2019/20 – 2022/23 Statement of Intent

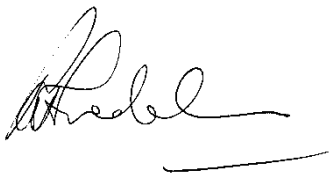
Incorporating the Statement of Performance Expectations

Auckland District Health Board

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

The Auckland District Health Board Statement of Intent incorporating the Statement of Performance Expectations is signed for and on behalf of:

Auckland District Health Board



Pat Snedden
Chair

William Davis
Deputy Chair

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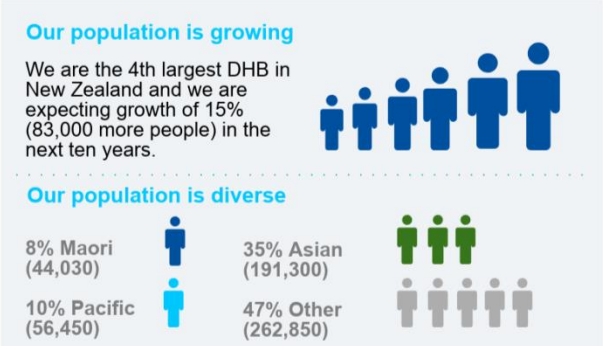
SECTION 1: Statement of Intent 2019/20 to 2022/23

About Auckland DHB

Who we are

Auckland DHB is the Government's funder and provider of health services to the estimated 555,000 residents living in the Auckland isthmus and the islands of Waiheke and Great Barrier.

Auckland DHB operates the biggest teaching hospital and largest research centre in New Zealand. We provide many highly specialised services to the whole of New Zealand.



The age composition of Auckland residents is younger than New Zealand as a whole, with 36% in the 25-44 age group, compared with 27% in this age group nationally. Auckland has 11% of its population in the 65+ age group, compared with 16% nationally.

Our population is diverse and rapidly growing. 8% of Auckland residents are Māori, 10% are Pacific, and 35% are Asian. Over 40% of our population were born overseas. Our Asian population is proportionally our fastest growing population, and projected to increase to 33% of the total in the next ten years.

Auckland's population is generally healthier than that of New Zealand as a whole. We have the one of the highest life expectancies in New Zealand at 83.2 years, with an increase of 3.1 years since 2001. Our obesity rates are lower than national rates, but more than half of our adults are overweight (61%) and one in four of our adults are classified as obese (26%). Our smoking rates are the lowest in the country - 12% are current smokers (New Zealand Health Survey 2016/17).

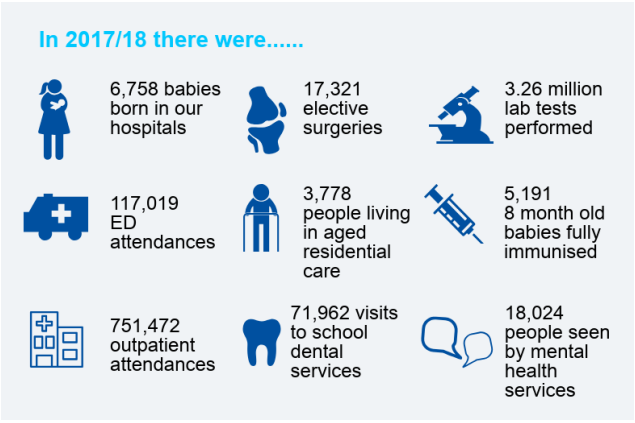
Cardiovascular disease is the most common cause of death for residents of Auckland DHB (32%). Cancer is the second highest cause of death (27%), and there are close to 2,500 new cancer registrations in Auckland every year. Although our cancer 5 year survival ratios are among the highest in New Zealand (69%), and our CVD and cancer mortality rates are declining, a large proportion of all deaths in those aged under 75 are amenable through healthcare interventions (48% or 416 deaths in 2015).

We have a similar deprivation profile to New Zealand as a whole. Almost one in five (19%) of our total population and 22% of preschool children live in the poorest areas (Quintile 5 – Census 2013). 27% of Māori and 40% of Pacific people live in Quintile 5 areas, concentrated in Rosebank/Avondale in the west, Mt Roskill and the CBD, and the eastern and southern areas from Glen Innes to Mt Wellington and Otahuhu. These individuals experience poorer health outcomes than those living in areas that are more affluent.

What we do

Services are delivered from Auckland City Hospital (New Zealand's largest public hospital), Greenlane Clinical Centre and the Buchanan Rehabilitation Centre. We also provide community child and adolescent health and disability services, community mental health services and district nursing. Around 11,100 people are employed by Auckland DHB.

We have a budget of $2.4billion in 2019/20.



Auckland DHB is unique in that we provide specialist services not available within other DHBs, including organ transplant services, specialist paediatric services, epilepsy services and high risk obstetrics. We also provide some specialist tertiary services for the other northern region DHBs, including cardiac surgery and specialist cancer services.

The key challenges we are facing

Although the majority of our population enjoy very good health and the financial performance of our organisation has been strong, a number of challenges exist as a provider and funder of health services.

Growing and aging population – the population will increase to approximately 637,000 over the next ten years, and the 65+ population will increase by more than 40% over the next 10 years. Combined with growth in demand, this will place considerable pressure on heavily utilised services and facilities, including primary and community health services (older people currently occupy around half of available beds).

Prevention and management of long-term conditions – the most common causes of death are cardiovascular disease and cancer, and a large proportion of all deaths for those under the age of 75 are considered amenable through healthcare interventions (48% or 416 deaths in 2015).

Health inequalities – particular populations in our catchment continue to experience inequalities in health outcomes. This is most starkly illustrated by the gap in life expectancy of 4.8 years for Māori and 8.6 years for Pacific compared with other ethnicities.

Patient-centred care – patients, whānau and our community are at the centre of our health system. We want people to take greater control of their own health, be active partners in their own care and access relevant information when they need it.

One system – we need to ensure healthcare is seamless across the continuum and reduce disconnected and replicated services, as well as fragmentation of data and information between and across hospital, community and other services.

Financial sustainability – the financial challenge facing the broader health sector and Auckland DHB is substantial, with the current trajectory of cost growth estimated to outweigh revenue growth by 2025. We need to make deliberate and focused strategic investment relevant to the specific needs of our population. This may require making some hard decisions about where we commit resource including reallocation of investment into services where we know we can achieve better outcomes.

Given the aforementioned challenges, we have identified the following risks as being relevant for 2019/20, as well as opportunities that will enable us to address these challenges.

1. **Ensuring long-term sustainability through fiscal responsibility**

   To ensure we continue to live within our means we need to focus on:

   - Effective governance and strong clinical leadership
   - Connecting the health system and working as one system
   - Delivering the best evidence-based care to avoid wastage
   - Ensuring tight cost control to limit the rate of cost growth pressure.

2. **Changing population demographics**

   To cope with our growing and ageing population, we need to:

   - Engage patients, consumers and their families and the community in the development and design of health services and ensuring that our services are responsive to their needs
   - Assist people and their families to better manage their own health, supported by specialist services delivered in community settings as well as in hospitals
   - Increase our focus on proven preventative measures and earlier intervention.

3. **Meeting future health needs and the growing demand for health services**

   To deliver better outcomes and experience for our growing population, we must maintain momentum in key areas:

   - Focus on upstream interventions to improve the social and economic determinants of health, within and outside of the health system
   - Providing evidence-based management of long-term conditions
   - Working as a whole system to better meet people's needs, including working regionally and across Government and other services.
   - Quality improvement in all areas
   - Ongoing development of services, staff and infrastructure
   - Involving patients and family in their care.

Our direction – a strategy to 2020 and beyond

Our **vision** is *Kia kotahi te oranga mo te iti me te rahi o te hāpori* - healthy communities; world-class healthcare; achieved together. This means helping Aucklanders to live well and stay well. At times, this involves co-designing solutions with the community to provide quality health care and support, as we do in Tāmaki. We also input into public policy, address inequities, and tackle the stressors associated with the way we live and, in some parts of Tāmaki Makaurau, the poverty in our communities. We know that the social determinants of health impact Aucklanders' wellbeing and choices. The regulatory environment can also support, or fail to support, healthy living and behaviours. Working collectively on these issues across the metro Auckland DHBs and with social sector agencies is becoming increasingly important.

As a funder and provider of services, we make sure people have healthcare services that are high quality, safe and empowering. To do this, we work across the whole system with patients, whānau, staff, iwi, communities, other health and disability providers, and social sector agencies. We are also committed to the Northern Regional Alliance long-term investment plan for both infrastructure and service redesign to meet the needs of our population in the future.

Our **values** are lived by our staff every day. They reflect our culture and the way we work, while we stand beside patients and their whānau to provide care. Our values are:

Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua*

Strategic Themes

Of the seven strategic themes, four were brought into focus in the last financial year. The themes determine the way our services are planned, delivered and developed. Four key areas of focus in 2019/2020 were:

Community, whānau and patient-centric model of care	We support people to live well and stay well, making sure that people are informed about health and able to determine the health outcomes they want. What matters to communities, patients and whānau guides how the DHB determines priorities.
Emphasis on operational and financial sustainability	We are shifting our focus from the volume of work to the value of work, from outputs to outcomes. We keep searching for value and efficiency and look for opportunities to increase revenue. We are working to reduce clinical and financial risk through collaborating across the four regional DHBs.
Emphasis and investment on treatment and keeping people healthy	We deliver 'world-class healthcare' but also work to prevent ill health. We support people to stay healthy and independent as they age. Our resources are directed to the areas and communities of high need.
Outward focus and flexible, service orientation	To reduce inequities, we need to focus on long-term population health outcomes and we need to work with other agencies to achieve this. We have a statutory accountability for the health of Aucklanders and will speak out on important issues.

Link between strategy, strategic risk and strategic programmes

Auckland DHB's strategic direction is reflected in these three interrelated areas, and the table below shows their connections:

- The **Strategy for Auckland DHB** outlines the key outcomes we want to achieve and provides a framework for prioritising activity over the longer term; key strategic outcomes are taken from Auckland DHB's vision
- Our **Strategic Risks** attempt to gauge the potential impact on the organisation if we do not achieve our outcomes; these risks are identified by our Board and Finance, Risk and Assurance Committee
- The **Strategic Programmes** that will deliver the outcomes and mitigate risk in the short, medium and long term; these programmes were developed by the Executive Leadership Team and account for most of the new activity scheduled for the year (other new initiatives are proposed for 2019/20, e.g. the Sustainability, Transport, and Retail Strategies).

Strategic outcome	Strategic risk	Strategic programme
Healthy communities Achieving the best, most equitable health outcomes for the populations we serve	• Meeting our Treaty of Waitangi obligations and achieving equitable outcomes across different population groups • Providing services for our population across the whole care continuum and within budget	Mental Health Patient and Whānau-Centred Care Models of Care
World-class healthcare People have rapid access to healthcare that is reliable, equitable, high quality and safe	• Retaining high quality care and good health outcomes as demands increase • Providing the best specialist services for the rest of the country within budget • Working well and efficiently with our neighbouring DHBs • Being prepared to respond to any sudden health or infection incidents • Developing services for the future when we have immediate issues with our facilities	Building for the Future Clinical Quality and Safety Outpatients Patient Flow Provider Financial Sustainability Asset Management
Achieved together Working as active partners across the whole system: staff, patients, whānau, iwi, communities, and others	• Maintaining a great workforce culture which staff and public are proud of • Providing services in the event of any IT systems disruption or natural disasters • Keeping pace with changes in technology and expectations	People Security for Safety Information Management Systems Programme

National, regional and sub-regional strategic direction

National

Auckland DHB operates as part of the New Zealand health system. Our overall direction is set by the Minister's expectations and 'This is Our Plan – the Government's Priorities for New Zealand'. The Government's 30-year plan provides the strategic framework for developing the Annual Plan content, linking health system priorities and the whole-of-government priority outcomes.

The objectives of DHBs are outlined within the Health and Disability Act (2000). These objectives include:

- Improve, promote, and protect the health of communities
- Reduce inequalities in health status
- Integrate health services, especially primary and hospital services
- Promote effective care or support of people needing personal health services or disability support.

Auckland DHB is committed to working in partnership with the Auckland Regional Public Health Service in their work on health promotion/improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system, and in undertaking regulatory functions.

The New Zealand Health Strategy provides DHBs with a clear direction and road map to deliver more integrated health services. Auckland DHB is committed to delivering on the Strategy's over-arching vision of 'All New Zealanders live well, stay well, get well'.

The actions detailed in Section 2 of this plan align to the Minister's expectations and the Government's priority outcomes.

We actively work with other agencies to support at risk families and progress outcomes for children and young people, including the Ministry for Children, Oranga Tamariki. We will continue to work with New Zealand Health Partnerships Limited to progress initiatives.

Regional

The Northern Region Long-Term Health Plan (NRLTHP) was developed to articulate the strategic direction for the Northern Region and to identify the investments necessary to ensure the ongoing delivery of high quality healthcare. It identifies the key challenges for the four Northern Region DHBs and sets some 'next steps' priorities for regional planning work, ISSP (and implementation) and capital investment. The regional

work plan will continue to be developed around the NRLTHP, reflecting the Ministry's identified areas of focus as closely as possible, including actions, milestones and performance indicators for achievement during 2019/20.

Sub-regional

Auckland and Waitematā DHBs have a bilateral agreement that joins governance and some activities. Furthermore, collaboration across the whole northern region has become increasingly critical as we strive to deliver services for our whole population, invest across the health system, and increase coordination of care to improve access, equity and outcomes of health care and reduce unnecessary duplication.

2019/20 Strategic Intentions

At the Auckland DHB and Ministry of Health (MoH) Strategic Conversation meeting in May 2019, several priority areas were discussed. While many of the themes are common across the country, some insights and suggestions were specific to this conversation; key themes are included below.

Equity
Equity is an important priority. Auckland DHB plans to redesign services for population growth, co-designed and in partnership with Māori and Pacific leaders. Projects include screening for abdominal aortic aneurysms, self-testing for human papilloma virus, and bariatric surgery.

Our values approach aims to challenge institutional racism that contributes to unfair outcomes. A review of end-to-end pathways (from community to hospital and home) to dismantle unfair services is underway.

A Northern Iwi Partnership Board is being formed to recognise shared responsibility to achieve Māori health outcomes and advance Māori wellbeing. This board includes Te Kahu o Taonui and Te Whānau o Waipāreira, with Auckland, Northland and Waitematā DHBs.

The civil society concept is used to support equity work with our Pacific communities. Key priorities include women and children at Starship Hospital and Tamaki, dental outcomes in children, targeted smoking cessation, the Pacific insight framework and workforce pilots.

Mental health
Auckland DHB views the mental health inquiry as an opportunity to transform the system and is working with our community to better understand their needs. While we provide a range of services, a systematic mental health service is lacking, including workforce challenges and a fragmented service with multiple external providers. Fundamental changes across PHOs, NGOs, DHBs and schools, using co-design, are needed.

Primary care
Service improvement in primary care can be challenging to progress. We need to challenge our PHOs more and hold them to account. The Ministry will support us in this regard.

Financial performance and sustainability
In the last six years, Auckland DHB maintained our financial position. As costs increase each year, we can no longer hold this position while improving equity and maintaining sustainable services to our local population.

We urge that national services be costed and accurate prices calculated so that we receive appropriate funding for services provided to other DHBs. Appropriate commissioning of national and tertiary services and determining which specialist services should be provided in which centres is needed.

2018/19 was a particularly difficult year, with industrial action delaying electives activity and IDF flows. Trendcare will be difficult to fund; 40 extra RMOs per year are required for compliant rosters. Although efficiencies were gained with patient flow and a reduced length of stay, we need another 20 beds per year. Analysis of DRGs showed 17% growth in adult medicine and 15% in cancer and blood services in the past 8 years. Opportunities for savings, while few, will be sought.

The Northern Region Long-Term Health Plan has the potential to strengthen the working and sustainability of the region. Continuing to improve regional networks is essential. Commissioning secondary service across the region will also support this approach.

Workforce
Auckland City Hospital is New Zealand's largest public hospital and clinical research facility. Auckland DHB is the largest provider of secondary and tertiary services in New Zealand, with a significant role in training the New Zealand health workforce in specialised skillsets.

Ongoing work ensures safe staffing and our commitment to CCDM. We employ new graduate nurses and support them in their first year of practice. We developed a 'thrive' strategy to maximising the income of lower paid roles through access to job-specific training and financial capability education, and improve staff health and wellbeing with access to free health checks and enhanced working conditions. National support is needed regarding our workforce issues in mental health and anaesthetic theatre technicians, and training of nurse-led endoscopy.

Digital and IT
Auckland DHB has a vast IT programme integrated into our core business. The sector has wide differences in IT systems, with varied risk of cyber attacks and the risk of

data loss and service disruption. National CIOs share ideas and discuss progress across the sector.

Auckland DHB is working to ensure our systems remain safe and reliable. A stocktake and risk assessment is being undertaken. The Northern Region ISSP Programme will transform and integrate the system across the region.

Delivering on our strategy in 2019/20

Our focus for the year ahead is achieving equity for Māori and Pacific living in our district. To reduce inequities, we need to focus on long-term population health outcomes and we need to work with other agencies to achieve this. We are increasingly aware of the societal, institutional and personal factors that contribute to inequity, disadvantage and distress. Our initial direction is to identify and understand areas where our systems and structures directly or indirectly contribute to institutional racism. In addition, we are undertaking work on short-term pipeline projects to accelerate Māori and Pacific health gain.

We support people to live well and stay well, making sure that people are informed about health and able to determine the health outcomes they want. People should have the opportunity to actively shape their care and support. We are moving towards a self-determined care approach, which allows individuals and whānau to determine what matters most to them, exercise control over their care plan, and receive the support they need from health and other agencies.

We deliver world-class healthcare but also work to prevent ill health. Auckland DHB strives to uphold 'right patient, right care, right place – every time.' The provision of high quality, safe and reliable care is a core strategic objective. Our Clinical Quality and Safety (CQS) Programme aims to develop a safe and just culture with the patient at the centre, where staff speak out for safety. We aim to have an environment where high performing teams deliver safe and reliable care and robust data informs continual practice improvement, and evidence-based decision-making.

We will implement our Mental Health Plan, which was developed to direct the changes signalled in the Government's 2018 Mental Health Inquiry.

Auckland DHB will continue to contribute to the Government's priority outcome of environmental sustainability, including reducing carbon emissions, to address the impacts of climate change on health.

Ongoing financial constraints remain a key challenge. Measured financial stewardship will require increasing collaboration across the three Metro Auckland DHBs and real specificity about the models of care needed to improve the quality of services for underserved populations. The strategic programmes that follow will help us to focus on the critical areas where we need to drive change in 2019/20. They will also advance the regional aspirations in the NRLTHP and ensure that we meet the expectations of the Minister of Health.

Key programmes and initiatives this year

Clinical Quality and Safety

'Right patient, right care, right place – every time'. The provision of high quality, safe and reliable care every day is a core Auckland DHB strategic objective. The programme aims to strengthen our safety systems and processes, continue developing a safe and just culture with patients in the centre, and enhance leadership and capability in clinical quality improvement and safety at all levels of the organisation.

Outpatient Model of Care

This programme aims to ensure outpatient services are easy to access, easy to understand, and available at a time, place and method that meets community needs and reduces unnecessary travel to our hospitals.

Security for safety

The purpose of this programme is to strengthen security across all Auckland DHB sites to improve the safety of all staff, patients, families/whānau, visitors and contractors.

People programme

The People programme delivers on our promises to our staff; outstanding professional and personal development opportunities for everyone; to champion and support your physical and mental wellbeing, just as you do for those we serve; and transparency and fairness to ensure we can all live our values and commitments.

Āhua Awhi (Models of Care)

The programme focuses on cross-sectoral work optimising end-to-end pathways of care that integrate models of primary, secondary, community and self-care. This recognises that many of the biggest levers impacting health, wellbeing and system efficiency reside in the care provided beyond the walls of the hospital setting.

Facilities Infrastructure Remediation

This programme will minimise the risk to ongoing service delivery by ensuring critical facilities infrastructure is operational, enable future growth in capacity on our sites, improve compliance with current legislation and achieve a greater cost-effectiveness of facilities infrastructure wherever new or replacement assets are deployed. This will lead to reduced failures of critical assets and a better, safer and more sustainable environment.

Mental Health
The Ministry of Health has funded Auckland DHB and our Primary Health Organisation and Non-Government Organisation partners to upscale and evaluate interventions that support people with moderate mental health needs. Our current work programme revolves around three themes: Access and choice, Equally Well, and Zero Suicide.

Building for the Future
By 2020, Auckland City Hospital is forecast to have insufficient physical bed spaces for adult patients, with limited mitigating options. This programme will plan and incrementally deliver the adult inpatient and related supplementary capacity required over the next 10 years to address the challenge and pressure of population growth on inpatient areas.

Information Management Systems and the Hospital Administration Replacement Project
This programme will strengthen and stabilise our information infrastructure to ensure continuity of service including replacement of our Patient Administration System (PAS) as identified in the Northern Regional Information Services Strategic Plan (ISSP). The replacement will deliver a modern, fit-for-purpose PAS to enable business transformation and can integrate at a regional level.

Provider Financial Sustainability
Living within our means is core to sustaining our services, and we will continue with the key priority of delivering services in a cost efficient and productive manner. This programme provides visibility and transparency over all of Auckland DHB's savings and efficiency plans linked to improving financial performance.

A new approach for 2020-2025

In 2019/20, we will develop our organisational strategy for 2020-2025. Our wider environment is changing. Financial sustainability requires us to explore self-directed care in our communities. If the future state is individuals and whānau determining their own health priorities and working with the system to supply their needs, we require a more agile and responsive health system. We need to reconsider our operating model as equity and growth in our population make existing models of care unsustainable. We need to redesign with the community at the centre, to provide accessible and quality services close to homes and schools.

We will investigate the models of care developed at the margins and review system shifts to meet the needs of our diverse population. Productivity in the provider arm will remain a substantive focus while we seek to understand what is required for our Māori and Pacific populations.

We have an opportunity in our 2020-2025 Strategy to advance several regional and national imperatives. Firstly, we will continue to work with our neighbour DHBs to deliver the major work streams in the Northern Region Long-Term Health Plan. While the plan pertains mostly to major capital developments, building infrastructure and managing assets, it creates an imperative to alleviate the pressure on our hospitals by shifting more preventative, primary and secondary health services into community settings. Management attention and funding will focus on critical infrastructure risk remediation, work that allows our hospitals to function as they should. This pressure limits our attention given to strategic priorities, especially the new models of care that will ease the pressure on our hospitals downstream.

Secondly, we need to advance government priorities, notably behavioural health, child health, maternity care, midwifery and prevention. We need to increase our efforts to reduce carbon emissions and contribute to environmental sustainability.

Managing Our Business

Section 4 of our Annual Plan details how Auckland DHB will manage our functions and operations in order to deliver on our strategic intentions, and maintain our organisational health and capability.

Improving health outcomes for our population

Auckland DHB's performance framework demonstrates how the services that we choose to fund or provide contribute to the health of our population and result in the achievement of our longer-term outcomes and the expectations of Government.

Our performance framework reflects the key national and local priorities that inform this Annual Plan. There is considerable alignment between our performance framework, the System Level Measures framework set by the Ministry of Health, the Minister of Health's planning priorities, and the over-arching Government Priorities.

We have identified two overall long-term population health outcome objectives. These are:

- life expectancy at birth continues to increase
- inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced.

The outcome measures are long-term indicators; therefore, the aim is for a measurable change in health status over time, rather than a fixed target.

Our medium-term outcome goals and short-term priorities support these overall objectives. Equity is an over-arching priority in our performance framework and our goals focuses on three priority areas: child wellbeing, prevention and early intervention, and mental health.

For each measure, annual improvement milestones have been set, and local progress will be tracked. Our medium-term outcomes define our priorities for the next 3-5 years and allow us to measure the difference we are making for our population. Our short-term priorities are essential to the achievement of our outcome goals and are front-line measurements of the success of specific health processes or activities. To help identify equity gaps and measure progress, we will monitor all our medium term outcomes by ethnicity.

Child Wellbeing

We want to ensure that all children in our district have the best start to life. Pregnancy and early childhood is the most effective time to intervene to reduce inequalities and improve long term health and wellbeing.

Smoking is a leading risk factor for many diseases, and exposure to smoke during pregnancy and early childhood strongly influences health outcomes. Smoking rates among Māori and Pacific are double that of the other ethnicities and less than half of all Māori and Pacific babies currently live in smokefree households. By supporting whānau to quit, we aim to increase the number of babies living in smokefree homes.

Pacific children in particular have very high rates of admission to hospital for conditions that can be potentially prevented or managed by primary and community care. We will improve vaccination rates and access to oral health services to help keep these children out of hospital.

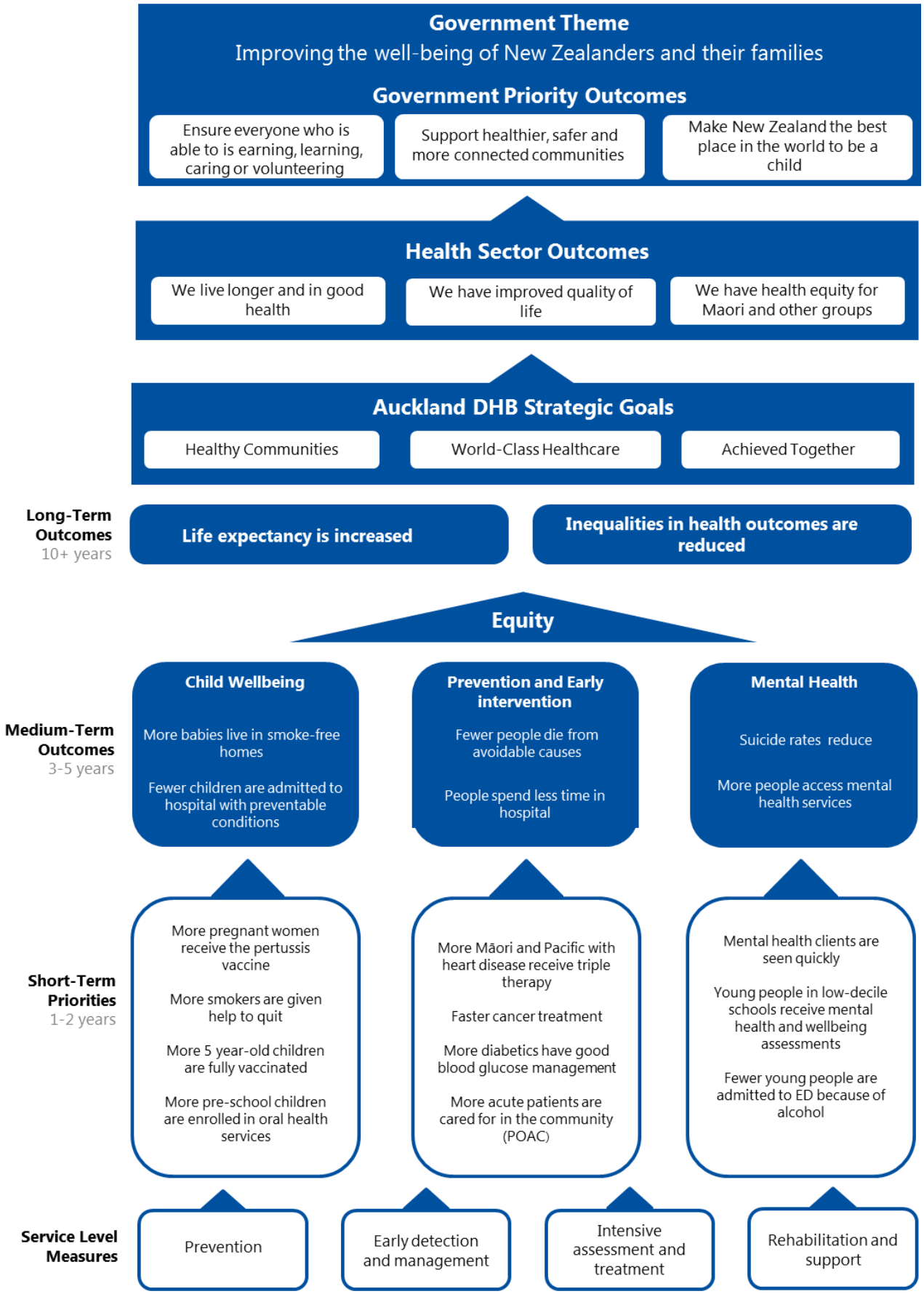
Prevention and Early Intervention

Preventative care is centred on individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Māori and Pacific have higher incidence of chronic conditions and experience poorer outcomes and we want to address this inequity. Our aim is for fewer people to die from potentially avoidable conditions. We also want to make sure that where possible, treatment and management happens in community settings and for people to spend less time in hospital when they are acutely unwell. The rates of cardiovascular disease and diabetes are higher for our Māori and Pacific populations. We need to focus on good management of these conditions through support and education and prescribing of appropriate medications, to improve the health outcomes of those most affected. Likewise, we need to continue to ensure that our cancer pathways remain timely and that there are no barriers to accessing cancer treatment.

Mental Health

Mental health and addiction problems affect the lives of many people in our district, with around 20% experience mental illness or distress. New Zealand has high suicide rates, with rates for Māori twice that of other ethnicities. We will ensure that practical help and support is available in the community to all people need it, but also that there is good access to acute mental health support when required. Young people in lower decile schools will be supported to receive help for mental health, alcohol and drug, sexual health, social and physical health issues.

Performance and intervention framework



Long-term outcomes

The long-term outcomes that we aim to achieve are to increase in life expectancy (measured by life expectancy at birth) and reduce ethnic inequalities (measured by the ethnic gap in life expectancy).

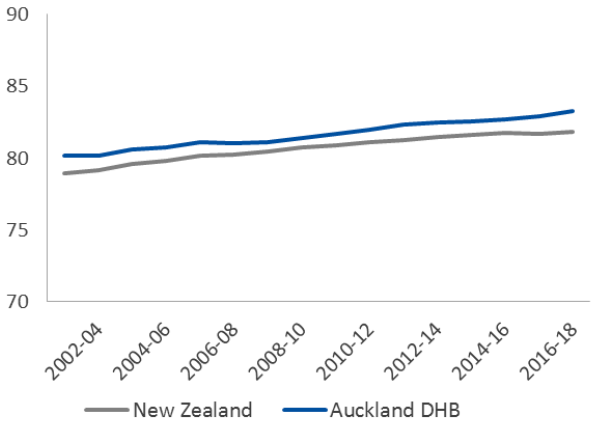
Increasing life expectancy

Life expectancy at birth is recognised as a general measure of population health status.

Overall, we have one of the highest life expectancies in the country at 83.2 years (2016-2018), which is 1.4 years higher than New Zealand as a whole. In Auckland, life expectancy has increased by 3.1 years since 2001, a similar increase to that seen across all of New Zealand.

Over the longer term, we aim to continue to increase life expectancy, and we are expecting a 2.2-year increase in life expectancy over the next decade.

Outcome Measure – Life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used.

Reduce inequalities for all populations

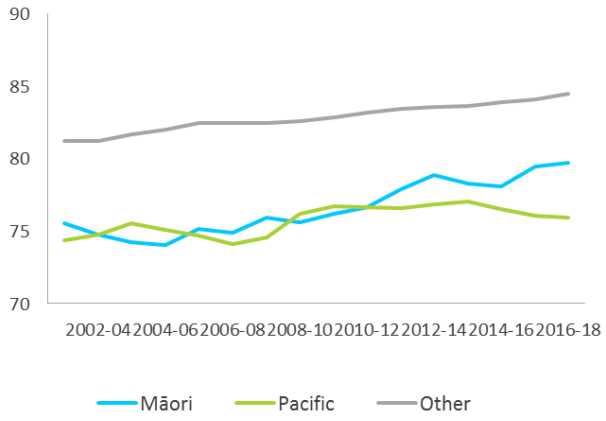
Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a life expectancy lower than other ethnicities, with a gap of 4.8 years for Māori and 8.6 years for Pacific (2016-2018).

Life expectancy has increased in our Māori (4.8 years) and Pacific (1.8 years) populations over the last decade and the gap in life expectancy, for Māori in particular, is gradually closing.

Higher mortality at a younger age from cardiovascular disease and cancers accounts for around half of the life expectancy gap in our Māori and Pacific populations.

We expect to see a reduction in the gap in life expectancy over the next decade.

Outcome Measure – Ethnic gap in life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. 'Other' ethnicity includes non-Māori/non-Pacific ethnicities.

Child Wellbeing

The foundations of a healthy adult life are laid in early childhood. Promoting healthy behaviours and environments, along with ensuring access to well integrated primary and community services can prevent health problems and improve health outcomes. We aim to increase the proportion of babies living in smoke-free homes and reduce the number of children admitted to hospital with preventable health conditions.

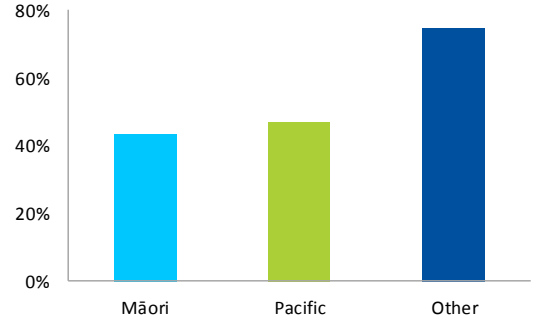
Medium-Term Outcomes

More babies live in smoke-free homes

Infants and young children are exposed to second-hand smoke more often in homes than in other places. Second-hand smoke exposure is associated with preventable and harmful effects in children, and the effects of exposure are lifelong. Exposure is a significant contributor to childhood health inequalities in children.

As at June 2018, less than half of all Māori and Pacific babies were living in a smokefree household in contrast to nearly three quarters of other ethnicities.

Proportion of babies living in smokefree households at 6 weeks postnatal

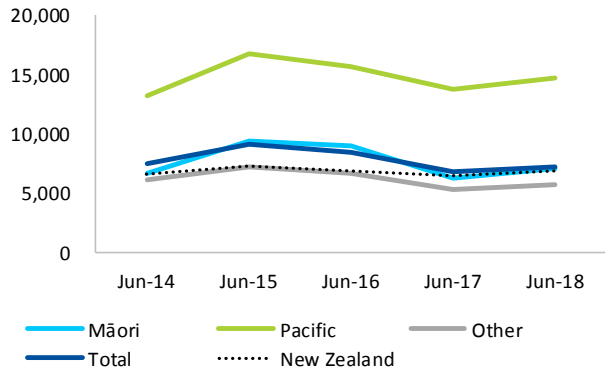


Fewer children are admitted to hospital with preventable conditions

We seek to reduce admission rates to hospital for a set of conditions that are potentially avoidable through prevention or management in primary care, known as ambulatory sensitive hospitalisations (ASH). In children, these conditions are mainly respiratory illnesses, gastroenteritis, dental conditions, and cellulitis.

In the 12 months to June 2018, there were 2,063 admissions in 0–4 year olds that were potentially avoidable. The overall rate of admissions (7,218 per 100,000) has declined slightly since 2014. Compared with other ethnicities, rates are slightly higher in Māori (7,099 per 100,000) and over twice as high in the Pacific population (14,748 per 100,000).

Ambulatory sensitive hospital admissions per 100,000 in those aged 0–4 years



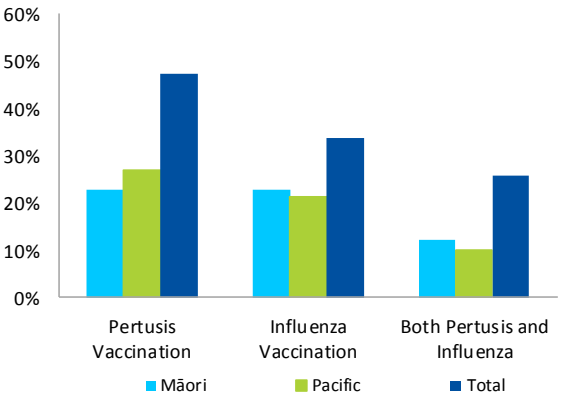
Short-Term Priorities

More pregnant women receive antenatal immunisations

Respiratory conditions are the largest contributor to ASH rates in Auckland. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants that can lead to further respiratory complications. Both are vaccine preventable, and vaccination during pregnancy protects both mother and baby against the diseases for the first few months of life.

Pregnant women are recommended to have both vaccinations every pregnancy. For babies born in 2018, only 31% of mothers received both vaccinations during pregnancy, with rates much lower for Māori and Pacific.

Proportion of pregnant women receiving pertussis and/or influenza vaccinations in pregnancy



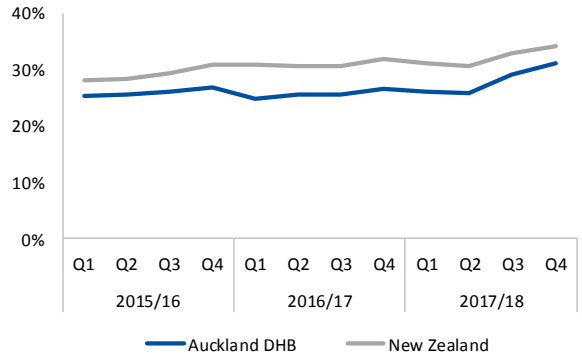
More smokers are given help to quit

Life-long smoking is associated with a decade of life lost for an individual. Quitting smoking before the age of 40 years, and preferably much earlier, will reduce about 90% of the years of life lost from continued smoking.*

In 2013, there are an estimated 42,400 smokers aged 15+ years in Auckland DHB. We need to reduce this to around 25,800 to reach our Smokefree 2025 target of fewer than 5% of our adult (age 15+ years) population who smoke.

A quit attempt is more likely to be successful if support, such as a referral to quit smoking services, and/or pharmacological smoking cessation aids are provided.

Proportion of smokers receiving cessation support in primary care

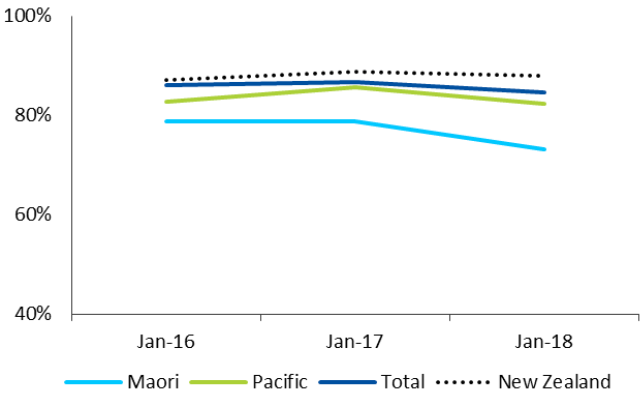


More five year-old children are fully vaccinated

Immunisation is one of the most effective and cost-effective medical interventions to prevent disease. Vaccine-preventable diseases (such as measles, mumps, and rubella) can cause serious health problems, disabilities, and even death. Immunisation protects not only the child, but others that are unable to be vaccinated, via herd immunity.

Receiving scheduled vaccinations provides a good opportunity for children and families to engage with health services on a relatively regular basis.

Proportion of children fully vaccinated by five years of age

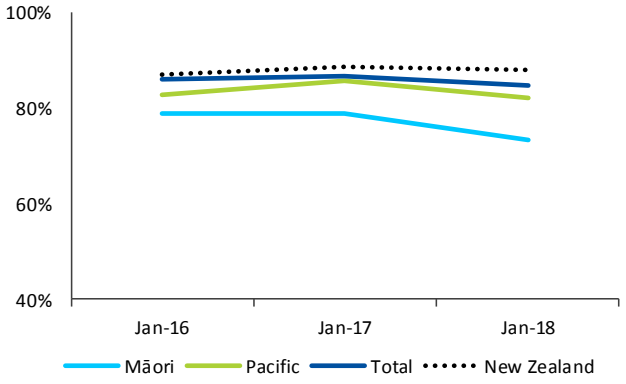


More pre-school children are enrolled in oral health services

Dental care comprises a leading cause of preventable admission to hospital among pre-school children. The consequences of poor dental health in childhood can carry on into adulthood. Prevention and early intervention are key to reducing the number of children hospitalised for dental conditions.

Dental care for preschool children is free; however, a large number of children are not enrolled in oral health services. We aim to ensure that all children are enrolled in oral health services and receiving dental care.

Proportion of pre-school children enrolled in oral health services



Prevention and Early Intervention

Chronic diseases are the leading cause of death and disability, with increasing prevalence linked to increasing health costs. Preventative care is centred around individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Identifying and preventing potential problems downstream, such as addressing the socio-economic determinants of health, is one strategy to improve health outcomes. When people do become unwell, prompt diagnosis and early intervention in the initial stages can have significant impact on the outcome. Our aim is for fewer people to die from potentially avoidable conditions and for people spend less time in hospital when they are acutely unwell.

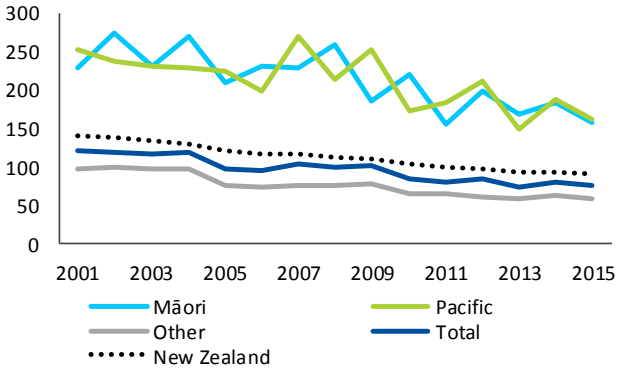
Medium-Term Outcomes

Fewer people die from avoidable causes

Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist.

In 2015, we estimate that 416 deaths (48% of all deaths in those aged under 75 years) in Auckland DHB were potentially amenable. The rate of amenable mortality has is currently 74.9 per 100,000 population.

Mortality rate from conditions considered amenable, per 100,000 population

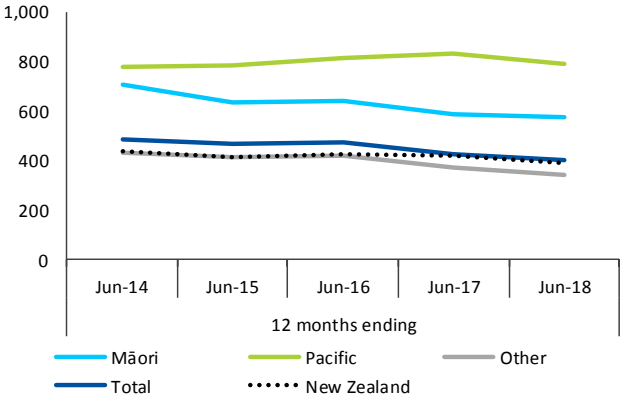


People spend less time in hospital

Acute admissions account for approximately half of all hospital admissions in New Zealand. Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressures on DHB staff and facilities. Reductions may result from effective management in primary care, optimising hospital patient flow, discharge planning, community support services and good communication between healthcare providers.

Although our standardised rate of acute bed days has slowly declined since 2014, it remains higher than the national rate (401 vs. 386 per 1,000 population).

Acute hospital bed days per 1,000 population



Short-Term Priorities

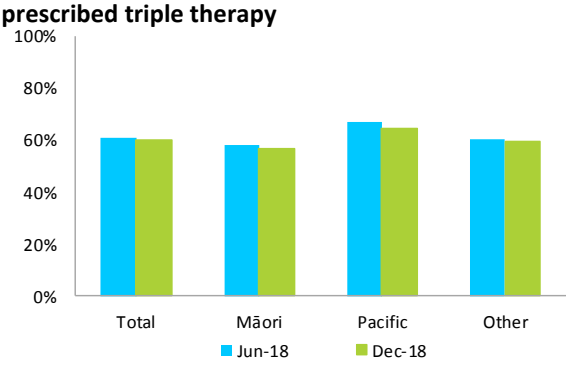
More Māori and Pacific with heart disease receive triple therapy

New Zealand guidelines recommend that, where appropriate, people who experience a heart attack or stroke are treated with a combination of medications known as triple therapy (aspirin or another antiplatelet/ anticoagulant agent, a beta-blocker and a statin).

We aim to ensure that all of our patients who have had a CVD event are receiving the best possible care.

Currently, 59% of the Metro Auckland Māori and Pacific population who have had a CVD event are prescribed triple therapy medication.

Proportion of Māori and Pacific with a prior CVD event prescribed triple therapy

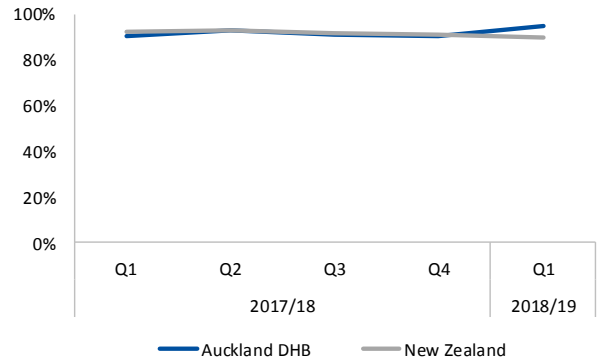


Faster cancer treatment

Cancer is a leading cause of morbidity and mortality in Auckland DHB, accounting for over one quarter of all deaths. Prompt investigation, diagnosis and treatment increases the likelihood of better outcomes for cancer patients, and assurance regarding waiting time can reduce the stress on patients and families at a difficult time.

We aim to ensure that patients diagnosed with cancer receive their first treatment or other management within 62 days.

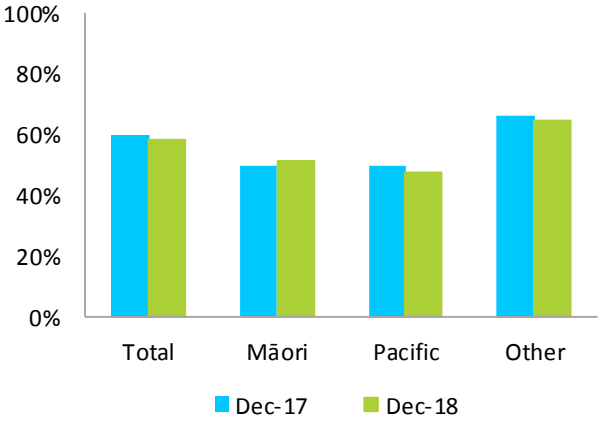
Proportion of cancer patients receiving treatment within 62 days of referral

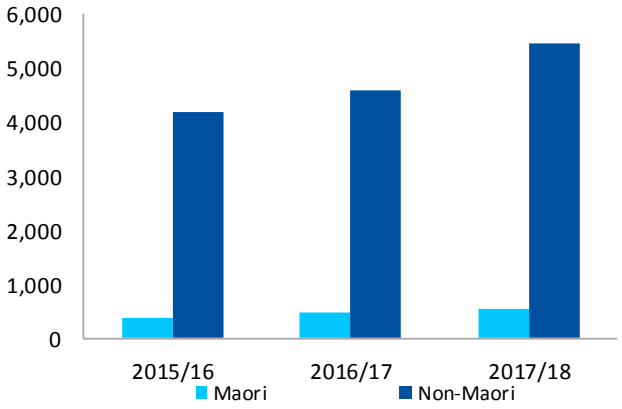


More diabetics have good blood glucose management

The management of type 2 diabetes is multi-faceted. Following diagnosis, patients require education to self-manage their condition and make lifestyle changes. HbA1c is a measure of an average blood glucose (average blood sugar) level over the past few months and can be used as an indicator of a patient's diabetes control. Well managed diabetes decreases the onset and progression of microvascular complications such as retinopathy, nephropathy and neuropathy.

Proportion of diabetics with good blood glucose management

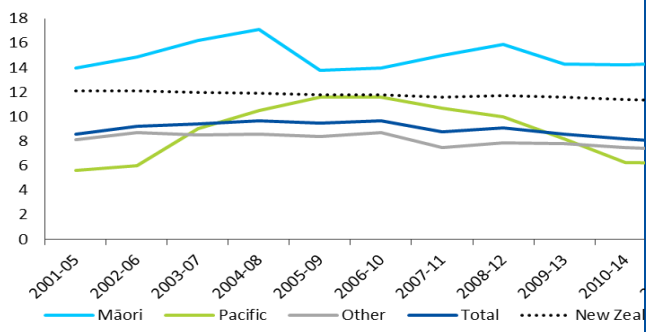


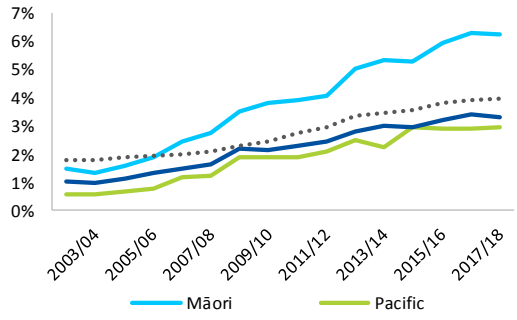
More acute patients are cared for in the community (POAC)	
Primary Options for Acute Care (POAC) provides healthcare professionals with access to investigations, care or treatment for their patient, when the patient can be safely managed in the community. Access to existing community infrastructure and resources is utilised to provide services that prevents an acute hospital attendance or shortens hospital stay for patients who do attend or are admitted. The aim of POAC is to deliver timely, flexible and coordinated care, meeting the healthcare needs of individual patients in a community setting. We aim to have more individuals being treated (where appropriate) through the POAC pathway, thus preventing unnecessary and costly acute hospital admission.	**Number of POAC referrals** 

Mental Health

Mental health and addiction problems affect the lives of many people in our district. Each year, around one in five of our population experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. In addition, New Zealand has persistently high suicide rates. Improving mental health outcomes of our population does not lie solely with the health system; there are clear links between poverty and poor mental health. We aim to ensure that practical help and support is available in the community to people need it; our people need safe and affordable houses, good education, jobs and income for mental wellbeing.

Medium-Term Outcomes

Suicide rates reduce	
Suicide is a serious health and social issue. Suicide rates are a sign of the mental health and social wellbeing of the population. Suicide prevention initiatives aim to promote protective factors, reduce risk factors for suicide and improve the services available for people in distress. Although our suicide rates are lower than the national rate, it is unacceptably high, and we aim for zero suicide. Reducing suicide rates requires a whole-of-government approach to supporting wellbeing and addressing multiple social determinants.	**Rate of suicide per 100,000 population** 

More people access mental health services	
Each year, around one in five individuals experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. While not all individuals with mental health and addiction challenges needs or will seek to access a specific service intervention, over time, more people should be able to access support. Given the current prevalence, the expected access rates should be higher than the current 3%.	**Access rates to mental health services** 

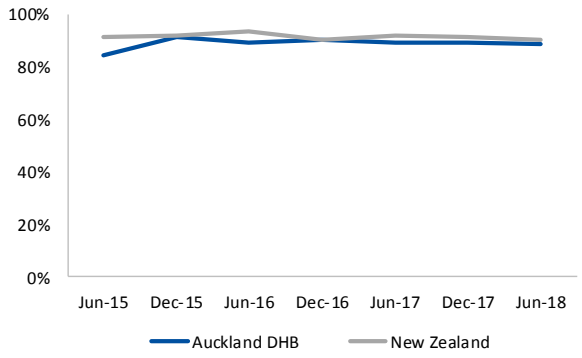
Short-Term Priorities

Mental health clients are seen quickly

Individuals experiencing mental distress or with mental health needs do not always require a referral or access to specialist mental health services. However, where a need does arise and people reach a point of crisis, it is critical to intervene quickly with a variety of well-supported and culturally safe treatment options, which may include a referral to specialist mental health services.

We aim to ensure that when individuals are referred to specialist mental health services, they are seen quickly.

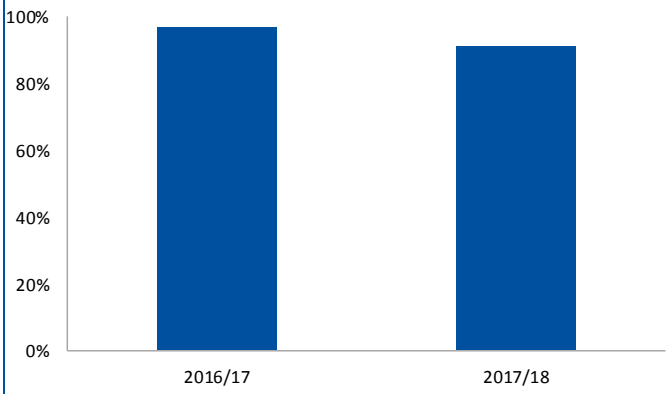
Proportion of referrals to mental health services that are seen within eight weeks



Young people in low-decile schools receive mental health and wellbeing assessments

Adolescence is a challenging time when many emotional and physical changes take place. Most adolescents make it through their teenage years and enter adulthood without major trauma. However, for some teenagers this may be a very dangerous time of experimentation. HEEADSSS is a validated assessment tool that is commonly used to help assess youth wellbeing through a series of questions relating to home life, education/employment, eating, activities, drugs, sexuality, suicide/depressions and Safety. The tool is administered to year 9 students in a number of schools and provides a mechanism for health professionals to evaluate young people's developmental stage, risk taking behaviour, risk and protective factors for them and the environment around them.

HEEADSSS assessment coverage



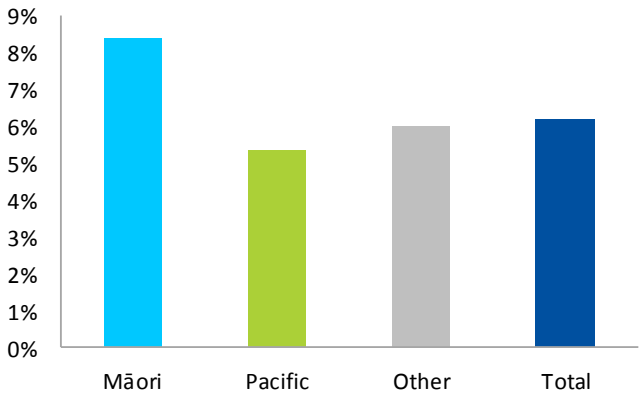
Fewer young people are admitted to ED because of alcohol

Alcohol is deemed the most commonly used recreational drug in New Zealand. Alcohol contributes to violence, self-harm, injuries and many medical conditions, and is responsible for over 1,000 deaths and 12,000 years of life lost each year in New Zealand*.

Identifying and monitoring alcohol-related ED presentations enables DHBs to better understand the contribution of excessive alcohol consumption to ED presentations for young people. It is a starting point to encourage DHBs to move toward screening that is more extensive, brief intervention and referrals (including to primary care and community care).

* Connor J, Kydd R, Rehm J, Shield K. Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Wellington: Health Promotion Agency; July 2013.

Proportion of youth Emergency Department presentations related to alcohol (12 months to Dec-18)



SECTION 2: STATEMENT OF PERFORMANCE EXPECTATIONS – AUCKLAND DHB 2019/20

The Statement of Performance Expectations is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for the 2019/20 year. Recent actual performance data are used as the baseline. The Crown Entities Act 2004 requires the DHB's Statement of Performance Expectations (SPE) to include forecast financial statements for the financial year, prepared in accordance with generally accepted accounting practice. The DHB's forecast financial statements for the year ended 30 June 2020 are included in Appendix C and the Financial Performance Summary table is included in Section 2 of this Annual Plan document. Both these form part of the DHB's SPE for the 2019/20 financial year.

Measures within this Statement of Performance Expectations represent those outputs/activities we deliver to meet our goals and objectives in Section 2 and our Statement of Intent, and also provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of key indicators.

Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures will be reported in the DHB's Annual Report, and audited at year-end by the DHB's auditors, AuditNZ.

Performance measurement framework

Our focus for 2019/20 is on delivering the key targets identified in our performance framework, which will ultimately result in better health outcomes for our population, measured by our two high level outcomes:

- an increase in life expectancy
- a reduction in the ethnic gap in life expectancy

The measures in this section link to the national, regional and local strategic direction covered in our Statement of Intent.

Targets and achievements

Targets and comparative baseline data for each of the output measures are included in the following sections. When assessing achievement against each measure, we use a grading system to rate performance. This helps to identify where performance was on target, very close to target or less than expected.

The criteria used to allocate these grades are as follows:

Criteria		Rating	
On target or better		Achieved	🟢
95–99.9%	0.1–5% away from target	Substantially achieved	🔵
90–94.9%*	5.1–10% away from target*	Not achieved, but progress made	🟡
<90%	>10% away from target**	Not achieved	🔴

*and improvement on previous year

** or 5.1–10% away from target and no improvement on previous year

Key to output tables

Symbol	Definition
Ω	Measure is demand driven – not appropriate to set target
↓	A decreased number indicates improved performance
↑	An increased number indicates improved performance
↔	Maintain current performance
Q	Measure of quality
V	Measure of volume
T	Measure of timeliness
C	Measure of coverage

Output class 1: Prevention Services

Preventative services protect and promote health by targeting changes to physical and social environments that engage and support individuals to make healthier choices. Prevention services include: health promotion to prevent illness and reduce unequal outcomes; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services, e.g. immunisation and screening services. By supporting people to make healthy choices and maintain good health, effective prevention can significantly improve health outcomes. The DHB works with the Auckland Regional Public Health Service to promote and protect wellness and prevent disease.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Health promotion			
% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months	C	92%	90%
% of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking	C	97%	90%
Number of pregnant women smokers referred to the stop smoking incentive programme	Q	104[1]	110
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Q	100%	95%
Number of clients engaged with Green Prescriptions	V	4,444[2]	4,500
% of clients engaged with Green Prescriptions - *Māori* - *Pacific* - *South Asian*	C	 *14*[2] *21*[2] *16*[2]	 *11%* *17%* *18%*
Immunisation			
% of pregnant women receiving pertussis vaccination in pregnancy - *Māori* - *Pacific* - *Asian*	C	54%[2] *34%*[2] *30%*[2] *62%*[2]	50% (or maintain if >50%)
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness - *Māori* - *Pacific*	C	18% 10% 13%	15%
% of eight months olds will have their primary course of immunisation on time - *Māori* - *Pacific*	C	94% *86%* *93%*	95%
% of five year olds will have their primary course of immunisation on time - *Māori* - *Pacific* - *Asian*	C	86% *78%* *85%* *89%*	95%
Rate of HPV immunisation coverage	C	83%	75%
Population-based screening			
% of women aged 50-69 years having a breast cancer screen in the last 2 years	C	63%	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	65%	80%
HEEADSSS assessment coverage in DHB funded school health services	C	99%	95%
% of 4 year olds receiving a B4 School Check	C	91%	90%
Proportion of newborn babies offered and received completed hearing screening within 1 month	V	97%	90%

[1] Q4 2017/18 to Q3 2018/19 data.

[2] CY2018 data. Differs from the result published in the 2017/18 Annual Report, which is for the 2017/18 financial year (4,316).

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Auckland Regional Public Health Service[3]			
Number of tobacco retailer compliance checks conducted	V	372	300
Number of alcohol license applications and renewals (on, off club and special) that were inquired into	V	2,112	Ω
% of smear-positive pulmonary tuberculosis cases contacted by the Public Health Nurse within 3 days of clinical notification	Q	New indicator	98%
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol	Q	New indicator	95%
% of compliance assessments conducted of large and medium networked drinking water supplies	Q	100%	100%

Output class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various settings, including general practice, community and Māori health services, pharmacist services and child and adolescent oral health services. Access to these services ensures that those at risk, or with disease onset, are recognised early and their condition is appropriately managed. Early detection and management services also enable patients to maintain their functional independence with less invasive intervention.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Primary health care			
Rate of primary care enrolment in Māori	C	76%	90%
Number of referrals to Primary Options for Acute Care (POAC)	V	6,028	6,036
% of people with diabetes aged 15-74 years and enrolled with Auckland DHB practices who does not have an HbA1c in the last 15 months - *Māori* - *Pacific*	C	12% *14%* *14%*	<12.0%
% of people with diabetes aged 15-74 years and enrolled with Auckland DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol - *Māori* - *Pacific*	Q	62% *53%* *51%*	65%
% of Māori patients with prior CVD who are prescribed triple therapy	Q	58%[4]	62%
% of Pacific patients with prior CVD who are prescribed triple therapy	Q	65%[4]	67%
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds: - *Māori* - *Pacific*	Q	3,551[4] *7,123*[4] *8,856*[4]	<3,480 <6,981 <8,679
Average response score to the primary care survey question 'in the last 12 months, when you ring to make an appointment how quickly do you usually get to see your current GP?'	T	6.1[4]	6.7
Pharmacy			
Number of prescription items subsidised	V	6,780,428[5]	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	28,713	Ω
Number of community laboratory tests	V	3,260,656	Ω

[3] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.
[4] CY2018 data.
[5] Full year result; differs from the result published in the 2017/18 Annual Report, which is for Q1-3.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Oral health[6]			
% of preschool children enrolled in DHB-funded oral health services - *Māori* - *Pacific* - *Asian*	C	92% *69%* *92%* *87%*	95%
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 - *Māori* - *Pacific* - *Asian*	Q	0.64 *0.89* *1.04* *0.57*	<0.65
% of children caries free at five years of age - *Māori* - *Pacific* - *Asian*	Q	61% *50%* *31%* *58%*	61%
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years	C	77%	85%

Output Class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by specialist providers in facilities that co-locate clinical expertise and specialised equipment, such as a hospital or surgery centre. These services include ambulatory, ED and inpatient services (acute and elective streams), such as diagnostic, therapeutic and rehabilitative services. Effective and prompt resolution of medical and surgical emergencies and treatment of significant conditions reduces mortality, restores functional independence and improves health-related quality of life, thereby improving population health.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Acute services			
Number of ED attendances	V	117,019	Ω
% of ED patients discharged, admitted or transferred within six hours of arrival	T	91%	95%
Rate of alcohol-related ED admissions for 15-24 year olds	Q	6.2%[7]	↓
% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	T	95%	90%
% of potentially eligible stroke patients thrombolysed	C	12%	10%
% of ACS inpatients receiving coronary angiography within 3 days	T	90%	70%
Maternity			
Number of births in Auckland DHB hospitals	V	6,758	Ω
Elective (inpatient/outpatient)			
Number of planned care interventions	V	New indicator	23,831[8]
% of people receiving urgent diagnostic colonoscopy in 14 days	T	100%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days	T	74%	70%
% of patients waiting longer than 4 months for their first specialist assessment	T	0.1%	0%
% of accepted referrals receiving their CT scan within 6 weeks	T	93%	95%
% of accepted referrals receiving their MRI scan within 6 weeks	T	68%	90%

[6] All oral health measures have CY2017 data as baseline.
[7] CY2018 data.
[8] This target is subject to final Ministry of Health approval.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Quality and patient safety			
% of opportunities for hand hygiene taken	Q	86%	80%
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.21	<0.25
% of older patients assessed for the risk of falling	Q	90%	90%
% of falls risk patients who received an individualised care plan	Q	94%	90%
Rate of in-hospital falls resulting in fractured neck of femur per 1,000 admissions	Q	3.9	<8.4[9]
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision	Q	97%	100%
% of hip and knee procedures given right antibiotic in right dose	Q	96%	95%
Surgical site infections per 100 hip and knee operations	Q	1.17[10]	<0.93[11]
% of 'yes, completely' responses to the national inpatient survey question 'did a member of staff tell you about medication side effects to watch for when you went home'	Q	53%	55%
Mental Health			
% of population who access Mental Health services	C		
- Age 0–19 years		3.31%	3.42%
- *Māori*		*6.21%*	*6.16%*
- Age 20–64 years		3.50%	3.70%
- *Māori*		*10.50%*	*10.16%*
- Age 65+ years		2.89%	3.15%
- *Māori*		*3.78%*	*3.50%*
% of 0-19 year old clients seen within 3 weeks	T		
- Mental Health		68%	80%
- Addictions		95%	80%
% of 0-19 year old clients seen within 8 weeks			
- Mental Health		89%	95%
- Addictions		98%	95%

Output Class 4: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination provided by the Needs Assessment and Service Coordination (NASC) Service for a range of services, including palliative care, home-based support, and residential care services. Rehabilitation and support services are provided by the DHB and non-DHB sector, e.g. residential care providers, hospice and community groups. Effective support services restore function and help people to live at home for longer, therefore improving quality of life and reducing the burden of institutional care costs.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Home-based support			
Proportion of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI)	Q	97%	95%
Palliative care			
Total number of contacts in the community	V	9,226	Ω
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	2%	<4%
Residential care			
ARC bed days	V	931,284	Ω

[9] Sep 2014 to Jun 2017 national median.
[10] Full year result; differs from the result published in the 2017/18 Annual Report, which is for Q1-3.
[11] Sep 2015 to Nov 2017 national median.

Financial Performance Summary

Statement of Comprehensive Income	2017/18 Audited Actual $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Funding						
Government & Crown Agency Sourced	1,468,855	1,582,373	1,657,122	1,730,794	1,803,218	1,874,932
Non-Government & Crown Agency Sourced	92,191	98,730	104,020	104,714	105,415	106,120
IDFs & Inter-DHB Sourced	632,613	660,368	700,269	732,735	766,719	802,299
Total Funding	**2,193,659**	**2,341,471**	**2,461,413**	**2,568,243**	**2,675,352**	**2,783,351**
Expenditure						
Personnel Costs	962,102	1,268,450	1,115,793	1,160,425	1,201,043	1,237,075
Outsourced Costs	128,030	141,366	140,486	144,059	147,728	150,758
Clinical Supplies Costs	276,418	302,473	304,099	312,565	321,035	330,187
Infrastructure and Non-Clinical Supplies Costs	208,928	214,416	215,830	232,162	249,806	277,931
Payments to Providers	513,804	546,962	594,191	607,502	634,354	660,934
IDF Outflows	103,218	100,170	111,013	116,246	121,385	126,470
Total Expenditure	**2,192,499**	**2,573,837**	**2,481,413**	**2,572,958**	**2,675,352**	**2,783,351**
Share of associate joint venture surplus/(deficit)	**(147)**	**399**	**-**	**-**	**-**	**-**
Net Surplus/(Deficit)	**1,013**	**(231,967)**	**(20,000)**	**(4,715)**	**0**	**0**
Other comprehensive income						
Gains/(Losses) on Property Revaluations	-	83,512	-	-	-	-
Cash flow hedges	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**1,013**	**(148,455)**	**(20,000)**	**(4,715)**	**0**	**0**

Statement of Service Performance (Four-year plan)

Prospective summary of revenues and expenses by output class	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Early detection				
Total revenue	507,832	529,872	551,971	574,253
Total expenditure	460,852	477,853	496,870	516,928
Net surplus/(deficit)	**46,980**	**52,019**	**55,101**	**57,325**
Rehabilitation and support				
Total revenue	252,900	263,876	274,881	285,978
Total expenditure	257,355	266,849	277,468	288,670
Net surplus/(deficit)	**(4,455)**	**(2,973)**	**(2,587)**	**(2,692)**
Prevention				
Total revenue	22,256	23,222	24,191	25,167
Total expenditure	31,044	32,189	33,470	34,822
Net surplus/(deficit)	**(8,788)**	**(8,967)**	**(9,279)**	**(9,655)**
Intensive assessment and treatment				
Total revenue	1,678,425	1,751,273	1,824,309	1,897,953
Total expenditure	1,732,162	1,796,067	1,867,544	1,942,931
Net surplus/(deficit)	**(53,737)**	**(44,794)**	**(43,235)**	**(44,978)**
Consolidated ADHB				
Total revenue	2,461,413	2,568,243	2,675,352	2,783,351
Total expenditure	2,481,413	2,572,958	2,675,352	2,783,351
Net surplus/(deficit)	**(20,000)**	**(4,715)**	**0**	**0**

SECTION 3: FINANCIAL PERFORMANCE

Financial Management Overview

Our organisational vision is Healthy Communities, World-class Healthcare, Achieved Together. This vision will be achieved by working with our strategic partners and stakeholders across the whole system, including our staff, patients, customers, suppliers, shared service agencies, providers and communities, to deliver high quality, effective, efficient and safe services that will achieve the best outcomes for the populations we serve. Effectively managing our financial, human, assets and other resources is critical to long-term financial sustainability and overall progress towards our vision.

Significant steps have been taken to manage cost growth at Auckland DHB over the past seven years. A comprehensive savings programme delivered over $270M savings in the last six years, with a further $51M savings planned for the current year (2019/20). This, combined with good financial management, has seen the DHB generate surpluses for the past seven years as shown in the table below. However, costs continuing to increase at a faster pace than funding growth are putting the DHB financial sustainability at risk. For the first time in seven years, the DHB has generated a deficit in 2018/19 (audited result).

	2011/12 Actual $'000	2012/13 Actual $'000	2013/14 Actual $'000	2014/15 Actual $'000	2015/16 Actual $'000	2016/17 Actual $'000	2017/18 Actual $'000	2018/19 Budget $'000	2018/19 Forecast $'000
Net Surplus / (Deficit)	736	154	264	355	2,872	3,162	1,013	0	(231,967)

The $232M deficit in 2018/19 is primarily driven by a significant increase in the provision ($212M) for the liability relating to non-compliance with the Holidays Act. A small provision of $6.9M had been carried from prior years. ADHB participated in a national workstream with other DHBs, employee unions and MBIE to develop a framework for assessing if DHB payroll systems are compliant with the Holidays Act, while also providing principles and guidance for remediation where this is not the case.

The balance of the deficit reflects significant cost pressures experienced in the year which could not be fully offset against available revenue, nor savings initiatives. Key drivers for the deficit include the below.

- Significant salary step increases from Multi Employer Contract Agreements (MECA) settled at rates greater than planned levels and not fully funded.
- Strikes related to MECA bargaining had a dual adverse effect for ADHB, revenue impact through under-delivery of volumes for services with funding that is washed up, i.e. Inter-District Flows (IDF) and electives; and cost impact through volumes and on costs of delivering services.
- Cost pressures in clinical supplies and infrastructure costs greater than plan and funded levels.
- Public Health Services core contract funding increase budgeted but not received.
- Impairment of the National Oracle Solution (NOS) investment.
- Actuarial valuation of staff liabilities for Retiring Gratuities and Long Service Leave. Valuation of liabilities is mainly impacted by salary cost growth rates, Treasury discount rates and the differential between these rates.
- Provisions for IDF and Elective volume wash-ups.

Financial Sustainability

We have maintained a financially stable position and lived within our means for the past seven years through a deliberate financial sustainability strategy that has generated savings in excess of $270M. This involved the below.

- Prioritising work programmes to get the best health service and outcomes for the local, regional and national population that we serve.
- Investing in sustainable programmes to enable us to deliver strategic change across the continuum of services we provide (primary, secondary and tertiary) to achieve our vision for **Healthy communities - World-class healthcare - Achieved together**.
- A culture of financial responsibility, accountability and discipline, supported by continuous improvement to ensure that our activities and investments add value to our patients and stakeholders, improve productivity and efficiencies, reduce waste and enable us to realise benefits of investments.

- Encouraging our people to identify areas of improvement and innovation in our processes, systems and models of care, applying our organisational values and maintaining a strong focus on delivering the best care for our patients, clients and customers.
- Working with our regional counterparts to harness the capacity and capability for solving problems together including savings opportunities, service changes and models of care.
- Working regionally to ensure that our local and regional service demand/capacity gaps and asset related risks are well understood locally and by central agencies. Developing plans to remediate risks, increase capacity, improve technology and implement changes in models of care on a timely basis. We developed the first Northern Region Long Term Investment Plan (NRLTIP) which describes our immediate and long-term capacity requirements for the northern region given regional population demographics (growing and ageing population), projected growth in demand and capacity stock take analysis. The NRLTIP also describes the regional ISSP Key investments required across the region to replace existing assets, address risks of ageing technology, facilities and infrastructure, address quality and compliance issues, increase capacity and improve efficiencies are articulated in the NRLTIP.

Key investment programmes developed and under development to address these risks and requiring Crown funding support include the below.

1. **Facilities Infrastructure Remediation Programme (FIRP).** This investment addresses significant risks of ageing critical infrastructure, the need to increase resilience and enable future facility capacity expansion required at our main hospital campuses to meet future service growth. To develop the programme, we completed a comprehensive expert assessment of the condition and risks of our infrastructure assets, most of which have been in place for over 100 years when the hospitals were first built. The $1B programme business case was approved by the Ministers of Health and Finance (joint Ministers). Tranche One Business Case costing $305M was approved by responsible Ministers in August 2018 and is under implementation. Tranche Two business case was approved by the Auckland DHB Board, endorsed by the region and submitted to the joint Ministers for approval.
2. **Building for the Future Programme (BFTF).** This investment will deliver additional clinical and support services capacity required over the next ten years as outlined in the NRLTIP, thereby ensuring sustainability of Auckland DHB service delivery. Additional capacity is driven by the growing and ageing population for Auckland metro, exerting significant pressures on most health services, with shortfalls projected in inpatient acute beds, operating and interventional rooms, diagnostic suites, cancer care and critical care. The Integrated Stroke Unit costing $30M has been approved by the joint Ministers and will deliver additional capacity needed in the short term. A business case to increase Operating Theatre capacity was approved by the Auckland DHB Board, endorsed by the region and submitted to the joint Ministers for approval. The BFTF Programme Strategic Stage Case (with an estimated cost of $300M) was also approved by the Auckland DHB Board, endorsed by the region and submitted to the joint Ministers for approval; this requires endorsement/approval by the Capital Investment Committee and potentially the joint Ministers because of its size.
3. **Hospital Administration System Replacement Programme (HARP).** This investment will replace antiquated information systems and technology to ensure sufficient resilience and capacity to support the services we provide. HARP is premised on comprehensive risk assessment undertaken on the DHB's clinical and business applications, which produced a Risk Heat Map. From this work, combined with regional ISSP and NRLTIP work, Auckland DHB developed a stabilisation programme (under implementation), prioritising investments to address immediate risks while the long term solution is being developed through the business case for HARP. Indicative funding required for HARP is $39.5M. The business case is currently being developed.

Crown support is required to ensure affordability of these significant investments, both in capital and for operational impacts of the investment, subject to approval by the joint Ministers.

We also invest in baseline asset replacement, upgrades and refurbishments using internally generated cash. As assets are a key enabler for the delivery of health services, we have been increasing our maturity in good practice asset management and now understand our assets, their condition, risks and functionality better. We have developed asset replacement plans and these indicate a bow wave of clinical equipment assets that need to be replaced over the next five years. Part of the bow wave is due to previous prioritisation of our internally generated cash to meet capital needs not only for baseline asset renewals, but also to meet capacity increase, technology improvement and to address quality and compliance issues. Crown

funding support will be required to address the bow wave in a timely manner. A request for Crown funding up to $60M has been submitted to the Ministry.

We are working with our regional counterparts on service development and investment planning to address our capacity gaps, deliver better outcomes for our population, ensure investment decisions are robust, services are not duplicated unnecessarily and, to ensure coherent planning for resources we compete for (e.g. workforce, contractors, funding etc.).

At the start of the financial year, a deficit of $56.97M was planned for 2019/20 (flowing on to deficits in the out years). This deficit was based on information known at the time and applying the cost and activity trends at the time. The large deficit was not acceptable to the DHB as this threatens our long term financial sustainability. A deficit is an issue for ongoing ability to meet our obligations to our patients, staff, suppliers and funders and, our ability to maintain and manage our assets, which are a key enabler for health service delivery. Given the critical nature and importance of services we provide to our population, regionally and nationally as provider of last resort, the deficit needs to be addressed with urgency. We are committed to and have been putting tremendous effort to develop turn around strategies to bring us back to a sustainable path and breakeven position. Our context is described in the following sections. At the time the plan was completed, the DHB made an undertaking to continue working on reviewing and improving the budgets. To date some measures have been put in place to manage resources and cost growth which, combined with other one off favourable outturns year to date (to December 2019), have resulted in us being able to reduce the planned deficit from $56.97M to $20M. The year-end forecast result is expected to be within this revised budget.

Financial Planning Setting

We have been able to live within our means in the past by containing cost growth through process and system improvements, contracting, procurement, cash management, revenue maximisation, staffing mix strategies and various one-off savings, delivering most of the easy to implement savings in excess of $270M over the last six years. Short term savings are not possible to bridge the funding/cost gap especially considering the significant step increase in costs following the employment agreement settlements (and consequential expectations this creates for unsettled MECAs) and other cost pressures. We understand the key drivers for the position we are in and have strategies for the internal elements that are within our control (such as productivity, efficiencies, process improvements and cost effectiveness) which we will work on with our staff, shared services, other DHBs, our suppliers and stakeholders.

However, we are not able to resolve on our own the structural deficits relating to national funding mechanisms, cost/pricing gaps and service demand related impacts on revenue and costs for tertiary and national services. We are willing to work with central agencies and other DHBs to address systemic issues, inefficiencies, inequities, risk/benefit trade-offs and to develop a commissioning approach to national and tertiary services that are appropriately funded. Key issues include the below.

Funding Subsidisation for other populations

A large proportion of our planned deficit for 2019/20 relates to a funding gap for national services (estimated at $47M), with the balance relating to costs for services we provide for our own population. Our Funder has been subsidising costs for services provided to other DHBs' populations, leaving us with limited opportunities to invest in our own population to sustainably manage future pressure on our secondary and tertiary services. We have delayed implementing initiatives for our local population, as we are constrained in our ability to make the necessary investments in our primary care and community services due to the need to live within our means across all services we provide. The growth and ageing of the local and national population, combined with poor diets, increasingly sedentary lifestyles, advances in technology and a growing prevalence of long-term chronic conditions, is driving increasing demand on already stretched health services. Improving the health and well-being of our community from a young age through to old age and, investing in innovative and cost effective models of care would assist in bending the growing demand for secondary and tertiary health services.

Cost/Price Gap

The cost/pricing gap needs to be addressed. Analysis of historical pricing for health services (which determines funding for purchase of services) indicates that prices lag behind the indicated cost of providing services. The national technical pricing work indicates that there is a significant gap between the price paid for services and the average cost of delivering those services. The pricing gap impact is more pronounced for Auckland DHB as the largest provider of IDF services (>$600M) and a provider of last resort, very high cost national services such as organ transplants. Pricing issues mean that we are not funded appropriately to meet the costs of delivering these services, which is not sustainable.

While services we provide benefit the people we serve, having unresolved funding issues places tremendous strain on our ability to live within our means and to explore innovation opportunities. The impact to Auckland DHB of not implementing fully the national pricing technical results is further exacerbated by the frequent demands on our DHB to respond to additional referrals in excess of what is formally agreed and funded by other DHBs via the IDF and Funding Envelope arrangements. Previous attempts to resolve IDF pricing issues at a regional level have not been sustainable and a national solution is required. We are willing to (and have started) working with the Ministry on commissioning of tertiary and national services to ensure there service specifications are developed with corresponding outcomes and matched by appropriate pricing for sustainable services.

We also face sustainability challenges in terms of affordability of investments we are implementing or developing which have significant operational cost impacts on depreciation and capital charge. Ministry of Health support for these is requested as part of each business case developed for Ministerial approval.

Key Assumptions for Financial Projections

Revenue Growth

Most of Auckland DHB's revenue is from the Ministry of Health, mainly population-based funding (PBFF) for the Auckland DHB population, IDF revenue (for services delivered for other DHBs' populations) and funding for the national services we provide.

- The Ministry of Health funding for 2019/20 is based on the Funding Envelope advice provided to DHBs on 31 May 2019 and other updates advised subsequently.
- For the out-years, we have assumed that funding increase will average 2.5% for demographic growth and 1.9% for cost pressure, thus overall average increase of 4.4% in each of the planning years. The funding envelope advice letter indicated that:

  "The Government has made no decisions on out-year funding increases. To ensure consistency across DHBs, your Board should assume that the standard DHB funding allocation methodology will be applied in out-years as indicated in this advice". We have assumed that any increase in organ transplant volumes above contracted levels will be funded and the transplant purchase framework and pricing will be updated".

- All other funding is based on contracts or estimated uplifts/reductions based on historical analysis.
- Any capital charge increases relating to projects approved by the Ministers are assumed to be cost neutral (i.e. fully offset by additional Ministry of Health operational revenue).
- This plan assumes full funding will be paid for Elective volume delivery and strike impacts will not be unfavourably washed up.

Overall, our funding increase from the 2018/19 audited position is $119.547M, with $74.7M increase in Ministry funding, $39.9M for IDFs and Inter-provider revenue and $5.3M in other income.

Expenditure Growth

Expenditure growth from the audited result for 2018/19 is $92.4M, although the year on year expenditure movement is distorted by the significant expenditure in the 2018/19 audited result relating to the Holidays Act provision. The underlying expenditure growth is driven by demographic growth pressure on services provided for the local, regional and national population, cost growth from MECA settlements and assumptions (including automatic step increases), staff FTE volume growth, cost of capital for investments, inflationary pressure and/or contractual pricing on clinical and non-clinical supplies and services. Key expenditure assumptions include the below.

- Settled MECAs have been budgeted at settlement levels and an average of 3.5% cost growth per annum in all other personnel costs (reflecting both employment contracts price factor and FTE volumes growth factor) during the planning period. This reflects the impact of employment agreement settlements and assumptions for unsettled MECAs expiring during the planning horizon.
- Clinical supplies cost growth reflects inflation factor in current contracts, estimation of price change on supplies, adjustments for known specific information within services and growth in volume of services provided by the DHB. healthAlliance Procurement and Supply chain teams and other national entities continue to negotiate contract prices to realise more savings in this area.

- Infrastructure cost growth (not including interest, depreciation and capital charge) in this category is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. Interest expense has been replaced with capital charge, which attracts a higher rate but with the bottom-line impact fully offset by additional funding from the Ministry. Capital charge reflects the estimated Crown equity position at balance date at 6% capital charge. A full asset revaluation was completed by 30 June 2019 and this resulted in land and building asset values increasing by $83.5M. This improvement in value has flow on operational impact on depreciation ($5.1M) and on capital charge ($5M). Both impacts have been included in the revised 2019/20 budget, noting that capital charge is cost neutral as additional Ministry of Health revenue is assumed to offset this, while depreciation impact has to be absorbed by the DHB.
- Funder payments reflect historical cost growth patterns, demographic growth factor, inflationary factor, demand modelling (for demand-driven areas such as pharmaceuticals, primary health and aged residential care and for other areas), contractual arrangements in place with providers and investments required in priority areas and specific initiatives funded expenditure.
- Out-years' expenditure growth is planned in line with the assumed future funding growth path and it has been assumed that while some of the budget improvements in 2019/20 are one-off, decisions will be required to enable the DHB to bring back the result towards breakeven. The planning process for 2020/21 underway, together with Ministry of Health funding to be advised for that year will determine if a breakeven plan will be developed for 2020/21 onwards.

Financial Risks

The key risks and challenges for us during the planning horizon include the following.

Ability to maintain financial sustainability and deliver breakeven results

DHB expenditure is very sensitive to changes in the cost of settlement of MECAs. A 1% change in personnel costs for Auckland DHB equates to $11.2M (2019/20 planned cost). Any settlements above the assumed cost of settlement and not funded will have a bottom-line impact. 2018/19 has seen significant step increases in settled MECAs and this potentially creates expectations for future MECA settlements. This plan assumes that settlements will be within affordable levels.

Sustainability of Services

Provision of sustainable services is dependent on the ability to live within our means. In the past, the deficit generated in the Provider Arm has been fully offset by surpluses in the Funder Arm but this is not sustainable hence the deficits projected. Easy to achieve savings are becoming more difficult to find and structural deficits need to be addressed by considering the revenue and cost structures of services provided. Any further cost pressures beyond planned levels will increase the risk of service sustainability.

InterDistrict Flows

The DHB revenue is sensitive to IDF wash-ups. If services delivered are below contract for washed up areas, the DHB's bottom-line could be impacted if there is insufficient capacity to absorb such shocks to the system.

Ability to invest in services

Currently, the DHB has very little, if any, ability to invest in areas that will reduce long-term demand for expensive hospital-based services. The DHB is constrained as these issues cannot be resolved by the DHB alone and input is required from the Ministry and other DHBs to resolve.

Ability to invest in capital

Significant capital investment for remediation of aged facilities infrastructure, major upgrades and investment in new technology and clinical equipment replacement is required. Crown funding will be required to finance major redevelopment and upgrade projects, including funding or other mechanisms to alleviate the impact of large capital programmes on operating performance. We have assumed that flow on costs of Crown funded capital programmes are fully offset by additional funding.

Impact of Strikes, Measles Outbreak and Corona Virus

The planned deficit for 2019/20 of $20M assumes that funding will be received to offset additional costs relating to the measles outbreak. The plan also assumes that full elective revenue (as planned) will be paid to the DHB if any under delivery to the plan is due to the impact of strikes. The deficit planned could also be at risk if there is a corona virus outbreak as that could potential impact the DHB's ability to deliver Electives and IDF volumes to plan.

Forecast Financial Statements

The Board of Directors of the Auckland DHB is responsible for issuing forecast financial statements, including the appropriateness of the assumptions underlying the forecast financial statements.

The revised forecast financial statements for the period 2019/20 to 2022/23 included in this Annual Plan are authorised by the Board of Directors on 26 February 2020.

The forecast financial statements were prepared to comply with the requirements of Section 149G of the Crown Entities Act. The forecast financial statements may not be appropriate for use for any other purpose.

In line with the requirements of Section 149G of the Crown Entities Act 2004, we provide both the forecast financial statements of Auckland DHB and its subsidiaries (together referred to as 'Group') and Auckland DHB's interest in associates and jointly controlled entities.

The Auckland DHB group consists of the parent, Auckland DHB and Auckland District Health Board Charitable Trust (controlled by Auckland DHB). Joint ventures are with healthAlliance N.Z. Limited and NZ Health Innovation Hub Management Limited. The associate company is Northern Regional Alliance Limited.

The tables below provide a summary of the forecast consolidated financial statements for the audited result for 2017/18 and 2018/19 and, financial and plans for years 2019/20 to 2022/23.

The forecast financial statements were prepared based on the key assumptions for financial forecasts and the significant accounting policies summarised in the Significant Accounting Policies outlined in this plan. The actual financial results achieved for the period covered are likely to vary from the forecast/plan financial results presented. Such variations may be material.

Statement of Comprehensive Revenue and Expenses – Group

	2017/18 Audited $'000	2018/19 Audited $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,468,855	1,582,373	1,657,122	1,730,794	1,803,218	1,874,932
Non-Government & Crown Agency Sourced	92,191	98,730	104,022	104,714	105,415	106,120
IDFs & Inter-DHB Sourced	632,613	660,368	700,269	732,735	766,719	802,299
TOTAL FUNDING	**2,193,659**	**2,341,471**	**2,461,413**	**2,568,243**	**2,675,352**	**2,783,351**
EXPENDITURE						
Personnel Costs	962,102	1,268,450	1,115,793	1,160,425	1,201,043	1,237,075
Outsourced Costs	128,030	141,366	140,486	144,059	147,728	150,758
Clinical Supplies Costs	276,418	302,473	304,099	312,565	321,035	330,187
Infrastructure & Non-Clinical Supplies Costs	208,928	214,416	215,830	232,162	249,806	277,931
Payments to Providers	513,804	546,962	594,191	607,502	634,354	660,934
IDF Outflows	103,218	100,170	111,013	116,246	121,385	126,470
TOTAL EXPENDITURE	**2,192,499**	**2,573,837**	**2,481,413**	**2,572,958**	**2,675,352**	**2,783,351**
Share of associate and joint venture surplus/(deficit)	**(147)**	**399**	**-**	**-**	**-**	**-**
NET SURPLUS/(DEFICIT)	**1,013**	**(231,967)**	**(20,000)**	**(4,715)**	**0**	**0**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	-	83,512	-	-	-	-
Cash flow hedges	-	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**1,013**	**(148,455)**	**(20,000)**	**(4,715)**	**0**	**0**

The deficit of $232M for 2018/19 is primarily due to a provision for the liability for non-compliance with the Holidays Act. The deficit planned for 2019/20 is $20M, reducing to $4.7M in 2020/21 and breakeven thereafter, provided Ministry of Health funding is sufficient to fully offset expenditure growth. Auckland DHB is committed to operating in a financially sustainable manner. However, the support of the Ministry and other DHBs will be required to address the funding related issues stated in this annual plan.

Statement of Comprehensive Revenue and Expenses – Parent

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,468,855	1,582,373	1,657,122	1,730,793	1,803,218	1,874,932
Non-Government & Crown Agency Sourced	91,154	97,389	104,966	105,639	106,318	107,004
IDFs & Inter-DHB Sourced	632,613	660,368	700,274	732,735	766,719	802,299
TOTAL FUNDING	**2,192,622**	**2,340,130**	**2,462,361**	**2,569,167**	**2,676,255**	**2,784,235**
EXPENDITURE						
Personnel Costs	962,102	1,267,898	1,115,795	1,160,426	1,201,041	1,237,073
Outsourced Costs	128,029	141,365	140,477	144,057	147,729	150,756
Clinical Supplies Costs	276,418	302,475	304,101	312,565	321,035	330,187
Infrastructure & Non-Clinical Supplies Costs	208,640	214,286	216,387	233,483	251,114	279,771
Payments to Providers	513,804	546,962	594,196	607,503	634,354	660,934
IDF Outflows	103,218	100,167	111,017	116,246	121,384	126,470
TOTAL EXPENDITURE	**2,192,211**	**2,573,153**	**2,481,973**	**2,574,280**	**2,676,657**	**2,785,191**
Share of associate and joint venture surplus/(deficit)	-	-	-	-	-	-
NET SURPLUS/(DEFICIT)	**411**	**(233,023)**	**(19,612)**	**(5,114)**	**(403)**	**(957)**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	-	83,512	-	-	-	-
Cash flow hedges	-	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**411**	**(149,511)**	**(19,612)**	**(5,114)**	**(403)**	**(957)**

Interest, Depreciation and Capital Charge

Included in infrastructure and non-clinical supplies costs are capital-related costs in the form of Interest, Depreciation and Capital Charge (IDCC).

Depreciation reflects the size and value of our asset base and rates of annual usage applied to the asset classes and the impact of new Capital expenditure investment in facilities and equipment over time and impact of asset revaluations and asset impairments.

Capital charge reflects the Crown's return on investment in the DHB and is impacted by upward movements in asset valuations, debt equity conversion noted above and the capital charge rate policy. These costs are summarised in the table below.

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
FINANCING COSTS						
Interest	-	410	1,295	1,480	1,671	1,863
Depreciation	47,565	52,306	55,331	58,115	70,537	94,035
Capital Charge	55,406	54,278	45,986	57,358	60,395	61,463
TOTAL FINANCING COSTS	**102,972**	**106,994**	**102,612**	**116,952**	**132,603**	**157,360**
% of Infrastructure & Non Clinical Supply Costs	**49%**	**50%**	**47%**	**50%**	**53%**	**57%**

To maintain overall sustainability, we need to continue investing in assets required to support the growing demand for our services. To maintain financial sustainability, this investment needs to be affordable to the DHB, meaning that all associated financing costs must be met within the funding available.

Statement of Cashflows – Group

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
CASHFLOW FROM OPERATING ACTIVITIES						
Cash was provided from						
MoH and other Government/Crown	2,101,417	2,252,016	2,357,395	2,463,529	2,544,937	2,602,232
Other Income	78,347	72,041	98,577	99,269	99,969	100,675
Total Operating Cash Inflow	**2,179,764**	**2,324,057**	**2,455,972**	**2,562,798**	**2,644,906**	**2,702,907**
Cash was applied to						
Payments for Personnel	(926,588)	(1,034,016)	(1,115,796)	(1,120,427)	(1,171,042)	(1,196,482)
Payments for Supplies	(496,812)	(555,249)	(568,359)	(612,063)	(607,148)	(613,149)
Capital Charge Paid	(55,406)	(54,278)	(45,986)	(57,358)	(60,395)	(61,463)
Net GST Paid	478	(14)	-	-	-	-
Payments to Providers and other DHBs	(617,020)	(633,164)	(705,212)	(703,749)	(725,893)	(747,404)
Total Operating Cash Outflow	**(2,095,349)**	**(2,276,721)**	**(2,435,353)**	**(2,493,597)**	**(2,564,478)**	**(2,618,498)**
NET CASHFLOW FROM OPERATING ACTIVITIES	**84,416**	**47,335**	**20,619**	**69,201**	**80,428**	**84,409**
INVESTING ACTIVITIES						
Cash was provided from						
Interest Received	5,761	5,867	5,448	5,447	5,447	5,447
Proceeds from Sale of Fixed Assets	63	113	-	-	-	-
Decrease/(Increase) in Investments	(23,258)	(1,488)	-	30,000	-	-
Total Investing Cash Inflow	**(17,434)**	4,492	5,448	35,447	5,447	5,447
Cash was applied to						
Capital Expenditure	(45,705)	(65,653)	(160,020)	(201,999)	(149,229)	(96,013)
NET CASH (OUTFLOW) FROM INVESTING ACTIVITIES	**(63,139)**	**(61,161)**	**(154,572)**	**(166,552)**	**(143,782)**	**(90,566)**
FINANCING ACTIVITIES						
Proceeds from Capital Raised/(Repaid) from the Crown	-	8,082	95,448	101,999	74,229	21,013
Proceeds from Loans Raised	4,406	4,886	13,514	8,833	3,833	3,833
Cash flow hedge	-	-	-	-	-	-
Interest Paid	-	(410)	(1,296)	(1,480)	(1,671)	(1,863)
NET CASH (OUTFLOW) FROM FINANCING ACTIVITIES	**4,406**	**12,558**	**107,666**	**109,352**	**76,391**	**22,983**
NET CASH INFLOW/(OUTFLOW)	**24,927**	**(58)**	**(26,287)**	**12,001**	**13,037**	**16,826**
Cash & cash equivalents at the start of the year	**72,178**	**97,105**	**97,047**	**70,760**	**82,761**	**95,798**
Cash & cash equivalents at the end of the year	**97,105**	**97,047**	**70,760**	**82,761**	**95,798**	**112,624**

The Operating cashflow movement reflects the operating deficits planned. The improvement in cash in later years reflects the capital impacts of strategic projects which are assumed to be funded. Baseline Capital is limited to $55M of depreciation per year and the strategic projects funded by the Crown have Crown equity injections assumed to support the projects.

Statement of Cashflows – Parent

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
CASHFLOW FROM OPERATING ACTIVITIES						
Cash was provided from						
MoH and other Government/Crown	2,101,417	2,252,016	2,357,396	2,463,528	2,544,937	2,602,231
Other Income	75,109	71,684	96,073	96,766	97,466	98,173
Total Operating Cash Inflow	**2,176,526**	2,323,700	2,453,469	2,560,295	2,642,403	2,700,404
Cash was applied to						
Payments for Personnel	(926,588)	(1,034,016)	(1,115,795)	(1,120,426)	(1,171,041)	(1,196,482)
Payments for Supplies	(494,604)	(553,490)	(565,117)	(608,828)	(603,911)	(610,148)
Capital Charge Paid	(55,406)	(54,278)	(45,986)	(57,358)	(60,395)	(61,463)
Net GST Paid	496	166	-	-	-	-
Payments to Providers	(617,020)	(633,164)	(705,213)	(703,749)	(725,893)	(747,405)
Total Operating Cash Outflow	(2,093,122)	(2,274,781)	(2,432,111)	(2,490,361)	(2,561,241)	(2,615,497)
NET CASHFLOW FROM OPERATING ACTIVITIES	**83,404**	**48,919**	**21,357**	**69,934**	**81,162**	**84,908**
INVESTING ACTIVITIES						
Cash was provided from						
Interest Received	5,231	5,259	4,683	4,683	4,683	4,917
Proceeds from Sale of Fixed Assets	63	113	-	-	-	-
Decrease/(Increase) in Investments	(21,755)	(2,411)	30	30,030	30	30
Total investing Cash Inflow	**(16,461)**	**2,961**	**4,713**	**34,713**	**4,713**	**4,947**
Cash was applied to						
Capital Expenditure	(45,667)	(65,653)	(160,020)	(201,999)	(149,229)	(96,013)
NET CASH (OUTFLOW) FROM INVESTING ACTIVITIES	**(62,128)**	**(62,692)**	**(155,312)**	**(167,286)**	**(144,516)**	**(91,066)**
FINANCING ACTIVITIES						
Proceeds from Capital Raised/(Repaid) from the Crown	-	8,082	95,448	101,999	74,229	21,013
Proceeds from Loans Raised	4,406	4,886	13,514	8,833	3,833	3,833
Cash flow hedge	-	-	-	-	-	-
Interest Paid	-	(410)	(1,295)	(1,480)	(1,671)	(1,863)
NET CASH (OUTFLOW) FROM FINANCING ACTIVITIES	**4,406**	**12,558**	**107,667**	**109,353**	**76,391**	**22,983**
NET CASH INFLOW/(OUTFLOW)	**25,682**	**(1,215)**	**(26,287)**	**12,000**	**13,037**	**16,825**
Cash & cash equivalents at the start of the year	**69,725**	**95,407**	**94,192**	**67,905**	**79,905**	**92,942**
Cash & cash equivalents at the end of the year	**95,407**	**94,192**	**67,905**	**79,905**	**92,942**	**109,767**

Statement of Financial Position – Group

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
ASSETS						
Current assets						
Cash and cash equivalents	95,407	94,192	67,905	79,905	92,944	109,767
Trust/special funds/Other Investments	47,492	31,154	31,154	16,155	16,154	16,156
Debtors & other receivables	92,564	86,869	86,869	86,869	86,868	86,869
Prepayments	1,225	996	996	996	996	996
Inventories	13,853	14,356	14,356	14,356	14,356	14,356
Total Current Assets	**250,541**	**227,567**	**201,280**	**198,281**	**211,318**	**228,144**
Non-current assets						
Trust/special funds/Other Investments	15,308	32,200	32,200	17,200	17,200	17,200
Property, Plant and Equipment	1,021,658	1,117,386	1,233,039	1,347,964	1,411,969	1,418,829
Intangible Assets	11,081	8,524	8,097	8,097	8,097	8,097
Investment in joint ventures & associates	63,990	71,003	71,003	71,003	71,003	71,003
Total Non-Current Assets	**1,112,037**	**1,229,113**	**1,344,339**	**1,444,264**	**1,508,269**	**1,515,129**
TOTAL ASSETS	**1,362,578**	**1,456,680**	**1,545,619**	**1,642,545**	**1,719,587**	**1,743,273**
LIABILITIES						
Current liabilities						
Trade and other payables	165,684	166,325	167,606	157,607	157,605	157,605
Employee benefits	194,319	409,422	409,422	409,422	409,422	409,422
Interest-bearing loans & borrowings	764	1,176	3,976	5,976	6,976	7,976
Restricted trust funds	1,275	1,308	-	-	-	-
Total Current Liabilities	**362,042**	**578,231**	**581,004**	**573,005**	**574,003**	**575,003**
Non-current liabilities						
Employee Benefits	56,094	69,894	69,894	69,894	69,894	69,894
Interest-bearing loans & borrowings	4,510	8,983	19,697	27,344	29,157	30,830
Total Non-Current Liabilities	60,604	78,877	89,591	97,238	99,051	100,724
TOTAL LIABILITIES	**422,646**	**657,108**	**670,595**	**670,243**	**673,054**	**675,727**
EQUITY						
Public Equity	881,298	889,380	984,828	1,086,827	1,161,056	1,182,069
Accumulated deficit	(484,349)	(717,130)	(737,512)	(742,625)	(743,028)	(743,434)
Other reserves	515,639	599,151	599,151	599,151	599,151	599,151
Cash flow hedge reserve	-	-	-	-	-	-
Trust/special funds	27,343	28,158	28,558	28,957	29,359	29,766
TOTAL EQUITY	**939,931**	**799,571**	**875,025**	**972,310**	**1,046,539**	**1,067,552**
NET ASSETS	**939,931**	**799,571**	**875,025**	**972,310**	**1,046,539**	**1,067,552**

The movement in Crown equity balances reflects the significant impact of the deficit relating to the Holidays Act provision and subsequent deficits planned for 2019/20 and 2020/21, offset by impact of the asset revaluation in 2018/19 of $83.5M and equity injections for strategic capital projects funded by the Crown.

Statement of Financial Position – Parent

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
ASSETS						
Current assets						
Cash and cash equivalents	95,407	94,192	67,905	79,905	92,942	109,767
Trust/special funds/Other Investments	31,275	16,308	14,044	(986)	(1,016)	(1,046)
Debtors & other receivables	93,610	88,191	88,366	88,683	88,683	88,683
Prepayments	1,225	996	996	996	996	996
Inventories	13,853	14,356	14,356	14,356	14,356	14,356
Total Current Assets	**235,370**	**214,043**	**185,667**	**182,954**	**195,962**	**212,756**
Non-current assets						
Trust/special funds/Other Investments	0	15,000	15,000	0	0	0
Property, Plant and Equipment	1,020,718	1,116,448	1,232,095	1,346,998	1,411,003	1,417,863
Intangible Assets	11,081	8,524	8,097	8,097	8,097	8,097
Investment in joint ventures & associates	63,452	70,066	70,647	70,647	70,647	70,647
Total Non-Current Assets	**1,095,252**	**1,210,038**	**1,325,839**	**1,425,742**	**1,489,747**	**1,496,607**
TOTAL ASSETS	**1,330,621**	**1,424,081**	**1,511,506**	**1,608,696**	**1,685,708**	**1,709,363**
LIABILITIES						
Current liabilities						
Trade and other payables	161,602	162,692	162,062	152,708	153,079	154,006
Employee benefits	194,319	409,396	409,422	409,422	409,422	409,422
Interest-bearing loans & borrowings	764	1,176	3,976	5,976	6,976	7,976
Restricted trust funds	1,275	1,308	-	-	-	-
Total Current Liabilities	**357,957**	**574,572**	**575,460**	**568,106**	**569,477**	**571,404**
Non-current liabilities						
Employee Benefits	56,094	69,895	69,894	69,894	69,894	69,894
Interest-bearing loans & borrowings	4,510	8,983	19,697	27,344	29,157	30,830
Total Non-Current Liabilities	**60,604**	**78,878**	**89,591**	**97,238**	**99,051**	**100,724**
TOTAL LIABILITIES	**418,561**	**653,449**	**665,052**	**665,344**	**668,528**	**672,128**
EQUITY						
Public Equity	881,298	889,380	984,828	1,086,827	1,161,056	1,182,069
Accumulated deficit	(484,877)	(717,900)	(737,512)	(742,625)	(743,028)	(743,983)
Other reserves	515,639	599,151	599,151	599,151	599,151	599,151
Cash flow hedge reserve	-	-	-	-	-	-
Trust/special funds	-	-	-	-	-	-
TOTAL EQUITY	**912,060**	**770,631**	**846,467**	**943,352**	**1,017,179**	**1,037,234**
NET ASSETS	**912,060**	**770,631**	**846,467**	**943,352**	**1,017,179**	**1,037,234**

Disposal of Land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, we will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. We will comply with the relevant protection mechanism that addresses the Crown's obligations under Te Tiriti o Waitangi and any processes related to the Crown's good governance obligations in relation to Māori sites of significance.

Statement of Changes in Net Assets/Equity – Group

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
BALANCE AT 1 JULY	**938,918**	**939,931**	**799,571**	**875,025**	**972,310**	**1,046,539**
Comprehensive Income/(Expense)						
Surplus/Deficit for the Year	1,013	(231,967)	(20,000)	(4,715)	0	0
Gains/(Losses) on Property Revaluations	-	83,512	-	-	-	-
Cashflow Hedge Reserve and Other movements	-	-	6	-	-	-1
TOTAL COMPREHENSIVE INCOME	**939,931**	**791,476**	**779,577**	**870,310**	**972,310**	**1,046,538**
OWNER TRANSACTIONS						
Capital Contributions from the Crown	-	8,082	95,448	101,999	74,229	21,013
BALANCE AT 30 JUNE	**939,931**	**799,571**	**875,025**	**972,310**	**1,046,539**	**1,067,552**

The shareholder's equity position is impacted by the planned deficits and Crown Equity injections for capital projects.

Statement of Changes in Net Assets/Equity – Parent

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
BALANCE AT 1 JULY	**911,649**	**912,060**	**770,631**	**846,467**	**943,352**	**1,017,179**
Comprehensive Income/(Expense)						
Surplus/Deficit for the Year	411	(233,023)	(19,612)	(5,114)	(403)	(957)
Gains/(Losses) on Property Revaluations	-	83,512	-	-	-	-
Cashflow Hedge Reserve and Other movements	-	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**912,060**	**762,549**	**751,019**	**841,353**	**942,949**	**1,016,222**
OWNER TRANSACTIONS						
Capital Contributions from the Crown	-	8,082	95,448	101,999	74,229	21,013
BALANCE AT 30 JUNE	**912,060**	**770,631**	**846,467**	**943,352**	**1,017,179**	**1,037,234**

Additional Information

Financial performance for each of the DHB arms is summarised in the tables below and on the following pages.

Funder Arm Financial Performance

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
REVENUE						
Government & Crown Agency Sourced	1,372,549	1,476,042	1,554,317	1,626,961	1,698,346	1,769,012
Non-Government & Crown Agency Sourced	0	0	0	0	0	0
IDFs & Inter-DHB Sourced	612,935	643,399	686,191	718,516	752,358	787,793
TOTAL REVENUE	**1,985,484**	**2,119,441**	**2,240,507**	**2,345,477**	**2,450,704**	**2,556,805**
EXPENDITURE						
Payment to Provider	1,315,185	1,390,833	1,467,977	1,551,798	1,628,147	1,704,507
Payment to Governance	13,945	14,730	15,323	15,782	16,256	16,743
Total Payments to Internal Provider	**1,329,130**	**1,405,563**	**1,483,299**	**1,567,580**	**1,644,403**	**1,721,250**
NGO Expenditure						
Personal Health	318,920	339,219	370,984	375,350	392,571	407,809
Mental Health	35,534	37,601	41,329	42,046	43,345	45,376
DSS	156,030	167,285	177,592	185,615	193,753	202,840
Public Health	1,910	1,417	2,817	2,951	3,081	3,225
Māori Health	1,412	1,446	1,468	1,539	1,605	1,681
Total Payments to NGO providers	**513,806**	**546,968**	**594,191**	**607,503**	**634,354**	**660,931**
IDF Outflows	103,217	100,166	111,013	116,245	121,385	126,470
Total Payments to External Providers	**617,023**	**647,134**	**705,204**	**723,748**	**755,739**	**787,401**
TOTAL EXPENDITURE	**1,946,154**	**2,052,698**	**2,188,507**	**2,291,327**	**2,400,140**	**2,508,650**
SURPLUS/(DEFICIT)	**39,332**	**66,743**	**52,000**	**54,150**	**50,563**	**48,155**
Other Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**
TOTAL COMPREHENSIVE INCOME	**39,332**	**66,743**	**52,000**	**54,150**	**50,563**	**48,151**

The Funder is planning a surplus in each of the planning years, which partially offsets planned deficits in the Provider arm but is not sufficient to achieve a breakeven result. The DHB's Production Plan Template will be submitted to the Ministry, which summarises the service volumes planned for 2019/20.

The joint Funder collaboration arrangements between Auckland and Waitematā DHBs remain in place, with Funding Administration staff employed by Waitematā DHB on behalf of the two DHBs. Funder arm financial plans and performance for Auckland DHB continue to be reported through the Auckland DHB financial accounts and statement of service performance.

Additional funding resulting in the overall DHB surplus is accounted for in the DHB funder arm. The planned Funder result assumes that funding for this is sustained in future years.

Provider Arm Financial Performance

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
INCOME						
MoH Base via Funder	1,315,185	1,390,833	1,467,977	1,551,798	1,628,147	1,704,507
MoH Direct	55,602	61,720	61,017	61,627	62,244	62,866
Other	152,422	159,329	159,889	161,138	162,404	163,680
TOTAL INCOME	**1,523,209**	**1,611,882**	**1,688,883**	**1,774,563**	**1,852,795**	**1,931,053**
EXPENDITURE						
Personnel	958,486	1,264,253	1,111,619	1,156,085	1,196,550	1,232,447
Outsourced Services	115,217	129,627	125,547	128,758	132,047	134,760
Clinical Supplies	276,225	302,103	303,944	312,405	320,871	330,021
Infrastructure & non clinical supplies	206,859	212,843	211,937	228,158	245,666	273,590
Other	6,330	5,434	7,826	8,022	8,222	8,387
TOTAL EXPENDITURE	**1,563,116**	**1,914,260**	**1,760,873**	**1,833,427**	**1,903,357**	**1,979,204**
SURPLUS/(DEFICIT)	**(39,907)**	**(302,378)**	**(71,991)**	**(58,862)**	**(50,562)**	**(48,152)**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	-	83,512	-	-	-	-
Cash flow hedges	-	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**(39,907)**	**(218,866)**	**(71,991)**	**(58,862)**	**(50,562)**	**(48,152)**

The Provider Arm financial plan is for a deficit in each of the planning years. This is partially offset by the surpluses in the Funder. Funding issues described in the Financial Sustainability and Financial Planning Setting sections mainly relate to the Provider arm. As a provider of last resort, Auckland DHB accepts referrals from other DHBs for national services and for IDF services, irrespective of the funding allowed in the Funding Envelope. Funding issues for IDFs and some of the national services have been signalled to other DHBs and the Ministry. These issues need to be resolved at national and regional level as they are systemic. The DHB will continue working on the internal issues to improve productivity, improve processes and contain cost growth within controllable areas.

Governance and Funding Administration Arm Financial Performance

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Revenue from Funder Arm	13,945	16,109	15,323	15,782	16,256	16,743
Revenue Other	4	1	-	-	-	-
TOTAL INCOME	**13,949**	**16,110**	**15,323**	**15,782**	**16,256**	**16,743**
EXPENDITURE	**12,359**	**12,443**	**15,323**	**15,782**	**16,256**	**16,743**
SURPLUS/(DEFICIT)	**1,590**	**3,667**	**0**	**0**	**0**	**0**
TOTAL COMPREHENSIVE INCOME	**1,590**	**3,667**	**0**	**0**	**0**	**0**

The Governance and Funding Administration arm continues to perform within the funding allocated, with breakeven forecast for the planning period.

Capital Expenditure

The Capital Intentions for the DHB have been included in the Annual Plan financial templates and are summarised in the table below. The capital plan reflects the level of capital able to be funded from internally generated cash (mainly depreciation free cashflow) as well as strategic projects that are funded by Crown Equity. Ongoing capital investment is required to meet growth in services, compliance-related investments and investments in information technology. The Regional LTIP developed informs the main investment requirements prioritised for the region. Auckland DHB has three strategic projects included in the regional LTIP that are being progressed or in development, that is; FIRP, HARP and BFTF. A brief overview of these has been provided in this plan. Strategic projects that have not yet been approved are not included in this plan.

	2017/18 Audited $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
FINANCING SOURCES						
Free cashflow from depreciation	47,564	52,306	55,331	58,115	70,537	94,035
External Crown Funding	-	8,082	95,448	101,999	74,229	21,013
Private Funding – Finance leases	4,406	4,886	13,514	8,833	3,833	3,833
Donations	-	-	-	-	-	-
Cash Reserves	(6,265)	(1,083)	(4,273)	33,052)	630	(22,868)
TOTAL FINANCING	**45,705**	**64,191**	**160,020**	**201,999**	**149,229**	**96,013**
BASELINE CAPITAL EXPENDITURE						
Land	-	1,000	-	-	-	-
Buildings and Plant	20,114	37,520	29,124	60,000	35,000	35,000
Clinical Equipment	14,683	21,233	24,228	20,000	20,000	20,000
Other Equipment	589	1,496	4,560	8,000	8,000	8,000
Information Technology (Hardware)	1,884	323	6,480	1,000	1,000	1,000
Intangible Assets (Software)	-	1,740	-	-	-	-
Motor Vehicles	-	779	612	1000	1000	1000
TOTAL BASELINE CAPITAL PAYMENTS	**38,486**	**64,191**	**65,004**	**90,000**	**65,000**	**65,000**
STRATEGIC INVESTMENTS						
Land	-	-	-	-	-	-
Buildings & Plant	6,501	-	91,272	101,999	74,229	21,013
Clinical Equipment	-	-	2,496	-	-	-
Other Equipment	718	-	1,248	-	-	-
Intangible Assets (Software)	-	-	-	10,000	10,000	10,000
Motor Vehicles	-	-	-	-	-	-
TOTAL STRATEGIC CAPITAL EXPENDITURE	**7,219**	**-**	**95,016**	**111,999**	**84,229**	**31,013**
TOTAL CAPITAL PAYMENTS	**45,705**	**64,191**	**160,020**	**201,999**	**149,229**	**96,013**

Banking Facilities and Covenants

Term Debt Facilities and Covenants

Auckland DHB does not have any more term debt.

Shared Commercial Banking Services

Auckland DHB continues to participate in the DHBs' shared commercial banking arrangements with BNZ, other DHBs and New Zealand Health Partnership Limited (NZHPL). Under these arrangements, DHBs are not required to maintain separate overdraft or stand by facilities for working capital.