Auckland District Health Board **Annual Report 2013 | 2014**

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland DHB

International Nurses and Midwives Day 2013

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CHAIR AND CHIEF EXECUTIVE ANNUAL REPORT FOREWORD 2013-2014

2013/14 has been a year of major progress and achievement for our DHB. We have made substantial progress against the six national health targets, achieving all six targets by year end – one of only two DHBs in the country to do so. Alongside these excellent performance results, we have achieved a breakeven financial result as budgeted and embarked on a significant programme of organisational renewal and transformation.

Achievement

The achievement of our primary care targets has been accomplished by working collaboratively and with the support of our primary health organisations (PHOs) - Alliance Health Plus, Auckland PHO, National Hauora Coalition and ProCare. Their extraordinary efforts are warmly acknowledged as we surpassed two key targets that support people in maximising their own health and wellbeing. We reached 92 per cent for the More Heart and Diabetes Checks health target - the highest rate in the country and 100 per cent of our patients in primary care were offered advice to quit smoking, well ahead of the 90% target. Neither of these would have been possible without a shared commitment between PHOs, their clinical leaders, their GPs and every member of their practice teams.

While achieving the National Health and the Better Public Service targets and addressing Board priorities, the organisation has also sharpened its focus on culture and the efficient and effective delivery of services. Underpinning the former were important and transformational steps in preparing to review and refresh the organisation's values. By year's end, we were ready to listen to hundreds of patients, whānau, staff and provider partners describe what a good health experience is for them. The outcome from this work will help us develop a shared set of values that align with everyone while describing the quality of care we can all aspire to.

Getting our house in order

We are very pleased to report that we delivered a balanced budget for 2013/14, in the context of a very challenging financial landscape. With this came progress towards greater financial sustainability. We are embedding efficiency as a part of our culture with efforts such as making more than $74m in savings in the 2013/14 financial year. –This is an important milestone as there is yet more value from our health dollar that we will need to find in the coming years.

Our focus on service improvement has resulted in very significant bed day savings, as a result we freed-up bed space equivalent to having 91 fewer patients in Auckland City Hospital. This is ninety-one fewer patients on every day and every night of the year. This was achieved in the face of a near-unprecedented uplift in acute demand. In six out of the 12 months to June 2014, more than 5,000 patients presented to our Adult Emergency Department each month.

As the following pages reveal, these examples are the base for achieving our goal of healthy communities and quality healthcare for the Auckland DHB population. Collaborative work such as that already described has seen improved results across a range of indicators in the community. There are still some gaps that stubbornly resist narrowing. Life expectancy at birth differentials according to ethnicity (page 20) are the sobering note that must bring with it an even greater resolve to apply new methods of collaboration and improvement for all our population.

None of these achievements would have been possible without the sustained commitment of our staff, many of whom are also busy stretching themselves and growing as they step up and into new positions of clinical leadership and accountability.

Clinical leadership

Our journey of transformation is now being driven by a new model of clinical leadership that requires a single point of accountability for delivering results. Clinical leaders have taken this on in each of the eight major patient-facing directorates including Adult Medical Services, Women's Health and Cancer and Blood Services. This renewal is reflected elsewhere in the organisation and at governance level with the new Board. This Board took up the reins in December 2013, when we welcomed new members Douglas Armstrong QSO and Morris Pita.

Similarly, strategic renewal and foundation work is enabling us to embrace future challenges beyond the hospital walls. There we are working in localities with communities and with primary care partners to focus on what we must do to maintain and improve wellness and address health need. In this regard, as in the values work, we are placing the voice of our patients and the wider community at the centre.

The year under review was notable in that for the first time we aggregated the views of our community and inpatients in a

large, empirically-sound dataset. This holds the insights of a group of more than 11,000 people. We are applying these insights to ensure service design work and new models of care deliver the right patient experience in the right way at the right time.

The Board was also pleased to note that for the first time more than 80 per cent of inpatients reported their care to be good or better. We believe we can surpass this and see similar or greater improvement expressed by patients and families in the community setting.

Collaboration and partnerships

There is still much to do to support this, as we achieve ever-closer bilateral collaboration between the Auckland and Waitemata DHBs. There is, among whanau ora providers, GPs, pharmacies, NGOs and private providers a great deal of untapped potential for collaboration and regional delivery of services. As we move more quickly and with greater determination to tap this potential for our patients and community, we will require our organisation to be actively mindful of the individual who stands at the centre. And we will never forget, nor take for granted, our privilege to be working with our community-based healthcare partners and organisations. They are so numerous, space constraints mean we can scarcely mention but a few.

Last year we expressed gratitude to our charitable funding partners the Starship Foundation and the A+ Trust, whom we gratefully acknowledge again this year. We also give thanks to the efforts of research and workforce partner the University of Auckland – notably in the form of the Auckland Academic Health Alliance. So too, we acknowledge the partnership with Auckland University of Technology, in our Design for Health and Wellbeing Lab.

As we embark on another year of challenges we thank all DHB staff and our partner providers for their efforts in 2013/14. While we urge interested readers to read this document in full, those seeking an overview might choose to focus on the sections on service performance (pages 24-38) where you'll find the key results and metrics describing a year of achievement and challenge.

We also commend this annual report to the incoming Minister of Health the Hon Jonathan Coleman and wish him every success.

Dr Lester Levy CNZM

Chair

Auckland District Health Board

Ailsa Claire OBE

Chief Executive

Auckland District Health Board

MĀORI TE TIRITI - PARTNERSHIP STATEMENT

Kaua e mahue atu tētahi ki waho | Don't leave anybody out

This annual report shows that significant gains in Māori health have been achieved in the past 12 months. Te Rūnanga o Ngāti Whātua acknowledges the achievement of several national health targets and performance indicators for Māori, and the progress that has been made in achieving many others.

In particular, the successful attainment of the immunisation rates for Māori children is a valuable achievement. Timely immunisation ensures the most vulnerable members of our whānau are protected against many illnesses, and that whānau are engaging with health services early on in a child's life. Additionally, child and youth health is a priority for our organisation, given half of all Māori living in our communities are aged 25 years and under.

However, many indicators in this report also show that Māori often suffer disproportionately from health conditions compared to other groups in our communities. Perhaps the most striking within Auckland DHB's catchment area is the fact that Māori, on average, die seven years before their non-Māori neighbours. We are committed to a partnership with Auckland DHB to eliminate these health disparities and improve the health status of Māori living in our communities.

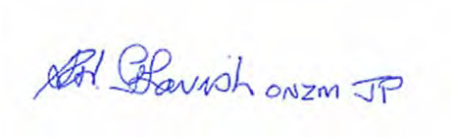
It is in the face of such inequities that Te Rūnanga o Ngāti Whātua and Auckland DHB entered into a partnership. In the past 12 months key milestones for this partnership have been achieved including:

- An increased level of Māori engagement in Auckland DHB planning developments, particularly with Ngāti Whātua representatives (e.g. the Auckland DHB's Annual Plan and Māori Health Plan).
- Ngāti Whātua involvement in key DHB forums, notably the Alliance with PHOs and the Locality Programme, both of which will have a major impact on Māori health across Auckland and Waitemata.
- Ngāti Whātua-led engagement between Māori health providers and Auckland DHB
- Greater involvement in reviewing research proposals to ensure research benefits accrue to Māori communities.

Once again, we restate our commitment to working in partnership with Auckland DHB to ensure whānau within the district achieve the best health outcomes. This annual report highlights the importance of our partnership, as we look back over our past achievements, but, more importantly, it provides the basis for our partnership as we look forward to the years ahead.

Our Te Tiriti o Waitangi Partner:

Te Rūnanga o Ngāti Whātua



R Naida Glavish JP

Chair, Te Rūnanga o Ngāti Whātua

Kaua e mahue atu tētahi ki waho

Don't leave anybody out

Our Te Tiriti o Waitangi Partners:

Te Runanga o Ngati Whatua

VISION AND VALUES

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

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

We have approximately 10,244 staff employed in providing health and medical services which equates to around 8,000 full-time equivalent positions (FTE) and we manage a budget of approximately two billion dollars.

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

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

The hospital has the largest elective surgery delivery system in New Zealand with nearly 22,000 elective discharges, approximately 40% of which are for other DHB populations.

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

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

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

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

OUR VISION

A healthy local population and quality health service across the continuum when people need it

Healthy Communities, Quality Healthcare

Hei Oranga Tika mo te iti me te Rahi.

OUR MISSION

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

OUR ORGANISATIONAL VALUES

Integrity, Respect, Innovation, Effectiveness

Kia u ki te tika me te pono.

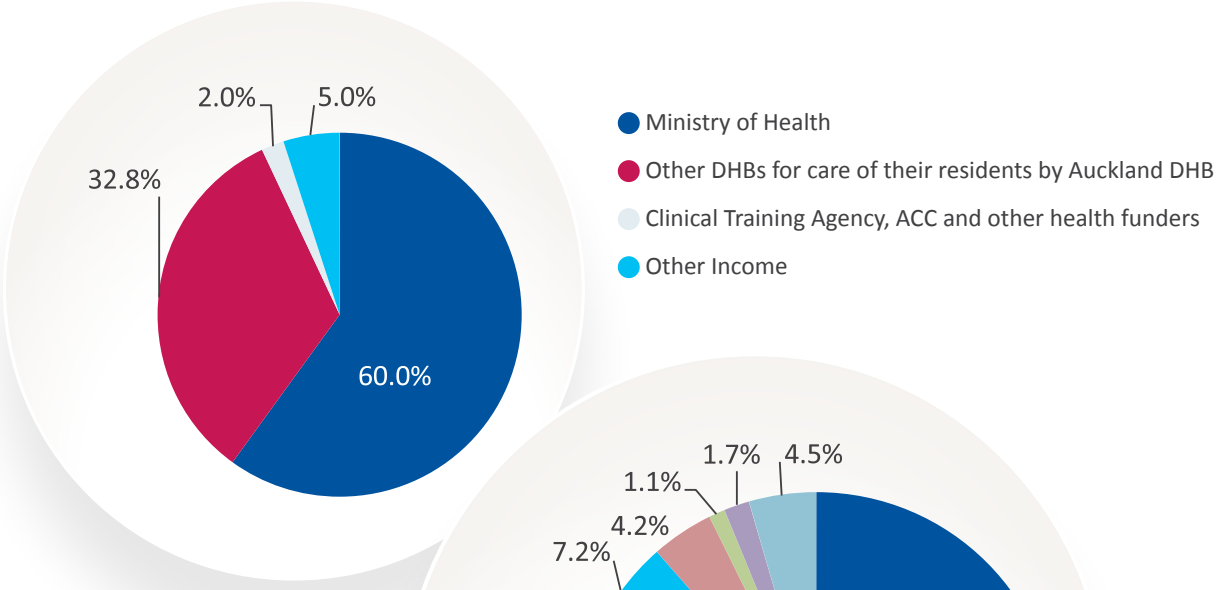
In the third quarter of the 2013/14 financial year we began drafting a strategy for the district health board. This began with the concept of self-directed care and focused on maximising health gain and providing safe, high quality, effective and sustainable services. The work underway will be completed by December 2014 in time to influence the 2015/16 Annual Plan.

A large scale project to refresh organisational values also began at this time and will continue into the 2014/15 year. Both the strategy and values work underway will result in changes to our Mission, Vision and Values. These will be reflected in the 2014/15 Annual Report.

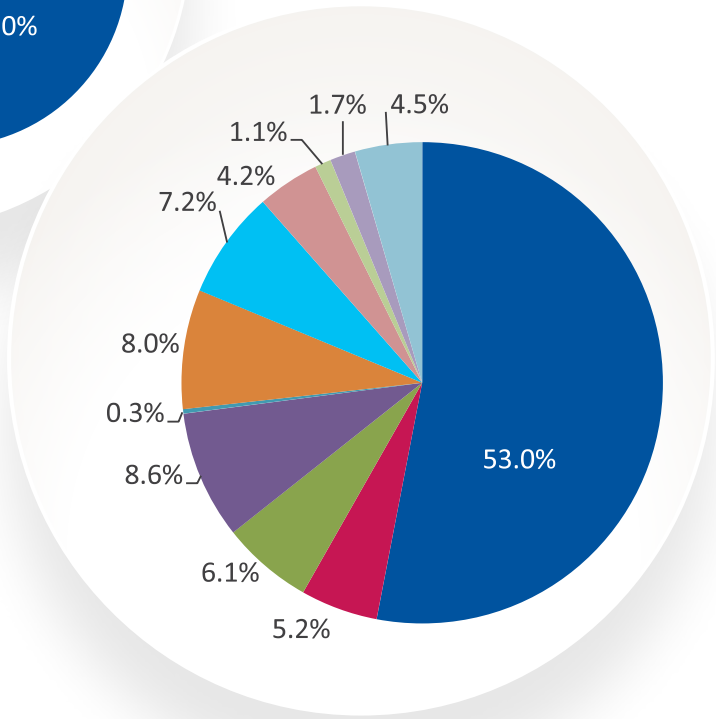

Great Barrier ward/local board area
Waiheke ward/ local board area
Waitematā ward/local board area
Orakei ward/local board area
Albert-Eden ward/local board area
Whau ward/local board area
Puketapapa ward/local board area
Maungakiekie - Tamaki ward/local board area
Part of the Otahuhu-Mangere ward/local board area
THE AUCKLAND DHB DISTRICT

HOW WE ALLOCATE OUR FUNDING

Where did the money come from



What was it spent on?



DISTRICT SNAPSHOT

Over 475,750 people live in our DHB area, with a projected growth of 16% or 75,850 more people by 2026.

We are a diverse population: 7.7% Māori, 10.9% Pacific, 31.4% Asian[1], 50% Pakeha and other New Zealanders. Auckland has one of the highest non-English, non-Māori speaking areas with over 100 languages spoken. 13% of our population do not speak English and need assistance or interpreting when attending health services.

Our population is relatively young: 16.6% are aged under 15 years, compared with 19.7% for all of NZ; and 10.3% of people living in the Auckland DHB district are aged 65 years and over, compared with 14.72% of the NZ population.

34% of our population live in areas with a New Zealand deprivation index of less than 7 (10 is the highest level of deprivation). Over 38% of all 0–14 year olds live in the highest deprivation areas of the city (NZ Dep 8, 9 and 10). Of that 38%, 72% are Pacific, 55% are Māori and 21% are Pakeha and other New Zealanders.

Cancer, heart disease and mental health remain the diseases placing the biggest health burdenon our district. The life expectancy gap for Māori is 7 years and for Pacific 9 years between these groups and other New Zealanders living within the Auckland district.

KEY FACTS AND FIGURES - Over the past year

- There were 7,362 babies born (7613 in 2012/13), nearly 13% of the country's total births.
- Auckland DHB vaccinated 57,681 (63,369 in 2012/13) children under six years of age.
- 317,790 school dental treatments were given to children in Auckland DHB. This compares with Waitemata DHB 256,911 and Counties Manukau DHB 310,842.
- 139,537 (91.9%)of the eligible population had a cardiovascular disease (CVD) risk assessment.
- Community Nurses made 96,500 home visits (95,400 in 2012).
- Auckland DHB subsidised 137 GP practices (same as 2012).
- There were 4,889,856 items prescribed by GPs for patients living in the Auckland DHB area (4,698,175 in 2013).
- 45,432(99.7%) of eligible smokers received smoking cessation advice in primary care.
- 44,229 women aged 45 to 69 years living in Auckland DHB area were screened by BreastScreen Aotearoa in the 24 months to May 2014. This compares to around 43,000 for the same period last year.
- As at March 2014, 101,566 women aged 25-69 years had had a cervical screen in the last 3 years, compared to 100,993 at the same time last year. Comparatively, Waitemata 111,849 (108,735) women were screened, 29,787 (29,569) Northland women and 90,818 (88,068) Counties Manukau women.
- Our hospitals provide 1,021 general beds, 144 mental health beds, 113 intensive care and high dependency beds, and 28 rehabilitation beds. There are 39 operating theatres and four cardiac investigation rooms.
- There were 328,401 (334,500 in 2013) attendances at outpatient clinics, of which 56% were Auckland DHB residents, 25% were Waitemata DHB residents, 14% were Counties Manukau DHB residents and 4% were from the rest of New Zealand.
- The adult Emergency Department had 69,700 (55,600 in 2013) visits, of which 81% were Auckland DHB residents. The Starship Children's ED department had 31,100 (31,000 in 2013) visits, of which 63% were Auckland DHB residents, 25% were Waitemata DHB residents, 10% were Counties Manukau DHB residents and 2% from the rest of New Zealand.
- There were 77,200 (79,500 in 2013) patient discharges from our medical specialties, of which 68% were for Auckland DHB's residents.
- Surgeons performed 23,700 (20,200 in 2013) elective surgeries, of which 51% were for Auckland DHB's residents, 26% were for Waitemata residents, 13% for Counties Manukau residents and the remaining 10% for patients from other parts of New Zealand.
- There were 25,100 (25,500 in 2013) acute surgical discharges from our hospitals.
- Auckland DHB saw 20,596 (19,770 in 2013) mental health clients. There were 11,771 mental health home visits in 2014.
- 3690 (5082 in 2013) people were assessed for Home Based Support Services.
- Auckland DHB subsidised the cost of aged residential care for approximately 3610 people (3670 in 2013).

[1]For the purposes of this Annual Report, the term 'Asian' describes culturally diverse communities with origins from the Asian continent and refers to Chinese, Indian, Southeast Asian and other Asian people excluding people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia. The term 'MELAA' refers to Middle Eastern, Latin American or African ethnicity groupings consisting of extremely diverse cultural, linguistic and religious groups.

HIGHLIGHTS AND ACHIEVEMENTS FOR THE YEAR

2013/ 2014

Auckland DHB was one of only two DHBs to meet all six health targets for the 2013/14 year and the first DHB, with its PHO partners, to achieve the quit smoking and cardiovascular and diabetes check targets.

2013

JUL

Starship Children's Hospital Level 6 Upgrade was completed

Ailsa Claire, Chief Executive and Lester Levy, Board Chair signed a pledge of support for the national health quality and safety campaign Open for Better Care

AUG

The Vodafone Warriors stepped in to help with the DHB's rheumatic fever throat swabbing campaign

SEPT

This month marked the ten year anniversary of Auckland City Hospital opening its doors to patients

OCT

Reduction in waiting times in the emergency department have seen a savings of 15,000 bed days in General Medicine since 2009

NOV

Auckland DHB publishes its first Quality Account

DEC

Work starts on Starship Children's Hospital Operating Room upgrade

Auckland DHB and AUT University hold their first design/health symposium

2014

JAN

The Women's Health directorate celebrates 50 years of National Women's history.

Clinical leadership is embedded in a single point of accountability model and seven senior appointment

FEB

Auckland – Waitemata collaboration initiatives continue or complete in the 2013-14 year include Māori Health; Pacific Health; Planning, Funding & Outcomes with Facilities & Development well underway

MAR

Around 160 staff providing contracted cleaning services became permanent staff. The decision was part of the wider objective of better managing our own environment.

Annual staff flu inoculation campaigns begins (achieving a record 75% by its end)

APR

Minister Jo Goodhew visited the Immunisation Clinic at Starship Children's Hospital as part of Immunisation Week

MAY

Auckland DHB and AUT University create a Design for Health and Wellbeing Lab (DHW Lab).

Auckland DHB achieves almost 77 per cent, four per cent above the national average, for its compliance with national hand hygiene standards

JUNE

Auckland DHB clinical researchers are awarded $2.7m in Health Research Council funding

Auckland – Waitemata collaboration scoping and planning continues in Sterile Services; Mental Health and Addiction Services and Women's Health

MOLLY'S STORY

"I think I'm ready to go out into the world now."

Molly Rowlandson was 20 years old when, on February 1, 2013, she was told she had leukemic cells. She can't remember much of that day, and at the time, didn't fully understand what the diagnosis actually meant. *"What's that? Is that cancer?' I'd never known anyone with cancer before, apart from a primary school friend's grandma…"* said Molly.

Molly had been travelling around the South Island with her family, when she noticed lumps behind her ears and throat. She also felt unusually tired, and had to take naps in the afternoon. Molly went to the doctor when she returned to Auckland, which was two days before she was due to fly to Wellington to continue a double degree in art history and marketing at Victoria University. *"The doctor was writing 'urgent' on everything, and I was thinking, 'oh, that's nice of him, he wants to make sure I get my flight on Sunday.' But no, that wasn't it,"* says Molly.

She and her parents were called back into the GP's office later that day. She remembers feeling ill, and panicky, in response to the news. I said *"Ok, what do I have to do to make it better? Let's get this underway and get it over with."*

But Molly recalls being admitted to hospital for the first time – and finding herself in an unfamiliar place among unfamiliar people – was terrifying at first. *"There were all these strangers, nurses and specialists, coming in and out, and I didn't know who any of them were. So Mum didn't leave my side because I was really scared. I was really freaked out. She stayed on the La-Z-Boy for a couple of nights, but that was pretty uncomfortable. Having a pull-out bed would be an incredible help in this sort of situation."*

"I struggled on Ward 62 as it was dark and depressing. The staff were fantastic, but we needed more space and facilities."

"If you're ill, you need your privacy. You want to be ill in dignity, if you can. Behind those ward curtains, you can hear everything…"

The experiences of people like Molly played a key role in the design of the new Northern Region Haematology and Bone Marrow facility called the Motutapu Ward which opened in August 2014. This new facility is a powerful example of co-design.

Co-design is a way of improving healthcare services with patients. Many service improvement projects have patient involvement but co-design focuses on understanding and improving patients' experiences of services as well as the services themselves. Patients like Molly as well as family and staff were involved in designing the Ward's functionality, layout and personal features. The result includes more single rooms with pull out beds for family stays, a whanau room with a kitchen, a private patient interview room for delivering and discussing sensitive medical information and a youth hang out area including desks and an X-Box.

"I feel well now, I feel good. I'm back to normal," Says Molly. Her hair has grown back, she's joined the gym, she's returned to university, part time, and has started an advertising internship. "I want to get my degree. I think I'm ready to go out into the world now."

WHAT ARE WE TRYING TO ACHIEVE?

Healthy communities, Quality healthcare - Hei Oranga Tika mo te iti me te Rahi

We want a healthy population where people are empowered to manage their own health and wellbeing, and who get the very best of health services when they need them. When people are unwell they rely on us to deliver the right care, at the right time and in the right way.

Patient and Whānau Determined Health care is the key approach to achieving our vision. This draws Whānau Ora and Self Directed Care into one patient and whānau-centred approach. People are the heart of the strategy for Auckland DHB. We put patients and whānau first; we respond to individual needs; we see people in the context of their whānau, their family, social support networks and communities of interest.

Health care delivery organisations exist to achieve better health outcomes, and this is our key focus. This requires us to continue to develop an organisation-wide culture that puts patients first, is relentless in the pursuit of fundamental standards of quality of care and which is enhanced by strong clinical leadership.

Through our Patient and Whānau Determined Health care approach, we aim to:

Lift the health of people living in Auckland DHB by shifting our focus upstream where problems and strengths are generated to improve health status across the population of Auckland. The positive contributors to good health lie in the family where lifestyle habits are engrained. We know that eating well; regular exercise; feeling safe and secure and having a sense of identity, belonging and purpose are critical to wellbeing. We also need to ensure that when required, people have access to the care they need, ensuring we involve family and whānau as partners in care. We want to empower patients and their families to achieve the goals they determine as priorities to maximise their health outcomes.

Achieve performance improvement through designing patient centred systems and processes that are capable of improving patient flow, outcomes and experience and clinically led continuous quality improvement to ensure that people receive the type of health service they need.

Provide the best return on investment in health by operating in a fiscally responsible manner and being accountable for the assets we own and manage. To remain a sustainable organisation we need to live within our means, managing tight cost controls, ensuring that we deliver services efficiently and effectively across our range of providers.

Over the past year we have made substantial progress towards developing and actioning our Patient and Whānau determined health care strategy. To continue this growth we need to embed those gains and focus on developing this into a longer term strategy with input from staff, patients, providers, localities and our iwi partners as well as a great many other stakeholders.

WHAT ARE WE TRYING TO ACHIEVE? *continued*

The following diagram presents the overall framework – illustrating the relationship between national and Board priorities, the overall outcomes we are trying to achieve in terms of increasing life expectancy and reducing ethnic inequalities in life expectancy. It also shows the impacts we will monitor to ensure we are making progress towards these outcomes.

Government Outcomes	**New Zealanders Live Longer, Healthier And More Independent Lives**		**The Health System Is Cost Effective And Supports A Productive Economy**	
MoH Priorities	Minister's Health Targets	Better Public Services	System Integration	
Northern Region Triple Aim	Health services are integrated, more convenient and people centred	New Zealanders are healthier and more independent	Future sustainability of health system is assured	
Auckland DHB vision and outcomes monitored	**Healthy communities, Quality healthcare**			
	Increase life expectancy		Reduce ethnic inequalities in life expectancy	
Auckland DHB Goals	**Patient and Whānau Determined Health**			
	Improved population health – lifting the health of people living in Auckland DHB		Performance improvement - Improved patient safety and experience	Providing the best return on investment in health
Auckland DHB Impacts monitored	• Smoking prevalence • Smokers given advice and help to quit • Childhood immunisations • After hours emergency care for under 6 year olds	• Heart and diabetes checks • Cancer survival • Faster cancer treatment • ED access • Elective Surgery • Reducing aged residential care clients presenting to ED	• Patient experience • Infection rates • Adverse clinical events • Falls	• Efficient and effective delivery of health services
Priority Populations	Māori	Pacific	Asian	Children Youth Older people
Output Classes	Prevention	Early Detection and Management	Intensive Assessment and Treatment	Rehabilitation and Support
Enablers	Patient and Family Empowerment	Workforce	Information and Communication Technology	Financial Sustainability

All programmes aim to reduce inequities, particularly for our Māori population and we monitor many of our indicators by ethnicity. Please see the section 'What difference have we made for our Māori population' on page 24 for information about our progress against key measures.

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

Our main outcome measures

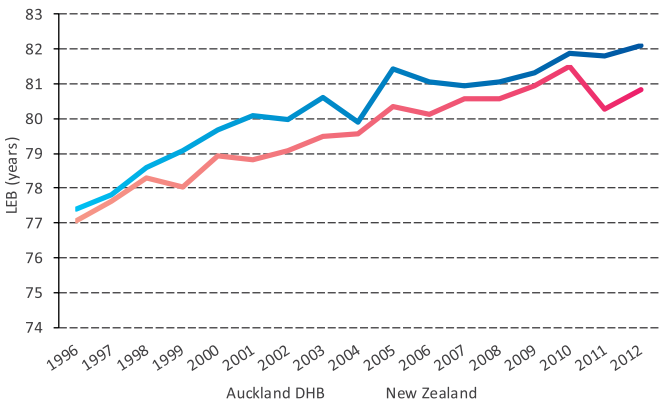
Outcomes are high level changes to states or conditions of society, the economy or the environment and they generally only come about through the influence of many different factors and the activities of multiple agencies. Therefore, as a DHB we need to work with others to ensure we are achieving the best possible outcomes across the whole system for our community.

Our main outcome measures are to increase life expectancy and reduce the inequalities in life expectancy between different ethnic groups. We would not expect to see progress within one year for these high level measures. Improvements are more likely to occur over five years based on the annual priorities and activities implemented.

Increase Life Expectancy

Life expectancy is recognised internationally as a measure of population health status. We expect to see the continued increase of around three years each decade. For New Zealand as a whole, the trend has been 2.8 years per decade over the last 15 years. In 2012 life expectancy in the Auckland DHB area was approximately 82 years.

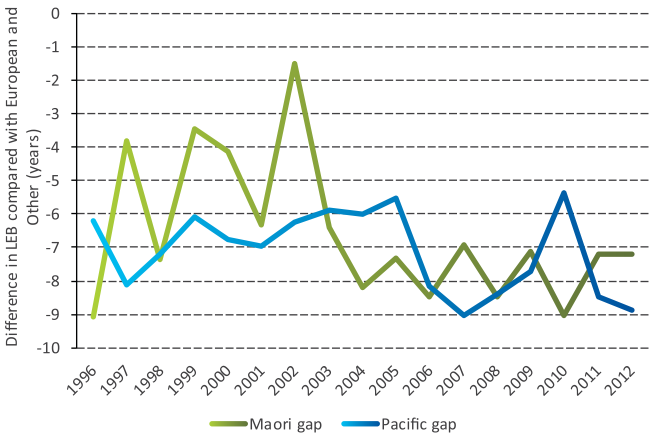
Trend in life expectancy at birth. Auckland DHB vs NZ 1996-2012*



Reduce Ethnic Inequalities in Life Expectancy

Life expectancy rates for Māori and for Pacific compared to other New Zealanders show significant differences between the ethnic groups within our community. We want to reduce this life expectancy gap to zero in the long term. There is still a gap of 7 years for Māori life expectancy and 9 years for Pacific. We continue to try and address these unacceptable differences in life expectancy as a health service priority, while also acknowledging that changes take time and require the attention of other sectors. Many of our programmes and services specifically target Māori and Pacific patients to improve outcomes for these populations. These are described throughout this report. Monitoring of our impacts for Māori is contained in the section: 'What difference have we made for our Māori population.'

Ethnic gap in life expectancy at birth Auckland DHB*



** Note: issues with 2013 data quality have limited the information presented here to 2012*

Our impact measures

We have identified measures for each of the key areas related to achieving our vision and our longer term strategy to deliver on our Patient and Whānau Determined Health Care Programme:

- Improved population health – lifting the health of people living in the Auckland DHB
- Performance improvement - Improved patient safety and experience
- Providing the best return on investment in health

The measures that sit within these areas are our impact measures, where individual DHB performance can have a measurable impact on the longer-term outcomes we are seeking. These represent areas of activity where the DHB can influence change and help to demonstrate the difference we are making in the health of our population. This section provides an update on our progress against some of the key measures within these outcomes areas.

Overall results show measurable gains in these areas. We have some of the lowest rates of mortality in the country for cancer and cardiovascular disease, some of the lowest smoking rates and one of the highest one year relative cancer survival rates in the country at 78.6%.

Improved population health – lifting the health of people living in Auckland DHB

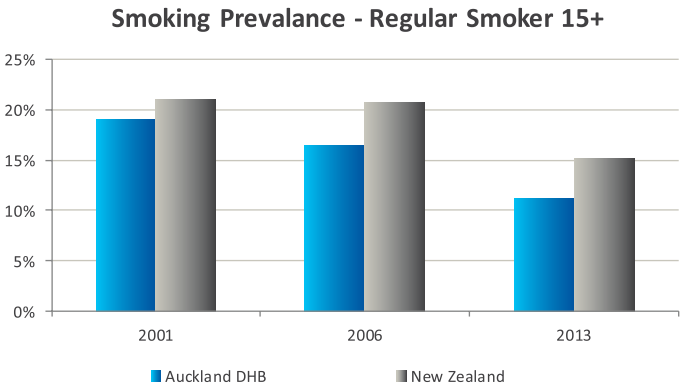
We focus at a population or community level on supporting people to maximise their health and wellbeing. Our role is to encourage healthy lifestyles in the whole population as well as more targeted activities for groups identified with specific health needs to improve overall health status. We have a significant role to play in improving the management of ill health. We provide or fund prevention and disease screening programmes such as breast and cervical screening; disease management programmes for long term conditions such as diabetes, rehabilitation and specialist hospital based services such as elective surgery and intensive care.

Healthy lifestyles

Smoking rates

Smoking is the leading modifiable risk factor in New Zealand and contributes to many deaths and hospitalisations in Auckland. Auckland's smoking rates have reduced significantly between censuses. The prevalence of smoking in Auckland DHB was 11.2% according to Census 2013. This is the lowest prevalence in the country and has reduced from 17% in 2006.

Fewer people are taking up smoking and there has been significant progress in encouraging people to quit. Providing advice and help to quit in both hospital and primary care settings has increased markedly over the year.

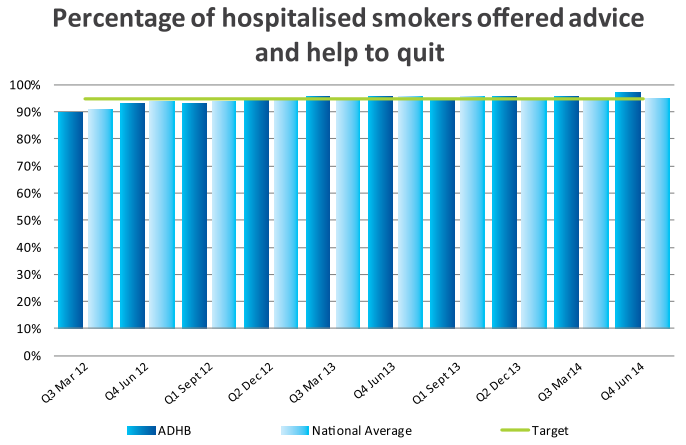


Percentage of hospitalised smokers who are given advice and help to quit

We have performed very well providing brief advice to smokers in hospital – 97% of hospitalised smokers received advice on quitting smoking in quarter four 2013/14.

This has been achieved through education, training, and continued auditing and surveillance on the part of ward staff, as well as prompts and support from ADHB Smokefree. A central triaging service for referrals aims to ensure that patients are followed up after discharge and GPs are notified that their patients have received brief advice and support to quit whilst in hospital.

Target	Achieved Result:
95%	97%



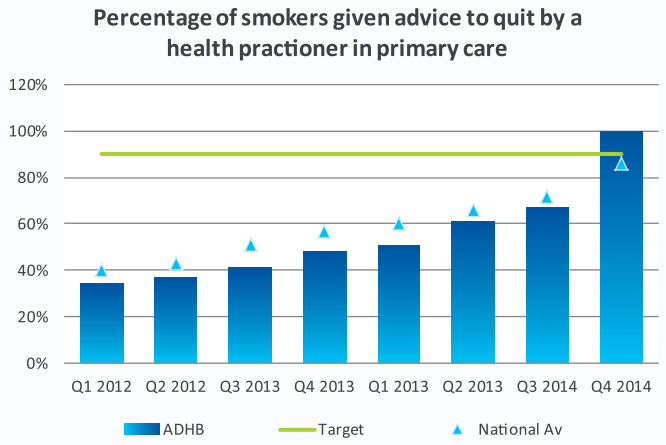
Healthy lifestyles *continued*

Percentage of smokers seen by a primary care practitioner given advice and help to quit

We achieved the second best result – 99.7% – in the country for the Better help for smokers to quit - primary care health target in quarter four, offering brief advice to over 45,400 smokers. This is a substantial improvement on results of one year ago – 48% at quarter 4 2012/13.

A key success factor in achieving the target is the leadership that has been shown by the PHOs. All of the PHOs put additional resources into project teams that supported General Practice to achieve the target. The DHBs also contributed additional funding to each PHO to proactively contact patients by text and phone that had missed receiving advice and support to quit from General Practice. The proactive text and phone calls proved to be a very useful activity and were well received by the patients they contacted. Of those contacted and given brief advice approximately 20% accepted an offer of support to quit. We aim to maintain the health target result, now that it is well embedded as a clinical intervention for practices.

Target	Achieved Result:
90%	100%



Well Children/Tamariki Ora

The wellbeing of children is critical to the wellbeing of the population as a whole and is both a regional and a national priority. Healthy children are more likely to become healthy adults.

Vaccine preventable childhood disease

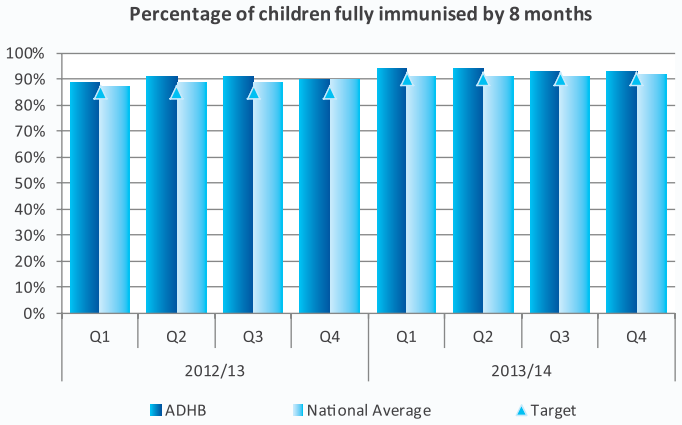
Ensuring as many children as possible are vaccinated against childhood diseases should have positive effects on those actually contracting these diseases. Our consistently high vaccination rates for 8 month olds have had a positive impact on the numbers of children hospitalised for vaccine preventable disease - 17 per 100,000 in 2013/14, down from 39 per 100,000 in 2012/13.

Percentage of children fully immunised at 8 months

We have consistently exceeded the 8 month immunisation target all year, as well as being above the national average every quarter. Steady gains have been made to reduce the equity gap with an increase of 4% for Māori and 10% for Pacific since September 2012.

Significant efforts have contributed to these results, including upskilling of practice nurses, midwives, wellchild providers, paediatricians and hospital based staff around new vaccines added to the vaccination schedule, continuing to work with PHOs and other primary care partners to improve coverage including working with PHOs, IMAC and the Māori health team to identify and work with practices with overdue vaccination episodes in Māori infants. Also working with Maternity Services and WCTO providers to help facilitate early enrolment with GPs.

Target	Achieved Result:
90%	93%



Free after hours-care for children under 6 years of age

Ensuring after hours acute care services are available to children at no cost improves health outcomes for this most vulnerable population group. Free after hours care is available to under 6 year olds across metro-Auckland from 11 Accident and Medical Clinics.

Prevalence of diabetes and cardiovascular disease

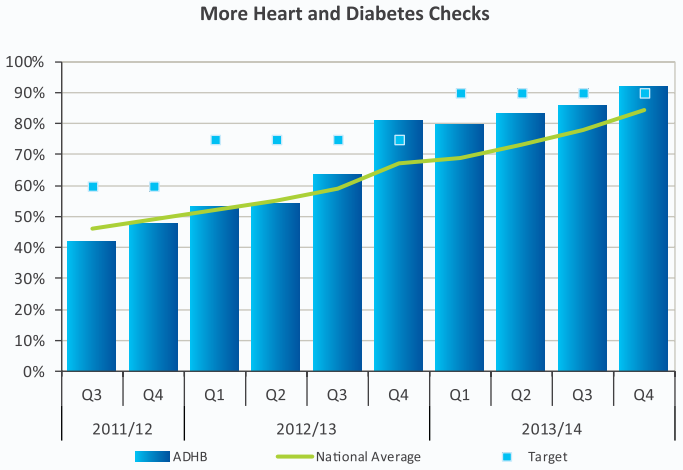
Cardiovascular mortality at Auckland DHB is amongst the lowest in the country and has decreased from 135 per 100,000 (2005) to 116 per 100,000(2011). Although the prevalence of diabetes is lower than some parts of New Zealand, there are 23,649 Auckland residents with diabetes and the number is increasing.

More Heart & Diabetes Checks

We achieved the best result in the country for the More Heart and Diabetes Checks health target in quarter four, reaching 92% or 13,537 eligible people, the only DHB in the country to achieve this health target. This is a substantial improvement on results of one year ago – 81.3% at quarter 4 2012/13, improving 9% for Maori and 4% for Pacific.

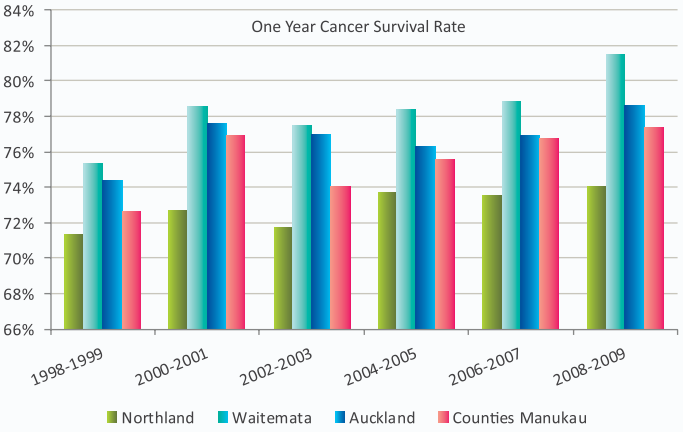
A number of strategies and tools have helped to vastly improve the performance against this target over time: PHO Service Agreements ensure general practice have the tools, support and skills to complete assessments. This includes the management and reporting of activity.

Target	Achieved Result:
90%	92%



Cancer incidence and survival

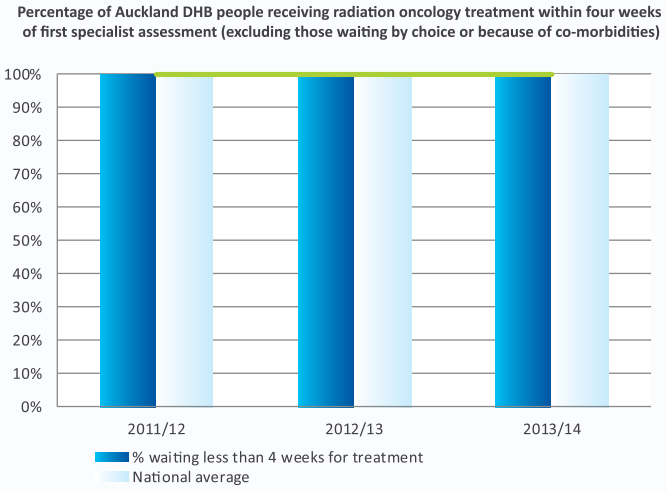
Our cancer mortality rate is lower than the country's average (126/100,000) at 119 per 100,000 population and we have one of the highest overall one year relative cancer survival rates in the country at 78.6%, up from 74.4% over ten years.



Shorter waits for cancer treatment

The Shorter Waits for Cancer Treatment health target has been met consistently for the past 5 years. None of our patients wait more than four weeks for radiotherapy or chemotherapy. There are no inequalities for Māori or others in these waiting times. We are also improving the waiting time at every stage of the journey.

Target	Achieved Result:
100%	100%



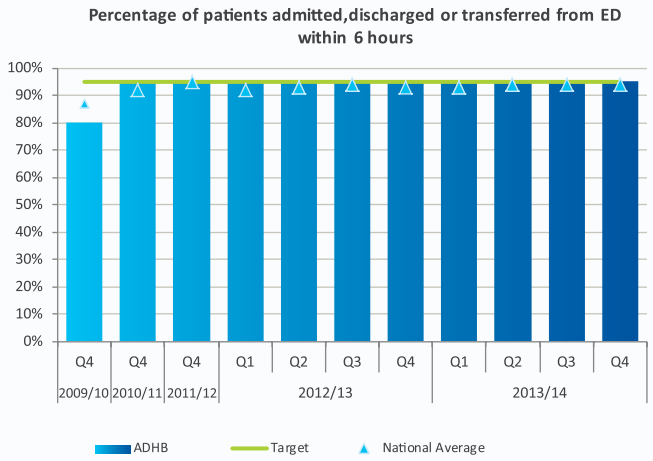
Access to appropriate care

Being able to access the right care at the right time in the right location is critical to ensuring patients gain the best health outcomes including the overall experience of the services they receive.

Shorter stays in emergency departments

We provide timely access to hospital services to enable people to live longer, healthier and more independent lives. This health target has been met consistently for the past 4 years, even though we have seen an increase of 18% in the number of people attending our emergency departments between 2009 and 2014, with 105,000 attendances in the 2013/14 financial year.

Target	Achieved Result:
95%	95%

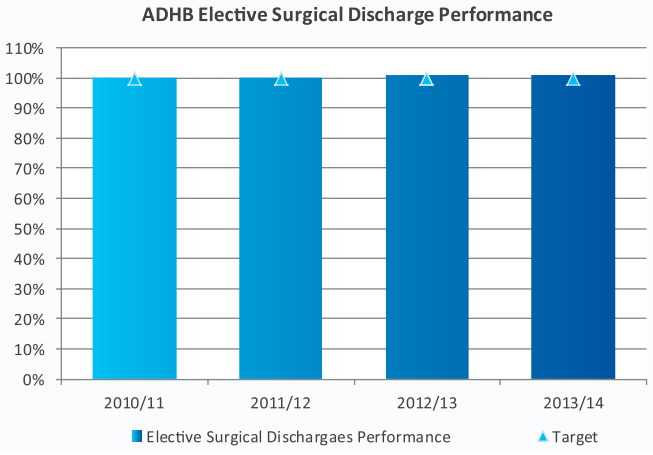


Improved access to elective surgery

We delivered 13,608 elective surgical discharges in 2013/14. This is a 14% increase over 2011/12 performance. We have also met waiting time targets, ensuring all people appropriately referred for a first specialist appointment or for surgery wait no longer than 4 months.

While we attained above the national target surgical intervention rate target for cataract surgery, we were below the national targets for the other 4 Ministry of Health measured procedures. We continue to streamline and our surgical pathways and management and prioritisation tools to ensure service efficiency and effectiveness.

Target	Achieved Result:
100% (13,499 discharges)	101% (13,608 discharges)



Performance improvement - Improved patient safety and experience

We have a significant role to play in providing safe, high quality care, ensuring that the health outcomes of those we serve are not negatively impacted through inaction, error or neglect. People who use our services should have a high level of trust and confidence in the health system and rate their experiences positively. Our DHB continuously strives for excellence in the healthcare we deliver, with an organisation-wide focus on quality to enhance patient safety and experience.

Improved patient experience

Patient experience survey

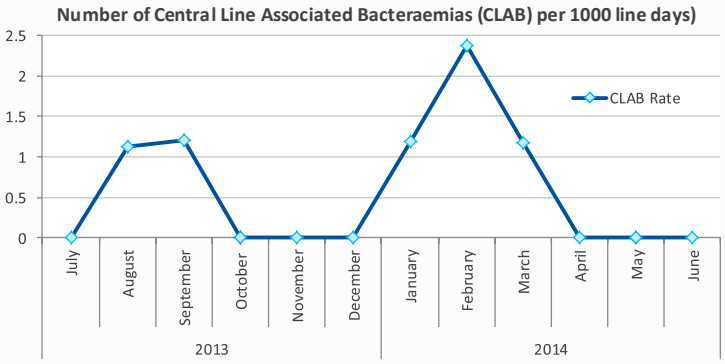
Measuring patient satisfaction with care received is a useful way of determining if we are doing the right things and uncovering any areas where we can improve on services. Increasingly there is evidence that quality is affected not only by the quality of technical care received, but also by the quality of interpersonal relationships (eg. staff, patients and families) - good patient experience and good clinical quality go hand-in-hand.

Patients are asked to rate the care they received overall during their whole stay in hospital. June 2014 results show a rating of 85% which is an improvement over time (June 2013 result was 81%) though just short of the 90% target.

Quality and safety of services

Central Line Associated Bacteraemia (CLAB)

The target of <1 CLAB infection per 1000 line days has been met as of 30 June 2014. Compliance with the standard processes for inserting and maintaining the central lines ('bundles' of care) is reported as one of the Health Quality and Safety Commission Quality and Safety Markers (insertion bundle). The Infection Prevention and Control team continues to provide teaching and support to wards in other areas where central lines are used.

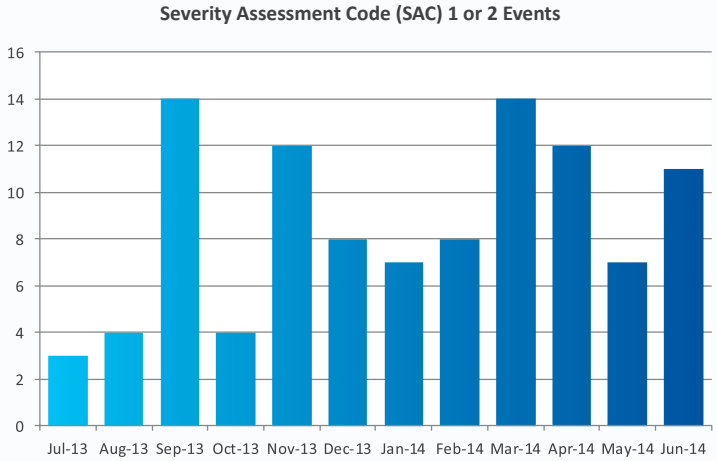


Quality and safety of services *continued*

Serious adverse clinical events

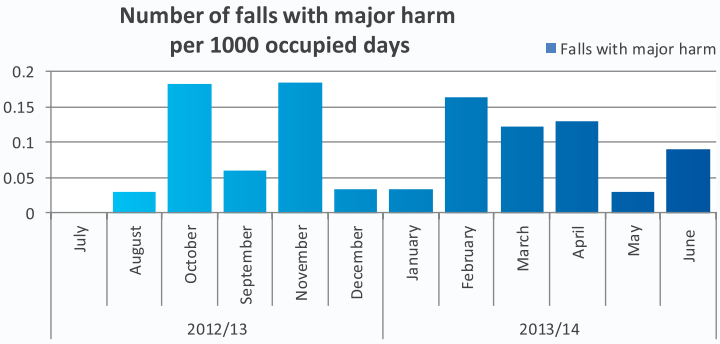
The overall increase in serious adverse events represents improved reporting and a greater focus on the need to learn from incidents.

We have provided specific open disclosure training workshops in partnership with the Medical Protection Society for senior clinicians and developed and delivered experience-based co-design professional development/education to staff. We participate in the Health Quality and Safety Commission's national patient safety campaign, 'Open for better care' which focuses on reducing events that cause harm to patients while they are in hospital.



Falls with major harm

Falls that cause harm have a major impact on the lives of older people (and their family/whanau) The ageing population means that it is imperative that we address the causes of falls in the elderly and commit to ongoing programmes to prevent them occurring. The Health Quality and Safety Commission's national patient safety campaign, 'Open for better care' incorporates a programme committed to preventing falls and injuries by promoting effective, evidence-based approaches.



Provide the best return on investment in health

DHB health resources must be managed efficiently and sustainably in order to meet present and future health needs. We need to demonstrate financial responsibility, covering all costs from our annual income. We will remain a sustainable organisation which manages its resources efficiently and achieves a break-even position each year.

2012/13 Audited $000	2013/14 Actual $000	2014/15 Plan $000	2015/16 Plan $000	2016/17 Plan $000
$154	$264	$27	$32	$40

WHAT DIFFERENCE HAVE WE MADE FOR OUR MĀORI POPULATION?

Auckland has made significant progress in recent years in reducing health inequalities. The DHB has eliminated inequalities in the following areas already:

- Better help for smokers to quit
  - Hospitalised
  - Primary care
- Breast screening
- Access to mental health services
- Mental health relapse prevention planning

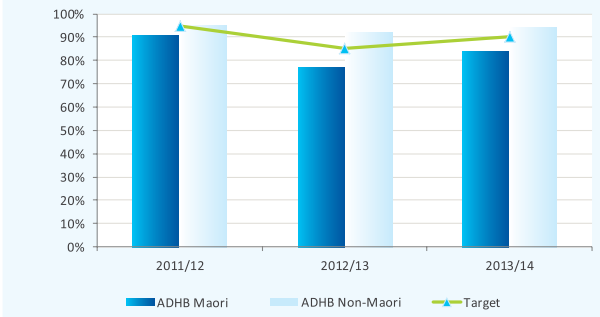
Other areas have recorded a marked improvement, although there is still some way to go to achieve equal performance. These include CVD risk assessment, PHO enrolment rates and diabetes annual reviews which continue to improve over time.

The mismatch between enrolment and coverage lead to the roll out of the Ethnicity Audit Tool (EDAT), one of the strategies to support PHO achievement of the target. The final EDAT was released in June 2013 and the project's roll out began in April 2014 under the auspice of Māori Health Gain with the collaboration of the Primary Care team at Waitemata and Auckland DHBs.

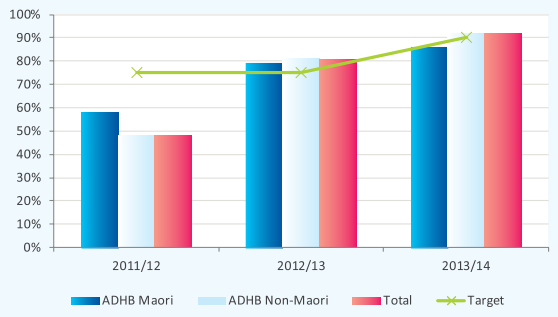
EDAT needs implementing in all general practices under both DHBs, collaboration between primary care providers, represented by the five PHOs under Waitemata and Auckland DHBs. Contracts are currently in place with these five PHOs to offer a training package that encompasses the Health and Disability Ethnicity Protocol as well as the specific implementation of EDAT in primary care.

During the year the cervical screening ethnicity data project was completed. The project found that correction of misclassification affecting Māori women would result in an approximately 30% increase in women recorded as Māori in the primary care data. We have been working with PHOs, the regional National Cervical Screening Programme register and the National Screening Unit to improve the accuracy of ethnicity data for women. The information we have obtained and the experience of undertaking this work has been very useful in other ethnicity data related projects.

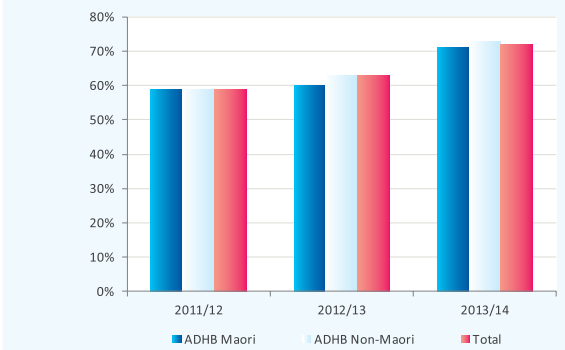
Percentage 8 month olds fully immunised



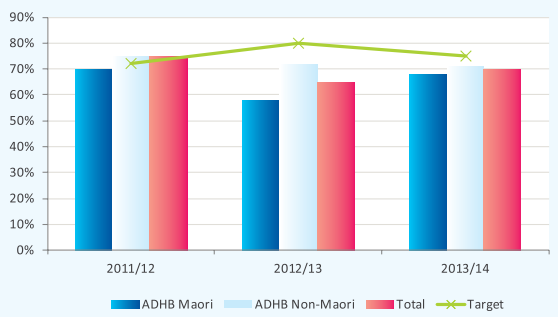
More heart and diabetes checks



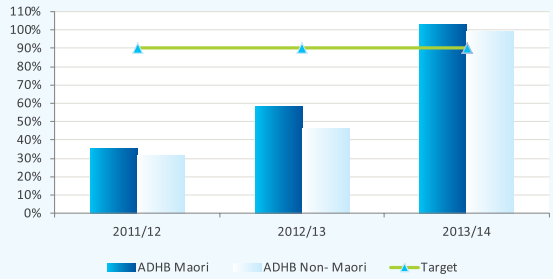
Diabetes annual reviews



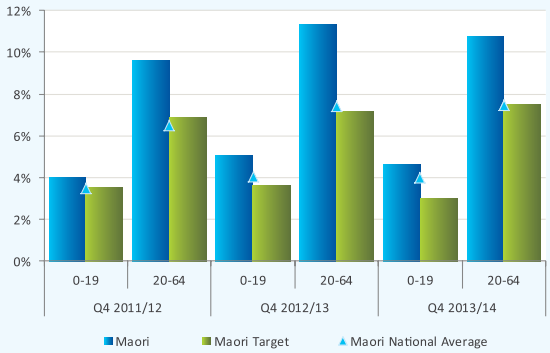
Diabetes management



Brief advice to quit – primary care smokers



Access rates to mental health services by age group



Māori Workforce Development

In late 2013, Te Rūnanga o Ngāti Whātua led the development of a Māori Workforce Development Strategy. A steering group was formed to guide the development of the strategy with representatives from Māori providers, PHOs, DHBs and DHB MoU partners.

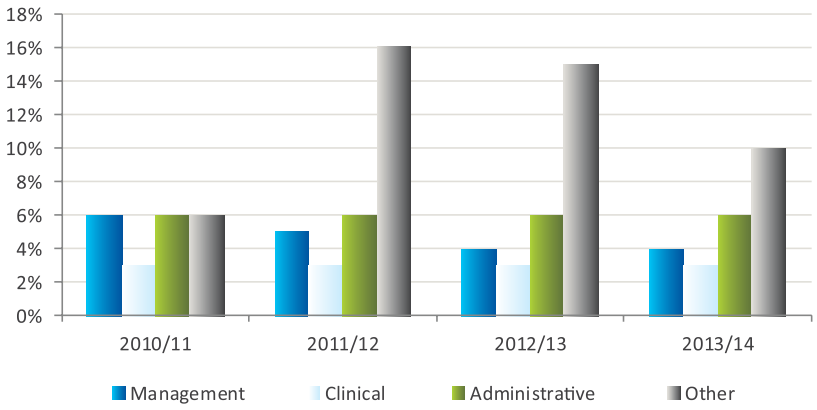
The Strategy was endorsed by the Board of Te Rūnanga o Ngāti Whātua in late June 2014, and presented to the Waitemata DHB Senior Management Team. Further consultation and 'socialisation' of the strategy is planned for early July 2014, with PHO CEOs, Manawa Ora and the Auckland DHB senior management team.

Current activities include:

- Rangatahi Programme targeting senior students
- Kia Ora Hauora programme targeting junior students at Tamaki College
- HWNZ Hauora Māori Training Fund.

% of Employees by Ethnicity

Percentage of Auckland DHB workforce that are Māori



STATEMENT OF SERVICE PERFORMANCE

Overview

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

Our DHB is responsible for monitoring and evaluating service delivery, including audits, for the full range of funded services. Therefore some of the measures chosen in each section reflect and seek to illustrate the performance of the broader health and disability services provided to Waitemata residents, not just those provided by the DHB. We also have a particular focus on continuing to improve health outcomes and reduce health inequalities for Māori. Therefore, a range of measures have been identified throughout the Statement of Service Performance that monitor our progress in improving the health and wellbeing of our Māori population, as identified in the Auckland DHB Māori Health Plan 2013/14.

National Health Targets

2013/14 was a year of impressive gains for our DHB. Maintaining and improving on key areas of service delivery and meeting the 6 national health targets through sustained efforts and achieving some great results with our primary care partners have had positive impacts on our performance. We have made substantial progress against the six national health targets, achieving all six targets by 2013/14 year end – one of only two DHBs in the country to do so. We are number one in the country for the More Heart and Diabetes Checks health target and in the top 10 DHBs for three of the others. Results show each quarter's performance result.

Health Targets

		Q1	Q2	Q3	Q4
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	✓ 95%	✓ 95%	✓ 95%	✓ 95%
Improved access to Elective Surgery	The volume of elective surgery will be increased by at least 4,000 discharges per year (nationally). This equates to 13,608 elective discharges for Auckland DHB for 2013/14	✓ 100%	✓ 100%	99%	✓ 101%
Shorter waits for Cancer Treatment	All patients, ready-for-treatment, will wait less than four weeks for radiotherapy or chemotherapy	✓ 100%	✓ 100%	✓ 100%	✓ 100%
Increased Immunisation	90 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014	✓ 94%	✓ 94%	✓ 93%	✓ 93%
Better help for Smokers to Quit	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years by July 2014. *Average for year: 85%*	80%	83%	86%	✓ 92%
More Heart and Diabetes Checks	**Secondary Care** 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, are offered brief advice and support to quit smoking	✓ 95%	✓ 96%	✓ 96%	✓ 97%
	Primary Care 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered advice and support to quit smoking. *Average for year: 70%*	51%	60%	67%	✓ 100%

KEY PERFORMANCE HIGHLIGHTS 2013/14

We are promoting and protecting our populations health

More than 45,000 smokers received brief advice to quit in hospital facilities or primary care. Auckland DHB was the second best performing DHB in the country for the percentage of smokers given brief advice to quit in primary care achieving 99.7% for this target. This was a very significant increase from last year's performance (48.1%). There has been a significant reduction in smoking prevalence between the 2006 and 2013 censuses from 17% to 11%, demonstrating the impact of efforts in this area.

Heart and diabetes checks have been another area of focus for the DHB. As at June 2014 139,537 people had had a CVD risk assessment achieving 92% coverage for our population, more than a 10% improvement on this time last year (81.3%). Auckland was the only DHB in the country to achieve this health target in 2013/14.

139,537 people (91% of the eligible Population) had a CVD risk assessment.

More than 57,000 children aged five and under received childhood vaccinations and 93% of children were fully immunised at 8 months. We have consistently exceeded the 8 month immunisation target all year, as well as being above the national average every quarter and are making good progress towards achieving the 95% uptake required for herd immunity.

The Before School Checks (B4SC) Service is another important opportunity to support children's health and wellbeing. It is a universal, comprehensive screening and health education opportunity for four year old children. Before School Checks (B4SC) coverage has continued to improve this year reaching 76% compared to 68% last year. However, we have not reached the national target of 90%.

The number of preschool and school children visiting oral health services increased from 77,811 last year to 79,581 this year. The percentage of children missing their annual free dental check has significantly reduced from 19% to 4%.

We are addressing inequalities for our population

Māori life expectancy in Auckland DHB is 76 years, 3 years above the national average for Māori across New Zealand (73 years) at birth (2012). Smoking prevalence has declined more than 10% for Māori between the 2006 and 2013 census to 26.3%.

Māori life expectancy in Waitemata DHB is 76 years, 3 years above the national average for Māori across New Zealand (73 years) at birth (2012).

Heart and diabetes checks for Māori have increased from 79% (2012/13) to 88% (2013/14). Immunisation uptake has improved by 7% since July 2012.

Smoking prevalence has declined by about 7% for Pacific between the 2006 and 2013 census to 20%. Heart and Diabetes checks have increased from 87% (2012/13) to 91%. Immunisation rates for Pacific 8 month olds (96%) are well above the target of 90% and above the overall rate of 93% for the DHB. Pacific breast screening rates (89%) are also well above the overall rates for the DHB of 70%.

Our hospital and specialist services are operating effectively

We delivered 13,608 elective surgical discharges in the past year, 109 more than the target and nearly 5% more than the previous year.

We delivered 13,608 elective surgical discharges in the past year, 109 more than the target and nearly 5% more than the previous year. More than 89,000 patients attended a first specialist assessment (FSA) during the year. We met Ministry of Health waiting time targets, ensuring people waited no more than 5 months for their FSA or for their surgery.

Our Emergency Departments continue to see increasing numbers of patients each year - 104,628 attendances in 2013/14 versus 102,183 last year. However, we have continued to meet the waiting time health target ensuring all patients are admitted, discharged or transferred within six hours.

We are also ensuring that anyone waiting for chemotherapy or radiotherapy is starting their treatment within 4 weeks. This target has been consistently met for a number of years, even though the weeks waiting has reduced over time.

Everyone waiting for chemotherapy or radiotherapy is starting their treatment within 4 weeks.

We managed 20,596 referrals to mental health services last year and provided 11,771 allied mental health home visits. Waiting time targets have been met or exceeded for adults across all services – mental health, CADS and forensic mental health. The Kari Centre established school liaison roles and have identified a new service model which will incorporate an acute response, assessment and brief intervention team managing triage using an approach informed by the Choice and Partnership Approach (CAPA).

We are improving patient safety and experience

We have completed an initial 'Patient and Family Centred Care' current state assessment and undertaken case-studies in 'Patients and Families as Partners in Care'. We are aiming to have our Patient and Family-Centred Programme fully developed by December 2014. We have an established patient experience survey which allows us to gauge our patients' satisfaction with the services they receive and provides a continuous quality check to help us improve.

Auckland DHB's implementation of the Health Quality and Safety Commission's "Open for Better Care Campaign" has resulted in hand hygiene compliance increasing to 75% in 2013, up from 70% in 2012 and central line associated bacteraemia (CLAB) decreasing by 40%.

Central line associated infection rates have decreased by 40%.

Regional collaboration on the 'First Do No Harm' (FDNH) projects has reduced both pressure injuries and falls resulting in serious harm by 20%.

We are offering effective rehabilitation and support services

Despite increasing numbers of referrals to our Needs Assessment and Service Coordination (NASC) service, 98% of clients continue to be assessed within 6 weeks. 96% of clients receiving long term home support services have received a comprehensive assessment to ensure they are obtaining the services they need and these people all have a completed care plan to ensure they receive appropriate, consistent ongoing care.

Over 95% of our Age Related Residential Care (ARRC) facilities are engaged in interRAI (comprehensive clinical assessment) training. An ARRC model with host facilities has been established initially for collaborative management of falls and pressure injuries. The Specialist Health of Older People team are proactively supporting ARRC including quarterly study days for nurses and health care assistants. The 'yellow envelope' has been implemented to improve transfer of clinical information between acute care and ARRC.

Over 95% of our Age Related Residential Care (ARRC) facilities are engaged in InterRAI (comprehensive clinical assessment) training.

We have also developed a procurement plan for a new Home Based Support Service (HBSS) model that will maximise patient independence. Co-design methodology workshops have been completed for the Dementia Care Pathway and work streams have been established. Flexible funding packages for respite care have also been established.

Our resources are managed well

Auckland DHB continues to live within its means. We will continue to ensure we remain a sustainable organisation which manages its resources efficiently, achieving a small surplus for 2013/14 and for 2014/15 and 2015/16. This will reduce the level of demand for additional funding by the DHB and the financial contribution by the community to the health system either directly through co-payments or indirectly through taxes.

OUTPUT CLASS MEASURES

Assessment of our 2013/14 performance is based on the following grading system. This allows for recognition of those measures where we have significantly increased our performance, but have not quite met the target set in the Statement of Intent. The criteria used to allocate these grades are as below. However, note that we consider each indicator on a case by case basis to ensure assessment of performance is appropriate.

Criteria	Rating
> 20% away from target	Not Achieved
9-20% away from target	Partly Achieved
0.01-9% away from target	Substantially Achieved
On target or better	Achieved
Not available	n/a

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

Those measures marked with ✳ were not previously reported in last year's annual report, baseline or 2012/13 figures provided have therefore not been audited.

The following tables include our output measures form the 2013/14 Statement of Service Performance by Output Class. Outputs are goods or service provided by departments and other entities. Outputs are a variety of types, including policy advice, administration of contracts and the provision of specific services, for example B4 School Checks or elective surgeries. Output measures are intended to reflect our performance over the year.

Key	Definition
Ω	Measure is demand driven – not appropriate to set target
↓	A decreased number indicates improved performance
↑	An increased number indicates improved performance
V	Volume measure
T	Timeliness measure
Q	Quality measure

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an Achieved' or Not Achieved' rating. These are indicated with a 'n/a' (not applicable).

Prevention Services

Preventative services are publicly funded services that protect and promote the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. This includes health promotion to ensure that illness is prevented and inequalities are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services such as immunisation and screening services.

Health promotion

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Alcohol legislative programme						
Number of license premises (on and club) risk assessed ✳	V[2]	1269	1235	1200 est.	1226	Achieved
Number of license premises (on and club) assessed as high risk ✳	V	608	n/a	400 est.	134	Achieved
Number of joint Controlled Purchase Operations (CPOs) conducted ✳	V[3]	n/a	325 (premises)	Note: target incorrect in SoI (30%)	9 CPOs 180 premises	n/a
Percentage of premises risk assessed with overall risk rating recorded as per audit protocol ✳	Q	92%	n/a	100% Note: target incorrect in SoI (237)	100%	Achieved
Smokefree legislative programme						
Number of retailer compliance checks conducted ✳	V[4]	571	457	500	302	Not achieved
Number of joint Controlled Purchase Operations (CPOs) conducted ✳	V[5]	498	498 (premises)	500	9 CPOs involving 227 premises	Not achieved
Outcome of operation is recorded as per audit protocol ✳	Q	82%	100%	≥85% est	100%	Achieved

[2]This number has stayed steady over the past 4 years

[3]CPOs are demand driven as requested by the Police (leading Agency)

[4]ARPHS staff capacity remained an issue in this area. One compliance officer vacancy was filled but training from the MoH still to be delivered. There have been four unsuccessful attempts to recruit to a second vacancy.

[5]CPOs targeted premises close to where transport hubs are located and where youth congregate. Areas of high deprivation were also taken into account.

Health Protection

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Notifiable Communicable Diseases Total number of communicable disease notifications per reporting period ✱	V	6,785	5,597	6,250 est	6,115	Achieved
Number of notifications investigated and found to be a confirmed or probable case ✱	V	5,214	4,706	5,100	4,941	Substantially achieved
Number of notifications investigated and found to be not a case ✱	V[7]	1,371	678	918 est	866	Achieved
Percentage of notifications with case status recorded ✱	Q	97%	100%	≥95%	99.9%	Achieved
Drinking Water Quality Number of DWSNZ Suppliers' Compliance Assessments conducted and reports completed ✱	Q[8]	272	260	270	263	Substantially achieved
Percentage of reports provided to water supplier within 20 working days ✱	Q	100%	100%	100%	100%	Achieved
Hazardous substances and New Organisms(HSNO) Total number of lead notifications received ✱	V[9]	133	112	150est	Total no 73 (72 confirmed and probable)	Achieved
Number of confirmed cases that occur as a consequence of occupational exposure ✱	V[10]	81	77 cases	90est	Cases -occupational exposure: 23 (22 individuals)	Achieved
Number of confirmed cases that occur as a consequence of non-occupational exposure ✱	V[11]	30	12 (23 under investigation at time of report)	30 est	30	Achieved
Proportion of cases with probable source identified ✱	Q[12]	84%[13]	49%	≥85%	94.3%	Achieved

Health Policy/Legislation, Advocacy and Advice

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Numbers of submissions made (demand driven)	V[14]	28	27	20 est.	45	n/a
Percentage of submissions signed off by Medical Officer of Health and the Service Manager ✱	Q	100%	100%	100%	100%	Achieved

Note the data to support all the above measures is for all three metro Auckland DHBs

[7] Large measles and Hepatitis A outbreaks in 2011/12 resulted in a higher than usual baseline number of notifications. Periods of outbreak are associated with an increase in notifications of cases that are subsequently determined to be not a case due to increased awareness of the duty to notify on suspicion. For this reason the 2011/12 baseline year had a higher than usual number of notifications that were subsequently determined to be not a case.

[8] The actual number is slightly lower than the baseline because water suppliers register and deregister during the year. This explains the difference between the baseline and the estimated number.

This is for all suppliers in the Auckland Region registered on the Register of Community Drinking Water Suppliers in New Zealand and WINZ 6 database

[9] ARPHS undertakes case investigation in a reactive capacity. The reduction in the number of lead notifications to ARPHS indicates perhaps an improved community awareness of the common exposure pathways to sources of lead. Although there is no obvious reason for the decline, ARPHS have taken measures in the last reporting period to increase awareness around sources of lead exposure such as recreational shooting, and use of certain traditional type remedies

[10] In line with reduced number of lead notifications to ARPHS – see note above

[11] In line with reduced number of lead notifications to ARPHS – see 9 above

[12] During the reporting period our information management system has been upgraded, resulting in better reporting

[13] It is not clinically possible to determine an appropriate source with 100% reliability in all cases, especially in cases where exposure has been relatively low.

[14] The estimated number (20) submissions made this year was exceeded. Highlights include consultation on Auckland Council's Unitary Plan (second round), Burials and Cremation Review, Alcohol Advertising and Sponsorship, the Land Transport Amendment Bill and the National Drug Policy.

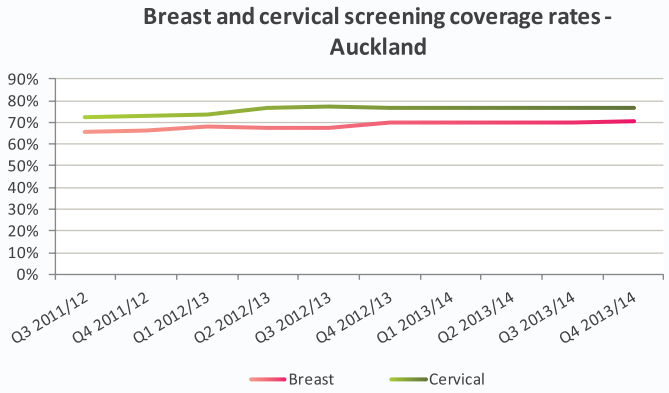
Population Based Screening

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Breast Screening						
Screening coverage rates among eligible groups: breast cancer ✱	V	69%	67.2%	70%	70.9%	Achieved
Proportion of women screened who report that their privacy was respected ✱	Q	97%	n/a	95%	96%	Achieved
Proportion of women screened who receive their results within 10 working days ✱	T	96.4%	n/a	95%	97.4%	Achieved

Breast Screening

Our breast screening coverage rates have improved from 66% to 71% between June 2011/12 and June 2013/14. Our cervical screening rates have also improved over time, up from 73% to 77% over the same time period. While cervical screening coverage rates for Māori and Pacific have remained relatively static over time at around 57% and 84% respectively, we've made more impressive gains for Māori and Pacific breast screening coverage – improving from 66% to 70% for Māori and from 82% to 89% for Pacific.

Breast and cervical screening programmes specifically target Māori and Pacific populations to improve coverage.



Population Based Screening

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Newborn hearing screening						
Number/proportion of babies screened	V[15]	7810 (96.31%) Dec '11 to Nov 2012	7,928 98.7%	100%	8452 99.9% July '13 to June 2014	Substantially achieved
Referral rate to audiology <=4%.	Q	1.6% Dec 2011 to Nov 2012	1.56%	<=4%.	2%	Achieved
Appropriate medical and audiological services initiated by 6 months of age for >=95% of infants referred through the programme	T	100%	100%	>=95%	100%	Achieved

[15]Data for Mar to June 2014 not available until Sept 2014

Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in various settings, including general practice, community and Māori health services, pharmacist services, community pharmaceuticals and child and adolescent oral health and dental services. These services are by their nature more generalist and preventative, usually accessible from multiple health providers and from a number of different locations within the DHB. Ensuring good access to early detection and management services for all population groups allows for prompt diagnosis of acute and chronic conditions and management and cure of treatable conditions.

Community Referred Testing and Diagnostics

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Number laboratory tests by provider- DML	V[16]	342,530	341,112	Ω	116,920	n/a
Number laboratory tests by provider- LTA	V	2,581,254	2,485,146	Ω	2,897,438	n/a
Number radiological procedures referred by GPs to hospital or to community providers – relative value unit result	V	43,460	40,714	Ω	44,350	n/a
Complaints as percentage of total no. of laboratory tests	Q	0.00001%	.003680%	↓	0.00103%	Not achieved
Average waiting time in minutes for a sample of patients attending Auckland DHB collection centres between 7am and 11am (peak collection time)	T[17]	6.3 mins 14 Jan – 1 Mar 2013	10.5 mins	< 30 mins	6.6 mins	Achieved
85% of accepted community referrals (accepted by the hospital) for CT and 75% for MRI scans receive their scan within 6 weeks (42 days) by July 2014	T[18]	64% overall As at Feb 2013	MRI 58% CT 66%	MRI 75% CT 85%	MRI 60% CT 89%	Partly achieved Achieved

Oral Health

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Enrolment numbers of children under five by ethnicity: • Māori • Pacific • Other • **Total population**	V[19]	 2,670 4,338 15,104 **22,162** (or 73%)	 2,670 4,338 15,104 **22,162** (or 73%)	**2013** 22,990 (76%) **2014** 80% enrolled	 2564 4181 15277 **22,022** (75%)	Substantially achieved
Utilisation rates for adolescents Auckland/Waitemata DHB Combined	V	81.4%	81.4%	**2013** 85% **2014** 85%	72.9%	Partly achieved
Number of complaints in the financial year	Q	8	13	↓	7	Achieved
Number of visits of preschool, and school children to oral health services (including adolescents)	V	84,246	84,246	86,800	84,420	Substantially achieved

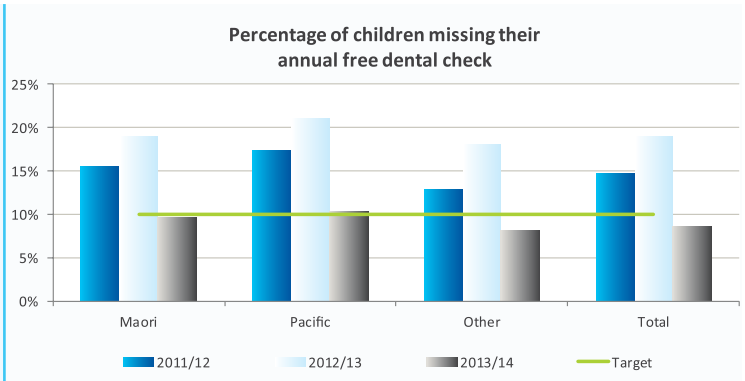
[16]Note DML ceased service provision late 2013
[17]Note this data is from LTA only
[18] CT scanning waiting times were improved through a patient throughput project, addition of extra sessions on available scanner, addition of extra scanner and regular auditing and management of wait lists
[19]76% of 0-4 year olds are enrolled compared to a target of 85%. Enrolment of 0-2 years, particularly Māori and Pacific, is a focus

Oral Health *continued*

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Arrears rates by ethnicity:	T			Overall		Achieved
• Māori		18.2%	18.2%	2013- 10%	9.6%	
• Pacific		19.0%	19.0%	2014- 10%	10.3%	
• Other		19.5%	19.5%		8.2%	
• **Total population**		19.2%	19.2%		8.6%	

Percentage of children missing their annual free dental check (arrears rates)

The introduction of new business rules and targeted programmes to improve overdue rates has improved performance from 19% in 2012/13 to 8.6% in 2013/14.



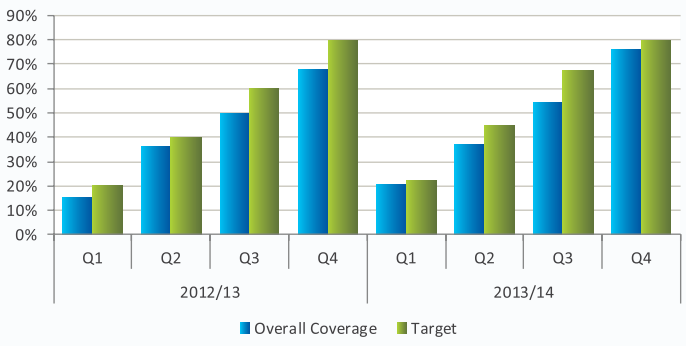
Primary Health Care

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Primary care enrolment rates	V	93%	93%	95%	92%	Substantially achieved
Cervical screening coverage for eligible women	V	77.5%	77.3% March 2013	75%	77%	Achieved
Percentage of B4 School Checks completed (overall coverage)	V	54%	75%	80% (year end target)	76%	Substantially achieved
Proportion of practices with cornerstone accreditation	Q	41%	53.73%	↑	41.61%	Achieved
GMS claims from after-hours providers per 10,000 of population	T	305 per 10,000	290.57 per 10,000	Ω	310 per 10,000	n/a

B4 School Checks

The B4SC Service is a universal, comprehensive screening and health education programme that includes measurement of height and weight, screening for vision and hearing concerns, oral health and an assessment of behavioural and developmental status.

Since 1 July 2014 the Royal New Zealand Plunket Society has been delivering the B4SC programme for Auckland DHB aiming to improve coverage over 2013/14 results. Auckland DHB achieved a final coverage of 76% overall and 80% for high needs populations, against a target of 80%.



Pharmacy

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Total value of subsidy provided ✱	V	$132,776,975	$128,436,884	Ω	$131,364,871	n/a
Number of prescriptions subsidised ✱	V	6,421,850	6,467,800	Ω	6,506,479	n/a
Proportion of prescriptions with a valid NHI number.	Q	96%	96.4%	100%	96.9%	Substantially achieved
The proportion of the population living within 30 minutes of an extended-hours pharmacy (ie any pharmacy open at 8pm on a Sunday)	T[20]	98%	98%	95%	98%	Achieved

[20]*Residents living on Waiheke and Great Barrier Islands do not have access to extended hours pharmacies within 30 mins*

Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services tend to be more complex, focused on individuals and are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital' or surgery centre. Effective and prompt resolution of medical and surgical emergencies and acute conditions reduces mortality, restores functional independence in the case of elective surgery and improves the health-related quality of life in older adults, thereby improving population health.

Acute Services

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Number of Emergency Department attendances (child and adult)	V	95,659	98,424	Ω	99,948	n/a
Acute WIES total (Provider)	V	93,838	93,516	Auckland Population- 50,895 IDF Population- 41,604 Total - 92,499	Auckland Population- 51,578 IDF Population- 40,528 Total - 92,106	Achieved
Readmission rates	Q[21]	10.2%	10.25 %	10.2%	9.8%	Achieved

[21]*Figures shown here are using new method of calculation- to be implemented in 2014/15, as the 2013/14 methods were flawed*

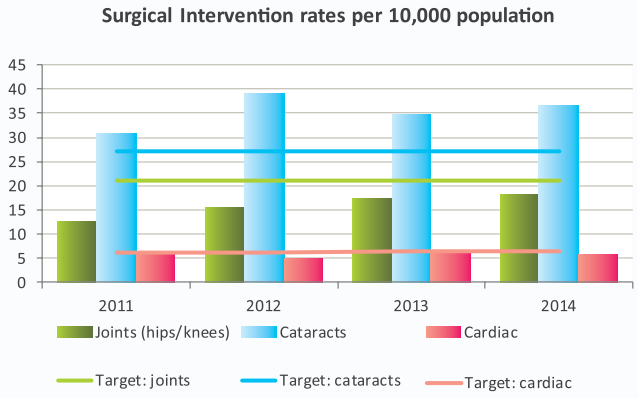
Elective (Inpatient/Outpatient)

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Standardised elective surgical intervention rate (per 10,000 of population):	V					
• Joints		16.49	17.68	21	18.14	Partly achieved
• Cataracts		32.78	34.79	27	36.61	Achieved
• Cardiac		5.34	6.23	6.5	5.69	Partly achieved
• PCR		12.22	12.97	11.9	11.91	Achieved
• Angiography		31.15	34.3	33.9	33.23	Substantially achieved
Number of first specialist assessment (FSA) outpatient consultations	V	83,795	89,983	Auckland population- 49,703 IDF Population- 33,581 Total - 83,284	Auckland Population- 52,043 IDF Population- 33,810 Total - 85,853	Achieved
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC ✱	Q	n/a	New measure	↓	Unavailable	n/a
Post-operative sepsis and DVT/PE rates- HQSC ✱	Q	Q	New measure	↓	Unavailable	n/a
Percentage of respondents who rate their care and treatment as very good or excellent		84%	83%	90%	83%	Substantially achieved
Patients waiting longer than five months for their first specialist assessment (FSA)*	T	0.5%	0%	0%	0.2%	Achieved
Patients given a commitment to treatment but not treated within five months*	T	0.5%	0%	0%	0.2%	Achieved

Note:
HQSC outcome measure data is not yet available by DHB. It is expected in November 2014.
MoH allows a small buffer when assessing performance against these indicators.

Surgical Intervention rates per 10,000 population

We are continuing to work with our surgical providers to improve surgical intervention rates appropriate for our population. While we are making steady improvements against targets, only cataract rates exceeded the target at 36.61 per 10,000 of population against a target of 27.



Maternity

Output Measures		Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Number of births	Number of mothers	V[22]	7,523	7,613	Ω	7223	n/a
	Number of babies	V[23]			Ω	7377	n/a
Number of first obstetric consultations		V[24]	4,410	4,561	4,500	4611	Achieved
Number of subsequent obstetric consultations		V[25]	4,348	4,136	Ω	3999	n/a
Proportion of all births delivered by caesarean section.		V[26]	32.5%	35.4%	↓	34.7%	Substantially achieved
Established exclusive breastfeeding at discharge excluding NICU admissions		Q[27]	81%	75.84%	≥80%	79%	Substantially achieved
Third/fourth degree tears for all primaparous vaginal births		Q[28]	2.2%	5.2%	↓	5.1%	Not achieved
Admission of term babies to NICU ✱		Q[29]	5.9%	6.1%	↓	6%	Substantially achieved
Number of women who registered at <13 weeks: ✱		T[30]	New measure	New measure	↑		
• for whom Auckland DHB is primary maternity provider						64%	n/a
• for whom LMC is primary maternity provider						49.1%	n/a

[22]Baseline = 2010/11 calendar year. Result = 2013/14 calendar year.
[23]Baseline = 2010/11 calendar year. Result = 2013/14 calendar year.
[24]Baseline = 2011 calendar year. Result = 2013 calendar year
[25]Baseline = 2011 calendar year. Result = 2013 calendar year.
[26]Baseline = 2012 calendar year. Result = 2013 calendar year
[27]Baseline = 2011 calendar year. Result = 2013 calendar year
[28]Baseline = 2011 calendar year. Result = 2013 calendar year
[29]Baseline = 2012 calendar year. Result = 2013 calendar year
[30]Result = 2013 calendar year

Assessment Treatment and Rehabilitation (Inpatient)

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
AT&R Bed days ✱	V	35,545	27,403	Ω	24,141	n/a
Number of AT&R inpatient events	V	1,996	2,305	Ω	1,418	n/a
In-hospital fractured neck of femur (FNOF) per 1000 admissions (age/sex standardised) – HQSC ✱	Q	7.6	New measure	↓	Unavailable	n/a
Proportion waiting 4 days or less from waitlist date to admission to AT&R service	T	86%	77.4%	90% ≤4 days	93% ≤4 days	Achieved

Note:
HQSC outcome measure data is not yet available by DHB. It is expected in November 2014

Mental Health

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Access Rates for total and specific population groups (defined as the proportion of the population utilising MH&A services in the last year)	V					
• Māori 0-19 years		4.42%	4.65%	3.0%	5.09%	Achieved
• Māori 20-64 years		10.36%	10.74%	3.3%	11.64%	Achieved
• Total 0-19 years		2.56%	2.65%	3.0%	2.91%	Substantially achieved
• Total 20-64 years		3.71%	3.72%	3.3%	3.95%	Achieved
• Total 65+ years		3.52%	3.59%		3.77%	n/a
Proportion of long term clients with Relapse Prevention Plan (RPP)	Q					
Adult						
• Māori		96%	99%	95%	96%	Achieved
• Pacific		99%	100%	95%	99%	Achieved
• Other		95%	97%	95%	93%	Substantially achieved
Child & Youth						
• Māori		100%	100%	95%	100%	Achieved
• Pacific		100%	100%	95%	100%	Achieved
• Other		91%	100%	95%	94%	Substantially achieved
Shorter waits for non-urgent mental health and addiction services: ✱	T					
• Seen within 3 weeks		60.8%	77%	80%	85.2%	Achieved
• Seen within 8 weeks		76.4%	95%	95%	96.6%	Achieved

Rehabilitation and Support Services

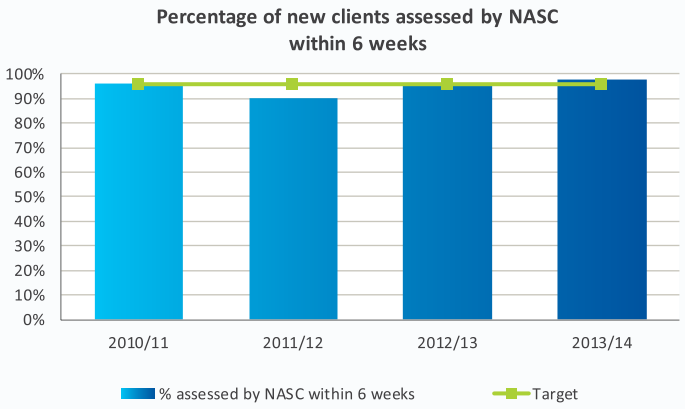
Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum of care these services provide support for individuals. By helping to restore function and independent living the main contribution of rehabilitation and support services to health is in improving health-related quality of life. There is some evidence that this may also improve length of life.

Home Based Support

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Total number of InterRAI assessments per month	V	400 per month	423	Ω	446 (5,354 full year)	n/a
The proportion of people aged 65 and older receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan	Q	84% calendar year 2012	95%	95%	95.6%	Achieved
Percentage of NASC clients assessed within 6 weeks	T	96% Oct/Nov 2011	98%	≥	97.7%	Achieved

Percentage of new clients assessed by NASC within 6 weeks

Despite increasing numbers of referrals to our Needs Assessment and Service Coordination (NASC) service, 98% of clients continue to be assessed within 6 weeks of referral. Timely assessment of mostly elderly patients is important to ensure that people get the support they need to remain in their own home or are appropriately placed in facilities that meet their needs.



Palliative Care

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Total no completed episodes of care (death or discharge)	V	911	876	Ω	812	n/a
Proportion of cancer patients admitted to hospice who are Māori, Pacific or Asian versus proportion of cancer deaths who are Māori, Pacific or Asian (historical baseline)	Q[31]	**Admissions** M 5% P 12% A 11% **Deaths** M 7% P 11% A 8%	 M 6% P 12% A 10% M7% P 11%	% admitted should reflect % deaths by ethnicity	**Admissions** M 6.8% P 11.2% A 8.7% **Deaths** M 6% P 11.2% A 7.9%	 Achieved Achieved Achieved
Proportion of patients acutely referred who had to wait >48 hours for a hospice bed	T[32]	11%	10%	↓	6.1%	Achieved

Residential Care

Output Measures	Notes	Baseline	2012/13 Results	2013/14 Target	2013/14 Results	Achievement
Total number of subsidised aged residential care bed days	V	954,667	980,702	≥	981,427	Achieved
Proportion of long term residents residing within facilities that have received InterRAI training who have had an InterRAI clinical assessment within the year*	Q	new measure	new measure	20%	96%	Achieved

[31]Has been clarified that "Admitted" or "Admissions" refers to patients who have been referred or referrals
[32]The West Auckland Hospice now has inpatient beds available, increasing bed capacity across the district overall

Auckland DHB Attendance at Board and Committee Meetings: July 2013 – June 2014

Board Member		Board *(10** meetings held per year)*	HAC (8 meetings held per year)	Audit and Finance (9*** meetings held per year	CPHAC (9 meetings held per year)	DiSAC (4 meetings held per year)	MHGAC (4 meetings held per year
	Dr Lester Levy , CNZM	10	6	8	8*	2*	3*
	Dr Lee Mathias, ONZM	9	7	8	9	x	x
	Jo Agnew	10	8	x	9	3	x
	Peter Aitken	9	7	8	9	x	x
	Judith Bassett, QSO	8	7	x	6	2	x
	Susan Buckland	2	1	x	5	2	x
	Dr Chris Chambers	10	8	x	9	x	2
	Rob Cooper*****						
	Robyn Northey	10	8	5	9	4	4
	Gwen Tepania-Palmer	8	7	5	5	x	4
	Doug Armstrong****, QSO	6	5	4	x	x	x
	Morris Pita****	5	5	2	x	x	0
	Ian Ward	10	8	8	x	x	x

Doug Armstrong and Morris Pita were newly appointed to the Board in October 2013

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

*** = One special meeting held on 9th Oct 2013*
**** = One special meeting held on 13th Sept 2013*
***** = Served six months as a result of Local Body elections*
****** = leave of absence and also ceased to be a member from December 2013.*

Statement of Waivers

The New Zealand Public Health and Disability Act 2000 s 42(4) provides as follows:

For the purposes of s 151 (1)(j) of the Crown Entities Act 2004, the annual report of a DHB must disclose any interests to which a permission, waiver, or modification given under clause 36(4) or clause 37(1) of Schedule 3 or clause 38(4) or clause 39(1) of Schedule 4 relates, together with a statement of who gave the permission, waiver, or modification, and any conditions of amendments to, or revocation of, the permission, waiver, or modification. For the 2013/14 year there were no permissions, waivers or modifications given under the clauses of this legislation

Trusts

Auckland DHB Charitable Trust (A+ Trust) is an independent charitable trust created by Auckland DHB. The Trust is a shareholder in a number of Crown Entity subsidiaries: Northern Region Alliance (formerly the Northern DHB Support Agency Limited), Northern Regional Training Hub Limited, New Zealand Health Innovation Hub Management Limited and healthAlliance NZ Limited. Canterbury, Counties Manukau, Waitemata and Auckland DHBs are limited partners in the New Zealand Health Innovation Hub. The Northern Region Alliance is an amalgamation of two previous subsidiary companies, the Northern Region DHB Support Agency Limited and the Northern Regional Training Hub Limited. The NRA is owned in four equal shares by Waitemata, Auckland, Counties Manukau and Northland District Health Boards.

Health Benefits Ltd (HBL) is a crown company that was set up in 2010 to help the health sector save money by reducing administrative, support and procurement costs for DHBs. Any savings will go back into supporting frontline health services. HBL works with DHBs to achieve these aims.

There are no plans to acquire shares or interests in any other company, trusts and/or partnerships.

Good employer obligations

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

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

"To recruit, develop and maintain a sustainable, responsive, collaborative and skilled health and disability workforce focused on the health needs of the population of Auckland DHB now and into the future".

Auckland DHB facilitates Human Resource policy which encompasses provisions generally regarded as a requirement for the fair and proper treatment of employees in all areas of their employment. Regardless of the minimum requirements of legislation, Auckland DHB continues to promote and protect the welfare and management of employees to the mutual benefit of employees, consumers and the organisation.

Auckland DHB values equal employment opportunities and identifies and removes any obstacles that may deny a potential or existing employee the opportunity to be equitably considered for employment of their choice and the chance to perform to their full potential. This is supported by policy and practised by representatives of Auckland DHB in the execution of activities relating to the recruitment and management of employees (or potential employees) including recruitment, pay and other rewards, career development and work conditions.

As a large organisation and employer we believe there is significant importance in adopting and advancing management and organisational practices and procedures that are effective and efficient in assisting the way we perform and provide health care. We think a high performance organisation begins with having an organisational culture where everyone is given the opportunity to contribute to the way the organisation evolves and adapts to change. In line with this, Auckland DHB is about to embark on a project of refreshing our organisational values – these will underpin everything we do. Our values will be developed in partnership with staff, patients and the wider community. The beginnings of this are the 'In Our Shoes' and 'In Your Shoes' sessions, which will take place at the start of August. We will be seeking input from staff, patients and the wider community to establish what Auckland DHB should value going forward.

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

Auckland DHB recognises and respects the Treaty of Waitangi as the founding document of New Zealand. The Treaty of Waitangi is the fundamental relationship between the Crown and Iwi. It provides the framework for Māori development, health and wellbeing. Auckland DHB's commitment to the development of Māori health is reinforced by its shared Waitemata and Auckland DHB Māori Health department, with a General Manager who sits on both DHBs' Senior Leadership Teams. He Kamaka Waiora, the joint Auckland and Waitemata District Health Board Māori Health team is responsible for policy development, planning and funding (in conjunction with planning and funding units), provider management, quality, and clinical leadership across the primary, secondary and tertiary sectors. Auckland DHB's Chief Advisor-Tikanga leads the organisation in managing relationships with manawhenua and Iwi Māori from a Tikanga perspective.

Auckland DHB supports the right of all employees to seek resolution of any complaint through the procedures contained in relevant legislation (e.g. the Employment Relations Act and the Human Rights Act). Providing a healthy and safe workplace for all employees, students, volunteers and contractors whilst they are at the Auckland DHB workplace for the purpose of Auckland DHB work and to patients and visitors in relation to safe use of the facilities is something that the DHB is dedicated to. Auckland DHB takes all practicable steps to:

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

Auckland DHB aims to constantly upgrade the management of health and safety at all levels and within all areas of the organisation by reviewing, developing and maintaining systems and processes that provide the framework for health and safety management (e.g. hazard management, accident reporting and investigation, staff induction and training, employee participation in health and safety committees).

GOOD EMPLOYER REPORT 2013/14

Leadership accountability & culture	• Implementation of a new organisational structure within a single point of accountability framework for a directorate (grouping of clinical services). Based on evidence that clinical leadership is essential for the delivery of quality care and patient safety, which in turn will drive better operational performance. The single point of accountability is now held by a clinician who is ultimately accountable for the performance of a directorate • Auckland DHB Welcome Day for all new staff • Multidisciplinary involvement in service planning • Nova magazine newsletter for staff; hard copy each month and a weekly electronic version • X-Factor (our staff talent show) and other annual events actively supported by senior leadership.

Recruitment, selection and induction	• Guides for managers on recruitment and selection
	• Induction guides for managers
	• Work experience days
	• Careers Centre website accessible internally and externally
	• Candidate and hiring manager satisfaction surveys
	• Internal promotion of vacancies via Nova magazine link and ADHB intranet site
	• Participating in the Ministry of Social Development's Mainstream Programme which facilitates sustainable work opportunities for people with disabilities
	• Preference programme for Māori and Pacific graduate nurses
	• Rangatahi Programme supports Māori and Pacific workforce development by seeking to:
	  • *Grow, develop, recruit and retain Māori and Pacific people in the health and disability sector in the Auckland district*
	  • *Provide options and support in the pursuit of health careers*
	  • *Ensure Rangatahi Māori and Pacific achieve their career potential*
	The purpose of the programme is to actively attract Rangatahi Māori and Pacific into the health workforce by removing barriers to entry. The Programme has two essential components; the first supporting Rangatahi Māori and Pacific to attain better educational qualifications and practical skills to enter health-related tertiary programmes and links them with tertiary education health programmes; the second facilitates the transition of new graduates into the health workforce.

Employee development, promotion and exit	• Alumni programme in place • Annual performance review and individual development/objective setting process • Numerous clinical, technical and non-clinical internal training programmes and workshops • Sabbaticals for Senior Medical Officers • Exit interviews and surveys conducted.

Flexibility & work design	• Flexible rostering practices subject to clinical requirements • Staff crèche/early learning centre on each of the two major sites.

Remuneration recognition & conditions	• Local Heroes awards is an exciting way of recognising the people in the Auckland DHB team who go above and beyond to make sure patients get the best possible care. It could be someone who always has a smile, takes a lost patient to their desired location or just puts in the extra effort to get the job done. Anyone can be nominated including clinical people providing direct care, support staff, those behind the scenes and our many volunteers. Nominations can be made by patients, family of patients and visitors or members of staff
	• Auckland DHB recognises the valuable contribution our staff make to patient care through recognition and/or awards for different lengths of service
	• Awards to publically acknowledge staff who deliver sustainable improvements for our patients and the organisation, in addition to those who contribute to improving the knowledge and skills of health and improving healthcare practice through research or education. All teams and individuals in all positions both clinical and non-clinical are encouraged to apply. The categories for the awards are:
	  • *Clinical*
	  • *Research*
	  • *Education*
	  • *Process and systems improvement*
	• Staff benefits with external providers
	• Recognition of retiring staff and staff who die in service through a tribute in NOVA
	• The majority of staff are on transparent Multi Employer Collective Agreements
	• The annual review of Individual Employment Agreement (IEA) is based on external market data and employee performance. Job size is determined using a job evaluation methodology that meets the NZ standard for gender neutrality.

Harassment & bullying prevention	• Harassment prevention policy in place • Workplace Violence Prevention Policy (as affecting staff) is in place • Bullying and harassment coaching seminars conducted • Formal and informal processes documented and available for response to harassment • Presentations provided to staff/teams as required/requested, to promote awareness.

Safe and healthy environment	Auckland DHB has an established network of around 300 health and safety representatives who represent their colleagues in matters relating to health and safety in the workplace. We also have a focus on having a healthy workplace and wellness and a number of on-going initiatives include: • ACC Partnership Programme - tertiary accredited • Health and Safety committees, which include Māori and Pacific representatives, Auckland Regional Public Health and internal clinical health and safety representatives • Dedicated lifestyle section in Auckland DHB's newsletter • Support material available for staff and managers to understand and manage workplace stress • Free work-related Occupational Health assessments for staff • Workstation assessments • Work area safety checks.
Safe and healthy environment	The focus has expanded from workplace auditing and hazard identification to include Workplace Wellness, Health & Safety Representatives being 'Wellness Champions' as well as safety champions. Furthermore, Auckland DHB has a number of healthy workplace initiatives in place including:
Nutrition	• *Nutrition criteria for Auckland DHB leased space, comprising generic criteria (e.g. no full sugar soft drinks, no deep fried food) and tailored criteria based on the food and beverages the vendor sells. Criteria are included in all new leases and existing leases when they come up for renewal* • *Dedicated physical facilities for staff who are breastfeeding* • *Continuing to maintain and promote healthy options in the Staff cafeteria including:* · *Promoting the sale of fresh fruit, freshly made wraps and panini (healthy content made on site), sushi and reducing pies and pastry goods and the portion sizes of cakes, scones, and slices* · *Removal of confectionary, potato chips and other high calorie snacks* · *Removal of high sugar content beverages, carbonated sweetened drinks, full fat milk drinks and large volume sports beverages from vending machines* · *Sandwiches without butter are available at one of the staff cafes* · *All café recipes are analysed and modified to reduce salt, sugars and saturated fat* • *Nutrition information is provided for staff on the Eat Well and Feel Great intranet site* • *Ongoing health and nutrition poster promotions*
Physical Activity	• *On site Yoga and Pilates classes* • *'Feet Beat' continues, with 29 Auckland DHB teams participating in 2013, involving 192 members of staff* • *Health matters site "Be Active" is in place and was designed specifically to align with mental and physical wellness themes as important to Auckland DHB staff and families (updated at least monthly)* • *Staff benefits – discounts on gym memberships and other healthy living activities*

Smoke Free	• *"Quit Now" stand – smoke free services run a Quit Now stand in the Auckland City Hospital foyer, providing support* • *A two storey banner promoting smoke free and providing contact information for those wanting to quit was installed in a mezzanine area in the Auckland City Hospital* • *A permanent stand containing quit information is located at the foyer of the main entrance of the Auckland City Hospital* • *Smoking cessation services at Auckland DHB's Welcome Day orientation for all new employees including presentation from the Smoke Free team* • *Smoke free grounds* • *Annual promotion of World Smoke Free Day, where staff are encouraged to quit* • *In-house smoking cessation support and intranet information is available for staff*
Workplace Wellbeing Initiatives	• *Free heart health checks* • *Kidney Health Warrant of Fitness campaign (Kidney Health New Zealand)* • *Domestic violence-free programme available to staff* • *Influenza vaccine programme for staff* • *Independent employee assistance programme for staff* • *Information provided to staff about shift and night work and healthy sleep, among other health related information*

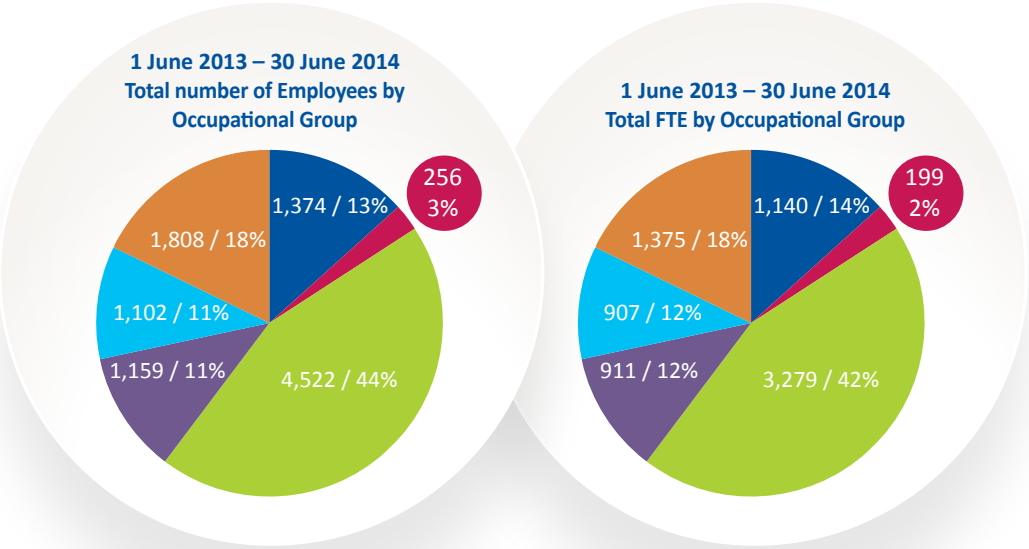
In addition to above, the Auckland DHB promotes to staff external initiatives such as the Feet Beat 8-week walking challenge, Push Play, the YMCA Walk/Run series, 5+A Day, World Diabetes Day, White Ribbon, Safety NZ Week (ACC) and Sun Smart Week.

Sustainability	We have made some significant changes to reduce energy consumption over the last few years, including: • *Converting boilers from coal to gas* • *Installing a co-generation plan* • *Installing a pilot solar water heating system* • *Replacing 2,500 light bulbs with energy efficient alternatives* With our 10,000+ staff even the smallest changes we each make can add up to a big difference so staff are encouraged to submit their sustainability ideas to assist in reducing our environmental footprint.

WORKFORCE DEMOGRAPHICS

The charts below show how employees are distributed across the different occupational groups at the Auckland DHB during the reporting year 1/7/13 to 30/6/14. The largest occupational group is nursing with 4,411 employees comprising approximately 3,225 Full Time Equivalents (making up 43% and 39% of the overall organisation respectively). The entire Auckland DHB is comprised of just over 10,200 employees and 7,800 FTE. Recent increases in Headcount and FTE are attributable to the insourcing of cleaning staff.

- Medical
- Technical support
- Technical patient care
- Nursing
- Household
- Administration



Staff Turnover

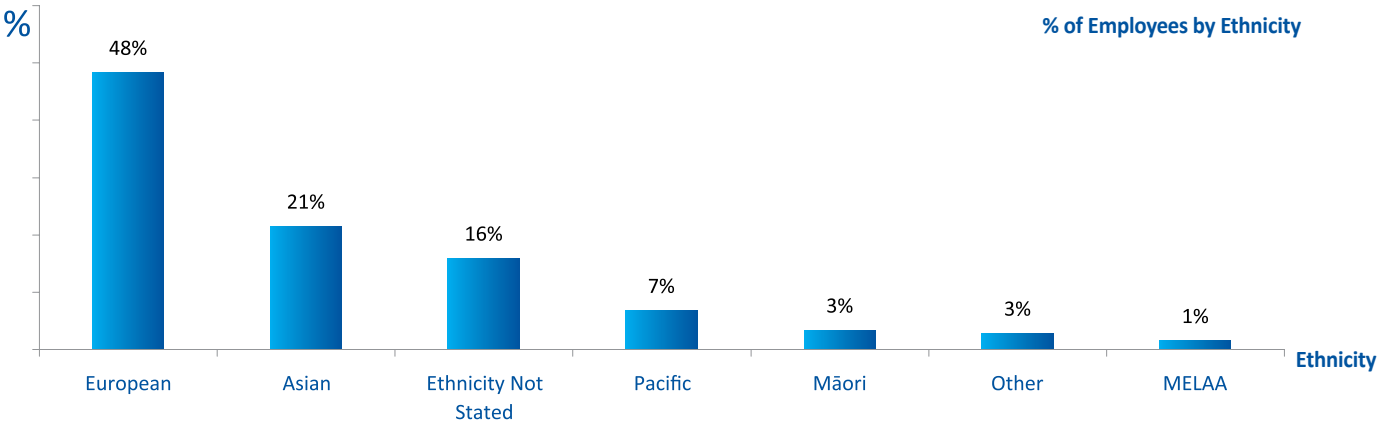
Voluntary staff turnover for the past year has remained relatively stable when compared with the previous year. Voluntary turnover for the year ended 30 June 2014 was 9.4%.

Employee Disability

On appointment, staff are asked whether they have or identify with having a disability. A system is being implemented so that information can be reported in future.

Employee Diversity

Staff are asked to disclose ethnicities on appointment and approximately 18% of employees choose not to. Many employees have a diverse ethnic background. The graph below shows all the ethnic groups that compose 1% or greater of our workforce.

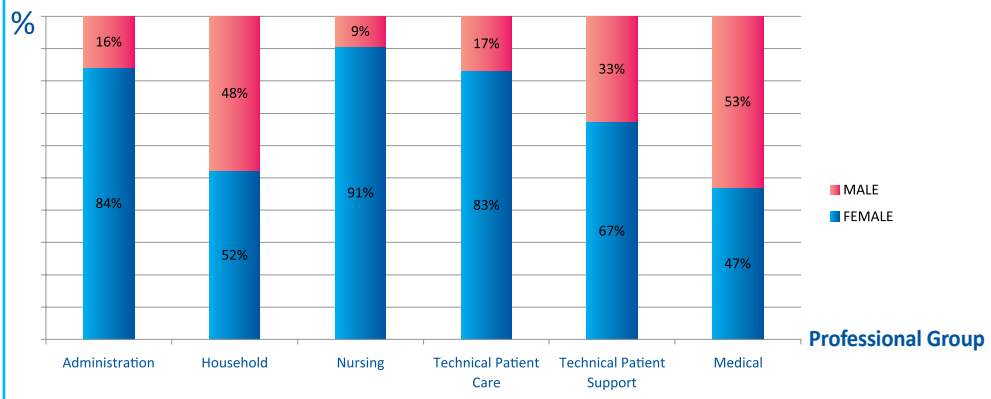


* MELAA is a group amalgamation of Middle Eastern, Latin American and African ethnicities

Gender

The chart below shows gender differences by occupational groups at the DHB. Females account for around 77% of employees. A number of techniques are used to support pay and employment equity, such as job evaluation for nursing staff and employees covered by individual employment agreements (IEAs), to determine the internal relativity of positions. The job sizing for IEA positions is based on a method that meets the New Zealand standard of gender neutrality and is linked back to external market data for salary setting. Annual step increments for staff of both genders are applied on a number of Collective Employment Agreements and formal performance appraisals are undertaken against goals and competency assessments.

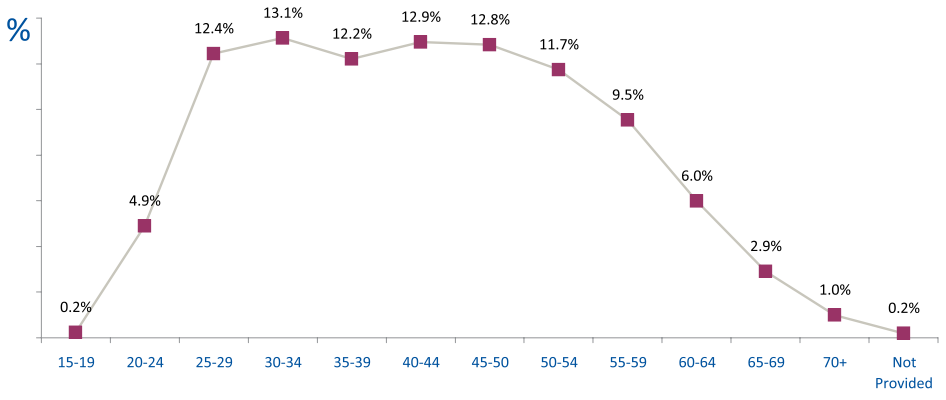
Occupational Splits by Gender



Age of Workforce

The chart below shows a mild skew, although relatively closely approximates the national distribution. Although not present in the chart, when analysing the number of employees by age groupings over the prior five years there is some evidence of an ageing workforce. Although this is reasonably minimal, it is being monitored and factored into long-term workforce planning.

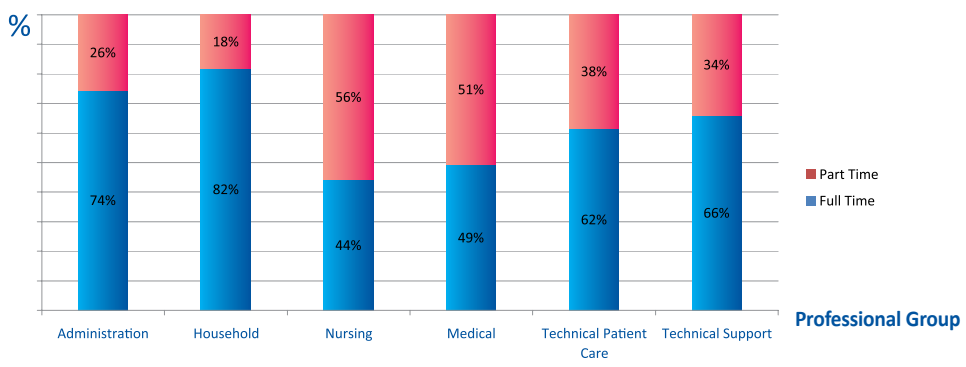
Percentage of Employees by Age Grouping



Full-time Vs Part-time Employees

The chart below shows that the majority of staff are full time employees (at around 55%, the rest being part time). There are differing ratios across the various occupational groups. While not displayed, the ratio of full-time to part-time staff across Auckland DHB for the past five years has remained relatively stable, although the Medical group has increased its part time staff from 31% to 51%.

% of Employees that are Part Time & Full Time



Insurance

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

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2014

	Notes	Group Budget 2014 $000	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Revenue						
Patient care revenue	2a	1,938,522	1,796,665	1,755,371	1,796,665	1,755,371
Interest Income		8,007	7,297	7,273	6,606	6,329
Other revenue	2b	56,069	59,648	57,422	57,530	56,165
Total revenue		**2,002,598**	**1,863,610**	**1,820,066**	**1,860,801**	**1,817,865**
Expenses						
Personnel costs	3a	793,771	808,136	770,141	808,136	770,141
Depreciation and amortisation costs	11a,b	41,157	40,329	39,816	40,329	39,816
Outsourced services		71,699	86,082	88,411	86,082	88,411
Clinical Supplies		212,068	215,589	213,045	215,589	213,045
Infrastructure and non-clinical expenses		66,845	64,804	69,526	64,804	69,526
Other district health boards		104,044	103,840	105,570	103,840	105,570
Non-health board provider expenses		617,491	449,567	441,795	449,567	441,795
Capital charge	15	37,182	37,227	33,500	37,227	33,500
Interest expense		16,340	16,293	17,698	16,293	17,698
Other expenses	3b	41,916	41,491	40,581	40,924	39,653
Total expenses		**2,002,513**	**1,863,358**	**1,820,083**	**1,862,791**	**1,819,155**
Share of surpluses of joint ventures & associates	5	0	12	171	0	0
Surplus/(deficit)		**85**	**264**	**154**	**(1,990)**	**(1,290)**

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2014

	Notes	Group Budget 2014 $000	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Surplus/ (deficit)		85	264	154	(1,990)	(1,290)
Gains/(Losses) on property revaluations	6	0	38,609	36,213	38,609	36,213
Total Comprehensive Income/(Loss)		**85**	**38,873**	**36,367**	**36,619**	**34,923**

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

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

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2014

GROUP	Notes	Actual 2014 $000	Budget 2014 $000	Actual 2013 $000
Balance as at 1 July		**480,146**	**482,315**	**441,896**
Comprehensive income/(expense)				
Surplus/ (deficit) for period		264	85	154
Other comprehensive income/(expense)		38,609	0	36,213
Total comprehensive income/(expense)		**38,873**	**85**	**36,367**
Owner Transactions		0	0	0
Capital contributions to the Crown		0	0	1,883
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	6	**519,019**	**482,400**	**480,146**

PARENT	Notes	Actual 2014 $000	Budget 2014 $000	Actual 2013 $000
Balance as at 1 July		**459,265**	**436,313**	**422,459**
Comprehensive income/(expense)				
Surplus/ (deficit) for period		(1,990)	943	(1,290)
Other comprehensive income/(expense)		38,609	0	36,213
Total comprehensive income/(expense)		**36,619**	**943**	**34,923**
Owner Transactions				
Capital contributions to the Crown		0	0	1,883
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	6	**495,884**	**437,256**	**459,265**

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

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

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2014

	Notes	Group Budget	Group Actual		Parent Actual	
		As at 30/06/14 $000	As at 30/06/14 $000	As at 30/06/13 $000	As at 30/06/14 $000	As at 30/06/13 $000
Current Assets						
Cash and cash equivalents	7	48,715	90,210	80,727	90,210	80,727
Trust/special funds	8a	5,570	16,387	14,085	0	0
Patient & restricted trust funds	8b	1,130	1,169	1,146	1,169	1,146
Debtors & other receivables	9	63,484	47,302	48,811	50,669	51,341
Prepayments		1,589	1,060	1,350	1,060	1,350
Inventories	10	13,865	12,211	12,884	12,211	12,884
Total Current Assets		**134,353**	**168,339**	**159,003**	**155,319**	**147,448**
Non-Current Assets						
Trust/special funds	8a	4,855	10,783	12,846	0	0
Property, plant and equipment	11a	893,327	898,464	871,958	897,564	871,058
Intangible assets	11b	105	12,166	8,627	12,166	8,627
Derivative financial instruments	19	0	722	1,072	722	1,072
Investments in joint ventures & associates	5	55,055	40,138	25,016	39,880	24,770
Total Non-Current Assets		**953,342**	**962,273**	**919,519**	**950,332**	**905,527**
Total Assets		**1,087,695**	**1,130,612**	**1,078,522**	**1,105,651**	**1,052,975**

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

The accompanying notes form an integral part of these financial statements

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2014

	Notes	Group Budget	Group Actual		Parent Actual	
		As at 30/06/14 $000	As at 30/06/14 $000	As at 30/06/13 $000	As at 30/06/14 $000	As at 30/06/13 $000
Current Liabilities						
Trade and other payables	13a	131,904	115,742	117,493	113,916	112,827
Employee benefits	13b	144,807	151,801	142,894	151,801	142,894
Provisions	13c	0	1,770	1,803	1,770	1,803
Interest-bearing loans and borrowings	14,18	61,345	82,670	12,761	82,670	12,761
Patient & restricted trust funds	8b	1,130	1,169	1,146	1,169	1,146
Total Current Liabilities		**339,186**	**353,152**	**276,097**	**351,326**	**271,431**
Non-Current Liabilities						
Employee benefits	13b	21,938	33,941	27,954	33,941	27,954
Interest-bearing loans and borrowings	14,18	244,171	224,500	294,325	224,500	294,325
Total Non-Current Liabilities		**266,109**	**258,441**	**322,279**	**258,441**	**322,279**
Total Liabilities		**605,295**	**611,593**	**598,376**	**609,767**	**593,710**
Net Assets		**482,400**	**519,019**	**480,146**	**495,884**	**459,265**
Equity						
Public equity	6a	576,247	576,798	576,798	576,798	576,798
Accumulated deficit	6b	(483,362)	(487,037)	(485,047)	(487,543)	(485,553)
Other reserves	6c	370,584	406,629	368,020	406,629	368,020
Trust/special funds	6d	18,931	22,629	20,375	0	0
Total Equity		**482,400**	**519,019**	**480,146**	**495,884**	**459,265**

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

Dr Lester Levy
Chair

Dated: 29 October 2014

Ian Ward
Chair, Audit and Finance Committee

Dated: 29 October 2014

The accompanying notes form an integral part of these financial statements

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2014

	Notes	Group Budget	Group Actual		Parent Actual	
		2014	2014	2013	2014	2013
		$000	$000	$000	$000	$000
Cash flows from operating activities						
Cash receipts from Ministry of Health and patients		1,922,072	1,919,345	1,901,163	1,919,345	1,901,163
Interest received		8,007	7,297	7,272	6,641	6,188
Other Receipts		71,719	75,220	73,866	75,438	72,865
Cash paid to employees		(793,775)	(792,888)	(768,344)	(792,888)	(768,344)
Cash paid to suppliers		(1,114,060)	(1,100,329)	(1,112,029)	(1,099,989)	(1,112,591)
Interest paid		(16,340)	(16,209)	(18,127)	(16,209)	(18,127)
Net goods and services taxes refunded/(paid)		0	572	521	431	444
Capital charges paid		(37,182)	(37,227)	(33,819)	(37,227)	(33,819)
Net cash inflow from operating activities	7	**40,441**	**55,781**	**50,503**	**55,542**	**47,779**
Cash flows from investing activities						
Proceeds from sale of property, plant and equipment		0	188	0	188	0
Decrease/(Increase) in investments and restricted trust funds		(20,944)	(16,853)	(9,869)	(16,614)	(7,145)
Purchase of property, plant and equipment		(55,325)	(29,633)	(37,814)	(29,633)	(37,814)
Net cash (outflow) from investing activities		**(76,269)**	**(46,298)**	**(47,683)**	**(46,059)**	**(44,959)**
Cash flows from financing activities						
Repayment of loans		(108)	(10,000)	(63,500)	(10,000)	(63,500)
Proceeds from borrowings		0	10,000	65,243	10,000	65,243
Proceeds from capital contributed/(repaid)		0	0	1,883	0	1,883
Net cash inflow/(outflow) from financing activities		**(108)**	**0**	**3,626**	**0**	**3,626**
Net (decrease)/increase in cash and cash equivalents		**(35,936)**	**9,483**	**6,446**	**9,483**	**6,446**
Cash and cash equivalents at start of the year		**84,651**	**80,727**	**74,281**	**80,727**	**74,281**
Cash and cash equivalents at end of the year	**7**	**48,715**	**90,210**	**80,727**	**90,210**	**80,727**

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

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

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

Note 1

Accounting policies

Reporting entity

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

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

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

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

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

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to ADHB, are:

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

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

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

Statement of compliance

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

1

Basis of preparation

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

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

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

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

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

Basis for consolidation

Subsidiaries

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

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

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

Joint Ventures

A joint venture is an entity over whose activities ADHB has joint control, established by contractual agreement. The consolidated financial statements include ADHB's joint interest in the joint venture, using the equity method, from the date that joint control commences until the date that joint control ceases. There are no differences in accounting policies between the parent and joint venture entities.

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

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

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

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

Associates

Associates are those entities in which ADHB has the power to exert significant influence, but not control, over the financial and operating policies. ADHB holds a 33% shareholding in Northern Regional Alliance Limited (NRA).

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

Northern Regional Alliance Limited is an associate with Auckland, Counties-Manukau and Waitemata DHBs. It exists to support and facilitate employment and training for Resident Medical Officers across the three Auckland regional DHBs and to provide a shared services agency to the four Auckland regional District Health Boards in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution.

Foreign Currency

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

Budget Figures

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

Equity

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

Property, Plant and Equipment (PPE)

The major classes of PPE are as follows:

- Freehold land
- Freehold buildings (including fitouts and underground infrastructure)
- Plant, equipment and vehicles
- Leased assets
- Work in progress

Owned Assets

Except for land and buildings, items of PPE are stated at cost, less accumulated depreciation and impairment losses.

Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every 3 years. The latest revaluation for land was done on 30 June 2014. The latest revaluation for buildings was done on 30 June 2013. Any increase in value of a class of land and buildings is recognised directly to other comprehensive income unless it offsets a previous decrease in value recognised in the surplus or deficit, in which case the increase is recognised in the surplus or deficit. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the surplus or deficit.

Additions to PPE between valuations are recorded at cost.

Where material parts of an item of PPE have different useful lives, they are accounted for separately.

Disposal of PPE

Where an item of PPE is disposed of, the gain or loss recognised in the surplus or deficit is calculated as the difference between the net sales price and the carrying amount of the asset. When revalued assets are sold, the amount included in revaluation reserves in respect of those assets are transferred to accumulated surplus.

Leased assets

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

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

Subsequent costs

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

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

Asset Class	2014	2013
Freehold buildings (including fitouts and underground infrastructure)	1-89 years	1-89 years
Plant, equipment and vehicles	2-20 years	2-20 years
Leased assets	4-8 years	4-8 years

The residual value, useful life and depreciation method of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to PPE on its completion and then depreciated. The work in progress balance includes both PPE and intangible assets.

Intangible Assets

Computer software

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

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

Amortisation of computer software is charged to the surplus or deficit on a straight line basis over its estimated useful life. The useful life of computer software is calculated over 3 years (2013: 5 years) from the date that the software is available for use (refer Note 11b). Impairment losses are provided for on a continuing basis as required.

Auckland DHB has made payments totalling $11,858k (2013: $8,297k) to Health Benefits Limited (HBL) in relation to the Finance, Procurement and Supply Chain (FPSC) Programme. The FPSC Programme is a national initiative, facilitated by HBL, whereby all 20 DHBs will move to a national shared services model for the provision of finance, procurement and supply chain services.

FPSC rights

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by Health Benefits Limited (HBL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by HBL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Interest-Bearing Loans and Borrowings

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

Derivative financial instruments

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

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

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

DHB Bond FRA

Auckland DHB entered into a Bond Forward Rate Agreement (FRA) with Westpac Bank on 3 Aug 2012. This was to hedge the exposure to rising interest rates in future.

Each year the fair value of the Bond FRA is recognised in the accounts. The net fair value of the ADHB Bond FRA at 30 June 2014 was a net asset position of $722k (2013: $1,072k).

Trade and other receivables

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

Inventories

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

Cash and cash equivalents

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

Assets held for sale

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

Impairment of financial assets

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

Financial instruments

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

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

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

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

Employee benefits

Defined Contribution Plan (DCP)

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

Retiring Gratuities and Long Service Leave

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

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

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

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

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

Provisions

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

Restructuring

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

Revenue

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

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

In accordance with Generally Accepted Accounting Practice and NZ IFRS, surpluses of income over expenditure are reported through the Statement of Financial Performance. Where such surpluses are in respect of Mental Health Ring Fenced Revenue, the unspent portion of the revenue is only available to be spent on Mental Health Services in subsequent accounting periods.

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

Interest income is recognised using the effective interest method.

Lease Expenses

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

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

Goods and Services Tax (GST)

All amounts are shown exclusive of GST, except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Borrowing Costs

Borrowing costs are recognised as an expense when incurred.

Change in accounting policies

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

Cost of Service (Statement of Service Performance)

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

Cost Allocation

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

Cost Allocation Policy

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

Criteria for Direct and Indirect Costs

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

Cost Drivers for Allocation of Indirect Costs

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

	Notes	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
2	**REVENUE**				
a	***Patient care revenue***				
	Health & disability services (MoH contracted revenue)	1,231,177	1,198,484	1,231,177	1,198,484
	ACC contract revenue	17,137	15,161	17,137	15,161
	Inter district patient inflows	516,032	504,519	516,032	504,519
	Revenue from other district health boards	15,054	20,338	15,054	20,338
	Other patient care related revenue	17,265	16,869	17,265	16,869
	Total patient care revenue	**1,796,665**	**1,755,371**	**1,796,665**	**1,755,371**
b	***Other revenue***				
	Gain on sale of property, plant & equipment	66	0	66	0
	Donations and bequests	4,168	8,837	2,704	7,711
	Rental income	7,888	7,194	7,888	7,194
	Gain on financial assets	666	302	0	0
	Other income	46,860	41,089	46,872	41,260
	Total other income	**59,648**	**57,422**	**57,530**	**56,165**
3	**EXPENSES**				
a	***Personnel costs***				
	Wages and salaries	769,854	753,786	769,854	753,786
	Contributions to defined contribution plans	23,542	19,380	23,542	19,380
	Increase/(decrease) in liability for employee benefit	14,894	(3,016)	14,894	(3,016)
	Restructuring provision for employee costs	(154)	(9)	(154)	(9)
	Total personnel costs	**808,136**	**770,141**	**808,136**	**770,141**
b	***Other expenses***				
	Fees to auditor				
	- fees to Audit New Zealand for audit of financial statements	258	252	258	252
	- fees to Audit New Zealand for audit of financial statements (Auckland DHB Charitable Trust)	16	15	16	15
	- fees to Audit New Zealand for other services	0	0	0	0
	Operating leases	3,800	4,001	3,800	4,001
	Impairment of debtors	2,056	3,297	2,056	3,297
	Board members' fees	385	381	385	381
	Loss on disposal of property, plant and equipment	0	71	0	71
	Loss on derivatives – financial instruments	350	81	350	81
	Loss on financial assets	0	97	0	0
	Foreign currency loss	3	2	3	2
	Other expenses	34,623	32,384	34,056	31,553
	Total other expenses	**41,491**	**40,581**	**40,924**	**39,653**

Note

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

	Notes	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
4	**TAXATION**				
	ADHB is a Crown Entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 2007.				
5	**INVESTMENTS IN JOINT VENTURES & ASSOCIATES**				
	Non Current Assets				
	Results of joint ventures & associates				
	Share of post acquisition surplus	12	171	0	0
	Share of net surpluses of joint venture & associates	12	171	0	0
	Carrying amount at the beginning of the year	25,016	20,226	24,770	19,724
	Net movement in Investments	15,110	4,619	15,110	5,046
	Carrying amount at end of year	**40,138**	**25,016**	**39,880**	**24,770**
	Represented by:				
	Class A Shares in HealthAlliance NZ Limited (joint venture)	200	200	200	200
	Class B Shares in HealthAlliance NZ Limited (joint venture)	39,679	24,569	39,679	24,569
	Other shares in joint ventures & associates	1	1	1	1
	Share of post-acquisition retained surpluses	258	246	0	0
		40,138	**25,016**	**39,880**	**24,770**

Note 5(i)

A Memorandum of Understanding was signed between Health Alliance NZ Ltd and Auckland DHB, Counties Manukau DHB , Northland DHB and Waitemata DHB that C Class shares are to be issued by Health Alliance NZ Ltd in exchange for the transfer of ownership of DHB's IT assets (and other ancillary assets). Total value issued at 30 June 2014 is $39,679k (2013: $24,569k represents the baseline value of ADHB's IT assets transferred .

	2014 % Interest held	2013 % Interest held
Name of joint ventures (Principal activity)		
Treaty Relationship Company Limited (joint venture for health initiatives with local iwi)	50	50
HealthAlliance NZ Limited (provider of shared services to Northern Region DHBs and Health Benefits Limited)	20	20
NZ Health Innovation Hub Management Limited (joint venture / limited partnership with Northern Region DHBS to realise products and services to assist healthcare in NZ and overseas)	25	25
Name of associates (Principal activity)		
Northern Regional Alliance Limited (management of a number of regional contracts on behalf of the Auckland region DHBs and co-ordinations trainee medical personnel) formed 1 March 2013 (previously Northern DHB Support Agency Limited/ Northern Regional Training Hub Limited)	33	33

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

		Group Actual		Parent Actual	
		As at 30/06/14	As at 30/06/13	As at 30/06/14	As at 30/06/13
6	**CAPITAL AND RESERVES**	$000	$000	$000	$000
a	***Public equity***				
	Opening balance	576,798	574,915	576,798	574,915
	Contributions from/(repayment to) the Crown	0	1,883	0	1,883
	Balance at end of year	**576,798**	**576,798**	**576,798**	**576,798**
b	***Accumulated deficits***				
	Opening balance	(485,047)	(483,757)	(485,553)	(484,263)
	Operating surplus/(deficit)	264	154	(1,990)	(1,290)
	Transfer to trust/special funds	(2,254)	(1,444)	0	0
	Balance at end of year	**(487,037)**	**(485,047)**	**(487,543)**	**(485,553)**
c	***Other Reserves***				
	Revaluation Reserve				
	Opening balances	368,020	331,807	368,020	331,807
	Net Movement	38,609	36,213	38,609	36,213
	Balance at end of year	**406,629**	**368,020**	**406,629**	**368,020**
d	***Trust/special funds***				
	Opening balances	20,375	18,931	0	0
	Transfer from accumulated deficits (Note 6b)	2,254	1,444	0	0
	Balance at end of year	**22,629**	**20,375**	**0**	**0**
		519,019	**480,146**	**495,884**	**459,265**

Other reserves

Revaluation reserve

The revaluation reserve relates to the independent valuation by Telfer Young (Auckland) Ltd of land at 30 June 2014 and buildings at 30 June 2013 –see Note 11.

Trust / special funds

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

Trust/special funds	2014 Actual $000	2013 Actual $000
Balance at beginning of year	20,375	18,931
Transfer from retained earnings in respect of:		
Interest received	1,358	1,148
Donations and funds received	3,025	1,763
Transfer to retained earnings in respect of:		
Funds spent	(2,129)	(1,467)
Balance at end of year	**22,629**	**20,375**

		Group Actual		Parent Actual	
		As at 30/06/14	As at 30/06/13	As at 30/06/14	As at 30/06/13
7	**CASH AND CASH EQUIVALENTS**	$000	$000	$000	$000
	Current assets				
	Bank balance	172	192	172	192
	Short term deposits	7	195	7	195
	Health Benefits Limited	90,031	80,340	90,031	80,340
	Cash & cash equivalents in the statement of cash flows	**90,210**	**80,727**	**90,210**	**80,727**

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

Auckland DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the all District Health Boards dated 12 November 2012. This Agreement enables HBL to "sweep' DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement allows individual DHBs to borrow funds from HBL, which will incur interest at on-call interest rate received by HBL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of month's Provider Arm funding plus GST. For Auckland DHB, that equates to $105.272m (2013: $102.893m).

7 CASH AND CASH EQUIVALENTS	Notes	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
RECONCILIATION OF REPORTED OPERATING SURPLUS/(DEFICIT) WITH NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES					
Reported net surplus/(deficit) for the year	6	**264**	**154**	**(1,990)**	**(1,290)**
Add non-cash items:					
Share of associate and joint venture surplus	5	(12)	(171)	159	0
Depreciation and amortisation expense		40,329	39,818	40,329	39,818
Net (gains)/ losses on derivative financial instruments		(316)	(1,207)	(316)	(1,207)
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		(66)	0	(66)	0
***Add movements in statement of financial position items*:**					
(Increase)/Decrease in debtors and other receivables		1,509	7,435	1,120	8,265
(Increase)/Decrease in prepayments		290	(69)	290	(69)
(Increase)/Decrease in inventories		673	1,233	673	1,233
Increase/(Decrease) in creditors and other payables		(1,751)	5,231	482	2,950
Increase/ (Decrease) in provision		(33)	1,096	(33)	1,096
Increase/(Decrease) in employee entitlements		14,894	(3,017)	14,894	(3,017)
Net cash inflow/(outflow) from operating activities		**55,781**	**50,503**	**55,542**	**47,779**

Short term deposits (restricted)	Group Actual As at 30/06/14 $000	Group Actual As at 30/06/13 $000	Parent Actual As at 30/06/14 $000	Parent Actual As at 30/06/13 $000
8a TRUST/SPECIAL FUNDS				
Current assets				
Bank balances (restricted)	4,420	892	0	0
Short term deposits (restricted)	9,901	13,193	0	0
Investment Bonds (at market)/(restricted)	2,066	0	0	0
Portfolio Investments	0	0	0	0
	16,387	**14,085**	**0**	**0**
Non – current assets				
Long term deposits (restricted)	0	1,500	0	0
Investment Bonds (at market)/(restricted)	801	2,094	0	0
Portfolio Investments	9,982	9,252	0	0
	10,783	**12,846**	**0**	**0**

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

Term deposits

Interest is receivable on fixed term deposits at a weighted average of 4.11% (2013:4.0%)

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

The carrying amounts of term deposits with maturities less than 12 months approximate their fair value. The fair value of term deposits with remaining maturities in excess of 12 months is $802k (2013: $2,094k). The fair values are based on discounted cash flows using market quoted interest rates for term deposits with terms to maturity similar to the relevant investments.

		Group Actual		Parent Actual	
		As at 30/06/14	As at 30/06/13	As at 30/06/14	As at 30/06/13
8b	**PATIENT AND RESTRICTED TRUST FUNDS**				
	Current assets				
	Patient trust	2	9	2	9
	Restricted fund deposit	1,167	1,137	1,167	1,137
		1,169	**1,146**	**1,169**	**1,146**
	Current liabilities				
	Patient trust	2	9	2	9
	Restricted fund deposit	1,167	1,137	1,167	1,137
		1,169	**1,146**	**1,169**	**1,146**

Patient trust

ADHB administers certain funds on behalf of patients. These funds are held in a separate bank account.

Restricted fund deposit

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

9	**DEBTORS AND OTHER RECEIVABLES**				
	Ministry of Health receivables	21,802	25,168	21,802	25,168
	Other receivables	15,107	18,917	13,978	18,080
	Other accrued income	12,521	7,506	17,017	10,873
	Less provision for impairment	(2,128)	(2,780)	(2,128)	(2,780)
		47,302	**48,811**	**50,669**	51,341

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

10	**INVENTORIES**				
	Pharmaceuticals	1,697	1,697	1,697	1,697
	Surgical and medical supplies	10,481	11,154	10,481	11,154
	Other supplies	33	33	33	33
		12,211	**12,884**	**12,211**	**12,884**

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2014 was $12,211k (2013: $12,884k). Write-down/ (up) of inventories amounted to $1,382k (2013: $664k).

11a PROPERTY, PLANT and EQUIPMENT

GROUP 2014	Freehold land (at valuation)	Freehold buildings, fitouts & infrastructure (at valuation)	Plant, equipment and vehicles	Leased Improve-ments	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost						
Balance at 1 July 2012	163,809	604,933	278,401	885	13,799	1,061,827
Additions	0	0	0	0	29,392	29,392
Additions from Work in Progress	0	11,915	8,789	2	(20,706)	0
Disposals	0	(7)	(7,299)	(21)	0	(7,327)
Reclassifications	0	6,998	(6,776)	(108)	0	114
Revaluations	45,512	(54,392)	0	0	0	(8,880)
Balance at 30 June 2013	**209,321**	**569,447**	**273,115**	**758**	**22,485**	**1,075,126**
Cost						
Balance at 1 July 2013	209,321	569,447	273,115	758	22,485	1,075,126
Additions	0	0	0	0	27,910	27,910
Additions from Work in Progress	0	13,403	16,723	0	(30,126)	0
Disposals	0	(381)	(5,634)	0	0	(6,015)
Transfers	0	0	954	0	0	954
Reclassifications	(36,366)	36,366	0	0	0	0
Revaluations	38,609	0	0	0	0	38,609
Balance at 30 June 2014	**211,564**	**618,835**	**285,158**	**758**	**20,269**	**1,136,584**
Depreciation and impairment losses						
Balance at 1 July 2012	0	(21,966)	(196,356)	(731)	0	(219,053)
Depreciation charge for the year	0	(21,526)	(18,016)	(46)	0	(39,588)
Disposals	0	7	10,370	20	0	10,397
Reclassifications	0	(4,868)	4,786	65	0	(17)
Revaluations	0	45,093	0	0	0	45,093
Balance at 30 June 2013	**0**	**(3,260)**	**(199,216)**	**(692)**	**0**	**(203,168)**
Depreciation and impairment losses						
Balance at 1 July 2013	0	(3,260)	(199,216)	(692)	0	(203,168)
Depreciation charge for the year	(1,217)	(22,293)	(16,482)	(37)	0	(40,029)
Disposals	0	381	5,634	0	0	6,015
Transfers	1,217	(1,283)	(872)	0	0	(938)
Balance at 30 June 2014	**0**	**(26,455)**	**(210,936)**	**(729)**	**0**	**(238,120)**

Note: Underground infrastructure was recognised for the first time at 30 June 2013 as part of the freehold land asset class. These assets are more appropriately classified as part of Freehold buildings & fitouts and as such have been transferred to this asset class at 30 June 2014.

11a PROPERTY, PLANT and EQUIPMENT (continued)

GROUP 2014	Freehold land (at valuation) $000	Freehold buildings, fitouts & infrastructure (at valuation) $000	Plant, equipment and vehicles $000	Leased improve-ments $000	Work in progress $000	Total $000
Carrying Amounts						
At 1 July 2012	163,809	582,967	82,045	154	13,799	842,774
At 30 June 2013	**209,321**	**566,187**	**73,899**	**66**	**22,485**	**871,958**
Carrying Amounts						
At 1 July 2013	209,321	566,187	73,899	66	22,485	871,958
At 30 June 2014	**211,564**	**592,380**	**74,222**	**29**	**20,269**	**898,464**

11a PROPERTY, PLANT and EQUIPMENT

PARENT 2014	Freehold land (at valuation)	Freehold buildings, fitouts & infrastructure (at valuation)	Plant, equipment and vehicles	Leased Improve-ments	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost						
Balance at 1 July 2012	163,809	604,933	278,401	885	12,899	1,060,927
Additions	0	0	0	0	29,392	29,392
Additions from Work in Progress	0	11,915	7,889	2	(19,806)	0
Disposals	0	(7)	(7,299)	(21)	0	(7,327)
Reclassifications	0	6,998	(6,776)	(108)	0	114
Revaluations	45,512	(54,392)	0	0	0	(8,880)
Balance at 30 June 2013	**209,321**	**569,447**	**272,215**	**758**	**22,485**	**1,074,226**
Cost						
Balance at 1 July 2013	209,321	569,447	272,215	758	22,485	1,074,226
Additions	0	0	0	0	27,910	27,910
Additions from Work in Progress	0	13,403	16,723	0	(30,126)	0
Disposals	0	(381)	(5,634)	0	0	(6,015)
Transfers	0	0	954	0	0	954
Reclassifications	(36,366)	36,366	0	0	0	0
Revaluations	38,609	0	0	0	0	38,609
Balance at 30 June 2014	**211,564**	**618,835**	**284,258**	**758**	**20,269**	**1,135,684**
Depreciation and impairment losses						
Balance at 1 July 2012	0	(21,966)	(196,356)	(731)	0	(219,053)
Depreciation charge for the year	0	(21,526)	(18,016)	(46)	0	(39,588)
Disposals	0	7	10,370	20	0	10,397
Reclassifications	0	(4,868)	4,786	65	0	(17)
Revaluations	0	45,093	0	0	0	45,093
Balance at 30 June 2013	**0**	**(3,260)**	**(199,216)**	**(692)**	**0**	**(203,168)**
Depreciation and impairment losses						
Balance at 1 July 2013	0	(3,260)	(199,216)	(692)	0	(203,168)
Depreciation charge for the year	(1,217)	(22,293)	(16,482)	(37)	0	(40,029)
Disposals	0	381	5,634	0	0	6,015
Transfers	1,217	(1,283)	(872)	0	0	(938)
Balance at 30 June 2014	**0**	**(26,455)**	**(210,936)**	**(729)**	**0**	**(238,120)**

Note: Underground infrastructure was recognised for the first time at 30 June 2013 as part of the freehold land asset class. These assets are more appropriately classified as part of Freehold buildings & fitouts and as such have been transferred to this asset class at 30 June 2014.

11a PROPERTY, PLANT and EQUIPMENT (continued)

PARENT 2014	Freehold land (at valuation)	Freehold buildings, fitouts & infrastructure (at valuation)	Plant, equipment and vehicles	Leased improve-ments	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Carrying Amounts						
At 1 July 2012	163,809	582,967	82,045	154	12,899	841,874
At 30 June 2013	**209,321**	**566,187**	**72,999**	**66**	**22,485**	**871,058**
Carrying Amounts						
At 1 July 2013	209,321	566,187	72,999	66	22,485	871,058
At 30 June 2014	**211,564**	**592,380**	**73,322**	**29**	**20,269**	**897,564**

Valuation Information

Land was independently valued on 30 June 2014 by Telfer Young (Auckland) Ltd. Buildings, fitouts & infrastructures were last revalued on 30 June 2013 by Telfer Young (Auckland) Ltd.

PROPERTY, PLANT and EQUIPMENT (continued)

11b	GROUP & PARENT INTANGIBLE ASSETS	FPSC rights Cost	Software & development costs Cost	Total
		$000	**$000**	**$000**
	Cost			
	Balance at 1 July 2012	0	2,030	2,030
	Additions	8,297	125	8,422
	Reclassifications	0	490	490
	Balance at 30 June 2013	**8,297**	**2,645**	**10,942**
	Balance at 1 July 2013	8,297	2,645	10,942
	Additions	3,561	288	3,849
	Balance at 30 June 2014	**11,858**	**2,933**	**14,791**
	Amortisation & Impairment Losses			
	Balance at 1 July 2012	0	(1,501)	(1,501)
	Amortisation charge for the year	0	(228)	(228)
	Reclassifications	0	(586)	(586)
	Balance at 30 June 2014	**0**	**(2,315)**	**(2,315)**
	Amortisation & Impairment Losses			
	Balance at 1 July 2013	**0**	**(2,315)**	**(2,315)**
	Amortisation charge for the year	0	(300)	(300)
	Disposals	0	6	6
	Reclassifications	0	(16)	(16)
	Balance at 30 June 2014	**0**	**(2,625)**	**(2,625)**
	Carrying Amounts			
	At 1 July 2012	0	529	529
	At 30 June 2013	**8,297**	**330**	**8,627**
	At 1 July 2013	8,297	330	8,627
	At 30 June 2014	**11,858**	**308**	**12,166**

PROPERTY, PLANT and EQUIPMENT (continued)

11b INTANGIBLE ASSETS (continued)

At 30 June 2014, the DHB had made payments totalling $3,561k (2013: $8,297k) to HBL in relation to the Finance, Procurement and Supply Chain ("FPSC") programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

These FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying FPSC assets.

It is expected that the final costs of the FPSC programme will exceed the original budget. HBL is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the DHBs. The current expectation of the Board is that the FPSC programme will proceed as originally planned. In this scenario, the DRC of the FPSC rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired. However, the future of the FPSC programme is uncertain and any future decision to re-scope or discontinue the FPSC programme will require a reassessment of the recoverable amount (i.e. DRC) of the FPSC rights.

The carrying amounts of all property, plant and equipment are reviewed on an on-going basis. Any impairment in value is recognised immediately. A review of computer software resulted in a nil impairment movement (2013: Nil).

12a CONTINGENT ASSETS

There are no contingent assets at 30 June 2014 (2013: Nil).

12b CONTINGENT LIABILITIES

Lawsuits against the DHB

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

Superannuation Schemes

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

	Notes	Group Actual As at 30/06/14 $000	Group Actual As at 30/06/13 $000	Parent Actual As at 30/06/14 $000	Parent Actual As at 30/06/13 $000
13a	**TRADE AND OTHER PAYABLES**				
	Current				
	Creditors and accrued expenses	80,549	80,381	80,776	80,585
	GST, PAYE & FBT payable	24,860	24,326	25,099	24,424
	Income in advance	10,333	12,786	8,041	7,818
		115,742	**117,493**	**113,916**	**112,827**

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

13b	**EMPLOYEE BENEFITS**				
	Current				
	Liability for long service leave	2,480	2,662	2,480	2,662
	Liability for sabbatical leave	300	300	300	300
	Liability for retirement gratuities	5,946	5,607	5,946	5,607
	Liability for annual leave	88,269	82,718	88,269	82,718
	Liability for sick leave	1,023	1,023	1,023	1,023
	Liability for continuing medical leave and expenses	21,431	20,423	21,431	20,423
	Salaries and wage accrual	32,352	30,161	32,352	30,161
		151,801	**142,894**	**151,801**	**142,894**
	Non Current				
	Liability for long service leave	1,940	1,310	1,940	1,310
	Liability for retirement gratuities	26,926	22,059	26,926	22,059
	Liability for continuing medical leave and expenses	5,075	4,585	5,075	4,585
		33,941	**27,954**	**33,941**	**27,954**

Salaries and wages accrual is calculated as the expected cost to be paid within the next 12 months relating to the financial year being reported, including allowance for known salary and wage movements. The two major elements included in the accrual of $21.6m (2013 $18.6m) are unpaid days $7.5m (2013: $4.8m) and $14.1m (2013: $13.8m) salaries and wages for June paid in July.

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used is the 3 year plus risk-free rate as advised by Treasury. The salary inflation factor has been determined after considering historical salary inflation patterns and future movements. A weighted average discount rate of 5.5% (2013: 5.5%) and an inflation factor of 1.0% (2013: 1.0%) were used.

13c	**PROVISIONS**				
	Current				
	ACC Partnership Programme	1,541	1,734	1,541	1,734
	Litigation	6	0	6	0
	Restructuring	223	69	223	69
		1,770	**1,803**	**1,770**	**1,803**

		Notes	Group Actual As at 30/06/14 $000	Group Actual As at30/06/13 $000	Parent Actual As at 30/06/14 $000	Parent Actual As at 30/06/13 $000
13c	**PROVISIONS (continued)**					
	Movement for each class of provisions are as follows:					
	ACC Partnership Programme					
	Opening balance		1,734	1,757	1,734	1,757
	Additional provisions made during year		222	1,126	222	1,126
	Charged against provision for the year		(415)	(1,149)	(415)	(1,149)
	Unused amounts reversed during year		0	0	0	0
	Closing balance	(i)	**1,541**	**1,734**	**1,541**	**1,734**
	Litigation Provision					
	Opening balance		0	13	0	13
	Additional provisions made during year		6	0	6	0
	Charged against provision for the year		0	0	0	0
	Unused amounts reversed during year		0	(13)	0	(13)
	Closing balance	(i)	**6**	**0**	**6**	**0**
	Restructuring Provision					
	Opening balance		69	60	69	60
	Additional provisions made during year		223	69	223	69
	Charged against provision for the year		(69)	(53)	(69)	(53)
	Unused amounts reversed during year		0	(7)	0	(7)
	Closing balance	(iii)	**223**	**69**	**223**	**69**

Notes

(i) ***ACC Partnership Programme***

Liability valuation

An external independent Actuary, M.A. Lardies, has calculated the liability as at 30 June 2014. The Actuary has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the Actuary's report.

Risk margin

A risk margin of 11% (2013 11%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

The risk margin has been determined after consideration of past claims history, costs, and trends.

The risk margin is intended to achieve a 75% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

Key assumptions

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

• an average assumed rate of inflation of 2.5% for 30 June 2014 and 2015;

• a weighted average discount factor of 2.95% for 30 June 2014 and 30 June 2015 that has been applied to future payment streams;

• claim inception rates based on analysis of historical claim experience of the DHB. It has been assumed that 81% will result in medical claims only, and 19% will result in an element of time off work;

• the expected future Average Claim Payment per accident is $3,330 (2013:$3,550)

13c PROVISIONS (continued)

(i) ***ACC Partnership Programme (continued)***

Insurance risk

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

The DHB is responsible for managing claims for a period of up to 48 months following the end of the 12 months period of cover in which the claim has occurred. At the end of 48 months, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis.

A stop loss limit of 107% of the DHB Standard Levy is used. The stop loss limit means the DHB will carry the total cost of all claims only up to a total of $3,643,822 incurred in the cover period from 1 April 2013 to 31 March 2014 (2013/2014 ACC Claim Year).

(ii) Litigation

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

(iii) Restructuring

The provisions relate to $115k redundancy to be paid out in September 2014 as a result of a senior medical review by ADHB Mental Health & Addictions Directorate and $108k redundancy payments to be made between September and December 2014 as a result of a the collaborative provision of Funding Services between Auckland and Waitemata District Health Boards.

13d Defined Contribution Plan (DCP)

The DCP (with National Provident Fund) is a multi-employer defined benefit scheme. At 30 June 2014 ADHB contributions to the fund were fully paid - see Note 3a for details.

The DBP Contributors Scheme ('the Scheme') is a multi-employer defined benefit scheme. Insufficient information is available to use defined benefit accounting, as it is not possible to determine, from the terms of the Scheme, the extent to which the deficit will affect future contributions by employers, as there is no prescribed basis for allocation.

As at 31 March 2014, the Scheme had a past service surplus of $16.2million (8% of the liabilities). This amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of NZ IAS 19.

The Actuary to the Scheme recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report, the Actuary recommended employer contributions remain suspended.

		Group Actual		Parent Actual	
		As at 30/06/14 $000	As at 30/06/13 $000	As at 30/06/14 $000	As at 30/06/13 $000
14	**INTEREST-BEARING LOANS AND BORROWINGS**				
	Current				
	Secured loans				
	Crown Loan	80,000	10,000	80,000	10,000
	Interest on Borrowings	2,845	2,873	2,845	2,873
	Unexpired set up cost on borrowings	(175)	(112)	(175)	(112)
		82,670	**12,761**	**82,670**	**12,761**
	Non-current				
	Secured loans				
	Crown Loan	174,500	244,500	174,500	244,500
	15 year Capital Bonds, maturing 15 September 2015	50,000	50,000	50,000	50,000
	Unexpired set up cost on borrowings	0	(175)	0	(175)
		224,500	**294,325**	**224,500**	**294,325**
	Secured loans				
	The details of terms and conditions are as follows:				
	Borrowings are repayable:				
	Less than one year	82,670	12,586	82,670	12,586
	One to two years	50,000	120,000	50,000	120,000
	Two to five years	53,500	50,000	53,500	50,000
	Over five years	121,000	124,500	121,000	124,500
		307,170	**307,086**	**307,170**	**307,086**

Auckland DHB's formal application to the Ministry of Health (via the National Health Board) for a loan of $50m required to refinance the bonds maturing in September 2015 was approved in August 2014.

Interest rate summary	**% pa**	**% pa**	**% pa**	**% pa**
Crown Loan	3.02-6.295	3.20-6.295	3.02-6.295	3.20-6.295
Capital Bonds	7.75	7.75	7.75	7.75
Borrowing facilities				
Crown Loan	254,500	254,500	254,500	254,500
Capital Bonds	50,000	50,000	50,000	50,000
Working capital	0	0	0	0

Crown Loan

The loan facility is provided by the National Health Board unit, which is part of the Ministry of Health.

Capital bonds

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

Working capital facility

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

14 INTEREST-BEARING LOANS AND BORROWINGS (continued)

Security and terms

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

ADHB cannot perform the following actions:

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

ADHB must also meet the following covenants:

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

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

		Group Actual		Parent Actual	
		As at 30/06/14 $000	As at 30/06/13 $000	As at 30/06/14 $000	As at 30/06/13 $000
15	**CAPITAL CHARGE**	37,227	33,500	37,227	33,500

The DHB pays a capital charge to the Crown twice a year on 30 June and 31 December. The charge is based on the previous six month actual closing equity balance. The capital charge rate for the year ended 30 June 2014 was 8% (2013:8%)

16 CAPITAL COMMITMENTS AND OPERATING LEASES

	GROUP AND PARENT	As at 30/06/14 $000	As at 30/06/13 $000
a	***Capital commitments***		
	Property, Plant and equipment	48,536	33,494
	Intangible assets (FPSC rights)	561	4,123
		49,097	**37,617**

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

b ***Non-cancellable operating lease commitments as lessor***

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

GROUP AND PARENT	As at 30/06/14 $000	As at 30/06/13 $000
Not later than one year	5,110	4,863
Later than one year and not later than five years	17,183	17,183
Later than five years	16,866	18,686
	39,159	**40,732**

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

c ***Non-cancellable operating lease commitments as lessee***

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

GROUP AND PARENT	As at 30/06/14 $000	As at 30/06/13 $000
Not later than one year	1,973	1,870
Later than one year and not later than five years	2,343	2,256
Later than five years	240	327
	4,556	**4,453**

Operating leases relate to property rentals and computer equipment.

17 TRANSACTIONS WITH RELATED PARTIES

a Subsidiary

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

PARENT	2014 Actual $000	2013 Actual $000
Sales to ADHB Charitable Trust	44	52
Purchases from ADHB Charitable Trust	1,797	693
Outstanding balance receivable from ADHB Charitable Trust	4,895	3,875
Outstanding balance payable to ADHB Charitable Trust	0	0

b Joint ventures & associates

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

	Notes	Group Actual		Parent Actual	
		As at 30/06/14 $000	As at 30/06/13 $000	As at 30/06/14 $000	As at 30/06/13 $000
GROUP AND PARENT					
Sales to joints & associates					
HealthAlliance N.Z. Limited (joint venture)		2,148	2,936	2,148	2,936
Northern Regional Training Hub Limited (associate)		0	168	0	168
Northern DHB Support Agency Limited (associate)		0	498	0	498
Northern Regional Alliance Limited (associate)		2,028	388	2,028	388
		4,176	**3,990**	**4,176**	**3,990**
Purchases from joint ventures & associates					
HealthAlliance N.Z. Limited (joint venture)		46,150	35,979	46,150	35,979
NZ Health Innovation Hub Management Ltd (joint venture)		0	400	0	400
Northern Regional Training Hub Limited (associate)		0	3,247	0	3,247
Northern DHB Support Agency Limited (associate)		0	2,587	0	2,587
Northern Regional Alliance Limited (associate)		8,880	2,807	8,880	2,807
		55,030	**45,020**	**55,030**	**45,020**
Outstanding balances receivable from joint ventures & associates					
HealthAlliance N.Z. Limited (joint venture)		702	301	702	301
Northern Regional Alliance Limited (associate)		34	80	34	80
	9	**736**	**381**	**736**	**381**

17 TRANSACTIONS WITH RELATED PARTIES (continued)	Notes	Group Actual		Parent Actual	
		As at 30/06/14 $000	As at 30/06/13 $000	As at 30/06/14 $000	As at 30/06/13 $000
Outstanding balances payable to joint ventures & associates					
HealthAlliance N.Z. Limited (joint venture)		5,802	6,016	5,802	6,016
Northern Regional Alliance Limited (associate)		711	1,095	711	1,095
	13a	**6,513**	**7,111**	**6,513**	**7,111**

These transactions were made on commercial terms and conditions, and at market rates. No related party debts have been written off or forgiven during the year. No trading transactions were made with Treaty Relationship Company Ltd during 2014 and 2013.

c Compensations

The key management personnel compensations are as follows:

GROUP & PARENT	2014 Actual $000	2013 Actual $000
Short - term employment benefits	6,801	3,764
Post - employment benefits	280	75
Long - term employment benefits	8	14
Termination benefits	114	0
	7,203	**3,853**

The 2014 key management personnel comprises the Senior Leadership Team and the Clinical Directors of Services (2013: Senior Management Team).

The disclosure of key management personnel compensations for 2014 is based on actual employment benefits paid (2013: $4,323k based on contracted employment benefits). The prior year comparatives (2013) have been adjusted accordingly for comparable purposes based on the actual employee benefits.

(i)	Fees paid to Board Members		385	381
(ii)	Fees paid to Committee Members		7	9
		17j	392	390

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

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

No Board members received compensation or other benefits in relation to cessation (2013: Nil).

Note

17 c (i) &(ii) Refer to Statutory Information (Note 17 j) for data by members.

17 TRANSACTIONS WITH RELATED PARTIES (continued)

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

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

d Significant transactions with government –related entities

The DHB has received funding from the Other Government agencies of $30.315m (2013: $25.759m) to provide health services in the Auckland area for the year ended 30 June 2014.

Revenue earned from other DHBs for the care of patients outside the DHB's district amounted to $516.032m (2013: $504.519m) for the year ended 30 June 2014. Expenditure to other DHBs for their care of patients from the DHB's district amounted to $103.840m (2013: $105.570m) for the year ended 30 June 2014.

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

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

The DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2014 totalled $2.143m (2013 $1.591m). These purchases included the purchase of electricity from Meridian Power New Zealand Limited, and postal services from New Zealand Post.

f Investments in Crown entities

ADHB has a related party relationship with Health Benefits Limited in relation to the Finance Procurement & Supply Chain (FPSC) Programme and DHB Shared Commercial Banking Arrangements. The transactions with Health Benefits Limited during the year were as follows:

	Notes	Group Actual		Parent Actual	
		As at 30/06/14 $000	As at 30/06/13 $000	As at 30/06/14 $000	As at 30/06/13 $000
GROUP AND PARENT					
FPSC Programme Contribution by DHB – Operating		1,944	623	1,944	623
FPSC Programme Contribution by DHB – Capital for B Class shares		11,858	8,297	11,858	8,297
Interest Revenue from HBL Treasury Services		6,336	2,786	6,336	2,786
Interest Receivable at year end		1,312	1,044	1,312	1,044
Capital Commitment to FPSC programme		561	4,123	561	4,123
Funding provided by DHB		579	555	579	555
Shared Banking Fees		16	13	16	13
		22,606	**17,441**	**22,606**	**17,441**

17 TRANSACTIONS WITH RELATED PARTIES (continued)

g Transactions with related parties involving key personnel

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

Related party	Board members and nature of their interest in the related party		Transaction value between ADHB and related party		Balance outstanding between ADHB and related party		Nature of Service
			30/06/2014 $000	30/06/2013 $000	30/06/14 $000	30/06/2013 $000	
Eltham Investments (previously Ward Property Developments Ltd)	Ian Ward, Director	Payments	0	28	0	0	Board member fees
		Receipts	0	0	0	0	

17 TRANSACTIONS WITH RELATED PARTIES (continued)

h Employee remuneration

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

Remuneration Range	Medical	Non- Medical	Number of Employees
$1,130,000-$1,140,000	1		1
$1,120,000-$1,130,000	1		1
$1,010,000-$1,020,000	1		1
$720,000-$730,000	1		1
$700,000-$710,000	1		1
$650,000-$660,000	1		1
$610,000-$620,000	1		1
$570,000-$580,000	1	1	2
$540,000-$550,000	1		1
$530,000-$540,000	5		5
$520,000-$530,000	1		1
$510,000-$520,000	2		2
$500,000-$510,000	1		1
$490,000-$500,000	5		5
$480,000-$490,000	1		1
$460,000-$470,000	4		4
$450,000-$460,000	4		4
$440,000-$450,000	2		2
$430,000-$440,000	4		4
$420,000-$430,000	1		1
$410,000-$420,000	4		4
$400,000-$410,000	8		8
$390,000-$400,000	9		9
$380,000-$390,000	7		7
$370,000-$380,000	11		11
$360,000-$370,000	15		15
$350,000-$360,000	12		12
$340,000-$350,000	23		23
$330,000-$340,000	21	3	24
$320,000-$330,000	16		16
$310,000-$320,000	13	2	15
$300,000-$310,000	18		18
$290,000-$300,000	22	1	23
$280,000-$290,000	16	1	17
$270,000-$280,000	28	1	29
$260,000-$270,000	40		40
$250,000-$260,000	24		24
$240,000-$250,000	17	2	19
$230,000-$240,000	29		29
$220,000-$230,000	31	1	32
$210,000-$220,000	35		35
$200,000-$210,000	35	3	38
$190,000-$200,000	42	1	43
$180,000-$190,000	43	2	45

17 TRANSACTIONS WITH RELATED PARTIES (continued)

h Employee remuneration (continued)

Remuneration Range	Medical	Non- Medical	Number of Employees
$170,000-$180,000	37	2	39
$160,000-$170,000	42	2	44
$150,000-$160,000	47	9	56
$140,000-$150,000	65	12	77
$130,000-$140,000	71	21	92
$120,000-$130,000	62	43	105
$110,000-$120,000	62	81	143
$100,000-$110,000	74	154	228
Grand Total	**1,018**	**342**	**1,360**

Note:

Of the 1,360 employees shown above, 1,018 are or were medical or dental employees and 342 are or were neither medical nor dental employees.

Total Remuneration over $100,000 a year

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

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

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

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

i Employee Termination

Termination payments	Payment $	Employees
Total	2,135,728	95

During the year ended 30 June 2014, termination payments were made in respect of 95 employees (102 payments, $2,465,423 in year ended 30 June 2013). Termination payments consist of settlements and redundancy payments made during the year.

17 TRANSACTIONS WITH RELATED PARTIES (continued)

j Board Member Remuneration

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

	Actual 2014 $000	Actual 2013 $000
Dr Lester Levy (Chair)	70	70
Dr Lee Mathias	39	39
Jo Agnew	31	31
Peter Aitken	32	31
Doug Armstrong**	18	0
Judith Bassett	30	30
Susan Buckland*	13	30
Dr Chris Chambers	30	30
Rob Cooper*	11	27
Robyn Northey	33	32
Gwen Tepania-Palmer	30	31
Morris Pita**	17	0
Ian Ward	31	30
Total board member remuneration	**385**	**381**

Board members not re-elected December 2013 *
New Board members elected as at December 2013 **

Co-opted committee members

Payments made to committee members appointed by the Board who are not Board members during the financial years amounted to $7k

Norman Wong (Audit and Finance Committee) $2k

Mataroria Lyndon (MaGAC) $0.50k

Matire Harwood (MaGAC) $0.25K

Ann Kolbe (HAC) $1.75k

Dairne Kirton (DiSAC) $0.75k

Russell Vickery (DiSAC) $1k

Jan Moss (DiSAC) $1k

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

18 FINANCIAL INSTRUMENTS

Credit Risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (2014-47%, 2013-39%). It is assessed to be a low risk and high-quality entity due to its nature as the Government funded purchaser of health and disability support services.
The status of receivables at the reporting date is as follows:

GROUP

Debtors and other receivables	Gross 2014 $000	Impairment 2014 $000	Gross 2013 $000	Impairment 2013 $000
Not past due	41,721	(14)	43,719	(11)
Past due 0-30 days	3,943	(177)	2,174	(189)
Past due 31-90 days	2,200	(371)	3,134	(473)
Past due 91-360 days	722	(722)	1,643	(1,186)
Past due more than 1 year	844	(844)	921	(921)
Total	**49,430**	**(2,128)**	**51,591**	**(2,780)**

PARENT

Debtors and other receivables	Gross 2014 $000	Impairment 2014 $000	Gross 2013 $000	Impairment 2013 $000
Not past due	45,608	(14)	46,777	(11)
Past due 0-30 days	3,727	(177)	1,881	(189)
Past due 31-90 days	1,896	(371)	2,906	(473)
Past due 91-360 days	722	(722)	1,636	(1,186)
Past due more than 1 year	844	(844)	921	(921)
Total	**52,797**	**(2,128)**	**54,121**	**(2,780)**

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

Debtors and other receivables	GROUP 2014 Actual $000	GROUP 2013 Actual $000	PARENT 2014 Actual $000	PARENT 2013 Actual $000
Gross	49,430	51,591	52,797	54,121
Individual impairment	(2,128)	(2,780)	(2,128)	(2,780)
Net total	**47,302**	**48,811**	**50,669**	**51,341**

Movement in the provision for impairment loss	GROUP 2014 Actual $000	GROUP 2013 Actual $000	PARENT 2014 Actual $000	PARENT 2013 Actual $000
Opening balance	2,780	1,684	2,780	1,684
Increase/(decrease) in doubtful debts	(652)	1,096	(652)	1,096
Closing balance	**2,128**	**2,780**	**2,128**	**2,780**

At the balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the Statement of Financial Position.

18 FINANCIAL INSTRUMENTS *(continued)*

Liquidity

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

Liquidity risk

The following table sets out the contractual cash flows for all financial liabilities. Future interest payments on floating rate debt are based on the floating rate of the instrument at balance date, The amounts disclosed are the contractual undiscounted cash flows.

GROUP

2014	**Interest Rate Type**	Balance Sheet $000	Contractual Cash Flow $000	6 Months or less $000	6-12 Months $000	1-2 Years $000	2-5 Years $000	More than 5 years $000
Interest-bearing loans and borrowings	Fixed	307,170	364,929	9,963	87,840	7,576	128,071	131,479
Creditors and accrued expenses	Nil	80,549	80,549	80,549	0	0	0	0
Total		**387,719**	**445,478**	**90,512**	**87,840**	**7,576**	**128,071**	**131,479**

2013		Balance Sheet $000	Contractual Cash Flow $000	6 Months or less $000	6-12 Months $000	1-2 Years $000	2-5 Years $000	More than 5 years $000
Interest-bearing loans and borrowings	Fixed	307,086	375,173	8,118	18,092	85,713	123,340	139,910
Creditors and accrued expenses	Nil	80,381	80,381	80,381	0	0	0	0
Total		**387,467**	**455,554**	**88,499**	**18,092**	**85,713**	**123,340**	**139,910**

PARENT

2014	**Interest Rate Type**	Balance Sheet $000	Contractual Cash Flow $000	6 Months or less $000	6-12 Months $000	1-2 Years $000	2-5 Years $000	More than 5 years $000
Interest-bearing loans and borrowings	Fixed	307,170	364,929	9,963	87,840	7,576	128,071	131,479
Creditors and accrued expenses	Nil	80,776	80,776	80,776	0	0	0	0
Total		**387,946**	**445,705**	**90,739**	**87,840**	**7,576**	**128,071**	**131,479**

2013	**Interest Rate Type**	Balance Sheet $000	Contractual Cash Flow $000	6 Months or less $000	6-12 Months $000	1-2 Years $000	2-5 Years $000	More than 5 years $000
Interest-bearing loans and borrowings	Fixed	307,086	375,173	8,118	18,092	85,713	123,340	139,910
Creditors and accrued expenses	Nil	80,585	80,585	80,585	0	0	0	0
Total		**387,671**	**455,758**	**88,703**	**18,092**	**85,713**	**123,340**	**139,910**

18 FINANCIAL INSTRUMENTS (continued)

Contractual maturity analysis of financial assets

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

	Carrying Amount $000	Contractual cash flow $000	Less than I year $000	1-2 years $000	2-5 years $000	More than 5 years $000
GROUP 2014						
Cash and cash equivalents						
Bank Balances	172	172	172	0	0	0
Term deposits	7	7	7	0	0	0
Health Benefits Limited	**90,031**	**91,343**	**91,343**	**0**	**0**	**0**
	90,210	**91,522**	**91,522**	**0**	**0**	**0**
Trust/Special Funds						
Cash at bank (restricted)	4,420	4,420	4,420	0	0	0
Term deposits	9,901	10,032	10,032	0	0	0
Portfolio Investments	9,982	9,982	0	0	9,982	0
Investment Bonds (at market)(restricted)	2,867	2,801	2,000	801	0	0
	27,170	**27,235**	**16,452**	**801**	**9,982**	**0**
Patient and restricted trust funds						
Patient trust	2	2	2	0	0	0
Restricted fund deposits	1,167	1,167	1,167	0	0	0
	1,169	**1,169**	**1,169**	**0**	**0**	**0**
Debtors and Other Receivables	47,302	47,302	47,302	0	0	0
Grand Total	**165,851**	**167,228**	**156,445**	**801**	**9,982**	**0**
GROUP 2013						
Cash and cash equivalents						
Bank Balances	192	192	192	0	0	0
Term deposits	195	195	195	0	0	0
Health Benefits Limited	**80,340**	**81,384**	**81,384**	**0**	**0**	**0**
	80,727	**81,771**	**81,771**	**0**	**0**	**0**
Trust/Special Funds						
Cash at bank (restricted)	892	894	894	0	0	0
Term deposits	14,693	18,948	18,948	0	0	0
Portfolio Investments	9,252	9,252	0	0	9,252	0
Investment Bonds (at market)(restricted)	2,094	2,000	0	2,000	0	0
	26,931	**31,094**	**19,842**	**2,000**	**9,252**	**0**
Patient and restricted trust funds						
Patient trust	9	9	9	0	0	0
Restricted fund deposits	1,137	1,137	1,137	0	0	0
	1,146	**1,146**	**1,146**	**0**	**0**	**0**
Debtors and Other Receivables	48,811	48,811	48,811	0	0	0
Grand Total	**157,615**	**162,822**	**151,570**	**2,000**	**9,252**	**0**

18 FINANCIAL INSTRUMENTS (continued)

	Carrying Amount $000	Contractual cash flow $000	Less than I year $000	1-2 years $000	2-5 years $000	More than 5 years $000
PARENT 2014						
Cash and cash equivalents						
Bank Balances	172	172	172	0	0	0
Short term deposits	7	7	7	0	0	0
Health Benefits Limited	90,031	90,031	90,031	0	0	0
	90,210	**90,210**	**90,210**	**0**	**0**	**0**
Patient and restricted trust funds						
Patient trust	2	2	2	0	0	0
Restricted fund deposits	1,167	1,167	1,167	0	0	0
	1,169	**1,169**	**1,169**	**0**	**0**	**0**
Debtors and Other Receivables	**50,669**	**50,669**	**50,669**	**0**	**0**	**0**
Grand Total	**142,048**	**142,048**	**142,048**	**0**	**0**	**0**
PARENT 2013						
Cash and cash equivalents						
Bank Balances	192	192	192	0	0	0
Short term deposits	195	195	195	0	0	0
Health Benefits Limited	80,340	81,384	81,384	0	0	0
	80,727	**81,771**	**81,771**	**0**	**0**	**0**
Patient and restricted trust funds						
Patient trust	9	9	9	0	0	0
Restricted fund deposits	1,137	1,137	1,137	0	0	0
	1,146	**1,146**	**1,146**	**0**	**0**	**0**
Debtors and Other Receivables	**51,341**	**51,341**	**51,341**	**0**	**0**	**0**
Grand Total	**133,214**	**134,258**	**134,258**	**0**	**0**	**0**

18 FINANCIAL INSTRUMENTS (continued)

Interest rate risk and currency risk

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

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

Interest rate risk

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

No financial instruments on interest rate swaps are held at 30 June 2014 (2013: Nil)

DHB Bond FRA

Auckland DHB entered into a Bond Forward Rate Agreement (FRA) with Westpac Bank on 3 Aug 2012. This was to hedge the exposure to rising interest rates in future.

Each year the fair value of the Bond FRA is recognised in the accounts. The net fair value of the ADHB Bond FRA at 30 June 2014 was a net asset position of $722k (2013 $1,072k).

Foreign currency risk

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

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

The Group had not entered into any foreign exchange contracts at balance date (2013: Nil).

18 FINANCIAL INSTRUMENTS (continued)

Classification and fair values

The classification and fair values together with the carrying amounts shown in the statement of financial position are as follows

GROUP 2014	Note	Financial Liabilities at Fair value	Designated at Fair Value through Profit & Loss	Loans and Receivable	Available for Sale	Financial Liabilities at Amortised Cost	Carrying Amount	Fair Value
		$0	$0	$0	$0	$0	$0	$0
Trade and other receivables	9	0	0	47,302	0	0	47,302	47,302
Cash and cash equivalents	7	0	0	90,210	0	0	90,210	90,210
Trust / Special Funds	8a	0	12,849	14,321	0	0	27,170	27,170
Investments in joint ventures and associates	5	0	0	0	40,138	0	40,138	40,138
Patient and restricted trust funds		0	0	0	0	0	0	0
Assets	8b	0	0	1,169	0	0	1,169	1,169
Liabilities	8b	(1,169)	0	0	0	0	(1,169)	(1,169)
Interest rate swaps:		0	0	0	0	0	0	0
Assets	19	0	722	0	0	0	722	722
Liabilities	19	0	0	0	0	0	0	0
Forward exchange contracts:		0	0	0	0	0	0	0
Assets	19	0	0	0	0	0	0	0
Liabilities		0	0	0	0	0	0	0
Secured bank loans	14	0	0	0	0	(307,170)	(307,170)	(308,129)
Trade and other payables	13a	0	0	0	0	(115,742)	(115,742)	(115,742)
Bank overdraft	7	0	0	0	0	0	0	0
		(1,169)	**13,571**	**153,002**	**40,138**	**(422,912)**	**(217,370)**	**(218,329)**
Unrecognised (gains)/losses								**959**
GROUP 2013								
Trade and other receivables	9	0	0	48,811	0	0	48,811	48,811
Cash and cash equivalents	7	0	0	80,727	0	0	80,727	80,727
Trust / Special Funds	8a	0	11,346	15,585	0	0	26,931	26,931
Investments in joint ventures and associates	5	0	0	0	25,016	0	25,016	25,016
Patient and restricted trust funds		0	0	0	0	0	0	0
Assets	8b	0	0	1,146	0	0	1,146	1,146
Liabilities	8b	(1,146)	0	0	0	0	(1,146)	(1,146)
Interest rate swaps:		0	0	0	0	0	0	0
Assets	19	0	1,072	0	0	0	1,072	1,072
Liabilities	19	0	0	0	0	0	0	0
Forward exchange contracts:		0	0	0	0	0	0	0
Assets	19	0	0	0	0	0	0	0
Liabilities		0	0	0	0	0	0	0
Secured bank loans	14	0	0	0	0	(307,086)	(307,086)	(315,689)
Trade and other payables	13a	0	0	0	0	(117,493)	(117,493)	(117,493)
Bank overdraft	7	0	0	0	0	0	0	0
		(1,146)	**12,418**	**146,269**	**25,016**	**(424,579)**	**(242,022)**	**(250,625)**
Unrecognised (gains)/losses								**8,603**

18 FINANCIAL INSTRUMENTS (continued)

Classification and fair values

The classification and fair values together with the carrying amounts shown in the statement of financial position are as follows

PARENT 2014	Note	Financial Liabilities at Fair value	Designated at Fair Value through Profit & Loss	Loans and Receivable	Available for Sale	Financial Liabilities at Amortised Cost	Carrying Amount	Fair Value
		$0	$0	$0	$0	$0	$0	$0
Trade and other receivables	9	0	0	50,669	0	0	50,669	50,669
Cash and cash equivalents	7	0	0	90,210	0	0	90,210	90,210
Trust / Special Funds	8a	0	0	0	0	0	0	0
Investments in joint ventures and associates	5	0	0	0	39,880	0	39,880	39,880
Patient and restricted trust funds		0	0	0	0	0	0	0
Assets	8b	0	0	1,169	0	0	1,169	1,169
Liabilities	8b	(1,169)	0	0	0	0	(1,169)	(1,169)
Interest rate swaps:		0	0	0	0	0	0	0
Assets	19	0	722	0	0	0	722	722
Liabilities	19	0	0	0	0	0	0	0
Forward exchange contracts:		0	0	0	0	0	0	0
Assets	19	0	0	0	0	0	0	0
Liabilities		0	0	0	0	0	0	0
Secured bank loans	14	0	0	0	0	(307,170)	(307,170)	(308,129)
Trade and other payables	13a	0	0	0	0	(113,916)	(113,916)	(113,916)
Bank overdraft	7	0	0	0	0	0	0	0
		(1,169)	**722**	**142,048**	**39,880**	**(421,086)**	**(239,605)**	**(240,564)**
Unrecognised (gains)/losses								**959**
PARENT 2013								
Trade and other receivables	9	0	0	51,341	0	0	51,341	51,341
Cash and cash equivalents	7	0	0	80,727	0	0	80,727	80,727
Trust / Special Funds	8a	0	0	0	0	0	0	0
Investments in joint ventures and associates	5	0	0	0	24,770	0	24,770	24,770
Patient and restricted trust funds		0	0	0	0	0	0	0
Assets	8b	0	0	1,146	0	0	1,146	1,146
Liabilities	8b	(1,146)	0	0	0	0	(1,146)	(1,146)
Interest rate swaps:		0	0	0	0	0	0	0
Assets	19	0	1,072	0	0	0	1,072	1,072
Liabilities	19	0	0	0	0	0	0	0
Forward exchange contracts:		0	0	0	0	0	0	0
Assets	19	0	0	0	0	0	0	0
Liabilities		0	0	0	0	0	0	0
Secured bank loans	14	0	0	0	0	(307,086)	(307,086)	(315,689)
Trade and other payables	13a	0	0	0	0	(112,827)	(112,827)	(112,827)
Bank overdraft	7	0	0	0	0	0	0	0
		(1,146)	**1,072**	**133,214**	**24,770**	**(419,913)**	**(262,003)**	**(270,606)**
Unrecognised (gains)/losses								**8,603**

18 FINANCIAL INSTRUMENTS (continued)

Fair Value Hierarchy Disclosures

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

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

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

	Notes	Valuation technique			
		Total	Quoted market price	Observable inputs	Significant non-observable inputs
		$000	$000	$000	$000
GROUP					
As at 30 June 2014					
Financial Assets					
Portfolio investments	8a	9,982	9,982	0	0
Local authority bond	8a	801	801	0	0
GROUP					
As at 30 June 2013					
Financial Assets					
Portfolio investments	8a	9,252	9,252	0	0
Local authority bond	8a	2,094	2,094	0	0

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

Estimation of fair values analysis

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

Derivatives

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

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

Interest-bearing loans and borrowings

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

18 FINANCIAL INSTRUMENTS (continued)

Restricted/special funds

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

Trade and other receivables / payables

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

Interest rates used for determining fair value

The entity uses the Government yield curve as of 30 June 2014 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

GROUP & PARENT	2014 Actual %	2013 Actual %
Derivatives	4.335%	4.335%
Loans and borrowings	3.02-6.295%	3.02-6.295%

Capital management

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

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

There have been no material changes in ADHB's management of capital during the period.

Sensitivity Analysis

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

At 30 June 2014, it is estimated that a general increase of 1% in interest rates would increase the surplus or deficit by approximately $3.7m (2013: $3.3m). Interest rate swaps have been included in this calculation.

At 30 June 2014, it is estimated that a general decrease of 1% in interest rates would decrease the surplus or deficit by approximately $4.1m (2013: $3.6m). Interest rate swaps have been included in this calculation.

	Group Actual As at 30/06/14	Group Actual As at 30/06/13	Parent Actual As at 30/06/14	Parent Actual As at 30/06/13
19 DERIVATIVE FINANCIAL INSTRUMENTS				
Non – Current Assets				
Derivatives in gain (mark to market)	722	1,072	722	1,072

20 MAJOR VARIATIONS FROM BUDGET

Statement of Financial Performance

Auckland DHB recorded a surplus of $0.264m which was $0.179m favourable to budget.

Major favourable variance:

Non-health board provider expenses $167.9m. Amalgamation of primary healthcare organisations (PHOs) within the Auckland region has resulted in Auckland DHB being given responsibility for the regional contract for Procare, a primary healthcare organisation servicing the wider Auckland Region. In addition Auckland DHB acts as the lead DHB for the Labtest contract within the Auckland region. Consequently Auckland DHB receives some $141.4m by way of contribution to these contracts from Counties Manukau and Waitemata DHBs. This is in effect an agency arrangement. Accordingly, in the actual results the contributions $141.4m was treated as an offset of expenditure. At the time the budgeted results were prepared the contribution from Counties Manukau and Waitemata DHBs was regarded as revenue.

Major unfavourable variances:

Patient care revenue $141.8m. This variance occurs as the contribution described above to Procare and Labtests has been treated as an offset to cost for the reasons described above.

Statement of Changes in Equity

Total Equity of $519.0m as at June 2014 was $36.6m favorable to budget, driven by the revaluation of Land as at 30 June 2014 $38.6m.

Statement of Financial Position

Total Assets as at June 2014 were $1,132.6m which was above budget of $1,087.7m by $44.9m driven by the revaluation of Land as at 30 June 2013 $38.6m

Statement of Cash Flows

Cash and Cash Equivalents of $90.2m at June 2014 was $41.4m favorable to budget driven by a lower than budgeted Capital expenditure $25.7m and lower than budget payments to suppliers $8.9m.

21 EVENTS SUBSEQUENT TO BALANCE DATE

Nil (2013: Nil)

22 KEY SOURCES OF ESTIMATED UNCERTAINTY

As indicated in Note 1, the preparation of financial statements in conformity with NZ IFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses.

Management has identified the following critical accounting policies for which significant judgements, estimates and assumptions are made:

Accrual of continuing medical education leave and expenses in employee benefits

The provision for the above is $26.506m as at 30 June 2014 (2013 $25.0m). The calculation of this accrual assumes that the utilisation of this annual entitlement, that can be accumulated over 3 years, will be 65% of the full entitlement (2013 – 65%).

Estimation of useful lives of assets

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

Debtors impairment

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

Fair value of Property, Plant and Equipment (PPE)

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

Earthquake-Prone Buildings

Auckland DHB has four buildings that have been confirmed as “earthquake prone” under the relevant legislation by structural engineers. These will require action to demolish or strengthen within the next 15 years. Two of these are at the Greenlane campus (the Costley Block and Building 5) and are currently vacant with long term plans still to be confirmed. The other two (Building 7 and Building 13) at the Auckland campus are being occupied on an interim basis with plans to vacate and demolish in the medium term. All these structures were valued at zero in the June 2014 valuation.

23 DISTRICT STRATEGIC PLAN (DSP)

The Ministry of Health (National Health Board), via the change to legislation, now require DHBs to undertake longer term planning through a regional planning process. As a result a Northern Region Health Plan has been developed and submitted to the National Health Board. This covers the intentions of the four DHBs in the Northern Region. An implementation plan to cover specific activities and responsibilities has also been developed.

COST OF SERVICE STATEMENT – for year ending 30 June 2014

New Output Class Name (effective from 1 July 2011)	Prevention Services ($'000)		Early Detection and Management ($'000)		Intensive Assessment & Treatment ($'000)		Rehabilitation and Support ($'000)		Total	
in $'000s	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**
Total Revenue	22,107	19,895	528,311	567,794	1,273,881	1,264,436	180,277	153,475	2,004,576	2,005,600
Expenditure										
Personnel	15,523	13,483	3,238	14,520	762,393	741,658	26,773	13,580	807,927	783,241
Outsourced Services	4,424	71	68	980	80,682	82,762	840	387	86,014	84,200
Clinical Supplies	250	224	234	1,106	226,243	229,190	3,837	3,034	230,565	233,554
Infrastructure & Non-Clinical Supplies	4,507	2,477	2,449	27,672	170,814	140,550	7,263	9,997	185,033	180,696
Payments to Providers	968	798	496,264	518,771	54,023	66,287	143,521	137,968	694,776	723,824
Total Expenditure	25,672	17,053	502,252	563,049	1,294,155	1,260,447	182,234	164,966	2,004,314	2,005,515
Net Surplus / (Deficit)	**(3,565)**	**2,842**	**26,059**	**4,745**	**(20,275)**	**3,989**	**(1,957)**	**(11,491)**	**262**	**85**

The budget figures above are those agreed by the Board in the Annual Plan. During the year DHB reviewed the allocation of the tertiary adjuster revenue and expenditure between output classes. This resulted in a more accurate allocation to output classes. The changes are as shown in the table below.

Output Class Name	Prevention Services ($'000)	Early Detection and Management ($'000)	Intensive Assessment & Treatment ($'000)	Rehabilitation and Support ($'000)	Total
	Budget	Budget	Budget	Budget	Budget
Revenue per Statement of Intent	19,895	567,794	1,264,436	153,475	**2,005,600**
Revenue per revised allocation	20,615	522,277	1,280,407	179,299	**2,002,598**
Change	720	(45,517)	15,971	25,824	**(3,002)**
Expenditure per Statement of Intent	17,053	563,049	1,260,447	164,966	**2,005,515**
Expenditure per revised allocation	23,252	520,859	1,271,711	186,691	**2,002,513**
Change	6,199	(42,190)	11,264	21,725	**(3,002)**
Net Change	**(5,479)**	**(3,327)**	**4,707**	**4,099**	**0**

Statement of Responsibility

For the year ended 30 June 2014

In terms of the Crown Entities Act 2004, we hereby certify that:

- We have been responsible for the preparation of these financial statements and statement of service performance and the judgements used therein.
- We have been responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.
- We are of the opinion that these financial statements and statement of service performance fairly reflect the financial position and operations of this Crown Entity for the year ended 30 June 2014.

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

Dr Lester Levy
Chair

Dated: 29 October 2014

Ian Ward
Chair, Audit and Finance Committee

Dated: 29 October 2014

GLOSSARY

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

GLOSSARY

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

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Auckland District Health Board and group's financial statements and performance information for the year ended 30 June 2014

The Auditor-General is the auditor of Auckland District Health Board (the Health Board) and group. The Auditor-General has appointed me, J R Smaill, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and performance information of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 49 to 97, that comprise the statement of financial position as at 30 June 2014, the statement of financial performance, statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the Health Board and group on pages 13 to 38 and page 98 that comprises the statement of service performance, and which includes outcomes.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 49 to 97:

- comply with generally accepted accounting practice in New Zealand; and

- fairly reflect the Health Board and group's:
    - financial position as at 30 June 2014; and
    - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information because of limited control on information from third-party health providers

Reason for our qualified opinion

Some significant performance measures of the Health Board and group, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers, such as primary health organisations. The Health Board and group's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Health Board and group for the period ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 13 to 38 and 98:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 29 October 2014. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Our audit of the financial statements involved evaluating:

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

Our audit of the performance information involved evaluating:

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

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

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

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

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

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

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

Responsibilities of the Auditor

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

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

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

J R Smaill
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand


Auckland DHB
Anaesthesia Team

Auckland District Health Board

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

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