

**Counties Manukau  
District Health Board**

**Urology  
Health Services Plan**

## 1.0 Current Services

The configuration and service provision of Urology Services across the Auckland metropolitan has been guided by a regional project undertaken in 2004. This project determined the strategic direction for 2004-2007 and recommended that the provision of Urology Services would be reviewed again in 2008. Counties Manukau DHB has a strong view to provide its own secondary urology services on site at Manukau SuperClinic. This would account for approximately 95% of the current activity provided for the CMDHB population from ADHB facilities.

The Urology Service in the Auckland region currently serves a population estimated at 1.25 million people. There are nine urologists employed with the public service in Auckland with a joint Auckland District Health Board/Waitemata District Health Board appointment. Eight of the nine urologists are based at ADHB and one is based at WDHB.

The ADHB service provides a Level 5 capability when based on the NSW Role Delineation criteria i.e.:

- A full range of diagnostic and treatment services performed by Urologists and Specialist Anesthetists with the ability to deal with complex major diagnostic and treatment procedures in association with other specialties.
- Training and Research are carried out through the ADHB service.

At present the three district health boards Waitemata District Health Board (WDHB), Auckland District Health Board (ADHB) and Counties Manukau District Health Board (CMDHB), provide a mix of services locally and centrally across the Auckland Region. ADHB and WDHB conduct outpatient, day stay and inpatient surgery while CMDHB provides only outpatient and day-patient urology services. Urologists with dual appointments provide inpatient elective services at ADHB and WDHB.

The ADHB service co-ordinates urology services across the region including registrar and fellowship training, undergraduate and postgraduate medical training, regional research unit, quality group, and recruitment of SMOs.

Urology is a highly sub-specialised service including:

- Andrology
- Complex kidney stone surgery
- Female urology
- Laparoscopic intervention
- Major and routine urological oncology
- Routine oncology
- Paediatric urology
- Reconstructive surgery
- General urology
- Urethral injuries.

Services for people spinal cord injuries are provided by a visiting ADHB specialist at CMDHB facilities (Manukau SuperClinic and the Auckland Spinal Unit (Bairds Road).

### 1.1 Regional Acute Service

The regional acute service at Auckland City Hospital (ACH) is staffed by nine urologists, together with registrars and nurses. The service relies on uro-radiology and is recognised nationally for its expertise. There is a high level of intensive care requirement for patients once they present to the intensive care unit.

The three District Health Boards reached an agreement in 2004 that in the foreseeable future (three years) acute activity will be managed at ACH and for this reason most urologists

employed within the greater Auckland region will have an association and affiliation with ADHB. Because the management of acute admissions can be either acute or semi acute this will necessitate the provision of both outpatient and inpatient operating sessions at ACH for those urologists involved in acute services. The provision of acute urology admissions will be subject to the full RSP project in 2008.

## **1.2 Inpatient Elective Services**

Inpatient elective services are currently available at both ADHB and WDHB, with the more complex inpatient elective services provided at ADHB. There is a very small portion (30 WIES) of elective daypatient urology surgery provided from the Manukau SuperClinic in 2007/08 for CMDHB residents.

The majority of the elective services for Counties Manukau residents are provided by ADHB clinicians at ADHB facilities (refer Appendix One for the volume breakdown by WIES and discharge by facility).

## **1.3 Day Surgery**

Day surgery commenced at CMDHB in March 2004.

## **1.4 Referrals from Primary Care**

Avoiding inappropriate referrals from primary care is important as specialist resources are to be efficiently utilised.

Studies have been undertaken in the United Kingdom to assess the proportion of patients referred from general practice to a urologist and resulting recommendations made regarding the importance of educating general practitioners about the management of certain conditions and that for some groups of patients with certain conditions urological review is not necessary.

The Auckland urologists have therefore developed general practitioner guidelines, and teaching sessions are held with interested general practitioners for purposes of continuing medical education and update. Benefits of this model include management of any inappropriate referrals and better ensuring that those people who are seen in the hospital setting are those who need to be seen in such an environment.

