Annual Report 2011/2012

Waitemata District Health Board

Best Care for Everyone

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CHAIR/CEO STATEMENT

2011/2012 was a remarkable year for the DHB. The year saw the largest expansion of facilities and services at Waitemata since the DHB first came into existence. Along with this growth, the DHB has also excelled in its overall performance, with a dramatic improvement in performance as measured by the health targets – together with Auckland DHB, Waitemata DHB achieved the greatest improvement in Shorter Stays in Emergency Departments and Better Help for Smokers to Quit than any other DHB in the country. The potential that was always inherent within the organisation has now begun to be realised.

These improvements are a direct result of the dedication and hard work of the many thousands of people who work for the DHB. Strong clinical leadership and engagement at all levels has been key to these achievements along with an increased emphasis on the quality of the patient experience for those in our care. Quality initiatives have focused on improving medication safety, decreasing hospital falls, pressure injuries, infection and readmission rates. Alongside this, we continually strive to create a culture of consistent care and consideration for our patients, clients and families. At the end of the 2011/12 year, the DHB achieved five of the six national health targets, and is well on track to achieving the new national target of more heart and diabetes checks for our population. Our DHB's historic problem area, the performance of the emergency departments, has now been consigned to the past. A new Emergency Department and Assessment and Diagnostic Unit at North Shore Hospital (coupled with initiatives on improving patient flow) has meant that our DHB has consistently exceeded the 95% target of all emergency department patients admitted, discharged or transferred in six hours or less, since March 2012.

Some 95% of all two year olds in our district are also now fully immunised for the first time, protecting our children against the most common infectious childhood diseases. The achievement of the immunisation target is a tremendous achievement for our DHB, making us one of the first large DHBs in the country to reach the target. Equity between the immunisation rate for the overall population and Māori has also been achieved. The support of the primary care sector has been crucial in achieving this target.

We continue to invest in new facilities that will enable us to serve our communities to the highest possible standard well into the future. Developments completed this year include:

- The Lakeview Cardiology Centre, a 25 bed-facility which brings a coronary care unit, a step-down unit, a cardiology ward and two cardiac catheterisation laboratories together in one place. The extra catheter laboratory means shorter patient waits for procedures such as coronary angiograms, stents and pacemaker implants, and also shorter hospital stays.
- Full commissioning of the 50 bed Assessment & Diagnostic Unit last November, completing the final component of new emergency services facilities at North Shore Hospital.
- The commissioning of a new state of the art CT scanner at North Shore Hospital.
- A new 1200 space carparking building at North Shore, significantly increasing parking capacity for the public and staff.
- The opening of the new Awhina Health Campus at Waitakere hospital in joint association with Unitec.
- The opening of a further four new school dental clinics at Belmont, Northcross, Forrest Hill and Silverdale as part of our facilities modernisation programme for child oral health.
- Expansion of the Rangatira paediatric unit at Waitakere Hospital. This expansion sees the addition of 10 extra beds, a new indoor playroom, an outdoor garden area, parent kitchen and negative pressure isolation room for children with infectious diseases. The expansion will help us keep up with growing demand (the unit sees more than 2500 children each year) and children will be able to be admitted more quickly. It will also save many families from having to travel to Starship in Auckland. The expansion has also created a more inviting and welcoming environment for children and their families.

We have also started construction of the Elective Surgery Centre (ESC) building. Located at the North Shore Hospital site, the ESC is a $39 million facility that will be dedicated solely to providing elective surgical procedures. The aspiration for the project is to create a highly efficient and cost effective centre for fast stream elective surgical services – one that would be New Zealand's most productive, with results better than that achieved in both private and other public hospitals in the country. Once completed in July 2013 it is expected to perform nearly 6,000 operations a year across all specialties.

The 2011/12 year also saw the start of the four-year national pilot for bowel screening in our district. The first screening programme of its kind in New Zealand, the programme will see 134,000 eligible people in our district aged between 50 and 74 tested for bowel cancer, the second most common cancer in the country. As a nation our death rate from bowel cancer is one of the highest in the developed world. In our district alone more than 100 people die from the disease each year – the screening programme will help reduce these deaths. Whilst the programme is still less than a year old, more than 7500 returned screening kits have been tested picking up five bowel cancers and five cancerous polyps. These figures are encouraging not

only because they show that people are receptive to a screening programme for bowel cancer, but that regular screening can help save lives through early diagnosis and treatment.

Along with the BowelScreening programme, we've also added new services for our population, including:

- A Gestational Diabetes service providing assessment and support for women without previously diagnosed diabetes who develop the condition during pregnancy.
- A new one-stop, nurse-led clinic for diagnosing haematuria (blood in the urine), a possible indicator of cancer. The new clinic has dramatically cut down on wait times from five months to around 30 days.
- A Long Term Oxygen Therapy service providing assessment, equipment, education and support for adults and children in our district who require oxygen support via cylinders or concentrators in their own homes, either for long term use or palliative support. It is the first phase of a planned expansion of our DHB's respiratory services, which will eventually include a Lung Function Lab and sleep services.

Financially, our DHB has continued to live within its means during 2011/12, ending the year with a small surplus which will be re-invested back into our services and facilities. The business transformation programme initiated in 2010/11 has continued to deliver efficiencies and increased productivity while still enabling our organisation to respond to our population's increasing health needs.

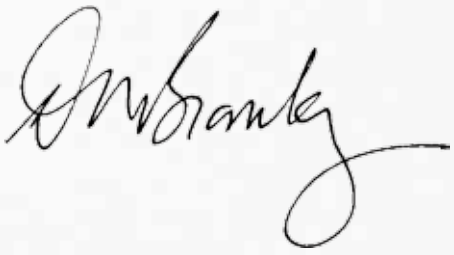
Regionally our DHB was part of a landmark project to significantly improve after hours medical access for those needing urgent care. As of September last year Aucklanders have been able to access a network of Accident and Medical (A&M) clinics that are open evenings, weekends and public holidays until at least 10pm. Four clinics covering north, west, south and east Auckland are operating 24-7. The initiative, developed through a taskforce representing the three Auckland DHBs, the region's Primary Health Organisations and Auckland's A&M clinics, means nearly half of all Aucklanders can enjoy reduced medical consultation charges. The difference is significant. For example, in Henderson, children under 6 who were previously charged $31 and up to $36 on a public holiday are now seen free after hours. The Henderson A&M is one of seven clinics now seeing under six year olds for free.

A bilateral collaboration initiative is also underway between our DHB and Auckland DHB to improve the quality of health service delivery across both DHBs. This move is driven by a focus on patient needs, rather than boundary lines between DHBs. Regionalisation through collaboration is a strategic priority for both DHBs and a number of areas, such as Māori health, have been identified for closer working ties between the two DHBs to enhance health outcomes and provide more seamless service delivery for people in both districts.

Looking to the future, we enter into 2012/13 as an organisation on an upward trajectory. There is still much to do in order to realise our aspiration of being the best performing DHB in the country. But the investments we have made over recent years stand us in good stead as we strive to further improve on the high level of care and commitment we have to the communities we serve.

An organisation is however only as good as its people. We are fortunate to have so many dedicated, talented and hardworking people working within our DHB and partner organisations. None of our successes to date would have been possible without them. On behalf of the Board and Executive Leadership Team we wish to thank all our staff and partners who have made the 2011/12 year such an outstanding one.

Dr Lester Levy
Chair
Waitemata District Health Board



Dr Dale Bramley
CEO
Waitemata District Health Board

DISTRICT SNAPSHOT

Waitemata District Health Board serves the largest DHB population in the country – nearly 560,000 people. It has the second fastest growing population of New Zealand's 20 DHBs.

We employ around 6,810 people in more than 30 different locations and manage a budget of more than $1.3 billion a year, serving residents of Rodney, the North Shore and Waitakere.

Waitemata DHB operates North Shore Hospital, on the shores of Lake Pupuke in Takapuna, and Waitakere Hospital in west Auckland.

Locally we provide emergency, medical, surgical, maternity, community health and mental health services. We also provide a range of services for the Auckland region, including child rehabilitation and respite at Takapuna's Wilson Centre, forensic psychiatric services at the Mason Clinic in Point Chevalier, oral health services for children and young people and Community Alcohol and Drug Services from multiple locations.

Our district is a diverse one, made up of 18% Asian (mostly Chinese, Indian and Korean), 10% New Zealand Māori, 10% Pacific peoples with around 60% European and Other ethnicities.

MISSION – 2011/12

To make a healthy difference

VISION AND VALUES

During 2011/12 we undertook an exercise to review and refresh the organisation's vision, purpose and values. Over past months, staff have been involved in the process to select a refreshed set of values for our DHB. Our new values and purpose have now been finalised, and will be rolled out across the organisation over 2012/13.

VALUES – 2011/12

Openness:
Ensuring transparency of process, structure and communication

Integrity:
Being truthful, sincere, fair and consistent in all dealings

Compassion:
Being thoughtful of people's needs and supporting them in ways that protect their mana

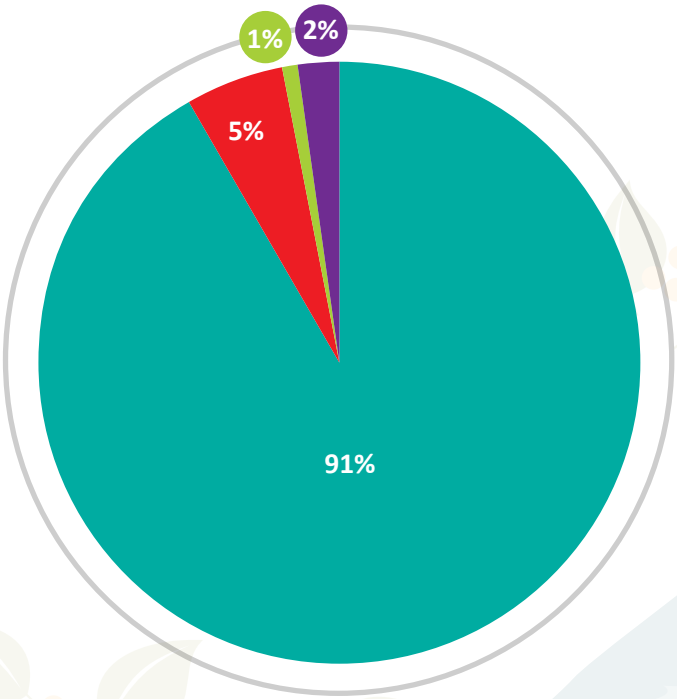
Customer focus:
Spending time and energy to ensure that patients, clients and customers are well served

Respect:
Acknowledging a person's dignity

THE WAITEMATA DHB DISTRICT

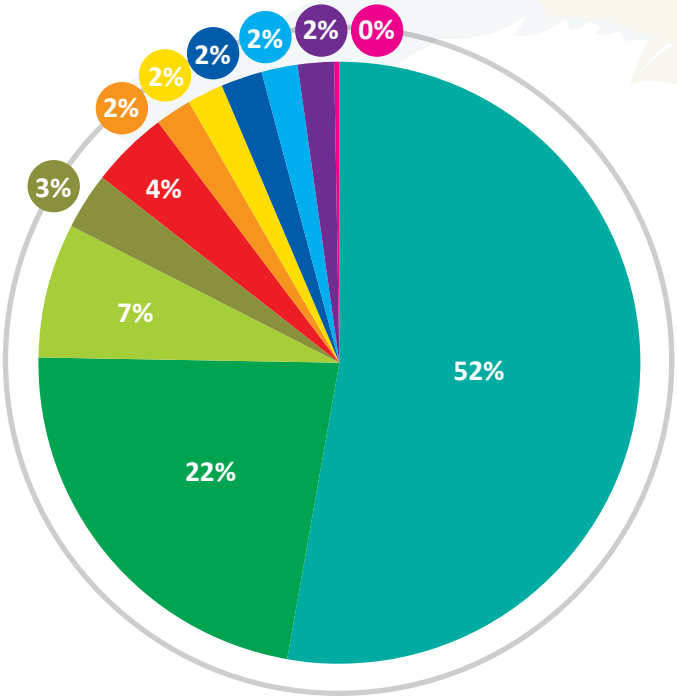
HOW WE ALLOCATE OUR FUNDING

Where did the money come from?



- Ministry of Health
- Other DHBs for care of their residents by WDHB
- Clinical Training Agency, ACC and other health funders
- Other income

What was it spent on?



- Waitemata DHB's own hospital and community health services
- Other DHBs mainly for care of Waitemata DHB residents
- Community pharmaceuticals
- Primary care
- Private hospitals
- Personal health contracts
- Mental health (NGOs, private providers)
- Community laboratory tests
- Home support services
- Rest homes
- Other

KEY FACTS AND FIGURES — OVER THE PAST YEAR

Where possible, comparative data for other DHBs is presented in order to give a sense of scale of our activities and provide context to our performance.
(note figures in brackets are for previous year)

- **6,584** babies were born in our hospitals *(6,695)*. This is nearly 11% of the country's total births for the 2011/12 year of 61,031. For the same period, there were 7,761 babies born in Auckland DHB facilities – being nearly 13% of the country's total births for 2011/12.
- Waitemata residents made **178,187** attendances at an outpatient clinic. This was 32.4% of the population (attendances/population). Comparatively Northland residents made only 54,823 outpatient attendances, but this was 34.5% of their population and Counties Manukau residents made 151,325 attendances – 30% of their population. Auckland residents made 147,728 outpatient attendances – 32.1% of their population.
- There were **118,232** attendances at an Emergency department (ED) by Waitemata residents during 2011/12 – 21.5% of the population (attendances/population). 104,708 *(97,884)* of these attendances were to North Shore or Waitakere hospital Emergency Care Centres (ECCs). During the same time period, Northland resident attendances to an ED totalled 42,432 or 26.7% of their population, compared to Counties Manukau residents – 93,482 attendances or 18.6% of their population. Auckland residents made 84,610 ED attendances during the same period, 18.4% of their population.
- **566,379** *(487,970)* school dental treatments were given to children across the Auckland metro region - 32% for Waitemata DHB children and 30% for Auckland DHB children.
- **78,032** *(74,614)* vaccinations were given to Waitemata children aged five and under. Over the same period, 63,579 vaccinations were given to Auckland children. 95% of two-year-olds were fully immunised in both DHBs by year end.
- We saw **26,594** *(26,685)* mental health clients.
- Specialist nurses carried out **4,832** *(5,229)* home visits.
- **13,634** *(11,348)* smokers hospitalised in Waitemata DHB facilities were offered advice and help to quit smoking. During the same period 12,856 smokers hospitalised in Auckland DHB facilities were offered this advice.
- We carried out **180,573** *(158,127)* radiology procedures in our hospitals. Auckland DHB carried out 267,056 during the same period.
- **15,891** *(13,786)* elective surgeries were performed for Waitemata residents. This was more than 10% of total national elective discharges for the 2011/12 year. During the same period, there were 11,981 elective surgical discharges of Auckland DHB patients – around 8% of the national total.
- There were **12,843** *(12,360)* acute surgical discharges from our facilities.
- **11,327** *(11,726)* Waitemata DHB people had free diabetes checks. Auckland DHB recorded 13,484 of these checks.
- **39,045** *(39,396)* women underwent screening with Breastscreen Waitemata Northland. Screening coverage reached 69%.
- There were **12,944** *(12,901)* mental health home visits.

2011/12 HIGHLIGHTS AND ACHIEVEMENTS

2011/2012

Achieved five out of six national health targets:

- Shorter stays in emergency departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit.

Also substantially achieved new health target of more heart and diabetes checks.

2011 August

- New CT scanner at North Shore Hospital.

September

- Regional after hours project to improve after hours access for those needing urgent medical care commences.

October

- Lakeview Cardiology Centre at North Shore Hospital opens
- BowelScreening pilot starts
- New school dental clinics at Belmont Intermediate and Northcross Intermediate open.

November

- Assessment & Diagnostic Unit at North Shore Hospital is fully commissioned
- New 1200 space carparking building at North Shore Hospital opens.

2012 February

- Construction starts for the Elective Surgery Centre at North Shore Hospital.

April

- New gestational diabetes service starts at Waitemata DHB
- Long term oxygen therapy service starts at Waitemata DHB
- New dental clinics at Forrest Hill School and Silverdale School open.

May

- New Awhina Health Campus facilities at Waitakere Hospital open.

June

- Expansion works to Rangatira paediatric unit at Waitakere Hospital is completed.

FEEDBACK

I just wanted to pass on that the care my partner received at ED NSH yesterday afternoon was exemplary. My partner who had bronchitis suddenly became breathless and could not walk or barely talk. She is normally very fit and healthy. We got triaged to Emergency and initially the triage RN thought she would have to be admitted. The triage RN was fabulous and the SMO was brilliant. They did ECG, blood tests and chest x-ray all within two hours. They decided it was an asthma attack which she has never had in her life. So after IV medication and ventolin via spacer she responded most favourably, enough to be discharged. All this happened within three hours. The SMO even trained her on how to use ventolin and a peak flow monitor personally. He took time too and asked her three times if she had any questions. He was fastidious in ensuring she had all the discharge information, scripts and medical sick letter. We are both RNs so very aware of care standards. It was the best care I have ever witnessed both in public and private settings.

The facilities were great, and having left the DHB six months ago when Lakeview was still new and the parking lot incomplete I was pleasantly surprised by how great the new facilities were and the parking is just fantastic - what an achievement.

I recently participated in the Waitemata Health Board bowel screening pilot programme. Following an abnormal reading of my bowel motion sample I had a colonoscopy which fortunately came back clear but I wish to express my gratitude for the professional and caring treatment that I received during this stressful time.

My wife is a bowel cancer survivor (after treatment by the same surgeon that did my colonoscopy) so I realise the extreme importance of early detection and treatment. I would therefore like to commend the Government initiative in this screening programme and hope that it continues and further funding allows it to be extended to the whole of New Zealand.

Major surgery, without a doubt, can be a potentially frightening experience; however I felt calm and confident as a result of all the preparatory education and professional manner of the North Shore and Waitakere personnel.

I am emailing to say I am so impressed with the care I have received since seeing [the] Diabetic Nurse. My Diabetes control is perfect now, I was not well, overweight and on many oral medications. After seeing the Diabetologist I am now feeling very well. I have been put on new types of Insulin (Lantus) and Byetta which is working very well for me. The ongoing care and monitoring of my Diabetes is outstanding.

Waitemata DHB attendance at board and committee meetings: July 2011 – June 2012

The next Waitemata DHB Board elections will be held in 2013.

Board Member	Board 9 Mtgs	HAC 9 Mtgs	Audit and Finance 9 Mtgs	CPHAC 10 Mtgs	DiSAC 4 Mtgs	MHGAC 4 Mtgs
 Lester Levy	7	7	8	8	3	3
 Max Abbott	8	8	8	9	1	x
 Pat Booth	9	9	x	10	4	x
 Sandra Coney	8	7	x	9	4	x
 Rob Cooper *Leave of Absence: February – July 2011*	5	5	2	1	x	4
 Warren Flaunty	8	8	8	9	x	x
 Wendy Lai	7	7	9	x *(member until July 2011)*	x	3
 James Le Fevre	8	8	x	1 *(member until July 2011)*	x	2
 Christine Rankin	7	9	8	8	x	x
 Allison Roe	9	9	x	9	x	x
 Gwen Tepania-Palmer	8	9	x	2 *(member from March 2012)*	x	4

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

x = not a member of committee

Statement of Waivers

The New Zealand Public Health and Disability Act 2000 s 42(4) provides as follows: for the purposes of s 151 (1)(j) of the Crown Entities Act 2004, the annual report of a DHB must disclose any interests to which a permission, waiver, or modification given under clause 36(4) or clause 37(1) of Schedule 3 or clause 38(4) or clause 39(1) of Schedule 4 relates, together with a statement of who gave the permission, waiver, or modification, and any conditions of amendments to, or revocation of, the permission, waiver, or modification.

For the 2011/12 year there were no permissions, waivers or modifications given under the clauses of this legislation.

Trusts

Waitemata DHB is associated with the following trusts:

Wilson Home Trust

Waitemata DHB is trustee for the Wilson Home Trust for children with physical disabilities. Waitemata DHB provides rehabilitation and respite services for children with disabilities from facilities at the Wilson Home, which it leases from the trust.

Three Harbours Health Foundation

Waitemata DHB is the appointer of trustees to this charitable trust. Funds from the trust are made available mainly for clinical research, provision of patients' comforts and amenities, staff training and education, and clinical equipment. Associated trusts, North Shore Hospital Foundation and West Auckland Health Services Foundation, operate under the umbrella of the Three Harbours Health Foundation.

Good employer obligations

Waitemata DHB is committed to meeting its legal and ethical obligations to be a good employer. The Good Employer Framework is used to guide the core objectives of the Waitemata DHB Human Resources Strategic Plan.

Waitemata DHB is a member of the EEO Trust and the organisation's Good Employer Policy makes clear that the DHB will provide:

- Good and safe working conditions
- An equal employment opportunities programme
- Recognition of the employment requirements of women
- Recognition of the employment requirements of men
- Recognition of the employment requirements of persons with disabilities
- The impartial selection of suitably qualified persons for employment
- Recognition of the aims, aspirations and employment requirements of Māori people
- Recognition of the aims, aspirations, cultural differences and employment requirements of Pacific Island peoples and peoples from other ethnic or minority groups
- Opportunities for the enhancement of the abilities of individual employees.

Waitemata DHB's Good Employer Policy upholds the requirements of the Employment Relations Act 2000, the Race Relations Act 1971, the Human Rights Act 1993, the Health and Safety in Employment Act 1998, the State Sector Act 1998 and the Crown Entities Act 2004.

These commitments are demonstrated and supported by Human Resources at a regional, organisational and service level through various activities, key initiatives and programmes including:

- Participation in national Multi Employer Collective Agreements (MECA) which provide national consistency in pay and conditions of employment

- Job-sizing processes which are designed to provide fair and consistent salaries that comply with collective employment agreement requirements and which take account of pay rates for comparable jobs in the private sector
- A staff satisfaction survey to identify and implement ways to improve morale and job satisfaction
- A Staff Information intranet site to give guidance on issues such as fraud awareness and our commitment to a smoke free environment
- Provision of occupational health and safety services for staff, including the ability to 'self-refer' for any work related health issue for which an employee may wish to receive medical care or advice
- Access to an independent and confidential Employee Assistance Programme to which employees may self-refer and have ready access
- Information and access to services to support employees facing issues related to family violence outside the workplace
- Well publicised and supported bullying and harassment prevention programme which means that staff have a clear process and are provided with support when raising issues of behavioural concern in the workplace
- Provision of clinical skill development opportunities to enhance patient safety, with an emphasis on emergency management and 'moving and handling'
- Tertiary level accreditation with ACC which means that Waitemata DHB staff can be confident of a safer workplace, and timely in-house management of workplace incidents
- Access to a comprehensive range of education and learning opportunities designed to meet professional, clinical and career aspirations and needs
- A dedicated culturally and linguistically diverse learning programme to focus specifically on diversity and inclusion to enhance good working relationships
- Commitment to providing flexible working practices where appropriate
- Workforce development strategies designed to build a workforce which reflects the diverse nature of the Waitemata DHB population, with an increasing focus on the needs of our current aging workforce
- Professional placements and other scholarship and career development opportunities provided by the DHB to recognise the aims, aspirations, cultural differences and employment requirements of our diverse population
- Waitemata DHB's disability strategy coordinator role which advises the DHB on ways of removing barriers to employing people with disabilities
- Provision of comprehensive recruitment training for managers which includes identification of gender and other bias and how to apply a fair and equitable appointment process
- Initiatives to support the aging workforce and employees at all life stages in the workplace.

Insurance

Waitemata DHB arranged Professional Indemnity, Directors and Officers Liability and Statutory Liability insurance through a collective insurance scheme organised by District Health Boards New Zealand (DHBNZ). The purpose of taking out this insurance was to ensure that no board member or employee incurred monetary loss as a result of his or her acts or omissions, provided they acted in good faith and in performance of the DHB's functions.

OVERVIEW

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

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

The DHB's planning and funding role is responsible for planning, promoting and undertaking service contracting with organisations including our own hospital services (North Shore and Waitakere Hospitals). However, we do not deliver all services ourselves within our own hospitals. Our DHB also contracts services from other providers, including other DHBs who often provide more specialist services. One example is the provision of specialist cancer treatment, only offered at some hospitals. Some services are funded and contracted directly by the Ministry of Health, for example breast and cervical screening as well as the provision of disability support services for people aged less than 65 years. Our DHB is responsible for monitoring and evaluating service delivery, including audits, for the full range of funded services. Therefore some of the measures chosen in each section reflect and seek to illustrate the performance of the broader health and disability services provided to Waitemata residents, not just those provided by the DHB. We also have a particular focus on continuing to improve health outcomes and reduce health inequalities for Māori. Therefore, a range of measures have been identified throughout the Statement of Service Performance that monitor our progress in improving the health and wellbeing of our Māori population, as identified in the Waitemata DHB Māori Health Plan 2011/12.

Waitemata DHB's performance has improved considerably in the last few years, particularly with regard to the national health targets. In general we set stretch targets to drive the organisation to improve our performance. Assessment of our 2011/12 performance is based on the same grading system used in 2010/11. This allows for recognition of those measures where we have significantly increased our performance, but have not quite met the target set in the Statement of Intent. The criteria used to allocate these grades is as follows:

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

Where a measure is made up of multiple components, each with its own target, an average has been applied to determine performance.

The following diagram presents the overall framework - illustrating the relationship between national and Board priorities, impacts sought and measures used to assess performance which are included in the SSP.

Vision	**To make a healthy difference**						
National Priorities	Services closer to home	Safe and efficient services for older people	Improving service and reducing waiting times	Strengthened clinical leadership	Support for the Health Quality and Safety Commission	Regional collaboration	Living within our Means
Northern Region Health Plan Strategic Goals	Population Health *Adding to and increasing the productive life of people in the northern region*		Patient Experience *Aiming for zero patient harm and performance improvement*		Cost/Productivity *The region's health resources are efficiently and sustainably managed to meet present and future health needs*		
Waitemata DHB Board's Priority Actions	Chronic disease management	Bowel Screening	Priority populations and services	Elective Surgery	Emergency Care	Culture	Clinical Leadership	Regionalisation through collaboration	New Models of Care	Living within our Means

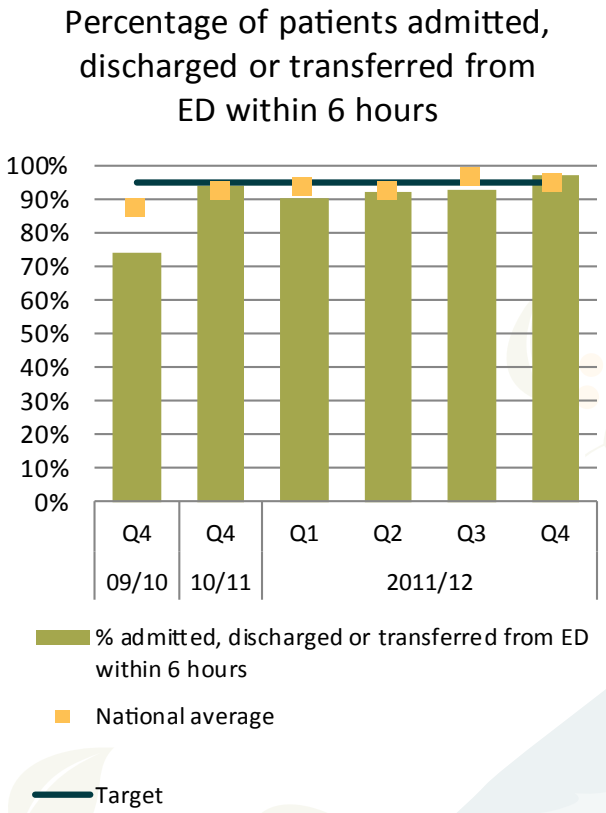
Impacts	• **Increased life expectancy** • **Reduced health inequalities** • Prevention of illness • Prompt diagnosis of acute and chronic conditions • Maintenance of functional independence • Good access to effective pharmaceutical treatments • Effective and prompt resolution of medical and surgical emergencies and acute conditions • Increased survival/reduced mortality from breast and bowel cancer • Management and cure of treatable conditions • Improved oral health of children and young people • Improved independence and quality of life of older people • Fewer incidences of communicable diseases • Reduced demand for secondary care services • **Reduced rates of smoking**	• Improved waiting times for our services • **Improved patient satisfaction** • Fewer adverse clinical events • Improved engagement of our community – including Māori, Pacific and Asian – with our health services • Improved engagement of clinicians and other health professionals • **Improved quality of life due to surgical intervention** • **Improved emergency care** • **Patients less likely to be readmitted**	• Reduced demand on specialist outpatient appointments • Minimising unnecessary use of high cost secondary care ("gate-keeping") • Lower per capita out of pocket and total expenditure on pharmaceuticals • Prevention of illness • More services delivered in primary care and community based settings • **Prudent financial management**
Impact Measures	• % of hospitalised smokers offered advice and help to quit • Smoking prevalence amongst hospitalised smokers • % of 2 year olds fully immunised • Proportion of women aged 45-69 who had a breast screen in the past 12 months • % of eligible population screened for bowel cancer • Mental health services access rates • Proportion of long term mental health clients with relapse prevention plans • Proportion of babies fully and exclusively breastfed at 6 weeks, 3 months and 6 months • Proportion of eligible people with diabetes receiving their 'Get Checked' assessment • Proportion of people with diabetes with good diabetes management at the time of their 'Get Checked' assessment • The percentage of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing absolute CVD risk in the last five years. • Average number of decayed, missing or filled teeth in year 8 children • Proportion of children who are caries free at 5 years • Hospitals discharge rates for falls (PP15) where the fall occurred in a residential institution • Elective services standardised intervention rates for our population	• Patients waiting longer than six months for their first specialist assessment (FSA) • Patients given a commitment to treatment but not treated within six months. • % of patients surveyed who are 'satisfied' or 'very satisfied' with the service they received • Rate of adverse clinical events • % of patients admitted, discharged, or transferred from an Emergency Department (ED) within six hours. • Hospital readmission rates • % of Waitemata cancer patients needing radiation therapy who receive it within 4 weeks of their first specialist assessment • Improve the volume of elective surgical procedures undertaken • Total QALYs gained from the five Ministry of Health selected procedures • Post-operative infection rates • Increased number of compliments • Reduced number of complaints	• Achieve financial break-even result • Regional achievement of national health targets • healthAlliance savings achieved

Output Class	Prevention	Early Detection and Management	Intensive Assessment and Treatment	Rehabilitation and Support
	• Health Protection • Health Promotion • Health Policy/Legislation Advocacy and Advice • Population Based Screening	• Community referred Testing & Diagnostics • Oral Health • Primary Health Care • Pharmacy	• Acute Services • Maternity • Elective (Inpatient/Outpatient) • Assessment, Treatment and Rehabilitation (Inpatient) • Mental Health	• Home Based Support • Palliative Care • Residential Care

Note: Impacts in bold are our main impact measures

COST OF SERVICE STATEMENT – FOR YEAR ENDING 30 JUNE 2012

New Output Class Names (effective from 1 July 2011)	Intensive Assessment and Treatment		Rehabilitation and Support		Early Detection and Management		Prevention Services		Total	
Output Class Names	**Hospital Services**		**Support Services**		**Primary and Community Services**		**Public Health Services**		**Total**	
In $'000s	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**
Total Revenue	747,735	707,599	204,942	194,405	394,058	436,049	27,806	28,787	1,374,541	1,366,840
Expenditure										
Personnel	360,280	330,616	30,656	32,290	73,498	91,525	12,790	12,786	477,224	467,217
Outsourced Services	37,997	25,335	5,556	4,406	7,752	7,013	1,349	980	52,654	37,734
Clinical Supplies	66,704	59,741	4,718	4,864	13,606	16,538	2,368	2,310	87,396	83,455
Infrastructure and Non-clinical supplies	72,962	74,071	6,626	7,556	14,670	20,505	2,553	2,865	96,811	104,997
Payment to providers	209,141	217,836	156,566	145,289	280,849	300,466	8,891	9,846	655,447	673,437
Total Expenditure	747,084	707,599	204,122	194,405	390,375	436,049	27,951	28,787	1,369,532	1,366,840
Net Surplus/ (Deficit)	651	0	820	0	3,683	0	(145)	0	5,009	0

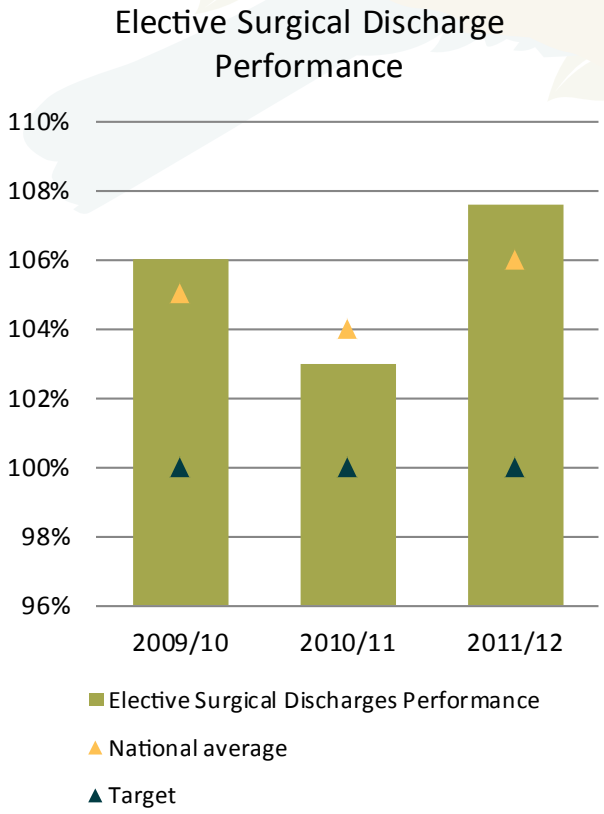


Target: 95% Achieved

Result: 97%

A new Emergency Department and Assessment and Diagnostic Unit at North Shore Hospital (coupled with initiatives on improving patient flow) has meant that our DHB has consistently exceeded the 95% target of all emergency department patients admitted, discharged or transferred in six hours or less, since March 2012.

Waitemata DHB's result is the sixth best nationally.



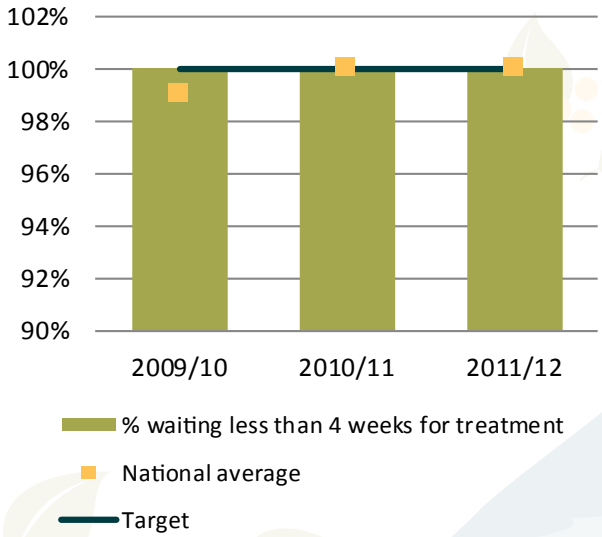
Target: 100% (14,771 discharges) Achieved

Result: 107.6% (15,891 discharges)

Continuing efforts to make more efficient use of theatre time and ensure that patients receive their surgery within acceptable timeframes has resulted in an ongoing improvement in performance year on year. More than 10% of the country's elective surgery during 2011/12 was performed for Waitemata DHB residents. Note that some elective surgery is carried out in other DHBs' facilities for Waitemata residents.

Waitemata DHB's result is the seventh best nationally.

% of Waitemata people receiving radiation oncology treatment within four weeks of first specialist assessment (excluding those waiting by choice or because of co-morbidities)



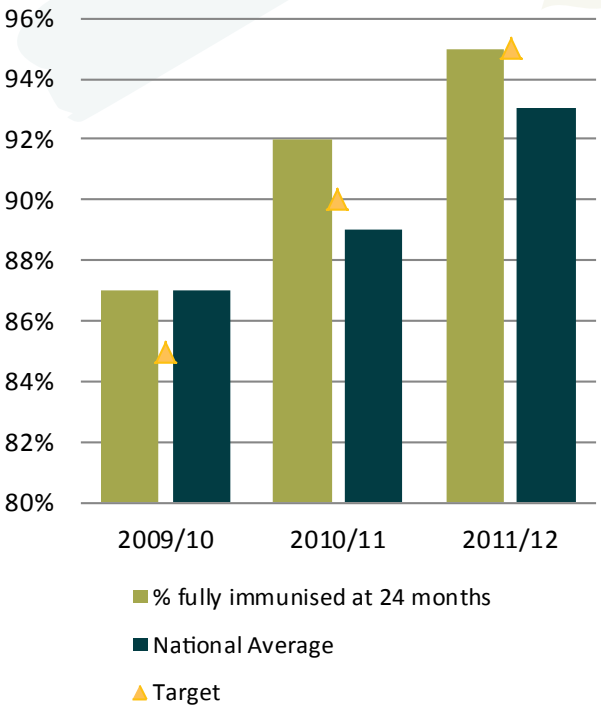
Target: 100% Achieved

Result: 100%

This target has been met consistently for the past three years with little outsourcing of services. Chemotherapy waiting times will be added to this health target for 2012/13.

All DHBs are meeting this target.

Percentage of children fully immunised by 24 months

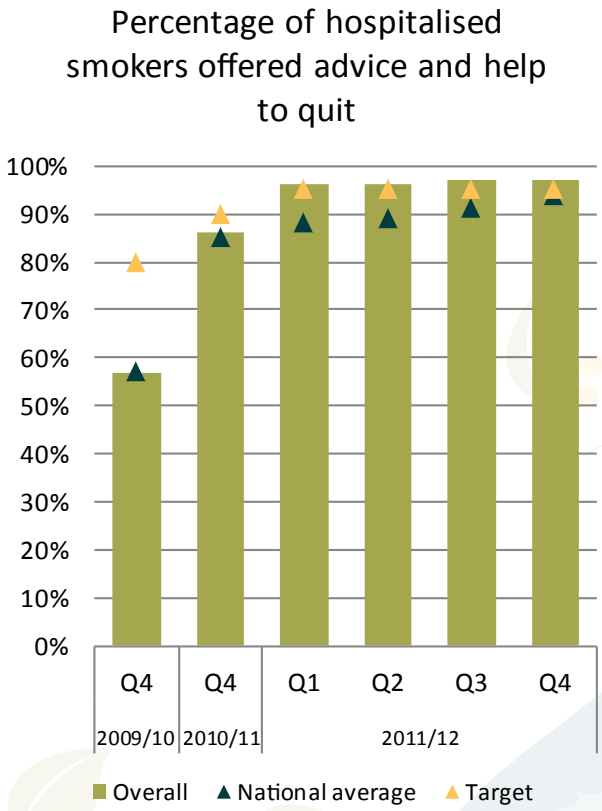


Target: 95% Achieved

Result: 95%

We achieved the immunisation coverage rate of 95% for the first time. For the month of June an overall coverage rate of 96% was achieved. This excellent result was made possible by a coordinated approach by all providers across the District. Over the next year we intend to maintain this coverage rate for 24 month olds while meeting the new eight month Health Target.

Waitemata DHB's result is the eighth best nationally.

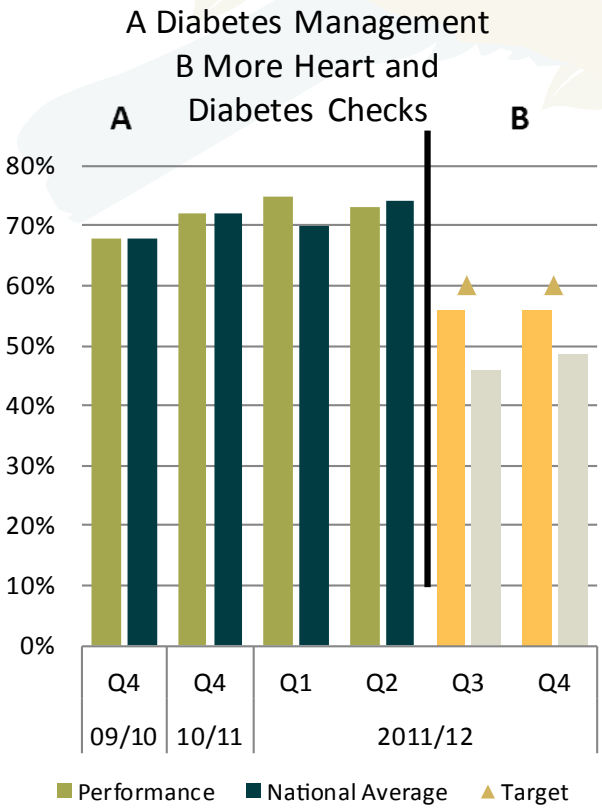


Target: 95% Achieved

Result: 97%

Waitemata's performance against the target has remained consistent throughout 2011/12 with an average of 96% achieved over this period. Continued staff education, promotion of nicotine replacement therapy (NRT) and ensuring data is captured accurately have all had a positive impact on performance.

Waitemata DHB's result is the second best nationally.



More Heart and Diabetes Checks Target: 60% Substantially achieved

Result: 56%

Note: this health target changed during 2011/12. For the first six months the target was derived from averaging the results of diabetes 'Get Checked', diabetes management and cardiovascular risk blood tests performance. For the second half of the year, performance assessment has been based on the percentage of the eligible population having cardiovascular risk assessments in primary care. Therefore these two sets of data cannot be compared.

We remain committed to working with PHOs to achieve this Health Target. Waitemata DHB worked closely with Waitemata PHO to increase screening rates in the last quarter of the year. We also continued to monitor service delivery through ProCare Networks Limited. This led to an improvement in coverage. Each PHO has produced a service plan detailing how the health target will be achieved. Waitemata PHO is working with the Māori Hauora Coalition to increase coverage within their practices.

Waitemata DHB's result is the eighth best nationally.

OUTPUT CLASS MEASURES

The following tables include our output and impact measures from the 2011/12 Statement of Service Performance by Output Class. Impact measures are measurements of longer term outcomes and we would not expect to see real changes on a year by year basis - annual fluctuations will occur and it is only over an extended period of time that it is possible to determine the overall change occurring. Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not achieved' rating. These are indicated with a ✶ symbol. Output measures are intended to reflect our performance over the year.

Prevention Services

Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Health Protection	Outbreaks investigated	2	3	✶		Incorrect baseline recorded as 75 – should have been 2.
	Number of contacts traced	664	1221	✶		
	Communicable disease protocols up-to-date	unavailable	100%	100%	Achieved	
	Communicable disease protocols adhered to	unavailable	100%	100%	Achieved	
	Number of emergency hazard investigations conducted	unavailable	0	✶		
	Chemical and hazardous substance injury and poisoning protocol adhered to	unavailable	100%	100%	Achieved	
	Proportion of water supplier compliance/non-compliance with duties under the Act reported to the water supplier within 20 working days	unavailable	100%	100%	Achieved	
	Number of emergency response exercises participated in	6	5	✶		
	Number of emergencies responded to	3	3	✶		
	Emergency Plan up-to-date	unavailable	Yes	Yes	Achieved	
	Proportion of reports submitted to the Environmental and Border Health Protection team and a copy to the Public Health Operations portfolio manager immediately or within 24 hours of occurrence of a public health event or emergency with inter-district, national or potentially international implications	unavailable	100%	100%	Achieved	17 reports.

Health Protection Impact Measures			
Measure	2010/11 Result	2011/12 Result	Direction required for Improvement
Number of outbreaks investigated	89%	45%	↑
Number of environmental hazards detected	22	12	n/a

Evaluation reports and inquiries into emergency responses:

- There are currently a number of independent reviews into the response to the Christchurch Earthquake in February 2011. Auckland Regional Public Health Service (ARPHS) contributed by deploying staff who were working within the structures that are currently being evaluated.
- ADHB and regional health agencies conducted independent debriefs of the 2011/12 measles outbreak, which ARPHS played a major part in.
- Although there were no emergencies arising as a direct result of the Rugby World Cup 2011 (however some outbreaks occurred around the same time), ARPHS participated intensively in emergency planning prior, and monitoring/reporting during the event. Also, some of our prior planning (e.g. around alcohol and tobacco staffing) mitigated some issues that could have escalated if they hadn't been proactively addressed. Regional and national agencies held a number of debriefs around this event.

OUTPUT CLASS MEASURES: Prevention Services *continued*

Sub-Output Class	Output Measures		Baseline	2011/12	2011/12 Target	Achieved	Comments
Health Promotion	Number of premises who submit a liquor licence application to ARPHS and all problematic premises that receive a compliance check		unavailable 100%	365 (83) 100%	✶ 100%	n/a Achieved	
	Proportion of liquor licensing alcohol compliance protocol for visits adhered to		unavailable	100%	100%	Achieved	
	Proportion of liquor licensing applications processed within 15 days		unavailable	100%	100%	Achieved	
	Proportion of tobacco complaints responded to within 5 days		unavailable	100%	100%	Achieved	
	Number of programmes:	Enua Ola	30	31	30	Achieved	
		Asian groups	4	4	4	Achieved	
		Ethnic specific breastfeeding classes	3	3	3	Achieved	
	Number of sessions:	Enua Ola	1,200	1,200	1,200	Achieved	
		Asian groups	160	234	160	Achieved	
		Ethnic specific breastfeeding classes	44	42	48	Substantially achieved	
	Average attendance per session:	Enua Ola	30	27	30	Substantially achieved	
		Asian groups	n/a	32	30	Achieved	
		Ethnic specific breastfeeding classes	n/a	8	10	Substantially achieved	
	% of funding going to programmes with a logic model		0%	35%	25%	Achieved	
Health Policy/ Legislation Advocacy and Advice	Numbers of submissions made		17	24	✶		
	Submissions policy adhered to		unavailable	100%	100%	Achieved	
	Submission documents submitted by deadline		unavailable	100%	100%	Achieved	

Health Promotion & Health Policy/Legislation Advocacy and Advice Impact Measures				
Measure		2010/11 Result	2011/12 Result	Direction required for Improvement
Proportion of controlled purchase operations in which alcohol or tobacco product sales are sold to minors		Not available	Alcohol: 6% Tobacco: 4%	↓
Breastfeeding rates at:	six weeks	68%	65%	↑
	three months	58%	56%	
	six months	26%	25%	
* See graph in Early Detection and Management section				
Changes in draft legislation/regulation/policy made in response to submissions		Not available	24	↑

OUTPUT CLASS MEASURES: Prevention Services *continued*

Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Population Based Screening	Screening coverage rates among eligible groups: breast cancer	64.8%	68.9%	70%	Substantially achieved	
	Proportion of women screened who report that their privacy was respected	98%	99%	95%	Achieved	
	Proportion of women screened who receive their results within 10 working days	98.7%	96%	95%	Achieved	
	Screening coverage rates among eligible groups: bowel cancer	unavailable	54%	15%	Achieved	For invitations sent out between January-June 2012.
	Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure or any other investigations	unavailable	not avail	90%		The first customer satisfaction survey will be undertaken during the three months July/Aug/Sept 2012 i.e. six months after colonoscopy began, with findings reported in October 2013.
	Proportion of eligible individuals who are recalled for screening within 24 months of their previous invitation for screening	unavailable	not avail	95%		The first recalls will not occur until January 2014.

Population Based Screening Impact Measures			
Measure	2010/11 Result	2011/12 Result	Direction required for Improvement
Imputed years of life gained among Waitemata domiciled women through breast screening	15.96	15.73	↑
Imputed QALYs gained through bowel screening of Waitemata residents	n/a	50.36	↑

Early Detection and Management

Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Community Referred Testing and Diagnostics	Number laboratory tests by provider - DML	823,690	352,844	✶		12 months rolling average to March 2012 - full 2011/12 year not yet available, some volumes missing from LTA numbers.
	Number laboratory tests by provider - LTA	2,350,191	3,027,520	✶		
	Number radiological procedures	Incorrectly recorded 28,284	31,374	✶		This indicator was incorrectly recorded as total images. Should be community referred radiological procedures only - baseline being: 28,284 for 2010/11.
	Complaints as percentage of total no. of laboratory tests	0.02%	0.002%	↓	Achieved	
	Average waiting time in minutes for a sample of patients attending Waitemata DHB collection centres between 7am and 11am (peak collection time)	9.5 mins	7 mins	< 30 mins	Achieved	
	Percentage of critical test results phoned through to appropriate contact person within 1 hour (a. referrer, b. patient, c. police). (metro Auckland DHBs)	99%	99%	>98%	Achieved	

Community Referred Testing and Diagnostics Impact Measures			
Measure	**2010/11 Result**	**2011/12 Result**	**Direction required for Improvement**
The percentage of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing absolute CVD risk in the last five years	80.4%	84% (as at 31 March 2012)	↑

Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Oral Health	Enrolment rates in children under five	24,569	29,250	25,395	Achieved	
	Utilisation rates for adolescents	60.70%	61%	65%	Substantially achieved	The combined Auckland/Waitemata result would be 69% against a combined target of about 70%.
	Number of visits of preschool, and school children to oral health services (including adolescents)	124,272	113,232	142,857	Not achieved	There has been some disruption to services resulting from the roll-out of new dental facilities and models of care in the district which has impacted on arrears rates, numbers of visits and complaints. As new processes become embedded, performance in these measures should improve.
	Number of complaints for the financial year	10	15	↓	Not achieved	
	Arrears rates	13%	15%	10%	Not achieved	

Oral Health Impact Measures			
Measure	2010/11 Result	2011/12 Result	Direction required for Improvement
Percentage of children caries free and average Decayed , Missing and Filled Teeth of year 8 children by ethnic group	Caries free: 57% DMFT: 1.02	Caries free: 57% DMFT: 0.99	↑ ↓
Percentage of children caries free and average decayed , missing and filled Teeth of 5-year-old children by ethnic group	Caries free: 64% DMFT: 1.47	Caries free: 65% DMFT: 1.44	↑ ↓

Sub-Output Class	Output Measures		Baseline	2011/12	2011/12 Target	Achieved	Comments
Primary Care	Ethnic-specific primary care enrolment rates:	Asian	76%	77.74%	80%	Substantially achieved	
		Māori	74%	74.62%	80%	Substantially achieved	
	Immunisation health target achievement		90%	95%	95%	Achieved	
	Cervical screening coverage		76.1%	73.3%	not included		The way this measure is calculated has changed between 2010 and 2011. A metro-Auckland Cervical Screening Governance group has been established which will set up a coordination service charged with developing and implementing strategies to improve cervical screening coverage.
	Proportion of practices with cornerstone accreditation		50%	57%	↑	Achieved	RNZCGP website for accredited practices
	GMS claims from after-hours providers per 10,000 of population		465/10,000	413/10,000	✶		Note: result is for 2011 calendar year (data not yet available for 2011/12 year). Also, there were less public holidays in 2011 than previous year that fell on weekdays.

Primary Health Care Impact Measures			
Measure	2009 Result	2011 Result	Direction required for Improvement
Proportion of high grad cervical cytological abnormalities among the cohort of Waitemata women eligible for HPV immunisation	1.03%	1.95%	↓

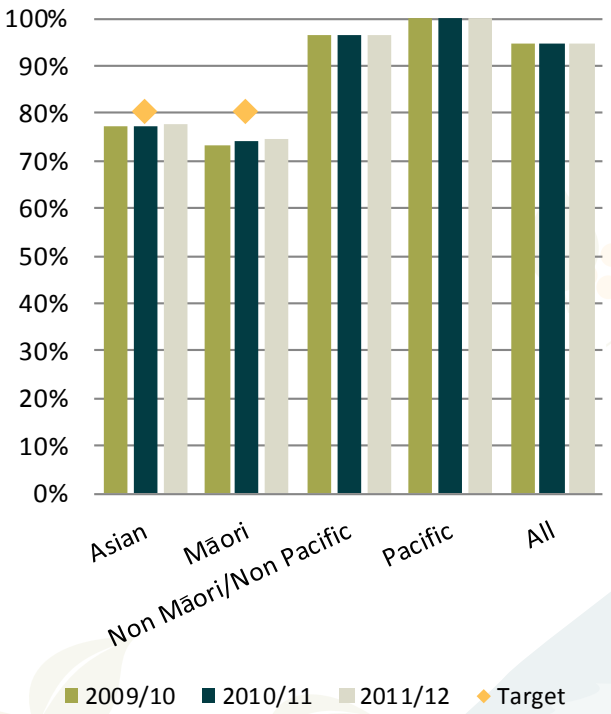
Primary Health Care Impact Measures							
Measure	2010/11 Result			2011/12 Result			Direction required for Improvement
Proportion of people with diabetes who receive free annual checks	55%			61%			↑
Proportion of people with diabetes who have satisfactory or better diabetes management	73%			73%			↑
Standardised acute:	ADHB	WDHB	CMDHB	ADHB	WDHB	CMDHB	
discharge rate	1.04	1.04	0.86	1.02	1.05	0.86	↓
case-weights	1.14	0.97	1.10	1.10	0.97	1.12	↑
trend and benchmarked against other DHBs							
The percentage of two year olds fully immunised by July 2012	*See Health Targets section above*						

OUTPUT CLASS MEASURES: Early Detection and Management *continued*

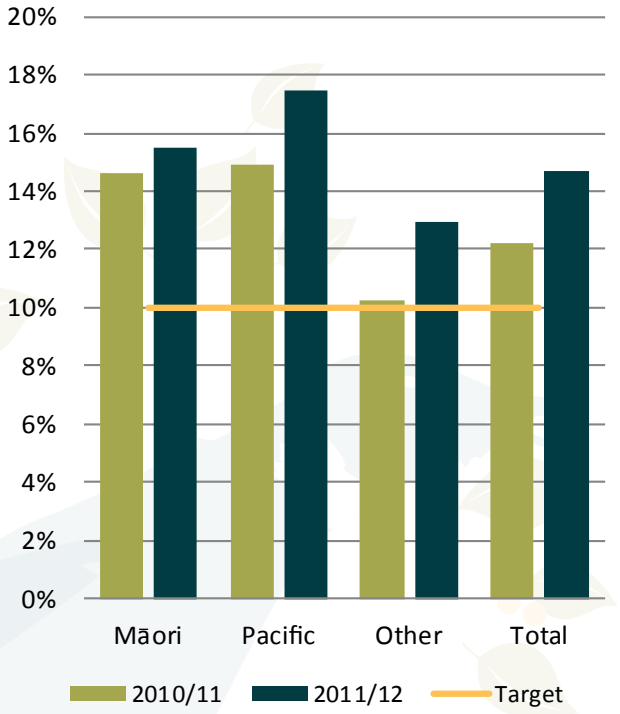
Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Pharmacy	Total value of subsidy provided	$107,012,646	$116,359,969	✶		
	Proportion of dispensing expenditures relative to expenditure on pharmaceuticals	29%	30%	✶		
	Number of prescriptions subsidised	5,943,760	6,468,103	✶		12 months rolling to Mar 12 (full 2011/12 data not yet available).
	Number of Medicine Use Reviews conducted by community pharmacy	unavailable	175	↑	Achieved	
	Proportion of prescriptions with a valid NHI number	97%	97%	95%	Achieved	
	The number of extended-hours pharmacies associated with after-hours accident and medical centres	4	4	4	Achieved	

Pharmacy Impact Measures			
Measure	2010/11 Result	2011/12 Result	Direction required for Improvement
Proportion of hypertensive patients (identified from hospital discharge records) who receive anti-hypertensive medication within six months of last discharge	85%	81%	↑

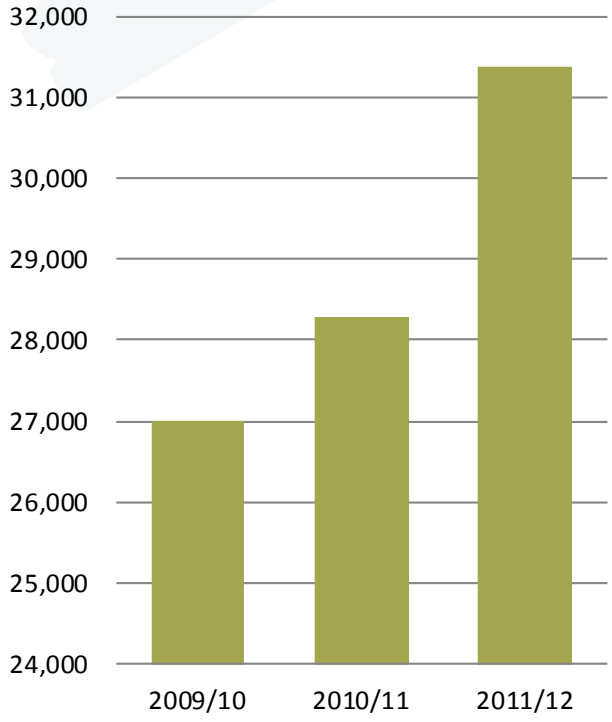
Percentage of Waitemata DHB Population enrolled with a PHO



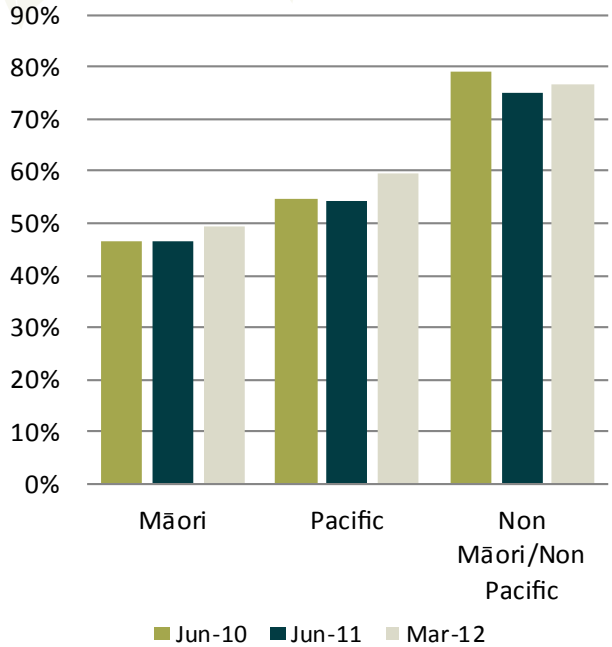
Percentage of children missing their annual free dental check



Number of community referred radiological procedures



Percentage of eligible population receiving cervical screen - 3 year coverage rates



Note: age group changed in 2012 from 20-69 years to 25-69 years

Māori Health Plan indicators

A key success has been the achievement of the immunisation health target for Māori children, the same level as for non-Māori in the district. Our focus remains on diabetes and CVD as we strive to achieve targets for Māori which are at the same level as non-Māori.

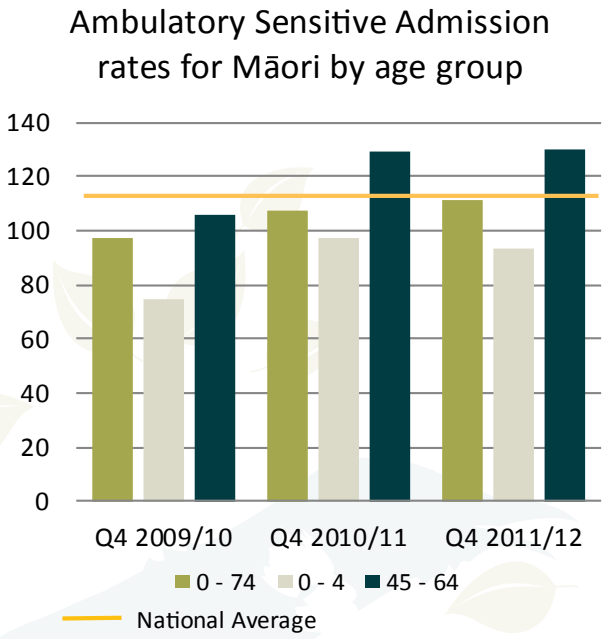
Waitemata DHB is realigning the current CVD risk assessment and Diabetes Assessment Review contracts and reports with PHOs to support the delivery of the CVD and diabetes targets. We continue to work with PHOs to align the PHO Māori Health Plans.

The funding previously allocated to Diabetes Get Checked will be utilised for a targeted approach for priority Māori, Pacific, Asian and other patients with poorly managed diabetes for 2012/13.

Waitemata DHB is currently looking to fund additional breastfeeding and lactation services to improve breastfeeding rates. Specifically these services would include:

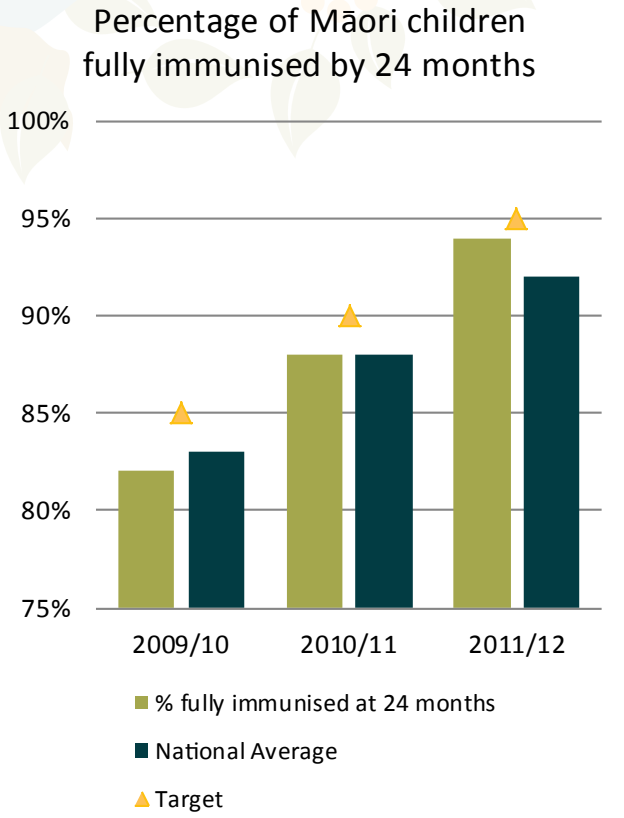
- Antenatal breastfeeding workshops
- Breastfeeding resources
- Lactation consultant Outpatient Services
- Lactation consultant Inpatient Services
- The continuation of the district wide Māori lactation service.

Ethnicity data collection by PHOs in the Waitemata district has previously been shown to require improvement. Quality PHO ethnicity data is necessary for the identification of local Māori health priorities, monitoring inequalities and allocating resources at the primary health care level. Work continues to improve practice level ethnicity misclassification to provide a true picture of enrolment and performance across a range of indicators.



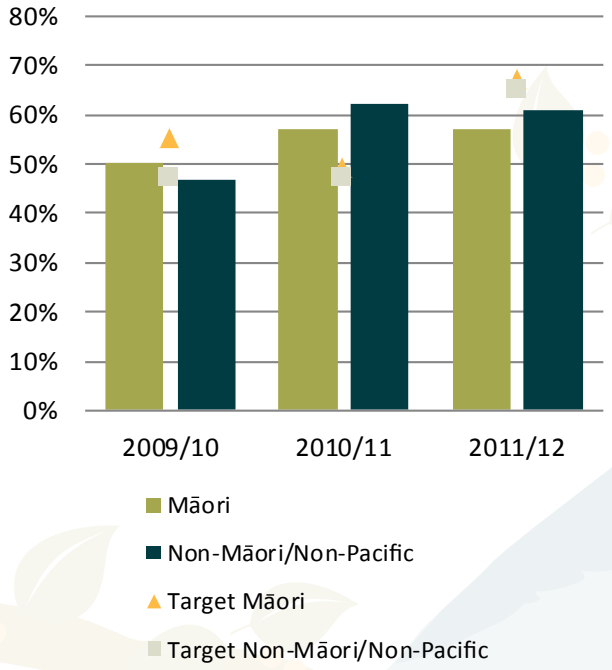
Measured 6 monthly

	Q2 2010/11	Q2 2011/12
0-74	105	104
0-4	97	90
45-64	115	130

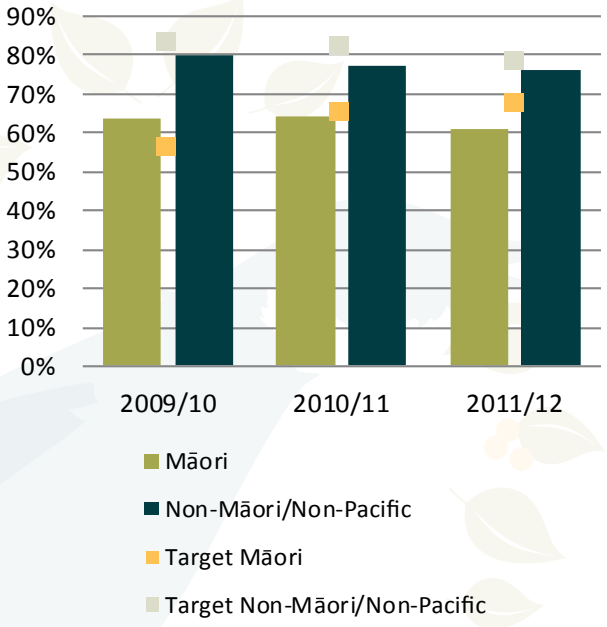


Māori Health Plan indicators

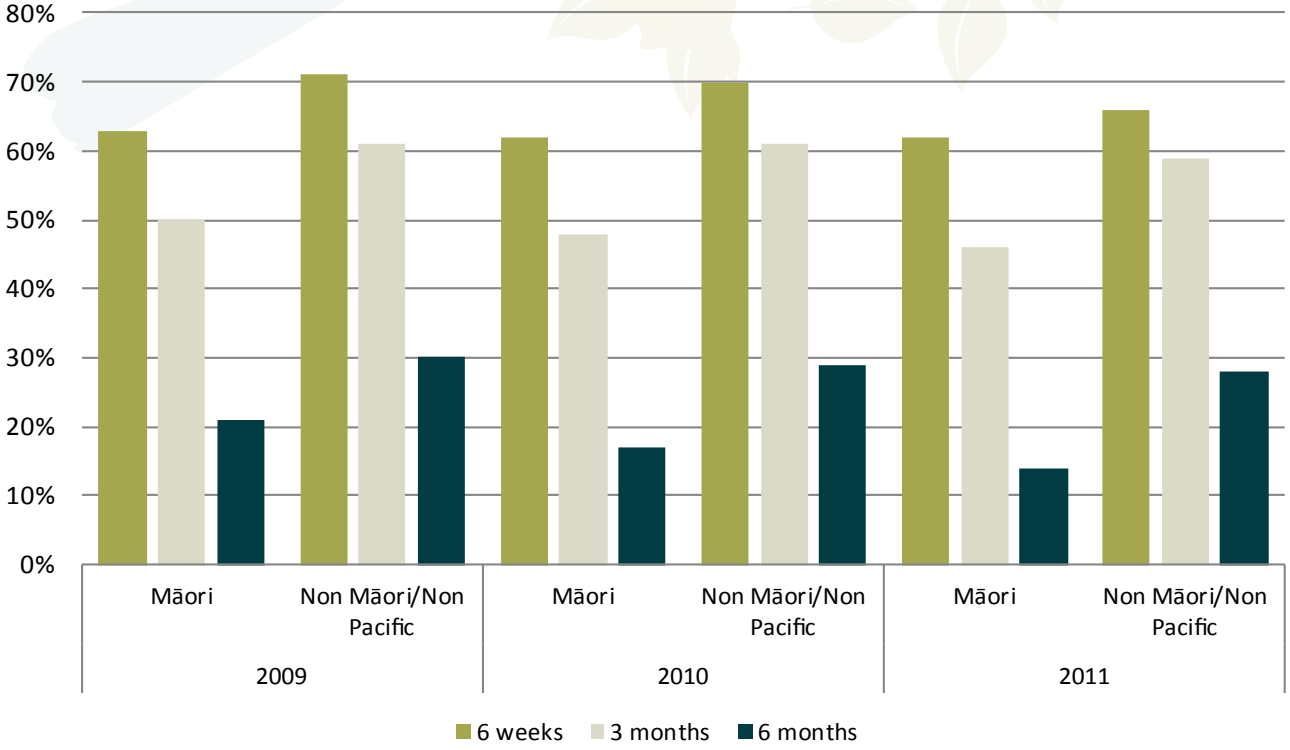
Percentage of Māori with diabetes attending free annual check: Get Checked



Percentage of Māori receiving Get Checked assessment with satisfactory or better diabetes management



Full and exclusive breastfeeding rates



OUTPUT CLASS MEASURES *continued*

Intensive Assessment and Treatment

Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Acute Services	Number of ED attendances	81,388	104,708	✶		
	Acute medical and surgical discharges	48,101	45,478	↓	Achieved	
	Readmission rates	10.21%	10.83%	10.21%	Substantially achieved	Q4 result.
	Proportion of the population living within 30 minutes travelling time of an ED service	93%	100%	90%	Achieved	
	Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival	80%	97%	95%	Achieved	Health Target.

Acute Services Impact Measures					
Measure	2010/11 Result	2011/12 Target	2011/12 Result	Achievement	Direction required for Improvement
Standardised mortality ratio	1.35%	Be among the four DHBs with the lowest standardised mortality ratio	1.44%	Amongst the eight lowest DHBs in the country	↓

** Note: result for year ending March 2012. Waitemata DHB's mortality rates have consistently been amongst the lowest nationally for the past 5 years.*

Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Maternity	Number of deliveries.	6,746	6,636	✶		
	Number of first obstetric consultations	2,628	3,269	✶		
	Number of subsequent obstetric consults	1,958	2,546	✶		
	Caesarean section rate	25.9%	26.58%	↓	Substantially achieved	
	Established breastfeeding at discharge	79.8%	78.35%	75%	Achieved	
	Documentation of smoking status and offer of help to quit	81%	100%	95%	Achieved	Health Target - result as at 30/6/2012.
	Proportion of women with antenatal BMI calculated	n/a	98.24%	97.3%	Achieved	
	Gestation at first booking	n/a	20.32%	21.60%	Substantially Achieved	Proportion in first trimester (first 13 weeks) at first booking.

Maternity Impact Measures			
Measure	2010/11 Result	2011/12 Result	Direction required for Improvement
Third/fourth degree tears for all first births	29	23	↓
APGAR score <=6 at 5 mins for live term infants	100	96	↓
Blood loss>= 1500ml following a vaginal birth	57	49	↓

OUTPUT CLASS MEASURES: Intensive Assessment and Treatment *continued*

Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Elective (Inpatient/ Outpatient)	Compliance with national health target for surgical discharges	12,859	15,891	14,771	Achieved	Health Target.
	Standardised elective surgical intervention rate	264.37/ 10,000	294.54/ 10,000	292/ 10,000	Achieved	Note: data pertains to 2011 calendar year.
	Number of case-weights in relation to health target	17,479.71	21,899.70	Incorrectly recorded 20,460.4	Achieved	
	Number of outpatient consultations	105,830	114,998	✸		
	Readmission rates					Not able to be calculated for electives separately.
	Post-operative hospital-acquired bacteraemia rates	0.05%	0.002%	↓	Achieved	
	Patients waiting longer than six months for their first specialist assessment (FSA)	1.2%	0%	0%	Achieved	Q4 result.
	Patients given a commitment to treatment but not treated within six months	3.2%	0%	0%	Achieved	Q4 result.

Elective (inpatient/outpatient) Impact Measures			
Measure	2010/11 Result	2011/12 Result	Direction required for Improvement
Total QALYs (Quality Adjusted Life Years) gained from the five Ministry of Health selected procedures calculated as the number of procedures multiplied by QALYs per procedure as follows:			
Hip replacement (primary) = 0.85	335	334	
Hip replacement (revision) = 0.15	8	8	↑
Knee replacement (primary) = 0.8	330	425	
Cataract = 1.1	1,373	1,924	
CABG = 1.3	221	315	
PCI = 1.64	1,168	1,073	

OUTPUT CLASS MEASURES: Intensive Assessment and Treatment *continued*

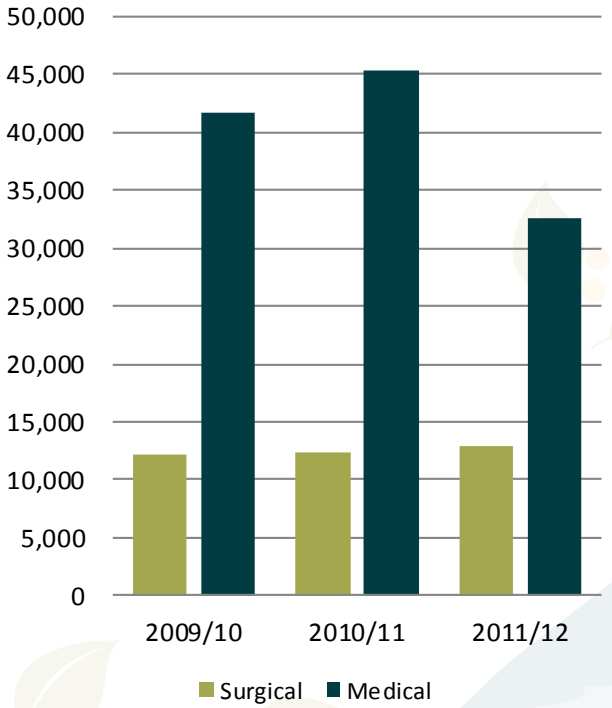
Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Assessment Treatment and Rehabilitation (Inpatient)	AT&R Bed days	35,474	37,502	✶		
	Average no. of falls per 1,000 occupied bed days	13	10	↓	Achieved	
	AT&R average waiting time (waitlist date to transfer to AT&R)	unavailable	4.7 days	≤ 4 days	Partly achieved	Acute demand pressure has increased demand on this service and therefore the time taken to transfer patients to the service.

Assessment Treatment and Rehabilitation (Inpatient) Impact Measures	
Measure	**2011/12 Result**
The proportion of patients with an improvement in function between AT&R admission and discharge as measured by the Barthel Index	Not available - the service are no longer using the Barthel and are now measuring function using the FIM (Functional Independence Measure), which is not electronically recorded yet

OUTPUT CLASS MEASURES: Intensive Assessment and Treatment *continued*

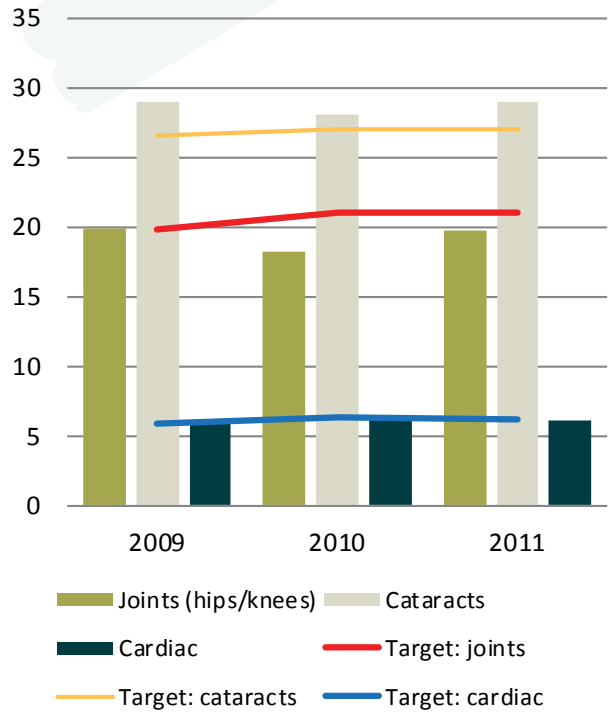
Sub-Output Class	Output Measures		Baseline	2011/12	2011/12 Target	Achieved	Comments
Mental Health	Access Rates for total and specific population groups (defined as the proportion of the population utilising MH&A services in the last year):	Māori 0-19 years	3.38%	3.52%	3.48%	Achieved	
		Māori 20-64 years	6.81%	7.41%	6.86%	Achieved	
		Other 0-19 years	2.40%	2.45%	2.50%	Substantially achieved	
		Other 20-64 years	3.12%	3.10%	3.15%	Substantially achieved	
		Total 0-19 years	2.55%	2.62%	2.65%	Substantially achieved	
		Total 20-64 years	3.43%	3.46%	3.47%	Achieved	
		Total 65+ years	2.71%	2.42%	2.76%	Partly achieved	There are access issues due to limited inpatient mental health beds for older adults in Waitemata DHB. Multiple initiatives are underway to address this.
	Proportion of long term clients with Relapse Prevention Plan (RPP) in the above population groups:	Adult	98%	97.5%	95%	Achieved	
		Child & Youth	84%	94.12%	95%	Substantially achieved	
	Alcohol and drug service waiting times and waiting list report – waiting times should fall within target for maximum waiting time for each service:	Inpatient detoxification (maximum waiting time)	< 21 days	< 21 days	< 21 days	Achieved	
		Specialist prescribing (maximum waiting time)	< 7 days	< 7 days	< 7 days	Achieved	
		Structured counselling (maximum waiting time)	0 days	21 days	0 days	Not achieved	One organisation shuts down completely for a month over Christmas which impacts on the waiting times for this service.

Acute medical and surgical discharges

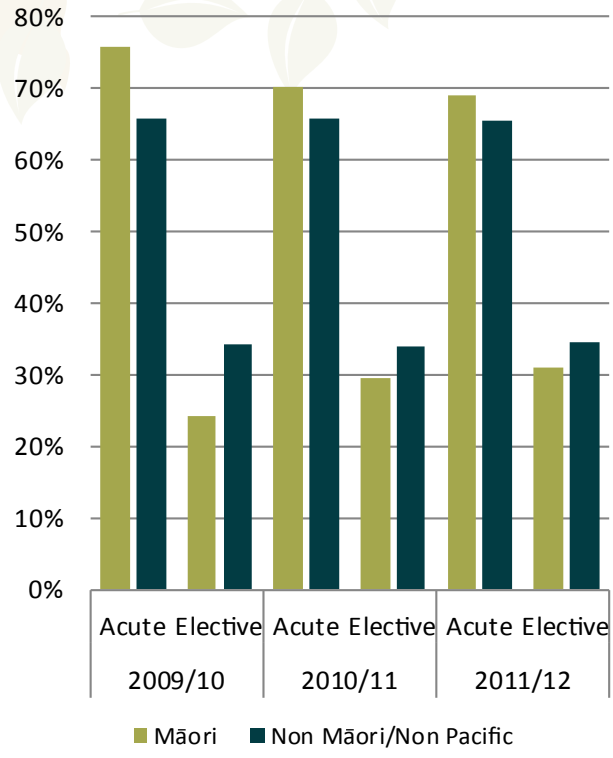


Obstetric Consultations

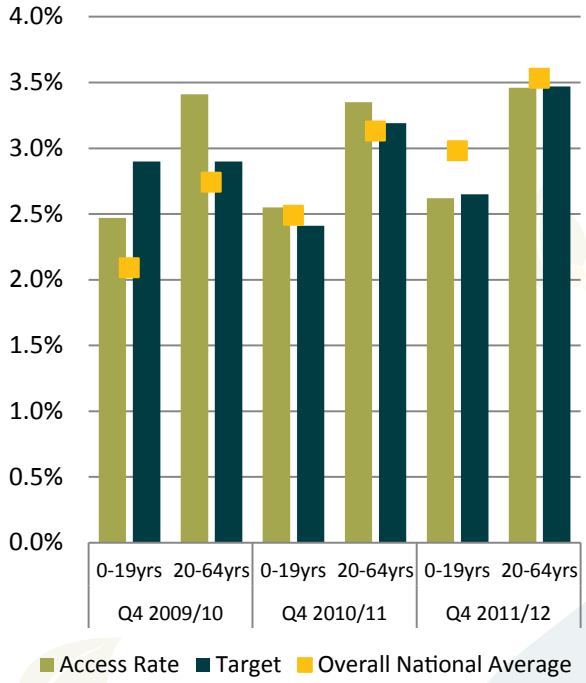
Surgical Intervention rates per 10,000 population



Caesarian section rate



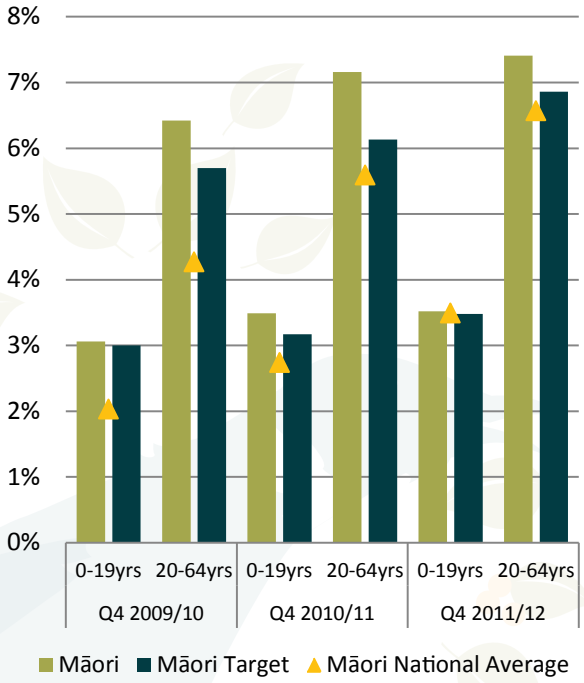
Access rates to mental health services by age group



Measured 6 monthly

	Q2 2010/11	Q2 2011/12
0-19 years	2.55%	2.62%
20-64 years	3.43%	3.43%

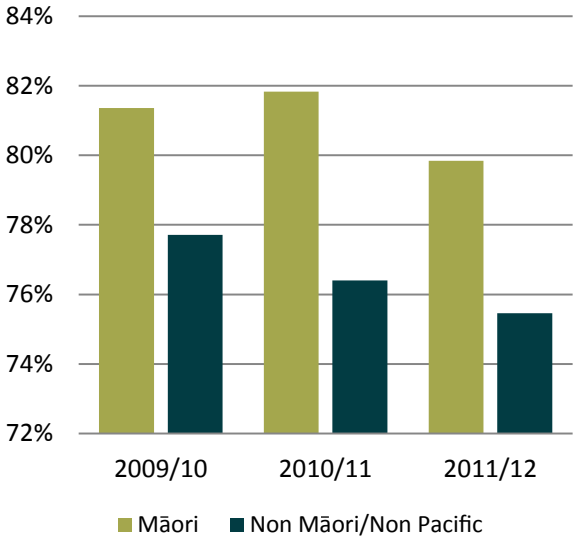
Māori access rates to mental health services by age group



Measured 6 monthly

	Q2 2010/11	Q2 2011/12
0-19 years	3.38%	3.6%
20-64 years	6.81%	7.5%

Exclusive Breastfeeding at Hospital Discharge



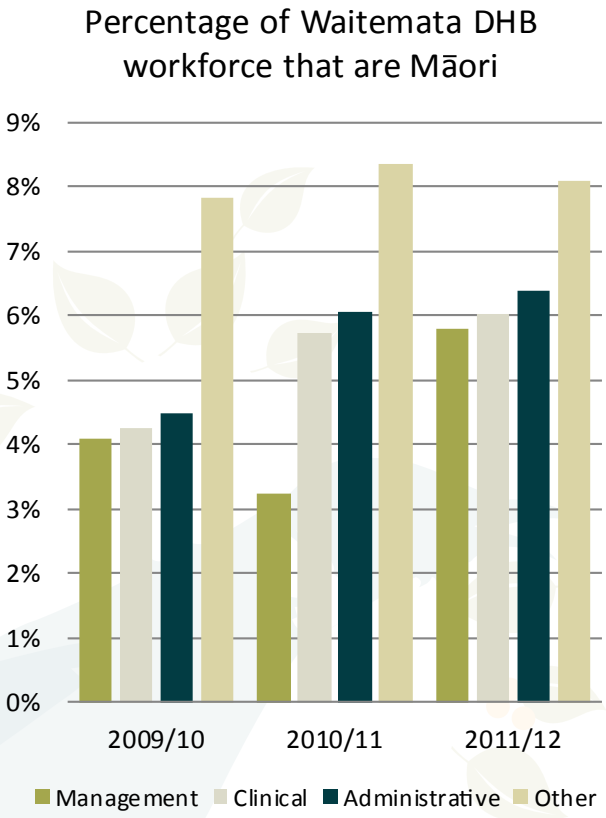
Māori Health Plan indicators

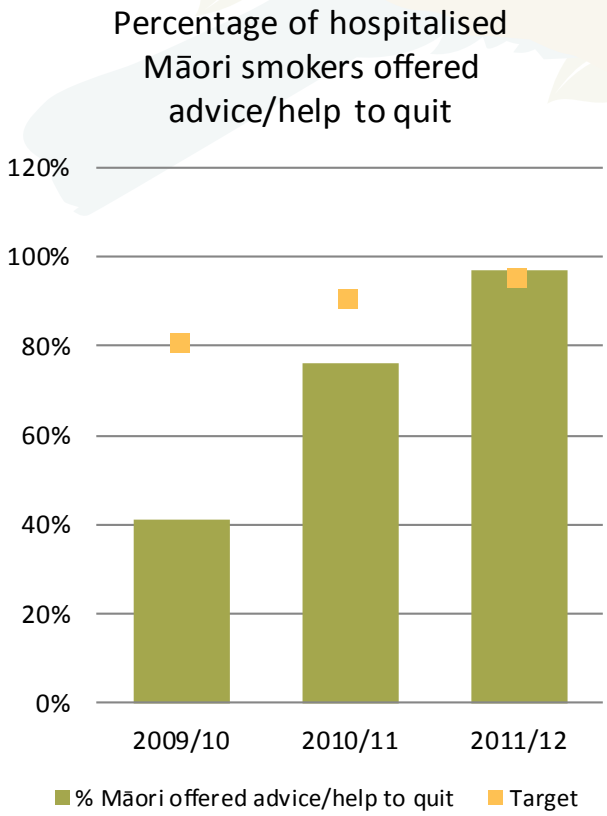
Māori Health staff from both Auckland and Waitemata DHBs are working closely to reconfigure Māori health services and align strategies and consolidate the workforce across Auckland. Both Māori and Pasifika utilisation of services is higher than their representation within the overall workforce. We are working with the Kia Ora Hauora work programme (Health Workforce New Zealand) to:

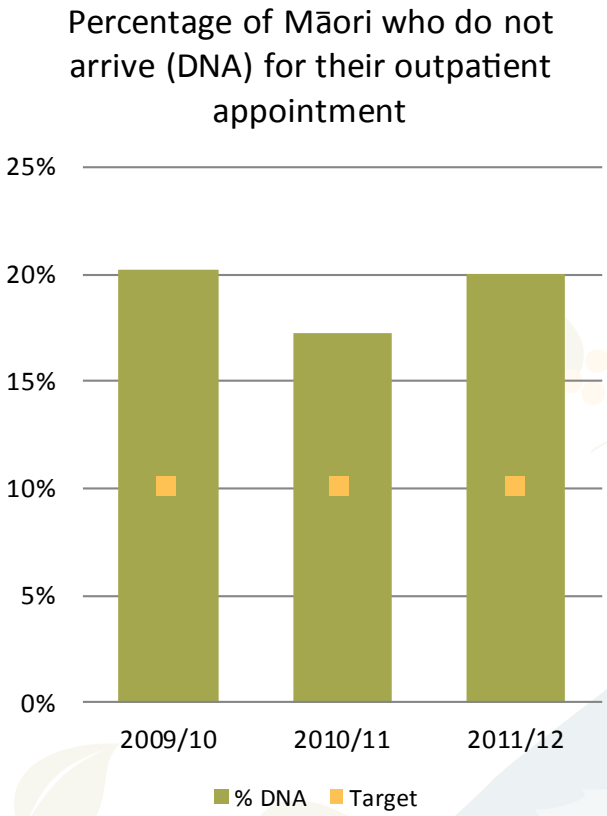
- work with careers advisors and subject teachers to promote science subjects at school
- create opportunities to engage with priority schools that show the link between health and science
- ensure all students engaged in the programme have access to the WDHB scholarship programme to reduce financial barriers
- ensure all students engaged in the programme have a focus on career development planning.

We have also been involved in supporting the development of a Health & Science Academy at Hato Petera College.

The percentage of Māori hospitalised smokers offered advice and help to quit is the same as the overall result, exceeding target at 97%.







Reducing DNA rates for Māori is a particular area of focus going forward.

Telephone contact prior to booked appointment is now occurring for both Māori and Pacific patients. Also, a questionnaire has been designed to understand the reasons for DNA. Those patients who DNA on more than three consecutive occasions will be asked to complete the survey. The results should assist us to formulate strategies for reducing DNA rates.

Rehabilitation and Support Services

Sub-Output Class	Output Measures		Baseline	2011/12	2011/12 Target	Achieved	Comments
Home Based Support	Average number of hours per month of home based support services for:	Personal care	52,300	56,760	↑	Achieved	The aging population has resulted in a huge increase in the number of hours required for personal care services. Correspondingly HBSS have reduced the amount of hours dedicated to household management, as the service focuses primarily on the health needs of its clients.
		Household management	26,280	22,235	↑	Partly achieved	
	Number of complaints received regarding home based support		0	0	Maintain	Achieved	
	Percentage of NASC clients assessed within 6 weeks		95%	91%	95%	Substantially achieved	

Home Based Support Impact Measures			
Measure	2010/11 Result	2011/12 Result	Direction required for Improvement
Proportion of people over 65 years receiving HBSS	15%	14%	↑
Proportion of people [population] in residential care aged over 65	3.96%	3.97%	Maintain or ↓
Hospitals discharge rates for falls where the fall occurred at home	n/a	This measure was removed from the suite of DHB reporting requirements by the Ministry of Health who were to supply the data	↓
Proportion of people assessed to have high or very high needs who reside in their own home	34%	36%	↑
InterRAI depression rating scale change since assessment	Can only be measured by ad-hoc audit which did not occur during 2010/11	Can only be measured by ad-hoc audit which has not occurred during 2011/12	

OUTPUT CLASS MEASURES: Rehabilitation and Support Services *continued*

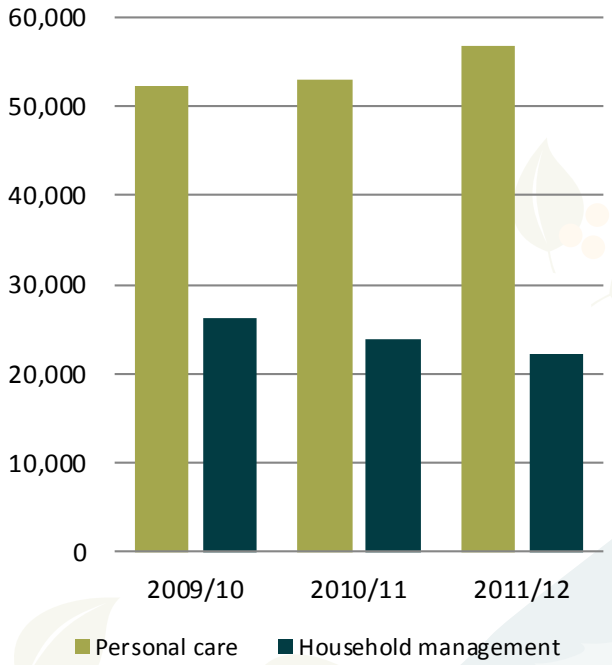
Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Palliative Care	Hospice palliative care bed day occupancy	68%	94.90%	↑	Achieved	Of funded beds (13).
	Number of people who died while receiving hospice care	896	895	✶		
	Numbers of initial hospice assessments	889	889	✶		
	Specialist palliative care consults (hospice)	2,742	2,947	✶		
	Overall patient satisfaction with hospice services (community and inpatient)	95%	99%	↑	Achieved	

Palliative Care Impact Measures		
Measure	**2009 Result**	**Direction required for Improvement**
Proportion of deaths from palliative conditions occurring outside of hospitals	29.5%	↑

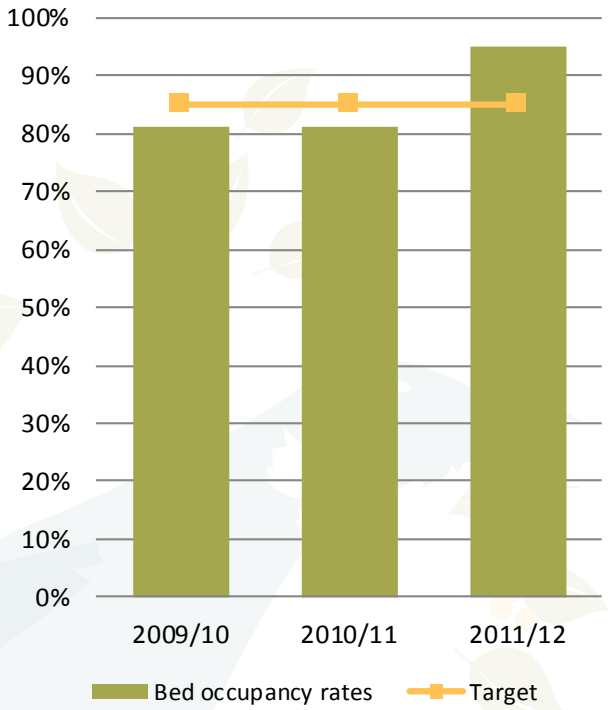
Sub-Output Class	Output Measures	Baseline	2011/12	2011/12 Target	Achieved	Comments
Residential Care	Total number of subsidised aged residential care bed days	705,486	776,293	✶		12 months to end of March 2012.
	Rest home audit reports	40/60	30/58	↑	Partly achieved	Note: these are certification audits. Facilities can be certified for 1, 2 or 3 years and when ownership changes which determines how many are completed annually.
	Number of complaints received about aged residential care provider/s	16	15	↓	Achieved	
	Percentage of NASC clients assessed within 6 weeks	95%	91%	95%	Substantially achieved	

Residential Care Impact Measures	
Measure	**2011/12 Result**
Standardised acute admission rates from residential care	1,720/100,000 65+ population
Hospitals discharge rate for falls where the fall occurred in a residential institution	This measure was removed from the suite of DHB reporting requirements by the Ministry of Health who were to supply the data
InterRAI depression rating scale change since assessment	Can only be measured by ad-hoc audit which has not occurred during 2011/12

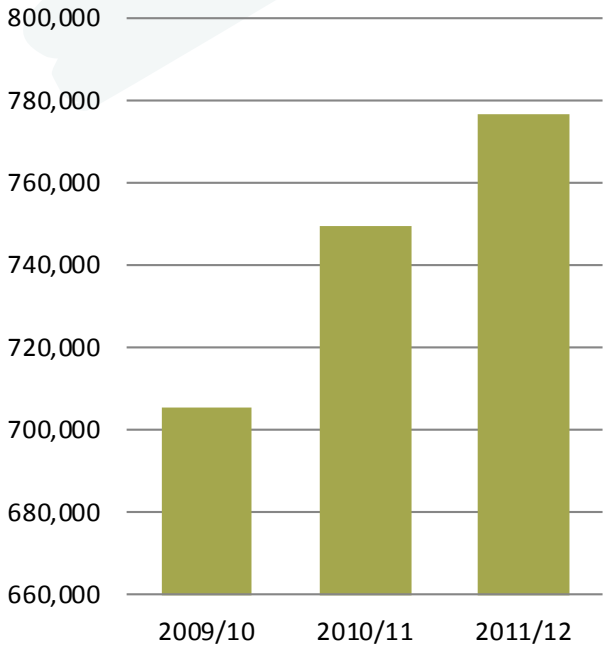
Average number of hours per month of home based support services



Bed occupancy rates: hospice beds



Total number of subsidised aged residential care bed days



Number of complaints received about aged residential care providers

FINANCIAL STATEMENTS

WAITEMATA DISTRICT HEALTH BOARD 2011-12

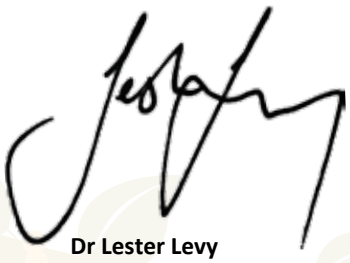
Prepared under New Zealand equivalents to International Financial Reporting Standards.

STATEMENT OF RESPONSIBILITY

The Board is responsible for the preparation of the Waitemata District Health Board and group's financial statements and the statement of service performance, and for the judgements made in them. The Board of the Waitemata District Health Board have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the Board's opinion, these financial statements and statement of service performance fairly reflect the financial position and operations of the Waitemata District Health Board for the year ended 30 June 2012.

Signed on behalf of the Board:



Dr Lester Levy
Chairperson
31 October 2012

Max Abbott
Board Member
31 October 2012

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2012

		Group		Parent		
		Actual	Actual	Actual	Budget	Actual
		2012	2011	2012	2012	2011
	Notes	$000	$000	$000	$000	$000
Income						
Patient care revenue	2	1,344,411	1,293,818	1,344,293	1,340,837	1,293,790
Interest Income		3,820	5,149	3,486	3,448	4,701
Other income	3	26,922	22,628	26,762	22,555	21,731
Total income	31	1,375,153	1,321,595	1,374,541	1,366,840	1,320,222
Expenditure						
Personnel costs	4	477,224	447,634	477,224	467,217	447,634
Depreciation and amortisation expense	13,14	21,322	23,784	21,322	24,593	23,784
Outsourced services		52,654	42,724	52,654	37,735	42,724
Clinical supplies		81,090	71,787	81,090	78,757	71,787
Infrastructure and non-clinical expenses		53,837	54,023	53,837	52,061	54,023
Other district health boards		335,168	304,310	335,168	315,234	304,310
Non-health board provider expenses		320,279	344,078	320,279	358,203	344,078
Capital charge	5	12,406	14,222	12,406	14,222	14,222
Interest expense		11,350	10,356	11,290	15,262	10,305
Other expenses	6	5,003	4,372	4,262	3,556	3,803
Total expenditure	31	1,370,333	1,317,290	1,369,532	1,366,840	1,316,670
Share of associate surplus / (deficit)	12	0	0	0	0	0
Surplus / (deficit)		**4,820**	**4,305**	**5,009**	**0**	**3,552**
Other comprehensive income						
Impairment of land and buildings	19	(2,588)	(6,400)	(2,588)	0	(6,400)
Revaluation of land and buildings	19	(540)	(4,116)	(540)	0	(4,116)
Total other comprehensive income (expense)		(3,128)	(10,516)	(3,128)	0	(10,516)
Total comprehensive income / (expense)		**1,692**	**(6,211)**	**1,881**	**0**	**(6,964)**

Explanations of major variances against budget are provided in note 31.

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 30 JUNE 2012

		Group		Parent		
		Actual	Actual	Actual	Budget	Actual
		2012	2011	2012	2012	2011
	Notes	$000	$000	$000	$000	$000
Balance at 1 July		165,709	166,299	159,693	167,957	161,036
Comprehensive income / (expense)						
Surplus / (deficit) for the year		4,820	4,305	5,009	0	3,552
Other comprehensive income		(3,128)	(10,516)	(3,128)	0	(10,516)
Total comprehensive income		**1,692**	**(6,211)**	**1,881**	**0**	**(6,964)**
Owner transactions						
Capital contributions from the Crown		5,191	5,621	5,191	5,288	5,621
Balance at 30 June	**19**	**172,592**	**165,709**	**166,765**	**173,245**	**159,693**

Explanations of major variances against budget are provided in note 31.

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2012

	Notes	Group Actual 2012 $000	Group Actual 2011 $000	Parent Actual 2012 $000	Parent Budget 2012 $000	Parent Actual 2011 $000
Assets						
Current assets						
Cash and cash equivalents	7	69,473	53,634	68,677	4,604	52,516
Debtors and other receivables	8	25,628	27,838	25,771	30,500	27,811
Investments	9	1,302	1,981	0	0	0
Inventories	10	5,012	4,961	5,012	6,000	4,961
Prepayments		527	61	527	500	61
Non-current assets held for sale	11	0	8,551	0	0	8,551
Total current assets		101,942	97,026	99,987	41,604	93,900
Non-current assets						
Investments	9	13,383	3,288	9,535	0	0
Property, plant and equipment	13	466,804	434,596	466,804	519,014	434,596
Intangible assets	14	0	4,266	0	5,419	4,266
Total non-current assets		480,187	442,150	476,339	524,433	438,862
Total assets		**582,129**	**539,176**	**576,326**	**566,037**	**532,762**
Liabilities						
Current liabilities						
Creditors and other payables	15	95,504	103,891	95,528	82,087	103,493
Borrowings	16	100,313	34,237	100,313	0	34,237
Employee entitlements	17	71,853	62,467	71,853	64,330	62,467
Provisions	18	441	562	441	655	562
Total current liabilities		268,111	201,157	268,135	147,072	200,759
Non-current liabilities						
Borrowings	16	120,936	153,958	120,936	225,920	153,958
Employee entitlements	17	20,490	18,352	20,490	19,800	18,352
Total non-current liabilities		141,426	172,310	141,426	245,720	172,310
Total liabilities		**409,537**	**373,467**	**409,561**	**392,792**	**373,069**
Net assets		**172,592**	**165,709**	**166,765**	**173,245**	**159,693**
Equity						
Crown equity	19	103,015	97,824	103,015	102,776	97,824
Accumulated surpluses / (deficits)	19	(63,491)	(68,500)	(63,491)	(70,416)	(68,500)
Revaluation reserves	19	127,241	130,369	127,241	140,885	130,369
Trust funds	19	5,827	6,016	0	0	0
Total equity		**172,592**	**165,709**	**166,765**	**173,245**	**159,693**

Explanations of major variances against budget are provided in note 31.

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2012

	Notes	Group Actual 2012 $000	Group Actual 2011 $000	Parent Actual 2012 $000	Parent Budget 2012 $000	Parent Actual 2011 $000
Cash flows from operating activities						
Receipts from patient care:						
MoH		1,331,796	1,393,868	1,331,796	1,330,056	1,393,868
Other		41,508	33,194	40,026	34,879	30,720
Interest received		3,465	5,184	3,119	1,905	4,905
Payments to suppliers		(850,799)	(913,493)	(848,564)	(845,552)	(911,968)
Payments to employees		(464,699)	(437,478)	(464,699)	(467,217)	(437,478)
Capital charge		(15,182)	(12,130)	(15,182)	(14,222)	(12,130)
Interest payments		(11,197)	(10,083)	(11,197)	(15,262)	(10,083)
Goods and services tax (net)		965	(6,127)	965	(4,000)	(6,127)
Net cash flow from operating activities	20	35,857	52,935	36,264	20,587	51,707
Cash flows from investing activities						
Receipt from sale of property, plant and equipment		0	52	0	0	52
Receipt from sale or maturity of investments		85	0	0	0	0
Purchase of property, plant and equipment		(58,423)	(59,604)	(58,423)	(63,916)	(59,604)
Purchase of intangible assets		0	(1,160)	0	0	(1,160)
Acquisition of investments		0	(1,770)	0	0	0
Net cash flow from investing activities		(58,338)	(62,482)	(58,423)	(63,916)	(60,712)
Cash flows from financing activities						
Capital contributions from the Crown		5,190	5,621	5,190	5,288	5,621
Proceeds from borrowings		33,130	22,000	33,130	23,540	22,000
Repayment of borrowings		0	0	0	0	0
Net cash flow from financing activities		38,320	27,621	38,320	28,828	27,621
Net (decrease) / increase in cash and cash equivalents		**15,839**	**18,074**	**16,161**	**(14,501)**	**18,616**
Cash and cash equivalents at the start of the year		53,634	35,560	52,516	19,105	33,900
Cash and cash equivalents at the end of the year	7	**69,473**	**53,634**	**68,677**	**4,604**	**52,516**

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

Explanations of major variances against budget are provided in note 31.

The accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1 STATEMENT OF ACCOUNTING POLICIES FOR THE YEAR ENDED 30 JUNE 2012

REPORTING ENTITY

The Waitemata District Health Board (the DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown.

The consolidated financial statements of WDHB for the year ended 30 June 2012 comprise WDHB and its subsidiaries (together referred to as "Group") and WDHB's interest in associates and jointly controlled entities. The WDHB group consists of the parent, Waitemata District Health Board and Three Harbours Health Foundation (controlled by Waitemata District Health Board), joint ventures are healthAlliance N.Z. Limited (20%), Health Innovation Hub Limited (25%), Awhina Health Campus and associate companies are Northern Regional Training Hub Ltd (33%) (formerly Auckland Regional RMO Service Limited) and Northern DHB Support Agency (34%).

The DHB's subsidiary, associates and joint venture are incorporated and domiciled in New Zealand.

The DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. Accordingly, the DHB has designated itself and the group as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

The DHB has reported in note 30 on the patient trust monies which it administers.

The financial statements for the DHB are for the year ended 30 June 2012, and were approved by the Board on 31 October 2012.

BASIS OF PREPARATION

Statement of compliance
The financial statements of the DHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement base
The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land, and buildings.

Functional and presentation currency
The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the DHB, its subsidiary, associates and joint ventures is New Zealand dollars (NZ$).

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

Early adopted amendments to standards
The following amendments to standards have been early adopted:

- Amendments to NZ IAS 1 Presentation of Financial Statements. The amendments introduce a requirement to present, either in the statement of changes in equity or the notes, for each component of equity, an analysis of other comprehensive income by item. The DHB has decided to present this analysis in note 19.

- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – The purpose of the new standard and amendments is to harmonise Australian and New Zealand accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The main effect of the amendments on the DHB is that certain information about property valuations is no longer required to be disclosed. Note 13 has been updated for these changes.

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

- NZ IFRS 9 *Financial Instruments will* eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1: Classification and Measurement, Phase 2: Impairment Methodology, and Phase 3: Hedge Accounting. Phase 1: Has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

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

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

Compliance with the Crown Entities Act
Section 139(2) of the Crown Entities Act 2004 requires WDHB in its Statement of Intent to include two forecast financial statements, the first for the parent and the second for the group. WDHB did not comply with this requirement in respect of its Statement of Intent for 2011/12.

SIGNIFICANT ACCOUNTING POLICIES

Subsidiaries

Subsidiaries are entities in which WDHB has the capacity to determine the financing and operating policies and from which it has entitlement to significant ownership benefits. The financial statements include WDHB and its subsidiaries, the acquisition of which are accounted for using the purchase method. The effects of all significant intercompany transactions between entities are eliminated on consolidation. In WDHB's financial statements, investments in subsidiaries are recognised at cost less any impairment losses.

The DHB does not consolidate its subsidiary Milford Secure Properties as it is dormant and is not material.

Joint ventures
A joint venture is a contractual arrangement whereby two or more parties undertake an economic activity that is subject to joint control.

Waitemata DHB is party to three joint ventures arrangements. One is a jointly controlled operation; Awhina Health Campus. The DHB recognises in its financial statements the assets it controls, the revenue that it earns, the liabilities and expenses that it incurs from this joint operation.

The second joint venture is healthAlliance N.Z. Limited, which is a jointly controlled entity. The interest in this joint venture is not accounted for as it is not material to Waitemata District Health Board.

The third joint venture is Health Innovation Hub Limited, which is a jointly controlled entity. The interest in this joint venture is not accounted for as it is not material to Waitemata District Health Board.

Associate

An associate is an entity over which the DHB has significant influence and that is neither a subsidiary nor an interest in a joint venture. The interests in Northern DHB Support Agency and Northern Regional Training Hub Ltd (formerly Auckland Regional RMO Service Limited) are not accounted for as they are not material to Waitemata District Health Board.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

MOH revenue

The DHB is primarily funded through revenue received from the MoH, which is restricted in its use for the purpose of the DHB meeting its objectives.
Revenue from the MoH is recognised as revenue when earned.

ACC contracted revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Revenue from other DHBs

Inter district patient inflow revenue occurs when a patient treated within the Waitemata DHB region is domiciled outside of Waitemata. The MoH credits Waitemata DHB with a monthly amount based on estimated patient treatment for non Waitemata residents within Waitemata. An annual wash up occurs at year end to reflect the actual non Waitemata patients treated at Waitemata DHB.

Interest income

Interest income is recognised using the effective interest method.

Rental income

Lease income under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Provision of services

Revenue derived through the provision of services to third parties is recognised in proportion to the stage of completion at the balance date.

Donations and bequests

Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/(deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Interest expense

The DHB has elected to defer the adoption of the revised NZ IAS 23 *Borrowing Costs (Revised 2007)* in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities. Therefore, all borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ$ (the functional currency) using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.

Bank overdrafts are shown within borrowings in current liabilities in the statement of financial position.

Debtors and other receivables

Debtors and other receivables are recorded at their face value, less any provision for impairment.

A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

A bank deposit is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the bank, probability that the bank will enter into receivership or liquidation, and default in payments are considered indicators that the deposit is impaired.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. The loss of service potential of inventories held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the period of the write-down.

Non-current assets held for sale
Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised. Non-current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment
Property, plant, and equipment consist of the following asset classes:

- land;
- buildings;
- clinical equipment;
- IT equipment; and
- other equipment and motor vehicles.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations
Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years.

The carrying values of land and buildings are assessed annually by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive income and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive income.

Additions
The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

Work in progress is recognised at cost, less impairment, and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

Disposals
Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses.

Subsequent costs
Costs incurred subsequent to initial acquisition are capitalised only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation
Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Buildings (including components) 6 to 60 years (1.67%-16.67%)
Clinical equipment 3 to 20 years (5%-33%)
Other equipment and motor vehicles 3 to 15 years (6.67%-33%)
IT Equipment 5 to 15 years (6.67%-20%)

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

Intangible assets
Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Acquired software 3 to 5 years (20% - 33%)
Internally developed software (20% - 33%)

Impairment of property, plant, and equipment and intangible assets
Property, plant, and equipment and intangible assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the service potential of the asset is not primarily dependent on the asset's ability to generate net cash inflows and where the DHB would, if deprived of the asset, replace its remaining service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Creditors and other payables
Creditors and other payables are generally settled within 30 days so are recorded at their face value.

Borrowings
Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date. Borrowings where the DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date are classified as current liabilities if the DHB expects to settle the liability within 12 months of the balance date.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

Long-term entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the
- likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows for entitlements. The inflation factor is based on the expected long-term increase in remuneration for employees.

Presentation of employee entitlements

Sick leave, continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, sabbatical leave, and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

Employer contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditure will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are not recognised for future operating losses.

Restructuring

A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Partnership Programme

The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of two years up to a specified maximum amount. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for on-going claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are

discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity
Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- Crown equity;
- accumulated surpluses;
- revaluation reserves; and
- trust funds.

Revaluation reserves
These reserves are related to the revaluation of land and buildings to fair value.

Trust funds
This reserve records the unspent amount of donations and bequests provided to Three Harbours Health Foundation.

Goods and services tax
All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax
The DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

Budget figures
The budget figures are derived from the statement of intent as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Cost allocation
The DHB has determined the cost of outputs using the cost allocation system outlined below.

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

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions
In preparing these financial statements, the Board has made estimates and assumptions concerning the future.

These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations
Note 13 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

Employee entitlements valuations
Note 17 provides information about the estimates and assumptions applied in the measurement of revalued employee entitlements. The most recent valuation of sick, long service and retiring leave were performed by a registered independent valuer, Aon New Zealand and the valuation is effective as at 30 June 2012.

Estimating useful lives and residual values of property, plant, and equipment
The useful lives and residual values of property, plant, and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires the DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the DHB, and expected disposal proceeds (if any) from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciable amount of an asset, therefore affecting the depreciation expense recognised in the surplus or deficit and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second-hand market prices for similar assets; and
- analysis of prior asset sales.

The DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Critical judgements in applying accounting policies
Management has exercised the following critical judgements in applying accounting policies:

Leases classification
Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

The DHB has exercised its judgement on the appropriate classification of leases, and has determined a number of lease arrangements are finance leases.

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

2 PATIENT CARE REVENUE

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Health and disability services (MoH contracted revenue)	1,250,715	1,201,312	1,250,715	1,201,312
ACC contract revenue	9,231	8,759	9,231	8,759
Inter district patient inflows	74,869	76,764	74,869	76,764
Revenue from other district health boards	3,594	2,386	3,476	2,358
Other patient sourced revenue	6,002	4,597	6,002	4,597
Total patient care revenue	**1,344,411**	**1,293,818**	**1,344,293**	**1,293,790**

3 OTHER INCOME

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Gain on sale of property, plant and equipment	1,059	52	1,059	52
Clinical Training Agency	9,093	7,963	9,093	7,963
Donations and bequests received	513	237	386	71
Rental income	553	514	553	514
Professional, training and research	2,570	3,564	2,537	2,833
Other income	13,134	10,298	13,134	10,298
Total other income	**26,922**	**22,628**	**26,762**	**21,731**

4 PERSONNEL COSTS

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Salaries and wages	459,849	433,500	459,849	433,500
Contributions to defined contribution schemes	5,851	8,854	5,851	8,854
Increase/(decrease) in liability for employee entitlements	11,524	5,280	11,524	5,280
Total personnel costs	**477,224**	**447,634**	**477,224**	**447,634**

Contributions to defined contribution schemes include KiwiSaver, State Sector Retirement Savings Scheme and the Government Superannuation Fund.

5 CAPITAL CHARGE

The DHB pays a capital charge to the Crown twice a year. The charge is based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2012 was 8% (2011: 8%).

6 OTHER EXPENSES

		Group		Parent	
		Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Audit fees for WDHB financial statement audit		181	177	181	177
Audit fees (for subsidiaries financial statements)		9	7	9	7
Prior year under provision for audit fees		0	8	0	7
Operating lease expense		1,482	1,250	1,482	1,250
Impairment of debtors		2,167	1,726	2,167	1,726
Board members fees	Note 24	379	384	379	384
Restructuring expense		0	31	0	31
Koha		5	6	5	6
Other expenses		780	783	39	215
Total other expenses		**5,003**	**4,372**	**4,262**	**3,803**

7 CASH AND CASH EQUIVALENTS

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Cash at bank and on hand	9	529	0	516
Call deposits	787	53,105	0	52,000
Health Benefits Limited	68,677	0	68,677	0
Total cash and cash equivalents for the purposes of the statement of cash flows	**69,473**	**53,634**	**68,677**	**52,516**

The carrying value of cash at bank and term deposits with maturities less than three months approximates their fair value. Cash and cash equivalents include funds of $796k (2011: $1.18m) donated or bequeathed for a specific purpose. The use of the funds 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 recognised in the surplus or deficit and is transferred from/to trust funds in equity.

Waitemata DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at on-call interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of one month's Provider Arm funding, less net Inter-District In-Flows, plus GST. For Waitemata DHB that equates to $41.962m. As at 30th June 2012, Waitemata DHB still had in place an un-used overdraft facility of $1m, on a fully fluctuating basis and cash advance facility of $39m. These facilities have since been terminated.

8 DEBTORS AND OTHER RECEIVABLES

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Ministry of Health	14,827	20,841	14,827	20,841
Other receivables	8,472	5,830	8,615	5,803
Other accrued revenue	3,973	2,836	3,973	2,836
Less: Provision for impairment	(1,644)	(1,669)	(1,644)	(1,669)
Total debtors and other receivables	**25,628**	**27,838**	**25,771**	**27,811**

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

Impairment
The ageing profile of trade receivables at year end is detailed below:

	Group 2012			Group 2011		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	8,349	0	8,349	13,224	0	13,224
Past due 1-30 days	3,483	0	3,483	813	0	813
Past due 31-60 days	636	(304)	332	826	(560)	266
Past due 61-90 days	376	(262)	114	404	(281)	123
Past due > 90 days	1,549	(1,078)	471	1,190	(828)	362
Total	**14,393**	**(1,644)**	**12,749**	**16,457**	**(1,669)**	**14,788**

All receivables greater than 30 days in age are considered to be past due.

The provision for impairment has been calculated based on a review of significant debtor balances and a collective assessment of all debtors (other than those determined to be individually impaired) for impairment. The collective impairment assessment is based on an analysis of past collection history and write-offs. Individually impaired receivables are assessed as impaired due to the significant financial difficulties being experienced by the debtor and management concluding that the likelihood of the overdue amounts being recovered is remote.

Movements in the provision for impairment of receivables are as follows:

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Balance at 1 July	1,669	1,634	1,669	1,634
Additional provisions made	2,167	1,726	2,167	1,726
Receivables written off	(2,192)	(1,691)	(2,192)	(1,691)
Balance at 30 June	**1,644**	**1,669**	**1,644**	**1,669**

9 INVESTMENTS

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Current portion				
Term deposits with maturities greater than 3 months and remaining duration less than 12 months	1,302	1,981	0	0
Total current portion	1,302	1,981	0	0
Non-current portion				
Term deposits with maturities greater than 3 months and remaining duration greater than 12 months	3,848	3,288	0	0
Investment in joint venture healthAlliance N.Z. Limited	9,535	0	9,535	0
Total non-current portion	13,383	3,288	9,535	0
Total investments	**14,685**	**5,269**	**9,535**	**0**

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

The fair value of term deposits with a remaining duration greater than 12 months is $3.848m (2011: $3.288m). The fair value has been calculated based on quoted market prices at the balance sheet date without deduction for transaction costs. There is no impairment provision for investments.

The fair value of investment in healthAlliance N.Z. Limited is same as book value $9.535m.

10 INVENTORIES

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Pharmaceuticals	567	518	567	518
Surgical and medical supplies	4,445	4,443	4,445	4,443
Other supplies	0	0	0	0
Total inventories	**5,012**	**4,961**	**5,012**	**4,961**

The amount of inventories recognised as an expense during the year was $4.507m (2011: $1.409m), which is included in the clinical supplies line item of the statement of comprehensive income.

The write-down of inventories held for distribution amounted to $0 (2011: $206k). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2011: $nil). However, some inventories are subject to retention of title clauses.

11 NON-CURRENT ASSETS HELD FOR SALE

As at 30 June 2011, the DHB owned IT equipment and software which had been classified as held for sale following the Boards approval to sell these assets to its joint venture shared service provider healthAlliance N.Z. Limited. The sale was completed on 01 July 2011.

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Non-current assets held for sale include:				
IT Hardware	0	5,216	0	5,216
Software	0	3,335	0	3,335
Total non-current assets held for sale	**0**	**8,551**	**0**	**8,551**

12 INVESTMENTS IN ASSOCIATES, JOINT VENTURES AND PARTNERSHIP

	Interest held at 30-Jun-12	Balance date
Investments in joint ventures		
healthAlliance N.Z. Limited	20%	30-Jun
Health Innovation Hub Limited	25%	30-Jun
Investments in associates		
Northern DHB Support Agency	33.30%	30-Jun
Northern Regional Training Hub Ltd (formerly Auckland Regional RMO Service Limited)	34%	30-Jun

Summary of financial information of joint ventures

	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus $000
2012					
healthAlliance N.Z. Limited	61,453	19,629	41,824	90,485	0
Health Innovation Hub Limited	0	0	0	0	0
Total	**61,453**	**19,629**	**41,824**	**90,485**	**0**
2011					
healthAlliance N.Z. Limited	14,446	14,446	0	42,252	0
Health Innovation Hub Limited	0	0	0	0	0
Total	**14,446**	**14,446**	**0**	**42,252**	**0**

12 INVESTMENTS IN ASSOCIATES, JOINT VENTURES AND PARTNERSHIP (CONTINUED)

Summary of financial information of associates

	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus $000
2012					
Northern DHB Support Agency	6,059	5,387	672	8,253	38
Northern Regional Training Hub Ltd (formerly Auckland Regional RMO Service Limited)	2,414	2,365	49	3,033	47
Total	**8,473**	**7,752**	**721**	**11,286**	**85**
2011					
Northern DHB Support Agency	5,929	5,295	634	9,875	5
Northern Regional Training Hub (formerly Auckland Regional RMO Service Limited)	2,238	2,236	2	2,880	0
Total	**8,167**	**7,531**	**636**	**12,755**	**5**

Share of surplus / (deficit) of associate entities.

	Actual 2012 $000	Actual 2011 $000
Share of surplus / (deficit) before tax:	28	1
Les: Tax expense	0	0
Share of surplus/ (deficit)	**28**	**1**

The Group's share of the surplus /(deficit) above has not been accounted for on the grounds of materiality.

13 PROPERTY, PLANT, AND EQUIPMENT

Parent and Group	Land $000	Buildings $000	Clinical equipment $000	Other equipment $000	IT Equipment $000	Work in progress $000	Total $000
Cost or valuation							
Balance at 1 July 2010	109,419	244,606	75,962	32,874	32,369	26,018	521,248
Additions from WIP	0	51,791	7,630	531	1,845	(61,797)	0
Revaluation increase/(decrease)	0	(32,263)	0	0	0	0	(32,263)
Additions to WIP	0	0	0	0	0	57,568	57,568
Disposals	0	0	0	(1,153)	(27,422)	0	(28,575)
Balance at 30 June 2011	109,419	264,134	83,592	32,252	6,792	21,789	517,978
Balance at 1 July 2011	109,419	264,134	83,592	32,252	6,792	21,789	517,978
Additions from WIP	0	50,655	10,650	1,265	0	(62,570)	0
Revaluation increase/(decrease)	2,481	(18,288)	0	0	0	0	(15,807)
Additions to WIP	0	0	0	0	0	56,385	56,385
Disposals	0	0	0	(128)	(2,787)	0	(2,915)
Balance at 30 June 2012	111,900	296,501	94,242	33,389	4,005	15,604	555,641
Accumulated depreciation and impairment losses							
Balance at 1 July 2010	0	10,282	49,588	20,786	26,432	0	107,088
Depreciation expense	0	11,465	5,575	1,909	2,434	0	21,383
Impairment losses	0	6,400	0	0	0	0	6,400
Elimination on disposal/transfer	0	0	0	(1,142)	(22,200)	0	(23,342)
Elimination on revaluation	0	(28,147)	0	0	0	0	(28,147)
Balance at 30 June 2011	0	0	55,163	21,553	6,666	0	83,382
Balance at 1 July 2011	0	0	55,163	21,553	6,666	0	83,382
Depreciation expense	0	12,681	6,305	2,005	156	0	21,147
Impairment losses	0	2,588	0	0	0	0	2,588
Elimination on disposal/transfer	0	0	0	(125)	(2,886)	0	(3,011)
Elimination on revaluation	0	(15,269)	0	0	0	0	(15,269)
Balance at 30 June 2012	0	0	61,468	23,433	3,936	0	88,837
Carrying amounts							
At 1 July 2010	109,419	234,324	26,374	12,088	5,937	26,018	414,160
At 30 June and 1 July 2011	109,419	264,134	28,429	10,699	126	21,789	434,596
At 30 June 2012	**111,900**	**296,501**	**32,774**	**9,956**	**69**	**15,604**	**466,804**

The total amount of property, plant, and equipment in the course of construction is $15.604m (2011: $21.789m).
The net carrying amount of assets held under finance leases is $323k (2011: $406k) for clinical equipment.
IT assets in Work In Progress $6.049m will be transferred to healthAlliance N.Z. Limited once completed.

Valuation
The total fair value of land and buildings valued by M E Gamby of Telfer Young as at 30 June 2012 amounted to $408.401m.

13 PROPERTY, PLANT, AND EQUIPMENT (CONTINUED)

Land
Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely.

Restrictions on the DHB's ability to sell land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

The most recent valuation of land was performed by a registered independent valuer, E Gamby of Telfer Young and the valuation is effective as at 30 June 2012.

Buildings
Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity;
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information;
- The remaining useful life of assets is estimated;
- Straight-line deprecation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value.

The most recent valuation of buildings was performed by a registered independent valuer, E Gamby of Telfer Young and the valuation is effective as at 30 June 2012.

Impairment
The review and revaluation of buildings resulted in the impairment loss of $2.588m. This consists of $205k in addition to $6.400m in 2011 for a leaky building and $13k (2011: $0) seismic upgrade cost at the Mason Clinic, $503k (2011: $0) seismic upgrade cost at North Shore Hospital and $1.867m (2011: $0) seismic upgrade cost at Waitakere Hospital. Condition assessments and remediation plans have been prepared for all buildings. A tender has been let for urgent temporary and minor repairs. Unspent capital and operational funds have been reprioritised into a provision to cover repair costs, with the full programme of work expected to take two to three years. Litigation advice has been taken and legal action is planned. Decanting space options for housing patients are also being worked through.

Restrictions on title
The DHB does not have full title to the Crown land it occupies but transfer is arranged if and when land is sold. Some of the DHB's land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981 and, in relation to some land, a right of first refusal in favour of Tamaki Makaurau pursuant to the provisions of a Deed of Settlement with the Crown in relation to Treaty of Waitangi claims.

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential Waitangi Tribunal claims cannot be quantified and is therefore not reflected in the value of the land.

14 INTANGIBLE ASSETS

Movements for each class of intangible assets are as follows:

	Acquired software $000	Internally developed software $000	Total $000
Cost			
Balance at 1 July 2010	30,890	3,228	34,118
Additions from WIP	1,351	(641)	710
Additions to WIP	927	561	1,488
Transfer to assets held for sale	(32,050)	0	(32,050)
Balance at 30 June 2011 / 1 July 2011	1,118	3,148	4,266
Transfer to assets held for sale	(1,118)	(3,148)	(4,266)
Balance at 30 June 2012	0	0	0
Accumulated amortisation and impairment losses			
Balance at 1 July 2010	26,313	0	26,313
Amortisation expense	2,401	0	2,401
Transfer to assets held for sale	(28,714)	0	(28,714)
Balance at 30 June 2010 / 1 July 2011	0	0	0
Amortisation expense	175	0	175
Transfer to assets held for sale	(175)	0	(175)
Balance at 30 June 2012	0	0	0
Carrying amounts			
At 1 July 2010	4,577	3,228	7,805
At 30 June 2011 / 1 July 2011	1,118	3,148	4,266
At 30 June 2012	0	0	0

There are no restrictions over the title of the DHB's intangible assets; nor are any intangible assets pledged as security for liabilities. As at 1 July 2011, all intangible assets have been transferred to healthAlliance N.Z. Limited.

15 CREDITORS AND OTHER PAYABLES

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Creditors and accrued expenses	88,384	92,789	88,408	92,448
GST payable	5,768	6,781	5,768	6,724
Capital charge payable	471	3,245	471	3,245
Income in advance	881	1,076	881	1,076
Total creditors and other payables	**95,504**	**103,891**	**95,528**	**103,493**

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

16 BORROWINGS

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Current portion				
Finance leases	83	83	83	83
Crown Health Financing Agency loans	100,230	34,154	100,230	34,154
Total current portion	100,313	34,237	100,313	34,237
Non-current portion				
Finance leases	240	316	240	316
Crown Health Financing Agency loans	120,696	153,642	120,696	153,642
Total non-current portion	120,936	153,958	120,936	153,958
Total borrowings	**221,249**	**188,195**	**221,249**	**188,195**
Borrowing facility limits				
Crown Health Financing Agency loan facility limit	262,820	225,920	262,820	225,920
Overdraft facility	40,000	40,000	40,000	40,000
Total borrowing facility limits	**302,820**	**265,920**	**302,820**	**265,920**

Crown Health Financing Agency loans
The Crown Health Financing Agency (CHFA) loans are secured by a negative pledge.
Without the CHFA's prior written consent, the DHB cannot perform the following actions:

- create any security over its assets except in certain defined 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;
- dispose of any of its assets except disposals in the ordinary course of business or disposal for full fair value; or
- provide or accept services other than for proper value and on reasonable commercial terms.

All financial covenants were waived by the CHFA.

CHFA was disestablished as at 30 June 2012. The loan portfolio administration function was transferred to the National Health Board (under the Ministry of Health) and borrowing are still provided by the NZ Treasury Debt Management Office.

The fair value of CHFA borrowings is $237.739m (2011: $201.445m). Fair value has been determined by the Government bond rate plus 15 basis points.

Overdraft facility
The DHB has an overdraft facility with Westpac Bank ($1m) and with ANZ ($39M). The facility is secured by a negative pledge. Without Westpac/ANZ's prior written approval, the DHB cannot perform the following actions:

- create any security over its assets except in certain defined 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
- dispose of any of its assets except disposals in the ordinary course of business or disposal for full fair value;
- provide services to or accept services from a person other than for proper value and on reasonable commercial terms.

16 BORROWINGS (CONTINUED)

Finance leases
Finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default. The net carrying amount of assets held under finance lease is disclosed in note 13.

The fair value of finance leases is $323k (2011: $399k). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 2.5% to 5.1% (2011: 2.5% to 5.1%).

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Minimum lease payments payable:				
No later than one year	108	108	108	108
Later than one year and not later than five years	313	412	313	412
Later than five years	0	0	0	0
Total minimum lease payments	421	520	421	520
Future finance charges	(98)	(121)	(98)	(121)
Present value of minimum lease payments	323	399	323	399
Present value of minimum lease payments				
No later than one year	83	83	83	83
Later than one year and not later than five years	240	316	240	316
Later than five years	0	0	0	0
Total present value of minimum lease payments	323	399	323	399

Description of finance leasing arrangements
The DHB has entered into a finance lease for clinical equipment. There are no restrictions placed on the DHB by any of the finance leasing arrangements.

17 EMPLOYEE ENTITLEMENTS

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Current portion				
Accrued salaries and wages	18,655	13,181	18,655	13,181
Annual leave	44,300	41,459	44,300	41,459
Sick leave	1,078	807	1,078	807
Sabbatical leave	300	300	300	300
Continuing medical education leave	5,360	4,985	5,360	4,985
Long service leave	319	179	319	179
Retirement gratuities	1,841	1,556	1,841	1,556
Total current portion	71,853	62,467	71,853	62,467
Non-current portion				
Continuing medical education leave	3,926	3,920	3,926	3,920
Long service leave	5,208	4,584	5,208	4,584
Retirement gratuities	8,639	7,747	8,639	7,747
Sick leave	2,717	2,101	2,717	2,101
Total non-current portion	20,490	18,352	20,490	18,352
Total employee entitlements	**92,343**	**80,819**	**92,343**	**80,819**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. An inflation factor of 1.0% (2011: 2.0%) was used.

18 PROVISIONS

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Current portion				
ACC Partnership Programme	441	562	441	562
Total current portion	441	562	441	562
Total provisions	**441**	**562**	**441**	**562**

Movements for each class of provision are as follows:

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Balance at 1 July 2011	562	635	562	635
Movement in provisions	(121)	(73)	(121)	(73)
Amounts used	0	0	0	0
Balance at 30 June 2012	**441**	**562**	**441**	**562**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON, has calculated the liability as at 30 June 2012. The actuary has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuary's report.

Risk margin

A risk margin of 11% (2011: 11%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

The risk margin has been determined after consideration of past claims history, costs, and trends. The risk margin is intended to achieve a 75% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

Key assumptions:

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

- an average assumed rate of inflation of 3% (2011: 4%);
- a weighted average discount factor of 3.5% (2011: 3.8%) has been applied.

Insurance risk

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

The DHB is responsible for managing claims for a period of up to 24 months following the lodgement date. At the end of 24 months, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis.

19 EQUITY

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Crown equity				
Balance at 1 July	97,824	92,203	97,824	92,203
Capital contributions from the Crown	5,191	5,621	5,191	5,621
Repayment of capital to the Crown	0	0	0	0
Balance at 30 June	103,015	97,824	103,015	97,824
Accumulated surpluses/(deficits)				
Balance at 1 July	(68,500)	(72,052)	(68,500)	(72,052)
Surplus/(deficit) for the year	4,820	4,305	5,009	3,552
Revaluation reserves transfer on disposal	0	0	0	0
Transfer from/(to) trust funds	189	(753)	0	0
Balance at 30 June	(63,491)	(68,500)	(63,491)	(68,500)
Revaluation reserves				
Balance at 1 July	130,369	140,885	130,369	140,885
Impairment loss	(2,588)	(6,400)	(2,588)	(6,400)
Revaluations	(540)	(4,116)	(540)	(4,116)
Balance at 30 June	127,241	130,369	127,241	130,369
Revaluation reserves consist of:				
Land	106,414	103,933	106,414	103,933
Buildings	20,827	26,436	20,827	26,436
Total revaluation reserves	127,241	130,369	127,241	130,369
Trust funds				
Balance at 1 July	6,016	5,263	0	0
Movement	(189)	753	0	0
Balance at 30 June	5,827	6,016	0	0
Total equity	**172,592**	**165,709**	**166,765**	**159,693**

Included in the DHBs accumulated surpluses/deficits are $12.2m (2011: $ 8.5m) of unspent mental health ring fenced funding representing the excess of funding received over relevant mental health expenses since this funding was established.

20 RECONCILIATION OF NET SURPLUS/(DEFICIT) TO NET CASH FLOW FROM OPERATING ACTIVITIES

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Net surplus/(deficit)	4,820	4,305	5,009	3,552
Add/(less) non-cash items				
Depreciations and amortisation expense	21,322	23,784	21,322	23,784
Total non-cash items	21,322	23,784	21,322	23,784
Add/(less) items classified as investing or financing activities				
Unrealised (gain)/ loss investments	1,112	(124)	1,052	0
(Gains)/losses on disposal of property, plant and equipment	0	(52)	0	(52)
Total items classified as investing or financing activities	1,112	(176)	1,052	(52)
Add/(less) movements in statement of financial position items				
Debtors and other receivables	1,520	(2,024)	1,372	(2,289)
Inventories	(51)	607	(51)	607
Creditors and other payables	(4,020)	22,142	(3,594)	21,808
Provisions	(121)	(73)	(121)	(73)
Employee entitlements	11,275	4,370	11,275	4,370
Net movements in working capital items	8,603	25,022	8,881	24,423
Net cash flow from operating activities	**35,857**	**52,935**	**36,264**	**51,707**

21 CAPITAL COMMITMENTS AND OPERATING LEASES

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Capital commitments				
Property, plant and equipment	38,260	40,963	38,260	40,963
Intangible assets	3,589	440	3,589	440
Total capital commitments	**41,849**	**41,403**	**41,849**	**41,403**

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

21 CAPITAL COMMITMENTS AND OPERATING LEASES (CONTINUED)

Non-cancellable operating lease commitments as lessor
The future aggregate receipts to be received under other non-cancellable contractual operating commitments are as follows:

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Not later than one year	205	207	205	207
Later than one year and not later than five years	652	622	652	622
Later than five years	39	84	39	84
Total other non-cancellable operating lessor	**896**	**913**	**896**	**913**

The majority of these commitments relate to leasing out sites to the third parties.

Non-cancellable operating lease commitments as lessee
The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Not later than one year	6,454	5,722	6,454	5,722
Later than one year and not later than five years	13,275	15,588	13,275	15,588
Later than five years	2,160	2,491	2,160	2,491
Total non-cancellable operating leases	**21,889**	**23,801**	**21,889**	**23,801**

The DHB leases a number of buildings under operating leases, the largest of which are as follows:

- A mental health and administration building is leased with an expiry date of 04 May 2019, with a right of renewal for a further five year period with an annual rent increase of 2%.
- A mental health unit in West Auckland is leased with an expiry date of 29 March 2016, with a right of renewal for a further two periods of five years each, and a review to market rent every three years.

Other non-cancellable contractual operating commitments
The future aggregate payments to be paid under other non-cancellable contractual operating commitments are as follows:

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Not later than one year	30,804	59,649	30,804	59,649
Later than one year and not later than five years	51,438	75,819	51,438	75,819
Later than five years	0	19	0	19
Total other non-cancellable operating leases	**82,242**	**135,487**	**82,242**	**135,487**

The majority of these commitments relate to the purchase of health services to be provided by other health service providers.

22 CONTINGENCIES

Contingent liabilities
Lawsuits against the DHB
Waitemata DHB and its associates have been notified of six potential legal claims at 30th June 2012 which creates a contingent liability totalling approximately $575k (2011: one claim approximately $200k).

At balance date, Unitec Institute of Technology have granted $435k (2011: $217k) towards the refurbishment of Awhina Health Campus which was completed on 02 November 2011. $435k (2011: $217k) is recognised as a contingent liability dependent on conditions in the joint venture agreement.

Contingent assets
The DHB has no contingent assets (2011: $nil).

23 RELATED PARTY TRANSACTIONS

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

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

Significant transactions with government-related entities
The DHB has received funding from the Crown and ACC of $1.260b (2011: $1.210b) to provide health services in the Waitemata area for the year ended 30 June 2012.

Revenue earned from other DHBs for the care of patients outside the DHB's district amounted to $78.70m (2011: $79.15m) for the year ended 30 June 2012. Expenditure to other DHBs for their care of patients from the DHB's district amounted to $306.23m (2011: $304.31m) for the year ended 30 June 2012.

Collectively, but not individually significant, transactions with government-related entities
In conducting its activities, the DHB is required to pay various taxes and levies (such as GST, FBT, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The DHB is exempt from paying income tax.

The DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2012 totalled $1.46m (2011: $1.93m). These purchases included the purchase of electricity from Genesis Energy, air travel from Air New Zealand, and postal services from New Zealand Post.

No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2011: $nil).

There were no commitments with related parties.

23 RELATED PARTY TRANSACTIONS (CONTINUED)

Related party transactions with the DHB's subsidiary, associates, joint ventures and partnership

	Actual 2012 $000	Actual 2011 $000
Subsidiary – The Three Harbours Health Foundation		
Services provided to the DHB	6	402
Payable for services provided to the DHB	0	0
Services provided by the DHB	1,242	1,280
Receivable for services provided by the DHB	403	424
Associate – Northern Regional Training Hub Ltd		
(formerly Auckland Regional RMO Service Limited)		
Services provided to the DHB	2,370	2,447
Payable for services provided to the DHB	0	0
Services provided by the DHB	68	43
Receivable for services provided by the DHB	9	3
Associate – Northern DHB Support Agency Limited		
Services provided to the DHB	2,963	2,684
Payable for services provided to the DHB	233	0
Services provided by the DHB	870	1,414
Receivable for services provided by the DHB	73	80

	Actual 2012 $000	Actual 2011 $000
Joint Venture – healthAlliance N.Z. Limited		
Services provided to the DHB	22,394	17,790
Payable for services provided to the DHB	595	13
Services provided by the DHB	143	101
Receivable for services provided by the DHB	207	275
Joint Venture partner– Unitec Institute of Technology		
Services provided to the DHB	55	49
Payable for services provided to the DHB	0	0
Services provided by the DHB	505	639
Receivable for services provided by the DHB	57	180
Joint Venture Partner– Health Innovation Hub Limited		
Services provided to the DHB	0	0
Payable for services provided to the DHB	230	0
Services provided by the DHB	0	0
Receivable for services provided by the DHB	0	0

23 RELATED PARTY TRANSACTIONS (CONTINUED)

Transactions with key management personnel
Key management personnel compensation

	Actual 2012 $000	Actual 2011 $000
Salaries and other short-term employee benefits	2,956	2,827
Post-employment benefits	0	0
Other long-term benefits	10	10
Termination benefits	145	23
Total key management personnel compensation	**3,111**	**2,860**

Key management personnel include the Chief Executive and the other seven members of the management team (2011: eight members).

Related party directorships involving key management personnel
Members of the Executive Leadership Team with related party directorship roles:

Name	Title	Director of:
Dr Dale Bramley	Chief Executive Officer	Northern Regional Training Hub Ltd (formerly Auckland Regional RMO Service Limited)
		Northern DHB Support Agency
Rosalie Percival	Chief Financial Officer	Auckland DHB (acting CFO)
Debbie Holdsworth	Chief Planning & Funding Officer	Northern DHB Support Agency

23 RELATED PARTY TRANSACTIONS (CONTINUED)

Related party transactions involving Board members

During the year, the DHB transacted with entities in which Waitemata Board members or Senior Management had governance, shareholder or other interests, as set out in the following table. Board members do not participate in decisions directly related to funding of related entities and the terms and conditions of those arrangements are no more favourable than the DHB would have adopted if there were no relationship.

			Transactions 2011/12 $000				
			Payments	Receipts	Outstanding at 30 June		
Board Member	Relationship	Organisation	to	From	Payable	Receivable	Nature of Service
Max Abbott	Pro-vice chancellor and Dean, Faculty of Health and Environmental Sciences	Auckland University of Technology	396	588		186	Workforce development in nursing, podiatry and other healthcare professions. Evaluation of public health programme.
	Patron	Raeburn House	3				Mental health promotion, networking and information.
	Board Member	Health Workforce New Zealand		1			Postgraduate nurse training
Pat Booth	Consulting Editor	Fairfax Suburban Papers in Auckland	2		1		Advertising
Lester Levy	Professor (Adjunct) of leadership	University of Auckland	220	667	76	99	Evaluation services
	CEO	NZ Leadership Institute	155				Programme delivery learning group
	Deputy Chair	Health Benefits Limited	969		68		DHB business case instalments
	Chair	Auckland District Health Board	29,948	7,068	8,173	2,231	Various services, including HUB services for Child Health and Housing, Pacific smoking cessation and ambulance transfers.
Sandra Coney	Elected Member and Chair Parks Committee	Auckland Council	265				Rates and resource consent fees.
Rob Cooper	Board Member	Auckland District Health Board	29,948	7,068	8,173	2,231	Various services, including HUB services for Child Health and Housing, Pacific smoking cessation and ambulance transfers.

23 RELATED PARTY TRANSACTIONS (CONTINUED)

			Transactions 2011/12 $000				
			Payments	Receipts	Outstanding at 30 June		
Board Member	Relationship	Organisation	to	from	Payable	Receivable	Nature of Service
Warren Flaunty	Member Henderson, Massey, Rodney and Upper Harbour Local Boards	Auckland Council	265				Rates and resource consent fees.
	Trustee	West Auckland Hospice	1,769	1	146		Palliative assessment care.
	Shareholder	Metlifecare Limited	643		1		Funding of aged care services at Metlifecare facilities.
	Shareholder	EBOS Group Ltd	75		5		Healthcare consumables from EBOS and its subsidiary Health Support Limited.
	Shareholder	Pharmacy Brands Ltd	32,718				Payments to pharmacy franchises, Amcal, Care chemist, Life pharmacy, Unichem and Radius pharmacy under the Pharmacy Brands umbrella.
	Shareholder	Westgate Pharmacy Limited	2,607				Provision of community pharmacy services.
	Chair	Three Harbours Health Foundation	6	1,242		403	Health workforce development and reimbursement of clinical research costs.
Wendy Lai	Partner	Deloitte	65				Consulting services, health and business management.
	Board member	Rodney Health Link	39				Personal health project
James Le Fevre	Member	Associated Salaried Medical Specialists	1				National ASMS meeting attendance cost
Christine Rankin	Member Upper Harbour Local Board	Auckland Council	265				Rates and resource consent fees.
Allison Roe	Board Member	North Shore Hospital Foundation		44			Total receipts and payments to the Three Harbours Health Foundation, which includes the North Shore Hospital Foundation.

23 RELATED PARTY TRANSACTIONS (CONTINUED)

Board Member	Relationship	Organisation	Transactions 2011/12 $000 Payments to	Receipts from	Outstanding at 30 June Payable	Receivable	Nature of Service
Gwen Tepania-Palmer	Board Member	Auckland District Health Board	29,948	7,068	8,173	2,231	Various services, including HUB services for Child Health and Housing, Pacific smoking cessation and ambulance transfers.

Senior Management	Relationship	Organisation	Transactions 2011/12 $000 Payments to	Receipts from	Outstanding at 30 June Payable	Receivable	Nature of Service
Rosalie Percival	Director resigned Aug 11	healthAlliance N.Z. Limited	22,394	153	48	19	Various outsourced services including finance, IT and procurement
Dr Dale Bramley	Director	Northern DHB Support Agency	2,963	870	233	73	Contribution to operational budget
	Chair	Northern Regional Training Hub (formerly Auckland Regional RMO Service Limited)	2,596	69		10	Junior doctors training coordination services
	Chief Examiner	NZ College of Public Health Medicine	2				2012 fellowship fee
Debbie Holdsworth	Director	Northern DHB Support Agency	2,963	870	233	73	Contribution to operational budget

24 BOARD MEMBER REMUNERATION

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

	Actual 2012 $000	Actual 2011 $000
Dr Lester Levy (Chair)	70	67
Prof Max Abbott (Deputy Chair)	38	39
Pat Booth	31	31
Sandra Coney	30	17
Rob Cooper	27	15
Warren Flaunty	31	33
Wendy Lai	29	32
James Le Fevre	27	18
Christine Rankin	31	18
Allison Roe	30	17
Gwen Tepania–Palmer	29	30
Mary-Anne Benson Cooper	0	13
Lynne Coleman	0	13
Wyn Hoadley	0	14
Brian Neeson	0	15
Total board member remuneration	**373**	**372**

Co-opted committee members
Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $5.5k (2011: $12k)

Norman Wong (Audit and Finance Committee) $2k, Eru Lyndon (CPHAC and MaGAC) $3k, North Shore Community Health Voice (CPHAC) $0.25k, Lyvia Marsden (CPHAC) $0.25k.

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

No Board members received compensation or other benefits in relation to cessation (2011: $nil).

25 EMPLOYEE REMUNERATION

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

Total remuneration paid:

	Actual 2012	Actual 2011		Actual 2012	Actual 2011
$100,000 – 109,999	164	132	$330,000 – 339,999	5	5
$110,000 – 119,999	69	64	$340,000 – 349,999	8	4
$120,000 – 129,999	52	53	$350,000 – 359,999	2	2
$130,000 – 139,999	40	26	$360,000 – 369,999	1	1
$140,000 – 149,999	26	30	$370,000 – 379,999	4	4
$150,000 – 159,999	20	21	$380,000 – 389,999	2	0
$160,000 – 169,999	27	23	$390,000 – 399,999	1	2
$170,000 – 179,999	19	24	$400,000 – 409,999	0	4
$180,000 – 189,999	26	14	$410,000 – 419,999	2	1
$190,000 – 199,999	15	24	$420,000 – 429,999	1	1
$200,000 – 209,999	27	19	$430,000 – 439,999	0	2
$210,000 – 219,999	13	20	$440,000 – 449,999	1	1
$220,000 – 229,999	19	19	$450,000 – 459,999	0	0
$230,000 – 239,999	19	14	$460,000 – 469,999	1	1
$240,000 – 249,999	15	16	$470,000 – 479,999	2	2
$250,000 – 259,999	21	16	$480,000 – 489,999	0	0
$260,000 – 269,999	13	14	$490,000 – 499,999	0	0
$270,000 – 279,999	20	10	$500,000 – 509,999	0	0
$280,000 – 289,999	9	13	$510,000 – 519,999	1	1
$290,000 – 299,999	6	4	$520,000 – 529,999	0	0
$300,000 – 309,999	10	8	$530,000 – 539,999	0	0
$310,000 – 319,999	8	6	$540,000 – 549,999	0	0
$320,000 – 329,999	7	6	$550,000 – 559,999	1	0
			Grand Total	**677**	**607**

During the year ended 30 June 2012, 71 (2011: 79) employees received compensation and other benefits in relation to cessation totalling $1.892m. (2011: $1.823m).

26 EVENTS AFTER THE BALANCE DATE

There were no significant events after the balance date.

27 FINANCIAL INSTRUMENTS

27A FINANCIAL INSTRUMENT CATEGORIES

The carrying amounts of financial assets and liabilities in each of the NZ IAS 39 categories are as follows:

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
Loans and receivables				
Cash and cash equivalents	69,473	53,634	68,677	52,516
Debtors and other receivables	25,628	27,838	25,771	27,811
Investments	14,685	5,269	9,535	0
Total loans and receivables	109,786	86,741	103,983	80,327
Financial liabilities measures at amortised cost				
Creditors and other payables (excluding income in advance and GST)	94,682	96,034	88,879	95,693
Borrowings – CHFA loans	220,926	187,796	220,926	187,796
Finance leases	323	399	323	399
Total financial liabilities measured at amortised cost	315,931	284,229	310,128	283,888

27B FAIR VALUE HIERARCHY

There are no financial instruments measured at fair value in the statement of financial position.

27C FINANCIAL INSTRUMENT RISKS

The DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Market risk

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. The DHB has no financial instruments that give rise to price risk.

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. The DHB's exposure to fair value interest rate risk arises from bank deposits and bank loans that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the DHB as investments and borrowings are generally held to maturity.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

Sensitivity analysis

As at 30 June 2012, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have been $673k lower/higher (2011: $122k).

27C FINANCIAL INSTRUMENT RISKS (CONTINUED)

Currency risk
Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. As at year end Waitemata DHB had no direct exposure to foreign currency risk (2011: nil).

Sensitivity analysis
As at 30 June 2012, if the NZ dollar had weakened/strengthened by 5% against the US dollar with all other variables held constant, the surplus for the year would have seen an insignificant impact.

The DHB has no outstanding foreign denominated payables at balance date (2011: $nil).

Credit risk
Credit risk is the risk that a third party will default on its obligation to the DHB, causing it to incur a loss. Due to the timing of its cash inflows and outflows, surplus cash is held as demand funds with Health Benefits Limited who invest with registered banks.

In the normal course of business, exposure to credit risk arises from demand funds with Health Benefits Limited, debtors and other receivables. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position.

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

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The MoH is the largest debtor (approximately 41%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

Credit quality of financial assets
The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates.

	Group		Parent	
	Actual 2012 $000	Actual 2011 $000	Actual 2012 $000	Actual 2011 $000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalents and investments				
AA	0	56,902	0	52,516
AA-	72,496	0	68,677	0
A	784	776	0	0
BBB	688	0	0	0
Total cash, cash equivalents and investments	73,968	57,678	68,677	52,516
COUNTERPARTIES WITHOUT CREDIT RATINGS				
Investments	10,190	1,225	9,535	0
Debtors and other receivables				
Existing counterparty with no defaults in the past	25,628	27,838	25,771	27,811
Existing counterparty with defaults in the past	0	0	0	0
Total debtors and other receivables	25,628	27,838	25,771	27,811

27C FINANCIAL INSTRUMENT RISKS (CONTINUED)

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that the DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining demand funds with and the availability of funding through the treasury services agreement with Health Benefits Limited.

The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the treasury services agreement with Health Benefits Limited who maintain an overdraft facility.

Contractual maturity analysis of financial liabilities, excluding derivatives

The table below analyses financial liabilities (excluding derivatives) into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. Future interest payments on floating rate debt are based on the floating rate of the instrument at balance date. The amounts disclosed are the contractual undiscounted cash flows.

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2011						
Creditors and other payables	96,034	96,034	96,034	0	0	0
Finance leases	399	399	83	83	233	0
CHFA loans	187,796	201,445	0	0	0	201,445
Total	284,229	297,878	96,117	83	233	201,445
2012						
Creditors and other payables	96,682	96,682	96,682	0	0	0
Finance leases	323	323	83	83	157	0
CHFA loans	220,926	237,739	410	1,640	2,460	233,229
Total	317,931	334,744	97,175	1,723	2,617	233,229

Parent	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2011						
Creditors and other payables	95,693	95,693	95,693	0	0	0
Finance leases	399	399	83	83	233	0
CHFA loans	187,796	201,445	0	0	0	201,445
Total	283,888	297,537	95,776	83	233	201,445
2012						
Creditors and other payables	88,879	88,879	88,879	0	0	0
Finance leases	323	323	83	83	157	0
CHFA loans	220,926	237,739	410	1,640	2,460	233,229
Total	310,128	326,941	89,372	1,723	2,617	233,229

28 CAPITAL MANAGEMENT

The DHB's capital is its equity, which comprises Crown equity, accumulated surpluses, revaluation reserves, and trust funds. Equity is represented by net assets.

The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that the DHB effectively achieves its objectives and purposes, while remaining a going concern.

29 THREE HARBOURS HEALTH FOUNDATION

The DHB has consolidated its wholly-owned subsidiary Three Harbours Health Foundation (THHF). The DHB's investment in THHF is accounted for at cost of $0 (2011: $nil).

For the year ended 30 June 2012, THHF had total revenue of $1.854m (2011: $2.653m) and a net deficit of $156k (2011: $753k surplus). THHF had assets of $6.206m (2011: $6.539m) and liabilities of $379k (2011: $523k) as at 30 June 2012.

30 PATIENT TRUST MONIES AND RESTRICTED FUNDS

	Actual 2012 $000	Actual 2011 $000
Balance at 1 July	82	70
Monies received	750	735
Payments made	740	723
Balance at 30 June	92	82

The DHB administers funds on behalf of certain patients, which are held in bank accounts that are separate from the DHB's normal banking facilities. Patient fund transactions and balances are not recognised in the DHB's financial statements.

31 EXPLANATION OF MAJOR VARIANCES AGAINST BUDGET

Explanations for major variances from the DHB's budgeted figures in the statement of intent are as follows:

Statement of comprehensive income
Total revenue for the year was $7.701m higher than budgeted, mainly due to unbudgeted additional funding for various programmes including:

- Oral health business case
- Electives services productivity pilots
- Health Benefits Limited funding
- HPV funding
- Primary health care interpreter services
- IDF service changes for haemodialysis & school dental services

Expenditure was $2.692m greater than budget for the year, mostly due to the service changes and specific programmes mentioned above. There were some significant variances between cost categories:

31 EXPLANATION OF MAJOR VARIANCES AGAINST BUDGET (CONTINUED)

- Adverse personnel costs are mainly in nursing, additional overtime costs, higher usage of internal bureau staff covering vacancies and demand related activity with higher occupancy, additional health service assistants than planned, maternity leave returns and gratuity payments. Adverse medical staff costs reflect SMO allowances, overtime, training costs, superannuation costs and house officers' costs. Adverse staff costs also include the impact of PSA MECA lump sum payments/accruals for Allied Health & Nursing staff. Some of the costs are covered by additional revenue and others are demand driven, acuity driven and staff cover requirements related.

- Adverse outsourced costs reflect part time staff to cover for vacancies, increased volumes for outsourced specialist and community radiology services.

Statement of changes in equity
The surplus was $5.009m greater than budgeted due to the statement of comprehensive income explanations provided above.

The revaluations and impairment of buildings $3.128m was not anticipated or budgeted.

Statement of financial position
Cash and cash equivalents were greater than budget by $64.073m. From operating activities, it was mainly due to additional revenues as described above, along with the timing of receipts and accrued creditors and payables. From investing activities, capital expenditure under spent by $17.066m due to timing of projects, savings and under spends in some projects. Opening cash and cash equivalents position was greater than budget by $33.411m.

Debtors and receivables are $4.729m less than anticipated, due to timing of receipts and accrued revenue, contributing to the favourable cash position above.

Assets held for sale $8.551m has been all transferred to healthAlliance N.Z .Limited as at 1 July 2011.

Creditors and other payables were $13.441m higher than planned, due to higher than anticipated levels of accrued expense largely from IDF positions and demand driven payments.

Investments were $9.535m higher than planned, mainly due to IT asset sales to healthAlliance N.Z .Limited resulting in the investment in healthAlliance N.Z. Limited.

Total borrowings were $4.671m less than budgeted, following an improved cash position.

Employee entitlements were $8.213m higher than planned, mainly due to increase in AON valuation on sick leave, long service leave and retirement gratuities. Salary and wage accruals were higher than last year due to wage rates increase and timing of payruns around the year end.

There was a large movement in property, plant and equipment, mainly due to the IT asset transfer to healthAlliance N.Z. Limited being completed on 1 July 2011 and $9.535m is now under investments. Land and building revaluation by Telfer young has been carried out resulting in an overall reduction of $3.1m.

Statement of cash flows
Receipts from patient care $128.514m appear far greater than budget, mostly due to net IDF receivables and payable positions being offset. The offsetting variance is reflected in payments to suppliers being similarly higher than budgeted.

Capital expenditure cash spend was below plan by $17.066m, mainly due to timing of projects, savings and under spends in some projects.

Independent Auditor's Report

To the readers of Waitemata District Health Board and group's financial statements and statement of service performance for the year ended 30 June 2012

The Auditor-General is the auditor of Waitemata District Health Board (the Health Board) and group. The Auditor-General has appointed me, Karen MacKenzie, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and statement of service performance of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 43 to 84, that comprise the statement of financial position as at 30 June 2012, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board and group on pages 15 to 41.

Opinion

In our opinion:

- the financial statements of the Health Board and group on pages 43 to 84:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health Board and group's:
    - financial position as at 30 June 2012; and
    - financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board and group on pages 15 to 41:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Health Board and group's service performance for the year ended on 30 June 2012, including:
    - the performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
    - the revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 31 October 2012. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and statement of service performance are free from material misstatement.

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board and group's financial statements and statement of service performance that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

The Board is responsible for preparing financial statements and a statement of service performance that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board and group's financial position, financial performance and cash flows; and
- fairly reflect the Health Board and group's service performance achievements.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

Responsibilities of the Auditor

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

Independence

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

Other than the audit, we have no relationship with or interests in the Health Board or any of its subsidiaries.

Karen MacKenzie
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Matters relating to the electronic presentation of the audited financial statements and statement of service performance

This audit report relates to the financial statements and statement of service performance of Waitemata District Health Board (the Health Board) and group for the year ended 30 June 2012 included on the Health Board's website. The Board is responsible for the maintenance and integrity of the Health Board's website. We have not been engaged to report on the integrity of the Health Board's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from these financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 31 October 2012 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

Legislation in New Zealand governing the preparation and dissemination of financial information may differ from legislation in other jurisdictions.

Waitemata District Health Board

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Waitemata
District Health Board

Best Care for Everyone