AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland District Health Board

2012 Annual Report

integrity | respect | innovation | effectiveness - kia u ki te tika me te pono

2012 ANNUAL REPORT

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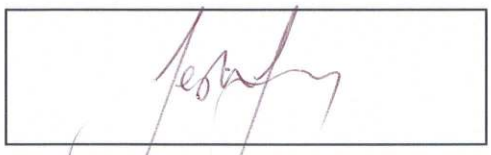
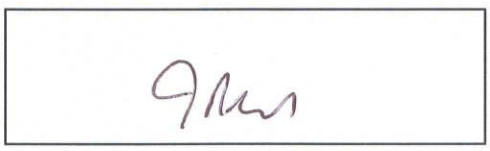
The Board Members are pleased to present the report of Auckland District Health Board (ADHB) and the Group comprising ADHB, its subsidiary Charitable Trust, joint ventures and associates for the year ended 30 June 2012.

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



Dr Lester Levy
Chair

Dated: 16 November 2012



Ian Ward
Chair, Audit and Finance Committee

Dated: 16 November 2012

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

Address for Service

Auckland District Health Board
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Greenlane Clinical Centre
Greenlane West
Epsom
Auckland 1051

Postal Address

Private Bag 92189
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Telephone: (09) 630 9817
Facsimile: (09) 639 9816
Website: www.adhb.govt.nz

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)

Joint Interim Chief Executives from 31 March 2012 to 30 September 2012

Ngaire Buchanan
Dr Margaret Wilsher

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

Senior leadership team for Auckland DHB

Ngaire Buchanan	General Manager, Operations
Dr Margaret Wilsher	Chief Medical Officer
Margaret Dotchin	Executive Director of Nursing
Carolyn Simmons Carlsson	Acting Director Allied Health, Scientific, & Technical
Naida Glavish	Chief Advisor Tikanga

Children's Healthcare Service Group

Dr Richard Aickin	Director
Sarah Little	Nurse Director
Fionnagh Dougan	General Manager

DIRECTORY (continued)

Mental Health and Addictions Healthcare Service Group

Dr Clive Bensemann	Director
Anna Schofield	Nurse Director
Helen Wood	General Manager

Adult Healthcare Service Group

Dr Barry Snow	Director
Jane Lees	Nurse Director
Andrew Davies	Performance Director

Cardiovascular Healthcare Service Group

Dr Peter Ruygrok	Director
Margaret Dotchin	Nurse Director
Peter Lowry	Acting General Manager

Women's Healthcare Service Group

Maggie O'Brien	Midwifery Director
Vacant	Director
Vacant	Nurse Director
Kirsty Walsh	Acting General Manager

Cancer and Blood Healthcare Service Group

Dr Richard Sullivan	Director
Margaret Dotchin	Nurse Director
Robyn Dunningham	Acting 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	General Manager Maori Health
Hilda Fa'asalele	General Manager Pacific Health
Brent Wiseman	Chief Financial Officer
Linda Wakeling	General Manager Information Management Services
Vivienne Rawlings	General Manager Human Resources

Chair Foreword

I will leave it to our Interim Chief Executives to paint a comprehensive picture of our performance and achievements (and there are many) during the course of the 2011/12 year in their report, which follows. It is particularly pleasing to note that our patients now wait less time to access cancer care and surgery, experience a shorter length of stay in the hospital and can access more services in their community than before.

The performance and achievements that the Interim Chief Executives talk to is a direct result of the dedication and hard work of our staff at the Auckland District Health Board. We are fortunate to have so many dedicated and talented people who go above and beyond the call of duty to deliver their very best for our patients and population. On behalf of the Board, thank you to all our staff for everything you have done throughout 2011/12 - it is appreciated and valued. I also thank both Dr Margaret Wilsher and Ngaire Buchanan for taking on the challenging role of Joint Interim Chief Executive while we awaited the arrival of our new Chief Executive, Ailsa Claire.

I would like to take this opportunity to provide a more reflective perspective developed by myself and the Board over our first six months in office, January through June 2011, which forms the basis for our future trajectory.

While the Auckland District Health Board is on the whole performing well we think at this point in its journey the organisation can and must do better. After all the Auckland District Health Board plays a critical role, not just within our district, but also as a regional and national provider of services. Around half our services are provided to patients from other District Health Boards, with many of these services having a complexity and degree of specialist expertise not available at other District Health Boards. As there are no or limited alternatives for these patients as well as our own local population, our organisation needs to be performing to its highest potential. We should be aspiring to not just meet, but to exceed targets as we build bolder and more ambitious plans for what we can achieve for our patients and population.

At the heart of the matter is the need to unlock the full potential inherent within the organisation while developing a much deeper philosophy and capability around keeping our district population well. This is in addition to providing them with timely access to the clinical interventions they need. Harnessing the talents and skills of all our people will be key to this.

It all starts with a change in culture and mindset. At this point I would like to make a very important clarification and that is to shatter the prevailing myth that organisations need to change because they are broken and that to change means discarding the past. The reality is that we need to change because our context (and that of other health organisations) is changing (dramatically and at speed) and also that successful adaptive change builds on the past rather than discarding it. I would also like to reanimate the meaning of culture which is all too often interpreted as being what it feels like to work in an organisation rather than what it is – the specific focus of the organisation.

I observed the need for a change in the culture and mindset in the early months of my Chairmanship in 2011. In my view this change is required because the Auckland District Health Board has not kept pace with the speed of the changing context. I sense that the culture of the organisation needs to become more outward focused to one that emphasises the utmost levels of care and consideration for every single patient (and their family) and puts the health status of our population at the forefront of every decision we make. We need to develop a culture that promotes greater levels of autonomy for self directed patient care and one in which our patients and population have access to much more information to assist them in better managing their health. We need a greater sense of urgency and commitment to finding innovative models of care and key to this is becoming very much better at working collaboratively with others. A critical part of the requirement for a re-calibration of the culture at the Auckland District Health Board is to ensure absolute consistency of quality, greater transparency, enhanced accountability and much stronger fiscal responsibility.

But culture and mindset change is not an overnight process and consequently we have no time to waste in building a momentum for change which will extend to every facet of our services.

This year saw a significant renewal of our senior executive leadership team, with a new Chief Executive, a new Chief Financial Officer, a new Director of Nursing, a new Director of Allied Health and Technical and a new General Manager of the Mental Health service . Key new appointments have also been made in the executive and clinical management of flagship services such as Starship and Children's Health and National Women's Health. All of these appointments will play an important part in moving the organisation onto a new trajectory.

As I said previously, while the organisation is performing well enough, there remain some key issues that have not been previously recognised or dealt with and resolving these is a critical priority.

In March this year, the Board was confronted with an unexpected adverse financial result. It required a tremendous effort by everyone in the organisation to correct this in a very short time period and I would like to personally thank all of our staff who demonstrated very clearly their ability to respond adaptively and meet our shared commitments. This kind of surprise should not occur as it is disruptive to all and under the leadership of the new Chief Executive the Board expects a move to anticipate and better manage both risks and issues.

Sir William Osler, sometimes called the father of modern medicine said, 'The good physician treats the disease; the great physician treats the patient who has the disease.' In the same way that it might not be possible for there to be good and great in the same physician, I think that there cannot be good and great in the same organisation – at Auckland District Health Board good needs to be pushed aside to make way for great.

Our sublimely talented people, our wonderful concentration of intellectual capital, our brilliant assets, our partnerships and relationships as well as our financial resources leaves me feeling very optimistic that if we properly confront the reality of where we currently are – we will be able to get to where we need to be.

Dr Lester Levy
Chairman
Auckland District Health Board

Joint Interim Chief Executives' Foreword

Over the last six months of intense activity it has been a privilege to work with such dedicated individuals and teams. We have seen an extraordinary response in a number of areas including our health targets, meeting a breakeven budget while continuing to provide for the needs of our population, community and staff. We would like to extend thanks to all of our staff for the support we have enjoyed over this time.

Performance
We achieved four out of six of the national health targets for the year 2011-12. In the remaining two areas, we delivered major improvements. We acknowledge staff for their extraordinary efforts in delivering our targets while we faced fiscal constraints and rising demand.

Despite the improvements noted we must confront the facts. Our efforts in delivering advice to smokers to quit and in providing cardio-vascular disease and diabetes checks failed to meet the targets. These targets are set in order to deliver improved population health, and with that reduced demand on our hospital services. They are important and we must deliver on them. That is recognized and our teams are determined to deliver sustainable delivery of all targets next year.

The Emergency Departments experienced an increase in demand, with more than 21,000 patients coming through the doors. Of these 95% were admitted, discharged or transferred within six hours. This year we hosted the Rugby World Cup and the planning put in place beforehand paid off. During the tournament, the Auckland City Hospital Adult Emergency Department saw a 56% increase in presentations. Despite this, and thanks to a whole-of-hospital effort, we continued to meet the six-hour target.

We exceeded our target to achieve 11,951 elective surgery discharges. This was due to the dedicated focus of the surgical teams, as well as the increased use of the refurbished and expanded operating rooms at the Greenlane Surgical Unit. This facility will be critical to achieving further increases in volume and reductions in waiting time for 2012-13. However we face challenges with more elective discharges and shorter waiting time for surgery in the next year and the processes for delivering the new elective surgical targets will need to improve.

Our team at the Northern Regional Cancer and Blood Service has consistently met the target for patients ready for radiotherapy waiting less than four weeks.

In the year under review, 95% of two-year-olds were fully-immunised. This has been a significant achievement and reflects a 20% increase over the last three years. Of particular note, was a reduction in the gap between Maori and non-Maori immunisation rates, with Maori coverage now at 91%.

As noted above, we did not meet the target to provide advice and support for hospital smokers to quit. Our result of 93% was a remarkable one considering our performance of 83% at the start of the year. We did not meet the cardio-vascular target, which required 60% of the eligible population to have had their disease risk assessment in the last five years. We are working to make improvements in this and in particular in the way we collect data.

Development
We have continued to invest in new facilities. These have included:

- a new Haemodialysis Unit at Greenlane. The Unit provides a more comfortable and homely environment for renal patients and it brings together support and training for both peritoneal and haemodialysis patients.

- a Pharmacy Aseptic Production Unit opened at Auckland City Hospital. The new unit means 100% of chemotherapy dispensing can be carried out in-house.
- 2012 also saw the opening of a new car park at Auckland City Hospital providing an additional 390 public spaces along with new retail outlets for our patients, visitors and staff.
- The building and refurbishment of dental clinics for children and adolescents continued. Eleven out of the proposed fourteen have been completed. These new clinics have a big focus on prevention through education and early detection of decay.
- The new eye clinic at Greenlane officially opened in June. Eye health is a significant and increasing issue with an additional 2,400 outpatients treated in 2011-12. The new clinic and processes will help us meet the demand and provide better, more convenient and timely access for ophthalmology outpatients.
- Hearty Towers moved to new premises within the Greenlane campus. The new site provides more space and an improved standard of accommodation for patients with, for example, ensuites in all rooms.

Regional Collaboration for quality
The Northern Region Health Plan (NRHP) and closer collaboration with Waitemata DHB were two key and notable efforts in improving quality and service delivery.

Patient safety continued to be a key focus for us all in the northern region. Under the auspices of the NRHP, we led the First Do No Harm campaign on behalf of the region. With a Memorandum of Understanding with the Health Quality and Safety Commission, we participated in the Central Line Associated Bacteraemia (CLAB) campaign during January-March. This led to impressive early results. We now count in months the time elapsed since the last CLAB infection was recorded.

Auckland DHB took a national lead on the hand hygiene programme. This programme has also contributed to a reduction in the number of infections in our hospitals. Much more work is required to deliver the target for all wards and clinical areas.

A partnership approach has been successfully developed between Auckland DHB and aged residential care facilities to reduce the number of falls with harm and pressure injuries suffered by older people in care. A similar approach is strengthening the relationship with the University of Auckland's Faculty of Medical and Health Sciences, with whom we are developing an Academic Health Alliance.

We have been actively progressing opportunities to work more closely with Waitemata DHB. Our aim is to improve quality and service delivery across both DHBs. This collaboration is driven by a focus on our patients, rather than boundary lines. A number of areas including Finance, Maori Health, Pacific Health, Mental Health and Planning and Funding are already forging closer ties to enhance health outcomes and provide more seamless services for people in both districts.

Finance
We recorded a small surplus for the year ended 30 June. This was a turnaround from March, when a significant deficit was forecast. The action we took was rapid and relatively blunt and the responsiveness of the organisation, teams and individual staff was humbling. Our financial management and control now needs to move to a more sophisticated level in which we all can play a role. While we have a way to go before we reach that point, we were greatly encouraged by the innovation and commitment staff displayed in responding to the Zero Deficit challenge.

Our review gives cause for celebration, for optimism and for some regret at what was not achieved. It has been a privilege to lead in this time of transition and we thank all our staff and partners for our successes throughout 2011/12. It is sincerely appreciated and valued.

We now welcome Ailsa Claire and the healthcare vision she brings. This Annual Report describes the efforts of an organisation deeply committed to healthy communities and quality health care. We commend it to you, our Board and the people we serve.

Ngaire Buchanan
Joint Interim Chief Executive

Dr Margaret Wisher
Joint Interim Chief Executive

SUMMARY OF PERSONNEL POLICIES FOR THE YEAR ENDED 30 JUNE 2012

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 2011/12

Auckland District Health Board is committed to meetings its statutory, legal and ethical obligations to be a good employer including providing equal opportunities.

The vision of the Auckland District Health Board (ADHB) is:

> *"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".*

ADHB 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.

Regardless of the minimum requirements of legislation, ADHB continues to promote and protect the welfare and management of employees to the mutual benefit of employees, consumers and the organisation.

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 supported by policy and practised by 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 and work conditions.

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. 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.

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).

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).

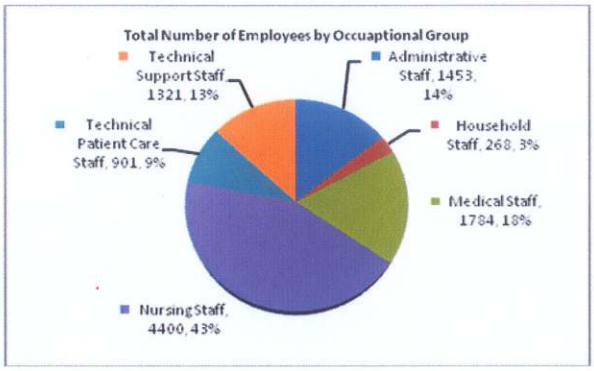
GOOD EMPLOYER REPORT 2011/12

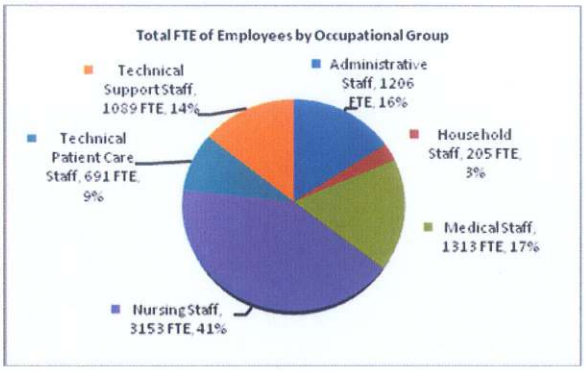
leadership accountability & culture	• Clinical/managerial partnership. • ADHB Welcome Day for all new staff • Individual Service Planning Days – multidisciplinary involvement. • Nova Magazine newsletter for staff • X-Factor – annual staff talent show actively supported by senior leadership.
recruitment, selection and induction	• Guides for managers on recruitment and selection • Induction guides for managers. • Support of Overseas Candidates • Work Experience Days. • Open Days at Children's and Women's services. • Careers Centre website accessible internally & externally. • Candidate and hiring manager satisfaction surveys. • Internal promotion of vacancies via Nova Magazine link and ADHB Intranet site. • Participating in the Ministry of Social Development's Mainstream Programme – to get people with disabilities into work. • Preference programme for Maori and Pacific graduate nurses. • Rangatahi Programme: This programme supports Maori and Pacific workforce development by seeking to: - *Grow, develop, recruit and retain Maori and Pacific in the health and disability sector in the ADHB region* - *Provide options and support in the pursuit of health careers* - *Ensure Rangatahi Maori and Pacific achieve their career potential* The purpose of the Programme is to actively attract Rangatahi Maori and Pacific into the health workforce by removing barriers to entry. The Programme has two essential components; the first supporting Rangatahi Maori and Pacific to attain better educational qualifications and practical skills to enter health-related tertiary programmes and links them with tertiary education health programmes; the second facilitates the transition of new graduates into the health workforce. The programme was piloted in 2007 and the first eight graduates completed at the end of 2011.
employee development, promotion and exit	• Alumni programme in place. • Annual performance review and individual development/objective setting process. • Numerous clinical, technical, and non-clinical internal training programmes and workshops. • Sabbaticals for Senior Medical Officers. • Exit interviews and surveys conducted. • Entry surveys conducted.
flexibility & work design	• Flexible rostering practices subject to clinical requirements. • Review of family friendly initiatives. • Staff Crèche on each site.

remuneration recognition & conditions	• Nova awards – peer recognition of individuals or teams living the organisational values • Long service awards • Awards introduced to publically acknowledge staff who deliver sustainable improvements for our patients and the organisation. In addition to those who contribute to improving the knowledge and skills of health and improving healthcare practice through research or education. All teams and individuals in all positions both clinical and non-clinical were encouraged to apply. The categories for the Awards are: - clinical - research - education - process and systems improvement. • Staff benefits with external providers. • Recognition of retiring staff & staff who die in service through a tribute in NOVA. • The majority of staff are on transparent Multi Employer Collective Agreements. • 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.
harassment & bullying prevention	• Harassment policy in place. • Workplace Violence Prevention Policy (as affecting staff) is in place. • Bullying and harassment coaching seminars conducted. • Formal and informal processes documented and available for response to harassment. • Presentations provided to staff/teams as required/requested, to promote awareness.
safe and healthy environment	• ACC Partnership Programme - Tertiary accredited. • GM lead Health & Safety committees, which also include Maori, Pacific Island, Auckland Regional Public Health, internal clinical H&S Reps. • 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. • Free influenza vaccine programme for staff, students on placement and many contractors. • 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. • Dedicated Lifestyle section in ADHB's newsletter. • 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). • DV-Free (domestic violence) free programme available to staff (staff contact people trained and awareness sessions run for all staff to attend). • Support material available for staff and managers to understand and manage workplace stress. • EAP services provided free to staff. • Free work-related Occupational Health assessments for staff. • Workstation assessments. • Work area safety checks. • Staff breastfeeding policy & facilities. • Weight Watchers onsite meetings.

WORKFORCE DEMOGRAPHICS

The pie charts below show how employees are distributed across the different occupational groups at the ADHB. The largest occupational group is nursing with 4400 employees comprising approximately 3150 Full Time Equivalents (making up 43% and 41% of the overall ADHB respectively). The entire ADHB is comprised of just over 10000 employees and 7650 FTE.



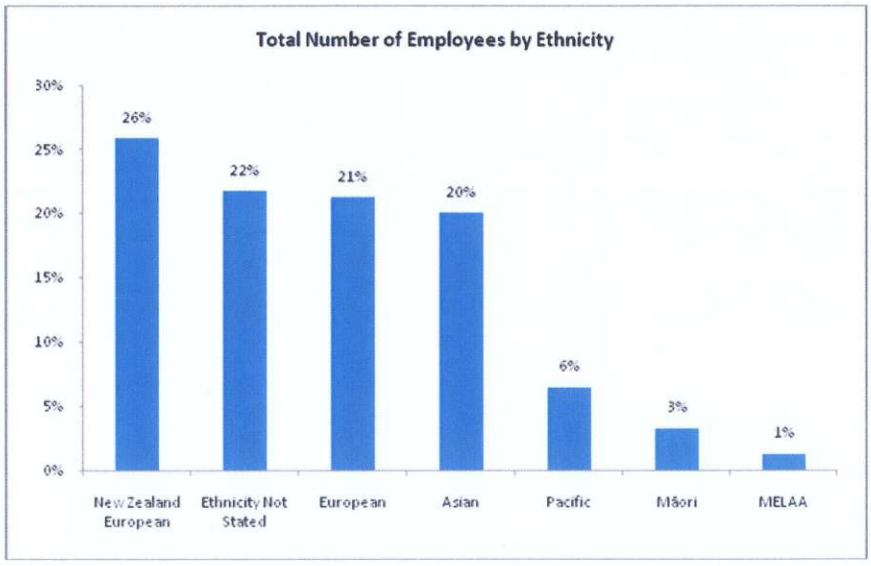


Staff Turnover

The ADHB has had a stable staff turnover for the past year. Voluntary turnover for the year ended 30 June 2012 was 9.1% which is approximately the same as last year.

Employee Diversity

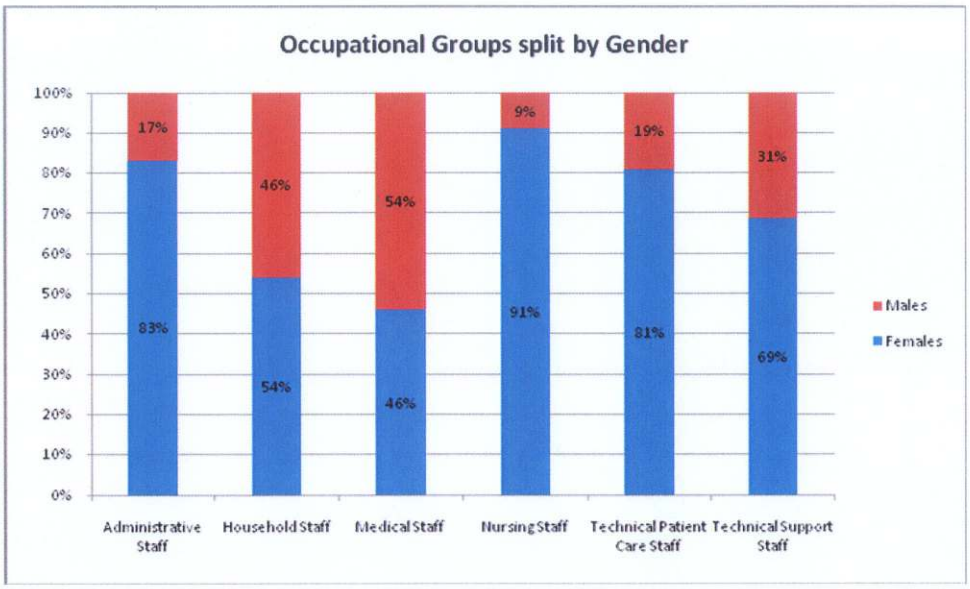
Staff are requested to disclose their ethnicities on appointment and approximately 22% of employees choose not to. Many employees have a diverse ethnic background and believe it would be disrespectful to identify with one ethnic group over another. The graph below shows all the ethnic groups that compose greater than 1% of our workforce.



Note: MELAA represents a group amalgamation of Middle Eastern, Latin American and African ethnicities.

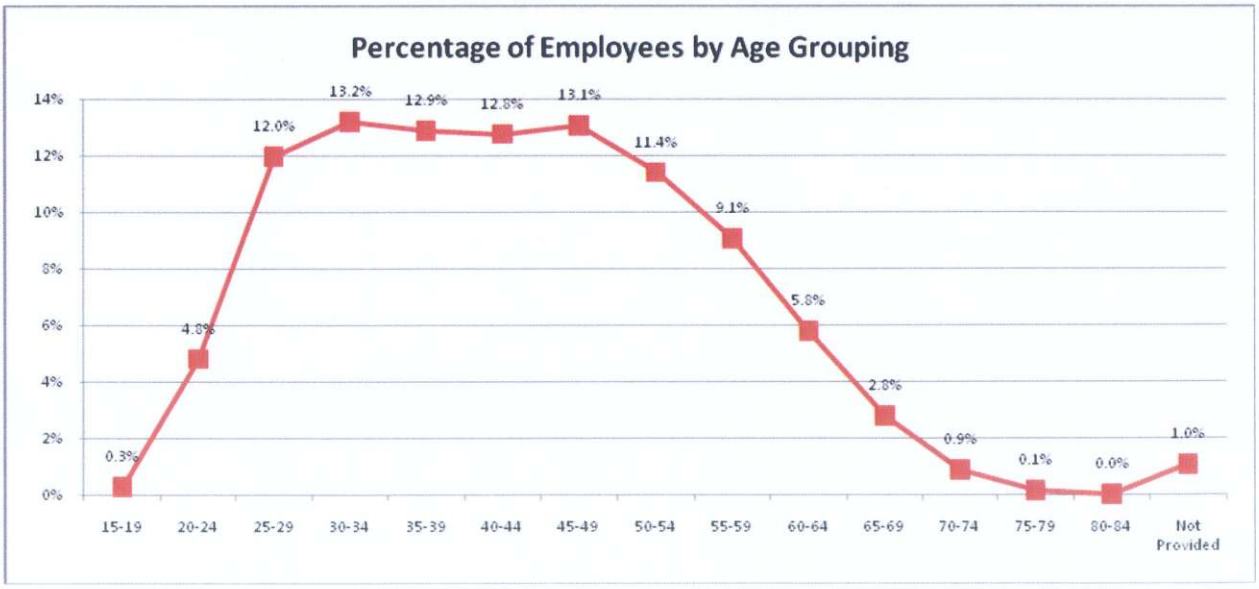
Gender

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 2012, 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 Collective Employment Agreements, and formal performance appraisals against goals and competency assessments.



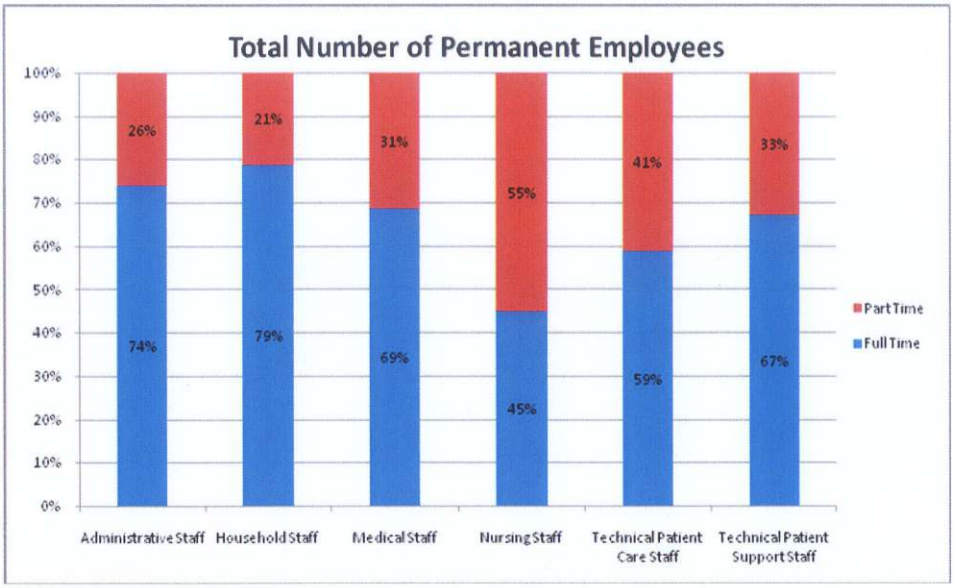
Age of Workforce

The percentage 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%.

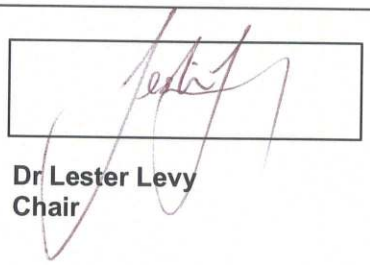


STATEMENT OF RESPONSIBILITY
FOR THE YEAR ENDED 30 JUNE 2012

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;

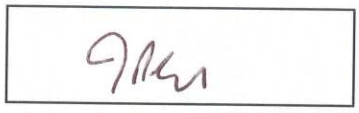
2. The Board and management of ADHB accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting; and

3. In the opinion of the Board and management of ADHB, the financial statements and statement of service performance for the year ended 30 June 2012 fairly reflect the financial position and operations of ADHB.



Dr Lester Levy
Chair

Dated: 16 November 2012



Ian Ward
Chair, Audit and Finance Committee

Dated: 16 November 2012

Ngaire Buchanan
Joint Interim Chief Executive

Dated: 16 November 2012

Dr Margaret Wilsher
Joint Interim Chief Executive

Dated: 16 November 2012

STATUTORY INFORMATION

In respect of the financial year ended 30 June 2012 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

BOARD COMMITTEES AS AT 30 JUNE 2012 - STATUTORY COMMITTEES

Community and Public Health Advisory Committee - Joint with Waitemata District Health Board

Dr Lee Mathias (ADHB), Chair
Max Abbott (WDHB)
Jo Agnew (ADHB)
Peter Aitken (ADHB)
Judith Bassett (ADHB)
Pat Booth (WDHB)
Susan Buckland (ADHB)
Dr Chris Chambers (ADHB)
Sandra Coney (WDHB)
Robin Cooper (ADHB/WDHB)
Warren Flaunty (WDHB)
Tim Jelleyman (external)
Dr Lester Levy (ADHB/WDHB)
Eru Lyndon (external)
Robyn Northey (ADHB)
Christine Rankin (WDHB)
Allison Roe (WDHB)
Gwen Tepania-Palmer (ADHB/WDHB)

Disability Support Advisory Committee - Joint with Waitemata District Health Board

Sandra Coney (WDHB), Chair
Max Abbott (WDHB)
Jo Agnew (ADHB)
Pat Booth (WDHB)
Susan Buckland (ADHB)
Michele Cavanagh (external)
Marie Hull-Brown (external)
Dairne Kirton (external)
Dr Lester Levy (ADHB/WDHB)
Jan Moss (external)
Robyn Northey (ADHB)
Susan Sherrard (external)
Russel Vickery (external)

Hospital Advisory Committee

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

BOARD COMMITTEES AS AT 30 JUNE 2012 - BOARD ESTABLISHED COMMITTEES

Audit and Finance Committee

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

Maori Health Gain Advisory Committee - Joint with Waitemata District Health Board

Robin Cooper (ADHB/WDHB), Chair
Dr Chris Chambers (ADHB)
Kere Cookson-Ua (external)
Matire Harwood (external)
Wendy Lai (WDHB)
James Le Fevre (WDHB)
Dr Lester Levy (ADHB/WDHB)
Eru Lyndon (external)
Mataroria Lyndon
Robyn Northey (ADHB)
Josie Smith(external)
Gwen Tepania-Palmer (ADHB/WDHB)

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 2012		
Operating surplus /(deficit)	736	(2,129)
Share of net surpluses of associates	1	0
Net surplus/(deficit)	737	(2,129)
Equity of ADHB as at 30 June 2012		
Current assets	195,139	170,769
Non-current assets	873,211	869,680
Total assets	1,068,350	1,040,449
Current liabilities	363,994	355,530
Non-current liabilities	262,460	262,460
Total liabilities	626,454	617,990
Total equity	441,896	422,459

Capital Charge

The capital charge for the year ended 30 June 2012 was $32,936 million (to 30 June 2011: $34,491 million) and is treated as an operating expense – note 15.

Equity Comparisons

No equity has been repaid to the Crown (to 30 June 2011, Nil).

Financial Statements

The financial statements of ADHB and the Group for the year ended 30 June 2012 are included separately in this report. The Group consists of ADHB, the Auckland District Health Board Charitable Trust (beneficial control) and associated entities, Northern Regional Training Hub Limited (33% owned), Northern DHB Support Agency Limited (33% owned), Treaty Relationship Company Limited (50% owned), healthAlliance N.Z. Limited (20% owned) and NZ Health Innovation Hub Management Limited (25% owned).

Interests Register

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

(a) Board Members' Fees	Year ended 30/6/12 $	Year ended 30/6/11 $
Dr Lester Levy (Chair)	71,375	40,732
Dr Lee Mathias (Deputy Chair)	40,687	22,584
Jo Agnew	31,250	32,875
Peter Aitken	27,917	17,817
Judith Bassett	29,563	16,847
Susan Buckland	31,000	32,000
Dr Chris Chambers	30,500	31,438
Robin Cooper	27,125	28,500
Robyn Northey	33,750	19,317
Gwen Tepania-Palmer	30,000	17,317
Ian Ward	31,802	33,625
Fees paid to Board Members	**384,969**	**293,052**

(b) Previous Board Members' Fees	Year ended 30/6/11 $
Pat Snedden (Chair)	38,158
Harry Burkhardt (Deputy Chair)	24,818
Dr Brian Fergus	16,430
Dr Ian Scott	15,433
Rt Hon Bob Tizard	16,245
Seiuli Dr Juliet Walker	12,683
Fees paid to Board Members*	**123,767**

*Previous board members' fees do not cover the full financial year.

(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.

Interests Register (continued)

(d) Committee Members' Fees	Year ended 30/6/12 $	Year ended 30/6/11 $
Lautalie Aumua	250	250
Michelle Cavanagh	1,000	-
Fa'avae Gagamoe	-	1,000
Latoa Halatau	250	2,500
Dairne Kirton	1,000	750
Assoc Prof Anne Kolbe	2,000	3,500
Asenati Lole - Taylor	813	1,563
Mataroria Lyndon	1,000	-
Bruce McCarthy	500	2,313
Akateni MacCauley	1,000	1,000
Melino Maka	-	3,500
Liz Mitchelson	-	1,000
Jan Moss	1,000	-
Rev Alfred Ngaro	250	2,000
Puawai Rameka	-	1,750
Susan Sherrards	1,500	1,750
Farida Sultana	-	1,250
Nanar Tan	-	1,500
Russell Vickery	1,250	-
Lynda Williams	-	2,500
Norman Wong	1,750	-
Fees paid to Committee Members	**13,563**	**28,126**

Interests Register (continued)

(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 (Adjunct) of Leadership, University of Auckland Business School; Co-Director, New Zealand Leadership Institute, UOA Business School; Deputy Chair, Health Benefits Limited; Independent Chairman, Tonkin & Taylor; Chairman, Waitemata District Health Board
Dr Lee Mathias (Deputy Chair)	Managing Director, Lee Mathias 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; Chair, Tamaki Transformation Transitional Board; Chair, Health Promotional Establishment Board
Jo Agnew	Professional Teaching Fellow, School of Nursing, Auckland University; Casual Staff Nurse, ADHB
Peter Aitken	Pharmacy Locum; Consultant/ Director/ Shareholder, Pharmacy Care Systems Limited; Owner, Pharmacy New Lynn Medical Centre.
Judith Basset	Nil
Susan Buckland	Self employed, Writing, Editing & Public Relations; Professional Conduct Committee Member, Medical Council of New Zealand; Member, Professional Conduct Committee, Occupational Therapy Board; Member, Northern Regional Ethics Committee
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
Gwen Tepania-Palmer	Board Member, Waitemata District Health Board; Board Member, Manaia PHO; Chair, Ngati Hine Health Trust; Committee Member, Te Tai Tokerau Whanau Ora
Ian Ward	Principal/Director, C-4 Consulting Limited; Board Member, NZ Blood Service; Advisor, Francis Group Consulting

(f) Schedule of Board and Committee Meeting Attendances 2012

ADHB Board Meetings

Member	Meetings held	Meetings attended	Remarks
Dr Lester Levy, Chair	11	11	
Dr Lee Mathias, Deputy Chair	11	11	
Jo Agnew	11	9	
Peter Aitken	11	9	Leave of absence granted for 1 meeting
Judith Bassett	11	10	
Susan Buckland	11	10	
Dr Chris Chambers	11	9	
Robin Cooper	11	5	Leave of absence granted for 2 meetings
Robyn Northey	11	10	
Gwen Tepania-Palmer	11	11	
Ian Ward	11	11	

ADHB Community and Public Health Advisory Committee -Joint with WDHB

Member	Meetings held *	Meetings attended	Remarks
Dr Lee Mathias (ADHB), Chair	10	10	
Max Abbott (WDHB)	9	6	
Jo Agnew (ADHB)	10	8	
Peter Aitken (ADHB)	10	9	Leave of absence granted for 1 meeting
Judith Bassett (ADHB)	4	3	
Pat Booth (WDHB)	9	9	
Susan Buckland (ADHB)	10	10	
Dr Chris Chambers (ADHB)	10	10	
Sandra Coney (WDHB)	9	8	
Robin Cooper (ADHB/WDHB)	9	1	Leave of absence granted for 1 meeting
Warren Flaunty (WDHB)	9	8	
Tim Jelleyman (external)	9	8	
Dr Lester Levy (ADHB/WDHB)	10	8	
Eru Lyndon (external)	9	8	
Alfred Ngaro (external)	2	1	
Robyn Northey (ADHB)	10	9	
Christine Rankin (WDHB)	9	7	
Allison Roe (WDHB)	9	8	
Gwen Tepania-Palmer (ADHB/WDHB)	4	2	
Ian Ward (ADHB)	1	1	

* Note: Meeting held numbers reflect when the person is a member of the committee

(f) Schedule of Board and Committee Meeting Attendances 2012 (continued)

ADHB Disability Support Advisory Committee -Joint with WDHB

Member	Meetings held	Meetings attended
Sandra Coney (WDHB), Chair	5	5
Max Abbott (WDHB)	5	1
Jo Agnew (ADHB)	5	4
Pat Booth (WDHB)	5	5
Susan Buckland (ADHB)	5	3
Michele Cavanagh (external)	5	4
Marie Hull-Brown (external)	5	5
Dairne Kirton (external)	5	4
Dr Lester Levy (ADHB/WDHB)	5	3
Jan Moss (external)	5	4
Robyn Northey (ADHB)	5	4
Susan Sherrard (external)	5	4
Russell Vickery (external)	5	5

ADHB Hospital Advisory Committee

Member	Meetings held	Meetings attended	Remarks
Judith Bassett, Chair	10	9	
Jo Agnew	10	8	
Peter Aitken	10	8	Leave of absence granted for 1 meeting
Susan Buckland	10	9	
Dr Chris Chambers	10	8	
Robin Cooper	10	4	Leave of absence granted for 2 meeting
Assoc Prof Anne Kolbe	10	8	
Dr Lester Levy	10	10	
Dr Lee Mathias	10	10	
Robyn Northey	10	9	
Gwen Tepania-Palmer	10	9	
Ian Ward	10	10	

ADHB Audit and Finance Committee

Member	Meetings held	Meetings attended	Remarks
Ian Ward, Chair	9	9	
Peter Aitken	9	7	Leave of absence granted for 1 meeting
Dr Lester Levy	9	9	
Dr Lee Mathias	9	9	
Robyn Northey	9	9	
Gwen Tepania-Palmer	9	4	
Norman Wong	9	6	

(f) Schedule of Board and Committee Meeting Attendances 2012 (continued)

ADHB Maori Health Gain Advisory Committee-Joint with WDHB

Member	Meetings held	Meetings attended
Robin Cooper (ADHB/WDHB),Chair	3	3
Gwen Tepania-Palmer (ADHB/WDHB), Co-Chair	3	3
Kere Cookson-Ua (external)	3	2
Matire Harwood (external)	3	0
Dr Chris Chambers (ADHB)	3	3
Wendy Lai (WDHB)	3	3
James Le Fevre(WDHB)	3	2
Dr Lester Levy (ADHB/WDHB)	3	3
Eru Lyndon (external)	3	3
Mataroria Lyndon (external)	3	3
Robyn Northey (ADHB)	3	3
Josie Smith (external)	3	3

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 2012

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
Roger Jarrold	Appointed 12 December 2008
Dr. S. Macfarlane	Appointed 11 March 2005
Tim MacAvoy	Appointed 14 August 2009
Phillipa Poole	Appointed 14 August 2009
Dr Margaret Wilsher*	Appointed 1 June 2010
Brent Wiseman*	Appointed 13 February 2009

* Ex Officio Trustee - under new Trust Deed dated 7 Apr 2006

Trustee changes post balance date

Brent Wiseman, CFO ex officio Trustee resigned from ADHB on 27 July 2012. The new CFO will become an ex officio Trustee when the appointment has been made by ADHB.
Robyn Northey has been nominated by ADHB to be the ex officio board representative and the appointment will be effective from 10 August 2012.

Employee remuneration

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

Remuneration Range	Medical	Non- Medical	Number of Employees
$1,360,000-$1,370,000	1		1
$1,280,000-$1,290,000	1		1
$980,000-$990,000	1		1
$950,000-$960,000	1		1
$860,000-$870,000	1		1
$850,000-$860,000	1		1
$830,000-$840,000	1		1
$810,000-$820,000	1		1
$670,000-$680,000	1		1
$610,000-$620,000	1		1
$600,000-$610,000	2		2
$580,000-$590,000	1		1
$560,000-$570,000	1		1
$550,000-$560,000	3		3
$530,000-$540,000	2		2
$520,000-$530,000	3		3
$510,000-$520,000	2		2
$500,000-$510,000	1		1
$480,000-$490,000	1	1	2
$470,000-$480,000	2		2
$460,000-$470,000	2		2
$450,000-$460,000	5		5
$440,000-$450,000	3		3
$430,000-$440,000	2		2
$420,000-$430,000	3		3
$410,000-$420,000	2		2
$400,000-$410,000	4		4
$390,000-$400,000	4		4
$380,000-$390,000	6		6
$370,000-$380,000	8		8
$360,000-$370,000	7		7
$350,000-$360,000	5		5
$340,000-$350,000	16		16
$330,000-$340,000	21		21
$320,000-$330,000	15	1	16
$310,000-$320,000	23	1	124
$300,000-$310,000	17		17
$290,000-$300,000	10	2	12
$280,000-$290,000	21		21
$270,000-$280,000	24		24
$260,000-$270,000	26	2	28
$250,000-$260,000	22	1	23
$240,000-$250,000	25	1	26
$230,000-$240,000	15	1	16
$220,000-$230,000	26		26
$210,000-$220,000	35		35
$200,000-$210,000	31		31
$190,000-$200,000	39		39
$180,000-$190,000	31	1	32

Employee remuneration (continued)

Remuneration Range	Medical	Non- Medical	Number of Employees
$170,000-$180,000	39	4	43
$160,000-$170,000	43	6	49
$150,000-$160,000	49	7	56
$140,000-$150,000	44	12	56
$130,000-$140,000	64	22	86
$120,000-$130,000	54	44	98
$110,000-$120,000	59	57	116
$100,000-$110,000	60	131	191
Grand Total	**888**	**294**	**1,182**

Note:

Of the 1,182 employees shown above, 888 are or were medical or dental employees and 294 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 1,435 compared with the actual total number of employees of 1,182.

Total Remuneration over $100,000 a year

Each year, as required by the Crown Entities Act, our annual report shows numbers of employees receiving total remuneration over $100,000 per year, in bands of $10,000. Employee numbers are categorised into medical and non-medical.

The highest earners in this chart are all surgeons who work in a cardiac model of care that requires them to look after one patient through their journey of care with us. This means the surgeons operate, then remain on call to be called back to care for their patient as or if required.

As a consequence of high volumes of complex acute operations and higher numbers of complex elective operations and procedures, there were often multiple surgeons on call who were called-back frequently. In addition, the requirement to meet new elective throughput targets has required additional Saturday operating lists for which a premium is paid.

Nevertheless the growth in demand was met and a growth in throughput was achieved. For the 2011/12 financial year, around two additional cases were being completed each week.

Our model of care is, however, changing - making 2011-12 a rather unusual and unique year and one unlikely to be repeated. Auckland District Health Board (ADHB) made a very significant push in cardiac surgery, delivering more operations to more New Zealanders, getting over a peak level of demand while carrying surgeon vacancy. This additional work, as well as payment for work done over previous years as a result of job sizing, is all included together with regular remuneration in the amounts above. ADHB is gearing up capacity for the future by employing more surgeons and, all things being equal, this will ensure a better balancing of resources.

Employee termination

Termination payments	Payment $	Employees
Total	1,317,156	77

During the year ended 30 June 2012, termination payments were made in respect of 77 employees (91 payments, $1,455,209 in year ended 30 June 2011). 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	2012 $000	2011 $000
Audit Fees	244	237

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: 16 November 2012

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2012

	Notes	Group Budget	Group Actual		Parent Actual	
		2012 $000	2012 $000	2011 $000	2012 $000	2011 $000
Revenue						
Patient care revenue		1,793,954	1,698,104	1,634,656	1,698,104	1,634,656
Other revenue		86,949	90,751	87,903	86,701	85,944
Total revenue	2	**1,880,903**	**1,788,855**	**1,722,559**	**1,784,805**	**1,720,600**
Expenses						
Employee benefit cost	3a	741,320	755,535	727,849	755,535	727,849
Outsourced Services		31,634	94,196	58,082	94,196	58,082
Direct treatment cost		238,885	199,282	202,756	199,282	202,756
Funder payments		659,643	542,641	516,453	542,641	516,453
Indirect treatment costs	3b	41,971	42,674	43,833	42,674	43,833
Property, equipment & transport costs.	3c	45,750	43,285	49,267	43,285	49,267
Other operating expenses	3d	22,620	20,022	20,126	18,837	18,621
Capital charge	3e	34,873	32,936	34,491	32,936	34,491
Depreciation and amortisation expenses	3f	45,173	39,694	51,146	39,694	51,146
Finance costs	3g	18,936	17,854	18,219	17,854	18,219
Total expenses		**1,880,805**	**1,788,119**	**1,722,222**	**1,786,934**	**1,720,717**
Share of surpluses of joint ventures & associates		0	1	32	0	0
Surplus/(deficit)		**98**	**737**	**369**	**(2,129)**	**(117)**

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2012

	Notes	Group Budget	Group Actual		Parent Actual	
		2012 $000	2012 $000	2011 $000	2012 $000	2011 $000
Surplus/ (deficit)		98	737	369	(2,129)	(117)
Gains/(Losses) on property revaluations	6	0	(174)	(21,557)	(174)	(21,557)
Total Comprehensive Income/(Loss)		**98**	**563**	**(21,188)**	**(2,303)**	**(21,674)**

Explanations of major variances against budget are provided in note 20.

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

STATEMENT OF CHANGES IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2012

GROUP	Notes	Actual 2012 $000	Budget 2011 $000	Actual 2011 $000
Balance as at 1 July		439,521	458,807	454,577
Prior period adjustment		0	0	2,438
Adjusted balance		**439,521**	**458,807**	**457,015**
Comprehensive income/(expense)				
Surplus/ (deficit) for prior period	24			227
Surplus/ (deficit) for period		737	98	142
Other comprehensive income/(expense)		(174)	0	(21,557)
Total comprehensive income/(expense)		**563**	**98**	**(21,188)**
Owner Transactions				
Capital contributions to the Crown		1,812	3,594	3,694
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	6	**441,896**	**462,499**	**439,521**

PARENT	Notes	Actual 2012 $000	Budget 2011 $000	Actual 2011 $000
Balance as at 1 July		422,950	458,905	440,930
Comprehensive income/(expense)				
Surplus/ (deficit) for period		(2,129)	(788)	(117)
Other comprehensive income/(expense)		(174)	0	(21,557)
Total comprehensive income/(expense)		**(2,303)**	**(788)**	**(21,674)**
Owner Transactions				
Capital contributions to the Crown		1,812	3,594	3,694
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	6	**422,459**	**461,711**	**422,950**

Explanations of major variances against budget are provided in note 20.

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

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2012

	Notes	Group Budget	Group Actual		Parent Actual	
		As at 30/06/12 $000	As at 30/06/12 $000	As at 30/06/11 $000	As at 30/06/12 $000	As at 30/06/11 $000
Current Assets						
Cash and cash equivalents	7	52,545	94,081	108,125	94,081	108,125
Trust/special funds	8a	3,948	22,078	18,067	0	0
Patient & restricted trust funds	8b	0	1,120	1,093	1,120	1,093
Debtors & other receivables	9	59,754	62,324	56,206	60,032	54,140
Prepayments		3,213	1,419	3,025	1,419	3,025
Inventories	10	12,454	14,117	12,021	14,117	12,021
Non-current assets held for sale	11c	0	0	20,041	0	20,041
Total Current Assets		131,914	195,139	218,578	170,769	198,445
Non-Current Assets						
Trust/special funds	8a	10,078	2,129	3,898	0	0
Property, plant and equipment	11a	901,908	842,774	829,099	841,874	829,099
Intangible assets	11b	(1)	529	535	529	535
Derivative financial instruments	19	3,041	7,553	5,945	7,553	5,945
Investments in joint ventures & associates	5	20,274	20,226	502	19,724	1
Total Non-Current Assets		935,300	873,211	839,979	869,680	835,580
Total Assets		1,067,214	1,068,350	1,058,557	1,040,449	1,034,025

Explanations of major variances against budget are provided in note 20.

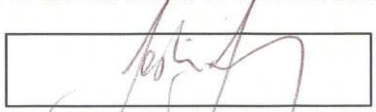
The accompanying notes form an integral part of these financial statements

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2012

	Notes	Group Budget	Group Actual		Parent Actual	
		As at 30/06/12 $000	As at 30/06/12 $000	As at 30/06/11 $000	As at 30/06/12 $000	As at 30/06/11 $000
Current Liabilities						
Bank overdraft	7	0	19,800	24,800	19,800	24,800
Trade and other payables	13a	147,027	125,262	145,994	116,798	138,033
Employee benefits	13b	125,367	148,827	136,320	148,827	136,320
Provisions	13c	0	1,830	2,071	1,830	2,071
Interest-bearing loans and borrowings	14,18	3,742	66,694	23,249	66,694	23,249
Loans from joint ventures & associates	5	0	375	375	375	375
Derivative financial instruments	19	0	86	0	86	0
Patient & restricted trust funds	8b	1,139	1,120	1,093	1,120	1,093
Total Current Liabilities		277,275	363,994	333,902	355,530	325,941
Non-Current Liabilities						
Employee benefits	13b	23,246	21,747	21,747	21,747	21,747
Interest-bearing loans and borrowings	14	304,194	240,713	263,110	240,713	263,110
Derivative financial instruments	19	0	0	277	0	277
Total Non-Current Liabilities		327,440	262,460	285,134	262,460	285,134
Total Liabilities		604,715	626,454	619,036	617,990	611,075
Net Assets		462,499	441,896	439,521	422,459	422,950
Equity						
Public equity	6a	577,171	574,915	573,103	574,915	573,103
Accumulated deficit	6b	(477,217)	(483,757)	(481,629)	(484,263)	(482,134)
Other reserves	6c	353,538	331,807	331,981	331,807	331,981
Trust/special funds	6d	9,007	18,931	16,066	0	0
Total Equity		462,499	441,896	439,521	422,459	422,950

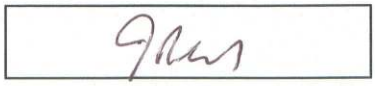
Explanations of major variances against budget are provided in note 20.

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



Dr Lester Levy
Chair

Dated: 16 November 2012



Ian Ward
Chair, Audit and Finance Committee

Dated: 16 November 2012

The accompanying notes form an integral part of these financial statements

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2012

	Notes	Group Budget	Group Actual		Parent Actual	
		2012	2012	2011	2012	2011
		$000	$000	$000	$000	$000
Cash flows from operating activities						
Cash receipts from Ministry of Health and patients		1,872,717	1,910,063	1,814,447	1,908,253	1,813,663
Interest received		7,329	7,779	6,617	5,925	5,714
Cash paid to employees		(743,895)	(742,462)	(715,730)	(742,462)	(716,042)
Cash paid to suppliers		(1,065,933)	(1,091,656)	(978,238)	(1,091,076)	(977,202)
Interest paid		(18,735)	(17,806)	(19,540)	(17,806)	(19,540)
Net goods and services taxes refunded/(paid)		0	(1,200)	3,594	(1,258)	3,576
Capital charges paid		0	(40,288)	(36,048)	(40,288)	(36,048)
Net cash inflow from operating activities	7	51,483	24,430	75,102	21,288	74,121
Cash flows from investing activities						
Proceeds from sale of property, plant and equipment		91	19,531	268	19,531	268
Decrease/(Increase) in restricted trust funds		36	(2,269)	(1,007)	(27)	(26)
Decrease/(Increase) in investments		(5,464)	(19,724)	0	(19,724)	0
Purchase of property, plant and equipment		(72,166)	(53,824)	(51,547)	(52,924)	(51,547)
Net cash (outflow) from investing activities		(77,503)	(56,286)	(52,286)	(53,144)	(51,305)
Cash flows from financing activities						
Repayment of loans		3,594	(20,000)	(70,000)	(20,000)	(70,000)
Proceeds from borrowings		21,000	41,000	70,000	41,000	70,000
Proceeds from capital contributed/(repaid)		0	1,812	3,694	1,812	3,694
Net cash inflow/(outflow) from financing activities		24,594	22,812	3,694	22,812	3,694
Net (decrease)/increase in cash and cash equivalents		(1,426)	(9,044)	26,510	(9,044)	26,510
Cash and cash equivalents at start of the year		53,971	83,325	56,815	83,325	56,815
Cash and cash equivalents at end of the year	7	**52,545**	**74,281**	**83,325**	**74,281**	**83,325**

The GST (net) component of cash flows from operating activities reflects the net GST paid to and received from the IRD. The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes and to be consistent with the presentation basis of the other primary financial statements.

Explanations of major variances against budget are provided in note 20.

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.

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

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to ADHB, 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 3 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/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply for PBEs before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, ADHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means ADHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, ADHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Statement of compliance

The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). 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).

1

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.

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 Ventures

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.

healthAlliance N.Z. Limited is a joint venture company with Health Benefits Limited and Counties-Manukau, Northland and Waitemata DHBs that exists to provide a shared services agency to the four northern DHBs in respect to information technology, procurement and financial processing.

NZ Health Innovation Hub Management Limited
The four largest District Health Boards (Counties Manukau, Auckland, Waitemata and Canterbury) have established a national Health Innovation Hub. The Hub will engage with the DHBs, clinicians and Industry to collaboratively realise and commercialise products and services that can make a material impact on healthcare in NZ and internationally.

The Hub has been structured as a limited partnership, with the four foundation DHBs each having a 25% shareholding in the limited partnership and the general partner, NZ Health Innovation Hub Management Limited, which was incorporated on 26 June 2012.

1 SIGNIFICANT ACCOUNTING POLICIES (continued)

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: Northern Regional Training Hub Limited (previously Auckland Regional RMO Services 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.

Northern Regional Training Hub Limited is an associate 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 an associate 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.

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.

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.

1 SIGNIFICANT ACCOUNTING POLICIES (continued)

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	2012	2011
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

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.

1 SIGNIFICANT ACCOUNTING POLICIES (continued)

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 5 years (2011: 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.

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.

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 NZ IFRS, 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 2012, there was an amount of $6,118k unspent revenue in respect of Mental Health Ring Fenced Revenue (as at 30 June 2011 - $10,894k 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

ADHB group have adopted NZ IAS 24 during the financial year, which has had only a presentational or disclosure effect:

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.

NZ IFRS 7.44L • NZ IFRS 7 *Financial Instruments: Disclosures* – The effect of early adopting these amendments is that 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.

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

Certain comparative figures for prior period have been reclassified where necessary to be consistent with current year's presentation.

	Notes	Group Actual 2012 $000	Group Actual 2011 $000	Parent Actual 2012 $000	Parent Actual 2011 $000
2 REVENUE					
Patient care revenue		1,698,104	1,634,656	1,698,104	1,634,656
Interest received – other		5,960	6,019	5,960	6,019
Interest received – Charitable Trust		1,093	1,135	0	0
Donations and bequests		5,139	6,358	5,139	5,401
Gain on disposal of assets		0	50	0	50
Gain on derivatives – financial instruments		3,496	2,099	3,496	2,099
Other revenue		75,063	72,242	72,106	72,375
Total Revenue		1,788,855	1,722,559	1,784,805	1,720,600
3 EXPENSES					
a ***Employee benefit costs***					
Wages and salaries		731,061	706,374	731,061	706,374
Contributions to defined contribution plans	(i)	11,967	11,039	11,967	11,039
Increase/(decrease) in liability for employee benefit		12,507	10,436	12,507	10,436
Total employee benefit costs		755,535	727,849	755,535	727,849
b ***Indirect treatment costs***					
Bad debts written off		3,897	4,576	3,897	4,576
Increase (decrease) in estimated doubtful debts		(1,650)	1330	(1,650)	1330
Other indirect treatment costs		40,427	37,927	40,427	37,927
Total indirect treatment costs		42,674	43,833	42,674	43,833
c ***Property, equipment & transportation cost***					
Rental and operating lease costs		3,574	4,723	3,574	4,723
Other property, equipment & transportation cost		39,711	44,544	39,711	44,544
Total property, equipment & transportation cost		43,285	49,267	43,285	49,267
d ***Other operating expenses***					
Remuneration of auditor					
- audit fees: statutory accounts		244	237	244	237
Board Members' fees		385	417	385	417
Research costs		7,758	6630	7,758	6,630
Loss on disposal of assets		618	0	618	0
Other expenses		11,017	12,842	9,832	11,337
Total other operating expenses		20,022	20,126	18,837	18,621
e ***Capital charge (note 15)***		32,936	34,491	32,936	34,491
f ***Depreciation and impairment expenses***					
Depreciation		39,694	51,146	39,694	51,146
Impairment loss/(gain) – software (note 11b)		0	0	0	0
Total depreciation and impairment expenses		39,694	51,146	39,694	51,146
g ***Finance costs***					
Interest expense		17,856	18,234	17,856	18,234
Foreign currency loss/(gain)		(2)	(15)	(2)	(15)
Total finance costs		17,854	18,219	17,854	18,219

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).

	Notes	Group Actual 2012 $000	Group Actual 2011 $000	Parent Actual 2012 $000	Parent Actual 2011 $000
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 VENTURES & ASSOCIATES					
Non Current Assets					
Results of joint ventures & associates					
Share of post acquisition surplus		1	32	0	0
Share of net surpluses of joint venture & associates		1	32	0	0
Carrying amount at the beginning of the year		502	470	1	1
Shares in Health Alliance NZ Ltd (joint venture)					
Class A Shares		200	0	200	0
Class C Shares	(i)	19,523	0	19,523	0
Carrying amount at end of year		20,226	502	19,724	1
Represented by:					
Shares in joint ventures & associates		19,724	1	19,724	1
Share of post-acquisition retained surpluses		502	501	0	0
		20,226	502	19,724	1
Current Liabilities					
Loans from joint ventures & associates		375	375	375	375

Note 5(i)

A Memorandum of Understanding was signed between Health Alliance NZ Ltd and Auckland DHB, Counties Manukau DHB , Northland DHB and Waitemata DHB that C Class shares are to be issued by Health Alliance NZ Ltd in exchange for the transfer of ownership of DHB's IT assets (and other ancillary assets). The amount $19,523k represents the baseline value of ADHB's IT assets transferred on 29 June 2012.

	2012 % Interest held	2011 % Interest held
Name of joint ventures (Principal activity)		
Treaty Relationship Company Limited (joint venture for health initiatives with local iwi)	50	50
healthAlliance N.Z. Limited (provider of shared services to Northern Region DHBS and Health Benefits Limited)	20	0
NZ Health Innovation Hub Management Limited (joint venture / limited partnership with Northern Region DHBS to realise products and services to assist healthcare in NZ and overseas)	25	0
Name of associates (Principal activity)		
Northern Regional Training Hub 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 30/06/12	As at 30/06/11	As at 30/06/12	As at 30/06/11
6	**CAPITAL AND RESERVES**	**$000**	**$000**	**$000**	**$000**
a	***Public equity***				
	Opening balance	573,103	569,409	573,103	569,409
	Contributions from/(repayment to) the Crown	1,812	3,694	1,812	3,694
	Balance at end of year	574,915	573,103	574,915	573,103
b	***Accumulated deficits***				
	Opening balance	(481,629)	(481,545)	(482,134)	(482,017)
	Operating surplus/(deficit)	737	369	(2,129)	(117)
	Transfer to trust/special funds	(2,865)	(453)	0	0
	Balance at end of year	(483,757)	(481,629)	(484,263)	(482,134)
c	***Other Reserves***				
	Revaluation Reserve				
	Opening balances	331,981	353,538	331,981	353,538
	Net Movement	(174)	(21,557)	(174)	(21,557)
	Balance at end of year	331,807	331,981	331,807	331,981
d	***Trust/special funds***				
	Opening balances	16,066	15,613	0	0
	Transfer from accumulated deficits (Note 6b)	2,865	453	0	0
	Balance at end of year	18,931	16,066	0	0
	Grand Total	**441,896**	**439,521**	**422,459**	**422,950**

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 - 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	**2012 Actual $000**	**2011 Actual $000**
Balance at beginning of year	16,066	15,613
Transfer from retained earnings in respect of:		
Interest received	1,093	1,135
Donations and funds received	10,615	7,889
Transfer to retained earnings in respect of:		
Funds spent	(8,843)	(8,571)
Balance at end of year	18,931	16,066

7 CASH AND CASH EQUIVALENTS	Group Actual As at 30/06/12 $000	Group Actual As at 30/06/11 $000	Parent Actual As at 30/06/12 $000	Parent Actual As at 30/06/11 $000
Current assets				
Bank balance	2,553	7,080	2,553	7,080
Short term deposits	91,528	101,045	91,528	101,045
Cash & cash equivalents	94,081	108,125	94,081	108,125
Bank overdrafts	(19,800)	(24,800)	(19,800)	(24,800)
Cash & cash equivalents in the statement of cash flows	74,281	83,325	74,281	83,325
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 2012. Unused portion of the facility at 30 June 2012 was $45.2m (2011 $40.2m).

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 2012 $000	Group Actual 2011 $000	Parent Actual 2012 $000	Parent Actual 2011 $000
Reported net surplus/(deficit) for the year	6	737	369	(2,129)	(117)
Add non-cash items:					
Employee entitlements		13,073	12,119	13,881	11,807
Depreciation and impairment loss		39,694	51,146	39,694	51,146
Joint ventures & associates	5	(1)	(32)	0	0
Bad Debts Written off		3,897	4,576	3,897	4,576
(Increase)/Decrease in derivative financial instruments		(1,799)	1,392	(1,799)	1,392
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		(618)	(50)	(618)	(50)
Add movements in working capital items:					
(Increase)/Decrease in receivables		(9,238)	1,260	(6,020)	1,080
(Increase)/Decrease in inventories		(2,096)	(5,377)	(2,096)	(5,377)
Increase/(Decrease) in payables		(19,246)	9,673	(23,549)	9,638
Increase/(Decrease) in funds held in trust		27	26	27	26
Net cash inflow/(outflow) from operating activities		24,430	75,102	21,288	74,121

	Group Actual		Parent Actual	
	As at 30/06/12	As at 30/06/11	As at 30/06/12	As at 30/06/11
8a TRUST/SPECIAL FUNDS				
Current assets				
Bank balances (restricted)	99	94	0	0
Short term deposits (restricted)	21,979	17,973	0	0
	22,078	18,067	0	0
Non – current assets				
Long term deposits (restricted)	0	1,800	0	0
Investment Bonds (at market)/(restricted)	2,129	2,098	0	0
	2,129	3,898	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	10	11	10	11
Restricted fund deposit	1,110	1,082	1,110	1,082
	1,120	1,093	1,120	1,093
Current liabilities				
Patient trust	10	11	10	11
Restricted fund deposit	1,110	1,082	1,110	1,082
	1,120	1,093	1,120	1,093

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 DEBTORS AND OTHER RECEIVABLES				
Ministry of Health receivables	26,499	28,346	26,499	28,346
Other receivables	21,652	17,396	20,365	16,992
Other accrued income	15,857	13,798	14,852	12,136
Less provision for impairment	(1,684)	(3,334)	(1,684)	(3,334)
	62,324	56,206	60,032	54,140

The carrying value of debtors and other receivables approximates their fair value.

	Group Actual		Parent Actual	
	As at 30/06/12	As at 30/06/11	As at 30/06/12	As at 30/06/11
10 INVENTORIES				
Pharmaceuticals	1,703	849	1,703	849
Surgical and medical supplies	12,386	11,143	12,386	11,143
Other supplies	28	29	28	29
	14,117	12,021	14,117	12,021

The amount of inventories recognised as an expense during the year ended 30 June 2012 was $90,986k (2011 76,688k).

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2012 was $14,117k (2011 12,021k). Write-down/ (up) of inventories amounted to ($65k) for 2012 (2011 $86k).

11a PROPERTY, PLANT and EQUIPMENT

GROUP 2012	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 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 increase/(decrease)	(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**
Cost						
Balance at 1 July 2011	163,554	572,793	260,228	890	17,699	1,015,164
Additions	0	0	0	0	53,132	53,132
Additions from Work in Progress	255	31,871	24,901	5	(57,032)	0)
Disposals	0	0	(6,728)	(10)	0	(6,738)
Transfer to Non-current assets held for sale	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	0	269	0	0	0	269
Balance at 30 June 2012	**163,809**	**604,933**	**278,401**	**885**	**13,799**	**1,061,827**
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)**
Depreciation and impairment losses						
Balance at 1 July 2011	0	(57)	(185,314)	(694)	0	(186,065)
Depreciation charge for the year	0	(21,813)	(17,769)	(47)	0	(39,629)
Disposals	0	0	6,727	10	0	6,737
Transfer to Non-current assets held for sale	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	0	(96)	0	0	0	(96)
Balance at 30 June 2012	**0**	**(21,966)**	**(196,356)**	**(731)**	**0**	**(219,053)**

11a PROPERTY, PLANT and EQUIPMENT (continued)

GROUP 2012	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 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**
Carrying Amounts						
At 1 July 2011	163,554	572,736	74,914	196	17,699	829,099
At 30 June 2012	163,809	582,967	82,045	154	13,799	842,774

11a PROPERTY, PLANT and EQUIPMENT

PARENT 2012	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 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 increase/(decrease)	(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**
Cost						
Balance at 1 July 2011	163,554	572,793	260,228	890	17,699	1,015,164
Additions	0	0	0	0	52,232	52,232
Additions from Work in Progress	255	31,871	24,901	5	(57,032)	0)
Disposals	0	0	(6,728)	(10)	0	(6,738)
Transfer to Non-current assets held for sale	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	0	269	0	0	0	269
Balance at 30 June 2012	**163,809**	**604,933**	**278,401**	**885**	**12,899**	**1,060,927**
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)**
Depreciation and impairment losses						
Balance at 1 July 2011	0	(57)	(185,314)	(694)	0	(186,065)
Depreciation charge for the year	0	(21,813)	(17,769)	(47)	0	(39,629)
Disposals	0	0	6,727	10	0	6,737
Transfer to Non-current assets held for sale	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	0	(96)	0	0	0	(96)
Balance at 30 June 2012	**0**	**(21,966)**	**(196,356)**	**(731)**	**0**	**(219,053)**

11a PROPERTY, PLANT and EQUIPMENT (continued)

PARENT 2012	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 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**
Carrying Amounts						
At 1 July 2011	163,554	572,736	74,914	196	17,699	829,099
At 30 June 2012	163,809	582,967	82,045	154	12,899	841,874

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. Additions to Property, Plant & Equipment for the year ended 30 June 2012 are recorded at cost.

PROPERTY, PLANT and EQUIPMENT (continued)

GROUP & PARENT

11b INTANGIBLE ASSETS	Note	Total
Software & development costs		**$000**
Cost		
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**
Balance at 1 July 2011		1,977
Additions		59
Disposals		(6)
Transfer to Non-current assets held for sale		0
Reclassifications		0
Balance at 30 June 2012		**2,030**
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)**
Amortisation & Impairment Losses		
Balance at 1 July 2011		(1,442)
Amortisation charge for the year		(65)
Disposals		6
Transfer to Non-current assets held for sale		0
Reclassifications		0
Balance at 30 June 2012		**(1,501)**
Carrying Amounts		
At 1 July 2010		10,145
At 30 June 2011		**535**
At 1 July 2011		535
At 30 June 2012		**529**

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 (2011 Nil).

11c NON-CURRENT ASSETS HELD FOR SALE

The DHB owns assets which have been classified as held for sale following the establishment of healthAlliance N.Z.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 2012 $000	Actual 2011 $000
Equipment & vehicles	0	9,150
IT Software	0	10,891
	0	**20,041**

12a CONTINGENT ASSETS

There are no contingent assets at 30 June 2012 (2011 $1.4m).

12b CONTINGENT LIABILITIES

Lawsuits against the DHB

The DHB has been notified of six legal claims against it but asseses that it is not likely to be found liable under these claims. All the claims are patient related. The DHB is vigorously contesting the claims and there is uncertainty as to what any legal judgement may be. The DHB believes that any court award will be met by its insurers.

Superannuation Schemes

The employer is a participating employer in the DBP Contributors Scheme ('the Scheme') which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, the employer could be responsible for the entire deficit of the Scheme (see note [13d]). Similarly, if a number of employers ceased to participate in the Scheme, the employer could be responsible for an increased share of the deficit.

	Notes	Group Actual As at 30/06/12 $000	Group Actual As at 30/06/11 $000	Parent Actual As at 30/06/12 $000	Parent Actual As at 30/06/11 $000
13a TRADE AND OTHER PAYABLES					
Current					
Creditors and accrued expenses		90,278	96,612	87,312	94,086
GST,PAYE & FBT payable		18,963	20,930	18,983	21,008
Capital Charge payable		319	7,671	319	7,671
Income in advance		15,702	20,781	10,184	15,268
		125,262	145,994	116,798	138,033

Creditors and other payables are non-interest bearing and are normally settled on 30-day term. Therefore, the carrying value of creditors and other payables approximates their fair value.

13b EMPLOYEE BENEFITS					
Current					
Liability for long service leave		2,245	2,019	2,245	2,019
Liability for sabbatical leave		300	300	300	300
Liability for retirement gratuities		5,627	4,904	5,627	4,904
Liability for annual leave		81,524	75,781	81,524	75,781
Liability for sick leave		1,006	531	1,006	531
Liability for continuing medical leave and expenses		24,239	23,347	24,239	23,347
Salaries and wage accrual		33,886	29,438	33,886	29,438
		148,827	136,320	148,827	136,320
Non Current					
Liability for long service leave		1,428	941	1,428	941
Liability for retirement gratuities		20,319	20,806	20,319	20,806
		21,747	21,747	21,747	21,747

Salaries and wages accrual is calculated as the expected cost to be paid within the next 12 months relating to the financial year being reported, including allowance for known salary and wage movements. The two major elements included in the accrual of 33.9m are Unpaid Days $21.4m and Back-Pay $8.7m. The job sizing accrual included in Back-Pay is based on the assessment made of additional work carried out as the result of changes in ADHB's model of care, as described on Page 29

The present value of long service leave and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used is the 3 year plus risk-free rate as advised by Treasury. The salary inflation factor has been determined after considering historical salary inflation patterns and future movements. A weighted average discount rate of 6% (2011 6%) and an inflation factor of 1.5% (2011 2.5%) were used.

13c PROVISIONS					
Current					
ACC Partnership Programme		1,757	1,825	1,757	1,825
Litigation		13	0	13	0
Restructuring		60	246	60	246
		1,830	2,071	1,830	2,071

	Notes	Group Actual As at 30/06/12 $000	Group Actual As at 30/06/11 $000	Parent Actual As at 30/06/12 $000	Parent Actual As at 30/06/11 $000
13c PROVISIONS (continued)					
Movement for each class of provisions are as follows:					
ACC Partnership Programme					
Opening balance		1,825	1,769	1,825	1,769
Additional provisions made during year		559	950	559	950
Charged against provision for the year		(627)	(894)	(627)	(894)
Unused amounts reversed during year		0	0	0	0
Closing balance	(i)	1,757	1,825	1,757	1,825
Litigation Provision					
Opening balance		0	0	0	0
Additional provisions made during year		13	0	13	0
Charged against provision for the year		0	0	0	0
Unused amounts reversed during year		0	0	0	0
Closing balance	(ii)	13	0	13	0
Restructuring Provision					
Opening balance		246	74	246	74
Additional provisions made during year		(71)	246	(71)	246
Charged against provision for the year		(115)	(74)	(115)	(74)
Unused amounts reversed during year		0	0	0	0
Closing balance	(iii)	60	246	60	246

Notes

(i) *ACC Partnership Programme*

Liability valuation

An external independent actuarial valuer, MA Lardies, has calculated the liability as at 30 June 2012. 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% (2011 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 3% for 30 June 2013 and 2014;
- a weighted average discount factor of 3.5% for 30 June 2013 and 30 June 2014 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 $4,500.

13c PROVISIONS (continued)

(i) *ACC Partnership Programme (continued)*

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 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 107.4% 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 $5,227,112 incurred in the cover period from 1 April 2010 to 31 March 2012 (2011/2012 ACC Claim Year).

(ii) Litigation

The provision relates to contractual disputes, internal investigation and tax audit advice.

(iii) Restructuring

The provision relates to the termination of New Zealand Manufactured Data Base Contract with the New Zealand Food Safety Authority ($53k), and relates to TinyBites Café weekend closure ($7k).

13d Defined Contribution Plan (DCP)

The DCP (with National Provident Fund) is a multi-employer defined benefit scheme. At 30 June 2012 ADHB contributions to the fund were fully paid - see Note 3a for details.

The DBP Contributors Scheme ('the Scheme') 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 the deficit will affect future contributions by employers, as there is no prescribed basis for allocation.

As at 31 March 2011, the Scheme had a past service surplus of $37.582 million (16.4% of the liabilities). This amount is exclusive of Employer Superannuation Contribution Tax. 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 recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report, the Actuary recommended employer contributions remain suspended.

	Group Actual		Parent Actual	
	As at 30/06/12 $000	As at 30/06/11 $000	As at 30/06/12 $000	As at 30/06/11 $000
14 INTEREST-BEARING LOANS AND BORROWINGS				
Current				
Secured loans				
Crown Health Financing Agency	63,500	20,000	63,500	20,000
Interest on Borrowings	3,298	3,345	3,298	3,345
Unexpired set up cost on borrowings	(104)	(96)	(104)	(96)
	66,694	23,249	66,694	23,249
Non-current				
Secured loans				
Crown Health Financing Agency	191,000	213,500	191,000	213,500
15 year Capital Bonds, maturing 15 September 2015	50,000	50,000	50,000	50,000
Unexpired set up cost on borrowings	(287)	(390)	(287)	(390)
	240,713	263,110	240,713	263,110

14 INTEREST-BEARING LOANS AND BORROWINGS (continued)

	Note	Group Actual		Parent Actual	
		As at 30/06/12 $000	As at 30/06/11 $000	As at 30/06/12 $000	As at 30/06/11 $000
Secured loans					
The details of terms and conditions are as follows:					
Borrowings are repayable:					
Less than one year		66,694	23,249	66,694	23,249
One to two years		9,888	63,397	9,888	63,397
Two to five years		119,825	129,713	119,825	129,713
Over five years		111,000	70,000	111,000	70,000
		307,407	286,359	307,407	286,359

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	4.26-6.345	4.26-6.90	4.26-6.345	4.26-6.90
Capital Bonds	7.75	7.75	7.75	7.75
Borrowing facilities				
Crown Health Financing Agency	254,500	254,500	254,500	254,500
Capital Bonds	60,000	50,000	50,000	50,000
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 2012 was $45.2m (2011 $40.2m).

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 30/06/12 $000	As at 30/06/11 $000	As at 30/06/12 $000	As at 30/06/11 $000
15 CAPITAL CHARGE	32,936	34,491	32,936	34,491

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 2012 (8 percent for fiscal year 2011) 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 30/06/12 $000	As at 30/06/11 $000
a ***Capital commitments***			
Approved and contracted		5,334	6,827
Approved and to be contracted		32,304	36,577
		37,638	43,404
Term classification of commitments			
Less than one year		37,638	36,604
One to two years		0	6,800
Two to five years		0	0
Over five years		0	0
		37,638	43,404
b ***Operating commitments***			
Leases	(i)	4,878	4,695
Other	(ii)	421,185	521,626
		426,063	526,321

GROUP AND PARENT	Leases		Other		Total	
	As at 30/06/12 $000	As at 30/06/11 $000	As at 30/06/12 $000	As at 30/06/11 $000	As at 30/06/12 $000	As at 30/06/11 $000
Term classification of operating commitments						
Less than one year	2,134	2,251	103,644	122,660	105,778	124,911
One to two years	1,522	1,080	76,910	89,967	78,432	91,047
Two to five years	1,169	1,278	225,827	217,601	226,996	218,879
Over five years	53	86	14,804	91,398	14,857	91,484
	4,878	4,695	421,185	521,626	426,063	526,321

Notes

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

16b(ii) The other operating commitments comprised:

- $416m (2011 $512m) expected payment schedules for contracts entered in the Ministry of Health's Computerised Management System (CMS).
- $5m (2011 $9m) 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	2012 Actual $000	2011 Actual $000
Sales to ADHB Charitable Trust	87	(16)
Purchases from ADHB Charitable Trust	183	99
Outstanding balance receivable from ADHB Charitable Trust	2,964	2,523
Outstanding balance payable to ADHB Charitable Trust	0	5

b Joint ventures & associates

ADHB has a related party relationship with its joint ventures & associates and with its executive officers. Joint ventures 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 30/06/12 $000	As at 30/06/11 $000	As at 30/06/12 $000	As at 30/06/11 $000
GROUP AND PARENT					
Sales to joints & associates					
healthAlliance N.Z. Limited (joint venture)		4,022	0	4,022	0
NZ Health Innovation Hub Management Ltd (joint venture)		0	0	0	0
Northern Regional Training Hub Limited (associate)		249	241	249	241
Northern DHB Support Agency Limited (associate)		430	585	430	585
		4,701	826	4,701	826
Purchases from joint ventures & associates					
healthAlliance N.Z. Limited (joint venture)		26,882	0	26,882	0
NZ Health Innovation Hub Management Ltd (joint venture)		0	0	0	0
Northern Regional Training Hub Limited (associate)		4,121	4,414	4,121	4,414
Northern DHB Support Agency Limited (associate)		3,094	3,264	3,094	3,264
		34,097	7,678	34,097	7,678
Outstanding balances receivable from joint ventures & associates					
healthAlliance N.Z. Limited (joint venture)		0	0	0	0
NZ Health Innovation Hub Management Ltd (joint venture)		0	0	0	0
Northern Regional Training Hub Limited (associate)		0	10	0	10
Northern DHB Support Agency Limited (associate)		0	69	0	69
	9	0	79	0	79

17 TRANSACTIONS WITH RELATED PARTIES (continued)	Notes	Group Actual		Parent Actual	
		As at 30/06/12 $000	As at 30/06/11 $000	As at 30/06/12 $000	As at 30/06/11 $000
Outstanding balances payable to joint ventures & associates					
healthAlliance N.Z. Limited (joint venture)		713	0	713	0
NZ Health Innovation Hub Management Ltd (joint venture)		0	0	0	0
Northern Regional Training Hub Limited (associate)		589	377	589	377
Northern DHB Support Agency Limited (associate)		255	253	255	253
	13a	1,557	630	1,557	630

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 2012 and 2011.

c Compensations

The key management personnel compensations are as follows:

GROUP & PARENT		2012 Actual $000	2011 Actual $000
Short - term employment benefits	(i)	4,405	4,182
Long - term employment benefits	(ii)	2	18
		4,407	4,200
Fees paid to Board Members	(iii)	385	417
Fees paid to Committee Members	(iv)	14	28
		399	445

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)

All related party transactions have been entered into on an arms' length basis.

The DHB is a wholly –owned entity of the Crown.

d Significant transactions with government –related entities

The DHB has received funding from the Crown and ACC of $17.187m (2011 $17.179m) to provide health services in the Auckland Central area for the year ended 30 June 2012.

Revenue earned from other DHBs for the care of patient's outside the DHB's district amounted to $701.131m (2011 $632.466m) for the year ended 30 June 2012. Expenditure to other DHBs for their care of patients from the DHB's district amounted to $120.971m (2011 $112.038m) for the year ended 30 June 2012

e Collectively, but not individually, significant, transactions with government-related entities35

In conducting its activities, the DHB is required to pay various taxes and levies (such as GST, FBT, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The DHB is exempt from paying income tax.

The DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2012 totalled $1.518m (2011 $2.201 m). These purchases included the purchase of electricity from Genesis, air travel from Air New Zealand, and postal services from New Zealand Post.

17 TRANSACTIONS WITH RELATED PARTIES (continued)

f Transactions with related parties involving key personnel

Related party	Board & Senior (SM) members and nature of their interest in the related party		Transaction value between ADHB and related party		Balance outstanding between ADHB and related party	
			30/06/2012	30/06/2011	30/06/12	30/06/2011
			$000	$000	$000	$000
APLS NZ	Richard Aicken (SM), Member	Payments	8	0	0	0
		Receipts	0	0	0	0
ASMS	Dr Chris Chambers, Member	Payments	3	0	0	0
		Receipts	0	0	0	0
ADHB Charitable Trust	Dr Lester Levy, Trustee	Payments	163	0	0	0
		Receipts	7,713	0	2,964	0
Epsom Anaesthetic Group	Dr Chris Chambers, Associate	Payments	263	137	25	19
		Receipts	0	0	0	0
Francis Group	Ian Ward, Advisor	Payments	0	0	0	0
		Receipts	2	0	0	0
Hauora Whanui	Gwen Tepania-Palmer, Director	Payments	0	0	0	0
		Receipts	2	0	0	0
Health Benefits Limited	Dr Lester Levy, Deputy Chair	Payments	859	0	0	0
		Receipts	7	235	0	1
Medical Council of NZ	Susan Buckland, Member	Payments	6	0	0	0
		Receipts	6	0	0	0
Midwifery Council of NZ	Dr Lee Mathias, Member	Payments	62	0	0	0
		Receipts	0	0	0	0
Northern DHB Support Agency	Dr Denis Jury, Director	Payments	3,094	0	255	0
		Receipts	430	0	0	0
Ngati Hine Health Trust	Gwen Tepania-Palmer, Chair Rob Cooper, Chief Executive	Payments	0	0	0	0
		Receipts	3	0	0	0
NZ Blood Service	Ian Ward, Member	Payments	25,151	0	0	0
		Receipts	399	0	26	0
NZ Resuscitation Council	Richard Aicken (SM), Member	Payments	30	0	0	0
		Receipts	0	0	0	0
NZ Leadership Institute	Dr Lester Levy, Co-Director	Payments	0	6	0	0
		Receipts	0	0	0	0
Occupational Therapy Board of NZ	Susan Buckland, Member	Payments	5	0	0	0
		Receipts	0	0	0	0
Starship Foundation	Richard Aicken (SM), Member	Payments	0	0	0	0
		Receipts	2	0	0	0
Tonkin & Taylor Ltd	Dr Lester Levy, Independent Chairman	Payments	7	0	0	0
		Receipts	0	0	0	0
Te Runanga o Ngati Whatua	Rangimarie Naida Glavish (SM)- Chair	Payments	0	87	0	115
		Receipts	0	17	0	0
University of Auckland	Dr Lester Levy, Professor (Adjunct) of Leadership, Business School	Payments	8,237	2,733	0	0
	Rob Cooper, Chair-Whanau Ora Governance Group	Receipts	3,396	6,155	0	0
Waitemata District Health Board	Dr Lester Levy – Chair Gwen Tepania-Palmer, Member	Payments	7,069	2,733	2,228	241
	Rob Cooper, Member	Receipts	27,350	6,155	7,964	2,416
Ward Property Developments Ltd	Ian Ward, Director	Payments	33	0	3	0
		Receipts	0	0	0	0

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 (2012-42%, 2011-48%). 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 receivables at the reporting date is as follows:

GROUP

Debtors and other receivables	Gross 2012 $000	Impairment 2012 $000	Gross 2011 $000	Impairment 2011 $000
Not past due	52,334	(9)	50,706	(38)
Past due 0-30 days	5,145	(230)	3,656	(573)
Past due 31-90 days	5,493	(409)	2,098	(717)
Past due 91-360 days	944	(944)	2,765	(1,691)
Past due more than 1 year	92	(92)	315	(315)
Total	64,008	(1,684)	59,540	(3,334)

PARENT

Debtors and other receivables	Gross 2012 $000	Impairment 2012 $000	Gross 2011 $000	Impairment 2011 $000
Not past due	50,436	(9)	48,802	(38)
Past due 0-30 days	4,842	(230)	3,525	(573)
Past due 31-90 days	5,402	(409)	2,067	(717)
Past due 91-360 days	944	(944)	2,765	(1,691)
Past due more than 1 year	92	(92)	315	(315)
Total	61,716	(1,684)	57,474	(3,334)

In summary, debtors and other receivables are determined to be impaired as follows:

Debtors and other receivables	GROUP 2012 Actual $000	GROUP 2011 Actual $000	PARENT 2012 Actual $000	PARENT 2011 Actual $000
Gross	64,008	59,540	61,716	57,474
Individual impairment	(1,684)	(3,334)	(1,684)	(3,334)
Net total	62,324	56,206	60,032	54,140

Movement in the provision for impairment loss	GROUP 2012 Actual $000	GROUP 2011 Actual $000	PARENT 2012 Actual $000	PARENT 2011 Actual $000
Opening balance	3,334	2,004	3,334	2,004
Increase/(decrease) in doubtful debts	(1,650)	1,330	(1,650)	1,330
Closing balance	1,684	3,334	1,684	3,334

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

2012	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	307,407	322,507	12,507	68,889	24,001	96,144	120,966
Trade and other payables	Nil	90,278	90,278	90,278	0	0	0	0
Bank overdraft	Fixed	19,800	19,800	19,800	0	0	0	0
Derivative financial instruments –interest rate swaps in loss	Fixed/Floating	86	107	107	0	0	0	0
Total		417,571	432,692	122,692	68,889	24,001	96,144	120,966

2011		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	96,612	96,612	96,612	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		408,048	493,083	150,403	8,218	79,764	159,673	95,025

18 FINANCIAL INSTRUMENTS (continued)

Liquidity risk (continued)

PARENT

2012	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	307,407	322,507	12,507	68,889	24,001	96,144	120,966
Trade and other payables	Nil	87,311	87,311	87,311	0	0	0	0
Bank overdraft	Fixed	19,800	19,800	19,800	0	0	0	0
Derivative financial instruments –interest rate swaps in loss	Fixed/Floating	86	107	107	0	0	0	0
Total		414,604	429,725	119,725	68,889	24,001	96,144	120,966

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	94,086	94,086	94,086	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		405,522	490,557	147,877	8,218	79,764	159,673	95,025

18 FINANCIAL INSTRUMENTS (continued)

Contractual maturity analysis of financial assets

The table below analyses ADHB and group's financial assets into relevant maturity groups based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include interest receipts.

	Carrying Amount	Contractual cash flow	Less than I year	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000
GROUP 2012						
Cash and cash equivalents						
Bank Balances	2,553	2,553	2,553	0	0	0
Short term deposits	91,528	92,163	92,163	0	0	0
	94,081	**94,716**	**94,716**	**0**	**0**	**0**
Trust/Special Funds						
Cash at bank (restricted)	99	99	99	0	0	0
Short term deposits	21,979	22,491	22,491	0	0	0
Investment Bonds (at market)(restricted)	2,129	2,344	126	126	2,092	0
	24,207	**24,934**	**22,716**	**126**	**2,092**	**0**
Patient and restricted trust funds						
Patient trust	10	10	10	0	0	0
Restricted fund deposits	1,110	1,110	1,110	0	0	0
	1,120	**1,120**	**1,120**	**0**	**0**	**0**
Debtors and Other Receivables	62,324	62,324	62,324	0	0	0
Grand Total	**181,732**	**183,094**	**180,876**	**126**	**2,092**	**0**
GROUP 2011						
Cash and cash equivalents						
Bank Balances	7,080	7,080	7,080	0	0	0
Short term deposits	101,045	101,592	101,592	0	0	0
	108,125	**108,672**	**108,672**	**0**	**0**	**0**
Trust/Special Funds						
Cash at bank (restricted)	94	94	94	0	0	0
Short term deposits	17,973	18,387	18,387	0	0	0
Long term deposits	1,800	1,959	95	1,864	0	0
Investment Bonds (at market)(restricted)	2,098	2,469	126	126	2,217	0
	21,965	**22,909**	**18,702**	**1,990**	**2,217**	**0**
Patient and restricted trust funds						
Patient trust	11	11	11	0	0	0
Restricted fund deposits	1,082	1,082	1,082	0	0	0
	1,093	**1,093**	**1,093**	**0**	**0**	**0**
Debtors and Other Receivables	**56,206**	**56,206**	**56,206**	**0**	**0**	**0**
Grand Total	**187,389**	**188,880**	**184,673**	**1,990**	**2,217**	**0**

18 FINANCIAL INSTRUMENTS (continued)

	Carrying Amount $000	Contractual cash flow $000	Less than I year $000	1-2 years $000	2-5 years $000	More than 5 years $000
PARENT 2012						
Cash and cash equivalents						
Bank Balances	2,553	2,553	2,553	0	0	0
Short term deposits	91,528	92,163	92,163	0	0	0
	94,081	**94,716**	**94,716**	**0**	**0**	**0**
Patient and restricted trust funds						
Patient trust	10	10	10	0	0	0
Restricted fund deposits	1,110	1,110	1,110	0	0	0
	1,120	**1,120**	**1,120**	**0**	**0**	**0**
Debtors and Other Receivables	**60,032**	**60,032**	**60,032**	**0**	**0**	**0**
Grand Total	**155,233**	**155,868**	**155,868**	**0**	**0**	**0**
PARENT 2011						
Cash and cash equivalents						
Bank Balances	7,080	7,080	7,080	0	0	0
Short term deposits	101,045	101,592	101,592	0	0	0
	108,125	**108,672**	**108,672**	**0**	**0**	**0**
Patient and restricted trust funds						
Patient trust	11	11	11	0	0	0
Restricted fund deposits	1,082	1,082	1,082	0	0	0
	1,093	**1,093**	**1,093**	**0**	**0**	**0**
Debtors and Other Receivables	**54,140**	**54,140**	**54,140**	**0**	**0**	**0**
Grand Total	**163,358**	**163,905**	**163,905**	**0**	**0**	**0**

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, with external advice as requested, 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 (79-80) and have fixed swap rates ranging from 6.85 per cent to 7.75 per cent. At 30 June 2012 ADHB had interest rate swaps with a notional contract amount of $50m (2011 $50m).

The net fair value of swaps at 30 June 2012 was a net asset position of $7,467k (2011 $5,668k). 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 (2011 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 2012	Note	Financial Liabilities at Fair value	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
Trade and other receivables	9	0	0	63,743	0	0	63,743	63,743
Cash and cash equivalents	7	0	0	94,081	0	0	94,081	94,081
Trust / Special Funds	8a	0	2,129	22,078	0	0	24,207	24,207
Investments in joint ventures and associates	5	0	0	0	20,226	0	20,226	20,226
Patient and restricted trust funds								
Assets	8b	0	0	1,120	0	0	1,120	1,120
Liabilities	8b	(1,120)	0	0	0	0	(1,120)	(1,120)
Interest rate swaps:								
Assets	19		7,553	0	0	0	7,553	7,553
Liabilities	19	(86)	0	0	0	0	(86)	(86)
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	(307,407)	(307,407)	(331,559)
Trade and other payables	13a	0	0	0	0	(125,262)	(125,262)	(125,262)
Bank overdraft	7	0	0	0	0	(19,800)	(19,800)	(19,800)
		(1,206)	9,682	181,022	20,226	(452,469)	(242,745)	(266,897)
Unrecognised (gains)/losses								24,152

18 FINANCIAL INSTRUMENTS (continued)

Classification and fair values (continued)

GROUP 2011	Note	Financial Liabilities at Fair value	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
Investments in joint ventures and associates	5	0	0	0	502	0	502	502
Patient and restricted trust funds								
Assets	8b	0	0	1,093	0	0	1,093	1,093
Liabilities	8b	(1,093)	0	0	0	0	(1,093)	(1,093)
Interest rate swaps:								
Assets	19	0	5,945	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	(145,994)	(145,994)	(145,994)
Bank overdraft	7	0	0	0	0	(24,800)	(24,800)	(24,800)
		(1,370)	8,043	188,316	502	(457,153)	(261,662)	(275,942)
Unrecognised (gains)/losses								14,280

18 FINANCIAL INSTRUMENTS (continued)

Classification and fair values (continued)

PARENT 2012	Note	Financial Liabilities at Fair value	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	61,451	0	0	61,451	61,451
Cash and cash equivalents	7	0	0	94,081	0	0	94,081	94,081
Trust / Special Funds	8a	0	0	0	0	0	0	0
Investments in joint ventures and associates	5	0	0	0	19,724	0	19,724	19,724
Patient and restricted trust funds								
Assets	8b	0	0	1,120	0	0	1,120	1,120
Liabilities	8b	(1,120)	0	0	0	0	(1,120)	(1,120)
Interest rate swaps:								
Assets	19	0	7,553	0	0	0	7,553	7,553
Liabilities	19	(86)	0	0	0	0	(86)	(86)
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	(307,407)	(307,407)	(331,559)
Trade and other payables	13a	0	0	0	0	(116,798)	(116,798)	(116,798)
Bank overdraft	7	0	0	0	0	(19,800)	(19,800)	(19,800)
		(1,206)	7,553	156,652	19,724	(444,005)	(261,282)	(285,434)
Unrecognised (gains)/losses								24,152

18 FINANCIAL INSTRUMENTS (continued)

Classification and fair values (continued)

PARENT 2011	Note	Financial Liabilities at Fair value	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
Investments in joint ventures and associates	5	0	0	0	1	0	1	1
Patient and restricted trust funds								
Assets	8b	0	0	1,093	0	0	1,093	1,093
Liabilities	8b	(1,093)					(1,093)	(1,093)
Interest rate swaps:								
Assets	19		5,945	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)
		(1,370)	5,945	166,383	1	(449,192)	(278,233)	(292,513)
Unrecognised (gains)/losses								14,280

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 :

- 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	Observable inputs	Significant non-observable inputs
		$000	$000	$000	$000
GROUP					
As at 30 June 2012					
Financial Assets					
Local authority bond	8a	2,129	2,129	0	0
GROUP					
As at 30 June 2011					
Financial Assets					
Local authority bond	8a	2,098	2,098	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 2012 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

GROUP & PARENT	2012 Actual %	2011 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 2012						
Current & Non-Current Monetary Assets						
Cash and cash equivalents	4.23%	94,081	0	0	0	94,081
Restricted/special funds	4.37%	22,078	2,129	0	0	24,207
Patient and restricted trust funds	2.48%	1,120	0	0	0	1,120
Total Monetary Assets		117,279	2,129	0	0	119,408
Current & Non-Current Monetary Liabilities						
Bank overdraft	3.15%	19,800	0	0	0	19,800
Interest–bearing loans and borrowings						
Crown Health Financing Agency	4.09%	63,500	10,000	70,000	111,000	254,500
Bonds	7.75%	0	0	50,000	0	50,000
Interest on borrowings		3,298	0	0	0	3,298
Unexpired set up cost on borrowings		(104)	(112)	(175)	0	(391)
Total Monetary Liabilities		86,494	9,888	119,825	111,000	327,207
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	3.15%	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

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 2012						
Current & Non-Current Monetary Assets						
Cash and cash equivalents	2.72%	94,081	0	0	0	94,081
Patient and restricted trust funds	2.48%	1,120	0	0	0	1,120
Total Monetary Assets		95,201	0	0	0	95,201
Current & Non-Current Monetary Liabilities						
Bank overdraft	3.15%	19,800				19,800
Interest–bearing loans and borrowings						
Crown Health Financing Agency	4.09%	63,500	10,000	70,000	111,000	254,500
Bonds	7.75%	0	0	50,000	0	50,000
Interest on borrowings		3,298	0	0	0	3,298
Unexpired set up cost on borrowings		(104)	(112)	(175)	0	(391)
Total Monetary Liabilities		86,494	9,888	119,825	111,000	327,207
As at 30 June 2011						
Current & Non-Current Monetary Assets						
Cash and cash equivalents	3.14%	108,125	0	0	0	108,125
Patient and restricted trust funds	2.45%	1,093	0	0	0	1,093
Total Monetary Assets		109,218	0	0	0	109,218
Current & Non-Current Monetary Liabilities						
Bank overdraft	3.15%	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

The Crown Health Financing Agency has undertaken to provide funding when the bonds mature. They will also refinance their advances when they are due.

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.

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 2012, it is estimated that a general increase of 1% in interest rates would decrease the surplus or deficit by approximately $1.3m (2011 $1.6m). Interest rate swaps have been included in this calculation.

19 DERIVATIVE FINANCIAL INSTRUMENTS

	Group Actual As at 30/06/12	Group Actual As at 30/06/11	Parent Actual As at 30/06/12	Parent Actual As at 30/06/11
Current Assets				
Interest rate swaps in gain (mark to market)	0	0	0	0
Non – Current Assets				
Interest rate swaps in gain (mark to market)	7,553	5,945	7,553	5,945
Current Liabilities				
Interest rate swaps in loss (mark to market)	86	0	86	0
Non - Current Liabilities				
Interest rate swaps in loss (mark to market)	0	277	0	277

20 MAJOR VARIATIONS FROM BUDGET

Statement of Comprehensive Income
ADHB recorded a surplus of $0.737m which was $0.639m favourable to budget.

ADHB began the process of adopting national chart of accounts during FY13 financial year. This resulted in the reorganisation of various account grouping in the income statement during the reporting year. The budgets for the reporting year were prepared before the reorganisation whereas the actuals reflect the post-reorganisation position.

Major favourable variances were:

- Patient care revenue $47m(before adjustment of PHO revenue deemed to be agency income of $143m: see note 25) - Amalgamation of primary healthcare organisations (PHOs) within the Auckland region saw ADHB being given responsibility for the regional contract for Procare, a primary healthcare organisation servicing the wider Auckland Region. This provided ADHB with extra Ministry of Health and IDF funding of $27m resulting in a favourable revenue variance. Extra revenue of $11m was also generated by delivering funding side-contracts to Ministry of Health creating a favourable variance in revenue and unfavourable variance in direct and indirect treatment costs.
- Direct treatment costs $40m – reorganisation of budget between direct treatment costs and outsourced costs by $41m.
- Depreciation $6m – prior year asset write-down timing reducing base for depreciation and delays in budgeted capital projects.
- Other revenue $4m,
- Property & equipment costs $2m,
- Other operating expenses $2m and
- Financial income from derivatives $2m

Major unfavourable variances were:

- Outsourced costs $63m, - higher costs due to outsourcing of clinical services and the reorganisation of budget $41m to direct treatment costs
- Funder payments to third party providers $26m (before adjustment of PHO expense deemed to be agency expense of $143m:see note 25), - associated funding costs for regional PHOs
- Employee costs $14m – includes SMO job resizing payouts of $8.7m
- Indirect treatment costs $1m

20 MAJOR VARIATIONS FROM BUDGET (continued)

Statement of Changes in Equity

Total Equity of $441.9m as at June 2012 was $20.6m unfavourable to budget. The budget was set in March 2011 in the District Annual Plan. The balance as at June 2011 was $436.9m. The increase of $5m between June 2011 and June 2012 related principally to Crown Contributions of $1.8m and Trust Funding of $3.1m.

Statement of Financial Position

Total Assets and Total Liabilities as at June 2012 were $1,068m which was in line with budget of $1,067.2m

Statement of Cash Flows

Cash and Cash Equivalents of $74.3m at June 2012 was $21.8m favourable to budget. The budget was set in March 2011 in the District Annual Plan. The movement between June 2011 and June 2012 of $9m is described in the statement on page 35.

21 EVENTS SUBSEQUENT TO BALANCE DATE

Nil

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 $24.2m as at 30 June 2012 (2011 $23.3m). 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 (2011 – 65%).

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.

22 KEY SOURCES OF ESTIMATED UNCERTAINTY (continued)

Earthquake-Prone Buildings

The DHB is aware that a number of buildings are, or may be potentially, affected by local territorial authority policies for 'earthquake-prone' buildings (Earthquake-Prone Building Policies) required to be in place under the Building Act 2004. The Earthquake-Prone Building Policies may require building owners to undertake engineering investigations and subsequent structural upgrading, demolition or other steps to meet the requirements of the Earthquake-Prone Building Policies. Unless otherwise stated, the valuer's estimate makes no allowance for any costs of investigation, upgrading, demolition or other steps which may be incurred by the DHB to meet the requirements of the Earthquake-Prone Building Policies.The valuer is not qualified to determine earthquake-prone' status of the buildings. The valuer's estimate is therefore subject to review, investigation and assessment of seismic performance of the building, by a suitably qualified building engineer, to determine the 'earthquake-prone' status of the building and where required, an estimate of any costs for structural upgrading, demolition or other steps required for the building to meet the requirements of Earthquake-Prone Building Policies. If the building is found to be 'earthquake-prone', this finding is likely to impact on the value of the property, and our estimate may materially alter as a result.

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.

24 RESTATEMENT OF COMPARATIVE INFORMATION

The memorandum of understanding dated 1 May 2006, between the Trust and the Auckland District Health Board ("ADHB") provides delegated authority for ADHB to complete existing research as agent for the Trust. From September 2006 research funds were progressively transferred from ADHB to the Trust; instalments transferred were allocated for current or future research in the particular clinical unit/service of source.

Pool funds held by the Trust that have been received and not yet expended were previously treated as a liability. A review of the conditions of the research pool funds was undertaken to identify the total outstanding liability. Pool funds that were received for a specified purpose, but have no repayment conditions attached to the funds have been treated as revenue in the year that they were received. The comparative amounts have been restated to reflect the increase in value in the Trust's equity, the table below shows the effect of this treatment.

24 RESTATEMENT OF COMPARATIVE INFORMATION (continued)

STATEMENT OF FINANCIAL PERFORMANCE

GROUP	Before Adjustment Actual 2011 $000	Adjustment Actual 2011 $000	Restated Balance Actual 2011 $000
Patient care revenue	1,733,454	(98,798)	1,634,656
Other revenue	87,676	227	87,903
Total revenue	**1,821,130**	**(98,571)**	**1,722,559**
Expenses			
Employee benefit cost	727,849	0	727,849
Outsourced Services	58,082	0	58,082
Direct treatment cost	202,756	0	202,756
Funder payments	615,251	(98,798)	516,453
Indirect treatment costs	43,833	0	43,833
Property, equipment & transport costs.	49,267	0	49,267
Other operating expenses	20,126	0	20,126
Capital charge	34,491	0	34,491
Depreciation and amortisation expenses	51,146	0	51,146
Finance costs	18,219	0	18,219
Total expenses	**1,821,020**	**(98,798)**	**1,821,020**
Share of surpluses of joint ventures & associates	32	0	32
Surplus/(deficit)	**142**	**227**	**369**

STATEMENT OF COMPREHENSIVE INCOME

Surplus/ (deficit)	142	227	369
Gains/(Losses) on property revaluations	(21,557)	0	(21,557)
Total Comprehensive Income/(Loss)	**(21,415)**	**227**	**(21,188)**

STATEMENT OF CHANGES IN EQUITY

Opening balance	454,578	2,437	457,015
Surplus/ (deficit) for period	142	227	369
Other comprehensive income/(expense)	(21,557)	0	(21,557)
Total comprehensive income/(expense)	**433,163**	**2,664**	**435,827**
Capital contributions to the Crown	3,694	0	3,694
Equity	**436,857**	**2,664**	**439,521**

24 RESTATEMENT OF COMPARATIVE INFORMATION (continued)

STATEMENT OF FINANCIAL POSITION

GROUP	Before Adjustment Actual 2011 $000	Adjustment Actual 2011 $000	Restated Balance Actual 2011 $000
Current Assets			
Cash and cash equivalents	108,125	0	108,125
Trust/special funds	18,067	0	18,067
Patient & restricted trust funds	1,093	0	1,093
Debtors & other receivables	56,206	0	56,206
Prepayments	3,025	0	3,025
Inventories	12,021	0	12,021
Non-current assets held for sale	20,041	0	20,041
Total Current Assets	**218,578**	**0**	**218,578**
Non-Current Assets			
Trust/special funds	3,898	0	3,898
Property, plant and equipment	829,099	0	829,099
Intangible assets	535	0	535
Derivative financial instruments	5,945	0	5,945
Investments in joint ventures & associates	502	0	502
Total Non-Current Assets	839,979	0	839,979
Total Assets	**1,058,557**	**0**	**1,058,557**

24 RESTATEMENT OF COMPARATIVE INFORMATION (continued)

STATEMENT OF FINANCIAL POSITION

GROUP	Before Adjustment Actual 2011 $000	Adjustment Actual 2011 $000	Restated Balance Actual 2011 $000
Current Liabilities			
Bank overdraft	24,800	0	24,800
Trade and other payables	148,658	(2,664)	145,994
Employee benefits	136,320	0	136,320
Provisions	2,071	0	2,071
Interest-bearing loans and borrowings	23,249	0	23,249
Loans from joint ventures & associates	375	0	375
Derivative financial instruments	0	0	0
Patient & restricted trust funds	1,093	0	1,093
Total Current Liabilities	**336,566**	**(2,664)**	**333,902**
Non-Current Liabilities			
Employee benefits	21,747	0	21,747
Interest-bearing loans and borrowings	263,110	0	263,110
Derivative financial instruments	277	0	277
Total Non-Current Liabilities	**285,134**	**0**	**285,134**
Total Liabilities	**621,700**	**(2,664)**	**619,036**
Net Assets	**436,857**	**2,664**	**439,521**
Equity			
Public equity	573,103	0	573,103
Accumulated deficit	(481,629)	0	(481,629)
Other reserves	331,981	0	331,981
Trust/special funds	13,402	2,664	16,066
Total Equity	**436,857**	**2,664**	**439,521**

25 RESTATEMENT OF COMPARATIVE AGENCY RELATIONSHIP INFORMATION

The comparative figures for patient care revenue and funder payments have been reduced by $99m) (with no change to the surplus) to reflect the agency transactions on host contracts with other DHBs. The $99m estimate is based on best available information due to the complexity and number of contracts involved. In 2012/13 a sector wide review of agency type transactions will be undertaken and clarity sought from the Ministry of Health on how financial reporting will be best reflected in terms of the NZ IFRS

Due to the delays caused by quantifying these adjustments the DHB has breached section 156(2)(b) of the Crown Entities Act 2004 by approving its annual report more than 4 months after the end of the financial year.

The reinstatement affected both Group and Parent figures.

STATEMENT OF SERVICE PERFORMANCE

OVERVIEW

Before the start of each financial year and after they have been approved by our Board, our Financial and Non Financial Targets for the next three years are subjected to parliamentary approval. These targets include the Minister of Health's six Health Targets

This Statement of Service Performance describes how we performed against those targets which were centred on achieving three main measures:

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

These main measures take into account National, Regional and Local Health priorities. The recognition of the need to improve Maori Health inequities is an integral part of these priorities.

During the year we managed to break even and achieved another record year in terms of clinical and community health achievements. Refer to Appendix One for a comparison of ADHB's performance of the Minister's six National Health Targets.

Highlights of the year include

- **Rugby World Cup**

During the Rugby World Cup Adult Emergency Department experienced an increase of 56 % on the standard daily rate of attendance (150) and at times saw one new patient arriving every 2-3 minutes. The Adult Emergency Department experienced the busiest 48 hour period in its history as the World Cup opened in Auckland.

During the six weeks from the official opening on 9th September until the final on 23rd October the Adult Emergency Department achieved and at times exceeded the Minister's six hour waiting time target for ED patients.

- **New Car Park**

In January 2012 the Auckland City Hospital Car Park Building was opened. The building provides 390 public car parks adjacent to the hospital main entrance plus two levels of retail / commercial tenancies on the Park Road boundary. Overall the project has met and/or exceeded its business case objectives. Public access and way-finding on the hospital site is much improved. The actual capital cost of the project at approx. $15million was well under the $18million forecast used in the business case. Growth in parking revenue associated with the project has also significantly exceeded the business case assumptions.

- **Seismic Survey**

Since 1999 ADHB has been pro-actively implementing a Seismic Risk Management Plan. The original Plan has now been substantially completed with a number of older unreinforced masonry buildings demolished or vacated. However the Christchurch earthquake saw the collapse of some relatively modern buildings, thus raising questions about previous assessments of risk. Seismic assessment techniques have also changed since the original engineering advice was provided to ADHB in 1999.

In light of this ADHB has undertaken updated seismic assessments on its major buildings constructed prior to the most recent standards. This new survey indicated five of ADHB's more modern buildings may also have issues. Based on this information the Board approved an updated Seismic Risk Management Plan in March 2012. The revised Plan includes budget to undertake more detailed assessments on the five buildings. These are now being prepared and will confirm whether action is required, and if so what strengthening options are available.

- **ADHB-WDHB closer collaboration**, in particular with the Intranet site, Collaboration Steering Group Changes, Human Resources, Legal, Communications, Finance and Maori Health.

The Statement of Service Performance has been grouped into four output classes which clearly define the service delivery activities undertaken by Auckland District Health Board.

Output Class	Description
Prevention Services	Protect and promote health to ensure that illness is prevented and unequal outcomes are reduced.
Early detection and management	Early detection and management with interventions that prevent problems at the earliest stage and offer treatment to stop problems becoming worse.
Intensive assessment and treatment	These services are complex and include Mental Health, Elective and Acute Hospital care.
Rehabilitation and support services	Needs assessment process includes Aged and palliative care

The DHB's funding and planning role is responsible for planning, promoting and undertaking service contracting with organisations including our own hospital services (Auckland City Hospital, Starship and Greenlane Clinical Centre). However, we do not deliver all services ourselves within our own hospitals. Our DHB also contracts services from other providers, including other DHBs which either provide specialist services or compliment our ability to meet demand.

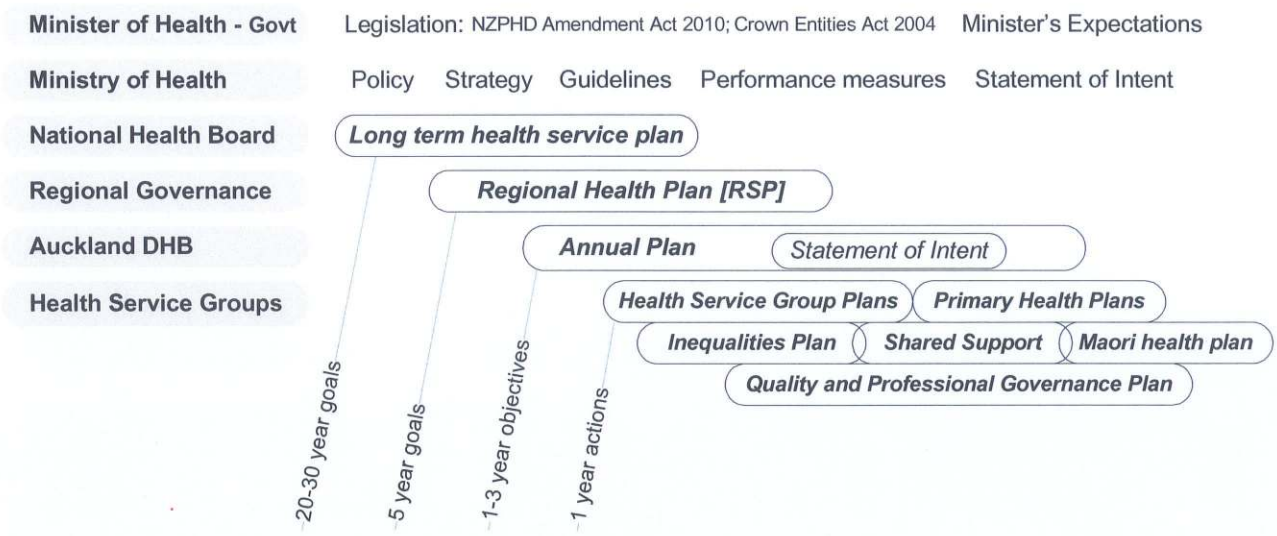
Auckland DHB's performance has improved considerably in the last few years. This was noted in the report of the recently completed certification audit which stated.

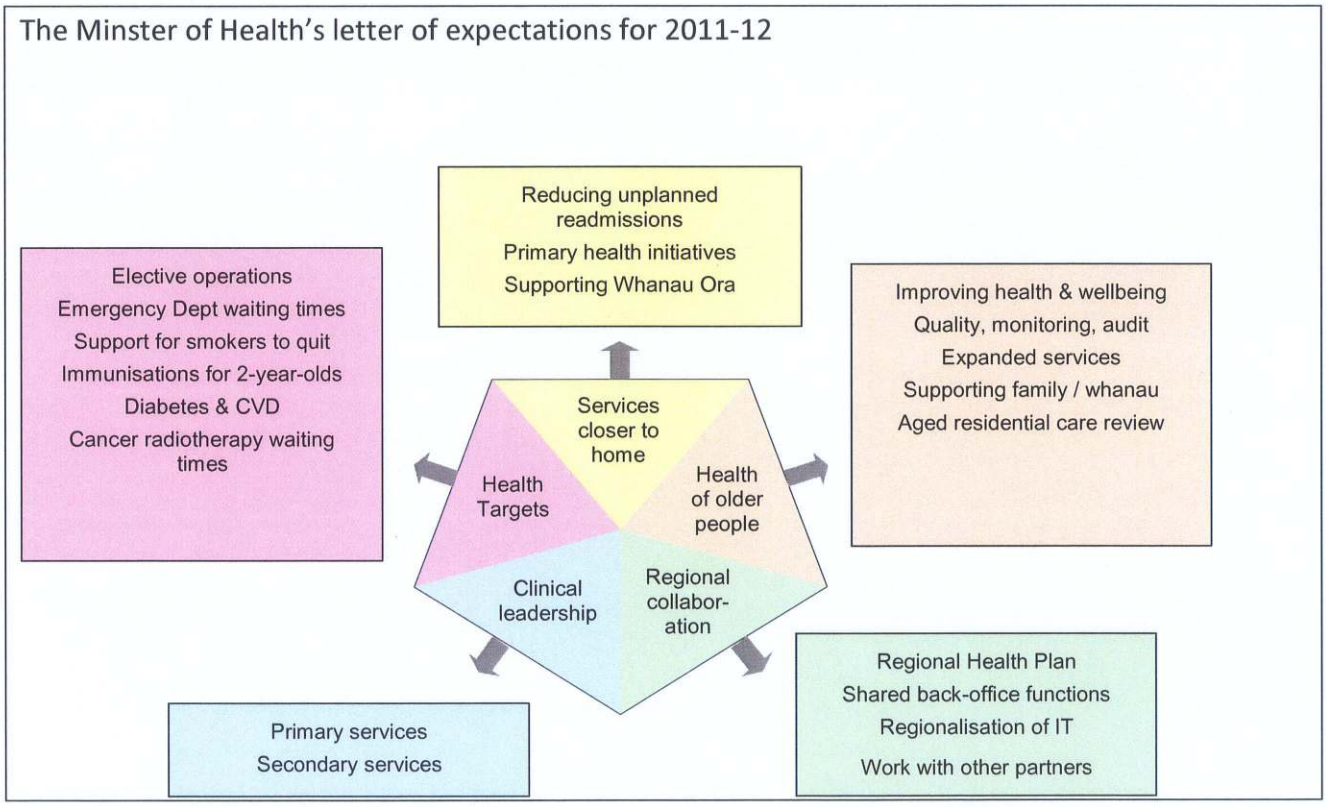
"A philosophy of improvement has been progressively installed throughout the organisation and is evident during the audit, in discussions with staff. The improvement culture is demonstrated with many examples of goal setting, measures and drivers being established for service delivery, decision making reviews occurring, clear roles and responsibilities and leadership being defined, and through a variety of improvement initiatives."
An example of this is a 19% increase in Orthopaedic elective procedures compared to the previous year.

On reviewing the 2011/12 performance there are a number of areas where the target set in the Statement of Intent has not quite been achieved. Therefore we have used a grading system consistent with Waitemata DHB to rate performance for each measure. This helps to identify those measures where performance has been close to target versus those where under-performance was more significant. The criteria used to allocate these grades are set out below.

Criteria	Rating	Symbol
On target or better	Achieved	
0.01-9% away from target	Substantially Achieved	
9-20% away from target	Partially Achieved	
>20% away from target	Not Achieved	
Where a measure is made up of multiple components, each with its own target, an average has been applied to determine performance		

Hierarchy of national, regional and local plans





The diagram above summarises the Minister's expectations and how they are interdependent. These include:

- Six Specific Targets
- Clinical and financial responsibility
- Primary care –closer integration
- Regional Collaboration
- Health of Older People
- Clinical Leadership

Overview of service delivery and anticipated outputs

Overview of service delivery and anticipated outputs for the year to 30 June 2012			
Prevention services	**Early detection and management**	**Intensive assessment and treatment**	**Rehabilitation and support services**
Outcomes anticipated			
Monitoring and enforcement of liquor and tobacco premises to ensure compliance with regulations	Enrolment in PHO affiliated general practice teams	Acute inpatient services	Home based support services
Smoking cessation advice and support delivered by health professionals in secondary and primary care	Nurse and GP consultations for enrolled population • Diagnose and treat acute and long term conditions • Refer to secondary care services when appropriate • Social support and advice to families	Emergency Department services	Residential care services
Breastfeeding services are providing appropriate and accessible information and advice to mothers and their families	Prevention work: • Immunisation • Advice and help to quit smoking	Non-specialist antenatal & obstetric consultations	Specialist end of life care
Primary care services performing immunisations	Community referred laboratory tests and other diagnostic services	Amniocentesis	
Immunisation services (through general practice , outreach immunisation services, schools and other community settings)	Community dispensing of pharmaceutical products subsidised in accordance with Pharmac stipulations	Maternity inpatient, outpatient care & follow -up	
Girls immunised against human Papillomavirus		Labour & delivery services	
Oral health education		Postnatal inpatient, primary & outpatient care.	
Oral examinations and treatment among preschool children, and adolescents		Specialist neo-natal care	
Fluoridation advocacy outputs		Elective inpatient and Outpatient services	
		Sub-acute inpatient care of older adults	
		A matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health and Addiction services covering Child, Adolescent & Youth; Adult and Older Adult Age bands	
		Services comprise • Acute and intensive services • Community based clinical treatment & therapy services Services to promote resilience, recovery and connectedness	

Cost of Service Statement – for year ending 30 June 2012

	Intensive Assessment and Treatment		Rehabilitation and Support		Early Detection and Management		Prevention Services		Total	
Output Class Names	Hospital Services		Support Services		Primary and Community		Public Health Services		Total	
in $ '000	Actual 2012	Budget 2012	Actual 2012	Budget 2012	Actual 2012	Budget 2012	Actual 2012	Budget 2012	Actual 2012	Budget 2012
Total Revenue	1,238,180	1,218,559	141,678	144,382	386,663	498,609	22,334	19,353	1,788,855	1,880,903
Total Expense	(1,229,865)	(1,208,534)	(156,746)	(151,876)	(382,271)	(500,317)	(19,236)	(20,078)	(1,788,118)	(1,880,805)
Surplus/(Deficit)	8,315	10,025	(15,068)	(7,494)	4,392	(1,708)	3,098	(725)	737	98
Expenditure										
Personnel	716,749	701,237	12,568	12,663	11,048	11,450	15,170	15,970	755,535	741,320
Outsourced Services	88,967	26,465	1,149	999	2,450	2,394	1,630	1,776	94,196	31,634
Clinical Supplies, Infrastructure & Other Costs	378,290	434,280	7,090	3,111	8,773	8,968	1,593	1,849	395,746	448,208
Payments to Providers	45,859	46,552	135,939	135,103	360,000	477,505	843	483	542,641	659,643
	1,229,865	1,208,534	156,746	151,876	382,271	500,317	19,236	20,078	1,788,118	1,880,805

Principles for the allocation of funding

The principles are to:

- maintain Auckland DHB base services to meet acute demand
- continue improving performance on the six National Health Targets and other Ministry of Health performance requirements
- implement other Government initiatives and commitments, including the Minister's Letter of Expectations.

The Minister's Letter of Expectations requires the organisation to achieve a break even position within the allocated funding. This requires reprioritisation and reallocation of resources and investment in tools such as lean thinking and the Health Excellence Framework in order to enable new ways of working, reduce variation and ensure avoidance of waste.

The New Zealand Public Health and Disability Act 2000 established 21 (now 20) District Health Boards throughout New Zealand with the role and function to provide, or fund the provision of, health and disability services in their district. DHBs are charged with:

- improving, promoting, and protecting the health of communities
- integrating 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 Auckland District Health Board (Auckland DHB) is a major funder and provider of health care services. The organisation funds and provides community based and secondary services to central Auckland, tertiary services to the Auckland region and tertiary services nationally.
Auckland DHB will improve the health of the Auckland DHB population by focusing on the factors that most influence health and reduce health inequalities between groups.

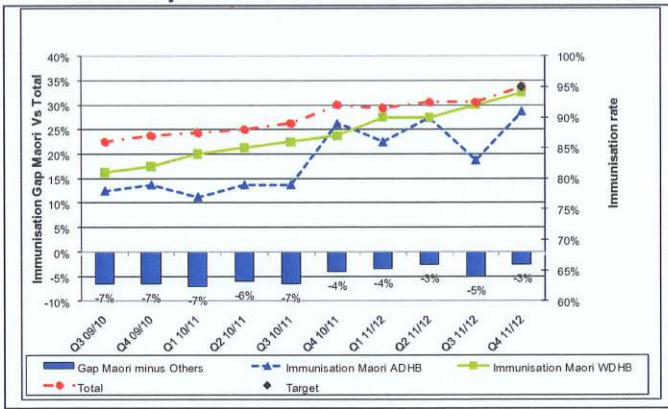
Progress on improving Maori Health

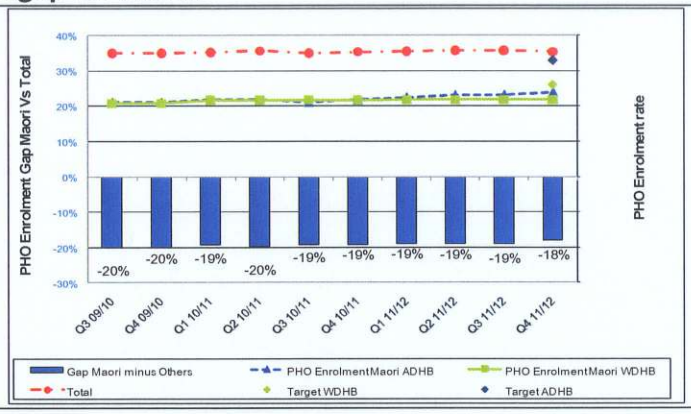
The nine key measures of Maori health are commented on below.

Results for the year have been mixed in achieving a reduction in the Health Gap between Maori and Total population.

Measure	Improved	Worse	No Change
Immunisation	achieved		
PHO Enrolment	achieved		
Diabetes		not achieved	
Diabetes Management		not achieved	
Hospitalised smokers advised to quit	achieved		
Breast screening		not achieved	
Cervical Screening			partially achieved
Breast Feeding at 6 months	not achieved		
Cardiovascular	Maori rates above "Total" no negative gap refer to page 89		

Nine Key Health Measures –Focus on the health gap for Maori





Immunisation –ADHB population

The level of Maori children fully immunised at 24 months is 91% for the quarter ended June 2012 and an average of 88% for the year and a gap of 5% below the total average of 93%.This is an improvement on last year when the rate was an average of 81% and 89% respectively with a gap of 8% below Total.

A small amount of extra funding was received from the Ministry of Health for Immunisation activities to help increase coverage. After consultation with the ADHB Immunisation Governance Group ADHB held a one day symposium in July specifically targeting practice nurses

PHO Enrolment –ADHB Population

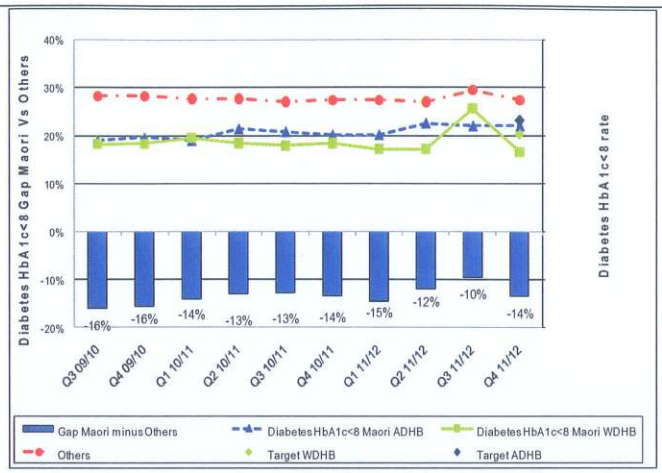
The level of Maori enrolment in PHOs has increased to 77 % for the fourth quarter of 2012 ended June 2012 and averaged 88% for the year with a gap of 18% below the Total average of 94%. This is an improvement on last year when the rate was an average of 74% and 93% respectively with a gap of 19% below Total

Specific initiatives to reach the target include enrolling Māori newborns with a primary care provider, using the return location of the mother and providing her with options to register herself and her newborn with a nearby practice. Also, a school based whānau ora project will ensure that all children within an identified group in the school are enrolled with a GP. If they are not enrolled, their parents will be contacted to ensure this occurs. A whānau ora inpatient programme will also ensure Māori patients receive enrolment information before discharge.

Progress on improving Maori Health

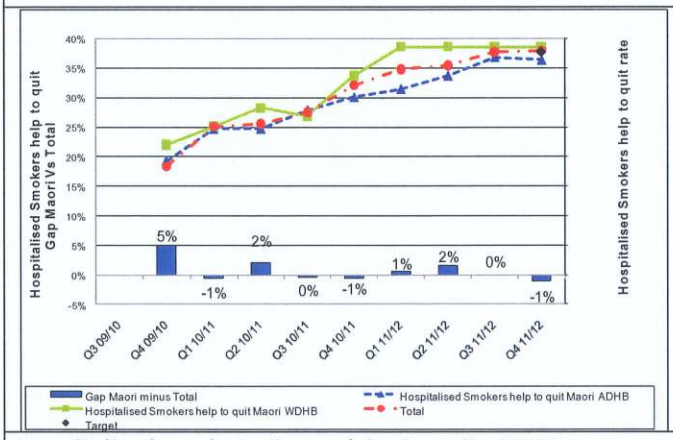
Diabetes-ADHB Population

The level of Maori Diabetes checks is 59% for the quarter ended June 2012 and an average of 58% for the year with a gap of 3% below the Total average of 61% for the year This is a worsening of the rates for last year of 60% and 56% respectively. At the end of the June 2012 Quarter Maori was the same as the Total.



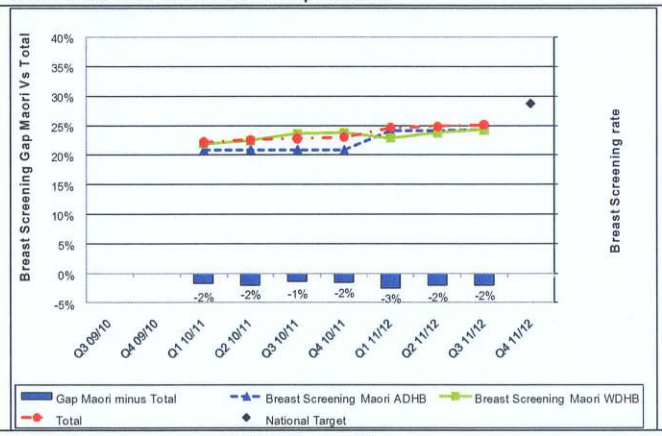
Diabetes Management-Auckland Population

The level of Maori Diabetes Management is 70% for the quarter ended June 2012 and an average of 70% for the year with a gap of 10% below the Total average of 80% for the year. The Average annual rate increased from 67% last year for Maori compared to 79% for Total and a gap of 12%
From 1 July 2012 the Diabetes Get Checked Programme is to be replaced with the Diabetes Care Improvement Package (DCIP). PHO practices will have flexibility on how the funding under the DCIP can be better utilised to support better diabetes care.
The MOH continues to require practices to provide diabetes annual reviews as part of good clinical care, for all people with diabetes enrolled in a practice.



Hospitalised smokers given advice to quit -ADHB population

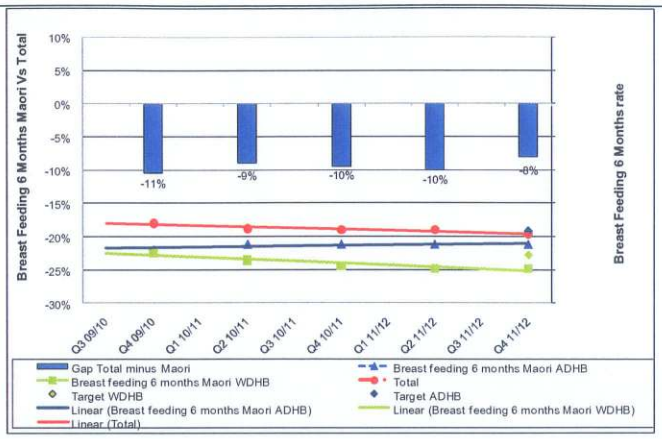
The level of advice to quit smoking to hospitalised Maori is 92% for the quarter ended June 2012and an average of 88% for the year with a gap of 4% below the total average of 92%. This is an improvement on an average of 71% for last year for Maori and 72% for Total.



Breast screening –ADHB Population

For the quarter ended March 2012 Maori breast screening rates were 65% compared to Total of 67% a gap of 2%. This is an increase of 7 % from the same quarter last year when the rate was 58% compared to Total of 62%. The gap has widened however the absolute outcome has improved.
The NSU currently contracts with providers to provide breast screening and promotion activity, a process which Auckland DHB is not a part of. The Auckland DHB is involved in breast screening forums and working with primary care providers to promote a focus on Māori and other high needs communities. In spite of this, the data shows that our district is achieving well against the national target for Māori.

Progress on improving Maori Health



Cervical Screening –ADHB Population

For the quarter ended March 2012 Maori cervical screening rates were 53% compared to Total of 74% a gap of 21%. This is an increase of 3 % from the same quarter last year when the rate was 50% compared to Total of 71%. The gap has remained the same however the outcome has improved. Prior to July 2012, cervical screening was overseen by NSU. Many of their functions have been devolved to the Auckland DHB and its metro-Auckland DHB partners to develop a more regional approach to reach the cervical screening target. Considerable effort is now going into revitalising cervical screening activity and results in the region. Three new strategies are being implemented: new regional governance arrangements; establishment of a regional coordination service, and; more free smears. The latter addresses one of the issues around access to cervical smears, cost, which is an ongoing issue for many Māori families.

Breast Feeding at 6 Months-ADHB Population

For the quarter ended December 2011 Maori breast feeding rates at 6 months for Maori were 22% compared to 26% for total a gap of 4%. For the quarter ended December 2010 Maori breastfeeding rates were unchanged at 22% compared with Total of 28% at the same time. The gap has reduced because the Total breast feeding rate has decreased by 2% ADHB supported two projects; the Community Breastfeeding Service (CBS) which is executed via a contract with Plunket, and the Ngati Whatua O Orakei Maori Health Services breastfeeding peer counselling training. The breastfeeding contracts end on 31 July when ADHB stops receiving HEHA (Healthy Eating Healthy Action) funding.

Cardiovascular

Auckland DHB has performed well in pursuit of this target for Maori, currently at just 1.4% below the target of 60% for quarter three. To provide context, the total population figure for Auckland DHB is 14.2% below the 60% target for this priority in the same quarter.

The PPP programme has different performance targets set for PHOs which differ from the national target. In order to address this issue, Auckland DHB will work with PHOs to re-align these targets in the next round of negotiations for PPP. Additionally, the CVD risk assessment contracts will also be re-aligned in partnership with PHOs to better meet this health target. (PPP = PHO Performance Programme)

The Māori health team will work to reach agreements with PHOs in our district to have this priority included in their Māori health plans. It is proposed also that LTC Coordinators funded by the DHB work closely with practice staff to develop identification and call back systems for eligible Māori patients.

Recording of data for Cardiovascular checks changed from Quarter three onwards.

Relative performance was

	Maori	Total
Q3	58.6%	45.8%
Q4	57.9 %	47.8%

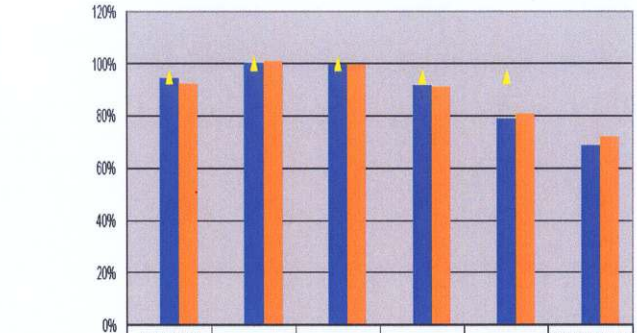
Maori performance is above the Total.

National Targets

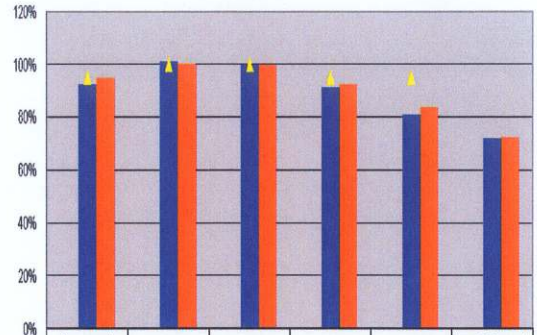
National Health Targets are set by the Minister and are reported on Quarterly.

The charts below are from The Ministry of Health and show ADHB performance for each Quarter

Quarter	Shorter stays in ED	Improved access to elective surgery	Shorter waits for Cancer treatment	Increased Immunisation	Better help for smokers to quit	Better diabetes and cardiovascular services
Q1	substantially	achieved	achieved	substantially	partially	partially
Q2	achieved	achieved	achieved	substantially	partially	partially
Q3	achieved	substantially	achieved	achieved	substantially	not
Q4	achieved	achieved	achieved	achieved	substantially	not



	Shorter Stays in Emergency Departments	Improved Access to Elective Surgery	Shorter Waits for Cancer Treatment	Increased Immunisation	Better Help for Smokers to Quit	Better Diabetes and Cardiovascular Services
Ranking quarter one 2011/12	10	12	1	10	18	13
Quarter four 2010/11	94.6%	100.3%	100.0%	91.9%	79.0%	68.8%
Quarter one 2011/12	92.4%	101.2%	100.0%	91.2%	80.8%	72.0%
National goal	95.0%	100.0%	100.0%	95.0%	95.0%	



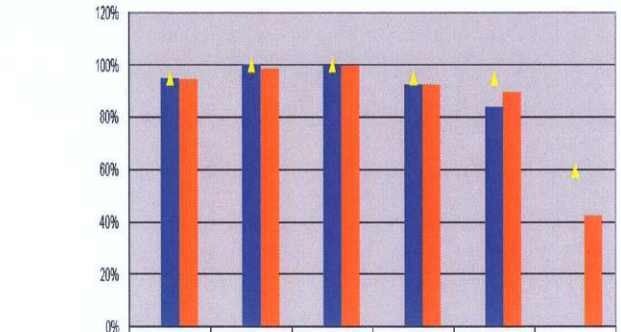
	Shorter stays in Emergency Departments	Improved Access to Elective Surgery	Shorter Waits for Cancer Treatment	Increased Immunisation	Better Help for Smokers to Quit	Better Diabetes and Cardiovascular Services
Ranking quarter two 2011/12	6	16	1	9	17	16
Quarter one 2011/12	92.4%	101.2%	100.0%	91.2%	80.8%	72.0%
Quarter two 2011/12	95.0%	100.2%	100.0%	92.4%	83.8%	72.5%
National goal	95.0%	100.0%	100.0%	95.0%	95.0%	

Quarter One

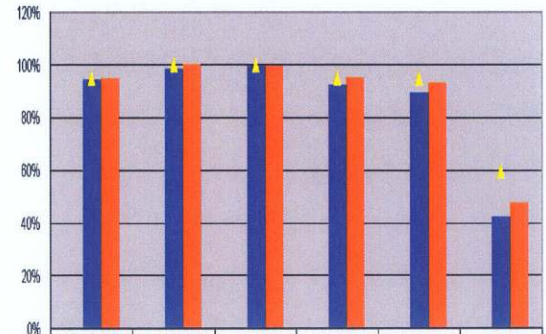
Goal not achieved in Better Help for Smokers to Quit. Diabetes and Cardiovascular is the average of three indicators –CVD assessesd+Diabetes Annual Check+Diabetes Management

Quarter Two

Goal not achieved in Better Help for Smokers to Quit but improved from 79% to 80.8% Diabetes and Cardiovascular is the average of three indicators –CVD assessesd+Diabetes Annual Check+Diabetes Management



	Shorter stays in Emergency Departments	Improved Access to Elective Surgery	Shorter Waits for Cancer Treatment	Increased Immunisation	Better Help for Smokers to Quit	More heart and diabetes checks
Ranking quarter three 2011/12	11	18	1	11	13	16
Quarter two 2011/12	95.0%	100.2%	100.0%	92.4%	83.8%	
Quarter three 2011/12	94.8%	99.7%	100.0%	92.4%	83.8%	42.3%
National goal	95.0%	100.0%	100.0%	95.0%	95.0%	60.0%



	Shorter stays in Emergency Departments	Improved Access to Elective Surgery	Shorter Waits for Cancer Treatment	Increased Immunisation	Better Help for Smokers to Quit	More heart and diabetes checks
Ranking quarter four 2011/12	12	20	1	3	13	15
Quarter three 2011/12	94.8%	99.7%	100.0%	92.4%	83.8%	42.3%
Quarter four 2011/12	94.6%	100.3%	100.0%	95.4%	93.4%	47.8%
National goal	95.0%	100.0%	100.0%	95.0%	95.0%	60.0%

Quarter Three

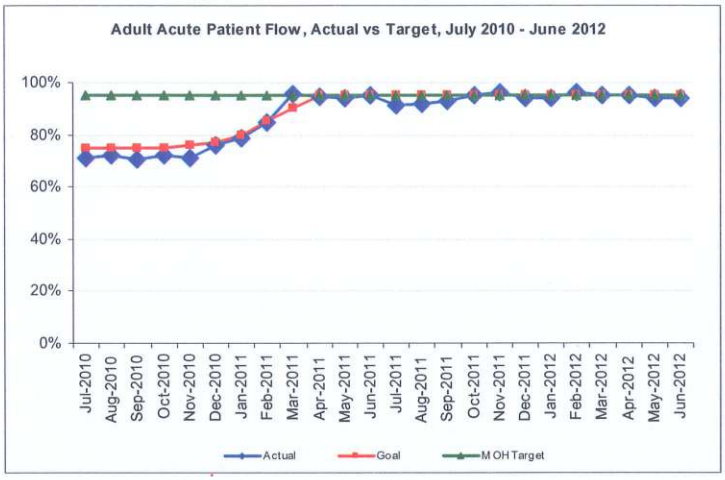
Goal not achieved for Better Help for Smokers to Quit. Improved to 83.8% this Quarter. "More heart and diabetes checks" is only CVD checked in the last 5 years.

Quarter Four

Goal not achieved for Better Help for Smokers to Quit. Improved to 93.4 % this Quarter. "More heart and diabetes checks" is only CVD checked in the last 5 years.

National Health Targets –Reported Quarterly

At least 95% of patients will be admitted, discharged or transferred from Auckland Emergency Departments within 6 hours-Adult



Group	Target	Actual	Performance
Total	95%	Q4 94%	substantially
Total	95%	Annual 94%	substantially

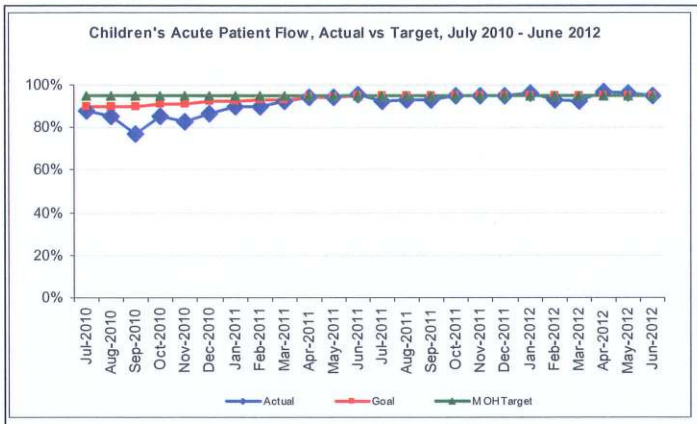
AED for the fourth quarter end was 94%. There have been periods of inconsistency of performance against the target during the quarter. Analysis of the inconsistency has been undertaken at the daily breech meeting. Actions taken to improve performance include General Medical Clinical Director presence at the breach meeting and/or communicating and escalating detail of breaches to the relevant service. Escalating 'near' breaches to relevant teams within General Medicine especially when late sign on times have occurred. Agreement to progress with phase 2 of acute adult flow project using a Lean Six Sigma DAMIC (Define Analyse Measure Improve Control) approach addressing the 3 and 2 hours sign on time, currently this is in define stage.

Activities undertaken to achieve to target since it was introduced include:

-
- Appointed a Charge nurse patient flow coordinator
- Improved access to Radiology
- Streamlined documentation for safer transfer
- Improved triage processes
- Improved bed management to remove "bed block" and make beds available to the Emergency Department
- Established an ED short stay unit
- Increased timely overnight transfers from ED to inpatient wards

National Health Targets –Reported Quarterly

At least 95% of patients will be admitted, discharged or transferred from Auckland Emergency Departments within 6 hours-Child



Group	Target	Actual	Performance
Total	95%	Q4 96%	achieved
Total	95%	Annual 94%	substantially

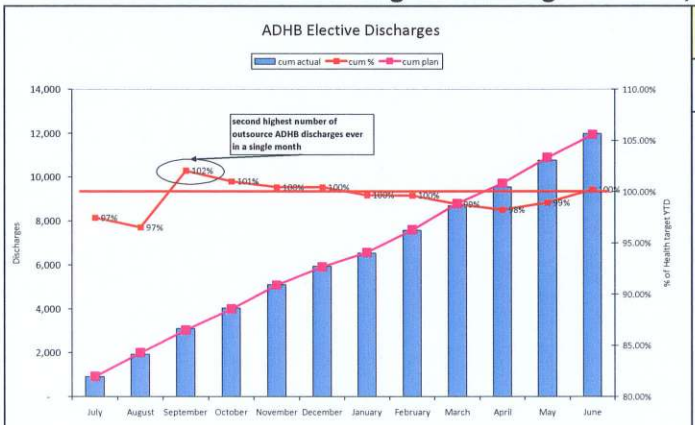
Performance remains in control and continues to be sustained around the target levels. Staff shortages and increased early winter demand has made achievement of the target more challenging; however the quarter end position was 96%. Improvements made to date have been embedded.

During the coming year there will be a continued focus on improving targeted areas to ensure that performance remains comfortably above 95%.

Improvements to date:

- Increased completion and accuracy of Estimate Discharge Date (EDD's) for current inpatients
- Improvement in the forecasting of short term occupancy levels
- Changes to the call back registrar guidelines to improve timeliness of patient review
- Capacity planning project commenced to ensure better longer term planning
- Bed turnaround reviewed which has resulted in a reduction of time taken
- Moved ward reviews to outpatient area to free bed spaces
- Cohorted patients with low complexity and reduced staffing for this group, freeing staff to care for increasing numbers of higher acuity patients
- Rostered additional senior staff onto periods of high admissions, to improve decision-making speed

Improved access to elective surgery
Increase ADHB Elective Surgical Discharges from 11,149 to 11,950



Group	Target	Actual	Performance
ADHB	11,950	11,981	achieved

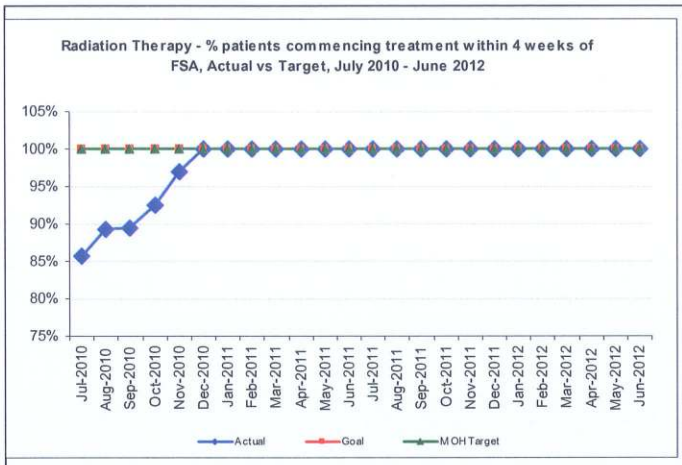
1. In the year to June we slightly over achieved target
2. Outsourcing continues for Pediatric general surgery, Orthopedics and Cardiac
3. Ophthalmology continues with weekend lists.

The actual number of elective discharges in the year to 2011 was 11,179. In the year to 30 June 2012 we increased volumes by 802 to 11,981.

National Health Targets –Reported Quarterly

Shorter waits for Radiation Therapy

100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks of a decision to treat from 31 December 2010.



Group	Target	Actual	Performance
Total	100%	100%	achieved

The service is 100% compliant for June 2012

Key risks which may impact capacity to deliver to the target in the coming months:

1. Ongoing Radiation therapist vacancies may impact our treatment capacity
2. The current Pinnacle planning software is due to be upgraded and replacement software is currently being evaluated. The current platform limits the number of complex patients able to be planned at any one time

Pre- booked HDR(High Density Radiology) Brachytherapy is limiting the number of Linac Treatment slots available.

Radiation Oncology Wait times – June 2012

- In June 100% of eligible patients were treated within the 4 week target timeline.

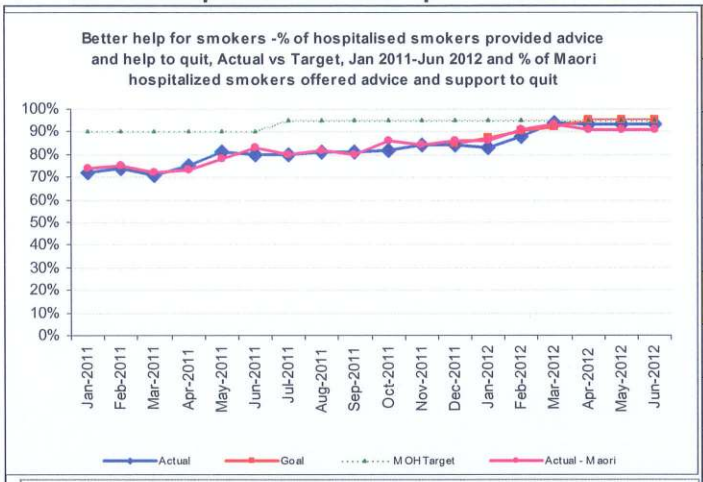
Ongoing initiatives to maintain the 4 week target

- **A public/private Model of care** enables our clinicians to treat public patients at Auckland Radiology Group. The service is only outsourcing as required to meet the 28 day target.
- **Introduction of new technology:** The introduction of V-Mat treatment has the potential to reduce treatment times for specific tumour groups by up to 50% when fully implemented mid 2012.
- **Aria project**: A project is well underway to develop a full electronic record within the LINAC machine's operating system. Project end has been further extended following delays to the ARIA software upgrade. The upgrade was finalised in early March with the project due to be completed by July 2012.
- **An "Operational team"** measures KPI's to prioritise the waitlist and analyse performance on a weekly basis. This is ongoing.
- **A daily Waitlist report** enables daily monitoring and immediate remedial action if required. This is ongoing

National Health Targets –Reported Quarterly

Better help for smokers to quit

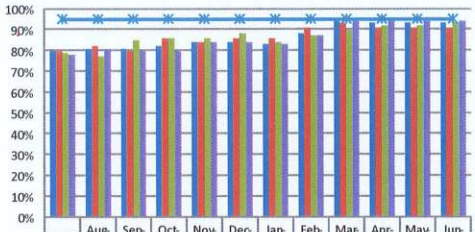
95% of hospitalised smokers provided advice and help to quit by 1/07/2012



Group	Target	Actual Q4	Performance
Maori	95%	91%	substantially
Pacific	95%	93%	substantially
Other	95%	94%	substantially
Total	95%	93%	substantially

Group	Target	Actual Q4	Performance
Maori	95%	87%	substantially
Pacific	95%	87%	substantially
Other	95%	86%	substantially
Total	95%	87%	substantially

% of hospitalised smokers offered advice to quit



	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
% of Total hospitalised smokers offered advice and support to quit	80%	81%	81%	82%	84%	84%	83%	88%	94%	93%	93%	93%
% of Maori hospitalised smokers offered advice and support to quit	80%	82%	80%	86%	84%	86%	86%	91%	93%	91%	91%	91%
% of Pacific hospitalised smokers offered advice and support to quit	79%	77%	85%	86%	86%	88%	84%	87%	90%	92%	92%	93%
% of Other hospitalised smokers offered advice and support to quit	78%	81%	80%	80%	84%	84%	83%	87%	94%	94%	94%	94%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Comments

Result: The final result for quarter 4 was 93.4%

Through a very busy time the Emergency Department maintained a good result. Weekly checks of all results were undertaken in June and feedback given to the small number of wards that had missed brief advice. Spot chart audits were completed in Adult Health during the month. Investigation into a system for capturing patients who are discharged directly from ACH theatres is underway. The number of smokers in this group is small but contributes to the deficit. The function to enable generation of a brief advice letter for all smokers with the Electronic Discharge Summary from AED and APU - similar to Waitemata DHB - is currently being tested and is due to go live by mid July.

The ABC Outcomes survey results are to be published at ADHB in early July. The survey results were very positive. 77% of the 412 patients surveyed recalled receiving brief advice and of those that made a quit attempt 33% were quit at 4 weeks. The ADHB results showed that 87% recalled the advice, 82% made a quit attempt and of those 51% were quit at 4 weeks.

Achievements:

- World Smokefree Day promotions based on the theme "it's About Whanau" took place in the week of the 28th May 2012

Immediate Actions to improve performance

A. **Focus on short stay/high volume areas to achieve**

- AED and APU continue to monitor and maintain performance

B. Improve engagement of clinical workforce to achieve

- Reports on events discharged and coded in the month to be available for services and reported weekly to the Organisation Management Meeting and Board
- To work with Registrars to determine barriers and support mechanisms to assist junior doctors complete the ABC in clinical documents and EDS (Electronic Discharge & Transfer Summary

C. Data collection systems and processes to achieve

- Smoking and Brief advice column to be added to Ward electronic whiteboards to monitor the ABC completion
- Investigation of generation of a Brief Advice Brochure with the EDS for AED
- Research – ADHB joining 7 other DHBs is participating in a ABC Outcomes survey funded by the MOH to measure the outcomes of Brief Advice given in hospitals- Final results out in June
- Final coding decision in contradictory cases to be based on Discharge Letter smoking status and brief advice

D. Communications – planned activities

- An NRT working Group as been established to develop an NRT promotion campaign to all clinical staff

National Health Targets –Reported Quarterly

More Heart and Diabetes Checks

The National target for "Better Diabetes and Cardiovascular Services "changed from 1 January 2012.
The first two quarters reported the combined performance from three activities

(a) 90 percent of the eligible adult population will have had their cardiovascular disease risk assessed in the last five years;
(b) An increased percent of people with diabetes will attend free annual checks;
(c) An increased percent of people with diabetes will have satisfactory or better diabetes management.

ADHB achieved 72% for both quarters.
No specific target was set for these two quarters.
From 1 January 2012 the 'Better diabetes and cardiovascular services' health target was replaced with a new national target called 'More heart and diabetes checks' and a target of 60% for the period January 2012 to June 2012.
We achieved 42% for the third quarter and 48% for the fourth quarter which was below the target of 60%

Group	Target	Actual	Performance
Total Q4	60%	Q4 47.8%	not

Commentary:
This is the second reporting of this target, where we achieved 47.8 %(the third Qtr was 42%) against the 60% target. The data does not include data for Alliance Health +, which has 12 practices in ADHB, and is hosted through CMDHB. Therefore the performance shown is only for the remaining 3 ADHB PHO's.
Whilst we did not meet target overall, we exceeded target for Pacific by 4.3% and were just under target for Maori, by 1.4%. We will continue to work with PHOs to improve performance across all ethnicities, particularly for the "Other" group.
ADHB will be realigning the current incentive based CVD Risk Assessment and Management contract with PHO's to support the delivery of this new target. With the implementation of Acute Predict, there is an opportunity to work with the service provider (Enigma) to ensure there is a link between Acute predict and PHOs to capture secondary care screening to contribute towards this health target.

Past activities:

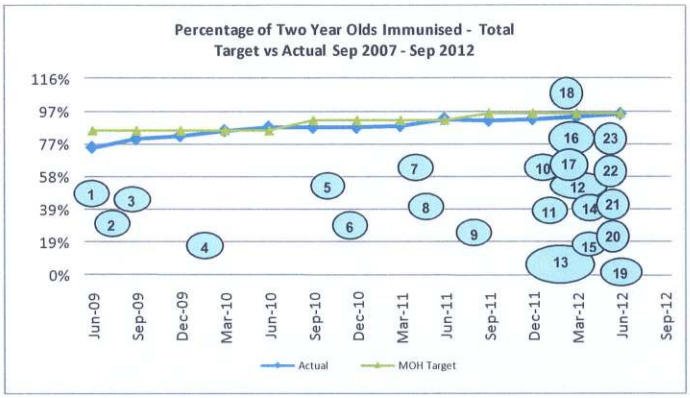
- ADHB funds the license for an electronic clinical decision support tool with Enigma. This is available for all ADHB PHOs (although is currently only utilised by Auckland PHO and Procare)

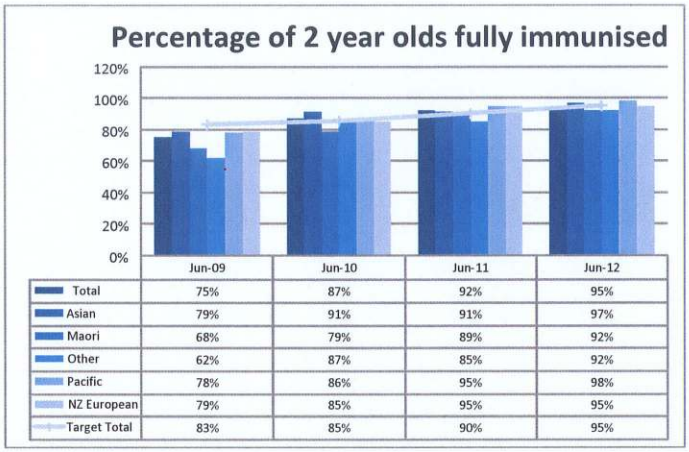
Recent and Current activities:

- The Long Term Condition Quality Improvement Coordinators support CVD screening and management in primary care.

National Health Targets –Reported Quarterly

Increased immunisation-95% of two year olds will be fully immunised by July 2012





	Jun-09	Jun-10	Jun-11	Jun-12
Total	75%	87%	92%	95%
Asian	79%	91%	91%	97%
Maori	68%	79%	89%	92%
Other	62%	87%	85%	92%
Pacific	78%	86%	95%	98%
NZ European	79%	85%	95%	95%
Target Total	83%	85%	90%	95%

Group	Target	Actual	Performance
Total	95%	95%	achieved

Project Risks / Comments:

ADHB has met the MoH Immunisation target of 95% of 2 year olds being fully immunised. The coverage rate for Maori is 91%. ADHB continues to have one of the lowest decline rates for immunisation in the country at 2.2%

ADHB has started to plan for the new immunisation rate of 85% of eight month olds to be fully immunised by July 2013, this then extends to 90% by July 2014 and 95% by January 2015. Initial information from MoH indicates that ADHB's eight month immunisation coverage rate is 88%. A workshop was held in June to look at gaps in the process and strategies to improve the eight month coverage rate.

The joint ADHB/ WDHB Immunisation Operations Project Manger role has been appointed to and the person has started

Commenced planning on a DVD to promote timeliness of immunisation, contra indications and dispelling clinician myths about immunisation. Developing an online survey for parents with babies/ toddlers asking about their immunisation experiences. Working with IMTS on making changes to the Starship electronic discharge letters to include immunisation status in order to improve communication with primary care

- **Activities (describing events on the chart above)**

1. Practice level reporting available and 2
2. Primary care Immunisation Co-ordinators funded - ongoing
3. ADHB Immunisation Strategy approved
4. Funding application made to Starship Foundation to fund social marketing programme. Not approved.
5. Data cleansing project in primary care approved and funded
6. Scoping project for multi-agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices. Results from audit included over 6000 immunisation events being manually entered on NIR.
8. Letters sent to all parents who are noted on the NIR as having declined immunisation for their child to check that this is correct. Follow up activity planned for November 2011 to include phone calls by practices if decline not certain to confirm.
9. Health promotion activities including posters and DVDs displayed in all Community Link sites across Auckland. Health education delivered in 8 PD sites supported by Corrections. Positive feedback on both Immunisation and SUDI presentations from attendees and supervisors.
10. Automated referral to outreach services when a child is overdue for any scheduled immunisation.
11. Letter to all practices regarding importance of timeliness of early immunisation and providing each practice with their current 6 month coverage rate.
12. Exploring the implementation of a DHB/WDHB joint appoint for an Immunisation Operations Manager
13. Identifying unimmunised children by NHI and information distributed to Immunisation Coordinators for follow up.
14. Planning activities for Starship in National Immunisation Week – 23-29 April 2012
15. Planning an Immunisation Study Day for Midwives – 11 May 2012
16. Joint ADHB & Waitemata DHB appointed Immunisation Operation Manager position to be advertised in April
17. April – Immunisation Week. Lots of activities in Starship to promote opportunistic immunisation
18. Midwives immunisation study day, facilitated by IMAC – a first for ADHB
19. Eight month Immunisation Target Workshop
20. Immunisation Operations Project Manager role started
21. Planning for the development of DVD for clinicians
22. Development of online survey for parents about their immunisation experiences
23. Working with IMTS on making changes to the Starship electronic discharge letter, to include immunisation status

PREVENTION SERVICES: Measures

Main Measure: Lift the Health of the ADHB population

Preventative services protect and promote health in the whole population or in identifiable sub-populations. This output class comprises services designed to enhance the health status of the population by focusing on population-wide physical and social environments to influence health and wellbeing.

Main Measure	Lift the Health of the ADHB population
Initiatives	Alcohol and tobacco regulatory activities
Outputs	Monitoring and enforcement of liquor and tobacco premises to ensure compliance with regulations
Impact	Reduced breaches of the Smokefree and alcohol legislation and reduced number of sales to minors
Outcome	Reduction in alcohol and tobacco related harm

Measure

No of compliance checks for liquor premises conducted

Group	Target	Actual	Performance
Night visits	240	319	achieved
Day visits	550	527	substantially

Auckland Regional Public Health Service (ARPHS) provides alcohol regulatory services across the region. ARPHS has 3 FTE responsible for On the Club licensed premises. These compliance checks are performed to ensure that premises are meeting their host responsibility obligations under the Sale of Liquor Act 1990.
The targets that are being assessed are for the entire Auckland region and cover the three DHBs. The numbers provided in the Performance column are ADHB specific

No of compliance checks for tobacco premises conducted

Group	Target	Actual	Performance
Liquor	132	132	achieved
Tobacco	229	229	achieved

ARPHS provides tobacco regulatory services across the region.
3 FTE are responsible for assessing compliance with the Smokefree Environments Act 1990.
We conduct inspections on licensed premises to ensure that their smoking areas comply with the legislation and protect those who do not wish to smoke from harm from second hand smoke.
We also conduct compliance checks on tobacco retailers to ensure that they comply with the legislation.
Day and night visits are not appropriate indicators for this measure.
Numbers provided in the Performance column are ADHB specific

No of alcohol licenses applications reported on

Group	Target	Actual	Performance
Number of alcohol licenses reported on	1,200	681	not

Application for On and Club-Licenses are investigated to ensure licensees meet their host responsibility obligations and are reported on to the Direct Licensing Agency as per the requirements of the Sale of Liquor Act 1990.
The targets that are being assessed are for the entire Auckland region and cover the three DHBs so are not an appropriate measure for ADHB alone. Numbers provided in the Performance column are ADHB specific

PREVENTION SERVICES: Measures

Number of controlled purchases operations	Group	Target	Actual	Performance
	Alcohol	500	154	not
	Tobacco	300	131	not
	Commentary ARPHS supports Police to conduct alcohol controlled purchase operations, contributing to a reduction in alcohol related harm by preventing young people purchasing alcohol. ARPHS conducts tobacco controlled purchase operations to contribute to preventing the uptake in young people. The targets are being assessed for the entire Auckland region and cover the three DHBs so are not an appropriate measure for ADHB alone. Numbers provided in the Performance column are ADHB specific.			
Number of Smokefree complaints closed	Group	Target	Actual	Performance
	No of Smokefree complaints closed	60	39	not
	Commentary The targets for that are being assessed for the entire Auckland region and cover the three DHBs so are not an appropriate measure for ADHB alone. Numbers provided in the performance column are ADHB specific.			

PREVENTION SERVICES: Measures

Main Measure	Lift the Health of the ADHB population			
Initiatives	Improve access to smoking cessation services Identify with work and those groups of people who have a high proportion of smokers Train clinical staff to deliver smoke-free interventions			
Outputs	Smoking cessation advice and support delivered by health professionals in secondary and primary care			
Impact	Lower prevalence of smoking related conditions Reduced proportion of smokers in the population A long term reduction in smoking related admission			
Outcome	Increasing smoke-free environments and people Reduction in smoking-related chronic diseases Reduced admissions to hospital by children with a smoking related admission			
Measure				
Number of pregnant women and their families enrolled in smoking cessation programmes	Group	Target	Actual	Performance
	No of pregnant women and their families	450	212	not
	Commentary This disappointing result is due to fluctuating staffing levels resulting in inability to fully promote the Pregnancy Smoking Cessation service. A full compliment of staff will be in place for the new financial year and promotion to range of providers is planned for August			
Eligible patients attending primary care get advice and help to quit by July 2012	Group	Target	Actual	Performance
	% of eligible patients	90%	62%	not
	Commentary 62% Verified data for Quarter 2 (Verification of data is not available from the Ministry until well after the end of the following quarter.) Despite much activity by the PHO Smokefree Coordinators the rate of recording brief advice is increasing slowly. There have been issues with the accuracy of data collection for some PHOs which were rectified in the latter part of the year. ADHB is working closely with Waitemata DHB to assist the PHOs meet the target. Performance varies greatly between GP practises			

PREVENTION SERVICES: Measures

Actions to stop smoking are accurately recorded	Group	Target	Actual	Performance
	% of recording	100%	93%	substantially
	Recording and coding of Brief Advice has improved over the year.			

PREVENTION SERVICES: Measures

Main Measure	Lift the Health of the ADHB population
Initiatives	Encourage and ensure local providers are promoting ,protecting and supporting breastfeeding Work with populations that have lower breastfeeding rates
Outputs	Breastfeeding services are providing appropriate and accessible information and advice to mothers and their families
Impact	Healthy children Reduced likelihood of acquiring long term conditions later in life
Outcome	Healthier children Improved women's health Whanau Ora aspirations achieved for Mama and Pepi

Measure | **Target** | **Performance** | **Commentary**

Number of women enrolled with the Community Breastfeeding Service

Group	Target	Actual	Performance
No of women enrolled	900	1,030	achieved

Commentary
Engagement with this service was extremely positive.
Unfortunately, the Ministry of Health has discontinued funding for this service and it is being terminated

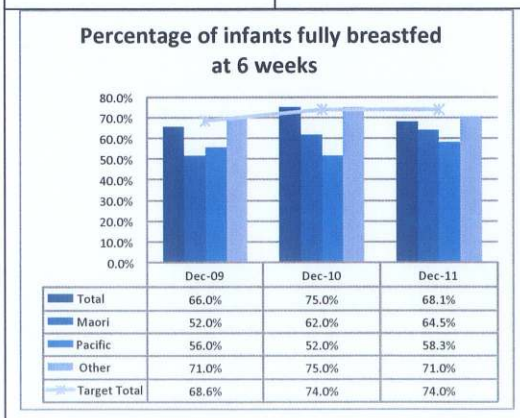
Number of Well Child providers achieving Baby Friendly Community Initiative accreditation

Group	Target	Actual	Performance
No of providers	2	0	not

Commentary
Accreditation within the timeframe was not possible but the audit will be undertaken in November. Initial assessments were delayed due to Christchurch based provider. All staff had to undertake training and perceived relevance varied between providers and staff groups.

Breastfeeding rates 6 weeks

Group	Target	Actual	Performance
Maori	64%	64.5%	achieved
Pacific	60%	58.3%	substantially
Other	74%	71%	substantially
Total	74%	68.1%	substantially

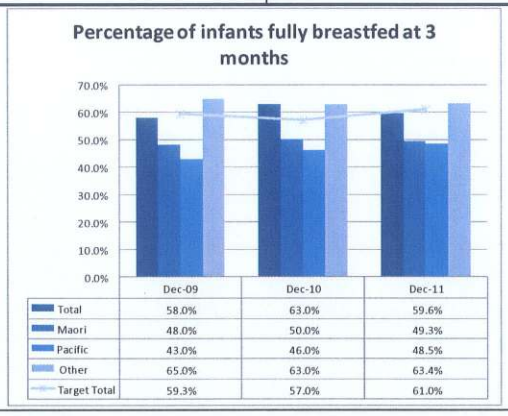


Commentary
Data comes from Plunket via the Ministry of Health and is at 31 December 2011.
The total target was not achieved; however it is extremely pleasing to see that the target for Maori was achieved. Maori breastfed at 6 weeks has increased from 52% in December 2009 to 64.5% in December 2011

PREVENTION SERVICES: Measures

Breastfeeding rates at 3 months

Group	Target	Actual	Performance
Maori	55%	49.3%	partially
Pacific	50%	48.5%	substantially
Other	65%	63.4%	substantially
Total	61%	59.6%	substantially

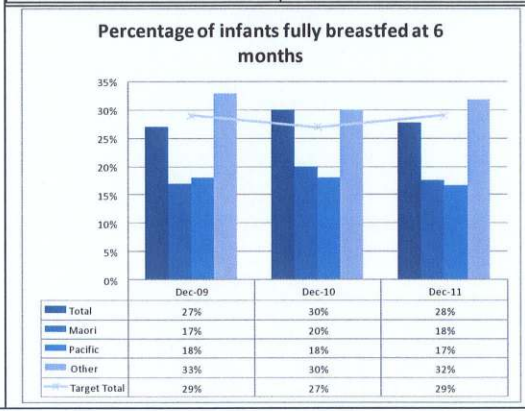


Commentary

Data comes from Plunket. While the Total and Pacific targets were close to being achieved, the results were somewhat disappointing.
Structural factors beyond the control of the health sector contribute to this outcome
Maori breastfed at 3 months has increased slightly from 48% in December 2009 to 49.3% in December 2011

Breastfeeding rates at 6 months

Group	Target	Actual	Performance
Maori	24%	17.5%	partially
Pacific	20%	16.6%	substantially
Other	32%	31.8%	achieved
Total	29%	27.7%	substantially



Commentary

Data comes from Plunket. As with rates at 3 months, the results were somewhat disappointing but as noted, structural factors beyond the control of the health sector contribute to this outcome
Contributing factors may include the economic climate and need to return to work, paid parental leave policy, the age of the mother and grand-parents views on breast feeding.
Maori has increased by 1% from December 2009 at 17% to 18% in December 2011

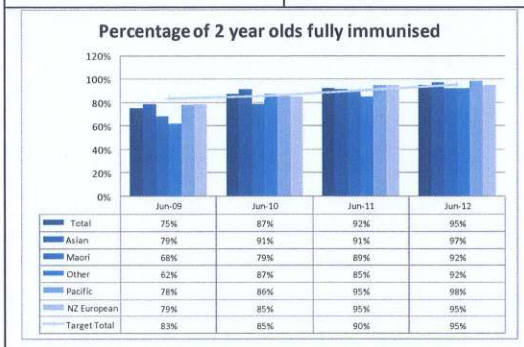
PREVENTION SERVICES: Measures

Main Measure	Lift the health of Auckland
Initiatives	Fund providers to deliver vaccinations against : Measles, Diphtheria, Pertussis, Mumps,Influenza,Tetanus,Human Papillomavirus, Rubella
Outputs	Primary care services performing immunisations Immunisation services (through general practice, outreach immunisation services , schools and other community settings) Girls immunised against human Papillomavirus
Impact	Hospital admissions for vaccine preventable disease (including cervical cancer and pre-cancerous lesions) in children and adults are reduced Reduced incidence from mortality from vaccine preventable diseases among children and adults Reduced incidence of cervical cytological abnormalities
Outcome	Healthier children and adults : lower incidence of vaccine –preventable disease and cervical cancer in females

Measure

Percentage of 2 year olds fully vaccinated

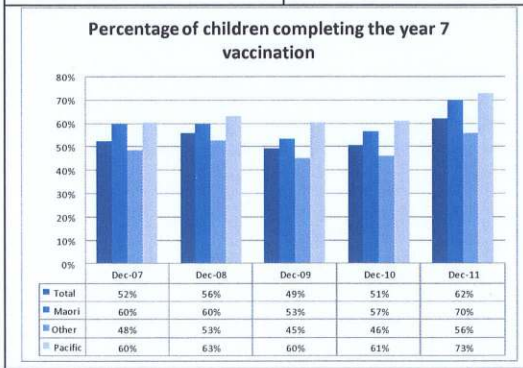
Group	Target	Actual	Performance
Total	95%	95%	achieved



Commentary
This was a very positive increase
Maori has increased from 68 % in 2009 to 92% in June 2012. This is an encouraging outcome.

Percentage of Year 7 children vaccinated D Tap-IV

Group	Target	Actual	Performance
Total	60%	62%	substantially



Commentary
This was a very positive increase
Maori has increased from 60% in December 2007 to 70% in December 2011.

Measure	Target	Performance	Commentary
Percentage of Year 8 girls vaccinated for Human Papillomavirus, dose 3	62%	60% substantially	The HPV programme is delivered in schools by Public Health Nurses employed by the DHB. If families decline this service they are encouraged to access the vaccine through their general practice. From the cohort of girls born in 1998, 1,458 received all 3 doses of the vaccine out of an estimated eligible population of 2,410 girls. Information about the vaccine is recorded on the National Immunisation Register. Coverage for Pacific and for Maori girls was pleasing with coverage rates for Other (55%) ethnicity lower than both Pacific (82%) and Maori (60%) rates. The total coverage rate was 60%. There is a high decline rate (32%) for this programme.

PREVENTION SERVICES: Measures

Main Measure	Lift the health of Auckland
Initiatives	Fund and provide services for metro Auckland region that promote, improve, maintain and restore good oral health: -Health promotion activities for children & adolescents living in disadvantaged areas. Particularly Maori and Pacific peoples. -Oral health examination and education provided to preschool children & their parents -Oral health examination and education for school age children & adolescents -Oral health examination and treatment services for low income adults -Advocacy of community water fluoridation
Outputs	Oral Health education Oral examinations and treatment among preschool children, school children and adolescents Fluoridation advocacy outputs (varied)
Impact	Better oral health for children and adolescents Carries among children and adolescents is prevented Carries is detected early and treated before major damage to teeth occurs Improvement of overall oral health with the reduction of inequalities among different ethnic groups More adolescents are engaged with oral health services
Outcome	Improved Health Greater equity Living within our means Confidence and trust in the health system

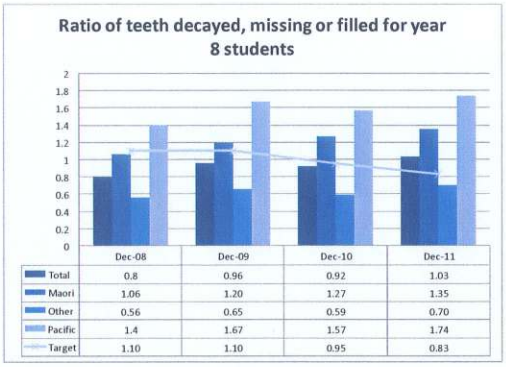
Measure	**Target**	**Performance**	**Commentary**
Enrolment rates for children<5 years and low income adults	**Group**	**Target**	**Actual**	**Performance**
	Children<5 years and low income adults	21,763	21,514	substantially
	Same target as noted below. Note that ARDS (Auckland Regional Dental Service) do not provide services to low income populations Same target as noted below. Same target as noted below. Note that ARDS do not provide services to low income populations			
Enrolment and preventative oral health care for preschoolers	Group	Target	Actual	Performance
	Number enrolled	21,763	21,514	substantially
	Enrolments for pre school children has improved since the last reporting period and ARDS and the Pre-School co-ordinators have worked hard to substantially achieve this ambitious target. Main focus this year has been on the implementation of the Oral Health Business case however, going forward the focus will shift to further improving on these targets and concentrating on the Maori & Pacific Island <5 year population			
Oral Health Quality: Annual Clinical Audit report	Report unavailable .All clinicians have bi-annual clinical audits. In addition service audits are performed regularly.			

PREVENTION SERVICES: Measures

Measure

Total number of permanent teeth of year 8 children, DMFT

Group	Target	Actual	Performance
Maori	.92	1.35	not
Pacific	.92	1.74	not
Other	.92	.70	achieved
Total	.92	1.03	partially



Commentary

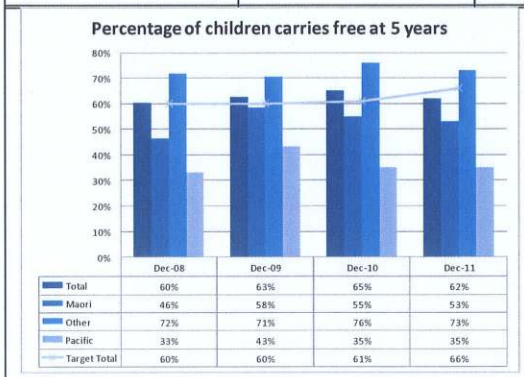
This is a schools based programme. Data is for the School year to 31 December 2011

The Maori ration of teeth decayed, missing or filled for year 8 students has worsened from 1.06 in December 2007 to 1.35 in December 2011

There is a focus on enrolling and treating high risk children, particularly Maori and Pacific children. The new dental clinics tend to be sited in areas of high deprivation and mobile clinics prioritise schools and preschools with high Maori and Pacific enrolments, including Kohanga Reo and Pacific Language Nests. High risk children are seen six monthly and are more likely to have BW radiographs and preventative care.

Percent carries free at five years

Group	Target	Actual	Performance
Maori	69%	53%	partially
Pacific	69%	35%	not
Other	69%	73%	achieved
Total	69%	62%	substantially



Commentary

This is a schools based programme. Data is for the School year to 31 December 2011

Maori percentage of children carries free at 5 years has increased from 46% in December 2008 to 53% in December 2011

Regional preschool and DNA strategies have been developed and rolled out. Some priority actions include:

- Reinforcement of oral health education and benefits of targeting to all dental staff.
- Use of motivational interviewing techniques
- Encourage parental attendance at appointments
- Follow up of appointments and failed appointments

Use Maori, Pacific and Asian support groups to target high risk groups

PREVENTION SERVICES: Measures

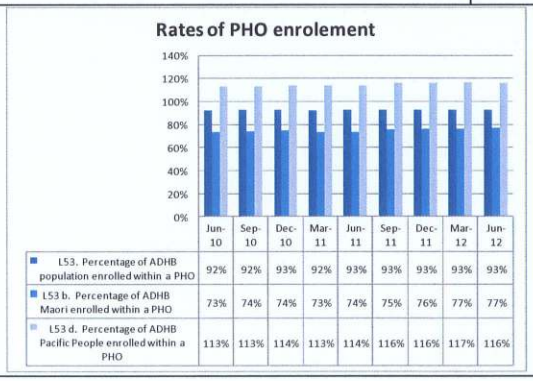
<table>
<tr><th>Measure</th><th colspan="2">Target</th><th>Performance</th><th>Commentary</th></tr>
<tr><td>Oral Health Quality: Number of complaints and incidents</td><td colspan="2">Jan - June 2012 Volume (Visits Vs Complaints)
<table><tr><th>Region</th><th>Number of Visits</th><th>Number of Complaints</th><th>Complaint per visit</th></tr><tr><td>Central</td><td>44,631</td><td>3</td><td>0.00007</td></tr></table></td><td></td><td>ARDS performance data as shown in the table indicates that the number of complaints in the last 6 months is very low. The total number of complaints for the year 2011/12 is 7.

The total number of incidents for the year was 51. 62% of incidents were categorised as Employee General Events and majority of events were reported as being of minimum to moderate level of severity (Level 1 to 3).</td></tr>
<tr><td rowspan="2">Oral Health Quality: Arrears rates</td><td>Group</td><td>Target</td><td>Actual</td><td>Performance</td></tr>
<tr><td>% not examined 0-12 years</td><td>10%</td><td>16.3%</td><td>not</td></tr>
<tr><td colspan="4">Oral health services in the Auckland Metro region are currently in transition. The majority of clinics are not working to full productivity due to new staff (who need to be orientated), staff training for all staff and the delivery of two new diagnostic vans in the next quarter. This has resulted in fewer children being screened, resulting in slower clinic referrals. The expectation is that productivity will increase when new facilities are running to capacity and new models of care are fully implemented.

The following is being actioned to increase pre school enrolments:

1. Identify and utilise Maori, Pacific and Asian support groups to target high risk groups
2. Make links with Whanu Ora programme
3. Increase and strengthen the contacts with Plunket and Well Child providers, GPs and private dentists
4. Weekly visits are made to postnatal wards in WDHB area to explain the oral health service to new mothers and offer enrolment
5. Raising awareness of dental service at early childhood centres</td></tr>
<tr><td>Oral Health Quality: Waiting time</td><td colspan="2">Same target as noted above.</td><td colspan="2">Same target as noted above.
Same target as noted above. ARDS use the arrears measure to capture this measure (i.e. % of children who haven't been seen in their specific waiting time/period).</td></tr>
</table>

PREVENTION SERVICES: Measures
EARLY DETECTION AND MANAGEMENT: Measures

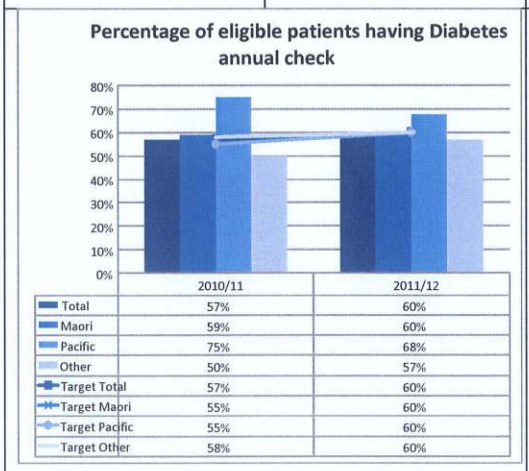
Main Measure	Lift the health of Auckland		
Initiatives	Subsidise primary care services provided by GPs, including programmes like diabetes "get checked" CVD Risk assessment and management, Primary Options etc Subsidise primary care work provided by Primary Health Organisations including diabetes coordination, services to improve access for high risk groups Subsidise region-wide work to improve the performance of primary care through the GAIHN (Greater Auckland Integrated Health Network)		
Outputs	Enrolment PHO affiliated general practice teams Nurse and GP consultations for enrolled population : -diagnose and treat acute and long term conditions -refer to secondary care services when appropriate -social support and advice to families		
Impact	Prevention of illness Management and cure of treatable conditions Proportion of diabetic detected and managed appropriately (national health target) Maintenance of functional independence Minimising unnecessary use of high cost secondary care Incidence rate(and inequalities in) invasive cervical cancer		
Outcome	Improved health Greater equity Living within our means Confidence and trust in the health system		
Measure	**Target**	**Performance**	**Commentary**
Diabetes Get Checked	See graph below	See graph below	See graph below
Satisfactory Diabetes Management	See graph below	See graph below	See graph below
Meet all ethnic-specific rates for primary care enrolment			**Commentary** It is pleasing to see Maori rates increasing to 74% at June 2012 compared with 74% a year ago. Enrolment rates have remained constant over the last 8 quarters, with a slight increase for Maori. However, Maori and Pacific percentages are impacted by the validity of GP level coding of ethnicity.

	Jun-10	Sep-10	Dec-10	Mar-11	Jun-11	Sep-11	Dec-11	Mar-12	Jun-12
L53. Percentage of ADHB population enrolled within a PHO	92%	92%	93%	92%	93%	93%	93%	93%	93%
L53 b. Percentage of ADHB Maori enrolled within a PHO	73%	74%	74%	73%	74%	75%	76%	77%	77%
L53 d. Percentage of ADHB Pacific People enrolled within a PHO	113%	113%	114%	113%	114%	116%	116%	117%	116%

EARLY DETECTION AND MANAGEMENT: Measures

Cervical screening coverage to contract	Group	Target	Actual	Performance
	% covered	75%	73.7%	substantially
	This data is at the end of March 2012 for the Total eligible population aged 25-69 years. There is a delay in receipt of data provided by the Ministry of Health. The Ministry of Health is working to provide coverage data from the National Cervical Screening Programme Register in a more timely manner. Considerable efforts are going into improving equity in coverage.			
Quality:- Proportion of practices with ACC accreditation	61% of general practices within ADHB boundaries have ACC accreditation. This means that a large proportion of patients can receive accident related care with their own GP or medical home which improves continuity of care and delivers care at a location convenient to the patient. This measure is outside of the control of the DHB but it can gives an indication of the quality of general practice and a holistic approach to their patient's care. ACC have ceased accreditation for new providers this year as they feel they have sufficient coverage with the current providers they have - so this will impact on the measure in future years. The integrated primary care team will try to discuss with ACC how this may impact on new developments within Auckland such as IFHCs. (Integrated Family Health Clinics)			
Quality- Proportion of practices with cornerstone accreditation	No target specified Actual for the year to June 2012 is 53% CORNERSTONE is an accreditation programme specifically designed by the Royal New Zealand College of General Practitioners for general practices in New Zealand. Accreditation is a self assessment and external peer review process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system.			

	Group	Target	Actual	Performance
Diabetes get checked	Maori	60%	60%	achieved
	Pacific	60%	68%	achieved
	Other	60%	57%	substantially
	Total	60%	60%	achieved

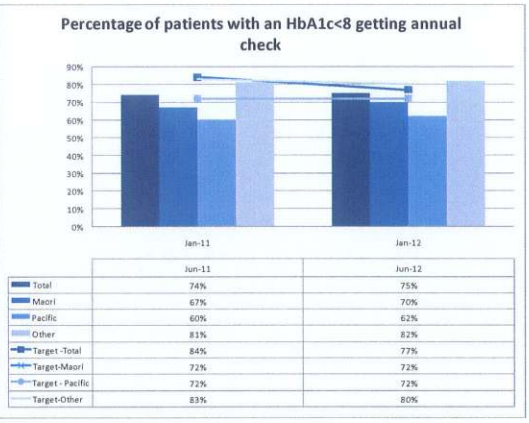


Commentary

Overall we improved our performance between 2010/11 and 2011/12 despite the increased prevalence from 21,342 in 2010/11 to 23,203 in 2011/12. We have continued to perform above target for our Pacific populations, which is strengthened by the HVAZ programme where Parish Community Nurses hold health screenings in the churches, identify people with long term conditions and refer/link them to appropriate services

EARLY DETECTION AND MANAGEMENT: Measures

	Group	Target	Actual	Performance
Satisfactory Diabetes Management	Maori	72%	70%	substantially
	Pacific	72%	62%	partially
	Other	80%	82%	achieved
	Total	77%	75%	substantially

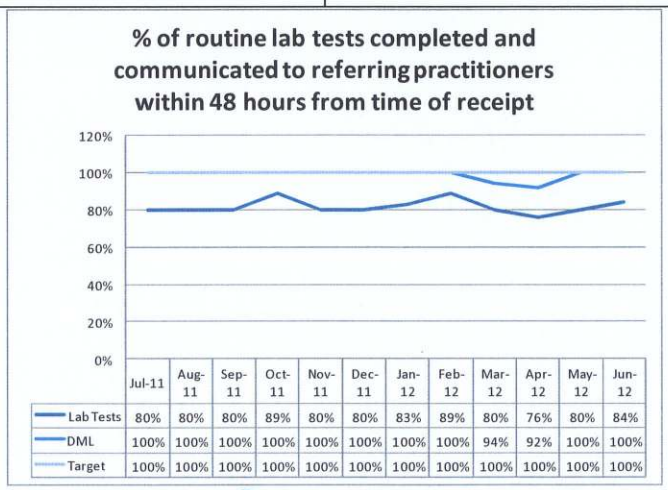


	Jun-11	Jun-12
Total	74%	75%
Maori	67%	70%
Pacific	60%	62%
Other	81%	82%
Target -Total	84%	77%
Target-Maori	72%	72%
Target - Pacific	72%	72%
Target-Other	83%	80%

Commentary

There was a small improvement in diabetes management across all ethnicities between the two years, despite the stretch targets for Maori and Pacific not being achieved. We have a number of services to support better diabetes management, including community group diabetes self management education, and a generic long term condition self management education programme being run through the Pacific churches under HVAZ

EARLY DETECTION AND MANAGEMENT: Measures

Main Measure	Lift the health of Auckland		
Initiatives	Purchase and monitor community referred testing and diagnostic services including -laboratory tests -radiological services for cardiology , neurology, audiology, endocrinology, respiratory -pacemaker physiology tests -ante-natal screening		
Outputs	Community referred laboratory tests and other diagnostics services		
Impact	Prompt diagnosis of acute and chronic conditions Reduced demand on specialist outpatient Ratio of diagnostic laboratory tests in relation to need e.g. no of Hb1a1c tests per estimated prevalence of diabetes, benchmarked against other DHBs		
Outcome	Improved health Greater equity Living within our means Confidence and trust in the health system		
Measure	**Target**	**Performance**	**Commentary**
Number of laboratory tests	None specified	2,809,568 tests performed in the year April 2011 to March 2012. This compares with 2,790,764 in the previous year	An increase in laboratory tests performed reflects continued access to required diagnostic testing
Number of radiological images	GP referred figures only – note unit of measure wrong in SOI, should be procedures, not images No target specified	267,056 all ADHB radiology procedures. Radiological procedures referred by GP's completed • 3,629 CTs • 4,528 MRIs • 609 PETs	There has been an increase in utilisation of private providers with an increase in volumes provided through ADHB. The use of private providers for CT has reduced (3,776 to 3,629) and MRI (5,235 to 4,528) has reduced.
% of routine laboratory tests (by volume) completed and communicated to referring practitioners within 48 hours from time of receipt	 Jul-11 Aug-11 Sep-11 Oct-11 Nov-11 Dec-11 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12 Lab Tests 80% 80% 80% 89% 80% 80% 83% 89% 80% 76% 80% 84% DML 100% 100% 100% 100% 100% 100% 100% 100% 94% 92% 100% 100% Target 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% Lab Tests Auckland partially achieved Year Average 82% DML substantially achieved Year Average 99 % No target specified but we expect 100%		Labtests Auckland provide all services for general practitioners, midwives and for tests requested by your DHB clinician when you are seen as an outpatient. For more information on Labtests and the location of their collection rooms and opening hours DML provide all services for medical specialists working in private practice, private hospitals and private specialist clinics (including all Fertility clinics), and Rest Homes and Geriatric Hospitals as certified by the Ministry of Health. For more information on DML and the location of their collection rooms and opening hours

EARLY DETECTION AND MANAGEMENT: Measures

Measure	Target	Performance	Commentary
% of urgent tests completed and communicated within either 3 hours of receipt of the sample at the lab or the timeframe determined by the Laboratory Clinical Board for that particular type of test	No target specified but we expect greater than 98%	100%  achieved	Percentage of critical test results phoned through to appropriate contact person within 1 hour
Fasting blood lipid tests per head of population at risk(CVD risk assessment health target measure	Target 90% (Baseline 79%)	Data is only available until the end of March and it is at 83%  substantially	Target not achieved within available data range of 9 months but improvement has occurred.

EARLY DETECTION AND MANAGEMENT: Measures

Main Measure	Lift the health of Auckland		
Initiatives	Purchase and monitor community referred testing and diagnostic services including -laboratory tests -radiological services for cardiology , neurology, audiology, endocrinology, respiratory -pacemaker physiology tests -ante-natal screening		
Outputs	Community referred laboratory tests and other diagnostics services		
Impact	Prompt diagnosis of acute and chronic conditions Reduced demand on specialist outpatient Ratio of diagnostic laboratory tests in relation to need e.g. no of Hb1a1c tests per estimated prevalence of diabetes, benchmarked against other DHBs		
Outcome	Improved health Greater equity Living within our means Confidence and trust in the health system		
Measure	**Target**	**Performance**	**Commentary**
Quality-Value of diagnostic testing purchased	Not specified		Projected spend on labs $25.3M,at March 2012 $18.6m (last quarter not yet available)
Quality- Unit cost of tests benchmarked against that paid by other DHBs	Not specified		Not relevant unless making a national comparison as a metro region contract
Quality-Accreditation and annual reports for community laboratory services	Not specified.	Diagnostic Medab, Auckland are a fully IANZ accredited medical testing laboratory based in the Auckland suburb of Ellerslie Labtests has been providing pathology service to the Auckland community since August 2009 and is one of the few laboratories to achieve full IANZ accreditation in its first audit.	Labtests Auckland provides all services for general practitioners, midwives and for tests requested by your DHB clinician when you are seen as an outpatient. DML provide all services for medical specialists working in private practice, private hospitals and private specialist clinics (including all Fertility clinics), and Rest Homes and Geriatric Hospitals as certified by the Ministry of Health
Quality-Proportion of tests that are repeated	No target specified but we expect recollects to be less than 1%	Average 0.25% achieved	Community lab tests are managed by Diagnostic MedLabs and Labtests NZ. ADHB notes that their performance was within expectations

EARLY DETECTION AND MANAGEMENT: Measures

Main Measure	Lift the health of Auckland
Initiatives	Subsidise the community based provision of prescribed pharmaceuticals
Outputs	Community dispensing of pharmaceutical products subsidised in accordance with Pharmac stipulations
Impact	Good access to effective pharmaceutical treatments Lower per capita out of pocket and total expenditure on pharmaceuticals Prescription rates in relation to need (patients with NMDS recorded diagnoses) for sentinel conditions (e.g. hypertension and diabetes) benchmarked against other DHBs Achieving all targets in the PHO Performance Programme
Outcome	Improved Health Greater equity Living within our means Confidence and trust in the health system

Measure	**Target**	**Performance**	**Commentary**
Total value of subsidy provided	None specified.	$122m	Pharmaceuticals represent a significant proportion of the health spend and is an efficient and effective intervention
Proportion of dispensing expenditures relative to expenditure on pharmaceuticals	None specified	$34.5m/$122m=28%	The proportion of dispensing relative to drug expenditure reflects the proportion of the pharmacy budget which DHBs remain accountable for which directly correlates to decisions PHARMAC makes on its drug spend i.e. if PHARMAC makes savings and reinvests more in drugs on it's budget, the DHB's dispensing budget will also increase outside of the DHB's control.
No. of prescriptions subsidised	None specified.	4,383,143 prescriptions	Over 4.3 M prescriptions have been dispensed within ADHB
No. of individuals receiving subsidised prescriptions	None specified	We cannot specify the numbers of individuals receiving prescriptions; only the number of items dispensed (6.4M items) and total value ($4.56M) to certain population groups. However all NZ residents are entitled to subsidised prescriptions which in ADHB equates to a domiciled population of 468K	All NZ residents are entitled to subsidised prescriptions which in ADHB equates to a domiciled population of 468k
Quality: Proportion of prescriptions with a valid NHI number	Target 98%	96%  substantially	NHI compliance continues to increase , The new Community Pharmacy Services agreement reinforces that all prescriptions must be processed with an NHI number which should further drive this indicator

INTENSIVE ASSESSMENT AND TREATMENT: Measures

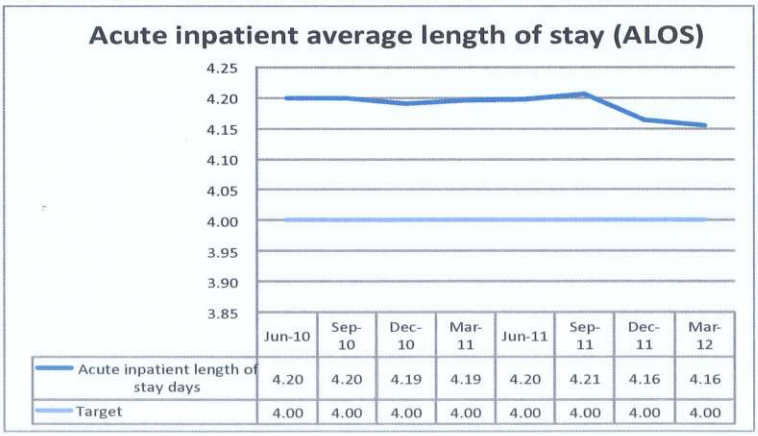
These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a "hospital". They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventative, diagnostic, therapeutic, and rehabilitative services.
- Inpatient services(acute and elective streams) including diagnostic, therapeutic and rehabilitation services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

Main Measure	Lift the health of Auckland
Initiatives	Timely access to acute care and appropriate timely discharge Improve Emergency Department capacity and services to meet needs Timely transfer to appropriate services from Emergency Department service Ensure good access to support services in the community or primary care level to support patient recovery following an acute event
Outputs	Acute inpatient services Emergency Department services
Impact	Effective and prompt resolution of medical and surgical emergencies and acute conditions Reduced mortality Positive patient experience re wait times Standardised mortality rate for acute myocardial infarction within 30 days of admission benchmarked against rates in other DHBs. Reduced number of acute re-admissions
Outcome	Improved health Greater equity Living within our means Citizen confidence and trust in the health system

Measure	**Target**	**Performance**	**Commentary**
Percent of patients admitted , discharged or transferred from ED within 6 hours	95%	National target see above	National target see above
4 week Maximum waiting times for chemotherapy treatment (from the decision to treat)	100%	National Target se above	National Target see above
Acute patient length of stay	4.0 days	See graph below	See graph below
Acute re admissions to hospital, standardised	9.95%	See graph below	See graph below
Quality –100% of patients requiring impatient referral are referred to an inpatient specialty within 3 hours	3 hours	See graph below	See graph below

Acute patient length of stay	Group	Target	Actual	Performance
	Total	4.0 days	4.16 days	substantially

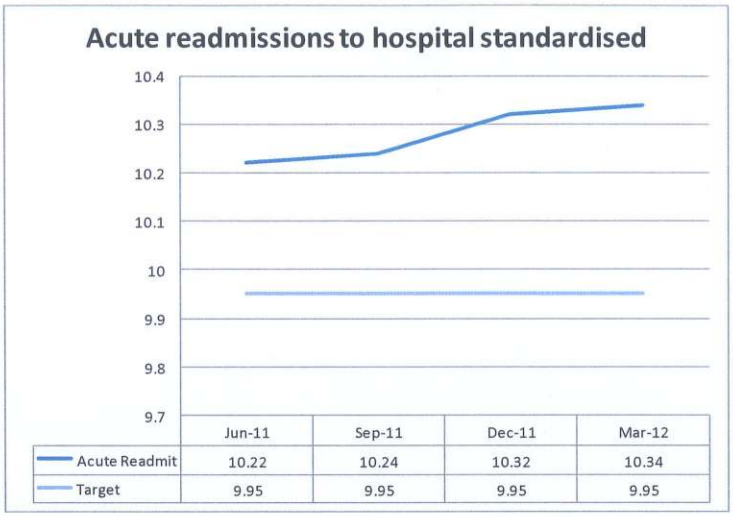


Days for average length of stay

Commentary

The SOI target was an average length of stay for acute inpatients of 4.0 days over the year.
The MoH target was a 25% improvement each quarter which would result in 4.0 days in the March 2012 quarter
ADHB has continued to improve the ALOS for our patients over the 2011/12 year. We have made significant improvement in General Medicine, General Surgery and Orthopaedics length of stay for our acute patients.
Unfortunately this measure does not show the true results as patients that are able to be treated and discharged the same day are not reflected in the data.

INTENSIVE ASSESSMENT AND TREATMENT: Measures



	Jun-11	Sep-11	Dec-11	Mar-12
Acute Readmit	10.22	10.24	10.32	10.34
Target	9.95	9.95	9.95	9.95

Group	Target	Actual	Performance
Total	9.95%	10.3%	

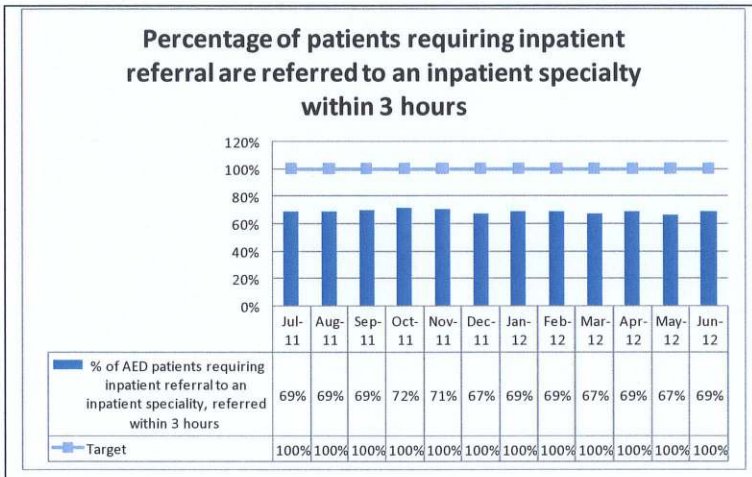
Commentary

The lowest readmission rate in NZ was the West Coast DHB at 7.96% in Q4. The highest was Taranaki at 11.52%.

ADHD rates are affected by the recurring treatment required with some illnesses.

Examples of this are "

The highest readmission rates are Adult Oncology 25.81%, Renal Medicine 23.69%, Paediatric Haematology/Oncology 22.83% and Renal Transplant 22.67%



	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
% of AED patients requiring inpatient referral to an inpatient speciality, referred within 3 hours	69%	69%	69%	72%	71%	67%	69%	69%	67%	69%	67%	69%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Group	Target	Actual	Performance
Total	100%	69%	not

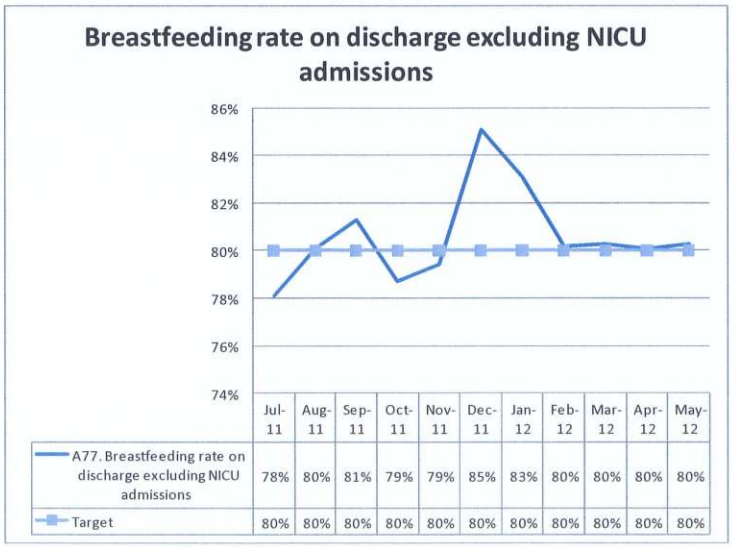
Commentary

ADHB has had stable performance on the referrals within 3 hours across the year. ADHB's emergency department works in conjunction with the inpatient specialty team to deliver the overall result for the patient. While the referrals target 100% referrals in 3 hours was not met we have achieved the target of 95% of patients discharged, transferred or admitted within 6 hours.

INTENSIVE ASSESSMENT AND TREATMENT: Measures

Main Measure	Lift the health of Auckland
Initiatives	Providing safe ,accessible maternity , obstetric and neonatal care services
Outputs	Non-specialist antenatal & obstetric consultations Amniocentesis Maternity inpatient, outpatient care & follow-up Labour and delivery services Postnatal inpatient, primary & outpatient care Specialist neo-natal care
Impact	Live births Safe children Healthy baby Healthy mother Improved maternal mental health
Outcome	Improved population health Reduced inequities Trusted health system Living within our means

Measure	Target	Performance	Commentary
% of term elective Caesarean performed at <39 weeks	35%	achieved	More active work needs to go into further improvement, but some pleasing progress has been made Actual at the end of June 2012 was 43%
Breastfeeding rate on discharge excluding NICU admissions	> = 80%	See graph below	See graph below
Quality- Reduced maternal deaths (baseline 8, 3009	None specified.	2	This measure will not be used in future as there are more sensitive quality measures
Quality- Reduced admissions to NICU (baseline 10.4% 2009)	None specified	10.9 % in 2011	The rate has remained relatively stable over recent years



Group	Target	Actual	Performance
Total	>=80%	81%	achieved

Commentary

The target was achieved. This remains an important focus of the service

INTENSIVE ASSESSMENT AND TREATMENT: Measures

Main Measure	Lift the health of Auckland
Initiatives	Provide and purchase elective inpatient and outpatient services
Outputs	Elective inpatient services Elective outpatient services
Impact	Restoration of functional independence Longer life Positive patient experience
Outcome	Improved health Greater equity Living within our means

Measure	Target	Performance	Commentary
Compliance with national target for surgical discharges	11,950 National target see above	Target: 11,950 / Actual: 11,981 achieved	National Target see above The Health Target is measured in discharges (patient numbers) and excludes dermatology, oral health, paediatric cardiac, adult congenital heart and cardiology.
Total QALYs gained from the 5 Ministry of Health selected procedures,(calculated as the number of procedures multiplied by QALYs per procedure: -Hip(primary) = 0.85 -Hip (revision)=0.15c -Knee=.8c -Cataract(1st eye)=1.25 -Cataract(both eyes)=2.1d -Cataract (2nd eye) =0.92d -CABG=1.3 -PCI=1.64	See QALY table below QALY = Quality-adjusted life year. A QALY is a measure of the amount and quality of life gained from an operation No target specified		The $ per QALY will give us a direction for what we need to do more and how to prioritise

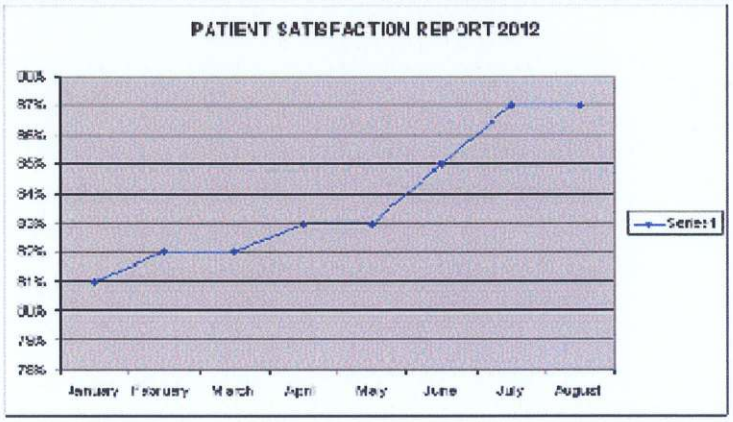
QALY DRG	Operation Weight	Maori ADHB	Others ADHB	Pacific ADHB
CABG	1.3	7	72	23
Cataract	1.25	60	906	246
HIP primary	0.85	15	156	9
HIP revision	0.15	1	8	0
Knee	0.8	8	126	26
PCI	1.64	5	194	15
Total	**5.99**	**96**	**1462**	**319**

The QALY is a measure of the value of health outcomes. Since health is a function of length of life and quality of life, the QALY was developed as an attempt to combine the value of these attributes into a single index number. The basic idea underlying the QALY is simple: it assumes that a year of life lived in perfect health is worth 1 QALY (1 Year of Life × 1 Utility value = 1 QALY) and that a year of life lived in a state of less than this perfect health is worth less than 1. In order to determine the exact QALY value, it is sufficient to multiply the utility value associated with a given state of health by the years lived in that state. QALYs are therefore expressed in terms of "years lived in perfect health": half a year lived in perfect health is equivalent to 0.5 QALYs (0.5 years × 1 Utility), the same as 1 year of life lived in a situation with utility 0.5 (e.g. bedridden) (1 year × 0.5 Utility). QALYs can then be incorporated with medical costs to arrive at a final common denominator of cost/QALY. This parameter can be used to develop a cost-effectiveness analysis of any treatment.

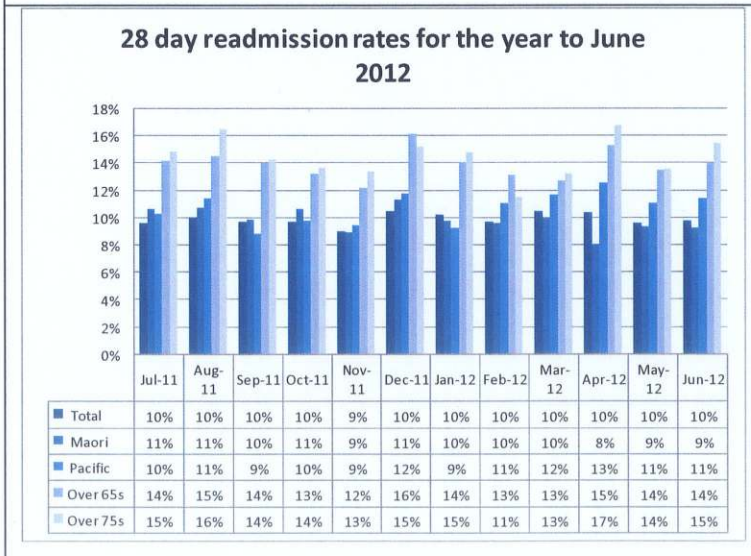
INTENSIVE ASSESSMENT AND TREATMENT: Measures

Main Measure	Lift the health of Auckland
Initiatives	Provide and purchase elective inpatient and outpatient services
Outputs	Elective inpatient services Elective outpatient services
Impact	Restoration of functional independence Longer life Positive patient experience
Outcome	Improved health Greater equity Living within our means

Measure	Target	Performance	Commentary
Increasing overnight bed capacity(Greenlane)	30	New 29 bed ward on Level 2 of Greenlane Clinical Centre Building 1 being opened 1st October 2012.	Existing 22 bed spaces in overnight ward on Level 2 of Building 7 at Greenlane will be closed when new ward opens.
Quality-Patient satisfaction	See graph below	See graph below	See graph below
Quality- Readmission rates	See graph below	See graph below	See graph below
Quality- Post –operative hospital acquired bacteria rates	See graph below	See graph below	See graph below
Quality-ESPI compliance	See graph below	See graph below	See graph below



In December 2011we commenced a new online (e-mail) process for gauging patient experience information. The graph shows that patients experience has been rated as very good or excellent at 87% of all patients surveyed.



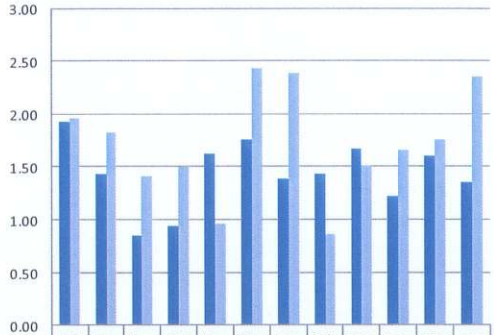
	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Total	10%	10%	10%	10%	9%	10%	10%	10%	10%	10%	10%	10%
Maori	11%	11%	10%	11%	9%	11%	10%	10%	10%	8%	9%	9%
Pacific	10%	11%	9%	10%	9%	12%	9%	11%	12%	13%	11%	11%
Over 65s	14%	15%	14%	13%	12%	16%	14%	13%	13%	15%	14%	14%
Over 75s	15%	16%	14%	14%	13%	15%	15%	11%	13%	17%	14%	15%

Group	Target	Actual	Performance
Maori	10%	10%	achieved
Pacific	9%	11%	substantially
Over 65	14%	14%	achieved
Over 75	15%	14%	achieved
Total	10%	10%	substantially

Commentary:
The largest contributors to the readmission rate are: Adult Oncology 25.81%,Adult Renal 23.62% and Child Oncology 22.83%

INTENSIVE ASSESSMENT AND TREATMENT: Measures

Blood stream infections per 1,000 bed days in the year to June 2012



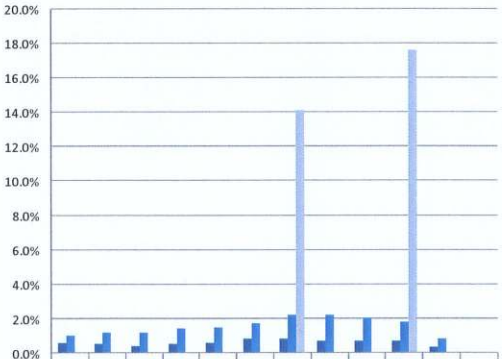
	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Adult bloodstream infections (per 1000 bed-days)	1.93	1.43	0.84	0.94	1.63	1.76	1.39	1.44	1.66	1.22	1.60	1.36
Child bloodstream infections (per 1000 bed-days)	1.96	1.83	1.41	1.50	0.96	2.43	2.38	0.86	1.51	1.65	1.76	2.35

Group	Target	Actual	Performance
Adult	1.44	1.43	substantially
Child	1.32	1.72	not

Commentary:

As an organisation, we participate and are the lead DHB, in the national hand hygiene programme on behalf of the Health Quality & Safety Commission. Nationally trained auditor audit hand hygiene compliance in all our ICU and high risk settings three times per year. Results are fed back in a timely manner to key stake holders. Ongoing education around the '5 Moments' for hand hygiene is provided by our Hand Hygiene Co-ordinator and Infection Prevention & Control team. This education has been instrumental in raising staff awareness of the effect that good hand hygiene compliance has on the reduction in healthcare associated infections

Elective Service Performance Indicators for the year to June 2012



	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
(ESPI 2) Patients waiting longer than six months for their FSA	0.6%	0.5%	0.4%	0.5%	0.6%	0.8%	0.8%	0.7%	0.7%	0.7%	0.3%	
(ESPI 5) Patients given a committment to treatment but not treated within six months	1.0%	1.2%	1.2%	1.4%	1.5%	1.7%	2.2%	2.2%	2.0%	1.8%	0.8%	
(ESPI 6) Patients in active review with no clinical assessment within the last 6 months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	14.1%	0.0%	0.0%	17.6%	0.0%	

Group	Target	Actual	Performance
FSA	.8%	.7%	achieved
Not Treated	2.3%	1.8%	achieved
Not assessed	0%	17.6%	not

Commentary:

First specialist assessments (FSA) are an important component of the elective flow. Patients having an FSA may be referred to a surgical wait-list, but they may also be managed medically and in some cases a decision may be made that no treatment is required. This has an implication for production planning in that an increase of 100 in a target for surgical discharges may require an additional 200-300 FSAs to provide 100 additional surgical cases on the wait-list.

An ADHB objective was to have no patients waiting over 6 months for an elective procedure by 30 June 2012.

We are confident that we have met the target. Final confirmation from the Ministry of Health is expected by the middle of August.

INTENSIVE ASSESSMENT AND TREATMENT: Measures

Main Measure	Lift the health of Auckland
Initiatives	Provide an inpatient specialist geriatric evaluation, management and rehabilitation service for older adults
Outputs	Sub-acute inpatient care of older adults
Impact	Maximising functional independence and health-related quality of life in older adults The proportion of patients with an improvement in function between Assessment Treatment and Rehabilitation admission and discharge as measured by a standard test of function
Outcome	Improved health Greater equity Living within our means Citizen confidence and trust in the health system

Measure	Target	Performance	Commentary
Standardised discharge rate Standardised bed-day rate	**Older People's Health (OPH)** service provides inpatient and outpatient care and is spread over two sites; inpatient services are based at Auckland City Hospital while outpatient and community services are based at Greenlane Clinical Centre. Older People's Health looks after the over 65-year-old population of Central Auckland and offers assessment, treatment and rehabilitation services. These services are provided by a team of specialist professionals including doctors, nurses, physiotherapists, occupational therapists, speech language therapists, dietitians, social workers and service coordinators who specialise in conditions that affect older people. They all work together as a team to assess and diagnose your condition and ensure older adults have the support required to live as independently as possible. There are currently 100 inpatient beds, a domiciliary assessment service, outpatient clinics and interdisciplinary day assessment clinics. The interdisciplinary day assessment includes Stroke Clinic, Parkinsons Clinic and Auckland City Memory Service. Also available is the Community Rehabilitation Programme to assist people who need some assistance to get back to how they were functioning prior to illness or who need help with the transition back to their home situation after a period in hospital.		
Proportion of patients newly-institutionalised(benchmark: Other DHBs)	None specified		New admissions to age residential care recorded as part of the HOP Scorecard Feb – Jun12 Rest home level care – 207 Hospital level care - 367
Proportion of patients admitted acutely with CVA who are seen in a stroke unit	79%	77% at Dec 2011 substantially	All patients with a confirmed stroke are admitted to the stroke unit. Exceptions are if patients suffer from an underlying condition, which takes precedence and it would be more beneficial to the patient to be treated under the care of another specialty. There are no age limitations.
Assessment Treatment and Rehabilitation (inpatient) waiting time (average days per patient)	None specified	1.79 (average days per patient)	86% of patients were seen within 4 days

INTENSIVE ASSESSMENT AND TREATMENT: Measures

Main Measure	Lift the health of Auckland
Initiatives	Provide and /or contract mental health inpatient, outpatient, community, residential ,rehabilitation support and liaison services
Outputs	A matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health and Addiction services covering Child , Adolescent & Youth; Adult and Older Adult Age bands Services comprise -acute and intensive services -community based clinical treatment and therapy services - services to promote resilience, recovery and connectedness
Impact	Social integration and improved quality of life Mental health access rate is a proxy measure for determining the impact of our mental health services on improving the quality of life for people with severe mental illness or who have issues with alcohol or drug addiction
Outcome	Living within our means Citizen confidence and trust in the health system

Measure

Access rates for total and specific population groups (proportion of the population using Mental Health and Addiction services in the last year) Total/child & youth/adult/older adult/population (all ethnicities)

Total

Group	Target	Actual	Performance
Age 0-19	2.53%	2.42%	substantially
Age 20-64	3.30%	3.65%	achieved
Age 65+	3.58%	3.38%	substantially

Commentary
Access rates for Maori youth were higher than 'others' and lower performance on others slightly reduced the overall figure for youth. For older adults it was lower figures for Maori and other.
For all groups access rates are slowly rising and is the focus on specific project work this year
Extra number of clients =909 as advised by MOH

Access rates for total and specific population groups (proportion of the population using Mental Health and Addiction services in the last year) Maori/child & youth/adult/older adult/population (all ethnicities)

Maori

Group	Target	Actual	Performance
Age 0-19	2.53%	2.42%	substantially
Age 20-64	3.30%	3.65%	achieved
Age 65+	3.58%	3.38%	substantially

Commentary
Access rates for younger and adult Maori are above target. There is a discussion on the usefulness of this, because whilst it seems good ideally access would happen sooner and so be lower at specialist level of service delivery.

Access rates for total and specific population groups (proportion of the population using Mental Health and Addiction services in the last year) Pacific/child & youth/adult/older adult/population (all ethnicities)

Pacific

Group	Target	Actual	Performance
Age 0-19	No target	1.75%	Refer above
Age 20-64	No target	4.28%	Refer above
Age 65+	No target	2.47%	Refer above

Commentary
There are no targets for access for Pacific as these fit under the "other" category.

INTENSIVE ASSESSMENT AND TREATMENT: Measures

Measure	Target	Performance	Commentary
Quality-95% of long term clients(in the above population groups)have a Relapse Prevention Plan	95%	achieved	Relapse planning is a key part of recovery and social inclusion as it contributes to avoidance of readmission to inpatient units. ADHB performs consistently above target.
Quality- Alcohol and drug service waiting times and waiting list (Policy Priority 8)	There are no specific targets for 2011 to 2012 as this is a developmental output measure which was designed to inform the creation of future performance measures. These have since been introduced for 2012 to 2013 as described in the commentary.	The DHB reported information collected from NGOs and this provided longest wait time and service name for adult and youth services split by ethnicity – Maori and Other.	This target was introduced about a year ago and has been extremely difficult to implement and monitor. The Ministry have now moved this to include mental health and addiction services and at the same time now access this data through PRIMHD. This should provide a more consistent measure of the target and contribute to the possibility of wait time improvements. Targets for last year suffered from definition confusion and reporting variations and are therefore unreliable PRIMHD (pronounced 'primed') is a Ministry of Health single national mental health and addiction information collection of service activity and outcomes data for health consumers

REHABILITATION AND SUPPORT SERVICES: Measures

Rehabilitation and support services are delivered following a "needs assessment' process and coordination input by Needs Assessment and Service Coordination services. The NASC service arranges the services that support the patient, including palliative care services, home based support services and residential care.

Main Measure	Lift the health of Auckland
Initiatives	Use the InterRAI tool to ensure people who need home based support services receive them in a timely way Give those with complex needs priority access to home support services Provide timely access to home support services Provide timely access to assessment, treatment and support services for older people with complex health problems
Outputs	Home based support services
Impact	Older people with complex needs remain living in their home for longer Fewer people over 65 years presenting to Emergency Department Fewer people over 75 years admitted to hospital as a result of a fall Respite care available and improving quality of life
Outcome	People living as independently as possible Good quality of life for people who depend on support services

Measure	Target	Performance	Commentary
Total number of home-based support service hours	650,000	816,000 achieved	Equates to 4.15 hours on average per client week
Number of people 85 yrs and over supported in their own homes with complex package of care	660	898 achieved	The restorative Home Based Support Service model provides a responsive service that in conjunction with more flexible funding for respite care has enabled elderly complex clients to remain in their own homes.
Number of low-level clients self managing on support packages from key workers	150	2,611 achieved	Clients receiving home based support services are categorised as non-complex and complex, Currently non complex clients are 70% of the total 3,730 clients
Number of reassessments for clients receiving home-based support services	9,480	6,180 not	This number is an underestimate as the recording for complex clients only has the latest re-assessment.

REHABILITATION AND SUPPORT SERVICES: Measures

Main Measure	Lift the health of Auckland
Initiatives	Use the InterRAI tool to ensure people who need home based support services receive them in a timely way Give those with complex needs priority access to home support services Provide timely access to home support services Provide timely access to assessment, treatment and support services for older people with complex health problems
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Measure	**Target**	**Performance**	**Commentary**
Increase access to respite care	480 achieved	124 clients formal respite ; 75 clients flexible respite care; 92 clients dementia day care programmes; 1,320 claims for carer support (note will include some repeat claims for clients over quarters)	There has been a marked increase in the uptake of flexible packages of care in the last quarter as this new approach becomes well understood by both assessors and clients.
% of people over 65 years presenting to the Emergency Dept	24%	24%	The percentage of people over 65 years presenting at the Emergency Department is in line with expectations
% of people over 75 years of age hospitalised for falls	Non Specified	There were 1,471 patients over 75years of age admitted during the year to June as the result of falls. This is 7.6% of the total over 75 population of 19,290	We have a project team working with the Residential Care industry to reduce the number of falls. Data collection on falls and the causes is being collected in a standardised way. This will improve our understanding and show where we need to take action.
Quality-No of complaints received about home based support service providers.	Non specified	10.2 per month	Recording started in Feb 2012; 51 complaints were received up to June 2012

REHABILITATION AND SUPPORT SERVICES: Measures

Main Measure	Lift the health of Auckland
Initiatives	Access to subsidised beds is based on assessed need Contracted beds are available for people requiring long-term residential care
Outputs	Residential care services
Impact	Quality of life for those dependent on aged residential care Better management of chronic conditions for those aged 65 years and over Reduced no of falls and presentations to ED
Outcome	Support and protection for the ageing population

Measure	**Target**	**Performance**	**Commentary**
Quality of life for those in Aged Residential Care: No of complaints	25% reduction (cumulative)	10 complaints received Feb-June 2012	Complaints are now recorded on the monthly 'Health of Older People Scorecard,' this commenced in February 2012. A baseline for 2011/12 is not available.
Quality : 100% of residential care services meet required certification standards	100%	100% of residential care services meet the certification standards for varying terms(most3-4 years)	As part of the certification process, partially attained criteria are identified and must be actioned by the provider. These are followed up through surveillance audits and the ADHB quality facilitator.

REHABILITATION AND SUPPORT SERVICES: Measures

Main Measure	Lift the health of Auckland
Initiatives	Contract with hospice services to provide care Provide specialist palliative care services Fund home-based palliative care
Outputs	Specialist end of life care
Impact	Community based assistance provided to patients at end of life and to their families Reduced demand on hospitals
Outcome	Improve quality of life remaining for patients through information, co ordination and communication

Measure	**Target**	**Performance**	**Commentary**
Number of patients who die in their place of choice	None specified		"number of patients who die in their place of choice" Hospice provides us with reporting but nothing along these lines.
Number of palliative clients accessing primary care under the subsidised DHB/PHO partnership	Maintain at 150	195	195 clients did not exceed the contract budget

MINISTRY OF HEALTH
MANATŪ HAUORA

DHB	Shorter stays in Emergency Departments			Improved access to Elective Surgery			Shorter waits for Cancer Treatment Radiotherapy			Increased Immunisation			Better help for Smokers to Quit			More Heart and Diabetes Checks		
	2010 Q4 %	2011 Q4 %	2012 Q4 %	2010 Q4 %	2011 Q4 %	2012 Q4 %	2010 Q4 %	2011 Q4 %	2012 Q4 %	2010 Q4 %	2011 Q4 %	2012 Q4 %	2010 Q4 %	2011 Q4 %	2012 Q4 %	2010 Q4 %	2011 Q4 %	2012 Q4 %
Auckland	***80***	***95***	***95***	***104***	***100***	***100***	***100***	***100***	***100***	***87***	***92***	***95***	***49***	***79***	***93***	***65***	***69***	***48***
Bay of Plenty	84	90	89	100	104	105	100	100	100	76	87	91	51	77	94	64	72	62
Canterbury	92	96	87	109	97	102	97	99.5	100	91	90	91	57	71	90	64	66	20
Capital and Coast	80	74	87	102	103	100	100	100	100	89	91	94	44	97	96	69	73	53
Counties Manukau	97	97	97	106	108	111	100	100	100	86	90	95	59	86	93	69	74	52
Hawke's Bay	93	94	96	101	103	108	100	100	100	92	93	96	75	91	93	71	75	58
Hutt Valley	87	87	91	104	102	101	100	100	100	91	91	94	83	91	96	72	75	34
Lakes	88	89	89	105	111	121	100	100	100	87	89	94	57	100	99	67	72	56
MidCentral	84	87	90	96	106	106	100	100	100	89	92	95	53	85	91	74	77	42
Nelson Marlborough	98	97	98	105	100	103	97	100	100	89	87	87	52	90	96	66	69	50
Northland	86	90	95	118	119	115	100	100	100	77	83	84	55	93	94	70	73	54
South Canterbury	97	97	98	101	101	104	89	100	100	91	92	96	75	94	96	69	72	42
Southern	85	83	90	110	101	105	100	100	100	95	93	95	62	79	96	69	74	44
Tairawhiti	92	96	98	101	101	101	100	100	100	85	90	95	64	85	90	65	68	50
Taranaki	93	96	90	104	106	120	100	100	100	85	88	91	40	83	90	74	81	59
Waikato	83	89	92	105	102	107	100	100	100	86	91	92	62	81	89	66	73	57
Wairarapa	97	98	97	108	112	102	100	100	100	94	94	94	87	99	96	75	76	66
Waitemata	74	94	97	106	103	108	100	100	100	87	92	95	57	86	97	68	72	56
West Coast	100	100	100	100	107	110	100	100	100	85	84	78	57	83	90	69	72	57
Whanganui	94	91	98	108	116	108	100	100	100	87	89	91	42	97	97	70	80	61
Target	**95**	**95**	**95**	**100**	**100**	**100**	**100**	**100**	**100**	**85**	**90**	**95**	**80**	**90**	**95**	**n/a**	**n/a**	**60**
ADHB Rank	**=16**	**7**	**8**	**=11**	**=18**	**=11**	**=1**	**=1**	**=1**	**=10**	**=4**	**=3**	**=17**	**=17**	**=12**	**=17**	**=17**	**15**

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 2012

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 31 to 87, that comprise the statement of financial position as at 30 June 2012, the statement of financial performance, 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 of the Health Board and group on pages 88 to 130.

Opinion

In our opinion:

- the financial statements of the Health Board and group on pages 31 to 87:
    - comply with generally accepted accounting practice in New Zealand; and
    - fairly reflect the Health Board and group's:
        - financial position as at 30 June 2012; 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 88 to 130:
    - 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 2012, 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 16 November 2012. 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, we have no relationship with or interests in the Health Board or any of its subsidiaries.

John Scott
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand