Auckland District Health Board **Annual Report 2012 | 2013**

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

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CHAIRMAN'S FOREWORD

Auckland District Health Board is one of the largest and most dynamic publicly funded health systems is Australasia. For board members, the very significant responsibilities inherent to our roles are carried with a sense of privilege in giving public service coupled with a real admiration at what can be achieved by the concerted efforts of so many talented and dedicated health professionals and support staff. In approving this Annual Report, the board thanks each and every member of staff for their commitment and hard work on behalf of our patients and population.

We are also always aware of our national responsibilities, as our patients are not only Aucklanders residing in our district. We treat or fund treatment for thousands more New Zealanders from all across the country. Maintaining a clear sense of where we fit in the national health picture is important, particularly when we consider the strategic challenges the board is engaged with. One – the financial and demographic challenge – has a reality and complexity that cannot be overstated. If one considers that the current growth in costs is increasing at two and a half times the increase in funding, you can clearly sense the scale of that challenge.

I have said elsewhere that our challenge is to more thoughtfully, more carefully and with greater discipline control our costs, particularly in the provider arm of the organisation. As the Health Budget showed with its allocation of increases to existing or emerging needs, efficient allocation of resources must often break from the traditional model. Often, in the past, this has been to pour the majority of new resources into hospitals, rather than into the community.

The board requires the organisation to ensure it has the same focus on efficient allocation of funding to ensure there is a very significant uplift in performance to meet rising health needs. We are well beyond the point of simply providing services in the same way that we have in the past. While the board is pleased with the achievements of the past year it would misrepresent the case to say we are satisfied. There are plenty of ideas and now we need to match them with a real commitment to change linked to an enhanced capacity for implementation.

Capacity development remained a continuing focus over the year we report on here. We proceeded at pace with the renewal of the senior executive team, appointing an experienced and capable new chief executive, Ailsa Claire. The Board has considerable confidence that the required acceleration in the change in mind-set and culture is underway with new leaders in finance, allied health, nursing, funding, strategy and planning. While these new appointments range across different professional disciplines, they have much in common, in particular, clinical leadership experience and capability. The members of the renewed leadership team are themselves already doing much in renewing the ranks reporting to them and in practical, productive collaboration with providers. Similar efforts working with health and social sector leaders in Auckland to seek out opportunity on behalf of our population are pleasing to see.

While collaboration with partners has improved, notably with regards to PHOs in working more efficiently to achieve national health targets, there is much more to do, although it is important to recognise the excellent achievement of PHOs in achieving the community CVD target during the current year. This is particularly so in collaborating more closely with Waitematā DHB. Consider the Albany resident who stumbles and injures themselves while shopping in Newmarket. They care nothing for which DHB provides the service, only that they get the very best care, as close to their home and in the most convenient method as is possible. Too much time and energy continues to be spent on fruitless debates as to the 'rules' of who should be funding what and where.

The same might be said for greater regionalisation. There are promising signs, however, in the form of safety and quality campaigns that have reduced the harm experienced by patients in the care of publicly-funded facilities across the region. In particular, the Board was pleased to see data which showed Auckland DHB exceeding the Health Quality and Safety Commission's quality marker for hand hygiene and reducing to zero the number of grade three and four pressure injuries.

Another sign of headway is the better integration of services we fund and which are provided by primary care, non-governmental and community organisations. In June, the Board endorsed a revised PHO Services Agreement that took effect on 1 July 2013 and brought in new clauses to assist PHOs in clarifying aspects of after-hours and holiday cover. All are essential if we are to be true to our patient-centred word. That same month saw the completion of child and adolescent oral health's reconfiguration, when the last of 14 new on-site and six mobile dental clinics across Auckland was established at the Greenlane Clinical Centre campus.

District health boards are big ships to turn around and after three years of this board's tenure, I am pleased to report very good signs of progress. We are starting to navigate our way to a new future.

None of this or numerous other achievements would be possible without the hard work of a great many individuals, groups and organisations - a number too great to detail here. However two (the Starship Foundation and A+ Trust), must be acknowledged. Their fund-raising and sponsorship efforts are strategic and ambitious, and projects such as Starship's Level 6 refurbishment and the Trust's scholarship programme are deeply appreciated by the board.

I thank the board for their efforts in what has been a demanding year. All members' terms finish in early December of this year and whether or not they depart or return, each is owed a public debt of gratitude for their services rendered. I finish by adding my personal thanks, wish all members and staff well and commend this Annual Report to the Minister, Hon Tony Ryall.

Dr Lester Levy CNZM

Chair

Auckland District Health Board

CHIEF EXECUTIVE'S FOREWORD

It's been 10 months since I took up the role of chief executive at Auckland District Health Board. As I reflect on that period, I want to first thank you all for your welcome and the support I have received. I acknowledge how much it helped in adapting to the New Zealand health system after so long away.

Thanks are also owed to those who covered the chief executive's role and kept the wheels on the bus during a time of some difficulty. I recognise it is not easy for an organisation when a significant number of the leadership team change and so I acknowledge those who stepped up.

In looking back over those 10 months in preparing to write this foreword, I realised I wanted to touch on why I came to work here. I saw an organisation with a reputation for excellence and achievement. I also saw that the Board was initiating changes to meet the challenges of rising demand and expectations, costly technological and medical advances and limitations on financial growth. I felt there was a real opportunity to work with the people who make Auckland DHB great, to add my experience into the mix as we move to a place where we not only cope with the challenges, but excel.

Since taking up the post many of my perceptions of excellence and achievement have been confirmed. I also have found an organisation full of skilled people committed to doing the right thing for our diverse mix of patients and the very community that gives Auckland DHB its 'license to operate'. While we are a complex organisation with international, national and regional commitments, it's that local population who are at the core of our reason for being. We are here to support the population of Auckland to maximise their well-being while also delivering safe, effective and sustainable services to them and the rest of New Zealand. Yet in many ways the provision of those services - especially tertiary services in the hospital setting - has dominated the organisation. Our focus on that local population has perhaps not been as sharp as it should be. In reality, this is where we must tighten our focus if we are to see true health gain while we build a more sustainable DHB.

I have seen examples of the type of work that will put us on that sustainable footing - co-design with patients and support for self-directed care are two - but to my mind it should be more systematic. Embedded in everything we do, in fact. This means, for example, that we need to rethink the level of community services that are needed to truly provide the support people need. I believe that we are funding many more people in residential homes or through hospital-based activity than would be the case if we had a more focused, population-based approach.

One of the key pieces of work we have been doing is to develop partnerships with PHOs and community providers. These are the building blocks for the locality-based frameworks in which we will develop self-directed, whanau-directed care and the primary and community services we need to support Auckland residents to maximise their health and well-being. I have been very pleased with the response to this work and the strength of the alliances which are developing.

Within the organisation, one of my early concerns was a confused management structure which clouded accountability. We are, I believe, an unnecessarily bureaucratic and rules-based organisation. And to what effect? The strong innovation and improvement approaches I could see were frustrated by the complexity of getting things done and staff desire to change was being stifled.

Another surprise was that while we acknowledged clinical leadership, we did not properly support this in training or infrastructure. The first thing we need to do is sort out accountability and embed clinical leadership at the heart of these changes. Why is clinical leadership so important? Because of the opportunities it presents when embraced in its entirety. This means not only heads of the large medical or nursing divisions in big health systems such as ours; it means frontline clinicians as well. Recent policy shifts around the world toward population accountability, global budgets, value-based purchasing and outcome measurement put a premium on teamwork and thus on frontline clinical leadership.

Similarly, I found Auckland DHB to be an organisation where a significant number of the underpinning systems were unstable. In response, our emphasis was a 'steady the ship' approach - stabilise the organisation sufficiently for us to move forward.

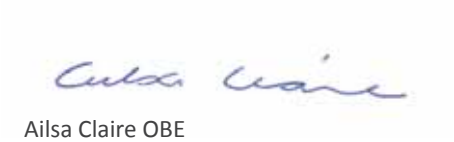
So what's the plan now? Develop a clear organisation and system-wide strategy. This will both support and develop our population to maximise their well-being. It will deliver safe, cost-effective services to them and the rest of New Zealand. By doing the right thing for patients we will deliver on this strategy, achieve quality indicators (including national targets) and ensure that we live within our means. We cannot do this alone. The partnerships we form with patients, communities and other organisations will be critical – hence the work on locality-based frameworks noted earlier.

I hope that people have felt that I am trying to develop an open and transparent style of leadership, personally and organisationally. Change, in my book, is an iterative approach involving staff, patients and management/leadership as co-producers. I have also been focusing on our accountability to the population not only for the decisions we make, but also for safe and effective services. We can only discharge this accountability if we know what is important to patients and to our funders and also how we would assess ourselves as achieving the quality we are striving for. Achieving targets set by others gives us earned autonomy and an opportunity to demonstrate excellence. Achieving targets set by patients and ourselves gives us confidence and assurance.

Thus the plan is reasonably simple:

- continue to stabilise the organisation
- develop the strategy
- work in partnership
- measure and be accountable for what we do
- achieve the plan through strengthened clinical leadership, alliances, clear accountability and transparency.

So after 10 months, some highs and some lows, I take some satisfaction in celebrating the year's successes as set out in this annual report. We have the talent and scale to really soar. I encourage our talented staff and dedicated partners to share ideas and, more importantly, tell us what is preventing you from making change.



Ailsa Claire OBE

Chief Executive

Auckland District Health Board

We are a diverse population

8% Māori; 11% Pacific People; 31% Asian; 50% Others (being comprised of 34% NZ European; 10% Other European; 5% New Zealanders and 1% Middle Eastern, Latin American, African)*.

**This data is extracted from the 2006 total response adjusted to the 2013/14 population. The 2013 Census data is not yet available.*

DISTRICT SNAPSHOT

Auckland City Hospital is New Zealand's largest public hospital as well as the largest clinical research facility. There are approximately one million patient contacts each year, including local hospital and outpatient services.

We have three major facilities: Auckland City Hospital in Grafton, Greenlane Clinical Centre and the Buchanan Rehabilitation Centre in Pt Chevalier.

We have approximately 10,000 staff employed in providing health and medical services which equates to a little over 8,000 full-time equivalent positions (FTE) and we manage a budget of approximately one billion dollars.

More than half the work done within Auckland DHB hospitals is for people who live outside Auckland city.

Locally we provide emergency, medical, surgical, maternity, community health and mental health services. Some specialist services are provided for people in the Northern, Midland and Central regions.
These include: organ transplant (heart, lung and liver), specialist paediatric services, epilepsy surgery and high-risk obstetrics.

The hospital has the largest elective surgery delivery system in New Zealand with 22,000 elective discharges, approximately 52% of which are for other DHB populations.

MISSION

Our Vision

A healthy local population, and quality health service across the continuum when people need it – Healthy Communities, Quality Healthcare
Hei Oranga Tika mo te iti me te Rahi.

Our Mission

To deliver the right care, at the right time, in the right way.

Our organisational values

Integrity, Respect, Innovation, Effectiveness
Kia u ki te tika me te pono.

Integrity We are open, fair, honest and transparent in everything we do.

Respect We care about and will be responsive to the needs of our diverse people and communities.

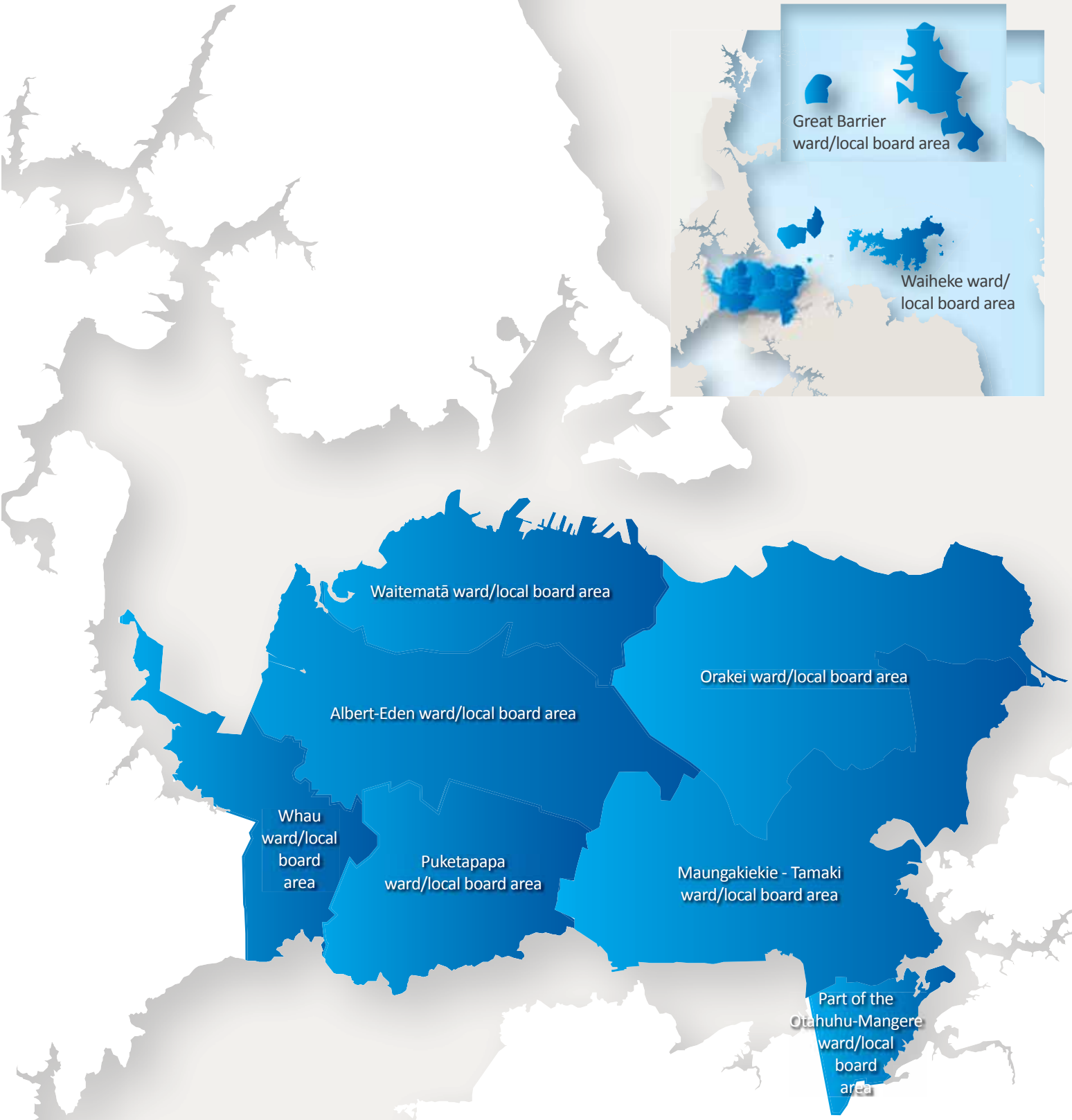
Innovation We will provide an environment where people can challenge current processes and generate new ways of learning and working.

Effectiveness We will apply our learning and resources to achieve better outcomes.

Three goals focus our decisions and actions:

1. Lift the health of people in the Auckland DHB area
2. Lead performance improvement
3. Live within our means

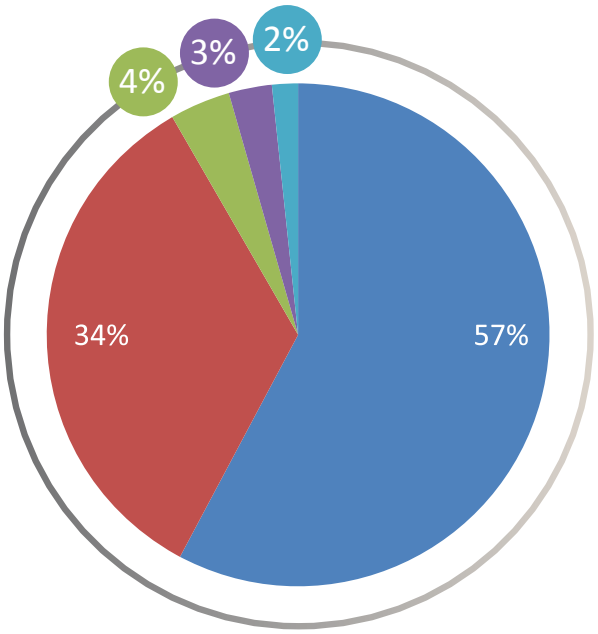
These goals align with the triple aim in the Northern Region Health Service Plan. They help us focus on distinct streams of work, all important in meeting our statutory and government policy responsibilities. Performance measures help us track progress in each area so that we know where we are making a difference and where we need to improve.



THE AUCKLAND DHB DISTRICT

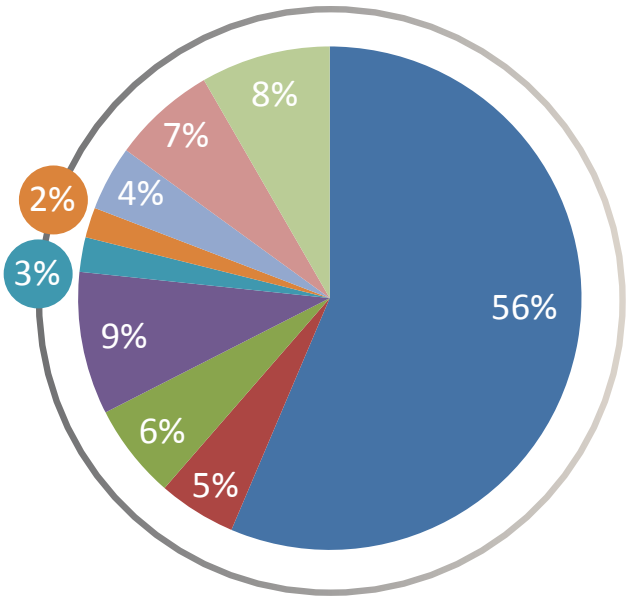
HOW WE ALLOCATE OUR FUNDING

Where did the money come from?



- Ministry of Health
- Inter District Flow - inflow
- Clinical Training Agency, Accident Compensation Corporation
- National Services
- Other Income

What was it spent on?



- Auckland DHB own hospital
- Inter District Flow - outflows
- Community Pharmacies
- Primary Care
- Non-governmental Organisations
- Mental Health (Non-governmental Health Organisations)
- Community Laboratories
- Health of older people
- Other

KEY FACTS AND FIGURES 2012/2013

Community Services

- 5082 (5609 in 2012) people were assessed for Home Based Support Services.
- Community Nurses made 95,400 home visits (73,758 in 2012).
- There were 7613 babies born (7759 in 2011/12).
- 234,143 school dental treatments were given to children in Auckland DHB. This compares with Waitematā DHB 206,482 & Counties Manukau DHB 253,776.
- Auckland DHB vaccinated 63,369 (63,604 in 2011/12) children under six years of age.
- 16,723 women aged 50 to 69 years living in Auckland DHB area were screened by BreastScreen Aotearoa (14,213 in 2012).
- Auckland DHB provided free diabetes checks to 63% of its target population, against a target of 60%. (66% of Māori and 82% of Pacific people received diabetes checks). In 2012 we also achieved 60% of the target for diabetes checks, (60% of Māori and 68% of Pacific people).
- Auckland DHB saw 19,896 (17,974 in 2012) mental health clients. There were 12,301 mental health home visits in 2013.
- Auckland DHB subsidised the cost of aged residential care for approximately 3670 people (3589 in 2012).
- Auckland DHB subsidised 138 GP practices (137 in 2012).
- There were 4,698,175 items prescribed by GPs for patients living in the Auckland DHB area (4,529,820 in 2012).

Hospital services

- Our hospitals provide 1,021 general beds, 144 mental health beds, 113 intensive care and high dependency beds, and 28 rehabilitation beds. There are 39 operating theatres and four cardiac investigation rooms.
- There were 334,500 (321,000 in 2012) attendances at outpatient clinics, of which 54% were Auckland DHB residents, 25% were Waitematā DHB residents, 14% were Counties Manukau DHB residents and 6% were from the rest of New Zealand.
- The adult Emergency Department had 55,600 (54,000 in 2012) visits, of which 82% were Auckland DHB residents. The Starship Children's ED department had 31,000 (30,000 in 2012) visits, of which 97% were Auckland DHB residents, 26% were Waitematā DHB residents and 10% were Counties Manukau DHB residents.
- There were 79,500 (76,500 in 2012) patient discharges from our medical specialties, of which 66% were for Auckland DHB's residents.
- Surgeons performed 20,200 (19,800 in 2012) elective surgeries, of which 52% were for Auckland DHB's residents, 26% were for Waitematā residents, 12% for Counties Manukau residents and the remaining 10% for patients from other parts of New Zealand.
- There were 25,500 (25,400 in 2012) acute surgical discharges from our hospitals.

2012/13 HIGHLIGHTS AND ACHIEVEMENTS

2012/2013

Achieved five national health targets

- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit
- More Heart and Diabetes Checks

2012

JUL

- Auckland DHB receives Gen-i Public Sector Excellence Award for the 'Blood is a Gift' project in Improving Value Through Business Transformation category.
- Completed building 14 on-site and six mobile dental health clinics throughout the Auckland region; a $10.4m investment in children's and adolescent oral health.
- Key leadership positions take up roles as part of changes in Auckland DHB: Margaret Dotchin – Executive Director of Nursing, Sue Waters – Executive Director Allied Health Scientific and Technical, Karin Drummond – General Manager Women's Health.
- Major refurbishment to Buchanan Mental Health facility in Point Chevalier.

AUG

- More than $550,000 raised in Dry July. fundraising campaign.
- Diabetes self management courses began and ran throughout the year. Also offered in Samoan, Mandarin, Cantonese and Hindi.

SEPT

- Totara Ward opens at Greenlane Clinical Centre, providing care for Ophthalmology patients and adult patients from other surgical services.
- Auckland DHB recognised by Minister of Health for providing more elective surgery for patients and reducing waiting times.

OCT

- Ailsa Claire starts as Chief Executive, Auckland DHB.

NOV

- Dr Sue Fleming appointed as Medical Director, National Women's Health.
- Auckland DHB is the first New Zealand DHB to introduce a free online self-help service aimed at improving emotional well-being for people in need.
- Starship Children's Hospital celebrated 21 years.

DEC

- NZ Heart and Lung Transplant Service celebrated 25 years. More than 250 heart transplant operations performed over this time.
- 6.5 million dollar upgrade to Level 6, Starship Children's Hospital gets underway.

2013

JAN

- Local Heroes begins. The staff-nominated award scheme for Auckland DHB staff who go above and beyond to provide the best possible care for our patients and their families begins.

FEB

- One-off manual audit carried out as part of a range of interventions to prevent our patients from falling.
- Project launches with focus on educating pregnant women and their carers about the importance of maintaining good iron levels during pregnancy.

MAR

- Planning begins for transition of community-referred laboratory services.
- Joint Auckland and Waitematā Child Health improvement plan is published.

APR

- Pasifika Week at Auckland DHB.
- Pilot for Lead Patient Support Person project begins in some wards.

MAY

- Professor Stephen Munn appointed convenor of the NZ Health Innovations Hub's Health Services and Clinical Advisory Group.
- Free Heart Health Checks offered to all staff who work or are contracted by Auckland DHB. 543 staff were screened.

JUN

- New Assessment to Discharge planner introduced
- Forty-two churches in Auckland participate in the Healthy Village Action Zone (HVAZ) Nutrition Awards.

PATIENT FEEDBACK

I would like to thank, from the bottom of my heart, Mr McIvor, Mr Patel and his wonderful and dedicated team for the success of my operation and the amazing kindness and understanding I have received from all the people concerned with my care. Their dedicated care resulted in my early discharge. I am now going ahead with radiation therapy... With their [doctors and nurses] encouragement and caring, I now feel I shall get through this journey and hopefully see light at the end of the tunnel.

Patient of Ward 74 and Radiation Therapy

I am compelled to write to tell you about the excellent care we had when I took my husband to the Accident and Emergency Department. The care he received was brilliant. My husband was acutely unwell when he arrived at 7.30am. He underwent a range of tests and was diagnosed with a pulmonary embolism by lunchtime! So very well done – we are so grateful that things were managed so professionally and that he is on the road to recovery.

Wife of an Emergency Department patient

Your hospital is, in my opinion, a world-leader in patient care. The care given to me in Ward 42 was excellent and the surgical procedure carried out by Mr Alison and his team was brilliant...Thank you and your staff for taking the time and effort to do a difficult job so professionally.

Patient of Ward 42

I just wanted to thank the team of nurses, physiotherapists and supporter/helpers from Ward 77 who looked after me. Thank you for all the care and patience you provided. I haven't been in a hospital for over 50 years and the experience at Auckland City Hospital Ward 77 was just amazing and helped me in my recovery. I am walking every day now!

Patient of Ward 77

Well done and thank you to the wonderful paediatric emergency staff. I had to bring my six-year-old son in following a fall on Sunday and every staff member we encountered was helpful, friendly, patient and comforting. Every step of the way I felt informed and that my son was receiving the best care possible.

Mother of a patient seen by the Children's Emergency Department

Auckland DHB attendance at board and committee meetings: July 2012 – June 2013

The next Auckland DHB Board elections will be held in October 2013

Board Member	Board 8 Mtgs	HAC 8 Mtgs	Audit and Finance 8 Mtgs	CPHAC 8 Mtgs	DiSAC 4 Mtgs	MHGAC 4 Mtgs
 Dr Lester Levy , CNZM	7	6	7	6*	*	*
 Dr Lee Mathias, ONZM	8	8	8	8	X	1
 Jo Agnew	8	8	X	7	4	X
 Peter Aitken	7	7	8	5	X	X
 Judith Bassett, QSO	7	6	X	8	X	X
 Susan Buckland	7	7	X	6	4	X
 Dr Chris Chambers	8	8	X	7	X	2
 Robin Cooper	5	4	X	2	X	2
 Robyn Northey	7	7	8	7	4	4
 Gwen Tepania-Palmer	8	8	8	5	X	4
 Ian Ward	7	7	6	X	X	X

Note: Attendance at committee meetings is only shown for members of the committees. Additionally, some Board members attend some meetings of committees of which they are not members.

x = not a member of committee ** Ex -Officio member*

GOOD EMPLOYER OBLIGATIONS REPORT 2012/13

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

The Auckland DHB Human Resource Department's Vision 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 Auckland DHB now and into the future."

Auckland DHB 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, Auckland DHB continues to promote and protect the welfare and management of employees to the mutual benefit of employees, consumers and the organisation.

Auckland DHB 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 Auckland DHB 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 an organisational culture where everyone is given the opportunity to contribute to the way the organisation evolves and adapts to change. Auckland DHB'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.

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

Auckland DHB 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 Māori development, health and wellbeing. Auckland DHB's commitment to the development of Māori health is reinforced by its Māori Health department, with a General Manager who sits on the DHB's Senior Leadership Team. He Kamaka Oranga, the Māori Health team is responsible for policy development, planning and funding, provider management, quality, and clinical leadership across the primary, secondary and tertiary sectors. Auckland DHB's Chief Advisor-Tikanga leads the organisation in managing relationships with manawhenua and Iwi Māori from a Tikanga perspective.

Auckland DHB 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).

The Auckland DHB is dedicated to providing a healthy and safe workplace for all employees, students, volunteers and contractors whilst they are at the Auckland DHB workplace for the purpose of Auckland DHB work and to patients and visitors in relation to safe use of the facilities. Auckland DHB 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

Auckland DHB 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 2012/13

Leadership accountability & culture	• Clinical/managerial partnership. • Auckland DHB Welcome Day for all new staff. • Multidisciplinary involvement in service planning. • Nova Magazine newsletter for staff; hard copy each month and a weekly electronic version. • 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. • Work experience days. • Careers Centre website accessible internally & externally. • Candidate and hiring manager satisfaction surveys. • Internal promotion of vacancies via eNova link and Auckland DHB's Intranet site. • Participating in the Ministry of Social Development's Mainstream Programme – to get people with disabilities into work. • Preference programme for Māori and Pacific graduate nurses. • Rangatahi Programme: This programme supports Māori and Pacific people workforce development by seeking to: • *Grow, develop, recruit and retain Māori and Pacific people in the health and disability sector in the Auckland DHB region.* • *Provide options and support in the pursuit of health careers.* • *Ensure Rangatahi Māori and Pacific people achieve their career potentials.* The purpose of the Programme is to actively attract Rangatahi Māori and Pacific people into the health workforce by removing barriers to entry. The Programme has two essential components, the first supporting Rangatahi Māori and Pacific people 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, and another eight graduates completed at the end of 2012.
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.
Flexibility & work design	• Flexible rostering practices subject to clinical requirements. • Staff Crèche on each of the two major sites.

Remuneration recognition & conditions	• Local Heroes awards – peer and patient/family recognition of individuals or teams living the organisational values.
	• Healthcare Excellence Awards to publicly 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 encouraged to apply. The categories for the Awards are:
	  • *clinical*
	  • *research*
	  • *education*
	  • *process and systems improvement.*
	• Staff benefits with external providers.
	• 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. • Anti-bullying and anti-harassment coaching seminars are 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	• Up until 2012 Auckland DHB has had a well established network of 269 Health & Safety representatives who represent their colleagues in matters relating to Health & Safety in the workplace. Some of that work and initiatives include: • ACC Partnership Programme - Tertiary accredited • GM lead Health & Safety committees, which also include Māori, Pacific Island, Auckland Regional Public Health, internal clinical Health & Safety representatives • Support material available for staff and managers to understand and manage workplace stress • Free work-related Occupational Health assessments for staff • Workstation assessments • Work area safety checks

Safe and healthy environment	From 2012 the focus has expanded from workplace auditing and hazard identification to include Workplace Wellness, and there is a focus on the Health & Safety Representatives to be 'Wellness Champions' as well as safety champions. Furthermore, Auckland DHB has a number of initiatives in place to ensure Auckland DHB is a healthy workplace, including Nutrition, Physical Activity, Smoke Free, and Workplace Wellbeing, as outlined on the following page.

Nutrition	• Nutrition criteria on Auckland DHB leased space, comprising of generic criteria (e.g. no full sugar soft drinks, no deep fried food) and tailored criteria based on the food and beverages the vendor sells. Criteria are included in all new leases and existing leases when they come up for renewal.
	• As part of a review of the staff breastfeeding policy, new physical facilities were identified and equipment purchased and promoted to staff.
	• Staff cafeteria improvements include:
	  • *Promoting the sale of fresh fruit and freshly made wraps and panini (healthy content made on site), and reducing pies and pastry goods and the portion sizes of cakes, scones, and slices.*
	  • *Removal of confectionary, potato chips and other high calorie snacks.*
	  • *Removal of high sugar content beverages, and no carbonated sweetened drinks, full fat milk drinks or large volume sports beverages are sold in vending machines.*
	  • *Sandwiches with no butter option are available at one of the staff cafes.*
	  • *All café recipes are analysed and modified to reduce salt, sugars and saturated fat.*
	  • *Nutrition information is provided for staff on the intranet site called Eat Well and Feel Great.*
	  • *Health and nutrition poster promotions are ongoing.*

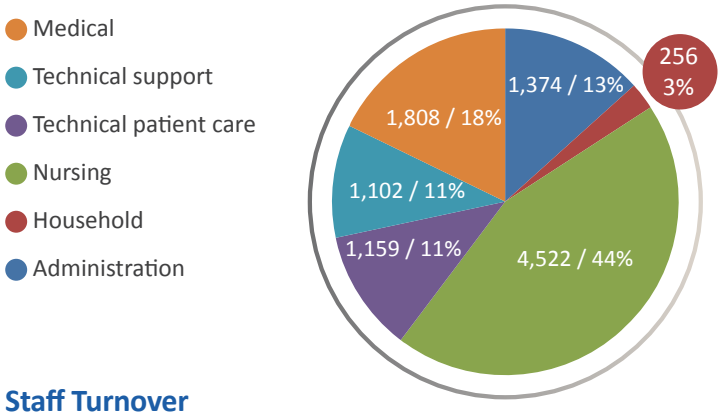
Physical Activity	• Free bike hire - an initiative between Auckland DHB and Auckland Transport started in March 2013. • Yoga classes. • Pilates classes. • Feet Beat continues, with 33 Auckland DHB teams participating in 2012, which is up from 27 in the previous year. • Health matters site "Be Active" is in place and was designed specifically to align with mental and physical wellness themes as important to Auckland DHB staff and families (updated at least monthly). • Staff benefits – discounts on gym memberships and other healthy living activities.
Smoke Free	• "Quit Now" stand – smoke free services run a Quit Now stand in the foyer of the Auckland City Hospital providing support. • A two storey banner promoting smoke free and providing contact information for those wanting to quit was installed in a mezzanine area in the Auckland City Hospital. • A permanent stand containing quit information is located at the foyer of the main entrance of the Auckland City Hospital. • Smoking cessation services at Auckland DHB's Welcome Day orientation for all new employees including presentation from the Smoke Free team. • Smoke free grounds remain ongoing. • Annual promotion of World Smoke Free Day, where staff are encouraged to quit. • In-house smoking cessation support for staff. • Information is available for staff to access on the intranet.
Workplace Wellbeing Initiatives	• Free heart health checks to all eligible staff. • Domestic violence-free programme available to staff. • Influenza vaccine programme for staff. • Independent employee assistance programme for staff. • Information provided to staff about shift and night work and healthy sleep, among other health related information.

In addition to above, the Auckland DHB promotes external initiatives to staff, such as such as Push Play, the YMCA Walk/Run series, 5+A Day, World Diabetes Day, White Ribbon, Safety NZ Week (ACC), and Sun Smart Week.

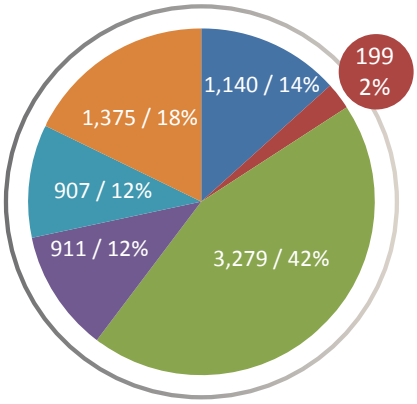
WORKFORCE DEMOGRAPHICS

The pie charts below show how employees are distributed across the different occupational groups at the Auckland DHB. The largest occupational group is nursing with 4,522 employees comprising approximately 3,279 Full Time Equivalents (making up 44% and 42% of the overall Auckland DHB respectively). The entire Auckland DHB is comprised of just over 10,000 employees and 7,800 FTE.

Total number of Employees by Occupational Group



Total FTE by Occupational Group

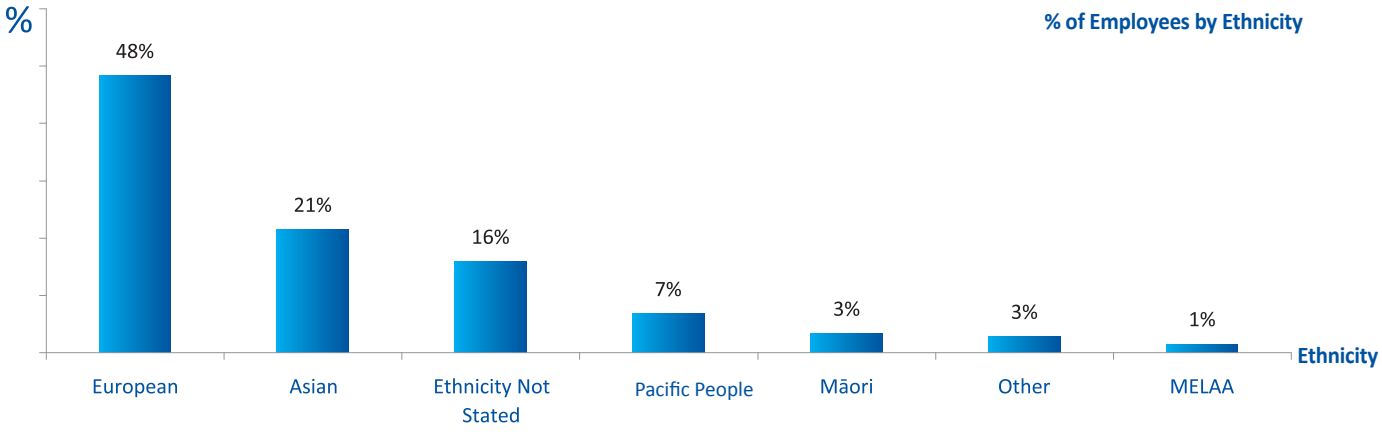


Staff Turnover

The Auckland DHB has had a stable staff turnover for the past year. Voluntary turnover for the year ended 30th June 2013 was 9.5%, which is approximately the same as the previous year.

Employee Diversity

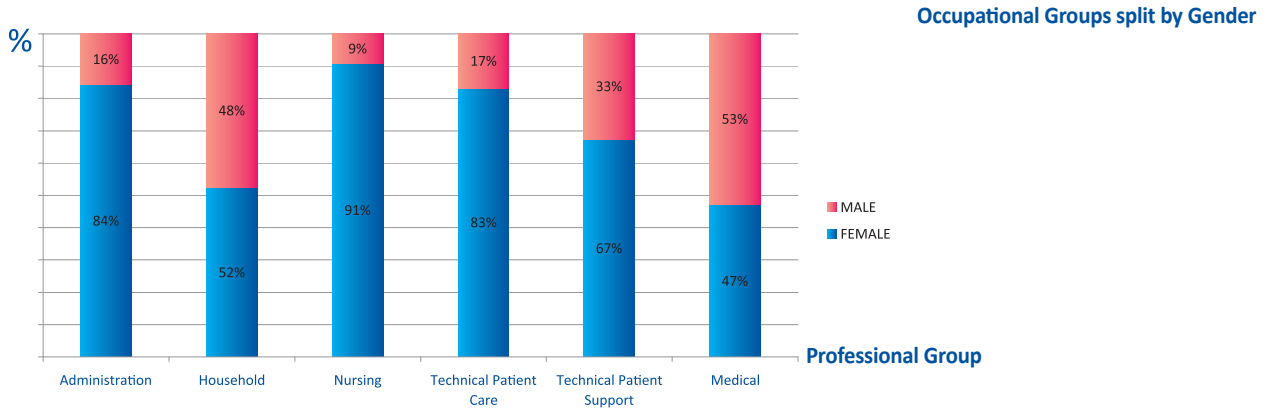
Staff are asked to disclose ethnicities on appointment and approximately 16% of employees choose not to. Many employees have a diverse ethnic background and believe it would be disrespectful to identify with one ethnic group over another. The graph below shows all the ethnic groups that compose 1% or greater of our workforce.



* MELAA is a group amalgamation of Middle Eastern, Latin American and African ethnicities

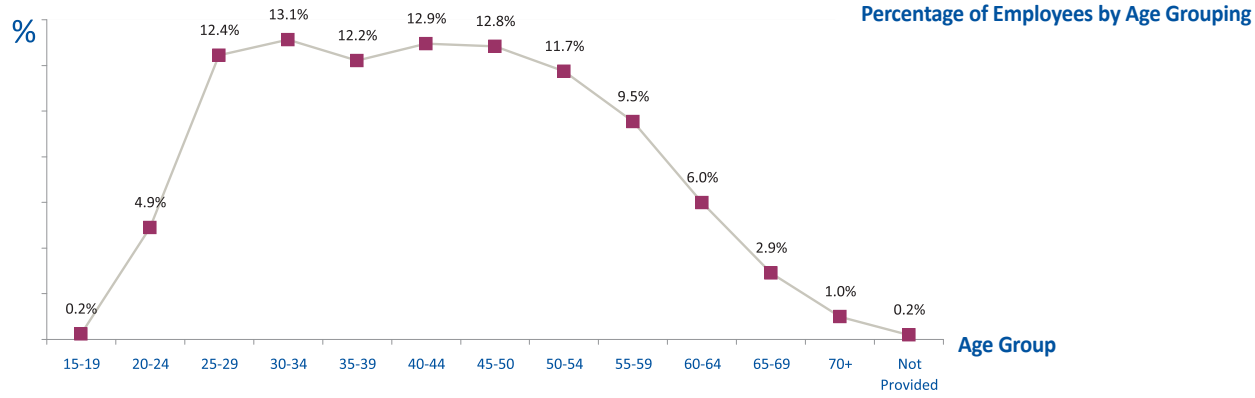
Gender

The Occupational Groups Split by Gender chart below shows the varying gender differences according to occupational groups at the Auckland DHB. Females account for around 78% of employees. A number of techniques are used to support pay and employment equity, such as job evaluation for Nursing and Individual Employment Agreements for employees to determine the internal relativity of positions (and in the case of all IEA positions the job sizes are based on a method that meets the NZ standard of gender neutrality and 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.



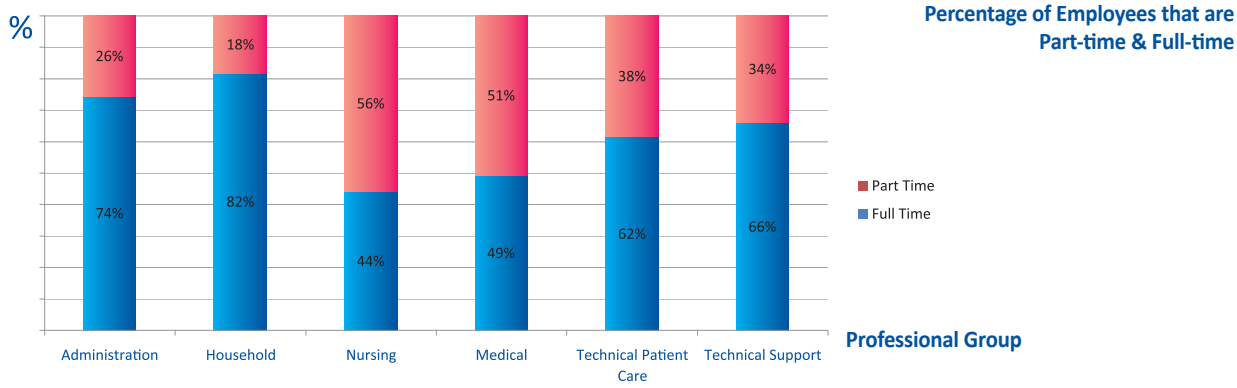
Age of Workforce

The Percentage of Employees by Age chart below shows a mild skew, although relatively closely 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 Percentage of Employees that are Part-time & Full-time chart below shows the majority of employees are permanently employed (at around 55%, with approximately 45% 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 Auckland DHB for the past five years has remained relatively stable, although Medical has increased its part-time staff from 31% to 51%.



STATEMENT OF SERVICE PERFORMANCE

OVERVIEW

The Statement of Service Performance (SSP) presents a snapshot of the services provided for our population, across the continuum of care. The SSP is grouped into four output classes (refer table below). The four Output Classes assist DHBs to convey their performance story in relation to the health services provided to their population recognising the funding received, Government priorities, national decision-making and Board priorities. Each output class section includes measures which help to evaluate the DHB's performance over time. These include the health targets reported on at page 25.

Output Class	Description
Prevention services	Prevention services are publicly-funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.
Early detection and management	Services provided in the community by general practitioners, pharmacists, district nurses, Plunket and many others. These services are preventative and treatment services focused on individuals and smaller groups of individuals.
Intensive assessment and treatment	Specialist services delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are at the complex end of treatment services and focused on individuals.
Rehabilitation and support services	Rehabilitation and support services are delivered to people with long-term disabilities, people with mental health conditions and people who have age-related disabilities. These services encompass home-based support services, residential care support services, day services and palliative care services.

The DHB's planning and funding function is responsible for planning, promoting and undertaking service contracting with organisations including our own hospital services.

Planning and funding staff work with Healthcare Service Groups within the provider arm to make sure the allocation of funding meets our population's health needs and that our patients receive Better, Sooner, More Convenient services.

While some community services are provided through our provider arm (A+ Links Home Health Care, Rehab Plus, community mental health services, community child health and disability services), we also contract with non-government organisations (NGOs) to provide health and disability support services for people living in the Auckland DHB area.

Some services are covered by a regional contract and therefore cover people living across the wider Auckland region e.g. some general practice work, and supported accommodation for people with severe mental illness. Laboratories, Community Pharmacies, and Health of Older People are also funded by the Auckland DHB.

The funder also has alliance arrangements with three primary care partners in order to develop primary healthcare:

- Greater Auckland Integrated Health Network (GAIHN) covers over one million enrolled people across 4 PHOs within the greater Auckland region
- Alliance Health+ is a Pacific-led PHO working across Counties Manukau DHB and Auckland DHB
- National Hauora Coalition is a North Island consortium of PHOs focused on Whanau Ora and high needs populations

Criteria	Rating
>20% away from target	Not achieved
9-20% away from target	Partly achieved
0.01-9% away from target	Substantially achieved
On target or better	Achieved

Where a measure is made up of multiple components, each with its own target, an average has been applied to determine performance. The following diagram presents the overall framework - illustrating the relationship between national and Board priorities, impacts sought and measures used to assess performance which are included in the SSP.

