Box 7 - 8

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland District Health Board

# 2011 Annual Report

integrity | respect | innovation | effectiveness - ka u ki te hia nui te pono

The Board Members are pleased to present the report of Auckland District Health Board (ADHB) and the Group comprising ADHB, its subsidiary Charitable Trust, joint venture and associates for the year ended 30 June 2011.

**For and on behalf of the Board Members who authorised the issue of this annual report.**

**Dr Lester Levy**
**Chair**

**Dated: 5 October 2011**

**Ian Ward**
**Chair, Audit and Finance Committee**

**Dated: 5 October 2011**

**MISSION**

Auckland District Health Board (ADHB) will provide New Zealand's finest comprehensive health service through excellence and innovation in patient care, education, research and technology.

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

## DIRECTORY

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**Auditor**

Audit New Zealand
155 Queen Street
PO Box 1165
Auckland 1010

**Board Members**

Dr Lester Levy ,Chair (appointed)
Dr Lee Mathias, Deputy Chair (elected)
Jo Agnew (elected)
Peter Aitken (elected)
Judith Bassett (elected)
Susan Buckland (elected)
Dr Chris Chambers (elected)
Robin Cooper (appointed)
Robyn Northey (elected)
Gwen Tepania-Palmer (appointed)
Ian Ward (appointed)

**Chief Executive**

Garry Smith

**Management**

Auckland District Health Board is organised into six Healthcare Service Groups, all led by a Clinical Director. These concentrate the effort of the organisation onto the key priority areas:

Child Health

Cancer and Blood

Women's Health

Mental Health and Addictions

Adult

Cardiovascular disease

**Senior leadership team for Auckland DHB**

| | |
|---|---|
| Garry Smith | Chief Executive |
| Dr Margaret Wilsher | Chief Medical Officer |
| Taima Campbell | Executive Director of Nursing |
| Janice Mueller | Director Allied Health, Scientific, & Technical |
| Naida Glavish | Chief Advisor Tikanga |

**Children's Healthcare Service Group**

| | |
|---|---|
| Dr Richard Aickin | Director |
| Vacant | Nurse Director |
| Elizabeth Wood | General Manager - Starship (Acting) |

**Mental Health and Addictions Healthcare Service Group**

| | |
|---|---|
| Dr Clive Bensemann | Director |
| Anna Schofield | Nurse Director |
| Fionnagh Dougan | General Manager |

**Adult Healthcare Service Group**

| | |
|---|---|
| Dr Barry Snow | Director |
| Margaret Dotchin | Nurse Director |

**Cardiovascular Healthcare Service Group**

| | |
|---|---|
| Dr Peter Ruygrok | Director |
| Fionnagh Dougan | General Manager |

**Women's Healthcare Service Group**

| | |
|---|---|
| Maggie O'Brien | Midwifery Director |
| Vacant | Director |
| Vacant | Nurse Director |
| Kirsty Walsh | General Manager (Acting) |

**Cancer and Blood Healthcare Service Group**

| | |
|---|---|
| Dr Richard Sullivan | Director |
| Fionnagh Dougan | General Manager |

**Senior team that support activity across the organisation**

| | |
|---|---|
| Dr Ian Civil | Director of Surgery |
| Dr Vanessa Beavis | Director Peri-operative Services & Clinical Support Services |
| Ngaire Buchanan | General Manager Operations & Clinical Support Services |
| Greg Balla | Director Performance and Innovation |
| Dr Denis Jury | Chief Planning & Funding Officer |
| Aroha Haggie | Maori Health Gain Manager |
| Hilda Fa'asalele | General Manager Pacific Health |
| Brent Wiseman | Chief Financial Officer |
| Johan Vendrig | Chief Information Officer |
| Vivienne Rawlings | General Manager Human Resources |

# Chairman and Chief Executive's Review

It has been a busy and rewarding year in which much has been achieved, with more still to be achieved. We have improved the healthcare status of the people of Auckland and worked hard to get more value from the tax-payer funding we receive.

**Fresh approach with a new Board**

On 6 December 2010, the 2007 Board handed over the reins to the new Board led by Dr Lester Levy, with Dr Lee Mathias as Deputy. We would like to thank the six outgoing Board members, Pat Snedden (Chair), Harry Burkhardt (Deputy Chair), Dr. Brian Fergus, Dr Ian Scott and the Rt Hon Bob Tizard for their dedicated service to ADHB over the years they have served on the Board.

The new Board leadership and its members provide an opportunity to work more closely with Waitemata DHB (WDHB) as Dr Levy is the Chair of both organisations. Other new and shared appointments brought new skills and regional perspectives to the Board, with an early focus on Maori health.

The Board has established ten priorities for management to focus upon. They reflect a mix of national targets, regional goals and ADHB-specific improvement areas and informed both planning for the 2011/12 year and internal reporting processes.

The Board has also started a process of integrating a number of Board and management processes between ADHB and WDHB with joint board committees established and the integration of some teams such as primary care planning and funding.

**Regional collaboration**

The metro Auckland DHBs collectively made progress with the implementation of change in the way the sector works together.

Significant effort has been focussed on the regional components of Government's Better Sooner More Convenient Strategy (BSMC). For the year in review this centred on structural change and improving primary-secondary system efficiency. When the strategy was released in October 2009, there were 19 primary health organisations (PHOs) in the Auckland metro region and by 1 July 2011, these had reduced in number to seven. Three of these are cross-boundary PHOs, with ProCare operating across the entire region; Alliance Health+ and National Hauora Coalition operating across Auckland and Counties Manukau health districts.

Continuously improving primary and secondary care efficiency and effectiveness requires a high level of cooperation between the three Auckland metro DHBs and primary care providers. The amalgamation ensures that scarce resources are better managed by eliminating duplication and enabling providers to more easily invest in improved systems and processes. All of this has the potential to drive delivery of better quality care closer to where patients and our population need it to be and there are many examples of where this is already starting to work very well.

Closer collaboration through structural change was just one strategy. Substantial gains are in the offing with the establishment of the Greater Auckland Integrated Health Network and its aggregation of health providers and funders. It is an alliance of seven independent partners who have agreed to pursue a collaborative approach to change management and system improvement. Its members are ProCare; East Health Trust; Auckland PHO; Waitemata PHO and, with the three Auckland metro District Health Boards, they have coalesced with a primary focus of preventing avoidable admissions to hospital.

The regional collaboration with other DHBs and PHOs to align themselves in this way is an example of the collective effort being made at both national and regional levels to work towards more effective and efficient delivery of healthcare services. These clinically-focused initiatives are matched by efforts to control administrative costs. In March, the regional shared-services organisation set-up was completed with the establishment of healthAlliance. The shared-services teams will undertake a range of initiatives over the next five years to integrate a number of non-clinical functions both regionally and nationally. Their goal is to help DHBs deliver quality healthcare at a lower cost by working smarter and reducing duplication and administrative costs.

Planning has been given a stronger regional focus in the form of the Northern Region Health Plan (NRHP), which was published in April. The plan's three priority goals of 'First, do no harm', 'The Informed Patient' and 'Life and years' are the basis for projects of regional collaboration on healthcare services delivery over the 2011-12 year. The ADHB's 2011-12 District Annual Plan reflects these initiatives with DHB-specific objectives to support them, such as those in the Advance Care Planning work stream

**Working across the social sector**

We recognise that building strong intersector relationships helps improve health gain for vulnerable and hard-to-reach groups, especially some Maori and Pacific people and people living with mental illness and addictions, disability, or deprivation in other forms.

In many cases, intersector co-operation is part of business-as-usual. However, there are a number of initiatives that should be singled out for note in the 2010-11 year. Notable are Snug Homes, the insulation of homes with children with respiratory disease; the Auckland Homeless Taskforce and the Tamaki Transformation Project and its work stream establishing health career pathways for young people in that part of our district. The first group of students from the latter initiative registered during the 2010-11 year to start their health education.

Another example can be seen in Starship Children's Hospital, where the Children's Health Service Group worked closely with Children Youth and Families and NZ Police to develop a Memoranda of Understanding to enhance and tighten the protection of children at risk from non-accidental injury.

**Healthcare Excellence shapes healthcare structure**

Our drive for healthcare excellence emphasises that the patient comes first in every situation. This focus requires a renewed commitment to 'do no harm' and thus a zero tolerance for error, variation and waste joins rigorous cost control to enable more patient-centred care. The uniqueness of our patients becomes the only variation we manage and clinical staff can enlarge their focus on that, rather than matters that take them away from the bedside.

To achieve this goal we are improving the whole healthcare system, including suppliers and customers, rather than changing individual aspects of it. This requires hands-on leadership rather than oversight from a distance and we are investing in our clinical leadership team to support this approach. It also requires an integrated focus on specific patient groups. To achieve this we have realigned the management of our organisation through the introduction of six Healthcare Service Groups from 1 July this year and defined our vision as follows:


To guide the necessary decision-making and improvement processes, we have adopted an internationally-recognised performance framework and adapted it to New Zealand conditions as represented above. This Healthcare Excellence framework provides the basis for delivering on five critical success factors for healthcare excellence:

- increased patient safety
- better quality care
- maintaining economic stability
- improved health status
- staff engagement.

This change requires better management of the patient journey and has been the focus of our work in the last year. An example is our 'Releasing Time to Care' programme that streamlined services, improved the patient experience and frees-up nurses' time to spend more of it with patients and increase the volume of services delivered with the same resources. In one department, this succeeded in reducing the average patient length-of-stay by one full day.

These results are pleasing, but in many respects, the journey has just started. There is plenty of scope for further improvement now and over coming years. Work is carried out with the full involvement of clinical staff and this close collaboration between clinicians and the service improvement teams is building a culture of continuous improvement with rigorous accountability. Over the last year, our teams undertook 106 projects to lift health status and improve business processes whilst ensuring we remained within our budget.

**Developing our work force**

Our achievements in the last year were only possible with a committed workforce. We employ around 10,000 people and staff turnover is low, with an average length of service of over eight years in nearly all employee groups.

There is good representation from most ethnic groups, although we recognise that addressing health inequalities will require further growth in our Maori and Pacific workforces.

We have increased the number of Medical Officers and Senior Medical Officers and while the Resident Medical Officer establishment has stayed the same, actual numbers have increased. This was a successful strategy which gives us a much higher level of resilience in delivering services to our population.

ADHB was one of four successful pilot sites for a nurse-prescribing initiative in diabetes management that led to an expansion of practise. We believe we need to develop smarter and more practical ways of utilising our health workforce to deliver these kinds of services, and innovative ways like this are the way forward.

Our commitment to training has never been higher. Not only are we the largest trainer of resident medical officers in New Zealand, we also contract to run a programme to assist overseas-trained doctors complete their licensing exam. This was a New Zealand first.

Service and performance improvement initiatives are also resulting in a close working collaboration between clinicians and expert staff that is resulting in a greater level of shared expertise in this important area.

**The strength of our research**

ADHB hosts the largest clinical research facility in New Zealand, with a portfolio of 684 projects in 2010. During the year some 230 new research projects were approved and 150 commercial clinical trials were active. The largest category of research at ADHB is audit activity. This examines treatment, care and resource allocation to improve current practice. This sustained search for truth and a better way of doing things drives performance improvement and excellence in all our endeavours from education, clinical practice to process and systems improvements.

Despite a challenging economic climate, financial support remained solid due to our international reputation, the scale of our clinical research facility and the quality of our research teams. This made ADHB attractive to sponsor companies and research funding organisations and saw more than 150 clinical trials secure commercial sponsorship.

**National health targets**

ADHB works hard to ensure that our organisation delivers on New Zealand's national health targets. These are stretch targets and it takes dedicated effort by clinicians, staff and management to achieve the targets. Of the six, we were able to achieve or exceed in four and, while we fell short with two, in those we made substantial gains on previous years. An example is the number of patients given advice about giving up smoking. At 9,008, this was 6,000 more than the number in the previous year.

The following table identifies our performance as at year end. Please note the data may differ slightly from the Statement of Service Performance in this Annual Report. The latter figures are based on the annual targets in our Statement of Intent and show our performance for the whole year.

| Target | We achieved |
|---|---|
| Goal: 95% of patients admitted, discharged or transferred from ED within six hours | 95% |
| Goal: All patients receive their radiation therapy within four weeks of decision to treat. | 100% |
| Goal: Deliver 11,149 elective surgery discharges in 2010/11 | 11,182 |
| Goal: Increase cardiovascular risk assessments to 79% of the eligible adult population | 79% |
| Goal: Increase the rate of people with diabetes attending free annual checks to 57% | 54% |
| Goal: 84% of people with diabetes having satisfactory or better diabetes management | 73% |
| Goal: 90% of two-year-olds to be fully-immunised by July, 2011. | 92% |
| Goal: 90% of hospitalised smokers to be given advice and help to quit. | 80% |

The improvements in the rate of immunisation for children under two were outstanding, with a significant reduction in the level in inequity between population groups, particularly with respect to Maori and Pacific.

The screening and check programmes for diabetes and cardiovascular disease have shown good improvements, albeit with a shortfall against targets in some areas. The performance of our radiation therapy team has also been remarkable with treatment waiting times for cancer patients continuing to beat the target throughout the year despite pressures on the service.

Indicators such as emergency department bed waits show what a difference targets and two years of focussed improvement activity can make. Average wait time has dropped from 7 hours 48 minutes to 1 hour 26 minutes.

**Ensuring we get it right**

While our staff work hard to get it right first time, sometimes our systems and processes conspire against success. There are situations where things go wrong and others where risks are identified before they do. Our risk management systems underpin these and have been improved.

We also made progress with improvement in our complaints resolution service. Under the oversight of our clinical leadership group, our complaints and compliments process has significantly improved its response time. The average turnaround to resolution for consumers was driven down to 15 days from 19 the year prior. That includes appropriate consultation with the services and clarification of any uncertainties.

In the year to 30th June 2011 ADHB received:

- 715 complaints
- 385 expressions of concern about a negative experience where the consumer is not seeking a formal response from ADHB
- 657 compliments

Of these complaints:

- 233 related to the quality of care and treatment received
- 193 related to accessibility to treatment, for example getting a specialist appointment after referral, delays in treatment or surgery and specific treatments we do not supply
- the majority of complaints (533) were received directly from consumers
- 45 complaints were received through the office of the Health and Disability Commissioner. The Commissioner chose to take no further action in all of these.

While we are proud of the fact that we cared for 322,000 outpatients and discharged more than 127,000 inpatients, the complaint and concern figures above represent 1,100 missed opportunities to deliver quality care. That is a matter of regret to us.

Our transformation to a more patient-centred health system must include design that captures patient and community views if it is to be sustainable. We added another tool for collecting these views in 2011, when the Reo Ora Healthvoice website went live. This is a consumer participation and access point that enables the public to influence ADHB design and decision-making.

During May and June, patients and carers were asked to provide ADHB with feedback about their current experience of the Greenlane Surgical Unit, ward and Ophthalmology day stay. The things they said helped us plan changes to some of our processes and the physical environment and, in another innovation, we were able to use Reo Ora Healthvoice to reflect this fact back to them.

**Spending our capital wisely**

The gains we are achieving require investment. Some benefits can be secured within existing resources but others require new infrastructure and capital expenditure. ADHB manages a capital expenditure budget each year of more than $70 million, with at least $50 million spent in most years on approved projects that are designed to improve patient access and the delivery of services. Only a relatively small proportion of this spend represents routine replacements for existing plant and machinery.

A notable improvement was the substantial upgrade of facilities, systems and processes for elective services in the form of the Greenlane Surgical Unit. This delivered three new operating rooms as well as one refurbished and extended operating room. This expenditure includes a new sterile supplies department and the relocation of departments to ensure better patient access and flows allowing separation of acute, non acute, adult and paediatric patients. This programme of work was partly completed by year-end and will continue into the current year.

Patient and visitor access to our services is also being improved at the Grafton campus with a substantial new car park building that will bring the public much closer to the Auckland City Hospital building.

There has also been investment to ensure an increased focus on oral healthcare. We commissioned 14 new clinics at schools and four mobile facilities. This is the largest new investment in oral healthcare since the 1960s and is supported by an increase in capital and operational funding from the Ministry of Health.

**Managing our finances and service performance**

For the fourth year in a row, ADHB has maintained financial break even whilst achieving significant service improvements and progress on our key health targets. Good financial management is critical to ensuring we can deliver the right care, at the right time, in the right way without the distraction of having to manage budget deficits. At the same time, we are managing our finances with the new perspective of increased efficiency. We are enabling more services to be provided at no extra cost rather than just reducing costs and putting at risk a service's ability to operate effectively.

We have made good efficiency gains during the year, with 106 improvement projects undertaken by our clinical and management teams. This process is ongoing but formally structured in an improvement programme led chiefly by our frontline medical, nursing, allied and technical staff. Wider staff input was sought, captured and acted upon under the 'Concord' banner. This is a programme to reduce clinical waste and improve the quality of healthcare by providing the right amount of healthcare in the right way. Concord projects are those that go across more than one service or where the solution can be adapted to other areas within Auckland District Health Board.

The total revenue of ADHB for last year was in excess of $1.8 billion, of which approximately 60% was spent providing services through the hospitals and outpatient clinics. The remaining 40% funded primary care, mental health and community services. Not all of the project activity described above was focused on the hospitals. An increasing proportion of time has been spent working with other providers to support effective operating structures – such as the PHO aggregation noted earlier and in improving systems – such as automating the transfer of patient referrals. Process improvement is a third focus, such as appointing three Long-Term Condition Quality Improvement Coordinators to work with primary care providers to improve diabetes registers and recall systems.

The volume of services we provided shows that a high proportion of our work is for other DHB populations. The table below gives the inpatient volumes for last year in WIES – units which weights the services performed for patients according to their degree of complexity. The services for other populations predominantly reflect the specialist national and regional services that ADHB provides, such as child health and liver transplants.

| Service | For our population | For other DHBs | Total services |
|---|---|---|---|
| | # | # | # |
| Acute | 50,307 | 41,776 | 92,083 |
| Elective | 13,772 | 18,202 | 31,974 |
| **Total** | **64,079** | **59,978** | **124,057** |
| **Proportion** | **52%** | **48%** | **100%** |

A large proportion of our services is also delivered in the outpatient setting and this comprised $388 million of services last year. This was a broadly similar level of services to the previous year but disguised an increase in underlying services to our population as some services for other populations were repatriated to local DHBs.

**Looking forward**

As we start the 2011/12 year, we are better prepared to undertake the work required to deliver the right care, at the right time, in the right way to our population whilst living within our means.

The Board's ten priorities are:

- Emergency care
  - achieve six hour target
- Elective surgery
  - achieve elective surgical procedures target
- Shorter wait times for cancer treatment
  - achieve four-week target for radiation treatment
  - provide medical oncology treatment within timeframes
- Health of older people
  - "one point of entry to all specialist services
  - integrate and streamline service
  - specialised inpatient areas for stroke, dementia and delirium
  - effective outreach programmes
- Clinical leadership
  - authentic clinical engagement and leadership at all levels of the organisation from the bedside to the boardroom
  - clinicians involved in all critical strategic and operational decisions (including all major business cases)
- Culture
  - renew and consolidate the culture to one of professionalism, clinical excellence coupled with patient service (consistent, considerate, thoughtful, kind and empathetic care for every patient)
- New models of care
  - develop and implement new models of care for:
    - fast-stream elective surgery
    - readmission prevention (focussed on chronic diseases)
    - whanau ora
- Chronic disease management
  - enhanced treatment for heart disease and diabetes
  - reduced waiting times for elective cardiac surgery
  - implementation of clinical pathways across the care continuum
- Regionalisation through collaboration
  - collaboration at a regional level as an over-riding principle
  - collaboration, interaction and integration (where relevant and appropriate) with Waitemata District Health Board as a critical priority
- Living within our means
  - Financial deficits are not acceptable

We cannot achieve this without the solid support of our staff and the many dedicated healthcare providers in the community. On behalf of the Board and Management, we offer thanks to our staff and providers for their continued commitment and dedication in striving to deliver excellent healthcare services to the Auckland population.

Dr Lester Levy
**Chairman**

Garry Smith
**Chief Executive**

## SUMMARY OF PERSONNEL POLICIES
## FOR THE YEAR ENDED 30 JUNE 2011

ADHB is committed to being a good employer and to the principles of the Treaty of Waitangi. To this end ADHB has proactively pursued strategies to optimise the relationship between employees and their work performance in its endeavour to achieve the highest quality of work life for staff and the highest quality of healthcare for our patients.

Part of this process has been the widespread involvement of staff at all levels and all occupational groups in multi-disciplinary quality improvement groups and the formation of redesign teams aimed at improving ADHB's overall performance and efficient utilisation of its capital, material and human resources.

ADHB has continued to maintain its investment in its employees through training and development opportunities and the enhancement of its staff counselling and rehabilitation after injury services.

# Good Employer Obligations Report 2010/11

## REQUIREMENT

The Auckland District Health Board (ADHB) is required to report on the extent to which it complies with "good employer" policies, under sections 118 and 151 of the Crown Entities Act 2004.

Auckland District Health Board's (ADHB) vision:
*"To recruit, develop and maintain a sustainable, responsive, collaborative and skilled health and disability workforce focused on the health needs of the population of ADHB now and into the future".*

To align with this vision the Auckland District Health Board (ADHB) employs the following "Good Employer Principles".

## PRINCIPLES

ADHB believes a good employer is one that facilitates Human Resource policy which encompasses provisions generally regarded as a requirement for the fair and proper treatment of employees in all areas of their employment and also contains policies which adhere to the provisions of the Health & Disability Services Act 1993.

ADHB aims to vigorously assert any legislative requirements in this regard and will maintain and implement systems and programmes to assist this principle.

Regardless of the minimum requirements of legislation, ADHB will continue to promote and protect the welfare and management of employees to the mutual benefit of employees, consumers and the organisation. ADHB is ardently dedicated to its staff and its services.

ADHB values equal employment opportunities and identifies and removes any obstacles that may deny a potential or existing employee the opportunity to be equitably considered for employment of their choice and the chance to perform to their full potential. This is a key principle practised by all representatives of ADHB in the execution of activities relating to the recruitment and management of employees (or potential employees) including recruitment, pay and other rewards, career development, work conditions and wherever else applicable.

Policies and practices that are free from any discriminatory element that has the potential to deny a person equal opportunity is the foundation of ADHB's Human Resources Policy.

## ORGANISATION VALUES AND CULTURE

As a large organisation and employer we believe there is significant importance in adopting and advancing management and organisational practices and procedures that are effective and efficient in assisting the way we perform and provide health care. We think a high performance organisation begins with having an organisational culture where everyone is given the opportunity to contribute to the way the organisation evolves and adapts to change. For ADHB, establishing this culture starts with having clearly defined and stated values. Consequently, all of ADHB's activities are underpinned by the key values that define the way we behave and inform our decision making. These organisational values are:

- Integrity – this means being open, fair, honest and transparent in everything we do
- Respect – this means being responsive to the needs of our diverse people and communities
- Innovation – this means providing an environment where people can challenge current processes and generate new ways of learning and working
- Effectiveness – this means we will apply our learning and resources to achieve better outcomes for our communities.

ADHB shall ensure that employees maintain proper standards of integrity and conduct in accordance with ADHB's "Values" and the State Services Commission "Code of Conduct".

ADHB recognises and respects the Treaty of Waitangi as the founding document of New Zealand. The Treaty of Waitangi is the fundamental relationship between the Crown and Iwi. It provides the framework for Maori development, health and wellbeing. ADHB's commitment to the development of Maori health is reinforced by its Maori Health department, with a General Manager who sits on the DHB's Senior Leadership Team. He Kamaka Oranga, the Maori Health team is responsible for policy development, planning and funding, provider management, quality, and clinical leadership across the primary, secondary and tertiary sectors. ADHB's Chief Advisor-Tikanga leads the organisation in managing relationships with manawhenua and Iwi Maori from a Tikanga perspective.

## COMPLAINTS

ADHB supports the right of all employees to seek resolution of any complaint through the procedures contained in relevant legislation (e.g. the Employment Relations Act and the Human Rights Act).

## HEALTH & SAFETY

Providing a healthy and safe workplace for all employees, students, volunteers and contractors whilst they are at the ADHB workplace for the purpose of ADHB work and to patients and visitors in relation to safe use of the facilities is something that ADHB is dedicated to. ADHB takes all practicable steps to:

- Comply with relevant legislation, regulations, code of practice and safe operating procedures
- Provide a safe and healthy workplace, equipment and conditions
- Establish and insist on safe work practices
- Provide training in health and safety requirements
- Ensure accurate reporting and recording of workplace accidents
- Ensure all managers have an understanding of health and safety and are reviewed against their designated responsibilities
- Support employee participation in health and safety management.

ADHB aims to constantly upgrade the management of health and safety at all levels and within all areas of the organisation by reviewing, developing and maintaining systems and processes that provide the framework for health and safety management (e.g. hazard management, accident reporting and investigation, staff induction and training, employee participation in health and safety committees).

## GOOD EMPLOYER REPORT 2010/11

*The Human Rights Commission has suggested that Crown entities should report under the following seven key "elements" relating to recruiting, developing, managing and retaining staff.*

| Element/Measurement | Policies & Procedures | Programmes |
|---|---|---|
| **leadership accountability & culture** | • Organisational values.<br>• Regular Union-employer meetings .<br>• CE "State of the Nation" addresses to all staff.<br>• Integrated and partnership based management structure.<br>• Clinical Quality and Professional Governance model.<br>• Bi-cultural policy. | • Management assessment and development process.<br>• Clinical/managerial partnership.<br>• ADHB Welcome Day – initial address to participants by Chief Executive.<br>• Individual Service Planning Days – multidisciplinary involvement.<br>• Nova Magazine (electronic and hard copy) newsletter for staff).<br>• Goodwill Meet & Greet (Senior Management Team serve festive treats to all staff).<br>• X-Factor – annual staff talent show actively supported by senior leadership. |

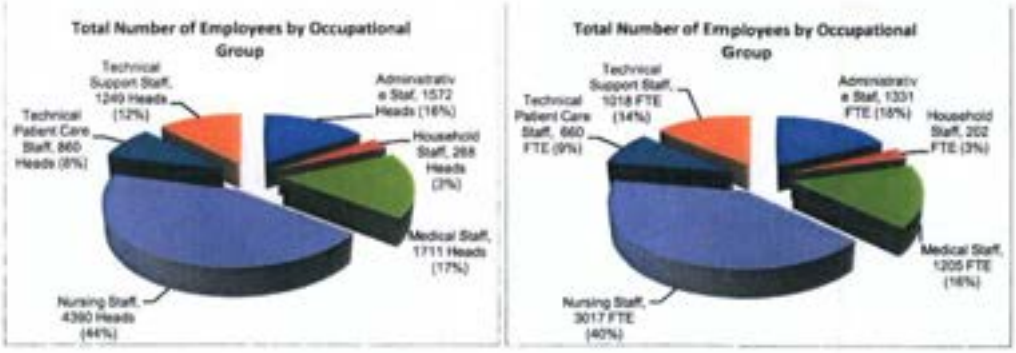
| | | |
|---|---|---|
| **recruitment, selection and induction** | • Intranet based guides for recruitment & selection.<br>• In-house Careers Centre.<br>• Staff have access to intranet based recruitment site.<br>• Wide media coverage and advertising.<br>• Participation in overseas and local recruitment expos. | • Induction guides for managers.<br>• Support of Overseas Candidates social evenings.<br>• Work Experience Days.<br>• Open Days at Children's and Women's services.<br>• Careers Centre evening for local candidates to meet and talk about job opportunities.<br>• Careers Centre website accessible internally & externally.<br>• Candidate and hiring manager satisfaction surveys.<br>• Internal promotion of vacancies via Nova Magazine link and ADHB Intranet site.<br>• Participating in the Ministry of Social Development's Mainstream Programme – to get people with disabilities into work.<br>• Preference programme for Maori and Pacific graduate nurses. |
| **employee development, promotion and exit** | • Guides to training and coaching staff.<br>• Documented exit procedures<br>• Majority of staff on MECAs have continuing education provisions.<br>• Other staff have the ability to negotiate specific training and development opportunities. | • Alumni programme in place.<br>• Annual performance review and individual development/objective setting process.<br>• Numerous clinical, technical, and management internal training programmes and workshops.<br>• Sabbaticals for Senior Medical Officers.<br>• Exit interviews and surveys conducted.<br>• Entry surveys conducted. |
| **flexibility & work design** | • Flexible rostering practices subject to clinical requirements. | • Participation in the Department of Labour's pay and employment equity review (ongoing), including pay equity across genders.<br>• Review of family friendly initiatives.<br>• Staff Crèche on each site. |
| **remuneration recognition & conditions** | • The majority of staff are on transparent MECAs.<br>• The annual review of IEA remuneration is based on external market data and employee performance. Job size is determined using a job evaluation methodology that meets the NZ standard for gender neutrality.<br>• Clinical staff are embedded in integrated the DHB's management structure. | • Nova awards – peer recognition of individuals or teams living the organisational values<br>• Long service awards<br>• Celebration week – a week of activities celebrating clinical, teaching and research achievements.<br>• Staff benefits with external providers.<br>• Recognition of retiring staff & staff who die in service through a tribute in NOVA. |

| | | |
|---|---|---|
| **harassment & bullying prevention** | • Harassment policy in place.<br>• Workplace Violence Prevention Policy (as affecting staff) is in place.<br>• HR led bullying and harassment coaching seminars conducted. | • Formal and informal processes documented and available for response to harassment.<br>• Presentations provided to staff/teams as required/requested, to promote awareness. |
| **safe and healthy environment** | • Dedicated Occupational Safety & Health department.<br>• Health & Safety Policy in place.<br>• Harassment Policy in place.<br>• Workplace Violence Prevention Policy in place.<br>• A series of key performance indicators measuring various forms of staff well-being. | • ACC Partnership Programme - Tertiary accredited. Good relationships with third party provider. "In house" case manager added to team in 2010<br>• GM lead Health & Safety committees, which also include Maori, Pacific Island, Auckland Regional Public Health, internal clinical H&S Reps.<br>• Staff Wellness initiatives, some of which include onsite Pilates, Yoga, Zumba classes and massage. Healthy Eating Healthy Action (HEHA), Heartbeat Challenge and staff smoke free initiatives put in place.<br>• Free influenza vaccine programme for staff, students on placement and many contractors.<br>• Promotion to staff of external initiatives such as the Feet Beat 8-week walking challenge, Push Play, the YMCA Walk/Run series, 5+A Day, World Diabetes Day, White Ribbon, Safety NZ Week (ACC), and Sun Smart Week.<br>• Dedicated Lifestyle section in ADHB's newsletter (both electronic and hard copy).<br>• A Dedicated Health Matters website designed specifically to align with mental and physical wellness themes as important to ADHB staff and families (updated at least monthly).<br>• DV-Free (domestic violence) free programme available to staff (staff contact people trained and awareness sessions run for all staff to attend).<br>• Support material available for staff and managers to understand and manage workplace stress.<br>• EAP services provided free to staff.<br>• Free work-related Occupational Health assessments for staff.<br>• Workstation assessments.<br>• Work area safety checks.<br>• Staff breastfeeding policy & facilities.<br>• Weight Watchers weekly onsite meeting. |

## WORKFORCE DEMOGRAPHICS

### *Size of ADHB's Workforce*

The two pie charts bellow show the breakdown of ADHB staff by Occupational Group. Nursing is ADHB's largest occupational group (at 44% and 40% for headcount and FTE respectively), from around 10,000 heads and nearly 7,500 FTE.




### *Staff Turnover*

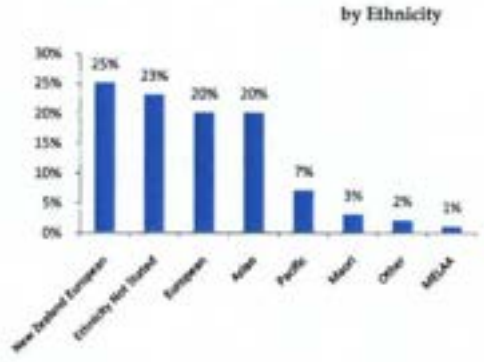
Voluntary staff turnover for year ended 30 June 2011 was 9.1%, which is a reduction from the prior year.

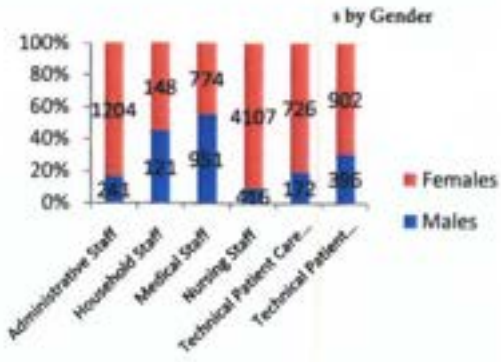
### *Employee Diversity*

Employees are not required to disclose their ethnicities to the ADHB and around 23% choose not to do so (reduced from 28% five years ago). Many employees have a diverse ethnic background and believe it would be disrespectful to identify with one ethnic group over another. The graph below shows all the ethnic groups that compose greater than 1% of our workforce.

### *Gender*

The Total Number of Employees by Gender chart below shows the varying gender differences according to occupational groups at the ADHB. Females account for around 77% of employees. At a snapshot in June 2011, females represented approximately 75% of the senior management team. A number of techniques are used to support pay and employment equity, such as job evaluation for Nursing and IEA employees to determine the internal relativity of positions (and in the case of all IEA positions the job sizes based on a method that meets the NZ standard of gender neutrality are linked back to external market data for salary setting), annual step increments for staff of both genders on a number of CEAs, and formal performance appraisals against goals and competency assessments.



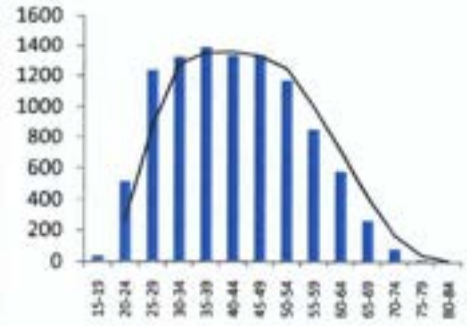
### *Age of Workforce*

The Total Number of Employees by Age chart below shows a mild skew in ages, the distribution of employees by age groupings somewhat approximates a normal distribution. Although it's not present in the chart, when analysing the number of employees by age groupings over the prior five years there is some evidence of an ageing workforce, and although it is reasonably minimal, it is being monitored, and factored into long-term workforce planning.

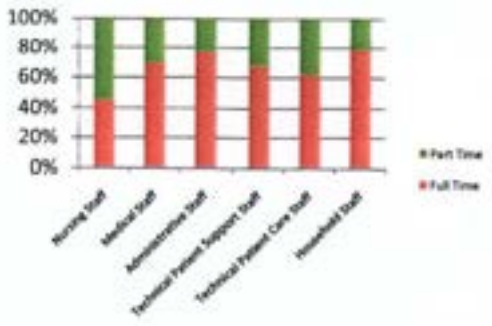
### *Full-time Vs Part-time Employees*

The Total Number of Permanent Employees chart below shows the majority of employees are permanently employed (at around 59%, with approximately 41% being part time), and with differing ratios across the various occupational groups. While not displayed, the ratio of full-time to part-time staff across ADHB for the past five years has remained relatively stable, although Medical has increased it's ratio of part-time staff by 5%.

**Total Number of Employees by Age Grouping**




**Total Number of Permanent Employees**



## STATEMENT OF RESPONSIBILITY
## FOR THE YEAR ENDED 30 JUNE 2011

1. The Board and management of ADHB accepts responsibility for the preparation of the financial statements, statement of service performance and the judgements used in them;

2. The Board and management of ADHB accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting; and

3. In the opinion of the Board and management of ADHB, the financial statements for the year ended 30 June 2011 fairly reflect the financial position and operations of ADHB.

| | | |
|---|---|---|
| **Dr Lester Levy**<br>**Chair** | **Ian Ward**<br>**Chair,**<br>**Audit and Finance**<br>**Committee** | **Garry Smith**<br>**Chief Executive** |
| **Dated: 5 October 2011** | **Dated: 5 October 2011** | **Dated: 5 October 2011** |

## STATUTORY INFORMATION

In respect of the financial year ended 30 June 2011 the Board members of ADHB submit the following report:

**Members of the Board - Current**

| Board member | Experience with ADHB |
|---|---|
| Dr Lester Levy, Chair (appointed) | From December 2010 |
| Dr Lee Mathias, Deputy Chair (elected) | From December 2010 |
| Jo Agnew (elected) | From December 2007 |
| Peter Aitken (elected) | From December 2010 |
| Judith Bassett (elected) | From December 2010 |
| Susan Buckland (elected) | From December 2007 |
| Dr Chris Chambers (elected) | From December 2004 |
| Robin Cooper (appointed) | From December 2007 |
| Robyn Northey (elected) | From December 2010 |
| Gwen Tepania-Palmer (appointed) | From December 2010 |
| Ian Ward (appointed) | From December 2007 |

**Members of the Board – Ceased December 2010**

| Board member | Experience with ADHB |
|---|---|
| Patrick Snedden (Chair) | From December 2007 |
| Harry Burkhardt (Deputy Chair) | From June 2003 |
| Dr Brian Fergus | From December 2007 |
| Dr Ian Scott | From December 2001 |
| Rt Hon Bob Tizard | From December 2007 |
| Selull Dr Juliet Walker | From December 2007 |

## BOARD COMMITTEES AS AT 30 JUNE 2011 - STATUTORY COMMITTEES

### Community and Public Health Advisory Committee

| | | |
|---|---|---|
| Dr Lee Mathias (Chair) | Susan Buckland | Robyn Northey |
| Jo Agnew | Dr Chris Chambers | Gwen Tepania-Palmer |
| Peter Aitken | Robin Cooper | Ian Ward |
| Judith Bassett | Dr Lester Levy | |

### Disability Support Advisory Committee

| | | |
|---|---|---|
| Jo Agnew (Chair) | Daime Kirton | Susan Sherrard |
| Susan Buckland | Dr Lester Levy | Nanar Tan |
| Marie Hull-Brown | Robyn Northey | |

### Hospital Advisory Committee

| | | |
|---|---|---|
| Dr Chris Chambers (Chair) | Robin Cooper | Dr Lee Mathias |
| Jo Agnew | Assoc Prof Anne Kolbe | Robyn Northey |
| Peter Aitken | Dr Lester Levy | Gwen Tepania-Palmer |
| Susan Buckland | Prof Iain Martin | Ian Ward |

## BOARD COMMITTEES AS AT 30 JUNE 2011 - BOARD ESTABLISHED COMMITTEES

### Audit and Finance Committee

| | | |
|---|---|---|
| Ian Ward (Chair) | Dr Lee Mathias | Assoc Prof Norman Wong |
| Peter Aitken | Robyn Northey | |
| Dr Lester Levy | Gwen Tepania-Palmer | |

### Maori Health Advisory Committee

| | | |
|---|---|---|
| Robin Cooper (Chair) | Dr Lester Levy | Puawai Rameka |
| Dr Chris Chambers | Liz Mitchelson | Tereki Stewart |
| Kere Cookson-Ua | Gwen Tepania-Palmer | |

## Principal Activities

The ADHB functions are set out in section 23(1) of the New Zealand Public Health and Disability Act 2000. It is responsible for the funding of health services.

ADHB provides its own hospital and health services at:

- Auckland City Hospital
- Greenlane Clinical Centre
- Community and Mental Health Service sites
- Point Chevalier

## Review of Operations

| | Group $000 | Parent $000 |
|---|---|---|
| **Results for the year ended 30 June 2011** | | |
| Operating surplus /(deficit) | 110 | (117) |
| Share of net surpluses of associates | 32 | 0 |
| Net surplus | 142 | (117) |
| **Equity of ADHB as at 30 June 2011** | | |
| Current assets | 218,578 | 198,445 |
| Non-current assets | 839,979 | 835,580 |
| Total assets | 1,058,557 | 1,034,025 |
| Current liabilities | 336,566 | 325,941 |
| Non-current liabilities | 285,134 | 285,134 |
| Total liabilities | 621,700 | 611,075 |
| Total equity | 436,857 | 422,950 |

## Capital Charge

The capital charge for the year ended 30 June 2011 was $34,491 million (to 30 June 2010: $35.921 million) and is treated as an operating expense – note 15.

## Equity Comparisons

No equity has been repaid to the Crown (to 30 June 2010, Nil).

## Financial Statements

The financial statements of ADHB and the Group for the year ended 30 June 2011 are included separately in this report. The Group consists of ADHB, the Auckland District Health Board Charitable Trust (beneficial control) and associated entities, Auckland Regional RMO Services Limited (33% owned), Northern DHB Support Agency Limited (33% owned) and Treaty Relationship Company Limited (50% owned).

