Auckland District Health Board

Annual Report 2014 | 2015

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

TABLE OF CONTENTS

CHAIRMAN/CEO STATEMENT

Dr Lester Levy, CNZM
Chairman

Ailsa Claire, OBE
Chief Executive Officer

The healthcare we provide depends on the experience, skill, commitment and dedication of our staff and we want to acknowledge and recognise how hard working our people are at the outset of this report. The commitment and skills of our staff have resulted in a year of significant achievement and we thank them on behalf of our patients, their family/whanau and the community that we serve.

During the early part of the 2015 winter which fell in the year of this report, Auckland DHB faced the challenge of meeting the health needs of an unprecedented number of patients requiring our care and expertise. The dedication and skills of our staff, working together, ensured we were able to deliver high quality care and treatment throughout this difficult time as we experienced a sustained 'surge' of patients in need of care.

The challenge and our response truly reflected our shared values which are derived from what our staff and patients say matter most to them. The four values are:

- Welcome/Haere Mai - we see you and welcome you as a person
- Respect/Manaaki - we respect, nurture and care for each other
- Together/Tūhono - we are a high performing team pf patients, family and colleagues
- Aim High/Angamua - we aspire to excellence and safest care.

These values guide our decisions, behaviour and actions as we work to deliver on our strategic priorities.

In our hospital settings Auckland DHB has met the target for elective surgical discharges and no patients were waiting for more than four months for their first specialist assessment. Our Emergency Department treated 102,792 people, several thousand more than the previous year and despite that ensured that 94 percent of patients were discharged or admitted within six hours of arrival. The 10 year average growth rate of Emergency Department presentations is 3.8 percent, which continues to pose a very significant challenge to Auckland DHB.

More than 7,000 babies were delivered in our maternity services and more than three quarters of the new mothers were exclusively breastfeeding at discharge.

Our population has the lowest smoking rate of any DHB at 11 percent and overall life expectancy in Auckland is higher than the national average, increasing by 2.6 years in the past decade. Over the same period the life expectancy of our Maori population has increased 4.2 years reflecting the success of community partnerships and health campaigns. Mortality rates for cancer and cardiovascular disease are among the lowest in the country and the five year survival rate for cancer patients is among the highest in the country.

Auckland DHB continues to champion clinician leadership with the goal of moving decision-making as close as possible to the patient. To support this we have forged more direct partnerships with PHOs, NGOs and Maori health providers.

The principles of co-design with patients have been applied to a number of settings, the redesign of Motutapu, our new Northern Region Haematology and Bone Marrow Transplant Unit and the significant upgrades to the operating theatres for Starship Children's Hospital, both good examples of this. In a community setting, Auckland DHB is working closely with Ngati Whatua to support a whanau ora approach in the Tamaki region.

Partnerships have also been formed with the University of Auckland through the Auckland Academic Health Alliance which seeks to connect patient needs with the highest quality clinical and laboratory based research. The Auckland Academic Health Alliance will promote the development of an Integrated Cancer Centre and Centre for Heart Research, leveraging the research and clinical skills of staff at the University and DHB.

Auckland DHB has also developed a partnership with Auckland University of Technology leading to the creation of the Design for Health and Wellbeing Lab, where AUT staff and students work alongside clinicians on patient-centered projects ranging from spatial and wayfaring design to child-friendly medical equipment.

A growing population, which is growing in diversity and which has increasing demand for services means Auckland DHB needs to be adaptive and disciplined to remain financial sustainable. Again, due to the work of our staff we continue to 'live within our means' and delivered a small surplus at the end of this financial year.

Auckland DHB continues to build on its bilateral collaboration with Waitemata District Health Board sharing a joint planning and funding team and a range of other organisational and patient focused support services.

It has been a year of challenge and change - there still remains much to do in working to create a more 'joined-up' health system for our communities and patients. Overall, Auckland DHB can report that it remains firmly on track to meet its strategic priorities that will continue to improve the health outcomes for the people we serve.

Dr Lester Levy CNZM

Chair
Auckland District Health Board

Ailsa Claire OBE

Chief Executive
Auckland District Health Board

MĀORI TE TIRITI - PARTNERSHIP STATEMENT

R Naida Glavish ONZM

Tū Tonu ngā Manaakitanga!

This whakatauākī represents Ngāti Whātua's sacred obligation to manaaki, or care for, all of those within our tribal boundary. It is meant as exaltation and a challenge to hold fast to this obligation.

It is helpful to bear this whakatauākī in mind as we reflect on the achievements of the past year presented in this Annual Report. I am extremely pleased to note that an increased number of tamariki were fully immunised at 8 months of age, and over 95% of tamariki started school having had their B4 School checks completed. The health and development of the most vulnerable members of our whānau is crucial for the future of our communities.

As we acknowledge all of those who have contributed to a milestone year for Māori health, we also need to challenge ourselves to do more. Many indictors in this report show that Māori often suffer disproportionately from health conditions compared to other groups in our communities. One only needs to view life expectancy data to get a sense of how immense the challenge to eliminate health inequities between Māori and non-Māori really is.

When I look back over the past year, and all of its achievements, the theme that emerges is partnership. The combined efforts of hospital based services, primary care providers and community organisations have contributed to a dramatic drop in the number of our whānau smoking. In order to eliminate smoking from our communities completely, every part of the health sector must be mobilised behind our vision for a smokefree Aotearoa.

As a Tiriti o Waitangi partner, Te Rūnanga o Ngāti Whātua understands the importance of having a strong and trusting relationship with the District Health Board in order to achieve Māori health gain. The completion of the Auckland DHB and Waitemata DHB Māori Health Workforce Development Strategy is testament to our partnership. This strategy has set the goal of increasing the Māori health workforce across these two DHBs to 13 percent. Although ambitious, this past year and all its important achievements leads me to believe that alongside our colleagues from the DHBs, primary care and community health sector we will achieve this target.

Te Rūnanga o Ngāti Whātua remains steadfast to our commitment to working in partnership with Auckland DHB. This annual report highlights the importance of our partnership, 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 Glavish ONZM JP

Rangimarie Naida Glavish ONZM
Co-Chair, Te Rūnanga o Ngāti Whātua

THE AUCKLAND DISTRICT

Our population

We are the fourth largest and one of the fastest growing DHBs in New Zealand. Auckland has 478,000 residents and we expect population growth of 15% (70,000 more people) by 2025

We are ethnically diverse with 8% Māori, 11% Pacific, 29% Asian and the remainder European/Other

In 2014 6,036 babies were born to Auckland DHB mothers

Our life expectancy is among the highest in New Zealand at 82.5 years, slightly higher than the national figure

Our Organisation

We employee over 10,000 staff

Our budget in 2014/15 was $2.1 billion (group)

Our major facilities are Auckland City Hospital, Greenlane Clinical Centre and Buchannan Rehabilitation Centre

We are the largest trainer of doctors in New Zealand and a national leader in Clinical Research

We are a specialist provider of services including organ transplant services (heart, lung and liver), specialist paediatric services, epilepsy surgery and high-risk obstetrics

Buchanan Rehabilitation Centre

Greenlane Clinical Centre

Auckland City Hospital

KEY 2014/15 HIGHLIGHTS

We are one of healthiest populations in New Zealand

Life expectancy in Auckland is 82.5 years (2014), slightly higher than the national figure and continues to increase. Our mortality rates from cardiovascular disease and cancer, the two biggest causes of death, are among the lowest in the country. Our five year survival rates for those diagnosed with cancer are among the highest in the country. This is a strong testament to our excellent performance in the area of cancer detection and treatment. Our smoking rates continue to decline and we now have the lowest smoking rate of any DHB in the country.

Our district's children get a healthy start to llife

Our infant mortality rate continues to decline (4.5 per 1,000 live births 2010-12) and is lower than the national rate. Our immunisation rates are very high, with 94% of our 8-month old children fully immunised on-time. Coverage rates for Before School Checks are among the highest in New Zealand at 96%, and remain well above the national target.

We are tackling health inequalities in our population

Life expectancy among our Māori and Pacific populations continues to rise and in 2014 was 79.4 years for Māori and 77.4 years for Pacific. Life expectancy of our Māori population is increasing faster than any other population group having increased 4.2 years over the past decade. Immunisation coverage among Māori and Pacific children continues to increase and we are now fully immunising 86% of Māori children and 93% of Pacific children by 8 months of age. Cervical and breast screening rates continue to climb with Pacific breast screening rates above the overall DHB rate.

Our hospitals are performing exceedingly well

We delivered 13,902 elective procedures in 2014/15 against a target of 13,872. CT and MRI volumes have increased by 4.5%. Our hospitals are performing exceedingly well with compliance across the Health Quality and Safety markers.

Our population has rapid access to services

Our emergency departments treat and see more people faster than ever before, with 94% of patients discharged, admitted or transferred within six hours. Waiting times for elective surgery have reduced with 100% of patients waiting no longer than four months for their first assessment, and nearly 100% waiting no longer than four months for their first treatment.

We lived within our means

We have lived within our means during the 2014/15 financial year and generated a surplus of $355,000. We have continued to invest in growing our frontline staffing numbers to keep up with demand. Doctor, nurse and allied health staff FTE has grown over the period (with the number of doctors at Auckland growing 31% (190 FTE) since FY2009/10), while efficiencies in back office functions and business transformation have resulted in financial savings.

We remain the largest research and teaching hospital in NZ

We are the largest clinical research facility in New Zealand with a research portfolio that comprises over 1,100 projects. Our doctors, nurses, allied health professionals and scientists engage in research that attracts funding, participation and peer esteem both from New Zealand and internationally.

WHAT ARE WE TRYING TO ACHIEVE?

Our aim is to create healthy communities by helping and empowering people to achieve the health outcomes that matter to them and their whānau. We aim to provide world-class healthcare through a health system that places people, patients and whānau at the centre. We want to see Aucklanders enabled to take more responsibility for their own health.

During 2014/15 our organisation's vision and values have underpinned our work as a provider and funder of health and disability services.

Our vision is:

Patient and Whānau Determined Health

Patient and Whānau determined health draws Whānau Ora and self-directed care into one patient and whānau-centred approach. 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.

Our shared values reflect what our staff and patients told us were important to them. These values guide us in the way we do things, the decisions we make and the internal culture that we strive for.

Welcome | Haere Mai
We see you, we welcome you as a person

Respect | Manaaki
We respect, nurture and care for each other

Together | Tūhono
We are a high performing team
patients, family and colleagues

Aim High | Angamua
We aspire to excellence and the safest care

Throughout 2014/15 our strategic priorities to ensure we fulfil our responsibilities as a district health board were:

- Maximise health and wellbeing across our population
- Provide safe, effective and sustainable services for people living in Auckland
- Provide safe, effective and sustainable tertiary and national services for the people of New Zealand and the Pacific

Along with creating healthy communities, Auckland DHB's hospitals are teaching hospitals. Auckland DHB partners with the University of Auckland in an Academic Health Alliance, aiming to deliver research-informed healthcare alongside clinical teaching and training.

Auckland Academic Health Alliance

"The aim is for rapid translation of research findings from 'bench to bedside'"

- **Professor Stuart McCutcheon**

Better patient outcomes are the goal of the Auckland Academic Health Alliance, which links the University of Auckland and the Auckland District Health Board. The Alliance has established a closer relationship between University and hospital-based research – ensuring a faster translation of clinical research into patient care. The alliance has further positioned Auckland DHB as one of the most academic institutions in the country outside of Universities.

By fostering and supporting collaborative, patient-based research between the institutions, the Auckland Academic Health Alliance directly binds the vital needs of patients with the highest quality clinical and laboratory-based research. The result is that clinical research is targeted and meaningful, clinical teaching is invigorated and most importantly, that scientific breakthroughs and medical care advances can reach patients faster. Along with better outcomes for patients, the heath workforce will also be strengthened by training, attracting and retaining highly skilled professionals.

The first major initiative of the Auckland Academic Health Alliance will be the development of an Integrated Cancer Centre. A business case is being developed to transform cancer services in Auckland. The vision is for a multidisciplinary, inter-institutional centre focused on improving health outcomes for people with cancer through advanced clinical care, research, education and training and community engagement.

WHAT DIFFERENCE HAVE WE MADE FOR THE HEALTH OF OUR POPULATION?

We have the lowest smoking rate of any DHB in the country

Our mortality rate from cancer is among the lowest in the country and the lowest in the North Island

We have one of the highest survival rates from cancer of any DHB

Our outcomes framework (over-page) forms an essential part of the way we are held to account for making a difference to the health of our population. The framework focuses on the two high-level outcomes we want to achieve across the health system and beyond.

These outcomes are to:

- increase life expectancy and quality of life
- reduce ethnic inequalities

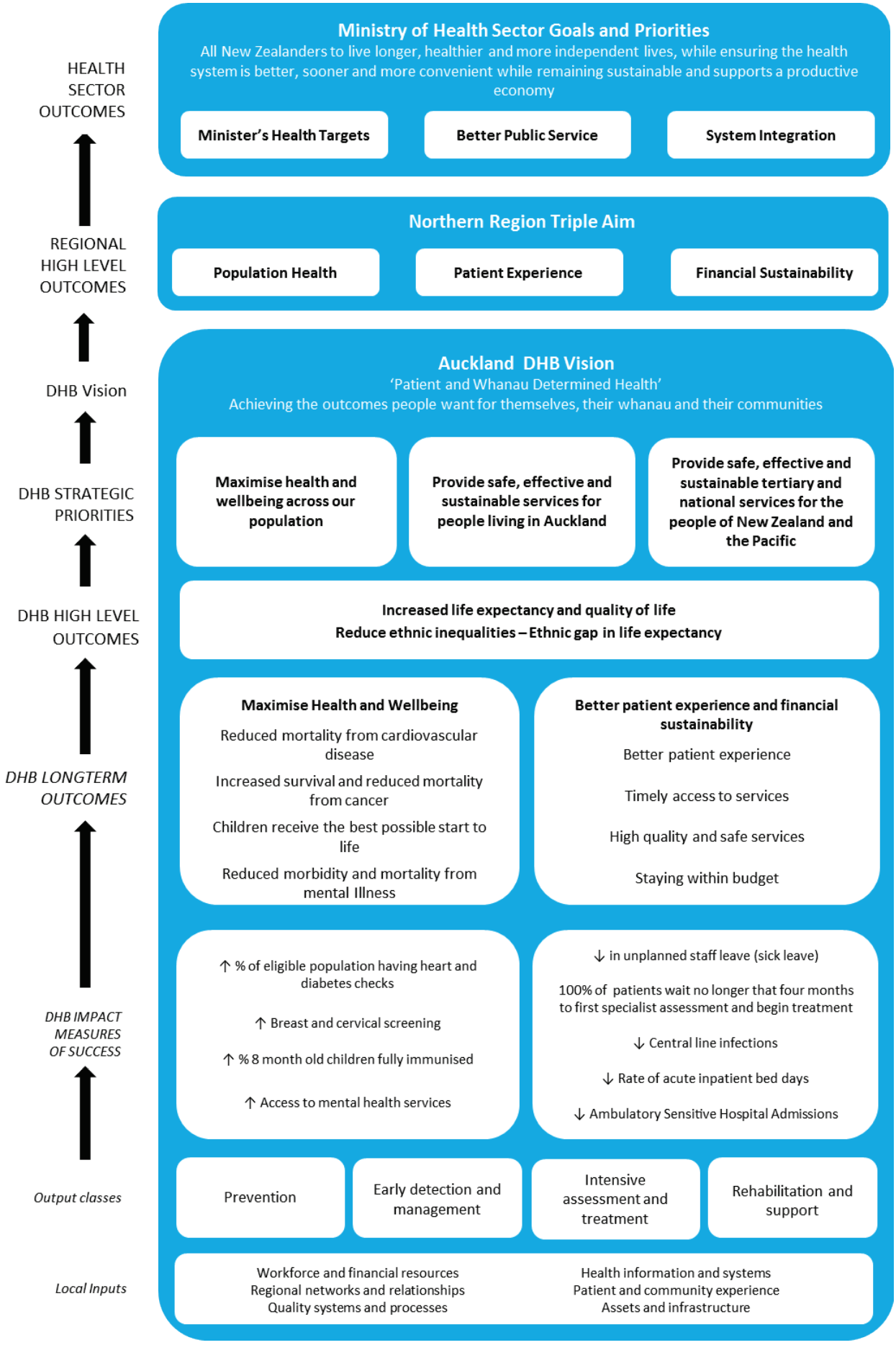
While we will be able to provide information on the performance against both these high-level outcomes, the nature of population health is such that the improvements in these outcomes will take years – sometimes even decades – to see marked change. To measure our performance over a shorter time period we report on a set of supporting health indicators that help focus our understanding of how well we are doing year by year and ensure we provide 'world-class healthcare'. These indicators cover the full spectrum of what we, and our population, understand health to be. Our long-term outcomes are focused on developing and maintaining positive trends over time (five to ten years) rather than achieving fixed annual targets. Sitting underneath the long-term outcome indicators, we have a second set of impact measures which can measure our direct impact over a shorter time period (one to five years).

Our outputs, detailed in the Statement of Performance, present a snapshot of the services provided for our population and helps evaluate the DHB's performance over time. Where measures are contained in both our outcome and output frameworks we have only reported on them in one section of the report.

Overall the progress against our indicators suggests we are delivering on our vision and we remain a high performing DHB that is truly making a difference to the health of our population. Our smoking rates continue to decline and we now have the lowest smoking rate of any DHB in the country. Our mortality rates from cardiovascular disease and cancer also continue to decline and remain below the national average and among the lowest in the country. The children in our district continue to experience the best start to life with high rates of immunisation, and excellent performance across other child health indicators.

Our population has continued to have access to health services when needed, with 100% of patients waiting no longer than four months for their first assessment, and nearly 100% waiting no longer than four months for their first treatment. Patients requiring emergency treatment are receiving this in timely manner with our emergency departments admitting, discharging or transferring 94% of attendees within six hours.

OUR OUTCOMES FRAMEWORK



HIGH LEVEL OUTCOMES

Improving Life Expectancy

The high level outcomes that we aim to achieve for the people in our population are to increase their life expectancy and quality of life and to reduce the ethnic inequalities that are present. Although an increase in life expectancy does not directly translate to improvements in quality of life, many of our outcome and impact indicators are likely to contribute to this.

*Life expectancy is **higher** in Auckland when compared with the whole of New Zealand*

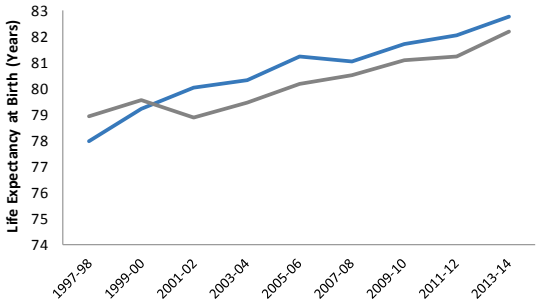
*Life expectancy has increased **2.6 years** over the past decade*

An increase in life expectancy at birth

82.5 Years 2014

79.9 years 2004

Our population continues to have one of the highest life expectancies* in the country at 82.5 years, which in 2014 was slightly higher than the national figure of 82.1 years. In Auckland, life expectancy has increased by 2.6 years over the past 10 years.



*Life expectancy of our Māori population has increased **4.2 years** over the past decade*

A reduction in the ethnic gap in life expectancy

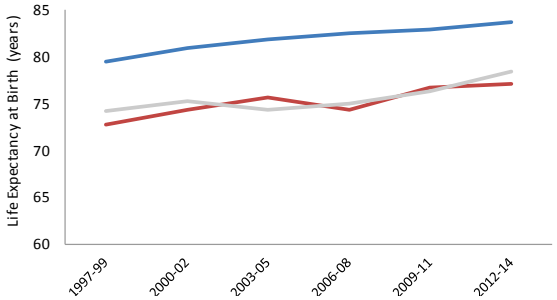
6.5 years Pacific 2012-14

6.2 years 2003-05

5.2 years Māori 2012-14

7.5 years 2003-05

Life expectancy among our Māori and Pacific populations is similar to that of New Zealand. However, significant differences in life expectancy remain between ethnic groups within our district. Māori and Pacific people continue to have a lower life expectancy compared with other ethnicities, with a gap of 5.2 years for Māori and 6.5 years for Pacific. Although life expectancy is increasing in our Pacific population, it is doing so at a slower rate compared with our other population groups, having only increased by 1.6 years over the previous decade. Within our Māori population, life expectancy has increased faster than any other ethnic group, increasing by 4.2 years over the past decade.



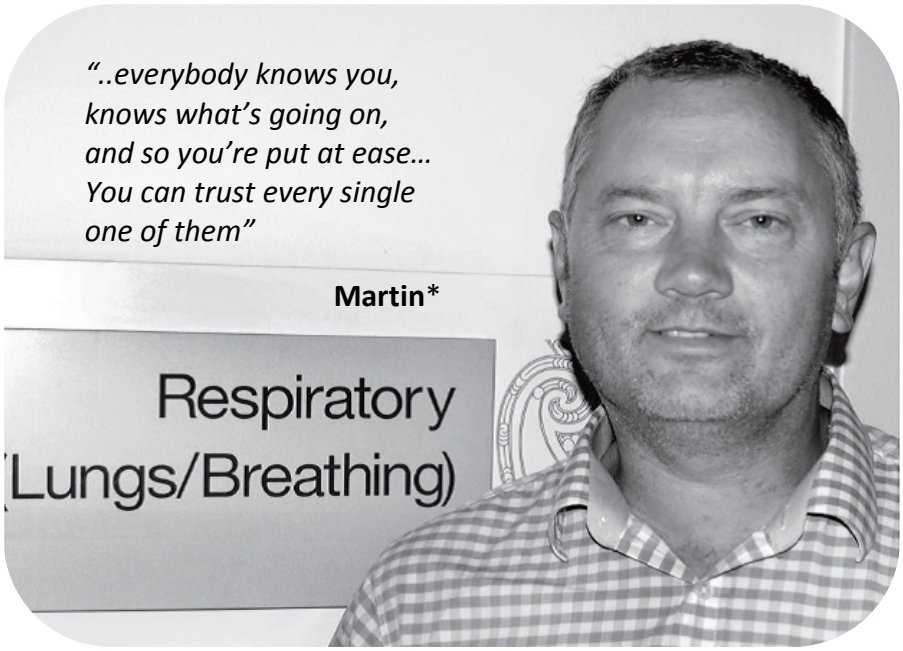
*Note: The most recent life expectancy data available is for the 2014 calendar year. Two-year combined rates have been presented to reduce the effect of year to year variations in death rates.

Martin's story

"I do things now that people just take for granted"

I always knew that with cystic fibrosis, there's not any cure. I was either going to die or get a transplant. I couldn't walk to my letterbox unaided, without a walking frame or oxygen, so I really wanted my life back. I got married in 2010, had a son in 2011, and in 2013 I ended up having a double lung transplant. It's a scary thing but I had to do it myself, for my wife and my little baby. You get wheeled in and the room's massive, totally overwhelming, but everybody knows you, knows what's going on, and so you're put at ease. All those people surrounding you when you're in that bad situation. You can trust every single one of them.

I sort of do things now that people just take for granted. You know, I can take my son - he's only three - take him for a shoulder ride up to the waterfalls at Piha, and take him out in the canoe and stuff. They're things that everybody does and think nothing of it. But when you've been through what I've been through, it's incredible. I can't personally go around and thank everyone. There are loads I've never met. I know they are just doing their job. But just doing their job, it saves lives.



* Note: Throughout this report, patient names have been changed to protect confidentiality

MAXIMISE HEALTH AND WELLBEING

'People will be supported to be healthier and take greater responsibility for their own health'

***Impact measure:* 92%** *of our eligible population received a heart and diabetes check, an increase from 80% in Q1 13/14*

55.3% *of patients that have had an ischaemic event are receiving and adhering to their triple therapy medication (Q3 14/15)*

Our population received **540** *coronary revascularisations in 14/15 adding a total of* **840** *quality adjusted life years to our population*

11.3% *of ischaemic stroke patients were thrombolysed (full year), an increase from 8.9% in 13/14*

In order to maximise health and wellbeing we want to see our population taking more responsibility for their own health, at home, in their neighbourhoods and in the everyday places where real health belongs. It is the everyday lifestyle choices that make the difference to individual health and to reducing overall population rates of cancer, cardiovascular disease and diabetes. We need to improve the detection and management of these diseases, as well as ensuring rapid assessment and treatment for patients when they are ill.

Reduced mortality from cardiovascular disease

Cardiovascular disease is the leading cause of mortality in Auckland DHB and it contributes significantly to premature deaths. Cardiovascular disease is largely preventable with lifestyle change, early intervention and effective management. Significant gains have been made over the past decade in the treatment of cardiovascular disease as well as improvements in lifestyle.

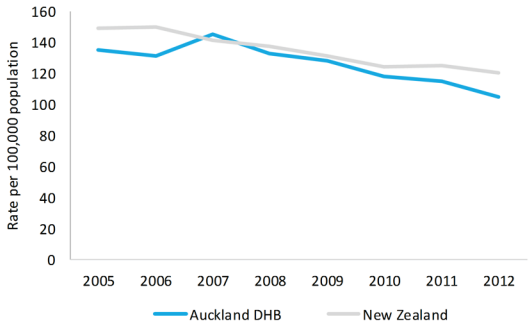
Long-term outcome

A reduction in mortality from cardiovascular disease

104.7
2012*

131.0
2006

Mortality due to CVD has declined steadily over the previous eight years and continues to trend downwards. The rate* in Auckland (104.7 per 100,000 population) is consistently lower than the national rate (120.3 per 100,000 population) and remains among the lowest in the country.



We made strong gains in 2014/15 in ensuring our population at risk of developing cardiovascular diseases are detected early and those developing disease are well managed. Ninety-two percent of our eligible population are now having their cardiovascular disease risk assessed, an increase from 80% from September 2013 and is our impact measure in reducing mortality from cardiovascular disease. Of our population that have experienced blood clots that have resulted in a heart attack or stroke, 55.3% are currently receiving and adhering to their triple therapy medication with a slight increase from 54.6% as at March 2013. Among ischaemic stroke patients, we thrombolysed 11.3%, an increase from 8.9% in 2013/14.

540 people in our population, who required surgical intervention for their coronary conditions, received coronary revascularisations. This resulted in over 840 quality adjusted life years gained by our population. This was a slight decrease of 48 QALYs on the previous year.

*Note: Mortality rate calculations require complete coded deaths data. An official 'cause of death' becomes available approximately two years following a death, 2012 is the most recent complete year available.

Carol's story

"I was optimistic that this would give me back my life"

I was diagnosed with pulmonary hypertension in 2006. I couldn't do much without really panting and catching my breath.

Come 2008 my respiratory specialist suggested that I should consider putting myself on the transplant list. I was not in good shape back then. He was telling me that it might take a long time for me to get one, because of my size. The donors often have a much bigger frame. But it was just like a miracle. After just two months of waiting, I had the call from the transplant services in October 2008. It was a big shock. My husband and I went to pick up the kids, just to hold them and talk to them before the operation, because I didn't know if I would wake up after that.

I didn't know what to expect, but I did take the chance, the risk. I was optimistic that this would give me back my life. I wanted to have that energy again to enjoy life, to just walk around with my kids and play with them again, and even just do simple chores at home, which I couldn't do when I was sick. That was the biggest miracle in my life. It was worth the risk. I've been blessed with really good doctors. All the staff are so supportive, informative and friendly. When I was really down and weak, one nurse would hold my hand and just be there for me during that difficult time. I'd like to thank all of them.

Impact measure: ***66%*** *of 50 to 69 year old women had been screened for breast cancer (as at June 2015), a slight decline from 70% at the same point in 2014.*

79% *of eligible 25-69 year old women had been screened for cervical cancer (June 2015), an increase from 75% at June 2014.*

78% *of people diagnosed with cancer survive one year and* ***66%*** *survive five years after their diagnosis, the third highest five-year-survival rate in New Zealand*

We have the lowest smoking rate of any DHB in the country at ***11%*** *a decrease from 17% in 2006*

Increased survival and reduced mortality from cancer

Cancer is the second leading cause of mortality in Auckland DHB and contributes significantly to a high proportion of all premature deaths. To ensure that there continues to be a reduction in mortality from cancer, there needs to be concerted action in prevention, early detection and treatment.

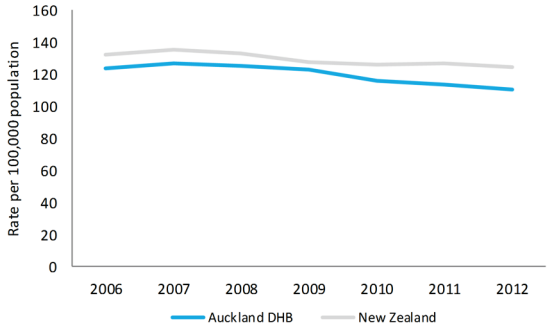
Long-term outcome

A reduction in mortality from cancer

Mortality from cancer has declined steadily over the years and continues to decrease. The rate in Auckland DHB (110.6 per 100,000 population) is consistently lower than the national rate (124.0 per 100,000 population) and is among the lowest in the country.

110.6
2012

123.8
2006



We have made strong gains in cancer screening coverage and reducing the time patients with a high suspicion of cancer wait before receiving their first specialist assessment and their first cancer treatment. Cervical screening coverage rates have increased to 79% at June 2015 from 75% in June 2014. We are making gains in reducing the ethnic inequalities, with a steady increase in coverage within our Asian population from 59% in June 2014 to 66% in June 2015. Screening in our Pacific population remains above the national target at 81% as at June 2015. However, screening in our Māori population remains below target at only 57% as at June 2015. Breast screening coverage overall was at 66% at June 2015, a slight decrease on the previous year, due in part to a change in the eligible population source data. Coverage within our Pacific population at 75%, remains above the national target of 70%, however screening rates in Māori are lower than all other ethnic groups at only 62% as at June 2015.

We are making progress towards reaching the new cancer health target. In Q4 2014/15 59.3% of patients received their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer compared with 50% in Q3 2014/15.

Smoking is one of the most significant risk factor for many cancers. In 2014/15 96% of smokers seen in hospital were provided with brief advice to quit. In primary care 98% received brief advice to quit and 28% received cessation support.

For individuals diagnosed with cancer in 2010-11, the one year survival rate was 77.9%, one of the highest of any DHB, increasing from 74.4% in 1998-1999. Survival rates within Auckland, and nationally, are lower to those observed in some other countries, such as Australia. This is indicative that there is room for improvement in the diagnosis, treatment and care of those diagnosed with cancer.

World class leukaemia and blood cancer centre opened

Every day, six New Zealanders are diagnosed with a blood cancer - that's around 2,200 New Zealanders a year.

Blood cancers combined (leukaemia, lymphoma and myeloma) are the 5th most common cancer in New Zealand and are the third biggest cancer killer.

It is estimated that there are 10,000 New Zealanders living with leukaemia, lymphoma, myeloma or a related blood condition.

Motutapu Ward, the new Northern Region Haematology and Bone Marrow Transplant Unit, officially opened to patients in August 2014. Motutapu Ward is a purposely designed facility that will promote wellness and provide an outstanding environment for patients. This regional facility caters to patients in the upper north island, from Cape Reinga to the Bombays, and beyond. The facility is future proofed to cater for emerging needs and population growth over the next 10-15 years and is in keeping with national and international specifications.

The unit and rooms include evidence based design features, and importantly, have been co-designed with patients. This has resulted in a customised environment which has balanced the patient's clinical and non-clinical needs. There are ten extra beds, which increases capacity by 50%. This will significantly reduce patient waiting times for treatment. Altogether there are 16 single rooms, 3 four-bedded and one double room; fold down beds for family members staying overnight; and ensuites with sluice facilities. The ward is fitted with full HEPA filtration, which constantly circulates clean air, providing optimal infection control. There are two negative pressure rooms (isolated clean air systems). A number of rooms in the unit have dedicated dialysis equipment. This reduces disruption for patients with kidney failure who would previously be transferred to Intensive Care for dialysis.

The goal of the ward redesign was to ensure high standards of patient care, in one place, in the best possible setting for patients and staff, with a focus on promotion of health, rather than illness. Auckland DHB staff were involved from the planning stage and now enjoy a much brighter and more spacious working environment. Patients also have a far improved setting to receive care and treatment.

Over one million dollars was raised by the A+ Trust for the redesign and development of the Motutapu Ward.

Impact measure: ***94%*** *of Auckland children were fully immunised by eight months of age (full year), an increase from 90% in Q4 2012/13*

Children receive the best possible start to life

The creation of healthy generations of children, who can enjoy their lives to the fullest and reach their potential as they develop into adults, is critical to the region's future. The most effective time to intervene in terms of reducing inequalities and improving long term health and wellbeing outcomes is before birth and in early childhood.

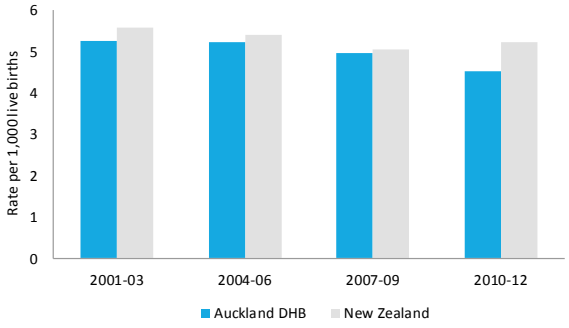
Long-term outcome

A reduction in infant mortality

The infant mortality rate (death of a live-born baby within the first year of life) within Auckland is slightly lower at 4.5 per 1,000 live births (2010-12) when compared with the national rate of 5.2 per 1,000 live births (2010-12). The rate in Auckland has consistently been lower than the national rate.

4.5
2010-12

5.3
2001-03



6,036 *babies were born to Auckland DHB mothers in 2014*

Children visited our school dental services ***79,276*** *times in 2014/15*

We have made substantial gains in ensuring our children experience the best start to life. Our impact measure in child health is increasing our immunisation rates at eight months of age. During 2014/15 we fully immunised 94% of children by eight months of age compared to 90% in 2012/13 and 92% in 2013/14. With our strong focus and ongoing work in this area, we are in a good position to reach the national 95% target over the coming year. Despite not reaching the target, the equity gap is closing with the eight month immunisation rate in Māori children increasing from 81% in Q1 2012/13 to 86% in Q4 2014/15.

96% *of 4 year olds in the Auckland district received their B4 School Check*

The Before School Check 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. We have continued our solid performance this year with coverage rates of 96%, exceeding the 90% national target. We also achieved excellent coverage across ethnicities with 91% of Māori and 94% of Pacific children having their Before School Check.

Through our Rheumatic Fever prevention programme we are making gains in reducing Rheumatic Fever in our population. The programme includes provision of sore throat clinics in identified schools, GP clinics, pharmacies and by referring eligible families to the Auckland Healthy Homes Initiative. We have seen a steady reduction in the three year combined first episode rheumatic fever hospitalisation rate from 3.4 per 100,000 population (45 episodes) in 2009/11 to 2.7 per 100,000 population (38 episodes) in 2012/14.

Reducing the burden of rheumatic fever on our population

*There were **15** first hospital admissions for rheumatic fever in the Auckland district in 2014/15, a decrease from 17 in the previous year.*

Reducing the burden of rheumatic fever is a national priority. Our rapid response services make it easier for children and young people to get their sore throats checked and treated if necessary, by providing family-friendly access to sore throat services in high incidence areas. These services have been established in 39 GP practices and pharmacies and swabbing clinics in 16 schools throughout the Auckland DHB region. The school-based programme's also has an emphasis on improving health literacy and families'/whānau awareness of key rheumatic fever prevention messages.

We have continued our support for the Auckland Healthy Homes Initiative, the joint venture between the National Hauora Coalition and Alliance Health Plus. The initiative identifies families with children living in crowded households and at risk of rheumatic fever. The initiative facilitates access to a range of interventions to reduce crowding and the risk of rheumatic fever. Families identified through our rapid response and school based clinics as well as in hospital are referred to the initiative.

*ADHB delivered school-based throat swabbing clinics in **16** high needs primary schools. Nearly **7000** children were swabbed across the entire Auckland region.*

Immunisation – Preventing disease through vaccination

*We are immunising **94%** of eight month old children on time*

Over recent years we have made substantial improvements and developed initiatives to increase immunisation rates in our priority populations and close the equity gap. Three years ago 88% of Pacific children and 81% in Māori had received their primary series of immunisations by eight months of age. We are now routinely immunising between 94-95% of Pacific children and 88-89% of Māori children on time. These are dramatic improvements on what has been an historical equity gap.

Our strong results in immunisation have been driven by a number of initiatives directly targeting parents as well as working with our health care providers. These include developing general practice resources and increasing knowledge and awareness of immunisation guidelines as well as providing support and education for midwives and general practice staff. We have also developed Outreach Immunisation Services that offer flexible arrangements for vaccination services by providing services both in the home or community settings. This service has now been integrated across Auckland and Waitemata DHBs. We have also established robust processes for opportunistic immunisation by consistently identifying and offering immunisation to children overdue for immunisation, including those presenting at Starship hospital.

Impact measure: ***2.9%*** *of our 0-19 year olds and* ***4%*** *of 20-64 year olds accessed mental health services (full year as at March 2015)*

85% *of mental health clients were seen within three weeks (full year as at March 2015)*

We undertook ***11,528*** *mental health home visits*

94% *of children and youth were discharged from community based mental health services with a transition (discharge) plan (June 2015)*

Reduced morbidity and mortality from mental illness

Mental illness is one of the leading causes of disability and overall health loss in our population. Many common mental health problems, such as depression, anxiety and substance abuse, emerge early in life and have life-long consequences. Ensuring early access to appropriate services for those with mental health problems and substance abuse issues will have a positive impact on health and social outcomes for our population.

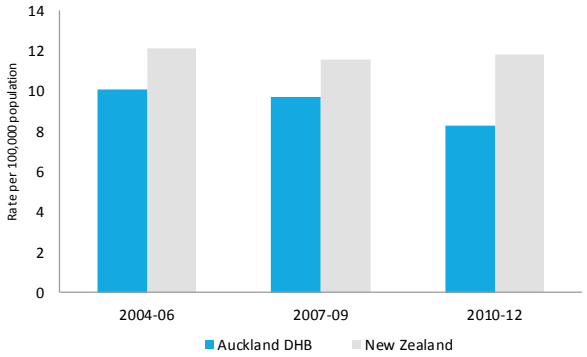
Long-term outcome

A reduction in suicide rates

Our three-year suicide rate (8.3 per 100,000 population) is the second lowest in the country and has consistently declined since 2004-2006. Our rate remains below the national rate (11.8 per 100,000 population). In 2012 there were 45 suicides.

8.3
2010-12

10.1
2001-03



Access rates to mental health and addiction services, our impact measure, have increased in 0-19 year olds from 1.9% in 2009/10 to 2.9% and from 3.3% to 4% in our 20-64 year olds. We have exceeded waiting time targets for mental health, with 85% seen by our services within three weeks and 96% seen within eight weeks. Waiting times for specialist alcohol and drug services are also decreasing with 90% of those aged 19 years and under accessing services within 3 weeks. The recently developed joint Auckland and Waitemata DHB draft Suicide Prevention and Postvention Action Plan for 2015 - 2017 focuses on developing a Suicide Prevention and Postvention Inter-agency Working Group; developing a centralised suicide and self-harm data collection process and workforce development including within primary care focusing on at risk clients and postvention support.

A significant achievement in Maternal Mental Health was the opening of He Kakano Ora, the new Auckland and Waitemata DHB Crisis Respite and Support Hours Service. The service, provided by WALSH Trust, began providing support hours to women in their own homes and residential respite services in June.

A significant amount of work is underway in our most deprived neighbourhoods to find out what services are needed and how these should be delivered. During the past year the focus has been on enhancing mental health services with and for the people of Tamaki. The community want more prevention and early intervention work undertaken in primary care. The DHB and primary health care are now working with the community on a new service design.

Jane's Story

"Even though you think you can fix it yourself, it doesn't work that way. You always need somebody else to talk to."

Red is a colour of strong emotion, and passion, and I'm quite a passionate person. Once upon a time, I was passionate about losing a lot of weight, and I think that that passion suddenly turned to sadness which I think is also red, and anger, and guilt, which is also red to me.

I got referred by a doctor to go to the Kari centre about a year ago, and I've been treated for bulimia nervosa for that long. I wasn't very certain about going. I didn't like the idea of somebody telling me that I had anything wrong with me.

When I got diagnosed, it was quite hard. You don't want to talk to someone about that, it's such a huge insecurity. Even though you think you can fix it yourself, it doesn't work that way. You always need somebody else to talk to. Once I was there and started talking to the counsellor she made me feel very comfortable and I opened up to her straight away. It's just like going to a friend's house. It's where you can go and review your improvements and get a good reflection of how far you've come. Through my journey I've learned to love myself, and more for people around me, which is still red to me. I couldn't have improved or realised how sick I was if it wasn't for the Kari centre, and I'm so grateful for everything they've done for me. I think that coming down to someone's level, and putting yourself in their shoes is probably the best way that you can understand them.

BETTER PATIENT EXPERIENCE AND FINANCIAL SUSTAINABILITY

'People will receive timely, safe and high quality services when they need them, while we ensure these services remain sustainable into the future'

Impact measure: *Staff sick leave hours as percentage of total hours has reduced to 2.9%*

4,132 *Patients completed our local patient survey (2014/15 full year)*

86% *of our adult patients felt staff treated them with respect and dignity while they were in hospital during February 2015, an increase from 82% in November 2014*

We have a significant role to play in providing safe, high quality care. People who use our services should have a high level of trust and confidence in the health system and rate their experiences positively. We need to ensure rapid access to diagnosis and treatment for patients and consumers and a smoothly integrated transition between the providers of care. In addition we are also focused on the sustainability of our organisation, ensuring that our services are provided in a financially sustainable manner and managed efficiently

Better patient experience

Patient experience is an important indicator in assessing the quality of the care we provide and is strongly linked to overall health outcomes. Our focus is on individualised care and tailoring of services to meet patient and whānau needs and engaging them as partners in their care. An enhanced patient experience leads to better emotional health, symptom resolution, less reported pain and more effective self-management. We also have concentrated on the key outcomes for other important constituencies that support us. Primarily this is our clinical and non-clinical staff. We know that an engaged and satisfied workforce is linked with better patient experience and improved health outcomes.

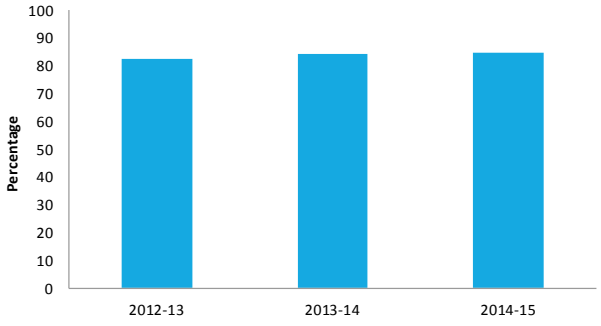
Long-term outcome

An increase in the percentage of patients that rate their care and treatment as very good or excellent

84.7% 2014-15

82.6% 2012-13

Measuring patient satisfaction with care received is a useful way of determining if we are doing the right things and allows us to identify areas where we can improve on the services we provide our patients. The percentage of inpatients rating their care as very good or excellent has increased from 82.6% in 2012/13 to 84.7% in 2014/15.



Over the past three years more than 12,000 patients have completed our inpatient experience survey. Their ratings and comments have provided us with invaluable feedback about what matters to our patients, what dimensions of care make the most difference to them, how they rate our performance, what we are doing well and suggestions for improvement. We are now using the feedback from our patients in redesigning the public spaces within our hospitals and in the design of our 'patient and whānau centred care' programme.

Teuila's story

"I know all the staff well, and they do awesome work"

When I first got sick, it was a sort of 'get-on-with-it' feeling.

I've always been optimistic. It's just part of the routine now. I am a long-term patient here and a mother of two children. I come in for treatment and then off to work. I'm so used to coming in and having dialysis and going to work. It's such a normal part of my life.

So I know all the staff well, and they do awesome work. I've known the ones who have been here as long as me and they're just awesome. You're informed upfront and if you have any concerns you can go to them. They know what they're doing and I trust them. That's the thing. You can tell them, 'Look, this isn't working', and they work around it. Because, for me—working, kids, dialysis— I'm a bit of a nightmare. I can come any time of the day and they accommodate me and that's what makes it work.

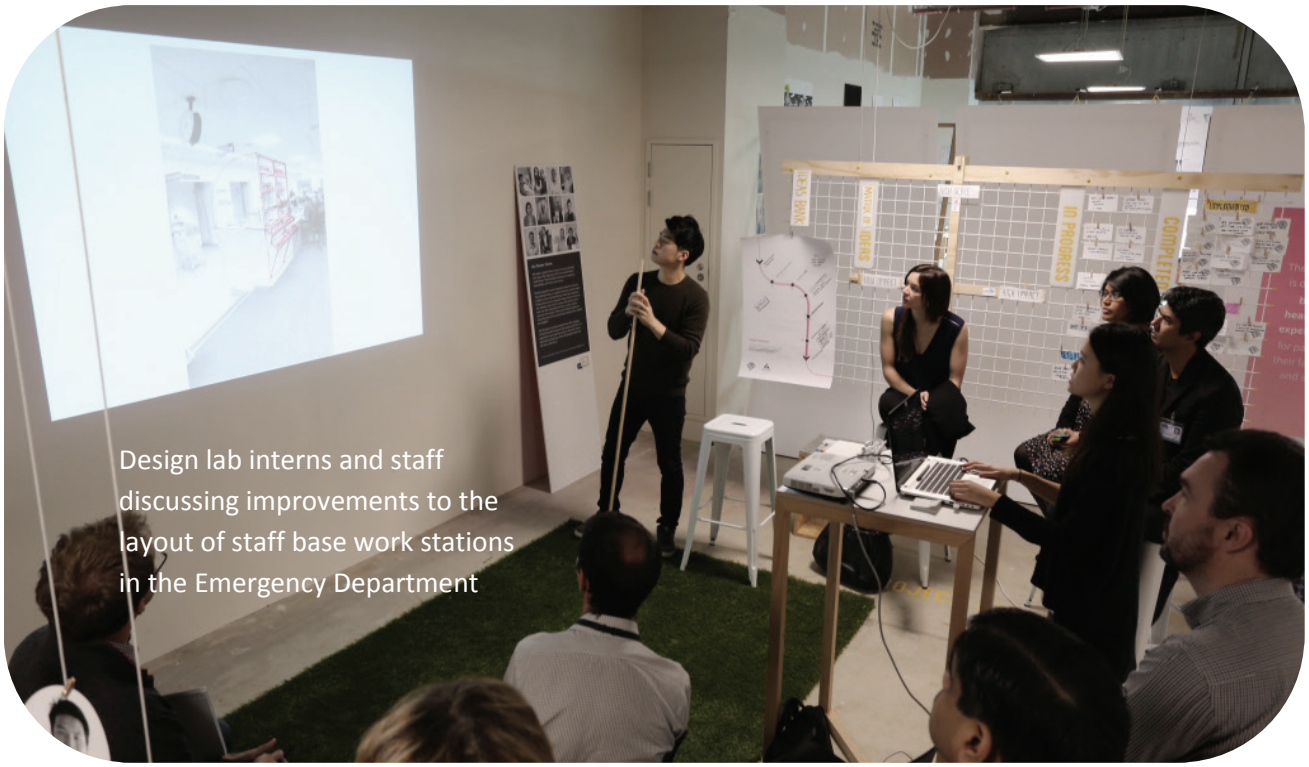
Design for health and wellbeing

'Improving healthcare experiences for patients, their families and our staff'

Child-friendly medical equipment and navigation guides are among the patient-friendly innovations being created at a first-in-kind hospital design centre to improve the experience of staff, patients, families and visitors. Situated within the Auckland City hospital grounds, Auckland District Health Board and the Auckland University of Technology (AUT) have joined forces to establish the Design for Health and Wellbeing Lab.

Working on a project-by-project basis in the areas of graphic, product, and service design, the Lab is characterised by its empathetic, user-centred approach to solving complex hospital-based design problems. The Lab is a working knowledge hub that encourages staff, patients, families and other hospital users to ask questions, share insights, challenge assumptions, and contribute to meaningful design outcomes. It further aims to reduce the physical and emotional complexities that may arise in the healthcare environment and in the delivery of care. Being located within New Zealand's largest public hospital provides an authentic learning and development environment and is already delivering design-led solutions to the DHB.

The team at the lab is currently working on diverse patient-centred projects that place the experience of the patient and their families at the forefront and enhance the DHB's clinical expertise. The lab complements Auckland DHB's existing teaching and innovation ethos as well as bringing an entirely new capability into the organisation. The lab will create a further vital link with patients, families, staff and all those who interact with our services to improve the health of our community and improve health outcomes.



Design lab interns and staff discussing improvements to the layout of staff base work stations in the Emergency Department

Impact measure: ***100%*** *of patients waited no longer than four months for their first specialist assessment and* ***99.5%*** *waited no longer than four months to begin treatment (June 2015)*

There were ***102,792*** *attendances at our Emergency Departments*

We discharged, admitted or transferred ***94%*** *of patients attending ED within 6 hours*

91,874 *first specialist assessments were provided at outpatient clinics*

Timely access to hospital services

Ensuring timely access is one of the most important elements of health care. Patients waiting for health services face undue stress in addition to their underlying health conditions. We have made a priority of working to reduce wait times. A core element of reducing wait times has been our investment in medical specialists and infrastructure required for treatment as well as improving and refining our clinical pathways.

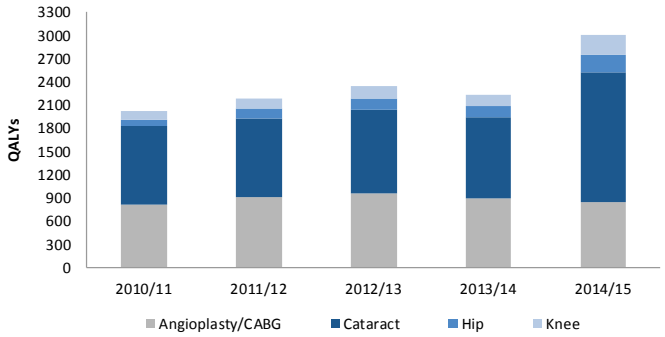
Long-term outcome

An increase in Quality Adjusted Life Years gained from selected procedures

3,009
2014-15

2,232
2013-14

Surgery significantly contributes to quality of life by remedying or improving disabling conditions. Using the measure of quality adjusted life years (QALY) it is possible to estimate the number of quality years of life gained by our population through five procedures for which QALYs have been calculated. In 2014/15 our population gained a total of 3,009 QALYS, an increase of over 770 QALYs on the previous year.



In 2014/15 we delivered 13,902 elective procedures, an increase of 2% on the previous year and exceeding our target of 13,872. Waiting times for elective surgery, our main impact measure in timely access to hospital services, have reduced with 100% of patients waiting no longer than four months for their first assessment, and nearly 100% waiting no longer than four months for their first treatment. Our emergency departments are performing well with 94% of patients waiting no longer than six hours to be admitted, transferred or discharged.