## **1.5 Special Equipment**

Up until October 2007, there was a regional **mobile** lithotripsy machine that is made available to the region. This mobile machine was in Auckland monthly and was used for kidney and ureteric stone treatments on an elective basis. Standard regional criteria ensured equity of access to the service at Green Lane Clinical Centre (GCC).

However as of January 2008 a **fixed site** ESW lithotripter will be based at Greenlane Clinical Center for the treatment of kidney and ureteric stones. Permanent location in Auckland will mean that this modality of treatment is available every week and will enable acute ESWL to be provided.

Details of current service volumes are attached as an appendix to this workstream.

# **Trends and Future Directions**

## **2.1 Overview**

The ADHB Urologists have a concept of developing a "Centre of Excellence". This is defined as being an expert "centre" where patients seeking comprehensive medical expertise and state-of-the-art treatment options for urologic conditions ranging from prostate, kidney and

bladder cancer to kidney stones and voiding dysfunction are available. These centres have strong clinical leadership, teaching and research functions.

In the Auckland metropolitan environment, care would not necessarily also have to be provided from one "centre" in terms of facility. For example you may concentrate on certain specialities in different DHB facilities; however this is subject to further discussion with the region as part of the 2008 Regional Service Planning process. One factor that is relatively clear however is that the clinical governance, teaching and research would have to be fully integrated and therefore be a regionally-led function. While this is an admirable goal planning must be couched in the New Zealand environment and applicable to the funding DHBs and their strategic direction e.g. secondary care provision of services locally where they are sustainable, integrated provision of care across the care continuum.

Urology subspecialty interests include oncology, the management of stones, incontinence, reconstructive urology, laparoscopy, infertility and impotence. Academic urology, together with teaching and research is becoming increasingly relevant as significant changes in urology practice unfold. There is some evidence that that sub-specialisation offers better outcomes when high rather than low volumes are achieved at single rather than multiple centres. This needs to be factored into any future development of urological services in the metro-Auckland area.

Subspecialty interests could be performed in either one centre, or potentially an urologist could perform a particular subspecialty interest across two sites (volume and staffing dependent). A model suggested at the time of the previous regional review in 2004 was that each centre would have a unique contribution for the provision of urology services for its own District Health Board population as well as for the Auckland region. To provide an integrated service there would be the requirement that senior medical officers be utilised effectively and that training positions be integrated across the region together with the development of academic urology in the foreseeable future. This would allow the model of dual site appointments emanating from ADHB to CMDHB.

Evolving technology and its impact on clinical practice is also a factor in structuring future service provision in urology. Overall the general international trends in provision of urological treatment are towards minimally invasive urologic surgery, including laparoscopic approaches to the removal of prostate, kidney, bladder and adrenal cancers. These are very technically challenging surgeries, but offer many advantages to the patient: shorter recovery time, less scarring and less blood loss. The result of this international trend means urology has become more of an outpatient and ambulatory service than an inpatient elective service. This trend is likely to increase as numerous studies have assessed and compared the costs of treatment performed in an inpatient, daypatient and outpatient setting. Not surprisingly those procedures performed in an outpatient or day surgery setting were associated with significantly lower costs when compared with an inpatient setting.

A further change of practice is the increasing medical management of lower urinary tract symptoms and benign prostatic hyperplasia (BPH). Specific medication is favored because of its reduced side effects, ease of dosage and specificity in the urinary tract. It should be noted that while cost savings are present when surgery is avoided, studies have shown that the huge increase in the number of men demanding the medical treatment, together with an ageing population have resulted in significant medical costs. As this is a relatively new advance in practice it is also unknown whether patients who are managed pharmacologically have their surgery *delayed* rather than permanently avoiding surgery. Long term prospective studies are being undertaken and are required to establish the effectiveness and cost-effectiveness of office based urological care. There is a possible increased role here for primary care in the medical management of a subset of these patients.

