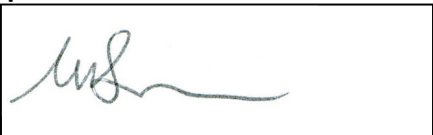
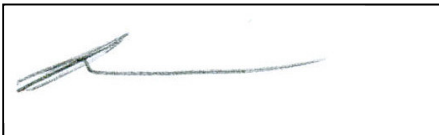


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The Board Members are pleased to present the report of Auckland District Health Board ("ADHB") and the Group comprising ADHB, its subsidiary company and associates for the year ended 30 June 2006.

For and on behalf of the Board Members who authorised the issue of this annual report.	
	
W. K. F. BROWN Chair	H. J. BURKHARDT Chair Audit Committee
Dated: 05/10/06	Dated: 05/10/06



AUCKLAND DISTRICT HEALTH BOARD

MISSION

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

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

DIRECTORY

Address for Service

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

Postal Address

PO Box 26417
Auckland
Telephone: (09) 630 9817
Facsimile: (09) 639 9816

Auditor

Ernst & Young (on behalf of the Office of the Auditor-General)
41 Shortland Street
PO Box 2146
Auckland 1

Board Members

W.K.F. Brown (Chair)	B.J. de Geest
R.B. Keenan (Deputy Chair)	Dr. V.T. Hope
Dr. A.R. Bierre *	Dr. D.M. Nash
Dr. J.D. Blue (resigned 25 October 2005)	J. Retimana
H.J. Burkhardt	Dr. I.K. Scott
Dr. C.J.W. Chambers	

*Granted Leave of Absence 14 January 2006 to 30 June 2006

Chief Executive

G.R. Smith

Executive Management

T. Campbell	(Executive Director of Nursing and Midwifery)
Dr. S. Child	(Director, Clinical Training)
M. Dotchin	(General Manager, Adult Services)
F. Dougan	(General Manager, Greenlane and Mental Health Services)
K. Hyman	(General Manager, Women's and Children's Health)
R. Jarrold	(Chief Financial Officer)
Dr. D. Jury	(Chief Planning and Funding Officer)
K. MacDonald	(General Manager, Maori Health)
S. Mayo-Smith	(Chief Information Officer)
J. Mueller	(Director, Allied Health)
Dr. N. J. Murray*	(General Manager, Auckland City Hospital)
A. Norton	(General Manager, Human Resources)
Dr. A. Pelkowitz	(Clinical Leader, Planning and Funding)
A. Redican	(General Manager, Pacific Health)
F. Ritsma	(General Manager, Clinical Speciality Services)
Dr. D. Sage	(Chief Medical Officer)
Dr. M. Wilsher	(Medical Director, Adult Services)

*Seconded to Southland District Health Board 1 January 2006 to 30 June 2006



AUCKLAND DISTRICT HEALTH BOARD

DIRECTORY (continued)

Clinical Board

Dr. D. Sage (Chair)
Dr. R. Aickin
Dr. N. Argyle
Dr. J. Bent
M. Broodkoorn
T. Campbell
R. Conway
Dr. R. Franklin
Dr. R. Frith

Dr. J. Henley
Dr. B. Kent
Dr. D. Knight
Dr. C. McArthur
J. Mueller
Dr. A. Pelkowitz
Dr. M. Wilsher
A. Yates

CHAIRMAN'S REVIEW

Four years back, as a new chairman to ADHB, four new goals were set, being to finish the building program, get traction on the change program, get control of our finances and the main inspirational goal of Lifting the Health of our Auckland population.

Slowly we have progressed with the first three as the new Auckland City Hospital and the Green Lane Clinical Centre were completed and moved into with newly adopted ways of doing things which required a bedding in phase as several of the heroic claims of the building advocates had to be modified. The Board wishes to thank all staff involved in that period where commitment and restraint were required.

During this period Ministry of Health devolved significantly more of their responsibilities to DHBs including Care of The Elderly, Disability Support and together with the institution of Primary Healthcare Organisations, the already difficult task of operating ADHB grew as did its operating budget from some \$800m to over \$1.2billion.

The 2005/06 financial year can be looked back on with some satisfaction. Largely due to increased productivity we not only reduced our budgeted deficit by nearly \$20m, but importantly we made inroads into serving our own population's health needs, which had tended to suffer from financial pressures mixed with the fact that more than half of our income comes from servicing other DHB districts.

Service reviews were undertaken to enable us to benchmark our costs and improve our productivity against other tertiary providers so that accurate costing information supported our ongoing battles to get paid at the appropriate rates for the complex work that ADHB carries out for other DHBs.

This journey has a way to go yet, as we seek to have logical and defensible costing systems agreed with Ministry of Health and other DHB officials. ADHB has in the past relied on various special adjuster payments to recognise the complexity of cases referred to us, however these adjuster payments have often been removed on a whim by the centre, and this has led to an almost relentless assault on costs and efficiencies that can seem overwhelming and more than the health team can continue to actively face.

Nevertheless I am delighted with the approach and results achieved by ADHB and staff at all levels can be proud of their achievements. I have particularly enjoyed attending the quarterly meetings of Clinical Directors who have displayed innovation and determination to deliver cost effective health care.

Regional meetings have slowly improved the co-operation across Greater Auckland where the high daily movements of population can lead to confusion over the right place for the public to be treated and the need for the system to accommodate their wishes while correctly tracking the associated costs. A regional approach to laboratory services has resulted in a new contract to start next financial year with promised savings that will allow more health service delivery. This changed contract has not been without some dissatisfaction from the current provider, but the combined boards received strong clinical and financial advice that the new contract will offer an improved service.

There were times this year where events conspired to make an already difficult task even more challenging and the Board has been very proud of how well staff have managed these events. In particular June offered the combined difficulties of unexpected power outages, junior doctor strikes and a hospital crowded with patients affected by the very cold snap that hit the country.



AUCKLAND DISTRICT HEALTH BOARD

Much progress has been made with innovative delivery of services both within the hospital and within the community and we will build on this. Our improved productivity has also lifted our credibility with the centre and while the pressure to get rid of the last of our losses will remain there is a growing feeling that the current team can achieve the required break-even position in the next two years.

Thanks to all involved at ADHB

WAYNE BROWN

Chairman on behalf of the Board.

CHIEF EXECUTIVE'S REVIEW OVERVIEW

The 2005/06 financial year has been a very significant one for the ADHB. We have made major strides towards meeting our long term goals and have surpassed some of our short term goals of living within our means, leading performance improvement and lifting the health of people in Auckland city. This outstanding achievement would not have been possible without a huge effort by a large number of people and the continued dedication of ADHB staff.

The most significant highlight of the 2005/06 financial year was the substantial reduction of the deficit. Our target was a budgeted deficit of about \$65 million, but we did far better than this, with a deficit of \$46 million. This was achieved through a lift in productivity (a rise in the number of outputs, or outcomes, at approximately the budgeted cost) as well as holding back on capital investments. The improved deficit position and reduced spending meant less money borrowed resulting in lowered interest and depreciation costs. And this impressive improvement was accomplished without extraordinary redundancies.

All this has been achieved within the complexity of the ADHB. Not only are we the country's largest district health board, but our organisation is more than just hospitals, it is one which takes responsibility for the health of its community with a whole system, multi-sectoral approach to population health, features of a true DHB.

ADHB encompasses many community providers (such as adult community mental health services), and works with other organisations supporting programmes aimed at lifting the health of Aucklanders. A great example of this is the 'Snug Homes for Auckland' project launched in May, which is jointly funded by both public and private organisations to improve insulation of the homes of 500 Auckland families, as part of our Child Health Improvement Plan.

As the country's largest DHB we do not just serve our own significant population, we are also a provider of both regional and national services. We provide tertiary services for patients from predominately Northland, Waitemata and Counties Manukau District Health Boards, and a range of highly specialised services for New Zealand such as heart, lung and liver transplants; paediatric intensive care unit transfers; major head trauma requiring neurosurgery and high risk obstetrics. Over the past year, we have been working to address the logistical and funding considerations around being a provider of these services to other DHBs.

We are also involved in a number of regional and national projects, such as adopting the Family Violence Intervention programme and following national health strategies such as the New Zealand Health Strategy, the Primary Healthcare Strategy and He Korowai Oranga Maori Health Strategy in our aim to reduce health inequalities and improve health outcomes for Maori in Auckland City.

Beginning the year

We began the 2005/06 financial year with a forecasted deficit of \$65 million and, as one of our priority goals is to live within our means, a key focus has been on the four root causes of our deficit: infrastructure costs, funding levels, staffing and salaries and efficient delivery of services.

Another focus was to ensure that the Annual Services Planning flowed into the District Annual Plan taking direction from our District Strategic Plan and our overall vision of Healthy Communities, Quality Healthcare. Until this year, the Annual Services Planning was conducted independently.

We had major initiatives planned under the 'Our Health 2020' banner to lift the health of people in Auckland city, which is one of our three priority goals. This is a core focus for the ADHB, and includes initiatives in Cardiovascular Disease and Diabetes, the Child Health Improvement Plan, Mental Health and the Health of Older People.

Our third priority goal was to lead performance improvement. This is our commitment to ensuring that all health and support services are integrated and have effective organisation wide systems and processes and all decision-making is evidence and values-based.

ACHIEVEMENTS

1. Live within our means

The combination of the Services Review and work that was already underway on increasing productivity has resulted in a substantial reduction in the deficit. The actual loss for the 05/06 year was \$46 million, compared to the \$65 million budgeted at the beginning of the financial year. Further savings are contained in the service plans over the next three years but are clearly achievable as you will note in the “tasks ahead” mentioned later.

The Services Review project has seen the establishment of a best-practice planning process which has not only helped the ADHB in its work to address the deficit, but has also helped to clearly establish the way forward for each of the services. 68 of the ADHB’s provider-based services underwent the review process, with a further 17 others using an alternative approach because their uniqueness did not easily lend themselves to the benchmarking process against similar service providers.

As a result of the reviews, evidence-based planning is now fully embedded at the ADHB. The three year plans will be reviewed annually in conjunction with annual budgeting and will feed into the District Annual Plan. Other positive outcomes from the Services Review include the potential for innovation being identified in a number of areas and these are being activated as projects going forward. Gaining certainty of patients flows from referring DHB’s is a critical part of the plan to ensure resources are scheduled in a timely way to deliver this work load – especially workforce.

We have been working on the four identified root causes of our deficit: infrastructure costs, funding levels, staffing and salaries and efficient delivery of services. We have largely dealt with the infrastructure pieces of the equation, by a change of our bond structure reducing financing costs and reduction in our capital expenditure plans. Funding (service configuration) is an ongoing dialogue with the various funding parties. Staffing and the efficient delivery of services have been examined in the Service Reviews. The question of wage costs is continually being addressed as the pay gap is the only area where we have yet to make significant progress. The various national MECA pay settlements have tended to close the pay gap from the bottom up, rather than the top down, as we had anticipated, but there is still a material difference to understand and address.

2. Lift the health of people in Auckland City

The four key areas identified as part of our Health 2020 plan are Child Health, Mental Health, the Health of Older People and Cardiovascular Disease and Diabetes. Each one of them has a specific component dedicated to reducing inequalities and we continue to build upon our reputation as a provider of health excellence with Auckland City Hospital’s Admission and Planning Unit featuring as a finalist at this year’s NZ Health Innovation Awards.

Child Health

We have developed a Child Health Improvement plan, where the focus is on co-ordinating different groups across child health and other sectors to improve health outcomes for children. This includes getting Auckland kids enrolled with a PHO, and strengthening primary care, immunisation and dental care. There is also a major effort to improve the co-ordination of services for children and young people.

One of the key priorities for child health includes respiratory disease. This is being addressed in part with the housing insulation project called ‘Snug Homes in Auckland’ which I referred to earlier, and is supported by the Energy Efficiency and Conservation Authority, Starship Foundation, PROCare PHO and Auckland City Council.

The other health priorities for children are injuries, hearing, immunisation, nutrition and obesity, skin sepsis and oral health.

We have also set up systems which ensure 95% of children born at ADHB are recorded on the national immunisation register and over 80% of ADHB children are immunised.

Mental Health

Our focus in this area is on asking people what they want and providing services to match need.

A draft mental health strategy has been developed and has gone out for community consultation, following an extensive period of development within the mental health sector. The next phase will be the development of an action plan to complement the strategic plan in the second half of 2006. Like the other Our Health 2020 plans, it takes a ‘whole-system’ approach to mental health and has the needs of the service user as a key focus.

We are also working on actively addressing the problem of labour shortages in mental health with innovative new approaches such as a highly successful recruitment pilot which improved the numbers of staff hired and was in the running for a Health Innovation Award.

Another initiative involves looking at home-based acute services with a housing pilot underway.

We are acting now to build on what we have, to deliver services for the mental health and addictions needs of the people of Auckland, both now and into the future.

Health of Older People

Coming up with solutions to improve the health and quality of life of older people is part of the 'whole system' approach to healthcare. It is taking an overall view of the health of older people rather than just focusing on older people in hospital. We are also working with mental health services to ensure people do not fall between the cracks of the two sets of services when they have both age-related and mental health conditions.

The first phases of consultation for the Healthy Aging 2020 Strategy have had a very enthusiastic response from stakeholders.

A quality improvement project for rest homes is underway, incorporating a data collection exercise to determine resident and health perspectives. This evidence-based cooperative approach is the first of its kind in New Zealand and it is hoped this will result in a reduction in the number of admissions to hospital for events such as falls.

Cardiovascular Disease and Diabetes

The development of a health improvement plan for cardiovascular disease and diabetes is progressing, but we have not met our targets for the diabetes "Get Checked" programme which provides a free annual diabetic review, either by GP or practice nurse, to patients with diagnosed Type 1 and Type 2 diabetes.

We are in the process of introducing the district-wide rollout of PREDICT, a software tool for GPs which assesses a patient's risk for cardiovascular disease and provides an electronic clinical decision support system to assist in the management of patients with CVD or diabetes. This gives a health practitioner the absolute cardiovascular risk score for the patient in front of them in about two minutes and recommends the most appropriate plan for intervention.

We have appointed a smoke-free co-ordinator, whose role is to implement Systems First, a best practice model to guide the development of Smokefree hospital systems in New Zealand. This means that all smokers admitted to hospital are assessed on their readiness to quit smoking. If so, the patient is offered referrals and cessation support, if not, they are supported to manage withdrawal while in hospital.

The work on Smokefree DHBs also has an internal focus with Smokefree messages aggressively promoted to staff and free smoking cessation services offered through our Occupational Health and Safety clinical practice nurses.

2006 NZ Health Innovations Awards

The introduction of the Admission and Planning Unit at Auckland City Hospital has attracted interest within New Zealand and overseas. The improved acute medical and surgical assessment project was developed to improve an admission process that at times was inefficient and involved the double handling of patients and led to the implementation of the 45-bed unit, run by Inpatient Services, providing rapid assessment, investigation and treatment. Established by Clinical Director John Henley, the unit has been recognised for its innovation and resourcefulness under the category of 'Process Improvement' in regards to its work on enhancing acute medical and surgical assessments, which in turn has saved Auckland City Hospital some 12,000 bed days per year.

3. Lead performance improvement

This means challenging past practices and making sure current decisions make the best use of resources for our population.

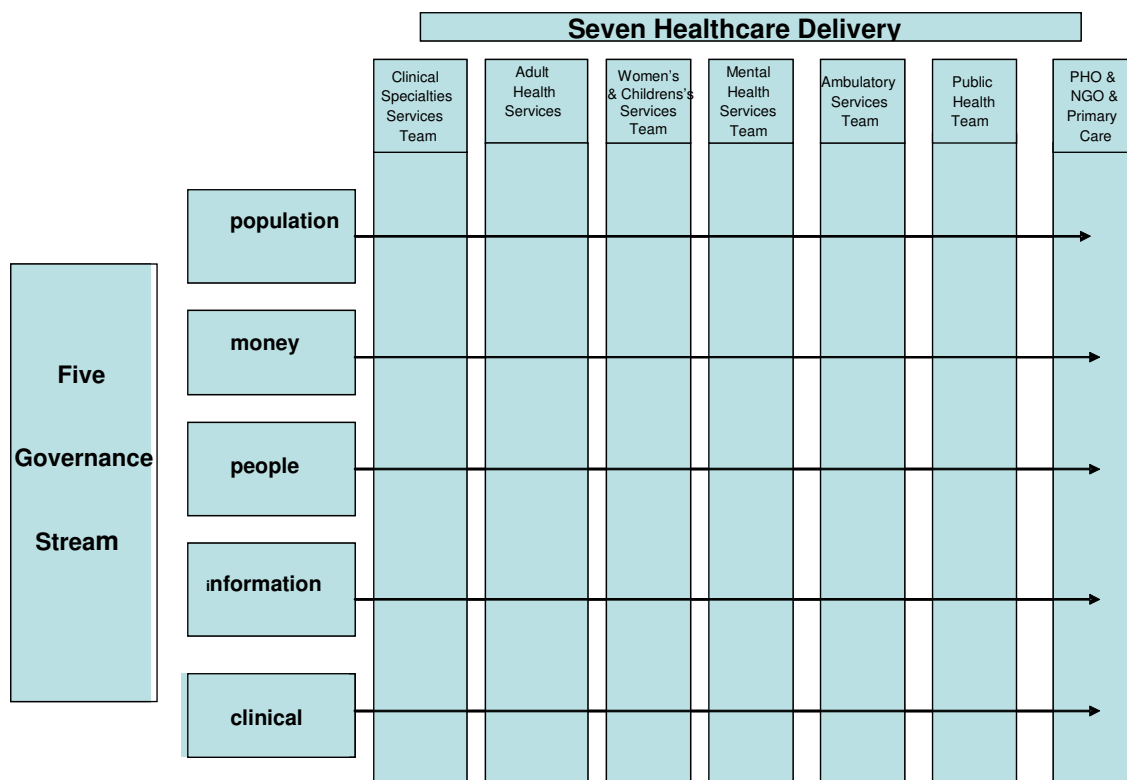
We have consulted widely on our strategic plan, and our annual plan was submitted on time, for the first time.

Integrated Management Structure

Clinicians and management working together is a successful model, with seven healthcare delivery teams and five governance streams in an integrated management and governance matrix.

The governance streams are planning & funding (population), finance (money), HR (people), ISIM (information systems and information management) and clinical.

The seven healthcare delivery teams are clinical specialties services, adult health services, women and children's services, mental health services, ambulatory services, public health and PHO, NGO and primary care teams.



Quality framework emerging

ADHB's commitment to providing quality healthcare to the Auckland community has been formalised with a new governing framework that refocuses quality management and improvement as an organisation-wide issue.

This includes an assurance reporting framework that integrates quality measures with all other performance measures and manages them together at all levels, with the aim of developing a culture which has continuous quality improvement embedded through the encouragement of quality initiatives and providing practical support with CQI toolkits and a quality support structure.

The new framework will be supported by effective reporting systems (utilising the Decision Support Unit) that cater to the diversity of the departments and services within ADHB, using key indicators and regular reviews that will manage the quality process. A Quality Service team that specialises in promoting quality improvement activities will be available to assist all departments throughout ADHB. The framework we have put in place ensures that our values of integrity, respect, innovation and effectiveness meet our ultimate objective – to lift the health of all Aucklanders.

Clinical Practice Committee

We have established a Clinical Practice Committee. This looks at resource prioritisation in practice at ADHB, and involves comparing requests for ADHB resources (usually augmented or innovative practice change requests) based on scoring for safety, efficacy and cost-effectiveness.

Productivity Drive

A new Operational Efficiency Programme of work has been established to improve our overall operating performance across the organisation. This programme comprises 3 key projects which are:

- Surgical Process Review – streamlining the end to end surgical patient journey.
- Capacity Planning – introduction of new production planning tools and processes
- After Hours Model of Care – reviewing the traditional model of after hours hospital care

The Surgical Process Review is an innovative new project that will examine the surgical process from booking to discharge. It may take up to two years to implement, but will have several key outcomes. These are reduced patient delays to access surgery, financial savings from improved efficiency and enhanced staff satisfaction. Part of the project involves reviewing our current systems to identify any blockages or interruptions in patient flow. This includes looking to eliminate 'double-handling', where a patient has to go through a process more than once because of cancellations or postponements. The project will also look at how we can more accurately predict the capacity of the wards and operating rooms, and how that capacity might be better co-ordinated between the two.

Waiting list management

The ADHB is working to achieve compliance with the Ministry of Health's Elective Services Performance Indicators (ESPIs) for managing patients for elective services. ESPIs monitor how patients are managed while waiting for an elective (non-urgent) service across all 21 DHBs. Of the eight ESPIs, we have identified ESPIs 2 and 5 as areas of concern. ESPI 2 relates to patients being seen for a first assessment within six months, and ESPI 5 to patients given certainty of treatment within six months. We are working to achieve ESPI compliance by putting in place measures which include working with clinical services to ensure ADHB complies with booking system principles and the waiting list guidelines, and refining business rules to clarify our referral and surgical list management, particularly with regard to other DHBs' patients. We are also developing reporting formats that integrate the way we report and manage referral demand, contract delivery and waiting lists to inform managers and funders.

All the projects take an evidence-based and measurable approach. The challenge is to manage these complex projects with limited resources.

VISION AND VALUES

Healthy Communities, Quality Healthcare is the vision for Auckland DHB. Our aim is to achieve the right mix of services for the people of Auckland city while balancing the needs of people who live outside our area and require our tertiary services.

Values

The NOVA Awards were introduced in 2005 as one way of recognising employees and teams whose own values align with the ADHB's four adopted values: integrity, respect, innovation and effectiveness. Staff are encouraged to nominate an individual or team who has demonstrated our values above and beyond that expected in the workplace. Recipients have included the Clinical Coding Team; Judi Leyland, a staff nurse at Epsom Day Unit; security guard Finian Ferriera; executive PA Pip Anderson; health care assistant Ana Taumata and mental health recruitment consultant Louise Ayrey. They, and all the other recipients, have been wonderful examples of our values in action.

Services and departments at ADHB can also now apply to become 'values accredited', demonstrating ways in which they have integrated our values into daily practices and behaviours. Epsom Day Unit and the Careers Centre are the first groups to apply for accreditation.

The year has not been without its challenges – especially June, when staff had to deal with both the one-day Auckland power outage and the Radiation Therapist and RMO strikes, all of which resulted in the reduction of clinical services and the redeployment of many of our staff. I was extremely impressed with the way in which our staff responded to these events. Many of the features of the strike response were a graphic illustration of integrity, respect, innovation and effectiveness. I was also delighted with the results of the accreditation survey which showed that the values appear to be becoming embedded within the organisation.

THE TASKS AHEAD

We will have a continued focus on reducing the remaining deficit. There are some areas where it is harder for us to effect change. For example, because we are in deficit, the ADHB gets penalised and receives its funding at the end of the month, not at the beginning, like all other DHBs. This accounts for about \$5-6million dollars per annum in interest contributing to the remaining deficit. Nationally agreed pricing for Tier II services also contributes to the deficit by between \$15-\$20million. But the balance of \$14million is up to us, improving productivity, clinical effectiveness and efficiency.

As a consequence, our objectives for 2006/2007 have the over-arching theme of productivity and efficiencies (including clinical effectiveness). We have changed the focus from the identification of the four root causes of our deficit to the implementation of solutions to remedy the deficit. We have developed and installed a quality framework which provides us with an excellent foundation on which to implement these solutions.

Designed to improve our overall operating performance across the organisation, the 3 significant projects; surgical process review, capacity planning and after hour model of care are in their early planning stages and beginning to gain momentum and I look forward to being able to report progress on these initiatives and others in my next annual report.

In the meantime, I wish to acknowledge the tremendous work by all of our staff to get us to where we are today.

Garry Smith
Chief Executive

SUMMARY OF PERSONNEL POLICIES FOR THE YEAR ENDED 30 JUNE 2006


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

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

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

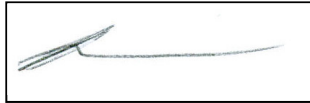
**STATEMENT OF RESPONSIBILITY
FOR THE YEAR ENDED 30 JUNE 2006**

1. The Board and management of ADHB accepts responsibility for the preparation of the financial statements and the judgements used in them;
2. The Board and management of ADHB accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting; and
3. In the opinion of the Board and management of ADHB, the financial statements for the year ended 30 June 2006 fairly reflect the financial position and operations of ADHB.



W. K. F. Brown
Chair

Dated: 05/10/06



H.J. Burkhardt
Chair Audit Committee

Dated: 05/10/06



G. R. Smith
Chief Executive

Dated: 05/10/06

STATUTORY INFORMATION

In respect of the financial year ended 30 June 2006 the Board members of ADHB submit the following report:

Members of the Board - Current

Board member	Experience with ADHB
Wayne Kelvin Forrest Brown (Chair)	From December 2001
Ross Barry Keenan (Deputy Chair)	From December 2004
Dr. Anthony Ronald Bierre*	From December 2004
Harry Jacques Burkhardt	From June 2003
Dr. Christopher John Wesley Chambers	From December 2004
Barry Joseph de Geest	From December 2004
Dr. Virginia Theresa Hope	From December 2004
Dr. Diane Mary Nash	From December 2001
John Retimana	From December 2001
Dr. Ian Kevin Scott	From December 2001

*Granted Leave of Absence 14 January 2006 to 30 June 2006

Members of the Board - Ceased

Dr. Jacqueline Diane Blue	Resigned October 2005
---------------------------	-----------------------

BOARD COMMITTEES AS AT 30 JUNE 2006 - STATUTORY COMMITTEES

Community and Public Health Advisory Committee

W. K. F. Brown (Chair)	B. J. de Geest	Dr. I. K. Scott
R. B. Keenan (Deputy Chair)	Dr. V. T. Hope	P. Stephenson
M. Anae	Dr. D. M. Nash	L. W. Timaloa
Dr. A. R. Bierre*	J. Retimana	A. Woodward
H. J. Burkhardt	P. Roseman	Dr. D. Wu
Dr. C. J. W. Chambers		

Disability Support Advisory Committee

B. J. de Geest (Chair)	M. E. M. Hull-Brown	J. Retimana
M. Baragwanath	S. Gildenlore	A. Tafil
B. Broome	Dr. V. T. Hope	
W. K. F. Brown	Dr. D. M. Nash	

Hospital Advisory Committee

W.K.F. Brown (Chair)	H.J. Burkhardt	Professor I. Martin
R.B. Keenan (Deputy Chair)	Dr. C.J.W. Chambers	Dr. D.M. Nash
Professor P.G. Alley	B.J. de Geest	J. Retimana
Dr. A.R. Bierre*	Dr. V.T. Hope	Dr. I.K. Scott

BOARD COMMITTEES AS AT 30 JUNE 2006 - BOARD ESTABLISHED COMMITTEES

Audit Committee

H.J. Burkhardt (Chair)	W.K.F. Brown	R. B. Keenan
Dr. A.R. Bierre*	B.J. de Geest	Dr. I.K. Scott

Quality Committee

Dr. D.M. Nash (Chair)	Dr. C.J.W. Chambers	J. Retimana
Dr. A.R. Bierre*	Dr. V.T. Hope	

Maori Health Advisory Committee

J. Retimana (Chair)	Dr. C. J.W. Chambers	L. Mitchelson
Dr. A.R. Bierre*	N. Glavish	P. Rameka
W. K. F. Brown	A. Hudson	
H.J. Burkhardt	J. Koea	

*Granted Leave of Absence 14 January 2006 to 30 June 2006

Principal activities

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

ADHB provides its own hospital and health services at:

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

Review of operations

	Group \$000	Parent \$000
Results for the year ended 30 June 2006		
Operating deficit	(46,555)	(46,938)
Share of net surpluses of associates	53	0
Net deficit	<u>(46,502)</u>	<u>(46,938)</u>
Equity of ADHB as at 30 June 2006		
Current assets	130,438	123,365
Non-current assets	701,923	699,345
Total assets	<u>832,361</u>	<u>822,710</u>
Current liabilities	216,558	216,358
Non-current liabilities	286,445	286,445
Total liabilities	<u>503,003</u>	<u>502,803</u>
Total equity	<u><u>329,358</u></u>	<u><u>319,907</u></u>

Capital Charge

The capital charge for the year ended 30 June 2006 was \$25.957 million (to 30 June 2005: \$17.909 million) and is treated as an operating expense – note 14.

Equity Comparisons

Equity injections of \$44.518 million were recognised in the period (to 30 June 2005 \$67.011 million).

Financial statements

The financial statements of ADHB and the Group for the year ended 30 June 2006 are included separately in this report. The Group consists of ADHB, the Auckland District Health Board Charitable Trust (beneficial control) and associated entities, Northern Clinical Training Network Limited (46% owned), Northern DHB Support Agency Limited (33% owned), Treaty Relationship Company Limited (50% owned) and Westkids Limited (50% owned).

Interests register

During the year the following entries were recorded in interests register to ADHB:

(a) Board Members' Fees	Year ended 30/6/06
	\$
W. K. F. Brown	87,688
Dr. A. R. Bierre	15,854
Dr. J. D. Blue	2,208
H. J. Burkhardt	29,937
Dr. C. J. W. Chambers	26,500
B. J. de Geest	29,000
Dr. V. T. Hope	26,500
R. B. Keenan	27,333
Dr D. M. Nash	26,500
J. Retimana	26,500
Dr I. K. Scott	29,500

Fees paid to Board Members

327,520

(b) Board Members use of ADHB information

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

(c) Board Members' interests

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

Board Member	Interest
W. K. F. Brown (Chair)	Chairman, Coastlines Group of Companies; Owner/Director of Waahi Paraone Ltd; Owner/Director of Alderton Construction Ltd; Owner/Director of Brown Consulting Ltd; Director, Open Group Ltd; Chairman, Transmission Holdings Ltd
R. B. Keenan (Deputy Chair)	Chairman, Cabletalk Group Ltd; Chairman, Southern Travel Group; Chairman, Auckland Regional Transport Network Ltd; Chairman, Allied Workforce Ltd; Director, Watercare Services Ltd; Director, Ngai Tahu Holdings Corporation; Director, Oceania Attractions Ltd; Director, Touchdown Ltd; Director, Oyster Bay Marlborough Vineyards Ltd; Deputy Chairman, Waitemata District Health Board; Deputy Chairman, Counties Manukau District Health Board
Dr. A. R. Bierre	Senior Lecturer (part-time) Department of Molecular Medicine and Pathology, University of Auckland; Owner/Director ZKTHB Ltd; Managing Director LABTESTS Auckland Ltd; Director LABTESTS New Zealand Ltd; Member, Medical Advisory Committee, New Zealand Breast Cancer Foundation, Consultant to ADHB (Service Reviews)
Dr. J. D. Blue	Breast Physician, Past President Australasian Society of Breast Physicians; Trustee, Breast Cancer Research Trust; Director, St Marks Group and BreastScreen Auckland and North; Steering Committee – NZ Breast Diseases conference 2005
H. J. Burkhardt	Owner/Managing Director of Replas Ltd; Owner/Director of Matta Products Ltd; Shareholder/Director of Remat Group Ltd; Shareholder/Director of Burkhardt Investments Ltd; Shareholder/Director Burris Ltd; Director Blue Skys Ltd; Director Reco Ltd; Shareholder of Solutions Dynamics Ltd; Trustee, ADHB Charitable Trust
Dr. C. J. W. Chambers	Employee ADHB; Wife employed by Safekids; Associate, Epsom Anaesthetic Group; Member ASMS; Executive HINZ
B. J. de Geest	Director, Renaissance Consulting Ltd; Director One2One Homecare Ltd; Director, Keane Group Ltd; Involvement with Disabled Persons Assembly
Dr. V. T. Hope	Employee, Institute of Environmental and Scientific Research; Senior Lecturer, School of Population Health, University of Auckland ; Member, Ministry of Health Technical Advisory Group – Southern Saltmarsh Mosquito; Member, Land Transport Committee, Auckland Healthcare Services; Member, Grants Committee, Asser Trust; Member, Biosecurity Ministerial Advisory Committee; Member, ASMS
Dr. D. M. Nash	General Medical Practitioner; Member, NZ Labour Party Policy Council; Member, NZ Labour Party Health and Social Welfare Policy Committee; Member of Procure Primary Health Organisation; Partner, Cairnhill Health Centre, Epsom
J. Retimana	Consultant Advisor to Territorial Authorities, Opus International Ltd, Transit NZ, Ngati Whatua Trust Board and Te Ure O Hau Investments; Director, Whangai Investments Ltd
Dr. I. K. Scott	Employee, Waitemata District Health Board as a Consultant, Auckland Regional Alcohol and Drug Service (RADS); Board member of the Alcohol Advisory Council of New Zealand

Auckland District Health Board Charitable Trust

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

Trustees of the Trust at 30 June 2006

Trustee	Experience with ADHB
Dr. R. Frith (Chair)	Appointed 9 October 2003
H. J. Burkhardt*	Appointed 7 April 2005
T. Campbell	Appointed 8 April 2004
Dr. I. Civil	Appointed 9 October 2003
Dr. J. Henley	Appointed 7 November 2002
R. Jarrold*	Appointed 7 April 2006
Dr. S. Macfarlane	Appointed 11 March 2005
Dr. A. Pelkowitz	Appointed 8 April 2004
Dr. D. Sage*	Appointed 3 August 2003
G. R. Smith*	Appointed 7 April 2006

*Appointed as Ex Officio Trustees from 7 April 2006

Employee remuneration

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

Remuneration Range	Number of Employees
\$480,000-\$490,000	1
\$430,000-\$440,000	1
\$420,000-\$430,000	1
\$410,000-\$420,000	1
\$400,000-\$410,000	2
\$370,000-\$380,000	5
\$360,000-\$370,000	4
\$350,000-\$360,000	2
\$330,000-\$340,000	4
\$320,000-\$330,000	1
\$310,000-\$320,000	5
\$300,000-\$310,000	8
\$290,000-\$300,000	12
\$280,000-\$290,000	6
\$270,000-\$280,000	15
\$260,000-\$270,000	24
\$250,000-\$260,000	27
\$240,000-\$250,000	11
\$230,000-\$240,000	23
\$220,000-\$230,000	21
\$210,000-\$220,000	16
\$200,000-\$210,000	23
\$190,000-\$200,000	17
\$180,000-\$190,000	36
\$170,000-\$180,000	22
\$160,000-\$170,000	33
\$150,000-\$160,000	29
\$140,000-\$150,000	40
\$130,000-\$140,000	60
\$120,000-\$130,000	49
\$110,000-\$120,000	88
\$100,000-\$110,000	104
Total	691

Note:

Of the 691 employees shown above, 579 are or were medical or dental employees and 112 are or were neither medical nor dental employees. If the remuneration of part-time employees were grossed-up to a full time equivalent basis, the total number of employees with full time equivalent salaries of \$100,000 or more would be 956 compared with the actual total number of employees of 691.

The remuneration received by the Chief Executive during the year ended 30 June 2006 falls within the salary band \$430,000-\$440,000.

Employee remuneration (continued)

Termination payments			
Payment \$	Employees	Payment \$	Employees
133	1	14,461	1
200	14	15,000	2
400	3	15,570	1
534	8	15,822	1
600	1	16,146	1
800	39	18,272	1
876	1	19,334	1
1,068	2	19,988	1
1,500	1	20,633	1
1,600	43	21,759	1
1,618	1	21,802	1
2,183	1	22,769	1
3,092	1	23,119	1
3,404	1	23,734	1
3,594	1	24,506	1
3,757	1	25,636	1
4,000	1	25,664	1
4,500	1	25,679	1
5,000	1	27,340	1
5,148	1	27,780	1
5,275	1	27,826	1
5,296	1	29,096	1
6,272	1	30,244	1
6,655	1	34,238	1
8,138	1	35,420	1
8,930	1	36,923	1
8,963	1	39,303	1
9,522	1	40,300	1
10,220	1	40,854	1
10,400	1	44,515	1
10,479	2	44,566	1
10,614	1	45,363	1
11,254	1	47,299	1
12,776	1	47,348	1
12,812	1	47,682	1
13,540	1	50,160	1
13,659	1	53,750	1
	Total	1,459,998	179

During the year ended 30 June 2006, termination payments were made in respect of 179 employees (216 payments in year ended 30 June 2005). Termination payments consist of settlements and redundancy payments made during the year.

Auditor

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

Remuneration to auditor

	\$
Audit fees	206,000
Other assurance and consultancy fees paid to Ernst & Young	<u>12,000</u>
Amounts paid/payable to Ernst & Young	<u><u>218,000</u></u>

Donations

ADHB did not make any donations during the year.

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



W. K. F. Brown
Chair

Dated: 05/10/06

AUCKLAND DISTRICT HEALTH BOARD

STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2006

	Notes	Group Budget	Group Actual		Parent Actual	
		2006 \$000	2006 \$000	2005 \$000	2006 \$000	2005 \$000
Total operating revenue	2	1,277,098	1,282,464	1,214,434	1,280,985	1,212,262
Share of net surpluses of associates	5	0	53	22	0	0
Total operating expenses		(1,342,641)	(1,329,019)	(1,272,566)	(1,327,923)	(1,270,126)
Total operating deficit before taxation	3	(65,543)	(46,502)	(58,110)	(46,938)	(57,864)
Taxation	4	0	0	0	0	0
Net deficit for the year		(65,543)	(46,502)	(58,110)	(46,938)	(57,864)

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

AUCKLAND DISTRICT HEALTH BOARD

STATEMENT OF MOVEMENTS IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2006

	Notes	Group Budget	Group Actual		Parent Actual	
		2006	2006	2005	2006	2005
		\$000	\$000	\$000	\$000	\$000
Equity at beginning of the year		329,220	329,220	177,132	320,205	167,871
Net deficit for the year		(65,543)	(46,502)	(58,110)	(46,938)	(57,864)
		263,677	282,718	119,022	273,267	110,007
Revaluation Reserves	6(ii)	0	2,122	143,187	2,122	143,187
Equity Injection		37,418	44,518	67,011	44,518	67,011
Equity at end of the year		301,095	329,358	329,220	319,907	320,205

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

AUCKLAND DISTRICT HEALTH BOARD

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2006

	Notes	Group Budget	Group Actual		Parent Actual	
		As at 30/06/06 \$000	As at 30/06/06 \$000	As at 30/06/05 \$000	As at 30/06/06 \$000	As at 30/06/05 \$000
Equity						
Public equity		628,275	635,375	590,857	635,375	590,857
Accumulated deficit	6 (i)	(479,107)	(460,450)	(413,564)	(460,777)	(413,839)
Revaluation Reserve	6 (ii)	143,187	145,309	143,187	145,309	143,187
Donations and bequests	6 (iii)	8,740	9,124	8,740	0	0
Total Equity		301,095	329,358	329,220	319,907	320,205
Represented by:						
Current Assets						
Cash, bank balances and investment bonds	7	4,286	11,406	10,513	4,470	6,507
Receivables and prepayments	8	104,397	109,663	102,097	109,526	101,955
Inventories	9	9,000	9,228	9,871	9,228	9,871
Property intended for sale	1(m)	0	141	148	141	148
Total Current Assets		117,683	130,438	122,629	123,365	118,481
Non-Current Assets						
Cash, bank balances and investment bonds	7	11,306	2,250	4,759	0	0
Property, Plant and Equipment	10	709,510	699,344	710,894	699,344	710,894
Investments in associates	5	276	329	276	1	1
Total Non-Current Assets		721,092	701,923	715,929	699,345	710,895
Total Assets		838,775	832,361	838,558	822,710	829,376
Current Liabilities						
Bank Overdraft	7	35,598	14,750	35,600	14,750	35,600
Payables and accruals	12	192,139	200,964	188,559	200,764	188,392
Borrowings		0	0	236	0	236
Funds Held in Trust		789	844	789	844	789
Total Current Liabilities		228,526	216,558	225,184	216,358	225,017
Non-Current Liabilities						
Payables and accruals	12	14,154	16,445	14,154	16,445	14,154
Borrowings	13	295,000	270,000	270,000	270,000	270,000
Total Non-Current Liabilities		309,154	286,445	284,154	286,445	284,154
Total Liabilities		537,680	503,003	509,338	502,803	509,171
Net Assets		301,095	329,358	329,220	319,907	320,205

The accompanying notes form an integral part of these financial statements

For and on behalf of the Board Members who authorised the issue of these financial statements on 05/10/06

W. K. F. BROWN
Chair

H. J. BURKHARDT
Chair Audit Committee

AUCKLAND DISTRICT HEALTH BOARD

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2006

	Group Budget	Group Actual	Parent Actual		
Notes	2006	2006	2005	2006	2005
	\$000	\$000	\$000	\$000	\$000
Cash Flows from Operating Activities					
Cash was provided from:					
Provision of health services	1,265,751	1,271,441	1,200,383	1,270,433	1,198,630
Interest received	1,286	2,111	1,692	1,636	1,192
	1,267,037	1,273,552	1,202,075	1,272,069	1,199,822
Cash was applied to:					
Employee costs	547,450	506,169	505,102	506,169	505,102
Other operating costs	719,095	739,236	691,819	738,174	689,363
Interest paid	20,814	18,784	19,430	18,784	19,430
	1,287,359	1,264,189	1,216,351	1,263,127	1,213,895
Net cash inflow / (outflow) from operating activities	(20,322)	9,363	(14,276)	8,942	(14,073)
Cash Flows from Investing Activities					
Cash was provided from:					
Proceeds from sale of fixed assets	6,639	128	258	128	258
Cash was applied to:					
Purchase of fixed assets	48,179	34,539	66,289	34,539	66,289
Net cash (outflow) from investing activities	(41,540)	(34,411)	(66,031)	(34,411)	(66,031)
Cash Flows from Financing Activities					
Cash was provided from:					
Proceeds from capital contributed	37,418	44,518	67,011	44,518	67,011
Proceeds from loans raised/ (repaid)	24,766	(236)	(45,653)	(236)	(45,653)
Net cash inflow from financing activities	62,184	44,282	21,358	44,282	21,358
Movement in cash and bank balances					
Opening balance	(20,328)	(20,328)	38,621	(29,093)	29,653
Net cash inflow / (outflow)	322	19,234	(58,949)	18,813	(58,746)
Closing bank balance	7 (20,006)	(1,094)	(20,328)	(10,280)	(29,093)

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

AUCKLAND DISTRICT HEALTH BOARD

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2006

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

	Group	Group Actual		Parent Actual	
	Budget	2006	2005	2006	2005
	2006	2006	2005	2006	2005
	\$000	\$000	\$000	\$000	\$000
Reported net deficits for the year	(65,543)	(46,502)	(58,110)	(46,938)	(57,864)
Add non-cash items:					
Depreciation and impairment loss	49,447	45,658	41,683	45,658	41,683
Associates	0	(53)	(22)	0	0
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets	(6,374)	(78)	992	(78)	992
Add movements in working capital items:					
(Increase) Decrease in receivables	(2,302)	(6,726)	(9,694)	(6,730)	(9,775)
(Increase) Decrease in inventories	870	643	(2,078)	643	(2,078)
Increase (Decrease) in payables	3,580	16,366	12,907	16,332	12,923
Increase (Decrease) in funds held in trust	0	55	46	55	46
Net cash inflow/(outflow) from operating activities	<u>(20,322)</u>	<u>9,363</u>	<u>(14,276)</u>	<u>8,942</u>	<u>(14,073)</u>

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

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2006

Note

1 STATEMENT OF ACCOUNTING POLICIES

Reporting Entity

Auckland District Health Board (ADHB) is established under the New Zealand Public Health and Disability Act 2000. ADHB is a Crown Entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

ADHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Financial Reporting Act 1993 and an issuer for the purposes of the Financial Reporting Act 1993.

ADHB and its subsidiary, the Auckland District Health Board Charitable Trust, comprise the Group.

The financial statements of ADHB and Group have been prepared in accordance with the Crown Entities Act 2004 and the Financial Reporting Act 1993.

Measurement Base

The accounting principles recognised as appropriate in the measurement and reporting of financial performance and financial position on a historical cost basis are followed by ADHB, with the exception that certain assets and liabilities specified below have been stated at fair value.

Going concern

The financial statements, which comply with the requirements of the Financial Reporting Act 1993 and the Public Finance Act 1989, are prepared on the basis that the ADHB is a going concern.

Budget figures

The budget figures are those approved by the Board. The budget figures have been prepared in accordance with the accounting policies adopted by the Board for the preparation of the financial statements.

1 STATEMENT OF ACCOUNTING POLICIES (continued)

Specific Accounting Policies

The following particular accounting policies which materially affect the measurement of financial performance and the financial position have been applied.

(a) Goods and Service Tax (GST)

All items in the financial statements are exclusive of GST with the exception of receivables and payables which are stated with GST included. The net amount of GST payable is included as part of payables in the Statement of Financial Position. In the Statement of Cash Flows, GST on receipts and GST on payments are offset to present a net amount of GST paid and presented as an operating cash outflow. Where GST is irrecoverable as an input tax then it is recognised as part of the related asset or expense.

(b) Basis of consolidation

Subsidiary

The consolidated financial statements include those of ADHB and the Auckland District Health Board Charitable Trust. The Auckland District Health Board Charitable Trust is accounted for using the purchase method, which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis. The ADHB Charitable Trust is consolidated as ADHB has beneficial control of the Trust. All significant inter-entity transactions are eliminated on consolidation.

Associates

Associates are entities in which ADHB holds an interest in the equity and over which ADHB exercises significant influence but does not control. Associates have been reflected in the consolidated financial statements on an equity accounting basis which recognises the ADHB's share of retained surpluses in the consolidated statement of financial performance and its share of post acquisition increases or decreases in net assets, in the consolidated statement of financial position. In ADHB's financial statements investments in associates are recognised at cost.

(c) Employee entitlements

Employee entitlements include liabilities for salary and wages, annual leave, long service leave and retirement gratuities accrued to employees for services rendered up to balance date. In determining the value of employee entitlements, salary and wages and annual leave are calculated on an actual entitlement basis whilst the other entitlements are calculated on an actuarial basis at current rates of pay.

(d) Taxation

Auckland DHB is a public authority under New Zealand Public Health and Disabilities Act 2000 and is exempt from Income tax under section CB3 of the Income Tax Act 1994.

(e) Foreign currency

Transactions denominated in foreign currencies (other than forward contracts) are translated at the rate of exchange ruling at the transaction date. Short-term transactions covered by forward exchange contracts are measured and reported at the forward rates specified in the contracts. At balance date foreign monetary assets and liabilities are translated at the closing rate and exchange differences arising from the translations are recognised in the Statement of Financial Performance.

Where a foreign monetary asset is designated as a hedge of a transaction denominated in a foreign currency, the exchange difference arising from their translations are recognised in the statement of financial performance.

(f) Accounts receivable

Accounts receivable are stated at expected realisable value after providing for doubtful and uncollectible debts.

(g) Inventories

Inventories are valued on the basis of the lower of cost, determined on a first-in first-out basis, and net realisable value. This valuation includes allowances for slow moving and obsolete inventories.

Note

1 STATEMENT OF ACCOUNTING POLICIES (continued)

(h) Leases

Finance leases, which effectively transfer to the entity substantially all of the risks and benefits incidental to ownership of the leased item, are capitalised at the lower of fair value of the leased property, and the present value of the minimum lease payments. The leased assets and corresponding liabilities are recognised in the statement of financial position and the leased assets are depreciated on a straight line basis over the period the entity is expected to benefit from their use.

Operating lease payments, where the lessors effectively retain substantially all the risks and benefits of ownership of the leased items, are charged as expenses in the periods in which they are incurred.

(i) Revenue recognition policy

Ministry of Health contract revenue and interest income are recognised on an accrual basis. Other operating revenue is recognised when earned or on receipt for delivery of service, whichever is earlier.

Donations and bequests received are treated as revenue on receipt, in the statement of financial performance. These funds are administered by the Auckland District Health Board Charitable Trust.

Donations and bequests from third party trusts are recognised as revenue only when actually received.

(j) Funds held in trust

Funds held on behalf of patients and the Ngati Whatua Trust Board are treated as a non-current liability "Funds held in trust" and are distributed to them as required.

(k) Research projects

Research costs are recognised in the statements of financial performance as incurred. Grants received in respect of research projects are recognised in the Statement of Financial Performance in the same period as the related expenditure. Research income not recognised in the period is held as Payables and Accruals in the Statement of Financial Position.

(l) Financial instruments

As a guardian of public money, ADHB must be risk averse and seek to minimise exposure arising from its treasury activity. ADHB is not authorised by Treasury policy to enter into any transaction which is speculative in nature. Financial instruments carried on the Statement of Financial Position includes cash and bank balances, receivables, payables and borrowings. These instruments are generally carried at their estimated fair value.

Investments in bonds are recognised at market value at balance date. Gains or losses on the investments are recognised in the Statement of Financial Performance. ADHB is also party to financial instruments that are not recognised in the financial statements. These include interest rate swaps and forward exchange contracts. Their primary purpose is to reduce exposure to fluctuations in foreign currency exchange rates and interest rates. Any gains or losses arising from exposure to foreign exchange instruments are offset against the related gains or losses on the recorded assets or liabilities being hedged. The net differential paid or received on interest swaps is recognised as a component of interest expense or interest revenue over the period of the agreement.

Note

1 STATEMENT OF ACCOUNTING POLICIES (continued)

(m) Property Plant and Equipment

There are eight classes of property plant and equipment:

- Freehold Land
- Land Improvements
- Plant and Equipment
- Freehold Buildings
- Building Fitout and Services
- Leasehold Improvements
- Work in Progress
- Leased Plant and Equipment

Items of property, plant and equipment are initially recorded at cost.

The building assets of ADHB are considered to be specialised assets and accordingly are valued where appropriate based on depreciated replacement cost (fair value). Valuations have been obtained through an independent valuer.

Valuations are carried out for Land, Buildings, Building Fitout and Services to reflect the service potential or economic benefit obtained through control of the asset. Valuation is based on the fair value of the asset. Where an asset is recorded using depreciated replacement cost, depreciated replacement cost is based on the estimated present cost of construction, reduced by factors for age and deterioration of the asset.

Classes of property, plant and equipment assets that are revalued, are revalued at least every five years.

For each property, plant and equipment asset project, borrowing costs incurred during the period required to complete and prepare the asset for its intended use are expensed.

Work in progress, which is not depreciated, is the cost of direct material, direct labour and direct overhead of capital works projects unfinished at balance date. When a project is finished the total cost of that project is transferred to buildings and/or plant and equipment.

The carrying amounts of all property, plant and equipment are reviewed on an ongoing basis. Any impairment in value is recognised immediately in the Statement of Financial Performance. If the recoverable amount of an asset is less than the carrying amount, the item is written down to its recoverable amount. The write down of an asset recorded at historical cost is recognised as an expense in the Statement of Financial Performance.

The carrying amount of an asset that has previously been written down to recoverable amount is increased to its current recoverable amount if there has been a reversal of the impairment loss. The increased carrying amount of the item will not exceed the carrying amount that would have been determined if the write down to recoverable amount had not occurred. On assets that are not revalued the reversal is recognised in the Statement of Financial Performance. On revalued assets the reversal is recognised as revenue to the extent that the impairment was recognised as an expense, and the balance is treated as an upward revaluation.

Gains and losses on disposal of property, plant and equipment are recognised as revenues or expenses in the Statement of Financial Performance.

Properties intended for sale are carried at the lower of cost and net realisable value and are recorded in current assets.

1 STATEMENT OF ACCOUNTING POLICIES (continued)

(n) Depreciation

Depreciation of property, plant and equipment, other than land and work in progress, is calculated on a straight line basis so as to allocate the cost of the assets, less their estimated residual values, over their useful lives as follows:

<u>Asset Class</u>	<u>2006</u>	<u>2005</u>
Freehold Buildings	1 to 89 years	1 to 89 years
Plant and Equipment	2 to 20 years	2 to 20 years
Building Fitout and Services	1 to 45 years	1 to 45 years
Leased Plant and Equipment	4 to 8 years	4 to 8 years
Leasehold Improvements	6 to 8 years	6 to 8 years

(o) Changes in accounting policies

There are no changes in accounting policies during the period.

(p) Comparatives

Where necessary, comparative information has been reclassified to achieve consistency in disclosure with the current year.

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

	Group Actual		Parent Actual	
	2006	2005	2006	2005
	\$000	\$000	\$000	\$000
2 REVENUE				
Patient Care Revenue	1,195,926	1,148,991	1,195,926	1,148,991
Interest received – other	1,636	1,192	1,636	1,192
Interest received – Charitable Trust	475	500	0	0
Donations and Bequests	0	1,672	0	0
Gain on disposal of assets	78	0	78	0
Other revenue	84,349	62,079	83,345	62,079
Total Revenue	1,282,464	1,214,434	1,280,985	1,212,262
3 OPERATING DEFICIT BEFORE TAXATION				
After charging/(crediting) :				
Remuneration of auditor				
- audit fees	206	196	206	196
- other services (assurance and consultancy fees)	12	2	12	2
Depreciation				
Freehold Buildings	3,865	4,922	3,865	4,922
Building Fitout and Services	13,418	7,922	13,418	7,922
Plant and Equipment	27,997	27,620	27,997	27,620
Leasehold Improvements	22	29	22	29
Leased Plant and Equipment	356	356	356	356
Total depreciation	45,658	40,849	45,658	40,849
Employee costs	544,075	512,001	543,976	512,001
Loss on disposal of assets	0	992	0	992
Board Members' fees	327	345	327	345
Impairment loss/(gain) (Note 10)	0	835	0	835
Interest expense	18,840	19,120	18,840	19,120
Finance costs	0	63	0	63
Foreign currency loss/(gain)	12	(44)	12	(44)
Rental and operating lease costs	8,202	9,625	8,202	9,625
Research costs	8,936	5,978	8,818	5,978
Bad debts written off	2,698	2,739	2,698	2,739
Increase (decrease) in estimated doubtful debts	256	1,119	256	1,119
Capital charge (Note 14)	25,957	17,909	25,957	17,909
4 TAXATION				

Auckland DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from Income Tax under Section CB 3 of the Income Tax Act 1994.

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

	Group Actual		Parent Actual	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
5 INVESTMENTS IN ASSOCIATES				
<i>Results of associates</i>				
Share of post acquisition surplus	53	22	0	0
Share of taxation	0	0	0	0
Share of net surpluses of associates	53	22	0	0
Carrying amount at the beginning of the year	276	254	0	0
Carrying amount at end of year	329	276	0	0
<i>Represented by:</i>				
Shares in associates (unlisted at cost)	1	1	1	1
Share of post-acquisition retained surpluses	328	275	0	0
	329	276	1	1

<i>Name of associates (Principal activity)</i>	2006 % Interest held	2005 % Interest held
Northern Clinical Training Network Limited (co-ordinates trainee medical personnel)	46	40
Northern DHB Support Agency Limited (management of a number of regional contracts on behalf of the Auckland region DHBs.)	33	33
Treaty Relationship Company Limited (joint venture for health initiatives with local iwi)	50	50
Westkids Limited (provides paediatric services in the community in West Auckland)	50	50

All associates have balance dates of 30 June.

ADHB do not have a share in any contingent liabilities or capital commitments of the associates.

Biomed Investments Limited was liquidated on 30 August 2005. Biomed Investments Limited was a holding company for investments in medical and laboratory supply companies. ADHB held a 50% share in this company.

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

6 EQUITY	Group Actual		Parent Actual	
	As at 30/06/06	As at 30/06/05	As at 30/06/06	As at 30/06/05
	\$000	\$000	\$000	\$000
(i) Accumulated deficits				
Opening balance	(413,564)	(355,721)	(413,839)	(355,975)
Operating deficit after deducting capital charge	(46,502)	(58,110)	(46,938)	(57,864)
Transfer to donations and bequests (Note 6(iii))	(384)	267	0	0
	<u>(460,450)</u>	<u>(413,564)</u>	<u>(460,777)</u>	<u>(413,839)</u>
(ii) Revaluation Reserve				
Land Revaluation Surplus	46,171	46,171	46,171	46,171
Land Improvement Revaluation Surplus	4,097	4,097	4,097	4,097
Building Revaluation Surplus	39,247	39,282	39,247	39,282
Building Fitout and Services Revaluation Surplus	55,794	53,637	55,794	53,637
	<u>145,309</u>	<u>143,187</u>	<u>145,309</u>	<u>143,187</u>
This revaluation reserve relates to land and buildings carried at valuation.				
(iii) Donations and bequests				
Opening balances	8,740	9,007	0	0
Transfer from accumulated deficits (Note 6(i))	384	(267)	0	0
	<u>9,124</u>	<u>8,740</u>	<u>0</u>	<u>0</u>

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

	Group Actual		Parent Actual	
	As at 30/06/06	As at 30/06/05	As at 30/06/06	As at 30/06/05
7 CASH, BANK BALANCES, OVERDRAFT AND INVESTMENT BONDS	\$000	\$000	\$000	\$000
<i>Current assets</i>				
Cash at bank	3,626	5,718	3,626	5,718
Cash at bank (restricted)	3,093	4,795	844	789
Investment Bonds (at market, restricted)	4,687	0	0	0
	<u>11,406</u>	<u>10,513</u>	<u>4,470</u>	<u>6,507</u>
<i>Non-current assets</i>				
Bank balances (restricted)	2,250	0	0	0
Investment Bonds (at market, restricted)	0	4,759	0	0
	<u>2,250</u>	<u>4,759</u>	<u>0</u>	<u>0</u>
	<u>13,656</u>	<u>15,272</u>	<u>4,470</u>	<u>6,507</u>
<i>Current Liabilities</i>				
Bank Overdraft	(14,750)	(35,600)	(14,750)	(35,600)
Closing Bank Balance	<u>(1,094)</u>	<u>(20,328)</u>	<u>(10,280)</u>	<u>(29,093)</u>
Trust Funds				
The restricted assets above are Trust Funds and are restricted exclusively for the purposes of a charitable nature and within New Zealand.				
8 RECEIVABLES AND PREPAYMENTS				
Accounts receivable	97,631	89,671	97,631	89,671
Provision for doubtful debts	(2,702)	(2,446)	(2,702)	(2,446)
	<u>94,929</u>	<u>87,225</u>	<u>94,929</u>	<u>87,225</u>
Prepayments	2,125	1,820	2,125	1,820
Amounts receivable from associates	0	29	0	29
Other receivables	12,609	13,023	12,472	12,881
	<u>109,663</u>	<u>102,097</u>	<u>109,526</u>	<u>101,955</u>
9 INVENTORIES				
Pharmaceuticals	579	346	579	346
Surgical and medical supplies	8,613	9,498	8,613	9,498
Other supplies	36	27	36	27
	<u>9,228</u>	<u>9,871</u>	<u>9,228</u>	<u>9,871</u>

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

	Group Actual		Parent Actual	
	As at 30/06/06	As at 30/06/05	As at 30/06/06	As at 30/06/05
	\$000 Group	\$000 Group	\$000 Parent	\$000 Parent
10.PROPERTY, PLANT and EQUIPMENT				
Total Gross Carrying Value				
Freehold Land (at valuation)	49,798	49,798	49,798	49,798
Land Improvements (at valuation)	4,097	4,097	4,097	4,097
Freehold Buildings (at valuation)	233,454	233,285	233,454	233,285
Building Fitout and Services (at valuation)	334,097	317,127	334,097	317,127
Plant and Equipment (at cost)	262,958	246,027	262,958	246,027
Leasehold Improvements (at cost)	749	727	749	727
Leased Plant & Equipment (at cost)	6,470	6,470	6,470	6,470
Work in Progress (at cost)	2,503	6,901	2,503	6,901
Total Gross Carrying Value	894,126	864,432	894,126	864,432
Accumulated depreciation				
Freehold Buildings	(3,835)	0	(3,835)	0
Impairment Loss - Computer Systems	(1,130)	(1,130)	(1,130)	(1,130)
Building Fitout and Services	(13,430)	0	(13,430)	0
Plant & Equipment	(170,169)	(146,575)	(170,169)	(146,575)
Leasehold Improvements	(579)	(551)	(579)	(551)
Leased Plant & Equipment	(5,639)	(5,282)	(5,639)	(5,282)
Total Accumulated Depreciation	(194,782)	(153,538)	(194,782)	(153,538)
Net Carrying Value				
Freehold Land	49,798	49,798	49,798	49,798
Land Improvements	4,097	4,097	4,097	4,097
Freehold Buildings	229,619	233,285	229,619	233,285
Building Fitout and Services	320,667	317,127	320,667	317,127
Plant & Equipment	91,659	98,322	91,659	98,322
Leasehold improvements	170	176	170	176
Leased plant & equipment	831	1,188	831	1,188
Work in progress	2,503	6,901	2,503	6,901
Total Net Carrying Value	699,344	710,894	699,344	710,894

	As at 30/06/06	As at 30/06/05
	\$000	\$000
	Group	Group
10.PROPERTY, PLANT and EQUIPMENT (continued)		
By Holding		
Freehold Assets	698,343	709,530
Leasehold Assets	1,001	1,364
	699,344	710,894

Impairment Loss

The carrying amounts of all property, plant and equipment are reviewed on an ongoing basis. Any impairment in value is recognised immediately. No impairment loss (2005: \$835k) was recognised as an expense in the Statement of Financial Performance

Valuation Information

Land, Buildings and associated fitouts and services were independently valued on 30 June 2005 by Telfer Young (Auckland) Ltd, a firm registered with Valuers of New Zealand at \$604.307m. This value assesses key parcels of land subject to restrictive covenants as having a Nil value. Telfer Young have provided a second valuation for \$749.118m which takes into account the value of these parcels if there were no restriction on the ability to sell that land. The Board takes the view that the appropriate valuation method is to reflect the fair value as being affected by the inability to sell this land due to the surrounding restrictive covenants.

Surplus land subject to disposal which is subject to due process with regard to the New Zealand Public Health and Disabilities Act 2000, including Ministerial approval, Public Works Act 1981, S.40, the mechanism for protection of Maori interests in Crown owned land and any other interests registered on the title or under any other applicable legislation (e.g. Reserves Act 1977), is held at cost as property intended for resale.

11 CONTINGENT ASSET

ADHB benefits from grants from the Greenlane Research and Educational Fund Trust (GREFT). This fund was set up for the purpose of administering funds to further the services in the cardio-thoracic surgical and cardiology units at Greenlane Hospital. The assets of the fund have not been consolidated in the financial statements because ADHB does not exercise control over the GREFT in terms of Financial Reporting Standard Number 37 "Consolidating Investments in Subsidiaries". Furthermore ADHB is unable to control the timing and amount of any distribution of funds, consequently it is not possible to estimate the future economic benefit to ADHB in terms of Financial Reporting Standard Number 15 "Provisions , Contingent Liabilities and Contingent Assets".

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

	Group Actual		Parent Actual	
	As at 30/06/06 \$000	As at 30/06/05 \$000	As at 30/06/06 \$000	As at 30/06/05 \$000
12 PAYABLES AND ACCRUALS				
<i>Current</i>				
Trade payables and accruals	81,485	84,382	81,352	84,382
Provisions	388	650	388	650
PAYE and GST	11,968	15,237	11,968	15,239
Employee entitlements	72,875	67,032	72,875	67,032
Amounts payable to associates	201	133	201	133
Other payables and accruals	34,047	21,125	33,980	20,956
	<u>200,964</u>	<u>188,559</u>	<u>200,764</u>	<u>188,392</u>
<i>Non-current</i>				
Employee entitlements	<u>16,445</u>	<u>14,154</u>	<u>16,445</u>	<u>14,154</u>

PROVISIONS

Litigation Provision

No provision has been made for litigation as it is believed that no material costs are likely to arise from outstanding legal issues.

Redundancy Provision

Opening balance	650	682	650	682
Additional provisions made during year	66	521	66	521
Charged against provision for the year	(328)	(553)	(328)	(553)
Closing balance	<u>388</u>	<u>650</u>	<u>388</u>	<u>650</u>
Total provisions	<u>388</u>	<u>650</u>	<u>388</u>	<u>650</u>

Note: The provision relates to expected costs arising from specific service reviews in progress at year-end. It is anticipated that all expenditure will be incurred in the next financial year.

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

	Group Actual		Parent Actual	
	As at 30/06/06 \$000	As at 30/06/05 \$000	As at 30/06/06 \$000	As at 30/06/05 \$000
13 BORROWINGS				
<i>Current</i>				
UDC Finance Lease	0	236	0	236
	<u>0</u>	<u>236</u>	<u>0</u>	<u>236</u>
<i>Non-current</i>				
Crown Health Financing Agency	150,000	150,000	150,000	150,000
15 year Bond, maturing 15 September 2015	50,000	50,000	50,000	50,000
10 year Bond, maturing 15 September 2010	70,000	70,000	70,000	70,000
	<u>270,000</u>	<u>270,000</u>	<u>270,000</u>	<u>270,000</u>
Borrowings are repayable:				
Less than one year	0	0	0	0
One to two years	150,000	0	150,000	0
Two to five years	70,000	150,000	70,000	150,000
Over five years	50,000	120,000	50,000	120,000
	<u>270,000</u>	<u>270,000</u>	<u>270,000</u>	<u>270,000</u>
Finance leases are repayable:				
Less than one year	0	236	0	236
One to two years	0	0	0	0
Two to five years	0	0	0	0
Over five years	0	0	0	0
	<u>0</u>	<u>236</u>	<u>0</u>	<u>236</u>
<i>Interest rates</i>	% pa	% pa	% pa	% pa
Crown Health Financing Agency	6.65 - 7.25	5.68 - 6.71	6.65 - 7.25	5.68 - 6.71
UDC Finance lease	-	9.45	-	9.45
Bonds	7.75	7.75	7.75	7.75

ADHB borrows funds based on covenants and a negative pledge deed. This includes the covenant that security cannot be given over assets of ADHB without prior written consent of the lender.

Finance leases were established prior to the enactment of New Zealand Public Health and Disabilities Act 2000.

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

	Group Actual		Parent Actual	
	As at 30/06/06 \$000	As at 30/06/05 \$000	As at 30/06/06 \$000	As at 30/06/05 \$000
13 BORROWINGS (continue)				
<i>Banking facilities</i>	Limit available	Limit available	Limit available	Limit available
The following banking facilities are available to ADHB:				
Revolving Cash Facilities:				
Crown Health Financing Agency	195,000	195,000	195,000	195,000
ASB	65,000	65,000	65,000	65,000
Total revolving cash facility	260,000	260,000	260,000	260,000
14 CAPITAL CHARGE	25,957	17,909	25,957	17,909

All DHBs are required to pay a capital charge to the Crown based on their shareholders' funds. The charge is set at 8 percent (11 percent as at 30/06/05) on shareholders' funds based on the monthly closing balance. ADHB has not paid a capital charge on donations received into the ADHB Charitable Trust.

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

	Group Actual		Parent Actual	
	As at 30/06/06 \$000	As at 30/06/05 \$000	As at 30/06/06 \$000	As at 30/06/05 \$000
15 COMMITMENTS				
(i) Capital commitments				
Approved and contracted	4,506	14,900	4,506	14,900
Approved and to be contracted	5,460	6,632	5,460	6,632
	9,966	21,532	9,966	21,532
Term classification of commitments				
Less than one year	9,966	21,532	9,966	21,532
One to two years	0	0	0	0
Two to five years	0	0	0	0
Over five years	0	0	0	0
	9,966	21,532	9,966	21,532
(ii) Operating commitments				
Term classification of commitments				
Less than one year	27,825	37,627	27,825	37,627
One to two years	10,559	10,468	10,559	10,468
Two to five years	2,352	6,897	2,352	6,897
Over five years	254	392	254	392
	40,990	55,384	40,990	55,384
16 TRANSACTIONS WITH RELATED PARTIES				
Associates identified in note 5 are related parties. The transactions with associates during the year:				
Sales to associates	56	146	56	146
Purchases from associates	4,948	3,697	4,948	3,697

These transactions were made on commercial terms and conditions and at market rates.
No related party debts have been written off or forgiven during the year.

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

17 FINANCIAL INSTRUMENTS

Credit Risk

To the extent ADHB has a receivable from another party there is a credit risk in the event of non-performance by that counter party. Financial instruments which potentially subject ADHB to credit risk principally consist of bank balances, receivables, foreign currency forward rate agreements and interest rate swaps.

ADHB manages its exposure to credit risk and limits the amount of credit exposure to any financial institution. The maximum exposure is disclosed in the fair value of financial assets and liabilities.

The ADHB receives 94.88% (30/06/05 95.27%) of its revenue from the Crown through the Ministry of Health. Accordingly the Board does not consider there is any risk arising from the concentration of credit with respect to accounts receivable.

The Ministry of Health owed ADHB \$83.389 million (30/06/05: \$76.409 million) as at 30 June 2006. The Ministry of Health has substantially cleared the debt by 4 July 2006 and the Board Members of ADHB believe the balance, after provisions, is fully recoverable.

Fair values of financial assets and liabilities

The estimated fair values of financial instruments that differ from carrying values are as follows:

	Group Actual	Parent Actual	Group Actual	Parent Actual
	As at	As at	As at	As at
	30/06/06	30/06/05	30/06/06	30/06/05
	\$000	\$000	\$000	\$000
Borrowings (non-current)	(278,382)	(278,576)	(278,382)	(278,576)
Off Balance Sheet financial instruments				
Interest rate swaps	5,373	6,512	5,373	6,512

The fair value of the Group's non-current borrowings are estimated based on the current market rates available to the Group for items of a similar nature and maturity.

The fair value of the interest rate swaps is current market valuation provided by the Group's bankers.

Interest rate risk and currency risk

Interest rate risk:

ADHB adopts a policy of spreading its interest rate exposure between fixed and floating rates. Interest rate swaps are used to achieve the appropriate mix of interest rate exposures as set out in the Board's treasury policy.

Foreign currency risk:

The Group had not entered into any foreign exchange contracts at balance date

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

17 FINANCIAL INSTRUMENTS (continued)

	Weighted Average Interest Rate %	GROUP				Total
		Maturity Periods				
		0 – 1 Years	1 – 2 Years	2 – 5 Years	Over 5 Years	
		\$000	\$000	\$000	\$000	\$000
Interest Rate Repricing Schedule						
As at 30 June 2006						
Monetary Assets						
Cash and bank balances	6.90%	6,719	2,250	0	0	8,969
Investment bonds	7.20%	4,687	0	0	0	4,687
Total Monetary Assets		11,406	2,250	0	0	13,656
Monetary Liabilities						
Bank Overdraft	7.55%	14,750	0	0	0	14,750
Crown Health Financing Agency	7.16%	0	150,000	0	0	150,000
Bonds	7.75%	0	0	70,000	50,000	120,000
Total Monetary Liabilities		14,750	150,000	70,000	50,000	284,750
Off Balance Sheet Items (Interest Rate Derivatives)						
Contract Value	6.43%	35,000	40,000	160,000	51,000	286,000
As at 30 June 2005						
Monetary Assets						
Cash and bank balances	6.15%	10,513	0	0	0	10,513
Investment bonds	7.15%	0	4,759	0	0	4,759
Total Monetary Assets		10,513	4,759	0	0	15,272
Monetary Liabilities						
Bank Overdraft	7.05%	35,600	0	0	0	35,600
Crown Health Financing Agency	6.67%	0	0	150,000	0	150,000
Bonds	7.75%	0	0	0	120,000	120,000
Finance leases	9.45%	236	0	0	0	236
Total Monetary Liabilities		35,836	0	150,000	120,000	305,836
Off Balance Sheet Items (Interest Rate Derivatives)						
Contract Value	6.17%	30,000	35,000	90,000	140,000	295,000

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

**17 FINANCIAL INSTRUMENTS
(continued)**

	Weighted Average Interest Rate %	PARENT				Total
		Maturity Periods				
		0 – 1 Years	1 – 2 Years	2 – 5 Years	Over 5 Years	
Interest Rate Repricing Schedule		\$000	\$000	\$000	\$000	\$000
As at 30 June 2006						
Monetary Assets						
Cash and bank balances	6.60%	4,470	0	0	0	4,470
Total Monetary Assets		4,470	0	0	0	4,470
Monetary Liabilities						
Bank Overdraft	7.55%	14,750	0	0	0	14,750
Crown Health Financing Agency	7.16%	0	150,000	0	0	150,000
Bonds	7.75%	0	0	70,000	50,000	120,000
Total Monetary Liabilities		14,750	150,000	70,000	50,000	284,750
Off Balance Sheet Items (Interest Rate Derivatives)						
Contract Value	6.43%	35,000	40,000	160,000	51,000	286,000
As at 30 June 2005						
Monetary Assets						
Cash and bank balances	5.77%	6,507	0	0	0	6,507
Total Monetary Assets		6,507	0	0	0	6,507
Monetary Liabilities						
Bank Overdraft	7.05%	35,600	0	0	0	35,600
Crown Health Financing Agency	6.67%	0	0	150,000	0	150,000
Bonds	7.75%	0	0	0	120,000	120,000
Finance leases	9.45%	236	0	0	0	236
Total Monetary Liabilities		35,836	0	150,000	120,000	305,836
Off Balance Sheet Items (Interest Rate Derivatives)						
Contract Value	6.17%	30,000	35,000	90,000	140,000	295,000

**NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006**

18 SEGMENTAL REPORTING

ADHB only operates in the area of the health and disability support services sector in the Auckland region.

19 MAJOR VARIATIONS FROM BUDGET

The ADHB recorded a net deficit of \$46m which was \$19m favourable to budget. Major favourable variances were Revenue from higher inpatient volumes \$13m offset by Direct Treatment Costs related to this additional volume \$10m, Employee Costs from unfilled vacancies \$3m, reduced Interest and Depreciation on savings and timing of the capital expenditure programme and improved operational performance \$7m and Other Operating Expenditure net savings of \$6m.

20 EVENTS SUBSEQUENT TO BALANCE DATE

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

21 INTERNATIONAL FINANCIAL REPORTING STANDARDS

In December 2002 the New Zealand Accounting Standards Review Board (ASRB) announced that New Zealand entities required to comply with NZ GAAP under the Financial Reporting Act would be required to apply International Financial Reporting Standards (IFRS) for financial periods commencing on or after 1 January 2007 with earlier adoption permitted from 1 January 2005. The new standards that have been approved by the ASRB for application in New Zealand are referred to as New Zealand equivalents to International Financial Reporting Standards (NZ IFRS) as certain adaptations have been made to reflect New Zealand circumstances.

Auckland District Health Board (ADHB) intends to present NZ IFRS for the first time for the year beginning 1 July 2007.

Transition Management

A conversion project (monitored by an internal NZIFRS steering committee) has been established. This project entails assessing the impacts of changes in financial reporting standards on ADHB's financial reporting and other related activities, then designing and implementing processes to deliver financial reporting on an NZIFRS compliant basis, as well as dealing with any related business impacts. This project is on-going and ADHB expects to be in a position to comply with the requirements of NZIFRS for the 30 June 2008 financial statements.

Description	Achievement
Report volumes within contracted levels (volumes split into ADHB residents and others)	Achieved – Volume reports on health care contracts analysed by DHB of domicile have been available to managers and others through 2005-06.
Improved cost recovery from ACC and others	Achieved – ACC revenue increased by almost 11% between 2004-05 and 2005-06
National Prioritisation Framework applied in decision making and funding allocations	Achieved The national prioritisation framework has been introduced to the Planning and Funding team, with implementation beginning in March 2006. This focused on piloting the tool on funding proposals from the Funding and Planning Team. The framework may be introduced over time within Planning and Funding activities, however there is more work required to adapt this national tool to local use. Current work focuses on linking the prioritisation tool into health inequalities work and strengthening the prioritisation tool in the area of equity.
Staff numbers kept within budgeted FTE levels	Not Achieved – actual 7,177 budget 7,156 FTEs
Achieve targets set for the management and administration review June 2006	Achieved – the M&A targeted a reduction of administrative staff costs to 10.5% of provider revenue, the figure at June 2006 was 10.4%
Service reviews completed by June 2006	Achieved – the service review process was completed by 30 June 2006
Return on Net Funds Employed – (45.36%) <i>Operating Margin/Net Funds Employed x 100</i>	Achieved – Actual - (-14.1%)
Operating Deficit to Revenue (-7.14%) <i>Operating Deficit /Total Operating Revenue x 100</i>	Achieved – Actual - (3.6%)
Interest Cover (2.00) <i>Calculation as per bank covenant</i>	Not Achieved – There has been a change in ADHB 's banking covenants' and ADHB complies with those
Debt to Debt plus Equity Ratio (65.00%) <i>Total Borrowings/Total Borrowings plus Equity x 100</i>	Achieved – actual 46.4%
Progress against the workforce action plan and Maori health workforce plan	Achieved Te Papa Oranga, a regional initiative is underway with positive progress being made. The first phase of the project has conducted a Regional Analysis across five training providers, whereby a stocktake of medical and health training courses available to Maori and a data analysis of student enrolments was undertaken. This preliminary work will also assist linking into and informing ADHB Maori health workforce development plan. The Maori health workforce plan is under development, as this should fall out of the broader ADHB workforce development plan which has been signed off. At the moment significant workforce initiatives are currently operating at a regional level. ADHB Whakapike Ake workforce programme is a joint venture for Maori and Pacific allied staff, and has also committed resources regionally to fund a Maori Mental Health workforce development co-ordinator, to lead a Maori Mental Health workforce development stocktake and a secondments programme. ADHB numbers of Maori workforce is analysed regularly through our internal Workforce Development Committee, whereby there is ongoing work to improve ethnicity data collection by standardising work force occupations and codes in line with sector ethnicity collection standards. He Kamaka Oranga encourages all Maori and Non Maori to participate in the Certificate of Hauora Maori.

Statement of Service Performance 2005-06

<p>Initiatives underway to achieve a competent and qualified Pacific health and disability sector</p>	<p>Achieved Pacific Island Community Health Worker Training (PICHWT) Programme A partnership between University of Auckland (School of Population Health) and Manukau Institute of Technology (MIT) has culminated in the development and enhancement of the new training programme to a Level 4 qualification. The enhanced programme was submitted to the MIT academic board and approved. In April, students, representatives from AHDB, the University of Auckland and Manukau Institute of Technology attended an inaugural powhiri for the programme which is designed to prepare individuals with the skills necessary to support and improve the health and well being of Pacific families, individuals and communities. It is anticipated this course could be the platform for ongoing professional development in the health sector. An official request has been made to the Prime Ministers office to officiate the formal launch. It is anticipated this course could be the platform for ongoing professional development in the health sector.</p> <p>Pacific Island Community Health Worker Training (PICHWT) Programme Presentation A presentation of the programme was made at the Ministry of Health Pacific Provider Fono at Waipuna Lodge, Auckland. This helped to promote the course and resulted in more people enrolling for the course.</p> <p>Therapy Workforce Development Project A joint initiative between ADHB and Auckland University of Technology to enhance opportunities for clinical placement of Pacific Physiotherapy and Occupational Therapy students within ADHB is being implemented. A number of Pacific Therapy final year students are currently on an eight week placement within ADHB and a support mechanism is in place to support them not only during their placement but also through their academic year.</p> <p>ADHB Workforce Human Resources Strategy Work is ongoing to ensure that ADHB's Draft Workforce Human Resources Strategy and Implementation Plan, incorporates the priorities identified within the Draft ADHB Pacific Workforce Development Plan</p>
<p>Health Needs Assessment report completed on local health needs and health inequalities</p>	<p>Achieved The Health Needs Assessment (HNA) is a key planning tool for all the work of the DHB's. The HNA was updated during 2004/2005 but is a 'living' document, updated on a regular basis as new information comes to hand. The HNA is published on the ADHB internet and intranet so is available to a wide cross section of people for use in planning, monitoring and information.</p>
<p>District Strategic Plan review and consultation completed June 2006</p>	<p>Partially Achieved - The draft Strategic Plan was released as a consultation document in September 2005 and underwent a full and formal consultation. The consultation feedback was analysed and the main themes used to modify the draft work. The consultation report is available on the ADHB website. The final Strategic Plan was adopted by the Board in February 2006 and is being laid out for publication. This version has however not been approved by the Ministry of Health because the financial forecasts need to be expanded to 5 years. This work is underway.</p>
<p>Strategic priorities reflected in planning and funding decisions July 2007 and ongoing</p>	<p>Achieved - The District Strategic Plan has established the main priorities for future work. These include:</p> <ul style="list-style-type: none"> • reduced health inequalities • child health • mental health • health of older people • reduced diabetes, CVD and cancer • increased independence for people with disabilities or high support needs <p>During 2005-06 work has progressed in these areas to develop local plans to implement changes. This work is ongoing.</p>

Continued work with Treaty partners and the Maori Health Advisory Committee to improve health gain	Achieved There is a Memorandum of Understanding between Auckland District Health Board and
Increased Maori participation in all consultation work	Te Runanga o Ngati Whatua.
Governance relationships strengthened with Te Runanga o Ngati Whatua to ensure planning priorities are reflected in planning and funding	<p>Report achievements against key objectives in the MoU: The following highlights the achievements met in the partnership principles, processes for engagement and funding and planning objectives between ADHB and local Iwi/Maori:</p> <ul style="list-style-type: none"> • Relationship with local Iwi/Maori is ongoing. • The District Strategic Plan was presented to MHAC with opportunity for Tihi Ora MAPO to provide input; this was completed in March 2006. • Progress is currently underway to engage Iwi/Maori Kaumatua/Kuia and whanau to participate in a community consultation Hui to inform the “Health of Older People” strategy with collaborative input from Tihi Ora MAPO. • The ongoing participation from Tihi Ora MAPO on the Funding Management Committee to provide input into ADHB funding and service planning decisions. • Ongoing inclusive approach for Auckland DHB and Tihi Ora MAPO to work together at an operational level to ensure involvement in Maori health funding and planning and service development activities. This includes joint meetings with Ministry of Health, ADHB Maori Health and Tihi Ora MAPO to confirm the allocation of funding under the Maori Provider Development Scheme 2006/2007, contract arrangements and monitoring. • ADHB meets bi-monthly with its Treaty partner, Te Runanga o Ngati Whatua through the Maori Health Advisory Committee (MHAC). The committee provides strategic advice to the Board and executive management on all ADHB Maori health issues. MHAC is part of ADHB’s reporting processes and meets the first Wednesday every second month. • The new membership confirmed by Te Runanga o Ngati Whatua comprise of four members: <ul style="list-style-type: none"> o Naida Glavish, o Liz Mitchelson, o Aroha Hudson, and o Puawai Rameki • Auckland DHB Board Members (including two Maori Board members) <ul style="list-style-type: none"> o John Retimana, o Harry Burkhardt, o Wayne Brown, o Jonathan Koea, and o Chris Chambers. • Management in attendance include: <ul style="list-style-type: none"> o General Manager, Maori Health – Kris MacDonald, o ADHB CEO - Garry Smith, o Chief Planning and Funding officer (CPFO) - Denis Jury, o Associate Director of Nursing, o Chief Advisor of Tikanga – Naida Glavish, and o Tihi Ora MAPO CEO – Tracy Walters, and o He Kamaka Oranga team. <p>NB: MHAC Minutes – February 2006 , April 2006 , May 2006 (June report)</p> <ul style="list-style-type: none"> • There have not been any formal training sessions on Treaty of Waitangi issues during this reporting period. All Board members have, in their declarations on obligations and duties, advised that they are familiar with Treaty of Waitangi issues and they also receive all papers submitted to the Maori Health Advisory Committee of the Board. <p>Measure 5, and 6</p> <p>5. Describe achievements against key deliverables in the implementation of ADHB Maori Health strategic plan or ADHB Maori Health action plan.</p> <ul style="list-style-type: none"> • ADHB Maori Health action plan is still a work in progress, however achievements against key deliverables within the plan are currently underway, which are highlighted below: <ul style="list-style-type: none"> • Active participation in the development of the “health of older people” improvement plan, identifying the needs and services required by Kaumatua and Kuia to inform the strategic direction through community consultation • Supporting Maori health provider development and capability through the targeting of the Maori provider development scheme (MPDS) • Ongoing progress with Te Papa Oranga – Career Pathways project

	<p>and</p> <ul style="list-style-type: none"> Participation with the development of the Mental health improvement plan <p>6. Measures 1, 2, 3, and 5 have been endorsed by the local iwi/Maori health relationships.</p> <ul style="list-style-type: none"> MoU is in place, with operational involvement in funding and planning, decision making, District Annual plan, and Maori health plans are usually endorsed by the MAPO.
Implement the regional work plan to achieve efficiency savings	<p>Achieved</p> <p>A wide range of initiatives have been progressed during 2005-06, including :</p> <p>RMO payroll, nursing bureau, internal audit, procurement, Laboratories, productivity review and SMO alignment.</p>
Implement the Auckland Regional Information Services Strategic Plan	<p>Achieved</p> <p>The implementation of the principles and projects that were agreed in the April 2005 update of the Auckland Regional ISSP is core to the project activities of ADHB's, CMDHB's and WDHB's Information Services Teams. The RISSP vision "improved health outcomes through information exchange" continues to drive our project priorities.</p> <p>Amongst a wide range of regionally aligned initiatives, the key highlights for the 2005/2006 financial year in this respect are:</p> <ul style="list-style-type: none"> Completion of the implementation of phase 3 of Testsafe which allows all DHB clinicians access to community lab test results Approval of the business case for Testsafe phase 4 which will allow GPs access to all community and DHB lab test results Selection of a regional preferred solution for the creation of a single Mental Health clinical information system for the region (project documentation available on request) Selection of a regional preferred vendor for the creation of a single electronic referrals system for the region (project documentation available on request) Selection of a regional preferred solution for ePharmacy and implementation of this solution in ADHB as the first cab of the rank. (project documentation available on request) Selection of a regional preferred solution for complaints and incidents and implementation of this solution in ADHB and WDHB (project documentation available on request) Establishment of a regular Regional ISSP Governance Group meeting in which the three CEOs and 2 CIOs of the region meet to agree regional priorities and initiatives (minutes & papers for these meetings are available on request) Establishment of a Regional Privacy Advisory Group (minutes & papers for these meetings are available on request) Agreement of (final draft) Regional Privacy and Security Guidelines to enable sharing of clinical information in line with privacy guidelines & legislation Development of a Regional Clinical Data Repository Strategy Document <p>Agreement of Regional application hosting principles.</p>
Improved management of inappropriate access to out-of-DHB hospitals	<p>Not Achieved</p>
Use the 5 year forecasting model to inform regional service planning and capacity planning.	<p>Partially Achieved</p> <p>– work commenced on setting up the five year planning tool in June 2006</p>
Implement the recommendations of the renal project.	<p>Partially Achieved</p> <p>- The renal project was finalised in November 2005, since then a regional project group and a number of subsidiary workstreams have been established to implement the recommendations.</p>
Develop a regional cancer control strategy implementation plan June 2006	<p>Achieved</p> <p>- ADHB has received funding from the DHB's to do a stocktake of services against the national Cancer Control Strategy Action Plan. This is for a local implementation plan. The project was due to be completed in June but has been delayed because of service reviews and the RMO strike. The project will be complete in July with recommendation for 4 projects towards the Action Plan.</p> <p>Regional Planning is being undertaken as part of RSP (the regional service planning process)</p>

Achieve regional efficiency gains through the Laboratory Supply Side Project	<p><u>Achieved</u></p> <p>Closer working arrangements have been introduced between the three Auckland DHB labs with the highest priority being given to cooperation on capital expenditure and standardising equipment.</p>
Implement the National Workforce Development Plan, Regional Maori Mental Health Action Plan, Tikanga Best Practice Policy	<p><u>Achieved</u></p> <p>Te Papa Oranga, a regional initiative is underway with positive progress being made. The first phase of the project has conducted a Regional Analysis across five training providers, whereby a stocktake of medical and health training courses available to Maori and a data analysis of student enrolments was undertaken. This preliminary work will also assist linking into and informing ADHB Maori health workforce development plan.</p> <p>The Maori health workforce plan is under development, as this should fall out of the broader ADHB workforce development plan which has been signed off. At the moment significant workforce initiatives are currently operating at a regional level.</p> <p>ADHB Whakapike Ake workforce programme is a joint venture for Maori and Pacific allied staff, and has also committed resources regionally to fund a Maori Mental Health workforce development co-ordinator, to lead a Maori Mental Health workforce development stocktake and a secondments programme.</p> <p>ADHB numbers of Maori workforce is analysed regularly through our internal Workforce Development Committee, whereby there is ongoing work to improve ethnicity data collection by standardising work force occupations and codes in line with sector ethnicity collection standards.</p> <p>He Kamaka Oranga encourages all Maori and Non Maori to participate in the Certificate of Hauora Maori.</p>
Maori health status defined within the health needs assessment	<p><u>Partially Achieved</u></p> <p>Although the population health section on Maori Health was not completed within the health needs analysis, the health status of Maori people is typically identified separately within other sections of the HNA e.g. hospitalisation data</p>
Identify the Maori specific spend annually and increase by 8%	<p><u>Achieved</u></p> <p>Maori specific spend increased from \$6m in 2004-05 to \$10m in 2005-06</p>
Ethnicity data collected	<p><u>Achieved</u></p> <p>Our Patient Administration System collects ethnicity as required by MoH. We have processes in place (implemented in the past 2 years and reinforced with documentation of processes, and staff training etc) so that patients check that their data is correct each time they present at outpatients.</p> <p>In ED, patients are requested to complete a registration form that includes ethnic group information. At times patients are not able to complete the form and if no family member is available we then have very little to go on, so the collection rate is not 100% in ED. There is little objection by patients to providing ethnicity information.</p>
Develop Maori PHOs and improve mainstream PHO performance for Maori	<p><u>Achieved</u></p> <p>Regular meetings occur with Maori-led PHO on contract arrangements and monitoring, the last meeting was dated 2 June 2006 regarding Maori health action plans and contract monitoring.</p> <p>Work is currently progressing well. Meetings have been held with Tamaki Healthcare PHO and AuckPac discussing a need to have a district wide Maori health plan, as different PHOs are at varying levels regarding their Maori health action plans.</p>
Complete projects: Do Not Attend, Discharge Planning, Whare Oranga	<p><u>Partially Achieved</u></p> <p>DNA</p> <p>There is difficulty obtaining true Maori Do Not Attend rates from information systems, we have requested a report from the Patient Information Manager who has been involved in evaluating the current Maori DNA rates.</p> <p>Discharge Planning;</p> <p>This is part of the Kaiatawhai Review and will be implemented into Whare Oranga once the design is complete and full capacity on board.</p> <p>Whare Oranga;</p> <p>The Whare Oranga service requires two co-ordinators and a nurse advisor and these positions have been approved and await appointment as the final part of the Kaiatawhai review. We await the appointment of a new manager to complete this work.</p>

Disability plan written	<u>Not Achieved</u>
Implement the primary health care strategy and monitor the effectiveness of Pacific PHOs	<p><u>Achieved</u> ADHB has an ongoing relationship with all its PHOs but more particularly the Pacific PHOs (AuckPAC and Tongan Health Society) who continue to embrace all the changes required of them and work with the Pacific communities to ensure services are appropriate and effective for Pacific people. The Pacific PHOs also continue to work collaboratively with other Pacific NGO providers in the primary health sector and the community including the Pacific churches in the development of the Healthy Village Action Zone framework. Draft ADHB Objectives 2006-2007 Draft ADHB objectives 2006 - 2007 for Pacific health have been developed and submitted for incorporation within the ADHB Objectives. Specific objectives to reduce inequalities include:</p> <ul style="list-style-type: none"> • Building healthy Pacific communities • Pacific Workforce Development
Models of service delivery for Pacific peoples	<p><u>Achieved</u> Pacific Health Advisory Group (PHAG) The Pacific Health Advisory group of 12 members from different backgrounds continue to meet on a monthly basis. The group is sponsored by the CEO of ADHB and have access to the Board and other committees via the CEO and GM Pacific. The role of the PHAG is to address the health disparities between Pacific people and others by improving the Pacific health status in central Auckland, otherwise known as, the Auckland District Health Board ("ADHB") area by:</p> <ul style="list-style-type: none"> • Ensuring that the priorities and needs of Pacific peoples are reflected in ADHB policy, planning and funding strategies, evaluation, monitoring and is aligned with the Lifting the Health of people in Auckland City strategy • Providing advice and recommendations to the CEO and Senior Management on all aspects of Pacific health.
Participate in the development of the Chronic Care Model	<p><u>Partially Achieved</u> The Chronic Care Model was discontinued, however Chronic care now sits under the Our Health 2020 strategy in particular Cardiovascular/Diabetes project. The PREDICT programme and the Tongan Health Society - Diabetes and education management services are also examples of initiatives that focus on chronic care management.</p>
Implement the priority areas in the Pacific Health and Disability Action Plan.	<p><u>Achieved</u> Auckland Pacific Disability Plan The Auckland Pacific Disability Whole of Life project is co-sponsored by MOH and Ministry of Pacific Islands Affairs (MPIA). ADHB GM Pacific is a member of the steering group and will continue to participate in the development of the plan. Health of Older Pacific People Project The results of a project undertaken to assess the needs of Pacific Older peoples within ADHB has been presented to the Pacific health team and the Funding and Planning Manager, Health of Older People. It provided a useful gap analysis and prioritisation framework for future service development. Pacific health team continue to liaise with the Planning and Funding Manager, Health of Older People, Disability and Palliative Care to identify what services for Older Pacific People can be delivered within the Healthy Village Action Zone framework. Pacific Day Service Discussions have been held regarding the establishment of a day service in Mt Roskill to provide support to Older Pacific People. If agreement is reached, this will result in a new service contract for 2006-2007.</p>
Participation of Pacific people in decision making, the development of strategies and plans for Pacific Health gain.	<p><u>Achieved</u> Healthy Village Action Zones Consultation meetings have been held with key stakeholder groups which include, Pacific churches, health providers, primary health organisations and the pacific community regarding the development of Healthy Village Action Zones.</p> <ul style="list-style-type: none"> • ongoing regular meetings with the three Pacific providers (Health Star Pacific, Tongan Health Society and Motootua Trust) and including Pacific Island Heartbeat whose church groups in its Health Promoting churches programme will be participating in the HVAZ development bringing the initial number of church groups to 40

	<ul style="list-style-type: none"> • three workshops with each of the three providers and representatives from each of the ten church groups who will be participating in the HVAZ – Phase one with approximately 50 people at each workshop – total 150 • a Stakeholder workshop including PHO, NGOs, other providers, sectors and agencies who wish to be involved in the HVAZ development – approximately 50 people • a combined workshop for all the three providers and representatives from each of the 30 church groups as Phase 2 of the HVAZ development – 100 participants <p>Healthy Village Action Zones, Establishment Steering Group A steering group from the stakeholder group has been established and have been scheduled to meet soon in order to progress developments.</p> <p>Pacific Health Advisory Group (PHAG) The Pacific Health Advisory group of 12 members from different backgrounds continue to meet on a monthly basis. The group is sponsored by the CEO of ADHB and have access to the Board and other committees via the CEO and GM Pacific. The role of the PHAG is to address the health disparities between Pacific people and others by improving the Pacific health status in central Auckland, otherwise known as, the Auckland District Health Board (“ADHB”) area by:</p> <ul style="list-style-type: none"> • Ensuring that the priorities and needs of Pacific peoples are reflected in ADHB policy, planning and funding strategies, evaluation, monitoring and is aligned with the Lifting the Health of people in Auckland City strategy • Providing advice and recommendations to the CEO and Senior Management on all aspects of Pacific health. <p>Three members of the PHAG have been elected by the Pacific communities onto the Auckland City Council’s Pacific Advisory Board. This will further strengthen ADHB’s relationships with both the Auckland City Council and the Pacific communities.</p> <p>Community and Public Health Advisory Committee (CPHAC), Pacific Representation It has been proposed that the Chair of the Pacific Health Advisory Group be the Pacific representative on CPHAC. A paper was submitted to CPHAC with a recommendation from the Pacific Health Advisory Group (PHAG) that it’s Chair Rev Alfred Ngaro, to be the Pacific representative on CPHAC. This recommendation has since been endorsed by CPHAC and Reverend Alfred Ngaro will begin his new role with CPHAC at its August meeting.</p> <p>Disability Support Advisory Committee (DSAC), Pacific Representation A process is underway to nominate a Pacific Island representative to the ADHB Disability Support Advisory Committee.</p> <p>Community Coordination Service ADHB continue to engage with the Pacific community through the communication coordination service.</p> <p>Auckland Regional DHBs Planning Session A Pacific Auckland Regional Planning Session was held between Waitemata DHB, Auckland DHB and Counties-Manukau DHB. The purpose of the meeting was to:</p> <ul style="list-style-type: none"> • Look at a joint work programme across the Auckland region, • Agree regional outcomes, work together and submit proposal or recommendations to Regional Funding group, • List regional projects; establish joint programmes and consistent processes. <p>It is anticipated further regional work will be undertaken in the future to enable a more consistent and effective approach towards helping improve the health of Pacific people in the Auckland region.</p>
<p>Redesign the Parish nursing service based on the evaluation recommendations.</p>	<p>Achieved</p> <p>Phase one of the Parish Nursing programme enhancement is progressing to target. Part of the enhancement is to incorporate into the service delivery, learnings from the North Health Church Information project in the 1990s and learnings from the evaluation of the Parish Nursing pilot. Looking at what was working well that needed to be maintained and what was not working so well that needed to be improved.</p> <p>The three Pacific health providers (Tongan Health Society, Health Star Pacific Trust and Moto’otua Trust) have each chosen ten church groups to participate in the ongoing delivery of existing health services within the Parishes while awaiting the outcome of a project to scope an enhanced model of Parish Nursing services and the possibility of Parish Nurses being part of a primary health care nurse strategy that is being developed.</p>

	The Parish Nursing services will be delivered within the Healthy Village Action Zone Framework.
Implementation plan that outlines activities across the organisation to reduce inequalities	Achieved The health equity tools, including the Ministry's Inequalities Framework and Health Equity Assessment Tool (HEAT) are applied to all new programmes funded by the DHB and will be applied to all policy developed by the ADHB in 2006/2007. The ADHB has to set up an 'inequalities working group' to apply these tools (or modifications of these tools) to all its strategic programmes to ensure that all programmes will address identified inequalities. Monitoring occurs through the Health Need Analysis (HNA) which will identify progress to reduce inequalities by age, gender, ethnicity or socioeconomic status.
The District Strategic Plan 2005 to 2010 provides leadership on priority populations	Achieved - Information from the analysis of local health needs and priorities for the city formed the basis of the District Strategic Plan and the priority work that flows from this. Implementation plans are underway to develop each priority area.
Plan developed to implement the NZ disability strategy	Achieved - Progress against implementation of the NZ Disability Strategy fits within the overall work plan of the ADHB Disability Support Advisory Committee (DSAC). In the 05/06 year the following work was undertaken under the direction of the DSAC committee to progress the Strategy's implementation: <ul style="list-style-type: none"> • Work was undertaken within the ADHB hospital provider service to expand interpretation and sign language services (NZ Disability Strategy Objective 3.2) • ADHB undertook participation in the development of Lu'i Ola - the Pacific Disability Action Plan, an intersectional initiative to promote collaborative planning and service delivery to Pacific disability service users (NZ Disability Strategy Objectives 12.2, 12.3 and 12.5) • The DSAC committee was involved in both the drafting, and disability language proofing of all reference and strategy documents produced by the ADHB including its Strategic and District Annual plans (NZ Disability Strategy Objectives 7.9 and 10.3) • The DSAC committee had governance level oversight responsibility for the development of Healthy Ageing 2020 – targeted at the over 65 disability community (NZ Disability Strategy Objectives 7.9 and 10.3) • The DSAC committee membership is currently being expanded to strengthen both Maori and Pacific representation (NZ Disability Strategy Objectives 11.1, 12.2 and 12.3) • A regional Select Committee submission is being led by the ADHB DSAC in respect of the Disability services provision inquiry being undertaken by the Social Services Select Committee (NZ Disability Strategy Objectives 5.1, 7.9 and 10.3) • A Disability audit of both the Greenlane Clinical Centre and Auckland City Hospital Campus has been scheduled (NZ Disability Strategy Objective 6.6) • A decision has been passed to pilot several key 06/07 Board documents in Disability accessible formats such as large print (NZ Disability Strategy Objectives 5.1 and 10.5) • Intersectional work is being undertaken with the Auckland City Council in respect of Older Persons Disability and the ACC Charter (NZ Disability Strategy Objective 6.7)
Expand primary health care to include allied health and health promotion activities	Achieved <ul style="list-style-type: none"> • Through the ADHB's health improvement plans of Our Health 2020, the focus of managing care for children, the elderly and those with heart disease and diabetes is moving from a predominantly hospital model to a whole-of-community model. This by its very nature includes public health and allied health activities and clinics. • The cardiovascular-diabetes plan has a steering group that includes a public health physician, a public health manager who is working on implementation of nutrition programmes in Pacific families, and a dietician. The Plan links to the key areas of improved exercise, improved nutritional advice and smoking

	<p>cessation through these and other steering group members. For example, the hospital's smoking cessation plan and the PHO smoking cessation plans are linked through representatives of the programmes that these plans work in.</p> <ul style="list-style-type: none"> • One of the early projects for diabetes patients that ADHB will be funding is a comprehensive diabetes education and self-management programme. Currently, this is not funded and the DHB has 2 proposals for providing this comprehensive programme to all our population with a focus on newly-diagnosed patients and on Maori, Pacific and high-needs patients. This programme is delivered by dietitians in the community and is a key component of Chronic Care Management. • Smoking cessation is offered to all patients screened for cardiovascular disease. Currently, the screening programme runs in one PHO and it will be funded to run in all PHOs from 2006/07. All PHOs have access to smoking cessation programmes for patients requesting such or identified at the time of GP or practice nurse consultations. • PHOs participate in green prescriptions and in various other health promotion activities, in part using the health promotion funding provided to them. • Within the hospital service, a smoking cessation programme is offered to all patients identified as smokers during acute admission and particularly those who are admitted with cardiovascular or respiratory conditions.
<p>Care Plus, Reduced Co-payments for Pharmaceuticals, services to improve access and Health Promotion funding all implemented</p>	<p>Achieved</p> <ul style="list-style-type: none"> • ADHB has implemented all the above programmes for its population. • From 1 July 2006 all 6 PHOs within the district will be implementing the Care Plus programme with the inclusion of Tongan Health Society. • Approximately 65% of the allocated places for Care Plus are filled, this is expected to rise over the next few months as strategies are put in place at the national and local levels to manage the enrolment process more appropriately. • There is full utilisation of reduced co-payments for pharmaceuticals. Patients who receive prescriptions from the GP with whom they are registered, pay \$4 per prescription item (plus a co-payment if such is deemed by Pharmac) • Health Promotion funding has been utilised to provide a range of services within each PHO. Examples of this include Green Prescriptions, Physical activity and nutrition, SNUG Homes housing insulation project. • Many SIA initiatives funded in 2004/ 2005 continue to be delivered. New initiatives include Diabetes Incentive programme for diabetes, CVD Diabetes Screening with a number of SIA initiatives being redesigned as service(s) mature.
<p>Integrated primary, secondary care for multiple and complex problems especially children and youth and older people</p>	<p>Achieved</p> <p>This is a key focus of the ADHB Child Health Improvement Plan 2006-2011. ADHB is currently working with a Maori-led PHO to develop a child health programme focussed on reducing inequalities which will include collaborating with Starship Children's Health paediatricians on an integrated and holistic primary/secondary care service. A paediatrician will hold clinics in the community seeing children with complex conditions referred by PHO GPs and the PHO will provide triage and ongoing case management. The service will be evaluated and if successful will act as a model for further implementation in ADHB.</p>
<p>Complete projects areas in the regional workplan</p>	<p>Achieved</p> <p>A wide range of initiatives have been progressed during 2005-06, including :</p> <p>RMO payroll, nursing bureau, internal audit, procurement, Laboratories, productivity review and SMO alignment.</p>
<p>Inter-district planning and service development (service shifts and facility planning)</p>	<p>Achieved</p> <p>Regional Service Planning was undertaken successfully during 2005-06. Of particular note was the finalisation of the Regional Growth Development document providing a strategic overview of the provision of DHB provider arm services over the next 20 years.</p>

Family Violence Intervention Guidelines implemented	<p><u>Achieved</u> – Referral pathways redefined and training provided to staff.</p>
Implement Acute Services Review findings and a quality monitoring framework	<p><u>Achieved</u> - The recommendations of the Acute Services review were introduced approximately three years ago. At that time the Regional Director of Mental Services was appointed and the Network North Coalition which includes a large group of stakeholders was established.</p> <p>As a consequence of the review, Packages of Care for the inpatient unit were implemented and have been operational for over one year. This successful new initiative which has been evaluated has received positive feedback from consumers, families and clinicians. It appears to be an effective mechanism for reducing readmissions. By making use of accumulated funding it has been possible to temporarily double the Packages of Care volumes.</p> <p>ADHB is also undertaking a Home Based Treatment pilot as an alternative to acute admissions and this also has an evaluation component.</p> <p>ADHB has two strands to its quality monitoring framework:</p> <ul style="list-style-type: none"> • Provider development through having a trained quality auditor who works in partnership with NGOs to ensure they are meeting the mental health standards. This has been highly successful and all ADHB residential rehabilitation facilities that were required to obtain certification did so. • Quality audit programme with a focus on NGOs that are not required to meet certification in the first round of audits. This programme will be rolled out over the next 2 years. <p>Funding made available to Auckland DHB as part of the outcome of the Mental Health Commission review for 2003–04 (\$4.49 million) has been committed to implement recommendations including the intensive support Packages of Care and ADHB's contribution to the appointment of a Regional Director, Mental Health Services and Mental Health Coalition. The Packages of Care are fully operational (Refer SER-05).</p> <p>Through the Network North Coalition a number of regional projects are underway to address issues identified by the review</p> <p>The ADHB provider arm services are further implementing the care co-ordinator roles in the acute mental health unit. The findings from the research pilot and evaluation have indicated that these roles increase client satisfaction, reduce readmissions and strengthen the capacity of integrating systems to ensure support for service users and their families/whanau.</p> <p>The Regional Mental Health Quality Framework has been completed. Auckland DHB developed a localised quality-monitoring framework in 2003–04, which was consistent with the regional framework. This became a regional project. All NGO providers in Auckland DHB passed certification requirements. Positive feedback from NGOs has been received in relation to the project. An audit programme has been commenced and will roll out over the next two years.</p>
Review data management systems	<p><u>Achieved</u> - The upgrade of Health Care Community (HCC) Clinical information systems (predominantly for outpatients) provides a comprehensive clinical record for both in and outpatients. This upgrade has been finished except for the Child and Family Unit which is due to go live in August 2006.</p> <p>In April 2006, the Ministry of Health established two projects under the Programme for Integration of Mental Health Data (PRIME). This programme consists of two main projects:</p> <ol style="list-style-type: none"> 1. National integrated Mental Health data collection for DHBs 2. Mental Health information reporting system (MHIRS) for NGOs. <p>ADHB has made provision in its provider Arm projects for 2006/07 and 2007/08 to allocate resources to work alongside the MOH programme manager to develop the requisite data management systems for ADHB. The purpose of this project is to improve the reporting base on Mental Health clients and in turn track improvements to service access.</p>

Stakeholder networks participate in planning and service development	<u>Achieved</u> -The stakeholder network has been in operation for approximately 5 years and that group is very involved in developing ADHB's local Mental Health Strategic Plan.
Blueprint funding allocated	<u>Achieved</u> - All Blueprint funding including 2005/06 funding has been allocated. 15.3 FTES are in place and a further 4.9 recruited/being recruited. 4 positions remain unfilled.
Issues associated with population based funding formula resolved • 1 Regional integrated care	<u>Achieved</u> - There has been significant work undertaken in 2005/06 to streamline processes in order to make regional work in the health of older peoples area more regional. This has been facilitated by a continued commitment to forums such as the regional Health of Older People (HOP) managers forum, and the expansion of the national Inter District Flows (IDF) group to include representatives from each of the respective portfolio areas. This has allowed for more informed discussion on specific issues such as HoP IDF's – which has resulted in increased accuracy in capturing residential care transfers and associated transfer payments. ADHB has achieved a significant IDF revenue flow for 2006/07 however this does not fully address the problem. This is due to the IDF methodology relying on poor data and defaults that leaves the cost of people with unknown domicile, or with conflicting domicile information, as an ADHB cost.
Issues associated with population based funding formula resolved • 2 Residential Care for Home Based Support Services	<u>Partially Achieved</u> This remains problematic despite significant work being undertaken by ADHB in feeding into the 06/07 national ARC negotiation. The net impact for example of the increase to Specialist Dementia and Private Hospital providers was \$500,000 which will compound in the out years due to the government revenue being allocated on a PBF share basis. The population based funding formula still also does not recognise the variable bed day (Territorial Local Authority) rates paid across the country. This has the most significant impact in the Auckland area (estimated \$4.7m) and has been referred to the MOH for resolution.
Issues associated with population based funding formula resolved • 3 Regional medium and long term needs assessment and service coordination	<u>Achieved</u> This has been progressed although not resolved completely – improved structures relating to data reporting and capture, and of agreed process for payment transfer have resulted in an improvement to this process. Although Needs Assessment and Service Coordination do not occur regionally, there are increasingly agreed regional standards being adhered to.
Engage Maori in planning activities	<u>Achieved</u> As part of the comprehensive consultation that was undertaken in the development of the Healthy Ageing 2020, specific hui was held to assess the needs of kaumatua and Kuia within the ADHB population. The themes which were discussed at the hui included the need for a trained workforce to deal with the significant growth in the ageing Maori population, the need for dedicated Kaupapa Maori services within mainstream Health of Older People services, and the need to recognise the work of the Whanau in caring for Kaumatua and Kuia.
Complete the work associated with the National Immunisation Register	<u>Achieved</u> The NIR is fully operational in ADHB with the birth cohort registered from 22 May 2005.
NIR functional and supporting MeNZ B programme	<u>Achieved</u> The NIR is fully operational in ADHB and has supported the MeNZB programme which completed on 30 June 2006 with an overall 0-19 years coverage rate achieved of 80.69% (dose 3).
Meningococcal Vaccination (MeNZ B) strategy implemented in the Eastern Corridor and ADHB	<u>Achieved</u> The ADHB MeNZB Vaccination funded programme completed on 30 June 2006. 89.80% coverage achieved for 1-4 years age group and 80.70% for 0-19 years (Eastern Corridor all ethnicities).
PHO immunisation rates for Maori and Pacific population improves by 25%	<u>Not Achieved</u>

<p>Joint sector work undertaken that focuses on children and young people</p>	<p>Achieved On-going participation in Strengthening Families Local Management Group</p> <p>Developing a MoU re joint work with Housing NZ.</p> <p>Participated in a joint sector project with the Energy Efficiency Conservation Authority and others to insulate homes of children with respiratory illness.</p> <p>Liaison with Auckland City Council, Ministry of Social Development, Housing NZ, Ministry of Education, Office of Children's Commissioner and other sectors on a range of child health related issues and projects.</p> <p>Joint sector stakeholder group involved in development of the ADHB Child Health Improvement Plan.</p>
<p>Auckland DHB Child health strategy completed</p>	<p>Achieved The ADHB Child Health Improvement Plan 2006-2011 "<i>Our Healthy Children</i>" was completed and approved by the Board in April 2006.</p>
<p>Percentage of children caries free at 5 years by ethnicity ADHB 2003 Asian: 64.9 European 83.3 Maori: 63 Pacific: 50.5 Other: 76.1</p>	<p>Partially Achieved Asian: 64.9 2004 69.2% European 83.3 2004 84.2% Maori: 63 2004 57.8% Pacific: 50.5 2004 47.5% Other: 76.1 2004 70%</p>
<p>Mean DMFT at 12 years by ethnicity, ADHB 2003 Asian 0.97 European 0.82 Maori 1.51 Pacific: 1.6 Other 0.9</p>	<p>Partially Achieved Asian 0.97 2004 0.97 European 0.82 2004 0.85 Maori 1.51 2004 1.62 Pacific: 1.6 2004 1.46 Other 0.9 2004 0.96</p>
<p>Programme with PHOs to meet case detection, case management and eye screening targets</p>	<p>Not Achieved During 2005/06, PHOs have participated in Diabetes Get Checked. Data from this programme are listed below</p> <p><i>Overall numbers who had free Get Checked examination</i></p> <p>1) All Patient numbers Target 6780 (60%) Actual 5639 (50%) 2004 Actual 4771 (44%)</p> <p>2) Maori Patients Target 1069 (70%) Actual 380 (25%) 2004 278 (19%)</p> <p>3) Pacific Patients Target 1462 (70%) Actual 1897 (91%) 2004 Actual 1582 (80%)</p> <p>4) All others Target 4610 (60%) Actual 3411 (44%) 2004 Actual 2711 (36%)</p> <p>-----</p> <p><i>HbA1c >8mmol/l (Case Management)</i> <i>All Patients</i> 2005 Target Less than 20% 2005 Actual 33% 2004 Actual 34%</p> <p><i>Maori</i> 2005 Target Less than 30%</p>

	<p>2005 Actual 39%</p> <p>2004 Actual 38%</p> <p><u>Pacific</u></p> <p>2004 Target Less than 30%</p> <p>2005 Actual 49%</p> <p>2004 Actual 48%</p> <p><u>All others</u></p> <p>2004 Target Less than 20%</p> <p>2005 Actual 24%</p> <p>2004 Actual 26%</p> <p>-----</p> <p><u>Retinal Screening Results</u></p> <p>ADHB Diabetes Centre undertakes retinal screening. Their records indicate that there were 8590 visits for retinal photography from 7208 different individuals in the past 24 months. Approximately 90% of these patients are from ADHB (+/- 6500).</p> <p>The Get Checked report on the other hand, noted that 2801 patients had undergone retinal screening within the past 2 years.</p> <p>The vast difference between these numbers reflects the difficulties that primary care clinicians have with entering "Get Checked" data and also the numbers of diabetics undergoing routine care whose names are not submitted through "Get Checked".</p> <p>A number of patients would also be sent for retinal screening <u>after</u> Get Checked</p> <p>-----</p> <p>While the numbers were greater than the previous year's and show a continuing improvement, these have not met targets.</p> <p>Review of the data revealed some contractual misunderstandings around targets set with individual PHOs. However, the main reason for underperformance is the Ministry's condition that the consultation be free of charge. Many GPs collected data on their diabetic patients but were unable to submit data if they had charged the patient.</p>
Access for Maori and Pacific improved	<p><u>Achieved</u></p> <p>Access for Pacific is at a record high (see above).</p> <p>Access for Maori was disappointing. Tamaki PHO were given a contract that stipulated that they should screen 500 patients in the year when their target was over 1000 and many ProCare GPs chose not to participate in Get Checked because of the funding issues. As these 2 PHOs have most of our Maori population, the target for Maori was always going to be an unlikely one to meet.</p> <p>These problems have largely been obviated by a) correcting the contract for 2006 and b) the new capitation funding for 45-64 year olds. In addition, access for all patients will improve as ADHB brings online the new electronic decision support programme that incorporates Get Checked.</p> <p>This programme can be monitored far more speedily and one of our key focuses is that it will reduce disparities rather than exaggerate them.</p>
Diabetes Strategic Plan 2004-08 developed	<p><u>Achieved</u></p> <p>The DHB's Strategic Plan for Diabetes and Cardiovascular disease is a bold attempt to align these 2 services into a single strategic plan. To our knowledge this has never been written up elsewhere.</p> <p>The Steering Group is currently writing up the Strategic Plan. It is expected that the Plan will be ready in draft form for public consultation by September 2006 and completed late in 2006.</p>
Providers have plans including KPIs for monitoring activities	<p><u>Achieved</u></p> <p>Monitoring activities have included the KPIs generated from Get Checked. These will continue and will be enhanced as the programmes become more sophisticated and expand to include risk management as well as risk assessment.</p>
Free Annual Diabetes Reviews (Get Checks) performed. (Target is 60%)	<p><u>Diabetes results reported above</u></p>
Target for good diabetes control (case management): Maori and Pacific (70%); All Others (80%)	<p><u>Diabetes results reported above</u></p>
Target for eye screening within the last 2 years (80%)	<p><u>Diabetes results reported above</u></p>

Healthy Eating Healthy Action Plan Implemented	<u>Not Achieved</u> Planning stage only
Heart Failure Project introduced with cardiac services	<u>Achieved</u> Heart failure project: This project is a collaborative work between Auckland DHB and PHOs in our area. The aim is to identify those people with Heart Failure and link them to the correct service, whether based in hospital outpatients or with a GP/practice nurse team for follow up and review. It should help addressing the continuum of care to reduce hospital admissions and re-admissions.
Manage growth in acute, elective services and vascular volumes within budget and guidelines	<u>Not Achieved</u> Cardiology, cardiothoracic and vascular surgery were collectively \$635,000 over budget for the year ended 30 June 2006.
Review cardiac services (cardiology, cardiothoracic and catheter laboratories) for the region	<u>Partially Achieved</u> With the decision to open a third regional cardiac catheterisation lab at North Shore Hospital, a number of reviews were underway or complete at 30 June 2006. These did not include cardiothoracic surgery but did encompass the Auckland Cardiology department and the impact of three regional catheter laboratories.
Implement cardiovascular risk assessment guidelines	<u>Achieved</u> Cardiovascular / diabetes decision support project (PREDICT). This project will enroll eligible people according to the cardiovascular / diabetes risk guide lines. The target is to screen all the eligible people for cardiovascular risks and to manage these risks. This project should help in early detection and management of CVD, diabetes, stroke and heart failure.
Research into basic mechanisms, novel therapies and clinical trials	<u>Achieved</u> The world class Cardiac research undertaken at ADHB over many years has continued during 2005-06
Activities from Healthy Eating Health Action	<u>Not Achieved</u> Planning stage only
Screening programmes with improved access figures for Maori and Pacific	<u>Not Achieved</u>
Improvement in waiting times for radiotherapy and chemotherapy	<u>Achieved</u> There are in fact no target wait times for chemotherapy. For radiation therapy the target is that all priority A patients wait less than four weeks, this was achieved during 2005-06
Radiotherapy and chemotherapy treatment waiting times within Ministry of Health Guidelines	
Implement palliative care services	<u>Achieved</u> The previously established ADHB Palliative Care team has employed a Nurse Practitioner and by so doing increased fte (to 4 nursing staff and 1.65 SMO and 1 registrar) so that it is now again providing Palliative Care services to surgery.
Identify research opportunities for clinical cancer treatment trials	<u>Achieved</u> Cancer trials and research activities are being conducted in the following fields :- ADJUVANT BREAST METASTATIC BREAST NEO-ADJUVANT BREAST ADJUVANT GASTRO-INTESTINAL METASTATIC GASTRO-INTESTINAL NON-TREATMENT GASTRO-INTESTINAL GERM CELL HEPATOCELLULAR RENAL CELL METASTATIC LUNG ADJUVANT OVARIAN METASTATIC OVARIAN METASTATIC PANCREATIC
Develop cancer treatment data collection	<u>Partially Achieved</u> In the absence of a national data base ADHB Adult non surgical Cancer service has worked on collecting data on radiation treatment. This is in its infancy.

Patient satisfaction meets or exceeds national DHB average	Not Achieved – actual 86% national 87% per Ministry of Health HBI definition																														
Proportion of Satisfied Customer Survey Respondents (93%)	Not Achieved – actual 90% target 93% based on satisfied, good and very good responses																														
Proportion of Very Good Customer Survey Respondents (52%)	Achieved – actual 58% target 52% based on very good responses to questionnaire																														
Percentage of Complaints Resolved/Closed (60%)	Achieved Actual 74.2%																														
Hospital Acquired Blood Stream Infections (per thousand inpatient admissions) (6.50)	Not Achieved Actual 6.63																														
Improve staff retention. Staff Turnover (voluntary) (16%)	Achieved Voluntary turnover from July 1 05 to 30 June 06 is 13.09%. Total turnover for the same time period is 15.31%.																														
Manage staff health. Sick Leave Rate (2.4%)	Achieved 2.4%.																														
Manage injury rates. Workplace Injuries. Lost Time Injury Frequency Rate (7.0)	Achieved Actual : 6.18																														
Institute the Pacific Cultural Competency framework	Achieved																														
Target discharge rate per 1,000. Babies weighing less than 2,500 grams. <ul style="list-style-type: none"> • Maori (65) • Pacific (57) Other (58) 	Achieved actual Maori 48.6, Pacific 51.4 and Other 56.6																														
Establish interdisciplinary assessment programme for 65+ with strong links to primary care Performance measure/standard definition: Numerator: Total number of hospital discharges (as identified by relevant ICD10 codes)	Not Achieved Below are the actual results for the main areas where action is required. In each case the rate is higher than the target rate. These admissions are considered “avoidable” because they are sensitive to prophylactic or therapeutic interventions.																														
Ambulatory sensitive hospital admissions Rate per 1000 for October 2004– September 2005*	<table border="1"> <thead> <tr> <th colspan="5">Ambulatory sensitive hospital admissions Rate per 1000 for 2005-06</th> </tr> <tr> <th>Age</th> <th>Total</th> <th>Maori</th> <th>Pacific</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>< 5</td> <td></td> <td></td> <td>103.4</td> <td></td> </tr> <tr> <td>5–14</td> <td></td> <td></td> <td>26.3</td> <td></td> </tr> <tr> <td>15–24</td> <td></td> <td>19.5</td> <td>20.5</td> <td></td> </tr> <tr> <td>65–74</td> <td></td> <td>93.9</td> <td>141.4</td> <td></td> </tr> </tbody> </table>	Ambulatory sensitive hospital admissions Rate per 1000 for 2005-06					Age	Total	Maori	Pacific	Other	< 5			103.4		5–14			26.3		15–24		19.5	20.5		65–74		93.9	141.4	
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<p>Denominator: Current census populations using medium projection.</p> <p>By ethnicity and by age (<5; 5-14; 15-24; 65-74)</p> <p>2006- 07 and 08: Achieve Ministry expectations under POP 13</p>	
<p>Inter-district flow volumes at 100% of contract and costs within budget</p> <p>100% accuracy of classification into ADHB population, DHB Referrers, ACC and overseas patients</p> <p>Report contract volumes for Auckland's population at up to 110%. Costs within budget. Classification 100% Accurate</p>	<p><u>Partially Achieved</u></p> <p>IDF inpatient volumes at 104% of contract ADHB inpatient volumes at 107% of contract</p> <p>Overall, provider costs were within budget, excluding the impact of not selling a property in the financial year.</p>
<p>All patients accepted for a first specialist assessment (FSA) seen within 6 months of the date of referral (ESPI 2) target 2%</p> <p>All patients who are given a commitment to treatment, receive it within 6 months (ESPI 5) target 5%</p> <p>No patient in active review fails to receive a review every 6 months (ESPI 6) target 15%</p> <p>Equity and timeliness of access to assessment, diagnostics, tests, procedures and treatments</p> <p>Improve Elective Service Performance Indicators and elective patient quality of care management.</p> <p>Contract volume management improved on previous year</p>	<p><u>Not Achieved</u></p> <p>Actual results to May 2006</p> <p>ESPI 2 5%</p> <p>ESPI 5 11%</p> <p>ESPI 6 49%</p>
<p>Occupancy Rate for Resourced Beds (85%)</p>	<p><u>Achieved</u></p> <p>- actual 85.52%</p>
<p>DRG-Based Average Length of Stay (3 days)</p>	<p><u>Not Achieved</u></p> <p>- actual 3.04</p>
<p>Elective Day of Surgery Admission Rate (80%)</p>	<p><u>Not Achieved</u></p> <p>- actual 70.5%</p>

AUDIT REPORT**TO THE READERS OF
AUCKLAND DISTRICT HEALTH BOARD AND GROUP'S
FINANCIAL STATEMENTS AND STATEMENT OF SERVICE
PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2006**

The Auditor-General is the auditor of Auckland District Health Board (the Health Board) and group. The Auditor-General has appointed me, Gordon Fulton, using the staff and resources of Ernst & Young, to carry out the audit of the financial statements and Statement of Service Performance of the Health Board and group, on his behalf, for the year ended 30 June 2006.

Qualified Opinion

Note 10 to the financial statements discloses two separate amounts for the value of land, buildings and associated fitout and services forming part of Property, Plant and Equipment ("the assets"). The fair value of the assets was independently assessed on 30 June 2005 by the valuer, Telfer Young (Auckland) Limited, at \$749,118,000. Also, at the request of the Health Board, the valuer carried out a valuation of the assets, excluding those parcels of land subject to restrictive covenants, and assessed a value of the remaining assets at \$604,307,000. The assets have been recorded in the financial statements of the Health Board at \$604,307,000. In our opinion, the revaluation has not been accounted for in accordance with Financial Reporting Standard No.3 *Accounting for Property, Plant and Equipment* ("FRS 3"), which requires the revaluation of all assets within a class of assets to be recorded at fair value. If the revaluation had been accounted for in accordance with the requirements of FRS 3, the effect on the financial statements would have been to increase the balance of Property, Plant and Equipment and the Revaluation Reserve in the Statement of Financial Position by \$144,811,000.

In our opinion, except for the failure to record the revaluation of land, buildings and associated fit outs and services in accordance with the requirements of FRS 3, the financial statements of the Health Board and group on pages 23 to 62:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's financial position as at 30 June 2006;

In our opinion, the financial statements of the Health Board and group on pages 23 to 62 fairly reflect:

- the results of its operations and cash flows for the year ended on 30 June 2006; and

- its service performance achievements measured against the performance targets adopted for the year ended on that date.

The audit was completed on 5 October 2006, and is the date at which our opinion is expressed.

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

Basis of Opinion

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

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

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and Statement of Service Performance. We found material misstatements that were not corrected, as we referred to in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and Statement of Service Performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

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

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and Statement of Service Performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and Statement of Service Performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

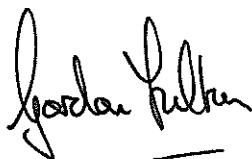
The Board is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements and Statement of Service Performance must fairly reflect the financial position of the Health Board and group as at 30 June 2006. They must also fairly reflect the results of operations and cash flows and service performance achievements for the year ended on that date. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

We are responsible for expressing an independent opinion on the financial statements and Statement of Service Performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001.

Independence

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

In addition to the audit we have carried out assignments in the area of consultancy services, which are compatible with those independence requirements. Other than the audit and these assignments, we have no relationship with, or interest in, the Health Board or any of its subsidiaries.



Gordon Fulton
Ernst & Young
On behalf of the Auditor-General
Auckland, New Zealand

Matters Relating to the Electronic Presentation of the Audited Financial Statements

This audit report relates to the financial statements of Auckland District Health Board and Group for the year ended 30 June 2006 included on Auckland District Health Board's web-site. The District Health Board's Board of Directors is responsible for the maintenance and integrity of the Auckland District Health Board's web site. We have not been engaged to report on the integrity of the Auckland District Health Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements. 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 related audit report dated 5 October 2006 to confirm the information included in the audited financial statements presented on this web site.

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