**Interests Register**

During the year the following entries were recorded in the Interests Register of ADHB:

| (a) Board Members' Fees | Year ended 30/6/11 $ | Year ended 30/6/10 $ |
|---|---|---|
| Dr Lester Levy (Chair) | 40,732 | 0 |
| Dr Lee Mathias (Deputy Chair) | 22,584 | 0 |
| Jo Agnew | 32,875 | 32,718 |
| Peter Aitken | 17,817 | 0 |
| Judith Bassett | 16,847 | 0 |
| Susan Buckland | 32,000 | 32,250 |
| Dr Chris Chambers | 31,438 | 31,000 |
| Robin Cooper | 28,500 | 28,750 |
| Robyn Northey | 19,317 | 0 |
| Gwen Tepania-Palmer | 17,317 | 0 |
| Ian Ward | 33,625 | 35,000 |
| **Fees paid to Board Members** | **293,052** | **159,718** |

| (b) Previous Board Members' Fees | Year ended 30/6/11 $ | Year ended 30/6/10 $ |
|---|---|---|
| Pat Snedden (Chair) | 38,158 | 86,125 |
| Harry Burkhardt (Deputy Chair) | 24,818 | 57,750 |
| Dr Brian Fergus | 16,430 | 36,188 |
| Dr Ian Scott | 15,433 | 34,000 |
| Rt Hon Bob Tizard | 16,245 | 35,750 |
| Seiuli Dr Juliet Walker | 12,683 | 30,500 |
| **Fees paid to Board Members** | **123,767** | **280,313** |

(c) **Board Members use of ADHB information**

No notices were received from the Board members requesting the use of ADHB information, received in their capacity as Board Members, which would not otherwise have been available to them.

| (d) Committee Members' Fees | Year ended 30/6/11 $ | Year ended 30/6/10 $ |
|---|---|---|
| Lautalie Aumua | 250 | 0 |
| Fa'avae Gagamoe | 1,000 | 2,750 |
| Latoa Halatau | 2,500 | 1,000 |
| Dairne Kirton | 750 | 1,500 |
| Assoc Prof Anne Kolbe | 3,500 | 4,750 |
| Asenati Lole - Taylor | 1,563 | 2,250 |
| Bruce McCarthy | 2,313 | 2,500 |
| Akateni MacCauley | 1,000 | 0 |
| Liz Mitchelson | 1,000 | 1,000 |
| Melino Maka | 3,500 | 2,000 |
| Rev Alfred Ngaro | 2,000 | 4,375 |
| Puawai Rameka | 1,750 | 2,250 |
| Susan Sherrards | 1,750 | 0 |
| Farida Sultana | 1,250 | 3,000 |
| Nanar Tan | 1,500 | 1,000 |
| Lynda Williams | 2,500 | 4,250 |
| **Fees paid to Committee Members** | **28,126** | **32,625** |

## (e) Board Members' Interests

The Board Members have declared that they may benefit from any contract that may be made with the entities listed below by virtue of their directorship or memberships of those entities:

| Board Member | Interest |
|---|---|
| Dr Lester Levy (Chair) | Professor of Leadership, University of Auckland Business School; Chief Executive, New Zealand Leadership Institute, UOA Business School; Deputy Chair, Health Benefits Limited; Independent Chairman, Tonkin & Taylor; Chairman, Waitemata District Health Board; Trustee, A+ Charitable Trust |
| Dr Lee Mathias (Deputy Chair) | Managing Director, Lee Mathias Limited; Director, Iris Limited; Director, Midwifery & Maternity Providers Organisation Limited; Director/Shareholder, Pictor Limited; Director, John Seabrook Holdings Limited; Chair, Tamaki Transformation Interim Board; Governance Advisor, AuPairlink Limited; Council Member, NZ Council of Midwives |
| Jo Agnew | Senior Lecturer Nursing, Auckland University; Casual Staff Nurse, ADHB |
| Peter Aitken | Pharmacy Locum; Director/ Shareholder, Pharmacy Care Systems Limited |
| Judith Basset | Nil |
| Susan Buckland | Self employed, Writing, Editing & Public Relations; Committee Member, Medical Council of New Zealand; Member, Professional Conduct Committee, Occupational Therapy Board |
| Dr Chris Chambers | Employee, ADHB; Wife employed by Starship Trauma Service; Clinical Senior Lecturer in Anaesthesia, Auckland Clinical School; Associate, Epsom Anaesthetic Group; Member, ASMS; Shareholder, Ormiston Surgical |
| Robin Cooper | Chief Executive, Ngati Hine Health Trust; Board Member, James Henare Research Centre, University of Auckland; Member, National Health Board; Chair, Whanau Ora Governance Group; Board Member, Waitemata District Health Board |
| Robyn Northey | Self employed Contractor; Board Member, Hope Foundation; Member, Northern Region Ethics Committee |
| Gwen Tepania-Palmer | Board Member, Waitemata District Health Board; Board Member, Manaia PHO; Chair, Ngati Hine Health Trust; Committee Member, Awanmarangi Waonangi; Committee Member, Te Tai Tokerau Whanau Ora |
| Ian Ward | Principal/Director, C-4 Consulting Limited |

## (f) Previous Board Members' Interests

| Board Member | Interest |
|---|---|
| Pat Snedden (Chair) | Consultant, Ngati Whatua o Orakei Maori Trust Board; Director, Watercare Services Ltd; Chairman, Housing New Zealand; Chairman, Tamaki Establishment Board; Chief Crown Negotiator, Ngati Kahu Claim; Chief Crown Negotiator, Muriwhenua Forum |
| Harry Burkhardt (Deputy Chair) | Owner/Managing Director, Replas Ltd; Owner/Director, Matta Products Ltd; Shareholder/Director, Remat Group Ltd; Trustee, ADHB Charitable Trust; Chairman, NZ Maori Arts & Craft Institute; Shareholder/Director, Matt I Ltd; Trustee, Matta LLC; Deputy Chairman and Negotiator Ngati Kuri Trust Board; Executive Member, Packaging Council of New Zealand; Chairman, Ngati Whatua o Orakei Health Clinic Limited |
| Dr Brian Fergus | Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland |
| Dr Ian Scott | Shareholder and Chairman, Auckland PHO; Locum General Practitioner; Member, Waiheke "Integrated Family Health Centre" Steering Group |
| Rt Hon Bob Tizard | Nil |
| Seiuli Dr Juliet Walker | Locum General Practitioner, Mangere - PHO TaPasefika, Grey Lynn - PHO Procare; Member, National Breast Screening Advisory Committee; Facilitator, RNZCGP General Practice Education Programme Stage II; Employee, contracted roster Doctor for Pohutukawa, ADHB; Panel Member, Medical Appeal Board, Work and Income |

**Auckland District Health Board Charitable Trust**

Auckland District Health Board Charitable Trust administers the donations, bequests and research funds to ADHB with the exception of funds held on behalf of patients and the Ngati Whatua Trust Board, which are still held by ADHB and will be distributed as required.

**Trustees of the Trust at 30 June 2011**

| Trustee | Experience with A+ Charitable Trust |
|---|---|
| Dr Richard Frith (Chair) | Appointed 12 October 2003 |
| John Barnett | Appointed 14 August 2009 |
| Harry Burkhardt | Reappointed 10 December 2010 |
| Taima Campbell | Appointed 8 April 2004 |
| Roger Jarrold | Appointed 12 December 2008 |
| Dr Lester Levy | Appointed 10 December 2010 |
| Dr. S. Macfarlane | Appointed 11 March 2005 |
| Tim MacAvoy | Appointed 14 August 2009 |
| Phillipa Poole | Appointed 14 August 2009 |
| Garry Smith* | Appointed 7 April 2006 |
| Dr Margaret Wilsher* | Appointed 1 June 2010 |
| Brent Wiseman* | Appointed 13 February 2009 |

*Appointed as Ex Officio Trustees from 7 April 2006 when new Deed of Trust effected.

## Employee remuneration

During the year, the following numbers of employees of ADHB received remunueration over $100,000.

| Remuneration Range | Medical | Non- Medical | Number of Employees |
|---|---|---|---|
| $550,000-$560,000 | | 1 | 1 |
| $540,000-$550,000 | 1 | | 1 |
| $520,000-$530,000 | 2 | | 2 |
| $510,000-$520,000 | 2 | | 2 |
| $500,000-$510,000 | 2 | | 2 |
| $490,000-$500,000 | 2 | | 2 |
| $480,000-$490,000 | 2 | | 2 |
| $470,000-$480,000 | 1 | | 1 |
| $460,000-$470,000 | 1 | | 1 |
| $440,000-$450,000 | 4 | | 4 |
| $430,000-$440,000 | 6 | | 6 |
| $420,000-$430,000 | 2 | | 2 |
| $410,000-$420,000 | 1 | | 1 |
| $400,000-$410,000 | 5 | | 5 |
| $390,000-$400,000 | 4 | | 4 |
| $380,000-$390,000 | 7 | | 7 |
| $370,000-$380,000 | 10 | | 10 |
| $360,000-$370,000 | 8 | | 8 |
| $350,000-$360,000 | 7 | | 7 |
| $340,000-$350,000 | 7 | | 7 |
| $330,000-$340,000 | 9 | | 9 |
| $320,000-$330,000 | 21 | | 21 |
| $310,000-$320,000 | 22 | | 22 |
| $300,000-$310,000 | 25 | 3 | 28 |
| $290,000-$300,000 | 13 | | 13 |
| $280,000-$290,000 | 16 | | 16 |
| $270,000-$280,000 | 13 | | 13 |
| $260,000-$270,000 | 21 | | 21 |
| $250,000-$260,000 | 21 | 3 | 24 |
| $240,000-$250,000 | 34 | 1 | 35 |
| $230,000-$240,000 | 21 | | 21 |
| $220,000-$230,000 | 22 | 1 | 23 |
| $210,000-$220,000 | 32 | 1 | 33 |
| $200,000-$210,000 | 30 | 1 | 31 |
| $190,000-$200,000 | 24 | | 24 |
| $180,000-$190,000 | 35 | | 35 |
| $170,000-$180,000 | 35 | 2 | 37 |
| $160,000-$170,000 | 38 | 3 | 41 |
| $150,000-$160,000 | 46 | 8 | 54 |
| $140,000-$150,000 | 40 | 9 | 49 |
| $130,000-$140,000 | 73 | 23 | 96 |
| $120,000-$130,000 | 53 | 44 | 97 |
| $110,000-$120,000 | 74 | 56 | 130 |
| $100,000-$110,000 | 79 | 125 | 204 |
| **Grand Total** | 871 | 281 | 1,152 |

**Note:**

Of the 1,152 employees shown above, 871 are or were medical or dental employees and 281 are or were neither medical nor dental employees.

If the remuneration of part-time employees were grossed-up to a full time equivalent basis, the total number of employees with full time equivalent salaries of $100,000 or more would be 1,392 compared with the actual total number of employees of 1,152

**Employee termination**

| Termination payments | Payment $ | Employees |
|---|---|---|
| Total | 1,455,209 | 91 |

During the year ended 30 June 2011, termination payments were made in respect of 91 employees (126 payments, $2,617,616 in year ended 30 June 2010). Termination payments consist of settlements and redundancy payments made during the year.

**Auditor**

The Controller and Auditor-General is appointed under section 43 of the New Zealand Public Health and Disability Act 2000. Audit New Zealand has been contracted to provide these services.

| Remuneration to auditor | 2011 $000 | 2010 $000 |
|---|---|---|
| Audit Fees | 237 | 260 |

**Donations**

ADHB did not make any donations during the year.

**For and on behalf of the Board Members who authorised the issue of this Annual Report.**

**Dr Lester Levy**
**Chair**

**Dated: 5 October 2011**

## STATEMENT OF FINANCIAL PERFORMANCE
## FOR THE YEAR ENDED 30 JUNE 2011

| | Notes | Group Budget | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|---|
| | | 2011 $000 | 2011 $000 | 2010 $000 | 2011 $000 | 2010 $000 |
| **Revenue** | | | | | | |
| Patient care revenue | | 1,662,465 | 1,733,454 | 1,615,457 | 1,733,454 | 1,615,457 |
| Other revenue | | 81,153 | 87,676 | 96,484 | 85,944 | 94,646 |
| Total revenue | 2 | 1,743,618 | 1,821,130 | 1,711,941 | 1,819,398 | 1,710,103 |
| **Expenses** | | | | | | |
| Employee benefit cost | 3a | 722,866 | 727,849 | 711,602 | 727,849 | 711,602 |
| Outsourced Services | | 34,188 | 54,006 | 48,050 | 54,006 | 48,050 |
| Direct treatment cost | | 187,251 | 202,756 | 191,471 | 202,756 | 191,471 |
| Funder payments | | 573,934 | 615,251 | 547,017 | 615,251 | 547,017 |
| Indirect treatment costs | 3b | 39,176 | 43,833 | 39,901 | 43,833 | 39,901 |
| Property, equipment & transport costs. | 3c | 49,223 | 49,267 | 48,431 | 49,267 | 48,431 |
| Other operating expenses | 3d | 25,841 | 24,202 | 20,928 | 22,697 | 19,744 |
| Capital charge | 3e | 36,617 | 34,491 | 35,921 | 34,491 | 35,921 |
| Depreciation and amortisation expenses | 3f | 54,310 | 51,146 | 48,338 | 51,146 | 48,338 |
| Finance costs | 3g | 20,154 | 18,219 | 20,087 | 18,219 | 20,087 |
| Total expenses | | 1,743,560 | 1,821,020 | 1,711,746 | 1,819,515 | 1,710,562 |
| Share of surpluses of joint venture & associates | | 0 | 32 | 84 | 0 | 0 |
| Surplus/ (deficit) | | 58 | 142 | 279 | (117) | (459) |

## STATEMENT OF COMPREHENSIVE INCOME
## FOR THE YEAR ENDED 30 JUNE 2011

| | Notes | Group Budget | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|---|
| | | 2011 $000 | 2011 $000 | 2010 $000 | 2011 $000 | 2010 $000 |
| Surplus/ (deficit) | | 58 | 142 | 279 | (117) | (459) |
| Gains/(Losses) on property revaluations | 6 | 0 | (21,557) | (27,739) | (21,557) | (27,739) |
| Total Comprehensive Income/(Loss) | | 58 | (21,415) | (27,460) | (21,674) | (28,198) |

The accompanying notes form an integral part of these financial statements.

## STATEMENT OF CHANGES IN EQUITY

## FOR THE YEAR ENDED 30 JUNE 2011

| GROUP | Notes | Public Equity | Accumulated surplus /(deficit ) | Other reserves | Trust / Special Funds | Total equity |
|---|---|---|---|---|---|---|
| | | $000 | $000 | $000 | $000 | $000 |
| **Balance as at 1 July 2009** | | 566,089 | (481,169) | 381,277 | 12,521 | 478,718 |
| Surplus/ (deficit) for the period | | 0 | (375) | 0 | 654 | 279 |
| Movement in revaluation of land and buildings | | 0 | 0 | (27,739) | 0 | (27,739) |
| Total comprehensive income and expense | | 0 | (375) | (27,739) | 654 | (27,460) |
| Contributions from/(repayment to) the Crown | | 3,320 | 0 | 0 | 0 | 3,320 |
| Total equity transactions | | 3,320 | 0 | 0 | 0 | 3,320 |
| **Balance as at 30 June 2010** | 6 | 569,409 | (481,544) | 353,538 | 13,175 | 454,578 |
| | | | | | | |
| **Balance as at 1 July 2010** | | 569,409 | (481,544) | 353,538 | 13,175 | 454,578 |
| Surplus/ (deficit) for the period | | 0 | (85) | 0 | 227 | 142 |
| Movement in revaluation of land and buildings | | 0 | 0 | (21,557) | 0 | (21,557) |
| Total comprehensive income and expense | | 0 | (85) | (21,557) | 227 | (21,415) |
| Contributions from/(repayment to) the Crown | | 3,694 | 0 | 0 | 0 | 3,694 |
| Total equity transactions | | 3,694 | 0 | 0 | 0 | 3,694 |
| **Balance as at 30 June 2011** | 6 | 573,103 | (481,629) | 331,981 | 13,402 | 436,857 |

| PARENT | Notes | Public Equity | Accumulated surplus /(deficit ) | Other reserves | Trust / Special Funds | Total equity |
|---|---|---|---|---|---|---|
| | | $000 | $000 | $000 | $000 | $000 |
| **Balance as at 1 July 2009** | | 566,089 | (481,558) | 381,277 | 0 | 465,808 |
| Surplus/ (deficit) for the period | | 0 | (459) | 0 | 0 | (459) |
| Movement in revaluation of land and buildings | | 0 | 0 | (27,739) | 0 | (27,739) |
| Total comprehensive income and expense | | 0 | (459) | (27,739) | 0 | (28,198) |
| Contributions from/(repayment to) the Crown | | 3,320 | 0 | 0 | 0 | 3,320 |
| Total equity transactions | | 3,320 | 0 | 0 | 0 | 3,320 |
| **Balance as at 30 June 2010** | 6 | 569,409 | (482,017) | 353,538 | 0 | 440,930 |
| | | | | | | |
| **Balance as at 1 July 2010** | | 569,409 | (482,017) | 353,538 | 0 | 440,930 |
| Surplus/ (deficit) for the period | | 0 | (117) | 0 | 0 | (117) |
| Movement in revaluation of land and buildings | | 0 | 0 | (21,557) | 0 | (21,557) |
| Total comprehensive income and expense | | 0 | (117) | (21,557) | 0 | (21,674) |
| Contributions from/(repayment to) the Crown | | 3,694 | 0 | 0 | 0 | 3,694 |
| Total equity transactions | | 3,694 | 0 | 0 | 0 | 3,694 |
| **Balance as at 30 June 2011** | 6 | 573,103 | (482,134) | 331,981 | 0 | 422,950 |

The accompanying notes form an integral part of these financial statements.

## STATEMENT OF FINANCIAL POSITION
## AS AT 30 JUNE 2011

| | Notes | Group Budget | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|---|
| | | As at 30/06/11 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 |
| **Current Assets** | | | | | | |
| Cash and cash equivalents | 7 | 34,293 | 108,125 | 70,865 | 108,125 | 70,865 |
| Trust/special funds | 8a | 11,508 | 18,067 | 10,680 | 0 | 0 |
| Patient & restricted trust funds | 8b | 0 | 1,093 | 1,067 | 1,093 | 1,067 |
| Trade & other receivables | 9 | 58,435 | 59,231 | 59,785 | 57,165 | 57,191 |
| Inventories | 10 | 12,106 | 12,021 | 11,220 | 12,021 | 11,220 |
| Derivative financial instruments | 19 | 0 | 0 | 3,182 | 0 | 3,182 |
| Non-current assets held for sale | 11c | 0 | 20,041 | 0 | 20,041 | 0 |
| **Total Current Assets** | | 116,342 | 218,578 | 156,799 | 198,445 | 143,525 |
| **Non-Current Assets** | | | | | | |
| Trust/special funds | 8a | 8,000 | 3,898 | 10,078 | 0 | 0 |
| Property, plant and equipment | 11a | 915,566 | 829,099 | 860,468 | 829,099 | 860,468 |
| Intangible assets | 11b | 24,607 | 535 | 10,145 | 535 | 10,145 |
| Derivative financial instruments | 19 | 4,399 | 5,945 | 4,189 | 5,945 | 4,189 |
| Investments in joint venture & associates | 5 | 386 | 502 | 470 | 1 | 1 |
| **Total Non-Current Assets** | | 952,958 | 839,979 | 885,350 | 835,580 | 874,803 |
| **Total Assets** | | 1,069,300 | 1,058,557 | 1,042,149 | 1,034,025 | 1,018,328 |

The accompanying notes form an integral part of these financial statements

## STATEMENT OF FINANCIAL POSITION
## AS AT 30 JUNE 2011

| | Notes | Group Budget | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|---|
| | | As at 30/06/11 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 |
| **Current Liabilities** | | | | | | |
| Bank overdraft | 7 | 0 | 24,800 | 14,050 | 24,800 | 14,050 |
| Trade and other payables | 13a | 137,189 | 148,658 | 134,628 | 138,033 | 124,455 |
| Employee benefits | 13b | 124,900 | 136,320 | 125,197 | 136,320 | 125,197 |
| Provisions | 13c | 0 | 2,071 | 1,843 | 2,071 | 1,843 |
| Interest-bearing loans and borrowings | 14,18 | 25,836 | 23,249 | 74,652 | 23,249 | 74,652 |
| Loans from joint venture & associates | 5 | 0 | 375 | 375 | 375 | 375 |
| Patient & restricted trust funds | 8b | 1,126 | 1,093 | 1,067 | 1,093 | 1,067 |
| **Total Current Liabilities** | | 289,051 | 336,566 | 351,812 | 325,941 | 341,639 |
| **Non-Current Liabilities** | | | | | | |
| Employee benefits | 13b | 20,880 | 21,747 | 22,434 | 21,747 | 22,434 |
| Interest-bearing loans and borrowings | 14 | 273,109 | 263,110 | 213,014 | 263,110 | 213,014 |
| Derivative financial instruments | 19 | 0 | 277 | 311 | 277 | 311 |
| **Total Non-Current Liabilities** | | 293,989 | 285,134 | 235,759 | 285,134 | 235,759 |
| **Total Liabilities** | | 583,040 | 621,700 | 587,571 | 611,075 | 577,398 |
| **Net Assets** | | 486,260 | 436,857 | 454,578 | 422,950 | 440,930 |
| **Equity** | | | | | | |
| Public equity | 6a | 573,362 | 573,103 | 569,409 | 573,103 | 569,409 |
| Accumulated deficit | 6b | (477,386) | (481,629) | (481,544) | (482,134) | (482,017) |
| Other reserves | 6c | 381,277 | 331,981 | 353,538 | 331,981 | 353,538 |
| Trust/special funds | 6d | 9,007 | 13,402 | 13,175 | 0 | 0 |
| **Total Equity** | | 486,260 | 436,857 | 454,578 | 422,950 | 440,930 |

**For and on behalf of the Board Members who authorised the issue of this Annual Report.**

**Dr Lester Levy**
**Chair**
**Dated: 5 October 2011**

**Ian Ward**
**Chair, Audit and Finance Committee**
**Dated: 5 October 2011**

The accompanying notes form an integral part of these financial statements

## STATEMENT OF CASH FLOWS
## FOR THE YEAR ENDED 30 JUNE 2011

| | Notes | Group Budget 2011 $000 | Group Actual 2011 $000 | Group Actual 2010 $000 | Parent Actual 2011 $000 | Parent Actual 2010 $000 |
|---|---|---|---|---|---|---|
| **Cash Flows from Operating Activities** | | | | | | |
| **Cash was provided from:** | | | | | | |
| Cash receipts from Ministry of Health and patients | | 1,744,508 | 1,814,673 | 1,706,293 | 1,813,663 | 1,701,990 |
| Interest received | | 4,436 | 6,617 | 5,109 | 5,714 | 3,924 |
| | | 1,748,944 | 1,821,290 | 1,711,402 | 1,819,377 | 1,705,914 |
| **Cash was applied to:** | | | | | | |
| Cash paid to employees | | (730,875) | (715,730) | (719,358) | (716,042) | (719,743) |
| Cash paid to suppliers | | (895,290) | (978,238) | (868,849) | (977,202) | (865,453) |
| Interest paid | | (19,910) | (19,540) | (20,686) | (19,540) | (20,200) |
| Net goods and services taxes refunded/(paid) | | 0 | 3,594 | 226 | 3,576 | 202 |
| Capital charges paid | | (36,617) | (36,048) | (37,741) | (36,048) | (37,741) |
| | | (1,682,692) | (1,745,962) | (1,646,408) | (1,745,256) | (1,642,935) |
| Net cash inflow from operating activities | 7 | 66,252 | 75,328 | 64,994 | 74,121 | 62,979 |
| **Cash Flows from Investing Activities** | | | | | | |
| **Cash was provided from:** | | | | | | |
| Proceeds from sale of property, plant and equipment | | (16) | 268 | 9 | 268 | 9 |
| Decrease/(Increase) in restricted trust funds | | (10,428) | (1,233) | (2,045) | (26) | (30) |
| | | (10,444) | (965) | (2,036) | 242 | (21) |
| **Cash was applied to:** | | | | | | |
| Purchase of property, plant and equipment | | (77,527) | (51,547) | (45,126) | (51,547) | (45,126) |
| Net cash (outflow) from investing activities | | (87,971) | (52,512) | (47,162) | (51,305) | (45,147) |
| **Cash Flows from Financing Activities** | | | | | | |
| **Cash was provided from:** | | | | | | |
| Proceeds from joint venture | | 0 | 0 | 375 | 0 | 375 |
| Repayment of loans | | 0 | (70,000) | (13,500) | (70,000) | (13,500) |
| Proceeds from borrowings | | 4,058 | 70,000 | 13,500 | 70,000 | 13,500 |
| Proceeds from capital contributed/(repaid) | | 925 | 3,694 | 3,320 | 3,694 | 3,320 |
| Net cash inflow/(outflow) from financing activities | | 4,983 | 3,694 | 3,695 | 3,694 | 3,695 |
| **Movement in cash and cash equivalents** | | | | | | |
| Opening cash and cash equivalents | | 51,029 | 56,815 | 35,288 | 56,815 | 35,288 |
| Net cash inflow/(outflow) | | (16,736) | 26,510 | 21,527 | 26,510 | 21,527 |
| **Closing cash and cash equivalents** | 7 | **34,293** | **83,325** | **56,815** | **83,325** | **56,815** |

The accompanying notes form an integral part of these financial statements.

Note 1 **SIGNIFICANT ACCOUNTING POLICIES**

**Reporting entity**

The reporting entity is the Auckland District Health Board (ADHB) which was created by the New Zealand Public Health and Disability Act 2000. ADHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993 and the Crown Entities Act 2004.

ADHB is a Public Benefit Entity (PBE), as defined under NZ IAS 1. ADHB's registered office is c/o Greenlane Clinical Centre, 214 Greenlane West, Epsom, Auckland 1051.

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

The consolidated financial statements include ADHB and its subsidiaries and interest in associates and jointly controlled entities.

ADHB has the power to amend the statements after they have been issued.

**Statement of compliance**

The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for Public Benefit Entities (PBE).

**Basis of preparation**

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that the following asset and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swaps), local government bond stock, land and buildings.

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

The preparation of financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Judgements made by management in the application of NZ IFRSs that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 22.

**Basis for consolidation**

Subsidiaries

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

Subsidiaries are consolidated from the date on which control is obtained by the group and cease to be consolidated from the date on which control is transferred out of the group.

1 SIGNIFICANT ACCOUNTING POLICIES (continued)

In preparing the consolidated financial statements, all intercompany balances and transactions, revenue and expenses and profit and losses resulting from intra - group transactions have been eliminated in full.

Joint Venture

A joint venture is an entity over whose activities ADHB has joint control, established by contractual agreement. The consolidated financial statements include ADHB's joint interest in the joint venture, using the equity method, from the date that joint control commences until the date that joint control ceases. There are no differences in accounting policies between the parent and joint venture entities.

Treaty Relationship Company Ltd is a joint venture company (50% owned) with Te Runanga O Ngati Whatua. Originally created as a vehicle through which to channel joint health related activities, it has not undertaken any business for some years and as at the date of this report work is underway to wind up the company.

Associates

Associates are those entities in which ADHB has the power to exert significant influence, but not control, over the financial and operating policies. ADHB holds shareholdings in the following associates: Auckland Regional RMO Services Limited (previously The Northern Clinical Training Network Limited) (33% owned) and Northern DHB Support Agency Limited (33% owned).

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

Auckland Regional RMO Services Limited is a joint venture company with Counties-Manukau and Waitemata DHBs, which exists to support and facilitate employment and training for Resident Medical Officers across the three Auckland regional DHBs.

Northern DHB Support Agency Limited is a joint venture company with Counties-Manukau and Waitemata DHBs which exists to provide a shared services agency to the three Auckland regional DHB boards in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution.

**Transactions eliminated on consolidation**

All inter-entity transactions are eliminated on consolidation.

**Foreign Currency**

Both the functional and presentation currency of ADHB and Group is New Zealand Dollars (NZD). Transactions in foreign currencies are translated at the exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the end of the reporting period are translated to NZD at the rate ruling at that date. Foreign exchange differences arising on translation and settlement are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the date the fair value was determined.

**Budget Figures**

The budget figures are those approved by the Board in its District Annual Plan and included in the Statement of Intent tabled in Parliament. The budgets have been prepared using the same accounting policies as those used in the preparation of these financial statements.

1 **SIGNIFICANT ACCOUNTING POLICIES (continued)**

**Equity**

Equity comprises Contributions from the Crown, Accumulated surpluses/ (deficits) and Reserves. Crown contributions are recognised at the amount received, accumulated surpluses/deficits in accordance with the financial results using generally accepted accounting principles, and reserves from changes in the value of land and buildings.

**Property, Plant and Equipment (PPE)**

The major classes of PPE are as follows:

- Freehold land
- Freehold buildings and fitouts
- Plant, equipment and vehicles
- Leased assets
- Work in progress

Owned Assets

Except for land and buildings, items of PPE are stated at cost, less accumulated depreciation and impairment losses.

Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every 3 years. The latest revaluation was done on 30 June 2011. Any increase in value of a class of land and buildings is recognised directly to other comprehensive income unless it offsets a previous decrease in value recognised in the surplus or deficit in which case the increase is recognised in the surplus or deficit. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the surplus or deficit.

Additions to PPE between valuations are recorded at cost.

Where material parts of an item of PPE have different useful lives, they are accounted for separately.

Disposal of PPE

Where an item of PPE is disposed of, the gain or loss recognised in the surplus or deficit is calculated as the difference between the net sales price and the carrying amount of the asset.

Leased assets

Leases where ADHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at the inception of the lease, less accumulated depreciation and impairment losses. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Operating lease payments are recorded as an expense in the surplus or deficit on a straight-line basis over the lease term.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of PPE when that cost is incurred if it is probable that the future economic benefit embodied within the item will flow to ADHB. All other costs are recognised in the surplus or deficit as an expense as incurred.

Depreciation is charged to the surplus or deficit using the straight line method. Land is not depreciated. Depreciation is set at rates that write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

| Asset Class | 2011 | 2010 |
|---|---|---|
| Freehold buildings and fitouts | 1-89 years | 1-89 years |
| Plant, equipment and vehicles | 2-20 years | 2-20 years |
| Leased assets | 4-8 years | 4-8 years |

1 SIGNIFICANT ACCOUNTING POLICIES (continued)

The residual value, useful life and depreciation method of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to PPE on its completion and then depreciated. Work in progress balance includes both PPE and intangible assets.

**Intangible Assets**

Computer software, which is not an integral part of the related hardware is treated as an intangible asset. Such intangible assets are acquired separately and are capitalised at cost less accumulated amortisation and impairment losses.

Subsequent expenditure on computer software is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates.

Amortisation of computer software is charged to the surplus or deficit on a straight line basis over its estimated useful life. The useful life of computer software is calculated over 7 years (2010 7 years) from the date that the software is available for use (refer Note 11b). Impairment losses are provided for on a continuing basis as required.

On 1 March 2011 Health Alliance was established to provide a shared services agency to ADHB for some information technology services – see note re "Assets held for sale" below.

**Interest-Bearing Loans and Borrowings**

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

**Derivative financial instruments**

ADHB uses foreign exchange and interest rate swap contracts to manage its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities. Such derivatives are accounted for as trading instruments, and are stated at fair value. Fair value movements are recognised in the surplus or deficit.

The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price. The fair value of interest rate swaps is the estimated amount that ADHB would receive or pay to terminate the swaps at balance date taking into account the current interest rates and the current credit worthiness of the counter-party.

ADHB classifies the value of derivatives into their current and non-current portions, based on their expected maturity dates.

**Trade and other receivables**

Trade and other receivables are recognised and carried at amortised cost amount less impairment. Impairment is calculated in accordance with the Board's credit management policy. Bad debts are written off during the period in which they are identified.

**Inventories**

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

1 SIGNIFICANT ACCOUNTING POLICIES (continued)

**Cash and cash equivalents**

Cash and cash equivalents comprise cash and call deposits with an original maturity of less than 3 months. Bank overdrafts that are repayable on demand and form an integral part of ADHB's cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flows.

**Assets held for sale**

Assets held for sale are measured at the lower of carrying amount or fair value less costs to sell. These relate to computer hardware, software, equipment and vehicles to be transferred to HealthAlliance NZ Limited on or after 1 July 2011

**Impairment of financial assets**

Financial assets are assessed for objective evidence of impairment at each balance date. Impairment losses are recognised in the surplus or deficit.

**Financial instruments**

Non-derivative financial instruments comprise investments in trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

A financial instrument is recognised if ADHB becomes a party to the contractual provisions of the instrument. Financial assets are de-recognised if ADHB's contractual rights to the cash flows from the financial asset expire or if ADHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Regular purchases and sales of financial assets are accounted for at trade date i.e. the date that ADHB commits itself to purchase or sell the asset. Financial liabilities are de-recognised if ADHB's obligations specified in the contract expire or are discharged and cancelled.

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

Gains or losses on restricted trust funds are recognised in the surplus or deficit.

**Employee benefits**

Defined Contribution Plan (DCP)

Obligations for contributions to DCPs are recognised as an expense in the surplus or deficit as incurred. ADHB makes contributions on behalf of staff to the National Provident Fund which are recognised in the surplus or deficit as incurred - see disclosure note 13d.

Retiring Gratuities and Long Service Leave

ADHB's net obligation in respect of Retiring Gratuities and Long Service Leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods calculated on an actuarial basis.

Annual Leave, Sick Leave, Continuing Medical Education Leave and Expenses

Annual Leave is a short-term obligation and is calculated on an actual basis at the amount ADHB expects to pay when staff take leave or resign.

Sick leave is a short-term obligation which represents the estimated future cost of sick leave attributable to the entitlement not used at balance date calculated as the amount expected to be paid.

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

1 SIGNIFICANT ACCOUNTING POLICIES (continued)

**Provisions**

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

Restructuring

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

**Revenue**

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is received monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Revenue from services provided is recognised to the proportion that the transaction is complete, when it is probable that the payment associated with the transaction will flow to ADHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by ADHB.

In accordance with Generally Accepted Accounting Practice and NZIFRS, surpluses of income over expenditure are reported through the Statement of Financial Performance. Where such surpluses are in respect of Mental Health Ring Fenced Revenue, the unspent portion of the revenue is only available to be spent on Mental Health Services in subsequent accounting periods. As at 30 June 2011, there was an amount of $8,610 k unspent revenue in respect of Mental Health Ring Fenced Revenue (as at 30 June 2010 - $3,210k unspent). The surplus will be applied to expenses incurred after balance date.

Trust and special fund donations received are treated as revenue on receipt, in the surplus or deficit. These funds are administered by the Auckland District Health Board Charitable Trust. Trust and special funds from third party trusts are recognised as revenue only when actually receipted.

Interest income is recognised using the effective interest method.

**Lease Expenses**

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Leases where ADHB assumes substantially all the risks and rewards of ownership are classified as finance leases. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

**Goods and Services Tax (GST)**

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

**Borrowing Costs**

Borrowing costs are recognised as an expense when incurred.

## 1 SIGNIFICANT ACCOUNTING POLICIES (continued)

### Change in accounting policies

There have been no changes in accounting policies during the financial year.

### Early adopted amendments to standards

NZ IFRS 7.44L • NZ IFRS 7 *Financial Instruments: Disclosures* – The effect of early adopting these amendments is the following information is no longer disclosed:

- the carrying amount of financial assets that would otherwise be past due or impaired whose terms have been renegotiated; and
- the maximum exposure to credit risk by class of financial instrument if the maximum credit risk exposure is best represented by their carrying amount in the statement of financial position.

### Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted

NZ IFRS standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the DHB, are:

NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following three main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus or deficit. The new standard is required to be adopted for the year ended 30 June 2014. The DHB has not yet assessed the effect of the new standard and expects it will not be early adopted.

FRS-44 *New Zealand Additional Disclosures* and *Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments)* – These were issued in May 2011 with the purpose of harmonising Australia and New Zealand's accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The amendments must first be adopted for the year ended 30 June 2012. The DHB has not yet assessed the effects of FRS-44 and the Harmonisation Amendments.

NZ IAS 24 *Related Party Disclosures (Revised 2009)* replaces NZ IAS 24 *Related Party Disclosures (Issued 2004)* and is effective for reporting periods commencing on or after 1 January 2011. The revised standard:

i) Removes the previous disclosure concessions applied by the DHB for arms-length transactions between the DHB and entities controlled or significantly influenced by the Crown. The effect of the revised standard is that more information is required to be disclosed about transactions between the DHB and entities controlled or significantly influenced by the Crown.

ii) Clarifies that related party transactions include commitments with related parties.

1 SIGNIFICANT ACCOUNTING POLICIES (continued)

**Cost of Service (Statement of Service Performance)**

The Cost of Service Statements, as reported in the Statement of Service Performance, report the net cost of services of ADHB and are represented by the cost of providing the services less all of the revenue that can be allocated to these activities.

**Cost Allocation**

ADHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to each service. Indirect costs are charged to each service based on cost drivers and related activity and usage information.

Criteria for Direct and Indirect Costs

Direct costs are those costs directly attributable to a service. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific service.

Cost Drivers for Allocation of Indirect Costs

The cost of internal services not directly charged to a service is held in central overhead pools, for example, the cost of building accommodation. The exceptions to this are ring-fenced services Mental Health and Public Health where an allocation of overheads is made, and some services that sell to third parties, for example LabPlus.

**Comparatives**

Comparative information has been reclassified as appropriate to achieve consistency in disclosure with the current year. In particular, in the Statement of Financial Performance, Outsourced Services have been shown as a separate line.

| | Notes | Group Actual 2011 $000 | Group Actual 2010 $000 | Parent Actual 2011 $000 | Parent Actual 2010 $000 |
|---|---|---|---|---|---|
| **2 REVENUE** | | | | | |
| Patient care revenue | | 1,733,454 | 1,615,457 | 1733,454 | 1,615,457 |
| Interest received – other | | 6,019 | 3,905 | 6,019 | 3,905 |
| Interest received – Charitable Trust | | 1,135 | 1,257 | 0 | 0 |
| Donations and bequests | | 6,358 | 7,335 | 5,401 | 6,560 |
| Gain/(loss) on disposal of assets | | 50 | 77 | 50 | 77 |
| Gain on derivatives – financial instruments | | 2,099 | 3,252 | 2,099 | 3,252 |
| Other revenue | | 72,015 | 80,658 | 72,375 | 80,852 |
| **Total Revenue** | | 1,821,130 | 1,711,941 | 1,819,398 | 1,710,103 |
| **3 EXPENSES** | | | | | |
| a *Employee benefit costs* | | | | | |
| Wages and salaries | | 706,374 | 692,531 | 706,374 | 692,531 |
| Contributions to defined contribution plans | (i) | 11,039 | 10,121 | 11,039 | 10,121 |
| Increase/(decrease) in liability for employee benefit | | 10,436 | 8,950 | 10,436 | 8,950 |
| Total employee benefit costs | | 727,849 | 711,602 | 727,849 | 711,602 |
| b *Indirect treatment costs* | | | | | |
| Bad debts written off | | 4,576 | 3,417 | 4,576 | 3,417 |
| Increase (decrease) in estimated doubtful debts | | 1330 | (60) | 1330 | (60) |
| Other indirect treatment costs | | 37,927 | 36,544 | 37,927 | 36,544 |
| Total indirect treatment costs | | 43,833 | 39,901 | 43,833 | 39,901 |
| c *Property, equipment & transportation cost* | | | | | |
| Rental and operating lease costs | | 4,723 | 5,088 | 4,723 | 5,088 |
| Other property, equipment & transportation cost | | 44,544 | 43,344 | 44,544 | 43,344 |
| Total property, equipment & transportation cost | | 49,267 | 48,432 | 49,267 | 48,432 |
| d *Other operating expenses* | | | | | |
| Remuneration of auditor | | | | | |
| - audit fees: statutory accounts | | 237 | 260 | 237 | 260 |
| Board Members' fees | | 417 | 440 | 417 | 440 |
| Research costs | | 6630 | 6,724 | 6,630 | 6,724 |
| Other expenses | | 16,918 | 13,503 | 15,413 | 12,319 |
| Total other operating expenses | | 24,202 | 20,927 | 22,697 | 19,743 |
| e Capital charge (note 15) | | 34,491 | 35,921 | 34,491 | 35,921 |
| f *Depreciation and impairment expenses* | | | | | |
| Depreciation | | 51,146 | 48,464 | 51,146 | 48,464 |
| Impairment loss/(gain) – software (note 11b) | | 0 | (126) | 0 | (126) |
| Total depreciation and impairment expenses | | 51,146 | 48,338 | 51,146 | 48,338 |

## 3 EXPENSES (continued)

| | Group Actual | | Parent Actual | |
|---|---|---|---|---|
| | 2011 $000 | 2010 $000 | 2011 $000 | 2010 $000 |
| g *Finance costs* | | | | |
| Interest expense | 18,234 | 20,068 | 18,234 | 20,068 |
| Foreign currency loss/(gain) | (15) | 19 | (15) | 19 |
| Total finance costs | 18,219 | 20,087 | 18,219 | 20,087 |

**Note**

3a(i) ADHB makes contributions to the National Provident Fund on behalf of some of its employees and is permitted under NZ IAS 19 (30) to use defined contribution reporting in relation to these (see note 13d).

## 4 TAXATION

ADHB is a Crown Entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 2007.

## 5 INVESTMENTS IN JOINT VENTURE & ASSOCIATES

**Non Current Assets**

| | | | | |
|---|---|---|---|---|
| ***Results of joint venture & associates*** | | | | |
| Share of post acquisition surplus | 32 | 84 | 0 | 0 |
| Share of net surpluses of joint venture & associates | 32 | 84 | 0 | 0 |
| Carrying amount at the beginning of the year | 470 | 386 | 1 | 1 |
| Carrying amount at end of year | 502 | 470 | 1 | 1 |
| *Represented by:* | | | | |
| Shares in joint venture & associates (unlisted at cost) | 1 | 1 | 1 | 1 |
| Share of post-acquisition retained surpluses | 501 | 469 | 0 | 0 |
| | 502 | 470 | 1 | 1 |
| **Current Liabilities** | | | | |
| Loans from joint venture & associates | 375 | 375 | 375 | 375 |

| | 2011 % Interest held | 2010 % Interest held |
|---|---|---|
| ***Name of joint venture (Principal activity)*** | | |
| Treaty Relationship Company Limited (joint venture for health initiatives with local Iwi) | 50 | 50 |
| ***Name of associates (Principal activity)*** | | |
| Auckland Regional RMO Services Limited (co-ordinates trainee medical personnel) | 33 | 33 |
| Northern DHB Support Agency Limited (management of a number of regional contracts on behalf of the Auckland region DHBs.) | 33 | 33 |

All the above related parties have balance dates of 30 June.

