Box 7 - 7

Auckland District Health Board

2010 Annual Report

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2010 ANNUAL REPORT

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The Board Members are pleased to present the report of Auckland District Health Board (ADHB) and the Group comprising ADHB, its subsidiary Charitable Trust, joint venture and associates for the year ended 30 June 2010.

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

P.N. Snedden	**H.J. Burkhardt**
Chair	**Chair Finance Committee**
Dated: 6 October 2010	**Dated: 6 October 2010**

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MISSION

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

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

DIRECTORY

Address for Service

Auckland District Health Board
First Floor Building 10
Greenlane Clinical Centre
Greenlane West
Epsom
Auckland 1051

Postal Address

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

Auditor

Audit New Zealand
155 Queen Street
PO Box 1165
Auckland 1010

Board Members

P.N. Snedden (Chair)
H.J. Burkhardt (Deputy Chair)
J.M. Agnew
S.M. Buckland
Dr. C.J.W. Chambers
R.J. Cooper
Dr. B.J. Fergus
Dr. I.K. Scott
Rt. Hon. R.J.Tizard
Seiuli Dr. J.M. Walker
I.R. Ward

Chief Executive

G.R. Smith

Executive Management

G. Balla	(Director, Performance & Innovation)
N. Buchanan	(General Manager, Operations)
T. Campbell	(Executive Director of Nursing)
M. Dotchin	(General Manager, Clinical Services)
F. Dougan	(General Manager, Clinical Services)
N. Glavish	(Chief Advisor Tikanga & General Manager, Maori Health)
K. Hyman	(General Manager, Clinical Services)
H. Fa'asalele	(General Manager, Pacific Health)
Dr. D. Jury	(Chief Planning and Funding Officer)
J. Mueller	(Director, Allied Health)
Dr. C. Palmer	(Clinical Leader, Population Health & Primary Care)
V. Rawlings	(General Manager, Human Resources Operations)
Dr. D. Sage	(Chief Medical Officer) to 1 June 2010
J. Vendrig	(Chief Information Officer)
Dr. M. Wilsher	(Chief Medical Officer) from 1 June 2010
B. Wiseman	(Chief Financial Officer)

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DIRECTORY (continued)

Clinical Board

- T. Campbell (Chair)
- Dr. R. Aickin
- G. Balla
- Dr. V. Beavis
- Dr. C. Bensemann
- Dr. J. Bent
- C. Byrne
- Mr. I. Civil
- M. Dotchin
- T. Du Villier
- S. Fitt
- Dr. R. Franklin
- Dr. R. Frith
- W. Guthrie
- Assoc. Prof. A. Jull
- Dr. M. Lane
- Dr. C. McArthur
- J. Mueller
- Dr. C. Palmer
- A. Schofield
- Dr. P. Weston
- Dr. M. Wilsher
- A. Yates

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CHAIRMAN'S REVIEW

The leadership team and staff at the Auckland District Health Board (ADHB) deserve congratulations as we celebrate another successful year for the organisation.

By continuing its programme of lead performance improvement and building upon previous achievements, the ADHB has demonstrated a determined focus to meet some tough health targets. This has been done without compromising the quality of the patient journey and the way in which the organisation provides its services.

It is with pride that I am able to report the ADHB, led by Chief Executive Garry Smith, has taken the three Board goals - *Lift the health of people in Auckland City; Live within our means; and Lead performance improvement* - and translated them into action. This has produced stellar results.

Committee highlights and achievements

The work of the ADHB's board members serving on committees has also enabled us to achieve these results and I commend the members for their efforts. The relevant bodies are the District Health Board itself; the Community and Public Health Committee; the Disability Support Committee and the Hospital Advisory Committee. There are three other committees and a group established to provide advice to the Board - Finance; Quality, Risk and Audit; Maori Health and the Pacific Advisory Group.

They all work to offer support, insight and knowledge that inform the Board and enable sound governance and strategic decisions to achieve the best outcomes for the people of Auckland. The Board's term is drawing to a close with the triennial District Health Board elections and I thank members for their exemplary public service. I would also like to make particular mention of the Quality Risk and Audit Committee. This committee monitors any risk exposures to the organisation and has produced tremendous insights into the ADHB and the ways in which it operates. Through this committee, we have seen significantly improved and simplified reporting.

It has also highlighted issues that have to be addressed at the governance level as the ADHB works towards achieving its goals.

Achieving results

For the third year running we have achieved a breakeven budget. These bottom line figures are important to our success, as patients ultimately benefit from any savings the ADHB makes. Without able leadership, the commitment and expertise provided by our Clinical Leaders, the support of the Board and the dedicated individuals, who keep the organisation running on a day-to-day basis, this could not have been achieved.

Underpinning the drive to realise positive financial results has been a continued focus on quality and performance improvement and we are seeing many positive results through this drive.

The ADHB's clinically led approach is also achieving tangible results, such as the innovative CONCORD programme. This has seen tremendous success. Two hundred ideas for improvement have been received from clinicians, nine projects have been completed, with a further 12 in progress. This has all been done while achieving significant financial savings.

We have continued to develop our Clinical Quality and Professional Governance Structure in a number of ways, including strengthening clinical leadership, promoting clinical engagement, enabling clinical leadership and accountability in planning, decision making and performance improvement, bringing clinical knowledge, innovation and capability to improve quality and safety, and strengthening the clinical and financial viability of services.

The ADHB has four levels of leadership roles – from the CEO to the patient – and at each of these levels there is strong clinical leadership. In addition to this, there is clear recognition of the importance of clinical leadership outside the formally appointed structures – the CONCORD programme is one such example.

The new Health Service Group realignment being rolled out brings together an increased investment in clinical leadership and professional governance roles, to enhance clinical engagement and input. This will improve the accountability and responsibility for decision-making across the whole healthcare system. The implementation of these leadership roles includes specific time allocated to the leadership functions in addition to clinical work.

Challenges

During the year under review there were three challenges where I want to acknowledge we did not achieve to the desired standard. These were the award of a community laboratory service contract to Labtests Auckland; the process of assembling Expressions of Interest (EOI) for primary care and our reporting of Maori and Pacific Island health gains in our district.

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Labtests was very controversial and difficult. We did make a stable landing, eventually, and we have full utilisation of the contract and savings to show for it. But along the way it was a very bumpy flight. We were pleased to be able to see, in May of this year, that Labtests achieved full and independent accreditation by IANZ (International Accreditation New Zealand). The accreditation is a credit to the staff and management of Labtests who worked very hard following a rocky start and on behalf of the Board I would like to express gratitude for the publics' patience shown in the lead-up to Labtests gaining that accreditation.

The primary care process started well with Ngati Whatua and all of the Primary Health Organisations on board. It was then paused as a result of a degree of disconnection between our processes and the national Expression of Interest process. We look forward to 2010-11 for the successful implementation of Ministerial priorities.

Reporting health gains in vulnerable sections of our population will, I believe, be solved more quickly. We have a gap in the metrics the Board requires for measuring the organisation's effectiveness in achieving Maori and Pacific Island health gains. The urgency of the need has increased and effective performance will be delivered in 2010/11.

Collaboration and innovation

There are a number of successes I would like to draw attention to, particularly those achieved in pursuing our goal to *Lift the health of people in Auckland City*.

We recognise that much of the organisation's health activity takes place outside the hospital with the primary care sector and other agencies, as the ADHB strives to deliver what patients both want and need. This requires innovation, dedication and, often, collaboration. The ADHB's partnerships with organisations, Government agencies and community programmes are examples of this collaborative approach.

Our work with Housing New Zealand Corporation on the Healthy Housing project continued and we reached our target this year, ensuring that people live in drier, warmer homes with improved access to primary care providers.

The ADHB, along with Waitemata and Manukau District Health Boards, is also working towards the implementation of the Better, Sooner, More Convenient (BSMC) Primary Care strategy across metro Auckland. The DHBs are providing support to the three business cases: GAIHN; Alliance Health+; and National Maori PHO Coalition.

The ADHB's commitment to the whanau approach continues and the organisation actively supports Whanau Ora. A regional strategy is being developed with Te Runanga o Ngati Whatua, following the signing of the Primary Care Plan between the five ADHB PHOs and Te Runanga o Ngati Whatua last year. This is building upon the excellent relationship between the ADHB and manawhenua.

The ADHB's innovative work around the successful Pacific Healthy Village Action Zone programme continues to produce outstanding results.

This year also saw the launch of initiatives to improve the patient care experience for patients from diverse ethnic, language and cultural backgrounds. These fall under the Auckland Regional Settlement Strategy Health Action Plan and is run by the metro Auckland DHBs and the Ministry of Health.

Other collaborative initiatives include the three DHBs devising mechanisms of working with Pan-Regional PHOs – the ADHB has been influential in achieving this and approval by the three DHB Chairs for regional planning around clinical and shared transactional services.

Building upon strengths

On behalf of the Board, we thank you all for the ongoing commitment to the health of the people of Auckland. I look forward to seeing the results of continued work on performance improvements and the associated patient benefits. We head into 2010/2011 year building achievement from a position of strength.

Pat Snedden

Chair

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CHIEF EXECUTIVE'S REVIEW

This year has been one of success for our organisation, as we have attained a number of key milestones of which I am very proud. The Auckland District Health Board (ADHB) has completed the 2009/2010 year ahead of budget financially, while increasing productivity, achieving higher levels of performance and quality improvements, and adding services.

While the breadth of continuum of care we provide presents us with many unique, often significant, challenges, the ADHB continues to grow, improve and excel. We do this by applying our whole of system approach to healthcare and with our commitment to quality.

Achieving goals and targets

Our commitment has driven us all as we have delivered upon our challenging *1+6+1* strategic organisational objectives – *Live within our means; Meet the six Ministry of Health Targets; Increase rate of cardiac bypass surgery.*

Through innovation and dedication, we have lived within our means by achieving a financial surplus of $279k, bettering the budgeted surplus of $17k. This is a remarkable feat on revenue of $1.7billion.

In terms of health outcomes, our work around improving Access to Elective Surgery exceeded the target; we achieved Shorter Waits for Radiation Therapy; and efforts around Increased Immunisation enabled us to surpass the target. A cause for celebration was around an additional target for our Cardiac Bypass Surgery project. The ADHB also surpassed this target, delivering 923 procedures and reducing the waiting list to 68.

We do still have some work to do around the area of Better Diabetes and Cardiovascular Services. To this end, the ADHB has committed significant resource in 2010. While we may not have achieved all targets, it is pleasing nonetheless to see improvements. For example, Better Help for Smokers to Quit rose from 15% (July 2009) to 66% as a result of significant action taken by many of our staff.

The ADHB also saw a 10% improvement around shorter stays in the Emergency Department, due to a strong clinically-led programme being in place.

Commitment to a healthier Auckland

Our commitment to the Board's goal of lifting the health of the people of Auckland remains strong. The ADHB supports a number of community programmes and notable examples have been the continuation of our good work in the fields of Maori and Pacific health.

A regional Whanau Ora outcomes framework and strategy is being developed with Te Rununga o Ngati Whatua. I am proud of the effort the ADHB made in 2009-10 on this initiative and the developments around our Ho Hou Rongo concept focusing on reducing violence within whanau.

Our Pacific Health's Healthy Village Action Zones programme is a real success story for the ADHB. It continues to produce great results and serves as a national example of healthcare excellence.

Another exciting community-focused initiative is the new school dental service created to provide better access to dental healthcare. The ADHB is funding 12 new dental clinics and 'rolling out' six new dental treatment vans across the Auckland area, as part of Government's Good Oral Health For All, For Life strategy. Ten of the clinics will be operational by 2011 and by the end of year under review we were looking forward to opening the first, in Sylvia Park.

The year closed a little early to see the signing of an $8m contract with an eating disorder services specialist, but this signalled another milestone for us, as it will see the ADHB playing a lead role in this area of mental healthcare. Under the three-year contract, a day clinic and residential treatment facility will be established by the end of 2010. Services will be available to Northern and Midland region DHB patients, as well as to the ADHB population and the work done over this year under review is a great testament to the team involved.

We also anticipate positive results for patients through improved access to primary care via the Better, Sooner, More Convenient (BSMC) strategy. During 2009-10, the Ministry of Health endorsed the development of the business cases of three consortia – Greater Auckland Integrated Health Network (GAIHN), Alliance Health+ and the National Maori PHO coalition – for the delivery of BSMC across metro Auckland. BSMC is about putting patients first, increasing the capacity and access of quality community based clinical services and managing shared and scarce resources effectively.

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Performance improvements and excellence
The ADHB continues to develop our Clinical Quality and Professional Governance Structure to harness clinical knowledge, innovation and capability to improve quality and safety for our patients. We recognise the importance of clinical leadership outside the formally appointed structures, such as in our successful CONCORD programme.

This year, we prepared for the introduction of the Healthcare Excellence framework to guide us as we seek to transform the way we deliver healthcare at the ADHB. Our aim is to make the ADHB the best place to receive care, the best healthcare provider to work for and the best place for clinical practice in New Zealand. It commits us to a journey of continuous improvement to ensure we are the best we can be today, while embracing new ways of working to deliver excellence into the future. Each of us has a role to play by integrating excellence into our everyday work.

There are numerous initiatives underway taking us on the road to excellence including Releasing Time to Care, and the Service Excellence programmes in Cardiac and Radiology. Releasing Time to Care has introduced this nurse led programme into a number of wards and clinical improvements have also seen Nurse Led Discharging introduced. This nurse-facilitated discharging enables a charge nurse or a clinical nurse advisor to discharge patients after-hours or on weekends, leading to patients being discharged on an average of 4.5 hours sooner. Daily Rapid Rounds are another innovation. These are a short daily ward meeting with nurses, doctors and allied health workers to coordinate the plan for a patient's hospital stay.

The ADHB has also introduced a Service Excellence programme to a number of services including Cardiac, Radiology and General Medicine. It is led by the service and focuses on the patient pathway, aiming to improve services for both patients and staff.

This year, we also introduced the Senior Leadership Walk Around Programme. This aims to contribute to the continuing development of a culture that puts patient safety at the centre of everything we do. The programme involves Senior Leaders of the organisation visiting all workplaces within the ADHB to promote the importance of patient safety concepts and incident reporting.

Another related improvement initiative is the realignment of our organisation into the Health Service Groups (HSGs) structure to support our journey to Healthcare Excellence and an increased emphasis on service delivery and outcomes. 2009-10 saw us make good progress on this drive to give HSGs responsibility for the whole system and so take accountability for patient care through the continuum. As the year ended we prepared for Phase 3, including the alignment of specialist services (i.e. Finance, HR, Planning and Funding, Maori Health, and Pacific Health) to support the new HSG structure. This will allow us to build on what is already in place, is less disruptive and will enable opportunities for learning and adjusting.

We could not do any of this without the support of our excellent people. The ADHB will continue to promote and protect the welfare and management of our staff to the mutual benefit of staff, patients and families and the organisation. To this end, all of our activities are underpinned by key values – integrity, respect, innovation, and effectiveness – which define the way we behave and inform our decision making.

Our Good Employer Report for 2009/2010 provides a barometer for us to assess our achievements around this approach, as measured by seven key 'elements'. These measures are based upon: leadership; recruitment and retention; staff development; worklife balance; reward and recognition; harassment and bullying prevention; and a safe and healthy environment. Within each of these measures are a number of innovative, supportive and effective programmes have been rolled out to achieve positive results for our staff.

This rounds out the picture of a year we can all be proud of. Thank you to all staff for enabling our dynamic organisation to achieve these results. Your actions have signalled a clear determination to meet, and exceed, expectations while ensuring quality of care for our patients remains at the top of our agenda.

Garry Smith

Chief Executive

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SUMMARY OF PERSONNEL POLICIES
FOR THE YEAR ENDED 30 JUNE 2010

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

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

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

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Good Employer Obligations Report 2009/10

REQUIREMENT

Under sections 118 and 151 of the Crown Entities Act 2004, ADHB is required to report on the extent to which it complies with "good employer" policies.

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

Auckland District Health Board (ADHB) applies the following "Good Employer Principles" to support our vision.

PRINCIPLES

ADHB believes that a good employer is one who operates a Human Resources policy containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment and encompasses the provisions of the New Zealand Public Health and Disability Act 2000.

ADHB is committed to this principle and will seek to actively uphold any legislative requirements in this regard and will put in place such systems and programmes to support this principle.

ADHB has a true commitment to its employees and its services. Regardless of the minimum requirements of legislation, ADHB will continue to promote and protect the welfare and management of employees to the mutual benefit of employees, consumers and the organisation.

Providing equal employment opportunities by eliminating any barrier 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 maximum is a key principle practised by all representatives of ADHB in the execution of activities relating to the recruitment and management of employees (or potential employees). This includes:

- Recruitment
- Pay and other rewards
- Career development
- Work conditions

ADHB's Human Resources policies and practices will be free from any discriminatory element that has the potential to deny a person equal opportunity.

ORGANISATION VALUES AND CULTURE

As a large organisation and employer we think it is important that we use and promote management and organisational practices that are effective and efficient in the way we operate and deliver health care. We believe a high performance organisation starts with having an organisational culture where everyone is able to contribute to the way the organisation develops and adapts to change. For ADHB, establishing this culture starts with having clearly articulated values. Consequently, all of ADHB's activities are underpinned by key values that define the way we behave and inform our decision making. These organisational values are:

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

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

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

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COMPLAINTS

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

HEALTH & SAFETY

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

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

ADHB strives to continuously improve the management of health and safety at all levels and within all areas of the organisation by reviewing, developing and maintaining systems 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 2009/10

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

Element/ Measurement	Policies & Procedures	Programmes

leadership accountability & culture	• Organisational values.
	• Regular Union-employer meetings .
	• CEO "State of the Nation" addresses to all staff.
	• Integrated and partnership based management structure.
	• Bi-cultural policy.
	• Clinical Quality and Professional Governance model.
		• Management assessment and development process.
		• Clinical/managerial partnership.
		• ADHB Welcome Day – initial address to participants by Chief Executive.
		• Individual Service Planning Days – multidisciplinary involvement.
		• Nova Magazine (electronic and hard copy) newsletter for staff).
		• X-Factor – annual staff talent show actively supported by senior leadership.
		• Continued development of our Clinical Quality and Professional Governance structure by:
		  ▪ Strengthening clinical leadership throughout the organisation
		  ▪ Promoting clinical engagement
		  ▪ Enabling clinical leadership and accountability in planning, decision making and performance improvement
		  ▪ Bringing clinical knowledge, innovation and capability to improving quality and safety
		  ▪ Strengthening the clinical and financial viability of services.
		
		In a formal sense, ADHB has 4 levels of leadership roles from the CEO to the patient and at each of these levels there is strong clinical leadership (e.g. at Level 1 - Chief Executive, Chief Medical Officer, Executive Director of Nursing, Director of Allied, Scientific & Technical).

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leadership accountability & culture (continued)		We also recognise the importance of strong clinical leadership outside the formally appointed structures. For example, the Concord programme is about reducing waste and improving the quality of healthcare, using the skills and attributes of senior doctors beyond their clinical practice and fostering strong clinical engagement. Concord is led by a senior doctor. After 10 months: • over 200 ideas have been captured from doctors, nurses and allied health staff • 12 major projects presently underway • 9 projects completed and delivering improvements • First $550,000 annual savings achieved and we are targeting $800,000 to $1.2M over the next months A new Health Service Group realignment completed in June brings together an increased investment in strong clinical leadership and professional governance roles to enhance clinical engagement and input and improve the accountability and responsibility for decision making across the whole healthcare system. The implementation of these clinical leadership roles includes specific time allocated to the leadership functions in addition to clinical work. PHO Clinical Leaders and Chief Executives included in Senior Leadership Team of the organisation. • Preparatory work has been carried out in 2009/10 and the organisation is now poised to launch Healthcare Excellence – based on the Baldridge Approach to Quality Improvement in 2010/11.
recruitment, selection and induction	• Intranet based guides for recruitment & selection. • In-house Careers Centre. • Staff have access to intranet based recruitment site. • Wide media coverage and advertising. • Participation in overseas and local recruitment expos.	• Induction guides for managers • Tikanga Recommended Best Practice Course • Treaty of Waitangi in Practice Course (to provide knowledge and skills necessary to understand the role of Te Tiriti o Waitangi in ADHB policy and practice) • Mandatory training for new staff (from week 1 through first 12 months of employment) • Development of comprehensive Virtual Learning Environment (e-learning) • Support of Overseas Candidates social evenings. • Work Experience Days. • Open Days at Children's and Women's services. • Careers Centre evening for local candidates to meet and talk about job opportunities. • Careers Centre website accessible internally & externally. • Candidate and hiring manager satisfaction surveys. • Internal promotion of vacancies via Nova Magazine link and ADHB Intranet site.
employee development, promotion and exit	• Guides to training and coaching staff. • Documented exit procedures • Majority of staff on MECAs have continuing education provisions. • Other staff have the ability to negotiate specific training and development opportunities.	• Alumni programme in place. • Annual performance review and individual development/objective setting process. • Numerous clinical, technical, and management internal training programmes and workshops. • Sabbaticals for Senior Medical Officers. • Exit interviews conducted.

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flexibility & work design	• Flexible rostering practices subject to clinical requirements.	• Participation in the Department of Labour's pay and employment equity review (ongoing). • Review of family friendly initiatives. • Staff Crèche on each site.
remuneration recognition & conditions	• The majority of staff are on transparent MECAs. • The annual review of IEA remuneration is based on market data and employee performance. • Clinical staff are embedded in integrated the DHB's management structure.	• Nova awards – peer recognition of individuals or teams living the organisational values • Long service awards • Celebration week – a week of activities celebrating clinical, teaching and research achievements. • Staff benefits with external providers. • Recognition of retiring staff & staff who die in service through a tribute in NOVA.
harassment & bullying prevention	• Harassment policy in place. • Workplace Violence Prevention Policy (as affecting staff) is in place. • HR led bullying and harassment coaching seminars conducted.	• Formal and informal processes documented and available for response to harassment. • Presentations and staff awareness training provided to staff/teams.

safe and healthy environment	• Dedicated Occupational Safety & Health department.
	• Health & Safety Policy in place.
	• Harassment Policy in place.
	• Workplace Violence Prevention Policy in place.
	• DVFree (domestic violence) Programme
	• A series of key performance indicators measuring various forms of staff well-being.
		• ACC Partnership Programme - Tertiary accredited. Good relationships with third party provider.
		• Staff leadership of service-based Health & Safety committees, which also include Maori, Pacific Island, Auckland Regional Public Health, internal clinical, and ACC representation.
		• Staff Wellness initiatives, some of which include onsite Pilates, Yoga programmes, and massage. Healthy Eating Healthy Action (HEHA) and staff smoke free initiatives put in place.
		• Free influenza vaccine programme for staff.
		• Promotion to staff of external initiatives such as the Feet Beat 8-week walking challenge, Push Play, the YMCA Walk/Run series, 5+A Day, World Diabetes Day, White Ribbon, Safety NZ Week (ACC), and Sun Smart Week.
		• Dedicated Lifestyle section in ADHB's newsletter (both electronic and hard copy).
		• A Dedicated Health Matters website designed specifically to align with mental and physical wellness themes as important to ADHB staff and families (updated at least monthly).
		• DVFree as an intervention to support employee wellbeing and a component of ADHB's commitment to a violence free organisation. This programme allows ADHB to make a difference to the lives of our employees and be a leader in creating best practice workplace policies and procedures. By proactively addressing this issue within ADHB we can:
		  ▪ Increase employee productivity and morale
		  ▪ Reduce employee absenteeism and turnover
		Our aim is to provide support for our employees who have experienced and been subjected to domestic violence. This approach will in turn enhance employee productivity, job satisfaction and organizational wellbeing. We are doing this through educating our employees about this important, yet often hidden issue, in order to be part of a larger community movement responding to domestic violence so that those affected by this no longer have to cope in silence or isolation.

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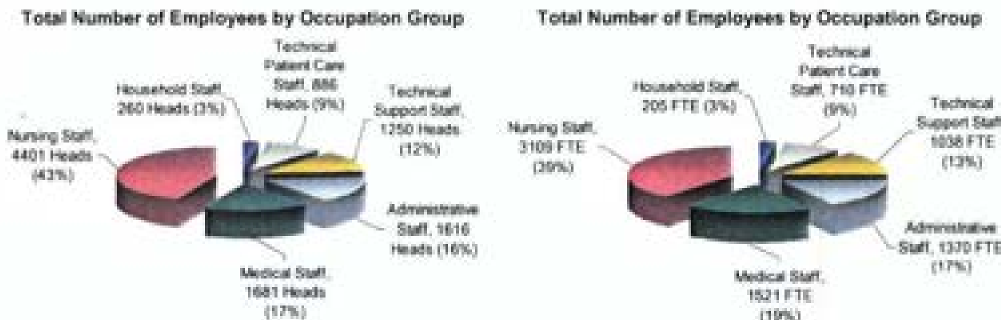
safe and healthy environment (continued)		We have a DVFree Policy which outlines how we will support employees to come forward as victims of domestic violence to help them be safe at work, reduce isolation, and maintain productive employment. We have selected appropriate DVFree contact people at each site to be available to support employees who are experiencing family violence and who wish to speak about their situation with someone not in management. Contact people are trained to recognize, respond and refer. They ensure confidentiality when an employee discloses they are being abused at home. They do not counsel victims. They do support an employee (victim) if they want to go to management. We have provided training for managers, contact people and HR to ensure our DVFree Policy is fully and appropriately implemented. Through these initiatives we have embedded into our systems ways of raising the general awareness of all our employees about domestic violence and our DVFree Policy so that: • There will be reduce stigma attached to those experiencing domestic violence • Employees are experiencing domestic violence will feel more comfortable and safe to seek support within ADHB, and will know where to seek help. • Support material available for staff and managers to understand and manage workplace stress. • EAP services provided free to staff. • Free work-related Occupational Health assessments for staff. • Workstation assessments. • Work area safety checks. • Staff breastfeeding policy & facilities. • Weight Watchers weekly onsite meeting. • Of note - Lost Time Injury rate reduced from 9 injuries per million hours worked to 7.5 over the past two years (a 16.7% reduction)

WORKFORCE DEMOGRAPHICS

Size of ADHB's Workforce

As displayed by the two pie charts below, Nursing is ADHB's largest occupational group (at 43% and 39% for headcount and FTE respectively), from a little over 10,000 heads and 7,960 FTE.



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Staff Turnover

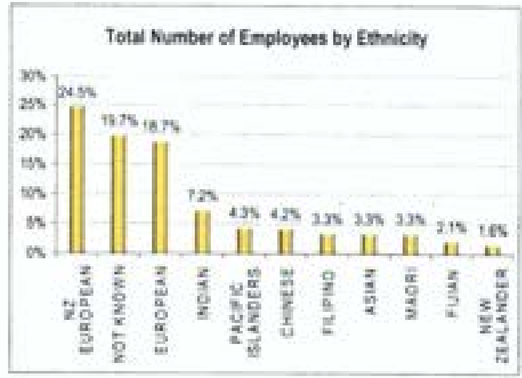
Voluntary staff turnover for year ended 30 June 2010 was 9.7% (2009 11%).

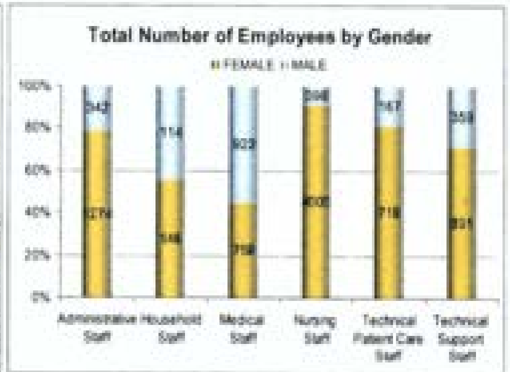
Employee Diversity

It is not mandatory for employees to disclose their ethnicities and around 20% choose not to do so (down from 28% five years ago). A number of employees have a mixture of ethnic background and some believe it is not respectful to identify one ethnic group over another. The table below identifies all ethnic groups that represent greater than 1% of our workforce. We are fortunate to have many other ethnic groups within our workforce, and while not displayed by the Total Number of Ethnicities chart below, over the past five years, reporting of Asian groups as an aggregate (including the Indian, Chinese, and Filipino groups below) has increased by approximately 5%.

Gender

As displayed in the Total Number of Employees by Gender chart below, there are gender differences across the varying occupational groups, and females comprise around 77% of the DHB's employees. At a snapshot in April 2010, females represented approximately 75% of the ADHB's senior management team. A number of mechanisms are used at ADHB to support pay and employment equity, such as job evaluation for Nursing and IEA employees to determine the internal relativity of positions (and in the case of all IEA positions the job sizes are linked back to external market data for salary setting), annual step increments for staff of both genders on a number of CEAs, and formal performance appraisals against goals and competency assessments.



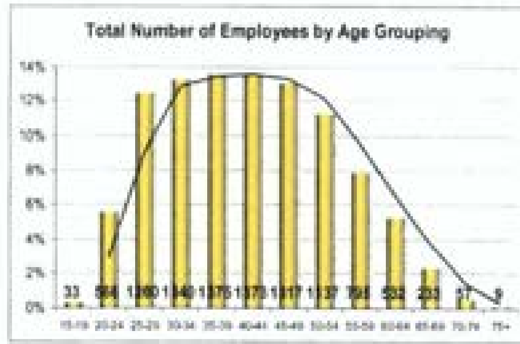


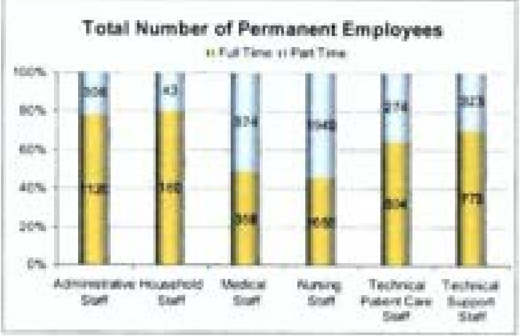
Age of Workforce

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

Full-time Vs Part-time Employees

As shown in the Total Number of Permanent Employees chart below, the majority of employees are permanently employed (at around 58%, with approximately 42% being part time), and the ratios differ across the various occupational groups. While not displayed, the ratio of full-time to part-time staff across ADHB for the past five years has remained relatively stable, although Medical has increased it's ratio of part-time staff by 5%.





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STATEMENT OF RESPONSIBILITY
FOR THE YEAR ENDED 30 JUNE 2010

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

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

3. In the opinion of the Board and management of ADHB, the financial statements for the year ended 30 June 2010 fairly reflect the financial position and operations of ADHB.

P.N. Snedden **Chair**	**H.J. Burkhardt** **Chair Finance Committee**	**G. R. Smith** **Chief Executive**
Dated: 6 October 2010	**Dated: 6 October 2010**	**Dated: 6 October 2010**

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STATUTORY INFORMATION

In respect of the financial year ended 30 June 2010 the Board members of ADHB submit the following report:

Members of the Board - Current

Board member	**Experience with ADHB**
Patrick Nesbit Snedden (Chair)	From December 2007
Harry Jacques Burkhardt (Deputy Chair)	From June 2003
Joanne Margaret Agnew	From December 2007
Susan Margaret Buckland	From December 2007
Dr. Christopher John Wesley Chambers	From December 2001
Robin John Cooper	From December 2007
Dr. Brian Joseph Fergus	From December 2007
Dr. Ian Kevin Scott	From December 2001
Rt. Hon. Robert James Tizard	From December 2007
Seiuli Dr. Juliet Maria Walker	From December 2007
Ian Ronald Ward	From December 2007

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BOARD COMMITTEES AS AT 30 JUNE 2010 - STATUTORY COMMITTEES

Community and Public Health Advisory Committee

Dr. B.J. Fergus (Chair)
J.M. Agnew
S.M. Buckland
H. J. Burkhardt
Dr. C. J. W. Chambers
R.J. Cooper
Rev. A. Ngaro
Dr. I. K. Scott
P.N. Snedden
F. Sultana
Rt. Hon. R.J.Tizard
Seiuli Dr. J.M. Walker
I.R. Ward
L. Williams

Disability Support Advisory Committee

J.M. Agnew (Chair)
S.M. Buckland
P. Druskovich
Tunumafono A. Fa'amoe
M. E. M. Hull-Brown
D.A. Kirton
S. Sherrard
N. Tan
Rt. Hon. R.J.Tizard

Hospital Advisory Committee

Dr. C.J.W. Chambers (Chair)
J.M. Agnew
S.M. Buckland
H.J. Burkhardt
R.J. Cooper
Dr. B.J. Fergus
Assoc. Prof. A. Kolbe
Prof. I. Martin
Dr. I.K. Scott
P.N. Snedden
F. Sultana
Rt. Hon. R.J.Tizard
Seiuli Dr. J.M. Walker
I.R. Ward
L. Williams

BOARD COMMITTEES AS AT 30 JUNE 2010 - BOARD ESTABLISHED COMMITTEES

Finance Committee

H.J. Burkhardt (Chair)
Dr. B.J. Fergus
Dr. I.K. Scott
P.N. Snedden
I.R. Ward
Rt. Hon. R.J.Tizard

Quality Risk and Audit Committee

Dr. I.K. Scott (Chair)
J.M. Agnew
S.M. Buckland
Dr. C.J.W. Chambers
Dr. B.J. Fergus
P.N. Snedden
Seiuli Dr. J.M. Walker

Maori Health Advisory Committee

R.J. Cooper (Chair)
H.J. Burkhardt
Dr. C. J.W. Chambers
T. Kingi
L. Mitchelson
P. Rameka
P.N. Snedden
T. Stewart

Pacific Health Advisory Committee

Rev. A. Ngaro (Chair)
Dr. C.J.W. Chambers
R.J. Cooper
Tafilelea F. Gagamoe
L. Halatau
Le'aufa'amulia A. Lole - Taylor
B. McCarthy
M. Maka
P.N. Snedden
Seiuli Dr. J.M. Walker
I.R. Ward

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Principal activities

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

ADHB provides its own hospital and health services at:

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

Review of operations

	Group $000	Parent $000
Results for the year ended 30 June 2010		
Operating surplus /(deficit)	195	(459)
Share of net surpluses of associates	84	0
Net surplus	279	(459)
Equity of ADHB as at 30 June 2010		
Current assets	156,799	143,525
Non-current assets	885,350	874,803
Total assets	1,042,149	1,018,328
Current liabilities	351,812	341,639
Non-current liabilities	235,759	235,759
Total liabilities	587,571	577,398
Total equity	454,578	440,930

Capital Charge

The capital charge for the year ended 30 June 2010 was $35.921 million (to 30 June 2009: $39.678 million) and is treated as an operating expense – note 15.

Equity Comparisons

No equity has been repaid to the Crown (to 30 June 2009, $35 million repaid).

Financial statements

The financial statements of ADHB and the Group for the year ended 30 June 2010 are included separately in this report. The Group consists of ADHB, the Auckland District Health Board Charitable Trust (beneficial control) and associated entities, Auckland Regional RMO Services Limited (33% owned), Northern DHB Support Agency Limited (33% owned) and Treaty Relationship Company Limited (50% owned)

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Interests register

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

(a) Board Members' Fees	Year ended 30/6/10 $	Year ended 30/6/09 $
P.N. Snedden (Chair)	86,125	88,000
H.J. Burkhardt (Deputy Chair)	57,750	65,378
J.M. Agnew	32,718	31,110
S.M. Buckland	32,250	32,250
Dr. C.J. Chambers	31,000	31,625
R.J. Cooper	28,750	29,875
Dr. B.J. Fergus	36,188	34,688
Dr. I.K. Scott	34,000	34,063
Rt. Hon. R.J.Tizard	35,750	35,063
Seiuli Dr. J.M. Walker	30,500	31,000
I.R. Ward	35,000	34,000
Fees paid to Board Members	**440,031**	**447,052**

(b) Board Members use of ADHB information

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

(c) Committee Members' Fees	Year ended 30/6/10 $	Year ended 30/6/09 $
P. Druskovich	0	750
Tunumafona A. Fa'amoe	0	250
Tafilelea F. Gagamoe	2,750	1,500
L. Halatau	1,000	2,900
D. Kirton	1,500	1,000
Assoc. Prof. A. Kolbe	4,750	750
Le'aufa'amulia A. Lole - Taylor	2,250	2,250
B. McCarthy	2,500	1,813
L. Mitchelson	1,000	2,000
M. Maka	2,000	2,000
Rev. A. Ngaro	4,375	4,125
P. Rameka	2,250	1,750
F. Sultana	3,000	1,750
N. Tan	1,000	0
L. Williams	4,250	4,500
Fees paid to Committee Members	**32,625**	**27,338**

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(d) Board Members' Interests

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

Board Member	Interest
P.N. Snedden (Chair)	Consultant, Ngati Whatua o Orakei Maori Trust Board; Director, Watercare Services Ltd; Chairman, Housing New Zealand; Chairman, Tamaki Establishment Board; Chief Crown Negotiator, Ngati Kahu Claim; Chief Crown Negotiator, Muriwhenua Forum
H. J. Burkhardt (Deputy Chair)	Owner/Managing Director, Replas Ltd; Owner/Director, Matta Products Ltd; Shareholder/Director, Remat Group Ltd; Trustee, ADHB Charitable Trust; Chairman, NZ Maori Arts & Craft Institute; Shareholder/Director, Matt I Ltd; Trustee, Matta LLC; Deputy Chairman and Negotiator Ngati Kuri Trust Board; Executive Member, Packaging Council of New Zealand; Chairman, Ngati Whatua o Orakei Health Clinic Limited
J.M. Agnew	Senior Lecturer Nursing, Auckland University; Casual Staff Nurse, ADHB
S.M. Buckland	Self employed, Writing, Editing & Public Relations; Committee Member, Medical Council of New Zealand; Member, Professional Conduct Committee, Occupational Therapy Board
Dr. C. J. W. Chambers	Employee, ADHB; Wife employed by Safekids; Associate, Epsom Anaesthetic Group; Member, ASMS; Shareholder, Ormiston Surgical; Member, Credentialing Committee for Ormiston Hospital; Surveyor, Quality Healthcare NZ
R.J. Cooper	Chief Executive, Ngati Hine Health Trust; Board Member, New Zealand Research Centre for Growth & Development; Advisory Trust Board Member, James Henare Research Centre, University of Auckland; Board Member, Manaia PHO Whangarei; Member, Whanau Ora Task Force; Member, National Health Board; Chair, Whanao Ora Governance Group
Dr. B.J. Fergus	Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland
Dr. I.K. Scott	Shareholder and Chairman, Auckland PHO; Locum General Practitioner; Member, Waiheke "Integrated Family Health Centre" Steering Group
Rt. Hon. R.J.Tizard	Nil
Seiuli Dr. J.M. Walker	Locum General Practitioner, Mangere - PHO TaPasefika, Grey Lynn - PHO Procare; Member, National Breast Screening Advisory Committee; Facilitator, RNZCGP General Practice Education Programme Stage II; Employee, contracted roster Doctor for Pohutukawa, ADHB; Panel Member, Medical Appeal Board, Work and Income
I.R. Ward	Chair, Advisory Board, Healthvision Limited; Principal/Director, C-4 Consulting Limited

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Auckland District Health Board Charitable Trust

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

Trustees of the Trust at 30 June 2010

Trustee	Experience with A+ Charitable Trust
Dr. R. Frith (Chair)	Appointed 12 October 2003
J. Barnett	Appointed 14 August 2009
H. J. Burkhardt*	Appointed 7 April 2005
T. Campbell	Appointed 8 April 2004
R. Jarrold	Appointed 12 December 2008
Dr. S. Macfarlane	Appointed 11 March 2005
T. MacAvoy	Appointed 14 August 2009
P. Poole	Appointed 14 August 2009
G. R. Smith*	Appointed 7 April 2006
Dr. M. Wilsher*	Appointed 1 June 2010
B. Wiseman*	Appointed 13 February 2009

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

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Employee remuneration

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

Remuneration Range	Medical	Non- Medical	Number of Employees
$660,000-$670,000	1		1
$540,000-$550,000		1	1
$530,000-$540,000	1		1
$510,000-$520,000	1		1
$500,000-$510,000	1		1
$480,000-$490,000	1		1
$470,000-$480,000	1		1
$460,000-$470,000	2		2
$450,000-$460,000	1		1
$440,000-$450,000	3		3
$430,000-$440,000	1		1
$420,000-$430,000	4		4
$410,000-$420,000	3		3
$400,000-$410,000	3		3
$380,000-$390,000	3		3
$370,000-$380,000	9		9
$360,000-$370,000	5		5
$350,000-$360,000	7		7
$340,000-$350,000	11		11
$330,000-$340,000	6		6
$320,000-$330,000	15		15
$310,000-$320,000	15		15
$300,000-$310,000	21		21
$290,000-$300,000	20	2	22
$280,000-$290,000	18	1	19
$270,000-$280,000	19	1	20
$260,000-$270,000	25		25
$250,000-$260,000	15	1	16
$240,000-$250,000	20	2	22
$230,000-$240,000	26		26
$220,000-$230,000	22	1	23
$210,000-$220,000	30	2	32
$200,000-$210,000	29		29
$190,000-$200,000	34	1	35
$180,000-$190,000	25	1	26
$170,000-$180,000	35	1	36
$160,000-$170,000	40	5	45
$150,000-$160,000	42	4	46
$140,000-$150,000	47	10	57
$130,000-$140,000	58	18	76
$120,000-$130,000	68	46	114
$110,000-$120,000	66	61	127
$100,000-$110,000	65	92	157
Total	819	250	1,069

Note:

Of the 1,069 employees shown above, 819 are or were medical or dental employees and 250 are or were neither medical nor dental employees. If the remuneration of part-time employees were grossed-up to a full time equivalent basis, the total number of employees with full time equivalent salaries of $100,000 or more would be 1,325 compared with the actual total number of employees of 1,069.

Remuneration in the Medical column may include one-off adjustments to base salary from job-sizing.

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Employee termination

Termination payments	Payment $	Employees
Total	2,617,616	126

During the year ended 30 June 2010, termination payments were made in respect of 126 employees (87 payments, $1,547,563 in year ended 30 June 2009). Termination payments consist of settlements and redundancy payments made during the year.

Auditor

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

Remuneration to auditor	2010 $000	2009 $000
Audit Fees	260	260

Donations

ADHB did not make any donations during the year.

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

P.N. Snedden
Chair

Dated: 6 October 2010

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STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2010

	Notes	Group Budget	Group Actual		Parent Actual	
		2010 $000	2010 $000	2009 $000	2010 $000	2009 $000
Revenue						
Patient care revenue		1,606,004	1,615,457	1,529,605	1,615,457	1,529,605
Other revenue		87,522	96,484	108,205	94,646	105,746
Total revenue	2	1,693,526	1,711,941	1,637,810	1,710,103	1,635,351
Expenses						
Employee benefit cost	3a	719,323	727,993	686,971	727,993	686,971
Direct treatment cost		210,194	223,130	217,708	223,130	217,708
Funder payments		543,114	547,017	521,457	547,017	521,457
Indirect treatment costs	3b	38,433	39,901	36,919	39,901	36,919
Property, equipment & transport costs	3c	53,100	48,432	49,252	48,432	49,252
Other operating expenses	3d	18,710	20,927	21,805	19,743	21,222
Capital charge	3e	39,501	35,921	39,678	35,921	39,678
Depreciation and amortisation expenses	3f	50,824	48,338	42,810	48,338	42,810
Finance costs	3g	20,311	20,087	20,904	20,087	20,904
Total expenses		1,693,510	1,711,746	1,637,504	1,710,562	1,636,921
Share of surpluses of joint venture & associates		0	84	20	0	0
Surplus/ (deficit)		16	279	326	(459)	(1,570)

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2010

	Notes	Group Budget	Group Actual		Parent Actual	
		2010 $000	2010 $000	2009 $000	2010 $000	2009 $000
Surplus/ (deficit)		16	279	326	(459)	(1,570)
Gains/(Losses) on property revaluations	6	0	(27,739)	(35,739)	(27,739)	(35,739)
Total Comprehensive Income/(Loss)		16	(27,460)	(35,413)	(28,198)	(37,309)

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

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STATEMENT OF CHANGES IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2010

GROUP	Notes	Public Equity	Accumulated surplus /(deficit)	Other reserves	Trust / Special Funds	Total equity
		$000	$000	$000	$000	$000
Balance as at 1 July 2008		601,089	(479,621)	417,016	10,647	549,131
Surplus/ (deficit) for the period		0	(1,548)	0	1,874	326
Movement in revaluation of land and buildings		0	0	(35,739)	0	(35,739)
Total comprehensive income and expense		0	(1,548)	(35,739)	1,874	(35,413)
Contributions from/(repayment to) the Crown		(35,000)	0	0	0	(35,000)
Total equity transactions		(35,000)	0	0	0	(35,000)
Balance as at 30 June 2009	6	566,089	(481,169)	381,277	12,521	478,718
Balance as at 1 July 2009		566,089	(481,169)	381,277	12,521	478,718
Surplus/ (deficit) for the period		0	(375)	0	654	279
Movement in revaluation of land and buildings		0	0	(27,739)	0	(27,739)
Total comprehensive income and expense		0	0	(27,739)	0	(27,739)
Contributions from/(repayment to) the Crown		3,320	0	0	0	3,320
Total equity transactions		3,320	0	0	0	3,320
Balance as at 30 June 2010	6	569,409	(481,544)	353,538	13,175	454,578

PARENT	Notes	Public Equity	Accumulated surplus /(deficit)	Other reserves	Trust / Special Funds	Total equity
		$000	$000	$000	$000	$000
Balance as at 1 July 2008		601,089	(479,988)	417,016	0	538,117
Surplus/ (deficit) for the period		0	(1,570)	0	0	(1,570)
Movement in revaluation of land and buildings		0	0	(35,739)	0	(35,739)
Total comprehensive income and expense		0	(1,570)	(35,739)	0	(37,309)
Contributions from/(repayment to) the Crown		(35,000)	0	0	0	(35,000)
Total equity transactions		(35,000)	0	0	0	(35,000)
Balance as at 30 June 2009	6	566,089	(481,558)	381,277	0	465,808
Balance as at 1 July 2009		566,089	(481,558)	381,277	0	465,808
Surplus/ (deficit) for the period		0	(459)	0	0	(459)
Movement in revaluation of land and buildings		0	0	(27,739)	0	(27,739)
Total comprehensive income and expense		0	(459)	(27,739)	0	(28,198)
Contributions from/(repayment to) the Crown		3,320	0	0	0	3,320
Total equity transactions		3,320	0	0	0	3,320
Balance as at 30 June 2010	6	569,409	(482,017)	353,538	0	440,930

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

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STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2010

	Notes	Group Budget	Group Actual		Parent Actual	
		As at 30/06/10 $000	As at 30/06/10 $000	As at 30/06/09 $000	As at 30/06/10 $000	As at 30/06/09 $000
Current Assets						
Cash and cash equivalents	7	62,396	70,865	61,938	70,865	61,938
Trust/special funds	8a	15,264	10,680	10,742	0	0
Patient & restricted trust funds	8b	0	1,067	1,037	1,067	1,037
Trade & other receivables	9	45,934	59,785	63,416	57,191	61,663
Inventories	10	11,348	11,220	11,717	11,220	11,717
Derivative financial instruments	19	0	3,182	7,209	3,182	7,209
Total Current Assets		134,942	156,799	156,059	143,525	143,564
Non-Current Assets						
Trust/special funds	8a	5,500	10,078	8,000	0	0
Property, plant and equipment	11a	930,128	860,468	888,801	860,468	888,801
Intangible assets	11b	11,185	10,145	12,766	10,145	12,766
Derivative financial instruments	19	2,823	4,189	1,358	4,189	1,358
Investments in joint venture & associates	5	366	470	386	1	1
Total Non-Current Assets		950,002	885,350	911,311	874,803	902,926
Total Assets		1,084,944	1,042,149	1,067,370	1,018,328	1,046,490

The accompanying notes form an integral part of these financial statements

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STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2010

	Notes	Group Budget	Group Actual		Parent Actual	
		As at 30/06/10 $000	As at 30/06/10 $000	As at 30/06/09 $000	As at 30/06/10 $000	As at 30/06/09 $000
Current Liabilities						
Bank overdraft	7	0	14,050	26,650	14,050	26,650
Trade and other payables	13a	140,342	136,397	133,127	126,224	125,157
Employee benefits	13b	115,463	125,197	118,008	125,197	118,008
Provisions	13c	375	74	4	74	4
Interest-bearing loans and borrowings	14,18	18,253	74,652	18,372	74,652	18,372
Loans from joint venture & associates	5	0	375	0	375	0
Derivative financial instruments	19	0	0	1,273	0	1,273
Patient & restricted trust funds	8b	1,100	1,067	1,037	1,067	1,037
Total Current Liabilities		275,533	351,812	298,471	341,639	290,501
Non-Current Liabilities						
Employee benefits	13b	25,818	22,434	20,673	22,434	20,673
Interest-bearing loans and borrowings	14	265,834	213,014	269,168	213,014	269,168
Derivative financial instruments	19	0	311	340	311	340
Total Non-Current Liabilities		291,652	235,759	290,181	235,759	290,181
Total Liabilities		567,185	587,571	588,652	577,398	580,682
Net Assets		517,759	454,578	478,718	440,930	465,808
Equity						
Public equity	6a	569,698	569,409	566,089	569,409	566,089
Accumulated deficit	6b	(468,955)	(481,544)	(481,169)	(482,017)	(481,558)
Other reserves	6c	417,016	353,538	381,277	353,538	381,277
Trust/special funds	6d	0	13,175	12,521	0	0
Total Equity		517,759	454,578	478,718	440,930	465,808

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

P.N. Snedden **Chair**	**H.J. Burkhardt** **Chair Finance Committee**
Dated: 6 October 2010	**Dated: 6 October 2010**

The accompanying notes form an integral part of these financial statements

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STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2010

	Notes	Group Budget	Group Actual		Parent Actual	
		2010	2010	2009	2010	2009
		$000	$000	$000	$000	$000
Cash Flows from Operating Activities						
Cash was provided from:						
Cash receipts from Ministry of Health and patients		1,688,973	1,706,293	1,629,604	1,701,990	1,621,159
Interest received		4,459	5,109	11,356	3,924	9,969
		1,693,432	1,711,402	1,640,960	1,705,914	1,631,128
Cash was applied to:						
Cash paid to employees		(711,478)	(719,358)	(686,354)	(719,743)	(683,823)
Cash paid to suppliers		(860,155)	(868,849)	(836,216)	(865,453)	(829,844)
Interest paid		(20,190)	(20,686)	(21,065)	(20,200)	(21,065)
Net goods and services taxes refunded/(paid)		0	226	(2,089)	202	(2,148)
Capital charges paid		(40,495)	(37,741)	(50,326)	(37,741)	(50,326)
		(1,632,318)	(1,646,408)	(1,596,050)	(1,642,935)	(1,587,206)
Net cash inflow from operating activities	7	61,114	64,994	44,910	62,979	43,922
Cash Flows from Investing Activities						
Cash was provided from:						
Proceeds from sale of property, plant and equipment		(21)	9	83	9	83
Decrease/(Increase) in restricted trust funds		72	(2,045)	(1,042)	(30)	(54)
		51	(2,036)	(959)	(21)	29
Cash was applied to:						
Purchase of property, plant and equipment		(61,000)	(45,126)	(42,344)	(45,126)	(42,344)
Net cash (outflow) from investing activities		(60,949)	(47,162)	(43,303)	(45,147)	(42,315)
Cash Flows from Financing Activities						
Cash was provided from:						
Proceeds from joint venture		0	375	0	375	0
Proceeds from loans raised/(repaid)		(3,600)	0	(10,500)	0	(10,500)
Proceeds from capital contributed/(repaid)		3,609	3,320	(35,000)	3,320	(35,000)
Net cash inflow/(outflow) from financing activities		9	3,695	(45,500)	3,695	(45,500)
Movement in cash and cash equivalents						
Opening cash and cash equivalents		62,222	35,288	79,181	35,288	79,181
Net cash inflow/(outflow)		174	21,527	(43,893)	21,527	(43,893)
Closing cash and cash equivalents	7	**62,396**	**56,815**	**35,288**	**56,815**	**35,288**

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

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NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2010

Note

1 **SIGNIFICANT ACCOUNTING POLICIES**

Reporting entity

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

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

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

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

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

Statement of compliance

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

Basis of preparation

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

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

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

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

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

Basis for consolidation

Subsidiaries

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

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

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1 SIGNIFICANT ACCOUNTING POLICIES (continued)

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

Joint Venture

A joint venture is an entity over whose activities ADHB has joint control, established by contractual agreement. The consolidated financial statements include ADHB's joint interest in the joint venture, using the equity method, from the date that joint control commences until the date that joint control ceases.

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

Associates

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

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

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

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

Transactions eliminated on consolidation

All inter-entity transactions are eliminated on consolidation.

Foreign Currency

Both the functional and presentation currency of ADHB and Group is New Zealand Dollars (NZD). Transactions in foreign currencies are translated at the exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at 30 June 2010 are translated to NZD at the rate ruling at that date. Foreign exchange differences arising on translation and settlement are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the date the fair value was determined.

Budget Figures

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

Equity

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

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1 **SIGNIFICANT ACCOUNTING POLICIES (continued)**

Property, Plant and Equipment (PPE)

The major classes of PPE are as follows:

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

<u>Owned Assets</u>

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 2010. 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.

<u>Disposal of PPE</u>

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.

<u>Leased assets</u>

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

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

<u>Subsequent costs</u>

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

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

Asset Class	2010	2009
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.

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SIGNIFICANT ACCOUNTING POLICIES (continued)

Intangible Assets

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

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

Amortisation of computer software is charged to the surplus or deficit on a straight line basis over its estimated useful life. The useful life of computer software is calculated over 7 years (2009 7 years) from the date that the software is available for use (refer Note 11b). Impairment losses are provided for on a continuing basis as required.

Interest-Bearing Loans and Borrowings

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

Derivative financial instruments

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

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

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

Trade and other receivables

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

Inventories

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

Inventories held for distribution

Inventories held for distribution are stated measured at cost, adjusted when applicable for any loss of service potential.

Cash and cash equivalents

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

Properties held for sale

Properties held for sale are measured at the lower of carrying amount or fair value less costs to sell.

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1 SIGNIFICANT ACCOUNTING POLICIES (continued)

Impairment of financial assets

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

Financial instruments

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

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

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

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

Employee benefits

Defined Contribution Plan (DCP)

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

Retiring Gratuities and Long Service Leave

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

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

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

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

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

Provisions

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

Restructuring

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

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1 SIGNIFICANT ACCOUNTING POLICIES (continued)

Revenue

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

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

In accordance with Generally Accepted Accounting Practice and NZIFRS, surpluses of Income over expenditure are reported through the Statement of Financial Performance. Where such surpluses are in respect of Mental Health Ring Fenced Revenue, the unspent portion of the revenue is only available to be spent on Mental Health Services in subsequent accounting periods. As at 30 June 2010, there was an amount of $3,210k unspent revenue in respect of Mental Health Ring Fenced Revenue (as at 30 June 2009 - $2,284k deficit). The surplus will be applied to expenses incurred after balance date.

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

Interest income is recognised using the effective interest method.

Lease Expenses

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

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

Income Tax

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

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.

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SIGNIFICANT ACCOUNTING POLICIES (continued)

Change in accounting policies

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

ADHB has adopted the following revisions to accounting standards during the financial year, which have had only a presentational or disclosure effect:

- NZ IAS 1 *Presentation of Financial Statements (Revised 2007)* replaces NZ IAS 1 *Presentation of Financial Statements (Issued 2004)*. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. ADHB has decided to prepare a separate statement of comprehensive income for the year ended 30 June 2010 under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated accordingly. Items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes in equity.

- Amendments to NZ IFRS 7 *Financial Instruments: Disclosures*. The amendments introduce a three-level fair value disclosure hierarchy that distinguishes fair value measurements by the significance of valuation inputs used. A maturity analysis of financial assets is also required to be prepared if this information is necessary to enable users of the financial statements to evaluate the nature and extent of liquidity risk. The transitional provisions of the amendment do not require disclosure of comparative information in the first year of application. ADHB has elected to disclose comparative information.

New standards and interpretations issued not yet adopted

Certain new standards, amendments and interpretations to existing standards have been published that are not yet effective for the year ended 30 June 2010, and have not been applied in preparing these Consolidated Financial Statements, as follows:

- NZ IAS 23 Borrowing costs (revised) – this has been deferred indefinitely for Public Benefit Entities.

- NZ IAS 24 Related Party Disclosures (Revised 2009) replaces NZ IAS 24 Related Party Disclosures (Issued 2004). The revised standard simplifies the definition of a related party, clarifying its intended meaning and eliminating inconsistencies from the definition.

- 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 on the classification and measurement of financial assets 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 instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. ADHB has not yet assessed the effect of the new standard and expects it will not be early adopted.

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SIGNIFICANT ACCOUNTING POLICIES (continued)

Cost of Service (Statement of Service Performance)

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

Cost Allocation

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

Cost Allocation Policy

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

Criteria for Direct and Indirect Costs

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

Cost Drivers for Allocation of Indirect Costs

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

Comparatives

Comparative information has been reclassified as appropriate to achieve consistency in disclosure with the current year.

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NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2010

		Notes	Group Actual		Parent Actual	
			2010	2009	2010	2009
			$000	$000	$000	$000
2	**REVENUE**					
	Patient care revenue		1,615,457	1,529,605	1,615,457	1,529,605
	Interest received – other		3,905	9,596	3,905	9,596
	Interest received – Charitable Trust		1,257	1,455	0	0
	Donations and bequests		7,335	8,972	6,560	7,065
	Gain/(loss) on disposal of assets		77	(339)	77	(339)
	Gain on derivatives – financial instruments		3,252	6,455	3,252	6,455
	Other revenue		80,658	82,066	80,852	82,969
	Total Revenue		1,711,941	1,637,810	1,710,103	1,635,351
3	**EXPENSES**					
a	*Employee benefit costs*					
	Wages and salaries		708,922	676,140	708,922	676,140
	Contributions to defined contribution plans	(i)	10,121	9,361	10,121	9,361
	Increase/(decrease) in liability for employee benefit		8,950	1,470	8,950	1,470
	Total employee benefit costs		727,993	686,971	727,993	686,971
b	*Indirect treatment costs*					
	Bad debts written off		3,417	3,519	3,417	3,519
	Increase (decrease) in estimated doubtful debts		(60)	(533)	(60)	(533)
	Other indirect treatment costs		36,544	33,933	36,544	33,933
	Total indirect treatment costs		39,901	36,919	39,901	36,919
c	*Property, equipment & transportation cost*					
	Rental and operating lease costs		5,088	5,456	5,088	5,456
	Other property, equipment & transportation cost		43,344	43,796	43,344	43,796
	Total property, equipment & transportation cost		48,432	49,252	48,432	49,252
d	*Other operating expenses*					
	Remuneration of auditor					
	- audit fees: statutory accounts		260	260	260	260
	Board Members' fees		440	447	440	447
	Research costs		6,724	6,239	6,724	6,239
	Other expenses		13,503	14,859	12,319	14,276
	Total other operating expenses		20,927	21,805	19,743	21,222
e	Capital charge (note 15)		35,921	39,678	35,921	39,678
f	*Depreciation and impairment expenses*					
	Depreciation		48,464	43,840	48,464	43,840
	Impairment loss/(gain) – software (note 11b)		(126)	(1,030)	(126)	(1,030)
	Total depreciation and impairment expenses		48,338	42,810	48,338	42,810

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3 EXPENSES (continued)

	Group Actual		Parent Actual	
	2010	2009	2010	2009
	$000	$000	$000	$000
g *Finance costs*				
Interest expense	20,068	20,881	20,068	20,881
Foreign currency loss/(gain)	19	23	19	23
Total finance costs	20,087	20,904	20,087	20,904

Note

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

4 TAXATION

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

5 INVESTMENTS IN JOINT VENTURE & ASSOCIATES

Non Current Assets				
Results of joint venture & associates				
Share of post acquisition surplus	84	20	0	0
Share of net surpluses of joint venture & associates	84	20	0	0
Carrying amount at the beginning of the year	386	366	1	1
Carrying amount at end of year	470	386	1	1
Represented by:				
Shares in joint venture & associates (unlisted at cost)	1	1	1	1
Share of post-acquisition retained surpluses	469	385	0	0
	470	386	1	1
Current Liabilities				
Loans from joint venture & associates	375	0	375	0

	2010 % Interest held	2009 % Interest held
Name of joint venture (Principal activity)		
Treaty Relationship Company Limited (joint venture for health initiatives with local iwi)	50	50
Name of associates (Principal activity)		
Auckland Regional RMO Services Limited (co-ordinates trainee medical personnel)	33	33
Northern DHB Support Agency Limited (management of a number of regional contracts on behalf of the Auckland region DHBs.)	33	33

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

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

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NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2010

		Group Actual		Parent Actual	
		As at 30/06/10	As at 30/06/09	As at 30/06/10	As at 30/06/09
6	**CAPITAL AND RESERVES**	**$000**	**$000**	**$000**	**$000**
a	***Public equity***				
	Opening balance	566,089	601,089	566,089	601,089
	Contributions from/(repayment to) the Crown	3,320	(35,000)	3,320	(35,000)
	Balance at end of year	569,409	566,089	569,409	566,089
b	***Accumulated deficits***				
	Opening balance	(481,169)	(479,621)	(481,558)	(479,988)
	Operating surplus/(deficit)	279	326	(459)	(1,570)
	Transfer to trust/special funds	(654)	(1,874)	0	0
	Balance at end of year	(481,544)	(481,169)	(482,017)	(481,558)
c	***Other Reserves***				
	Revaluation Reserve				
	Opening balances	381,277	417,016	381,277	417,016
	Net Movement	(27,739)	(35,739)	(27,739)	(35,739)
	Balance at end of year	353,538	381,277	353,538	381,277
d	***Trust/special funds***				
	Opening balances	12,521	10,647	0	0
	Transfer from accumulated deficits (Note 6b)	654	1,874	0	0
	Balance at end of year	13,175	12,521	0	0

Other reserves

Revaluation reserve

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

Trust / special funds

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

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

Trust/special funds	**2010 Actual $000**	**2009 Actual $000**
Balance at beginning of year	12,521	10,647
Transfer from retained earnings in respect of:		
Interest received	1,258	1,455
Donations and funds received	6,457	7,562
Transfer to retained earnings in respect of:		
Funds spent	(7,061)	(7,143)
Balance at end of year	13,175	12,521

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	Group Actual		Parent Actual	
	As at 30/06/10	As at 30/06/09	As at 30/06/10	As at 30/06/09
7 CASH AND CASH EQUIVALENTS	**$000**	**$000**	**$000**	**$000**
Current assets				
Bank balance	298	1,726	298	1,726
Short term deposits	70,567	60,212	70,567	60,212
Cash & cash equivalents	70,865	61,938	70,865	61,938
Bank overdrafts	(14,050)	(26,650)	(14,050)	(26,650)
Cash & cash equivalents in the statement of cash flows	56,815	35,288	56,815	35,288
Banking facility limit				
Revolving cash facility:				
CBA	65,000	65,000	65,000	65,000

Working capital facility

ADHB has a working capital facility supplied by Commonwealth Bank of Australia, New Zealand (CBA), which was established in February 2004. The facility consists of a bank overdraft and revolving bank multi-option credit facility. The facility was used at 30 June 2010. Unused portion of the facility at 30 June 2010 was $50.95m (2009 $38.35m).

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

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

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

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

	Notes	Group Actual		Parent Actual	
		2010	2009	2010	2009
		$000	$000	$000	$000
Reported net surplus/(deficit) for the year	6	279	326	(459)	(1,570)
Add non-cash items:					
Depreciation and impairment loss		48,338	42,810	48,338	42,810
Joint venture & associates	5	(84)	(20)	0	0
(Increase)/Decrease in derivative financial instruments		(106)	(5,228)	(106)	(5,228)
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		(77)	339	(77)	339
Add movements in working capital items:					
(Increase)/Decrease in receivables		2,639	16,905	4,572	15,331
(Increase)/Decrease in inventories		497	(954)	497	(954)
Increase/(Decrease) in payables		13,479	(9,323)	10,185	(6,861)
Increase/(Decrease) in funds held in trust		29	55	29	55
Net cash inflow/(outflow) from operating activities		64,994	44,910	62,979	43,922

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		Group Actual		Parent Actual	
		As at 30/06/10	As at 30/06/09	As at 30/06/10	As at 30/06/09
8a	**TRUST/SPECIAL FUNDS**				
	Current assets				
	Bank balances (restricted)	16	115	0	0
	Short term deposits (restricted)	10,664	10,627	0	0
		10,680	10,742	0	0
	Non – current assets				
	Long term deposits (restricted)	8,000	8,000	0	0
	Investment Bonds (at market)/(restricted)	2,078	0	0	0
		10,078	8,000	0	0

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

8b	**PATIENT AND RESTRICTED TRUST FUNDS**				
	Current assets				
	Patient trust	15	11	15	11
	Restricted fund deposit	1,052	1,026	1,052	1,026
		1,067	1,037	1,067	1,037
	Current liabilities				
	Patient trust	15	11	15	11
	Restricted fund deposit	1,052	1,026	1,052	1,026
		1,067	1,037	1,067	1,037

Patient trust

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

Restricted fund deposit

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

9	**TRADE AND OTHER RECEIVABLES**				
	Trade receivables due from non-related parties	12,679	23,374	11,951	22,829
	Trade receivables due from Ministry of Health	13,469	1,675	13,469	1,675
	Trade receivables due from related parties (note 17)	104	132	104	132
	Provision for doubtful debts	(2,004)	(2,064)	(2,004)	(2,064)
		24,248	23,117	23,520	22,572
	Accrued income Ministry of Health	18,785	22,839	18,785	22,839
	Accrued income	14,507	15,140	12,641	13,932
	Prepayments	2,245	2,320	2,245	2,320
		59,785	63,416	57,191	61,663

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	Group Actual		Parent Actual	
	As at 30/06/10	As at 30/06/09	As at 30/06/10	As at 30/06/09
10 INVENTORIES				
Pharmaceuticals	769	951	769	951
Surgical and medical supplies	10,410	10,735	10,410	10,735
Other supplies	41	31	41	31
	11,220	11,717	11,220	11,717

The amount of inventories recognised as an expense during the year ended 30 June 2010 was $74,317k (2009 $72,017k).

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2010 was $11,220k (2009 $11,717k). Write-down/ (up) of inventories amounted to $14k for 2010 (2009 ($248k)).

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11a PROPERTY, PLANT and EQUIPMENT

GROUP & PARENT	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 2008	245,814	606,244	237,234	4,463	3,783	1,097,538
Additions	0	0	3,691	17	34,548	38,256
Additions from Work in progress	0	6,151	23,896	0	(30,047)	0
Disposals	0	0	(6,720)	0	0	(6,720)
Transfer from current assets held for sale	69	333	0	0	0	402
Reclassifications	0	0	(128)	0	0	(128)
Revaluations	(44,546)	(7,547)	0	0	0	(52,093)
Balance at 30 June 2009	**201,337**	**605,181**	**257,973**	**4,480**	**8,284**	**1,077,255**
Cost						
Balance at 1 July 2009	201,337	605,181	257,973	4,480	8,284	1,077,255
Additions	0	76	0	2	42,421	42,499
Additions from Work in progress	0	7,056	20,472	0	(27,528)	0
Disposals	0	0	(7,821)	0	0	(7,821)
Revaluations	(19,841)	(26,981)	0	0	0	(46,822)
Balance at 30 June 2010	**181,496**	**585,332**	**270,624**	**4,482**	**23,177**	**1,065,111**
Depreciation and impairment losses						
Balance at 1 July 2008	0	0	(164,868)	(3,081)	0	(167,949)
Depreciation charge for the year	0	(19,155)	(24,167)	(23)	0	(43,345)
Disposals	0	0	6,661	0	0	6,661
Transfer from current assets held for sale	0	(301)	0	0	0	(301)
Reclassifications	0	3,104	(2,389)	(587)	0	128
Revaluations	0	16,352	0	0	0	16,352
Balance at 30 June 2009	**0**	**0**	**(184,763)**	**(3,691)**	**0**	**(188,454)**
Depreciation and impairment losses						
Balance at 1 July 2009	0	0	(184,763)	(3,691)	0	(188,454)
Depreciation charge for the year	0	(19,083)	(23,983)	(27)	0	(43,093)
Disposals	0	0	7,821	0	0	7,821
Revaluations	0	19,083	0	0	0	19,083
Balance at 30 June 2010	**0**	**0**	**(200,925)**	**(3,718)**	**0**	**(204,643)**

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11a PROPERTY, PLANT and EQUIPMENT (continued)

GROUP & PARENT	Freehold land (at valuation)	Freehold buildings & fitouts (at valuation)	Plant, equipment and vehicles	Leased improve-ments	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Carrying Amounts						
At 1 July 2008	245,814	606,244	72,366	1,382	3,783	929,589
At 30 June 2009	201,337	605,181	73,210	789	8,284	888,801
Carrying Amounts						
At 1 July 2009	201,337	605,181	73,210	789	8,284	888,801
At 30 June 2010	181,496	585,332	69,699	764	23,177	860,468

Valuation Information

Land, buildings and associated fitouts and services were independently valued on 30 June 2010 by Telfer Young (Auckland) Ltd (a firm registered with Valuers of New Zealand), at $766.8m (2009 $806.5m).

The reduction in value of land of $19.8m was caused by difficult market conditions for development land during the period. The main driver for the reduction in value of buildings of $19.9m was caused by deferred maintenance.

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PROPERTY, PLANT and EQUIPMENT (continued)

GROUP & PARENT

11b INTANGIBLE ASSETS

Software & development costs	Total
	$000
Cost	
Balance at 1 July 2008	56,778
Additions	3,303
Disposals	(365)
Balance at 30 June 2009	**59,716**
Balance at 1 July 2009	59,716
Additions	2,625
Disposals	(69)
Balance at 30 June 2010	**62,272**
Amortisation & Impairment Losses	
Balance at 1 July 2008	(47,583)
Amortisation charge for the year	(740)
Impairment losses	0
Reversal of impairment losses	1,030
Disposals	343
Balance at 30 June 2009	**(46,950)**
Amortisation & Impairment Losses	
Balance at 1 July 2009	(46,950)
Amortisation charge for the year	(5,372)
Impairment losses	0
Reversal of impairment losses	126
Disposals	69
Balance at 30 June 2010	**(52,127)**
Carrying Amounts	
At 1 July 2008	9,195
At 30 June 2009	**12,766**
At 1 July 2009	12,766
At 30 June 2010	**10,145**

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PROPERTY, PLANT and EQUIPMENT (continued)

11b INTANGIBLE ASSETS (continued)

Impairment Loss

The carrying amounts of all property, plant and equipment are reviewed on an ongoing basis. Any impairment in value is recognised immediately. A review of computer software resulted in a net impairment gain $126k (2009 $1,030k gain).

12a CONTINGENT ASSETS

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

12b CONTINGENT LIABILITIES

There are no contingent liabilities at 30 June 2010 (2009 Nil).

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		Notes	Group Actual		Parent Actual	
			As at 30/06/10 $000	As at 30/06/09 $000	As at 30/06/10 $000	As at 30/06/09 $000
13a	**TRADE AND OTHER PAYABLES**					
	Current					
	Trade payables to non related parties		38,680	40,004	37,746	39,461
	Trade payables due to related parties (note 17)		187	543	187	543
	ACC levy payable		3,090	4,479	3,090	4,479
	Income in advance		20,716	17,648	13,142	11,532
	ACC Partnership programme liability		1,769	1,507	1,769	1,507
	GST,PAYE & FBT payable		18,040	17,209	18,136	17,329
	Other payables and accruals		53,915	51,737	52,154	50,306
			136,397	133,127	126,224	125,157
13b	**EMPLOYEE BENEFITS**					
	Current					
	Liability for long service leave		2,510	1,994	2,510	1,994
	Liability for sabbatical leave		300	300	300	300
	Liability for retirement gratuities		4,350	3,792	4,350	3,792
	Liability for annual leave		70,582	64,965	70,582	64,965
	Liability for sick leave		520	462	520	462
	Liability for continuing medical leave and expenses		21,040	15,789	21,040	15,789
	Salaries and wage accrual		25,895	30,706	25,895	30,706
			125,197	118,008	125,197	118,008
	Non Current					
	Liability for long service leave		642	851	642	851
	Liability for retirement gratuities		21,792	19,822	21,792	19,822
			22,434	20,673	22,434	20,673
13c	**PROVISIONS**					
	Litigation Provision					
	Opening balance		4	3	4	3
	Additional provisions made during year		0	4	0	4
	Charged against provision for the year		(4)	(3)	(4)	(3)
	Unused amounts reversed during year		0	0	0	0
	Closing balance	(i)	0	4	0	4
	Restructuring Provision					
	Opening balance		0	96	0	96
	Additional provisions made during year		74	0	74	0
	Charged against provision for the year		0	(96)	0	(96)
	Unused amounts reversed during year		0	0	0	0
	Closing balance		74	0	74	0
	Total provisions	(ii)	74	4	74	4

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13c **PROVISIONS (continued)**

Notes

(i) **Litigation**

The provision relates to unpaid legal fees at year-end .

(ii) **Restructuring**

The provision relates to a redundancy pay-out , arising from the disestablishment of the Domino Midwifery Services at 30 June 2010.

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

The DCP (with National provident Fund) is a multi-employer defined benefit scheme. At 30 June 2010 ADHB contributions to the fund were fully paid - see Note 3a for details.

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

As at 31 March 2009, the scheme had a past service surplus of $15.3m (5.7% of the liabilities). This amount is exclusive of Specified Superannuation Contribution Withholding Tax (SSCWT). This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of NZ IAS 19.

The Actuary to the scheme has recommended the employer contribution continues at 1.0 times contributors' contributions. The 1.0 is inclusive of SSCWT.

	Group Actual		Parent Actual	
	As at 30/06/10 $000	As at 30/06/09 $000	As at 30/06/10 $000	As at 30/06/09 $000
14 INTEREST-BEARING LOANS AND BORROWINGS				
Current				
Secured loans				
Crown Health Financing Agency	0	13,500	0	13,500
10 year Capital Bonds, maturing 15 September 2010	70,000	0	70,000	0
Interest on Borrowings	4,741	4,872	4,741	4,872
Unexpired set up cost on borrowings	(89)	0	(89)	0
	74,652	18,372	74,652	18,372
Non-current				
Secured loans				
Crown Health Financing Agency	163,500	150,000	163,500	150,000
15 year Capital Bonds, maturing 15 September 2015	50,000	50,000	50,000	50,000
10 year Capital Bonds, maturing 15 September 2010	0	70,000	0	70,000
Unexpired set up cost on borrowings	(486)	(832)	(486)	(832)
	213,014	269,168	213,014	269,168

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14 INTEREST-BEARING LOANS AND BORROWINGS (continued)

	Note	Group Actual		Parent Actual	
		As at 30/06/10	As at 30/06/09	As at 30/06/10	As at 30/06/09
		$000	$000	$000	$000
Secured loans					
The details of terms and conditions are as follows:					
Borrowings are repayable:					
Less than one year		74,652	18,372	74,652	18,372
One to two years		19,904	69,168	19,904	69,168
Two to five years		143,110	80,000	143,110	80,000
Over five years		50,000	120,000	50,000	120,000
		287,666	287,540	287,666	287,540

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

Interest rate summary	% pa	% pa	% pa	% pa
Crown Health Financing Agency	4.26-6.90	6.095-6.90	4.26-6.90	6.095-6.90
Capital Bonds	7.75	7.75	7.75	7.75
Borrowing facilities				
Crown Health Financing Agency	184,500	163,500	184,500	163,500
Capital Bonds	120,000	120,000	120,000	120,000
Working capital CBA	65,000	65,000	65,000	65,000

Crown Health Financing Agency

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

Capital bonds

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

Working capital facility

ADHB has a working capital facility supplied by Commonwealth Bank of Australia, New Zealand (CBA), which was established in February 2004. The facility consists of a bank overdraft and revolving bank multi-option credit facility. Unused portion of the facility at 30 June 2010 was $50.95m (2009 $38.35m).

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14 INTEREST-BEARING LOANS AND BORROWINGS (continued)

Security and terms

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

ADHB cannot perform the following actions:

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

ADHB must also meet the following covenants:

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

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

	Group Actual		Parent Actual	
	As at 30/06/10 $000	As at 30/06/09 $000	As at 30/06/10 $000	As at 30/06/09 $000
15 CAPITAL CHARGE	35,921	39,678	35,921	39,678

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 2010 (8 percent for fiscal year 2009) on shareholder funds based on the monthly closing balance. ADHB has not paid a capital charge on donations received into the ADHB Charitable Trust.

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16 COMMITMENTS

	GROUP AND PARENT	Notes	As at 30/06/10 $000	As at 30/06/09 $000
a	*Capital commitments*			
	Approved and contracted		9,387	10,241
	Approved and to be contracted		19,900	10,954
			29,287	21,195
	Term classification of commitments			
	Less than one year		29,287	21,195
	One to two years		0	0
	Two to five years		0	0
	Over five years		0	0
			29,287	21,195
b	*Operating commitments*			
	Leases	(i)	4,419	5,775
	Other	(ii)	424,945	492,901
			429,364	498,676

GROUP AND PARENT	Leases		Other		Total	
	As at 30/06/10 $000	As at 30/06/09 $000	As at 30/06/10 $000	As at 30/06/09 $000	As at 30/06/10 $000	As at 30/06/09 $000
Term classification of operating commitments						
Less than one year	2,166	2,328	101,849	107,936	104,015	110,264
One to two years	1,018	1,587	91,375	78,374	92,393	79,961
Two to five years	1,142	1,548	225,702	300,072	226,844	301,620
Over five years	93	312	6,019	6,519	6,112	6,831
	4,419	5,775	424,945	492,901	429,364	498,676

Notes

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

16b(ii) The other operating commitments comprised:

- $419m (2009 $485m) expected payment schedules for contracts entered in the Ministry of Health's Computerised Management System (CMS).
- $6m (2009 $7m) outstanding operating purchase order commitments.

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17 TRANSACTIONS WITH RELATED PARTIES

a Subsidiary

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

PARENT	2010 Actual $000	2009 Actual $000
Sales to ADHB Charitable Trust	6,737	7,394
Purchases from ADHB Charitable Trust	125	119
Outstanding balance receivable from ADHB Charitable Trust	935	543
Outstanding balance payable to ADHB Charitable Trust	99	0

b Joint venture & associates

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

	Notes	Group Actual		Parent Actual	
		As at 30/06/10 $000	As at 30/06/09 $000	As at 30/06/10 $000	As at 30/06/09 $000
GROUP AND PARENT					
Sales to joint venture & associates					
Auckland Regional RMO Services Limited (associate)		241	323	241	323
Northern DHB Support Agency Limited (associate)		1,154	804	1,154	804
		1,395	1,127	1,395	1,127
Purchases from joint venture & associates					
Auckland Regional RMO Services Limited (associate)		4,258	3,345	4,258	3,345
Northern DHB Support Agency Limited (associate)		3,900	3,345	3,900	3,345
		8,158	6,690	8,158	6,690
Outstanding balances receivable from joint venture & associates					
Auckland Regional RMO Services Limited (associate)		0	22	0	22
Northern DHB Support Agency Limited (associate)		104	110	104	110
	9	104	132	104	132
Outstanding balances payable to joint venture & associates					
Northern DHB Support Agency Limited (associate)		187	543	187	543
	13a	187	543	187	543

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 2010 and 2009

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17 TRANSACTIONS WITH RELATED PARTIES (continued)

c Compensations

The key management personnel compensations are as follows:

GROUP & PARENT	Notes	2010 Actual $000	2009 Actual $000
Short - term employment benefits	(i)	5,271	4,730
Long - term employment benefits	(ii)	30	34
		5,301	4,764
Fees paid to Board Members	(iii)	440	447
Fees paid to Committee Members	(iv)	33	27
		473	474

Notes

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

17 c (iii) &(iv) Refer to Statutory Information (Page 20) for data by members.

d Board Members

During the year, ADHB supplied nursing advisory services to Housing New Zealand Ltd , which the chairman, P.N. Snedden is also the chair. The contracts invoiced totalled $117k (2009 Nil) and were supplied on normal commercial terms. There is no balance receivable from unpaid invoices at year end (2009 Nil). No payments were made to Housing New Zealand Limited (2009 Nil).

During the year, ADHB paid water and other water related services to Watercare Services Ltd, which the chairman. P.N. Snedden is also the chair. The services cost $23k (2009 72k) and were paid on normal commercial terms. There is a balance of $2k outstanding for unpaid invoices at year end (2009 $1k). No sales were made to Watercare Services Ltd (2009 Nil).

During the year, ADHB made a list of payments to Auckland PHO Ltd, which a board member, Dr. I. K. Scott is the chair and shareholder. The value of the payments made totalled $8.2m (2009 $7.4m) and were supplied on normal PHO contractual terms. There is a balance of $224k (2009 Nil) outstanding for unpaid invoices at year. No sales were made to Auckland PHO Ltd (2009 Nil).

18 FINANCIAL INSTRUMENTS

Credit Risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (2010-51%, 2009-38%). 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.

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18 FINANCIAL INSTRUMENTS (continued)

Credit Risk (continued)

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

GROUP

Trade receivables	Gross Receivable 2010 $000	Impairment 2010 $000	Gross Receivable 2009 $000	Impairment 2009 $000
Not past due	18,317	(38)	14,596	(46)
Past due 0-30 days	3,913	(357)	5,342	(309)
Past due 31-90 days	2,752	(666)	2,257	(831)
Past due 91-360 days	969	(642)	2,944	(836)
Past due more than 1 year	301	(301)	42	(42)
Total	26,252	(2,004)	25,181	(2,064)

PARENT

Trade receivables	Gross Receivable 2010 $000	Impairment 2010 $000	Gross Receivable 2009 $000	Impairment 2009 $000
Not past due	17,700	(38)	14,260	(46)
Past due 0-30 days	3,876	(357)	5,161	(309)
Past due 31-90 days	2,704	(666)	2,240	(831)
Past due 91-360 days	943	(642)	2,933	(836)
Past due more than 1 year	301	(301)	42	(42)
Total	25,524	(2,004)	24,636	(2,064)

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

Trade receivables	GROUP 2010 Actual $000	GROUP 2009 Actual $000	PARENT 2010 Actual $000	PARENT 2009 Actual $000
Gross trade receivables	26,252	25,181	25,524	24,636
Individual impairment	(2,004)	(2,064)	(2,004)	(2,064)
Net total trade receivables	24,248	23,117	23,520	22,572

Movement in the provision for impairment loss	GROUP 2010 Actual $000	GROUP 2009 Actual $000	PARENT 2010 Actual $000	PARENT 2009 Actual $000
Opening balance	2,064	8,465	2,064	8,465
Increase/(decrease) in doubtful debts	(60)	(6,401)	(60)	(6,401)
Closing balance	2,004	2,064	2,004	2,064

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.

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18 FINANCIAL INSTRUMENTS (continued)

Liquidity

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

Liquidity risk

The following table sets out the contractual cash flows for all financial liabilities and for derivatives that are settled on a gross cash flow basis.

GROUP

2010	Balance Sheet $000	Contractual Cash Flow $000	6 Months or less $000	6-12 Months $000	1-2 Years $000	2-5 Years $000	More than 5 years $000
Interest-bearing loans and borrowings	287,666	344,864	79,700	6,990	33,363	172,873	51,938
Trade and other payables	136,397	136,397	136,397	0	0	0	0
Bank overdraft	14,050	14,050	14,050	0	0	0	0
Derivative financial instruments –interest rate swaps in loss	311	328	48	112	114	54	0
Total	438,424	495,639	230,195	7,102	33,477	172,927	51,938

2009	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	287,540	362,251	9,882	23,340	86,069	112,849	130,111
Trade and other payables	133,127	133,127	133,127	0	0	0	0
Bank overdraft	26,650	26,650	26,650	0	0	0	0
Derivative financial instruments –interest rate swaps in loss	1,613	1,656	956	516	118	66	0
Total	448,930	523,684	170,615	23,856	86,187	112,915	130,111

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18 FINANCIAL INSTRUMENTS (continued)

Liquidity risk (continued)

PARENT

2010	Balance Sheet $000	Contractual Cash Flow $000	6 Months or less $000	6-12 Months $000	1-2 Years $000	2-5 Years $000	More than 5 years $000
Interest-bearing loans and borrowings	287,666	344,864	79,700	6,990	33,363	172,873	51,938
Trade and other payables	126,224	126,224	126,224	0	0	0	0
Bank overdraft	14,050	14,050	14,050	0	0	0	0
Derivative financial instruments –interest rate swaps in loss	311	328	48	112	114	54	0
Total	428,251	485,466	220,022	7,102	33,477	172,927	51,938

2009	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	287,540	362,251	9,882	23,340	86,069	112,849	130,111
Trade and other payables	125,157	125,157	125,157	0	0	0	0
Bank overdraft	26,650	26,650	26,650	0	0	0	0
Derivative financial instruments –interest rate swaps in loss	1,613	1,656	956	516	118	66	0
Total	440,960	515,714	162,645	23,856	86,187	112,915	130,111

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18 FINANCIAL INSTRUMENTS (continued)

Interest rate risk and currency risk

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

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

Interest rate risk

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

ADHB adopts a policy of ensuring that between 40 and 60 per cent of its exposure to changes in interest rates on borrowings is on a fixed rate basis. Interest rate swaps, denominated in NZD, have been entered into to achieve an appropriate mix of fixed and floating rate exposure within ADHB's policy. The swaps mature over the next five years following the maturity of the related loans (see Interest Rate Repricing Schedules, pages 65 - 66) and have fixed swap rates ranging from 6.85 per cent to 7.75 per cent. At 30 June 2010, ADHB had interest rate swaps with a notional contract amount of $115m (2009 $165m).

The net fair value of swaps at 30 June 2010 was $7,060k (2009 $6,954k). These amounts were recognised as fair value derivatives.

Foreign currency risk

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

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

The Group had not entered into any foreign exchange contract at balance date (2009 Nil).

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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 2010	Note	Held for Trading	Designated at Fair Value through Profit & Loss	Loans and Receivable	Available for Sale	Financial Liabilities at Amortised Cost	Carrying Amount Actual	Fair Value
		$000	$000	$000	$000	$000	$000	$000
Trade and other receivables	9	0	0	59,785	0	0	59,785	59,785
Cash and cash equivalents	7	0	0	70,865	0	0	70,865	70,865
Trust / Special Funds	8a	0	20,758	0	0	0	20,758	20,758
Patient and restricted trust funds	8b	0	0	1,067	0	0	1,067	1,067
Interest rate swaps:								
Assets	19	7,371	0		0	0	7,371	7,371
Liabilities	19	(311)	0		0	0	(311)	(311)
Forward exchange contracts:								
Assets	19	0	0		0	0	0	0
Liabilities		0	0		0	0	0	0
Secured bank loans	14	0	0		0	(287,666)	(287,666)	(313,542)
Trade and other payables	13a	0	0		0	(136,397)	(136,397)	(136,397)
Bank overdraft	7	0	0		0	(14,050)	(14,050)	(14,050)
		7,060	20,758	131,717		(438,113)	(278,578)	(304,454)
Unrecognised (gains)/losses								25,876

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18 FINANCIAL INSTRUMENTS (continued)

Classification and fair values (continued)

GROUP 2009	Note	Held for Trading	Designated at Fair Value through Profit & Loss	Loans and Receivable	Available for Sale	Financial Liabilities at Amortised Cost	Carrying Amount Actual	Fair Value
		$000	$000	$000	$000	$000	$000	$000
Trade and other receivables	9	0	0	63,416	0	0	63,416	63,416
Cash and cash equivalents	7	0	0	61,938	0	0	61,938	61,938
Trust / Special Funds	8a	0	18,742	0	0	0	18,742	18,742
Patient and restricted trust funds	8b	0	0	1,037	0	0	1,037	1,037
Interest rate swaps:								
Assets	19	8,567	0	0	0	0	8,567	8,567
Liabilities	19	(1,613)	0	0	0	0	(1,613)	(1,613)
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	(287,540)	(287,540)	(298,551)
Trade and other payables	13a	0	0	0	0	(133,127)	(133,127)	(133,127)
Bank overdraft	7	0	0	0	0	(26,650)	(26,650)	(26,650)
		6,954	**18,742**	**126,391**	**0**	**(447,317)**	**(295,230)**	**(306,241)**
Unrecognised (gains)/losses								**11,011**

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18 FINANCIAL INSTRUMENTS (continued)

Classification and fair values (continued)

PARENT 2010	Note	Held for Trading	Designated at Fair Value through Profit & Loss	Loans and Receivable	Available for Sale	Financial Liabilities at Amortised Cost	Carrying Amount Actual	Fair Value
		$000	$000	$000	$000	$000	$000	$000
Trade and other receivables	9	0	0	57,191	0	0	57,191	57,191
Cash and cash equivalents	7	0	0	70,865	0	0	70,865	70,865
Trust / Special Funds	8a	0	0	0	0	0	0	0
Patient and restricted trust funds	8b	0	0	1,067	0	0	1,067	1,067
Interest rate swaps:								
Assets	19	7,371	0	0	0	0	7,371	7,371
Liabilities	19	(311)	0	0	0	0	(311)	(311)
Forward exchange contracts:								
Assets	19	0	0	0	0	0	0	0
Liabilities	19	0	0	0	0	0	0	0
Secured bank loans	14	0	0	0	0	(287,666)	(287,666)	(313,542)
Trade and other payables	13a	0	0	0	0	(126,224)	(126,224)	(126,224)
Bank overdraft	7	0	0	0	0	(14,050)	(14,050)	(14,050)
		7,060		129,123		(427,940)	(291,757)	(317,633)
Unrecognised (gains)/losses								25,876

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18 FINANCIAL INSTRUMENTS (continued)

Classification and fair values (continued)

PARENT 2009	Note	Held for Trading	Designated at Fair Value through Profit & Loss	Loans and Receivable	Available for Sale	Financial Liabilities at Amortised Cost	Carrying Amount Actual	Fair Value
		$000	$000	$000	$000	$000	$000	$000
Trade and other receivables	9	0	0	61,663	0	0	61,663	61,663
Cash and cash equivalents	7	0	0	61,938	0	0	61,938	61,938
Trust / Special Funds	8a	0	0	0	0	0	0	0
Patient and restricted trust funds	8b	0	0	1,037	0	0	1,037	1,037
Interest rate swaps:								
Assets	19	8,567	0	0	0	0	8,567	8,567
Liabilities	19	(1,613)	0	0	0	0	(1,613)	(1,613)
Forward exchange contracts:								
Assets	19	0	0	0	0	0	0	0
Liabilities	19	0	0	0	0	0	0	0
Secured bank loans	14	0	0	0	0	(287,540)	(287,540)	(298,551)
Trade and other payables	13a	0	0	0	0	(125,157)	(125,157)	(125,157)
Bank overdraft	7	0	0	0	0	(26,650)	(26,650)	(26,650)
		6,954	**0**	**124,638**	**0**	**(439,347)**	**(307,755)**	**(318,766)**
Unrecognised (gains)/losses								**11,011**

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18 FINANCIAL INSTRUMENTS (continued)

Fair Value Hierarchy Disclosures

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

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

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

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

	Notes	Total	Valuation technique: Quoted market price	Valuation technique: Observable inputs	Valuation technique: Significant non-observable inputs
		$000	$000	$000	$000
GROUP					
As at 30 June 2010					
Financial Assets					
Derivatives	19	7,371	0	7,371	0
Local authority bond	8a	2,078	2,078	0	0
Financial Liabilities					
Derivatives	19	311	0	311	0
PARENT					
As at 30 June 2010					
Financial Assets					
Derivatives	19	7,371	0	7,371	0
Financial Liabilities					
Derivatives	19	311	0	311	0
GROUP					
As at 30 June 2009					
Financial Assets					
Derivatives	19	8,567	0	8,567	0
Financial Liabilities					
Derivatives	19	1,613	0	1,613	0
PARENT					
As at 30 June 2009					
Financial Assets					
Derivatives	19	8,567	0	8,567	0
Financial Liabilities					
Derivatives	19	1,613	0	1,613	0

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

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18 FINANCIAL INSTRUMENTS (continued)

Estimation of fair values analysis

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

Derivatives

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

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

Interest-bearing loans and borrowings

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

Restricted/special funds

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

Trade and other receivables / payables

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

Interest rates used for determining fair value

The entity uses the Government yield curve as of 30 June 2010 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

GROUP & PARENT	2010 Actual %	2009 Actual %
Derivatives	6.85-7.75	6.015 to 7.75
Loans and borrowings	4.26-7.75	6.095 to 7.75

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18 **FINANCIAL INSTRUMENTS (continued)**

Interest Rate Repricing Schedule

		GROUP				
		Maturity Periods				
	Weighted Average Interest Rate %	0 – 1 Years	1 – 2 Years	2 – 5 Years	More than 5 Years	Total
		$000	$000	$000	$000	$000
As at 30 June 2010						
Current & Non-Current Monetary Assets						
Cash and cash equivalents	3.58%	70,865	0	0	0	70,865
Restricted/special funds	5.64%	10,680	10,078	0	0	20,758
Patient and restricted trust funds	2.68%	1,067	0	0	0	1,067
Total Monetary Assets		82,612	10,078	0	0	92,690
Current & Non-Current Monetary Liabilities						
Bank overdraft	3.13%	14,050	0	0	0	14,050
Interest–bearing loans and borrowings						
Crown Health Financing Agency	6.20%	0	20,000	143,500	0	163,500
Bonds	7.75%	70,000	0	0	50,000	120,000
Interest on borrowings		4,741	0	0	0	4,741
Unexpired set up cost on borrowings		(89)	(96)	(390)	0	(575)
Total Monetary Liabilities		88,702	19,904	143,110	50,000	301,716
As at 30 June 2009						
Current & Non-Current Monetary Assets						
Cash and cash equivalents	4.00%	61,938	0	0	0	61,938
Restricted/special funds	6.52%	10,742	8,000	0	0	18,742
Patient and restricted trust funds	2.47%	1,037	0	0	0	1,037
Total Monetary Assets		73,717	8,000	0	0	81,717
Current & Non-Current Monetary Liabilities						
Bank overdraft	2.88%	26,650	0	0	0	26,650
Interest–bearing loans and borrowings						
Crown Health Financing Agency	6.37%	13,500	0	80,000	70,000	163,500
Bonds	7.75%	0	70,000	0	50,000	120,000
Interest on borrowings		4,872	0	0	0	4,872
Unexpired set up cost on borrowings		(257)	(89)	(312)	(174)	(832)
Total Monetary Liabilities		44,765	69,911	79,688	119,826	314,190

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18 **FINANCIAL INSTRUMENTS (continued)**

Interest Rate Repricing Schedule

	Weighted Average Interest Rate %	PARENT Maturity Periods 0 – 1 Years	1 – 2 Years	2 – 5 Years	More than 5 Years	Total
		$000	$000	$000	$000	$000
As at 30 June 2010						
Current & Non-Current Monetary Assets						
Cash and cash equivalents	3.58%	70,865	0	0	0	70,865
Patient and restricted trust funds	2.68%	1,067	0	0	0	1,067
Total Monetary Assets		71,932	0	0	0	71,932
Current & Non-Current Monetary Liabilities						
Bank overdraft	3.13%	14,050	0	0	0	14,050
Interest–bearing loans and borrowings						
Crown Health Financing Agency	6.20%	0	20,000	143,500	0	163,500
Bonds	7.75%	70,000	0	0	50,000	120,000
Interest on borrowings		4,741	0	0	0	4,741
Unexpired set up cost on borrowings		(89)	(96)	(390)	0	(575)
Total Monetary Liabilities		88,702	19,904	143,110	50,000	301,716
As at 30 June 2009						
Current & Non-Current Monetary Assets						
Cash and cash equivalents	4.00%	61,938	0	0	0	61,938
Patient and restricted trust funds	2.47%	1,037	0	0	0	1,037
Total Monetary Assets		62,975	0	0	0	62,975
Current & Non-Current Monetary Liabilities						
Bank overdraft	2.88%	26,650	0	0	0	26,650
Interest–bearing loans and borrowings						
Crown Health Financing Agency	6.37%	13,500	0	80,000	70,000	163,500
Bonds	7.75%	0	70,000	0	50,000	120,000
Interest on borrowings		4,872	0	0	0	4,872
Unexpired set up cost on borrowings		(257)	(89)	(312)	(174)	(832)
Total Monetary Liabilities		44,765	69,911	79,688	119,826	314,190

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

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18 FINANCIAL INSTRUMENTS (continued)

Capital management

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

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

There have been no material changes in ADHB's management of capital during the period other than revaluation of land and buildings as at 30 June 2010 as separately disclosed in this report.

Sensitivity Analysis

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

At 30 June 2010, it is estimated that a general increase of 1% in interest rates would increase the surplus or deficit by approximately $5.6m (2009 $6.9m). Interest rate swaps have been included in this calculation.

At 30 June 2010, it is estimated that a general decrease of 1% in interest rates would decrease the surplus or deficit by approximately $5.8m (2009 $7.2m). Interest rate swaps have been included in this calculation.

	Group Actual As at 30/06/10	Group Actual As at 30/06/09	Parent Actual As at 30/06/10	Parent Actual As at 30/06/09
19 DERIVATIVE FINANCIAL INSTRUMENTS				
Current Assets				
Interest rate swaps in gain (mark to market)	3,182	7,209	3,182	7,209
Non – Current Assets				
Interest rate swaps in gain (mark to market)	4,189	1,358	4,189	1,358
Current Liabilities				
Interest rate swaps in loss (mark to market)	0	1,273	0	1,273
Non - Current Liabilities				
Interest rate swaps in loss (mark to market)	311	340	311	340

20 MAJOR VARIATIONS FROM BUDGET

ADHB recorded a surplus of $0.3m which was $0.3m favourable to budget. Major favourable variances were patient care revenue $16m and capital charge $4m. Major unfavourable variances were employee costs $8m and direct treatment costs $12m.

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21 EVENTS SUBSEQUENT TO BALANCE DATE

No events have occurred subsequent to balance date that requires adjustment or disclosure in these financial statements.

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 $21.0m as at 30 June 2010 (2009 $15.8m). The calculation of this accrual assumes that the utilisation of this annual entitlement, that can be accumulated over 3 years, will be 63 % of the full entitlement (2009 – 57.5%). A difference of 5% in the utilisation rate represents a financial effect of $1.66m on the accrual.

Estimation of useful lives of assets

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

Debtors impairment

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

Fair value of Property, Plant and Equipment (PPE)

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

23 2010-12 STATEMENT OF INTENT

Auckland District Health Board and Group's 2010-12 Statement of Intent did not fully comply with the requirements of the Crown Entities Act 2004. Sections 142 (2) (b) and (c) of the Crown Entities Act 2004 require for each output class adopted, that the Statement of Intent:

- identify the expected revenue to be earned, and proposed expenses to be incurred, for each class of outputs;
  and
- comply with generally accepted accounting practice.

At the time the 2010-12 Statement of Intent was adopted, Auckland District Health Board and Group were unable to reliably identify the expected revenue and proposed expenses for each class of outputs. As a result, Auckland District Health Board and Group breached sections 142 (2) (b) and (c) of the Crown Entities Act 2004.

The breaches occurred because Auckland District Health Board and Group decided to adopt more relevant output classes, but they were not able to allocate the underlying budget information to the new output classes. The allocation process requires a substantial amount of work and there was insufficient time for it to be carried out between the time new output classes were adopted and the time the Statement of Intent was adopted.

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23 2010-12 STATEMENT OF INTENT (continued)

The new output classes have enabled Auckland District Health Board and Group to more meaningfully report service performance for the year ending 30 June 2010.

The Auckland District Health Board and Group are yet to identify the expected revenue to be earned and proposed expenses to be incurred for each output class.

The Auckland District Health Board plans to include expected revenue to be earned and proposed expenses to be incurred for each output class, in the next Statement of Intent.

24 DISTRICT STRATEGIC PLAN (DSP)

The Ministry of Health has not yet given consent to the ADHB District Strategic Plan (DSP) which was published in 2006 in accord with NZHDA Section 38.

The 2006 DSP, covering the period 2006 to 2010, was due to be reviewed in 2010. However, ADHB has been advised by Ministry of Health (National Health Board) that the review process will, through a change of legislation in train, be replaced by a regional planning process.

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context

Output Reporting for the Year Ending 30 June 2010

Cost of Service Statement for Year Ending 30 June 2010						
$'000						
		Funder	**Governance**	**Provider**	**Elimination**	**Total**
Actual	Revenue	1,546,082	8,825	1,142,081	(984,963)	1,712,025
	Expenditure	(1,533,804)	(13,779)	(1,149,126)	984,963	(1,711,746)
	Surplus/(Deficit)	**12,278**	**(4,954)**	**(7,045)**	**-**	**279**
Budget	Revenue	1,527,231	4,952	1,137,946	(976,603)	1,693,526
	Expenditure	(1,522,121)	(12,831)	(1,135,161)	976,603	(1,693,510)
	Surplus/(Deficit)	**5,110**	**(7,879)**	**2,785**	**-**	**16**
Variance	Revenue	18,851	3,873	4,135	(8,360)	18,499
	Expenditure	(11,683)	(948)	(13,965)	8,360	(18,236)
Variance	**Surplus/(Deficit)**	**7,168**	**2,925**	**(9,830)**	**-**	**263**

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Summary of Results by Output Class - $'000

Output Class Service		Actual 2009	Budget 2010	Actual 2010
Primary	Revenue	424,079	403,589	418,117
	Expenditure	(405,149)	(420,991)	(420,608)
	Surplus/(Deficit)	**18,930**	**(17,402)**	**(2,491)**
Hospital	Revenue	1,060,747	1,133,374	1,132,784
	Expenditure	(1,069,560)	(1,106,313)	(1,119,120)
	Surplus/(Deficit)	**(8,813)**	**27,061**	**13,664**
Support	Revenue	130,295	136,748	138,383
	Expenditure	(139,505)	(146,692)	(148,830)
	Surplus/(Deficit)	**(9,210)**	**(9,945)**	**(10,447)**
Public Health	Revenue	23,132	19,816	22,741
	Expenditure	(23,715)	(19,514)	(23,187)
	Surplus/(Deficit)	**(583)**	**302**	**(446)**
Total	Revenue	1,638,253	1,693,527	1,712,025
	Expenditure	(1,637,928)	(1,693,510)	(1,711,746)
	Surplus/(Deficit)	**325**	**16**	**279**

Output Classes

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

The Health Sector has worked together with the Office of the Auditor General and Audit New Zealand to develop an approach to assigning revenue and expenditure in a first attempt at deriving a financial summary in Output Class format.

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

It is considered that, by following the allocation of expenditure, the best demonstration of the allocation of resources by output class is achieved.

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The Statement of Service Performance includes Charts which are a graphical representation of performance during the year.
These Charts are maintained and reported on every month.
Targets are represented on the charts as an arrow on the right hand side. Annual targets have been adjusted according to the time period (monthly or quarterly as represented on the x axis).
Actual figures may be recalculated from total annual figures or if there has been a major change over the course of the year, the final June figure may be used.
Red Line dashes on the Chart represent the boundaries of normal variation.
Green Line is the mean of actual performance.

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
National targets for health			
Shorter stays in Emergency Departments 95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours by June 2011		Adult Acute Patient Flow, Actual vs Target, July 2009 - June 2011 100% 80% 60% 40% 20% 0% Jul-2009 Aug-2009 Sep-2009 Oct-2009 Nov-2009 Dec-2009 Jan-2010 Feb-2010 Mar-2010 Apr-2010 May-2010 Jun-2010 Jul-2010 Aug-2010 Sep-2010 Oct-2010 Nov-2010 Dec-2010 Jan-2011 Feb-2011 Mar-2011 Apr-2011 May-2011 Jun-2011 Actual Goal MOH Target	Not achieved Initial baseline for adult patients admitted or discharged from ED within 6 hours was 62%. This has been progressively improving to 69% in Qtr 2, 74% in Qtr 3. This level has been maintained in the April - June Qtr, despite significant increases in ED patient attendances (12% increase on same time last year, with significant increase in volume of triage 2 and triage 3 presentations). A number of improvements continue to be implemented to improve the flow of patients out of Adult ED (AED) to wards and data suggests that these are having an impact in the time taken to admit patients. Rollout out of rapid rounds continues. Forty two Nurse Facilitated discharges completed to end of June. Activity follows in AED completed to identify any opportunity to create more patient care time. AED triage processes under review. Discussion paper to be completed on direct ward admittance from ED specialists. Daily reporting to be developed on patients in AED with Length of Stay in AED>6 hours which will facilitate daily discussion and actions to over come delays. Ten additional beds opened as a buffer ward Monday-Friday 0700-1700 to manage increased winter volumes. Whilst this shift in performance has been maintained for the last seven months, we are still well below the goal of 95%.

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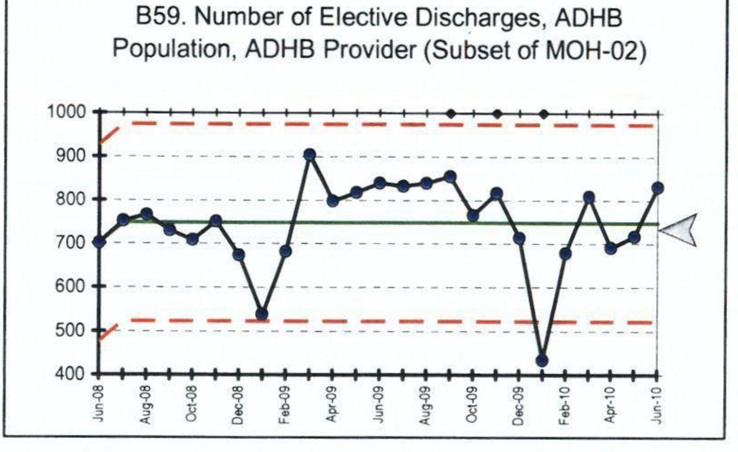
Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context

Improved access to surgery

For all of New Zealand the target is

The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1,400 per year)

For ADHB the target is 9,425 elective discharges



Achieved

The number of elective services discharges by the ADHB provider arm in 2009/10 was 8980, which exceeds the annual target of 8790. Please note that the target of 9425 is for the entire ADHB population, which includes patients treated at other DHBs. We cannot report on this target until the MoH produce the final Elective Services monitoring report for 2009/10, although it is expected that the target will be exceeded.

Discharges delivered from all providers for 2009/10. These numbers are off the MOH monthly caseload report taken 13 August 2010. These are an approximation as some surgical discharges do not have a procedure but they are good proxy.

You will note

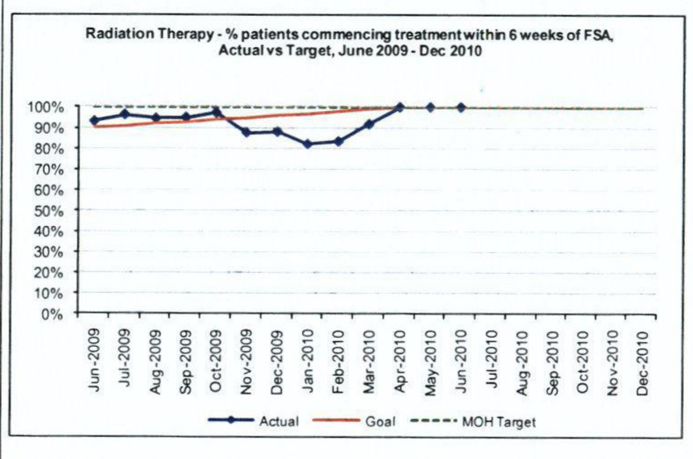
- Surgical discharges of 9,775 exceeded 2008/09 by 58 cases and 252 wies
- Surgical discharges of 9,775 exceeded MOH Health Target of 9,425 by 350 discharges

It is safe to say we have met ADHB share of MOH targets.

National targets for health

Shorter waits for cancer

Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010



Achieved

Performance increased to 100% in the April-June 2010 quarter. A number of improvements were implemented during that time, including

- Development of the capacity modelling tool
- Extension of shifts
- Outsourcing to Auckland Radiation Oncology and Waikato
- Daily waitlist reporting
- Improved forecasting capability
- Continual prioritisation and review of waiting list

The period of decommissioning and replacement of the MV5 linear accelerator, increased demand, patient complexity and Radiation Therapist (RT) vacancies continue to be significant risks. In order to deliver a sustainable service it is critical to recruit and retain a flexible RT workforce.

FSA =First Specialist Appointment

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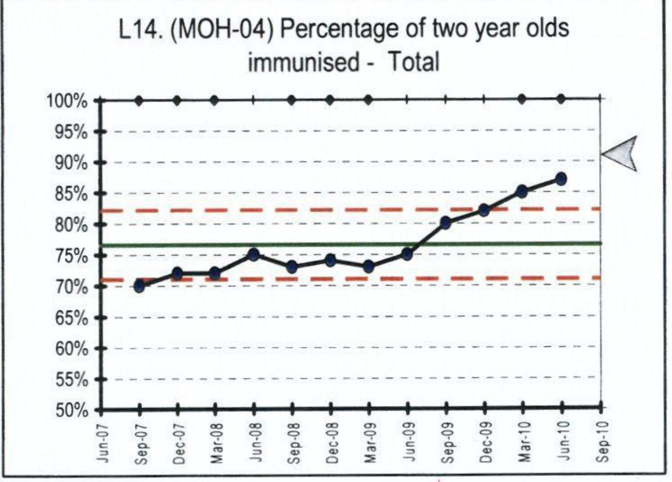
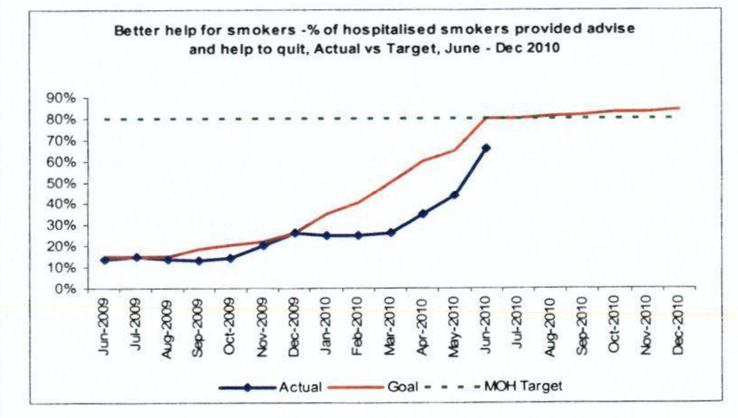
Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Increased Immunisation 85% of two year olds will be immunised by July 2010; 90% by July 2011; and 95 % by July 2012 Definitions: NIR=National Immunisation Register IMAC= The Immunisation Advisory Centre SSH=Starship Hospital PMS=Patient Management System			Achieved A 12% increase since 1 July 2009. ADHB Immunisation Governance Group very active through the year – produced an ADHB Immunisation Strategy. Good primary care engagement achieved. Planning & Funding worked with the NIR Team, Auckland's 5 PHOs, IMAC Outreach Immunisation Services team (OIS), and other stakeholders in order to achieve 87% coverage exceeding the MoH target of 85% for June 2010
National targets for health			
Better help for smokers to quit 80% of hospitalised smokers will be provided with advice and help to quit by July 2010; 90 % by July 2011: and 95 % by July 2012 Similar target for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme.			Not achieved While the target was not met by June 30 there was a significant increase to 66%. This was due to improvement in all services and the implementation of specific systems improvements to the Electronic Discharge Summary and the introduction of ABC documentation options to the Adult Emergency Dept, Admission and Planning Unit and Outpatients clinics. The full impact of these enhancements is yet to be realised as the events coded in June reflect only 2 weeks of the June discharges and the improvements went live 31 May. The Mental Health Services and National Women's Health reached 94% and 80% respectively and Adult Health Services whose patient numbers make up the bulk of the events coded reached a much improved 62%. The challenge is to reach the 80%, sustain that and move to 90% by July 2011.

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Better diabetes and cardiovascular services Increased percent of: a) the eligible adult population will have had their CVD risk assessed in the last 5 years **b)** people with diabetes will attend free annual checks **c)** people with diabetes will have satisfactory or better diabetes management		Diabetes Annual Checks Target vs Actual Mar 2008-Jun2010	Achieved There has been an improvement in the last quarter of the year. Activities appear to be having an impact which is positive. Discussions with our partner organisations are happening as this target will increasingly get more difficult as we increase the annual check volumes. This is because as we capture more of our diabetic population, more will have complex needs and as such have longer management care plans which will reflect in the management figures
Output Class : Public Health Services			
Health Protection			
Number of health assessments done of Early Childhood Education Centres	Up to 70	L01. Health assessments done of Early Childhood Education Centres The above chart shows the number of assessments made each month for the last two years. 59 assessments were made in the year to June 2010.	Achieved All ECEC Health and Safety Assessment requests are made directly by the industry on behalf of the MoE. It is difficult to anticipate the accurate number of requests from the centres as this not attributable to ARPHS and dependent on the MoE issuing of licences and the economic environment. Those assessments that were undertaken by the service were completed as per the appropriate protocols and procedures. ARPHS=Auckland Regional Public Health Service

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Investigations to monitor/improve the quality of drinking water.	Between 100-130	L02. Investigations to monitor/improve the quality of drinking water The above chart shows the number of investigations made each month since September 2008. 140 investigations were carried out in the year to June 2010.	Achieved ARPHS is required as part of legislation to undertake investigations and or assessments relating to customer complaints or water supplier notified adverse water quality or loss of supply events. Also included in these assessments are those that our Drinking Water Assessment Unit carried out in relation to compliance with the Drinking Water Standards. These 'assessments' contribute to improvements in the quality of drinking-water
Emergency investigations on hazardous substances and new organisms (HSNO)	100%	L03. Emergency investigations on hazardous substances and new organisms The above chart shows the number of emergency investigations since September 2008. 100% of necessary investigations were carried out.	Achieved The criteria for events reported for this purpose were recently rationalised. The number for 09/10 vs. the previous year shows a 2-fold increase. Many of these have been Fire Service emergencies (that are obviously random in nature). Those events relating to exposure to a HSNO-related material will have been influenced by recently-implemented direct laboratory notifications to the Medical Officer of Health and an enhanced awareness among both conventional and alternative medicine practitioners; and the general public; that agencies do exist to which such issues can be referred for investigation. HSNO=Hazardous Substances and New Organisms
Health promotion			
Prevalence of exposure of year ten students to second hand smoke inside the home	<25%	15%.	Achieved, however, this is not a target that is impacted by the DHB alone. This is the result of a whole sector response to tobacco control and the trend is pleasing to see.
Percentage of "never smokers" among year ten students	69%	69.7%.	Achieved, however, this is not a target that is impacted by the DHB alone. This is the result of a whole sector response to tobacco control and the trend is pleasing to see.

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Pacific smoking cessation programmes in Auckland DHB	240 enrolled	L07. Number enrolled on Pacific smoking cessation programs in Auckland DHB The above chart shows the number enrolled each month on Pacific smoking cessation programmes since July 2009. In the year to 30 June 2010 278 people were enrolled.	Achieved This service is Pacific focussed and has been in operation for 12mths. It is collaboration between ADHB and WDHB. 80% of combined ADHB and WDHB client population were of Pacific ethnicity and 78% of female clients were of child bearing age
Healthy Housing project: Assessments	200	L47. Number of Healthy Housing Project - Assessments The above shows the number of assessments made each month since July 2009. In the year to 30 June 2010 there were 501 assessments	Achieved Joint assessments are undertaken with Housing New Zealand (HNZC) in HNZC homes to identify housing, health and social needs of tenants living in priority areas. The number of Healthy Housing joint assessments undertaken with HNZC more than doubled in this financial year. This was due to a substantial increase in "one off" Government funding to HNZC for Healthy Housing interventions in 09/10. In addition to the MOH core contract, HNZC funded ARPHS to employ an extra Public Health Nurse 1FTE for the year to provide 250 extra joint assessments. This resulted in the highest number of joint assessments and consequently housing interventions undertaken in The Healthy Housing Programme since the programme commenced in 2001.

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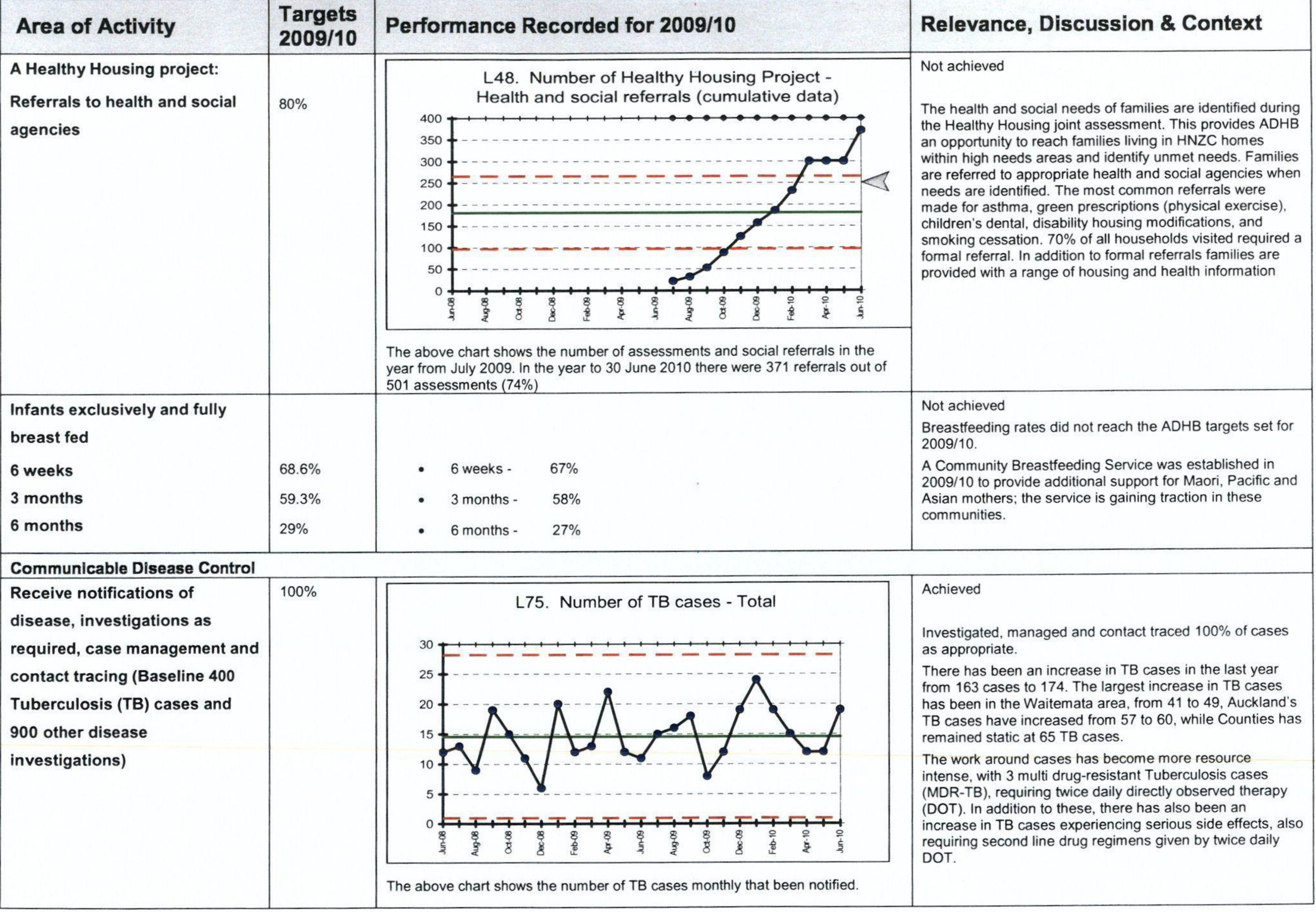

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
A Healthy Housing project: **Referrals to health and social agencies**	80%	L48. Number of Healthy Housing Project - Health and social referrals (cumulative data) The above chart shows the number of assessments and social referrals in the year from July 2009. In the year to 30 June 2010 there were 371 referrals out of 501 assessments (74%)	Not achieved The health and social needs of families are identified during the Healthy Housing joint assessment. This provides ADHB an opportunity to reach families living in HNZC homes within high needs areas and identify unmet needs. Families are referred to appropriate health and social agencies when needs are identified. The most common referrals were made for asthma, green prescriptions (physical exercise), children's dental, disability housing modifications, and smoking cessation. 70% of all households visited required a formal referral. In addition to formal referrals families are provided with a range of housing and health information
Infants exclusively and fully breast fed **6 weeks** **3 months** **6 months**	68.6% 59.3% 29%	• 6 weeks - 67% • 3 months - 58% • 6 months - 27%	Not achieved Breastfeeding rates did not reach the ADHB targets set for 2009/10. A Community Breastfeeding Service was established in 2009/10 to provide additional support for Maori, Pacific and Asian mothers; the service is gaining traction in these communities.
Communicable Disease Control			
Receive notifications of disease, investigations as required, case management and contact tracing (Baseline 400 Tuberculosis (TB) cases and 900 other disease investigations)	100%	L75. Number of TB cases - Total The above chart shows the number of TB cases monthly that been notified.	Achieved Investigated, managed and contact traced 100% of cases as appropriate. There has been an increase in TB cases in the last year from 163 cases to 174. The largest increase in TB cases has been in the Waitemata area, from 41 to 49, Auckland's TB cases have increased from 57 to 60, while Counties has remained static at 65 TB cases. The work around cases has become more resource intense, with 3 multi drug-resistant Tuberculosis cases (MDR-TB), requiring twice daily directly observed therapy (DOT). In addition to these, there has also been an increase in TB cases experiencing serious side effects, also requiring second line drug regimens given by twice daily DOT.

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Immunisation			
Immunisation status of babies, support GPs in submitting data to the NIR and follow-up children not immunised.	Up to 1300 referrals	1574 referrals for the year to 30 June 2010	Achieved
Percentage of children completing the year 7 vaccination, of those eligible and who have consented.	67%	These are the stats for the year 7 BOOSTRIX vaccination. This shows the data for the past 3 years. The data is for the school year and is entered into the KPI database in November. Year Total % 2007 52% 2008 56% 2009 49% Not available	Not available School based programme run over school year. Results not available until November each year.
Screening			
Participation in the National Breast Screening Programme by eligible women (2 year coverage rate for 50-64 yr old women) Baseline 42.9%	Contract Targets met Baseline 42.9%	Other 54.2 % Maori 51.9% Pacific 63.1% Total 55.0 %	Achieved Breast screening in Auckland DHB is provided by BreastScreen Auckland (BSA) under contract from the NSU.
Participation in the National Cervical Screening Programme by eligible women , particularly: Maori, Pacific and Asian women (3yr coverage rate for 20-65 yr women)	Contract Targets met Baseline 65%	70.35% Women 20-69 years screened in last 3 years (Total population) 60.86% Women 20-69 years screened in last 3 years (high needs)	Partially Achieved Four providers have been contracted to address the screening coverage for high needs women. Reporting indicates that coverage for high needs women may be 61%, however data variation indicates that the DHB needs to resolve with the providers how they verify that the smears are for priority group women.

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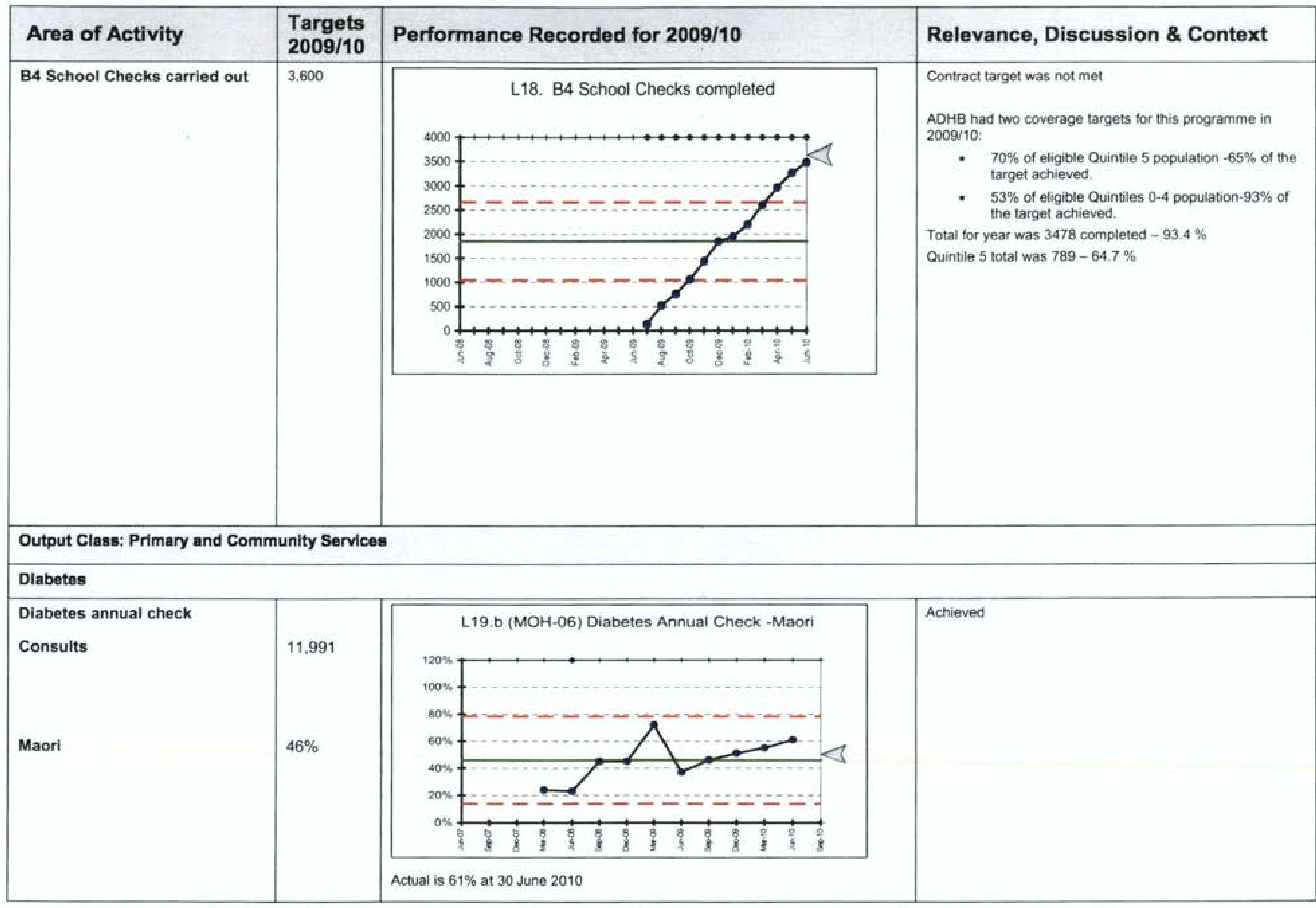

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
B4 School Checks carried out	3,600	L18. B4 School Checks completed	Contract target was not met ADHB had two coverage targets for this programme in 2009/10: • 70% of eligible Quintile 5 population -65% of the target achieved. • 53% of eligible Quintiles 0-4 population-93% of the target achieved. Total for year was 3478 completed – 93.4 % Quintile 5 total was 789 – 64.7 %
Output Class: Primary and Community Services			
Diabetes			
Diabetes annual check **Consults** **Maori**	 11,991 46%	L19.b (MOH-06) Diabetes Annual Check -Maori Actual is 61% at 30 June 2010	Achieved

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Pacific	58%	L19.d (MOH-06) Diabetes Annual Check -Pacific Actual is 74% at 30 June 2010	Achieved
Total	52%	L19. (MOH-06) Diabetes Annual Check -Total Actual is 56% as at 30 June 2010	Not achieved Overall we have not performed to expectation this year with a disappointing overall achievement of 46% for the year. However, within that, our performance for high needs groups including Maori and Pacific is encouraging. More work is needed to lift our activities across all groups.

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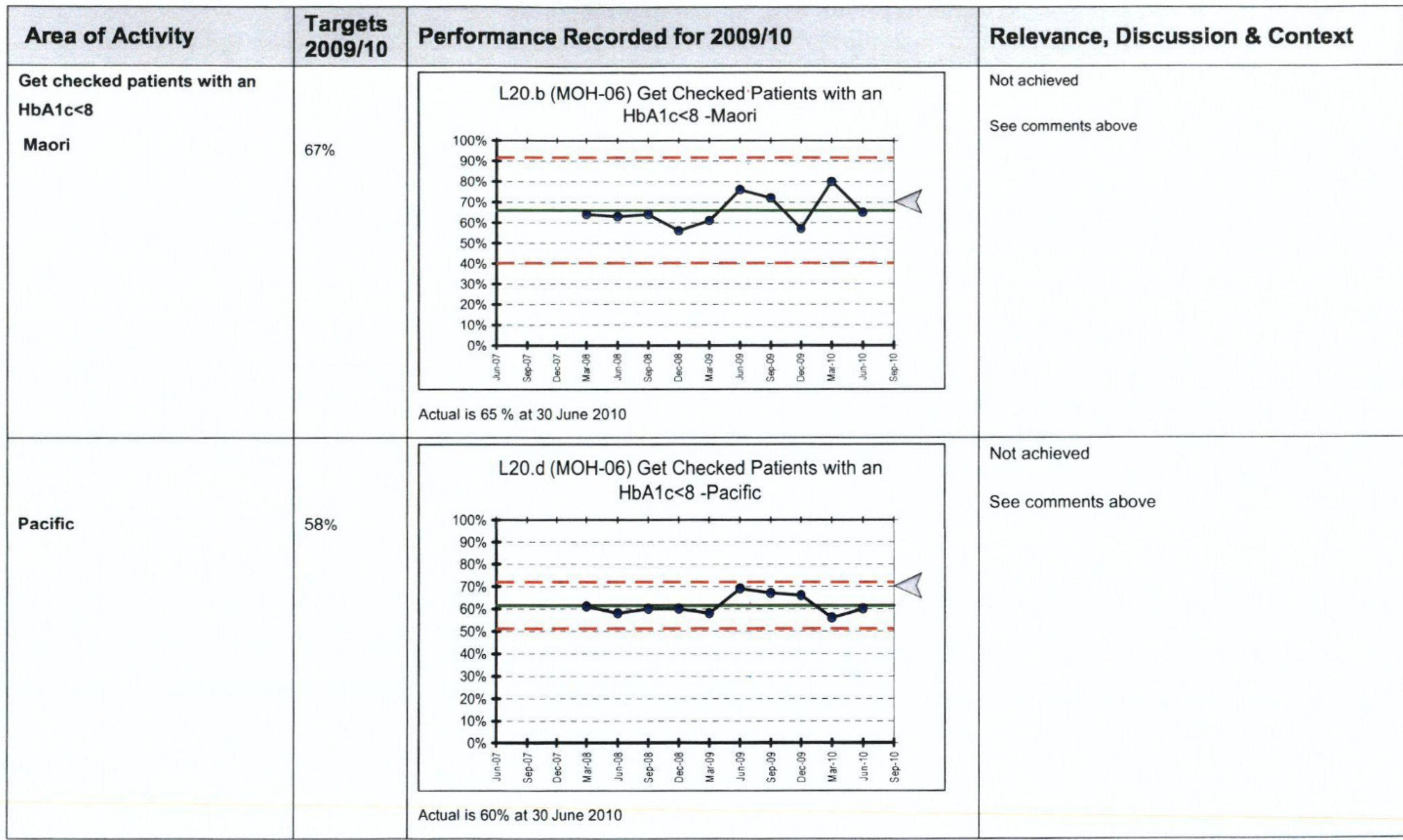

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Get checked patients with an HbA1c<8 **Maori**	67%	Actual is 65 % at 30 June 2010	Not achieved See comments above
Pacific	58%	Actual is 60% at 30 June 2010	Not achieved See comments above

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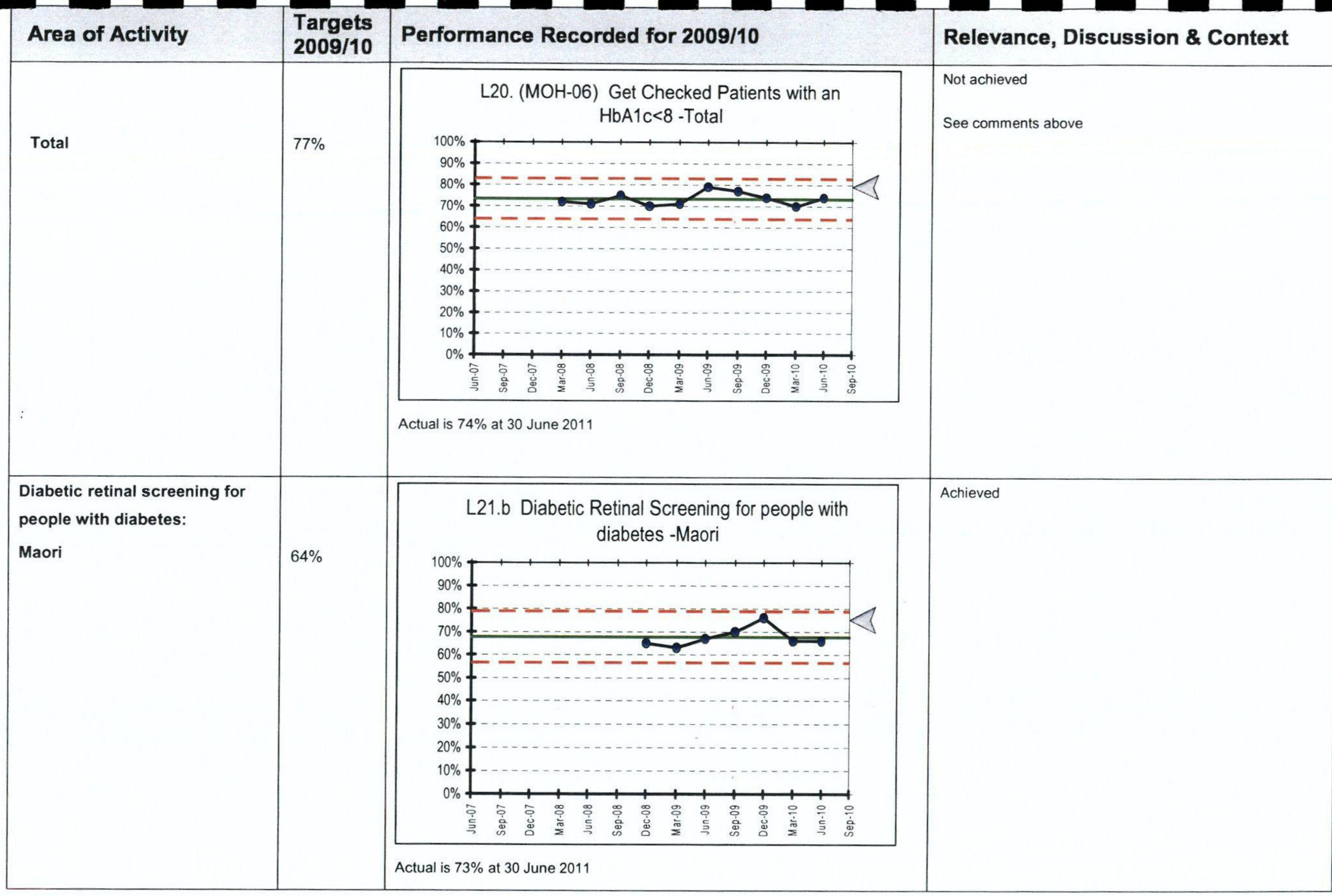

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Total	77%	L20. (MOH-06) Get Checked Patients with an HbA1c<8 -Total Actual is 74% at 30 June 2011	Not achieved See comments above
Diabetic retinal screening for people with diabetes: Maori	64%	L21.b Diabetic Retinal Screening for people with diabetes -Maori Actual is 73% at 30 June 2011	Achieved

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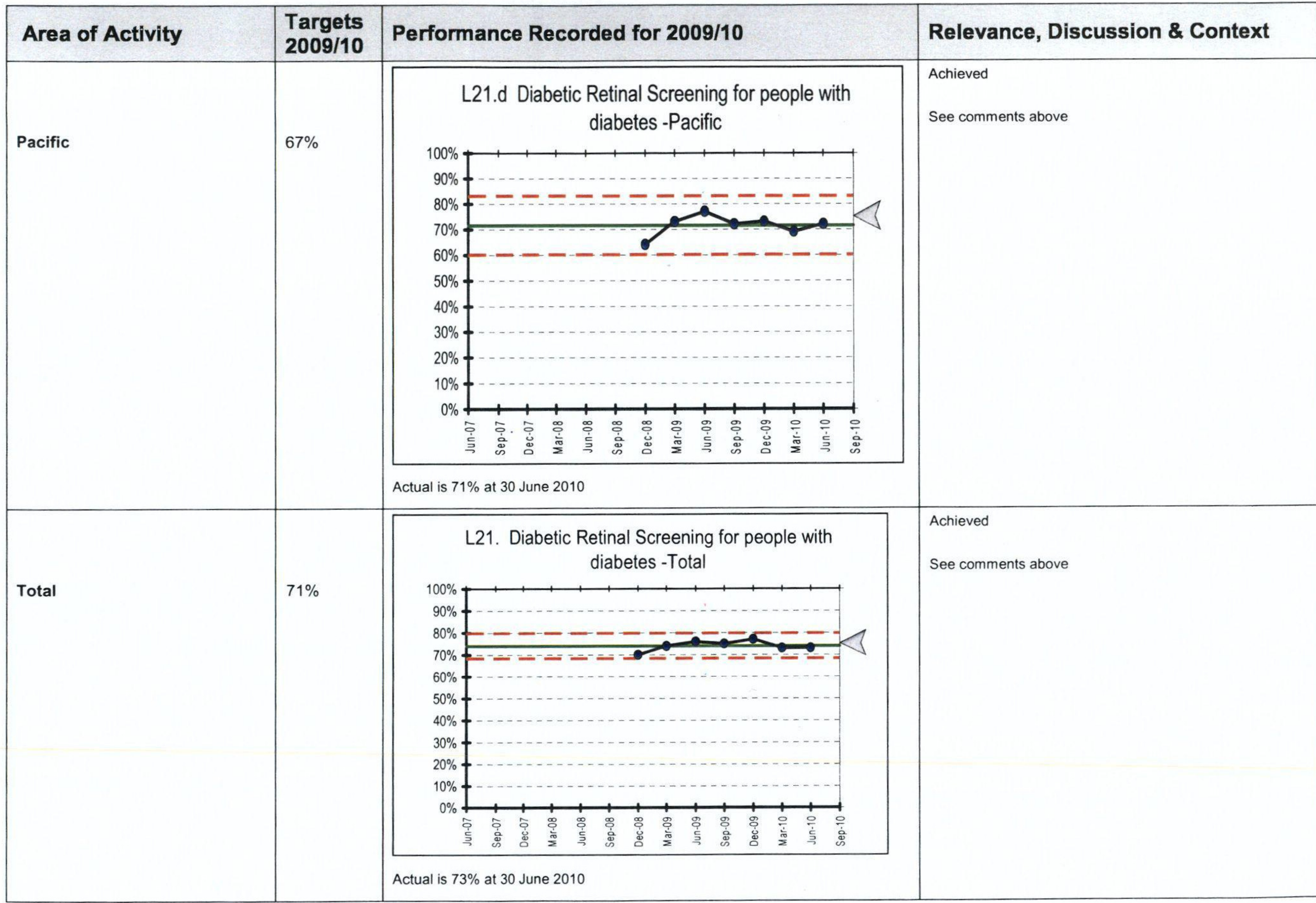

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Pacific	67%	L21.d Diabetic Retinal Screening for people with diabetes -Pacific Actual is 71% at 30 June 2010	Achieved See comments above
Total	71%	L21. Diabetic Retinal Screening for people with diabetes -Total Actual is 73% at 30 June 2010	Achieved See comments above

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Cardiovascular disease			
Cardiovascular risk screening (lipid and glucose or HbA1 **Maori**	71%	L22.b (MOH-06) Cardiovascular risk screening - Maori Actual is 73% at 30 June 2010	Achieved
Pacific	72%	L22.d (MOH-06) Cardiovascular risk screening - Pacific Actual is 75% at 30 June 2010	Achieved

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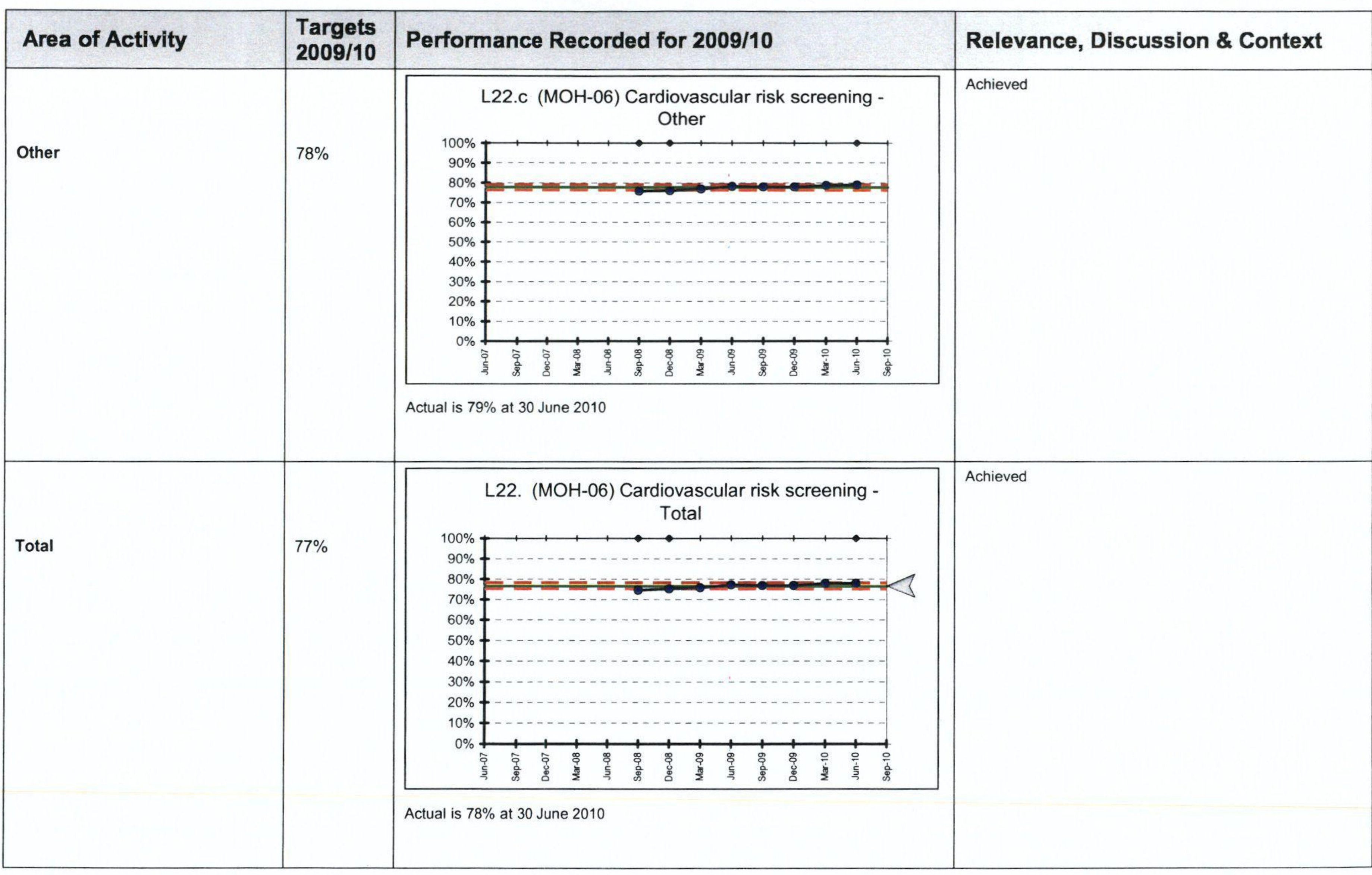

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Other	78%	L22.c (MOH-06) Cardiovascular risk screening - Other Actual is 79% at 30 June 2010	Achieved
Total	77%	L22. (MOH-06) Cardiovascular risk screening - Total Actual is 78% at 30 June 2010	Achieved

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Programmes and options for cardiac rehabilitation	5% increase for all groups	L74. People diagnosed with ACS attending a cardiac rehabilitation programme - Total ACS= Acute Coronary Syndrome	Achieved Our target for cardiac rehabilitation is to have at minimum 75% of people diagnosed with ACS to attend a rehabilitation course. The goal is to increase by 5% each year to achieve 90% attending. Currently we are meeting 75% although we do have some data analyses issues and further work on this is needed to ensure accuracy. We are also looking to ensure that the data reflects those able to undertake rehabilitation as a proportion of those diagnosed with ACS will not be able to participate for various physiological and psychological reasons.
PHO services			
Percent valid NHI on patient register	98%	Current reports indicate 98.07% valid NHI on patient registers	Achieved The PHOs report the data to the Ministry of Health and the DHB receives the enrolment rates data via NDSA.
Maori enrolment in PHO's	95%	72% Maori enrolment in PHOs (ADHB is investigating the accuracy of ethnicity enrolment data to ensure this data is an accurate representation of Maori enrolment)	Not Achieved ADHB has work underway to identify why Maori enrolment in PHOs is lower than the target. A contributing factor may be the way PHOs record ethnicity, but that has as yet to be determined.
All Children under 5 years of age are enrolled with a PHO	99%	100% of ADHB residents under 5years were enrolled in a PHO at 30 June 2010	Achieved ADHB has identified that while the total figure for children under 5 years enrolled in a PHO appears to have stayed constant, within that figure, the number of Maori and Pacific under 5years enrolled has been decreasing. In association with the comment immediately above ADHB has work underway to identify why the figures are showing this trend, it may be the way PHOs record ethnicity but that has yet to be determined.

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Care plus enrolled population (baseline 2008)	> 70% of eligible patients enrolled	L27. Care plus enrolled population (baseline 2008) 120% 100% 80% 60% 40% 20% 0% Jun-07 Sep-07 Dec-07 Mar-08 Jun-08 Sep-08 Dec-08 Mar-09 Jun-09 Sep-09 Dec-09 Mar-10 Jun-10 79.6% of ADHB eligible population enrolled as at June 2010	Achieved The PHOs report the data to the Ministry of Health and the DHB receives the enrolment rates data via NDSA.
Palliative client in receipt of PHO services	15% of clients	This data was not collected during the 2009/10 year. This has been rectified and data will be available for the 2010/11 year.	Not recorded

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Ambulatory Sensitive Admissions (ASH)			
Admissions to hospital for children under 5 that are avoidable or preventable by primary health **Maori**	Remain below 95% of the national average <95%	L29.b (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Maori 140 120 100 80 60 40 20 Jun-07 Sep-07 Dec-07 Mar-08 Jun-08 Sep-08 Dec-08 Mar-09 Jun-09 Sep-09 Dec-09 Mar-10 Jun-10 Sep-10	Achieved Our rates are very good for almost all the age groups, except age group 45-64. .ADHB was above the national average for all ethnic groups. To improve the 45 -64 age group .ADHB is currently running multiple projects trying to reduce these rates. These projects are: • Primary Options We have promised to increase volumes by 50% • Clinical Pathways Regional agreement on management of common conditions. • After hours Ensuring appropriate access to the right care at the right time • Patient Journey Project Before arrival at the hospital. • Hospital data sharing, including avoidable hospitalisation by cause. This data sharing is on a quarterly basis informing the PHO and their practices about hospitalisation data. All of the above will have an impact on ASH rates in our DHB

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Pacific	<95%	L29.d (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Pacific 140, 120, 100, 80, 60, 40, 20 Jun-07, Sep-07, Dec-07, Mar-08, Jun-08, Sep-08, Dec-08, Mar-09, Jun-09, Sep-09, Dec-09, Mar-10, Jun-10, Sep-10	Achieved See above for comments
Other	95%	L29.c (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Other 140, 120, 100, 80, 60, 40, 20 Jun-07, Sep-07, Dec-07, Mar-08, Jun-08, Sep-08, Dec-08, Mar-09, Jun-09, Sep-09, Dec-09, Mar-10, Jun-10, Sep-10	Achieved See above for comments

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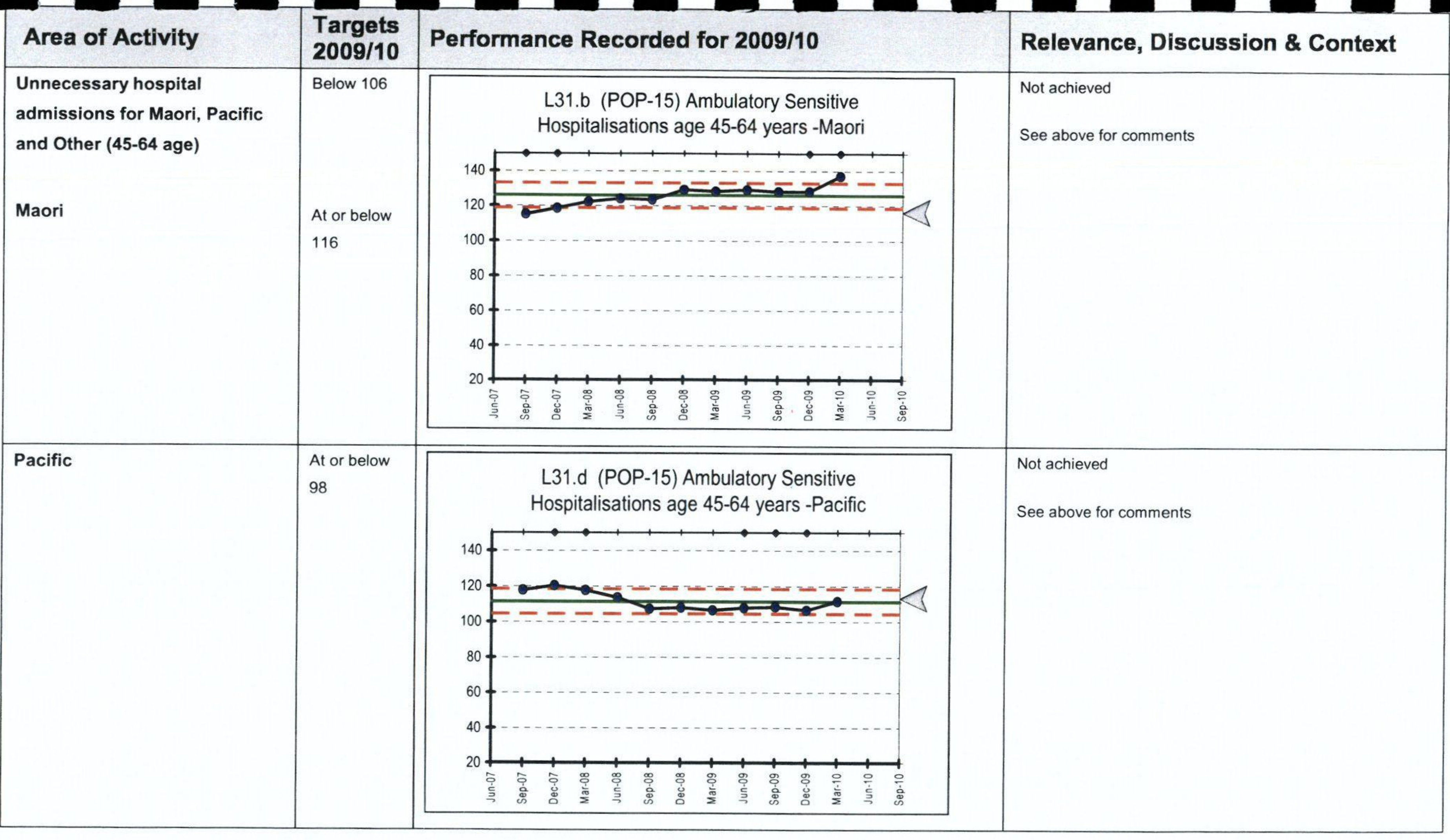

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Unnecessary hospital admissions for Maori, Pacific and Other (45-64 age)	Below 106		
Maori	At or below 116	L31.b (POP-15) Ambulatory Sensitive Hospitalisations age 45-64 years -Maori	Not achieved See above for comments
Pacific	At or below 98	L31.d (POP-15) Ambulatory Sensitive Hospitalisations age 45-64 years -Pacific	Not achieved See above for comments

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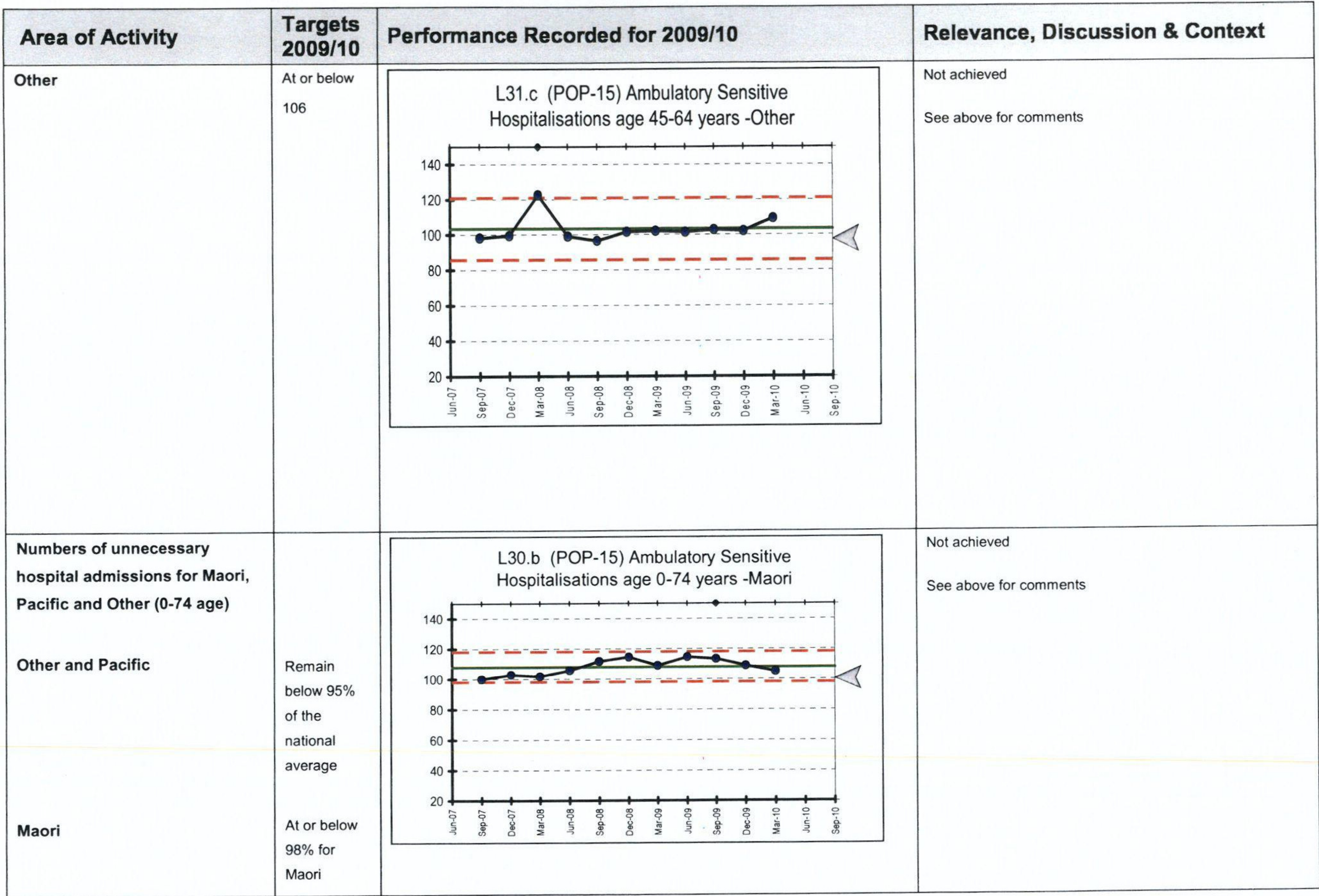

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Other	At or below 106	L31.c (POP-15) Ambulatory Sensitive Hospitalisations age 45-64 years -Other	Not achieved See above for comments
Numbers of unnecessary hospital admissions for Maori, Pacific and Other (0-74 age) **Other and Pacific** **Maori**	Remain below 95% of the national average At or below 98% for Maori	L30.b (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Maori	Not achieved See above for comments

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Pacific	<95%	L30.d (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Pacific	Achieved See above for comments
Other	<95%	L30.c (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Other	Not achieved See above for comments

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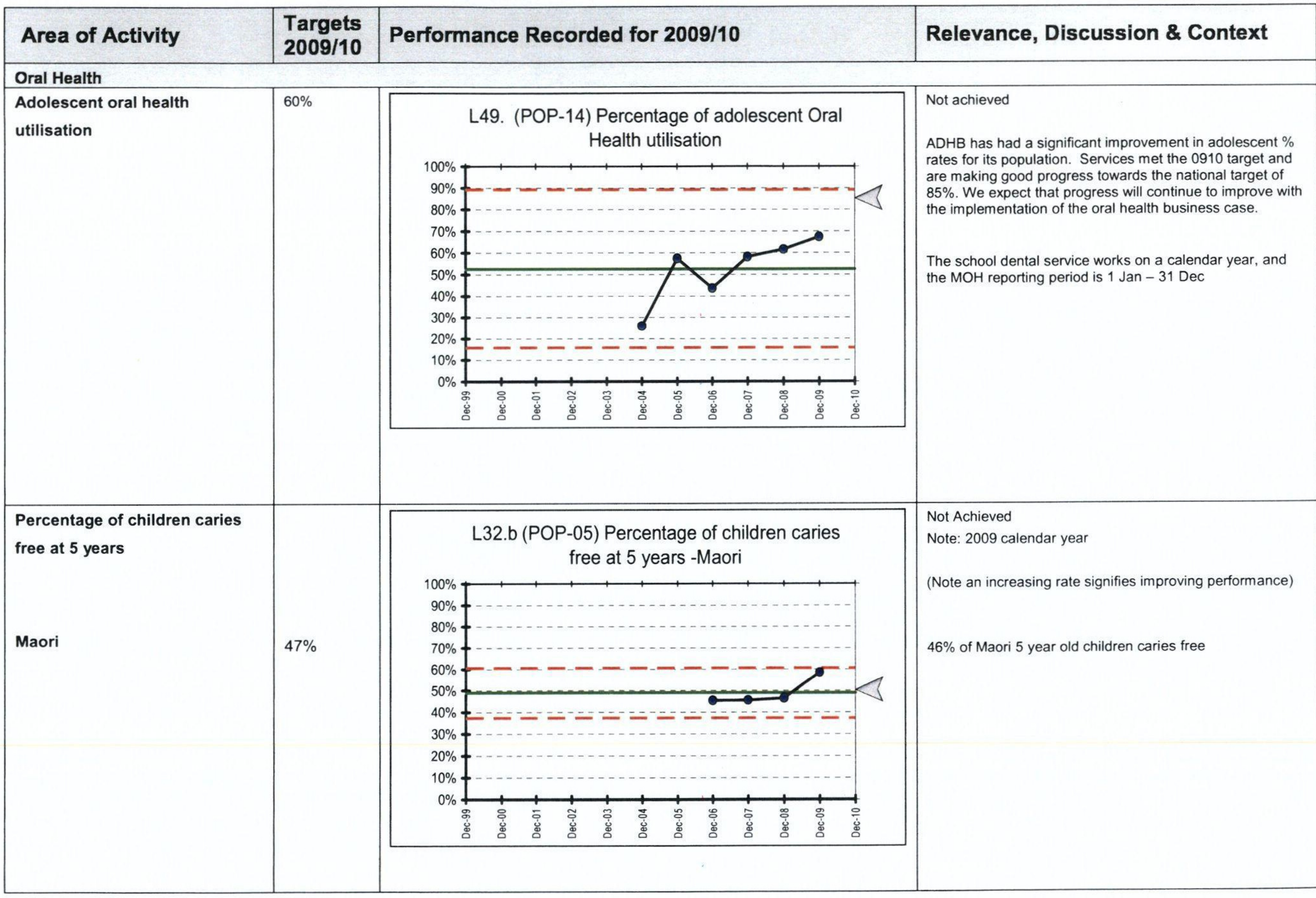

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Oral Health			
Adolescent oral health utilisation	60%	L49. (POP-14) Percentage of adolescent Oral Health utilisation	Not achieved ADHB has had a significant improvement in adolescent % rates for its population. Services met the 0910 target and are making good progress towards the national target of 85%. We expect that progress will continue to improve with the implementation of the oral health business case. The school dental service works on a calendar year, and the MOH reporting period is 1 Jan – 31 Dec
Percentage of children caries free at 5 years **Maori**	 47%	L32.b (POP-05) Percentage of children caries free at 5 years -Maori	Not Achieved Note: 2009 calendar year (Note an increasing rate signifies improving performance) 46% of Maori 5 year old children caries free

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Percentage of children caries free at 5 years	36%	L32.d (POP-05) Percentage of children caries free at 5 years -Pacific	
Pacific			36% of Pacific 5 year old children caries free
Asian	62%	L32. Percentage of children caries free at 5 years -Total	Note :2009 Calendar Year Asian data is not collected
European	80%		European data is not collected
Other	62%		71% of "Other' 5 year old children caries free
Total	62%		61% of all 5 year old children caries free (total) Further improvements should be gained over the next two years as a result of the oral health business case changes

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Number of teeth decayed, missing or filled (DMFT) for Year 8 students		L33.b (POP-04) Ratio of teeth decayed, missing or filled (DMFT) yr 8 students -Maori	Note: 2009 calendar year Mean DMFT (Decayed Missing and Filled teeth) (Note a decreasing rate signifies improving performance)
Maori	1.15		Not Achieved Maori Year 8 children=1.20
Pacific	1.6		Not Achieved Pacific Year 8 children=1.67
Asian	.75	L33.c (POP-04) Ratio of teeth decayed, missing or filled (DMFT) yr 8 students -Other	Asian and European data is not collected
European	.55		
Other	1.0		Achieved 'Other' Year 8 children= 0.65 Total Year 8 children =0.96 Although most of the targets were not met in 2009, there is an overall improvement since 2006 with Maori rates in particular reducing from 1.6DMFT to 1.2 DMFT

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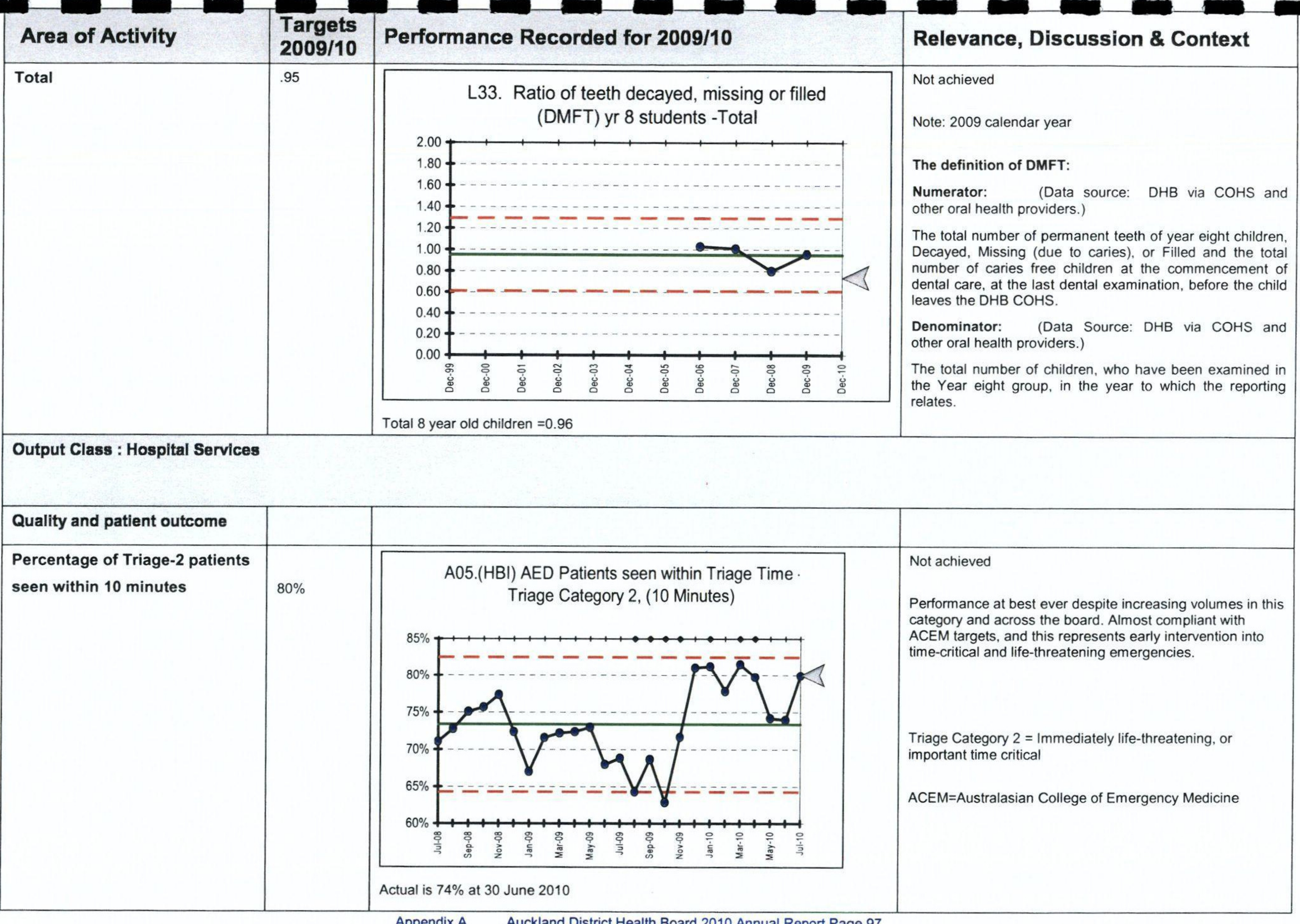

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Total	.95	L33. Ratio of teeth decayed, missing or filled (DMFT) yr 8 students -Total Total 8 year old children =0.96	Not achieved Note: 2009 calendar year **The definition of DMFT:** **Numerator:** (Data source: DHB via COHS and other oral health providers.) The total number of permanent teeth of year eight children, Decayed, Missing (due to caries), or Filled and the total number of caries free children at the commencement of dental care, at the last dental examination, before the child leaves the DHB COHS. **Denominator:** (Data Source: DHB via COHS and other oral health providers.) The total number of children, who have been examined in the Year eight group, in the year to which the reporting relates.
Output Class : Hospital Services			
Quality and patient outcome			
Percentage of Triage-2 patients seen within 10 minutes	80%	A05.(HBI) AED Patients seen within Triage Time - Triage Category 2, (10 Minutes) Actual is 74% at 30 June 2010	Not achieved Performance at best ever despite increasing volumes in this category and across the board. Almost compliant with ACEM targets, and this represents early intervention into time-critical and life-threatening emergencies. Triage Category 2 = Immediately life-threatening, or important time critical ACEM=Australasian College of Emergency Medicine

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Percentage of Triage-3 patients seen within 30 minutes	50%	A07.(HBI) AED Patients seen within Triage Time - Triage Category 3, (30 Minutes) Actual is 25% as at 30 June 2010	Not achieved Performance well below ACEM target with some recent deterioration. Inability to improve this target is hampered by large (>10%) increase in workload over the year. Business case for additional AED resourcing now approved and once actionned would be expected to improve on this measure. Triage Category 3=potentially life-threatening, potential adverse outcomes from delay >30min, or severe discomfort or distress.
Percentage of Triage-2 children seen within 10 minutes	55 %	A09.(HBI) CED Patients seen within Triage Time - Triage Category 2, (10 Minutes) Actual is 62 % as at 30 June 2010	Not Achieved Overall annual performance was 51%. A range of activities are occurring to improve performance in this area, including changes to patient flow and data collection. Last quarters performance was 61%.

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Percentage of Triage-3 children seen within 30 minutes	70%	A11.(HBI) CED Patients seen within Triage Time - Triage Category 3, (30 Minutes) Actual is 78% as at 30 June 2010	Achieved Overall annual performance was 70% for the year. CED continues to try to improve performance in this area, last quarters performance was 75%.
Adverse events causing significant harm	3 monthly	A30.Adverse events causing harm (SAC 1&2) Actual is 3 in June 2010	Not Achieved For the year 2009/10, a nationally consistent scoring system has been used to classify events as SAC 1 or 2. The Reportable events project has implemented an improved process for reporting & reviewing events. It would be expected that numbers of reported events increase however this does not indicate actual numbers have increased. In this context, the adequacy of the target measure needs to be considered further. SAC1= Severity Assessment Code 1(Extreme risk-immediate action required. SAC2=Severity Assessment Code 2 (High risk-senior management attention needed) RCA=Root Cause Analysis

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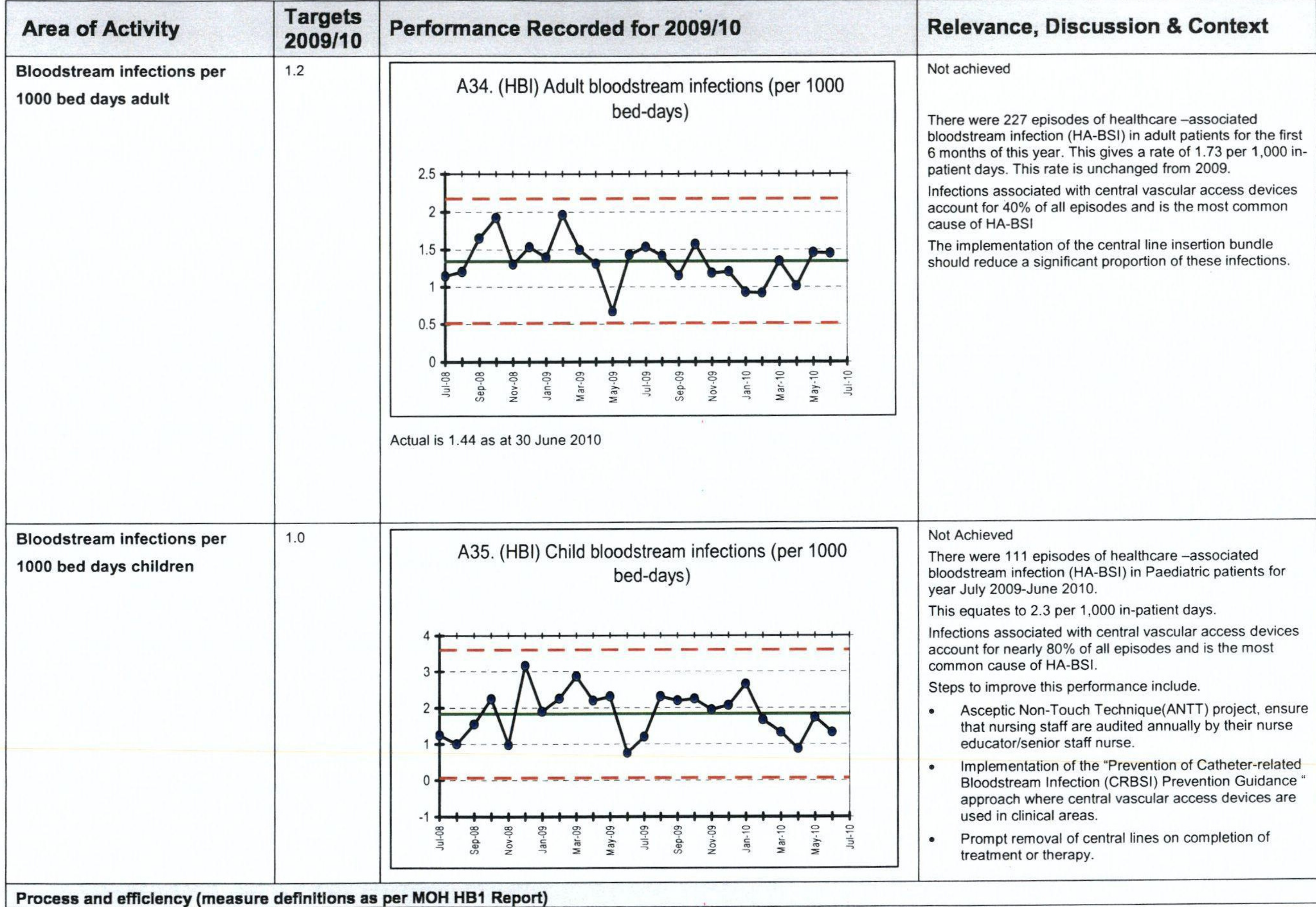

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Bloodstream infections per 1000 bed days adult	1.2	A34. (HBI) Adult bloodstream infections (per 1000 bed-days) Actual is 1.44 as at 30 June 2010	Not achieved There were 227 episodes of healthcare –associated bloodstream infection (HA-BSI) in adult patients for the first 6 months of this year. This gives a rate of 1.73 per 1,000 in-patient days. This rate is unchanged from 2009. Infections associated with central vascular access devices account for 40% of all episodes and is the most common cause of HA-BSI The implementation of the central line insertion bundle should reduce a significant proportion of these infections.
Bloodstream infections per 1000 bed days children	1.0	A35. (HBI) Child bloodstream infections (per 1000 bed-days)	Not Achieved There were 111 episodes of healthcare –associated bloodstream infection (HA-BSI) in Paediatric patients for year July 2009-June 2010. This equates to 2.3 per 1,000 in-patient days. Infections associated with central vascular access devices account for nearly 80% of all episodes and is the most common cause of HA-BSI. Steps to improve this performance include. • Asceptic Non-Touch Technique(ANTT) project, ensure that nursing staff are audited annually by their nurse educator/senior staff nurse. • Implementation of the "Prevention of Catheter-related Bloodstream Infection (CRBSI) Prevention Guidance " approach where central vascular access devices are used in clinical areas. • Prompt removal of central lines on completion of treatment or therapy.
Process and efficiency (measure definitions as per MOH HB1 Report)			

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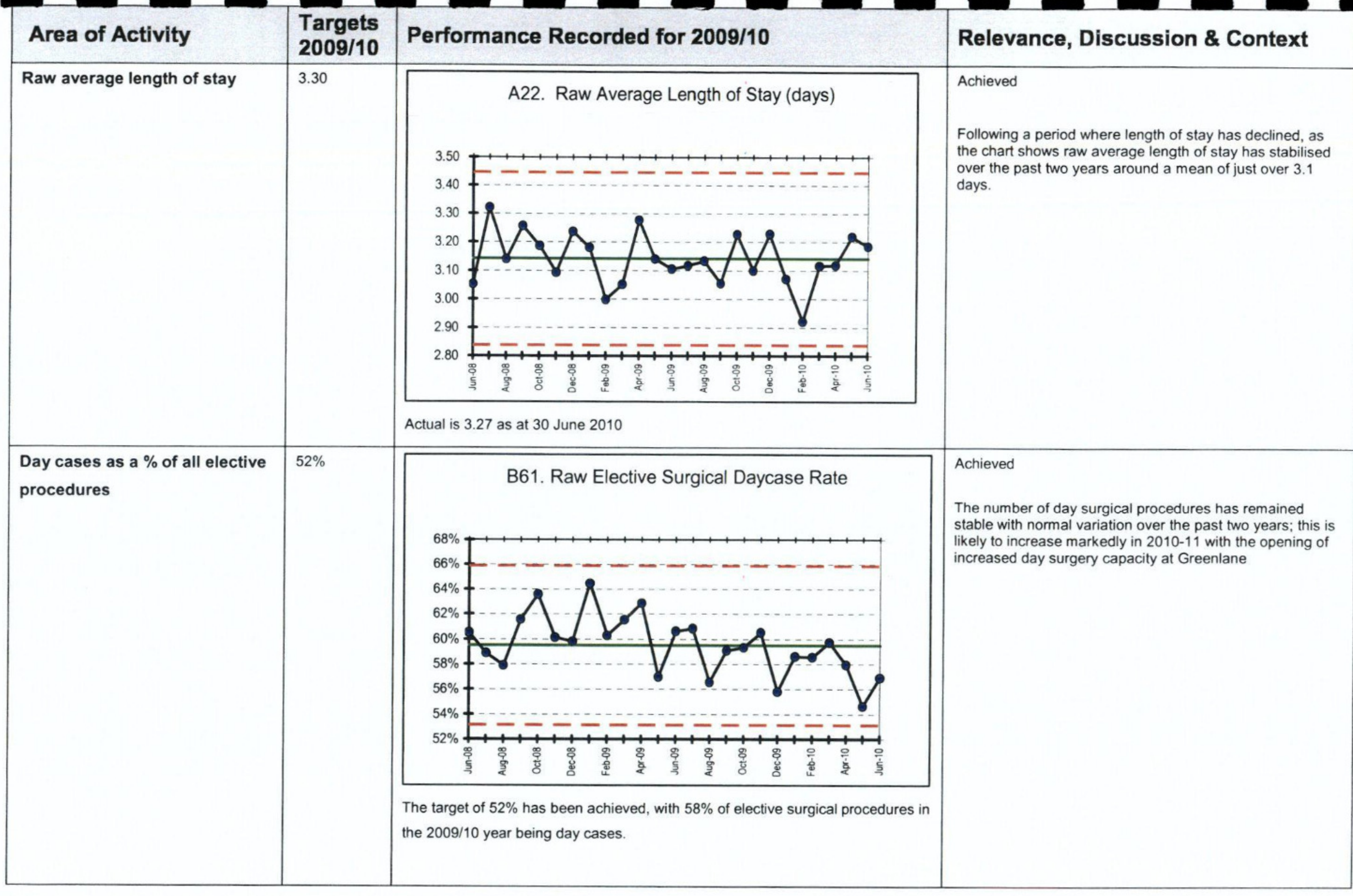

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Raw average length of stay	3.30	A22. Raw Average Length of Stay (days) 3.50 3.40 3.30 3.20 3.10 3.00 2.90 2.80 Jun-08 Aug-08 Oct-08 Dec-08 Feb-09 Apr-09 Jun-09 Aug-09 Oct-09 Dec-09 Feb-10 Apr-10 Jun-10 Actual is 3.27 as at 30 June 2010	Achieved Following a period where length of stay has declined, as the chart shows raw average length of stay has stabilised over the past two years around a mean of just over 3.1 days.
Day cases as a % of all elective procedures	52%	B61. Raw Elective Surgical Daycase Rate 68% 66% 64% 62% 60% 58% 56% 54% 52% Jun-08 Aug-08 Oct-08 Dec-08 Feb-09 Apr-09 Jun-09 Aug-09 Oct-09 Dec-09 Feb-10 Apr-10 Jun-10 The target of 52% has been achieved, with 58% of elective surgical procedures in the 2009/10 year being day cases.	Achieved The number of day surgical procedures has remained stable with normal variation over the past two years; this is likely to increase markedly in 2010-11 with the opening of increased day surgery capacity at Greenlane

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Median acute time to theatre for all suites (decimal hours)	4	A20. Median acute time to theatre (decimal hrs) - all suites The median time to theatre for the 2009/10 year is 4.12 hours, which exceeds the target of 4 hours.	Not achieved Median acute time to theatre is one of 14 acute process quality indicators monitored by the Quality, Risk and Audit Committee of the Board. The indicator has been relatively stable with only normal variation just above the target throughput the whole year.
Percentage of Did Not Attend (DNA) for specialist appointments	8.5%	A52. % DNA rate for outpatient appointments -All Ethnicities The percentage of DNAs for specialist appointments in the 2009/10 year is 8.8%, which is just over the target of 8.5%.	Not achieved The outpatient DNA rate has been a key focus for the Board during 2009/10, with initiatives being undertaken to reduce the rate. The rate in the second half of the year was below historical levels

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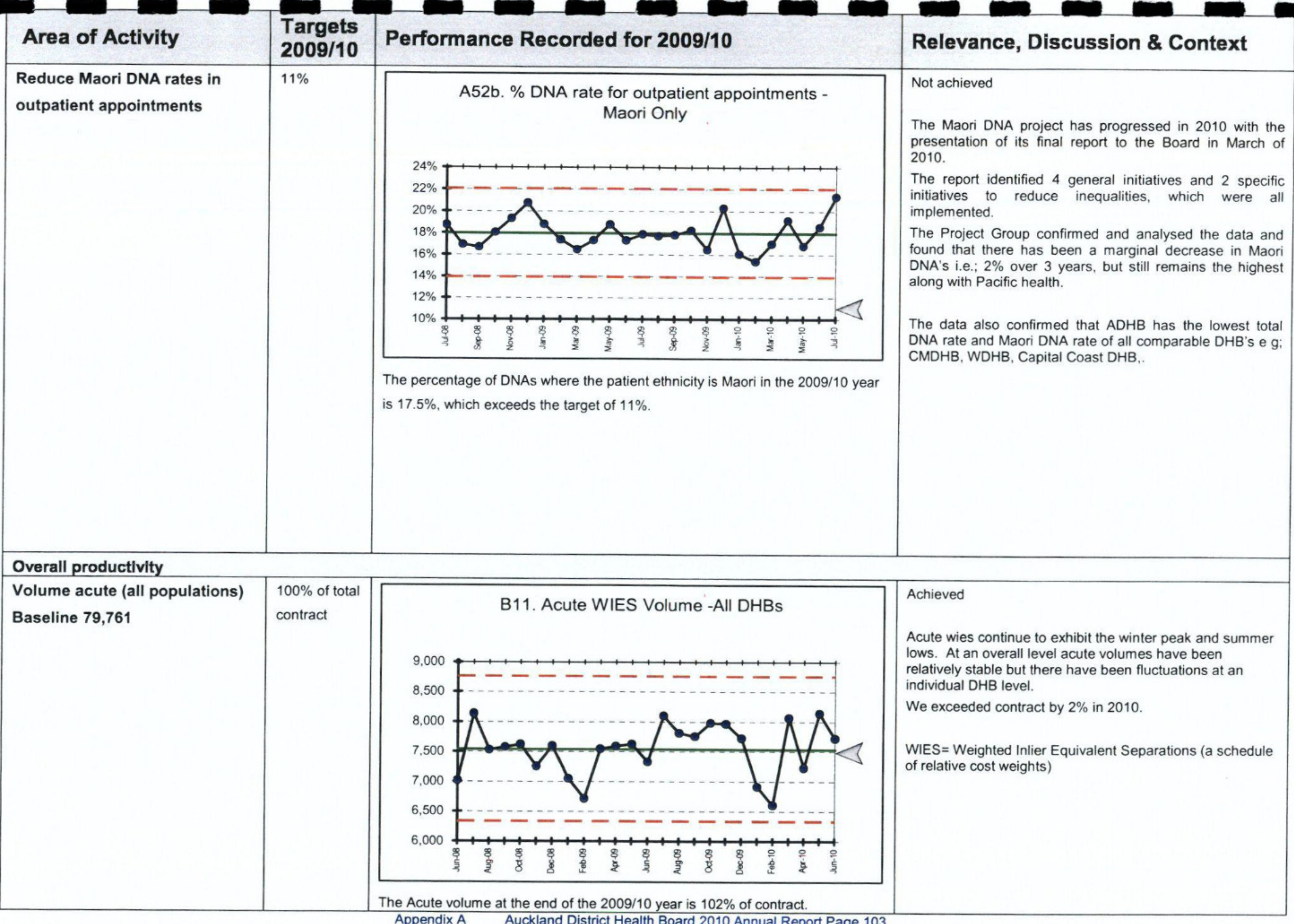

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Reduce Maori DNA rates in outpatient appointments	11%	A52b. % DNA rate for outpatient appointments - Maori Only (chart: 10%–24%, Jul-08 to Jul-10) The percentage of DNAs where the patient ethnicity is Maori in the 2009/10 year is 17.5%, which exceeds the target of 11%.	Not achieved The Maori DNA project has progressed in 2010 with the presentation of its final report to the Board in March of 2010. The report identified 4 general initiatives and 2 specific initiatives to reduce inequalities, which were all implemented. The Project Group confirmed and analysed the data and found that there has been a marginal decrease in Maori DNA's i.e.; 2% over 3 years, but still remains the highest along with Pacific health. The data also confirmed that ADHB has the lowest total DNA rate and Maori DNA rate of all comparable DHB's e g; CMDHB, WDHB, Capital Coast DHB,.
Overall productivity			
Volume acute (all populations) **Baseline 79,761**	100% of total contract	B11. Acute WIES Volume -All DHBs (chart: 6,000–9,000, Jun-08 to Jun-10) The Acute volume at the end of the 2009/10 year is 102% of contract.	Achieved Acute wies continue to exhibit the winter peak and summer lows. At an overall level acute volumes have been relatively stable but there have been fluctuations at an individual DHB level. We exceeded contract by 2% in 2010. WIES= Weighted Inlier Equivalent Separations (a schedule of relative cost weights)

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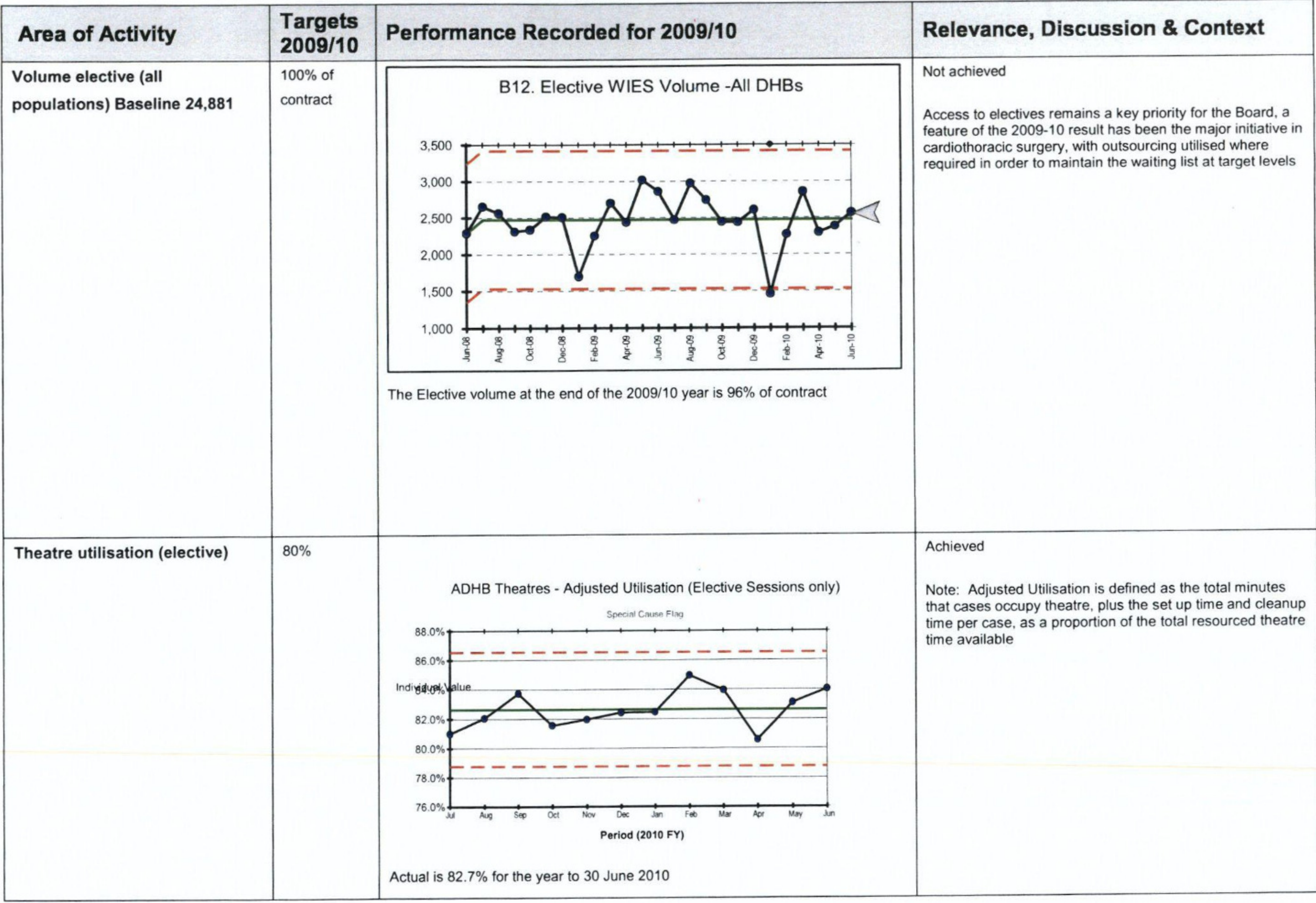

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Volume elective (all populations) Baseline 24,881	100% of contract	B12. Elective WIES Volume -All DHBs The Elective volume at the end of the 2009/10 year is 96% of contract	Not achieved Access to electives remains a key priority for the Board, a feature of the 2009-10 result has been the major initiative in cardiothoracic surgery, with outsourcing utilised where required in order to maintain the waiting list at target levels
Theatre utilisation (elective)	80%	ADHB Theatres - Adjusted Utilisation (Elective Sessions only) Actual is 82.7% for the year to 30 June 2010	Achieved Note: Adjusted Utilisation is defined as the total minutes that cases occupy theatre, plus the set up time and cleanup time per case, as a proportion of the total resourced theatre time available

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Bed utilisation	85%	Bed Occupancy for 2009/10 Average for year is 87.7%	Achieved Occupancy rates were at high levels throughout the first half of the year but with additional bed capacity (including a dedicated stroke unit) coming on stream from November 2009, occupancy rates eased in the second half of the year
Improve the rate of Elective Services			
Intervention rate per 1000 (standard discharge rate)	.94	.85	Partially achieved
Elective surgical discharges	250	225	Not achieved
Cardiac by-passes	5.93	4	Not achieved
Cataract Initiative	27	35	Achieved
Orthopaedic Initiative	18	29	Achieved

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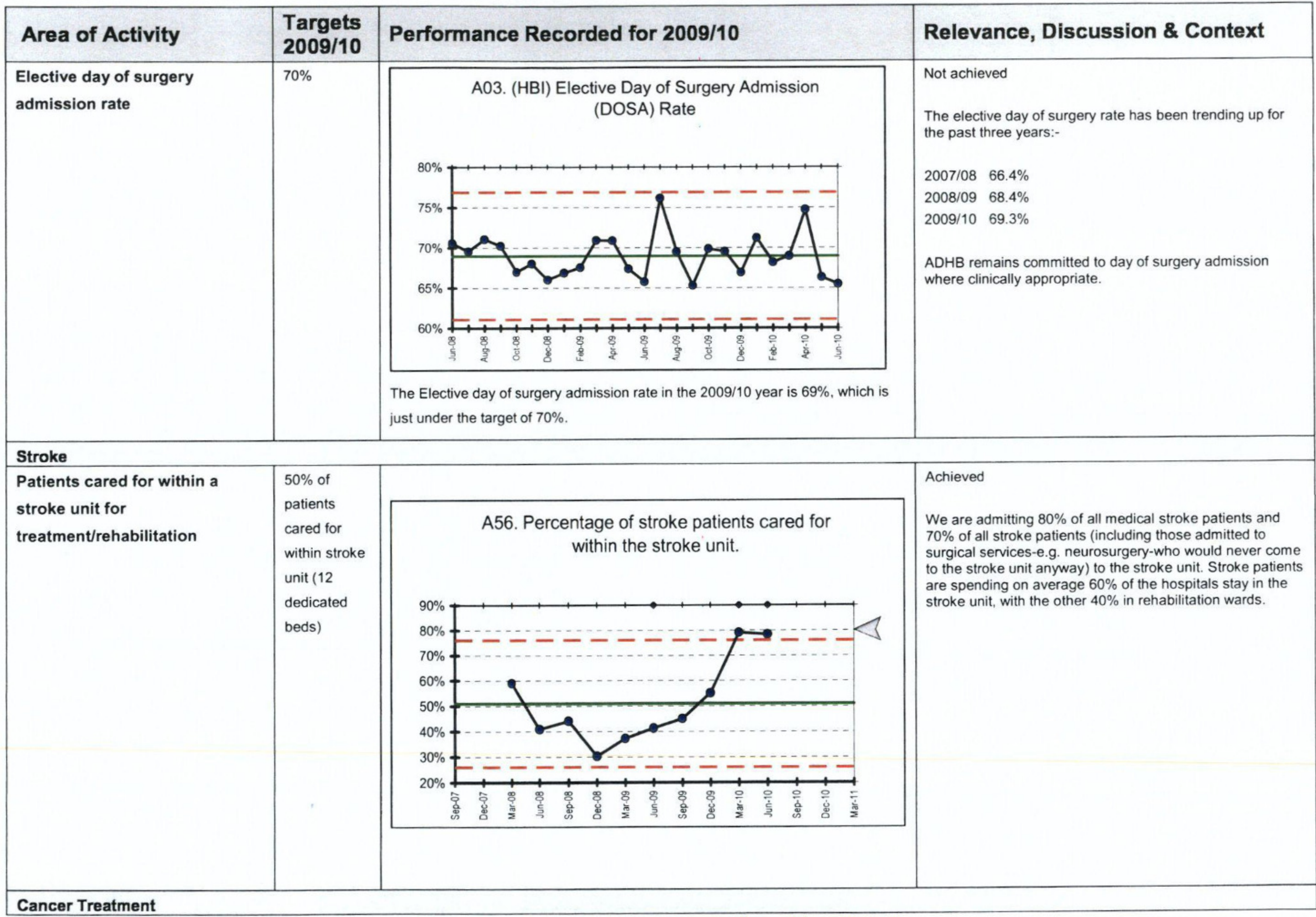

Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Elective day of surgery admission rate	70%	A03. (HBI) Elective Day of Surgery Admission (DOSA) Rate The Elective day of surgery admission rate in the 2009/10 year is 69%, which is just under the target of 70%.	Not achieved The elective day of surgery rate has been trending up for the past three years:- 2007/08 66.4% 2008/09 68.4% 2009/10 69.3% ADHB remains committed to day of surgery admission where clinically appropriate.
Stroke			
Patients cared for within a stroke unit for treatment/rehabilitation	50% of patients cared for within stroke unit (12 dedicated beds)	A56. Percentage of stroke patients cared for within the stroke unit.	Achieved We are admitting 80% of all medical stroke patients and 70% of all stroke patients (including those admitted to surgical services-e.g. neurosurgery-who would never come to the stroke unit anyway) to the stroke unit. Stroke patients are spending on average 60% of the hospitals stay in the stroke unit, with the other 40% in rehabilitation wards.
Cancer Treatment			

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
100 % of eligible cancer patients, except for Category D, receive radiotherapy treatment within six weeks of FSA/decision to treat	100%	B52. % of radiation oncology patients attending FSA within 6 weeks of referral Actual is 97.14% as at 30 June 2010	Not achieved The Northern Regional Cancer Centre achieved 94% target for the Auckland population in Quarter 1 until a surge in referrals in November 2009 (Quarter 2), combined with decommissioning of a Linear Accelerator impacted capacity to achieve the target. From December onwards, significant efforts were made to identify alternative options for patients and simple "C" radical breast and prostate patients were offered treatment at Waikato Hospital and a local private provider. The volume of patients referred to the Radiation Oncology service for treatment during Quarter 2 (92% to target) flowed through to impact on wait times/ results in Quarter 3 (83% to target).
Radiotherapy intervention rate	40%	The Northern Region Radiation Therapy intervention rate was confirmed in October 2009 at 39.7% (refer to the Radiation Therapy Strategic Plan April 2010). The IR for the 9/10 year will be confirmed by October 2010 (regional capacity has not materially changed from 2009 so an increase in the overall IR is not anticipated.	Not Achieved
Mental Health - At least 90% of long-term clients have up-to-date relapse prevention plans	90%	B63. Mental Health Percentage of people with relapse prevention plans	Achieved Relapse Planning remains a strong focus within services and a range of processes to support and inform this are in place. For much of the year compliance has sat above the 90% target and has been particularly stable since December 2009.

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Area of Activity	Targets 2009/10	Performance Recorded for 2009/10	Relevance, Discussion & Context
Output Class: Support Services			
Number of people > 85 years who are able to remain in their own homes	5% increase on baseline of 3,097		Not achieved, but baseline indicator is not accurate. Total number for the year is 1359
Number of low level clients self managing on support packages with input from key workers	10% increase on 2,352 per year		Not achieved, The number of low needs clients totals 2243, but the programme has yet to be fully implemented.
Number of reassessments for clients receiving home based support services	25% increase on 1 per year		Achieved. In the 09/10 year each client who was new to the service received a three monthly reassessment following their initial assessment and 90% of existing clients had a reassessment and are also now on 3 monthly reassessments.
Number of complaints from residential care	20% reduction on a base of 51		Achieved. Actual complaints from Residential care received in the 09/10 year total 34.
Number of palliative clients accessing primary care under the subsidised DHB/PHO partnership	20	51	Achieved
Education sessions delivered by specialist providers to aged care facilities	10	10	Achieved Target reached, and plans for further expansion of education programmes into aged care planned for 10/11 to include managers as well as clinical and care delivery staff.
Audit of residential mental health providers	30%	L42. Percentage of Mental Health providers audited over 3 yr cycle (starting 1 July 09) 120%, 100%, 80%, 60%, 40%, 20%, 0% Jun-07, Sep-07, Dec-07, Mar-08, Jun-08, Sep-08, Dec-08, Mar-09, Jun-09, Sep-09, Dec-09, Mar-10, Jun-10, Sep-10	Achieved The current audit cycle for mental health providers in the Northern Region is 3 years. During this period, all services that were in existence from 09/10 onwards and funded by ADHB have been audited. New services are added to the cycle after one year's service delivery. There will be years where the number of audits performed as a percentage total of mental health funded services will be over or under the 30% of service delivery mark. However, over the course of the audit cycle all mental health providers will be audited.
Percentage of people with enduring mental illness in paid work or education or appropriate discharges	15%	This information was not collected or reported on during the 09/10 year. It was collected during the 08/09 year, however this presented a number of difficulties and its reliability was questionable.	Not recorded

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LabTests

In 2009/10, approx 8,625,000 community laboratory tests were ordered in the Auckland region (inclusive of Auckland, Counties Manukau & Waitemata DHBs). This was around 2.9 per cent more tests than in the previous year. For Auckland DHB residents, on average 7,470 tests are ordered per day with the majority (78%) being ordered by GPs.

In September, LabTests took over responsibility for providing the majority of community laboratory testing. Diagnostic Medlab retained responsibility for delivering tests ordered by private specialists and rest homes, which equated to around 10 per cent of community laboratory volumes.

There were some performance issues at the time of the transition but LabTests is now a fully-accredited laboratory against international accreditation standards and both laboratories are performing well against a common set of key performance indicators focusing on turnaround times and accuracy of reporting. This is the first year in which these KPIs have been reported against.

Swine Flu

The H1N1 influenza pandemic presented a significant challenge, particularly during July and August, 2009 when up to 20 patients a day were presenting with influenza-like symptoms. The number of daily presentations in June, 2010 had fallen to between four and six.

The hospital managed well throughout the pandemic, with the main impact on the front door of the hospital, AED, CED and APU where patients were to be identified and placed in isolation.

Initially, patients suspected of H1N1 infection were isolated with full barrier nursing. As the numbers rose, patients were cohorted into six-bedded rooms. Keeping large numbers of patients in isolation was difficult for the ward staff.

Managing staff sickness was difficult and was co-ordinated by Occupational health. Large numbers of staff were affected and these numbers, along with the number of positive H1N1 patients in the hospital, were reported to the Ministry of Health each day.

Between July 1 and December 31, 2009, 54 adults and 63 children tested positive to H1N1 after admission to hospital. Over the same period, 497 children and 142 adults were admitted with flu-like symptoms.

The average length of stay in 2009-10 for adult patients testing positive to H1N1 was 5.4 days and six days for children.

The flu season arrived later in 2010 (August). Between January and June, five children and 17 adults were admitted.

ADHB recorded six H1N1-related deaths between July and August, 2009.

This was the first pandemic in recent years. The initial situation was managed by Public Health with support from the Regional IMT teams and the focus was on keeping the infection out of New Zealand and on keeping it out of hospital when ever possible. Management of significant numbers of hospital patients did not really happen until late July which was the peak of the 09 pandemic.

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Audit Report

To the readers of Auckland District Health Board and group's financial statements and statement of service performance for the year ended 30 June 2010

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 on her behalf. The audit covers the financial statements and statement of service performance included in the annual report of the Health Board and group for the year ended 30 June 2010.

Unqualified opinion

In our opinion:

- The financial statements of the Health Board and group on pages 25 to 69:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health Board and group's financial position as at 30 June 2010; and
    - the results of operations and cash flows for the year ended on that date.
- The statement of service performance of the Health Board and group on pages 70 to 109:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 6 October 2010, and 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 the Auditor, and explain our independence.

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Basis of opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and statement of service performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement and statement of service performance disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2010 and the results of operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health Board and group's standards of delivery performance achieved and revenue earned and expenses

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incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the New Zealand Institute of Chartered Accountants.

In addition to the audit we have carried out assignments in the area of an aviation fuel price adjustment, which are compatible with those independence requirements. Other than the audit and these assignments, we have no relationship 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

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