Vision	**Healthy communities , quality healthcare** – *Hei Oranga Tika, mo te iti me te Rahi*		
Government Policy	**Better, sooner, more convenient health services**		
Northern Region Goals	Population Health *Adding to and increasing the productive life of people in the northern region*	Patient Experience *Aiming for zero patient harm and performance improvement*	Cost/Productivity *The region's health resources are efficiently and sustainably managed to meet present and future health needs*
Joint Auckland DHB & Waitematā DHB Goals	**Improved population health**	**Improved patient safety and experience**	**Improved financial performance and productivity**

Priority Populations and Services						
Child Health	Youth Health	Māori Health	Pacific Health	Mental Health	Refugee and New Migrant Health	Renal and Respiratory Services

Impacts	• Improved life expectancy • Fewer admissions for falls of older people • Prevention of illness and fewer acute episodes • Prompt recovery from acute mental illness • Prompt diagnosis of acute chronic conditions • Restoration or maintenance of functional independence • Good access to effective pharmaceutical treatments • Effective and prompt resolution of medical and surgical emergencies and acute conditions • Increased survival/reduced mortality from common cancers • Management and cure of treatable conditions • Improved oral health of children and young people, with a reduction in ethnic inequalities • Improved acute and chronic care of older people • Maximising functional independence and quality of life for older people • Reduced mortality • Healthier children • Improved overall oral health	• Satisfactory waiting times for our services • Improved patient experience • Prevention of mental illness relapses • Fewer adverse clinical events • Improved engagement by our community – including Māori, Pacific and Asian peoples – with our health services • Improved engagement of clinicians and other health professionals • Improved quality of life due to surgical intervention • Improved emergency care • Patients less likely to be readmitted • Social integration and improved quality of life • Quality of life for those dependent on aged residential care • Increased life expectancy • Improved quality of life for patients with life-threatening illness (and for their families)	• Reduced demand on specialist outpatient appointments • Minimising unnecessary use of high cost secondary care • Lower per capita out-of-pocket and total expenditure on pharmaceuticals • Prevention of illness • More services delivered in primary care and community-based settings • Prudent financial management
Key Impact Measures	• Smoking prevalence amongst hospitalised smokers • Proportion of eligible people who have had a cardiovascular risk assessment in last 5 years • Proportion of eligible people who have had their annual diabetes review • Proportion of people who have good diabetes management in their annual review • Average number of decayed, missing or filled teeth in year 8 children • Proportion of children who are caries free at 5 years	• % of respondents who rate the care and treatment they receive as 'very good' or 'excellent' • Lower the incidence of central line associated bacteraemia • % reduction in falls resulting in major harm	• % of respondents who rate the care and treatment they receive as 'very good' or 'excellent' • Lower the incidence of central line associated bacteraemia • % reduction in falls resulting in major harm

Output Classes	Prevention	Early Detection and Management	Intensive Assessment and Treatment	Rehabilitation and Support
	• Health Protection • Health Promotion • Health Policy/Legislation advocacy and advice • Population based screening	• Community referred testing & Diagnostics • Oral Health • Primary Health care • Pharmacy	• Acute Services • Maternity • Elective (Inpatient/Outpatient) • Assessment, Treatment and Rehabilitation (Inpatient) • Mental Health	• Home Based Support • Palliative Care • Residential Care • Mental Health

COST OF SERVICE STATEMENT – FOR YEAR ENDING 30 JUNE 2013 ($000)

Output Class Names	Prevention		Early Detection & Management		Intensive Assessment & Treatment		Rehabilitation & Support		Total	
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Total Revenue	**19,479**	**19,779**	**396,572**	**563,908**	**1,237,236**	**1,221,333**	**166,950**	**163,326**	**1,820,237**	**1,968,346**
Expenditure										
Personnel	14,627	15,327	10,728	11,912	734,805	722,286	13,078	13,855	773,238	763,380
Outsourced Services	1,715	949	12,589	11,391	70,543	63,551	3,559	3,169	88,406	79,060
Clinical Supplies	442	553	7,462	7,986	206,434	207,463	3,015	2,924	217,351	218,926
Infrastructure and Non-clinical supplies	1,806	1,903	21,503	20,884	169,708	171,610	7,259	6,646	200,276	201,043
Payment to providers	356	462	351,454	516,727	47,450	46,492	141,551	142,164	540,812	705,845
Total Expenditure	**18,946**	**19,194**	**403,736**	**568,900**	**1,228,940**	**1,211,402**	**168,461**	**168,758**	**1,820,083**	**1,968,254**
Net Surplus/ (Deficit)	**533**	**585**	**(7,164)**	**(4,992)**	**8,297**	**9,931**	**(1,511)**	**(5,432)**	**154**	**92**

The allocation of Revenue and Expenses between Output Classes has been reviewed since preparing the Statement of Intent. This has resulted in a more accurate result based on Ministry of Health definitions and forms the basis for the numbers above.

The changes are shown in the table below

Output Class Names	Prevention	Early Detection & Management	Intensive Assessment & Treatment	Rehabilitation & Support	Total
	Budget	Budget	Budget	Budget	Budget
Revenue per Statement of Intent	**20,917**	**579,921**	**1,212,090**	**155,415**	**1,968,343**
Revenue per revised allocation	**19,779**	**563,905**	**1,221,333**	**163,326**	**1,968,343**
Change	**(1,138)**	**(16,016)**	**9,243**	**7,911**	**0**
Expenditure per Statement of Intent	**22,420**	**571,462**	**1,204,852**	**169,517**	**1,968,251**
Expenditure per revised allocation	**19,194**	**568,897**	**1,211,402**	**168,758**	**1,968,251**
Change	**(3,226)**	**(2,565)**	**6,550**	**(759)**	**0**
Net change	**2,088**	**(13,451)**	**2,693**	**8,670**	**0**

Output Classes *means the groups of outputs of a similar nature.*

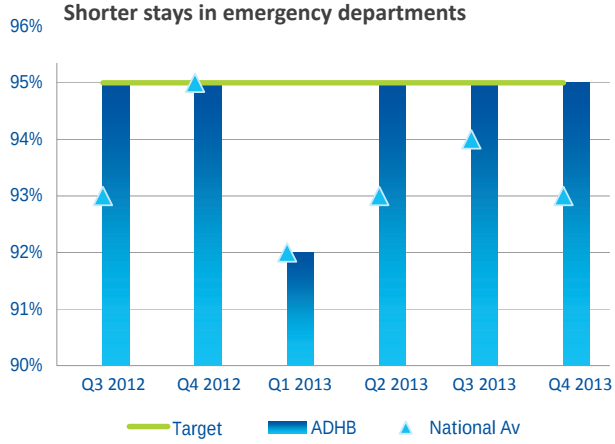
Outputs *means the goods or services are produced by the public entity. The term refers only to the goods and services produced for third parties; it excludes goods and services consumed within the reporting entity (such as services provided by legal, research, HR, and IT functions to other functional areas within the same entity) which are often referred to as "internal outputs".*

Acronyms and abbreviations *are explained in the glossary on pages 101 and 102.*

HEALTH TARGETS

These are a set of national measures specifically designed to improve the performance of health services.

Shorter stays in emergency departments



Target	**95 % of patients will be admitted, discharged, or transferred from the Emergency Department within 6 hours**
Result	**94% for the year. Target achieved in 3 out of 4 Quarters.**
Rating	**Substantially Achieved**

ED attendances in the year were 86,671 (64% Adult and 36% Children).

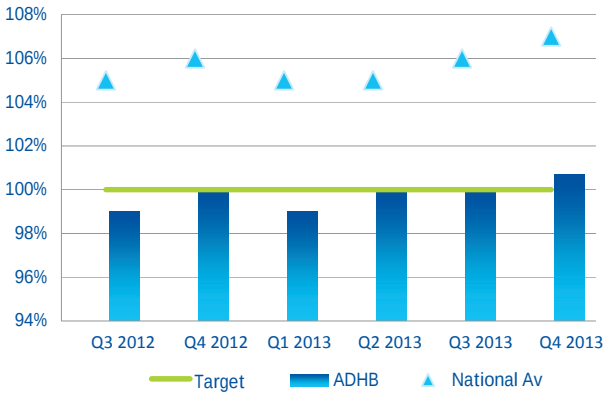
Of these attendances 81,599 (94%) patients were treated in compliance with the 6 hour target.

Attendances at the Children's Emergency Department were treated in compliance with the 6 hour target.

The first Quarter 2013 performance of 92% was due to a number of reasons including:

- Staff sick leave and vacancies of key staff
- Multiple presentations in a short timeframe
- Increased demand for side rooms
- High occupancy levels

Improved access to elective surgery

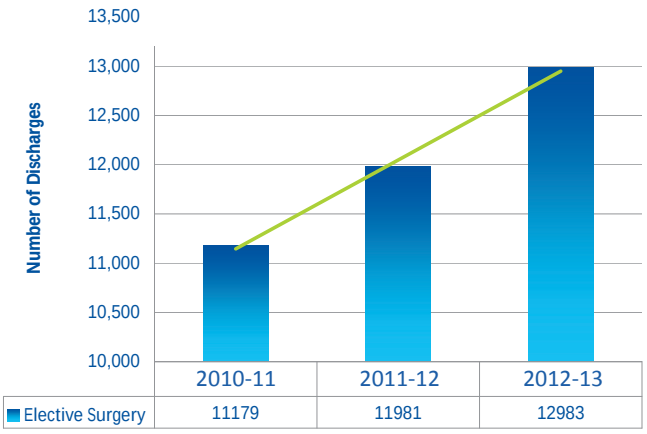


Target	**Increase the volume of elective surgery by delivering 12,891 elective discharges in 2012-13**
Result	**12,983**
Rating	**Achieved**

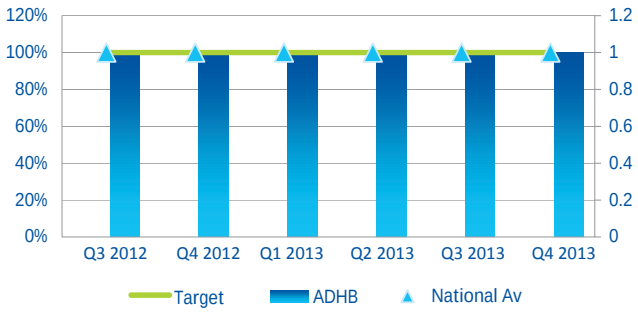
The achievement of elective targets is underpinned by a Ministry of Health funded Elective Services Programme of improvement.

Electives have increased from 11,179 in 2010-11 to 11,981 in 2011-12 to 12,983 in 2012-13. This is an increase of 15.3% over three years.

Elective surgery discharges for ADHB population



Shorter waits for cancer treatment (radiotherapy and chemotherapy)



Target	Everyone needing radiation or chemotherapy treatment will have this within four weeks
Result	100%
Rating	Achieved

This target has been consistently achieved.

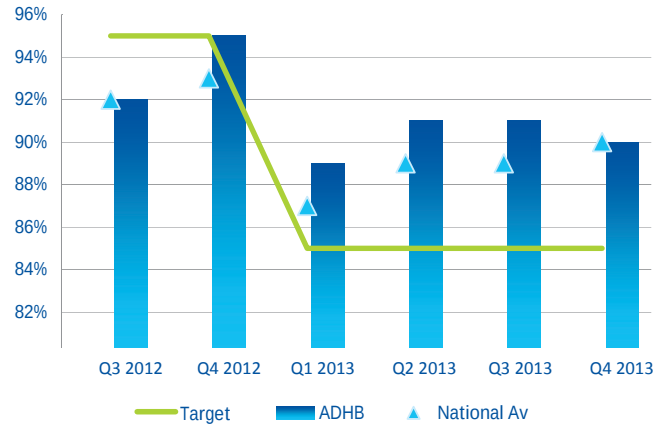
Chemotherapy

Adherence to the 4 week target is being achieved by daily monitoring of wait times and detailed Daystay and Clinic scheduling to manage a sustained growth in referrals that is impacting day stay capacity and resources.

Radiation Therapy

The commissioning of the new Radiation Therapy planning system by August 2013 will significantly increase planning capacity to continue to meet the 4 week target.

Increased immunisation (8-month-olds)



Target	85 % of eight month olds will have their primary course of immunisation (6 week, 6 month and 5 month immunisation events) on time
Result	90%
Rating	Achieved

Note Q3 2012 and Q4 2012 were targeted at 95% of two year olds being immunised.

From Q1 2013 the target changed to 85% of eight month olds

New immunisation guidelines focus on early engagement with parents

Education sessions were held for Practice Nurses in November 2012-the focus was on newborn enrolment and PVC vaccine

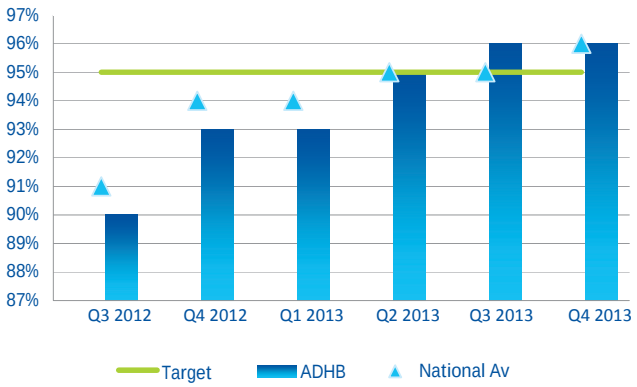
Particular focus was on GP practices with high Māori enrolment but low Māori coverage

A DVD to dispel common immunisation myths is being produced in partnership with IMAC for use with health professionals

Auckland DHB's coverage for the target population at 30 June 2013 exceeded the 85% annual target by 5%.

Māori immunisation rate at 8 months was 78%, Pacific people 87%, Asian 95%,Other 92% and NZE 91%

Better help for smokers to quit - hospitals



Target	95 % of hospitalised patients who smoke are offered brief advice and support to quit smoking
Result	96%
Rating	Achieved

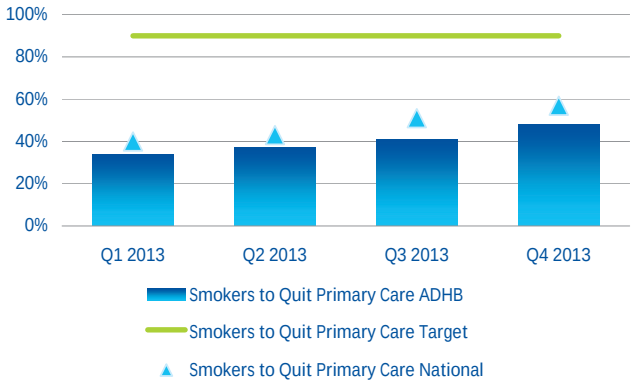
Auckland DHB achieved an overall status of 95.8% (96% rounded) in the 6 months January 2013 to the end of June 2013 inclusive.

Activities to achieve this target include:

- AED and APU are audited weekly
- Ongoing support for Women's Health HSG by Smokefree facilitators
- A poster campaign with weekly posters to let each area know how they are doing
- Weekly results are reported by ward/unit and accountable Manager
- Meetings with Nursing or Midwife Advisors are followed up and a discussion percentages are discussed'

Auckland DHB by Quarter achieved 34%,37% and 41% compared with National rates of 40%,43% and 51%.

Better help for smokers to quit - primary care



National Hauora Coalition PHO, Alliance Health Plus PHO and Auckland PHO

Activities to support the achievement of the health target include:

- Weekly reporting on progress
- Regular communication of key actions that support practices
- Practice visits by PHO staff

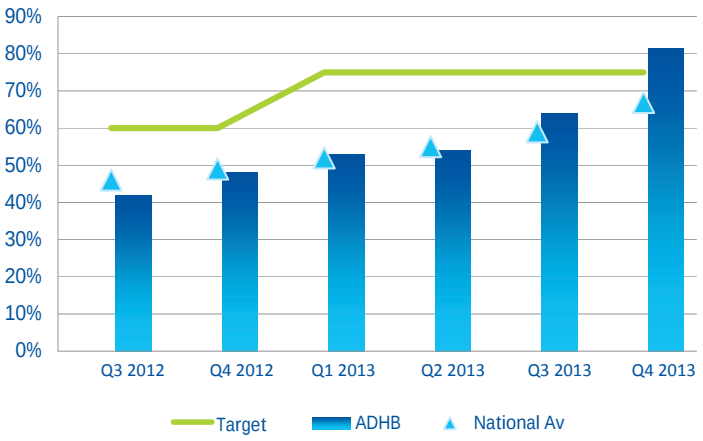
Target	90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit by July 2013
Result	48.1%
Rating	Not achieved

From Q1 July 2013 a quarterly target of 90% of eligible patients in Primary care are to be given advice to quit.

Auckland DHB by Quarter achieved 34%,37%, 41% and 48% compared with National rates of 40%,43% ,51% and 57%.

- PHOs Activities to Increase Activities in General
- Offering staff training and support
- Telephone intervention project assisting surgeries to identify and follow up patients identified as smokers with the offer of support
- World smokefree day competitions were spread across the ProCare network with prizes going to both Auckland DHB and Waitematā DHB Practices

% of ADHB population who have had their cardiovascular risk assessed in the last five years



Target	75% of the eligible population will have had their cardiovascular risk assessed in the last five years by July 2013
Result	81.3%
Rating	Achieved

Cardiovascular Disease Risk Risk Assessment data is sent to Auckland DHB by the PHOs weekly. The target of 75% has been met.

The CVD contract with the PHOs has incentive based funding attached to it with a support component and an incentive component.

Note the target in Q3 2012 and Q4 2012 was 60% of the eligible population.

For the year to June 2013 119,175 checks were undertaken compared with 50,307 in the year to June 2012.

The Ministry of Health has set a maternal health target for DHBs to make progress towards 90% of pregnant women who are identified as smokers at the time of confirmation of pregnancy, being given brief advice to stop smoking on booking with a Lead Maternity Carer.

Activities to achieve this include:

- Putting a system in place so the involved services can monitor their progress toward this national health target.
- Focus on helping pregnant women from Māori, and Pacific populations.
- Develop and implement a programme to increase referrals of pregnant women by private and DHB Lead Maternity Carers to promote pregnancy smoking cessation services .

Work is continuing on the above activities, however documenting brief advice given and capturing this electronically, is proving to be problematic so collecting data is on hold for Quarters 1 and 2 of the 2013-2014 year.

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 Māori Health inequities is an integral part of these priorities.

Throat-Swabbing for Rheumatic fever and Starship Children's Hospital, level 6 upgrade were two important local priorities.

Rheumatic Fever

In June 2012, the Government announced 10 Better Public Service targets each focused on outcomes. Reducing the incidence of Rheumatic Fever (RF) by two thirds to 1.4 cases per 100,000 nationally by 2017 is one of the targets. The Auckland DHB rate is reported as 3.5:100,000. The target rate at 2017 is 1.2:100,000. One of the strategies to achieve this target is a throat-swabbing programme within high-risk communities and schools in the DHB's area (expected to reach 35% of vulnerable children).

During 2012-13 Auckland DHB ran school throat swabbing programmes in two Mt Roskill schools and is now in the final stages of planning a much broader initiative to include a total of 16 schools in Otahuhu, Three Kings, Point England, Panmure and Glen Innes. This wider reaching programme has been made possible due to government funding and will enable Auckland DHB to more closely align with national RF targets by reaching more than 4,000 primary and secondary-aged students. During the last quarter of the 2013 financial year, the organisation developed plans to run an education and awareness campaign to further leverage government's investment.

Starship Level 6 Upgrade

Celebrations have marked the completion of a $6 million project to transform Level 6 of Starship Children's Hospital into a more modern, family-friendly environment.

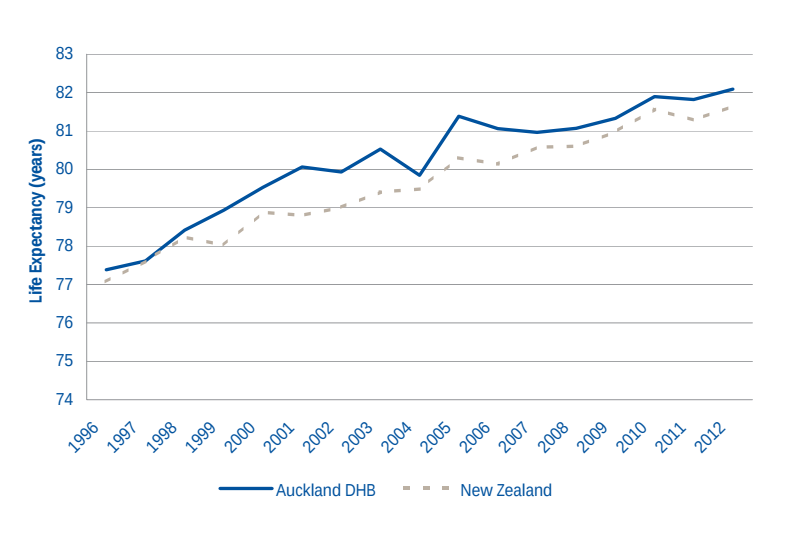
For Starship staff and the Starship Foundation team, which raised the sponsorship for the project, the re-opening creates the opportunity to better meet the needs of young patients and their families, as well as providing a better working environment.