Diagnostic imaging is a critical element in reducing the overall waiting time of a patient's care and in the last year MRI volumes at Auckland DHB increased by 6% and CT volumes by 4%.

*Impact measure: Central line infections are consistently below **1 per 1,000** line days*

*Over **95%** of older patients are having their risk of falling assessed*

*Compliance with the five moments of hand hygiene is nearly **80%** across all wards and **84%** within the nationally identified seven high risk clinical areas*

*The rate of healthcare associated Staphylococcus bacteraemia fell to **0.24** per 1,000 inpatient bed days in 2014/15*

High quality and safe services

To provide the very best care for all our patients, we need to ensure that the care we provide is safe and clinically effective. We have continued improving quality and safety through our First Do No Harm programme, being open and transparent about our performance and monitoring the Health Quality and Safety Commission's quality and safety markers (QSMs). We have aimed to improve in all areas of harm identified in the national patient safety campaign: Open for better care.

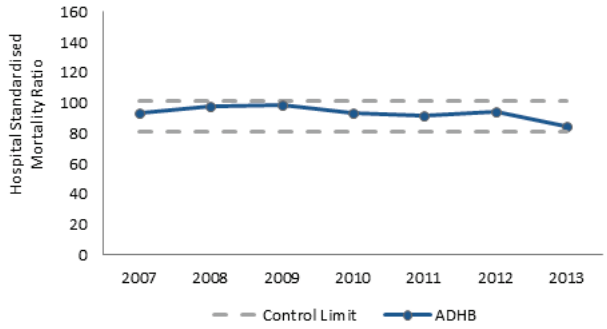
Long-term outcome

A reduction in the Hospital Standardised Mortality Ratio

85
2013

98
2009

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare outcomes that measures whether the death rate 30 days after hospital admission is higher or lower than would be expected compared to a 2007 baseline. Our HSMR has been steadily declining and is now lower than the national figure.



During 2014/15 we improved our compliance across the HQSC markers including good hand hygiene practice from 76% (Oct 2014) to 78% (June 2015) and the rate of central line infections are regularly below 1 per 1,000 line days. We have decreased the number of patient falls resulting in major harm from 1 per 5,000 bed days to less than 1 per 10,000 bed days. Our reported adverse events causing harm per 1,000 bed days was 0.3 for the year (0.26 for 2013/14) – however this fluctuated significantly over the year between 0.17 and 0.58. Our results in these areas have been driven by our clinicians working in partnership with patients, their whānau, the community, and our quality improvement team.

Through our partnership with the Design School at AUT, we have implemented projects aimed at making our physical environment easy to navigate, with good way finding, and well-designed spaces that contribute to the good health and wellbeing of staff and patients. A number of other projects and ward re-designs are planned and these will be rolled out over the coming year.

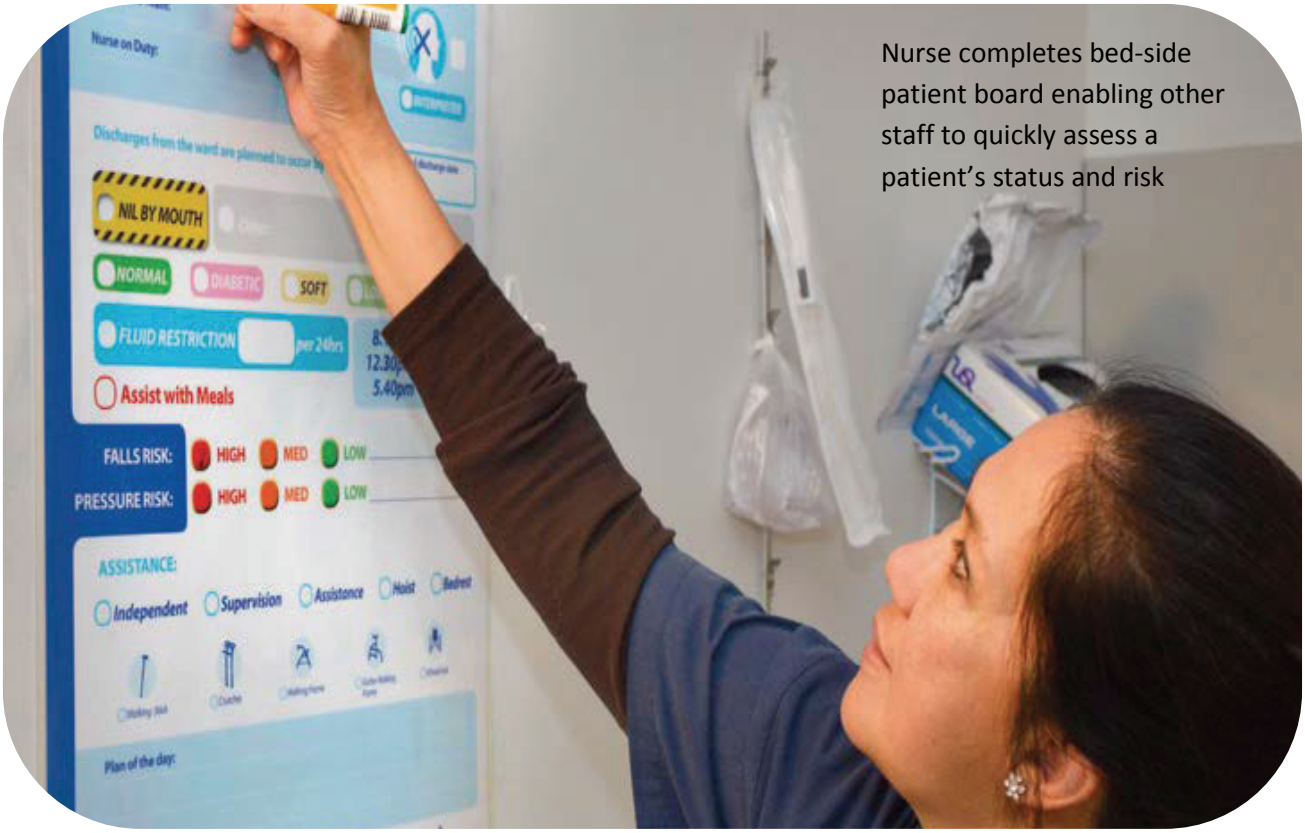
Best foot forward to reduce falls

Preventing patient falls and related injuries in healthcare settings is a goal for our hospitals. Falls are a high-risk and high-cost problem for all healthcare facilities.

Our focus on falls reduction is part of the First, Do No Harm regional campaign to prevent harm to patients from adverse clinical events while in our care. Coloured wristbands and a confusion screening tool are some of the latest techniques being used at Auckland City Hospital to help reduce the number of patients falling in wards.

The 'Falls Concept Ward' introduces a range of innovative and tested initiatives developed by Older People's Health specialists with an aim to reduce falls with harm by 20 percent. It is the latest concept by a dedicated team of health, nursing, medical and quality and safety staff who are working together to reduce that figure.

One of the new ideas includes patients wearing red, orange or green coloured wristbands to distinguish the mobility assistance they require - Red for hands-on assist, orange for supervision, and green for independent. Special focus is also being made of bed positions, toileting needs, and pain and medication levels. Other initiatives include sticky socks, improved toilet signage and post-fall review processes.



Nurse completes bed-side patient board enabling other staff to quickly assess a patient's status and risk

Health and Safety

'Strong Health and Safety leadership and commitment to safety for all'

Auckland DHB is committed to providing a safe and healthy environment for staff, patients, students, volunteers, contractors and visitors who work and use our facilities. Health and Safety is a top priority of the board, which has an active involvement in all aspects of Health and Safety in Auckland DHB. A Health and Safety Charter has been developed, adding weight to our existing Health and Safety Policy along with an independent health and safety systems audit in preparation for the changing health and safety legislation expected early 2016. Regular reporting is provided to the board so that health and safety risk across the organisation is transparent and can be addressed in a timely manner. Health and Safety key performance indicators and reporting has been integrated within the Management Operating System at Directorate and Service level and is a priority across the organisation. An audit schedule for 2015/16 is in place to monitor the organisation's standards and practice, a schedule which has benefited from working with our colleagues at Waitemata and Counties DHBs.

We have begun work to obtain Enviro-Mark certification. This work will ensure we have an effective system to reduce our environmental impacts and meet all the energy use and waste minimisation obligations expected from a responsible public service.

Hazard identification and risk management applies to all aspects of the work environment including the physical spaces, hazardous substances, biological hazards, ergonomic and psychosocial hazards that may put our workers and others at risk. The Occupational Health and Safety team work closely with Estates and Facilities to minimise these risks.

Auckland DHB maintains the highest rating in the ACC Partnership Programme and this enables us to ensure that staff injured in our workplace receive optimum care and return to work quickly and safely. Similarly, we made changes to our EAP provider which has seen a new contract in place for independent counselling and promoting wellbeing in the workplace. Auckland DHB is committed to continuous improvement in organisational culture, security and general wellbeing of our workers. The Auckland DHB Staff Wellbeing committee has been refreshed and re focused on the World Health Organization (WHO) healthy workplaces framework. Auckland DHB has held the HeartBeat Challenge award, as recognition for initiatives related to staff wellbeing, for the past 8 years and has developed an extensive work plan to advance work. Other successful staff wellbeing initiatives include the Staff Seasonal Influenza Campaign, which delivered over 7,500 vaccinations to our workers and achieved a voluntary 78% vaccination rate for patient contact staff.

We have achieved a ***break even*** *financial position for the past* ***seven*** *years*

Financial sustainability

We must ensure we are on a sustainable financial path into the future. This is extremely challenging in the current fiscally constrained environment that is also characterised by increasing demand for services (reflecting our population demographics) and operating costs and capital related costs growing at a pace faster than the funding growth.

Long-term outcome

Staying within budget

In 2014/15 we have 'lived within our means' and exceeded our forecasted budget expectations by delivering a financial surplus of $355k. This has been achieved in the face of reduced funding growth and managing to contain costs to affordable levels by providing services in a more efficient and cost effective way. We have commenced a number of business transformation and performance improvement initiatives that were identified and implemented by our staff. Further savings from national and regional initiatives will ensure we are well placed to continue delivering positive financial results in the coming years.

Financial year result ($,000)			
11/12	12/13	13/14	14/15
$737	$154	$264	**$355**

$49.55M *of savings achieved in the year to June 2015 through business transformation and efficiency improvements*

Our positive 2014/15 financial result has been driven by a number of cost saving projects within the DHB. We have focused on improving our surgical and theatre efficiency through refining patient pathways, streamlining our booking and scheduling system and reducing the need to outsource. Alongside this we have developed a nursing/midwifery model of care strategy to ensure we deliver the same standard of care throughout the organisation. Bed management has also been a key area of focus, ensuring we have the right clinical capacity at the right times – flexible staffing levels have assisted in managing low and high peak periods.

The rate of acute inpatient bed days has declined every year over the past five years, in 2014 there were ***392*** *acute inpatient bed days per 1,000 population, a decrease from 400 in 2013*

Clinical supply costs form a large proportion of our budget. Working with the healthAlliance supply chain teams has allowed us to realise the benefits from being a high volume buyer. Suppliers' contracts have been negotiated in closer alignment with the national catalogue and pricing, while standardising the product list. We have worked with theatres and ward staff to optimise materials and replenishment activities in line with supply chain levels. We have also sought to manage non clinical costs through reviewing third party contracts to improve service performance and delivery of services. This has resulted in cost savings in linen, waste management and printing.

The rate of ambulatory sensitive hospitalisations (ASH) has remained fairly stable over the last 5 years. In the 12 months to March 2015 the ASH rate was ***1,866*** *admissions per 100,000 –* ***93%*** *of the national average rate.*

Better management in the area of human resources has also resulted in significant savings. Management of staff vacancies, SMO job sizing allowances, skill-mix reviews, annual and sick leave monitoring and judicious use of bureau staff has allowed us to manage personnel costs more effectively.

WHAT DIFFERENCE HAVE WE MADE FOR THE HEALTH OF OUR MAORI POPULATION?

As a DHB we are committed to achieving the very best health outcomes for Māori and reducing inequalities. We want to see our Māori population living longer and enjoying a better quality of life. We want to see a system that is responsive to the health needs of our Māori population and is integrated, well resourced, and sustainable so that the gains we make today can be built upon by future generations.

Increase life expectancy in our Māori population

We have seen a steady gain in life expectancy among our Māori population with a gain of 4.2 years over the past decade. Māori living within our district experience among the highest life expectancy of Māori across all DHBs. The gap in life expectancy between Māori and other ethnicities has reduced from 7.5 years in 2003-05 to 5.2 in 2012-14. Higher mortality rates at a younger age from cancer and cardiovascular disease contribute over three years to the current 5.2 year gap.

78.5
2012-14

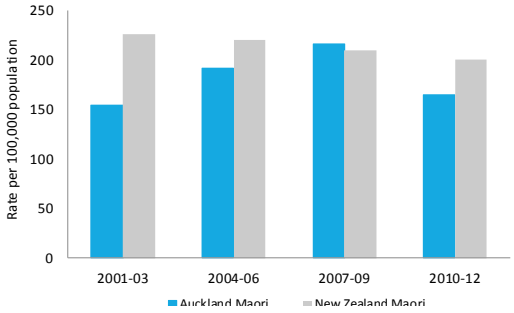
74.3
2003-05

Mortality from cancer among Māori

The mortality rate from cancer among our Māori population increased between 2001 and 2009, however has since declined and is now lower than the national Māori rate. The mortality rate from cancer remains over 50% higher than non-Māori within our district and remains the leading cause of death within our Māori population.

165.1
2010-12

192.1
2004-06



Life expectancy of our Māori population is among the highest in the country at ***79.4*** *years (2012-14)*

Smoking rates among our Māori population have declined from 37% in 2006 to ***26%*** *in 2013 and are the lowest of any DHB*

3,194 *Māori smokers received behavioural support to quit either with a referral to 'quit smoking' services or pharmacological smoking cessation aids (full year)*

62% *of eligible Māori women were screened for breast cancer (as at June 2015)*

We have made strong gains in Māori health over the past few years. Immunisation rates in eight month old Māori children increased from 77% in Q4 2012/13 to 87% in Q4 2014/15. B4 school checks in Māori children are well above the national target with 95% of children receiving their B4 School check in 2014/15 against a target of 90%. Cervical screening uptake in Māori women has remained relatively unchanged at between 56-57% over the previous three years. Māori receiving a heart and diabetes check has increased from 78% in Q1 2013/14 to 89% in Q4 2014/15. We are now supporting our Māori population to quit smoking better than ever with 98% of Māori smokers accessing primary care and 96% (Q4 2014/15) accessing our hospitals, receiving brief advice to quit.

*There were **786** Māori tamariki born in Auckland in 2014*

__86%__ of Māori tamariki are fully immunised on-time by 8 months of age (full year)

__89%__ of eligible Māori received a heart and diabetes check in the last 5 years (June 2015)

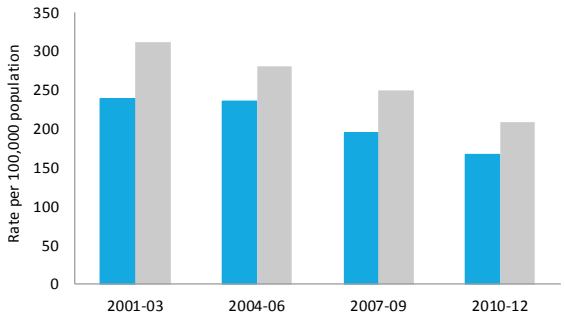
__85%__ of Māori diabetics received their annual review (full year)

Mortality from cardiovascular disease among Māori

166.8
2010-12

235.6
2004-06

The mortality rate from cardiovascular disease among our Māori population has significantly declined and is consistently lower than the national rate for Māori. However, the rate remains around 50% higher than non-Māori within our district and is the second leading cause of death within our Māori population.



Auckland DHB continued to support and roll out the Primary Care Ethnicity Data Audit Tool. We have exceeded the target of 95% of general practitioner practices implementing the audit tool by 30 June 2015 with implementation currently at 98%. This represents 234 practices across Waitemata and Auckland DHBs. Auditing of ethnicity data allows identification of errors. Being able to accurately identify those practices with high volumes of enrolled Māori patients helps us to focus services more appropriately

In June we finalised our new Māori Health Outcomes Framework. The framework (Ngā Painga Hauora) was developed in collaboration with Sir Mason Durie and Māori health providers throughout Auckland and Waitemata DHBs. The primary purpose of the framework is to measure the contribution the health sector is making towards improved health outcomes for Māori. In the first instance the framework will be used to measure the contribution Māori providers are making to Māori health outcomes as part of the integrated contracting process. Following this, the framework will be used to support measuring and reporting the health sector's contribution to Māori health outcomes.

Over the past year we have had a strong emphasis on developing our Māori health workforce. The joint Auckland and Waitemata DHB Māori Workforce Development strategy was officially endorsed by all major stakeholders including Te Runanga o Ngati Whatua and the Māori Health Gain Advisory Committee. We have also targeted young Māori to consider careers in health. The Kia Ora Hauora symposium targeted Year 10-13 students. A range of sessions were held over two days showcasing 12 different health professions and presentations from all the major tertiary study providers. A further symposium is planned for 2016.

Auckland and Waitemata DHB continue to allocate HWNZ Hauora Māori Training funding to students of the National Urban Māori Authority's Whānau Ora Diploma. A number of students have now graduated with a further intake taking place in July 2015.

BEING A GOOD EMPLOYER

Our vision is:

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

*We have **10,219** employees at Auckland DHB (8,160 FTE)*

Of our employees:
***49%** are NZ/European*
***3%** are Māori*
***8%** are Pacific*
***22%** are Asian*
***18%** are Other ethnicities/not stated*

***79%** of our employees are female and **21%** are male*

We strive to be a good employer at all ages and stages of our employees' careers. Auckland District Health Board is committed to meeting its statutory, legal and ethical obligations to be a good employer including providing equal employment opportunities (EEO). This is supported by policy and our good employer practices relating to the recruitment, pay and other rewards, career development and work conditions of all staff.

Our Good Employer policy makes clear that we will:

- Recognise the aims, aspirations and employment requirements of Māori people
- Recognise the aims, aspirations, cultural differences and employment requirements of Māori and Pacific Island people and people from other ethnic or minority groups
- Provide an organisational culture, with strong clinical leadership and accountability, where everyone is able to contribute to the way the organisation develops, improves and adapts to change
- Ensure that employees maintain proper standards of integrity and conduct in accordance with our values
- Provide a healthy and safe workplace
- Provide recruitment, selection and induction processes that recognise the employment requirements of women, men and persons with disabilities
- Provide opportunities for individual employee development and career advancement

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. The following innovative programmes show our commitment to being a good employer and employing a diverse workforce to care for our district and regional populations.

Leadership, Accountability and Culture

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. Our shared values of *Welcome, Respect, Together* and *Aim High* reflect what our staff and patients told us were important to them. These values guide us in the way we do things, the decisions we make and the internal culture that we strive for.

Auckland DHB champions clinical leadership, with a single point of accountability for a directorate now held by a clinician who is ultimately accountable for delivering results.

The DHB provides a comprehensive leadership development programme including modules and sessions designed to develop new leaders and grow new skills in developing people and performance, personal effectiveness, resolving conflict, coaching, cultural competency and leading our values.

The DHB participates in the HWNZ Leadership and Management Workstream.

*The average age of Auckland DHB's employees is **43**. 30% of staff members are aged 50 or over.*

__47%__ of our employees work part time (incl. casual staff)

__0.2%__ of our employees have declared a disability

__43%__ of our employees are in nursing related professions, making it the largest proportion of the workforce.

Recruitment, Selection and Induction

The DHB has a strong focus on growing and building the capacity of our Maori and Pacific workforces, with several programmes including:

The Rangatahi Programme has been developed for Māori and Pacific Island senior secondary school students to facilitate Māori and Pacific student recruitment and retention in secondary school, tertiary education, and transition into the health workforce.

A+ Trust Scholarships are provided for Maori and Pacific students.

Employee development, promotion and exit

Auckland DHB is committed to providing development opportunities for individuals, teams and services:

- Annual performance reviews are held for all staff and individual training and development objectives set. Numerous clinical, technical, and non-clinical internal training programmes and workshops are provided
- Senior Medical Officers are able to take sabbatical leave for the purposes of strengthening or acquiring clinical knowledge or skills or undertaking an approved course of study or research in matters relevant to their clinical practice. It is also a time for reflection and personal development
- The Pacific Nurse Educator provides clinical support, supervision and mentorship of Pacific nursing undergraduate students, new graduate nurses and MoH funded post graduate programme students
- The ANIVA Nursing Leadership programme funds 3-5 Pacific nurses annually to complete post–graduate programmes in Leadership
- Exit interviews and surveys conducted with departing staff
- Alumni programme in place to connect past employees of the DHB and develop and maintain professional networks.

Flexibility and work design

The DHB offers flexible rostering practices, subject to clinical requirements, and this is demonstrated by our large part time workforce.

A staff crèche/early learning centre is provided on each of the two major sites.

Remuneration, recognition & conditions

ADHB recognises the valuable contribution our staff make to patient care through recognition programmes and/or awards:

- Local Heroes awards recognise the people in the Auckland DHB team who go above and beyond to make sure patients get the best possible care
- Awards to publically acknowledge staff who deliver sustainable improvements for our patients and the organisation
- Long service awards
- Tributes to retiring staff through a tribute in NOVA.

The majority of staff are on transparent Multi Employer Collective Agreements. The annual review of IEA remuneration is based on external market data and employee performance. Job size is determined using a job evaluation methodology that meets the NZ standard for gender neutrality.

Harassment and bullying prevention

Harassment and bullying prevention is very important to Auckland DHB. A 'Values in Practice' workshop has been developed and will be rolled out in the organisation in 2015/16. Harassment Prevention and Workforce Violence Prevention policies are in place and bullying and harassment coaching seminars are offered and conducted.

Safe and healthy environment

Auckland DHB has a focus on providing not only a safe and healthy workplace but to also promoting Workplace Wellness. ADHB's 300 health and safety representatives are encouraged to be 'Wellness Champions', and there are a large number of Wellness initiatives in place covering nutrition, physical activity, smokefree, and general health. Workstation assessments, occupational health assessments and work area safety checks are carried out.

Auckland DHB has a Workplace Violence Prevention Committee. The purpose of this committee is to provide a co-ordinated approach to the implementation of the Auckland DHB Workplace Violence Prevention Policy. This committee has representatives from key stakeholders, the objectives of the committee are to;

- Promote safe systems of work and safe environments for staff in relation to potential verbal or physical aggression from patients or visitors
- Direct the annual strategy for Workplace Violence Prevention within Auckland DHB.

Auckland DHB has longstanding child protection and family violence policies that enable us to comply with the Vulnerable Children's Act. The policies are operationalised through a variety of mechanisms, all of which involve the multidisciplinary identification and assessment of babies and children at possible risk of harm. A practice framework to help Auckland DHB community and hospital based staff identify and manage actual and/or suspected child abuse and neglect is well established.

We have implemented new recruitment processes to comply with safety checking regulations. In order to create an organisation-wide culture of child protection, all interviews include specific Vulnerable Children's Act questions.

STATEMENT OF PERFORMANCE

Overview

The Statement of Performance (SP) presents a snapshot of the services provided for our population and how these services are performing, across the continuum of care provided. The SP is grouped into four output classes: Prevention services, Early Detection and Management, Intensive Assessment and Treatment and Rehabilitation and Support Services. Each output class section includes measures which help to evaluate the DHB's performance over time, recognising the funding received, Government priorities, national decision-making and Board priorities. These measures 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. Some of the measures in each section reflect the performance of the broader health and disability services provided to Auckland residents, not just those provided by the DHB. We have a particular focus on improving health outcomes and reducing health inequalities for Māori. Therefore, a range of measures throughout the SP monitor our progress in improving the health and wellbeing of our Māori population, as identified in the Auckland DHB Māori Health Plan 2014/15.

Measuring our outputs helps us to understand how we are progressing towards our impacts, and high level outcome measures of an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Auckland DHB population is now 82.5 years, an increase of 2.6 years since 2004. The life expectancy gap is 5.2 years for Māori and 6.5 years for Pacific.

National health targets

2014/15 was a year of impressive achievements for our DHB. Maintaining and improving key areas of service delivery and sustained efforts with our primary care partners have had positive impacts on our performance. Results below show the fourth quarter's performance result as well as a 12 month result where relevant.

Health Targets		Target	Q4 2014/15	Full Year
Shorter Stays in Emergency Departments	95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours.	**95%**	**95%**	**94%**
Improved Access to Elective Surgery	An increase in the volume of elective surgery by an average of 4000 discharges per year	**13,872**	**n/a**	**13,902**
Shorter waits for Cancer Treatment	All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy (Q1 only)*	**100%**	**n/a**	**100%***
Faster Cancer Treatment	85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment.*	**85%**	**60%**	**59%**
Increased Immunisation	95% of eight months olds will have their primary course of immunisation on time.	**95%**	**94%**	**94%**
Better Help for Smokers to Quit	95% of hospitalised smokers and	**95%**	**96%**	**96%**
	90% seen in primary care provided with advice to help quit	**90%**	**97%**	**98%**
More Heart and Diabetes Checks	90% of the eligible population have had their cardiovascular risk assessed over the last five years	**90%**	**92%**	**92%**

*From October 2014, the Shorter Waits for Cancer Treatment target was changed to Faster Cancer Treatment – 85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management), to be achieved by July 2016. Therefore the full year result shown for the Shorter Waits for Cancer Treatment health target is actually just for quarter one.

Output class measures

During 2014/15 we reviewed the criteria against which we measure our output performance for the year. As a result of this review we have developed a new grading system - below - and this has been applied to assess performance against each indicator in the Output Measures section. While this differs to that presented in the 2014/15 Annual Plan, it should give a clearer picture of our performance for the year and better identify those areas which require continued focus to ensure achievement. A rating has not been applied to to demand driven indicators.

Criteria		Rating	
On target or better		Achieved	
95-99.9%	0.1% - 5% away from target	Substantially Achieved	
90-94.9%	5.1% - 10% away from target*	Not achieved, but progress made	
<90%	>10% away from target**	Not Achieved	

*and improvement on previous year
** or 5.1-10% away from target and no improvement on previous year

The following tables include our output measures from the 2014/15 Statement of Performance by Output Class. Outputs are goods or services 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.

Symbol	Definition
Ω	Measure is demand driven – not appropriate to set target or grade the result
↓	A decreased number indicates improved performance
↑	An increased number indicates improved performance
Q	Measure of quality
V	Measure of volume
T	Measure of timeliness
C	Measure of coverage

Output Class 1: Prevention Services

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations. These services are designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes 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	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Percentage of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	Q	97.7%[1]	97%	95%	96%	●
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit	Q	55.2%[2]	99%	90%	98%	●
Number of people accessing Green Prescriptions	V	4,953	4019	6,062	5003[3]	●
Enforcement of the Smokefree Environments Act 1990						
Number of retailer compliance checks conducted	V	457	302	300	284[4]	●
Number of retailers visited where Controlled Purchase Operations (CPOs) were conducted	V	498	227	300	284	●
Enforcement of alcohol legislation						
Number of license applications[5] risk assessed	V	1,235	1226	1200 est.	4,354	●
Number of premises visited where joint Controlled Purchase Operations (CPOs) were conducted (alcohol)	V	325	180	400[6]	284[3]	●
Legislation advocacy and advice						
Number of submissions made (demand driven)	V	26	45	25 est.	55	●

HEALTH PROTECTION

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Communicable disease surveillance and control activities						
Total number of communicable disease notifications	V	5597	6,115	5,500 est	5617	●
Number of notifications investigated and found to be a confirmed or probable case	V	4706	4941	4,500 est	4564	●
Tuberculosis (TB)						
Number of TB contacts followed up	V	795	1080	750 est.	821	●
Percentage of TB and LTBI (Latent TB Infection) cases who have started treatment and have a recorded start date for treatment	Q	81%	84%	≥85%	99.9%	●
Percentage (and number) of eligible infants vaccinated with a BCG	C	98.4% (4,811)	98.3% (4613)	≥99% (4800)	97.1%	●

[1] Baseline data in 2014/15 Annual Plan was incorrect, figure should have been 96%
[2] Baseline data in 2014/15 Annual Plan was incorrect, figure should have been 60.5%
[3] MoH provided extra funding to increase target in 2014/15. ADHB is working with Sport Auckland to increase referrals in 2015/16.
[4] Lower than target as ARPHS had a CPO officer position vacant, all positions have been filled as of August 2015.
[5] On, off club and special. An 'on- licence' authorises the holder to sell and supply liquor for consumption on the premises (e.g. pub) as opposed to off- licences (e.g. liquor stores)
[6] Target changed in-year to 325.

HEALTH PROTECTION (continued)						
Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Refugee health screening service						
Number of quota refugees screened[7]	C	848	778	750	771	
Percentage of quota refugees commencing a vaccination programme as per NZ immunisation schedule	C	98%	new measure	98%	100%	
Drinking water quality						
Percentage of the population that received drinking-water from fully compliant supplies	Q	97%	new measure	≥95%	97%	

Note the services described in the above tables are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. The data to support all above measures is for all three metro Auckland DHBs.

POPULATION BASED SCREENING						
Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Breast Screening						
Coverage rates among eligible groups	C	70%	71%	70%	66% [8]	
Newborn Hearing Screening						
Number/proportion of babies screened	V	8493 or (100%)	8452 99.9%	76%	8452 97.3%	
Referral rate to audiology <=4%	Q	1.75%	2%	<=4%.	1.79%	
Appropriate medical and audiological services initiated by 6 months of age for infants referred through the programme.	T	100%	100%	>=95%	100%	

Output Class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various private, not-for-profit and government service settings. These include general practice, community and Māori health services, pharmacist services, and child and adolescent oral health and dental services. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Ensuring good access to early detection and management services for all population groups, including prompt diagnosis of acute and chronic conditions, management and cure of treatable conditions, contributes to preventing, ameliorating and curing ill health. Early detection and management services also enable patients to maintain their functional independence and prevent relapse of illness.

PRIMARY HEALTH CARE						
Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Primary care enrolment rates[9]	C	92%	92%	95%	92%	
95% of eight month olds fully immunised by December 2014	C	94%	93%	95%	94%	
Cervical screening coverage	C	77.1%	77%	80%	79%	
Percentage of B4 School Checks completed	C	37%	76%	90%	96%	
Percentage of diabetes patients with satisfactory or better diabetes management (HbA1c ≤64mmol/mol) *	Q	71%	70%	75%		
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	C	83.2%	92%	90%	92%	
GMS claims from after-hours providers per 10,000 of population	T	296	310	Ω	481	
Proportion of practices with cornerstone accreditation	Q	50%	42%	↑	49%	

*** Note**: The diabetes good management indicator results are unavailable due to inadequate data reporting systems. To be rectified in 2015/16.

[7] The NZ Government, in agreement with the UN, has a refugee quota programme which offers 750 places per year (+/- 10%).
[8] The number of screens carried out in the period to June 2015 was greater than the June 2014 volume, however the 2015 result uses the 2014 population projections as the denominator, which are significantly higher than the previous projections, therefore the coverage appears lower.
[9] Numerator 2015-Q2 enrolments, denominator 2014/15 population projections (2014 update)

COMMUNITY REFERRED TESTING & DIAGNOSTICS

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Number of community laboratory tests by provider - Diganostic Medlab (DML)[10] - Labtests Auckland (LTA)	V	349,007 2,634,222	116,920 2,897,438	Ω	4,544 3,068,105	
Number radiological procedures referred by GPs to hospital	V	40,666	44,350	Ω	46,790	
Number of complaints by community laboratory provider[11]	Q	LTA = 60	28	↓	LTA=31	
		DML = 29	29		No longer collected	
Average waiting time in minutes for a sample of patients attending collection centres between 7am and 11am	T	7.4 mins (LTA)	6.6 mins	< 30 mins	7.7 mins	
Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks	T	CT 89% MRI 66%	CT 89% MRI 60%	CT 90% MRI 80%	CT 82% MRI 44%[12]	

ORAL HEALTH

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Enrolment rates in children under five by ethnicity: • Māori • Pacific • Other • Total population	C	2,633-62% 4,194-73% 10,506-94% 22,107-74%	61% 73% 79% 75%	82%	57%[13] 69% 74% 71%	
Utilisation rates for adolescents	C	64%[14]	73%	85%	76%[15]	
Number of visits of preschool, and school children to oral health services (including adolescents)	V	79,233	84,420	n/a	79,276	
Number of complaints in the financial year	Q	11	7	↓	20[16]	
Arrears rates by ethnicity: • Māori • Pacific • Other • Total population	T	9.6% 10.3% 8.2% 8.8%	9.6% 10.3% 8.2% 8.6%	Overall 7%	8.1%[17] 7.0% 8.5% 8.1%	

PHARMACY

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Total value of subsidy provided	V	$128,436,885	$131,364,871	Ω	$132,789,417	
Number of prescription items subsidised	V	6,467,800	6,506,479	Ω	6,674,410	

[10] DML's laboratory contracts transferred to LTA from October 2013 and APS from October 2014.
[11] This result is for all 3 metro Auckland DHBs. LTA results only reported. DML no longer provides lab services.
[12] Outsourcing, additional sessions and recruitment/training of MRTs will increase CT and MRI volumes in 2015/16
[13] Duplicate enrolments slightly inflated historic enrolment figures, this has now been corrected. Closer linkages with Well Child providers are being developed to increase enrolment numbers in the 0-2 age range. Enrolment in maternity wards continues.
[14] Baseline data in 2014/15 AP incorrect, correct figure should be 84%
[15] CY2014 data. Adolescent utilisation has decreased nationally as population projections have increased and fewer duplicate patient records. A strategy to improve adolescent coverage has been developed and is currently being consulted on.
[16] Improved reporting practices have seen the number of recorded complaints in oral health increase.
[17] Recruitment in early 2015 has increased staff numbers and has already resulted in improvement in arrears (monitored weekly). Further recruitment is planned from the next graduating cohort from both AUT and Otago.

Output Class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital' or surgery centre. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services

On a continuum of care these services are at the complex end of treatment services and focused on individuals.

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	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Number of ED attendances	V	112,846	99,948	Ω	102,792	
Acute WIES total (DHB Provider)	V	91,898	92,106	95,329	92,764[18]	
Readmission rates – acute readmissions within 28 days (aged 75+ and total population)	Q	10.8% 7.92%	13.15% 9.8%	10.8% 7.92%	11.1% 8.2%[19]	
Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival.	Q	95%	95%	95%	94%	
Shorter waits for cancer treatment HT - all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy (no longer a health target as of October 2014)	T	Chemo 100% Radiation 100%	100%	100%	100%	
Percentage of stroke patients thrombolysed.	T	13.8%	8.4%	6%	10.2%[20]	

MATERNITY

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Number of births	V	7380	7377	Ω	7427	
Number of first obstetric consultations	V	4573	4611	Ω	4374	
Number of subsequent obstetric consults	V	4136	3999	Ω	3327	
Proportion of all births delivered by caesarean section	Q	34.7%	34.7%	↓	36%	
Established exclusive breastfeeding at discharge excluding NICU admissions	Q	75.8%	79%	75%	77%	
Third/fourth degree tears for all primiparous vaginal births	Q	5.1%	5.1%	↓	4.7%	
Admission of term babies to NICU	Q	6.2%	6%	↓	4.1%	
Number of women booking before end of 1st trimester	T		49%[21] 64%[22]	↑	45%[21] 68%[23]	

[18] Demand driven indicator, not appropriate to assess against a volume target.
[19] Readmissions April-14 to March-15
[20] April-14 to March-15
[21] ADHB primary maternity provider, data from ADHB local systems. ADHB reports 1st trimester as <13 weeks gestation.
[22] Independent LMC primary maternity provider. Data sourced from MAT data collection 2013 (ADHB does not collect independent LMC booking dates). MAT data reports 1st trimester as <12 weeks gestation.
[23] MAT data 2014. An improvement in data collection combined with small absolute numbers may account for this variation. Improving performance is an ongoing piece of work that we are focusing on both regionally and locally.

ELECTIVE (INPATIENT/OUTPATIENT)

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Delivery of health target for elective surgical discharges	V	12,982	13,608	13,872	13,902	
Number of first specialist assessment (FSA) outpatient consultations	V	90,062	85,853	Ω	91,874	
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC	Q	0.17	0.28	↓	0.23[24]	
Percentage of respondents who rate their care and treatment as very good or excellent*	Q	87.6%	83%	90%	85%	
Patients waiting longer than four months for their first specialist assessment (FSA)	T	4.42%	4.5%	0%	0%	
Patients given a commitment to treatment but not treated within four months.	T	5.67%	4.5%	0%	0.5%	

* was not explicitly identified in the Annual Plan as inpatients only survey, therefore not achieved

ASSESSMENT TREATMENT AND REHABILITATION (INPATIENT)

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
AT&R bed days	V	35,589	21,141	Ω	22,311	
No. of AT&R inpatient events	V	1,926	1,418	Ω	1293	
Proportion waiting 4 days or less from waitlist date to admission to AT&R service.	T	83%	93%	90%	88%	

MENTAL HEALTH

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Improving the health status of people with severe mental illness						
Access to mental health services:						
• Age 0-19, Māori	C	4.92%	5.09%	3.50%	5.12%	
• Age 0-19, Total		2.87%	2.91%	3.00%	2.91%	
• Age 20-64, Māori		11.71%	11.64%	7.50%	10.52%	
• Age 20-64, Total		3.93%	3.95%	3.50%	3.96%	
• Age 65+ Total		3.76%	3.77%	3.00%	3.34%	
Improving mental health services using transition (discharge) planning and employment						
Child and Youth with a Transition (discharge) plan.	Q	New measure		95%	51.1%[25]	
Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.						
% of clients seen within 3 weeks						
- Mental Health	T	73%	85%	80%	85%	
- Addictions		97%	75%		89%	
% of clients seen within 8 weeks						
- Mental Health	T	72%	97%	95%	96%	
- Addictions		91%	93%		94%	

[24] Preliminary HQSC data, 12 months to Jun-15, as at Sep-15. Baseline data in 2014/15 AP incorrectly based on single month, correct full year baseline to Jan-14 0.24, therefore target achieved.
[25] 12 months to Mar-15, as per MOH definition. New requirement in 2014/15, Jun-15 result 94%.

Output Class 4: Rehabilitation and Support Services

Rehabilitation and support is delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for a range of services including palliative care, home-based support services and residential care services.

We aim to have a fully inclusive community, where people are supported to live with independence and can participate in their communities. To achieve this aim, following their needs being assessed, support services are delivered to people with long-term disabilities, people with mental health problems and people who have age-related disabilities. Rehabilitation and support services are provided by the DHB and non-DHB sector, for example residential care providers, hospice and community groups.

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 evidence this may also improve length of life. Ensuring rehabilitation and support services are targeted to those most in need helps to reduce health inequalities. Effective support services make a major contribution to enabling people to live at home for longer, thereby not only improving their well-being but also reducing the burden of institutional care costs on the health system.

HOME BASED SUPPORT

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Total number of InterRAI assessments per month	V	418 per month	446	450	446[26]	
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	95%	96%	95%	97%[27]	
Percentage of NASC clients assessed within 6 weeks	T	100%	98%	↑	93%[28]	

PALLIATIVE CARE

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Total number of completed inpatient episodes of care (death or discharge)	V	777	812	Ω	795	
Proportion of cancer patients admitted to hospice against proportion of cancer deaths, by ethnicity[29] - Māori - Pacific - Asian	C	Admits:deaths 5%:7% 11%:10% 12%:8%	 7%:6% 11%:11% 9%:8%	1:1	 6%:6% 10%:9% 11%:9%	
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	10.1%	6%	↓	1%	

RESIDENTIAL CARE

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Total number of subsidised aged residential care bed days	V	975,624	981,427	Ω	982,309	
Proportion of aged care providers with 4 year audit certification[30]	Q	25%	26%	↑	26%	

[26] This is a demand driven service and it is inappropriate to set a monthly volume target. Volumes reported average per month.
[27] 12 months to March 2015
[28] Growing > 65 year old population is causing increased demand, with no additional resources pending review of the model for HBSS.
[29] Cancer deaths are used as a proxy for establishing hospice need between population groups. Ethnicity specific hospice admission rates should not be lower than cancer death rates if hospice service is providing equal access to all population groups.
[30] 4 year certification is infrequently awarded and considered 'gold standard'. Facilities must first demonstrate several years of continuous improvement.

Cost of Service Statement – for year ending 30 June 2015

Output Class	Prevention Services		Early Detection and Management		Intensive Assessment & Treatment		Rehabilitation and Support		Total	
in $'000s	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Total Revenue	**22,915**	**19,689**	**537,791**	**561,595**	**1,164,634**	**1,306,460**	**192,081**	**169,139**	**1,917,421**	**2,056,883**
Expenditure										
Personnel	16,704	15,627	2,696	18,962	777,026	783,714	33,803	14,121	830,230	832,425
Outsourced Services	1,990	1,020	53	1,513	100,911	86,881	695	238	103,650	89,652
Clinical Supplies	220	423	80	12,269	217,539	216,910	4,794	3,451	222,633	233,053
Infrastructure & Non-Clinical Supplies	3,322	2,248	679	3,740	190,024	167,451	7,555	2,320	201,581	175,760
Payments to Providers	1,282	1,100	501,321	520,139	(84,589)	56,529	140,958	148,198	558,972	725,967
Total Expenditure	**23,519**	**20,419**	**504,830**	**556,623**	**1,200,912**	**1,311,486**	**187,806**	**168,328**	**1,917,066**	**2,056,856**
Net Surplus/(Deficit)	**(604)**	**(730)**	**32,961**	**4,972**	**(36,277)**	**(5,026)**	**4,276**	**811**	**355**	**27**

Non-Departmental Appropriations

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs.

Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

ABOUT OUR ORGANISATION

Auckland DHB Attendance at Board and Committee Meetings: July 2014 – June 2015

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

x = not a member of the committee

Statement of Waivers

The New Zealand Public Health and Disability Act 2000 s 42(4) provides as follows:
For the purposes of s 151 (1)(j) of the Crown Entities Act 2004, the annual report of a DHB must disclose any interests to which a permission, waiver, or modification given under clause 36(4) or clause 37(1) of Schedule 3 or clause 38(4) or clause 39(1) of Schedule 4 relates, together with a statement of who gave the permission, waiver, or modification, and any conditions of amendments to, or revocation of, the permission, waiver, or modification. For the 2014/15 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.

Ministerial Directions

Directions issued by a Minister during the 2014/15 financial year, or that remain current are as follows:

- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000: https://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf
- Directions to support a whole of government approach, issued in April 2014 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on use of authentication services, issued in July 2008, continues to apply to all Crown agents apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction: www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF

FINANCIAL PERFORMANCE

Financial Statements

Statement of Responsibility

We are responsible for the preparation of the Auckland District Health Board and group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by Auckland District Health Board under section 19 A of the Public Finance Act 1989.

We have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of Auckland District Health Board for the year ended 30 June 2015.

Signed on behalf of the Board

Dr Lester Levy, CNZM
Chairperson

Dated: 28 October 2015

Ian Ward
Chair, Audit and Finance Committee

Dated: 28 October 2015

Statement Of Comprehensive Revenue And Expense For The Year Ended 30 June 2015

	Notes	Group Budget 2015 $000	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Revenue						
Patient care revenue	2	1,977,673	1,847,991	1,801,320	1,847,991	1,801,320
Interest Revenue		7,797	7,902	7,297	7,191	6,606
Other revenue	3	71,414	61,326	54,993	61,164	52,875
Total revenue		**2,056,884**	**1,917,219**	**1,863,610**	**1,916,346**	**1,860,801**
Expenses						
Personnel costs	4	832,425	830,230	808,136	830,230	808,136
Depreciation and amortisation costs	12,13	41,911	41,373	40,329	41,373	40,329
Outsourced services		89,652	103,650	86,082	103,650	86,082
Clinical Supplies		217,422	222,633	215,589	222,628	215,589
Infrastructure and non-clinical expenses		57,051	59,597	64,804	59,593	64,804
Other district health boards		108,226	110,189	103,840	110,189	103,840
Non-health board provider expenses		617,738	448,783	449,567	448,783	449,567
Capital charge	5	37,182	40,478	37,227	40,478	37,227
Interest expense		16,356	15,949	16,293	15,949	16,293
Other expenses	6	38,894	44,184	41,491	45,389	40,924
Total expenses		**2,056,857**	**1,917,066**	**1,863,358**	**1,918,262**	**1,862,791**
Share of associate and joint venture surplus/(deficit)	14	0	202	12	0	0
Surplus/(deficit)		**27**	**355**	**264**	**(1,916)**	**(1,990)**
Other comprehensive revenue and expense						
Item that will not reclassified to surplus/(deficit)						
Gains/(losses) on property revaluations	21	0	31,828	38,609	31,828	38,609
Cash flow hedges	21	0	(4,293)	0	(4,293)	0
Total other comprehensive revenue and expense		0	27,535	38,609	27,535	38,609
Total comprehensive revenue and expense		**27**	**27,890**	**38,873**	**25,619**	**36,619**

Statement Of Financial Position As At 30 June 2015

	Notes	Group Budget	Group Actual		Parent Actual	
		2015 $000	2015 $000	2014 $000	2015 $000	2014 $000
Assets						
Current Assets						
Cash and cash equivalents	7	51,557	83,858	90,210	83,858	90,210
Trust/special funds	8	11,966	10,644	16,387	0	0
Patient & restricted trust funds	9	0	1,208	1,169	1,208	1,169
Receivables	10	49,974	56,359	47,302	59,129	50,669
Prepayments		1,060	1,035	1,060	1,035	1,060
Inventories	11	12,267	13,154	12,211	13,154	12,211
Total Current Assets		**126,824**	**166,258**	**168,339**	**158,384**	**155,319**
Non-Current Assets						
Trust/special funds	8	10,783	17,299	10,783	0	0
Property, plant and equipment	12	920,183	952,323	898,464	951,423	897,564
Intangible assets	13	180	13,330	12,166	13,330	12,166
Derivative financial instruments	19	0	0	722	0	722
Investments in joint ventures & associates	14	42,663	42,632	40,138	42,172	39,880
Total Non-Current Assets		**973,809**	**1,025,584**	**962,273**	**1,006,925**	**950,332**
Total Assets		**1,100,633**	**1,191,842**	**1,130,612**	**1,165,309**	**1,105,651**
Liabilities						
Current Liabilities						
Payables & deferred revenue	15	134,521	145,707	115,742	144,580	113,916
Employee entitlements	16	151,632	159,463	151,801	159,463	151,801
Provisions	17	0	1,516	1,770	1,516	1,770
Borrowings	18	12,869	52,454	82,670	52,454	82,670
Patient & restricted trust funds	9	1,169	1,208	1,169	1,208	1,169
Total Current Liabilities		**300,191**	**360,348**	**353,152**	**359,221**	**351,326**

	Notes	Group Budget	Group Actual		Parent Actual	
		2015	2015	2014	2015	2014
		$000	$000	$000	$000	$000
Non-Current Liabilities						
Employee entitlements	16	25,500	30,085	33,941	30,085	33,941
Borrowings	18	294,500	254,500	224,500	254,500	224,500
Total Non-Current Liabilities		**320,000**	**284,585**	**258,441**	**284,585**	**258,441**
Total Liabilities		**620,191**	**644,933**	**611,593**	**643,806**	**609,767**
Net Assets		**480,442**	**546,909**	**519,019**	**521,503**	**495,884**
Equity						
Contributed capital	21	576,798	576,798	576,798	576,798	576,798
Accumulated surplus/(deficit)	21	(488,828)	(488,751)	(487,037)	(489,459)	(487,543)
Property Revaluation Reserve	21	368,022	438,457	406,629	438,457	406,629
Cash Flow Hedge Reserve	21	0	(4,293)	0	(4,293)	0
Trust/special funds	21	24,450	24,698	22,629	0	0
Total Equity		**480,442**	**546,909**	**519,019**	**521,503**	**495,884**

Explanations of major variances against budget are provided in note 30.

The accompanying notes form part of these financial statements.

Statement Of Changes In Net Assets/Equity For The Year Ended 30 June 2015

GROUP	Notes	Actual 2015 $000	Budget 2015 $000	Actual 2014 $000
Balance as at 1 July		**519,019**	**480,415**	**480,146**
Total comprehensive revenue/(expense) for the period		**27,890**	**27**	**38,873**
Owner Transactions				
Capital contributions to the Crown		0	0	0
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	21	**546,909**	**480,442**	**519,019**

PARENT	Notes	Actual 2015 $000	Budget 2015 $000	Actual 2014 $000
Balance as at 1 July		**495,884**	**436,313**	**459,265**
Total comprehensive revenue/(expense) for the period		**25,619**	**(1,793)**	**36,619**
Owner Transactions				
Capital contributions to the Crown		0	0	0
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	21	**521,503**	**434,520**	**495,884**

Statement Of Cash Flows For The Year Ended 30 June 2015

	Notes	Group Budget	Group Actual		Parent Actual	
		2015 $000	2015 $000	2014 $000	2015 $000	2014 $000
Cash flows from operating activities						
Cash receipts from Ministry of Health and patients		1,960,836	1,977,208	1,924,000	1,977,208	1,924,000
Other Receipts		90,316	73,507	70,565	71,661	70,586
Payments to employees		(839,016)	(825,171)	(792,888)	(825,171)	(792,888)
Payments to suppliers		(1,118,063)	(1,114,116)	(1,100,329)	(1,110,784)	(1,099,318)
GST (net)		0	2,536	572	2,319	860
Payments for capital charge		(37,182)	(40,478)	(37,227)	(40,478)	(37,227)
Net cash inflow from operating activities	20	**56,891**	**73,486**	**64,693**	**74,755**	**66,013**
Cash flows from investing activities						
Interest received		7,797	7,902	7,297	7,009	6,442
Receipts from sale of property, plant and equipment		0	28	188	28	188
Decrease/(Increase) in investments and restricted trust funds		(560)	(1,917)	(13,292)	(2,293)	(17,318)
Purchase of property, plant and equipment		(92,219)	(63,795)	(29,345)	(63,795)	(25,784)
Purchase of intangible assets			(600)	(3,849)	(600)	(3,849)
Acquisition of investments		0	(1,000)	0	(1,000)	0
Net cash (outflow) from investing activities		**(84,982)**	**(59,382)**	**(39,001)**	**(60,651)**	**(40,321)**
Cash flows from financing activities						
Interest paid		(16,356)	(16,051)	(16,209)	(16,051)	(16,209)
Repayment of loans		0	(80,000)	(10,000)	(80,000)	(10,000)
Proceeds from borrowings		199	80,000	10,000	80,000	10,000
Capital contributions from the Crown		0	0	0	0	0
Cash flow hedge		0	(4,405)	0	(4,405)	0
Net cash inflow/(outflow) from financing activities		**(16,157)**	**(20,456)**	**(16,209)**	**(20,456)**	**(16,209)**
Net (decrease)/increase in cash and cash equivalents		**(44,248)**	**(6,352)**	**9,483**	**(6,352)**	**9,483**
Cash and cash equivalents at start of the year		**95,805**	**90,210**	**80,727**	**90,210**	**80,727**
Cash and cash equivalents at end of the year	**7**	**51,557**	**83,858**	**90,210**	**83,858**	**90,210**

The accompanying notes form part of these financial statements.
Explanations of major variances to budget are provided in note 30.

Notes to the Financial Statements

1 SIGNIFICANT ACCOUNTING POLICIES

REPORTING ENTITY

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

ADHB has designated itself and the group as a public benefit entity (PBE) for financial reporting purposes.

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 (refer note 14 for listing).

The financial statements for the DHB are for the year ended 30 June 2015, and were approved by the Board on 28 October 2015.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of compliance

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

These financial statements comply with Public Sector PBE accounting standards.

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. The material adjustments arising on transition to the new PBE accounting standards are explained in Note 33.

Presentation currency and rounding

The consolidated financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

Standards issued that are not yet effective and not early adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on and after 1 Jul 2014. The DHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting statements was updated to incorporate requirements and guidance for the not-for-profit sector. These updated statements apply to PBEs with reporting periods beginning on or after 1 April 2015. The DHB will apply these updated standards in preparing its 30 June 2016 financial statements. The DHB expects there will be minimal or no change in applying these updated accounting standards.

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.

The investment in subsidiaries is carried at cost in ADHB's parent entity financial statements.

Joint Ventures
A joint venture is an entity over whose activities ADHB has joint control, established by a binding 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% investment in 2014 only) 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 was struck off the Companies Register on 22 May 2015.

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 Northern Region DHBs in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Revenue

The specific accounting policies for significant revenue items are explained below:

MOH revenue

The DHB is primarily funded through revenue received from the MoH.

This funding is restricted in its use for the purpose of the DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

Funding is recognised at the point of entitlement if there are conditions attached to the funding.

The fair value of revenue from the MoH has been determined to be equivalent to the amounts due in the funding arrangements.

ACC contracted revenue

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

Revenue from other DHBs

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

Donated services

Certain operations of the DHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the DHB.

Income from Grants

Income from grants includes grants given by other charitable organisations, government organisations or their affiliates. Income from grants is recognised when the funds transferred meet the definition of an asset as well as the recognition criteria of an asset. Grants are recognised when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as income received in advance and recognised as revenue when conditions of the grant are satisfied.

Research Income

Research costs are recognised in the Statement of Comprehensive Revenue and Expense as incurred. Revenue received in respect of research projects is recognised in the Statement of Comprehensive Revenue and Expense in the same period as the related expenditure.

Where requirements for Research income have not yet been met, funds are recorded as income in advance. The Trust receives income from organisations for scientific research projects, under PBE IPSAS 9 funds are recognised as revenue when the conditions of the contracts have been met. A liability reflects funds that are subject to conditions that, if unfulfilled, are repayable until the condition is fulfilled.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

Provision of services

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance sheet.

Donations and bequests
Donations and Bequests are received from the general public to be used for the general purpose of the Trust or for a specific programme or service. Donations and Bequests are recognised when the funds transferred meet the definition of an asset as well as the recognition criteria of an asset. Donations and Bequests are recognised when they become receivable unless there is an obligation in substance to return the funds if conditions of the donation are not met. If there is such an obligation, the donations are initially recorded as income received in advance and recognised as revenue when conditions of the donation or bequest are satisfied.

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

Borrowing costs
Borrowing costs are recognised as an expense in the financial year in which they are incurred.

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

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

At the commencement of the lease term, finance leases where the DHB is the lessee are recognised as assets and liabilities in the Statement of Financial Position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

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

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

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

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

Receivables
Short term receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that the DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.
After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

DHB bond FRA

ADHB uses Bond Forward Rate Agreements (Bond FRAs) to hedge interest rate repricing risk inherent in the maturity profile of its underlying Debt portfolio. Bond FRAs are initially recognised at fair value on the date the contract is entered into, and are subsequently re-measured at the fair value at each balance date. Where considered appropriate, ADHB applies hedge accounting to achieve the intention of Bond FRAs entered into.

The Bond FRA settlement position is recognised as a cash flow hedge reserve in other comprehensive revenue and expense and amortised in the Statement of Revenue and Expense over the term of the underlying debt instrument.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non –exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of costs (using the FIFO method) and net realisable value.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

Non-current assets held for sale

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

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

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

- Land;
- Buildings (including fitouts and underground infrastructure);
- Leasehold Improvements
- Plant, equipment and vehicles
- Work in progress

Owned Assets

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

The cost of property, plant and equipment acquired in a business combination is their fair value at the date of acquisition.

Revaluations

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

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes will be revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

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

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

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

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at fair value as at the date of acquisition.

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

Subsequent costs
Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

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

• Buildings (including components)	1-89 years	1.12%-100%
• Plant, equipment and vehicles	2- 20 years	5.00%-50%
• Leasehold improvements	4-8 years	12.5%-25%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

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

Intangible assets
Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

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

Business combination and goodwill
Business combinations are accounted for using the acquisition method. The acquisition method involves recognising at acquisition date, separately from goodwill, the identifiable assets acquired and the liabilities assumed. The identifiable assets acquired and the liabilities assumed are measured at their acquisition date fair values.

When the Group acquires a business, it assesses the financial assets and liabilities assumed for appropriate classification and designation in accordance with the contractual terms, economic conditions, the Group's operating or accounting policies and other pertinent conditions as at the acquisition date.

Goodwill is initially measured at cost, being the excess of the aggregate of the consideration transferred and the amount recognised for non-controlling interests over the net identifiable assets acquired and liabilities assumed.

After initial recognition, goodwill is measured at cost less accumulated amortisation and any accumulated impairment losses.

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

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

- Acquired software 3 to 5 years (20% - 33%)
- Internally developed software 3 to 5 years (20% - 33%)
- Goodwill 29 months (42%)

Indefinite life intangible assets are not amortised.

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.

Impairment of property, plant, and equipment and intangible assets

Non-cash generating assets
Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information.

If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.
The reversal of an impairment loss is recognised in the surplus or deficit.

Payables
Short-term payables are recorded at their face value.

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

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

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

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

A liability and an expense are recognised for bonuses where there is a contractual obligation, or where there is a past practice that has created a contractual obligation and a reliable estimate of the obligation can be made.

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

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

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

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

Defined benefit schemes
The DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. 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 surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis of allocation. The scheme is therefore accounted for as a defined contribution scheme. Further information on this scheme is disclosed in note 23.

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

Restructuring
A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced. Future operating costs are not provided for.

ACC Accredited Employers Programme
The DHB belongs to the ACC Accredited Employers Programme (the Full Self Cover Plan") whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, the DHB is liable for all its claims costs for a period of two years after the end of the cover period in which injury occurred. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for on-going claims passes to ACC.

The liability for the ACC Accredited Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity
Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:
- Contributed capital;
- Accumulated surplus/(deficit);
- Reserves - property revaluation and cashflow hedge; and
- Trust funds.

Reserves
The property valuation reserve is related to the revaluation of land and buildings to fair value. The cashflow hedge reserve relates to the hedge accounting treatment for the Bond FRA settlement position.

Trust funds
This reserve records the unspent amount of donations and bequests provided to the DHB.

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

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the Statement of Financial Position.

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

Commitments and contingencies are disclosed exclusive of GST.

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

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

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

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

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

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

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

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

Estimating the fair value of land and building revaluations
The significant assumptions applied in determining the fair value of land and buildings are disclosed in note 12.

Estimating useful lives and residual values of property, plant, and equipment
At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by the DHB, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the Statement of Financial Position. The DHB minimises the risk of this estimation uncertainty by:

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

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

Retirement and long service leave
Note 16 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

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

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

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

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

Agency relationship
Determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sales of goods or the rendering of services. The judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.

Some individual DHBs have entered into contracts for services with providers on behalf of themselves (contracting DHB) and other DHBs (recipient DHB). The contracting DHB makes payment to the provider on behalf of all the DHBs receiving the services, and the recipient DHB will then reimburse the contracting DHB for the cost of the services provided in its district. There is a Memorandum of Understanding that sets out the relationships and obligations between each of the DHBs. Based on the nature of the relationship between the contracting DHB and the recipient DHBs, the contracting DHB has assumed it has acted as agent on behalf of the recipient DHBs. Therefore the payments and receipts in relation to the other DHBs are not recognised in the contracting DHB's financial statements.

Comparative Figures
Comparative information has been reclassified as appropriate to achieve consistency in disclosure with the current year. Comparative information that has been restated as a result of the first time adoption of the PBE IPSAS standards is provided in note 33.

	Group Actual		Parent Actual	
	2015 $000	2014 $000	2015 $000	2014 $000
2 PATIENT REVENUE				
Health & disability services (MoH & other government revenue)	1,251,200	1,235,831	1,251,200	1,235,831
ACC contract revenue	18,297	17,137	18,297	17,137
Inter district patient inflows	545,146	516,032	545,146	516,032
Revenue from other district health boards	15,673	15,054	15,673	15,054
Other patient care related revenue	397	431	397	431
Other patient care related revenue	17,278	16,835	17,278	16,835
Total patient care revenue	**1,847,991**	**1,801,320**	**1,847,991**	**1,801,320**

	Group Actual		Parent Actual	
	2015 $000	2014 $000	2015 $000	2014 $000
3 OTHER REVENUE				
Donations and bequests	7,360	4,168	8,322	4,805
Gain on sale of property, plant & equipment	28	66	28	66
Gain on financial assets	1,186	666	0	0
Rental revenue	8,019	7,888	8,019	7,888
Accommodation revenue	510	554	510	554
Direct charges revenue	16,281	15,282	16,281	15,282
Drug Trial Revenue	616	484	616	484
Research Grants	12,225	11,935	12,287	9,846
Other revenue	15,101	13,950	15,101	13,950
Total other revenue	**61,326**	**54,993**	**61,163**	**52,875**
4 PERSONNEL COSTS				
Salaries and wages	801,295	769,546	801,295	769,546
Contributions to defined contribution schemes	25,352	23,542	25,352	23,542
Increase/(decrease) in liability for employee entitlements	3,806	14,894	3,806	14,894
Restructuring provision for employee exit costs	(223)	154	(223)	154
Total personnel costs	**830,230**	**808,136**	**830,230**	**808,136**

Note

Employer contributions to defined contribution plans include contributions to KiwiSaver, the State Sector retirement Savings Scheme, the Government Superannuation Fund, and the DBP Contributors Scheme.

5 CAPITAL CHARGE

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 2015 was 8% (2014:8%)

Notes	Group Actual		Parent Actual	
	2015 $000	2014 $000	2015 $000	2014 $000
6 OTHER EXPENSES				
Fees to auditor				
- fees to Audit New Zealand for audit of financial statements	265	258	265	258
- fees to Audit New Zealand for audit of financial statements (Auckland DHB Charitable Trust)	16	16	16	16
- fees to Audit New Zealand for other services	0	0	0	0
Operating leases	5,545	3,800	5,545	3,800
Impairment of debtors	200	(652)	200	(652)
Bad Debts	2,345	2,708	2,345	2,708
Board members' fees	394	385	394	385
Loss on disposal of property, plant and equipment	0	0	0	0
Loss on derivatives – financial instruments	722	350	722	350
Loss on financial assets	0	0	0	0
Foreign currency loss	15	3	15	3
Other expenses	34,682	34,623	35,887	34,056
Total other expenses	**44,184**	**41,491**	**45,389**	**40,924**

7 CASH AND CASH EQUIVALENTS	Group Actual 2015 $000	2014 $000	Parent Actual 2015 $000	2014 $000
Current assets				
Bank balance	81	172	81	172
Short term deposits	0	7	0	7
Health Benefits Limited	83,777	90,031	83,777	90,031
Cash & cash equivalents in the statement of cash flows	**83,858**	**90,210**	**83,858**	**90,210**

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 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 rates received by HBL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of a month's Provider Arm funding plus GST. For Auckland DHB, that equates to $108.893m (2014: $105.272m).

Assets recognised in a non-exchange transaction that are subject to restrictions
The DHB does not hold grant funding that is subject to restrictions.

8 TRUST/SPECIAL FUNDS	Group Actual 2015 $000	2014 $000	Parent Actual 2015 $000	2014 $000
Current assets				
Bank balances (restricted)	2,144	4,420	0	0
Short term deposits (restricted)	8,500	9,901	0	0
Investment Bonds (at market)/(restricted)	0	2,066	0	0
Portfolio Investments	0	0	0	0
	10,644	**16,387**	**0**	**0**
Non – current assets				
Long term deposits (restricted)	4,600	0	0	0
Investment Bonds (at market)/(restricted)	1,554	801	0	0
Portfolio Investments	11,145	9,982	0	0
	17,299	**10,783**	**0**	**0**

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

The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds are recognised in the surplus or deficit, and is transferred from/to trust funds in equity.

Term deposits
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 and investment bonds with maturities less than 12 months approximate their fair value. The fair value of term deposits and investment bonds with remaining maturities in excess of 12 months is $6,154k (2014: $801k). 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	
	2015	2014	2015	2014
9 PATIENT AND RESTRICTED TRUST FUNDS				
Current assets				
Patient trust	0	2	0	2
Restricted fund deposit	1,208	1,167	1,208	1,167
	1,208	**1,169**	**1,208**	**1,169**
Current liabilities				
Patient trust	0	2	0	2
Restricted fund deposit	1,208	1,167	1,208	1,167
	1,208	**1,169**	**1,208**	**1,169**

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.

	Group Actual		Parent Actual	
	2015	2014	2015	2014
10 RECEIVABLES				
Receivable (gross)	58,687	49,430	61,457	52,797
Less: provision for impairment	(2,328)	(2,128)	(2,328)	(2,128)
Total receivables	**56,359**	**47,302**	**59,129**	**50,669**
Total receivables comprise:				
Ministry of Health receivables (non-exchange transactions)	21,946	21,802	21,946	21,802
Other accrued income (exchange transactions)	34,413	25,500	37,183	28,867
	56,359	**47,302**	**59,129**	**50,669**

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

GROUP Receivables	Gross 2015 $000	Impairment 2015 $000	Gross 2014 $000	Impairment 2014 $000
Not past due	43,571	(28)	41,721	(14)
Past due 0-30 days	5,425	(196)	3,943	(177)
Past due 31-90 days	3,897	(455)	2,200	(371)
Past due 91-360 days	4,676	(1,298)	722	(722)
Past due more than 1 year	1,118	(351)	844	(844)
Total	**58,687**	**(2,328)**	**49,430**	**(2,128)**

PARENT Receivables	Gross 2015 $000	Impairment 2015 $000	Gross 2014 $000	Impairment2014 $000
Not past due	46,593	(28)	45,608	(14)
Past due 0-30 days	5,524	(196)	3,727	(177)
Past due 31-90 days	3,782	(455)	1,896	(371)
Past due 91-360 days	4,449	(1,298)	722	(722)
Past due more than 1 year	1,109	(351)	844	(844)
Total	**61,457**	**(2,328)**	**52,797**	**(2,128)**

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

Due to large number of receivables, the impairment assessment is generally performed on a collective basis, based on an analysis of past collection history and write-offs.

Movement in the provision for impairment loss	Gross 2015 Actual $000	Group 2014 Actual $000	Parent 2014 Actual $000	Parent 2014 Actual $000
Opening balance	2,128	2,780	2,128	2,780
Increase/(decrease) in doubtful debts	200	(652)	200	(652)
Closing balance	**2,328**	**2,128**	**2,328**	**2,128**

	Group Actual		Parent Actual	
	2015	2014	2015	2014
11 INVENTORIES				
Pharmaceuticals	1,901	1,697	1,901	1,697
Surgical and medical supplies	11,253	10,481	11,253	10,481
Other supplies	0	33	0	33
Total inventories	**13,154**	**12,211**	**13,154**	**12,211**

The write-down of inventories amounted to $1,399k (2014:$1,382k). There have been no reversals of write-downs.
No inventories are pledged as security for liabilities. (2014: Nil). However, some inventories are subject to retention of title clauses.

Other supplies –Stocks in Cafeterias (Auckland Support Building in Grafton, Tiny Bites in Starship and Oasis in Greenlane) were removed from inventory at 30 June 15 (2014:$33k).