The potential role of radical prostatectomy (RP) has been particularly debated for many years. The intervention is a relatively complex surgical intervention typically undertaken in large acute service hospitals. There is some concern that the risks of the surgery may outweigh the benefits. These include complications of impotence, incontinence and risk of death,

although the latter is remote. Evidence about the relationship between workload and outcome after radical prostatectomy suggests a greater relative risk of death in 'low-volume' hospitals, although it should be noted that the absolute risk was found to be less than one percent.

## 2.2 Prostate Cancer: Intervention Rates and Trends

A further feature for CMDHB planning is that data shows New Zealand European men have higher prostate cancer disease rates than both Maaori and Pacific Islands men. However, by using a community-based rate of elevated serum Prostate Specific Antigen (PSA, a marker of prostate disease), this study found that the actual occurrence of prostate cancer between these three groups is likely to be at least equal. Because prostate cancer rates are determined by patients seeking diagnosis and treatment for this disease, findings indicate cultural barriers in the health system for Maaori and Pacific Islands men. [NZMJ 11 February 2005, Vol 118 No 1209 Page 2 of 3].

New Zealand Public Health Intelligence (2003 update) projections of cancer incidence show that the overall risk of cancer is projected to remain essentially stable for both sexes, while the burden increases by about 30% – entirely the result of demographic trends (the expected increase in size and structural ageing of the New Zealand population).

Cancer sites projected to show 'major' changes in risk or burden however over the next decade include Prostate Cancer at a >20% increased risk (aged standardised). This is forecast to lead to a major increase burden or volume of around 56% out to 2011. The 2007 NZ Census data shows CMDHB has 226,920 Males within the local catchment which represents 10.96% of the total NZ Male population.

**Table 1 : Projected Prostate Cancer Rates 2001-2011**

	Prostate			
	Age	Projected* 2001	Projected 2011	Projected % change
Rates	15–24			
	25–44	0	0 (0,1)	39 (-3,76)
	45–64	38	52 (39,83)	37 (5,72)
	65–74	397	439 (352,682)	11 (-7,50)
	75+	1116	1448 (1006,1866)	30 (2,55)
	Total	84	102 (76,141)	21 (0,48)
Cases	15–24			
	25–44	2	2 (1,5)	35 (-2,78)
	45–64	162	281 (211,450)	74 (33,118)
	65–74	477	651 (549,1064)	37 (19,92)
	75+	891	1459 (1109,2057)	64 (40,113)
	Total	1532	2394 (1902,3515)	<b>56%</b> (37,101)

Notes: Rates per 100,000.

Total rate is age standardised to the WHO world population.

Observed values for prostate cancer are not used in this table due to the 'PSA effect'.

## 2.3 Prostate Cancer Guidelines / Screening

In 1997 the New Zealand National Health Committee (NHC) reviewed the evidence for population prostate screening and concluded:

- There was no evidence that screening significantly improved mortality from prostate cancer.
- There was the potential for significant harm and costs as a result of screening and confirmatory investigation for the 25% of men who would have a positive PSA result (three-quarters of whom would not have prostate cancer).
- There remained controversy about whether active clinical management improved the prognosis over active observation.
- Treatment options all carry a significant risk of adverse effects on bladder and bowel function, which may reduce overall quality of life.

*A Consultation Document on Prostate Cancer Screening in New Zealand*, published September 2003, essentially with the 1997 conclusions remaining unchanged. It commented that as (currently) there was no evidence from randomised controlled trials (RCT) that demonstrated whether or not population screening for prostate cancer has a positive effect on the mortality and morbidity from this disease a recommendation could not be made to support an organised, publicly funded screening programme.

There was however a spectrum of views within the advisory group on the issue of opportunistic screening.

Whilst screening is not proven due to the absence of completed RCTs, early intervention versus watchful waiting, is proven for prostate cancer with a statistically significant reduction in overall mortality for the early intervention group.

The Urology Society of New Zealand recommends:

- Individual men aged 50 to 70 years with at least a 10 year life expectancy should be able to be screened by annual DRE and PSA testing, after appropriate counseling regarding the potential risks and benefits of investigations and the controversies of treatment.
- It should be left to the individual doctor to decide whether to advocate testing in a man not requesting it.
- Universal population screening of asymptomatic men is not recommended in New Zealand at the time of this Health Services Plan.

This is another area where CMDHB has to keep a careful watching brief. If screening for prostate cancer is introduced into NZ there would be a massive increase in workload, given the projected increased incidence of prostate cancer in NZ and the fact that CMDHB has 11% of the total male population.

## 2.4 Urological Equipment Technology

Equipment technology is enabling much of the innovations in clinical care. Key changes are occurring in the following areas:

- **Laser technology.** The modality options for treating BPH also extend to laser technology. The Transurethral Resection of the Prostate Gland (TURP) procedure carries potential side effects and complications including bleeding, water intoxication, impotence, incontinence, urethral stricture, and retrograde ejaculation. Alternative treatments such as Transurethral Needle Ablation (TUNA) and Microwave Prostatron do not promise results as good as the traditional TURP. Laser operation with YAG has a high incidence of dysuria and a relatively longer recovery. These procedures usually require post-procedure catheters for several days. The newest treatment for BPH is the Photoselective Vaporization of the Prostate (PVP) approved by the FDA in November 2001. It is a minimally invasive outpatient/ambulatory/short stay procedure that offers excellent and immediate results with minimal complications. Patients are usually catheter free in less than 24 hours. Laser technology for treating BHP is common treatment internationally and available in some Urology centres throughout New Zealand but is not available through the Auckland service, principally due to cost

of implementation. This does however have significant potential benefits for patients as well as financial benefits and a feature CMDHB would like to see factored into any Regional Service Planning process which determines the future delivery of Urology services in the Auckland metropolitan.

- **Robotic Prostatectomy.** This (relatively new) surgical approach, referred to as robotic prostatectomy, represents a minimally invasive surgical technique designed to provide a safe and alternative way to remove the prostate gland in patients diagnosed with prostate cancer. A few studies to date have shown that robotic procedures are considerably more expensive than radical prostatectomy. Some preliminary papers also show this procedure to be as effective as radical prostatectomy in treatment of prostate cancer however as these are not Level 1 studies, based on robust scientific evidence we do not know well enough the advantages of this technology at the date of this HSP.

Robotic Prostatectomy has been implemented in the US and Europe for several years and just becoming available within the private sector in New Zealand. Patients will start questioning why the public sector is not using it. Therefore CMDHB should be aware of this emerging trend at least and have a view on robotic technology, keeping a watching brief on developments and evidence as it comes to hand.

- **Brachytherapy for the treatment of Prostate Cancer.** Low dose brachytherapy and radical prostatectomy is a treatment option for many men with early prostate cancer. A combination of high dose brachytherapy and radiotherapy is a treatment option for high grade, locally advanced prostate cancers. The relapse-free survival rate for brachytherapy (~85% at 10 to 15 years) is equal to the best surgical results. The published data to date shows advantages of brachytherapy include short hospital stay (overnight), a minimally invasive procedure with few side effects and early return to usual activity. However it should be noted our expert in-house opinion cautions against these results as they are based on a very selective cohort of patients with good prognoses.

High dose brachytherapy is available to CMDHB patients as treatment options through the public sector. (HDR available through Waikato DHB).

- **Positive Emission Tomography (PET) Scanning.** Using the radioactive glucose analogue FDG has now been shown to have great potential in certain applications within urology but further investigations are necessary to determine its eventual place as an imaging modality in genitourinary medicine. For example in testicular cancer, PET has a higher diagnostic accuracy than computed tomography (CT) for both staging and re-staging and should be the test of choice for the assessment of a CT-visualized residual mass following chemotherapy. In prostate, renal, and bladder cancer, the current role of PET is still being defined, but it has a high positive predictive value and can be used for problem solving in patients with indeterminate findings on conventional imaging. Its role in the diagnosis and staging of prostate cancer is hampered by the generally low glycolytic rate of most prostate tumours and their metastases. It has shown promise for staging and re-staging patients with advanced-stage disease and aggressive tumours suspected by a high tumour grade and high prostate-specific antigen velocity. PET has also demonstrated success when applied to renal cell carcinoma in classifying indeterminate renal masses as well as residual renal fossa masses following nephrectomy, gauging response to therapy, and staging and re-staging patients with a known diagnosis of renal cell carcinoma.

## 2.5 Growth and Demand for Urology Services

Forecasting for the CMDHB population needs to take into account the development of appropriate sub-specialisation for the Auckland region population, and the interface between primary and secondary care as well as emergent technology. Other significant issues for the

service include the impact of an ageing population on volume and hence service provision, the increasing incident of prostate cancer and the development of day patient and outpatient activity as a result of change in practice. This combination of factors make future provision and configuration of Urology services for the CMDHB population, a very difficult exercise and requires a robust, clinically led regional process to determine the direction.

Counties Manukau DHB at the date of this Plan is wishing to have the provision of urology services added to the workplan for 2008 for Regional Service Planning with a view to repatriating secondary urology outpatient and inpatient activity to CMDHB facilities for the local population. Counties Manukau DHB also wishes to investigate the benefits and costs of implementing new technologies in the context of the current model of care and to explore the option of providing only outpatient and core elective inpatient surgery at the Manukau Campus.

The objective of embarking upon a regional project will be to revisit the assumptions of the three year Plan completed in 2004 and prepare a revised document to look at the future configuration and model of care of an effective, safe, efficient secondary and tertiary Urology service. The purpose of the regional project is to take a long term strategic approach which may be phased in on an incremental basis, depending on the final solution. This plan will take into account demand and workforce issues and will include a financial impact analysis of removing this work from ADHB prior to any decision being made.

### **3.0 Key Directions**

- ✓ *Through Regional Services Planning process in 2008, explore development of local delivery of core elective urology surgery services at Manukau by ADHB through a "hub and spokes" model, or through development of a full local secondary care service.*

**APPENDIX ONE : INPATIENT VOLUMES**

**1.0 CURRENT ACTIVITY INPATIENTS BY SERVICE RELATED GROUP**

BY SRG				2004/05			2005/06			2006/07			
Patient Type	Admit Type	Day/Inpatient	Agency code	Discharges	Caseweights	acw	Discharges	Caseweights	acw	Discharges	Caseweights	acw	
Adult	Acute	Daypatient	Auckland	11	5.59	0.51	8	4.88	0.61	10	5.98	0.60	
			Counties	21	12.82	0.61	26	15.69	0.60	26	15.16	0.58	
			Manukau Non Northern Region	2	1.58	0.79	1	1.64	1.64	3	3.81	1.27	
		Daypatient Total			34	19.98	0.59	35	22.22	0.63	39	24.95	0.64
		Inpatient	Northland	Waitemata				1	0.78	0.78	2	2.09	1.04
				Auckland							1	2.34	2.34
			Counties	247	771.76	3.12	241	813.43	3.38	266	850.22	3.20	
			Manukau Non Northern Region	41	86.85	2.12	70	140.22	2.00	66	125.42	1.90	
		Inpatient Total			4	12.00	3.00				3	15.08	5.03
	Acute Total			292	870.61	2.98	312	954.43	3.06	338	995.14	2.94	
	Elective												
	Daypatient	Waitemata	Auckland								1	0.36	0.36
			Counties	25	11.38	0.46	21	12.21	0.58	21	12.51	0.60	
			Manukau	59	24.31	0.41	63	31.29	0.50	68	35.73	0.53	
		Daypatient Total			84	35.69	0.42	84	43.50	0.52	90	48.60	0.54
		Inpatient	Waitemata	Auckland								1	0.77
	Counties			362	727.23	2.01	342	708.71	2.07	370	726.65	1.96	
Manukau	40		43.71	1.09	14	12.33	0.88	53	70.16	1.32			
Non Northern Region	2		1.85	0.92				1	4.64	4.64			
Inpatient Total			404	772.79	1.91	356	721.04	2.03	425	802.22	1.89		
Elective Total			488	808.48	1.66	440	764.54	1.74	515	850.82	1.65		
Adult Total			814	1699.07	2.09	787	1741.19	2.21	892	1870.92	2.10		

**CURRENT ACTIVITY UROLOGY (CHILDREN)**

BY SRG				2004/05			2005/06			2006/07			
Patient Type	Admit Type	Day/Inpatient	Agency code	Discharges	Caseweights	acw	Discharges	Caseweights	acw	Discharges	Caseweights	acw	
Child	Acute	Daypatient	Auckland Counties	12	5.09	0.42	12	6.77	0.56	14	7.02	0.50	
			Manukau	12	5.86	0.49	9	4.74	0.53	11	5.45	0.50	
		Daypatient Total			24	10.96	0.46	21	11.51	0.55	25	12.47	0.50
		Inpatient	Auckland Counties	64	134.18	2.10	51	142.50	2.79	47	91.40	1.94	
			Manukau Non Northern Region	8	8.21	1.03	5	8.36	1.67	5	5.17	1.03	
	Inpatient Total			72	142.39	1.98	58	154.19	2.66	52	96.57	1.86	
	Acute Total			96	153.35	1.60	79	165.69	2.10	77	109.04	1.42	
	Elective	Daypatient	Auckland Counties	101	41.07	0.41	131	63.23	0.48	126	61.14	0.49	
				Manukau Non Northern Region				5	2.59	0.52	5	2.77	0.55
			Daypatient Total			101	41.07	0.41	136	65.82	0.48	132	64.40
		Inpatient	Auckland Counties	46	71.90	1.56	36	63.21	1.76	38	75.50	1.99	
			Manukau Non Northern Region	18	18.54	1.03	22	26.73	1.21	25	31.17	1.25	
	Inpatient Total			64	90.44	1.41	59	91.69	1.55	64	108.42	1.69	
	Elective Total			165	131.51	0.80	195	157.51	0.81	196	172.82	0.88	
	Child Total			261	284.86	1.09	274	323.20	1.18	273	281.86	1.03	
Grand Total				1075	1983.93	1.85	1061	2064.39	1.95	1165	2152.78	1.85	

## 2.0 CURRENT ACTIVITY : CMDHB BY PURCHASE UNIT

BY PUC (\$70.01)				2004/05			2005/06			2006/07			
Patient Type	Admit Type	Day/Inpatient	Agency code	Discharges	Caseweights	acw	Discharges	Caseweights	acw	Discharges	Caseweights	acw	
Adult	Acute	Daypatient	Northland	1	0.56	0.56							
			Waitemata								1	0.29	0.29
			Auckland Counties	127	36.22	0.29	112	34.81	0.31	154	48.52	0.32	
			Manukau	1	0.37	0.37							
		Non Northern region	1	0.37	0.37					1	0.25	0.25	
		<b>Daypatient Total</b>			<b>130</b>	<b>37.52</b>	<b>0.29</b>	<b>112</b>	<b>34.81</b>	<b>0.31</b>	<b>156</b>	<b>49.05</b>	<b>0.31</b>
	Inpatient	Northland									2	2.09	1.04
		Auckland	413	376.05	0.91	417	365.85	0.88	508	442.77	0.87		
		Non Northern region				1	0.97	0.97	4	2.62	0.66		
	<b>Inpatient Total</b>			<b>413</b>	<b>376.05</b>	<b>0.91</b>	<b>418</b>	<b>366.81</b>	<b>0.88</b>	<b>514</b>	<b>447.48</b>	<b>0.87</b>	
	<b>Acute Total</b>				<b>543</b>	<b>413.58</b>	<b>0.76</b>	<b>530</b>	<b>401.62</b>	<b>0.76</b>	<b>670</b>	<b>496.53</b>	<b>0.74</b>
	Elective	Daypatient	Waitemata								1	0.36	0.36
			Auckland Counties	39	15.25	0.39	26	12.84	0.49	23	12.68	0.55	
			Manukau	66	24.98	0.38	73	34.36	0.47	73	35.70	0.49	
			Non Northern region								1	0.29	0.29
<b>Daypatient Total</b>				<b>105</b>	<b>40.23</b>	<b>0.38</b>	<b>99</b>	<b>47.20</b>	<b>0.48</b>	<b>98</b>	<b>49.03</b>	<b>0.50</b>	
Inpatient		Northland									1	1.49	1.49
	Waitemata									1	0.77	0.77	
	Auckland Counties	327	476.54	1.46	348	520.70	1.50	377	591.21	1.57			
	Manukau	35	35.19	1.01	9	8.14	0.90	38	38.66	1.02			
Non Northern region	3	4.49	1.50										
<b>Inpatient Total</b>			<b>365</b>	<b>516.23</b>	<b>1.41</b>	<b>357</b>	<b>528.84</b>	<b>1.48</b>	<b>417</b>	<b>632.14</b>	<b>1.52</b>		
<b>Elective Total</b>				<b>470</b>	<b>556.46</b>	<b>1.18</b>	<b>456</b>	<b>576.04</b>	<b>1.26</b>	<b>515</b>	<b>681.17</b>	<b>1.32</b>	
<b>Adult Total</b>				<b>1013</b>	<b>970.04</b>	<b>0.96</b>	<b>986</b>	<b>977.66</b>	<b>0.99</b>	<b>1185</b>	<b>1177.70</b>	<b>0.99</b>	

## CURRENT ACTIVITY (CHILDREN)

BY PUC (\$70.01)				2004/05			2005/06			2006/07			
Patient Type	Admit Type	Day/Inpatient	Agency code	Discharges	Caseweights	acw	Discharges	Caseweights	acw	Discharges	Caseweights	acw	
Child	Acute	Inpatient	Non Northern region							1	0.25	0.25	
		Inpatient Total								1	0.25	0.25	
	Acute Total									1	0.25	0.25	
	Elective	Daypatient	Auckland								1	0.41	0.41
		Daypatient Total									1	0.41	0.41
	Elective Total										1	0.41	0.41
Child Total										2	0.66	0.33	
Grand Total				1013	970.04	0.96	986	977.66	0.99	1187	1178.36	0.99	

### 3.0 CURRENT ACTIVITY: OUTPATIENTS

	FSA			FU		
	2004/05	2005/06	2006/07	2004/05	2005/06	2006/07
DHB						
CMDHB	1,359	1,107	1,157	988	1,213	1,156
WDHB	6	2	4	7	10	16
ADHB	26	33	13	278	222	189
NDHB		2		4	16	1
Other DHBs	3	2	3	8	6	
Grand Total	1,394	1,146	1,177	1,285	1,467	1,362

#### 4.0 CURRENT ACTIVITY: DAY PATIENTS

	Cystoscopy			Lithotripsy			Urodynamics		
	2004/05	2005/06	2006/07	2004/05	2005/06	2006/07	2004/05	2005/06	2006/07
DHB	499	639	647				221	237	176
CMDHB	1	1	3						
WDHB	69	72	50	67	51	57	9	3	6
ADHB	1	2			1			4	
NDHB	3	1							
Other DHBs									
Grand Total	573	715	700	67	52	57	230	244	182