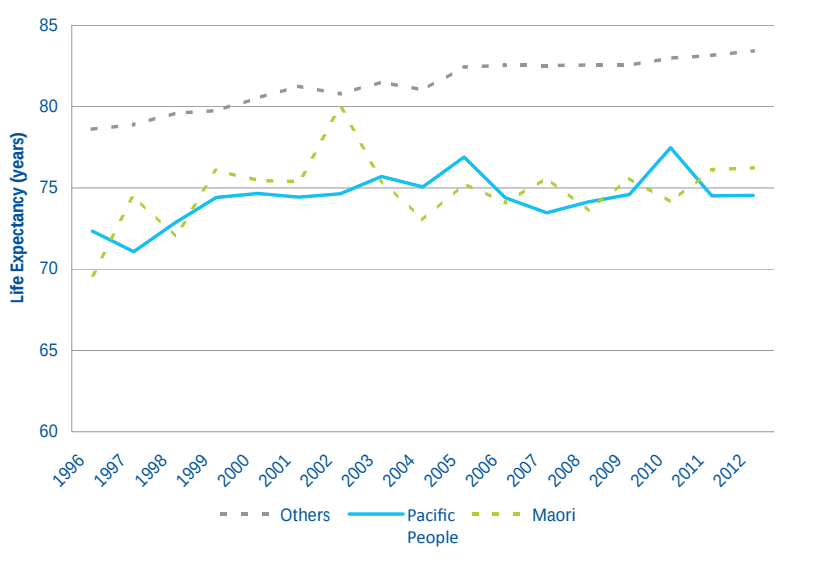
IMPACTS

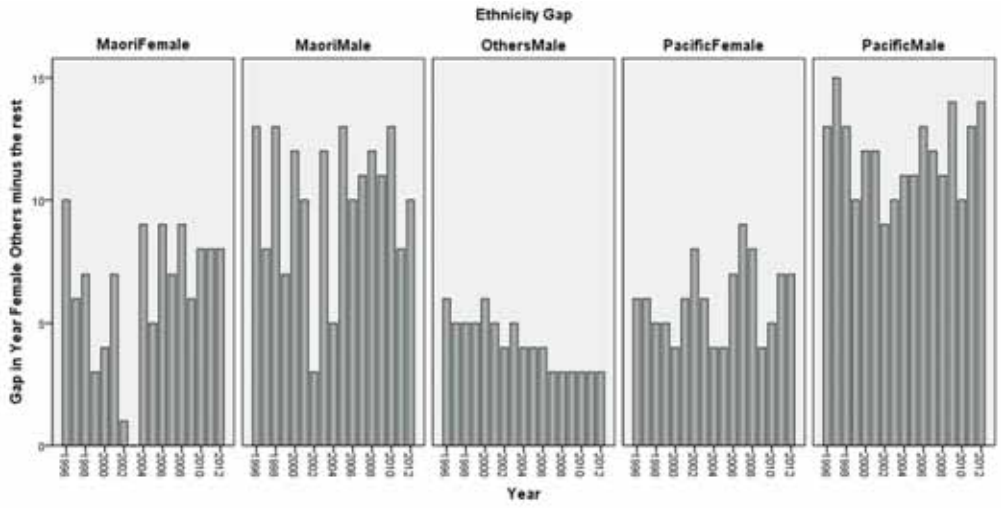
Main measures

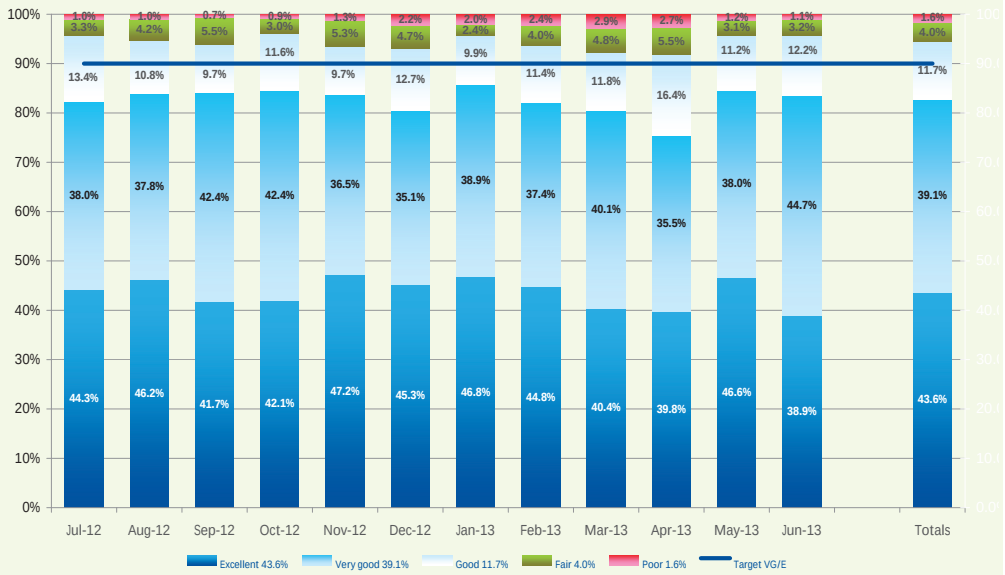
a) Improved population health

One of the key DHB objectives under the New Zealand Public Health and Disability Act is to improve, promote and protect the health of the population the DHB serves. For 2012-13 we focused on achieving national health targets and improving service integration as key areas which contribute to the achievement of this outcome.

Main measures	Rationale and current status
Increased life expectancy **Average annual increase in life expectancy at birth**	Life expectancy is recognised internationally as a measure of population health status. We expect to see the continued increase of around three years each decade. For New Zealand as a whole, the trend has been 2.8 years per decade over the last 15 years. In 2012 life expectancy in the Auckland DHB area was approximately 82 years.  If the mortality rate and all the other conditions that impact on life expectancy remain stable, our DHB life expectancy is expected to be 82.2 (SD 0.2) in year 2016

Main measures	Rationale and current status
Reduced inequalities (measured by the life expectancy gap)	Life expectancy rates for Māori and for Pacific people compared to other New Zealanders show significant differences between the ethnic groups within our community. We want to reduce this life expectancy gap to zero in the long term. There is still a gap of 7 years for Māori life expectancy and 9 years for Pacific people. We continue to try to address these unacceptable differences in life expectancy as a health service priority, while also acknowledging that changes take time and require the attention of other sectors.  Our target for future years is to reduce this gap in life expectancy for Māori and for Pacific people compared to Others. We do not have differential targets for different ethnic groups compared to Others. The health sector has an expectation that all New Zealanders should receive the same level of care and service regardless of ethnicity.
Gender gap **(measured by the life expectancy gap)**	Comparing the gender gap in life expectancy between the group with the best life expectancy (Other females) shows dramatic differences. In 2012 this gap for Pacific men was 14 years, followed by Māori men at 10 years, followed by Māori women at 8 years. This compares to Other men where the gap was 3 years. 2012-13 actions concentrated on diseases that most affect Māori and Pacific people. We want to see the gap between genders reduce over time, understanding that addressing inequalities takes time and requires the involvement of other sectors.



Main measures	Rationale and current status
Improved Patient Experience	Understanding when we haven't provided a positive patient experience, and when we have, helps us to improve our systems and processes so we can respond better to patients and their family / whanau. In 2011 we introduced a new and improved system for measuring patient experience. At the moment, this data is collected for inpatient stays and not for outpatients. The Concord and other quality improvement programmes will help us improve patient experience ratings over the longer term. Patients (from May 2012 data) believe three things make the most difference to the quality of their care and treatment: • Communication i.e. clear answers patients can understand (51%) • Feeling confident about the quality of their care and treatment (45%) • Getting coordinated care (40%) Our aim is to consistently achieve a positive patient experience of over 90% for all our patients in the long term. Patient Ratings for the care received while an inpatient at ADHB 
Financial: Breakeven Target	The DHB demonstrated that it lived with in its means as required by the Minister by achieving a small surplus of $154K. The was achieved on the back of a savings programme which contributed $66.9m of savings against a budget of $66.7m. Savings were in reduced Employee Costs ($25m) and increased Revenue ($18m) and reduced Administration Expenses ($11.4m).

OUTPUT CLASS MEASURES

The following tables include our output and impact measures from the 2012/13 Statement of Performance by Output Class. Impact measures are measurements of longer term outcomes and we would not expect to see real changes on a year by year basis – annual fluctuations will occur and it is only over an extended period of time that it is possible to determine the overall change occurring. Some output measures are demand driven and it is therefore not possible to set meaningful targets of these measures or assign "Achieved" or "Not achieved" ratings. These are indicated with a ✶symbol. Output measures are intended to reflect our performance over the year.

Prevention Services - Provided by Auckland Regional Public Health (ARPHS): the three District Health Boards of Auckland (Auckland DHB), Counties Manukau (CMDHB) and Waitematā (WDHB).

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Achieved	Comments Ref. - see next page
Health Protection	Outbreaks investigated	1,183	225	✶	Achieved	1
	Number of contacts traced in relation to CDC cases	664	2,250	650 ✶	Achieved	2
	Communicable diseases protocols up-to-date	100%	100%	100%	Achieved	3
	Communicate diseases protocols adhered to and in a timely manner	100%	100%	100%	Achieved	4
	Number of environmental hazard investigations conducted in relation to built environments	42	101	✶	Achieved	5
	Proportion of Hazardous and New Organisms (HSNO) events that are responded to appropriately	100%	100%	100%	Achieved	6
	Proportion of Public Health Risk Management Plan (PHRMP) reports submitted to the water supplier within 20 days	100%	100%	100%	Achieved	7
	Number of Emergency response exercises participated in	5	11	5	Achieved	8
	Emergency Plan up-to-date	Yes	Yes	Yes	Achieved	9
	Proportion of reports submitted to the Ministry of Health within 24 hours of occurrence of a public health event at the border	100%	100%	100%	Achieved	10

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Achieved	Comments Ref. - see next page
Health Promotion	Number of liquor license applications processed by ARPHS and all problematic premises that receive a compliance check	82%	96%	100%	Substantially Achieved	11
	Alcohol compliance protocols are adhered to when site visits are carried out	97%	97%	100%	Substantially Achieved	12
	Proportion of liquor licensing applications processed within 15 days	100%	100%	100%	Achieved	13
	Proportion of tobacco complaints responded to within 5 days	100%	100%	100%	Achieved	14

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Achieved	Comments Ref. - see next page
Legislation Advocacy and Advice	Number of submissions made	12	27	15 (demand driven)	Achieved	15
	Submissions policy adhered to	100%	100%	100%	Achieved	16
	Submission documents submitted by deadline	100%	96.3%	100%	Substantially Achieved	17

Health Promotion & Health Policy/Legislation Advocacy and Advice Impact Measures	
Comments ref.	
1	100% of outbreaks of diseases responded to as per protocol. Enteric disease outbreaks are investigated when there are 2 or more linked cases of gastroenteritis notified.
2	We have good mechanisms to measure Tuberculosis contacts via EpiSurv. Contacts of Vaccine Preventable diseases are more difficult to quantify because of system constraints. The NDCMS upgrade should provide improvements in this area.
3	All protocols are reviewed on a 3 yearly cycle. They are kept up to date as per schedule. The Health Protection Protocol Working Group oversees the development, sign-off and implementation of all relevant CDC protocols. Staff have 24/7 access to all protocols for normal and after-hours responses.
4	All communicable disease protocols are signed off by Public Health Medicine Specialists, overseen by the Health Protection Protocol Working Group. Public Health Nurses (PHNs) are guided by Best Practice guidelines, protocols and National Guidelines when following up notifiable diseases. Tuberculosis cases and contact files are reviewed by the PHN and MO fortnightly and audited quarterly and when cases are closed. Other notified diseases are reviewed with the PHN and Medical Officer prior to discharge. There have been no reports of serious breaches of protocols.
5	Examples of environmental hazard investigations include: • Hobsonville Land Company • Stokes Point (Grafton) • Asbestos found in Glendowie Park, Glendowie, Auckland.
6	There have been no reported breaches of protocols; highlights of some complex responses are detailed below: • ProFume; Public Health risk assessment of fumigant as part of application by MPI to EPA. • Chlorine incident (Hill Park): Incorrect mixture of chemicals at school pool. Fire service lead agency and ARPHS assisted with PH advice. • Suspected methamphetamine exposure: ARPHS received complaint of suspected exposure and following investigation of details referred to the Police and Auckland Council. • Lead poisoning cluster/outbreak caused by occupational hazard - ARPHS investigated and handed over to MBIE for follow-up. • ARPHS investigated and reported Ayurvedic medicine lead poisoning cases to MedSafe NZ.
7	All Public Health Risk Management Plan (PHRMP) reports were submitted to the water supplier within 20 working days as required under the HDWAA, 2007.
8	Significant work completed on aligning 'surge capacity' triggers, thresholds and guidelines with business-as-usual processes to strengthen organisational resilience and to treat as 'BAU' incidents that would otherwise have been scaled to an emergency response. Scenario planning and ad hoc emergency meetings held for: • Winter season gastroenteritis and influenza preparation/monitoring • Hobsonville Tornado, 7/2/13 Tsunami National • Advisory, seasonal influenza Code White and Tongariro volcanic alert risk assessments • H7N9 and MERS-CoV planning • Auckland drought planning/monitoring • Auckland DHB Legionella liaison and incident monitoring and refining interagency processes for ongoing airport Ill Traveller notifications.
9	Developed supplementary material to ARPHS Emergency Plan, including Standard Operating Procedures, Surge Capacity Plan, 'Assessment, Management and Triage Team' surge and emergency plan, alignment of emergency plans with After Hours Service Manual and Business Continuity Plan, site-based plans – including Auckland Airport and Ports of Auckland public health emergency contingency plan. Key revisions made to ARPHS Emergency Plan as 'live' document, based on above supplementary documents, as well as health sector review of Northern Regional Health Emergency Plan. ARPHS Emergency Plan scheduled for full review and revision in latter half of 2013.
10	All reports related to public health events (interceptions of mosquitoes and rodents) were submitted to the Ministry of Health within 24 hrs.
11	For the period of January-June 2013 we had 100% of high risk premises were visited. It is important to note that we implemented a new risk rating system in October 2012 which may have contributed to not all high risk premises being visited.
12	It is important to note that we utilise a protocol audit tool which looks at key steps of our entire licensing process as a proxy measure for this. We carry out the audit quarterly with a random sampling of files. The 3% variance from the target is due to human error. The reason these audits are carried out is to pick these up.
13	All applications were processed within 15 days of receiving them.
14	All tobacco complaints actioned within the 5 day period.
15	ARPHS contributed to a total of 27 submissions for 2012-13 (26 written by ARPHS and 1 endorsement of a submission written by the Paediatric Society). Highlights include submissions developed for Auckland Council's Unitary Plan and the Draft Auckland Region Public Transport Plan.
16	All submissions developed or contributed to by ARPHS were first put through a screening process where technical experts, policy staff and clinicians assessed the relevance and capacity of contributing to a submission opportunity. For those opportunities that passed screening, and a submission was developed for, a thorough peer review process took place ensuring the submission met our high internal quality standards. The review process included the Policy Team's Programme Supervisor, Level 4 Manager, Clinical Partner, relevant technical expert and finally the Service Manager.
17	26 submissions submitted by deadline. One submission missed the initial deadline but was able to be updated and sent out at a second opportunity for feedback.

OUTPUT CLASS MEASURES: Prevention Services *continued*

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Achieved	Comments Ref see below
Population Based Screening	**Newborn hearing screening**					
	Number/proportion of babies screened	7,576 or 95%	7,928 98.7%	100%	Substantially Achieved	18
	Referral rate to audiology	2%	1.56%	<=4%	Achieved	19
	Appropriate medical and audiological services initiated by 6 months of age for >=95% of infants referred through the programme	100%	100%	>=95%	Achieved	20

Population based Screening Impact Measures	
Comments ref.	
18	A review in 2012 of an aspect of the DHB's Newborn Hearing Screening Program identified 1,263 babies and infants that might not have been sreened correctly for hearing loss. Their parents were contacted and offered rescreening. An overall rate of 98.7% is slightly lower than the 100% government target 2012/13. This may have been attributed to staff vacancies/ new staff training. Also quick/early discharge of patients from hospital. To mitigate: 1. Vacancies filled. 2. New staff training given. 3. Increased outreach services/clinics. 4. Service delivery times on wards increased.
19	Referral rate of 1.56% exceeds the target of < 4% Reflects the quality of the service.
20	Exceeds the 95% target achieving 100%. A timely service provides prompt access.

OUTPUT CLASS MEASURES: Early Detection and Management

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Achieved	Comments Ref. - see below
Community Referred Testing & Diagnostics	Number of laboratory tests by provider	DML= 202,199 LTA = 2,511,224	341,112 To 31 March 2013	202,200 2,520,000	Achieved Substantially achieved	21 22
	Number of community referred radiological procedures	47,380	2,485,146	*	Achieved	23
	Complaints as a percentage of the total number of laboratory tests	.00199%	To 31 March 2013	<.00199%	Not achieved	24
	Average waiting time in minutes for a sample of patients attending Waitematā/Auckland collection centres between 7am and 11am (peak collection time)	7.8 minutes	40,714	<30 minutes	Achieved	25
	75% of accepted community referrals for MRI or CT scans receive their scan within 6 weeks (42 days) by July 2013	65%	.003680%	75%	Partly achieved	26

Community referred testing and diagnostics Impact Measures	
Comments ref.	
21, 22, 23, 24, 25	Community referred laboratory test volumes have continued to grow in 2012/13 with much of this growth linking to good uptake of the Diabetes Management Gudelines and Cardiac Risk Assessments. Waiting times in some collection centres have increased but are still well within the 30 minute contractual threshold. A switch from fasting to non fasting testing for some laboratory tests, should help reduce wait times early in the morning when they are currently the longest. There have been no serious or sentinel events this year. Complaints are tracking at less than 0.05% with most of these relating to collection centre wait times or minor phlebotomy issues.
26	75% of accepted community referrals for MRI or CT scans receive their scan within 6 weeks (42 days) by July 2013. Timely access to diagnostic testing makes an important contribution to good patient outcomes.

OUTPUT CLASS MEASURES: Early Detection and Management *continued*

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Achieved	Comments Ref. - see below
Oral Health	**Enrolment rates in children under 5:**					
	Māori	2,440	2,670			27
	Pacific people	4,189	4,388			27
	Other	14,017	15,104			27
	Overall	20,616	22,162	22,680	Substantially achieved	27
	Utilisation rates for adolescents	65.7%	81.4%	85%	Substantially achieved	28
	Number of visits of preschool and school children to oral health services (including adolescents)	20,195	84,246 2012 Calendar Year	n/a	n/a	29
	Number of complaints for the financial year	4	37	<4	Not achieved	30
	Non enrollment rates by ethnicity					
	Māori	18.2%	18%		Not Achieved	31
	Pacific people	19.0%	19%		Not Achieved	31
	Other	19.5%	20%		Not Achieved	31
	Overall	19.2%	20%	7%	Not achieved	31

Health Promotion & Health Policy/Legislation Advocacy and Advice Impact Measures	
Comments ref.	
27	The target has been met in 2012. Still more effort is being made to increase the percentage of enrolment by preschool coordinators visiting maternity wards and preschools and liaising with midwives and Māori, Pacific people and Asian services
28	The target has been met in 2012 and is on track to meet 2013 target.
29	Attendance figures have been consistently increasing over the past 12 months.
30	This is a very small % of those seen and the lowest of the three regions.
31	The 2012 actual is higher than the target of 7%. This was due to difficulty in filling vacancies, maternity leave, and more treatments provided at visits which cause the delay in examining more children.

OUTPUT CLASS MEASURES: Early Detection and Management *continued*

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Achieved	Comments Ref. - see below
Primary Care	Ethnic-specific primary care enrolment rates	Asian= 84% Māori=77%	74% 77%	80% 80%	Substantially achieved Substantially achieved	31
	Immunisation health target achievement	new	90%	85%	Achieved	32
	Cervical screening coverage	73.5%	77.3% March 2013	75%	Achieved	33
	Numbers of B4 School Checks completed (overall coverage)	38%	75%	80%	Substantially achieved	34
	Proportion of practices with cornerstone accreditation	47%	53.73%	>47%	Achieved	35
	GMS claims from after-hours providers per 10,000 of population (demand driven)	275 per 10,000	290.57	275*	Achieved	36
	Proportion of patients who smoke and are seen by a health practitioner in primary care that are offered brief advice and support to quit smoking	45.8%	48.1%	75%	Not achieved	37
	Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	45.8%	Q3 64% Q2 54% Q1 53% Q4 81.3%	75%	Achieved	38

Health Promotion & Health Policy/Legislation Advocacy and Advice Impact Measures	
Comments ref.	
31	Primary care enrolment rates give an indication of access to primary care health services. Differences between ethnicities reflect inequalities in access to primary care ethnic-specific primary care enrolment rates. There are known errors in ethnicity data and this could affect the results by up to 8%. The issue is particularly in the recording of Māori and Pacific data.
32	An overall rate of 91% has exceeded the 85% government target for 2012/13. 1. There were consistent efforts from primary care, and outreach services. 2. There has been a focus on Māori and Pacific babies. 3. Systems/processes have been reviewed and implemented such as children attending hospital alerts of non-vaccination status.
33	Cervical screening coverage is a good indicator of the preventive service output.
34	Performance against target improved by 10% over the previous year. Coverage is a standard measure of output from screening programmes.
35	Cornerstone is an accreditation system run by the Royal New Zealand College of General Practice. In order to be accredited practices must accurately assess their level of performance in relation to established standards.
36	The utilisation of primary care during weekends provides an indicator of the timeliness of the services available. If availability is low, or costs are too high, this will be reflected in the utilisation rate.
37	The DHB is working closely with PHOs to acheive the target.
38	The target was to achieve 75% of our population having had their cardiovascular risk assessed in the last five years by the fourth Quarter. Auckland DHB exceeded the target and is the top performing DHB in New Zealand and one of four that achieved the target outcome. Māori screening rates were 79% and Pacific people 86%. Auckland DHB have in place performance based contracts with some support funding up front and the remainder of the funding on achieving targets. New contracts will be sent out to achieve the 90 % target by June 2014. Additionally Auckland DHB fund three LTC coordinators to work with practices to ensure sustainable screening is in place.

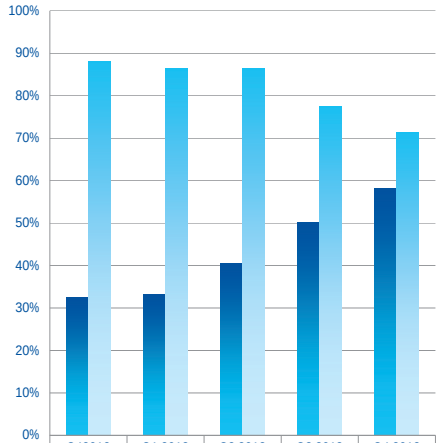
OUTPUT CLASS MEASURES: Early Detection and Management *continued*

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Achieved	Comments Ref. - see below
Pharmacy	Proportion of prescriptions with a valid NHI number	96%	96.4%	100%	Substantially achieved	39
	The proportion of the population living within 30 minutes of an extended-hours pharmacy (i.e. any pharmacy open at 8pm on a Sunday)	98%	98%	95%	Achieved	40

Health Promotion & Health Policy/Legislation Advocacy and Advice Impact Measures	
Comments ref.	
39	The new Community Pharmacy Services Agreement states that NHI numbers are compulsory. However as the NHI web service is not yet available, DHBs will not require full NHI compliance from community pharmacy until it is.
40	Residents living on Waiheke and Great Barrier Islands do not have access to extended hours pharmacies within 30 minutes.

Sub-output Community referral testing & Diagnostics

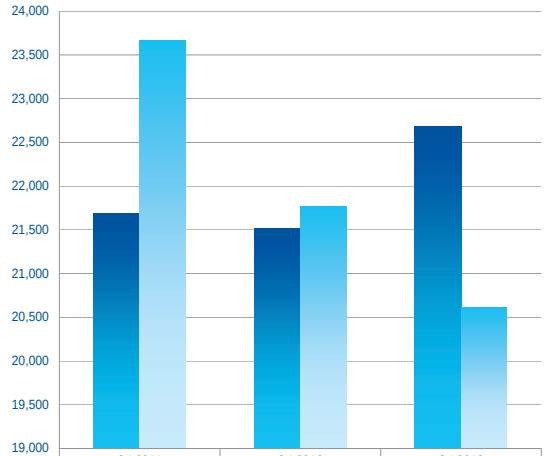
% of accepted community referrals for MRI or CT scans who receive their scan within 6 weeks



	Q42012	Q1 2013	Q2 2013	Q3 2013	Q4 2013
% MRI completed < 6 weeks	32%	33%	41%	50%	58%
% CT completed < 6 weeks	88%	86%	86%	78%	71%

Sub-output Oral Health

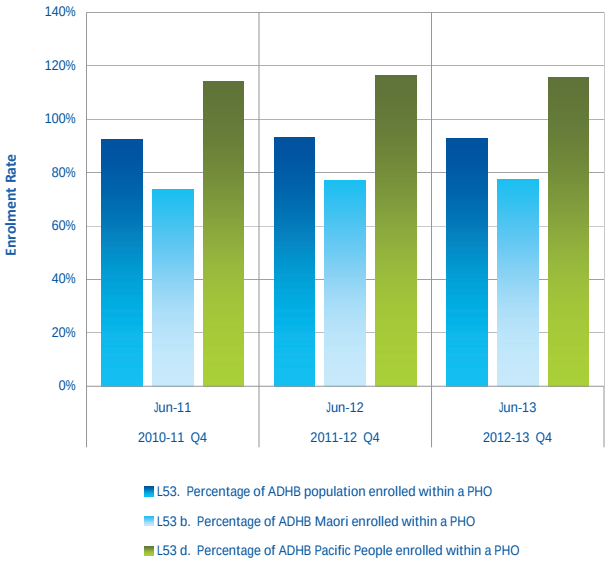
Number of under 5 year olds enrolled in Oral Health Services



	Q4 2011	Q4 2012	Q4 2013
Actual	21,687	21,514	22,680
Target	23,662	21,763	20,616

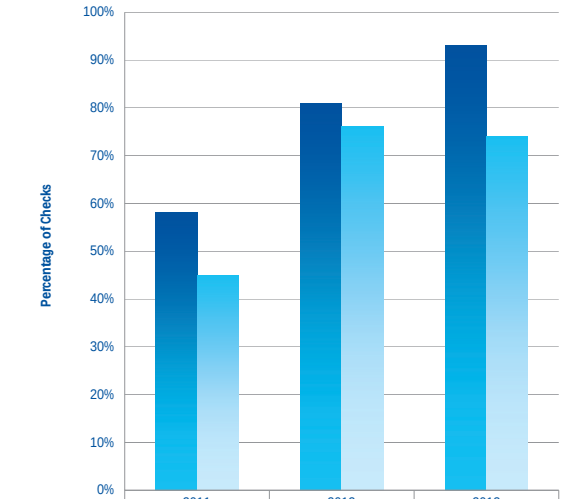
Sub-output Primary Care

% Ethnic specific enrolment rates in PHOs



Sub-output Primary Care

Before School Checks completed



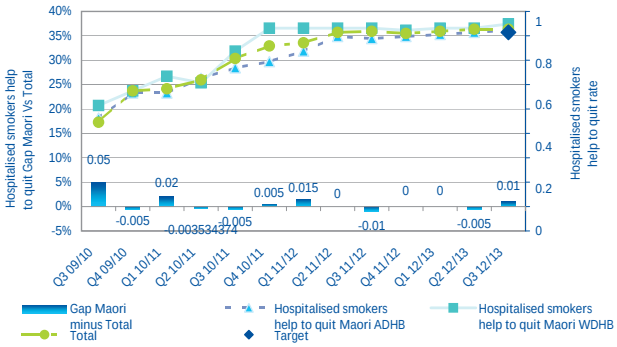
	2011	2012	2013
All	58%	81%	93%
High Dependancy	45%	76%	74%

High Dependency are children living in low decile areas or areas of high deprivation.

OUTPUT CLASS MEASURES: Early Detection and Management *continued*

Set out below are the key Māori health targets which identify the gap between Māori health and the health of the whole population

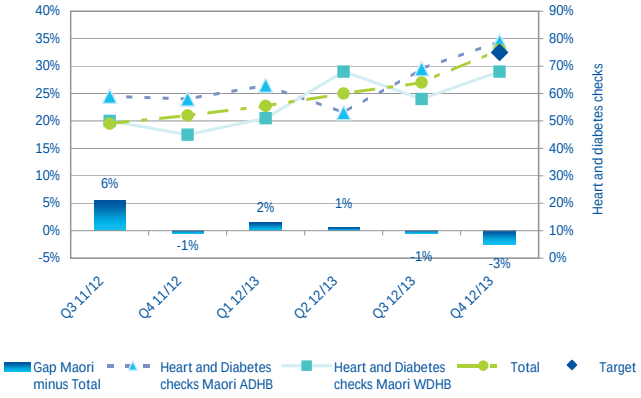
Hospitalised smokers given advice to quit smoking



Auckland DHB's performance has improved from the 2011/12 year and in Q2 of 2012/13 was 94%, which is 1% below target.

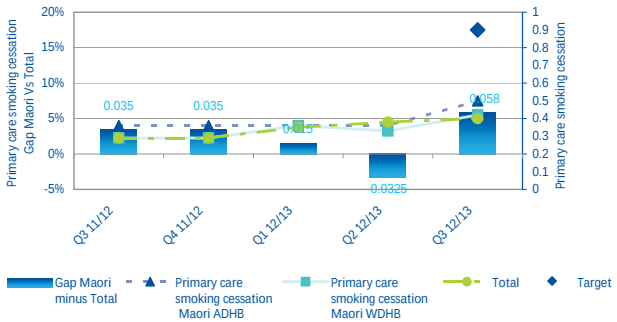
- **Consistent approach** – We remain committed to a consistent approach across both Auckland DHB and Waitematā DHB in attaining the smoking cessation target and steps are underway to ensure that appropriate Māori staff are now trained to provide smoking cessation advice.
- **Auckland DHB Tobacco Plan 2012 – 2014** - The new Draft Tobacco plan has been completed and is out for consultation.
- **In-patient wards** - All Kaiātawhai at Auckland DHB are now trained in smoking cessation.

Heart and Diabetes checks



More Heart and Diabetes Checks for Māori are below the target of 75% for both DHBs. Performance in the last quarter appears to have increased considerably for Waitematā DHB Māori and reduced for Auckland DHB Māori. Waitematā DHB began screening of hospital patients in October; Auckland DHB will use data from the Waitematā DHB programme to plan and roll out a similar approach. 18-19,000 Auckland DHB residents could be screened. In the next financial year, our focus will be on where Māori present in large numbers to hospital such as, diabetes clinic, renal, orthopaedics and ophthalmology to explore feasibility of opportunistic screening.

Primary Care advice given to quit smoking

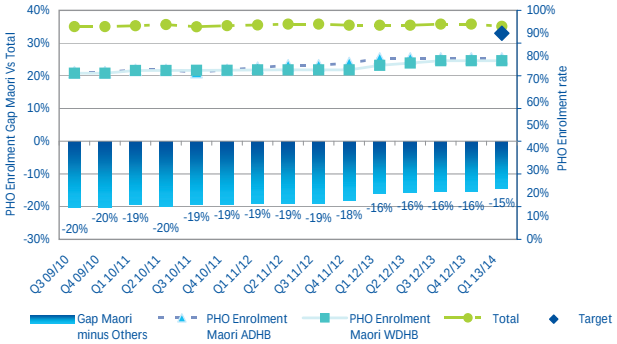


The DHBs are currently working with PHOs to ensure that the capture and submission of their Smokefree data is accurate.

Procare have initiated a project which began in March 2013 that has a 5 step process:

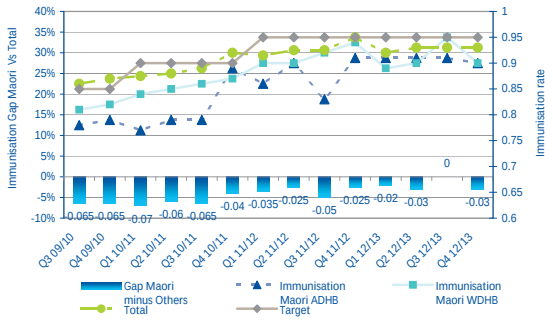
- **Step 1:** Identify practices starting with those with high Māori enrolled numbers.
- **Step 2:** Nurses use Dr Info to identify smokers.
- **Step3:** Nurse Advisor and/or health promoter will contact the practice to obtain consent to generate a letter.
- **Step 4:** The consent letter will be sent to the identified Māori patient and,
- **Step 5:** Patient contacted to see if they would like support to quit smoking.

PHO Enrolment



The mismatch between enrolment and coverage continues to be an issue. One of the strategies to support PHOs achievement of the target is the participation by GP practices in the roll out of the Ethnicity Audit Tool. Initial discussions held with Procare regarding this approach have been positive.

Immunisation two year olds

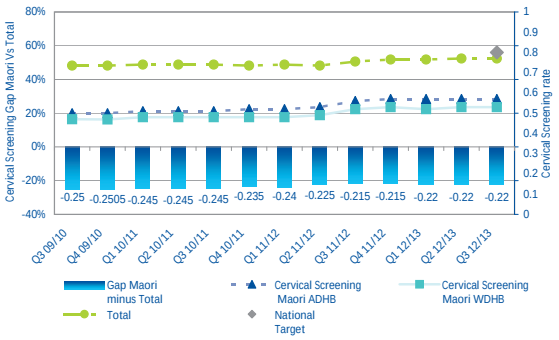


Waitematā and Auckland DHBs have developed initiatives to address the decline in 2 year old immunisations.

Initiatives identified include:

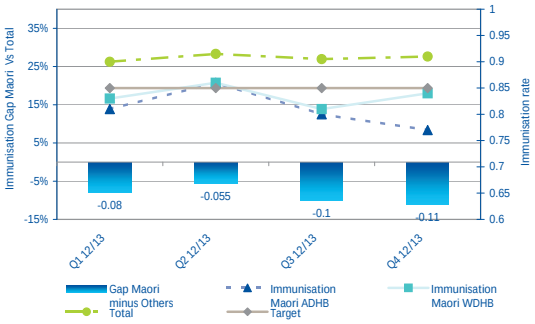
- An electronic discharge summary is being established at Waitākere hospital to allow ward staff access to the (NIR) National Immunisation Register to enable opportunistic vaccinations.
- PHO-led programme to visit GP practices in Auckland and Waitematā will commence in 2013. The aim is to embed the revised precall and recall plans.
- The Starship Children's Emergency Department is starting to systematically review the immunisation status of all high risk children admitted. If appropriate, opportunistic vaccinations will be undertaken.
- A strategy to determine an appropriate approach to address overdue Māori immunisation rates is being developed with NIR, Auckland DHB Immunisation Co-ordinators and Māori Well Child Providers across both DHBs.

Cervical screening



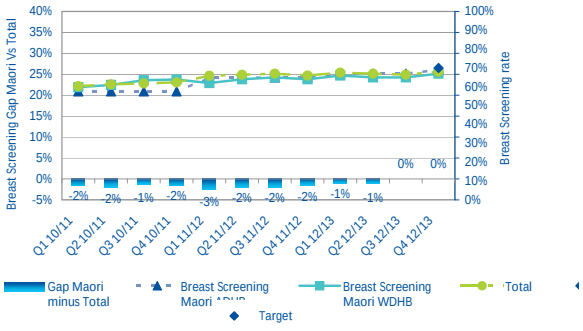
Cervical Screening coverage rates for Māori are well below target for both DHBs, and are significantly lower than the rates for the rest of the population. An Ethnicity Data Mis-classification project has been initiated within Waitematā DHB and actions from the Auckland Metropolitan Cervical Screening Project continue to be implemented.

Immunisation 8-month-olds



- PHO-led programme to visit GP practices in Auckland and Waitematā will commence in 2013. The aim is to embed the revised precall and recall plans.
- The Starship Children's Emergency Department is starting to systematically review of immunisation status of all high risk children admitted. If appropriate, opportunistic vaccinations will be undertaken.
- A strategy to determine an appropriate approach to address overdue Māori immunisation rates is being developed with NIR, Auckland DHB Immunisation Co-ordinators and Māori Well Child Providers across both DHBs.

Breast screening



A major breakthrough was the realisation that the coverage for Māori by the NCSP is underestimated by approximately 20% (in absolute terms) due to misclassification of ethnicity with many Māori being recorded under other ethnicities on the register. The CEO has launched a project to now recheck the ethnicity of all those identified as a mis-match.

The DHB and Primary Health Organisations (PHOs) in Waitematā have also implemented measures to increase the accuracy of ethnicity data on the lab forms. As a result, the proportion of practices that do not record ethnicity on the cervical smear laboratory form has dropped from over 50% to just 22% according to the results of audit we have just completed. PHOs are working with the remaining practices to ensure 100% compliance with laboratory forms, more accurately reflecting ethnicity.

OUTPUT CLASS MEASURES: Intensive Assessment and Treatment

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Rating	Comments Ref. - see below
Acute Services	Number of ED attendances (demand driven)	91,224	98,424	95,000 (demand driven)	Achieved	41
	Acute WIES total- Provider (demand driven)	92,172.6	93,516	92,173 (demand driven)	Achieved	42
	Re-admission rates (demand driven)	10.24%	10.25 %	10%	Substantially achieved	43
	Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival	95%	Q1 92% Q2 95% Q3 95% Q4 95%	95%	Substantially Achieved	44

Acute services Impact Measures	
Comments ref.	
41	Larger than planned number of ED attendances throughout the year. Work continues with primary care and community care models in an attempt to reduce this growth in demand.
42	Greater than planned volumes achieved as result of volume increase. 'Provider' describes our hospital and clinic-delivered services.
43	Re-admission rates were 9.94 % for the year to 30 June 2012 and have slightly increased to 10.25 % in the year to 30 th June 2013. Our re-admission rate is monitored in order to reflect any significant change in the % of patients re-admitting, as both an increase or a decrease could indicate a drop in the level of care for our patients. ADHB's overall discharge rate has not changed significantly in the last 4 years (9.83%, 10.11%, 9.94%, 10.25%) indicating the level of care has also remained stable over this time.
44	Achieved in all but Q1 (Winter). Further work is being done in the services to address performance in Q1 for 13/14.

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Achieved	Comments Ref. - see below
Maternity	Number of births (demand driven)	7,523	7,613	Demand Driven	Achieved	45
	Number of first obstetric consultations (demand driven)	4,410	4,561	4,500 (demand driven)	Achieved	46
	Number of subsequent obstetric consults (demand driven)	4,201	4,136	4,200 (demand driven)	Achieved	47
	Proportion of all births delivered by caesarean section	32.6%	35.4%	<32.6%	Substantially achieved	48
	Established breastfeeding at discharge excluding NICU admissions	81.5%	75.84%	>= 80%	Substantially achieved	49
	Third/fourth degree tears for all primiparous vaginal births	4.0%	5.2%	<4.0%		50
	Percentage of term elective caesarean performed at >=39 weeks	47.4%	48.81 %	>47.7%	Not achieved	51

Maternity Impact Measures	
Comments ref.	
45	Efforts to increase the number of women birthing at Birthcare have not been successful despite a number of strategies being implemented. A new strategy was employed by Birthcare of case-loading midwives. This did not result in an increase in births at Birthcare. A number of other strategies have now been implemented including rotating new staff across National Women's and Birthcare to build linkages and confidence in each of the services.
46	The number of first obstetric consultations over the last three financial years was 4,479, 4,257 and 4,561. This indicates that levels are fairly consistent year by year.

47	Number of subsequent obstetric consults (demand driven). An indicator of volume of service provided to our population.
48	There has been a steady but small increase in overall Caesarean Section rates over time. The percentage of term elective caesareans performed at or after 39 weeks was above target.
49	The reasons for this decrease are being examined in detail.
50	While the rate is above the target, the rates in our standard primigravida with and without episiotomy benchmarks well with the NZ wide data.
51	Percentage of term elective caesarean performed at >=39 weeks was above target.

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Rating	Comments Ref. - see below
Elective (Inpatient/ Outpatient)	Compliance with national health target for surgical discharges	11,179	12,983	12,891	Achieved	52
	Standardised elective surgical intervention rate per 10,000 of population		As at Dec 2012			
	Joints	12.70	17.68	21	Partially Achieved	
	Cataracts	35.45	34.79	27	Achieved	
	Cardiac	4.81	6.23	6.2-6.5	Achieved	
	PCR	13.71	12.97	11.9	Achieved	
	Angio	30.05	34.3	32.3	Achieved	
	Overall	282.67				
	Number of outpatient first specialist assessment (FSA) appointments	83,210	89,983	84,466 (demand driven)	Achieved	53
	Patient Experience- percentage of respondents who rate the care and treatment that they receive as "very good " or "excellent"	82%	83%	90%	Substantially achieved	54
	Patients waiting longer than six months for their first specialist assessment (FSA)	0.8%	0%	0%	Achieved	55
	Patients given a commitment to treatment but not treated within six months	2.4%	0%	0%	Achieved	56
	Compliance with national health target of 100% of patients needing radiation or chemotherapy treatment will have this within four weeks	Chemo 95%	100%	100%	Achieved	57
		Radiation 100%	100%	100%	Achieved	57

Elective (Inpatient / Outpatient) Impact Measures	
Comments ref.	
52	Auckland DHB has achieved the surgical discharge target. Since 2009/10 Auckland DHB has increased its elective volume delivery by 36% and has funded the majority of this increase out of baseline funding. This has been achieved through improvements to the patient flow and establishing new OR capacity at the Greenlane Surgical Unit. The target is monitored weekly and risk areas addressed.
53	Auckland DHB has continued to improve its FSA numbers as it meets the commitment to deliver on the patient wait time targets of zero over 5 months. Patient flow redesign has assisted with this through the clinic environment. These patient flows are reviewed weekly with patients at risk of breaching the target identified and their needs addressed.
54	Discharged inpatients provide feedback on their experience via an online survey in which they rate and describe the elements of care most important to them. Patients are also asked to give an overall rating of their experience during their stay. The percentage of patients who rated their overall care as "Very Good" or "Excellent" was 83% over the year.
55	Patients waiting longer than six months for their first specialist assessment (FSA) has been minimal through the year as at 30 June 2013 there was no patient waiting over 5 months for an FSA. This is a significant achievement for patients and Auckland DHB.
56	Patients given a commitment to treatment but not treated within six months.
57	Compliance with national health target of 100% of patients needing radiation or chemotherapy treatment will have this within four weeks. Auckland DHB has consistently met this target over a number of years now with robust processes to identify patients at risk and ensuring they start their treatment on time.

OUTPUT CLASS MEASURES Intensive Assessment and Treatment *continued*

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Rating	Comments Ref. - see below
Assessment Treatment and Rehabilitation	Number of AT & R inpatient events (demand driven)	1,996	2,305	* Demand Driven	Achieved	58
	Average no. of falls per 1,000 occupied bed days	7.6	4.04	<7.6	Achieved	59
	Proportion waiting 4 days or less from waitlist date to AT&R service	87%	77.40%	< 4 days	Partly achieved	60

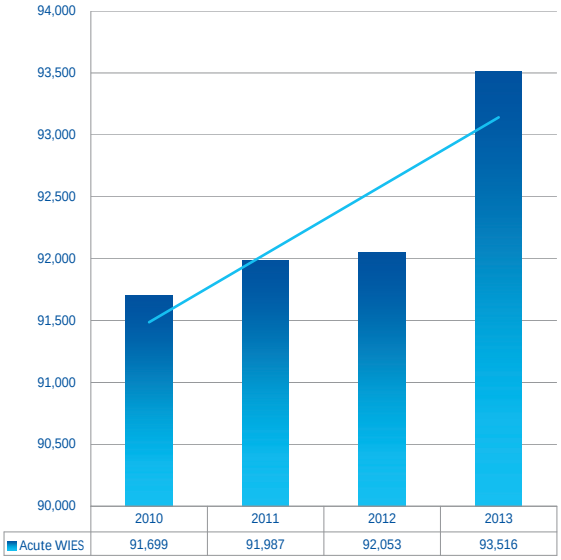
Assessment Treatment and Rehabilitation (Inpatient) Impact Measures	
Comments ref.	
58	Reduced Length of Stay has allowed for growth in events.
59	The results reflect a focus on in-service training.
60	Work continues on the access pathways to help lift performance in this measure.

Sub-Output Class	Output Measures	Baseline	Baseline 2012/13	2012/13 Target	Actual 2013	Rating	Comments Ref. - see below
Mental Health	Access rates for total and specific population groups (defined as the proportion of the population utilising MH&A services in the last year)	0-19					61
		Māori	4.21%	4.08%	4.65%	Achieved	
		Total	2.35%	2.53%	2.65%	Achieved	
		20-64					
		Māori	9.55%	8.18%	10.74%	Achieved	
		Total	3.61%	3.3%	3.72%	Achieved	
		65+	3.29%	3.58%	3.59%	Achieved	
	Proportion of long term clients with Relapse Prevention Plan (RPP) [target of 95%] in the above population groups (Policy Priorities 7)	Adult					
		Māori	98.5%	95%	99%	Achieved	62
		Pacific	100%	95%	100%	Achieved	
		Other	99%	95%	97%	Achieved	
		Child & Youth					
		Māori	100%	95%	100%	Achieved	
		Pacific	100%	95%	100%	Achieved	
		Other	100%	95%	100%	Achieved	
	Alcohol and drug service waiting times and waiting list report (Policy Priorities 8)-waiting times should fall within target for maximum waiting time for each service:	Seen within 3 weeks	61.70%	80%	63.2%	Not Achieved	63
	• Inpatient detox	Seen within 8 weeks	73.30%	95%	88.5%	Substantially Achieved	
	• Specialist prescribing						
	• Structured counselling						

Mental Health	
Comments ref.	
61	All targets met. This indicator demonstrates the utilisation of our mental health services in relation to our population size. Low "Access" rates would indicate that our services may not be reaching a high proportion of those who need them.
62	All targets met. There is evidence that relapse prevention programmes targeted to patients with a high risk of relapse/recurrence who have recovered after antidepressant treatment significantly improves antidepressant adherence and depressive symptom outcomes. The absence of a relapse prevention plan among mental health patients therefore indicates a failing in service quality.
63	There will be a project focussing on improving wait times.

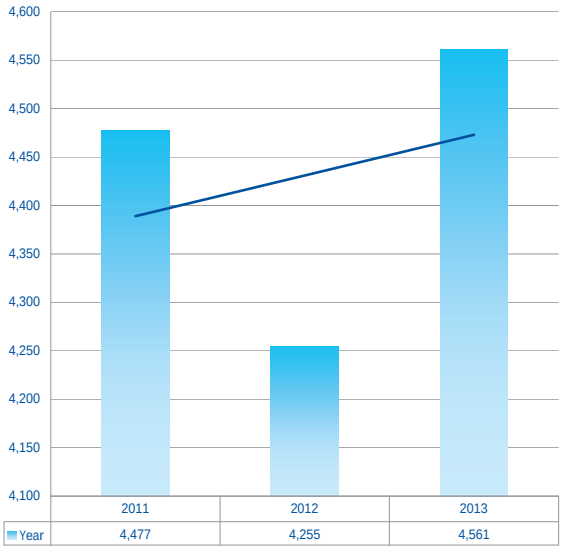
Sub-output Community referral testing & Diagnostics

Acute WIES



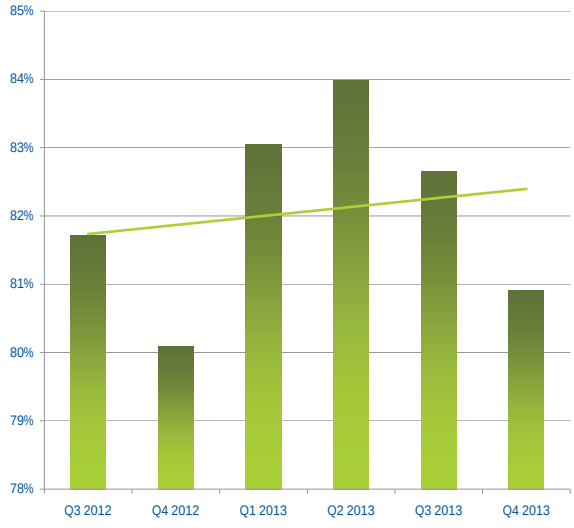
Sub-output Class Maternity

Number of first obstetric consultations



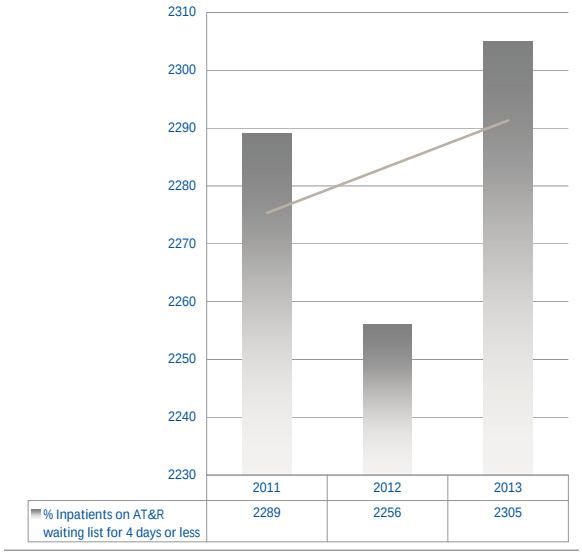
Sub-output Primary

% Very good and excellent ratings for overall patient experience for inpatients



Sub-output Primary

Number of AT & R inpatient events



OUTPUT CLASS MEASURES: Rehabilitation and Support Services

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Rating	Comments Ref. - see below
Sub-output Class: Home-based support services (HBSS)	Total no. of InterRAI assessments (demand driven)	130 per month	5,082 for the year Av. 423 a month	150 per month	Achieved	65
	The proportion of people aged 65 and older receiving long-term HBSS over the last three months who have received a comprehensive clinical assessment and a care plan completed	New	95%	95%	Achieved	66
	Percentage of NASC clients assessed within 6 weeks	96%	98%	> 96%	Achieved	

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Rating	Comments Ref. - see below
Sub-output Class: Palliative Care	Total number of completed episodes of care (death or discharge)	734	876	*	Achieved	67
	Proportion of cancer patients admitted to hospice who are Māori or Pacific people versus proportion of cancer deaths who are Māori and Pacific people (historical baseline)	Admissions M 5% P 12% A 11% Deaths M 7% P 11% A 8%	 6% 12% 10% 7% 11%	% admitted should reflect % deaths by ethnicity	 Achieved Achieved Achieved Achieved	68
	Proportion of patients acutely referred who had to wait> 48 hours for a hospice bed (demand driven)	11%	10%	<11%	Achieved	

Sub-Output Class	Output Measures	Baseline	2012/13	2012/13 Target	Rating	Comments Ref. - see below
Sub-output Class: Residential Care	Total number of subsidised aged residential care bed days	954,667	980,702	≥	Achieved	69
	Proportion of long-term residents (who are living in facilities that have received InterRAI training) who have had an InterRAI clinical assessment within the year	New	See note 70	20%	N/a	70
	Percentage of NASC clients assessed within 6 weeks	96%	95%	≥ 96 %	Substantially achieved	71

Comments ref.	
Home based support	
65	Volumes have increased to nearly three times the target.
66	The likely reason for 5.5% of clients not having recorded interRAI assessments is that they are still in draft form and hence not showing up in the system.
Palliative Care	
67	Volumes have increased to nearly three times the target.
68	The likely reason for 5.5% of clients not having recorded interRAI assessments is that they are still in draft form and hence not showing up in the system.
Residential Care	
69	Total number of subsidised aged residential care beds. Bed days are a standard measure of the volume of aged residential care service.
70	25(37%) of aged residential facilities in Auckland DHB are engaged in interRAI training. However it is not possible to access facility data on interRAI assessments. The issue is being addressed at a national level.
71	There are many variables prior to a NASC assessment for aged residential care e.g. referrals don't always reflect families' intentions, inpatient assessments may be required and there may be a long waiting list.

Qualified Audit Opinion regarding certain performance information

Audit New Zealand have qualified their audit opinion regarding certain non-financial performance information, as this information relies on the accuracy of data supplied by Primary Care (GP practices). This information is collected by Primary Health Organisations who then report this information to the Ministry of Health, who in turn publish the results to the public on a quarterly basis. The DHB includes this information in its reported performance information.

In the 2012/13 audit, Audit New Zealand applied a revised auditing standard to DHBs' service performance reports and has confirmed that, in their opinion, the Auckland DHB's control over much of this information is limited and that at present there are no practical audit procedures to determine the effect of this limited control. Accordingly, Audit New Zealand have qualified their report on the non-financial performance information of our DHB (and as we understand it all other DHBs, on that same basis).

We understand the reasoning behind their audit opinion as the systems and processes for collecting and understanding the data are complex and involve multiple parties and different clinical systems.

However, we consider our Primary Care service performance information to be materially accurate and complete because there are a range of processes that Primary Health Organisations use to monitor primary care data.

STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2013

	Notes	Group Budget	Group Actual		Parent Actual	
		2013	2013	2012	2013	2012
		$000	$000	$000	$000	$000
Revenue						
Patient care revenue	2a	1,904,502	1,755,371	1,727,436	1,755,371	1,727,436
Interest Income		6,974	7,273	7,053	6,329	5,960
Other revenue	2b	56,870	57,422	54,366	56,165	51,409
Total revenue		**1,968,346**	**1,820,066**	**1,788,855**	**1,817,865**	**1,784,805**
Expenses						
Personnel costs	3a	763,425	770,141	750,472	770,141	750,472
Depreciation and amortisation costs	11a,b	43,701	39,816	39,694	39,816	39,694
Outsourced services		79,038	88,411	94,198	88,411	94,198
Clinical Supplies		215,562	213,045	207,963	213,045	207,963
Infrastructure and non-clinical expenses		71,725	69,526	64,152	69,526	64,152
Other district health boards		109,447	105,570	97,493	105,570	97,493
Non-health board provider expenses		596,396	441,795	445,148	441,795	445,148
Capital charge	15	32,892	33,500	32,936	33,500	32,936
Interest expense		15,875	17,698	17,856	17,698	17,856
Other expenses	3b	40,193	40,581	38,207	39,653	37,022
Total expenses		**1,968,254**	**1,820,083**	**1,788,119**	**1,819,155**	**1,786,934**
Share of surpluses of joint ventures & associates	5	0	171	1	0	0
Surplus/(deficit)		**92**	**154**	**737**	**(1,290)**	**(2,129)**

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2013

	Notes	Group Budget	Group Actual		Parent Actual	
		2013	2013	2012	2013	2012
		$000	$000	$000	$000	$000
Surplus/ (deficit)		92	154	737	(1,290)	(2,129)
Gains/(Losses) on property revaluations	6	0	36,213	(174)	36,213	(174)
Total Comprehensive Income/(Loss)		**92**	**36,367**	**563**	**34,923**	**(2,303)**

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 2013

GROUP	Notes	Actual 2013 $000	Budget 2013 $000	Actual 2012 $000
Balance as at 1 July		**441,896**	**437,050**	**439,521**
Comprehensive income/(expense)				
Surplus/ (deficit) for prior period		154	92	737
Surplus/ (deficit) for period		36,213	0	(174)
Other comprehensive income/(expense)		36,367	92	563
Total comprehensive income/(expense)				
Owner Transactions		1,883	3,358	1,812
Capital contributions to the Crown		0	0	0
Repayment of capital to the Crown		480,146	440,500	441,896
Balance as at 30 June	6	**480,146**	**440,500**	**441,896**

PARENT	Notes	Actual 2013	Budget 2012 $000	Actual 2012 $000
Balance as at 1 July		**422,459**	**436,313**	**422,950**
Comprehensive income/(expense)				
Surplus/ (deficit) for period		(1,290)	(829)	(2,129)
Other comprehensive income/(expense)		36,213	0	(174)
Total comprehensive income/(expense)		**34,923**	**(829)**	**(2,303)**
Owner Transactions				
Capital contributions to the Crown		1,883	3,358	1,812
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	6	**459,265**	**438,842**	**422,459**

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 2013

	Notes	Group Budget	Group Actual		Parent Actual	
		As at 30/06/13 $000	As at 30/06/13 $000	As at 30/06/12 $000	As at 30/06/13 $000	As at 30/06/12 $000
Current Assets						
Cash and cash equivalents	7	23,000	80,727	94,081	80,727	94,081
Financing Deposit		31,500	0	0	0	0
Trust/special funds	8a	8,925	20,245	22,078	0	0
Patient & restricted trust funds	8b	1,175	1,146	1,120	1,146	1,120
Debtors & other receivables	9	67,028	50,431	61,823	49,140	59,532
Prepayments		0	1,350	1,419	1,350	1,419
Inventories	10	11,369	12,884	14,117	12,884	14,117
Total Current Assets		142,997	166,783	194,638	145,247	170,269
Non-Current Assets						
Trust/special funds	8a	2,145	6,686	2,129	0	0
Property, plant and equipment	11a	875,944	871,958	842,774	871,058	841,874
Intangible assets	11b	900	8,627	529	8,627	529
Derivative financial instruments	19	5,907	1,072	7,553	1,072	7,553
Investments in joint ventures & associates	5	17,027	25,016	20,226	24,770	19,724
Total Non-Current Assets		901,923	913,359	873,211	905,527	869,680
Total Assets		1,044,920	1,080,142	1,067,849	1,050,774	1,039,949

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 2013

	Notes	Group Budget	Group Actual		Parent Actual	
		As at 30/06/13 $000	As at 30/06/13 $000	As at 30/06/12 $000	As at 30/06/13 $000	As at 30/06/12 $000
Current Liabilities						
Bank overdraft	7	0	0	19,800	0	19,800
Trade and other payables	13a	146,400	119,113	121,471	110,626	113,008
Employee benefits	13b	124,892	147,479	152,117	147,479	152,117
Provisions	13c	0	1,803	1,830	1,803	1,830
Interest-bearing loans and borrowings	14,18	13,802	12,761	66,694	12,761	66,694
Loans from joint ventures & associates	5	0	0	375	0	375
Derivative financial instruments	19	0	0	86	0	86
Patient & restricted trust funds	8b	1,175	1,146	1,120	1,146	1,120
Total Current Liabilities		286,269	282,302	363,493	273,815	355,030
Non-Current Liabilities						
Employee benefits	13b	23,836	23,369	21,747	23,369	21,747
Interest-bearing loans and borrowings	14	294,315	294,325	240,713	294,325	240,713
Total Non-Current Liabilities		318,151	317,694	262,460	317,694	262,460
Total Liabilities		604,420	599,996	625,953	591,509	617,490
Net Assets		440,500	480,146	441,896	459,265	422,459
Equity						
Public equity	6a	576,461	576,798	574,915	576,798	574,915
Accumulated deficit	6b	(476,949)	(485,047)	(483,757)	(485,553)	(484,263)
Other reserves	6c	331,981	368,020	331,807	368,020	331,807
Trust/special funds	6d	9,007	20,375	18,931	0	0
Total Equity		440,500	480,146	441,896	459,265	422,459

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

Dr Lester Levy
Chair
Dated: 30 October 2013

Ian Ward
Chair, Audit and Finance Committee
Dated: 30 October 2013

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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2013

	Notes	Group Budget	Group Actual		Parent Actual	
		2013	2013	2012	2013	2012
		$000	$000	$000	$000	$000
Cash flows from operating activities						
Cash receipts from Ministry of Health and patients		1,885,475	1,901,163	1,832,326	1,901,163	1,832,326
Interest received		6,974	7,272	7,779	6,188	5,925
Other Receipts		75,805	73,866	77,737	72,865	75,927
Cash paid to employees		(783,572)	(768,344)	(742,462)	(768,344)	(742,462)
Cash paid to suppliers		(1,083,515)	(1,112,029)	(1,091,656)	(1,112,591)	(1,091,076)
Interest paid		(15,542)	(18,127)	(17,806)	(18,127)	(17,806)
Net goods and services taxes refunded/(paid)		(1,561)	521	(1,200)	444	(1,258)
Capital charges paid		(32,983)	(33,819)	(40,288)	(33,819)	(40,288)
Net cash inflow from operating activities	7	51,081	50,503	24,430	47,779	21,288
Cash flows from investing activities						
Proceeds from sale of property, plant and equipment		11,662	0	19,531	0	19,531
Decrease/(Increase) in investments and restricted trust funds		(5,228)	(9,869)	(21,993)	(7,145)	(19,751)
Purchase of property, plant and equipment		(91,836)	(37,814)	(53,824)	(37,814)	(52,924)
Net cash (outflow) from investing activities		(85,402)	(47,683)	(56,286)	(44,959)	(53,144)
Cash flows from financing activities						
Repayment of loans		0	(63,500)	(20,000)	(63,500)	(20,000)
Proceeds from borrowings		0	65,243	41,000	65,243	41,000
Proceeds from capital contributed/(repaid)		0	1,883	1,812	1,883	1,812
Net cash inflow/(outflow) from financing activities		0	3,626	22,812	3,626	22,812
Net (decrease)/increase in cash and cash equivalents		(34,321)	6,446	(9,044)	6,446	(9,044)
Cash and cash equivalents at start of the year		57,321	74,281	83,325	74,281	83,325
Cash and cash equivalents at end of the year	**7**	**23,000**	**80,727**	**74,281**	**80,727**	**74,281**

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.

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, Auckland DHB 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 Auckland DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, Auckland DHB 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).

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 Waitematā 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 was established by the four largest District Health Boards (Counties Manukau, Auckland, Waitematā and Canterbury). 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 New Zealand and internationally.

The Hub has been structured as a limited partnership, with the four foundation DHBs each having a 25% shareholding. It was incorporated on 26 June 2012.

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 a 33% shareholding in Northern Regional Alliance Limited (NRA), (previously Northern Regional Training Hub 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 Alliance Limited is an associate with Counties-Manukau and Waitematā DHBs. It exists to support and facilitate employment and training for Resident Medical Officers across the three Auckland regional DHBs and to provide a shared services agency to the four Auckland regional District Health 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 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.

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 2013. 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 Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at the inception of the lease, less accumulated depreciation and impairment losses. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Operating lease payments are recorded as an expense in the 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 Auckland DHB. 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	2013	2012
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.

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 (2012: 5 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.

Auckland DHB has made payments totalling $8,297k (2012: Nil) to Health Benefits Limited (HBL) in relation to the Finance, Procurement and Supply Chain (FPSC) Programme. The FPSC Programme is a national initiative, facilitated by HBL, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

HBL has issued B Class Shares to DHBs for the purpose of funding the development of the National Finance, Procurement and Supply Chain Shared Service. The following rights are attached to these shares;

- Class B Shares confer no voting rights
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by HBL from the Finance, Procurement and Supply Chain Shared Service
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the Assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.
- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

The rights attached to the "B" Class share include the right to access, under a service level agreement, shared services in relation to finance, procurement and supply chain services and, therefore, the benefits conferred through this access. The service level agreement will contain five provisions specific to the recognition of the investment within the financial statements of the NMDHB. The five provisions are:

- The service level agreement is renewable indefinitely at the option of the DHBs; and
- The DHBs intend to renew the agreement indefinitely; and
- There is satisfactory evidence that any necessary conditions for renewal will be satisfied; and
- The cost of renewal is not significant compared to the economic benefits of renewal; and
- The fund established through the on-charging of depreciation by HBL will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

The application of these five provisions mean the investment, upon capitalisation on the implementation of the FPSC Programme, resulting in the asset being recognised as an indefinite life intangible asset.

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

Auckland DHB 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 Auckland DHB would receive or pay to terminate the swaps at balance date taking into account the current interest rates and the current credit worthiness of the counter-party.

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

DHB Bond FRAs

Auckland DHB has entered into two derivative financial instruments known as Forward Rate Agreements (FRA's) with Westpac Bank on 3 Aug 2012. These instruments are used to hedge or minimise any substantial gains or losses from exposure to future government bond yields.

Each year the fair value of these derivatives financial instruments is recognised in the accounts. The net fair value of Auckland DHB Bond FRAs at 30 June 2013 was a net asset position of $1,072k (2012 Nil).

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.

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 Auckland DHB'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 Auckland DHB becomes a party to the contractual provisions of the instrument. Financial assets are de-recognised if Auckland DHB's contractual rights to the cash flows from the financial asset expire or if Auckland DHB 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 Auckland DHB commits itself to purchase or sell the asset. Financial liabilities are de-recognised if Auckland DHB'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. Auckland DHB 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

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

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

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

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.

Provisions

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

Restructuring

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

Revenue

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.

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 Auckland DHB 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.

Change in accounting policies

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

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 Auckland DHB and are represented by the cost of providing the services less all of the revenue that can be allocated to these activities.

Cost Allocation

Auckland DHB 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.

	Notes	Group Actual 2013 $000	Group Actual 2012 $000	Parent Actual 2013 $000	Parent Actual 2012 $000
2 REVENUE					
a ***Patient care revenue***					
Health & disability services (MoH contracted revenue)		1,198,484	1,137,502	1,198,484	1,137,502
ACC contract revenue		15,161	14,848	15,161	14,848
Interdistrict patient inflows		504,519	543,725	504,519	543,725
Revenue from other district health boards		20,338	16,197	20,338	16,197
Other patient care related revenue		16,869	15,164	16,869	15,164
Total patient care revenue		1,755,371	1,727,436	1,755,371	1,727,436
b ***Other income***					
Gain on sale of property, plant & equipment		0	0	0	0
Donations and bequests		8,837	5,139	7,711	2,182
Rental income		7,194	6,258	7,194	6,258
Gain on financial assets		302	0	0	0
Gain on derivatives – financial instruments		0	3,496	0	3,496
Other income		41,089	39,473	41,260	39,473
Total other income		57,422	54,366	56,165	51,409
3 EXPENSES					
a ***Personnel costs***					
Wages and salaries		755,242	726,184	755,242	726,184
Contributions to defined contribution plans	(i)	11,892	11,967	11,892	11,967
Increase/(decrease) in liability for employee benefit		3,016	12,507	3,016	12,507
Restructuring provision for employee costs		(9)	(186)	(9)	(186)
Total personnel costs		770,141	750,472	770,141	750,472
b ***Other expenses***					
Fees to auditor					
- fees to Audit New Zealand for audit of financial statements including for Auckland DHB Charitable Trust		267	244	267	244
- fees to Audit New Zealand for other services		0	0	0	0
Operating leases		4,001	4,006	4,001	4,006
Impairment of debtors		3,297	2,247	3,297	2,247
Board members' fees		381	385	381	385
Loss on disposal of property, plant and equipment		71	618	71	618
Loss on derivatives – financial instruments		81	0	81	0
Loss on financial assets		97	0	0	0
Foreign currency loss		2	(2)	2	(2)
Other expenses		32,384	30,709	31,553	29,524
Total other expenses		40,581	38,207	39,653	37,022

Note

3a(i) Auckland DHB 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 2013 $000	Group Actual 2012 $000	Parent Actual 2013 $000	Parent Actual 2012 $000

4 TAXATION

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

5 INVESTMENTS IN JOINT VENTURES & ASSOCIATES

Non Current Assets				
Results of joint ventures & associates				
Share of post acquisition surplus	171	1	0	0
Share of net surpluses of joint venture & associates	171	1	0	0
Carrying amount at the beginning of the year	20,226	502	19,724	1
Net movement in Investments	4,619	19,723	5,046	19,723
Carrying amount at end of year	25,016	20,226	24,770	19,724
Represented by:				
Class A Shares in Health Alliance NZ Ltd (joint venture)	200	200	200	200
Class B Shares in Health Alliance NZ Ltd (joint veture) (i)	24,569	19,523	24,569	19,523
Other shares in joint ventures & associates	1	1	1	1
Share of post-acquisition retained surpluses	246	502	0	0
	25,016	20,226	24,770	19,724
Current Liabilities				
Loans from joint ventures & associates	0	375	0	375

Note 5(i)

A Memorandum of Understanding was signed between Health Alliance NZ Ltd and Auckland DHB, Counties Manukau DHB , Northland DHB and Waitematā 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). Total value issued at 30 June 2013 is $24,569k (2012: $19,523k represents the baseline value of Auckland DHB's IT assets transferred on 29 June 2012) .

	2013 % Interest held	2012 % 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	20
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	25
Name of associates (Principal activity)		
Northern Regional Alliance Limited (management of a number of regional contracts on behalf of the Auckland region DHBs and co-ordinations trainee medical personnel) formed 1 Mar 2013	33	0
(previously Northern DHB Support Agency Limited/ Northern Regional Training Hub Limited)		
Northern Regional Training Hub Limited (co-ordination trainee medical personnel) amalgamated to Northern Regional Alliance Limited on 1 Mar 2013	0	33
Northern DHB Support Agency Limited (management of a number of regional contracts on behalf of the Auckland region DHBs.), name changed to Northern Regional Alliance Limited on 1 Mar 2013	0	33

All the above related parties have balance dates of 30 June. Auckland DHB does not have a share in any contingent liabilities or capital commitments of these related parties.

		Group Actual		Parent Actual	
		As at 30/06/13 $000	As at 30/06/12 $000	As at 30/06/13 $000	As at 30/06/12 $000
6	CAPITAL AND RESERVES				
a	***Public equity***				
	Opening balance	574,915	573,103	574,915	573,103
	Contributions from/(repayment to) the Crown	1,883	1,812	1,883	1,812
	Balance at end of year	576,798	574,915	576,798	574,915
b	***Accumulated deficits***				
	Opening balance	(483,757)	(481,629)	(484,263)	(482,134)
	Operating surplus/(deficit)	154	737	(1,290)	(2,129)
	Transfer to trust/special funds	(1,444)	(2,865)	0	0
	Balance at end of year	(485,047)	(483,757)	(485,553)	(484,263)
c	***Other Reserves***				
	Revaluation Reserve				
	Opening balances	331,807	331,981	331,807	331,981
	Net Movement	36,213	(174)	36,213	(174)
	Balance at end of year	368,020	331,807	368,020	331,807
d	***Trust/special funds***				
	Opening balances	18,931	16,066	0	0
	Transfer from accumulated deficits (Note 6b)	1,444	2,865	0	0
	Balance at end of year	20,375	18,931	0	0
	Grand Total	**480,146**	**441,896**	**459,265**	**422,459**

Other reserves

Revaluation reserve

The revaluation reserve relates to the independent valuation by Telfer Young (Auckland) Ltd of land and buildings at 30 June 2013 of $772.9m - 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 Auckland DHB's normal banking facilities.

Trust/special funds	2013 Actual $000	2012 Actual $000
Balance at beginning of year	18,931	16,066
Transfer from retained earnings in respect of:		
Interest received	1,148	1,093
Donations and funds received	1,763	2,789
Transfer to retained earnings in respect of:		
Funds spent	(1,467)	(1,017)
Balance at end of year	20,375	18,931

	Group Actual		Parent Actual	
	As at 30/06/13 $000	As at 30/06/12 $000	As at 30/06/13 $000	As at 30/06/12 $000
7 CASH AND CASH EQUIVALENTS				
Current assets				
Bank balance	192	2,553	192	2,553
Short term deposits	195	91,528	195	91,528
Health Benefits Limited	80,340	0	80,340	0
Cash & cash equivalents	80,727	94,081	80,727	94,081
Bank overdrafts	0	(19,800)	0	(19,800)
Cash & cash equivalents in the statement of cash flows	80,727	74,281	80,727	74,281
Banking facility limit				
Revolving cash facility:				
CBA	0	65,000	0	65,000

The carrying value of the current portion of investments approximates their fair value.

Auckland DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the all District Health Boards dated 12 November 2012. This Agreement enables HBL to "sweep' DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement allows individual DHBs to borrow funds from HBL, which will incur interest at on-call interest rate received by HBL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of month's Provider Arm funding plus GST. For Auckland DHB, that equates to $105.272m.

The DHB Treasury Services Agreement has replaced the working capital facility agreement of $65m supplied by the Commonwealth Bank of Australia, which was established in February 2004. The facility consisted of a bank overdraft and revolving bank multi-option credit facility. The unused portion of the facility at 30 June 2012 was $45.2m. This facility was cancelled on 19 December 2012.

7 CASH AND CASH EQUIVALENTS *(continued)*	Notes	Group Actual 2013 $000	Group Actual 2012 $000	Parent Actual 2013 $000	Parent Actual 2012 $000
RECONCILIATION OF REPORTED OPERATING SURPLUS/(DEFICIT) AFTER TAXATION WITH NET CASH INFLOW (OUTFLOW) FROM OPERATING ACTIVITIES					
Reported net surplus/(deficit) for the year	6	154	737	(1,290)	(2,129)
Add non-cash items:					
Share of associate and joint venture surplus	5	(171)	(1)	0	0
Increase in provision		1,096	(1,651)	1,096	(1,651)
Depreciation and amortisation expense		39,818	39,694	39,818	39,694
Net (gains)/ losses on derivative financial instruments		(1,207)	(1,799)	(1,207)	(1,799)
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		0	(618)	0	(618)
***Add movements in statement of financial position items*:**					
(Increase)/Decrease in debtors and other receivables		7,435	(5,341)	8,265	(2,123)
(Increase)/Decrease in prepayments		(69)	(1,606)	(69)	(1,606)
(Increase)/Decrease in inventories		1,233	(2,096)	1,233	(2,096)
Increase/(Decrease) in creditors and other payables		5,231	(15,962)	2,950	(20,265)
Increase/(Decrease) in employee entitlements		(3,017)	13,073	(3,017)	13,881
Net cash inflow/(outflow) from operating activities		50,503	24,430	47,779	21,288

8a TRUST/SPECIAL FUNDS	Group Actual As at 30/06/13 $000	Group Actual As at 30/06/12 $000	Parent Actual As at 30/06/13 $000	Parent Actual As at 30/06/12 $000
Current assets				
Bank balances (restricted)	892	99	0	0
Short term deposits (restricted)	4,660	21,979	0	0
Portfolio Investments	14,693	0	0	0
	20,245	22,078	0	0
Non – current assets				
Investment Bonds (at market)/(restricted)	2,094	2,129	0	0
Portfolio Investments	4,592	0	0	0
	6,686	2,129	0	0

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

Term deposits

Interest is receivable on fixed term deposits at a weighted average of 4.0% (30 June 2012 4.2%)

There is no impairment provision for investments. Equity investments are measured at fair value with fair value determined by reference to published bid price quotations in an active market.

The carrying amounts of term deposits with maturities less than 12 months approximate their fair value. The fair value of term deposits with remaining maturities in excess of 12 months is $2,094k (2012 $2,129k). The fair values are based on discounted cash flows using market quoted interest rates for term deposits with terms to maturity similar to the relevant investments.

8b PATIENT AND RESTRICTED TRUST FUNDS

	Group Actual		Parent Actual	
	As at 30/06/13	As at 30/06/12	As at 30/06/13	As at 30/06/12
Current assets				
Patient trust	9	10	9	10
Restricted fund deposit	1,137	1,110	1,137	1,110
	1,146	1,120	1,146	1,120
Current liabilities				
Patient trust	9	10	9	10
Restricted fund deposit	1,137	1,110	1,137	1,110
	1,146	1,120	1,146	1,120

Patient trust

Auckland DHB 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 Auckland DHB Treaty partner, Ngati Whatua.

9 DEBTORS AND OTHER RECEIVABLES

	Group Actual		Parent Actual	
	As at 30/06/13	As at 30/06/12	As at 30/06/13	As at 30/06/12
Ministry of Health receivables	25,168	26,499	25,168	26,499
Other receivables	18,917	21,652	18,080	19,361
Other accrued income	9,126	15,356	8,672	15,356
Less provision for impairment	(2,780)	(1,684)	(2,780)	(1,684)
	50,431	61,823	49,140	59,532

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

10 INVENTORIES

	Group Actual		Parent Actual	
	As at 30/06/13	As at 30/06/12	As at 30/06/13	As at 30/06/12
Pharmaceuticals	1,697	1,703	1,697	1,703
Surgical and medical supplies	11,154	12,386	11,154	12,386
Other supplies	33	28	33	28
	12,884	14,117	12,884	14,117

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2013 was $12,884k (2012 14,117k). Write-down/ (up) of inventories amounted to $664k for 2013 (2012 ($65k)).

11a PROPERTY, PLANT and EQUIPMENT

GROUP 2013	Freehold land (at valuation)	Freehold buildings & fitouts (at valuation)	Plant, equipment and vehicles	Leased Improvements	Work in progress	Total
	$000	$000	$000	$000	$000	$000
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**
Cost						
Balance at 1 July 2012	163,809	604,933	278,401	885	13,799	1,061,827
Additions	0	0	0	0	29,392	29,392
Additions from Work in Progress	0	11,915	8,789	2	(20,706)	0
Disposals	0	(7)	(7,299)	(21)	0	(7,327)
Transfer to Non-current assets held for sale	0	0	0	0	0	0
Reclassifications	0	6,998	(6,776)	(108)	0	114
Revaluations	45,512	(54,392)	0	0	0	(8,880)
Balance at 30 June 2013	**209,321**	**569,447**	**273,115**	**758**	**22,485**	**1,075,126**
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)**
Depreciation and impairment losses						
Balance at 1 July 2012	0	(21,966)	(196,356)	(731)	0	(219,053)
Depreciation charge for the year	0	(21,526)	(18,016)	(46)	0	(39,588)
Disposals	0	7	10,370	20	0	10,397
Transfer to Non-current assets held for sale	0	0	0	0	0	0
Reclassifications	0	(4,868)	4,786	65	0	(17)
Revaluations	0	45,093	0	0	0	45,093

Balance at 30 June 2013	**0**	**(3,260)**	**(199,216)**	**(692)**	**0**	**(203,168)**

11a PROPERTY, PLANT and EQUIPMENT *(continued)*

GROUP 2013	**Freehold land (at valuation)**	**Freehold buildings & fitouts (at valuation)**	**Plant, equipment and vehicles**	**Leased improvements**	**Work in progress**	**Total**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**
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**
Carrying Amounts						
At 1 July 2012	163,809	582,967	82,045	154	13,799	842,774
At 30 June 2013	**209,321**	**566,187**	**73,899**	**66**	**22,485**	**871,958**

11a PROPERTY, PLANT and EQUIPMENT *(continued)*

PARENT 2013	Freehold land (at valuation)	Freehold buildings & fitouts (at valuation)	Plant, equipment and vehicles	Leased Improvements	Work in progress	Total
	$000	$000	$000	$000	$000	$000
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**
Cost						
Balance at 1 July 2012	163,809	604,933	278,401	885	12,899	1,060,927
Additions	0	0	0	0	29,392	29,392
Additions from Work in Progress	0	11,915	7,889	2	(19,806)	0
Disposals	0	(7)	(7,299)	(21)	0	(7,327)
Transfer to Non-current assets held for sale	0	0	0	0	0	0
Reclassifications	0	6,998	(6,776)	(108)	0	114
Revaluations	45,512	(54,392)	0	0	0	(8,880)
Balance at 30 June 2013	**209,321**	**569,447**	**272,215**	**758**	**22,485**	**1,074,226**
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)**
Depreciation and impairment losses						
Balance at 1 July 2012	0	(21,966)	(196,356)	(731)	0	(219,053)
Depreciation charge for the year	0	(21,526)	(18,016)	(46)	0	(39,588)
Disposals	0	7	10,370	20	0	10,397
Transfer to Non-current assets held for sale	0	0	0	0	0	0
Reclassifications	0	(4,868)	4,786	65	0	(17)
Revaluations	0	45,093	0	0	0	45,093
Balance at 30 June 2013	**0**	**(3,260)**	**(199,216)**	**(692)**	**0**	**(203,168)**

11a PROPERTY, PLANT and EQUIPMENT *(continued)*

PARENT 2013	Freehold land (at valuation)	Freehold buildings & fitouts (at valuation)	Plant, equipment and vehicles	Leased improvements	Work in progress	Total
	$000	$000	$000	$000	$000	$000
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**
Carrying Amounts						
At 1 July 2012	163,809	582,967	82,045	154	12,899	841,874
At 30 June 2013	**209,321**	**566,187**	**72,999**	**66**	**22,485**	**871,058**

Valuation Information

Land, buildings and associated fitouts and services were independently valued on 30 June 2013 by Telfer Young (Auckland) Ltd (a firm registered with Valuers of New Zealand) at $775.4m (2012 $746.7m).

11b INTANGIBLE ASSETS

GROUP & PARENT	Note	HBL Class B Shares Cost	Software & development costs Cost	Total
				$000
Cost				
Balance at 1 July 2011		0	1,977	1,977
Additions		0	59	59
Disposals		0	(6)	(6)
Transfer to Non-current assets held for sale		0	0	0
Reclassifications		0	0	0
Balance at 30 June 2012		0	**2,030**	**2,030**
Balance at 1 July 2012		0	2,030	2,030
Additions		8,297	125	8,422
Disposals		0	0	0
Transfer to Non-current assets held for sale		0	0	0
Reclassifications		0	490	490
Balance at 30 June 2013		**8,297**	**2,645**	**10,942**
Amortisation & Impairment Losses				
Balance at 1 July 2011		0	(1,442)	(1,442)
Amortisation charge for the year		0	(65)	(65)
Disposals		0	6	6
Transfer to Non-current assets held for sale		0	0	0
Reclassifications		0	0	0
Balance at 30 June 2012		**0**	**(1,501)**	**(1,501)**
Amortisation & Impairment Losses				
Balance at 1 July 2012		0	**(1,501)**	**(1,501)**
Amortisation charge for the year		0	(228)	(228)
Disposals		0	0	0
Transfer to Non-current assets held for sale		0	0	0
Reclassifications		0	(586)	(586)
Balance at 30 June 2013		**0**	**(2,315)**	**(2,315)**

(Continued page 75)

11b INTANGIBLE ASSETS *(continued)*

GROUP & PARENT	Note	HBL Class B Shares Cost	Software & development costs Cost	Total
Carrying Amounts				
At 1 July 2011		0	535	535
At 30 June 2012		**0**	**529**	**529**
At 1 July 2012		0	529	529
At 30 June 2013		**8,297**	**330**	**8,627**

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 (2012Nil).

No impairment is recognised in HBL Class B Shares.

12a CONTINGENT ASSETS

There are no contingent assets at 30 June 2013 (2012 Nil).

12b CONTINGENT LIABILITIES

Lawsuits against the DHB

Auckland DHB is at any time confronted by a variety of claims, often from patients. As at year-end the quantum of all outstanding claims, including legal costs (if any), are minimal, and are also covered by insurance.

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		Parent Actual	
		As at 30/06/13	As at 30/06/12	As at 30/06/13	As at 30/06/12
		$000	$000	$000	$000

13a TRADE AND OTHER PAYABLES

Current				
Creditors and accrued expenses	82,001	86,487	78,384	83,522
GST,PAYE & FBT payable	24,326	18,963	24,424	18,983
Capital Charge payable	0	319	0	319
Income in advance	12,786	15,702	7,818	10,184
	119,113	121,471	110,626	113,008

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

	Group Actual		Parent Actual	
	As at 30/06/13	As at 30/06/12	As at 30/06/13	As at 30/06/12
Current	$000	$000	$000	$000
Liability for long service leave	2,662	2,245	2,662	2,245
Liability for sabbatical leave	300	300	300	300
Liability for retirement gratuities	5,607	5,627	5,607	5,627
Liability for annual leave	82,718	81,524	82,718	81,524
Liability for sick leave	1,023	1,006	1,023	1,006
Liability for continuing medical leave and expenses	25,008	24,239	25,008	24,239
Salaries and wage accrual	30,161	37,176	30,161	37,176
	147,479	152,117	147,479	152,117
Non Current				
Liability for long service leave	1,310	1,428	1,310	1,428
Liability for retirement gratuities	22,059	20,319	22,059	20,319
	23,369	21,747	23,369	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 $18.6m are Unpaid Days $4.8m and $13.8m salaries and wages for June paid in July.

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 5.5% (2012 6%) and an inflation factor of 1.0% (2012 1.5%) were used.

13c PROVISIONS

	Group Actual		Parent Actual	
	As at 30/06/13	As at 30/06/12	As at 30/06/13	As at 30/06/12
Current	$000	$000	$000	$000
ACC Partnership Programme	1,734	1,757	1,734	1,757
Litigation	0	13	0	13
Restructuring	69	60	69	60
	1,803	1,830	1,803	1,830

	Notes	Group Actual		Parent Actual	
		As at 30/06/13 $000	As at 30/06/12 $000	As at 30/06/13 $000	As at 30/06/12 $000
13c PROVISIONS *(continued)*					
Movement for each class of provisions are as follows:					
ACC Partnership Programme					
Opening balance		1,757	1,825	1,757	1,825
Additional provisions made during year		1,126	559	1,126	559
Charged against provision for the year		(1,149)	(627)	(1,149)	(627)
Unused amounts reversed during year		0	0	0	0
Closing balance	(i)	1,734	1,757	1,734	1,757
Litigation Provision					
Opening balance		13	0	13	0
Additional provisions made during year		0	13	0	13
Charged against provision for the year		0	0	0	0
Unused amounts reversed during year		(13)	0	(13)	0
Closing balance	(ii)	0	13	0	13
Restructuring Provision					
Opening balance		60	246	60	246
Additional provisions made during year		69	(71)	69	(71)
Charged against provision for the year		(53)	(115)	(53)	(115)
Unused amounts reversed during year		(7)	0	(7)	0
Closing balance	(iii)	69	60	69	60

Notes

(i) ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, MA Lardies, has calculated the liability as at 30 June 2013. 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% (2012, 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 2.4% for 30 June 2014 and 2015;
- a weighted average discount factor of 2.7% for 30 June 2014 and 30 June 2015 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 $3,550.

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 118% 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 $4,227,470 incurred in the cover period from 1 April 2012 to 31 March 2013 (2012/2013 ACC Claim Year).

(ii) **Litigation**

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

(iii) **Restructuring**

The provision relates to the redundancy provision to be paid out in July 13 as a result of Business Support review by Auckland Regional Public Health Services (ARPHS) .

13d DEFINED CONTRIBUTION PLAN (DCP)

The DCP (with National Provident Fund) is a multi-employer defined benefit scheme. At 30 June 2013 Auckland DHB 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 2013, the Scheme had a past service surplus of $17.4million (7.7% 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 30/06/13	As at 30/06/12	As at 30/06/13	As at 30/06/12
	$000	$000	$000	$000
14 INTEREST-BEARING LOANS AND BORROWINGS				
Current				
Secured loans				
Crown Loan	10,000	63,500	10,000	63,500
Interest on Borrowings	2873	3,298	2873	3,298
Unexpired set up cost on borrowings	(112)	(104)	(112)	(104)
	12,761	66,694	12,761	66,694
Non-current				
Secured loans				
Crown Loan	244,500	191,000	244,500	191,000
15 year Capital Bonds, maturing 15 September 2015	50,000	50,000	50,000	50,000
Unexpired set up cost on borrowings	(175)	(287)	(175)	(287)
	294,325	240,713	294,325	240,713

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

	Note	Group Actual		Parent Actual	
		As at 30/06/13 $000	As at 30/06/12 $000	As at 30/06/13 $000	As at 30/06/12 $000
Secured loans					
The details of terms and conditions are as follows:					
Borrowings are repayable:					
Less than one year		12,586	66,694	12,586	66,694
One to two years		120,000	9,888	120,000	9,888
Two to five years		50,000	119,825	50,000	119,825
Over five years		124,500	111,000	124,500	111,000
		307,086	307,407	307,086	307,407

The Ministry of Health's National Health Board business unit 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 Loan	3.20-6.295	4.26-6.345	3.20-6.295	4.26-6.345
Capital Bonds	7.75	7.75	7.75	7.75
Borrowing facilities				
Crown Loan	254,500	254,500	254.500	254,500
Capital Bonds	50,000	50,000	50,000	50,000
Working capital CBA	0	65,000	0	65,000

Crown Loan

The loan facility is provided by the National Health Board unit, 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 had a working capital facility supplied by Commonwealth Bank of Australia, New Zealand (CBA). The facility consisted of a bank overdraft and revolving bank multi-option credit facility. Unused portion of the facility at 30 June 2012 was $45.2m. This facility was cancelled on 19 December 2012 and replaced by the DHB Treasury Services Agreement.

Auckland DHB entered as a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs on 12 November 2012. This Agreement enables HBL to "sweep' DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at on-call interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of month's Provider Arm funding plus GST. For Auckland DHB, that equates to $105.272m.

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

Security and terms

Auckland DHB borrows funds based on covenants in a Negative Pledge Deed. This includes the covenant that security cannot be given over assets of Auckland DHB 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.

Auckland DHB 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.

Auckland DHB 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	
		2013	2012	2013	2012
		$000	$000	$000	$000
15	CAPITAL CHARGE	33,500	32,936	33,500	32,936

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 2013 (8 percent for fiscal year 2012) on shareholder funds based on the monthly closing balance. Auckland DHB has not paid a capital charge on donations received into the Auckland DHB Charitable Trust.

16 COMMITMENTS

	GROUP AND PARENT	Notes	As at 30/06/13 $000	As at 30/06/12 $000
a	***Capital commitments***			
	Approved and contracted		8,014	5,334
	Approved and to be contracted		29,603	32,304
			37,617	37,638
	Term classification of commitments			
	Less than one year		37,056	37,638
	One to two years		561	0
	Two to five years		0	0
	Over five years		0	0
			37,617	37,638
b	***Operating commitments***			
	Leases	(i)	4,453	4,878

		Leases	
GROUP AND PARENT		As at 30/06/13 $000	As at 30/06/12 $000
Term classification of operating commitments			
Less than one year		1,870	2,134
One to two years		1,194	1,522
Two to five years		1,062	1,169
Over five years		327	53
		4,453	4,878

Notes

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

17 TRANSACTIONS WITH RELATED PARTIES

a Subsidiary

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

PARENT	2013 Actual $000	2012 Actual $000
Sales to Auckland DHB Charitable Trust	52	87
Purchases from Auckland DHB Charitable Trust	693	183
Outstanding balance receivable from Auckland DHB Charitable Trust	3,875	2,964
Outstanding balance payable to Auckland DHB Charitable Trust	0	0

b Joint ventures & associates

Auckland DHB 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 30/06/13 $000	As at 30/06/12 $000	As at 30/06/13 $000	As at 30/06/12 $000
GROUP AND PARENT					
Sales to joints & associates					
healthAlliance N.Z. Limited (joint venture)		2,936	4,022	2,936	4,022
Northern Regional Training Hub Limited (associate)		168	249	168	249
Northern DHB Support Agency Limited (associate)		498	430	498	430
Northern Regional Alliance Limited (associate)		388	0	388	0
		3,990	4,701	3,990	4,701
Purchases from joint ventures & associates					
healthAlliance N.Z. Limited (joint venture)		35,979	26,882	35,979	26,882
NZ Health Innovation Hub Management Ltd (joint venture)		400	0	400	0
Northern Regional Training Hub Limited (associate)		3,247	4,121	3,247	4,121
Northern DHB Support Agency Limited (associate)		2,587	3,094	2,587	3,094
Northern Regional Alliance Limited (associate)		2,807	0	2,807	0
		45,020	34,097	45,020	34,097
Outstanding balances receivable from joint ventures & associates					
healthAlliance N.Z. Limited (joint venture)		301	0	301	0
Northern Regional Training Hub Limited (associate)		0	0	0	0
Northern DHB Support Agency Limited (associate)		0	0	0	0
Northern Regional Alliance Limited (associate)		80	0	80	0
	9	381	0	381	0

17 TRANSACTIONS WITH RELATED PARTIES *(continued)*

	Notes	Group Actual		Parent Actual	
		As at 30/06/13 $000	As at 30/06/12 $000	As at 30/06/13 $000	As at 30/06/12 $000
Outstanding balances payable to joint ventures & associates					
healthAlliance N.Z. Limited (joint venture)		6,016	5,072	6,016	5,072
NZ Health Innovation Hub Management Ltd (joint venture)		0	0	0	0
Northern Regional Training Hub Limited (associate)		0	588	0	588
Northern DHB Support Agency Limited (associate)		0	255	0	255
Northern Regional Alliance Limited (associate)		1,095	0	1,095	0
	13a	7,111	5,915	7,111	5,915

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 2013 and 2012.

c Compensations

The key management personnel compensations are as follows:

GROUP & PARENT		2013 Actual $000	2012 Actual $000
Short - term employment benefits		4,234	4,405
Long - term employment benefits		14	2
		4,248	4,407
Fees paid to Board Members	(i)	381	385
Fees paid to Committee Members	(ii)	9	14
		390	399

The DHB has provided a deed of indemnity to Board members for certain activities undertaken in the performance of the DHB's functions.

The DHB has effected Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation (2012 $nil).

Notes

17 c (i) & (ii) Refer to Statutory Information (Page 88) 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 $17.611m (2012 $17.187m) to provide health services in the Auckland Central area for the year ended 30 June 2013.

Revenue earned from other DHBs for the care of patient's outside the DHB's district amounted to $672.319m (2012 $701.131m) for the year ended 30 June 2013. Expenditure to other DHBs for their care of patients from the DHB's district amounted to $113.117m (2012 $120.971m) for the year ended 30 June 2013

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

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 2013 totalled $1.591m (2012 $1.518m). These purchases included the purchase of electricity from Meridian Power New Zealand Limited, 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 Auckland DHB and related party		Balance outstanding between Auckland DHB and related party	
			2013	2012	30/06/13	30/06/2012
			$000	$000	$000	$000
Eltham Investments Ltd (previously Ward Property Developments Ltd)	Ian Ward, Director	Payments	28	33	0	3
		Receipts	0	0	0	0
Hauora Whanui	Gwen Tepania-Palmer, Director	Payments	0	0	0	0
		Receipts	1	2	0	0

17 TRANSACTIONS WITH RELATED PARTIES *(continued)*

g Employee remuneration

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

Remuneration Range	Medical	Non- Medical	Number of Employees
$1,220,000-$1,230,000	1		1
$1,160,000-$1,170,000	1		1
$760,000-$770,000	1		1
$680,000-$690,000	2		2
$650,000-$660,000	1		1
$630,000-$640,000	1		1
$620,000-$630,000	2		2
$570,000-$580,000	1		1
$560,000-$570,000	1		1
$550,000-$560,000	1		1
$540,000-$550,000	2		2
$530,000-$540,000	5		5
$520,000-$530,000	3		3
$510,000-$520,000	4		4
$500,000-$510,000	2		2
$490,000-$500,000	3		3
$480,000-$490,000	2		2
$470,000-$480,000	4		4
$460,000-$470,000	1		1
$450,000-$460,000	4		4
$440,000-$450,000	4		4
$430,000-$440,000	3		3
$420,000-$430,000	5		5
$410,000-$420,000	8		8
$400,000-$410,000	7		7
$390,000-$400,000	10	1	11
$380,000-$390,000	13		13
$370,000-$380,000	18		18
$360,000-$370,000	14		14
$350,000-$360,000	10		10
$340,000-$350,000	17		17
$330,000-$340,000	15		15
$320,000-$330,000	10	2	12
$310,000-$320,000	25		25
$300,000-$310,000	15	1	16
$290,000-$300,000	21	1	22
$280,000-$290,000	24	3	27
$270,000-$280,000	24		24
$260,000-$270,000	23		23
$250,000-$260,000	28	1	29
$240,000-$250,000	20		20
$230,000-$240,000	26	1	27
$220,000-$230,000	31	3	34
$210,000-$220,000	36	1	37
$200,000-$210,000	37		37

17 TRANSACTIONS WITH RELATED PARTIES *(continued)*

g Employee remuneration *(continued)*

$190,000-$200,000	40	2	42
$180,000-$190,000	40	3	43
$170,000-$180,000	41	9	50
$160,000-$170,000	34	6	40
$150,000-$160,000	48	7	55
$140,000-$150,000	53	19	72
$130,000-$140,000	44	29	73
$120,000-$130,000	51	45	96
$110,000-$120,000	70	83	153
$100,000-$110,000	63	171	234
Grand Total	970	388	1,358

Note:

Of the 1,358 employees shown above, 970 are or were medical or dental employees and 388 are or were neither medical nor dental employees.

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 over $10,000. Employee numbers are categorised into medical and non-medical.

The highest earners in this chart are all surgeons who work in a particular model of care with us. This is one where the surgeons operate, then remain on call to be called back to care for their patients as, or if, required. As a consequence of high volumes of complex and acute operations and higher numbers of elective operations and procedures, there were a number of surgeons on call who were called-back frequently. In addition, the requirement to meet elective throughput targets has required additional Saturday operating lists, for which a premium was paid.

Nevertheless, growth in demand was met and a growth in throughput was achieved. Our model of care is, however changing. Auckland DHB made a significant push in cardiac surgery delivering more operations to more New Zealanders, getting through a peak level of demand while carrying surgeon vacancy. This additional work is included together with regular remuneration in the amounts above.

Similarly, backpay is also included in some of the higher amounts in this table. This is as a result of job-sizing and the determination that payments should be made for work done over previous years.

h Employee Termination

Termination payments	Payment $	Employees
Total	2,465,423	102

During the year ended 30 June 2013, termination payments were made in respect of 102 employees (77 payments, $1,317,156 in year ended 30 June 2012). Termination payments consist of settlements and redundancy payments made during the year.

17 TRANSACTIONS WITH RELATED PARTIES *(continued)*

i Board Member Remuneration

The total value of remuneration paid or payable to each Board member during the year was :

	Actual 2013 $000	Actual 2012 $000
Dr Lester Levy (Chair)	70	71
Dr Lee Mathias	39	41
Jo Agnew	31	31
Peter Aitken	31	28
Judith Bassett	30	29
Susan Buckland	30	31
Dr Chris Chambers	30	31
Rob Cooper	27	27
Robyn Northey	32	34
Gwen Tepania-Palmer	31	30
Ian Ward	30	32
Total board member remuneration	381	385

Co-opted committee members

Payments made to committee members appointed by the Board who are not Board members during the financial years amounted to $6.75k

Norman Wong (Audit & Finance Committee) $1k

Mataroria Lyndon (MaGAC) $1.25k

Ann Kolbe (HAC) $2k

Dairne Kirton (DiSAC) $1k

Russell Vickery (DiSAC) $0.75k

Jan Moss (DiSAC) $0.75k

The DHB has provided a deed of indemnity to Directors and Board Members for certain activities undertaken in the performance of the DHB's functions. The DHB has effected Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

18 FINANCIAL INSTRUMENTS

Credit Risk

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

Cash balances are held with Health Benefits Limited who enters into investments with registered banks that have a Standard and Poor's credit rating of at least A+. The DHB has experienced no defaults for these funds.

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 (2013-39%, 2012-42%). 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 2013 $000	Impairment 2013 $000	Gross 2012 $000	Impairment 2012 $000
Not past due	45,339	(11)	51,833	(9)
Past due 0-30 days	2,174	(189)	5,145	(230)
Past due 31-90 days	3,134	(473)	5,493	(409)
Past due 91-360 days	1,643	(1,186)	944	(944)
Past due more than 1 year	921	(921)	92	(92)
Total	53,211	(2,780)	63,507	(1,684)

PARENT

Debtors and other receivables	Gross 2013 $000	Impairment 2013 $000	Gross 2012 $000	Impairment 2012 $000
Not past due	44,576	(11)	49,936	(9)
Past due 0-30 days	1,881	(189)	4,842	(230)
Past due 31-90 days	2,906	(473)	5,402	(409)
Past due 91-360 days	1,636	(1,186)	944	(944)
Past due more than 1 year	921	(921)	92	(92)
Total	51,920	(2,780)	61,216	(1,684)

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

Debtors and other receivables	GROUP 2013 Actual $000	GROUP 2012 Actual $000	PARENT 2013 Actual $000	PARENT 2012 Actual $000
Gross	53,211	63,507	51,920	61,216
Individual impairment	(2,780)	(1,684)	(2,780)	(1,684)
Net total	50,431	61,823	49,140	59,532

Movement in the provision for impairment loss	GROUP 2013 Actual $000	GROUP 2012 Actual $000	PARENT 2013 Actual $000	PARENT 2012 Actual $000
Opening balance	1,684	3,334	1,684	3,334
Increase/(decrease) in doubtful debts	1,096	(1,650)	1,096	(1,650)
Closing balance	2,780	1,684	2,780	1,684

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 Auckland DHB's ability to meet its contractual obligations. Auckland DHB evaluates its liquidity requirements on an ongoing basis. In general, Auckland DHB 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

2013	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	307,086	375,173	8,118	18,092	85,713	123,340	139,910
Trade and other payables	Nil	82,001	82,001	82,001	0	0	0	0
Bank overdraft	Fixed	0	0	0	0	0	0	0
Derivative financial instruments – interest rate swaps in loss	Fixed/Floating	0	0	0	0	0	0	0
Total		389,087	457,174	90,119	18,092	85,713	123,340	139,910

2012		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	372,507	12,507	68,889	24,001	146,144	120,966
Trade and other payables	Nil	86,487	86,487	86,487	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		413,780	478,901	118,901	68,889	24,001	146,144	120,966

18 FINANCIAL INSTRUMENTS *(continued)*

Liquidity risk *(continued)*

PARENT

2013	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	307,086	375,173	8,118	18,092	85,713	123,340	139,910
Trade and other payables	Nil	78,384	78,384	78,384	0	0	0	0
Bank overdraft	Fixed	0	0	0	0	0	0	0
Derivative financial instruments – interest rate swaps in loss	Fixed/Floating	0	0	0	0	0	0	0
Total		385,470	453,557	86,502	18,092	85,713	123,340	139,910

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	372,507	12,507	68,889	24,001	146,144	120,966
Trade and other payables	Nil	83,522	83,522	83,522	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		410,815	475,936	115,936	68,889	24,001	146,144	120,966

18 FINANCIAL INSTRUMENTS *(continued)*

Contractual maturity analysis of financial assets

The table below analyses Auckland DHB 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 2013						
Cash and cash equivalents						
Bank Balances	192	192	192	0	0	0
Short term deposits	195	195	195	0	0	0
Health Benefits Limited	**80,340**	**81,384**	**81,384**	**0**	**0**	**0**
	80,727	**81,771**	**81,771**	**0**	**0**	**0**
Trust/Special Funds						
Cash at bank (restricted)	892	894	894	0	0	0
Short term deposits	14,693	18,948	18,948	0	0	0
Portfolio Investments	9,252	9,252	4,660	4,592	0	0
Investment Bonds (at market)(restricted)	2,094	2,000	0	2,000	0	0
	26,931	**31,094**	**24,502**	**6,592**	**0**	**0**
Patient and restricted trust funds						
Patient trust	9	9	9	0	0	0
Restricted fund deposits	1,137	1,137	1,137	0	0	0
	1,146	**1,146**	**1,146**	**0**	**0**	**0**
Debtors and Other Receivables	50,431	50,431	50,431	0	0	0
Grand Total	**159,235**	**164,442**	**157,850**	**6,592**	**0**	**0**
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	61,823	61,823	61,823	0	0	0
Grand Total	**181,231**	**182,593**	**180,375**	**126**	**2,092**	**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 2013						
Cash and cash equivalents						
Bank Balances	192	192	192	0	0	0
Short term deposits	195	195	195	0	0	0
Health Benefits Limited	80,340	80,340	80,340	0	0	0
	80,727	**80,727**	**80,727**	**0**	**0**	**0**
Patient and restricted trust funds						
Patient trust	9	9	9	0	0	0
Restricted fund deposits	1,137	1,137	1,137	0	0	0
	1,146	**1,146**	**1,146**	**0**	**0**	**0**
Debtors and Other Receivables	**49,140**	**49,140**	**49,140**	**0**	**0**	**0**
Grand Total	**131,013**	**131,013**	**131,013**	**0**	**0**	**0**
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	**59,532**	**59,532**	**59,532**	**0**	**0**	**0**
Grand Total	**154,733**	**155,368**	**155,368**	**0**	**0**	**0**

18 FINANCIAL INSTRUMENTS *(continued)*

Interest rate risk and currency risk

Exposure to interest rate and currency risks arise in the normal course of Auckland DHB'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 Auckland DHB'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.

Auckland DHB 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 Auckland DHB's policy. The swaps mature over the next five years following the maturity of the related loans and have fixed swap rates ranging from 6.85 per cent to 7.75 per cent. The swaps were closed on 7 Aug 2012. At 30 June 2013 Auckland DHB had interest rate swaps with a notional contract amount of $0m (2012 $50m).

The net fair value of swaps at 30 June 2013 was a net asset position of $0k (2012 $7,467k). These amounts were recognised as fair value derivatives.

DHB Bond FRAs

Auckland DHB has entered into two derivative financial instruments known as Forward Rate Agreements (FRA's) with Westpac Bank on 3 Aug 2012. These instruments are used to hedge or minimise any substantial gains or losses from exposure to future government bond yields.

Each year the fair value of these derivatives financial instruments is recognised in the accounts. The net fair value of Auckland DHB Bond FRAs at 30 June 2013 was a net asset position of $1,072k (2012 Nil).

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.

Auckland DHB'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 (2012 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 2013	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	51,781	0	0	51,781	51,781
Cash and cash equivalents	7	0	0	80,727	0	0	80,727	80,727
Trust / Special Funds	8a	0	11,346	15,585	0	0	26,931	26,931
Investments in joint ventures and associates	5	0	0	0	25,016	0	25,016	25,016
Patient and restricted trust funds:								
Assets	8b	0	0	1,146	0		1,146	1,146
Liabilities	8b	(1,146)	0	0	0	0	(1,146)	(1,146)
Interest rate swaps:								
Assets	19	0	1,072	0	0	0	1,072	1,072
Liabilities	19	0	0	0	0	0	0	0
Forward exchange contracts:								
Assets	19	0	0	0	0	0	0	0
Liabilities								
Secured bank loans	14	0	0	0	0	(307,086)	(307,086)	(315,689)
Trade and other payables	13a	0	0	0	0	(119,113)	(119,113)	(119,113)
Bank overdraft	7	0	0	0	0	0	0	0
		(1,146)	12,418	149,239	25,016	(426,199)	(240,672)	(249,275)
Unrecognised (gains)/losses								8,603
2012								
Trade and other receivables	9	0	0	63,242	0	0	63,242	63,242
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	(121,471)	(121,471)	(121,471)
Bank overdraft	7	0	0	0	0	(19,800)	(19,800)	(19,800)
		(1,206)	9,682	180,521	20,226	(448,678)	(239,455)	(263,607)
Unrecognised (gains)/losses								24,152

18 FINANCIAL INSTRUMENTS *(continued)*

Classification and fair values *(continued)*

PARENT 2013	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	51,781	0	0	51,781	51,781
Cash and cash equivalents	7	0	0	80,727	0	0	80,727	80,727
Trust / Special Funds	8a	0	11,346	15,585	0	0	26,931	26,931
Investments in joint ventures and associates	5	0	0	0	25,016	0	25,016	25,016
Patient and restricted trust funds								
Assets	8b	0	0	1,146	0		1,146	1,146
Liabilities	8b	(1,146)	0	0	0	0	(1,146)	(1,146)
Interest rate swaps:								
Assets	19	0	1,072	0	0	0	1,072	1,072
Liabilities	19	0	0	0	0	0	0	0
Forward exchange contracts:								
Assets	19	0	0	0	0	0	0	0
Liabilities	19							
Secured bank loans	14	0	0	0	0	(307,086)	(307,086)	(315,689)
Trade and other payables	13a	0	0	0	0	(119,113)	(119,113)	(119,113)
Bank overdraft	7	0	0	0	0	0	0	0
		(1,146)	12,418	149,239	25,016	(426,199)	(240,672)	(249,275)
Unrecognised (gains)/ losses								8,603
2012								
Trade and other receivables	9	0	0	60,951	0	0	60,951	60,951
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	(113,008)	(113,008)	(113,008)
Bank overdraft	7	0	0	0	0	(19,800)	(19,800)	(19,800)
		(1,206)	7,553	156,152	19,724	(440,215)	(257,992)	(282,144)
Unrecognised (gains)/ losses								24,152

18 FINANCIAL INSTRUMENTS *(continued)*

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 assets 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	Valuation technique			
		Total	Quoted market price	Observable inputs	Significant non-observable inputs
		$000	$000	$000	$000
GROUP					
As at 30 June 2013					
Financial Assets					
Portfolio investments	8a	9,252	9,252	0	0
Local authority bond	8a	2,094	2,094	0	0
GROUP					
As at 30 June 2012					
Financial Assets					
Local authority bond	8a	2,129	2,129	0	0

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

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.

18 FINANCIAL INSTRUMENTS *(continued)*

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 2013 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

GROUP & PARENT	2013 Actual %	2012 Actual %
Derivatives	4.335%	6.85-7.75
Loans and borrowings	3.20-6.295%	4.26-7.75

Capital management

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

Auckland DHB'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 Auckland DHB's management of capital during the period.

Sensitivity Analysis

In managing interest rate and currency risks Auckland DHB 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 2013, it is estimated that a general increase of 1% in interest rates would increase the surplus or deficit by approximately $3.3m (2012 $1.3m). Interest rate swaps have been included in this calculation.

At 30 June 2013, it is estimated that a general decrease of 1% in interest rates would decrease the surplus or deficit by approximately $3.6m (2012 $1.3m). Interest rate swaps have been included in this calculation.

19 DERIVATIVE FINANCIAL INSTRUMENTS

	Group Actual As at 30/06/13	Group Actual As at 30/06/12	Parent Actual As at 30/06/13	Parent Actual As at 30/06/12
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)	1,072	7,553	1,072	7,553
Current Liabilities				
Interest rate swaps in loss (mark to market)	0	86	0	86
Non - Current Liabilities				
Interest rate swaps in loss (mark to market)	0	0	0	0

20 MAJOR VARIATIONS FROM BUDGET

Statement of Comprehensive Income

Auckland DHB recorded a surplus of $0.154m which was $0.62m favourable to budget.

Auckland DHB completed the process of adopting national chart of accounts during the financial year. This resulted in the reorganisation of various account groupings in the income statement during the reporting year. Actual results are presented in the terms of the National Chart of Accounts. The budgets for the reporting year were prepared before the reorganisation was completed.

The comments below are based on a best possible reorganisation of budget to align with actual results.

Major favourable variance:

Other Provider Expenditure $154.6m. Amalgamation of primary healthcare organisations (PHOs) within the Auckland region has resulted in Auckland DHB being given responsibility for the regional contract for Procare, a primary healthcare organisation servicing the wider Auckland Region. In addition Auckland DHB acts as the lead DHB for the Labtest contract within the Auckland region. Consequently Auckland DHB receives some $147.5m by way of contribution to these contracts from Counties Manukau and Waitematā DHBs. This is in effect an agency arrangement. Accordingly, in the actual results the contribution of $147.5m was treated as an offset of expenditure. At the time the budgeted results were prepared, the contribution from Counties Manukau and Waitematā DHBs was regarded as revenue.

Major unfavourable variances:

Patient care revenue $149.1m. This variance occurs as the contribution described above to Procare and Labtests has been treated as an offset to cost for the reasons described above.

Statement of Changes in Equity

Total Equity of $480.1m as at June 2013 was $39.6m favourable to budget, driven by the revaluation of Land and Buildings as at 30 June 2013.

Statement of Financial Position

Total Assets and Total Liabilities as at June 2013 were $1,080.1m which was above budget of $1,044.9m by $35.2m driven by the revaluation of Land and Buildings as at 30 June 2013.

Statement of Cash Flows

Cash and Cash Equivalents of $80.7m at June 2013 was $57.7m favourable to budget driven by a lower than budgeted capital expenditure.

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 $25m as at 30 June 2013 (2012 $24.2m). 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 (2012 – 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.

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.

The DHB has completed its investigations into seismic upgrading for all buildings but all costs are currently not known. Seismic upgrading may be required to some buildings. The 2013 valuation for land and buildings was amended based on indications of impairment due to seismic strength assessment issues where these are known. This information is based on DHB Facilities Management estimates. The valuation is therefore subject to an estimate of any unknown costs for structural upgrading, demolition or other steps required for the building to meet the requirements of Earthquake-Prone Building Policies. This finding is likely to impact on the value of the property, and the 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.

ACC	Accident Compensation Corporation
ACH	Auckland City Hospital
AED	Auckland City Hospital Accident and Emergency Department
APLS NZ	Advanced Paediatric Life Support New Zealand
APU	Assessment and Planning Unit
ARPHS	Auckland Regional Public Health Service
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment and Rehabilitation
BAU	Business as Usual
Cardiac	Heart services
CDC protocols	Centre for Disease Control protocols
CEO	Chief Executive Officer
CMDHB	Counties Manukau District Health Board
CPHAC	Community and Public Health Advisory Committee
CT	Computerised Tomography Scan.
CTA	Clinical Training Agency
CVD	Cardiovascular disease.
DBP	Defined Benefit Pension plan.
DHB	District Health Board
DiSAC	Disability Support Advisory Committee
DML	Diagnostic Medical Laboratory
ED	Emergency Department
EPA	Environmental Protection Agency
FSA	First Specialist Assessment
FBT	Fringe Benefit Tax
FY13	2013 Financial Year
GCC	Greenlane Clinical Centre
GST	Goods and Services Tax
GMS	General Medical Subsidies
GP	General Practitioner
H7N9	Strain of bird flu
HAC	Hospital Advisory Committee
HBSS	Home Based Support Services
HDWAA	Health Drinking Water Amendment Act (New Zealand).
HSG	Health Service Group
HR	Human Resources
IEA	Individual Employment Contract
IT	Information Technology
IMAC	Immunisation Advisory Centre
InterRAI assessments	Standardised assessment system designed to help staff assess the medical, rehabilitation and support requirements of the older person.
LTA	Labtests Auckland
LTC coordinators	Long Term Conditions Coordinators
MBIE	Ministry of Business, Innovation and Enterprise
MERS-CoV	Middle East Respiratory Syndrome Coronavirus
MH&A	Mental Health and Addiction
MHGAC	Māori Health Gain Advisory Committee
MO	Medical Officer
MoH	Ministry of Health
MPI	Maximum Permissible Intake

MRI	Magnetic Resonance Imagery
NASC	Needs Assessment and Service Coordination
NCSP	National Cervical Screening Programme
NDCMS	Notifiable Disease Case Management System
NGOs	Non-governmental Organisations
NHI number	National Health Index
NICU	Neonatal Intensive Care Unit
NIR	National Immunisation Register
NZE	New Zealand European
NZIAS	International Accounting Standard Number 1
Obstetric	The medical specialty dealing with the care of women's reproductive tracts and their children during pregnancy, childbirth and immediately after the baby is born.
Opthalmology	Eye services
Paediatric	Children's medicine
Palliative care	An area of healthcare that focuses on relieving and preventing the suffering of patients with life threatening illness.
PAYE	Pay As You Earn Tax
PCR	Percutaneous Coronary Revascularisation
PCV	Pneumococcal Conjugate Vaccine
PHOs	Primary Health Organisations
PH	Public Health
Primiparous	Describing a woman giving birth for the first time
WDHB	Waitematā District Health Board
WIES	Weighted Inlier Equivalent Separations

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Auckland District Health Board and Group's financial statements and performance information for the year ended 30 June 2013

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 performance information of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 50 to 100, that comprise the statement of financial position as at 30 June 2013, 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 performance information of the Health Board that comprises the statement of service performance on pages 22 to 29 and 33 to 49 and the report about impacts on pages 30 to 32.

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Health Board and group on pages 50 to 100:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
    - financial position as at 30 June 2013; and
    - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reason for our qualified opinion

Some significant performance measures of the Health Board (including some of the national health targets and the corresponding district health board sector averages used as comparators) rely on information from third party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measures

that include advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 22 to 29, 33 to 49 and 30 to 32:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and impacts for the year ended 30 June 2013, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 30 October 2013. 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 performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, 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 performance information 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.

Our audit of the financial statements involved 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; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance;
- the material performance measures, including the national health targets; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We obtained all the information and explanations we required about the financial statements. However, as referred in our opinion, we did not obtain all the information and explanations we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information 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 and impacts.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and performance information, whether in printed or electronic form.

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 performance information 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 External Reporting Board.

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

Auckland District Health Board

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai