



Auckland District Health Board Statement of Intent 2007-10

18 June 2007

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

The status of this document

This version of 18 June 2007 is the final.

It was approved by the Community and Public Health Advisory Committee on 3 May 2007 and has been reviewed by the Ministry of Health and the Minister of Health.

It was submitted on 19 June 2007 for final approval by the Ministry of Health and the Minister.

For further information on this document please contact Julie Helean 09) 638 0390

Prepared in May 2007 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) please contact:
Julie Helean, jhelean@adhb.govt.nz phone 09 638 0390

Contents

Statement from Auckland DHB Chair and Chief Executive	5
1. Introduction	6
1.1 Legal requirements	6
1.2 The profile of the local population	6
1.3 Priorities for 2007-2010	9
1.4 The strategic framework	10
2. Three Goals	16
2.1 Goal one: Lift the health of people living in Auckland city	16
2.2 Goal two: Performance improvement	20
2.3 Goal three: Live within our means	22
3. The Governance and Management Structure	24
3.1 Governance	24
3.2 The integrated management structure	26
3.3 Implementing the Treaty of Waitangi	27
3.4 Provider arm/hospital services	29
3.5 Risks to achieving goals	34
4. Performance Targets	36
4.1 Health gain targets	36
4.2 Targets for performance improvement	46
4.3 Financial targets	49
5. Financial Information	52
5.1 The funding available	52
5.2 Financial management	54
5.3 Financial tables 2007 -2008	59
5.4 Statement of accounting policies	67
5.5 Other provisions	75

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

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

This is the message from the Auckland District Health Board.

We send greetings to you all.

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

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

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

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

Greetings, greetings, greetings

Statement from Auckland DHB Chair and Chief Executive

This Statement of Intent has been prepared by Auckland District Health Board (ADHB) 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 2007-08 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 2007–10 Statement of Intent is signed for and on behalf of the
AUCKLAND DISTRICT HEALTH BOARD

Wayne Brown
Chairman

Date

Ross Keenan
Deputy Chair

Date

Garry Smith
Chief Executive

Date

1. Introduction

1.1 Legal requirements

This Auckland DHB Statement of Intent sets out the organisation's objectives for the year ending 30 June 2008. 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 healthcare 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), and Westkids Ltd.

The Northern DHBs Support Agency (NDSA) develops its own Statement of Intent. Auckland DHB has a 1/3 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 does not have a controlling interest in any subsidiaries. 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.

1.2 The profile of the local population

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,

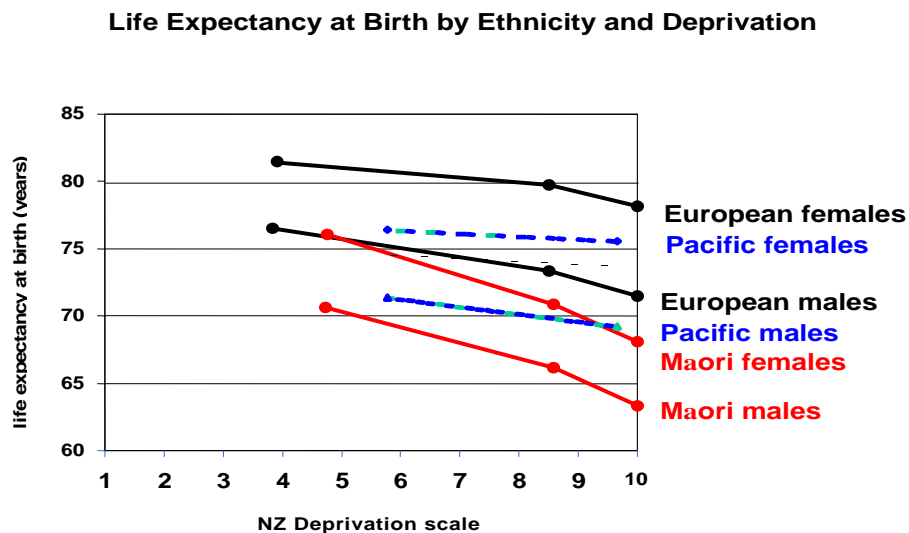
Auckland DHB manages the flow of people into our area for treatment. Over half the work carried out in the provider arm is for people living in other parts New Zealand (most of whom are from the other two DHBs in the metro Auckland area).

The Auckland DHB population projection for 2007–08 is 442,750 people (based on 2001 census data). From 2001 the Auckland DHB population has grown at approximately 2% per year. The local population is characterised by a great diversity of cultures, including people from 181 different ethnic groups. Of these approximately 8% are Maori; 12.2% Pacific; and 79.8% New Zealand European/other ethnic groups. We recognise the value in this diversity and respond to it as a benefit not a negative. Examples include working with communities of interest to support community-led health initiatives, and recognising the contribution each cultural grouping makes to improve health and respond to problems.

The majority of people living in the Auckland DHB area (72.5%) are working age adults (between 15 and 64 years). When examined by ethnicity, Maori and Pacific peoples have very young populations with about 47% of their populations under 24 years of age and less than 4.41% who are 65 years and older.

Evidence links lower socioeconomic status to inequalities in health status. Dep2001 is an index of deprivation, combining nine census variables from the 2001 census that reflect aspects of material and social deprivation. The scale of deprivation ranges from one to 10, where one represents the least deprived areas, and 10 the most deprived areas in New Zealand.

Approximately 41% of the Auckland DHB population lives in highly deprived areas (areas (quintiles 4-5) of the district. When compared by ethnic groups, approximately 75% of Pacific peoples and about 61% of Maori live in quintiles 4–5, compared with 33% of Europeans/others.



The previous graph shows life expectancy figures for the whole of New Zealand and is used within Auckland DHB to highlight the degree of difference between groups. Over time we want to contribute to national figures that show these unacceptable differences diminishing.

A population health needs analysis was undertaken in October 2001 and this work was further updated in 2005 to help with the development of the Strategic Plan to 2010 (refer to <http://www.adhb.govt.nz/healthneeds/>). The collection and analysis of information on health needs, health service use, and opportunities to address health inequalities is an essential activity to inform future health planning.

Population projections for Auckland city to 2011 indicate the following:

- Growth is expected in the proportion of Asian peoples in the population, with a reduction in the proportions of European, Maori and Pacific peoples.
- The proportion of Asian peoples is projected to increase by 154%.
- Approximately half (48%) of the Auckland DHB population will identify as European (64% in 2001); 33% as Asian (18% in 2001); 8% as Maori (8% in 2001); and 12% as Pacific peoples (13% in 2001).
- The greatest increase in numbers in 2011 will be among those aged 40–60 years, resulting in an extra 116,295 people (approximately).
- The greatest proportion of the population will be aged 20–39 years (34% of the population).
- The Auckland DHB population will experience a reduction in the overall proportion of 20–39 year olds and those aged under 20 years.
- There will be smaller increases in the number of those aged over 75, under 20 years, and between 20–39 years.
- In contrast to other parts of the Auckland region, and the rest of New Zealand where the proportion of those aged over 65 is growing, the proportion of older adults in the Auckland DHB area remains relatively constant.

Auckland DHB must reflect innovation and flexibility in future service planning in order to address socioeconomic differences in health status and to meet the future needs of our changing population.

1.3 Priorities for 2007-2010

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 2007–08, Government priorities and the Minister of Health's expectations.

The Minister of Health's expectations for the 2007–08 year

Chronic disease	Implement Healthy Eating Healthy Action, Cancer Control, Diabetes, Heart disease, and Tobacco Control strategies Early diagnosis and management of conditions such as diabetes and depression
Child and Youth Services	Use the Well Child review to inform future progress Progress oral health, child and youth mental health and sexual health services Implement the 'ready for school' health and wellness check, free primary health care for under sixes, newborn hearing screening and early intervention
Primary Health Care	Roll out low fees (and very low fees) to patients Focus on the maturation of PHOs, develop new models of service, involve a broader range of professionals, improve the primary/secondary interface
The Health of Older People	Changes to service delivery associated with a new assessment tool, new models of supportive care for people choosing to live at home, and training those in the sector
Infrastructure	Investments in the health information system require cooperation and coordination across the sector
Value for money	Improve the cost-effectiveness and gains of the New Zealand health system Achieve improvements in the quality of health care Get better value for money

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 Needs Assessment (<http://www.adhb.govt.nz/healthneeds/>) examined age, gender, ethnicity, socioeconomic status, and service use for people in Auckland.

The health problems responsible for the greatest burden of disease in our area:

- Cancer
- Cardiovascular disease (includes congestive heart failure)
- Diabetes
- Respiratory tract diseases
- Stroke
- Injuries (intentional and unintentional)
- Nervous system disease
- Mental health
- Cellulitis

Priority areas for local health gain:

- 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)

Our vision is:

Hei Oranga Tika Mo Te Iti Me Te Rahi

Healthy Communities, Quality Healthcare

Our approach to health goes well beyond disease states and health service provision

Three goals support the vision

All objectives in this District Annual Plan are aligned to three goals:

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

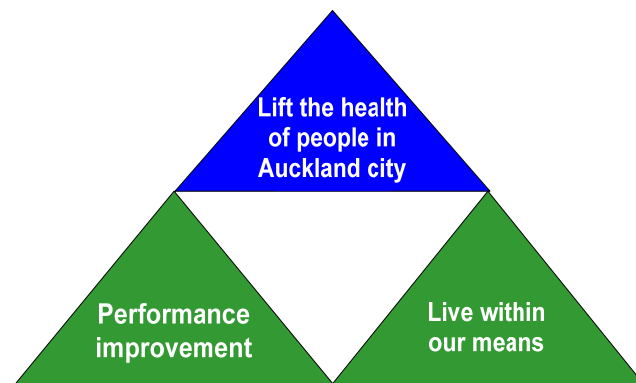
Organisational values

Integrity, Respect, Innovation, Effectiveness

"Kia u ki te tika me te pono"

1.4 The strategic framework

The vision *Hei Oranga Tika Mo Te Iti Me Te Rahi*, Healthy Communities, Quality Health Care reflects a focus on population health and on health in an interpretation that goes beyond disease states and health service provision. Three goals support the vision.



Goal 1: Lift the health of people in Auckland city

A whole system approach to health

First responsibility to people living in Auckland city

Achieve a vital few health outcomes:

- diabetes
- cardiovascular disease
- cancer
- child health
- the health of older people
- mental health
- reduce inequalities where there are groups with high need:
Maori, Pacific people, disabled people, refugee communities, people living in poverty

Strengthen primary health care and PHO development

Good links between primary and secondary care

Improve access to elective services

Goal 2: Performance improvement

Improve the quality of services, safeguard high standards of care

Clinical effectiveness

Systems and processes to support the clinical services

Information management and technology services

Provider arm efficiency and effectiveness

Decision making is fair, consistent and transparent

Workforce development and training

Analysis and research to understand our activities better

Plan for what's best across the region

Innovation

Goal 3: Live within our means

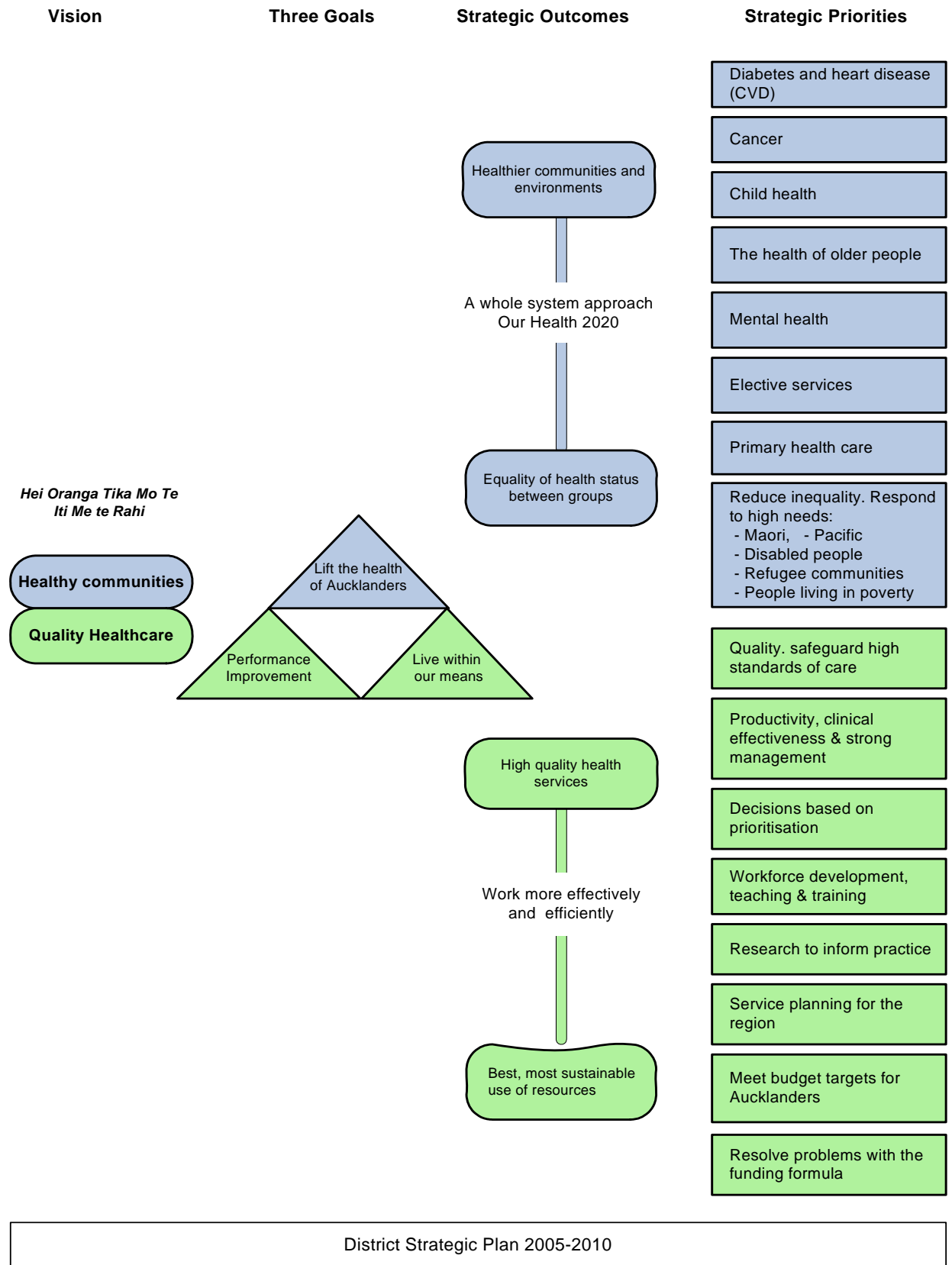
Strong financial management

Productivity, clinical effectiveness and strong management

Manage contracts and volumes for the hospital

Resolve problems related to the funding formula

The link between the strategic goals and activities for 2007–08



Annual Plan Objectives

Community screening	Integrate services	Heart failure programme	Cardiac care	Diabetes initiatives	Reduce alcohol, drug, tobacco harm	Stroke services
Prevent risk factors	Screening	Diagnosis & treatment	Support & rehabilitation	Integration	Research & surveillance	Palliative care
Maternity services	CHIP	Resilient families	Healthy lifestyles	NZ primary care strategy	Youth health	
Home support	Quality residential care	Primary care management of chronic conditions		New integrated models of Palliative care		
Work across a continuum	Sustain Mental Health	Improve quality	Child & youth services	Expand the workforce	Maori Mental Health	Regional plans
Meet local need	Prioritise using tools	Meet national guidelines	Orthopaedic initiative	Cataract initiative		
Policy & planning	Strengthen PHO action	Pharmacy & laboratory	Improve quality	Specific project work	A & M afterhours	Oral health plan
Treaty of Waitangi	Tihi Ora MaPO	He Kamaka Oranga	Chief Adviser Tikanga	Maori health action plan		
Healthy Village Action Zones	Action the NZ Disability Strategy	Advance the regional settlement strategy	Engage with communities			

Quality integrated	Accreditation & certification	Quality in the community	Improve reporting	Manage emergencies	Reduce infectious disease	
IS strategic plan		Help productivity of key users		Production planning		
Improve surgical services		Effective afterhours care	Performance improvement	IS support for health improvement plans		
Use the prioritisation framework		Integrate management & governance		Engage communities		
Recruit the right people	Retain staff	Develop people	Policies & processes	Industrial relationships	Legislation & regulation	
Research to improve care		Relationships to build knowledge		Good management systems in place		
Regional public health	Work with DHBs	Regional service planning	RMO project	Nursing bureau	Internal audit	Work with other bodies
Consolidate the gains made		Responsible financial management		Manage contracts & volumes		
Productivity & strong management			Resolve problems linked to the funding formula			

Key Indicators of Performance

Reduced risk factors, improved diabetes services & follow up, uptake of rehabilitation after coronary, organised stroke services
Radiation oncology & chemotherapy waiting times, new models of palliative care
National immunisation targets; reduced ambulatory sensitive hospitalisations
Ambulatory sensitive hospitalisations; supports for aging in place
Relapse prevention plans in place
Meet elective services performance indicators
High PHO enrolment; low cost care; oral health measures met; laboratory & pharm transactions have NHI
Maori engaged in decisions, Maori workforce developed; mainstream is responsive; funding increased
Pacific engaged in decisions; reduced inequalities between groups, independence for disabled people
Quality systems; improve the data provided to the national collections system
Good quality costing systems and coding
Improve provider arm efficiency & effectiveness via project work
National prioritisation processes used and SPNIA
Recruit and retain the right staff, staff development; industrial action managed
Research informs practice, relationships strengthened, best use of resources
Regional initiatives, best use of resources
Meet budget targets for the hospital, meet contracted volumes for other DHBs, manage labour costs and the clinical workforce
National and regional services funded appropriately

District Annual Plan 2007-2008

Major changes proposed for 2007-08

This Statement of Intent is devoted to areas where we propose to make changes during the 2007-08 year. Further detail is contained in our District Annual Plan 2007-08. 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 NZ Public Health and Disability Act 2000 and in the Operational Policy Framework.

The areas where the greatest changes will occur:

Develop a plan to coordinate action aimed at getting people more active and eating well

Build the nutrition and physical activity skills of community workers in Healthy Village Action Zones

Achieve a healthy food environment in schools and early childhood centres

Community based screening for heart disease and diabetes via PHOs using the software PREDICT™

Community self management programmes for people with heart failure, including home based and community/marae based cardiac rehabilitation programmes

Establish a centralised stroke unit and supports that will improve care to stroke patients

Establish a heart failure clinic

Improve access to surgical services for people with cancer

Establish a regional cancer network to improve cancer services

Improve waiting times for medical and radiation oncology and the management of data

Establish a psychology service for the medical and radiation oncology service

Establish an adolescent service for young people with cancer

Changes to National Section 88 for maternity services i.e. implement the devolved provider arm Section 88 revenue streams and obligations

Changes to maternity services that support birthing without medical intervention

Implement the newborn hearing screening

Change the way that Outreach Immunisation services are provided

Implement Ante Natal HIV Screening

Implement outcomes of the Review of Well Child Services

Change the way school based health activities are configured

Develop a youth health improvement plan

Get primary mental health services underway

Broaden mental health outcomes to include employment, education and housing

Improve services for older people, to enable independence and aging in place

Review the case management model of care for older people

Review Meals-On-Wheels and align to the Healthy Aging 2020 Plan

Explore alternatives to the 'managed bed' policy for older people

New contracting for services which improve access to, and use of, pharmaceuticals

Improve demand management, medicine compliance and distribution

Manage the interim laboratory contract and participate in the regional process for the laboratory contract from January 2009

Develop a local primary care strategy and within this, address the difficulties in devolving services to PHOs that are not aligned with a geographical area or contributing to the geographical planning of services in Auckland DHB

Consultation to address how we work collaboratively and resolve issues arising from the particular configuration of our PHOs

Improve community participation in primary health care and where appropriate move services closer to where people live

Develop a strategy around afterhours care for primary health care

Implement the Integrated Adult Palliative Care Plan across services

Develop a business plan for the reorientation of the regional Child and Adolescent Oral Health Service

Purchase additional elective surgery and assessment as sustainable funding

Finalise how people living on the border between Auckland DHB and Counties Manukau DHB will receive elective services by resolving traditional interdistrict flow arrangements i.e. it's possible that elective services for people in Otahuhu may be provided through the Manukau Super clinic in future

Reduce our reliance on private sector surgical contracts through longer term planning that gets the best value from the resources we have

Respond to the requirements of the NZ Sign Language Act 2006 especially disability competence training

Implement efficiency projects for the hospital: Surgical Process Review, After Hours Model of Care, Production Planning

Develop and implement DHBNZ Industrial Relations/Employment Relations strategy with improved communication and transparency in industrial relationships

Contribute appropriately in the negotiation of the national employment contracts (MECAs)

Transparent Senior Medical Officer policies and procedures through the employment cycle

Complete the SMO Job Size Project (to align SMO remuneration with MECA)

Advance the Regional Service Planning initiatives in progress

Implement the Regional Information Services Strategic Plan linked to the Health Information Strategy for NZ

Prepare for implementation of the Health Provider Index in Auckland DHB systems as per NZHIS specifications and timelines

Develop business cases for priority projects (eReferrals, eOrders, Health Provider Index, TestSafe, Well Child, Regional Mental Health System, etc)

Improve the quality of National Health Index and ethnicity data

Stocktake of the nature and scope of work that is undertaken by the regional structure that supports the DHBs. Assess if this needs to develop in the future to achieve the changes required in the region

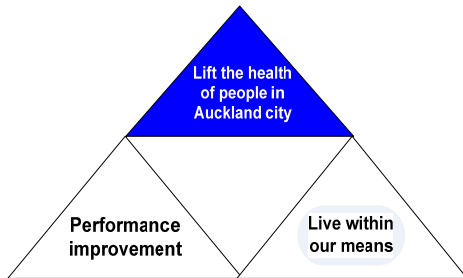
Address Auckland DHB losses arising from insufficient revenue with the Ministry of Health and the National Pricing Programme

Resolve the problem of erosion of specialist services created by the population based funding repatriation of service

Spend 5 million to develop a car park on the Grafton site. Other capital expenditure is subject to normal business case and Board approvals and sometimes, regional and Ministerial approvals

2. Three Goals

2.1 Goal one: Lift the health of people living in Auckland city



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.

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', a plan 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
- Local Mental Health Plan, 2006
- Healthy Ageing 2020, 2006
- CVD and Diabetes Plan (approved, yet to be published)
- Palliative Care Plan (in draft)
- Cancer Control Plan (approved, yet to be published)
- Plan for better eating and exercise (underway)

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.

Six 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 2007-08 we plan to have more specialist clinicians working alongside primary practitioners to provide more health services in the community.

Objectives for 2007-08 and beyond

The following objectives for this goal are summarised from our 2007-08 Annual Plan. Further detail is available in that Plan; available at www.adhb.govt.nz.

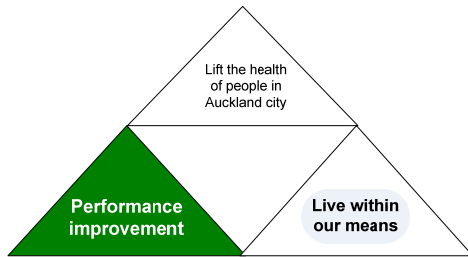
Objectives and actions for 2007-08 and beyond

Objectives	Actions
Reduce cardio-vascular disease and diabetes	<ul style="list-style-type: none"> • Community wide cardiovascular screening • Integrated Heart Failure programme • Expanded options for cardiac care • Diabetes initiatives • Minimise harm from alcohol, drugs and tobacco • Integration of intra hospital services and evaluation • Organised stroke services
Cancer	<ul style="list-style-type: none"> • Prevent risk factors for cancer: smoking, poor diet, inactivity, obesity, sun • Early detection and breast and cervical screening • Diagnosis and treatment • Support and rehabilitation • Planning, coordination and integration • Research and surveillance
Child, youth and women's health	<ul style="list-style-type: none"> • Improve maternity services • Implement the Child Health Improvement Plan • Strong and resilient families/whanau • Achieve healthy lifestyles and environments for children • Achieve the NZ Primary Health Care Strategy • Improve the health of young people
Older people	<ul style="list-style-type: none"> • Community and home based support • Improve service quality, particularly in residential care
Palliative care	<ul style="list-style-type: none"> • New models of palliative care • Improve care for Maori • Reduce health inequalities

Objectives	Actions
	<ul style="list-style-type: none"> • Primary health care • Workforce development • Quality improvements
People with a mental illness	<ul style="list-style-type: none"> • Services to sustain mental health for consumers • Improve the quality of services • Improve services for children and young people • Expand the professional workforce • Regional workforce development • Regional plan for mental health • Whanau Oranga Hinengaro Maori Mental Health Plan
Partnership with Maori	<ul style="list-style-type: none"> • Treaty of Waitangi statement: Partnership, Participation, Protection • Other arrangements that support the Treaty: He Kamaka Oranga and the Chief Advisor Tikanga • Implement the Maori health action plan • Improve the performance of contracted services • Maori mental health • Tamariki and Rangatahi health • Action on diabetes, CVD and stroke • Strengthen primary care • Improve provider arm services • Complete the Maori workforce development plan
Improve the health of Pacific people	<ul style="list-style-type: none"> • Community, workforce and provider development • Quality plans • Introduce healthy village action zones • Prevent violence in the home • Pacific primary care liaison positions • Assist the Pacific health advisory group
Other groups with high need	<p>Develop a structured approach to reducing inequalities</p> <ul style="list-style-type: none"> • Updated census data and more analysis • Establish priorities in the work programme • Make better use of the national equity tools <p>Improve the health of refugees and people from South Asia</p> <ul style="list-style-type: none"> • Goal 4 of the Auckland Regional Settlement Strategy • Expanded interpreter services • Increase access to primary care including mental health and wrap-around services • Reduce CVD and diabetes <p>Support independence for disabled people</p> <ul style="list-style-type: none"> • Increase participation of disabled people in governance and planning • Train Advisory Committee members to undertake their role

Objectives	Actions
	<ul style="list-style-type: none"> • Train staff to understand disability • Work with Auckland city on their research into disability • Resolve funding, and boundary issues for under 65 year olds and issues regarding equipment • Work with Auckland city to improve transport for disabled people • Respond to requirements of the NZ Sign Language Act
Primary health care	<ul style="list-style-type: none"> • Improve policy and planning • Strengthen PHO and primary health care activity • Improve relationships and collaboration • Specific areas of health improvement • Accident and Medical afterhours services • Community pharmacy contracts • Community laboratory contract • Oral health plans
Reducing risks linked to lifestyle	<ul style="list-style-type: none"> • Implement the national Healthy Eating Healthy Action programme • Help people to stop smoking
Elective services	<ul style="list-style-type: none"> • Match elective performance to the need in the community • Improve the prioritisation process • Elective service waiting times managed within Ministry of Health guidelines • Orthopaedic and Cataract initiatives

2.2 Goal two: Performance improvement



The following objectives are linked to the goal of performance improvement. These typically focus on work that cuts across all the health gain areas in the previous section.

The majority of efficiency issues for Auckland DHB sit in the provider arm, predominantly within Auckland City Hospital. Auckland DHB will achieve efficiencies where we can and will hold managers and clinicians accountable for these. 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.

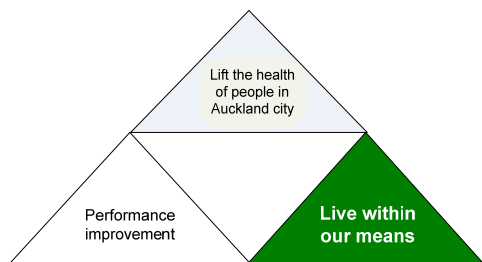
The three regional DHBs work closely together on issues in common, recognising the mobility of the greater Auckland population. Working regionally ensures that developments in one area of health do not create problems for others.

Objectives for 2007-08 and beyond

The following objectives are summarised from the 2007-08 District Annual Plan and link directly back to our District Strategic Plan.

Objectives	Actions
Quality and Standards of Care	<ul style="list-style-type: none"> • Continuous quality and safety improvements integrated into all operational activities • Maintain accreditation and certification for hospital and related services • Quality improvement in the community • Improve reporting of quality assurance • Improve the management of emergencies • Reduce infectious diseases
Information Management and Technology Services	<ul style="list-style-type: none"> • Auckland Regional Information Services Strategic Plan • Improve productivity of key user groups by improving access to information • Support the implementation of the health improvement plans
Provider Arm Efficiency and Effectiveness	<ul style="list-style-type: none"> • Review the operational efficiency of all surgical services • Use an effective after-hours model of care • Production planning
Decision Making	<ul style="list-style-type: none"> • Set priorities for funding using the national prioritisation framework • Integrated management and governance • Engage local communities in planning and funding decisions
Workforce Development and Training	<ul style="list-style-type: none"> • Recruit the right people/talent • Retain staff / talent • People development/ learning organisation • Human resources policy and process • Industrial relationships • Legislation and regulation
Research	<ul style="list-style-type: none"> • Research to improve healthcare delivery • Research informs future planning • Maintain strong relationships to build knowledge
Regional Work	<ul style="list-style-type: none"> • Action the Auckland Regional Public Health Service delivery plan • Collaborate in regional processes and programmes with neighbouring DHBs • Regional service planning • Regional efficiency project • Regional Nursing Bureau • Internal audit • Work with other bodies, sectors

2.3 Goal three: Live within our means



We have achieved a realistic and achievable position having addressed the factors driving our deficit. We are committed to achieving a break even position for the 2007–08 financial year. Significant gains have been made through controlling the growth in staff numbers, restraining capital expenditure, maintaining tight control over operational expenditure, and increasing our provider arm productivity.

There are some risks in achieving a break even position in 2007-08. Auckland DHB had a 7 percent cap imposed on the growth in funding for 2007-08 which means less funding than we anticipated under the population based funding formula. We also depend on additional funding for the specialist services we provide for the rest of the country (tier II services) and this issue has not yet been fully resolved.

Auckland DHB will revalue its assets again in 2010 following its policy however we may be required to undertake this exercise earlier than planned. The impact on the statement of financial performance may be an adverse one of up to \$20 million. Additional costs of this magnitude cannot be funded through the Population Based Funding Formula.

In 2007-08 Auckland DHB plan to work within the nationally agreed employee cost budget and we remain committed to our collective responsibilities in the sector. Our revenue is however affected by nationwide industrial action. This is because Auckland DHB, unlike most DHBs, gains over half of the provider arm revenue from other DHBs. Our revenue from customer DHBs drops when provider arm productivity drops during strike activity.

Objectives for 2007-08 and beyond

The following objectives for this goal are summarised from our 2007-08 Annual Plan.

Objectives	Actions
Our Approach to Financial Management	<ul style="list-style-type: none">• Consolidate the gains already made• Don't stop there• Improve responsibility in financial management
Productivity, Clinical Effectiveness and Strong Management	<ul style="list-style-type: none">• Keep the lid on issues which could lead to a deficit• Maintain costing systems and coding• Benchmarking and productivity work• Staff numbers: manage labour costs and the clinical workforce• Materials management/supply chain• Service changes• Dedicated projects for 2007–08 e.g. SMO numbers, operational efficiency programme, costing system, service reviews, pricing programme, operational costs of same day surgical unit
Manage Contracts and Volumes for the Hospital	<ul style="list-style-type: none">• Meet budget targets for the treatment of patients• PHO performance management (referred services expenditure)• Manage to contracted volumes
Problems Related to the Funding Formula	<ul style="list-style-type: none">• Resolve the cost of national and regional services• Funding issues: managing within the funding available• Secure Crown debt and equity funding

3. The Governance and Management Structure

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

3.1 Governance

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.

Wayne Brown (Chair)

Ross Keenan (Deputy Chair)

Harry Burkhardt

Chris Chambers*

Barry De Geest*

Virginia Hope*

Di Nash*

John Retimana

Ian Scott*

* Elected members October 2004.

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 in order to influence the broader determinants of health. This is achieved through the following activities:

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

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

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

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

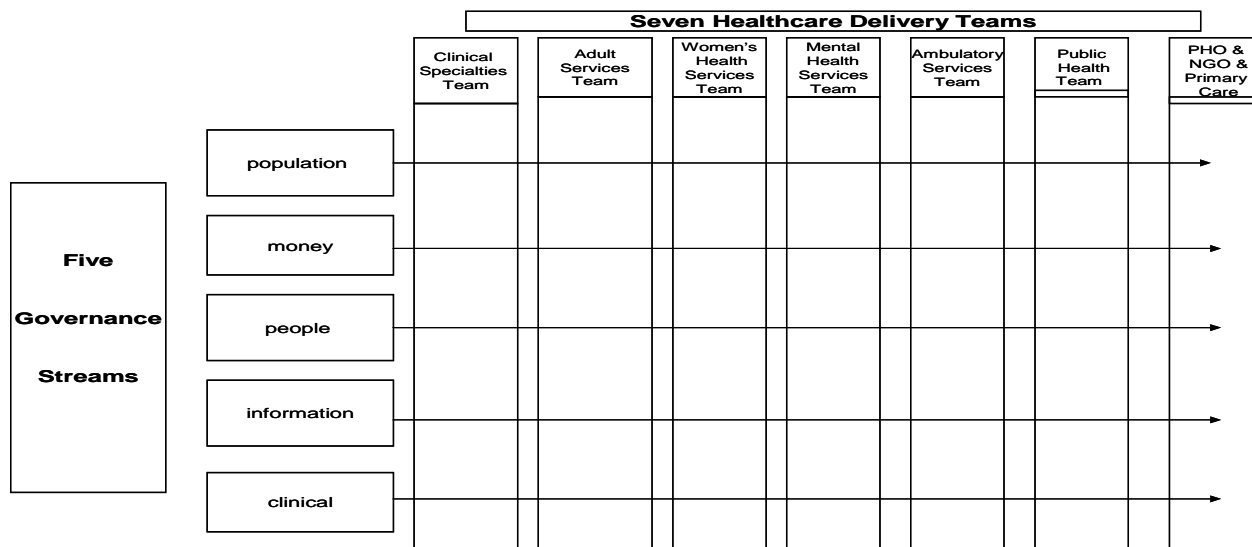
The Board has established other committees to provide advice.

Audit Committee	<p>Monitors the financial performance of the Auckland DHB, liaises with external auditors and receives reports for the internal auditor.</p>
Quality Committee	<p>Monitors clinical quality, patient satisfaction and accreditation of services.</p>
Maori Health Advisory Committee	<p>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</p>

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

3.2 The integrated management structure

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



A Senior 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.

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

The Senior Management Team

Garry Smith	Chief Executive
Ngairé Buchanan	General Manager Operations
Taima Campbell	Executive Director of Nursing
Margaret Dotchin	General Manager Clinical Services
Fionnagh Dougan	General Manager Clinical Services
Naida Glavish	Chief Advisor Tikanga and acting General Manager Maori Health
Kay Hyman	General Manager Clinical Services
Roger Jarrold	Chief Financial Officer
Denis Jury	Chief Planning and Funding Officer
Janice Mueller	Director of 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

A Pacific Health Advisory Group has been established to provide advice to the CEO and Senior Management Team on matters relating to Pacific health improvement.

3.3 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

<p>Partnership</p> <p>Manawhenua, are partners with Auckland DHB at the governance level</p>	<p>Memorandum of Understanding with Te Runanga o Ngati Whatua and its health operational arm Tihi Ora MaPO</p> <p>Formation of the Auckland DHB Maori Health Advisory Committee</p> <p>Ensure that Ngati Whatua, as manawhenua, is partners with ADHB at the governance level. This health partnership ensures the active protection of Maori interests in health planning and funding</p> <p>Meaningful consultation with Maori and involvement in planning health and disability services. ADHB as an agent of the Crown will continue to engage with Maori regarding the impact service changes may have on Maori communities and organisations</p>
<p>Participation</p> <p>Maori engagement in planning, development and delivery of health and disability services</p>	<p>Responsible and responsive to Maori communities in our district and those who use our services</p> <p>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</p> <p>Maori provider development</p>
<p>Protection</p> <p>Maori enjoy the same level of health as non-Maori</p>	<p>Commitment to the Maori Health Strategy, He Korowai Oranga and other national policy</p> <p>Inequalities framework and the health inequalities impact assessment tool</p>

<p>Safeguard Maori cultural concepts, values and practices</p> <p>Services will meet the rights/rites, needs, interests and aspirations of Maori</p>	<p>The national prioritisation framework which brings Treaty principles into a decision making tool</p> <p>We recognise the need for equity of participation, access and outcomes for all Maori</p> <p>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</p>
--	--

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.

3.4 Provider arm/hospital services

The following description relates to the provision of personal and family health services, plus mental health services and has a funding value \$790 million including all sources of Ministry of Health revenue.

Auckland DHB provider arm

Auckland DHB operates New Zealand's largest public hospital in New Zealand. The Auckland DHB provider arm is made up of the Auckland City Hospital and the Greenlane Clinical Centre and their related community-based services. The Auckland City Hospital includes services provided by Starship Children's Health and National Women's Health services. Greenlane Clinical Centre provides advanced day-care surgical hospital and comprehensive medical centre focusing on outpatient service, rehabilitation and hospital in the home services.

Over 50 percent of provider arm services are for people outside of the district. Project work continues on inter-district flows in order to gauge the volume of work flowing between DHBs and the costing for this.

The provision of national tertiary services exposes Auckland DHB to risks associated with high cost treatments that are not fully covered within the funding envelope. Transplant work (pancreatic-kidney in particular), blood products associated with haemophilia treatment, and some high cost pharmaceuticals continue to expose the organisation to

ongoing losses that cannot be retrieved through the population-based funding or inter-district flows projects.

Provider arm characteristics

- A total operating revenue of approximately \$790 million, over half of which is obtained for services provided to people from other DHBs
- Over 8,000 staff or approximately 7,300 full-time equivalent positions including bureau staff that comprises clinical, management and support staff in the hospitals and corporate and support functions
- Auckland DHB is the largest trainer of doctors in the country with approximately 1,000 medical staff of whom approximately 460 are in various stages of training (Registrars and House Officers)
- Auckland DHB is the largest clinical research facility in New Zealand and engages in work that attracts funding and participation from New Zealand and overseas
- Provides hospital and outpatient services for people domiciled in Auckland city
- Provides tertiary services for the northern region (a population of about 1.4 million). Over 50% of services are provided to people outside the district (inter-district flows/IDFs) and specialist services for New Zealand such as organ transplant (heart/lung/liver); high risk obstetrics; National Newborn Screening Services (contract with National Screening Unit) and neurosurgery to Northern and Midland region
- Acute services are provided together under one roof so patients can access the skills of multidisciplinary teams of specialists and specialist equipment
- Major programmes are in progress within the Auckland City Hospital such as the Operational Efficiency Programme co-ordinating all treatment activities to enhance clinical outcomes and achieving maximum efficiency through local, regional, and/or national coordination
- Starship Children's Health is a specialist paediatric centre that provides health services to children in Auckland city, and tertiary and quaternary services to children throughout New Zealand. In addition to providing care, Starship advises other professionals and leads national guidelines.

Efficiency gains

Auckland DHB performs efficiently and productively. The organisation has gone through several years of change to streamline care for patients and to find more efficient ways of working. There are a number of areas of exceptionally high performance:

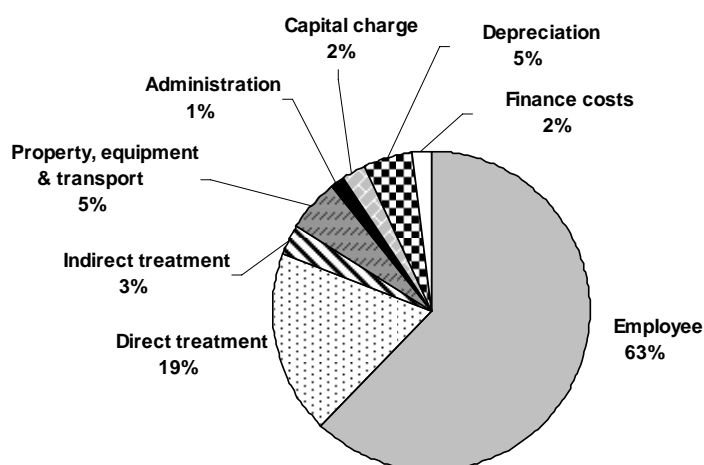
- The configuration of the hospital facility, which is streamlined for 24 hour management, provides specialised services with the clinical benefit of sub-speciality co located for patients requiring more multi-disciplinary care

- Effective acute front door processes with Adult Emergency Department and the Assessment and Planning Unit
- Integrated models of nursing care and new methods to monitor nursing resources coupled with the consolidation of clinical areas means more effective use of specialist and nursing resources
- Benchmarking has led to more efficient management in providing services e.g. in management and administration, cancer treatment services, and nursing
- The management and administration review decreased costs by \$15 million and brought Auckland DHB closer to the national average for the proportion of revenue consumed by administration costs. This is budgeted to continue in the future
- The regional benchmarking study indicated declining labour productivity in all three metro Auckland DHBs, however the decline has been least for Auckland DHB
- The three DHB Laboratories have committed to working more closely together with the formation of a DHB Laboratories Strategic Leadership Group to guide and oversee regional co-operation

Key issues into the future

- Over recent years the DHB has systematically tackled the causes of the deficit and has committed to a break even position in 2007-08
- Achieving this target relies on the continued productivity gains of recent years and controlling financial risks, especially wage increase greater than the Future Funding Track, and underfunded technology changes whether developed internally or imposed by regulation
- Managing financial pressures can be assisted to some extent by reducing the demand for hospital services. This requires strategic investments outside the hospital in priority areas i.e. lifestyle related risk factors that contribute to diabetes, cardiovascular disease and some cancers
- There is a workforce shortage due to global demand for skilled health professionals, the requirement for improved quality, and a high turnover of staff
- A number of specialities will need a significant increase to their elective inpatient and outpatient services to create certainty for patients in the booking system
- Hospital services need to be integrated with primary care so primary care has the clinical support and leadership to do more outside the hospital such as reducing admissions and readmissions for older people; streamlining processes relating to referrals and discharges.

Breakdown of provider arm funding for the 2007-08 financial year



Contracted Hospital Specialist Outputs

The following table summaries the broad areas of work carried out in the provider arm. More detail on each service area covered in the provider arm is covered in the Price Volume Schedule. The figures below include work done for the Auckland DHB population and work done for other districts.

Specialist service area	Unit of Measure	Outputs
Emergency Medicine	Attendances	48879
	Cost Weighted Discharges	2898
Haematology	Attendances	19408
	Cost Weighted Discharges	2062
Oncology	Attendances	93633
	Cost Weighted Discharges	2604
Cardiology	Attendances	13094
	Cost Weighted Discharges	8560
Cardiothoracic	Attendances	525
	Cost Weighted Discharges	9902
Respiratory Medicine	Attendances	10342
	Clients	2760
	Cost Weighted Discharges	2026
Vascular Surgery	Attendances	3866
	Cost Weighted Discharges	2715
Clinical Infectious Diseases	Tests	2059
Genetics	Attendances	1533
Physiotherapy	Contacts	6280
Social Work	Contacts	9763
Women's & Children's Therapy	Contacts	3260
General Medicine	Attendances	2271
	Cost Weighted Discharges	9452
Infectious Diseases	Attendances	1964
	Cost Weighted Discharges	310
Orthopaedics	Attendances	8511
	Cost Weighted Discharges	8041

Specialist service area	Unit of Measure	Outputs
Gastroenterology	Attendances	5024
	Cost Weighted Discharges	564
General Surgery		
	Attendances	10660
	Cost Weighted Discharges	8425
Liver Resections	Cost Weighted Discharges	737
Audiology	Tests	9656
Dermatology	Attendances	5051
	Cost Weighted Discharges	438
Diabetes	Attendances	3400
Endocrinology	Attendances	5350
	Cost Weighted Discharges	34
Immunology	Attendances	2959
	Cost Weighted Discharges	321
Ophthalmology	Attendances	39669
	Cost Weighted Discharges	3292
Oral Health	Attendances	16065
	Cost Weighted Discharges	1443
Rheumatology	Attendances	2710
	Cost Weighted Discharges	39
Sexual Health	Contact	22558
Pain Service	Attendances	2695
General Paediatrics	Attendances	9308
	Cost Weighted Discharges	2713
Paediatric Dermatology	Attendances	574
Paediatric Emergency department	Attendances	29726
	Cost Weighted Discharges	1611
Paediatric Endocrinology	Attendances	2659
	Cost Weighted Discharges	148
Paediatric Family Information Service	Service contacts	218412
Paediatric Family Options	Service contacts	347832
Paediatric Gastroenterology	Attendances	959
	Cost Weighted Discharges	375
Paediatric Haem/Onc	Attendances	6477
	Cost Weighted Discharges	1690
Paediatric Home Health Care	Service contacts	71197
Paediatric Infectious Diseases	Attendances	585
	Cost Weighted Discharges	427
Paediatric Neurology	Attendances	3931
	Cost Weighted Discharges	584
Paediatric Renal Medicine	Attendances	1615
	Cost Weighted Discharges	287
Paediatric Respiratory Medicine	Attendances	1327
	Cost Weighted Discharges	939
Paediatric Rheumatology	Attendances	1429
Well Child		
	Contacts	44135
Whakaruruhau	Service contacts	1217823
Newborn Services	Attendances	1801
	Cost Weighted Discharges	4454
Paediatric Cardiac		
	Attendances	2087
	Cost Weighted Discharges	4277
Paediatric Neurosurgery	Attendances	468
	Cost Weighted Discharges	845
Paediatric ORL	Attendances	5583
	Cost Weighted Discharges	1360
Paediatric Orthopaedics		
	Attendances	8616
	Cost Weighted Discharges	2445
Paediatric Pain Service	Attendances	8

Specialist service area	Unit of Measure	Outputs
Paediatric Palliative Care	Attendances	2136
Paediatric Surgery	Attendances	4529
	Cost Weighted Discharges	2807
Liver Transplants		
	Assessments	73
	Procedures	46
Neurology	Attendances	8717
	Cost Weighted Discharges	930
Neurosurgery	Attendances	2386
	Cost Weighted Discharges	6294
ORL		
	Attendances	10797
	Cost Weighted Discharges	2659
Renal Medicine	Attendances	11120
	Cost Weighted Discharges	1696
Renal Transplant		
	Cost Weighted Discharges	645
Urology	Attendances	3993
	Cost Weighted Discharges	2715
Fertility	Client Attendances	339
	Procedures	958
Gynaecology	Attendances	13997
	Cost Weighted Discharges	2850
Obstetrics		
	Attendances	4532
	Deliveries in catchment area	24986
	Deliveries in facility	7462

Notes - these services exclude those specialist support e.g. laboratory testing & radiology (MRI) etc

3.5 Risks to achieving goals



Lift the health of people in Auckland

Auckland has an aging population which is associated with increased burden of disease especially diabetes, cardio-vascular 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

We want to realise all the gains possible under the Primary Health Care Strategy. However this requires considerable culture change and a shared commitment to move from traditional approaches to a coordinated health system

Activities of other agencies and especially policy change can influence health. There needs to be more formal agreements where the activities of one agency will impact on others



Improving performance

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

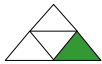
We need to progress major incident planning to make sure the various efforts across the organisation are co-ordinated

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 and carry out elective surgery

On July 1 2007 the current community laboratory contract expires. Following the over turning of a contract with a new provider, Auckland DHB will work with Waitemata DHB and Counties Manukau DHB to ensure the continuity of laboratory services



Living within our means

Auckland DHB has committed to achieving a break even position in the 2007-08 year. 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

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

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

The funding formula has introduced a cap for Auckland DHB and this limits the funding available to us in the financial year

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

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

4. Performance Targets

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 diagram showing the intervention logic for performance monitoring is covered on pages 12 and 13 of this document.

The following subset of objectives makes up our Statement of Service Performance and these cover the financial year 2007-08 and two further years. They are made up of a combination of quantitative and qualitative, financial and non financial measures, all of which link directly to our three key organisational goals.

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.

4.1 Health gain targets

Long term health gain objectives

The following measures relate to the vital few outcome areas that Auckland DHB wishes to achieve to the year 2010. They reflect priority areas taken from: the assessment of local population need, national priority areas for health, iwi engagement, and wider community consultation.

Having a vital few outcome areas means we can focus attention and resources on areas of high unmet need and the greatest burden of disease. Our responsibility as a DHB is to shift from an illness model to a wellness model of care. The approach to all these areas is covered in "Our Health 2020", the plan to achieve a whole system approach to problem areas by interventions across the continuum from health promotion to specialist intervention.

4.1.1 Reduce the impact of heart disease, diabetes and cancer

The approach to CVD, diabetes and cancer has been developed into plans which will affect service delivery in 2007-08.

Reducing CVD, diabetes and cancer starts with lifestyle changes since many of the risk factors involve poor diet, inactivity and smoking. We will do more promotion, prevention and early intervention; with a focus on Maori, Pacific and South Asian communities. We need to engage the communities most affected.

We plan to integrate primary health care and hospital services so that more work is done in the community where we can best prevent problems from becoming worse. This means greater clinical leadership to help manage complex conditions in primary care. The PHOs will also introduce the screening tool PREDICT™ which will pick up problems early on.

In 2007-08 we will roll out more programmes based on evidence of best outcomes for people with chronic problems. These will involve better self management of conditions and more help for people who need rehabilitation after acute heart failure.

Objective 2007-08	2007-08 targets	Target by 2010									
Reducing lifestyle related risk factors	Progress to achieving MoH Breastfeeding targets:										
	increase the breastfeeding rate at 6 weeks to 71 percent	Increase to 80 percent									
	increase the breastfeeding rate at 3 months to 57 percent	Increase to 70 percent									
	increase the breastfeeding rate at 6 months to 21 percent	Increase to 27 percent									
	2005-06 ADHB Breastfeeding (fully/exclusive) rate at 6 weeks was 68% (data provided by Plunket). An achievable target for 2007-08 is 71%.	Gaps between 'Other' compared to Maori, Pacific and Asian closing									
	Support the achievement of Baby Friendly Hospital Initiative accreditation										
	Work with Auckland City Council to implement the Baby Friendly Community Initiative										
	Proportion of adults (15+):										
	70% consuming at least 3 servings of vegetables per day	Gaps between ethnic groups and genders closing re fruit and vege consumption									
	62% consuming at least 2 servings of fruit per day										
Fruit and vegetable intake is adequate (trend data for 2002-03 NHS).											
<table border="1"> <thead> <tr> <th>Maori</th> <th>Pacific</th> <th>Asian</th> <th>Other</th> <th>Whole ADHB</th> </tr> </thead> <tbody> <tr> <td>33.7%</td> <td>30.6%</td> <td>31.2%</td> <td>45.0%</td> <td>40.0%</td> </tr> </tbody> </table>	Maori	Pacific	Asian	Other	Whole ADHB	33.7%	30.6%	31.2%	45.0%	40.0%	
Maori	Pacific	Asian	Other	Whole ADHB							
33.7%	30.6%	31.2%	45.0%	40.0%							
<table border="1"> <thead> <tr> <th>Male</th> <th>Female</th> </tr> </thead> <tbody> <tr> <td>30.7%</td> <td>49.5%</td> </tr> </tbody> </table>	Male	Female	30.7%	49.5%							
Male	Female										
30.7%	49.5%										
57% of year ten students have never smoked (ASH year ten survey data)	Increase rate to 60%										
85% of ADHB schools are health promoting schools	Increase to 87%										

	<p>Implement the Look Good Kai programme into 26 ADHB secondary schools</p> <p>Increase by 10, the number of retailers involved in Healthy Kai initiatives in Glen Innes</p>	<p>All ADHB secondary schools</p> <p>Increase over % for previous years</p>																																																						
<p>Improved care for people with heart disease and diabetes</p>	<p>> 65% patients meeting criteria have had a Get Checked assessment</p> <p>People with heart failure receive evidenced based care</p> <p>Implement electronic screening tool PREDICT in 90% of PHOs</p> <p>10% of eligible population screened for CVD and diabetes</p> <p>5% increase in screening rate for Maori and Pacific communities</p> <p>Community based self management programmes in place for chronic care</p> <p>30% of eligible people (total, Maori, Pacific) engaged in and completing cardiac rehabilitation support</p> <p>Free annual check Maori 67% Pacific 67% Others 67%</p> <p>Good management Maori 70% Pacific 70% Others 85%</p> <p>Retinal screening Maori 83% Pacific 83% Others 83%</p> <p>Diabetes: Case Detection (trend data 2003-2006)</p> <table border="1" data-bbox="467 1697 1050 1854"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> <th>2007</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td>14.5</td> <td>19.2</td> <td>24.9</td> <td>31.3</td> <td>67</td> </tr> <tr> <td>Other</td> <td>28.3</td> <td>36.5</td> <td>44.3</td> <td>64.9</td> <td>67</td> </tr> <tr> <td>Pacific</td> <td>71</td> <td>80.3</td> <td>90.8</td> <td>104.5</td> <td>67</td> </tr> <tr> <td>Total</td> <td>33.7</td> <td>42.1</td> <td>50.2</td> <td>67.7</td> <td></td> </tr> </tbody> </table> <p>Diabetes: Case Management</p> <table border="1" data-bbox="467 1892 1050 2016"> <tbody> <tr> <td>Maori</td> <td>53</td> <td>61.9</td> <td>60.8</td> <td>67.1</td> <td>70</td> </tr> <tr> <td>Other</td> <td>72.4</td> <td>74</td> <td>74.6</td> <td>77.2</td> <td>85</td> </tr> <tr> <td>Pacific</td> <td>55.3</td> <td>52.4</td> <td>52.7</td> <td>63.9</td> <td>70</td> </tr> <tr> <td>Total</td> <td>65.4</td> <td>65.8</td> <td>67.5</td> <td>72.7</td> <td></td> </tr> </tbody> </table>		2003	2004	2005	2006	2007	Maori	14.5	19.2	24.9	31.3	67	Other	28.3	36.5	44.3	64.9	67	Pacific	71	80.3	90.8	104.5	67	Total	33.7	42.1	50.2	67.7		Maori	53	61.9	60.8	67.1	70	Other	72.4	74	74.6	77.2	85	Pacific	55.3	52.4	52.7	63.9	70	Total	65.4	65.8	67.5	72.7		<p>> 70%</p> <p>10% increase on previous year</p> <p>100%</p> <p>10% increase from prior year</p> <p>5% increase from prior year</p> <p>10% increase in uptake from previous year</p> <p>50% of Maori and Pacific use rehabilitation</p> <p>Increase from prior year</p>
	2003	2004	2005	2006	2007																																																			
Maori	14.5	19.2	24.9	31.3	67																																																			
Other	28.3	36.5	44.3	64.9	67																																																			
Pacific	71	80.3	90.8	104.5	67																																																			
Total	33.7	42.1	50.2	67.7																																																				
Maori	53	61.9	60.8	67.1	70																																																			
Other	72.4	74	74.6	77.2	85																																																			
Pacific	55.3	52.4	52.7	63.9	70																																																			
Total	65.4	65.8	67.5	72.7																																																				

	<table border="1"> <tr> <td colspan="6">Diabetes: Retinal Screening</td> </tr> <tr> <td>Maori</td> <td>64.5</td> <td>64</td> <td>43.9</td> <td>68</td> <td>83</td> </tr> <tr> <td>Other</td> <td>68.2</td> <td>66.4</td> <td>53.6</td> <td>75.9</td> <td>83</td> </tr> <tr> <td>Pacific</td> <td>52.9</td> <td>51.6</td> <td>40.2</td> <td>70.3</td> <td>83</td> </tr> <tr> <td>Total</td> <td>62.7</td> <td>61.1</td> <td>48.5</td> <td>73.7</td> <td></td> </tr> </table>	Diabetes: Retinal Screening						Maori	64.5	64	43.9	68	83	Other	68.2	66.4	53.6	75.9	83	Pacific	52.9	51.6	40.2	70.3	83	Total	62.7	61.1	48.5	73.7		
Diabetes: Retinal Screening																																
Maori	64.5	64	43.9	68	83																											
Other	68.2	66.4	53.6	75.9	83																											
Pacific	52.9	51.6	40.2	70.3	83																											
Total	62.7	61.1	48.5	73.7																												
Reduced impact of some cancers	<p>Increase current breast screening rates for all groups by 5%</p> <p>Breast screening rate (Sept. 06 figures)</p> <ul style="list-style-type: none"> • 'High needs' 38.6% • Overall 38.27% <p>Increase current cervical screening rates for all groups over past years' performance</p>	<p>Rates increased by 5% per year towards national goal of 70%</p> <p>Continue to improve rates</p>																														
Improved treatment of cancers	<p>Improved waiting times for CT scans and MRI imaging</p> <p>Acutes /Therapy course /Standard protocols/suspect tumour, CT scans and MRI imaging must be done within the timeframe designated by the clinician (timely fashion)</p> <p>Non-urgent CT scan and MRI imaging - waiting times for CT scan - absolute maximum of 12 weeks waiting and absolute maximum MRI of 16 weeks</p> <p>All patients wait less than 8 weeks between First Specialist Assessment and the start of Radiation Oncology treatment (where appropriate and excluding Category D)</p>	<p>Meet all Ministry guidelines for cancer waiting times: radiation oncology, chemotherapy</p> <p>100% compliance within 8 week targets where appropriate</p>																														

4.1.2 Improved child and youth health

A Child Health Improvement Plan was developed in 2006 to prioritise and coordinate activity to improve child health status. The Plan covers work across the continuum from health promotion to specialist interventions for children who are very unwell.

Prevention programmes for Maori, Pacific, children living in poverty, and others with high need are a priority. There will be a focus on the Well Child national framework, especially breastfeeding, immunisation, nutrition, exercise and oral health. Over time these efforts will contribute to reduced diabetes, obesity, cardiac disease, and cancer.

Because of the importance of the wider determinants of health, we work with other agencies on improving housing, reducing neglect and trauma; and advocating on issues affecting families/whanau. We will do more to ensure that disabled children and young people get the assistance they need.

We want every child in Auckland enrolled with a PHO, with effort on reducing preventable admissions to hospital. We need to reduce inequalities in access to primary health care services for Maori and Pacific. Tertiary paediatrics services will work with primary care to expand community-based expertise in the care of serious illness and chronic conditions. The role of PHOs is critical in reducing any problems associated with disability or illness.

A youth health plan will be developed in 2007-08. Existing programmes focus on smoking, sexual health, teenage pregnancy, injury, suicide, child abuse, violence, drug and alcohol abuse. Well coordinated school-based health programmes are especially important.

Objective 2007-08	2007-08 targets	Target by 2010
PHO enrolment	90% of high needs groups enrolled in with a PHO	All ADHB children enrolled
Immunisation cover	Provide information on ADHB Birth cohort and maintain NIR Work towards the target of 95% of 2 year olds fully immunised: 70% children fully immunised at 6 months 80% children fully immunised by age 12 months 65% children fully immunised by age 18 months 80% children fully immunised by 2 years 80% DTaP vaccine dose three at one year of age 70% of children have received MMR dose 1 by 18 months Improved rates for Maori and Pacific over 2006-07 figures	89% coverage for 6 week immunisations 89% coverage 3 month immunisations 85% coverage 5 month immunisation 65% coverage 15 month immunisations
Oral health	Percentage of children caries free at 5 years: Total: 60% Maori: 44% Pacific: 35% Asian: 59% European: 80% Other: 80% Teeth of year eight children decayed, missing or filled (DMFT) Asian: 1.1 European: 0.8 Maori: 1.5 Pacific: 1.8 Other: 1.1 Total: 1.1 Progress towards 46% young people use of oral health services Ensure Auckland water supplies continue to be fluoridated with Onehunga targeted for fluoridation	5% improvement for Maori and Pacific 1.1 for Maori and Pacific 50% young people use of oral health services
Ambulatory sensitive hospitalisations	Remain below the national average Reduce % of avoidable hospital discharges (as identified by relevant ICD10 codes) for children and young people	Remain below national average 5% from previous year

Reduce % of avoidable hospital discharges for Maori and Pacific	5% reduction from previous year
The ADHB region and ethnic rate is currently greater than the total NZ (all ethnicity) national rate	

4.1.3 Improve the health and independence of older people

The Healthy Ageing 2020 Plan has been completed with priorities set for future work. The activities cover the continuum, starting with preventing problems and promoting good health and wellbeing. These include programmes to stop smoking, exercise, eat well, get mental and social stimulation; and falls prevention.

We work with other agencies to ensure older people have affordable housing and are supported to remain in the workforce. This includes advocacy work to reduce discrimination and the abuse of older people.

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 with increased independence.

We need to reduce the gap in life expectancy between Maori and Pacific people compared to 'Others', and we need to do more for older new migrants.

The management of chronic conditions is the focus for 2007-08 with more community-based PHO assistance for people with diabetes and heart disease. We know self management makes the biggest difference for people and we can orientate services to assist with this.

We will help healthcare providers treat early signs of mental health problems in older people; to recognise depression, and to improve the well being of older people with dementia and Alzheimers.

Objective 2007-08	2007-08 targets	Target by 2010
Ambulatory sensitive hospitalisations	Remain below the national average	Further reductions in ambulatory sensitive hospitalisations
	Reduction in ambulatory sensitive hospitalisations (by ICD10 codes) for 65-74 year olds	
Matching services to needs	10% reduction in number of assessments per person 65+ requiring help.	4% reduction in number of assessments per person
	Increase in number of people 85+ remaining in their own homes	5% increase from previous year

4.1.4 Improved services for people with mental illness

The local Mental Health Plan has been completed and will guide actions from 2007-08. A prioritisation framework is linked to this so that mental health funding is allocated to priority needs and shows a transparent process.

The Plan will focus on improved services for our high needs groups and where there are gaps in services. We will strengthen the role that primary health care takes in the care of people who are also using community mental health services. There is more that can be done in primary care settings to improve the physical and mental health of consumers.

The work of primary health care should expand over time to assess and manage mental health problems that are mild to moderate. This work, particularly brief interventions, can reduce the overall rate of mental illness in our local population.

We want to address the other needs of consumers like housing and employment by working more closely with other agencies.

We will improve the quality of service by accelerating training for our workforce and monitoring services better.

Objective 2007-08	2007-08 targets	Target by 2010												
Work towards Ministry of Health annual access targets	Child and youth (for total: Maori and others) 1.8 Adults (for total: Maori and others) 2.6 Older people (for total: Maori and others) 3.15 Our Access trend figures for 2005-06 year: <table border="1"> <thead> <tr> <th></th> <th>Target</th> <th>Actual</th> </tr> </thead> <tbody> <tr> <td>Children and adolescents</td> <td>1.8%</td> <td>0.76%</td> </tr> <tr> <td>Adults</td> <td>2.6%</td> <td>1.63%</td> </tr> <tr> <td>Older people</td> <td>3.15%</td> <td>3.07%</td> </tr> </tbody> </table>		Target	Actual	Children and adolescents	1.8%	0.76%	Adults	2.6%	1.63%	Older people	3.15%	3.07%	Improve trend towards Blueprint figures. Future targets to be agreed with Ministry of Health
	Target	Actual												
Children and adolescents	1.8%	0.76%												
Adults	2.6%	1.63%												
Older people	3.15%	3.07%												
Results for people with enduring severe mental illness	90% of long-term clients have plans in place to help prevent a relapse of the illness Percentage of adults with enduring serious mental illness (after two years or more of treatment since the first contact with a mental health service) Increasing number of long-term clients involved in paid work or education/training Implement some of the national KPIs within the 2006-07 KPI project	Maintain rate of 90% or better for relapse plans 5% reduction from 2006-07 figures 5% increase from previous figures												
Blueprint spend	Allocate 100% Blueprint funding as per the Annual Plan initiatives for 2007-08	Greater use of the prioritisation tool to allocate Blueprint money across priority areas												

4.1.5 Respond to high needs groups

The DHB is responsible for resolving significant and unacceptable inequalities in health status between groups in our city. Without remedial action inequalities can perpetuate over time and become worse.

In the first instance we make sure that Maori rights are protected under the Treaty of Waitangi via the partnership arrangement with Te Runanga O Ngati Whatua. We engage with other Maori communities to address the determinants of health.

The groups with greatest disadvantage are Maori, Pacific people, South Asians, refugee communities, disabled people, and people living in poverty. Our prioritisation process helps to manage the competition for health resources and makes resource allocation fair and transparent.

Our analytical work needs to continue so we understand more about the ways that age, gender, ethnicity and socioeconomic status affects health. As a DHB focused on population health, we are concerned with the wider determinants of health such as housing, income levels, social policy etc. We work with other agencies where there are overlaps.

Objective 2007-08	2007-08 targets	Target by 2010
Implement the Treaty of Waitangi	Evidence of Tihi Ora and Maori Health Advisory Committee involvement in all Planning and Funding initiatives to improve health gain Involvement of Treaty Partners in prioritising funding allocations Board members undertake Treaty of Waitangi training	Levels of engagement maintained Incoming Board and Committee members have training opportunities
Systematic approach to inequalities	Update the Health Needs Assessment with 2006 census data and reassess the inequalities identified Apply the national equity tool to address inequalities Improved ethnicity reporting across all Auckland DHB services and the workforce	Evidence of updated data and HEAT tool used in decision making More programmes and projects in place to promote ethnicity data collection
Maori health	All contracts due to expire in 2007-08 reviewed to ensure service specifications address Maori health need Funding for Maori health and disability initiatives increased by 7% Establish a family violence prevention programme Maori cardiac rehabilitation initiative and Healthy Lifestyle Planners (Ahua Ora) programme All PHOs have Maori health plans approved 5% reduction in DNAs for Maori using provider arm services	Improved analysis of the spend on Maori health 5% per annum reduction in DNA rates
Pacific health	Parish Community Nursing services underway with CVD and diabetes screening programmes in place in churches	5% improvement in community based

	<p>Improved rates of smoking cessation, breast and cervical cancer screening</p> <p>Numbers of people involved in programmes that improve nutrition and physical activity</p> <p>Increase in Well Child checks, immunisation, hearing and dental checks for Pacific children</p>	<p>screening rates</p> <p>20% increase in people attending lifestyle change programmes</p> <p>Increase in all child health checks</p>
Health gain for refugees and people from South Asia	<p>Updated regional data available on refugee and migrant health needs</p> <p>Improve refugee data collection in PHOs</p> <p>Expanded interpreter services available in primary care</p> <p>Improved rate of refugee and South Asian involvement in detection and treatment of CVD and diabetes</p> <p>Focus on actions under the Auckland Settlement Action Plan; Goal 4. Improve Physical and Mental Health Outcomes</p>	<p>Better systems for data collection on all target areas</p> <p>Specific targets for increased performance set in 2007-08</p>
Disabled people	<p>All planning, funding and service development work reflects a disability perspective</p> <p>Research completed on the disabled population to establish needs, barriers to service, service use, and gaps</p> <p>Auckland DHB staff have opportunities for training aimed at improved understanding of disability needs</p> <p>Funding and boundary issues resolved for people under 65 years re service links and the provision of equipment</p>	<p>Partnerships with other professional agencies to improve services</p> <p>Work across the ADHB reflects the social model of disability</p> <p>Knowledge used to set targets for 2010</p> <p>Evidence of staff undertaking training on disability issues</p> <p>Funding issues resolved</p>

4.1.6 Improve the rate of elective services

Auckland DHB needs to improve the rate of intervention for elective services. Work is underway with a special focus on orthopaedics and cataract initiatives.

The improvements lie in activity related to patient flow management, the level of service and order of service. We will also achieve equitable access to elective cardiac procedures for Maori.

Objective 2007-08	2007-08 targets	Target by 2010
Match performance to need	<p>Get more information to establish the right mix of services for local need</p> <p>Improve intervention rates for Maori and Pacific and where</p>	<p>Increase analysis and data collection to inform planning</p>

	other inequalities exist																												
Waiting times within guidelines	Meet elective services performance indicators for procedures under Ministry of Health guidelines	Increase internal capacity to deliver target interventions across 11 procedures																											
	Maintain compliance in all Elective Services Patient Flow Indicators (ESPIs)	All achieve the highest ratings in specific areas :																											
	<table border="1"> <thead> <tr> <th>ESPIs</th> <th>Threshold for compliance</th> <th>ADHB Target</th> </tr> </thead> <tbody> <tr> <td>1. communication of referral acceptance/ or non-acceptance/triage status within 10 working days to patient and GP/referrer</td> <td>> 90%</td> <td>> 90%</td> </tr> <tr> <td>2. patients waiting longer than six months for their first specialist assessment (FSA)</td> <td>< 2%</td> <td>< 2%</td> </tr> <tr> <td>3. patients waiting without a commitment to treatment whose priorities are higher than actual treatment threshold (ATT)</td> <td>< 5%</td> <td>< 5%</td> </tr> <tr> <td>4. clarity, certainty of plan of care / no patients on residual waiting lists</td> <td>Nil</td> <td>Nil</td> </tr> <tr> <td>5. patients given a commitment to treatment but not treated within six months</td> <td>< 5%</td> <td>< 5%</td> </tr> <tr> <td>6. patients in active review who have not received a clinical assessment within the last six months</td> <td>< 15%</td> <td>< 15%</td> </tr> <tr> <td>7. patients who have not been managed according to their assigned status and who should have received treatment</td> <td>< 5%</td> <td>< 5%</td> </tr> <tr> <td>8. percentage patients treated prioritised on national recognised tool</td> <td>> 90%</td> <td>> 90%</td> </tr> </tbody> </table>	ESPIs	Threshold for compliance	ADHB Target	1. communication of referral acceptance/ or non-acceptance/triage status within 10 working days to patient and GP/referrer	> 90%	> 90%	2. patients waiting longer than six months for their first specialist assessment (FSA)	< 2%	< 2%	3. patients waiting without a commitment to treatment whose priorities are higher than actual treatment threshold (ATT)	< 5%	< 5%	4. clarity, certainty of plan of care / no patients on residual waiting lists	Nil	Nil	5. patients given a commitment to treatment but not treated within six months	< 5%	< 5%	6. patients in active review who have not received a clinical assessment within the last six months	< 15%	< 15%	7. patients who have not been managed according to their assigned status and who should have received treatment	< 5%	< 5%	8. percentage patients treated prioritised on national recognised tool	> 90%	> 90%	ESPI 2 0.0%-2.0% ESPI 5 0.0%-5.0% ESPI 6 0.05-15.0% ESPI 8 90.1%-100%
	ESPIs	Threshold for compliance	ADHB Target																										
	1. communication of referral acceptance/ or non-acceptance/triage status within 10 working days to patient and GP/referrer	> 90%	> 90%																										
	2. patients waiting longer than six months for their first specialist assessment (FSA)	< 2%	< 2%																										
	3. patients waiting without a commitment to treatment whose priorities are higher than actual treatment threshold (ATT)	< 5%	< 5%																										
	4. clarity, certainty of plan of care / no patients on residual waiting lists	Nil	Nil																										
	5. patients given a commitment to treatment but not treated within six months	< 5%	< 5%																										
	6. patients in active review who have not received a clinical assessment within the last six months	< 15%	< 15%																										
7. patients who have not been managed according to their assigned status and who should have received treatment	< 5%	< 5%																											
8. percentage patients treated prioritised on national recognised tool	> 90%	> 90%																											
Introduce alternative service delivery options for ophthalmology																													
Recovery plans in place and operational for all procedure areas under target intervention rates																													
<table border="1"> <thead> <tr> <th></th> <th>Base</th> <th>Add</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Elective CWDs</td> <td>10,366</td> <td>1,525</td> <td>11,891</td> </tr> <tr> <td>Estimated elective discharges</td> <td>10,869</td> <td>1,573</td> <td>12,441</td> </tr> </tbody> </table>		Base	Add	Total	Elective CWDs	10,366	1,525	11,891	Estimated elective discharges	10,869	1,573	12,441																	
	Base	Add	Total																										
Elective CWDs	10,366	1,525	11,891																										
Estimated elective discharges	10,869	1,573	12,441																										
Initiatives	Total annual volume of 656 hip and knee joint replacements	Volume increased to meet changes in need																											
	Total annual 1038 cataract procedures	Improved compliance to Elective Services Performance Indicators																											

4.2 Targets for performance improvement

Long term efficiency objectives

The following measures relate to activities that cut across all the health gain priority areas. These activities concentrate on activities necessary to improve performance, typically efficiency and productivity, quality and safety.

4.2.1 Service quality and safety

We aim to continuously improve the quality of service and safeguard high standards of care. Much of this activity involves developing systems and processes, and extending beyond the hospital into PHOs and other providers. We want the whole sector to support and embed quality improvement.

We will comply with Health and Disability Safety Standards and attend to the accreditation/ credentialing needed to be a high-performing hospital.

Objective 2007-08	2007-08 targets	Target by 2010								
Clinical quality	<p>Improve clinical governance of quality and safety using clinical indicators</p> <p>Improved management of reported incidents including risk management strategies</p> <p>Hospital Acquired Bloodstream Infections (per thousand inpatient admissions) >6.8</p>	>6.8								
Number of falls in hospital	<p>Reduce numbers of falls while in care to under 1,000</p> <table border="1"> <thead> <tr> <th>2002-03</th> <th>2003-04</th> <th>2004-05</th> <th>2005-06</th> </tr> </thead> <tbody> <tr> <td>856</td> <td>1082</td> <td>1183</td> <td>1164</td> </tr> </tbody> </table>	2002-03	2003-04	2004-05	2005-06	856	1082	1183	1164	Continue to reduce falls
2002-03	2003-04	2004-05	2005-06							
856	1082	1183	1164							
Customer satisfaction	<p>Overall weighted satisfaction per customer survey</p> <p>>=87%</p> <p>Complaints resolved within 30 days</p> <p>>=65.0%</p>	<p>>=87%</p> <p>>=65% complaints resolved</p>								
Medical indicators of quality	<p>11.40 Patients Seen Within Triage Time Triage Category 4 - 1 hour AED</p> <p>Rate</p> <p>100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>2004 O D F A J A O D F A J A O D</p> <p>Month</p> <p>—●— Emergency Medicine - - - - Threshold (ACEM) — ACHS Major ED average</p>	Triage times increased from previous year								

	<p style="text-align: center;">11.50 Patients Seen Within Triage Time Triage Category 5 - 2 hours AED</p> <p style="text-align: center;">Improve triage times for category four closer to threshold rates</p>	
<p>Data provided to the National Collections Systems</p>	<p>Less than or equal to 1% of NHI duplicates require merging by NZHIS per DHB per quarter</p> <p>Less than or equal to 3% of the total number of NHI records are created with ethnicity status of 'Not Stated' or 'Other' per DHB per quarter</p> <p>Less than or equal to 4% of the number of discharge events with an error DRG</p>	

4.2.2 Human resource management

Our goal is to recruit and retain the right mix of staff with the right skills. We will increase the number of high quality staff, strengthen the intellectual capital of ADHB; and find new ways of using scarce human resources. Flexibility is key, both in work opportunities and more opportunity for medical and allied staff to work outside the hospital.

We will do more to support staff to provide the best healthcare to the people we serve. This means valuing staff and providing support to do high quality, culturally competent work. The Tikanga best practice guidelines and the Pacific cultural competency framework will help with this.

We will work with educational institutions and professional bodies to influence placements and quality of education. The relationship with the Faculty of Medical and Health Sciences is vital and we recognise the faculty's role as our partner for graduate medical and nursing teaching, and for research.

Objective 2007-08	2007-08 targets	Target by 2010
<p>Staff recruitment and retention</p>	<p>Improve staff retention through targeted programmes</p> <p>Maintain voluntary staff turnover at or under 12% (turnover 12% for 2006-07)</p>	<p>Further programmes to increase staff satisfaction</p> <p>Maintain turnover at or under 12%</p>
<p>Manage leave and lost time</p>	<p>Reduce the sick leave rate for high users (people using more than 50% of allocated sick leave annually)</p> <p>2006-07 sick leave rate 2.4% (whole organisation over 6 mths)</p> <p>2005-06 sick leave rate 2.4% over all organisation</p> <p>Manage injury rates. Workplace injuries. Lost time injury frequency rate 7.0.</p>	<p>Reduce sick leave for high users and address contributing factors where possible</p>

4.2.3 Productivity and efficiency

Efficiency means focusing on the client, streamlining care, providing the supports needed, and removing barriers to services.

Efficiency relates to how we organise the services. Reviews of all our services and other projects have shown us how we can work better. We will implement review findings and attend to service changes required.

We need to improve our waiting times for elective services. We also need to get the right mix of specialist services with secondary service to maintain clinical competence, quality, efficiency and service viability. This planning work is done with our neighbouring DHBs.

We will manage direct treatment costs and high cost patients. This means advocating for funding to recognise the specialist work we do for the rest of the country and our role as a hospital of last resort.

Objective 2007-08	2007-08 targets	Target by 2010
After hours model of care, Productivity planning and Surgical process review	Increase in surgical bed turnover Reduced surgery cancellations and theatre downtime Reduced waiting lists, length of stay and DNA rates Operating room internal efficiency measures meet benchmarks Discharge forecasting is accurate Staff resources managed: Nursing and Clinical hours per patient day	Specific targets under construction

4.3 Financial targets

Long term financial objectives

The following measures relate to being a disciplined organisation. There have been considerable gains over previous years to drive down a large deficit, however there is still more work to do to consolidate gains and to deliver a break even position.

4.3.1 Strong financial management

Over the long term we want greater efficiency and across the board reduction in cost. The activities in goal one: lift the health of people in Auckland should contribute to this by preventing problems outside the hospital; improving population health and reducing the demand for specialist services and associated high treatment costs.

We will set a deficit target each year with no variations and only expand the cost base where there is new revenue. Some issues around fair pricing for work need to be resolved with the sector and these are being discussed with the Ministry of Health.

Objective 2007-08	2007-08 targets	Target by 2010
Improve responsibility in financial management	<p>Net Operating Result is Break Even or better from 2007-08 onwards</p> <p>No initiatives advanced without associated funding</p> <p>Operating target surplus met for provider arm</p> <p>Funder arm achieves break even position</p> <p>Adhere to debt repayment programme</p>	<p>Maintain Break even or better position</p> <p>Maintain strict control of budget</p> <p>Achieve savings</p>
Staff costs	<p>Average of wage settlements agreed during 2007-08 to have 'headline' increase \leq FFT (future funding track)</p> <p>Reduce overpayments to staff by 50% from 2006-07 levels</p> <p>Administration costs to be maintained at \leq 10.5% of provider revenue (Ministry benchmark).</p>	<p>All wage increases within FFT</p> <p>Further gains in this area</p> <p>Costs maintained \leq 10%</p>
Demand driven costs	<p>Manage demand driven community laboratory and pharmaceutical costs.</p>	<p>Realise all the gains possible</p>
Facilities	<p>Environmental projects in place to reduce energy use with energy costs to below 2006-07 costs</p>	<p>Reduced energy use from previous year</p>
Problems related to the funding formula	<p>Resolve problems associated with the Population Based Funding Formula</p> <p>Resolve problems associated with the tertiary adjuster to ensure tertiary hospitals are fairly recompensed</p> <p>Retain the viability of specialty 24/7 services</p>	<p>Funding issues progressed</p> <p>Viable and sustainable funding base</p>

4.3.2 Productivity and clinical effectiveness

We have completed reviews of our service areas to find further efficiencies. In 2007-08 we will continue to implement review findings. We will keep infrastructure costs low and within funding; realise the cost saving efficiencies from benchmarking and our analytical work.

Provider arm expenditure is managed by each service operating to a business plan with outcomes.

We need to manage direct treatment costs and cost of treating people from other districts. There are tight controls and transparent decision making to manage changes in clinical practice, particularly high cost work. There is high clinician governance over service delivery and cost-effective care.

It is important that we manage the demand for specialist services and functions associated with our role as a hospital of last resort. We anticipate growing demand for services in some areas from population-based funding, but a reduction in others as other DHBs establish their own speciality areas.

Objective 2007-08	2007-08 targets	Target by 2010
Costing systems and coding	Improvements in the costing system and business intelligence systems 100% accuracy of classification into ADHB population, DHB referrers, ACC and overseas patients Refine our purchase unit reporting by revenue and cost	Accurate reporting for all events
Revenue management	Recommendations of the Coding Review to enhance decision making all implemented	Improved accuracy of feedback to customers
Procurement	40 key suppliers managed through quarterly business review process Participate in DHBNZ purchasing initiatives	
New technology	All new technology introduced through the prioritisation process and with funds attached (with help from Clinical Practice Committee and SPNIA)	

4.3.3 Manage contracts and volumes

The strategy for managing losses associated with our provider arm is to separate the hospital deficit from the wider Auckland DHB responsibility for population health gain. We will meet budget targets for the treatment of people living in Auckland city by managing contracts for the hospital as two businesses: one for Auckland DHB and one for other DHBs.

Keeping the cost of treating people from other districts within the provider arm depends on compliance to Auckland DHB contracts. To do this we need to track funding by linking patient NHI numbers to service use. This involves business intelligence systems for monitoring, analysis and benchmarking.

We will deliver just the work that is required by other DHBs; manage patient volumes by meeting contracted levels of service; and recover the costs for services provided to other DHBs.

Objective 2007-08	2007-08 targets	Target by 2010
Meet budget targets for treatment	Volumes within contracted levels with volumes split into ADHB residents and others (contract and others) Costs recovered from ACC and others	100% accuracy of coding with all costs recovered

Interdistrict flow volumes at 100% of contract and costs within budget	100% of costs recovered
Monthly meetings to manage IDF customers and variations agreed through the DHB of domicile	Interdistrict flows remain within budget

Reporting to the Minister of Health

The following table lists the reports made to the Minister, via the Ministry of Health, and the frequency of that reporting.

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

In addition to the above regular reporting, 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 2007-08 District Annual Plan will be taken out for public consultation.

5. Financial Information

5.1 The funding available

Base funding for 2007–08

The national population-based funding formula is used, with adjustments, to calculate the funding available to Auckland DHB each year. This funding is used by Auckland DHB to provide the range of services required by people living in Auckland city.

(\$ million)	(A+B+C)	A	B	C	D	(C+D)
	FE draft 2007/08 PV/ budget	Top slices	IDF inflows	ADHB	ADHB IDF outflows	Total ADHB population
Provider arm: personal health	710.022	23.026	355.725	331.271	42.496	373.767
Provider arm: DSS (65+)	28.988		12.645	16.343	8.138	24.481
Provider arm: mental health	82.552	2.032	13.740	66.780	11.902	78.682
Total provider arm	821.562	25.058	382.110	414.394	62.536	476.930
DSS - HOP NGO	91.410		1.586	89.824	0.495	90.319
Mental health - NGO	28.970	0.535	13.073	15.361	3.646	19.007
Community laboratories	63.500		43.914	19.586	0.581	20.167
Community pharmacies	95.630		21.743	73.887	11.910	85.798
PHO, GMS, PN, rural retention	71.000		14.612	56.388	10.186	66.575
Other	21.662		12.493	9.168	4.525	13.693
Total funder arm	372.171	0.535	107.420	264.215	31.342	295.558
Total provider & funder	1,193.733	25.593	489.530	678.609	93.879	772.488

Changes to population-based funding for 2007–08 include:

- additional funding for increases in population and for 'inflation' (future funding track/demographic growth fund)
- adjustments to inter-district flows
- adjustments to the base funding to incorporate Financial Reporting Standard 3, PHO, nurses pay jolt and PSA pay which were previously funded as top slice funding
- reduction in Mental Health funding to remove forensic mental health from DHB funded to Ministry of Health top slice funding to the DHBs that provide the service

- reduction of \$15 million of Auckland DHB population revenue used as price rebasing and passed to other DHBs

Auckland DHB will receive demographic growth funding in 2007-08 of \$28 million. This figure has been reduced from \$54 million by the Ministry of Health, implementing a 7% cap on the increase over last year's funding.

Mental health growth will be in line with our mental health ring fence obligations.

Growth in laboratory and pharmaceuticals is consistent with PHARMAC and Ministry of Health assumptions. These reflect the national Primary Care Strategy drivers.

Growth of 2% on the Auckland DHB population has been allowed for in aged residential care. The financial impact of the changes in income and asset testing and funding to match is uncertain.

Elective services

Funding for the Auckland population has been adjusted to reflect the demand for acute services experienced by the provider arm, and to improve access to elective services for the Auckland population. The contract with the provider arm is to purchase caseweights of service to bring Auckland close to the National Intervention Rate level.

The interdistrict flows volumes (the people that Auckland DHB treats from other DHBs) will reflect the volume of work agreed across the region and nationally; and despite ongoing repatriation of work, there is continuing demand from other DHBs for services. This is driven to some extent by additional electives and pressures to reduce waiting lists.

Disability support service imbalance

Despite the implementation of interdistrict flow for Disability Support Services residential care services for people aged 65 years and over, there remains an apparent over-servicing of the Auckland DHB population for access to these services. Part of this imbalance arises from the local authority (TLA) adjuster (approximately \$2.5 million) where Auckland DHB is required to pay a higher price per bed day than that received under the average population based funding revenue stream.

Services for Otahuhu

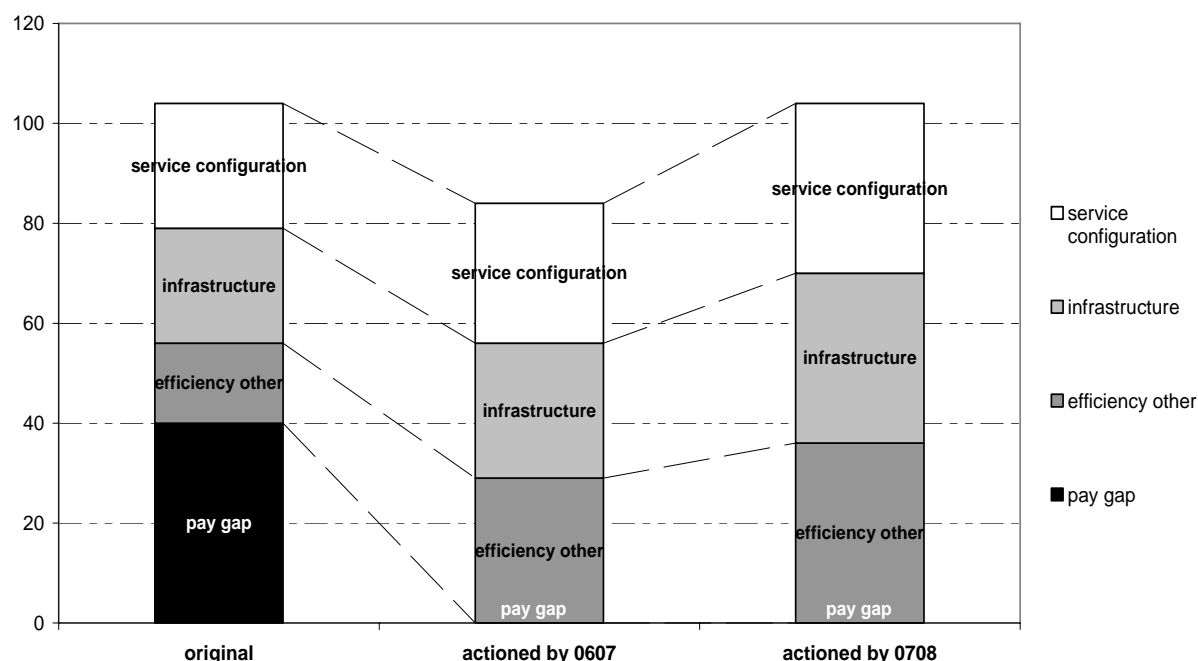
There have been historical problems associated with providing care for people living on the border between Auckland DHB and Counties Manukau DHB. Progress to improve the funding of services provided in Otahuhu is underway and this work to resolve interdistrict flow arrangements between the two DHB will continue in 2007-08.

5.2 Financial management

Reducing the deficit

Auckland DHB has exceeded original expectations in improving financial performance and is on a path to recovery from a large and serious deficit. The recovery process has addressed the four root causes of the deficit. The following chart shows the factors making up the deficit and the action on these.

Composition of and action on the deficit



Significant gains have been made through:

- tight Control over FTE (staff numbers) growth
- producing outputs in excess of FTE growth
- restraints on Capital Expenditure

Tight control over operational expenditure: simply getting more out of working more intelligently, working fixed assets harder and working closely with suppliers to take costs out of the supply chain and end product. This is being achieved in a climate of significant cost increases in the health sector.

Productivity (reported on a case weight per working day basis, against last year, against budget and against revenue) has increased and is an important contributor to our success

in reducing the deficit. Improvements have however slowed recently and have been impacted by strike action.

Benchmarking between DHBs has been used to identify productivity issues. This can identify differences but needs to focus more on implementing organisational change that alters performance with the required level of management buy-in. Change is best achieved by local teams of managers, supervisors and their immediate teams working together to identify and solve blockages.

Auckland DHB will address the timely measurement and reporting of production. This work will provide the base for measuring labour and direct costs against units of production, rather than against fixed budgets. Measuring costs as a percentage of output against last year and budget is critical in Auckland DHB where the provider arm is only paid for production and not cross subsidised by the Funder.

Issues and Assumptions

Cap on growth

We are committed to delivering a break even result in 2007-08. There are however some risks associated with achieving this.

Auckland DHB had a 7% cap imposed on the growth in funding for 2007-08. The linking of costing work (evidence based) and Population Based Funding streams by the Ministry of Health and 'rebasings' was not anticipated by Auckland DHB when committing to a break even position in 2007-08.

Alteration in policy leading to mixing costing disciplines and Population Based Funding introduces risk, in particular the elimination of any margin for error with the imposition of the 7% cap / rebasing. This will require close work with the Ministry of Health to resolve and support, so that we achieve a break even result for 2007-08 and later years.

Payment in advance

During 2007-08 Auckland DHB will be paid in advance each month for inter-district flows and NDOC payments due. Ministry of Health support will be required in implementing an equitable solution, as it is unreasonable for Auckland DHB to fund its customers out of Population Based Funding money, and then on the other hand attract attention for a high cost structure.

Payment for Tier II services

It is assumed that "Tier II" money will continue to be paid in 2007-08 at a level at least equal to 2006-07 i.e. \$15 million, and that there will be continued support from the Ministry of Health as this process continues in the Adult Services area.

Impacts of International Financial Reporting Standards

Some of the impacts of International Financial Reporting Standards are difficult to estimate in a reliable manner and are therefore not all quantified in the operating statement, particularly valuations of loans and interest rate swaps. We will continue to transact such valuation movements through the balance sheet and our Accounts may be in the meantime tagged for this reason.

Revaluation of assets

Auckland DHB policy is to revalue its assets at least every five years. The last revaluation occurred at 30 June 2005. Asset values are increasing at a rapid rate and any revaluation will be significant. 'Desktop' valuations are being done annually to monitor movements in values. Auckland DHB will revalue its assets again in 2010 following its policy however we may be required to undertake this exercise earlier than planned. The impact on the statement of financial performance may be an adverse one of up to \$20 million. Additional costs of this magnitude cannot be funded through the Population Based Funding Formula.

Future Funding Track

In line with Future Funding Track, the following rates have been used to determine budgets for 2007-08:

Employee Costs	2.603%
Direct Treatment Costs	2.603%
Other Costs	2.103%

The rate used for employee costs is 1.0% below the most recent labour cost index for public sector staff (Labour Cost Index and Quarterly Employment Survey: December 2006 quarter). While Auckland DHB will do its utmost to work within its employee cost budget, there is a responsibility on all involved in salary and wage negotiations to have reasonable expectations as to what can be afforded. A one percent variation in Auckland DHB staff costs converts to over \$6 million in additional costs. This will be an issue for later years as there are, following the nurses pay jolt, high expectations in the health sector with respect to wage and salary settlements.

Industrial action

The impact on Auckland DHB (and its patients) of the various strikes, in particular the Laboratory Workers, has been severe. In real terms much more than the reported \$1.4

million in loss when the task of 'winding down' and 'winding up' the organisation is considered.

Auckland DHB, unlike most DHBs, has more than 50% of its provider arm revenue from other DHBs and its revenue from these customer DHBs, in part, varies with production and in the future will be even more at risk.

Auckland DHB is committed to its collective responsibilities in the sector; however, it is not in a position where its revenue (cash) streams remain unaltered through nationwide industrial action. The cost to Auckland DHB is far in excess of settlements contemplated. For most DHBs a strike can (notwithstanding patients are not treated) improve DHB performance (in the short term) with revenue being allocated to the Provider on, for example, a 1/12th basis against a lower cost base during the strike. The Auckland DHB provider is only paid for actual production.

In future Auckland DHB expects support for aligning with this collective responsibility. As a stand alone business (and assessed as such), its response would be more fiscally driven under current rules.

Cost of tertiary services

The commitment of the sector and Ministry of Health in particular, to the Tier II process has been welcomed and Auckland DHB is keen to see similar vigour applied to the Tertiary Adjuster mechanism. Auckland 'costs' have, in the past, been excluded as being 'outlier'. There are two aspects to this:

- the analysis during the Tier II process has led to a process of classifying and identifying these 'outlier' costs and dealing with them
- because Auckland DHB is under intensive monitoring, we are paid in arrears and must pay capital charges monthly, making our costs consequently higher than other DHBs

Auckland DHB's costs are increasing at a rate lower than those of other DHBs and the rationale for excluding Auckland DHB's costs from the costing model is very questionable. Equally, the impact of including them generates perverse results and so the model is in need of the same scrutiny as that applied to Tier II work.

It is assumed that Auckland DHB will be no worse off than it currently is under future costing work. It is clearly evident that in an average cost (price) regime, if a DHB's costs are above the average, such DHBs are all but guaranteed a loss position. The larger the organisation and the more it is exposed to strict National Pricing (through the Interdistrict Flow regime), the larger the loss. There is now clear evidence of cross-subsidisation from Funder to Provider to mitigate this issue in the sector. Auckland DHB's Population Based

Funding is not large enough to cross-subsidise its Provider for its own and other providers' (Interdistrict Flow) populations.

Given the ongoing impact of average prices, exclusion of Auckland DHB's costs and the Funding cap, Auckland DHB is caught in a three-way squeeze. Committing to a break even position requires ongoing support from the Ministry of Health while the pricing mechanism is further refined, and until such time as the full Population Based Funding is applied to Auckland DHB. We have not assumed this full payment in 2008-09.

Capital Expenditure

Capital expenditure will be funded internally through depreciation charges. Auckland DHB intends to set aside long-term depreciation for debt repayment. The capital expenditure budget is set so that there is a \$10.5 million gap per annum between depreciation and capital expenditure to allow for the debt repayment.

A cash outlay budget for 2007-08 has been set at \$45.65 million. This includes the carry forward from the 2006-07 year of \$10 million and the Domain car park of \$5 million (the balance being incurred in 2008-09). Although this equates to the 2007-08 depreciation charge, it is offset by the reduction in the 2006-07 capital expenditure of \$10 million and includes the car park, an item which is outside of routine capital spending.

Treasury

The Negative Pledge Deed, as amended in 2005-2006, provides for three covenants to be complied with:

1. That cashflow for the year end 30 June is greater than zero
2. That the ratio of debt to debt plus equity is less than 65%
3. That the assets of the parent as a ratio to the assets of the group is greater than 92.5%

The covenants are met over the three financial years ended 30 June 2008, 2009 and 2010. The amortisation of debt at the rate of \$10.5 million per annum is included in each of the financial years. This is funded from long term depreciation on buildings with capital expenditure on plant and equipment limited to the amount of ordinary depreciation on those items.

Forecast

Note that the 2006-07 Forecast is as per IFRS. The GAAP forecast remains at \$20 million deficit. The difference is in the treatment of gains on interest rate hedges. The Funder Surplus in 2006-07 of \$26 million includes \$15 million of Tier II money. Being received part way into the year, it was decided not to alter the Provider Arm budget for 2006-07 and so retain the match of costs and revenues in the Provider for the year.

5.3 Financial tables 2007 -2008

Table1: Statement of Financial Performance

Accounting Basis	2005-06 Actual GAAP \$'000	2006-07 Forecast IFRS \$'000	2007-08 Budget IFRS \$'000	2008-09 Budget IFRS \$'000	2009-10 Budget IFRS \$'000
REVENUE					
Ministry of Health Funding					
Base - Provider	689,737	706,031	822,199	846,865	872,270
Base - Governance	2,824	2,907	2,997	3,087	3,180
Base - Funder	440,585	484,480	476,037	490,318	505,028
	1,133,146	1,193,418	1,301,233	1,340,270	1,380,478
Asset Revaluation	14,191	14,369	-	-	-
Other Contracts	32,111	49,850	60,131	61,935	63,793
	1,179,448	1,257,637	1,361,364	1,402,205	1,444,271
Other Revenue					
Other Patient Care Revenue	30,670	31,495	28,150	28,995	29,865
External Revenue	72,322	73,079	77,836	79,886	82,000
	102,992	104,574	105,986	108,881	111,865
TOTAL REVENUE	1,282,440	1,362,211	1,467,350	1,511,086	1,556,136
OPERATING COSTS					
Employee Costs	544,076	578,330	624,697	643,277	662,886
Treatment Costs	192,761	194,067	203,554	209,661	215,951
Funder Payments	437,155	462,265	490,255	504,963	520,112
Property & Equipment Maintenance	47,262	49,954	51,199	52,724	54,294
Administration	17,295	16,411	17,325	17,845	18,380
TOTAL OPERATING COSTS	1,238,549	1,301,027	1,387,030	1,428,470	1,471,623
OPERATING SURPLUS/(DEFICIT)	43,891	61,184	80,320	82,616	84,513
Non –operating costs					
Depreciation	45,658	44,412	45,094	48,264	51,283
Interest	18,856	19,290	21,969	20,886	20,212
Capital Charge	25,957	23,076	17,453	13,291	12,867
TOTAL NON OPERATING COSTS	90,471	86,778	84,516	82,441	84,362
Net surplus/(deficit) for year	(46,580)	(25,594)	(4,195)	175	151
Other Contributions					
Surplus on Sale of Assets	78	2,275	4,248	23	23
	78	2,275	4,248	23	23
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	(46,502)	(23,319)	53	198	174

Table 2: Statement of Financial Performance by Output Class

Accounting Basis	2005-06 Actual GAAP \$'000	2006-07 Forecast IFRS \$'000	2007-08 Budget IFRS \$'000	2008-09 Budget IFRS \$'000	2009-10 Budget IFRS \$'000
Governance					
Revenue	3,682	2,920	3,008	3,098	3,191
Operating Costs	(8,526)	(8,504)	(10,165)	(10,470)	(10,784)
Operating Margin	(4,844)	(5,584)	(7,157)	(7,372)	(7,593)
Non Operating Costs Depreciation, Interest & Capital Charge	(13)	(15)	(15)	(15)	(15)
Net Surplus/(Deficit) - Governance	(4,857)	(5,599)	(7,172)	(7,387)	(7,608)
Provider					
Revenue	880,644	872,257	977,422	1,006,459	1,036,371
Operating Costs	(840,115)	(828,756)	(894,823)	(921,495)	(949,440)
Operating Margin	40,529	43,501	82,599	84,964	86,931
Non Operating Costs Depreciation, Interest & Capital Charge	(92,362)	(89,589)	(84,501)	(82,427)	(84,348)
Profit on Sale of Land	-	2,275	4,248	23	23
Net Surplus/(Deficit) - Provider	(51,833)	(43,813)	2,346	2,560	2,606
Funder					
Revenue	453,150	492,176	486,921	501,529	516,574
Operating Costs	(442,962)	(466,083)	(482,042)	(496,503)	(511,398)
Operating Margin	10,188	26,093	4,879	5,026	5,176
Net Surplus/(Deficit) - Funder	10,188	26,093	4,879	5,026	5,176
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	(46,502)	(23,319)	53	198	174

Table 3: Employee Costs and FTE

Accounting basis	2005-06 Actual GAAP \$'000	2006-07 Forecast IFRS \$'000	2007-08 Budget IFRS \$'000	2008-09 Budget IFRS \$'000	2009-10 Budget IFRS \$'000
Medical	159,159	172,285	184,132	189,656	195,346
Nursing	175,573	192,950	207,904	214,141	220,566
Technical	86,601	96,744	106,240	109,428	112,710
Hotel Services	8,742	8,830	9,187	9,462	9,746
Administration & Stores	82,650	83,044	89,695	92,385	95,157
	512,725	553,853	597,158	615,072	633,525
% Increase over prior year		8.0%	7.8%	3.0%	3.0%
Other Employee Related Expenses	31,351	28,702	30,974	31,903	32,861
% Increase over prior year		-8.4%	7.9%	3.0%	3.0%
Savings required	-	(4,225)	(3,436)	(3,700)	(3,500)
	31,351	24,477	27,538	28,203	29,361
	544,076	578,330	624,696	643,275	662,886
	-	-	(0)	(0)	(0)
% Increase over prior year		6.3%	8.0%	3.0%	3.0%

FTE Measurement Basis	Contract FTE	Accrued FTE	Accrued FTE	Accrued FTE	Accrued FTE
FTE Numbers at 30 June - including additional MH FTE	7,158	7,640	7,936	7,936	7,936
Average Salary	\$76,009	\$75,698	\$78,717	\$81,058	\$83,529
% Increase		-0.4%	4.0%	3.0%	3.0%

Table 4: Statement of Financial Position

Accounting Basis	2005-06 Actual GAAP \$'000	2006-07 Forecast IFRS \$'000	2007-08 Budget IFRS \$'000	2008-09 Budget IFRS \$'000	2009-10 Budget IFRS \$'000
ASSETS					
CURRENT ASSETS					
Cash & Cash Equivalents	(8,032)	12,332	10,912	4,723	20,853
Term deposits (3 to 12 months)	4,687	3,639	3,639	3,639	3,639
Term deposits (> 12 months)	2,250	2,250	2,250	2,250	2,250
Inventory	9,228	9,826	9,826	9,826	9,826
Prepayments	2,535	4,565	4,796	4,945	5,098
Trade Receivables	108,861	111,289	31,476	31,849	32,206
	119,529	143,901	62,899	57,232	73,872
NON CURRENT ASSETS					
Investment in Associates- Non Current	328	328	328	328	328
Non Current Assets held for Resale	141	92			
Property, Plant & Equipment	685,835	670,636	672,707	659,610	646,600
Intangible Assets	13,505	9,161	7,645	5,479	3,205
	699,809	680,216	680,680	665,417	650,133
TOTAL ASSETS	819,338	824,117	743,579	722,649	724,005
LIABILITIES					
CURRENT LIABILITIES					
Employee Entitlements	89,708	105,372	110,684	107,360	115,243
Insurance Liabilities	3,347	4,020	4,223	4,354	4,489
Tax Payables	11,973	12,528	17,294	18,031	18,580
Deferred Revenue	31,164	35,686	29,771	28,903	29,198
Accounts Payable	79,449	84,078	89,514	92,107	94,684
	215,641	241,684	251,486	250,755	262,194
OTHER FINANCIAL LIABILITIES					
Capital Bonds	120,000	120,000	120,000	120,000	120,000
Crown Funding Authority	150,000	184,500	174,000	163,500	153,000
	270,000	304,500	294,000	283,500	273,000
Loan Interest Accruals	3,495	5,195	5,034	4,880	4,809
Capital Bonds - Establishment Expenses	-	(1,291)	(1,087)	(883)	(679)
Derivatives in Loss	-	542	542	542	542
Other Financial Liabilities	844	904	964	1,024	1,084
	4,339	5,350	5,453	5,563	5,756
	274,339	309,850	299,453	289,063	278,756
TOTAL LIABILITIES	489,980	551,534	550,939	539,818	540,950

(Table continues over page)

Accounting Basis	2005-06 Actual GAAP \$'000	2006-07 Forecast IFRS \$'000	2007-08 Budget IFRS \$'000	2008-09 Budget IFRS \$'000	2009-10 Budget IFRS \$'000
(table 4 continues)					
TAXPAYER'S FUNDS					
Taxpayer's Funds					
General Funds - Opening Balance	186,032	184,048	127,043	47,096	37,295
Net Surplus/(Deficit)	(46,502)	(23,319)	53	198	175
Capital Contributions	44,518	608	-	-	-
Capital Withdrawals	-	(35,000)	(80,000)	(10,000)	-
Other Movements	-	706	-	-	-
General Funds - Closing Balance	184,048	127,043	47,096	37,294	37,470
Revaluation Reserve					
Revaluation Reserve - Opening Balance	143,187	145,309	145,256	145,256	145,256
Movement in Revaluation Reserve					
- Land	-	-	-	-	-
- Buildings	2,122	(53)	-	-	-
Total Movement in Revaluation Reserve	2,122	(53)	-	-	-
Revaluation Reserve - Closing Balance	145,309	145,256	145,256	145,256	145,256
Cash flow Hedge Reserve					
Cash flow Hedge Reserve - Opening Balance	-	-	283	286	280
Revaluation Transfers into reserve	-	(2,827)	3	(6)	49
Other movements-transition to IFRS	-	3,110	-	-	-
Cash flow Hedge Reserve - Closing Balance	-	283	286	280	329
TOTAL TAXPAYER'S FUNDS	329,357	272,582	192,638	182,830	183,055
TOTAL ASSETS	819,337	824,116	743,577	722,648	724,005

Table 5: Statement of Cash Flows

Accounting Basis	2005-06 Actual GAAP \$'000	2006-07 Forecast IFRS \$'000	2007-08 Budget IFRS \$'000	2008-09 Budget IFRS \$'000	2009-10 Budget IFRS \$'000
<u>OPERATING ACTIVITIES</u>					
Cash provided from					
Receipts for services from the Crown	1,198,977	1,297,690	1,389,602	1,436,652	1,480,754
Repayment of Debtors by the Crown	-	-	74,717	-	-
Sale of services - 3rd parties	72,464	41,440	49,274	44,981	46,598
Total receipts for services	1,271,441	1,339,130	1,513,593	1,481,633	1,527,352
Rental income other		4,529	4,266	4,394	4,525
Miscellaneous receipts - 3rd parties		18,097	21,223	21,645	22,079
Total cash provided from operations	1,271,441	1,361,756	1,539,082	1,507,672	1,553,956
Cash distributed to					
Personnel costs	(506,169)	(561,960)	(616,440)	(646,131)	(654,727)
Suppliers - 3rd parties	(719,973)	(719,735)	(758,319)	(782,607)	(806,071)
Total personnel and suppliers payments	(1,226,142)	(1,281,695)	(1,374,759)	(1,428,738)	(1,460,798)
Capital charge payments	(19,263)	(23,235)	(16,059)	(13,301)	(12,973)
Total cash disbursed to operations	(1,245,405)	(1,304,930)	(1,390,818)	(1,442,039)	(1,473,771)
Net cash flow from operations	26,036	56,826	148,264	65,633	80,185
<u>INVESTING ACTIVITIES</u>					
Cash provided from					
Interest receipts	2,111	3,434	2,230	2,227	2,227
Proceeds from loans - CE	(236)	34,500	(10,500)	(10,500)	(10,500)
Proceeds from loans - 3rd parties		-	-	-	-
Total proceeds from loans	(236)	34,500	(10,500)	(10,500)	(10,500)
Sale of property plant and equipment	128	2,275	4,248	23	23
Total cash provided from investing	2,003	40,209	(4,022)	(8,250)	(8,250)

(Table continues over page)

Accounting Basis	2005-06 Actual GAAP \$'000	2006-07 Forecast IFRS \$'000	2007-08 Budget IFRS \$'000	2008-09 Budget IFRS \$'000	2009-10 Budget IFRS \$'000
(Table 5 continues)					
Cash distributed to					
Purchase of share investments and other securities	(2,179)	1,048	-	-	-
Purchase of property plant and equipment	(34,539)	(25,001)	(45,558)	(33,000)	(36,000)
Total cash disbursed to investing	(36,718)	(23,953)	(45,558)	(33,000)	(36,000)
Net cash flow from investing activities	(34,715)	16,256	(49,580)	(41,250)	(44,250)
<u>FINANCING ACTIVITIES</u>					
Cash distributed to					
Interest payments - CE	(10,361)	(9,392)	(11,892)	(11,092)	(10,335)
Interest payments - 3rd parties	(8,423)	(9,489)	(10,034)	(9,744)	(9,744)
Total interest payments	(18,784)	(18,881)	(21,926)	(20,836)	(20,079)
Capital contributions	44,518	608	0	-	-
Capital withdrawal	-	(35,000)	(80,000)	(10,000)	-
GST on outputs	160,305	170,276	183,950	189,652	195,531
GST on inputs	(86,809)	(90,337)	(95,292)	(98,246)	(101,291)
GST paid/refunded to IRD	(73,496)	(79,384)	(86,836)	(91,140)	(93,965)
Net GST	-	555	1,822	266	275
Total cash disbursed to financing	25,734	(52,718)	(100,104)	(30,570)	(19,804)
Net cash flow from financing	25,734	(52,718)	(100,104)	(30,570)	(19,804)
NET INCREASE/(DECREASE) IN CASH HELD	17,055	20,364	(1,420)	(6,187)	16,131
OPENING BALANCE CASH & CASH EQUIVALENTS	(25,087)	(8,032)	12,332	10,912	4,725
CLOSING BALANCE CASH & CASH EQUIVALENTS	(8,032)	12,332	10,912	4,725	20,856

Table 6: Balance Sheet Equity Ratio

Accounting Basis	2005-06 Actual GAAP \$'000	2006-07 Forecast IFRS \$'000	2007-08 Budget IFRS \$'000	2008-09 Budget IFRS \$'000	2009-10 Budget IFRS \$'000
Equity Position					
Crown Equity	(320,351)	(263,576)	(183,632)	(173,825)	(174,048)
Trust Equity	(9,851)	(9,911)	(9,971)	(10,031)	(10,091)
Net Equity	(330,202)	(273,487)	(193,603)	(183,856)	(184,139)
Total Debt					
Bank	(8,032)	-	-	-	-
Bonds	(120,000)	(120,000)	(120,000)	(120,000)	(120,000)
Crown Funding Authority	(150,000)	(184,500)	(174,000)	(163,500)	(153,000)
	(278,032)	(304,500)	(294,000)	(283,500)	(273,000)
Total Debt	(278,032)	(304,500)	(294,000)	(283,500)	(273,000)
Total Debt + Equity	(608,234)	(577,987)	(487,603)	(467,356)	(457,139)
Equity Ratio - to be less than 65%	45.7%	52.7%	60.3%	60.7%	59.7%

5.4 Statement of accounting policies

The reporting entity is the Auckland District Health Board (ADHB) 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 ADHB Group in accordance with NZ International Financial Reporting Standards.

Auckland DHB is a public benefit entity (PBE), as defined under 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 the 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 that are 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 ADHB Charitable Trust are consolidated into the preliminary opening NZ International Financial Reporting Standards 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), Treaty Relationship Company Limited (50% owned) and Westkids 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	<ul style="list-style-type: none"> Freehold land Land improvements Plant and equipment Freehold buildings Building fitout and services Leasehold improvements Work in progress Leased plant and equipment
Owned assets	<p>Except for land and buildings (as well as the assets vested from the hospital and health service – see below), items of Property, Plant and Equipment are stated at cost, less accumulated depreciation and impairment losses.</p> <p>Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every 5 years. The latest revaluation was done on 30 June 2005.</p> <p>Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the Income Statement in which case the increase is recognised in the Income Statement.</p> <p>Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the Income Statement.</p> <p>Additions to Property, Plant and Equipment between valuations are recorded at cost.</p> <p>Where material parts of an item of Property, Plant and Equipment have different useful lives, they are accounted for separately.</p>
Property, Plant and Equipment vested from the Hospital and Health Service	<p>Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Auckland Healthcare Services Limited (a hospital and health service) vested in Auckland DHB on 1 January 2001. Accordingly, assets were transferred to Auckland DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.</p>

Disposal of Property, Plant and Equipment 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:

<u>Asset Class</u>	<u>2007-08</u>	<u>2006-07</u>
Freehold Buildings	1-89 years	1-89 years
Plant and Equipment	2-20 years	2-20 years
Building Fitout 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 credit worthiness of the counter-party.

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	<p>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.</p> <p>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.</p> <p>Continuing medical education leave and expenses are calculated based on a discounted valuation of the estimated 3 years non-vesting entitlement under the current collective agreement with Senior Medical Officers based on current leave patterns.</p>

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 received.

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.

We will carry forward \$12 million underspend from 2006/07. Our normal capital expenditure will be \$25 million and we will spend \$5 million on the car park.

5.5 Other provisions

Capital expenditure

Our normal capital expenditure will be some \$20 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 2007-08 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