ADHB does not have a share in any contingent liabilities or capital commitments of these related parties.

| | | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|
| | | As at 30/06/11 | As at 30/06/10 | As at 30/06/11 | As at 30/06/10 |
| 6 | CAPITAL AND RESERVES | $000 | $000 | $000 | $000 |
| a | *Public equity* | | | | |
| | Opening balance | 569,409 | 566,089 | 569,409 | 566,089 |
| | Contributions from/(repayment to) the Crown | 3,694 | 3,320 | 3,694 | 3,320 |
| | **Balance at end of year** | 573,103 | 569,409 | 573,103 | 569,409 |
| b | *Accumulated deficits* | | | | |
| | Opening balance | (481,544) | (481,169) | (482,017) | (481,558) |
| | Operating surplus/(deficit) | 142 | 279 | (117) | (459) |
| | Transfer to trust/special funds | (227) | (654) | 0 | 0 |
| | **Balance at end of year** | (481,629) | (481,544) | (482,134) | (482,017) |
| c | *Other Reserves* | | | | |
| | ***Revaluation Reserve*** | | | | |
| | Opening balances | 353,538 | 381,277 | 353,538 | 381,277 |
| | Net Movement | (21,557) | (27,739) | (21,557) | (27,739) |
| | **Balance at end of year** | 331,981 | 353,538 | 331,981 | 353,538 |
| d | *Trust/special funds* | | | | |
| | Opening balances | 13,175 | 12,521 | 0 | 0 |
| | Transfer from accumulated deficits (Note 6b) | 227 | 654 | 0 | 0 |
| | **Balance at end of year** | 13,402 | 13,175 | 0 | 0 |

**Other reserves**

**Revaluation reserve**

The revaluation reserve relates to the independent valuation by Telfer Young (Auckland) Ltd of land and buildings at 30 June 2011 of $733.4m (2010 $766.8m) - see note 11.

**Trust / special funds**

Trust/special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the Trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from retained earnings to trust funds.

All trust funds are held in bank accounts that are separate from ADHB's normal banking facilities.

| **Trust/special funds** | **2011 Actual $000** | **2010 Actual $000** |
|---|---|---|
| **Balance at beginning of year** | 13,175 | 12,521 |
| Transfer from retained earnings in respect of: | | |
| Interest received | 1,135 | 1,258 |
| Donations and funds received | 7,458 | 6,457 |
| Transfer to retained earnings in respect of: | | |
| Funds spent | (8,366) | (7,061) |
| **Balance at end of year** | 13,402 | 13,175 |

| | | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|
| | | As at 30/06/11 | As at 30/06/10 | As at 30/06/11 | As at 30/06/10 |
| 7 | **CASH AND CASH EQUIVALENTS** | **$000** | **$000** | **$000** | **$000** |
| | ***Current assets*** | | | | |
| | Bank balance | 7,080 | 298 | 7,080 | 298 |
| | Short term deposits | 101,045 | 70,567 | 101,045 | 70,567 |
| | Cash & cash equivalents | 108,125 | 70,865 | 108,125 | 70,865 |
| | Bank overdrafts | (24,800) | (14,050) | (24,800) | (14,050) |
| | Cash & cash equivalents in the statement of cash flows | 83,325 | 56,815 | 83,325 | 56,815 |
| | ***Banking facility limit*** | | | | |
| | Revolving cash facility: | | | | |
| | CBA | 65,000 | 65,000 | 65,000 | 65,000 |

**Working capital facility**
ADHB has a working capital facility supplied by Commonwealth Bank of Australia, New Zealand (CBA), which was established in February 2004. The facility consists of a bank overdraft and revolving bank multi-option credit facility. The facility was used at 30 June 2011. Unused portion of the facility at 30 June 2011 was $40.2m (2010 $50.95m).

The CBA working capital facility is secured by a negative pledge. ADHB cannot perform the following actions:

- create any security over its assets except in certain circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health, and
- dispose of any of its assets except disposals at full value in the ordinary course of business.

ADHB must also meet a cash flow cover covenant, under which the Net Cash Flow excluding any Required Equity must be greater than zero. At all times since the facility was established the covenant has been met. The CBA facility has a limit of $65m.

**RECONCILIATION OF REPORTED OPERATING SURPLUS/(DEFICIT) AFTER TAXATION WITH NET CASH INFLOW (OUTFLOW) FROM OPERATING ACTIVITIES**

| | Notes | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|
| | | 2011 | 2010 | 2011 | 2010 |
| | | $000 | $000 | $000 | $000 |
| **Reported net surplus/(deficit) for the year** | 6 | 142 | 279 | (117) | (459) |
| Add non-cash items: | | | | | |
| Depreciation and impairment loss | | 51,147 | 48,338 | 51,147 | 48,338 |
| Joint venture & associates | 5 | (32) | (84) | 0 | 0 |
| (Increase)/Decrease in derivative financial instruments | | 1,392 | (106) | 1,392 | (106) |
| Add items classified as investing activities: | | | | | |
| Net loss/(gain) on disposal of fixed assets | | (50) | (77) | (50) | (77) |
| Add movements in working capital items: | | | | | |
| (Increase)/Decrease in receivables | | 948 | 2,639 | 456 | 4,572 |
| (Increase)/Decrease in inventories | | (801) | 497 | (801) | 497 |
| Increase/(Decrease) in payables | | 22,556 | 13,479 | 22,068 | 10,185 |
| Increase/(Decrease) in funds held in trust | | 26 | 29 | 26 | 29 |
| **Net cash inflow/(outflow) from operating activities** | | 75,328 | 64,994 | 74,121 | 62,979 |

| | | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|
| | | As at 30/06/11 | As at 30/06/10 | As at 30/06/11 | As at 30/06/10 |
| 8a | **TRUST/SPECIAL FUNDS** | | | | |
| | ***Current assets*** | | | | |
| | Bank balances (restricted) | 94 | 16 | 0 | 0 |
| | Short term deposits (restricted) | 17,973 | 10,664 | 0 | 0 |
| | | 18,067 | 10,680 | 0 | 0 |
| | ***Non – current assets*** | | | | |
| | Long term deposits (restricted) | 1,800 | 8,000 | 0 | 0 |
| | Investment Bonds (at market)/(restricted) | 2,098 | 2,078 | 0 | 0 |
| | | 3,898 | 10,078 | 0 | 0 |

The above assets are trust funds and are held by the ADHB Charitable Trust, comprising donated and research funds.

| | | | | | |
|---|---|---|---|---|---|
| 8b | **PATIENT AND RESTRICTED TRUST FUNDS** | | | | |
| | ***Current assets*** | | | | |
| | Patient trust | 11 | 15 | 11 | 15 |
| | Restricted fund deposit | 1,082 | 1,052 | 1,082 | 1,052 |
| | | 1,093 | 1,067 | 1,093 | 1,067 |
| | ***Current liabilities*** | | | | |
| | Patient trust | 11 | 15 | 11 | 15 |
| | Restricted fund deposit | 1,082 | 1,052 | 1,082 | 1,052 |
| | | 1,093 | 1,067 | 1,093 | 1,067 |

**Patient trust**

ADHB administers certain funds on behalf of patients. These funds are held in separate bank accounts and interest earned is allocated to the individual patients.

**Restricted fund deposit**

This interest earning fund was from sale proceeds on an endowment property, to be used in conjunction with ADHB Treaty partner, Ngati Whatua.

| | | | | | |
|---|---|---|---|---|---|
| 9 | **TRADE AND OTHER RECEIVABLES** | | | | |
| | Ministry of Health receivables | 28,346 | 32,254 | 28,346 | 32,254 |
| | Other receivables | 17,396 | 12,783 | 16,992 | 12,055 |
| | Provision for doubtful debts | (3,334) | (2,004) | (3,334) | (2,004) |
| | Other Accrued income | 16,823 | 16,752 | 15,161 | 14,886 |
| | | 59,231 | 59,785 | 57,165 | 57,191 |

| | Group Actual | | Parent Actual | |
|---|---|---|---|---|
| | As at 30/06/11 | As at 30/06/10 | As at 30/06/11 | As at 30/06/10 |
| **10 INVENTORIES** | | | | |
| Pharmaceuticals | 849 | 769 | 849 | 769 |
| Surgical and medical supplies | 11,143 | 10,410 | 11,143 | 10,410 |
| Other supplies | 29 | 41 | 29 | 41 |
| | 12,021 | 11,220 | 12,021 | 11,220 |

The amount of inventories recognised as an expense during the year ended 30 June 2011 was $76,688k (2010 $74,317k).

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2011 was $12,021k (2010 $11,220k). Write-down/ (up) of inventories amounted to $86k for 2011 (2010 $14k).

## 11a PROPERTY, PLANT and EQUIPMENT

| GROUP & PARENT | Freehold land (at valuation) | Freehold buildings & fitouts (at valuation) | Plant, equipment and vehicles | Leased Improve-ments | Work in progress | Total |
|---|---|---|---|---|---|---|
| | $000 | $000 | $000 | $000 | $000 | $000 |
| **Cost** | | | | | | |
| Balance at 1 July 2009 | 201,337 | 605,181 | 257,973 | 4,480 | 8,284 | 1,077,255 |
| Additions | 0 | 76 | 0 | 2 | 42,421 | 42,499 |
| Additions from Work in Progress | 0 | 7,056 | 20,472 | 0 | (27,528) | 0 |
| Disposals | 0 | 0 | (7,821) | 0 | 0 | (7,821) |
| Revaluations increase/(decrease) | (19,841) | (26,981) | 0 | 0 | 0 | (46,822) |
| **Balance at 30 June 2010** | **181,496** | **585,332** | **270,624** | **4,482** | **23,177** | **1,065,111** |
| **Cost** | | | | | | |
| Balance at 1 July 2010 | 181,496 | 585,332 | 270,624 | 4,482 | 23,177 | 1,065,111 |
| Additions | 0 | 0 | 0 | 0 | 46,291 | 46,291 |
| Additions from Work in Progress | 0 | 12,402 | 39,367 | 0 | (51,769) | 0 |
| Disposals | 0 | 0 | (7,216) | 0 | 0 | (7,216) |
| Transfer to Non-current assets held for sale | 0 | 0 | (34,390) | 0 | 0 | (34,390) |
| Reclassifications | 1 | 19 | (8,157) | (3,592) | 0 | (11,729) |
| Revaluations | (17,943) | (24,960) | 0 | 0 | 0 | (42,903) |
| **Balance at 30 June 2011** | **163,554** | **572,793** | **260,228** | **890** | **17,699** | **1,015,164** |
| **Depreciation and impairment losses** | | | | | | |
| Balance at 1 July 2009 | 0 | 0 | (184,763) | (3,691) | 0 | (188,454) |
| Depreciation charge for the year | 0 | (19,083) | (23,983) | (27) | 0 | (43,093) |
| Disposals | 0 | 0 | 7,821 | 0 | 0 | 7,821 |
| Revaluations | 0 | 19,083 | 0 | 0 | 0 | 19,083 |
| **Balance at 30 June 2010** | **0** | **0** | **(200,925)** | **(3,718)** | **0** | **(204,643)** |
| **Depreciation and impairment losses** | | | | | | |
| Balance at 1 July 2010 | 0 | 0 | (200,925) | (3,718) | 0 | (204,643) |
| Depreciation charge for the year | 0 | (21,516) | (25,731) | (41) | 0 | (47,288) |
| Disposals | 0 | 0 | 7,244 | 307 | 0 | 7,551 |
| Transfer to Non-current assets held for sale | 0 | 0 | 25,240 | 0 | 0 | 25,240 |
| Reclassifications | 0 | 113 | 8,858 | 2,758 | 0 | 11,729 |
| Revaluations | 0 | 21,346 | 0 | 0 | 0 | 21,346 |
| **Balance at 30 June 2011** | **0** | **(57)** | **(185,314)** | **(694)** | **0** | **(186,065)** |

11a PROPERTY, PLANT and EQUIPMENT (continued)

| GROUP & PARENT | Freehold land (at valuation) | Freehold buildings & fitouts (at valuation) | Plant, equipment and vehicles | Leased improve-ments | Work in progress | Total |
|---|---|---|---|---|---|---|
| | $000 | $000 | $000 | $000 | $000 | $000 |
| **Carrying Amounts** | | | | | | |
| At 1 July 2009 | 201,337 | 605,181 | 73,210 | 789 | 8,284 | 888,801 |
| At 30 June 2010 | 181,496 | 585,332 | 69,699 | 764 | 23,177 | 860,468 |
| **Carrying Amounts** | | | | | | |
| At 1 July 2010 | 181,496 | 585,332 | 69,699 | 764 | 23,177 | 860,468 |
| At 30 June 2011 | 163,554 | 572,736 | 74,914 | 196 | 17,699 | 829,099 |

**Valuation Information**

Land, buildings and associated fitouts and services were independently valued on 30 June 2011 by Telfer Young (Auckland) Ltd (a firm registered with Valuers of New Zealand), at $733.4m (2010 $766.8m).

The reduction in value of land of $17.9m was caused by difficult market conditions for development land during the period. The main driver for the reduction in value of buildings of $12.6m was caused by deferred maintenance and renewal costs.

PROPERTY, PLANT and EQUIPMENT (continued)

GROUP & PARENT

| | | Note | |
|---|---|---|---|
| 11b | **INTANGIBLE ASSETS** | | **Total** |
| | **Software & development costs** | | **$000** |
| | **Cost** | | |
| | Balance at 1 July 2009 | | 59,716 |
| | Additions | | 2,625 |
| | Disposals | | (69) |
| | **Balance at 30 June 2010** | | **62,272** |
| | Balance at 1 July 2010 | | 62,272 |
| | Additions | | 5,778 |
| | Disposals | | 0 |
| | Transfer to Non-current assets held for sale | | (66,742) |
| | Reclassifications | | 669 |
| | **Balance at 30 June 2011** | | **1,977** |
| | **Amortisation & Impairment Losses** | | |
| | Balance at 1 July 2009 | | (46,950) |
| | Amortisation charge for the year | | (5,372) |
| | Impairment losses | | 0 |
| | Reversal of impairment losses | | 126 |
| | Disposals | | 69 |
| | **Balance at 30 June 2010** | | **(52,127)** |
| | **Amortisation & Impairment Losses** | | |
| | Balance at 1 July 2010 | | (52,127) |
| | Amortisation charge for the year | | (3,858) |
| | Disposals | | (639) |
| | Transfer to Non-current assets held for sale | | 55,851 |
| | Reclassifications | | (669) |
| | **Balance at 30 June 2011** | | **(1,442)** |
| | **Carrying Amounts** | | |
| | At 1 July 2009 | | 12,766 |
| | At 30 June 2010 | | **10,145** |
| | At 1 July 2010 | | 10,145 |
| | At 30 June 2011 | | **535** |

PROPERTY, PLANT and EQUIPMENT (continued)

## 11b INTANGIBLE ASSETS (continued)

**Impairment Loss**

The carrying amounts of all property, plant and equipment are reviewed on an ongoing basis. Any impairment in value is recognised immediately. A review of computer software resulted in a nil impairment movement (2010 $126k reversal of impairment losses).

## 11c NON-CURRENT ASSETS HELD FOR SALE

The DHB owns assets which have been classified as held for sale following the establishment of HealthAlliance NZ Limited to provide a shared services agency for information technology, procurement and financial processing services. Also refer to Note 21- Events subsequent to balance date.

| | Actual 2011 $000 | Actual 2010 $000 |
|---|---|---|
| Equipment & vehicles | 9,150 | 0 |
| IT Software | 10,891 | 0 |
| | **20,041** | **0** |

## 12a CONTINGENT ASSETS

ADHB has commenced civil proceedings against an Auckland GP alleging fraudulent over claiming of capitation payment of approximately $1.4m. These civil proceedings were deferred to allow the hearing of the related criminal proceedings. The criminal proceedings concluded in early August 2010 when the GP changed his plea to guilty. Under NZ IAS 37 paragraph 31-35, there is a requirement for virtual certainty of the economic inflow for an asset to be recognised. As there has been no judicial consideration of either the quantum or the legal substance of ADHB's claims – the criminal proceedings related to only a subset of the assessed over claiming, and the GP is challenging ADHB's calculations. Also the financial ability of the GP to meet a repayment of this substance is unclear - thus virtual certainty has not yet been achieved in this case.

## 12b CONTINGENT LIABILITIES

There are no contingent liabilities at 30 June 2011 (2010 Nil).

| | Notes | Group Actual As at 30/06/11 $000 | Group Actual As at 30/06/10 $000 | Parent Actual As at 30/06/11 $000 | Parent Actual As at 30/06/10 $000 |
|---|---|---|---|---|---|
| **13a TRADE AND OTHER PAYABLES** | | | | | |
| ***Current*** | | | | | |
| Creditors and accrued expenses | | 96,612 | 92,757 | 94,086 | 90,062 |
| GST,PAYE & FBT payable | | 20,930 | 18,040 | 21,008 | 18,136 |
| Capital Charge payable | | 7,671 | 3,115 | 7,671 | 3,115 |
| Income in advance | | 23,445 | 20,716 | 15,268 | 13,142 |
| | | 148,658 | 134,628 | 138,033 | 124,455 |
| **13b EMPLOYEE BENEFITS** | | | | | |
| ***Current*** | | | | | |
| Liability for long service leave | | 2,019 | 2,510 | 2,019 | 2,510 |
| Liability for sabbatical leave | | 300 | 300 | 300 | 300 |
| Liability for retirement gratuities | | 4,904 | 4,350 | 4,904 | 4,350 |
| Liability for annual leave | | 75,781 | 70,582 | 75,781 | 70,582 |
| Liability for sick leave | | 531 | 520 | 531 | 520 |
| Liability for continuing medical leave and expenses | | 23,347 | 21,040 | 23,347 | 21,040 |
| Salaries and wage accrual | | 29,438 | 25,895 | 29,438 | 25,895 |
| | | 136,320 | 125,197 | 136,320 | 125,197 |
| ***Non Current*** | | | | | |
| Liability for long service leave | | 941 | 642 | 941 | 642 |
| Liability for retirement gratuities | | 20,806 | 21,792 | 20,806 | 21,792 |
| | | 21,747 | 22,434 | 21,747 | 22,434 |
| **13c PROVISIONS** | | | | | |
| ***Current*** | | | | | |
| ACC Partnership Programme | | 1,825 | 1,769 | 1,825 | 1,769 |
| Restructuring | | 246 | 74 | 246 | 74 |
| | | 2,071 | 1,843 | 2,071 | 1,843 |
| ***Movement for each class of provisions are as follows:*** | | | | | |
| ***ACC Partnership Programme*** | | | | | |
| Opening balance | | 1,769 | 1,506 | 1,769 | 1,506 |
| Additional provisions made during year | | 950 | 769 | 950 | 769 |
| Charged against provision for the year | | (894) | (506) | (894) | (506) |
| Unused amounts reversed during year | | 0 | 0 | 0 | 0 |
| Closing balance | (i) | 1,825 | 1,769 | 1,825 | 1,769 |
| ***Restructuring Provision*** | | | | | |
| Opening balance | | 74 | 0 | 74 | 0 |
| Additional provisions made during year | | 246 | 74 | 246 | 74 |
| Charged against provision for the year | | (74) | 0 | (74) | 0 |
| Unused amounts reversed during year | | 0 | 0 | 0 | 0 |
| Closing balance | (ii) | 246 | 74 | 246 | 74 |

## 13c PROVISIONS (continued)

**Notes**

### (i) *ACC Partnership Programme*

*Liability valuation*

An external independent actuarial valuer, MA Lardies, has calculated the liability as at 30 June 2011. The Actuary has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the Actuary's report.

*Risk margin*
A risk margin of 11% (2010 11%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

The risk margin has been determined after consideration of past claims history, costs, and trends.

The risk margin is intended to achieve a 75% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

Key assumptions

The key assumptions used in determining the outstanding claims liability are:

- an average assumed rate of inflation of 4% for 30 June 2012 and 2013;

- a weighted average discount factor of 3.8% for 30 June 2012 and 30 June 2013 that has been applied to future payment streams; and

- claim inception rates based on analysis of historical claim experience of the DHB. It has been assumed that 80% will result in medical claims only, and 20% will result in an element of time off work.

- the expected future Average Claim Payment per accident is $4,600.

*Insurance risk*
The DHB operates the Full Self Cover Plan. Under this plan, it assumes full financial and injury management responsibility for work-related injuries and illnesses for a selected management period and continuing financial liability for the life of the claim to a pre-selected limit.

The DHB is responsible for managing claims for a period of up to 48 months following the end of the 12 months period of cover in which the claim has occurred. At that time the the end of 48 months, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis.

A stop loss limit of 137% of the DHB Standard Levy is used. The stop loss limit means the DHB will carry the total cost of all claims only up to a total of $5,830,334 incurred in the cover period from 1 April 2010 to 31 March 2011 (2010/2011 ACC Claim Year).

### (ii) Restructuring

The provision relates to redundancies arising from a Mental Health and Addictions Healthcare Service Group change proposal at 30 June 2011.

**13d Defined Contribution Plan (DCP)**

The DCP (with National Provident Fund) is a multi-employer defined benefit scheme. At 30 June 2011 ADHB contributions to the fund were fully paid - see Note 3a for details.

The DCP is a multi-employer defined benefit scheme. Insufficient information is available to use defined benefit accounting as it is not possible to determine, from the terms of the scheme, the extent to which any surplus or deficit will affect future contributions by employers, as there is no prescribed basis for allocation. If any of the other participating employers ceased to participate in the scheme, ADHB could be responsible for financing a share of any shortfall in the fund in meeting its obligations.

As at 31 March 2010, the scheme had a past service surplus of $43.601m (18.2% of the liabilities). This amount is exclusive of Specified Superannuation Contribution Withholding Tax (SSCWT). This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of NZ IAS 19.

The Actuary to the scheme has recommended the employer contributions are suspended with effect from 1 April 2011

| | Group Actual | | Parent Actual | |
|---|---|---|---|---|
| | As at 30/06/11 $000 | As at 30/06/10 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 |
| **14 INTEREST-BEARING LOANS AND BORROWINGS** | | | | |
| ***Current*** | | | | |
| **Secured loans** | | | | |
| Crown Health Financing Agency | 20,000 | 0 | 20,000 | 0 |
| 10 year Capital Bonds, maturing 15 September 2010 | 0 | 70,000 | 0 | 70,000 |
| Interest on Borrowings | 3,345 | 4,741 | 3,345 | 4,741 |
| Unexpired set up cost on borrowings | (96) | (89) | (96) | (89) |
| | 23,249 | 74,652 | 23,249 | 74,652 |
| ***Non-current*** | | | | |
| **Secured loans** | | | | |
| Crown Health Financing Agency | 213,500 | 163,500 | 213,500 | 163,500 |
| 15 year Capital Bonds, maturing 15 September 2015 | 50,000 | 50,000 | 50,000 | 50,000 |
| Unexpired set up cost on borrowings | (390) | (486) | (390) | (486) |
| | 263,110 | 213,014 | 263,110 | 213,014 |

## 14 INTEREST-BEARING LOANS AND BORROWINGS (continued)

| | Note | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|
| | | As at 30/06/11 $000 | As at 30/06/10 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 |
| **Secured loans** | | | | | |
| The details of terms and conditions are as follows: | | | | | |
| Borrowings are repayable: | | | | | |
| Less than one year | | 23,249 | 74,652 | 23,249 | 74,652 |
| One to two years | | 63,397 | 19,904 | 63,397 | 19,904 |
| Two to five years | | 129,713 | 143,110 | 129,713 | 143,110 |
| Over five years | | 70,000 | 50,000 | 70,000 | 50,000 |
| | | 286,359 | 287,666 | 286,359 | 287,666 |

The Crown Health Financing Agency has undertaken to provide funding when the bonds mature. They will also refinance their advances when they are due. ADHB has undertaken to endeavour to repay $10.5m of advances per annum.

| ***Interest rate summary*** | % pa | % pa | % pa | % pa |
|---|---|---|---|---|
| Crown Health Financing Agency | 4.26-6.90 | 4.26-6.90 | 4.26-6.90 | 4.26-6.90 |
| Capital Bonds | 7.75 | 7.75 | 7.75 | 7.75 |
| ***Borrowing facilities*** | | | | |
| Crown Health Financing Agency | 254,500 | 184,500 | 254,500 | 184,500 |
| Capital Bonds | 50,000 | 120,000 | 50,000 | 120,000 |
| Working capital CBA | 65,000 | 65,000 | 65,000 | 65,000 |

**Crown Health Financing Agency**

The loan facility is provided by the Crown Health Financing Agency, which is part of the Ministry of Health.

**Capital bonds**

In September 2000, ADHB issued $120m of "credit-wrapped" bonds to the private sector. The subscribers to this issue were institutional investors. The bonds were issued with a coupon rate of 7.75%.

**Working capital facility**

ADHB has a working capital facility supplied by Commonwealth Bank of Australia, New Zealand (CBA), which was established in February 2004. The facility consists of a bank overdraft and revolving bank multi-option credit facility. Unused portion of the facility at 30 June 2011 was $40.2m (2010 $50.95m).

## 14 INTEREST-BEARING LOANS AND BORROWINGS (continued)

**Security and terms**

ADHB borrows funds based on covenants in a Negative Pledge Deed. This includes the covenant that security cannot be given over assets of ADHB without prior written consent of the Crown. Financial assets are part of Total Tangible Assets defined in the Negative Pledge Deed that secures funding from the three borrowing facilities.

ADHB cannot perform the following actions:

- create any security over its assets except in certain circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms), or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- dispose of any of its assets except disposals at full value in the ordinary course of business.

ADHB must also meet the following covenants:

- debt to debt plus equity: interest bearing debt is less than 65 per cent of the total of interest bearing debt plus equity.
- a cash flow cover covenant, under which the accumulated annual cash flow must be greater than zero.

The covenants have been complied with at all times since the facility was established. The Government of New Zealand does not guarantee any borrowings.

| | Group Actual | | Parent Actual | |
|---|---|---|---|---|
| | As at 30/06/11 $000 | As at 30/06/10 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 |
| **15 CAPITAL CHARGE** | 34,491 | 35,921 | 34,491 | 35,921 |

All DHBs are required to pay a capital charge to the Crown based on their shareholder funds. The charge is set at 8 percent for fiscal year 2011 (8 percent for fiscal year 2010) on shareholder funds based on the monthly closing balance. ADHB has not paid a capital charge on donations received into the ADHB Charitable Trust.

## 16 COMMITMENTS

| GROUP AND PARENT | Notes | As at 30/06/11 $000 | As at 30/06/10 $000 |
|---|---|---|---|
| **a** ***Capital commitments*** | | | |
| Approved and contracted | | 6,827 | 9,387 |
| Approved and to be contracted | | 36,577 | 19,900 |
| | | 43,404 | 29,287 |
| ***Term classification of commitments*** | | | |
| Less than one year | | 36,604 | 29,287 |
| One to two years | | 6,800 | 0 |
| Two to five years | | 0 | 0 |
| Over five years | | 0 | 0 |
| | | 43,404 | 29,287 |
| **b** ***Operating commitments*** | | | |
| Leases | (i) | 4,695 | 4,419 |
| Other | (ii) | 521,626 | 424,945 |
| | | 526,321 | 429,364 |

| | Leases | | Other | | Total | |
|---|---|---|---|---|---|---|
| GROUP AND PARENT | As at 30/06/11 $000 | As at 30/06/10 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 |
| ***Term classification of operating commitments*** | | | | | | |
| Less than one year | 2,251 | 2,166 | 122,660 | 101,849 | 124,911 | 104,015 |
| One to two years | 1,080 | 1,018 | 89,967 | 91,375 | 91,047 | 92,393 |
| Two to five years | 1,278 | 1,142 | 217,601 | 225,702 | 218,879 | 226,844 |
| Over five years | 86 | 93 | 91,398 | 6,019 | 91,484 | 6,112 |
| | 4,695 | 4,419 | 521,626 | 424,945 | 526,321 | 429,364 |

**Notes**

16b(i) Operating leases relate to property rentals, computer equipment and motor vehicles.

16b(ii) The other operating commitments comprised:

- $522m (2010 $419m) expected payment schedules for contracts entered in the Ministry of Health's Computerised Management System (CMS).
- $9m (2010 $6m) outstanding operating purchase order commitments.

## 17 TRANSACTIONS WITH RELATED PARTIES

### a Subsidiary

ADHB has 100% beneficial interest in Auckland District Health Board Charitable Trust. The ADHB Charitable Trust has a balance date of 30 June and was incorporated under the Charitable Trusts Act 1957. Details of transactions with the ADHB Charitable Trust are disclosed in note 6 under Trust/special funds.

| PARENT | 2011 Actual $000 | 2011 Actual $000 |
|---|---|---|
| Sales to ADHB Charitable Trust | 7,808 | 6,737 |
| Purchases from ADHB Charitable Trust | 89 | 125 |
| Outstanding balance receivable from ADHB Charitable Trust | 965 | 935 |
| Outstanding balance payable to ADHB Charitable Trust | 0 | 99 |

### b Joint venture & associates

ADHB has a related party relationship with its joint venture & associates and with its executive officers. Joint venture and associates identified in note 5 are related parties. The transactions with related parties during the year were as follows:

| | Notes | Group Actual | | Parent Actual | |
|---|---|---|---|---|---|
| | | As at 30/06/11 $000 | As at 30/06/10 $000 | As at 30/06/11 $000 | As at 30/06/10 $000 |
| **GROUP AND PARENT** | | | | | |
| **Sales to joint venture & associates** | | | | | |
| Auckland Regional RMO Services Limited (associate) | | 241 | 241 | 241 | 241 |
| Northern DHB Support Agency Limited (associate) | | 585 | 1,154 | 585 | 1,154 |
| | | 826 | 1,395 | 826 | 1,395 |
| **Purchases from joint venture & associates** | | | | | |
| **Auckland Regional RMO Services Limited (associate)** | | 4,414 | 4,258 | 4,414 | 4,258 |
| Northern DHB Support Agency Limited (associate) | | 3,264 | 3,900 | 3,264 | 3,900 |
| | | 7,678 | 8,158 | 7,678 | 8,158 |
| **Outstanding balances receivable from joint venture & associates** | | | | | |
| Auckland Regional RMO Services Limited (associate) | | 10 | 0 | 10 | 0 |
| Northern DHB Support Agency Limited (associate) | | 69 | 104 | 69 | 104 |
| | 9 | 79 | 104 | 79 | 104 |
| **Outstanding balances payable to joint venture & associates** | | | | | |
| Auckland Regional RMO Services Limited (associate) | | 377 | 0 | 377 | 0 |
| Northern DHB Support Agency Limited (associate) | | 253 | 187 | 253 | 187 |
| | 13a | 630 | 187 | 630 | 187 |

These transactions were made on commercial terms and conditions, and at market rates. No related party debts have been written off or forgiven during the year. No trading transactions were made with Treaty Relationship Company Ltd during 2011 and 2010.

17 TRANSACTIONS WITH RELATED PARTIES (continued)

c Compensations

The key management personnel compensations are as follows:

| GROUP & PARENT | Notes | 2011 Actual $000 | 2010 Actual $000 |
|---|---|---|---|
| Short - term employment benefits | (i) | 4,182 | 5,271 |
| Long - term employment benefits | (ii) | 18 | 30 |
| | | 4,200 | 5,301 |
| Fees paid to Board Members | (iii) | 417 | 440 |
| Fees paid to Committee Members | (iv) | 28 | 33 |
| | | 445 | 473 |

**Notes**

17 c (i) &(ii) Refer to Chief Executive and Executive Management (Page 3)

17 c (iii) &(iv) Refer to Statutory Information (Page 21) for data by members.

## 17 TRANSACTIONS WITH RELATED PARTIES (continued)

### d Transactions with related parties involving mainly key personnel

ADHB enters into transactions with government departments, state owned enterprises, crown entities and other third parties. Those transactions are entered under normal commercial terms. No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2010$ nil)

| Related party | Board members/ senior management and nature of their interest in the related party | | Transaction value between ADHB and related party | | Balance outstanding between ADHB and related party | |
|---|---|---|---|---|---|---|
| | | | 30/06/11 | 30/06/10 | 30/06/11 | 30/06/10 |
| | | | $000 | $000 | $000 | $000 |
| Auckland PHO Limited | Dr Ian Scott - Chair | Payments | 9,709 | 8,293 | 344 | 225 |
| | | Receipts | 0 | 0 | 0 | 0 |
| Epsom Anaesthetic Group | Dr Chris Chambers - Associate | Payments | 158 | 48 | 19 | 2 |
| | | Receipts | 0 | 0 | 0 | 0 |
| Healthvision Ltd | Ian Ward - Chair (till May11) | Payments | 3 | 10 | 0 | 0 |
| | | Receipts | 0 | 0 | 0 | 0 |
| Health Benefits Limited | Dr Lester Levy - Deputy Chair | Payments | 0 | 0 | 0 | 0 |
| | | Receipts | 270 | 736 | 1 | 619 |
| Housing NZ Limited | Pat Snedden * - Chair | Payments | 3 | 0 | 0 | 0 |
| | | Receipts | 42 | 104 | 0 | 0 |
| National Health Board | Robin Cooper - Member | Payments | 0 | 0 | 0 | 0 |
| | | Receipts | 0 | 0 | 0 | 0 |
| Ngati Whatua o Orakei Health Clinic Ltd | Harry Burkhardt *- Chair | Payments | 2 | 6 | 2 | 1 |
| | | Receipts | 0 | 0 | 0 | 0 |
| NZ Leadership Institute | Dr Lester Levy - Chief Executive | Payments | 7 | 0 | 0 | 0 |
| | | Receipts | 0 | 0 | 0 | 0 |
| Te Runanga o Ngati Whatua | Naida Glavish - Chair | Payments | 100 | 0 | 115 | 0 |
| | | Receipts | 19 | 3 | 0 | 0 |
| Waitemata District Health Board | Dr Lester Levy - Chair; Robin Cooper - Member; Gwen Tepania-Palmer - Member | Payments | 3,143 | 3,027 | 241 | 661 |
| | | Receipts | 7,078 | 5,260 | 2,416 | 1,272 |
| Watercare Services Limited | Pat Snedden * - Director | Payments | 899 | 19 | 2 | 1 |
| | | Receipts | 0 | 0 | 0 | 0 |

* Previous board members

## 18 FINANCIAL INSTRUMENTS

### Credit Risk

Financial instruments and derivatives, which potentially subject ADHB to concentrations of risk, consist principally of cash, short-term deposits, interest rate swaps and accounts receivable.

The Board places its cash and short-term deposits with high-quality financial institutions and has a policy that limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (2011-42%, 2010-51%). It is assessed to be a low risk and high-quality entity due to its nature as the Government funded purchaser of health and disability support services.

The status of trade receivables at the reporting date is as follows:

**GROUP**

| Trade receivables | Gross Receivable 2011 $000 | Impairment 2011 $000 | Gross Receivable 2010 $000 | Impairment 2010 $000 |
|---|---|---|---|---|
| Not past due | 20,968 | (38) | 18,317 | (38) |
| Past due 0-30 days | 3,656 | (573) | 3,913 | (357) |
| Past due 31-90 days | 2,098 | (717) | 2,752 | (666) |
| Past due 91-360 days | 2,765 | (1,691) | 969 | (642) |
| Past due more than 1 year | 315 | (315) | 301 | (301) |
| **Total** | 29,802 | (3,334) | 26,252 | (2,004) |

**PARENT**

| Trade receivables | Gross Receivable 2011 $000 | Impairment 2011 $000 | Gross Receivable 2010 $000 | Impairment 2010 $000 |
|---|---|---|---|---|
| Not past due | 20,726 | (38) | 17,700 | (38) |
| Past due 0-30 days | 3,525 | (573) | 3,876 | (357) |
| Past due 31-90 days | 2,067 | (717) | 2,704 | (666) |
| Past due 91-360 days | 2,765 | (1,691) | 943 | (642) |
| Past due more than 1 year | 315 | (315) | 301 | (301) |
| **Total** | 29,398 | (3,334) | 25,524 | (2,004) |

**In summary, trade receivables are determined to be impaired as follows:**

| Trade receivables | GROUP 2011 Actual $000 | GROUP 2010 Actual $000 | PARENT 2011 Actual $000 | PARENT 2010 Actual $000 |
|---|---|---|---|---|
| Gross trade receivables | 29,802 | 26,252 | 29,398 | 25,524 |
| Individual impairment | (3,334) | (2,004) | (3,334) | (2,004) |
| Net total trade receivables | 26,468 | 24,248 | 26,064 | 23,520 |

| Movement in the provision for impairment loss | GROUP 2011 Actual $000 | GROUP 2010 Actual $000 | PARENT 2011 Actual $000 | PARENT 2010 Actual $000 |
|---|---|---|---|---|
| Opening balance | 2,004 | 2,064 | 2,004 | 2,064 |
| Increase/(decrease) in doubtful debts | 1,330 | (60) | 1,330 | (60) |
| Closing balance | 3,334 | 2,004 | 3,334 | 2,004 |

At the balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the Statement of Financial Position.

18 **FINANCIAL INSTRUMENTS (continued)**

**Liquidity**

Liquidity risk represents ADHB's ability to meet its contractual obligations. ADHB evaluates its liquidity requirements on an ongoing basis. In general, ADHB generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities and has credit lines in place to cover potential shortfalls.

**Liquidity risk**

The following table sets out the contractual cash flows for all financial liabilities. Future interest payments on floating rate debt are based on the floating rate of the instrument at balance date, The amounts disclosed are the contractual undiscounted cash flows.

**GROUP**

| 2011 | Interest Rate Type | Balance Sheet $000 | Contractual Cash Flow $000 | 6 Months or less $000 | 6-12 Months $000 | 1-2 Years $000 | 2-5 Years $000 | More than 5 years $000 |
|---|---|---|---|---|---|---|---|---|
| Interest-bearing loans and borrowings | Fixed | 286,359 | 371,388 | 28,886 | 8,123 | 79,681 | 159,673 | 95,025 |
| Trade and other payables | Nil | 148,658 | 148,658 | 148,658 | 0 | 0 | 0 | 0 |
| Bank overdraft | Fixed | 24,800 | 24,800 | 24,800 | 0 | 0 | 0 | 0 |
| Derivative financial instruments –interest rate swaps in loss | Fixed/Floating | 277 | 283 | 105 | 95 | 83 | 0 | 0 |
| **Total** | | 460,094 | 545,129 | 202,449 | 8,218 | 79,764 | 159,673 | 95,025 |

| 2010 | | Balance Sheet $000 | Contractual Cash Flow $000 | 6 Months or less $000 | 6-12 Months $000 | 1-2 Years $000 | 2-5 Years $000 | More than 5 years $000 |
|---|---|---|---|---|---|---|---|---|
| Interest-bearing loans and borrowings | Fixed | 287,666 | 344,864 | 79,700 | 6,990 | 33,363 | 172,873 | 51,938 |
| Trade and other payables | Nil | 134,628 | 134,628 | 134,628 | 0 | 0 | 0 | 0 |
| Bank overdraft | Fixed | 14,050 | 14,050 | 14,050 | 0 | 0 | 0 | 0 |
| Derivative financial instruments –interest rate swaps in loss | Fixed/Floating | 311 | 328 | 48 | 112 | 114 | 54 | 0 |
| **Total** | | 436,655 | 493,870 | 228,426 | 7,102 | 33,477 | 172,927 | 51,938 |

## 18 FINANCIAL INSTRUMENTS (continued)

### Liquidity risk (continued)

**PARENT**

| 2011 | Interest Rate Type | Balance Sheet | Contractual Cash Flow | 6 Months or less | 6-12 Months | 1-2 Years | 2-5 Years | More than 5 years |
|---|---|---|---|---|---|---|---|---|
| | | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| Interest-bearing loans and borrowings | Fixed | 286,359 | 371,388 | 28,886 | 8,123 | 79,681 | 159,673 | 95,025 |
| Trade and other payables | Nil | 138,033 | 138,033 | 138,033 | 0 | 0 | 0 | 0 |
| Bank overdraft | Fixed | 24,800 | 24,800 | 24,800 | 0 | 0 | 0 | 0 |
| Derivative financial instruments –interest rate swaps in loss | Fixed/Floating | 277 | 283 | 105 | 95 | 83 | 0 | 0 |
| **Total** | | 449,469 | 534,504 | 191,824 | 8,218 | 79,764 | 159,673 | 95,025 |

| 2010 | Interest Rate Type | Balance Sheet | Contractual Cash Flow | 6 Months or less | 6-12 Months | 1-2 Years | 2-5 Years | More than 5 years |
|---|---|---|---|---|---|---|---|---|
| | | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| Interest-bearing loans and borrowings | Fixed | 287,666 | 344,864 | 79,700 | 6,990 | 33,363 | 172,873 | 51,938 |
| Trade and other payables | Nil | 124,455 | 124,455 | 124,455 | 0 | 0 | 0 | 0 |
| Bank overdraft | Fixed | 14,050 | 14,050 | 14,050 | 0 | 0 | 0 | 0 |
| Derivative financial instruments –interest rate swaps in loss | Fixed/Floating | 311 | 328 | 48 | 112 | 114 | 54 | 0 |
| **Total** | | 426,482 | 483,697 | 218,253 | 7,102 | 33,477 | 172,927 | 51,938 |

## 18 FINANCIAL INSTRUMENTS (continued)

### Interest rate risk and currency risk

Exposure to interest rate and currency risks arise in the normal course of ADHB's operations. Derivative financial instruments are used to manage exposure to fluctuations in foreign exchange rates and interest rates.

The Finance Committee, composed of Board members, provides oversight for risk management and derivative activities. This Committee determines the ADHB's financial risk policies and objectives, and provides guidelines for derivative instrument utilisation. This committee also establishes procedures for control and valuation, risk analysis, counterparty credit approval, and ongoing monitoring and reporting.

### Interest rate risk

Interest rate risk is the risk that the fair value of a financial instrument will fluctuate, or the cash flows from a financial instrument will fluctuate, due to changes in market interest rates.

ADHB adopts a policy of ensuring that between 40 and 60 per cent of its exposure to changes in interest rates on borrowings is on a fixed rate basis. Interest rate swaps, denominated in NZD, have been entered into to achieve an appropriate mix of fixed and floating rate exposure within ADHB's policy. The swaps mature over the next five years following the maturity of the related loans (see Interest Rate Repricing Schedules, pages 66 - 67) and have fixed swap rates ranging from 6.85 per cent to 7.75 per cent. At 30 June 2011 ADHB had interest rate swaps with a notional contract amount of $50m (2010 $115m).

The net fair value of swaps at 30 June 2011 was a net asset position of $5,668k (2010 $7,060k). These amounts were recognised as fair value derivatives.

### Foreign currency risk

Foreign exchange risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

ADHB's policy is to identify, define, recognise and record foreign exchange risks by their respective types and then to manage each risk under predetermined and separately defined risk control limits.

The Group had not entered into any foreign exchange contract at balance date (2010 Nil).

## 18 FINANCIAL INSTRUMENTS (continued)

### Classification and fair values

The classification and fair values together with the carrying amounts shown in the statement of financial position are as follows

| GROUP 2011 | Note | Held for Trading | Designated at Fair Value through Profit & Loss | Loans and Receivable | Available for Sale | Financial Liabilities at Amortised Cost | Carrying Amount Actual | Fair Value |
|---|---|---|---|---|---|---|---|---|
| | | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| Trade and other receivables | 9 | 0 | 0 | 59,231 | 0 | 0 | 59,231 | 59,231 |
| Cash and cash equivalents | 7 | 0 | 0 | 108,125 | 0 | 0 | 108,125 | 108,125 |
| Trust / Special Funds | 8a | 0 | 2,098 | 19,867 | 0 | 0 | 21,965 | 21,965 |
| Patient and restricted trust funds | 8b | 0 | 0 | 1,093 | 0 | 0 | 1,093 | 1,093 |
| Interest rate swaps: | | | | | | | | |
| Assets | 19 | 5,945 | 0 | 0 | 0 | 0 | 5,945 | 5,945 |
| Liabilities | 19 | (277) | 0 | 0 | 0 | 0 | (277) | (277) |
| Forward exchange contracts: | | | | | | | | |
| Assets | 19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Liabilities | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Secured bank loans | 14 | 0 | 0 | 0 | 0 | (286,359) | (286,359) | (300,639) |
| Trade and other payables | 13a | 0 | 0 | 0 | 0 | (148,658) | (148,658) | (148,658) |
| Bank overdraft | 7 | 0 | 0 | 0 | 0 | (24,800) | (24,800) | (24,800) |
| | | 5,668 | 2,098 | 188,316 | 0 | (459,817) | (263,735) | (278,015) |
| **Unrecognised (gains)/losses** | | | | | | | | 14,280 |

## 18 FINANCIAL INSTRUMENTS (continued)

### Classification and fair values (continued)

| GROUP 2010 | Note | Held for Trading | Designated at Fair Value through Profit & Loss | Loans and Receivable | Available for Sale | Financial Liabilities at Amortised Cost | Carrying Amount Actual | Fair Value |
|---|---|---|---|---|---|---|---|---|
| | | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| Trade and other receivables | 9 | 0 | 0 | 59,785 | 0 | 0 | 59,785 | 59,785 |
| Cash and cash equivalents | 7 | 0 | 0 | 70,865 | 0 | 0 | 70,865 | 70,865 |
| Trust / Special Funds | 8a | 0 | 2,078 | 18,680 | 0 | 0 | 20,758 | 20,758 |
| Patient and restricted trust funds | 8b | 0 | 0 | 1,067 | 0 | 0 | 1,067 | 1,067 |
| Interest rate swaps: | | | | | | | | |
| Assets | 19 | 7,371 | 0 | | 0 | 0 | 7,371 | 7,371 |
| Liabilities | 19 | (311) | 0 | | 0 | 0 | (311) | (311) |
| Forward exchange contracts: | | | | | | | | |
| Assets | 19 | 0 | 0 | | 0 | 0 | 0 | 0 |
| Liabilities | | 0 | 0 | | 0 | 0 | 0 | 0 |
| Secured bank loans | 14 | 0 | 0 | | 0 | (287,666) | (287,666) | (313,542) |
| Trade and other payables | 13a | 0 | 0 | | 0 | (134,628) | (134,628) | (134,628) |
| Bank overdraft | 7 | 0 | 0 | | 0 | (14,050) | (14,050) | (14,050) |
| | | 7,060 | 2,078 | 150,397 | 0 | (436,344) | (276,809) | (302,685) |
| **Unrecognised (gains)/losses** | | | | | | | | 25,876 |

## 18 FINANCIAL INSTRUMENTS (continued)

### Classification and fair values (continued)

| PARENT 2011 | Note | Held for Trading | Designated at Fair Value through Profit & Loss | Loans and Receivable | Available for Sale | Financial Liabilities at Amortised Cost | Carrying Amount Actual | Fair Value |
|---|---|---|---|---|---|---|---|---|
| | | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| Trade and other receivables | 9 | 0 | 0 | 57,165 | 0 | 0 | 57,165 | 57,165 |
| Cash and cash equivalents | 7 | 0 | 0 | 108,125 | 0 | 0 | 108,125 | 108,125 |
| Trust / Special Funds | 8a | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient and restricted trust funds | 8b | 0 | 0 | 1,093 | 0 | 0 | 1,093 | 1,093 |
| Interest rate swaps: | | | | | | | | |
| Assets | 19 | 5,945 | 0 | 0 | 0 | 0 | 5,945 | 5,945 |
| Liabilities | 19 | (277) | 0 | 0 | 0 | 0 | (277) | (277) |
| Forward exchange contracts: | | | | | | | | |
| Assets | 19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Liabilities | 19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Secured bank loans | 14 | 0 | 0 | 0 | 0 | (286,359) | (286,359) | (300,639) |
| Trade and other payables | 13a | 0 | 0 | 0 | 0 | (138,033) | (138,033) | (138,033) |
| Bank overdraft | 7 | 0 | 0 | 0 | 0 | (24,800) | (24,800) | (24,800) |
| | | 5,668 | 0 | 166,383 | 0 | (449,192) | (277,141) | (291,421) |
| **Unrecognised (gains)/losses** | | | | | | | | 14,280 |

## 18 FINANCIAL INSTRUMENTS (continued)

### Classification and fair values (continued)

| PARENT 2010 | Note | Held for Trading | Designated at Fair Value through Profit & Loss | Loans and Receivable | Available for Sale | Financial Liabilities at Amortised Cost | Carrying Amount Actual | Fair Value |
|---|---|---|---|---|---|---|---|---|
| | | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| Trade and other receivables | 9 | 0 | 0 | 57,191 | 0 | 0 | 57,191 | 57,191 |
| Cash and cash equivalents | 7 | 0 | 0 | 70,865 | 0 | 0 | 70,865 | 70,865 |
| Trust / Special Funds | 8a | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient and restricted trust funds | 8b | 0 | 0 | 1,067 | 0 | 0 | 1,067 | 1,067 |
| Interest rate swaps: | | | | | | | | |
| Assets | 19 | 7,371 | 0 | 0 | 0 | 0 | 7,371 | 7,371 |
| Liabilities | 19 | (311) | 0 | 0 | 0 | 0 | (311) | (311) |
| Forward exchange contracts: | | | | | | | | |
| Assets | 19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Liabilities | 19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Secured bank loans | 14 | 0 | 0 | 0 | 0 | (287,666) | (287,666) | (313,542) |
| Trade and other payables | 13a | 0 | 0 | 0 | 0 | (124,455) | (124,455) | (124,455) |
| Bank overdraft | 7 | 0 | 0 | 0 | 0 | (14,050) | (14,050) | (14,050) |
| | | 7,060 | 0 | 129,123 | 0 | (426,171) | (289,988) | (315,864) |
| **Unrecognised (gains)/losses** | | | | | | | | 25,876 |

## 18 FINANCIAL INSTRUMENTS (continued)

### Fair Value Hierarchy Disclosures

For those instruments recognised at fair value in the statement of financial position, fair values are determined according to the following hierarchy :

For those instruments recognised at fair value in the statement of financial position, fair values are determined according to the following hierarchy :

- Quotable market price (level 1) - Financial instruments with quoted prices for identical instruments in active markets.
- Valuation technique using observable inputs (level 2) - Financial instruments with quoted prices for similar instruments in active markets or quoted prices for identical or similar instruments in inactive markets and financial instruments valued using models where all significant inputs are observable.
- Valuation techniques with significant non-observable inputs (level 3) - Financial instruments valued using models where one or more significant inputs are not observable.

The following table analyses the basis of the valuation of classes of financial instruments measured at fair value in the statement of financial position:

| | Notes | Total | Valuation technique: Quoted market price | Valuation technique: Observable inputs | Valuation technique: Significant non-observable inputs |
|---|---|---|---|---|---|
| | | $000 | $000 | $000 | $000 |
| **GROUP** | | | | | |
| As at 30 June 2011 | | | | | |
| **Financial Assets** | | | | | |
| Local authority bond | 8a | 2,098 | 2,098 | 0 | 0 |
| **GROUP** | | | | | |
| As at 30 June 2010 | | | | | |
| **Financial Assets** | | | | | |
| Local authority bond | 8a | 2,078 | 2,078 | 0 | 0 |

There were no transfers between the different levels of the fair value hierarchy.

## 18 FINANCIAL INSTRUMENTS (continued)

### Estimation of fair values analysis

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the table.

### Derivatives

Forward exchange contracts are either marked to market using listed market prices or by discounting the contractual forward price and deducting the current spot rate. For interest rate swaps, broker quotes are used. Those quotes are back tested using pricing models or discounted cash flow techniques.

Where discounted cash flow techniques are used, estimated future cash flows are based on management's best estimates and the discount rate is a market related rate for a similar instrument at the balance date. Where other pricing models are used, inputs are based on market related data at the balance date.

### Interest-bearing loans and borrowings

Fair value is calculated based on discounted expected future principal and interest cash flows.

### Restricted/special funds

Local authority bonds are stated at market value. Trust investments are held to maturity.

### Trade and other receivables / payables

For receivables / payables with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables / payables are discounted to determine the fair value.

### Interest rates used for determining fair value

The entity uses the Government yield curve as of 30 June 2011 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

| GROUP & PARENT | 2011 Actual % | 2010 Actual % |
|---|---|---|
| Derivatives | 6.85-7.75 | 6.85-7.75 |
| Loans and borrowings | 4.26-7.75 | 4.26-7.75 |

## 18 FINANCIAL INSTRUMENTS (continued)

Interest Rate Repricing Schedule

| | | GROUP Maturity Periods | | | | |
|---|---|---|---|---|---|---|
| | Weighted Average Interest Rate % | 0 – 1 Years | 1 – 2 Years | 2 – 5 Years | More than 5 Years | Total |
| | | $000 | $000 | $000 | $000 | $000 |
| **As at 30 June 2011** | | | | | | |
| ***Current & Non-Current Monetary Assets*** | | | | | | |
| Cash and cash equivalents | 3.14% | 108,125 | 0 | 0 | 0 | 108,125 |
| Restricted/special funds | 5.22% | 18,067 | 3,898 | 0 | 0 | 21,965 |
| Patient and restricted trust funds | 2.45% | 1,093 | 0 | 0 | 0 | 1,093 |
| **Total Monetary Assets** | | 127,285 | 3,898 | 0 | 0 | 131,183 |
| ***Current & Non-Current Monetary Liabilities*** | | | | | | |
| Bank overdraft | | 24,800 | 0 | 0 | 0 | 24,800 |
| ***Interest–bearing loans and borrowings*** | | | | | | |
| Crown Health Financing Agency | 4.34% | 20,000 | 63,500 | 80,000 | 70,000 | 233,500 |
| Bonds | 7.75% | 0 | 0 | 50,000 | 0 | 50,000 |
| Interest on borrowings | | 3,345 | 0 | 0 | 0 | 3,345 |
| Unexpired set up cost on borrowings | | (96) | (103) | (287) | 0 | (486) |
| **Total Monetary Liabilities** | | 48,049 | 63,397 | 129,713 | 70,000 | 311,159 |
| **As at 30 June 2010** | | | | | | |
| ***Current & Non-Current Monetary Assets*** | | | | | | |
| Cash and cash equivalents | 3.58% | 70,865 | 0 | 0 | 0 | 70,865 |
| Restricted/special funds | 5.64% | 10,680 | 10,078 | 0 | 0 | 20,758 |
| Patient and restricted trust funds | 2.68% | 1,067 | 0 | 0 | 0 | 1,067 |
| **Total Monetary Assets** | | 82,612 | 10,078 | 0 | 0 | 92,690 |
| ***Current & Non-Current Monetary Liabilities*** | | | | | | |
| Bank overdraft | 3.13% | 14,050 | 0 | 0 | 0 | 14,050 |
| ***Interest–bearing loans and borrowings*** | | | | | | |
| Crown Health Financing Agency | 6.20% | 0 | 20,000 | 143,500 | 0 | 163,500 |
| Bonds | 7.75% | 70,000 | 0 | 0 | 50,000 | 120,000 |
| Interest on borrowings | | 4,741 | 0 | 0 | 0 | 4,741 |
| Unexpired set up cost on borrowings | | (89) | (96) | (390) | 0 | (575) |
| **Total Monetary Liabilities** | | 88,702 | 19,904 | 143,110 | 50,000 | 301,716 |

18 FINANCIAL INSTRUMENTS
(continued)

Interest Rate Repricing Schedule

| | | PARENT | | | | |
|---|---|---|---|---|---|---|
| | | Maturity Periods | | | | |
| | Weighted Average Interest Rate % | 0 – 1 Years | 1 – 2 Years | 2 – 5 Years | More than 5 Years | Total |
| | | $000 | $000 | $000 | $000 | $000 |
| **As at 30 June 2011** | | | | | | |
| ***Current & Non-Current Monetary Assets*** | | | | | | |
| Cash and cash equivalents | | 70,865 | 0 | 0 | 0 | 70,865 |
| Patient and restricted trust funds | | 1,067 | 0 | 0 | 0 | 1,067 |
| **Total Monetary Assets** | | 71,932 | 0 | 0 | 0 | 71,932 |
| ***Current & Non-Current Monetary Liabilities*** | | | | | | |
| Bank overdraft | | 24,800 | 0 | 0 | 0 | 24,800 |
| ***Interest-bearing loans and borrowings*** | | | | | | |
| Crown Health Financing Agency | | 20,000 | 63,500 | 80,000 | 70,000 | 233,500 |
| Bonds | | 0 | 0 | 50,000 | 0 | 50,000 |
| Interest on borrowings | | 3,345 | 0 | 0 | 0 | 3,345 |
| Unexpired set up cost on borrowings | | (96) | (103) | (287) | 0 | (486) |
| **Total Monetary Liabilities** | | 48,049 | 63,397 | 129,713 | 70,000 | 311,159 |
| **As at 30 June 2010** | | | | | | |
| ***Current & Non-Current Monetary Assets*** | | | | | | |
| Cash and cash equivalents | 3.58% | 70,865 | 0 | 0 | 0 | 70,865 |
| Patient and restricted trust funds | 2.68% | 1,067 | 0 | 0 | 0 | 1,067 |
| **Total Monetary Assets** | | 71,932 | 0 | 0 | 0 | 71,932 |
| ***Current & Non-Current Monetary Liabilities*** | | | | | | |
| Bank overdraft | 3.13% | 14,050 | 0 | 0 | 0 | 14,050 |
| ***Interest-bearing loans and borrowings*** | | | | | | |
| Crown Health Financing Agency | 6.20% | 0 | 20,000 | 143,500 | 0 | 163,500 |
| Bonds | 7.75% | 70,000 | 0 | 0 | 50,000 | 120,000 |
| Interest on borrowings | | 4,741 | 0 | 0 | 0 | 4,741 |
| Unexpired set up cost on borrowings | | (89) | (96) | (390) | 0 | (575) |
| **Total Monetary Liabilities** | | 88,702 | 19,904 | 143,110 | 50,000 | 301,716 |

The Crown Health Financing Agency has undertaken to provide funding when the bonds mature. They will also refinance their advances when they are due. ADHB has undertaken to endeavour to repay $10.5m of advances per annum.

## 18 FINANCIAL INSTRUMENTS (continued)

### Capital management

ADHB's capital is its equity which comprises Crown equity, reserves, Trust funds and retained earnings. Equity is represented by net assets. ADHB manages its revenues, expenses, assets, liabilities and general financial dealings prudently in compliance with the budgetary processes and Board financial policies.

ADHB's policy and objectives of managing the equity is to ensure that it achieves its goals and objectives, whilst maintaining a strong capital base. Capital is managed in accordance with the Board's Treasury policy and is regularly reviewed by the Board.

There have been no material changes in ADHB's management of capital during the period other than revaluation of land and buildings as at 30 June 2011 as separately disclosed in this report.

### Sensitivity Analysis

In managing interest rate and currency risks ADHB aims to reduce the impact of short-term fluctuations on the surplus or deficit. Over the longer-term, permanent changes in foreign exchange rates and interest rates would have an impact on this performance.

At 30 June 2011, it is estimated that a general increase of 1% in interest rates would decrease the surplus or deficit by approximately $1.6m ($1.9m). Interest rate swaps have been included in this calculation.

At 30 June 2011, it is estimated that a general decrease of 1% in interest rates would increase the surplus or deficit by approximately $1.6m ($2.1m). Interest rate swaps have been included in this calculation.

## 19 DERIVATIVE FINANCIAL INSTRUMENTS

| | Group Actual As at 30/06/11 | Group Actual As at 30/06/10 | Parent Actual As at 30/06/11 | Parent Actual As at 30/06/10 |
|---|---|---|---|---|
| **Current Assets** | | | | |
| Interest rate swaps in gain (mark to market) | 0 | 3,182 | 0 | 3,182 |
| **Non – Current Assets** | | | | |
| Interest rate swaps in gain (mark to market) | 5,945 | 4,189 | 5,945 | 4,189 |
| **Current Liabilities** | | | | |
| Interest rate swaps in loss (mark to market) | 0 | 0 | 0 | 0 |
| **Non - Current Liabilities** | | | | |
| Interest rate swaps in loss (mark to market) | 277 | 311 | 277 | 311 |

## 20 MAJOR VARIATIONS FROM BUDGET

ADHB recorded a surplus of $142k which was $84k favourable to budget. Major favourable variances were patient care revenue $80m and financial income from term deposits $4m. Major unfavourable variances were funder payments to third party providers $41m, direct and indirect treatment costs $22m and outsourced costs $21m. Amalgamation of PHOs within the Auckland region sees ADHB being given responsibility for the regional contract for Procare, a primary healthcare organisation servicing the wider Auckland Region. This provided ADHB with extra MoH and IDF funding of $32m resulting in a favourable revenue variance. Associated funding costs for regional PHOs resulted in unfavourable funder costs of $32m. Extra revenue of $14.6m was generated by delivering funding side-contracts to MoH creating a favourable variance in revenue and unfavourable variance in direct and indirect treatment costs.

## 20 MAJOR VARIATIONS FROM BUDGET (continued)

The modification of the Laboratory contract in 2011 and additional funding for Eating Disorders within Mental Health services increased the MoH funding by $4.7m and the associated funder costs by the same amount. Sector Capability and Innovation funding was introduced during 2011 financial year to cover "very-low-cost-access" and "care-plus" and was funded on a recovery basis. ADHB delivered $7.9m above budgeted figures and resulted in budget variances in both revenue and expenditure. The initiatives to reduce the waiting lists in Cardiac and Orthopaedics Services increased the numbers of surgical operations carried out in the private hospitals resulting in unbudgeted outsourced clinical services costs of $10m.

## 21 EVENTS SUBSEQUENT TO BALANCE DATE

On 18 July 2011, the Minister approved the establishment of HealthAlliance NZ Limited to be the legal vehicle with Health Benefits Limited and Counties-Manukau, Northland and Waitemata DHBs to provide a shared services agency to the four northern DHBs in respect to information technology, procurement and financial processing. Accordingly, the ADHB's 20% shareholding in the entity will be reflected in the 2011/12 financial year.

## 22 KEY SOURCES OF ESTIMATED UNCERTAINTY

As indicated in Note 1, the preparation of financial statements in conformity with NZ IFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses.

Management has identified the following critical accounting policies for which significant judgements, estimates and assumptions are made:

Accrual of continuing medical education leave and expenses in employee benefits

The provision for the above is $23.3m as at 30 June 2011 (2010 $21.0m). The calculation of this accrual assumes that the utilisation of this annual entitlement, that can be accumulated over 3 years, will be 65 % of the full entitlement (2010 – 63%). A difference of 5% in the utilisation rate represents a financial effect of $1.77m on the accrual.

Estimation of useful lives of assets

The estimation of the useful lives of assets has been based on historical experience as well as manufacturers' warranties (for plant and equipment), lease terms (for leased equipment) and turnover policies (for motor vehicles). In addition, the condition of the assets is assessed at least once per year and considered against the remaining useful life. Adjustments to useful lives are made when considered necessary.

Debtors impairment

The Board has a credit management policy in place that regularly reviews debts and makes provision for impairment based on the risk assigned to each customer category.

Fair value of Property, Plant and Equipment (PPE)

The value of PPE, apart from land and buildings, is stated at cost less accumulated depreciation and impairment losses. The useful lives of assets is determined as outlined above. Buildings assets are specialised and have been valued based on optimised depreciated replacement cost. Estimates of replacement cost have been completed for building structure, services and fitouts in accordance with Treasury guidelines. Land has been valued with regard to market values applying in the locality and to any special circumstances that may exist in respect of the land valued. The implication of any Restrictive Trusts on land titles has not been taken into account.

## 23 DISTRICT STRATEGIC PLAN (DSP)

The Ministry of Health (National Health Board), via the change to legislation, now require DHBs to undertake longer term planning through a regional planning process. As a result a Northern Region Health Plan has been developed and submitted to the National Health Board. This covers the intentions of the four DHBs in the Northern Region. An implementation plan to cover specific activities and responsibilities has also been developed.

## Statement of Service Performance for Auckland District Health Board for the year ending 30 June 2011

### Introduction

This Statement of Service Performance is prepared in accordance with Section 153 of the Crown Entities Act 2004.

- Is prepared in accordance with generally accepted accounting practice
- Describes each class of outputs (the final goods and services of ADHB grouped into Four Classes set out below on page 78). ADHB during the financial year
  - Compares service delivery performance with forecast performance
  - Compares actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses

Auckland District Health Board is a Crown Entity as defined in the Crown Entities Act 2004.

This Act requires each DHB to pursue its objectives in accordance with its district strategic plan, its annual plan, its statement of intent, and any directions or requirements given to it by the Minister (under section 33 of this Act or section 103 of the Crown Entities Act 2004, or under section 107 of the Crown Entities Act 2004.)

The objectives referred to above are contained in Section 22 (1) (a-k) of the NZ Public Health and Disability Act 2000 No 91.

These can be summarised as "*to provide or fund the provision of, health and disability services in their district with the purpose of:*

- *Improving, promoting, and protecting the health of communities;*
- *Promoting the integration of health services, especially primary and secondary care services;*
- *Promoting effective care or support of those in need of personal health services or disability support."*

The long term *vision* of Auckland DHB is 'Healthy Communities, Quality Healthcare, *Hei Oranga Tika Mo Te Iti Mei Te Rahi.* Three *goals* [1]overarch and focus all aspects and levels of the Auckland DHB healthcare system. Our eight high level outcomes (also called our vital health outcomes) provide direction for achievement of our goals and enable the *four output classes* to logically group our wide range of healthcare provision to enable us to present a coherent and measurable performance story.

While complying with the Public Health and Disability Act 2000, DHBs also have to meet requirements set by the Ministry of Health and the Minister of Health. These are summarised in the table below and are incorporated into our high level outcomes.

| **Government expectations for the 2010-11 year. Better, Sooner more convenient. (Refer to page 85)** | **National targets for health (Refer to pages 97 to 104)** |
|---|---|
| Improve service and reduce waiting times | Shorter stays in Emergency Departments |
| Increase elective surgical volumes year on year | Improved access to surgery |
| Improve Emergency Department waiting times | Shorter waits for cancer treatment |
| Improve cancer treatment waiting times | Increased immunisation |
| Primary Health Care Strategy | Better help for smokers to quit |
| Clinical Leadership | Better diabetes and cardiovascular services |
| Regional Co-operation | |
| More unified system | |

[1] Lift the health of people living in Auckland, Performance improvement and Live within our means

## Auckland DHB High Level Outcomes Framework

The link between the four output classes and our high level outcomes is demonstrated in the following table

| Auckland DHB Vision | Auckland DHB Goals | High Level Outcomes | High Level Measures | Impacts | Output Class 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|---|
| Healthy Communities, Quality Healthcare *Hei Oranga Tika Mo Te Iti Me Te Rahi* | Lift the health of people living in Auckland | Impacts from cancer, diabetes, and cardiovascular disease are minimised | ↓ morbidity & mortality from cancer, diabetes, and cardiovascular disease | Amelioration of cancer, diabetes, and cardiovascular disease symptoms and / or delay in their onset | √ | √ | √ | |
| | | Improved quality of life for people with mental health and / or addiction issues and their family / whanau | ↓ in mental health & addiction problems | Environments & services promote mental wellness and recovery | | | √ | √ |
| | | Improved quality of life for people with disabilities and their family / whanau | ↑ independence for people with disabilities and those who need support services | Continual reduction of barriers to progressing in society for people with disabilities | | | | √ |
| | | Improved quality of life for older people and their family / whanau | ↑ rates of 85+ yrs able to live independently | More older people are able to age in the environment of their choice | | | | √ |
| | | Healthier safer children | ↓ rates of ambulatory sensitive hospital admissions (ASH) for children | Earlier identification and appropriate interventions with vulnerable children and their family/whanau | √ | √ | | |
| | Performance improvement | Improve primary and secondary care integration | ↑ the number of primary options for acute care (POAC) | Improved access and efficiency of service delivery | | √ | | |
| | | Improve quality of hospital care while improving productivity | ↑ service throughput and productivity | Improved patient / client experience and outcomes | | | √ | |
| | Live within our means | People of New Zealand continue to have confidence in the levels of care available from Auckland DHB | Break-even position is maintained | Auckland DHB continues to meet the needs of its population and the advanced levels of intervention required by the sector | √ | √ | √ | √ |

The *four output classes* to logically group our wide range of healthcare provision to enable us to present a coherent and measurable performance story are…

Output Class 1: Public & Population Services
Output Class 2: Primary & Community Services
Output Class 3: Hospital Services
Output Class 4: Support Services

These are divided into a number of targets which are identified and commented on from pages 87-141 inclusive.

**Our three goals are:**

1. Lift the health of the people in Auckland
2. Performance Improvement
3. Live within our means.

The first Goal is expressed by a number of targets which are reported on extensively as outcomes against Health Targets.
The third goal "Live within our means" is covered by the Cost of Service Statement and Summary of Results by Output Class below.

**Goal 2: Performance Improvement.**

This is seen as a significant cornerstone to achieving the other 2 Goals. ADHB has a Director of Performance Improvement who works alongside the Chief Executive and with the Senior Leadership Team.

In the 2011 year a team engaged in performance improvement activities identified projects with potential annual savings of approximately $20m. (Including enabling a higher throughput of patients for no more staff or building cost). The non financial benefits included the following:

| Some of the Operational Improvements achieved in pursuit of our performance improvement goal by a dedicated performance improvement team | |
|---|---|
| Number of Bed days saved per year | 2,446 |
| Reduced length of stay for patients which enable ADHB to handle an 11% increase in volume with no additional FTE increase. Number of patients affected | 59,032 |
| Increased volume of elective cases | 226 |
| Reduce inappropriate blood transfusion, avoiding wastage of blood and non compliance with the New Zealand Blood Service cold chain protocols by 10% | $1.36m |
| Number of patients a year affected by Advance Care planning | 1,000 |
| The "Releasing Time to Care" programme has increased direct contact time for nurses on 35 wards from 30% to 37% | |
| Smoking cessation records completed increased from 5% to 75% | |

Performance improvement activities have been boosted by the introduction of a performance improvement framework branded as "Healthcare Excellence". A brief glimpse of what this is all about can be seen below.

# Healthcare Excellence

Healthcare Excellence is our Improvement Framework at the Auckland District Health Board. By introducing Healthcare Excellence we aim to provide the best healthcare in New Zealand and be the best healthcare provider to work for. It commits us to a journey of continuous improvement to ensure we are the best we can be today whilst embracing new ways of working to deliver excellence into the future.

## Why Healthcare Excellence

Our most compelling reason for introducing Healthcare Excellence is that we want to do better for our patients and better for the Auckland Community. If we want to continue providing quality healthcare into the future – staying the same is not an option!

Healthcare Excellence will allow us to build on our strengths, and at the same time respond to challenges, deliver results and prepare for the future

## Our Aims for Healthcare Excellence

The journey to Healthcare Excellence is a seven year plan and potentially never ending as we continuously improve in the search for excellence. We want to have ...

- **Increased patient safety** - make patient safety our highest priority where we have zero harm.
- **Better quality care** - the best patient centred care which results in high patient satisfaction and health outcomes
- **Economic sustainabilty** - where waste and variation is eliminated
- **Improved health status** - add value to the health status of our patients and community.
- **staff engagement** - a culture of continuous improvement, research and innovation where staff want to stay and strive towards excellence.

Achieving Healthcare Excellence will involve challenging the way we do things – our systems and processes. We can do this successfully if we listen to our patients, learn from each other and be prepared to change when it is right to do so for our patients and right for future healthcare.

## Programmes

The journey to Healthcare Excellence is a long term commitment but we are already making progress. A key focus over the last 18 months has been to improve processes and systems. Set out below is a summary of some of the improvement programmes already in place.

### Concord

Programme to reduce clinical waste and improve the quality of healthcare providing the right amount of healthcare in the right way.

### Productive Operating Room

The Productive Operating Room is about all operating room staff working together to improve their processes, resulting in a safer place for care and a better place to work.

### Releasing Time to Care

Releasing time to care is about ward teams looking at their systems and processes to improve the way things are done and reduce waste. This will mean that nurses get to spend more time with patients and their families, which in turn will improve the quality and safety of care we provide and increase job satisfaction.

### Service Excellence

The Service Excellence programme focuses on the end to end patient pathway and keeps the patient at the centre. The aim is to remove waste and inefficiency to make our services better for patients and better for staff. Service Excellence is owned and led by the services and involves all staff in the service

### Included Initiatives

**Adult Emergency Department Service Excellence**

**Cardiac Service Excellence**

**General Medicine Service Excellence**

**General Surgery Service Excellence**

**Orthopedic Service Excellence**

**Radiology Service Excellence**

### Surgical Performance Programme

The Surgical Performance Programme is about ensuring we deliver acute surgery on time and electives to contact. This will help manage increasing volumes, both for acute and elective, whilst at the same time providing a better patient experience through improved process flows.

### Valuing our patient's time

Valuing our patient's time is a hospital-wide campaign to make sure that a patient's length of stay is right for their care. We can all help value our patient's time by reducing the time patients spend waiting for referral, treatment, discharge and decisions about their care in emergency departments or on wards.

## Initiatives to improve performance

These are just a sample of some of the initiatives and developments that are taking place across ADHB to improve performance:

**Lab form designs**

The idea to reduce unnecessary lab tests was recommended through the ADHB intranet site (seeking improvement suggestions) to Concord. Working with clinical staff and Labplus 23 tick boxes were removed on the order form. The new form has reduced testing by 50% saving the organisation about $200k a year. To date the new form is easier to use and avoids some of the risks of missing test results

**Green Belt[2] Training**

Green Belt Training was introduced to provide staff with the knowledge and skills to solve some of our current challenges. A focus is on reducing waste and improving patient experience. A critical part of the training is the completion of projects and participants are mentored throughout. Over 60 people have already been trained with a queue of staff waiting to take part.

**Daily Rapid Rounds**

Rapid Rounds are a brief daily ward meeting between Doctors, nurses and allied health professionals to review each patient's plan for their hospital stay and discharge.

Rapid Rounds are being rolled out across wards in Auckland City Hospital. Some of the wards already implementing Rapid Rounds have seen the average length of stay reduce by up to 1 day.

**Releasing Time Care**

Releasing time to care is a programme where ward teams look at their systems and processes to improve the way things are done and reduce waste. This allows nurses to spend more time with patients and their families improving the quality and safety of care we provide and increase job satisfaction. 33 wards are now implementing Releasing time to care and in some of these direct care time has increased by 7%

**Better Management of Blood products**

This is a project to change transfusion practice based on scientific research and manage our blood products better. Through an education and awareness campaign and a better blood management process ADHB has to date saved 2,080 units of red blood cells and realised financial benefits of $1,654K in blood products and staff time in the year to June 2011.

[2] Green Belt refers to a skill level in the implementation of Six Sigma Lean Thinking improvement methodology.

**Goal 3** "Live within our means" was achieved again this year with Auckland District Health Board achieving a small surplus of $142k after income of $1,821m and expenditure of $1,821m.

The two tables below show performance by Service and Output Class

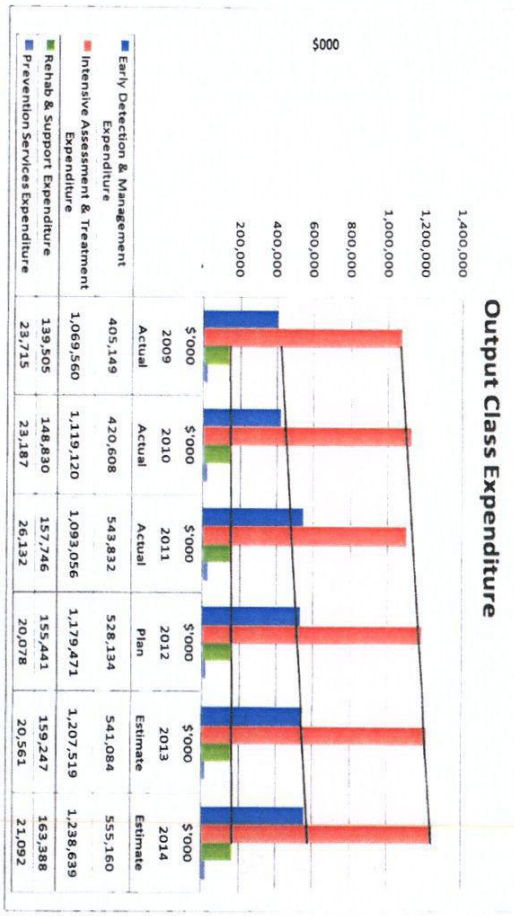
The Statement of Financial Performance has been recast to provide a Summary of Results by Output Class. This table is set out below.

It is important to note that the majority of revenue is not received in a manner which can easily be related to Output Classes. It is therefore the responsibility of District Health Boards to determine the allocation of resources in accordance with the needs of the population it serves and any Government Health Priorities.
It is considered that, by following the allocation of expenditure, the best demonstration of the allocation of resources by output class is achieved.

| Cost of Service Statement for the Year Ending 30 June 2011 | | | | | | |
|---|---|---|---|---|---|---|
| | | $'000 | | | | |
| | | Funder | Governance | Provider | Elimination | Total |
| Actual | Revenue | 1,651,461 | 5,057 | 1,178,057 | -1,013,411 | 1,821,163 |
| | Expenditure | -1,630,736 | -4,893 | -1,198,802 | 1,013,411 | -1,821,021 |
| | Surplus/(Deficit) | 20,725 | 163 | -20,746 | 0 | 142 |
| Budget | Revenue | 1,585,025 | 4,892 | 1,162,210 | -1,008,506 | 1,743,620 |
| | Expenditure | -1,584,126 | -5,844 | -1,162,097 | 1,008,506 | -1,743,561 |
| | Surplus/(Deficit) | 899 | -952 | 113 | 0 | 60 |
| Variance | Revenue | 66,435 | 165 | 15,847 | -4,905 | 77,542 |
| | Expenditure | -46,611 | 951 | -36,705 | 4,905 | -77,460 |
| | Surplus/(Deficit) | 19,825 | 1,116 | -20,858 | 0 | 82 |

## Output Class Summary

| Summary of Results by Output Class | | | | | | |
|---|---|---|---|---|---|---|
| Output Class Service | | Actual 2010 $'000 | Actual 2011 $'000 | Plan 2012 $'000 | Estimate 2013 $'000 | Estimate 2014 $'000 |
| Early Detection & Management | Revenue | 418,117 | 532,936 | 526,423 | 539,083 | 553,023 |
| | Expenditure | (420,608) | (543,832) | (528,134) | (541,084) | (555,160) |
| | **Surplus/(Deficit)** | **(2,491)** | **(10,896)** | **(1,711)** | **(2,001)** | **(2,137)** |
| Intensive Assessment & Treatment | Revenue | 1,132,783 | 1,101,254 | 1,193,064 | 1,221,756 | 1,253,350 |
| | Expenditure | (1,119,120) | (1,093,056) | (1,179,471) | (1,207,519) | (1,238,639) |
| | **Surplus/(Deficit)** | **13,663** | **8,198** | **13,593** | **14,238** | **14,712** |
| Rehab & Support | Revenue | 138,383 | 159,196 | 144,382 | 147,854 | 151,677 |
| | Expenditure | (148,830) | (157,746) | (155,441) | (159,247) | (163,388) |
| | **Surplus/(Deficit)** | **(10,447)** | **1,450** | **(11,059)** | **(11,393)** | **(11,711)** |
| Prevention Services | Revenue | 22,741 | 27,521 | 19,353 | 19,819 | 20,331 |
| | Expenditure | (23,187) | (26,132) | (20,078) | (20,561) | (21,092) |
| | **Surplus/(Deficit)** | **(446)** | **1,389** | **(725)** | **(742)** | **(761)** |
| Total | Revenue | 1,712,024 | 1,820,908 | 1,883,222 | 1,928,512 | 1,978,382 |
| | Expenditure | (1,711,745) | (1,820,766) | (1,883,125) | (1,928,410) | (1,978,279) |
| | **Surplus/(Deficit)** | **279** | **142** | **98** | **102** | **103** |



## Meeting Government expectations for the 2010-11 year.

| Expectation | Activities to achieve this | What we did |
|---|---|---|
| Improve service and reduce waiting times | Reduce excessive waiting times | Improved waiting times for ED and Cancer. Refer to page 86 and 87<br>Also National Targets on pages 97 and 98 as well as Output Class 3: from page 132 to138<br>Performance improvement profile increased with Healthcare Excellence .Refer to pages 79-82 |
| | Resources to support front line services | |
| | Implement productivity and quality and safety improvements | |
| Increase elective surgical volumes year on Year | Both first specialist assessments and surgery | Increased Elective volumes. Refer to pages 89 and 99 |
| | Move from reliance on spot purchasing from the private sector | ADHB has developed new operating and overnight surgical bed capacity at Greenlane to reduce its reliance on the private sector and to increase elective access for its population. |
| | Sustainable longer-term relationships to help grow elective surgery | ADHB now operates a full mix of purchasing options with the private sector and has moved these to a more medium term nature in terms of access. This ensures that outsourcing can occur as the need arises during the year and minimise contributing to short term increases and decreases in capacity requirements. |
| Improve Emergency Department waiting times | Improve performance in line with the 6 hour length of stay | Improved ED waiting times .Refer to pages 87,97 and 98 |
| Improve cancer treatment waiting times | Shorter interval between diagnosis and treatment, particularly radiation | Improved waiting times. Refer to pages 88 and 100 |
| Primary Health Care Strategy | Provide a wider range of services in community settings | Refer to Output Class 2 :Primary and Community Services from page 112 to 132 |
| | Services provided at no cost to patients | |
| | Consolidate PHOs where appropriate, acknowledging provider networks | |
| Clinical Leadership | Strengthen clinical engagement from governance through the organisation | Realigned services into Health Service Groups |
| Regional Co-operation | Identify real gains/results from collaborating with neighbouring DHBs | An ongoing expectation of improved purchasing power and shared clinical services was reinforced in 2011. |
| More unified system | Meet national expectations re shared services | During the year back office services were merged with Health Alliance. |
| | Make the most of collective procurement and back office rationalisation | |
| | Work on improvements from the MRG [3] report, such as quality and safety | |

[3] Ministerial Review Group "The Horn report"

# Rugby World Cup

The Government requires the following from District Health Boards during the Rugby World Cup:-

## *District Health Boards*

1) Identify and engage with local and regional health emergency management that will be required. Lead local health emergency planning.
2) Identify and engage with local Police District RWC planners and nominated planners from other agencies (Fire and Transport). Note these may not be the usual emergency management planners.
3) Check you have the most up to date versions of Ministry emergency plans: the Ministry website has the suite of national emergency health plans including the National Health Emergency Plan, infectious diseases, pandemic, hazardous substances, burns (under development), mass casualties (under development) plus there is the emergency management section in the *Environmental Health Protection Manual* (plus the hazardous substances, biosecurity, regulatory environments/ionising radiation sections), and the other advisory and guideline material we have provided.
4) Review your emergency plans for mass gatherings and check they will cover Rugby World Cup events in your area (especially hazard identification and risk assessment).
5) During the RWC2011 an enhanced Single Point of Contact regime will be put in place. DHBs will be expected to have identified a shadow CIMS[4] structure and be prepared to activate their Health Emergency Plans.

ADHB has complied with the above requirements.

The Police are the lead agency for the RWC and are responsible for the coordination of planning at national, regional and local levels. Planning is taking place internally and externally to health; the Manager – Emergency Management Service is engaged across all levels to ensure alignment of approach.

## World Cup Emergency Planning Tested

1) Around 80 staff have now participated in an exercise placing ADHB's Rugby World Cup emergency management plans under the microscope.
2) The exercise scenario on December 16 2010 was a grandstand fire and crowd crush at Eden Park during the World Cup.
3) Mirroring a real situation, staff from services which would be impacted by a mass casualty incident worked to treat and track the flow through the hospital of more than 100 simulated patients.
4) Emergency Management Service Manager is Justin Rawiri who said the exercise scenario, devised by Emergency medicine specialist Dr Mark Gardener, had been challenging and an invaluable test of ADHB's planning.
5) They, along with General Manager of Operations, Ngaire Buchanan, have since provided a face-to-face briefing to the Minister of Health, Tony Ryall.
6) Results from the exercise will be analysed by the ADHB Rugby World Cup Steering Group and incorporated into planning processes before the World Cup action kicks off in September.

[4] Co-ordinated Incident Management System

# Overview of how we performed against our Major Health Targets

## Faster treatment for thousands of ED patients

**Goal: For 95% of patients to be admitted, discharged or transferred from emergency departments within six hours**

ADHB result: 95% from March 2011 and 81.4 % for the year for Adult Emergency Department and 95% from March 2011 with an average of 88.1% for the year for the Children's Emergency Department which has also maintained 95% since March 2011

**OUR RESULT**

Delays for patients presenting through our adult and children's emergency departments have been cut dramatically over the last two years.

A hospital-wide campaign to value our patients' time has seen ADHB achieve the 2010-11 waiting time target despite a 21 per cent increase in patient numbers since 2009.

An extra 3,400 people have received treatment within the six-hour national target time in the last six months alone.

Although this target measures waiting times in the emergency departments, it is more a barometer of how well hospital-wide systems allow those requiring admission to be moved to where they need to be treated.

The reduction of delays embedded in systems has allowed faster patient transfers from the emergency departments, which, in turn, has reduced bottle-necks at the front door.

Reducing the ED length of stay means increased efficiency and capacity to treat other patients, with 33 per cent more ED patients now treated within six hours than in mid-2009.

The average length of patient stay has almost halved over two years to 3.6 hours.

Another benefit is that the number of patients who leave our EDs in frustration without receiving treatment is also falling.

**THE CHALLENGES**

The overriding challenge has been – and remains – to reduce time across the whole patient journey by focusing on removing unnecessary delays.

This has required a hospital-wide ownership of the target, rather than it being seen as a problem for the EDs to manage. The aim is to get the patient to the right place to receive the care they need sooner.

Meeting these goals has required thinking differently about the flow of acute patients across the hospital and ensuring beds and inpatient specialists are available to respond quickly to their needs.

The ongoing challenge is to maintain the momentum that has brought waiting times for patients down – particularly during the challenging busy winter months – and to keep driving changes by identifying further improvements.

**KEY INITIATIVES**

Physical and process changes in the triage registration areas have greatly reduced the times patients spend waiting for their initial triage assessment.

The Handover Hotline allows staff in the Adult ED and Admission Planning Unit to arrange a more timely and efficient patient handover process.

The creation of a Flow Coordinator position in ED prompts staff on the required chain of events to improve efficiency and keeps patients better informed.

Nurse-facilitated discharge allows patients to go home hours sooner by removing the need for a doctor to see them before departing. This allows improved bed turn-around times and efficiency.

The Rapid Rounds initiative sees ward staff have a five-minute team meeting so the entire team knows the plan for each patient's stay, eliminating miscommunication and ensuring length of stay is right for the patient's care.

**Comparing the last two years .....**
**June 2009 vs June 2011**

- **Number of patients waiting over 24 hours for a bed ... 98 vs 0**
- **Patients waiting over 12 hours for a bed ...21% vs 0.3%**
- **Average wait for a bed – all patients ... 7hrs 48 minutes vs 1hr 18 minutes**
- **General medicine patients – average wait for a bed ... 8hrs 32minutes vs 1hr 26 minutes**
- **Orthopedics patients – average wait for a bed ... 8hrs 6mins. vs 1hr 18 minutes**
- **General surgery patients – average wait for a bed ... 10hrs 10 minutes vs 1hr 3 minutes**

## Perfect record delivers timely cancer treatment

**Goal: For all patients needing radiation therapy to receive it within four weeks of the decision to treat.**

**ADHB result: 100%**

**OUR RESULT**

ADHB maintained its perfect record against the target of having all cancer patients requiring radiation therapy to have it within four weeks of their first specialist assessment.

The 100 per cent result achieved by the Auckland City Hospital-based Northern Regional Cancer and Blood Service was good news not only for patients within our own population area.

It also saw all cancer patients within the Northland, Waitemata and Counties Manukau DHB areas treated within four weeks under our regional service agreement.

The service achieved the target despite having between 40 and 60 new patients starting treatment each week.

By the end of June, 2,129 courses of treatments had been delivered during 2010-11.

**THE CHALLENGES**

The Ministry of Health cancer waiting time target reduced from six weeks to four weeks from the end of December.

The service had consistently met the six-week target and has also been able to achieve the reduced wait time target of four weeks every month since it came into effect.

This has only been achieved through the commitment and hard work of radiation oncologists, physicists, radiation therapists and scheduling staff to improve systems and processes and, therefore, patient waiting times.

Consistently achieving targets requires ongoing weekly monitoring of the wait list, prioritisation and planning using a multi-disciplinary approach.

Changes to weekly referral flows have created some challenges in managing variations in demand and complexity.

There will also be some loss of capacity during the decommissioning and replacement of a linear accelerator in August 2011.

An ongoing international recruitment programme aims to maintain radiation therapist staffing levels and the right skill mix to run the service.

**KEY INITIATIVES**

Once commissioned in December 2011, the new linear accelerator will complement the last machine installed late last year to deliver the latest treatment technologies available.

It will deliver more efficient patient throughput (particularly for complex treatments) and improved targeting of radiation therapy to the tumour site.

A new machine using the latest technology in the treatment of skin cancers and superficial tumours is also being commissioned.

Meanwhile, the number of treatment 'fractions' delivered to breast cancer patients was reduced in February 2011, based on clinical evidence. This has reduced the total treatment time for the patient and freed-up linear accelerator capacity.

The introduction of High-Dose Radiation Therapy will bring more convenient treatment for gynaecological patients. HDR treatment for prostate patients is planned at a later stage.

More flexible radiation therapist shift patterns are allowing the department to extend treatment hours when needed.

A move to full electronic recording is expected to further reduce patient planning and waiting times.

A total of 128 patients were referred for treatment by a local private provider (**A**uckland **R**adiation **O**ncology) or Waikato DHB last year.

A long-term partnership with **ARO** will allow ADHB clinicians to treat public patients at their facility to ensure sustainable capacity across the region as demand increases.

**Facts at a glance.....**

- **As of June 30, the Radiation Oncology team had achieved the cancer target waiting time for more than 430 consecutive days.**
- **In May and June, the average waiting time for patients clinically-assessed as requiring treatment within four weeks was down to 3.1 weeks.**

## More patients receive elective surgery

**Goal: To deliver 11,149 elective surgery discharges in 2010-11**

**ADHB result: 11,179 discharges delivered**

### OUR RESULT

ADHB's success against the Elective Surgery Health Target is a mighty result considering it required an 18 per cent lift in the discharge target in a single year.

A number of daily and monthly discharge records were set on the way to achieving the target, resulting in more patients receiving the procedures they need sooner.

Over the full 2010-11 year, the target increase was for more than 1700 additional Aucklanders receiving their elective surgery through ADHB.

The increased surgical volumes resulted in some phenomenal waiting time performances and reductions in patient backlogs.

In the second half of the year, 468 fewer people were waiting more than six months for their surgical procedure – a 66 per cent improvement.

At the same time, the surgical waiting list reduced by 17 per cent.

The clinic waitlist also fell by 12 per cent and the number of people awaiting clinic treatment was almost halved (48 per cent reduction).

### THE CHALLENGES

Despite the steep improvement curve of the last year, 2011-12 promises to be no less challenging.

ADHB has set itself the challenge of an extra 800 elective surgery discharges for the 2011-12 year and to have no one waiting longer than six months for clinics or surgery.

An exceptional effort in the final months helped overcome a slow start last year and Director of Surgery Ian Civil said a similar effort would be required across the entire 2011-12 year. "In the coming year, we have set ourselves a challenging target and by continuing the good work of the last quarter, we will see the new goals achieved in a more planned way throughout the year," he said.

### KEY INITIATIVES

The opening of the new Greenlane Surgical Unit (GSU) is having a significant impact on ADHB's capacity to meet the target.

Many of the services based at the GSU achieved major increases in patient throughput in the second half of the year once the facility was up and running. (See 'The Big Improvers')

ADHB is reviewing the Patient Flow Operational Plans for 2011-12 to focus on the wait times and production required to ensure patients in all services wait no longer than six months for their procedure.

**The Big Improvers (Elective surgery volume increases from January 1 to June 30 2011 over previous 6 months)**

| | |
|---|---|
| • Paediatric ORL | +61% |
| • Opthalmology | +44% |
| • Paediatric Orthopaedics | +40% |
| • ORL | +24% |
| • General Surgery | +23% |
| • Neurosurgery | +19% |
| • Paediatric Surgery | +10% |

**Facts at a glance.....**

- **An extra 55 patients a week received their elective surgery between January 1 and June 30, compared to the previous 6 months.**
- **Up until December 31, ADHB discharged 195 elective surgery patients a week on average.**
- **This had risen to 250 patients a week by June 30.**

## Shaping our plan for better diabetes and cardiovascular care

### *Goal:*

**1. To increase cardiovascular risk assessments to 79% of the eligible adult population**
**2. To increase the rate of people with diabetes attending free annual checks to 57%**
**3. To increase people with diabetes having satisfactory or better diabetes management to 84%**

### *ADHB result:* For the year to June 2011

1. 75%
2. 57%
3. 74%

**OUR RESULT**

ADHB set itself some challenging goals in this three-part target and although not all were achieved, solid foundations continue to be built for performance improvement over the next few years.

The targets for diabetes annual reviews and better management are set by individual DHBs to take into account the specific needs of their populations.

ADHB set high targets, reflecting our commitment to improving services to people in our community living with diabetes. However, the consequence of setting high targets and falling short of them is comparison with DHBs that have significantly different – and often lower – targets.

The diabetes management target has been set very high by ADHB – much higher than most other DHBs and higher than the other Auckland region DHBs.

One of the highlights of ADHB's results was the performance for all ethnicity groups on free diabetes annual checks, particularly for Maori and Pacific diabetics. These results were significantly higher than those of our counterparts.

The aim was for 55 per cent of both groups to receive their yearly check.
The Pacific target was exceeded by 20 per cent (75 per cent of the population whose free annual check occurred during the reporting period were tested) and the Maori target was achieved (57 per cent).

The appointment of Long-Term Condition Quality Improvement Coordinators between February and April was already paying-off with much better results in April and May.

The 'get checked' result was 59 per cent in April against the 57 per cent target and in May it had risen further to 65 per cent and 66% for the quarter to June.

**THE CHALLENGES**

ADHB and its primary health organisation (PHO) partners recognise considerable work still needs to be done to sustainably improve the diabetes annual review and management health outcomes.

A range of long-term initiatives are being developed and rolled-out but these will take time to reflect improvements.

Once foundations are firmly established, gains should become more noticeable.

Varying performance levels by PHOs are being addressed by working with those with the highest diabetic populations to drive improvements. Improvements in annual review performance over the last year have been confined to achievements among the Maori, Pacific and Indian populations.

**KEY INITIATIVES**

The three Long-Term Condition Quality Improvement Coordinators working in primary care have a clear focus on improving diabetes health outcomes.

They are working with practices to establish and maintain diabetes registers and recall systems to improve annual review rates.

Other initiatives to boost performance include providing a population audit tool to all primary care practices to identify people with long-term conditions and other technology assistance for smaller PHOs.

Culturally and linguistically-appropriate courses will be available to support people self-managing diabetes.

A Pacific self-management facilitator will train Healthy Village Action Zone parish nurses, community health workers and lay people.

There will be enhanced diabetes retinal screening, particularly in high-needs populations.

ADHB was one of the first DHBs to sign-up to the Diabetes Nurse-Prescribing project

**.Facts at a glance.....**

- **Good diabetes management is essential, as poor blood glucose control is a significant contributor to cardiovascular and renal disease.**
- **These are significant contributors to morbidity and disability and have a major impact on healthcare resources.**
- **Dialysis for a person with diabetes progressing to renal disease could cost around $80,000-a-year.**
- **But if the condition can be detected earlier and good management plans put in place, the cost to the healthcare system could be as little as $400-a-year.**
- **Diabetes is one of the major risk factors for cardiovascular disease.**

## Team work drives immunisation target success

**Goal: For 90% of two-year-olds to be fully-immunised by July, 2011.**

**ADHB result: 92% of two-year-olds were fully-immunised by the end of June.**

### OUR RESULT

The youngest Aucklanders have received a flying start to life thanks to a successful immunisation partnership between ADHB and its community-based service providers.

This alliance enabled ADHB to meet and exceed its 2010-11 Health Target goal for the full immunisation of 90 per cent of two-year-olds.

Over 2010-11, ADHB primary care practices boosted coverage by five per cent in this age group.

The result contributed to a 17 per cent improvement within the ADHB population over the last two years for this age cohort.

A project to improve patient information has enabled teams to target those infants overdue for their shots and have them brought back up to speed quickly.

The result of the team approach was the full immunisation of a total of 1388 of the 1513 two-year-olds in ADHB's population area.

This included some noteworthy improvements in immunisation rates among children from different ethnicities.

### THE CHALLENGES

ADHB must achieve an increased Immunisation Target of 95 per cent by the end of 2011-12 and ongoing coordination will be required to meet this goal.

Immunisation was declined by 3.6 per cent of families among ADHB's population last year, leaving a slim margin for achieving the new target.

There will also be ongoing work to increase coverage among six-month-olds, which currently stands at 74 per cent for age across the whole population and less among Maori (56 per cent) and Pacific (67 per cent).

Babies are most vulnerable up to around nine months of age, so it is critical that the six-week, three-month and five-month immunisations are delivered on time.

Some key barriers to families immunising their children include lack of awareness, competing priorities, fear, concerns about their child's health and access to primary care for reasons including cost (although immunisation is free for all children) and transport.

Achieving very high immunisation rates requires an excellent record of children and their immunisation status.

### KEY INITIATIVES

The National Immunisation Register is a critical tool for achieving high coverage rates as it allows teams to target solutions at individual children.

Primary care systems of pre-calling and re-calling parents for scheduled immunisation are another important way of ensuring compliance.

A general practice's relationship with a child's family and the immunisation knowledge of health professionals are also valuable.

ADHB's Outreach Immunisation Service, provided by the Immunisation Advisory Centre (IMAC), is also supporting those often-mobile families who face the greatest difficulties in attending a routine appointment with their primary care practice.

To get almost complete coverage means that all parts of the system need to work closely together.

**Facts at a glance.....**

- **Immunisation rates among children from key ethnicity groups have improved significantly over the last 12 months.**
- **Pacific immunisation is up 11 points in a year to 95 per cent.**
- **Maori immunisation is up 9 points to 88 per cent.**
- **And Asian immunisation is up 3 points to 94 per cent.**

## 6000 more smokers given help to quit

**Goal: For 90% of hospitalised smokers to be given advice and help to quit.**

**ADHB result: 80%**

### OUR RESULT

A huge effort to reach out to hospitalised smokers with advice and help to quit has seen an extra 6000 patients take the first step over the last year.

Although ADHB fell short of its 2010-11 goal, performance against this target came a long way over the course of the year.

Brief advice about quitting was given to 9,008 patients last year, up from 2,924 the previous year.

The number of referrals to smoking cessation services for 2010-11 was another success story – up more than a third to 1811 from 1167 the previous year.

When the targets were introduced in July, 2009, only 15 per cent of smoking patients were given brief advice on giving up.

By the end of June, the number had risen to 80 per cent – 14 per cent up on a year earlier.

The improvements are significant considering tobacco-related harm is a major contributor to avoidable disease and death.

The philosophy behind ADHB's approach to the target is that tobacco is the problem, not the smoker.

It recognises that quitting can be very difficult and many smokers want to give up but need help to do so.

With systems now in place, there is good cause to be optimistic about 2011-12.

### THE CHALLENGES

The key challenge to reaching the target is identifying and closing gaps which see some smoking patients not offered brief advice on quitting by staff.

When the Adult Emergency Department and Admission Planning Unit joined the programme last June, it saw an immediate spike in the overall rate of patients being given advice to quit.

Due to the high volume of patients passing through those units, it is critical to keep working hard to ensure patients aren't missed or significant further gains will be difficult to achieve.

Elective surgery patients are asked about their smoking status by the Short Stay Surgical team and those identifying as smokers are given brief advice on quitting.

A process is being implemented that will see the same messages reinforced on the day of surgery.

Another challenge is to embed smoking cessation advice as standard practice across all disciplines.

### KEY INITIATIVES

System refinement and staff training over the last two years has led to better results but sustained improvement will need to come from wards taking ownership of the target and incorporating their own checks.

Ongoing nurse training and nurse-initiated provision of Nicotine Replacement Therapy on wards in the form of gum and patches is helping patients cope with withdrawal whilst in hospital.

The introduction of a mandatory smoking section on the Electronic Discharge Summary has been an important tool for 'capturing' smoking patients.

Weekly performance 'league tables' are enabling wards and services to compare their results and generate ideas about improving data collection.

Daily chart audits have been introduced to help guard against patients being missed and have led to a significant reduction in the number who are not asked about their smoking status.

Innovation on wards has seen the introduction of measures such as checklists on daily handover sheets and routine daily checks by a designated staff member to ensure that patients have not been missed.

**Achievements at a glance.....**

- **Based on evidence that one in 40 smokers will quit as a result of receiving brief advice from a health professional, around 225 of the 9008 ADHB patients contacted last year will kick the habit.**
- **If that number could be replicated at each DHB around the country, New Zealand would have almost 4,500 fewer smokers**

## Table of Performance at a glance

### National Targets

| SOI Ref | Measure | Target | Achieved Yes/No | Please refer to comments on page |
|---|---|---|---|---|
| 1.1 | Shorter stays in Emergency Departments-Adult | 95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours | No (for full year) Yes from March 2011 | 97 |
| 1.2 | Shorter stays in Emergency Departments- Children's Emergency Department | 95% of patients will be admitted, discharged or transferred from an Emergency Department within six hours | No (for Full year) Yes from March 2011 | 98 |
| 2.0 | Improved Access to Surgery (Elective) | 11,149 discharges | Yes | 100 |
| 3.0 | Shorter waits for cancer treatment | 100% of patients requiring radiation treatment will receive this within four weeks (target by December 2010) | Yes | 100 |
| 4.0 | Increased Immunisation | 90% of two year olds will be fully immunised by July 2011 | Yes | 101 |
| 5.0 | Better help for smokers to quit | 90% of hospitalised smokers provided with advice and help to quit by July 2011 | No | 102 |
| 6.1 | Cardiovascular risk screening | Total 79% | Yes | 103 |
| 6.2 | Diabetes annual check | Total 57% | Yes | 104 |

### ADHB Targets

| SOI Ref | Measure | Target | Achieved Yes/No | Please refer to comments on page |
|---|---|---|---|---|
| 1ai) | Health assessments done of early childhood education centre | 100% | Yes | 105 |
| 1aii) | Investigations to monitor/improve the quality of drinking water | Between 100-130 | No | 105 |
| 1aiii) | Emergency investigations on hazardous substances and new organisms | 100% | Yes | 106 |
| 1bi) | Number enrolled on Pacific smoking cessation programmes in ADHB (cumulative target) | 240 | No | 106 |
| 1bii) | Number of healthy housing assessments and % referred to provider | Number of assessments 500 | No | 107 |
| 1biii) | Number of healthy housing assessments and % referred to provider | Number of referrals 80% | No | 107 |
| 1biv) | Infants exclusively and fully breast fed -6 weeks | 74% | No | 108 |
| 1biv) | Infants exclusively and fully breast fed -3 months | 57% | Yes | 108 |
| 1biv) | Infants exclusively and fully breast fed -6 months | 27% | Yes | 109 |
| 1 ci) | Communicable disease control -Number of TB cases | 100% | Yes | 109 |
| 1 cii) | Communicable disease control -Number of other disease investigations | 100% | Yes | 110 |

| SOI Ref | Measure | Target | Achieved Yes/No | Please refer to comments on page |
|---|---|---|---|---|
| 1di) | Support GP's in submitting data to the National Immunisation Register (NIR) and follow-up babies not immunised | Up to 1,300 referrals | No | 110 |
| 1 dii) | Percentage of two-year olds fully immunised for age | 90% National Target see above | Yes | 101 |
| 1diii) | Percentage of eligible and consented children completing the year 7 vaccination | 63% | No | 111 |
| 1ei) | Eligible women participating in the National Cervical Screening Programme, Particularly: Maori, Pacific and Asian women(3 yr coverage rate for 20-65 yr women) | Contrac t targets met | No | 111 |
| 1 eii) | B4 School Checks completed | 3,800 | No | 112 |
| 2 ai) | Percentage of eligible patients having diabetes - Maori | National Target see above 55% | Yes | 104 and 112 |
| 2 ai) | Percentage of eligible patients having diabetes - Pacific | National Target see above 55% | Yes | 104 and 113 |
| 2 ai) | Percentage of eligible patients having diabetes - Total | National Target see above 57% | Yes | 104 and 113 |
| 2aii) | Percentage "Get Checked patients with an HbA1c>8 Maori | 72% | No | 114 |
| 2aii) | Percentage "Get Checked patients with an HbA1c>8 Pacific | 72% | No | 114 |
| 2aii) | Percentage "Get Checked patients with an HbA1c>8 Total | 84% | No | 115 |
| 2aiii) | Percentage of patients with diabetes retinal screened Maori | 77% | No | 116 |
| 2aiii) | Percentage of patients with diabetes retinal screened Pacific | 77% | Yes | 116 |
| 2aiii) | Percentage of patients with diabetes retinal screened Total | 77% | No | 115 |
| 2bi) | Percentage of eligible patients cardiovascular risk screened Maori | 70% | Yes | 117 |
| 2bi) | Percentage of eligible patients cardiovascular risk screened Pacific | 70% | Yes | 117 |
| 2bi) | Percentage of eligible patients cardiovascular risk screened Other | 80% | Yes | 118 |
| 2bi) | Percentage of eligible patients cardiovascular risk screened Total | 79% | Yes | 118 |
| 2bii) | Percentage increase in programmes and options available for cardiac rehabilitation | 5% increase for all groups | Yes | 119 |
| 2ci) | Percent valid NHI on patient register | 98% | Yes | 119 |
| 2cii) | Percentage of Maori enrolled in PHOs | 80% | No | 120 |
| 2ciii) | Percentage of eligible enrolled patients enrolled on Care Plus(baseline 2008) | ≥ 70% of eligible patients enrolled | Yes | 120 |
| 2civ) | Percentage of palliative care clients in receipt of PHO services | 15% of clients | Not recorded | 121 |
| 2di) | Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health Maori | Remain below 95% of the national average | Yes | 122 |

| SOI Ref | Measure | Target | Achieved Yes/No | Please refer to comments on page |
|---|---|---|---|---|
| 2di) | Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health Pacific | Remain below 95% of the national average | Yes | 122 |
| 2di) | Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health Other | Remain below 95% of the national average | Yes | 123 |
| 2dii) | Percentage of unnecessary hospital admissions for Maori, (45 to 64) | Remain below the national average | No | 124 |
| 2dii) | Percentage of unnecessary hospital admissions for Pacific, (45 to 64) | Remain below the national average | No | 124 |
| 2dii) | Percentage of unnecessary hospital admissions for Other, (45 to 64) | Remain below the national average | No | 125 |
| 2diii) | Percentage of unnecessary hospital admissions for Maori, (0-74 age) | Remain below the national average | No | 126 |
| 2diii) | Percentage of unnecessary hospital admissions for Pacific (0-74 age) | Remain below the national average | Yes | 126 |
| 2diii) | Percentage of unnecessary hospital admissions for Other (0-74 age) | Remain below the national average | Yes | 127 |
| 2ei) | Percentage of oral health use | 68% | Yes | 127 |
| 2eii) | Percentage of children carries free at 5 years Maori | 50% | Yes | 128 |
| 2eii) | Percentage of children carries free at 5 years Pacific | 38% | No | 128 |
| 2 eii) | Percentage of children carries free at 5 years Other | 80% | No | 129 |
| 2eii) | Percentage of children carries free at 5 years Total | 66% | No | 129 |
| 2eiii) | Number of teeth of 8 year olds decayed ,missing r filled (DMFT) Maori | 1.0 | No | 130 |
| 2eiii) | Number of teeth of 8 year olds decayed ,missing r filled (DMFT) Pacific | 1.15 | No | 131 |
| 2eiii) | Number of teeth of 8 year olds decayed ,missing r filled (DMFT) Other | .55 | No | 131 |
| 2eiii) | Number of teeth of 8 year olds decayed ,missing r filled (DMFT) Total | .73 | No | 132 |
| 3ai) | Patients requiring radiation treatment will receive this within four weeks(target by December 2010) | National Target see above 100% | Yes | 100 |
| 3bi) | Percentage of Emergency Department patients who are admitted, discharged or transferred within 6 hours | National Target see above 100% | No | 97 & 98 |
| 3ci) | Reduce average length of stay (ALOS) for elective and arranged inpatient | 4.15 | No | 133 |
| 3cii) | Acute inpatient ALOS (average length of stay) | 4.15 | No | 133 |
| 3ciii) | Elective and Arranged Day of Surgery Admission | 60% | Yes | 134 |
| 3civ) | Percentage of non attendance (DNA) for specialist appointments | 8.5% | No | 135 |
| 3cv) | Percentage of Maori patients DNA rates in hospital services | 9% | No | 135 |

| SOI Ref | Measure | Target | Achieved Yes/No | Please refer to comments on page |
|---|---|---|---|---|
| 3di) | At least 90% of long-term clients have up relapse prevention plans by July 2011 | 90% | Yes | 135 |
| 3dii) | Percentage improved access to mental health services | 3.30% (adult) | Yes | 136 |
| 3ei) | Volume acute (all populations) | 92,133 100% of contract | No | 136 |
| 3eii) | Volume elective (all populations) | 33,615 100% of contract | No | 137 |
| 3fi) | Percentage of hospitalised smokers provided with advice and help to quit. | National Target see above | No | 102 |
| 3gi) | Number of elective services discharges | National Target see above | Yes | 99 |
| 3hi) | Number of hospital in-patient deaths within 30 days of admission as a proportion of all discharges including day cases | 1.39 | No | 137 |
| 3hii) | Percentage of unplanned acute readmissions within 28 days of discharge | 10.40% | No | 138 |
| 4ai) | Number of people ≥ 85 years who are able to remain in their own homes with support | 5% increase | No | 138 |
| 4aii) | Number of low level clients self managing on support packages with input from key workers | 150 | Yes | 138 |
| 4aiii) | Number of reassessments for clients receiving home based support services | 25% increase | Yes | 139 |
| 4bi) | Number of complaints | 25% reduction | No | 140 |
| 4ci) | Number of palliative clients accessing primary care under the subsidised DHB/PHO partnership | Increase to 100 | No | 140 |
| 4di) | Percentage of residential mental health providers audited | 30% | Yes | 141 |
| 4dii) | Percentage of people with enduring mental illness unpaid work, or education , or appropriate discharges | 15% | Not recorded | 141 |

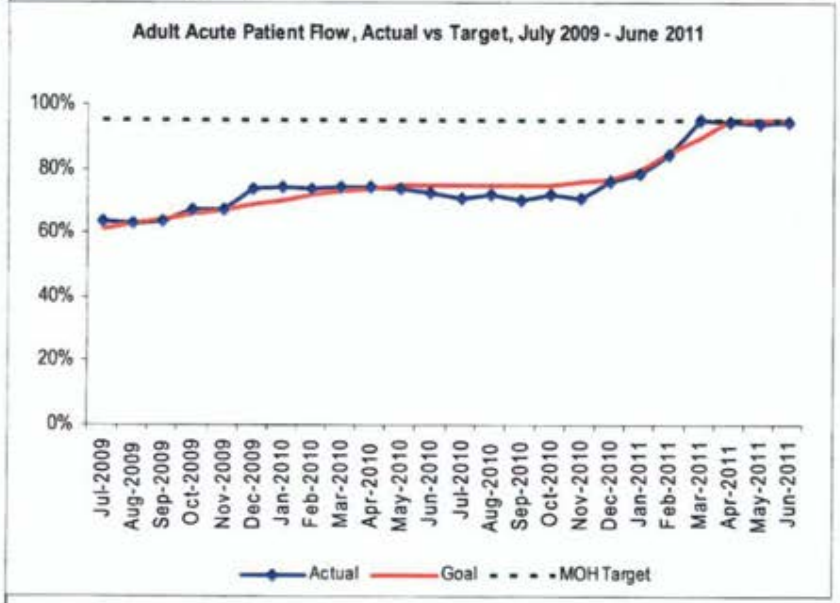
## National Health Targets

**National health targets help focus the efforts of all DHB's and make more rapid progress against key national priorities. The ADHB specific National Targets are set out below.**

**1. Shorter stays in Emergency Departments:**

***95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours***

**1.1 Adult Emergency Department**




**Project Risks / Comments:**

95% of patients were discharged or transferred from ED within 6 hours in June. This has increased from 71% in July 2010 and as can be seen from the attached graph we achieved the MoHzxc Target in March 2011. AED and inpatient services escalation plans are under discussion and are to be incorporated into standard work for team to respond to surges in demand. Capacity alerts updated to lower triggers to lead to an earlier response to pending access block. Rapid Improvement Event solutions being implemented to improve process for patient transfer from ED when inpatient bed is available. Daily breach meeting transferred to ED floor and incorporated into daily standard work. A daily rapid review process for balancing acute and elective admissions to match available service capacity under development. Close monitoring of performance through winter required to maintain performance and respond to early signals of deterioration. Rugby World Cup impact and response plans underway

**Improvements to date:**

***Streamlined AED processes and measurement and manage the challenge of growing demand***

Reviewed Medical / Nursing requirements for AED and approved business case for resource increase to match increased workload.
Charge nurse patient flow coordinator introduced
Improved access to Radiology
Streamlined documentation required for safe transfer
Improved triage processes.

***Managing bed block with additional resources***

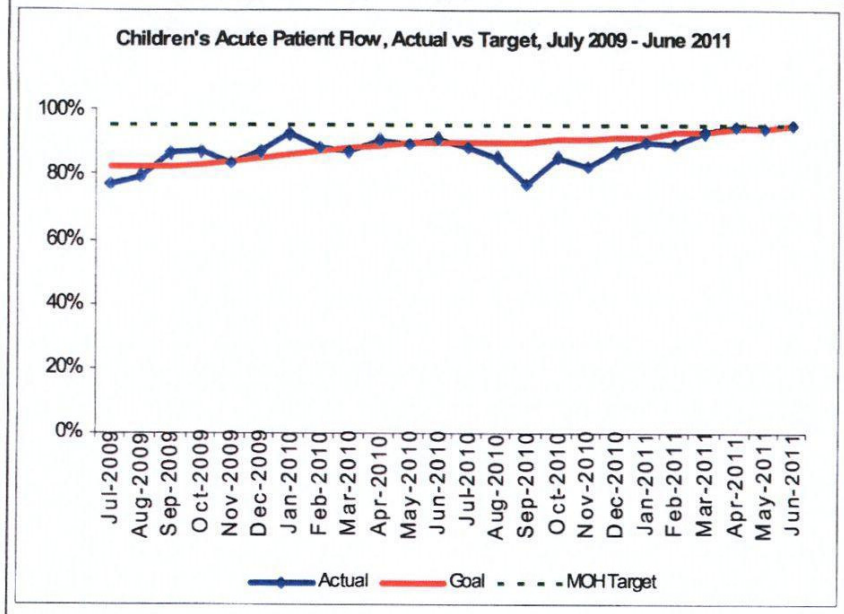
58 Additional beds opened 2009-2010
Winter Ward 31 General Medicine 10 additional beds August – October 2010

***Managing bed block & reducing the time patients wait through improved processes and teamwork***

Daily Rapid Rounds introduced in General Medicine (Feb 2010) and Orthopaedics (July 2010)
Nurse Facilitated Discharging in General Medicine (April 2010)
Improved Bed Management Communication via Estimated Discharge Dates, CMS upgrades, improved visual management, more efficient bed management meetings and earlier time of day discharging.
Daily "breech review meetings" to understand root causes and implement short term solutions.

| Activity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| 95% of patients will be admitted ,discharged or transferred from an Emergency Department within six hours | 76% | 70.2% | 95% | 81.4 % for the year<br>95% in June 2011 | Not Achieved<br>Achieved in June |

## 1.2 Children's Emergency Department




**Project Risks /Comments**: The improved performance of prior months continued into June where Starship achieved 95% of patients being processed within the six hour target. There were 13 days where greater then 95% was achieved. This is an improvement from 88% in July 2010.Progress over the year against the MoH Target can be seen in the attached graph.
Services continue to focus on the '2 component of the 3-2-1. Strategies are being developed to assist Registrars to review CED patients deemed needing of admission. Some of these strategies are, review of ward work loads, rosters - in particular the call back roster and the role of the House Officer. Services are also reviewing documentation duplication. There continues to be a positive commitment from staff to improve flow through Children's Emergency Department.
Wards are also focusing on bed turn over by reviewing and improving ward rounds, introducing rapid ward rounds, and becoming more accurate with Estimated Dates of Discharge.
The senior team is also improving data management, with the aim to have an overview of current inpatients, know expected patients and estimated acute volumes for the coming week in order to manage peak days and implement strategies that will reduce elective cancellations, extended waits in CED and staff resource issues, with the first formal weekly meeting to start on the 1st July.

**Improvements to date:**
Improvement in the Estimate Discharge Date (EDD's) for current inpatients
Improvement in the forecasting occupancy

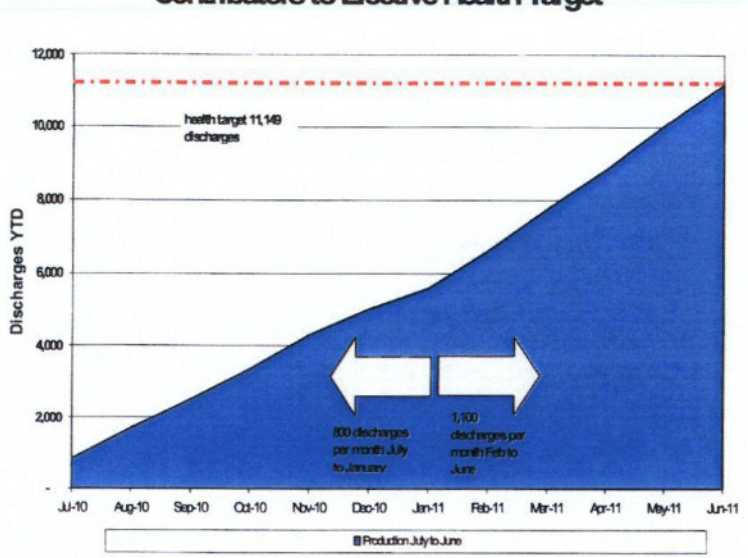
**Immediate Actions to Lift Performance**
Additional 11 medical beds opened
Increased awareness of ward staff regarding the transition lounge
Focus on EDD's and Implementation of the Capacity Planning Project

**Longer term projects**
The Capacity Planning Project:
Ability to consistently predict occupancy in order to plan ahead. The Capacity Planning Project is progressing well –formal meetings started on the 1st July, meet each Friday to review predicted occupancy. Identifying and resolve issues that impacted on accurate predictions. Some of these have been late notification of elective admissions, late cancellation by bureau staff and staff sickness and inconsistent pattern of acute admissions. A daily meeting at 3pm also occurs to review bed status and identify expected demand on beds for the following day.

| Activity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| 95% of patients will be admitted ,discharged or transferred from an Emergency Department within six hours | 76% | 86.2% | 95% | 88.1% for the year<br>95 % in June 2011 | Not Achieved<br>Achieved |

## 2. Improved Access to Surgery

***The volume of elective surgery will be increased by 2,000 discharges for the 2010-2011 year. ADHB target is 11,149 for the year***




**Risks / Comments:** June electives were adversely affected by bed availability resulting in elective cancellations and production shifting to non-ADHB patients waiting greater than 6 months

1. February was a record month for ADHB population access to surgical procedures at ADHB. This was exceeded by 11% in March. March was exceeded by 9% in May
2. Surgical waitlist reduced since January by 17%. Clinic waitlist reduced by 12%
3. People waiting greater than 6 months for clinic and surgery has more than halved since January
4. Over the last 6 months an extra 55 Auckland people are getting elective surgery each week compared to first 6 months.
5. Second 6 months production was 37% above the reported first 6 months (23% after recodes). Notable services by volume are
    1. Ophthalmology, +353 discharges, +45%
    2. General Surgery, +243 discharges, +24%
    3. Paed ENT, +218 discharges, +61%
    4. Adult ENT, +124 discharges ,+ 34%

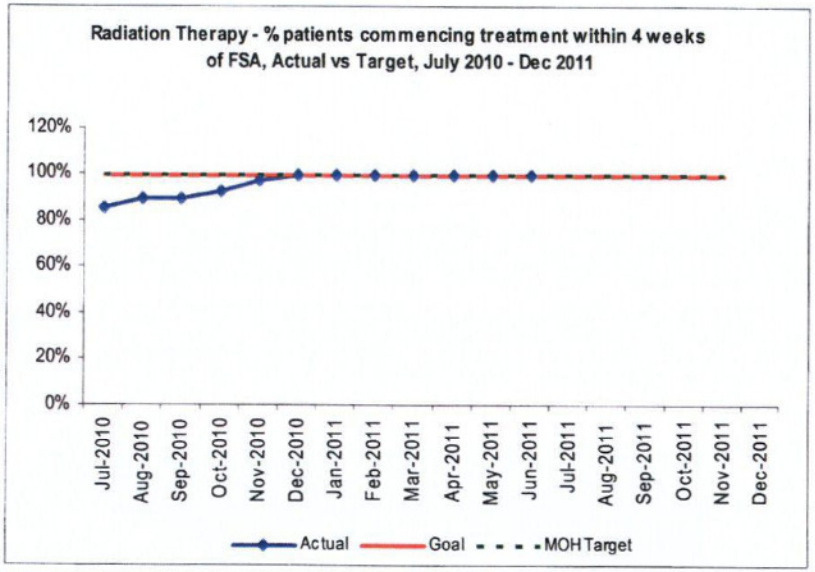
**Planned activities:**

1. Maintaining the increased level of in-house and outsource activity including new GSU capacity
2. Fortnightly meetings between the Director of Elective Services and service managers focussing on ESPI compliance and elective production.
3. Continuing to review the production plan at a daily level

| Activity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Discharges | 9,425 | 9,775 | 11,149 (note the target is incorrectly noted in the Statement of Intent as 10,227) | 11,179 | Achieved |

### 3. Shorter waits for cancer treatment

***Everyone needing radiation treatment will have this within four weeks by December 2010***




**Radiation Oncology Wait times – June 2011**

In June 100% of eligible patients were treated within the 4 week target timeline. As at 30 June Radiation Oncology has achieved more than 430 consecutive days of meeting the target.

**The following further improvements are in progress to sustain delivery:**

**Pantak [5] replacement** is underway and commissioning expected to be complete in July 2011

**Replacement of MV6 [6]**: Decommissioning commences early August until late December 2011. Evening shifts will be reinstated during this period to mitigate lost capacity

**Introduction of HDR [7]** for Gynaecological patients is currently being rolled out with a small number of patients receiving treatment in MV2.

**A public/private Model of care** has been developed to enable our clinicians to treat public patients at ARO[8]. Noting the variability in our referral flows, ARO have agreed to operate a 4 week rolling average of approx 4 patients per week from July 2011.

**Introduction of new technology:** The introduction of V-Mat treatment has the potential to reduce treatment times by up to 50% when fully implemented. A project team has been identified and will start work in July.

**Aria project**: A project is underway to develop a full electronic record within the LINAC machine's operating system. The project has been reviewed recently by Varian with excellent incremental improvements noted month on month. Project end expected Dec 2011.

**A weekly capacity modelling tool** has been developed and is now being used for future LINAC capacity planning, improved forecasting capability and management of workload.

An **"Operational team"** measures KPI's to prioritise the waitlist and analyse performance on a weekly basis.

A **daily Waitlist report** enables daily monitoring and immediate remedial action if required.

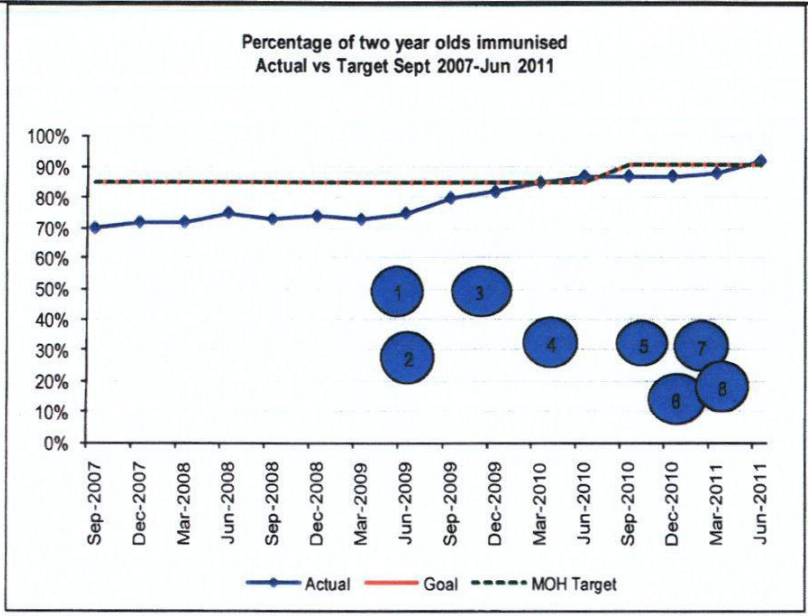
| Activity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % receiving treatment within 4 weeks of first specialist appointment | 100% | 100% | 100% | 100% | Achieved |

In the Chart above the Goal to achieve 100% commencing treatment within 4 weeks of their First Specialist Appointment prior to December 2010 reflects our aspiration rather than a goal.

[5] Pantak DXT 300 orthovoltage treatment machine
[6] MV6 is a linear accelerator
[7] HDR refers to enhanced images using Higher Dynamic Range Imaging
[8] Auckland Radiology Group

## 4. Increased Immunisation

***90 percent of two year olds will be fully immunised by July 2011; and 95 percent by July 2012.***




**Project Risks / Comments:**

As at 30 June 2011, ADHB's immunisation coverage (2 year olds full immunised all ethnicities) was 92% (regional target 90%, ADHB target 91%). On 30 June 2009 ADHB's immunisation coverage rate for Maori children aged 2 years was 68% (total coverage 75%). Maori coverage has now reached 88%, a 20 percentage points increase in two years. Pacific coverage was 78% and is now 95%. This achievement was the result of a huge effort by all providers, particularly general practices. It was also the result of more systematic and targeted approaches driven from ADHB Planning and Funding and the National Immunisation Register team. They were strongly supported by PHO based Immunisation Coordinators and more systematised outreach work by the Immunisation Advisory Centre based outreach team. Referrals to the outreach team nearly doubled earlier this year as the focus shifted to referring children overdue for scheduled immunisations much more quickly. This made the task of connecting with often mobile families easier. The relationship with PHO based Immunisation Coordinators has also been critical as has a district wide data analysis and improvement project. ADHB is committed to achieving the lowest possible incidence of vaccine preventable disease and to reducing inequalities by achieving the highest possible immunisation coverage across the whole population.

**Note the Statement of Intent identifies the target as 90% but the District Annual Plan has this at 91% to enable the Region to achieve 90%**

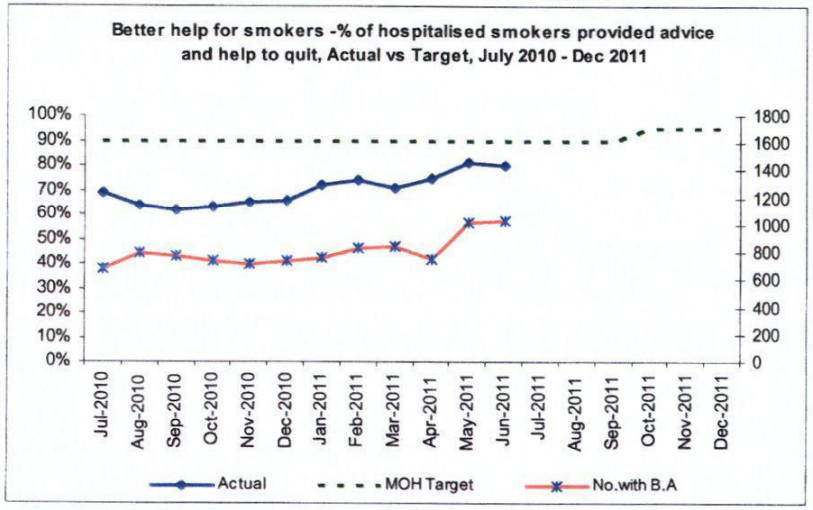
**Recent and Current activities**

1) Increase awareness project with PHOs driving information share
2) Practise based data (results) feedback
2a) Increase other feedback options
3) Improved understanding of IT linkages in Practice systems
4) Paper from the Auckland Diabetes Advisory Team to CPHAC requesting funding to implement improvements in diabetes care and management that will impact on National Health Targets.
5) Routine reports to clinical advisory leadership meetings
6) CPHAC initiatives for long term conditions quality improvement coordinators and population audit tool beginning to be implemented.
7) Regional shared care pathway work
8) Regional shared target setting and service outcomes

| Activity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of 2 year olds fully immunised | 74% | 86% | 91% | 92% | Achieved |

## 5. Better help for smokers to quit
## 5.1 Hospitalised smokers

***90 percent of hospitalised smokers will be provided with advice and help to quit by July 2011; and 95 percent by July 2012***




**Project Risks and Comments**

Of the 100,409 events coded in the 2010/11 financial year 13,667 (13.6%) were identified as smokers. A total of 9586 (70%) of all identified smokers were recorded as being given brief advice to stop smoking compared to 2924 (27%) the previous year. After a dip in the first six months from 69% in July the monthly rate reached 80% in May. The number of smokers recorded with brief advice increased from an average of 745 per month to around 1000 in May and June 2011.

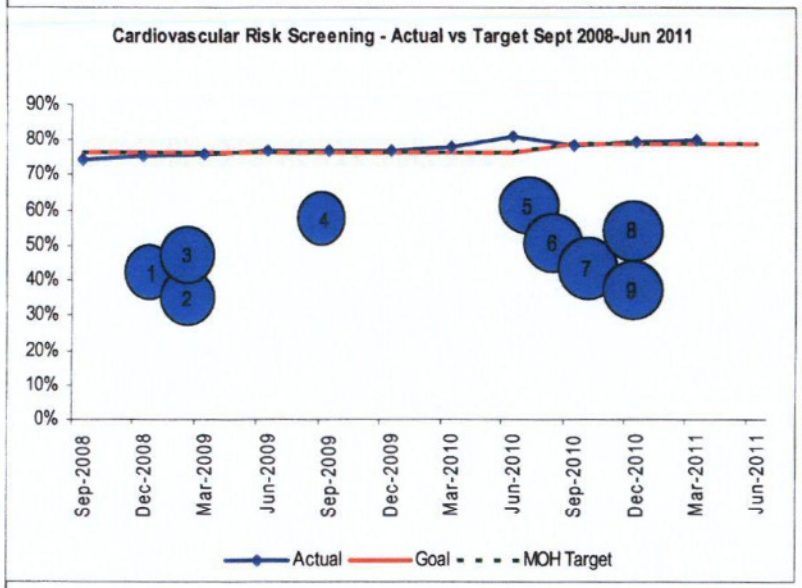
This is due to significant gains made in AED and APU and a growing number of wards implementing additional daily checks to ensure the ABC of smoking cessation is completed with every patient. These wards are routinely achieving the target. A focus on ward and coding audits identified gaps and issues that were addressed. Successful strategies have been shared with all services.

Work will continue with the Junior Doctors in order to reduce selection of the "not asked /not documented" option in the mandatory smoking section of the Electronic Discharge Summary. The key to lifting the results is continued improvement by the Emergency Department. Due to the high volumes and short stays AED represents the bulk of the shortfall with the remainder spread across all services in small numbers.

| Activity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of hospitalised smokers provided with advice to quit | 13% | 66% | 90% | 70% | Not Achieved |

**6. Better diabetes and cardiovascular services:**
**6.1 Cardiovascular Screening of eligible adult population**

***Increased percent of: (a) the eligible adult population will have had their CVD risk assessed in the last 5 years.***




**Project Risks / Comments:**
Project Risks / Comments:
The Q4 CVD data from the MOH is not yet available. However Q3 data showed a steady improvement on this target, giving us a 79.9% performance against a target of 79%. Individual targets for each ethnicity were also met.

We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract, which we will be reviewing in the coming months to ensure that incentives are properly aligned.

The data comes from the MOH and we do not have an annual position for the ADHB financial year. However as at quarter 4 we had achieved 78.8% against a target of 79% Total.

| Quarter | Maori | Pacific | Other | Total |
|---|---|---|---|---|
| One to June 2010 | 73.5% | 75.8% | 79.4% | 78.5% |
| Two to Sept 2010 | 74.5% | 76.7% | 80.3% | 79.45 |
| Three to Dec 2010 | 75.1% | 77.5% | 80.7% | 79.9% |
| Four to Mar 2011 | 74.3% | 76.1% | 79.6% | 78.8% |

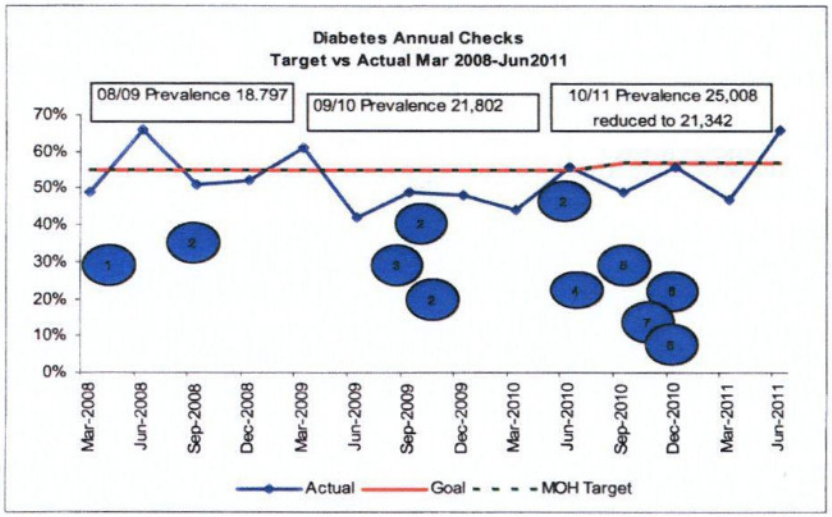
Source: Ministry of Health

**Recent and Current activities:**
) Support the uptake of an electronic CVD tool
2) Training and information system support for electronic tool
3) IT help line for GPs for risk assessment tool
4) Increase the cumulative incentive payments for achieving both good assessment and good management together
5) Review and reshape incentives to link with PPP targets
6) Enhance links to Green Rx and maximise primary care uptake
7) Continue to work in various workplaces to enhance CVD risk assessment for men
8) Link in with research looking at ways to optimise Pacific males participation in health self management
9) Work regionally to have similar focus on incentive goals

| Activity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of eligible patients cardiovascular risk screened-Total | 77% | 78% | 79% | 79% | Achieved |

## Better diabetes and cardiovascular services
## 6.2 Annual checks for people with diabetes

***Increased percent of: (b) people with diabetes will attend free annual checks***




**Project Risks / Comments**: ***How we ended up for the year***

Q4 shows a significant increase in the number of Diabetes Annual Reviews (DAR's) from the previous quarter, reaching 66% (9 % above target). Performance has been increasing steadily over the months with DAR's at 59% in April, 65% in May and 73% in June. The performance for "Other", which is where all of the underperformance has fallen, has shown a steady increase from 47% in March, to 50% in April, 53% in May and 67% in June, contributing to an overall Quarter 4 performance for Other of 57% (1% under target of 58%). Performance against target for Maori and Pacific continues to be strong, with Q4 performance for Pacific at 79% and for Maori 63% (against a target of 55%).

The Long Term Condition Quality Improvement Coordinators have visited a significant number of practices in ADHB and have gained a good understanding of systems and management of diabetes in Primary Care. They have supported and assisted practices to establish an accurate register of patients with diabetes, establish recall systems and utilise IT systems, such as Dr Info, to better manage their patients with Long Term Conditions. They have also met with a considerable number of stakeholders, including the Auckland Diabetes Centre, as part of their work to improve coordination of care between primary and secondary services.

Total for all ethnicities was 57% for the year. This is in line with target.

**Recent and Current activities**:

. 1) Increase awareness project with PHOs driving information share
2) Practise based data (results) feedback
2a) Increase other feedback options
3) Improved understanding of IT linkages in Practice systems
4) Paper from the Auckland Diabetes Advisory Team to CPHAC requesting funding to implement improvements in diabetes care and management that will impact on National Health Targets.
5) Routine reports to clinical advisory leadership meetings
6) CPHAC initiatives for long term conditions quality improvement coordinators and population audit tool beginning to be implemented.
7) Regional shared care pathway work
8) Regional shared target setting and service outcomes

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of eligible patients having Diabetes annual check-Total | 50% | 47% | 57% | 57% | Achieved |

## Better diabetes and cardiovascular services

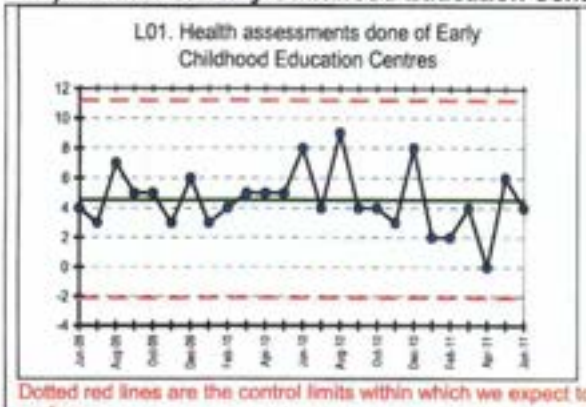
### Output Class 1: Public Health Services

The Auckland Regional Public Health Service is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau and Waitemata areas under contract from the ministry of Health. The service is responsible for improving population health outcomes and reducing inequalities. This work helps to reduce downstream demands on DHB's for personal health services.

### Output Class 1: Public Health Services

### 1 (a) Health protection

### 1ai) Number of Early Childhood Education Centres health assessed




Dotted red lines are the control limits within which we expect to perform.
The Blue line is the actual performance,
The Green line is the targeted performance

**Comment on performance for the year against target.**
During 2011-12 the ARPHS was actively engaged in promoting healthy and safe social and physical environments for children attending ECECs. ARPHS responded to all requests for health and safety inspections and inspected 49 ECECs. The majority of these inspections were conducted as part of the pre-licensing process, but three were in response to MoE requests following complaints.
Three disease outbreaks occurred in ECECs during the reporting period and ARPHS's ECEC and Disease Investigation teams conducted joint investigations in these centres. The ECEC team assessed hygiene and food safety during these investigations.

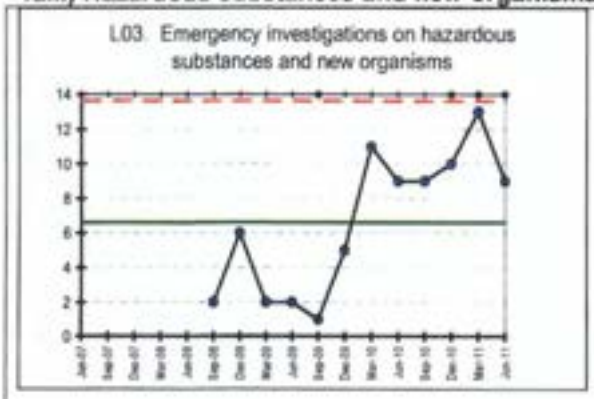
| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Number of Assessments | 60 | 59 | 100% (49) | 100% | Achieved |

### 1aii) Number of drinking water investigations to monitor/improve the quality.

**Comment on performance for the year against target.**
This service is demand driven. All incidents, complaints and notifications of threats to drinking water quality, received by the ARPHS, are investigated. Of the investigations carried out, four uncovered serious transgressions which required reporting to the MoH.
In total, 47 investigations were carried out. During the reporting period there were ten complaints and two major incidents. The major incidents were: E.coli transgressions (North Shore) and return to service plan post gas explosion (Onehunga) to which ARPHS provided immediate investigation and public health advice to prevent further outbreaks and related morbidity.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of investigations | 130 | 140 | Between 100-130 | 47 | Not achieved |

### 1aiii) Hazardous substances and new organisms emergency investigations

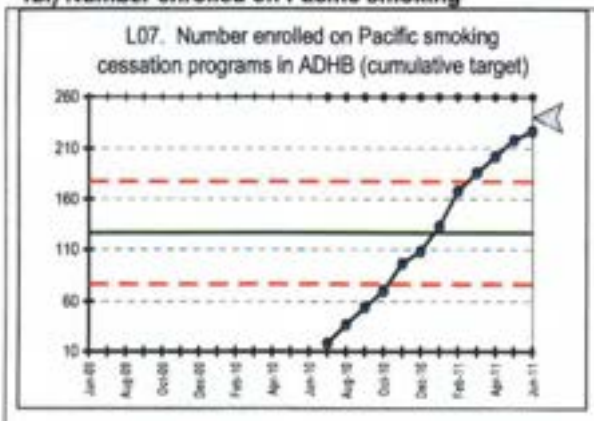



**Comment on performance for the year against target.**
All exposures, hazardous substance events and complaints of breaches of the HSNO Act, which were notified to the ARPHS, were investigated. A total of 42 investigations were carried out. The two most common categories of hazard were gas leaks and ammonia leaks.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of emergency investigations | 100% | 100% | 100% | 100% | Achieved |

### 1b) Health promotion

#### 1bi) Number enrolled on Pacific smoking




**Comment on performance for the year against target**
This is a new initiative
Despite delays in contract sign off for the period 1 October 2010 to 30 June 2011 enrolled client targets have been met and quit rates have remained high.
A consistent increase of new clients enrolled with Pacific Smoking Cessation service has resulted in part due to the considerable efforts made to develop and strengthen strategic relationships with key stakeholders in the health sector. Opportunities to promote the service at Pacific events including the Pasifika Festival, Western Springs and the ADHB Pasifika Festival week were useful, raising the service profile. Promotional resources profiling client success stories are now being used to encourage pacific individuals and their families to join the programme.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Number enrolled | New initiative | 278 | 240 | 217 | Not achieved |

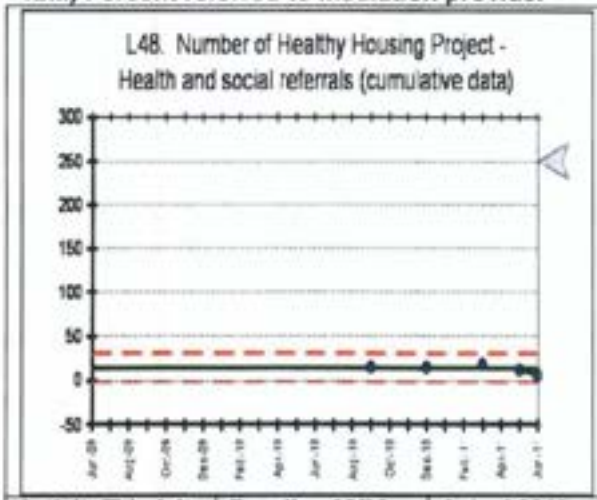
## 1b) Health promotion

### 1bii) Number of assessments


**Comment on performance for the year against target**
The Healthy Housing Project contract was amended to a target of 280 assessments. As such the Project has achieved 94% of the target number of joint health and social assessments in partnership with Housing New Zealand Corporation (HNZC). Targets were not reached due to the restructuring within HNZC over the last few months and the consequent unavailability of HNZC project coordinators to undertake joint assessments.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of Assessments | 200 | 501 | 500 | 263 | Not Achieved |

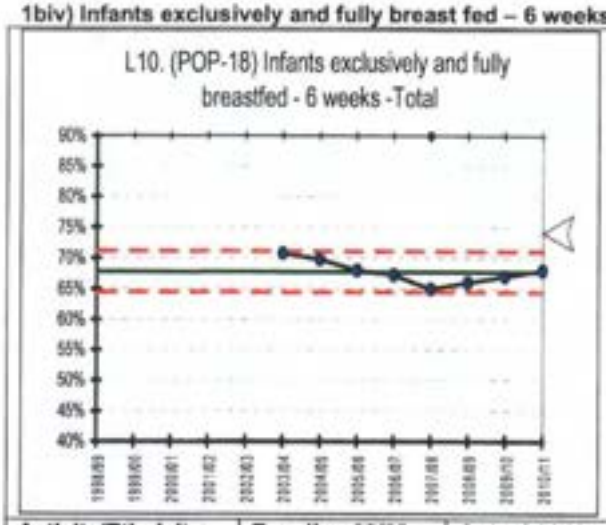
### 1biii) Percent referred to insulation provider




**Comment on performance for the year against target**
145 referrals for health and social needs were made by the Health Housing Project team in the 10/11 year. Referrals are made on the basis of need and all households requiring referrals for health and social needs we referred.
We refer 100% of people who need referring, in the last financial year that was 55% of clients

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of referrals | 80% | 74% | 80% | 55% | Not achieved |

### 1biv) Infants exclusively and fully breast fed – 6 weeks

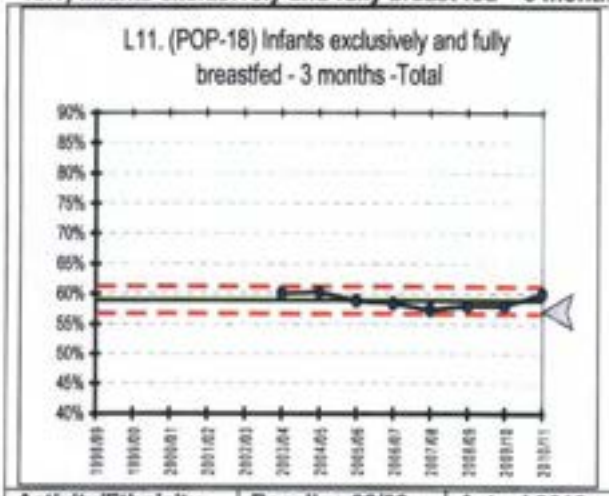



**Comment on performance for the year against target**
Slow progress but improved referral pathways for the Community Breastfeeding Service (CBS) will assist in providing support and preventing drop off in breastfeeding post discharge.

ADHB has a contract with Plunket for a Community Breastfeeding Service that employs Maori, Pacific and Asian breastfeeding support workers; 1,214 mothers and babies were enrolled with the service in 2010/11.
ADHB established agreements with Ngati Whatua O Orakei Health Services and Plunket to achieve Baby Friendly Community Initiative (BFCI) accreditation. The NZ Breastfeeding Authority is auditing this process, which focuses on health services protecting promoting and supporting breastfeeding.
A 2011 Breastfeeding Service Directory was developed and widely disseminated including NWH and Birthcare providing copies to new mothers so that they are well informed of breastfeeding support services available in their communities.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % Breastfed at 6 weeks | 66.6% | 67% | 74% | 68% | Not Achieved |

### 1biv) Infants exclusively and fully breast fed – 3 months



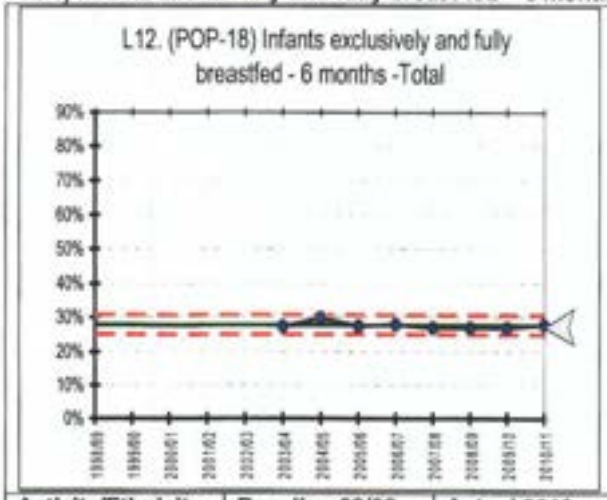

**Comment on performance for the year against target**
Target achieved; exceeding MoH target.

Data comes from Plunket via the Ministry of Health and is as at 31st December 2010.

The Community Breastfeeding Service is able to support mothers to maintain breastfeeding through till at least six months.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % Breastfed at 3 months | 57.3% | 58% | 57% | 60% | Achieved |

### 1biv) Infants exclusively and fully breast fed – 6 months




**Comment on performance for the year against target**
Target achieved; exceeding MoH target.

Data comes from Plunket via the Ministry of Health and is as at 31st December 2010.

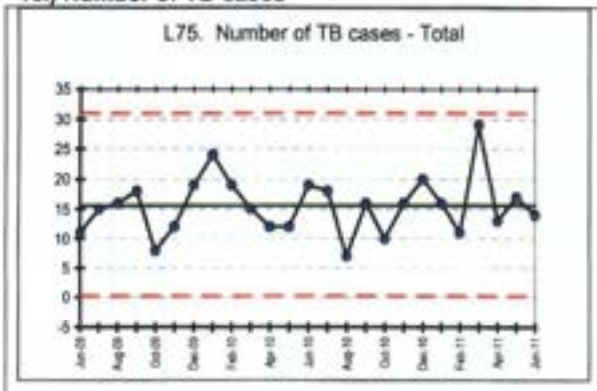
The Community Breastfeeding Service is able to support mothers to maintain breastfeeding through till at least six months.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achieved |
|---|---|---|---|---|---|
| % Breastfed at 6 months | 27% | 27% | 27% | 28% | Achieved |

## Output Class 1: Public Health Services

### 1c) Communicable Disease Control –Disease notifications: investigations as required

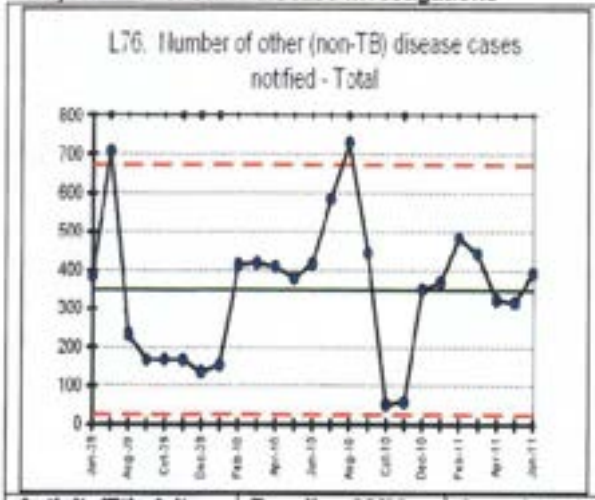
#### 1ci) Number of TB cases




**Comment on performance for the year against target**
During the 2010-11 financial year ARPHS's Communicable Diseases Team investigated all TB disease cases requiring investigation – a total of 187 investigations for the year. This is for the whole Auckland region. There were 64 TB disease cases in the ADHB region. There has been a consistently high rate of TB disease case notifications in ADHB this year. In nine out of the 12 months the highest number of TB disease cases requiring investigation was in the ADHB catchment.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Number of TB cases | 400 | 174 cases<br>100% | 100% | 187 cases<br>100% | Achieved |

### 1cii) Number of other disease investigations




**Comment on performance for the year against target**
Of the 4,551 disease cases notified to ARPHS, 2,786 required investigation. 264 of these investigations were carried out in the ADHB catchment.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Number of other communicable disease investigations | 900 | 3,772<br>100% | 100% | 4,551 cases<br>100% | Achieved |

## 1d) Immunisation

### 1di) Support GP's in submitting data to the National Immunisation Register (NIR) and follow-up-Babies/children not immunised

**The National Immunisation Register (NIR)** is a computerised information system that has been developed to hold immunisation details of New Zealand children.

The purpose of the NIR is to assist New Zealand to improve its immunisation rates. Improved immunisation coverage will offer individual protection against vaccine-preventable diseases and protection for the community against recurring epidemics

The NIR enables authorised health professionals to quickly and easily find out what vaccines a child has been given (this includes children whose family has shifted to another area or changed healthcare providers). This will help to make sure immunisations are given at the appropriate time.

The Register will also provide a more accurate record of immunisation coverage rates – regionally and nationally. This will enable better programme planning to target populations with the lowest immunisation rates.
Source: Ministry of Health

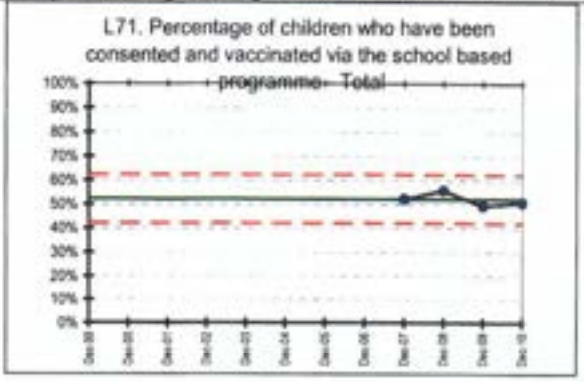
**Comment on performance for the year against target**
Major project undertaken to compare and correct data held on PMS and the NIR. Practice Nurse education + manual provided. All overdue children referred to outreach service.
New contracts entered into with PHOs for Immunisation Coordinators in primary care. PHOs and Outreach service represented on the ADHB Immunisation Governance Group. In 2011/12 it is planned to establish an operational group to develop an integrated approach to managing systems and processes associated with immunisation. This will be led in the first instance by ADHB Planning & Funding and include the Immunisation Coordinators, NIR staff, and the Outreach Immunisation service as well as representation from Waitemata DHB and in all likelihood Counties Manukau DHB.

PMS = Patient Management System

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Support GPS in submitting to the National Immunisation Register | 1,000-1,300 referrals to immunisation outreach services | 1,574 referrals | Up to 1,300 referrals | Not quantified | Not achieved |

1 dii) Percentage of two-year olds fully immunised is a National Target. Refer above to page 101

1diii) Percentage of eligible and consented children completing the year 7 vaccination




**Comment on performance for the year against target**
This is a schools based programme.

The Target is only the school based programme. An additional 20% of children decline due to already having had vaccine at GP.

The data is for the School year and is entered into the KPI database in November for the Year to 31 December 2010.

KPI= Key Performance Indicator

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % vaccinated | 57% | 49% | 63% | 51% | Not achieved |

## 1e) Screening

1ei) Eligible women participating in the National Cervical Screening Programme, particularly: Maori, Pacific and Asian women (3year coverage rate for 20-65 yr women)

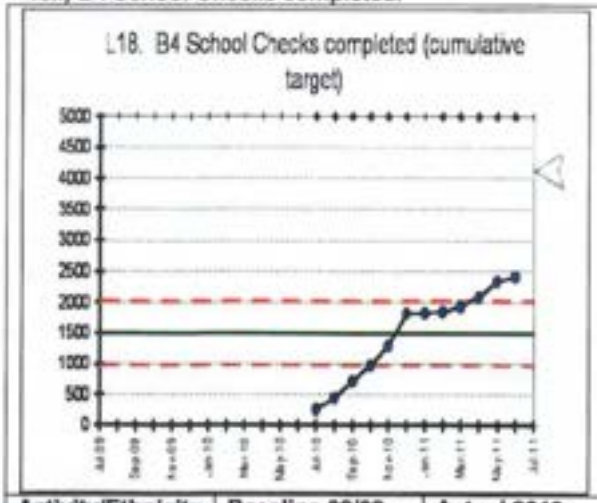
| | 3-Year Coverage Hysterectomy Adjusted (%) |
|---|---|
| Ethnicity | |
| Asian | 51.7% |
| Maori | 55.4% |
| Other ethnic groups | 86.5% |
| Pacific | 60.9% |
| Total | 76.1% |

**Comment on performance for the year against target**
Coverage data supplied are from December 2010 and are the most recent data available from the National Screening Unit.

All contractual obligations have been met. Draft report of Regional Service audit which took place on 27 July 2010 received June 2011. Audit report "recognised a high level of compliance with the requirements of the NCSP" and the Regional Service team were "commended by the auditors for their commitment to the provision of the women-focussed and caring services evident throughout this audit".
Although the target was not achieved significant progress was made. ADHB Planning & Funding is now the initial regional contact for the Ministry of Health with regard to cervical screening matters. The purpose of this is to facilitate a more coordinated approach.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % screened aged 20-65 | 65% | 70.35% | 80% (this was the contract target) | 76.1% | Not Achieved |

**1eii) B4 School Checks completed.**




**Comment on performance for the year against target**
ADHB did not achieve its targets for 2010/11. There were a number of contributing factors to this outcome, the main one being that ADHB transitioned to a primary care led service delivery model on 1 January 2011 and the uptake by general practices was slow and disappointing. Modifications to the service delivery model are being made.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Number of checks | 1,800 | 3,478 | 3,600 | 2,408 | Not Achieved |

## Output Class 2: Primary and Community Services

### Primary healthcare

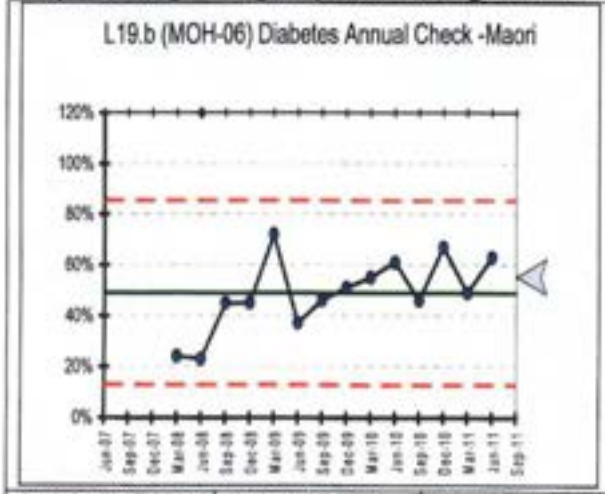
Sooner, Better, More Convenient Primary Health Care is a priority of government. We are working with our PHO partners to ensure the population of Auckland DHB has easy access to the general practice health services they require.

### Community Services

Auckland DHB contracts with a range of non government organisations and other community based providers to provide health and disability support services for people living in Auckland City.

The range of community health services includes a number of Maori and Pacific providers who focus on interventions to reduce health inequalities, in particular child health and reduction in rates of their respective morbidity and mortality from cancer, diabetes, and cardiovascular disease – these non residential services feature in the targets in this section of the Statement of Service Performance

**2 ai) Percentage of eligible patients having Diabetes annual check Maori**

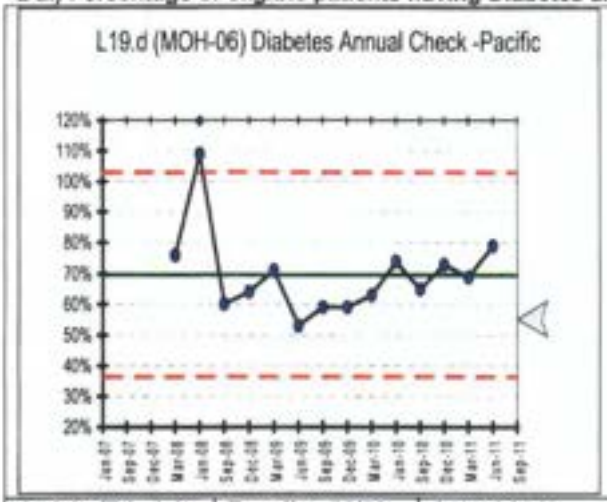



**Comment on performance for the year against target**
The target for this indicator is cumulative and is based on the number of Diabetes Annual Reviews (DARs) that were undertaken during 2010/11. However the graph shows quarterly activity rather than cumulative activity.

Overall we achieved 59% against a target of 55%. We also achieved target for most quarters during the 2010/11 year.

| Activity/Ethnicity | Baseline 08/09 | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of eligible patients having Diabetes annual check-Maori | 50% | 55% | 55% | 59% | Achieved |

**2 ai) Percentage of eligible patients having Diabetes annual check- Pacific**

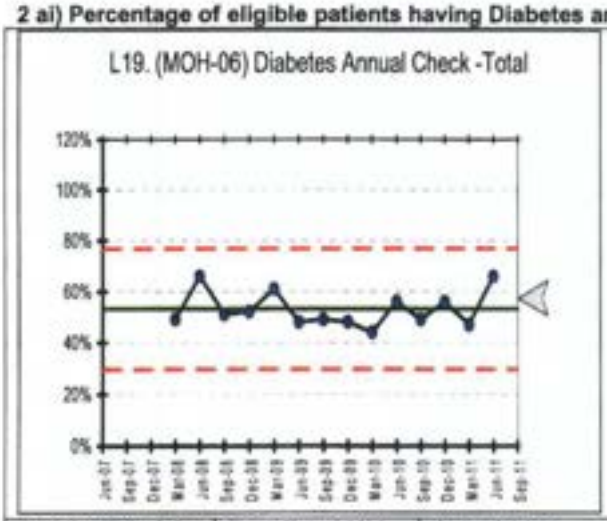



**Comment on performance for the year against target**
The target for this indicator is cumulative and is based on the number of Diabetes Annual Reviews (DARs) that were undertaken during 2010/11. However the graph shows quarterly activity rather than cumulative activity.

Overall we achieved 75% against a target of 55%, with an extra 550 Pacific people receiving their Diabetes Annual Review in 2010/11 compared to 2009/10.

| Activity/Ethnicity | Baseline 08/09 | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of eligible patients having Diabetes annual check-Pacific | 50% | 65% | 55% | 75% | Achieved |

**2 ai) Percentage of eligible patients having Diabetes annual check- Total**

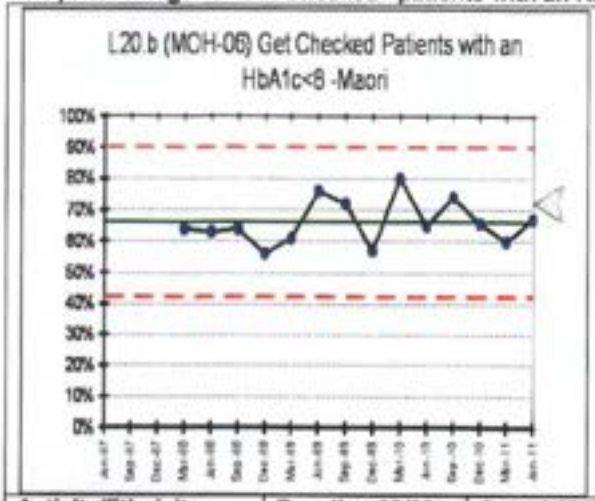



**Comment on performance for the year against target**
The target for this indicator is cumulative and is based on the number of Diabetes Annual Reviews (DARs) that were undertaken during 2010/11. However the graph shows quarterly activity rather than cumulative activity.

At year end we achieved this target, with a considerable amount of activity happening in the last quarter. The majority of underperformance fell into the "other" group, as targets for Maori and Pacific were met. A further 1784 Diabetes Annual Reviews were done in 2010/11 compared to 2009/10.

| Activity/Ethnicity | Baseline 08/09 | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of eligible patients having Diabetes annual check-Total | 50% | 47% | 57% | 57% | Achieved |

**2aii) Percentage of "Get Checked "patients with an HbA1c<8 Maori**



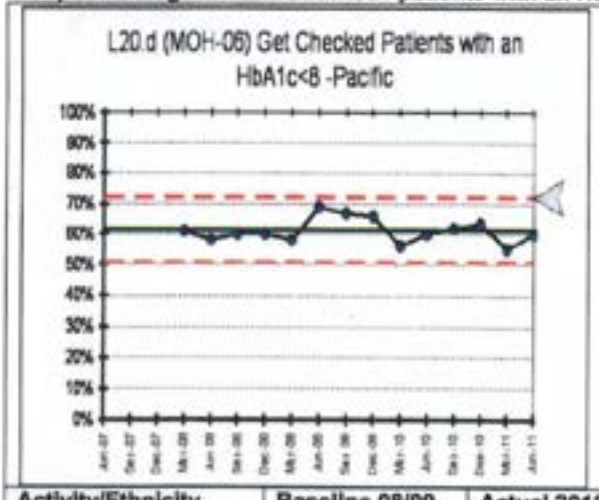

**Comment on performance for the year against target**
As above, the target for this indicator is cumulative and is based on the number of Diabetes Annual Reviews (DARs) that were undertaken with an HbA1c of ≤ 8%. However the graph is based on quarterly activity rather than cumulative activity.

Whilst this target has not been met, we have improved performance since 2009/10, where we achieved 63% of Maori with an HbA1c of ≤ 8%. In numbers, this is an increase of 477 people in 2009/10 with an HbA1c of ≤ 8% to 530 in 2010/11.

We have implemented a new Diabetes Self Management Education (DSME) contract at the start of 2010/11, which is being provided through our Maori PHO – Te Hononga O Tamaki Me Hoturoa and aims to achieve better access (in terms of location and cultural competency) for our High Needs populations.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % "get Checked" patients with an HbA1c<8 Maori | 70% | 63% | 72% | 67% | Not Achieved |

**2aii) Percentage of "Get Checked "patients with an HbA1c<8 Pacific**



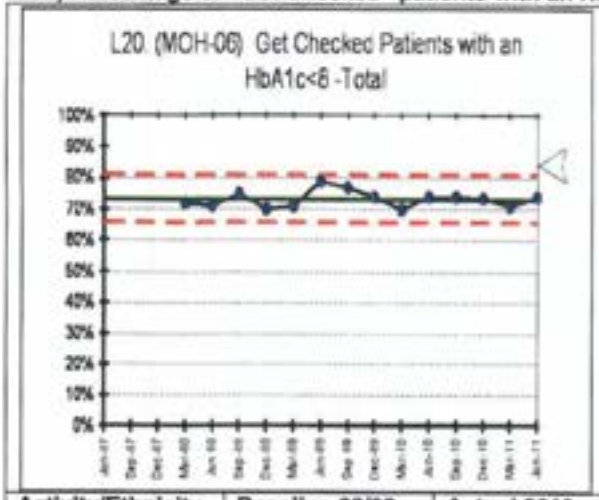

**Comment on performance for the year against target**
As above, the target for this indicator is cumulative and is based on the number of Diabetes Annual Reviews (DARs) that were undertaken with an HbA1c of ≤ 8%. However the graph is based on quarterly activity rather than cumulative activity.

Unfortunately we have not made much movement in this target, achieving 60% in 2008/09, 59% in 2009/10 and 60% in 2010/11. However as the number of checks has increased for Pacific, the number of people being managed with an HbA1c of ≤ 8% has also increased. In 2008/09 1,654 Pacific people had an HbA1c of of ≤ 8%, in 2009/10 this was 1,920 and in 2010/11 it was 2,279.

We have implemented activities to support this target for Pacific, including the DSME contract noted earlier and a generic self management programme that is being rolled out through the Healthy Village Action Zones framework. (Participating Pacific Churches in a network)

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % "get Checked" patients with an HbA1c<8 Pacific | 60% | 59% | 72% | 60% | Not Achieved |

**2aii) Percentage of "Get Checked "patients with an HbA1c<8 Total**



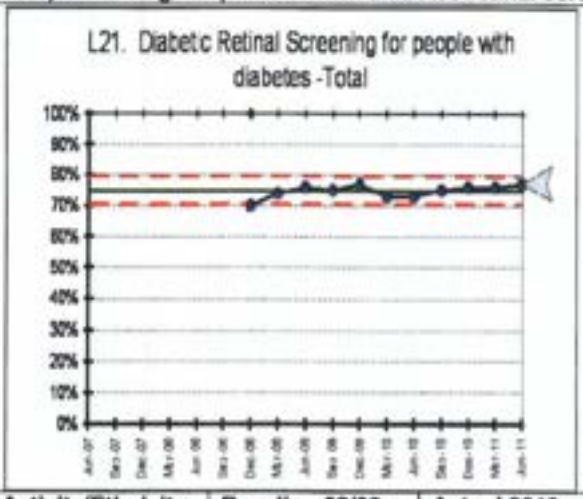

**Comment on performance for the year against target**
The target for this indicator is cumulative and is based on the number of Diabetes Annual Reviews (DARs) that were undertaken with an HbA1c of ≤ 8%. However the graph is based on quarterly activity rather than cumulative activity.

Overall we achieved 74% for this target, which is A 1% increase on the 2009/10 performance. It is important to also note the denominator increase between 2009/10 and 2010/11 due to the increased number of people receiving their DAR. In 2009/10 we completed 10,294 DARs while in 2010/11 we completed 12,078 DAR's. In 2009/10 of those people that had a DAR, 7,493 people that had an HbA1c of of ≤ 8% compared to 8,883 people in 2010/11 (a further 1,390 people with "satisfactory" diabetes management).

A number of primary care initiatives are in place to support better diabetes management, which aim to improve performance against this target.

| Activity/Ethnicity | Baseline 08/09 | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % "get checked" patients with an HbA1c<8 Total | 70% | 73% | 84% | 74% | Not Achieved |

**2aiii) Percentage of patients with diabetes retinal screened. Total**



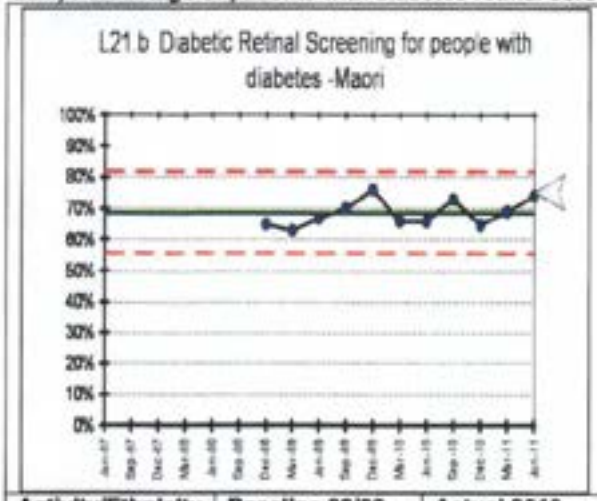

**Comment on performance for the year against target**
As above, the target for this indicator is cumulative and is based on the number of Diabetes Annual Reviews (DARs) that received retinal screening in the last two years. However the graph is based on quarterly activity rather than cumulative activity.

Unfortunately we were 1% below the target of 77% for this indicator. However this does represent an improvement from the 2009/10 year where only 71% of the population that had a DAR had their retinal screen in the last 2 years.

Once the community retinal screening project (A project to improve access to Diabetes photo screening services) is live, the addition of the community retinal screening sites will increase both access and capacity for our population and help us achieve target.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of patients with diabetes retinal screened-Total | 75% | 71% | 77% | 76% | Not Achieved |

**2aiii) Percentage of patients with diabetes retinal screened. Maori**



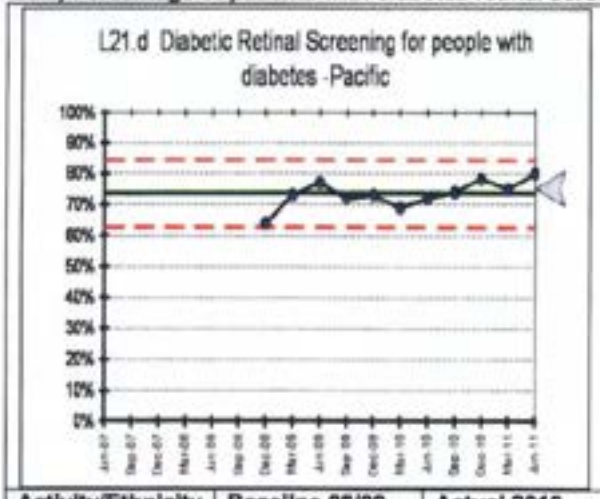

**Comment on performance for the year against target**
As above, the target for this indicator is cumulative and is based on the number of Diabetes Annual Reviews (DARs) that received retinal screening in the last two years. However the graph is based on quarterly activity rather than cumulative activity.

We did not achieve target for this indicator, falling 7% below target at year end. However performance has increased from 2009/10, where we achieved 66% retinal screening for Maori.

As above, the addition of the community retinal screening sites, which will be located in high needs areas, should improve access for Maori.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of patients with diabetes retinal screened - Maori | 75% | 66% | 77% | 70% | Not achieved |

**2aiii) Percentage of patients with diabetes retinal screened. Pacific**

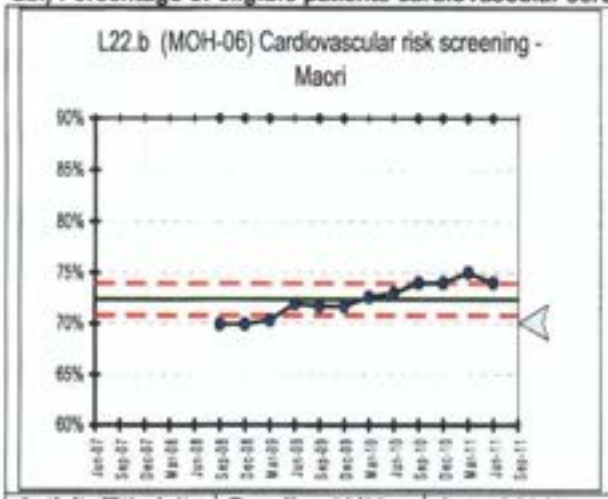



**Comment on performance for the year against target**
As above, the target for this indicator is cumulative and is based on the number of Diabetes Annual Reviews (DARs) that received retinal screening in the last two years. However the graph is based on quarterly activity rather than cumulative activity.

It is pleasing to see we have meet the target for Pacific retinal screening, which also shows a significant improvement from the 2009/10 year, where we achieved 69%.
As above, the addition of the community retinal screening sites, which will be located in high needs areas, should further improve access for Pacific populations.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of patients with diabetes retinal screened-Pacific | 75% | 69% | 77% | 77% | Achieved |

**2b) Cardiovascular Disease**
**Percentage of eligible patients cardiovascular screened –Included in National targets**
**2bi) Percentage of eligible patients cardiovascular screened - Maori**




**Comment on performance for the year against target**
The target for this indicator is cumulative, however the data in this graph shows quarterly activity based on a rolling 5 year period, with the Q4 period being 01 Apr 2006 to 30 June 2011.

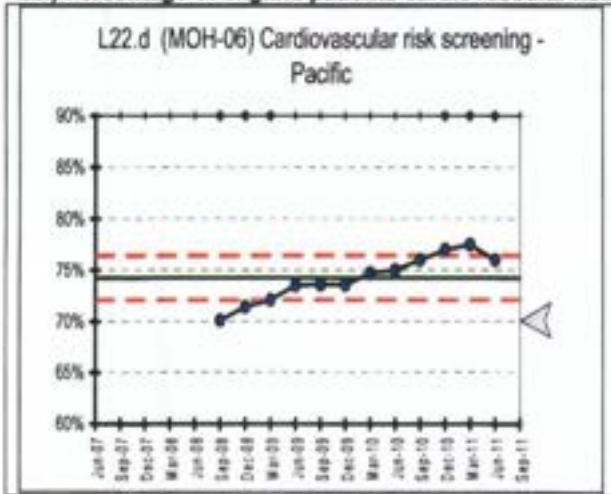
The data comes from the MOH and we do not have an annual position for the financial year. However as at quarter 4 (March 2011) we had achieved 74.3% against a target of 70% for Maori. Refer to chart on Page 103

Of note is that the MOH will be changing the basis of this target during the 2011/12 year.

The Ministry reporting year is Quarterly to Year Ended March 2011 and the actual for 2011 is at this date.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of eligible patients cardiovascular risk screened - Maori | 71% | 73% | 70% | 74% | Achieved |

**2bi) Percentage of eligible patients cardiovascular risk screened - Pacific**




**Comment on performance for the year against target**
The target for this indicator is cumulative, however the data in this graph shows quarterly activity based on a rolling 5 year period, with the Q4 period being 01 Apr 2006 to 31 Mar 2011.

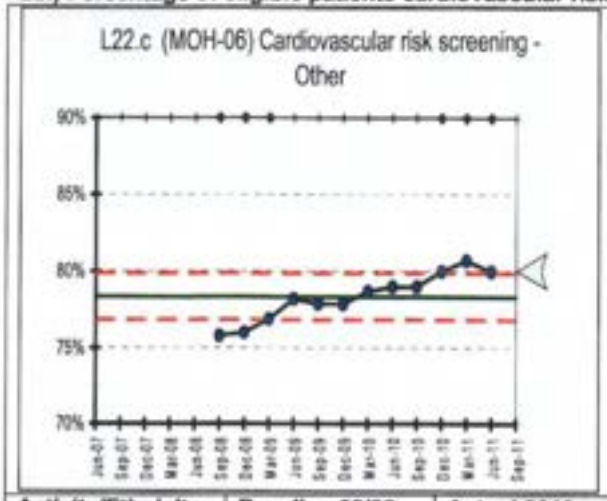
The data comes from the MOH and we do not have an annual position for the financial year. However as at quarter 4(March 2011) we had achieved 76.1% against a target of 70% for Pacific.

Of note is that the MOH will be changing the basis of this target during the 2011/12 year.

The Ministry reporting year is Quarterly to Year Ended March 2011 and the actual for 2011 is at this date.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of eligible patients cardiovascular risk screened - Pacific | 71% | 75% | 70% | 76% | Achieved |

**2bi) Percentage of eligible patients cardiovascular risk screened - Other**




**Comment on performance for the year against target**
The target for this indicator is cumulative, however the data in this graph shows quarterly activity based on a rolling 5 year period, with the Q4 period being 01 Apr 2006 to 31 Mar 2011.

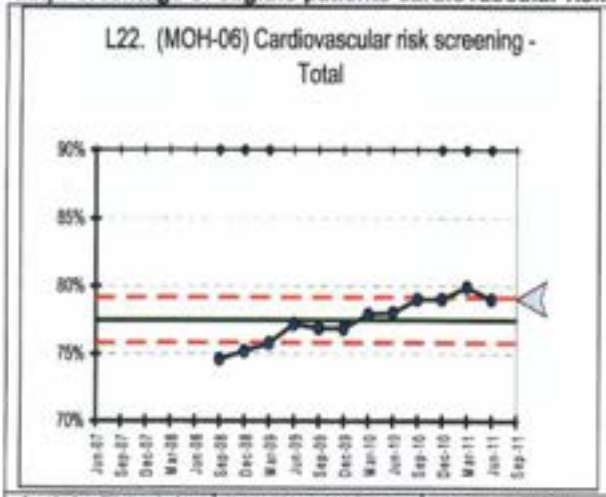
The data comes from the MOH and we do not have an annual position for the financial year. However as at quarter 4 we had achieved 79.6% against a target of 80% for Other.

Of note is that the MOH will be changing the basis of this target during the 2011/12 year.

The Ministry reporting year is Quarterly to Year Ended March 2011 and the actual for 2011 is at this date.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of eligible patients cardiovascular risk screened - Other | 78% | 79% | 80% | 80% | Achieved |

**2bi) Percentage of eligible patients cardiovascular risk screened - Total**




**Comment on performance for the year against target**
The target for this indicator is cumulative, however the data in this graph shows quarterly activity based on a rolling 5 year period, with the Q4 period being 01 Apr 2006 to 31 Mar 2011.

The data comes from the MOH and we do not have an annual position for the financial year. However as at quarter 4 we had achieved 78.8% against a target of 79% Total.

Of note is that the MOH will be changing the basis of this target during the 2011/12 year.

The Ministry reporting year is Quarterly to Year Ended March 2011 and the actual for 2011 is at this date.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of eligible patients cardiovascular risk screened-Total | 77% | 78% | 79% | 79% | Achieved |

**2bii) Percentage increase in programmes and options available for cardiac rehabilitation-Total**

A graph does not exist for this information.

**Comment on performance for the year against target**

**Exercise component of Cardiac rehab**

Although there has not been an increase in exercise cardiac rehab sessions in the 10/11 year (total 46) this is because of capacity (staff and space). These are well attended and there is a wait list. The project team are scoping a step down exercise in the community to match the education classes to better meet the demand and to offer improved options for people who find attending the GCC site difficult.

**Education component of Cardiac rehab**

The existing 24 courses currently being run have been increased by 5, with 1 additional evening course and 4 new community sessions in Avondale/Lynnfield

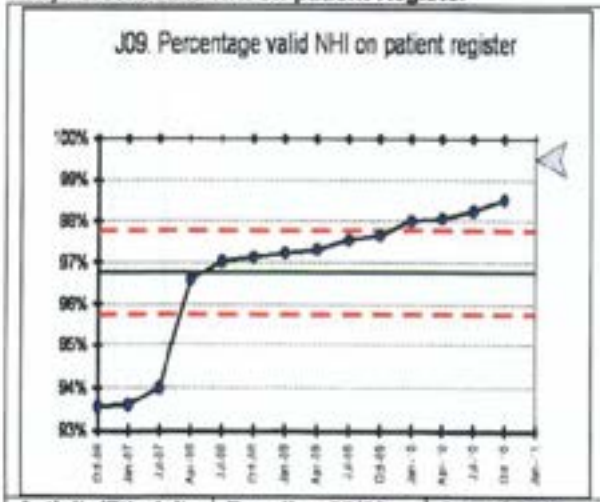
There has also been an increase in the utilisation of the structured Heart Guide approach, from 10 patients in 2009/10 to 60 in 2010/11.

There has also been the introduction of CPR courses of which 2 were run in 2010/2011 and it is planned to run 4 in 2011/2012

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % increase in programmes and options available for cardiac rehabilitation | 55% | 78% | 5% increase for all groups | 80% at March 2011 | Achieved |

**2c) PHO Services**

**2ci) Percent valid NHI on patient Register**



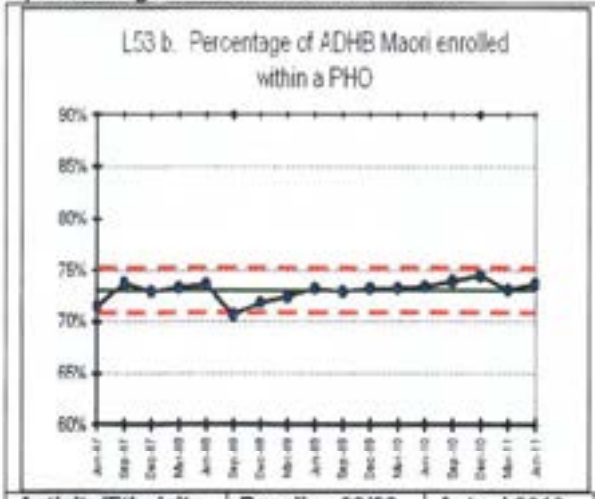

**Comment on performance for the year against target**

The latest data for this target is to October 2010.

As at the October 2009 the % valid NHI on the patient register was 97.66%. There has been an improvement of .86% in the year to October 2010

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % valid NHI on patient register | 97% | 97.66% | 98% | 98.52% | Achieved |

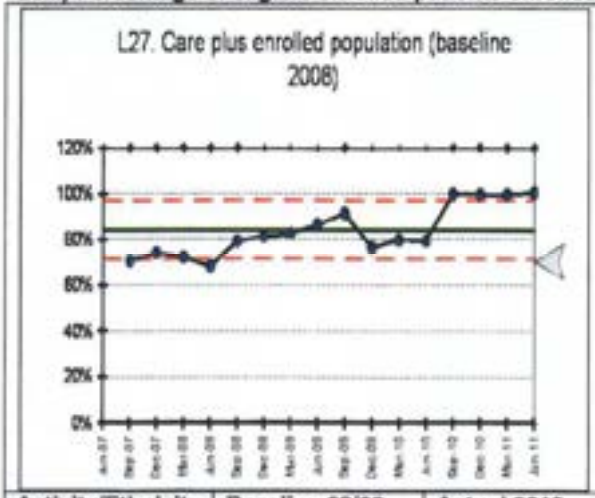
**2cii) Percentage of Maori enrolment in PHOs**




**Comment on performance for the year against target**
An initiative was started in 2010/11 to try to understand the enrolment issues around ethnicity within PHOs. This work is continuing.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % enrolled | 72.4% | 72% | 80% | 74% | Not achieved |

**2ciii) Percentage of eligible enrolled patients enrolled on Care Plus.**




**Comment on performance for the year against target**
Auckland DHB expects that the 100% of care plus enrolled population will continue. The funding is to be merged in to a flexible funding pool in the near future which will include SIA and HP funding and PHOs will be paid at a level equal to 100% funding. .

SIA = Services to Improve Access

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % enrolled population | 69.2% | 79.6% | > 70% of eligible patients enrolled - | 100% | Achieved |

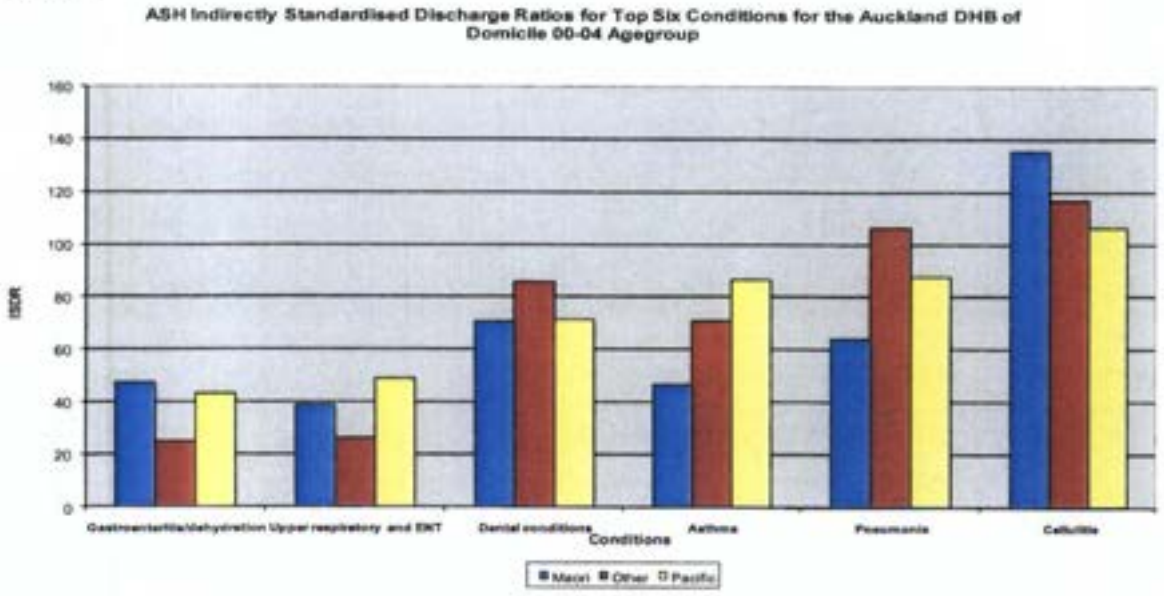
**2civ) Percentage of palliative care patients in receipt of PHO services**

| | |
|---|---|
| | **Comment on performance for the year against target**<br>Not reported on.<br><br>This is the same indicator as the information recorded in 4ci) Number of Palliative clients accessing primary care under the subsidised DHB/PHO partnership.<br><br>4ci) Number of palliative clients accessing primary care under the subsidised DHB/PHO partnership |

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Percentage of palliative care clients in receipt of PHO services | 1,200 deaths per year | Data not collected in 2009/10 | 15% of clients (cumulative) | Not recorded | Not recorded |

**2di) Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health**

**Age Under 5**




Source: Ministry of Health.
The Ministry records this data for the year to 31 March 2011.
Indirectly Standardised Discharge Ratio (IDSR) is the ratio of actual to expected Ambulatory Sensitive Hospitalisations

**2di) Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health – Maori**


**Comment on performance for the year against target**
This target is tracked by the Ministry of Health for the year to 31 March 2011.

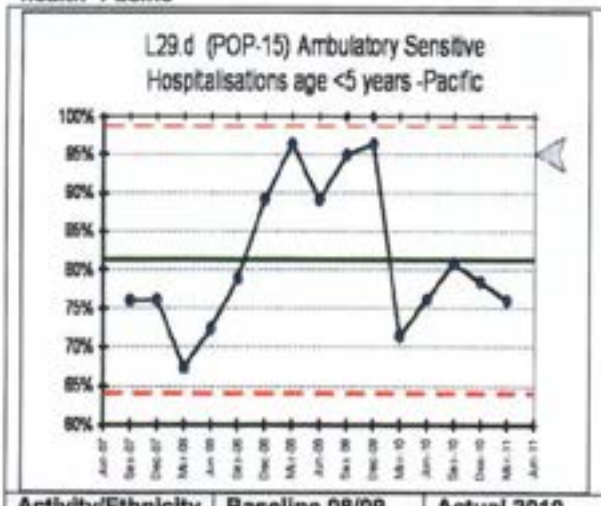
Age group 00-04, Auckland DHB rates were below the national average.

Refer to the above graph for the nature and relative prevalence of illness contributing to admissions.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of avoidable admissions under 5 yrs Maori | <95% | 68% | Remain below 95% of the national average | 68% as at March 2011 (the latest data from the MoH) | Achieved |

There is no "national average". In the indirect standardisation, the national is always 100%.
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

**2di) Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health -Pacific**




**Comment on performance for the year against target**
This target is tracked by the Ministry of Health for the year to 31 March 2011.

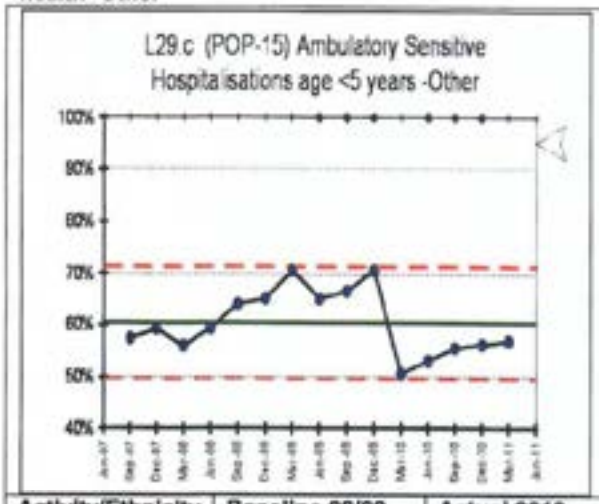
Age group 00-04, Auckland DHB rates were below the national average and the targets will remain below the national.

Refer to the above graph for the nature and relative prevalence of illness contributing to admissions.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of avoidable admissions under 5 yrs Pacific | <95% | 71% | Remain below 95% of the national average | 76% as at March 2011 (the latest data from the MoH) | Achieved |

There is no "national average". In the indirect standardisation, the national is always 100%.
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

**2di) Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health -Other**




**Comment on performance for the year against target**
This target is tracked by the Ministry of Health for the year to 31 March 2011.

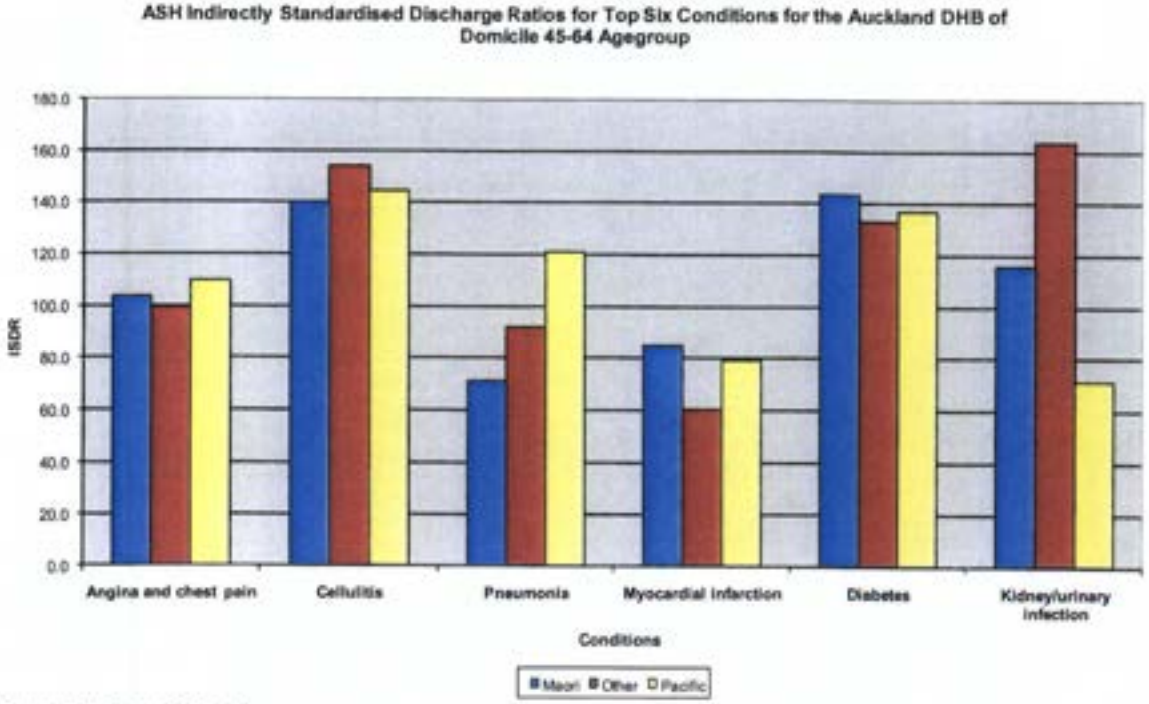
Age group 00-04, Auckland DHB rates were below the national average and the targets will remain below the national.

Refer to the above graph for the nature and relative prevalence of illness contributing to admissions.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of avoidable admissions under 5 yrs Other | <95% | 51% | Remain below 95 % of the national average | 57% as at March 2011 (the latest data from the MoH) n/a | Achieved |

There is no "national average". In the indirect standardisation, the national is always 100%.
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

**2dii) Percentage of unnecessary hospital admissions (45-64)**
**Age 45-64**




Source: Ministry of Health.
The Ministry records this data for the year to 31 March 2011.
Indirectly Standardised Discharge Ratio (IDSR) is the ratio of actual to expected Ambulatory Sensitive Hospitalisations

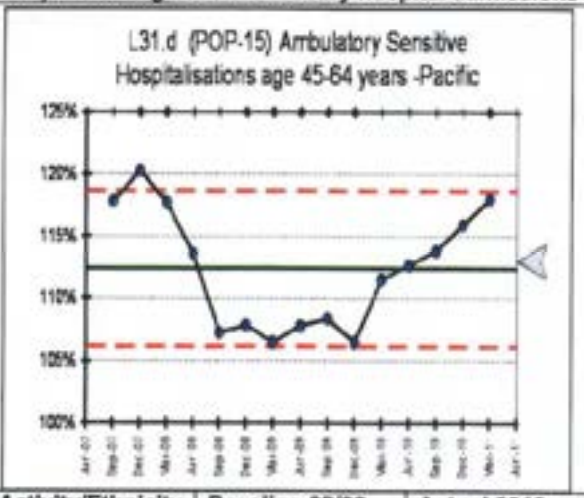
**2dii) Percentage of unnecessary hospital admissions for Maori (45-64)**


**Comment on performance for the year against target**
Auckland DHB is still under-achieving with ASH for age group 45-64.
Our rates, in the last report, were 126% for Maori, 118% for Pacific and 115% for the Others.
The main conditions leading to these high rates are: Angina / chest pain / Myocardial infarction, Cellulitis, Pneumonia, Diabetes and kidney / Urinary infection.
Auckland DHB is running many projects to address the above issues. All these projects need time to have noticeable effect. However, Auckland DHB is developing a new approach by developing clinical pathways in collaboration between the primary and the secondary care.
In-depth analysis of ASH was presented to both our PHO Forum and the Primary Care Advisory Group. It will be also presented for the hospital managers and the lead clinicians in ADHB.
Quarterly report showing the gaps by the ethnicities was developed and presented to the ADHB Board and the CPHAC.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of unnecessary hospital admissions for Maori age 45-64 | National average | 136% | Remain below national average | 126% | Not achieved |

There is no "national average". In the indirect standardisation, the national is always 100%.
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

**2dii) Percentage of unnecessary hospital admissions for Pacific (45-64)**

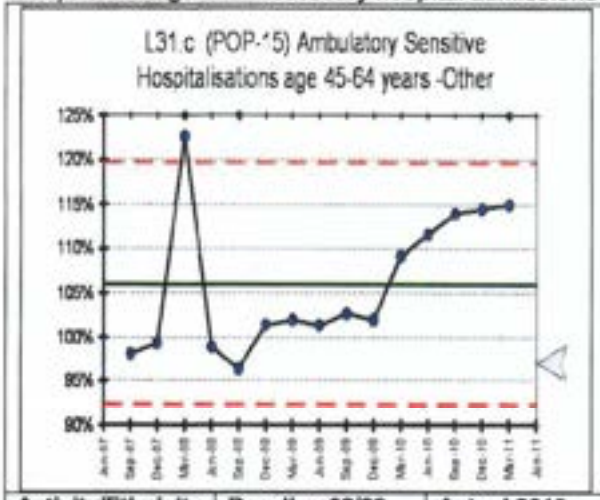



**Comment on performance for the year against target**
Auckland DHB is still under-achieving with ASH for age group 45-64.
Our rates, in the last report, were 126% for Maori, 118% for Pacific and 115% for the Others.
The main conditions leading to these high rates are: Angina / chest pain / Myocardial infarction, Cellulitis, Pneumonia, Diabetes and kidney / Urinary infection.
Auckland DHB is running many projects to address the above issues. All these projects need time to have noticeable effect. However, Auckland DHB is developing a new approach by developing clinical pathways in collaboration between the primary and the secondary care.
In-depth analysis of ASH was presented to both our PHO Forum and the Primary Care Advisory Group. It will be also presented for the hospital managers and the lead clinicians in ADHB.
Quarterly report showing the gaps by the ethnicities was developed and presented to the ADHB Board and the CPHAC.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of unnecessary hospital admissions for Pacific age 45-64 | National average | 113% | Remain below national average | 118% | Not achieved |

There is no "national average". In the indirect standardisation, the national is always 100%.
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

**2dii) Percentage of unnecessary hospital admissions for Other (45-64)**




**Comment on performance for the year against target**

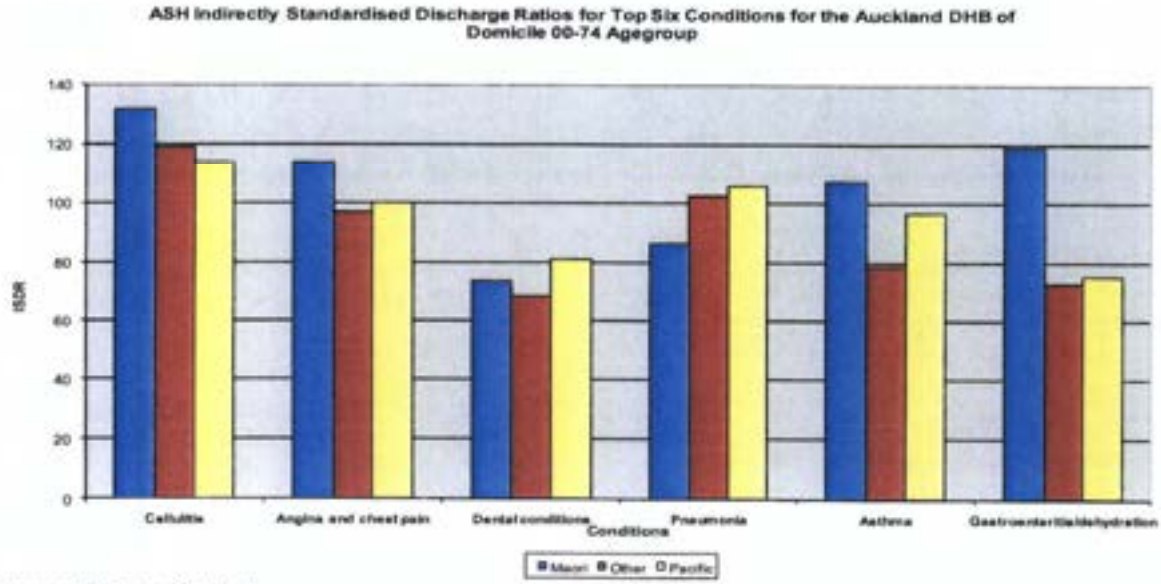
March 2011 was the latest. Next is Sept.
Auckland DHB is still under-achieving with ASH for age group 45-64.
Our rates, in the last report, were 126% for Maori, 118% for Pacific and 115% for the Others.
The main conditions leading to these high rates are: Angina / chest pain / Myocardial infarction, Cellulitis, Pneumonia, Diabetes and kidney / Urinary infection.
Auckland DHB is running many projects to address the above issues. All these projects need time to have noticeable effect.
However, Auckland DHB is developing a new approach by developing clinical pathways in collaboration between the primary and the secondary care.
In-depth analysis of ASH was presented to both our PHO Forum and the Primary Care Advisory Group. It will be also presented for the hospital managers and the lead clinicians in ADHB.
Quarterly report showing the gaps by the ethnicities was developed and presented to the ADHB Board and the CPHAC.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of unnecessary hospital admissions for Pacific age 45-64 age Other | National average | 112% | Remain below national average | 115% | Not achieved |

There is no "national average". In the indirect standardisation, the national is always 100%.
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

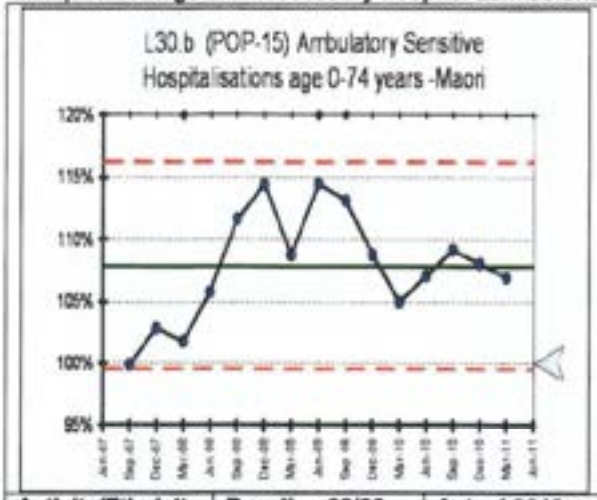
**2diii) Percentage of unnecessary hospital admissions for (0-74 age)**

**Age 0-74**




Source: Ministry of Health.
The Ministry records this data for the year to 31 March 2011.
Indirectly Standardised Discharge Ratio (IDSR) is the ratio of actual to expected Ambulatory Sensitive Hospitalisations

**2diii) Percentage of unnecessary hospital admissions for Maori (0-74 age)**




**Comment on performance for the year against target**
Only updated every 6 months

March 2011 was the latest. Next is Sept.

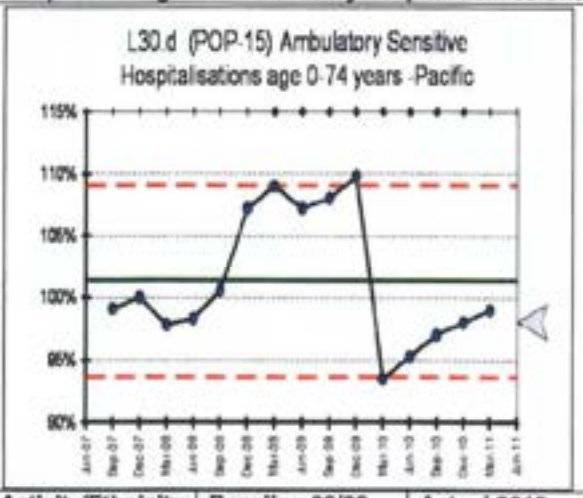
Age group 00-74 the difference between ADHB and the national rates were not significant and mostly driven by age group 45-64 (see age group 45-64).

Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of unnecessary hospital admissions for Maori age 0-74 age Other Maori | National average | 107% | Remain below national average | 107% | Not Achieved |

There is no "national average". In the indirect standardisation, the national is always 100%.
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

**2diii) Percentage of unnecessary hospital admissions for Pacific (0-74 age)**




**Comment on performance for the year against target**
Only updated every 6 months

March 2011 was the latest. Next is Sept.
Age group 00-74 the difference between ADHB and the national rates were not significant and mostly driven by age group 45-64 (see age group 45-64).

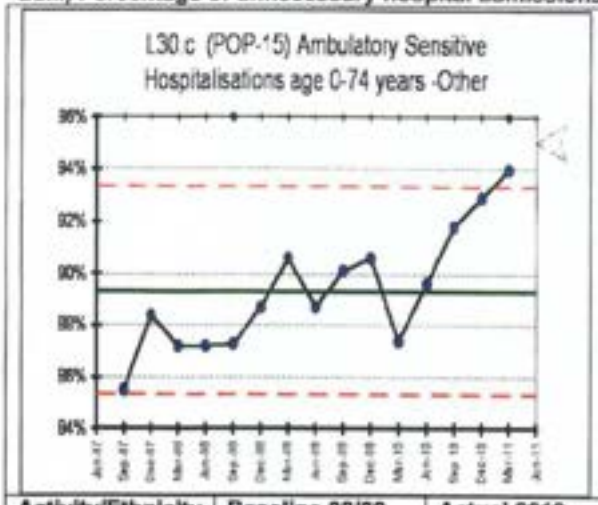
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

Data not updated for June 2011

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of unnecessary hospital admissions for Maori age 0-74 age Pacific | National average | 95% | Remain below national average | 99% | Achieved |

There is no "national average". In the indirect standardisation, the national is always 100%.
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

**2diii) Percentage of unnecessary hospital admissions for Other (0-74 age)**




**Comment on performance for the year against target**
Only updated every 6 months

March 2011 was the latest. Next is Sept.

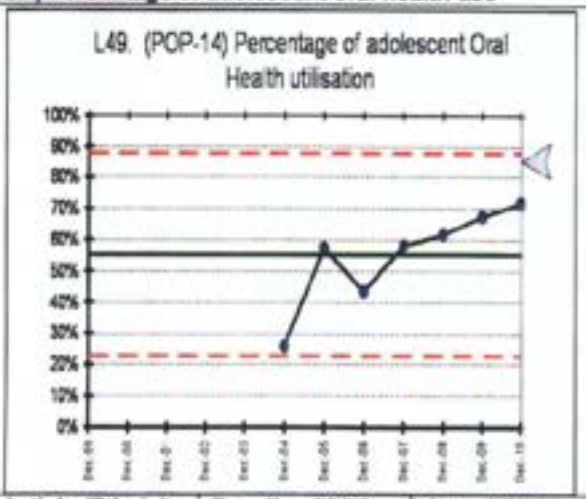
Age group 00-74 the difference between ADHB and the national rates were not significant and mostly driven by age group 45-64 (see age group 45-64).

Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of unnecessary hospital admissions for Maori age 0-74 age Other | National average | 90% | Remain below national average | 94% | Achieved |

There is no "national average". In the indirect standardisation, the national is always 100%.
Refer to the above chart for the nature and relative prevalence of illness contributing to admissions.

**2e) Oral Health**
**2ei) Percentage of adolescent oral health use**




**Comment on performance for the year against target**
Auckland DHB has exceeded the adolescent utilisation target for 2010/11. It is expected that the utilisation will continue to increase as the Regional Adolescent Utilisation Strategy is implemented.

Updated to calendar year December 2010

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % utilisation | 64.3% | 67% | 68% | 72% | Achieved |

**2eii) Percentage of children carries free at 5 years - Maori**


**Comment on performance for the year against target**
The area in which the first phase of clinics opened has a high Maori and Pacific Island population. Service in this area has been disrupted during this implementation phase and has resulted in children not being able to be seen and routine preventive treatment not undertaken. Auckland DHB's first phase of clinics has opened in high needs areas and therefore it is expected that the inequalities in these areas will decrease.

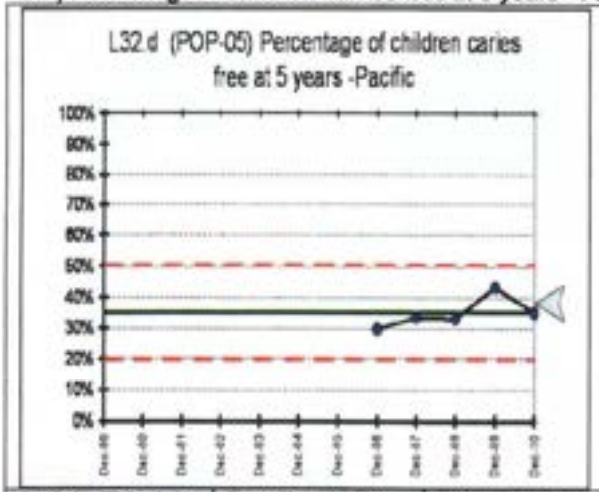
During 2011 Auckland DHB intends to work in collaboration with ARDS to focus on Maori and Pacific Island populations.

Updated to calendar year December 2010

ARDS= Auckland Regional Dental Service

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of children carries free at 5 yrs -Maori | 45.60 % | 58% | 50% | 55% | Achieved |

**2eii) Percentage of children carries free at 5 years - Pacific**




**Comment on performance for the year against target**
The area in which the first phase of clinics opened has a high Maori and Pacific Island population. Service in this area has been disrupted during this implementation phase and has resulted in children not being able to be seen and routine preventive treatment not undertaken. Auckland DHB's first phase of clinics has opened in high needs areas and therefore it is expected that the inequalities in these areas will decrease.

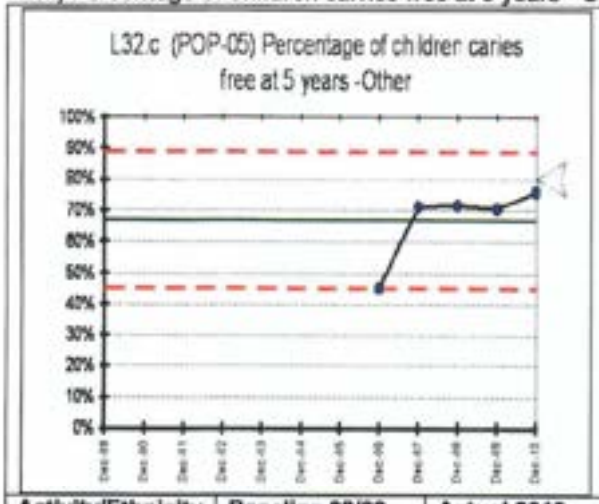
During 2011 Auckland DHB intends to work in collaboration with ARDS to focus on Maori and Pacific Island populations.

Updated to calendar year December 2010

ARDS= Auckland Regional Dental Service

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of children carries free at 5 yrs -Pacific | 36.20 % | 43% | 38% | 35% | Not Achieved |

**2eii) Percentage of children carries free at 5 years - Other**




**Comment on performance for the year against target**
The area in which the first phase of clinics opened has a high Maori and Pacific Island population. Service in this area has been disrupted during this implementation phase and has resulted in children not being able to be seen and routine preventive treatment not undertaken. Auckland DHB's first phase of clinics has opened in high needs areas and therefore it is expected that the inequalities in these areas will decrease.

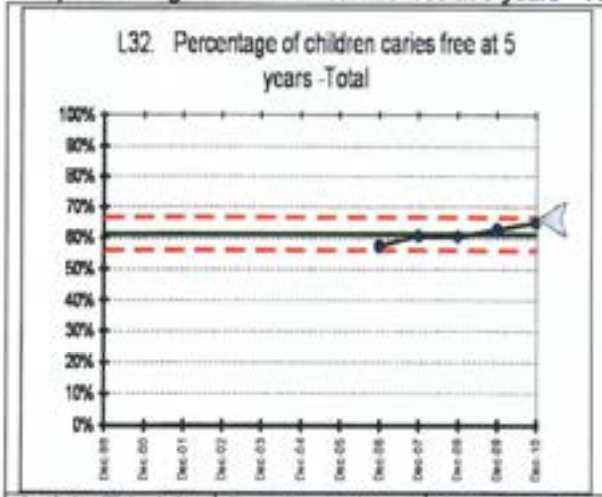
During 2011 Auckland DHB intends to work in collaboration with ARDS to focus on Maori and Pacific Island populations.

Updated to calendar year December 2010

ARDS =Auckland Regional Dental Services

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of children carries free at 5 yrs -Other | 71.50% | 71% | 80% | 76% | Not Achieved |

**2eii) Percentage of children carries free at 5 years - Total**




**Comment on performance for the year against target**
The area in which the first phase of clinics opened has a high Maori and Pacific Island population. Service in this area has been disrupted during this implementation phase and has resulted in children not being able to be seen and routine preventive treatment not undertaken. Auckland DHB's first phase of clinics has opened in high needs areas and therefore it is expected that the inequalities in these areas will decrease.

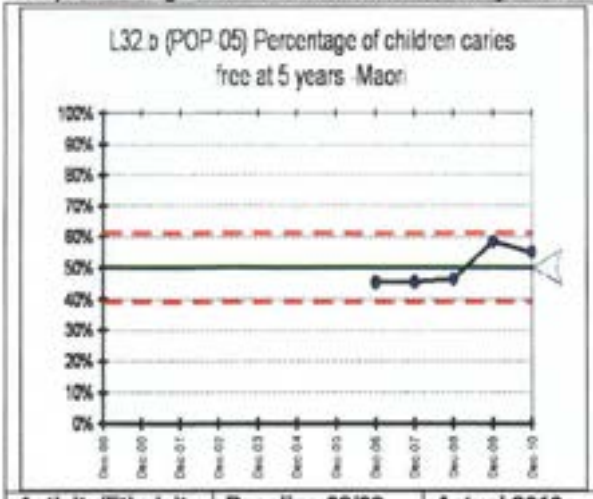
During 2011 Auckland DHB intends to work in collaboration with ARDS to focus on Maori and Pacific Island populations.

Updated to calendar year December 2010

ARDS= Auckland Regional Dental Service

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of children carries free at 5 yrs -Total | 61% | 63% | 66% | 65% | Not Achieved |

**2eii) Percentage of children carries free at 5 years - Maori**




**Comment on performance for the year against target**
The area in which the first phase of clinics opened has a high Maori and Pacific Island population. Service in this area has been disrupted during this implementation phase and has resulted in children not being able to be seen and routine preventive treatment not undertaken. Auckland DHB's first phase of clinics has opened in high needs areas and therefore it is expected that the inequalities in these areas will decrease.

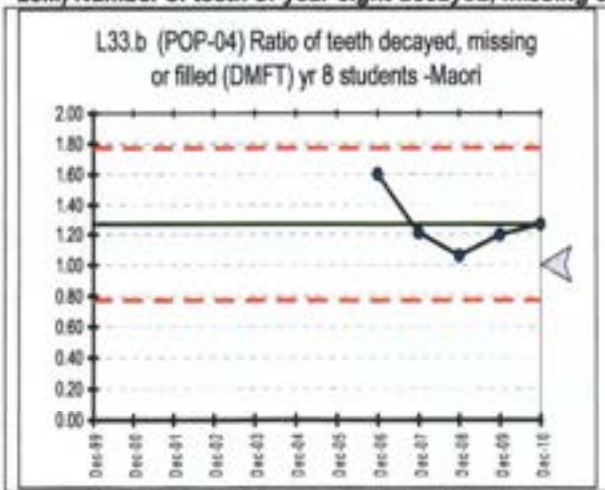
During 2011 Auckland DHB intends to work in collaboration with ARDS to focus on Maori and Pacific Island populations.

Updated to calendar year December 2010

ARDS= Auckland Regional Dental Service

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of children carries free at 5 yrs -Maori | 45.60 % | 58% | 50% | 55% | Achieved |

**2eiii) Number of teeth of year eight decayed, missing or filled. (DMFT)- Maori**

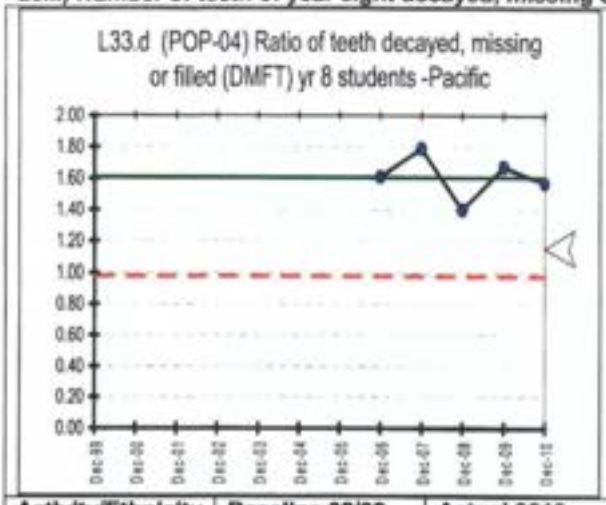



**Comment on performance for the year against target**
Many factors outside of the oral health service contribute to the DMFT scores. This includes environmental factors such as no fluoridation in some areas and poor nutrition and education for low socio-economic groups.
The implementation of the Auckland DHB Oral Health Business Case has also resulted in a larger number of children being screened and radiographed which has potentially increased the DMFT rate as these children may not have been seen previously. The increase in radiographs has meant that staffs are able to identify required dental care that would not have been identified with a visual exam.

Updated to calendar year December 2010

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of teeth of yr 8 students decayed missing or filled- Maori | 1.21 | 1.20 | 1.0 | 1.27 | Not achieved |

**2eiii) Number of teeth of year eight decayed, missing or filled. DMFT -Pacific**

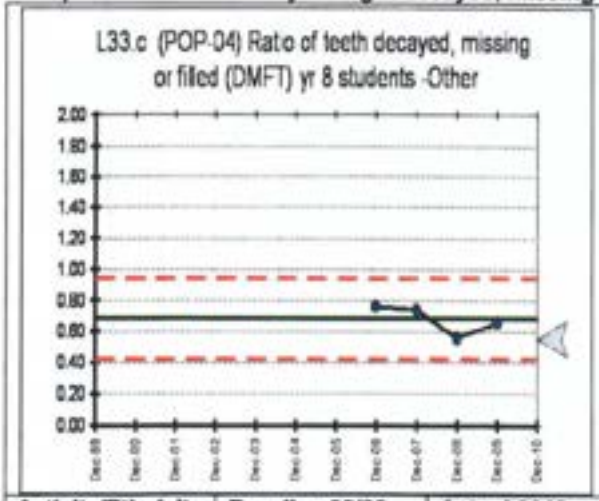



**Comment on performance for the year against target**
Many factors outside of the oral health service contribute to the DMFT scores. This includes environmental factors such as no fluoridation in some areas and poor nutrition and education for low socio-economic groups.
The implementation of the Auckland DHB Oral Health Business Case has also resulted in a larger number of children being screened and radiographed which has potentially increased the DMFT rate as these children may not have been seen previously. The increase in radiographs has meant that staff are able to identify required dental care that would not have been identified with a visual exam.

Updated to calendar year December 2010

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of teeth of yr 8 students decayed missing or filled - Pacific | 1.69 | 1.67 | 1.15 | 1.57 | Not Achieved |

**2eiii) Number of teeth of year eight decayed, missing or filled. DMFT - Other**

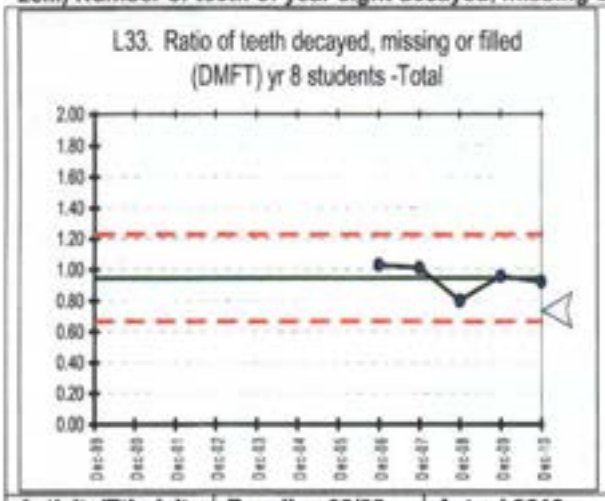



**Comment on performance for the year against target**
Many factors outside of the oral health service contribute to the DMFT scores. This includes environmental factors such as no fluoridation in some areas and poor nutrition and education for low socio-economic groups.
The implementation of the Auckland DHB Oral Health Business Case has also resulted in a larger number of children being screened and radiographed which has potentially increased the DMFT rate as these children may not have been seen previously. The increase in radiographs has meant that staff are able to identify required dental care that would not have been identified with a visual exam.

Updated to calendar year December 2010

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of teeth of yr 8 students decayed missing or filled - Other | .65 | .65 | .55 | .59 | Not Achieved |

**2eiii) Number of teeth of year eight decayed, missing or filled. (DMFT)-Total**




**Comment on performance for the year against target**
Many factors outside of the oral health service contribute to the DMFT scores. This includes environmental factors such as no fluoridation in some areas and poor nutrition and education for low socio-economic groups.
The implementation of the Auckland DHB Oral Health Business Case has also resulted in a larger number of children being screened and radiographed which has potentially increased the DMFT rate as these children may not have been seen previously. The increase in radiographs has meant that staffs are able to identify required dental care that would not have been identified with a visual exam.

Updated to calendar year December 2010

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of teeth of yr 8 students decayed missing or filled-Total | 1.21 | 1.20 | .73 | .92 | Not Achieved |

## Output Class 3: Hospital Services

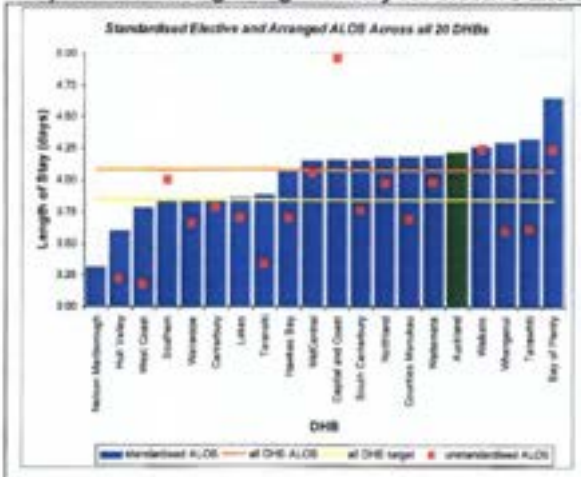
The targets in the Output Class "Hospital Services" set out the priority focus for the 2011 year.
The ultimate priority is on improving patient outcomes, with specific targets set for emergency department waiting times, additional elective surgery and reduced waiting times for cancer treatment.
All targets are subject to Clinical Quality and/or professional Governance requirements that comprise the measure. For example, management of hospital admissions, average length of stay and discharges have a very large number of quality control steps that must be undertaken at each phase within each of those steps on the patient journey.

**3a) Patients requiring radiation treatment will receiver this within four weeks by December 2010 -Refer to National Target number 3 Shorter waits for cancer treatment**

**3bi) Percentage of Emergency Department patients who are admitted, discharged or transferred within 6 hours.- Refer to National Target no 1.1 Adult and 1.2 Child**

### 3c) Patient journey

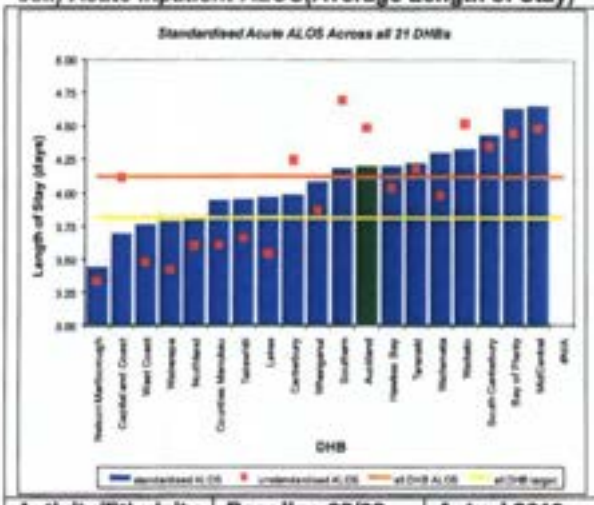
### 3ci) Reduce average length of stay for elective and arranged inpatients




**Comment on performance for the year against target**
This measure is calculated by the Ministry and data is currently only available up to 31st March 2011, with the push on ADHB electives in the last quarter which involved a focus on a number of key services with relatively low length of stay this measure may well improve for the full year.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Average Length of stay | 4.25 | Not Recorded | 4.15 | 4.22 | Not Achieved |

### 3cii) Acute inpatient ALOS(Average Length of Stay)

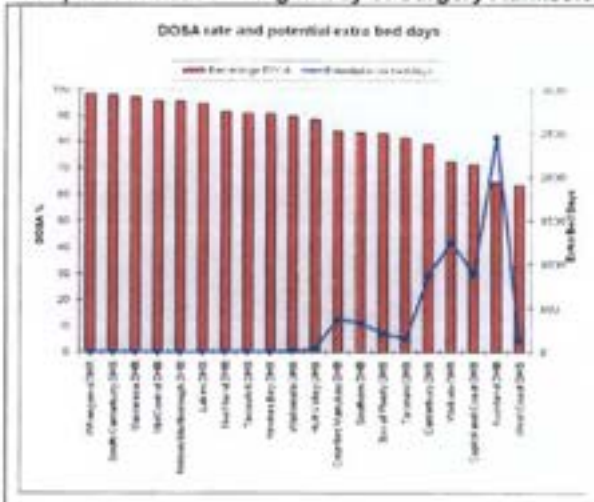



**Comment on performance for the year against target**
For the year ended 31 March 2011 ADHB average acute inpatient length of stay was 4.19 days compared with 3.94 days at Counties Manuakau and 4.29 days at Waitemata.

This target is tracked by the Ministry of Health.
No data is available for the year to March 2010

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Acute inpatient ALOS | 4.25 | Not recorded | 4.15 | 4.19 | Not Achieved |

### 3ciii) Elective and Arranged Day of Surgery Admission (DOSA)




**Comment on performance for the year against target**

ADHB admission rate for the year to 31 March 2011 was 63.6%. This compares with 83.2% at Counties Manukau and 89.3% at Waitemata.

ADHB's DOSA rate has historically been below other DHBs, but admission on the day of surgery remains a priority for the DHB, reflected in project work to promote the level

The attached chart is from the Ministry of Health and shows all 20 DHBs.

For ADHB, 56% of non-DOSA patients lie in 4 tertiary services which all have a low DOSA rate:

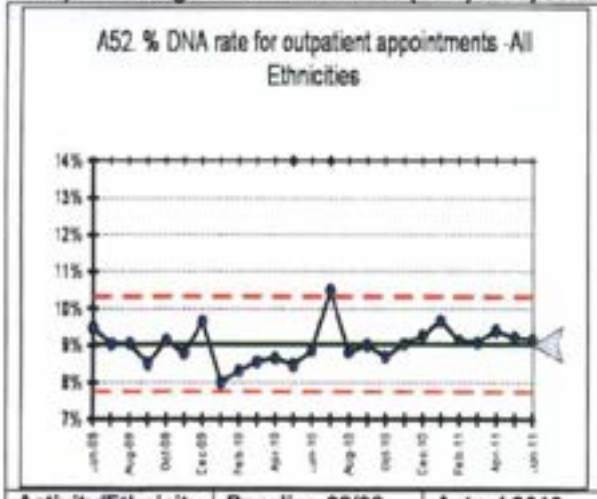
Cardiothoracic 16%
Neurosurgery 17%
Paediatric Cardiac 22%
Renal Medicine 16%

ADHB's DOSA rate excluding these services is 79%.

These 4 services have a low DOSA rate across all DHBs in New Zealand. However, after analysing the Health Roundtable benchmark data, ADHB has identified that Neurosurgery has the most potential for improvement. Therefore there is a project in place to improve Neurosurgery DOSA rate with a target of 60%. The project has not had time to show results in the 2010/11 financial year, but we hope to progress towards achieving this target next year.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Elective and arranged Day of Surgery admission | 56% | Not Recorded | 60% | 63.6% | Achieved |

### 3civ) Percentage of non attendance (DNA) for specialist appointments Total




**Comment on performance for the year against target**

Initiatives undertaken Since March 2010

| | |
|---|---|
| Flyer and 0800 number | Implemented. Every patient receives a flyer with their appointment letter reminding them of the importance of attending their appointment and consequences of not. |
| Invitation to Contact | Implemented in top 6 clinics, focusing on Māori in the first instance |
| Texting to confirm | Implemented in top 6 clinics, focusing on Māori in the first instance. |
| Children's play area in the main outpatients | Plans are underway to install a play area in the main OPD waiting area. Funded from the Starship Foundation and Hector Trust. |

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of non attendance for specialist appointments - Total | 9.2% | 8.8% | 8.5% | 9% | Not achieved |

**3cv) Percentage of Maori patients DNA rates in hospital services**

The target of 9% was set covering all appointments, not just specialist appointments. This target has not been achieved. Specialist appointment DNA rates also still remain very high at 17.9%, significantly higher than all ethnicity DNA rates of 9%.


**Comment on performance for the year against target**

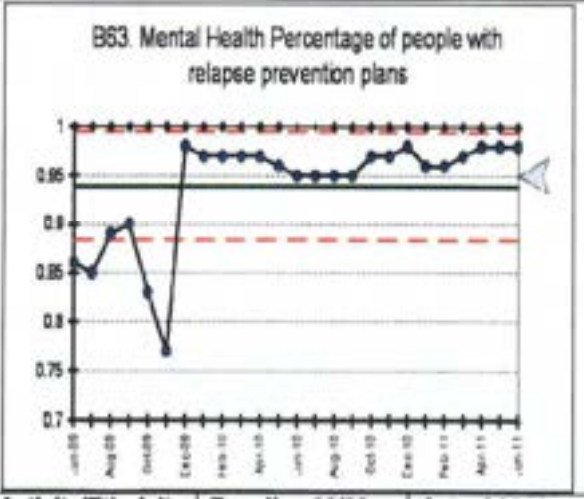
Initiatives undertaken since March 2010

| | |
|---|---|
| Contacting patients who have or are likely to due to a history of non attendance, focusing on Māori. | Via OP25 report. Patients who have in the past DNA'ed and have an appointment coming up are called to ensure they attend. This will be fully underway in the top 6 specialties by early March 2010. |
| Tracking on a daily basis the reasons why Māori people have not attended their appointments | Via OP25 report we now receive daily the patients who have DNA'ed the previous day and they are called to understand why they DNA'ed and to manage their appointment. |

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of non attendance for specialist appointments - Maori | 17.4% | 17.5% | Not specified | 17.9% | |
| % of non-attendance for total appointments-Maori | 11.5% | 11.2% | 9% | 11.8% | Not achieved |

**3d) Mental health clients**

**3di) At least 90% of long-term clients have up to date relapse prevention plans by July 2011**

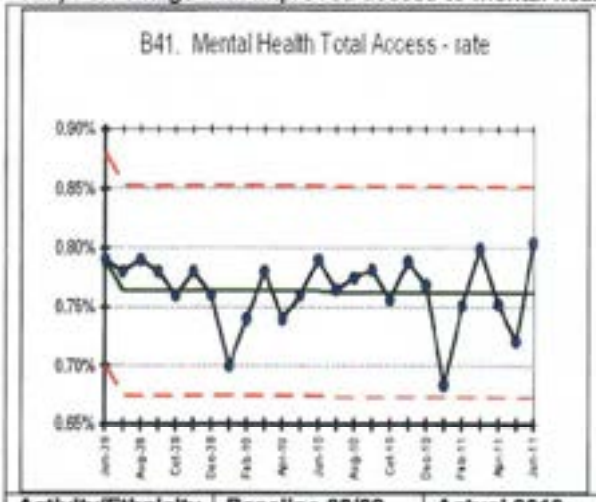



**Comment on performance for the year against target**

Relapsing planning has been a focus for clinical services over the last 2 years and has resulted in significant improvement in this area. This target has been met consistently and continues to remain a focus for service improvement and risk management.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of Mental Health patients with relapse prevention plans | 57% | 95% | 90% | 98% | Achieved |

### 3dii) Percentage with improved access to mental health services




**Comment on performance for the year against target**
This relates to 'Adult Access Rates Only'.

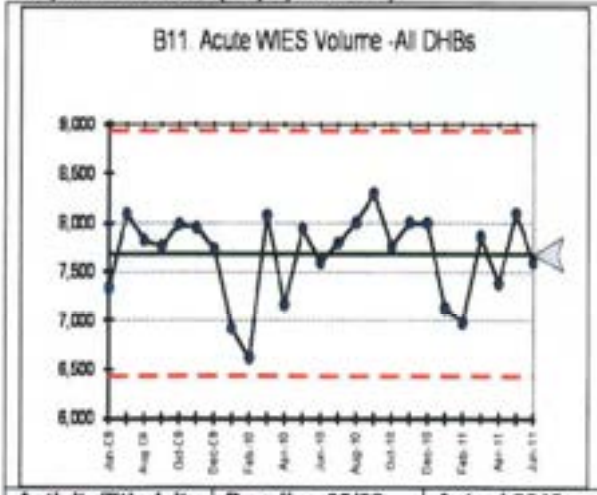
The graph shows actual ADHB clinical services access rates achieved.

The table below shows all provider (Clinical, NGO) access targets. But shows only the ADHB clinical services access rates achieved.

When all provider (Clinical and NGO) access rates are included ADHB achieved access rates of 3.47% against the combined target of 3.30%.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of Mental Health clients with improved access to mental health services | 2.8% | 3.44% (Adult) | 3.30% (adult) All provider | 3.47 % All provider | Achieved |

### 3e) Patient throughput
### 3ei) Volume acute (all populations)



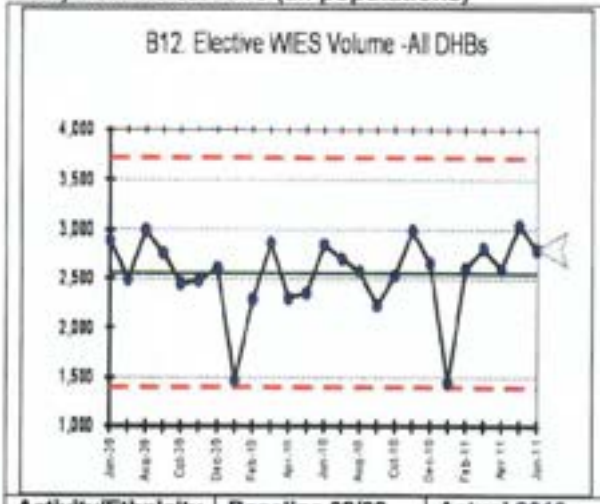

**Comment on performance for the year against target**
Acute wies for 2010/11 were less than 50 wies away from contract (99.95% of contract).

Acute WIES for 2010/11 were less than 50 WIES away from contract (99.95% of contract). These volumes were demand led, when volumes exceed contract the DHB does not have the discretion to refuse treatment: when volumes are less than contract the DHB is not in a position to promote demand.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Volume acute (all populations) | 79,761 Maternity not WIES funded in 2009. | 91,708 WIES[9] Contract 89,840 | 100% of contract 92,133 | 92,084 | Not Achieved |

[9] WIES describes a relative value for each patient event based on complexity.

### 3eii) Volume elective (all populations)



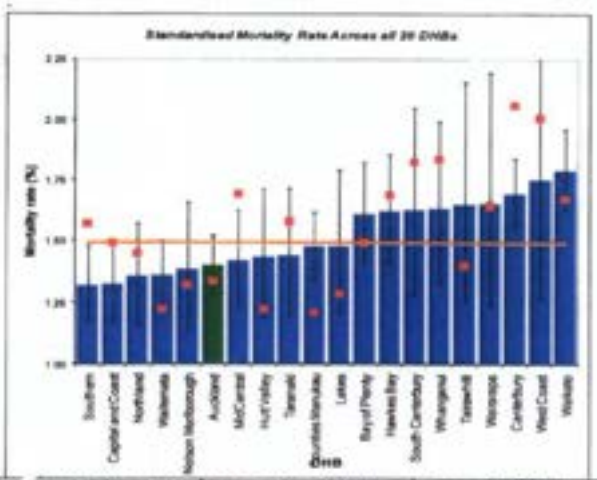

**Comment on performance for the year against target**
The substantial 2,058 wies improvement over 2009/10 (+7%) was pleasing not only for the wies but also the associated discharges and reductions in both waiting lists for surgery and clinics. These gains were assisted by the increased capacity coming on stream at Greenlane from April 2011 (eg we had an extra 17 ophthalmology lists per month over this time) and continued outsourcing however outsourcing was reduced from the 2009/10 year.
We have met the Ministry target for the number of discharges .This does not take into account the complexity of those cases.

The "Elective WIES" target is a summation of all the relative complexities related to the discharges for the year.
As the volume of discharges reached the Ministry target, the degree of complexity diminished as the more urgent cases were dealt with first.
The target assumed a higher average level of complexity than turned out to be the case in 2011.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| Volume elective (all populations) | 24,881 | 29,916 Contract 30,629 | 100% of contract 33,615 | 31,974 | Not Achieved |

**3f) Smoking patients**
**3fi) Percentage of hospitalised smokers provided with advice and help to quit –refer to National Targets 5.Better help for smokers to quit**
**3g) Patient discharges**
**3gi) Number of elective services discharges – refer to National Targets 2. Improved access to surgery**

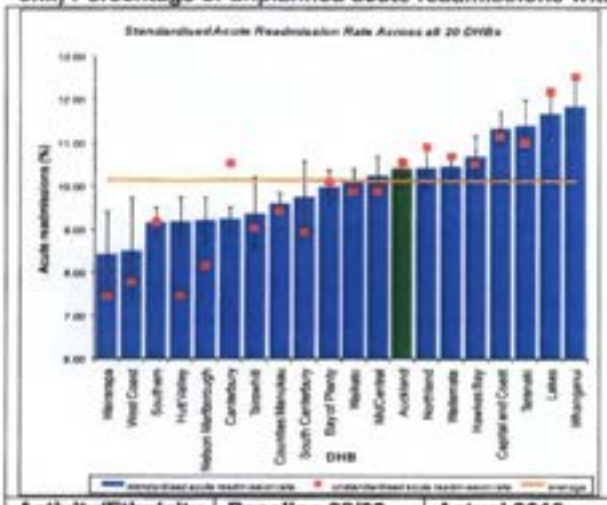
**3h) Patient outcome**
**3hi) Number of hospital in-patient deaths within 30 days of admission as a proportion of all discharges including day cases.**




**Comment on performance for the year against target**
For the year to 31 March 2011ADHB mortality rates were 958 out of 6,849 or 1.41%. The target is adjusted for expected deaths which produced an annual result of 1.43%
The other Auckland Region DHBs had adjusted rates of 1.43 for Counties Manukau and 1.52 for Waitemata
This target is tracked by the Ministry of Health.
No data is available for the year to March 2010
The 12-month Standardised Mortality Rate (SMR) in March of 1.40% is slightly lower than that of the previous 2 quarters (1.41%) and is well within the natural variability of a system with major biologic inputs. The target of "maintaining the status quo" has therefore been met. It should also be noted that using the Health Roundtable methodology that ADHB has an overall SMR of 87 (95% CI 79 - 95) significantly lower than average for the overall group. A more detailed analysis of SMRs for specific DRGs and services using Health Roundtable matched peers is currently being undertaken.
This target is recorded by the Ministry of Health who use a year ending 31 March.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of hospital in-patient deaths within 30 days of admission as a proportion of all discharges | 1.39 | Not recorded | 1.39 | 1.43 | Not Achieved |

### 3hii) Percentage of unplanned acute readmissions within 28 days of discharge




**Comment on performance for the year against target**
For the year to 31 March 2011 ADHB had an acute readmission rate of 10.41 %.
Eight DHBS had higher rates including Waitemata at 10.46%.

Nine DHBs had lower rates including Counties Manukau at 9.59%

Source : Ministry of Health

This target is tracked by the Ministry of Health.
No data is available for the year to March 2010

The readmission rate is not adjusted for case mix, and we have several tertiary services which have a high readmission rate due to the clinical conditions treated such as renal medicine and haematology/oncology.

This target is recorded by the Ministry of Health who use a year ending 31 March.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of unplanned acute readmissions within 28 days of discharge | 10.40% | Not recorded | 10.40% | 10.41% | Not Achieved |

## Output Class 4: Support Services

Auckland DHB aims to have a fully inclusive community, where people are supported to live with independence and can participate in their communities.
The targets below for 2011 are particularly relevant for people with long-term disabilities; people with mental health problems and people who have age related disabilities. Outputs that relate to the provision of support are aggregated into: home-based support services; residential care support services; day services; and palliative care services.

### 4a) People receiving services in their homes

### 4ai) Number of people ≥ 85 years who are able to remain in their own homes with support

**Comment on performance for the year against target**
The 2010/11 actual reported below is for new referrals – (definition has clearly been captured differently in previous years). We are assuming that the 08/09/10 data has been captured using total numbers rather then new referrals.
We are giving support so that people can remain in their own homes.
This is achieved through the use of interRAI to categorise clients according to their clinical complexity and then apply the case weighted package of funding to support their independence.
InterRAI stands for 'International Resident Assessment Instrument'. It got its name from the origins of the RAI in the early 1990's, when it was developed as an assessment and care planning tool for use in the residential care setting.
The interRAI has since expanded to develop 11 assessment systems for a range of specific situations (e.g. Home Care, Acute Care, Mental Health, etc.) but has kept the original name.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of people > 85 Years who are able to remain in their own homes with support | 800 | 1,359 | 840 (5% increase) | 412 | Not achieved |

**4aii) Number of low level clients self managing on support packages with input from key workers**

| | |
|---|---|
| | **Comment on performance for the year against target**<br>New programme<br><br>The target was well short of our actual as it was an estimate which with hindsight was too low. This maybe should have been 1500. |

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of low level clients self managing on support packages with input from key workers | New programme | 2,243 | 150 | 1,375 | Achieved |

**4aiii) Number of reassessments for Clients receiving home based support services.**

| | |
|---|---|
| | **Comment on performance for the year against target**<br>The assessment and reassessment function for clients has been incorporated as part of the new case management model, and targets for far more timely reassessment of clients against goals have been set for the past two years, which has led to a significant increase in reassessments being delivered. |

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| No of assessments for clients receiving home based support services | 5,134<br>1 per year | 5,134 | 25% increase | 7,073 | Yes |

b) Residential care clients

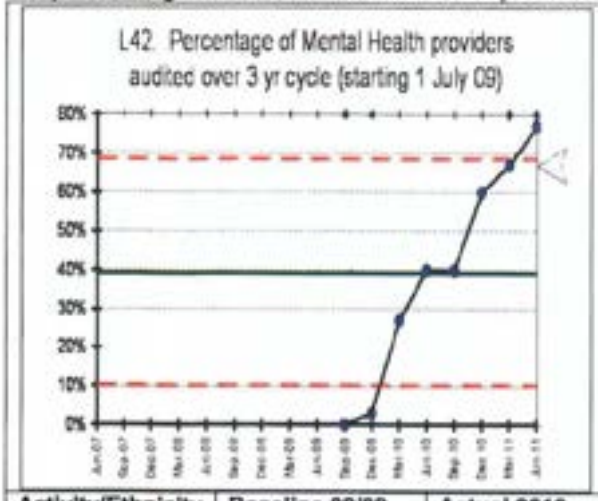
4bi) Number of complaints related to Residential care

| | | | | | |
|---|---|---|---|---|---|
| | | | **Comment on performance for the year against target**<br>Complaints are from a wide selection of rest homes. There is a raft of quality improvement programmes in place to try and reduce complaints so the actual result in part reflects raising awareness. We offer full management training and support to all facilities, as well as the presence of two Clinical Nurse Specialists who work with facilities to address quality and clinical concerns. All management training that is available to ADHB managers is now available to all residential care managers. | | |
| **Activity/Ethnicity** | **Baseline 08/09 actual** | **Actual 2010** | **Target 2010/11** | **Actual 2010/11** | **Achievement** |
| No of complaints related to residential care | 51 | 34 | 38 (a 25% reduction from the 08/09 | 55 | No |

4ci) Number of palliative clients accessing primary care under the subsidised DHB/PHO partnership

| | | | | | |
|---|---|---|---|---|---|
| | | | **Comment on performance for the year against target**<br>This is related to the Statement of Intent reference 2civ) Percentage of palliative care patients in receipt of PHO services.<br><br>Although the initial programme with Procare is running ahead of target, the plans to roll out the programme to other PHO's was circumvented by the occurrence of the business cases and therefore the further roll out was not undertaken. | | |
| **Activity/Ethnicity** | **Baseline 08/09 actual** | **Actual 2010** | **Target 2010/11** | **Actual 2010/11** | **Achievement** |
| No of Palliative clients accessing primary care under the subsidised DHB/PHO partnership | 60 | 51 | 100 | 55 | No |

**4di) Percentage of residential mental health providers audited**




**Comment on performance for the year against target**
The number of Mental Health Audits completed for the period 1 July 09 thru to 30 June 11 indicates that ADHB is on track to achieving the target of 100% MH NGO Services audited within the 1 July 09 to 30 June 12 period. Approximately 80% of the audits have been completed within 24 months of the 36 month period allocated.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of residential mental health providers audited | 30% | 40% | 30% | 37% | Achieved |

**4dii) Percentage of people with enduring mental illness in paid work, or education, or appropriate discharges**

**Comment on performance for the year against target**
This information was not collected or reported on during the 09/10 year. It was collected during the 08/09 year, however this presented a number of difficulties and its reliability was questionable. This data was not collected at all during10/11 and is no longer required by the MoH.

| Activity/Ethnicity | Baseline 08/09 actual | Actual 2010 | Target 2010/11 | Actual 2010/11 | Achievement |
|---|---|---|---|---|---|
| % of people with enduring mental illness in paid work, or education or appropriate discharges | 10.9% | Not recorded | 15% | Not recorded | Not Recorded |

## Capital Expenditure

As detailed in the table below ADHB had a total capital expenditure budget of $77.5m for the 2010/11 year. Actual expenditure against this budget was $51.7m, with the main areas of variance noted in the fixed assets section of the table in set out below. As the organisation has achieved breakeven, $20.9m of the 2010/11 capital projects will be carried forward into the 2011/12 year.

The table below reports the DAP Budget for 2010/11 (FY2011) and the Actual Spend against that budget. The CFwd column then specifies those projects contained within the DAP[10] FY2011 Budget which will carry over into the FY2012 (with a detailed listing of the specific projects to be carried forward) The Outer Year Deferrals column specifies those projects that will carry over to subsequent years.

## Capital Plan

| Capital Projects Report | DAP FY2011 | FY2011 Act | Variance | CFwd FY2012 | Outer Year Deferrals | DAP FY2012 | DAP FY2012 + CFwd |
|---|---|---|---|---|---|---|---|
| < 100K portfolios | 8,009 | 8,109 | -100 | 985 | | 7,975 | 8,961 |
| Must do priority 1 | 32,491 | 20,486 | 12,005 | 7,120 | 3,800 | 51,423 | 57,871 |
| Deferrals to next year | | | | | | | |
| **Capital Requests** | **40,500** | **28,595** | **11,905** | **8,105** | **3,800** | **59,398** | **66,831** |
| Debt / Equity Funded Projects | 32,027 | 19,971 | 12,056 | 12,563 | 1,077 | 22,729 | 29,226 |
| Donations | 5,000 | 3,131 | 1,869 | 285 | | 3,239 | 3,524 |
| **Additionally Funded Capital Requests** | **37,027** | **23,102** | **13,925** | **12,848** | **1,077** | **25,968** | **32,750** |
| **Total Capital Requests** | **77,527** | **51,697** | **25,830** | **20,953** | **4,877** | **85,366** | **99,581** |

| Carry forward + Deferrals | FY2012 | FY2013 | Total | Comments |
|---|---|---|---|---|
| CRIS IDM Upgrade | 1,000 | | 1,000 | Awaiting MOH approval July 11 |
| IGS0211 RosteringTA RiTA | 450 | | 450 | Business case under development |
| Shared Serv Oracle R12 Phase 1 | 449 | | 449 | Included in 2012 project |
| Knowledge Mangmnt & PRA Comp | 250 | | 250 | Business case under development |
| **IMTS** | **2,149** | | **2,149** | |
| P5593 ACH B01 Plant Rm Roof | 400 | | 400 | Deferred 2012 |
| P5621 GCC B4 HVAC Control Upg | 200 | | 200 | Deferred 2012 |
| ACH & GCC Upg Electr Switch | 200 | | 200 | Deferred 2012 |
| Child & Family Unit Alterations | 925 | | 925 | Business case under development |
| PC2/PC3 Upgd TB & Microbiology | 850 | | 850 | Business case under development |
| **Facilities** | **2,575** | | **2,575** | |
| Pinnacle Planning Sys Upgd | 150 | | 150 | Delayed due to Linear Accelerator replacement |
| Lumenis Holmium Laser 100 watt | 230 | | 230 | Order issued June 11 |
| **Clinical Equipment** | **380** | | **380** | |
| Starship Theatres build | 3,000 | 3,800 | 6,800 | Project under review, business case to be finalised |
| ACH Carpark | 3,934 | | 3,934 | Tender finalised Aug 10, budget phasing variance |
| Greenlane Surgical Unit | 8,297 | 1,077 | 9,374 | Project due for completion June 12, budget phasing was not available |
| Oral Health Project | 617 | | 617 | Budget phasing |
| **Strategic** | **15,848** | **4,877** | **20,725** | |
| **Total Deferrals** | **20,953** | **4,877** | **25,830** | |

[10] District Annual Plan

The key projects undertaken during 2010/11 were focused on improving facilities to assist patient access to services and to increase the ability of the organisation to deliver elective services.

The new car park at Grafton will have a total cost of $14.9 million with $6 million spent to 30 June 2011, and the remainder falling into 2011/12. This project will significantly improve patient access and the business case is based on the project being fully funded by the revenue flows from the parking and the retail and office accommodation. The project is running on time and budget with building works now at an advanced stage. The leasing programme is also getting under way with high level decision making around the parameters for tenant mix and pricing being the current focus.

The electives programme at Greenlane is a strategy to enable better delivery of elective services. The project is worth $27 million with $12 million spent to 30 June 2011. The work covers a wide range of facilities including:

- Three new operating theatres
- New sterile supply department
- Improved patient waiting and processing areas

The new operating theatres have been completed and the current focus is on completion of the Haemodialysis unit, the Ophthalmology Clinic relocation to the ground floor and new wards. The reconfiguration will improve patient access and flows, provide separation of acute, non acute, adult and paediatric patients.

The third major project is the continuation of the $10.4m Oral Health Project with $6m spent to 30 June 2011, and the remainder falling into 2011/12. This project will significantly improve the oral health of primary school children across the region. 4 mobile units and 5 clinics have been commissioned to date. A further 2 mobile units and 9 clinics will be commissioned during the 2011/12 year.

The fourth major programme of work undertaken in 2010/11 was in relation to IT systems to support initiatives to improve patient flow and communication with primary care providers. The $7 million spend to 30 June 2011 included $4 million of replacement IT equipment and infrastructure upgrades across the DHB, new patient information and upgrades including eReferrals, Endoscopy, Maternity records, ARMHIT[11].

Capital building works of $5m were also undertaken including construction of the Chemotherapy Production unit at a cost of $2 million.

$5 million worth of clinical equipment was purchased to improve the therapies available to patients and reduce the waiting time for cancer treatment radiotherapy assisting the goal of meeting the health targets. This programme included the commissioning of a replacement linear accelerator, kilovoltage irradiation and brachytherapy machines. A further $10.7 million was spent on improving patient care through the replacement and upgrading of clinical equipment.

[11] Auckland Regional Mental Health Information Technology

# Independent Auditor's Report

## To the readers of Auckland District Health Board and group's financial statements and statement of service performance for the year ended 30 June 2011

The Auditor-General is the auditor of Auckland District Health Board (the Health Board) and group. The Auditor-General has appointed me, John Scott, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and statement of service performance of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 30 to 76, that comprise the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance[1] of the Health Board and group on pages 77 to 143.

## Opinion

In our opinion:

- the financial statements of the Health Board and group on pages 30 to 76:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health Board and group's:
    - financial position as at 30 June 2011; and
    - financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board and group on pages 77 to 143:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Health Board and group's service performance for the year ended on 30 June 2011, including:
    - the performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and

- the revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 5 October 2011. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

## Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and statement of service performance are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board and group's financial statements and statement of service performance that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

## Responsibilities of the Board

The Board is responsible for preparing financial statements and a statement of service performance that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board and group's financial position, financial performance and cash flows; and
- fairly reflect the Health Board and group's service performance achievements.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

## Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

## Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the New Zealand Institute of Chartered Accountants.

Other than the audit and the audit of the Board's subsidiary entity, the Auckland District Health Board Charitable Trust, we have no relationship with or interests in the Health Board or its subsidiary.

John Scott
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand