receivables and prepayments	125,703	78,777	48,508	49,511	50,730
Inventories	10,407	10,046	10,481	10,858	11,304
Property intended for resale	78	76	-	-	-
	147,169	149,996	89,945	92,458	106,898
Non-current assets					
Restricted trust funds	6,000	6,000	6,000	6,000	6,000
Property, plant and equipment	668,526	881,858	891,910	1,099,726	1,087,838
Intangible assets	9,898	11,156	12,164	13,014	14,053
Derivatives in gain	21	925	925	925	925
Investment in associates	332	327	327	327	327
	684,777	900,266	911,326	1,119,992	1,109,143
TOTAL ASSETS	831,946	1,050,262	1,001,271	1,212,450	1,216,041
LIABILITIES					
Current liabilities					
Bank overdraft	3,351	-	-	-	-
Payables and accruals	222,939	233,286	227,715	233,721	246,829
Borrowings	15,793	17,617	15,372	15,154	14,802
Funds held in trust	910	965	1,037	1,109	1,181
Derivatives in loss	427	–	-	-	-
	243,420	251,868	244,124	249,984	262,812
Non-current liabilities					
Payables and accruals	20,938	20,938	22,937	23,694	24,665
Borrowings	292,711	280,401	272,148	261,864	251,580
	313,649	301,339	295,085	285,558	276,245
TOTAL LIABILITIES	557,069	553,207	539,209	535,542	539,057
EQUITY					
General funds					
Opening balance	177,887	129,187	129,319	94,319	94,362
Net surplus/(deficit)	(14,308)	26	(0)	43	51
Capital contributions	608	106	-	-	-
Capital withdrawals	(35,000)	–	(35,000)	-	-
Closing balance	129,187	129,319	94,319	94,362	94,413
Revaluation reserve					
Opening balance	145,267	145,267	367,736	367,736	582,543
Movement in revaluation reserve					-
– Land	–	188,105	-	13,000	-
– Buildings	–	34,364	-	201,807	-
Total movement in revaluation reserve	–	222,469	-	214,807	-
Closing balance	145,267	367,736	367,736	582,543	582,543
Cash flow hedge reserve					
Opening balance	3,109	423	-	7	3
Profit on sale of financial instruments	1,312				
Revaluation of financial instruments	(3,998)	(423)	7	(4)	25

	2006–07 Actual $000	2007–08 Forecast $000	2008–09 Plan $000	2009–10 Estimate $000	2010–11 Estimate $000
Closing balance	423	–	7	3	28
TOTAL EQUITY	274,877	497,055	462,062	676,908	676,984
NET ASSETS	831,946	1,050,262	1,001,271	1,212,450	1,216,041

Table 5: Statement of cash flows

	2006–07 Actual $000	2007–08 Forecast $000	2008–09 Plan $000	2009–10 Estimate $000	2010–11 Estimate $000
CASH FLOWS FROM OPERATING ACTIVITIES					
Cash was provided from					
Provision of health services	1,395,051	1,472,868	1,579,767	1,634,729	1,730,855
Repayment of debtors by the Crown	–	41,931	36,957	-	-
Interest received	4,061	10,780	13,311	11,911	11,188
	1,399,112	1,525,579	1,630,035	1,646,640	1,742,043
Cash was applied to					
Employee costs	(553,407)	(611,291)	(682,847)	(687,467)	(716,505)
Other operating costs	(795,120)	(789,631)	(851,882)	(881,700)	(932,901)
Interest paid	(17,865)	(24,167)	(21,158)	(19,912)	(18,434)
	(1,366,392)	(1,425,089)	(1,555,887)	(1,589,079)	(1,667,840)
Net cash flow from operating activities	**32,720**	**100,490**	**74,148**	**57,561**	**74,203**
INVESTING ACTIVITIES					
Cash provided from					
Proceeds from sale of fixed assets	2,527	(39)	39	-	-
Proceeds from sale of financial instruments	3,032				
Decrease/(increase) in restricted trust funds	(6,895)	(1,300)	72	72	72
	(1,336)	(1,339)	111	72	72
Cash was applied to					
Purchase of fixed assets and intangibles	(23,717)	(36,650)	(58,900)	(46,000)	(51,000)
Net cash (outflow) from investing activities	**(25,053)**	**(37,989)**	**(58,789)**	**(45,928)**	**(50,928)**
FINANCING ACTIVITIES					
Proceeds from capital raised/(repaid)	(34,392)	106	(35,000)	-	-
Proceeds from loans raised/(repaid)	34,500	(10,500)	(10,500)	(10,500)	(10,500)
Net cash (outflow) from financing activities	**108**	**(10,394)**	**(45,500)**	**(10,500)**	**(10,500)**
OPENING BANK BALANCE	**(11,126)**	**(3,351)**	**48,756**	**18,615**	**19,749**
NET CASH INFLOW/(OUTFLOW)	**7,775**	**52,107**	**(30,141)**	**1,133**	**12,775**
CLOSING BALANCE	**(3,351)**	**48,756**	**18,615**	**19,749**	**32,523**

Reconciliation of operating deficit with cash flows from operating activities	2006–07 Actual $000	2007–08 Forecast $000	2008–09 Plan $000	2009–10 Estimate $000	2010–11 Estimate $000
Total surplus/(deficit) for the year	(14,308)	26	(0)	43	51
Non-cash items					
Depreciation and impairment losses	44,307	44,460	47,840	52,141	61,849
Amortisation of borrowing costs	204	221	216	216	216
	44,511	44,681	48,056	52,357	62,065

Items classified as investing activities					
Gain on sale of property, plant and equipment	(2,138)	110	37	-	-
Items traded through cash flow hedge reserves	32	(1,754)	7	(4)	25
Movement in working capital					
(Increase)/decrease in receivables	(16,035)	46,926	30,269	(1,003)	(1,219)
(Increase)/decrease in inventories	(1,179)	361	(435)	(377)	(445)
(Increase)/decrease in payables	21,837	10,140	(3,786)	6,545	13,726
	4,623	57,427	26,048	5,165	12,062
Net cash flow from operating activities	32,720	100,490	74,148	57,561	74,203

Table 6: Balance sheet equity ratio

	2006–07 Actual $000	2007–08 Forecast $000	2008–09 Plan $000	2009–10 Estimate $000	2010–11 Estimate $000
Equity position					
Crown equity	(264,960)	(487,083)	(452,018)	(666,792)	(666,796)
Trust equity	(9,917)	(9,972)	(10,044)	(10,116)	(10,188)
Total equity	(274,877)	(497,055)	(462,062)	(676,908)	(676,984)
Total debt					
Bank	(3,351)	–	–	–	–
Bonds	(120,000)	(120,000)	(120,000)	(120,000)	(50,000)
Crown funding authority	(184,500)	(174,000)	(163,500)	(153,000)	(212,500)
	(307,851)	(294,000)	(283,500)	(273,000)	(262,500)
Total debt	(307,851)	(294,000)	(283,500)	(273,000)	(262,500)
Total debt + equity	(582,728)	(791,055)	(745,562)	(949,908)	(939,484)
Equity ratio – to be less than 65%	**52.8%**	**37.2%**	**38.0%**	**28.7%**	**27.9%**

6.5 Statement of Accounting Policies

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

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

Basis of preparation

In line with other District Health Boards, Auckland DHB is adopting International Financial Reporting Standards (IFRS). This process is in a transitional phase until the first set of financial reports is completed for the financial year ended 30 June 2008. Accordingly only a complete set of financial statements can provide a fair presentation of the financial position, financial performance and cash

flows of Auckland DHB Group in accordance with New Zealand International Financial Reporting Standards.

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

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

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

Basis for consolidation

Subsidiaries

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

Associates

Associates are those entities in which Auckland DHB has significant influence, but not control, over the financial and operating policies. Auckland DHB has shareholdings in the following associates: Northern Clinical Training Network Limited (40% owned), Northern DHB Support Agency Limited (33% owned), and Treaty Relationship Company Limited (50% owned).

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

Transactions eliminated on consolidation

All inter-entity transactions are eliminated on consolidation.

Foreign currency

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

Property, plant and equipment (PPE)

The major classes of property, plant and equipment	Freehold land Land improvements Plant and equipment Freehold buildings Building fitout and services Leasehold improvements Work in progress Leased plant and equipment
Owned assets	Except for land and buildings (as well as the assets vested from the hospital and health service – see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. 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 2005. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the income statement in which case the increase is recognised in the income statement. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the income statement. Additions to property, plant and equipment between valuations are recorded at cost. Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for separately.
Property, plant and equipment vested from the hospital and health service	Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Auckland Healthcare Services Limited (a hospital and health service) vested in Auckland DHB on 1 January 2001. Accordingly, assets were transferred to Auckland DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.
Disposal of property, plant and equipment	Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the income statement is calculated as the difference between the net sales price and the carrying amount of the asset.
Leased assets	Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at the inception of the lease, less accumulated depreciation and impairment losses. Minimum lease payments are apportioned between the finance

	charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis. Operating lease payments are recorded as an expense in the income statement 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 income statement as an expense as incurred.
Depreciation	Depreciation is charged to the income statement using the straight line method. Land is not depreciated. Depreciation is set at rates that write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows: **Asset class** / **2007–08** / **2006–07** Freehold buildings / 1–89 years / 1–89 years Plant and equipment / 2–20 years / 2–20 years Building fit-out and services / 1–45 years / 1–45 years Leased plant and equipment / 4–8 years / 4–8 years Leasehold improvements / 6–8 years / 6–8 years The residual value, useful life and depreciation method of assets is reassessed annually. Work-in progress is not depreciated. The total cost of a project is transferred to property, plant and equipment on its completion and then depreciated.
Intangible assets	Computer software not an integral part of the related hardware is treated as an intangible asset. Such intangible assets are acquired separately and are capitalised at cost. The useful lives are assessed as finite and amortisation expense is taken to the income statement. Intangible assets are tested for impairment where an indicator of impairment exists. Useful lives and amortisation methods are also examined on an annual basis and adjustments, where applicable, are made on a prospective basis.

Interest-bearing borrowings

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

Derivative financial instruments

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

Trade and other receivables

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

Inventories

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

Cash and cash equivalents

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

Non-current assets classified as held for sale

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

Impairment

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

Calculation of recoverable amount

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

Impairment losses and reversals of impairment losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on items of property, plant and equipment carried at revalued amounts is reversed through the relevant reserve to the extent that the impairment loss was previously recognised directly against any revaluation surplus. All other impairment losses are reversed through the income statement.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Investments

Restricted trust funds are initially recognised at cost, being the fair value of the consideration given. After initial recognition, these investments are classified at fair value through profit and loss and are measured at fair value.

Gains or losses on restricted trust funds are recognised in the income statement.

Employee benefits

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

Provisions

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

Restructuring

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

Revenue recognition

Revenue is recognised to the extent that it is probable that the economic benefits will flow to the Group and the revenue can be reliably measured. The following specific recognition criteria must be met before revenue is recognised.

From 1 July 2003, funding from the Ministry of Health has been made using a population based funding formula. In addition, Ministry of Health may contract for specific specialist treatments or procedures available only at certain facilities. From time to time during the year, Ministry of Health may provide funding for additional treatments. Ministry of Health revenue is recognised on a stage-of-completion basis.

Donations and bequests 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.

Donations and bequests from third party trusts are recognised as revenue only when actually receipted.

Interest income is recognised using the effective interest method.

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

Income tax

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

Goods and Services Tax (GST)

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

Borrowing costs

Borrowing costs are recognised as an expense when incurred.

Statement re other arrangements

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

6.6 Other Provisions

Capital expenditure

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

Surplus land

Surplus land subject to disposal which 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 2008–09 or the outer years.

Key lenders and arrangements

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

Key lenders and applicable covenants

Key tenders	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%