12 PROPERTY, PLANT and EQUIPMENT

GROUP	Land $000	Buildings, fitouts & infrastructure $000	Plant, equipment and vehicles $000	Leased Improvements $000	Work in progress $000	Total $000
Cost						
Balance at 1 July 2013	209,321	569,447	273,115	758	22,485	1,075,126
Additions/(transfers)	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**

PROPERTY, PLANT and EQUIPMENT (continued)

GROUP	Land $000	Buildings, fitouts & infrastructure $000	Plant, equipment and vehicles $000	Leased Improvements $000	Work in progress $000	Total $000
Cost						
Balance at 1 July 2014	211,564	618,835	285,158	758	20,269	1,136,584
Additions/(transfers)	0	0	0	0	63,223	63,223
Additions from Work in Progress	5,614	16,185	21,872	0	(43,671)	0
Disposals	0	(1)	(13,695)	0	0	(13,696)
Transfers	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	31,828	0	0	0	0	31,828
Balance at 30 June 2015	**249,006**	**635,019**	**293,335**	**758**	**39,821**	**1,217,939**
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)**
Depreciation and impairment losses						
Balance at 1 July 2014	0	(26,455)	(210,936)	(729)	0	(238,120)
Depreciation charge for the year	0	(24,284)	(16,763)	(20)	0	(41,067)
Disposals	0	1	13,695	0	0	13,696
Transfers	0	(5)	(120)	0	0	(125)
Balance at 30 June 2015	**0**	**(50,743)**	**(214,124)**	**(749)**	**0**	**(265,616)**

GROUP						
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**
Carrying Amounts						
At 1 July 2014	211,564	592,380	74,222	29	20,269	898,464
At 30 June 2015	**249,006**	**584,276**	**79,211**	**9**	**39,821**	**952,323**

PROPERTY, PLANT and EQUIPMENT (continued)

PARENT	Land $000	Buildings, fitouts & infrastructure $000	Plant, equipment and vehicles $000	Leased improvements $000	Work in progress $000	Total $000
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**
Carrying Amounts						
At 1 July 2014	211,564	592,380	73,322	29	20,269	897,564
At 30 June 2015	**249,006**	**584,276**	**78,311**	**9**	**39,821**	**951,423**

PARENT	Land $000	Buildings, fitouts & infrastructure $000	Plant, equipment and vehicles $000	Leased Improvements $000	Work in progress $000	Total $000
Cost						
Balance at 1 July 2013	209,321	569,447	272,215	758	22,485	1,074,226
Additions/(transfers)	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**
Cost						
Balance at 1 July 2014	211,564	618,835	284,258	758	20,269	1,135,684
Additions/(transfers)	0	0	0	0	63,223	63,223
Additions from Work in Progress	5,614	16,185	21,872	0	(43,671)	0
Disposals	0	(1)	(13,695)	0	0	(13,696)
Transfers	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	31,828	0	0	0	0	31,828
Balance at 30 June 2015	**249,006**	**635,019**	**292,435**	**758**	**39,821**	**1,217,039**
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)

PROPERTY, PLANT and EQUIPMENT (continued)

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)**
Depreciation and impairment losses						
Balance at 1 July 2014	0	(26,455)	(210,936)	(729)	0	(238,120)
Depreciation charge for the year	0	(24,284)	(16,763)	(20)	0	(41,067)
Disposals	0	1	13,695	0	0	13,696
Transfers	0	(5)	(120)	0	0	(125)
Balance at 30 June 2015	**0**	**(50,743)**	**(214,124)**	**(749)**	**0**	**(265,616)**

Valuation Information

ADHB owns land with a carrying value of $249m (2014 $211.6m) has been assessed as having its highest and best use activity for hospital use.

Valuation

The most recent valuation of land was performed by an independent registered valuer, Evan Gamby (M PROP STUD Distn, DIP UV, FNZIV (Life), LPINZ, FRICS) of Telfer Young (Auckland) Limited. The valuation is effective as at 30 June 2015.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. All titles other than those relating to 50 Grafton Road are noted by certificate 9918215.1 as being subject to Section 148 of Nga Mana Whenua o Tamaki Makaurau Collective Redress Act 2014 ("The Act") that the land is RFR land as defined in section 118 and is subject to Subpart 1 of Part 4 of The Act (which restricts disposal, including leasing of the land).

Values have been adjusted to reflect the imposition of Section 148 of The Act. Restrictions on ADHB's ability to sell land would normally not impair the value of the land because ADHB has operational use of the land for the foreseeable future and will substantially receive the full benefits of outright ownership.

Buildings

Buildings, fitouts & infrastructures were last revalued on 30 June 2013 by Telfer Young (Auckland) Ltd.
Specialised buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

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

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For ADHB's earthquake-prone buildings that are expected to be strengthened, the estimated earthquake-strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

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

Work in progress

Property, plant and equipment in the course of construction by class of asset is detailed below:

GROUP & PARENT	2015 $000	2014 $000
Buildings, fitouts and infrastructure	30,966	17,096
Plant, equipment and vehicles	8,855	3,173
Total work in progress	**39,821**	**20,269**

13 GROUP & PARENT INTANGIBLE ASSETS	FPSC rights Cost	Software & development costs Cost	NCSP contract Cost	Total
Cost	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 2013	8,297	2,645	0	10,942
Additions	3,561	288	0	3,849
Balance at 30 June 2014	**11,858**	**2,933**	**0**	**14,791**
Balance at 1 July 2014	11,858	2,933	0	14,791
Additions	562	38	870	1,470
Balance at 30 June 2015	**12,420**	**2,971**	**870**	**16,261**
Balance at 1 July 2013	**0**	**(2,315)**	**0**	**(2,315)**
Amortisation charge for the year	0	(300)	0	(300)
Disposals	0	6	0	6
Reclassifications	0	(16)	0	(16)
Balance at 30 June 2014	**0**	**(2,625)**	**0**	**(2,625)**
Amortisation & Impairment Losses				
Balance at 1 July 2014	**0**	**(2,625)**	**0**	**(2,625)**
Amortisation charge for the year	0	(155)	(151)	(306)
Disposals	0	0	0	0
Reclassifications	0	0	0	0
Balance at 30 June 2015	**0**	**(2,780)**	**(151)**	**(2,931)**
Carrying Amounts				
At 1 July 2013	8,297	330	0	8,627
At 30 June 2014	**11,858**	**308**	**0**	**12,166**
At 1 July 2014	11,858	308	0	12,166
At 30 June 2015	**12,420**	**191**	**719**	**13,330**

At 30 June 2015, the DHB had made payments totalling $562k (2014: $3,561k) 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.

In 2014 the government agreed to a proposal from DHBs to move the implementation of the shared services programmes from HBL to a DHB owned vehicle. This was agreed to be completed by 30 June 2015. DHB FPSC rights in HBL are expected to transfer into the new DHB owned vehicle.

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.

A revised FPSC programme business case was approved by all DHBs by 30 June 2015 and all DHBs have committed to providing funding required to complete the FPSC programme. The programme will be implemented by a DHB owned vehicle (NZ Health Partnerships Limited), in which all DHBs own equal "A" class voting shareholding of 5%. The investment in the FPSC asset transferred into the new company on 1 July 2015 with no change to the "B" class shareholding as there was no economic event giving rise to a change in the asset. The revised business case demonstrates that the investment generates a positive Net Present Value for ADHB. On this basis, the Depreciated Replacement Cost 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.

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 (2014: Nil).

Goodwill
During the year, ADHB purchased the Diagnostic Medlab (DML) Cervical Screening business. Goodwill was recognised to the extent that the purchase price exceeded the identifiable assets and liabilities. The fair value of the purchase was assessed as the Net Present Value of the future cash flows over the next 3 years.

The goodwill was recognised based on the expected cash flows resulting from the National Cervical Screening Programme (NCSP) contract underlying the business acquisition. This is a 3 year contract that was effective 1 July 2014.

	Fair value at acquisition date $000
Property , plant and equipment	130
Goodwill arising on acquisition	870
Purchase consideration transferred	**1,000**

The goodwill is amortised over the remaining period of the contract from acquisition date.

14 INVESTMENTS IN JOINT VENTURES & ASSOCIATES

General Information		2015 Interest held	2014 Interest held
Name of joint ventures	**Principal Activity**		
Treaty Relationship Company Limited (Struck off 22 May 2015)	Joint venture for health initiatives with local iwi	0%	50%
healthAlliance N.Z. Limited	Provider of shared services	20%	20%
NZ Health Innovation Hub Management Limited	Provision of services to grow NZ's health innovation sector	25%	25%
Name of associate	**Principal Activity**		
Northern Regional Alliance Limited	Provision of health support services	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.

Summary-financial information on a gross basis (unaudited) of joint ventures and associate

Year end 30 June 2015	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus $000
healthAlliance N.Z .Limited	125,389	23,492	101,897	123,276	(37)
NZ Health Innovation Hub Management Limited	1,157	185	972	699	(389)
Northern Regional Alliance Limited	11,627	10,117	1,510	14,969	124
Total Investments	138,173	33,794	104,379	138,944	(302)

Year end 30 June 2014	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus $000
Treaty Relationship Company Limited	0	0	0	0	0
healthAlliance N.Z. Limited	114,572	19,158	95,414	109,648	169
NZ Health Innovation Hub Management Limited	1,614	1,053	561	937	(740)
Northern Regional Alliance Limited	10,424	9,038	1,386	14,233	607
Total Investments	127,276	29,211	98,065	126,285	1,540

	Group Actual		Parent Actual	
	2015 $000	2014 $000	2015 $000	2014 $000
Share of surplus of joint ventures & associates				
Share of post-acquisition surplus	202	12	0	0
Non-Current Assets				
Investments in joint ventures and associate				
Class A Shares in healthAlliance N.Z. Limited (joint venture)	200	200	200	200
Class C Shares in healthAlliance N.Z. Limited (joint venture)	41,971	39,679	41,971	39,679
Other shares in joint ventures & associates	1	1	1	1
Share of post-acquisition retained surpluses	460	258	0	0
Total investments in joint ventures and associates	**42,632**	**40,138**	**42,172**	**39,880**

A Memorandum of Understanding was signed between health Alliance N.Z. Ltd and Auckland DHB, Counties Manukau DHB and Northland DHB that C Class shares are to be issued by health Alliance N.Z. Ltd in exchange for the transfer of ownership of DHBs' IT assets (and other ancillary assets). Total value issued at 30 June 2015 is $41,971k (2014: $39,679k represents the baseline value of ADHB's IT assets transferred.

	Group Actual		Parent Actual	
	2015 $000	2014 $000	2015 $000	2014 $000
15 PAYABLES & DEFERRED REVENUE				
Payables under exchange transactions				
Creditors	106,905	80,459	107,146	80,686
Income in advance	6,262	7,439	4,805	5,147
Total payables under exchange transactions	**113,167**	**87,898**	**111,951**	**85,833**
Payables under non- exchange transactions				
GST, PAYE & FBT payable	28,703	24,860	28,792	25,099
Income in advance	3,837	2,984	3,837	2,984
Total payables under non-exchange transactions	**32,540**	**27,844**	**32,629**	**28,083**
Total payables and deferred revenue	**145,707**	**115,742**	**144,580**	**113,916**

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.

16 EMPLOYEE ENTITLEMENTS

Current portion				
Liability for long service leave	1,534	2,480	1,534	2,480
Liability for sabbatical leave	500	300	500	300
Liability for retirement gratuities	6,761	5,946	6,761	5,946
Liability for annual leave	90,875	88,269	90,875	88,269
Liability for sick leave	1,076	1,023	1,076	1,023
Liability for continuing medical leave and expenses	23,644	21,431	23,644	21,431
Salaries and wages accrual	35,073	32,352	35,073	32,352
Total current portion	**159,463**	**151,801**	**159,463**	**151,801**
Non Current portion				
Liability for long service leave	1,928	1,940	1,928	1,940
Liability for retirement gratuities	28,157	26,926	28,157	26,926
Liability for continuing medical leave and expenses	0	5,075	0	5,075
Total non-current portion	**30,085**	**33,941**	**30,085**	**33,941**
Total employee entitlements	**189,548**	**185,742**	**189,548**	**185,742**

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 $24.9m (2014 $21.6m) are unpaid days $10.6m (2014: $7.5m) and $14.3m (2013: $14.1m) 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 have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and future movements. A weighted average discount rate of 4.39% (2014: 5.5%) and an inflation factor of 1.5% (2014: 2.0%) were used.

		Group Actual		Parent Actual	
		2015 $000	2014 $000	2015 $000	2014 $000
17 PROVISIONS					
Current portion					
ACC Partnership Programme		1,488	1,541	1,488	1,541
Litigation		28	6	28	6
Restructuring		0	223	0	223
Total provisions		**1,516**	**1,770**	**1,516**	**1,770**
Movement for each class of provisions are as follows:					
ACC Partnership Programme					
Opening balance		1,541	1,734	1,541	1,734
Additional provisions made during year		502	222	502	222
Charged against provision for the year		(555)	(415)	(555)	(415)
Unused amounts reversed during year		0	0	0	0
Closing balance	(i)	**1,488**	**1,541**	**1,488**	**1,541**
Litigation Provision					
Opening balance		6	0	6	0
Additional provisions made during year		28	6	28	6
Charged against provision for the year		(6)	0	(6)	0
Unused amounts reversed during year		0	0	0	0
Closing balance	(i)	**28**	**6**	**28**	**6**
Restructuring Provision					
Opening balance		223	69	223	69
Additional provisions made during year		0	223	0	223
Charged against provision for the year		(223)	(69)	(223)	(69)
Unused amounts reversed during year		0	0	0	0
Closing balance	(iii)	**0**	**223**	**0**	**223**

Notes

ACC Partnership Programme

Liability valuation

An external independent Actuary, MA Lardies FNZSA, has calculated the liability as at 30 June 2015. 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% (2014: 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:

- post valuation date claim inflation has been taken as 2.1% pa;
- weighted average discount factor of 3% has been applied to future payment streams; and
- claim inception rates based on analysis of historical claim experience of the DHB. It has been assumed that 80% will result in medical claims only, and 20% will result in an element of time off work.
- the expected future Average Claim Payment per accident is $3,270 (2014:$3,330).

Insurance risk

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

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

A stop loss limit of 223% 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 $5,633,649 incurred in the cover period from 1 April 2015 to 31 March 2016 (2015/2016 ACC Claim Year).

Litigation

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

Restructuring

Provision $0k (2014:$223k)

	Group Actual		Parent Actual	
	2015 $000	2014 $000	2015 $000	2014 $000
18 BORROWINGS				
Current portion				
Secured loans				
Crown Loan	0	80,000	0	80,000
15 year Capital Bond, maturing 15 September 2015	50,000	0	50,000	0
Interest on Borrowings	2,454	2,845	2,454	2,845
Unexpired set up cost on borrowings	0	(175)	0	(175)
Total current portion	**52,454**	**82,670**	**52,454**	**82,670**
Non-current portion				
Secured loans				
Crown Loan	254,500	174,500	254,500	174,500
15 year Capital Bond, maturing 15 September 2015	0	50,000	0	50,000
Total non-current portion	**254,500**	**224,500**	**254,500**	**224,500**
Total borrowings	**306,954**	**307,170**	**306,954**	**307,170**
Interest rate summary	**% pa**	**% pa**	**% pa**	**% pa**
Crown Loan	3.20-5.32	3.02-6.295	3.20-5.32	3.02-6.295
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%.

$70m of the bond was refinanced by Crown Loan on 15 September 2010. The balance of $50m will be refinanced by Crown Loan on 15 September 2015.

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 a month's Provider Arm funding plus GST. For Auckland DHB, that equates to $108.893m.

18 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.

The fair value of Crown loans is $261.628m (2014:$255.140m). Fair value has been determined using contractual cash flow discounted using by the Government bond rate plus 15 basis points.

	Group Actual As at 30/06/15	Group Actual As at 30/06/143	Parent Actual As at 30/06/15	Parent Actual As at 30/06/14
19 DERIVATIVE FINANCIAL INSTRUMENTS				
Non – Current Assets				
Derivatives in gain (mark to market)	0	722	0	722

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

		Group Actual		Parent Actual	
		2015 $000	2014 $000	2015 $000	2014 $000
Reported net surplus/(deficit) for the year	5	**355**	**264**	**(1,916)**	**(1,990)**
Add non-cash items:					
Share of associate and joint venture surplus	4	(202)	(12)	0	0
Depreciation and amortisation expense		41,373	40,329	41,373	40,329
Net (gains)/ losses on derivative financial instruments		722	(316)	722	(316)
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		(28)	(66)	(28)	(66)
Net loss/(gain) on financial assets		(1,186)	(666)	0	0
Net interest shown in investing and financing activities		8,263	8,912	9,156	9,815
***Add movements in Statement of Financial Position items*:**					
(Increase)/Decrease in debtors and other receivables		(7,057)	1,509	(7,511)	1,938
(Increase)/Decrease in prepayments		25	290	25	290
(Increase)/Decrease in inventories		(943)	673	(943)	673
Increase/(Decrease) in creditors and other payables		30,418	(1,085)	32,131	479
Increase/ (Decrease) in provision		(31)	(33)	(31)	(33)
Increase/(Decrease) in employee entitlements		1,777	14,894	1,777	14,894
Net cash inflow/(outflow) from operating activities		**73,486**	**64,693**	**74,755**	**66,013**

21 EQUITY	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
A Contributed Capital				
Opening balance 1 July	576,798	576,798	576,798	576,798
Contributions from/(repayment to) the Crown	0	0	0	0
Balance at 30 June	**576,798**	**576,798**	**576,798**	**576,798**
B Accumulated surplus/(deficit)				
Opening balance 1 July	(487,037)	(485,047)	(487,543)	(485,553)
Surplus/(deficit) for the year	355	264	(1,916)	(1,990)
Transfer to trust/special funds	(2,069)	(2,254)	0	0
Balance at 30 June	**(488,751)**	**(487,037)**	**(489,459)**	**(487,543)**
C Property revaluation reserves				
Opening balances 1 July	406,629	368,020	406,629	368,020
Revaluations	31,828	38,609	31,828	38,609
Balance at 30 June	**438,457**	**406,629**	**438,457**	**406,629**
D Cash Flow Hedge reserve				
Opening balances 1 July	0	0	0	0
Net movement	(4,293)	0	(4,293)	0
Balance at 30 June	**(4,293)**	**0**	**(4,293)**	**0**
E Trust/special funds				
Opening balances 1 July	22,629	20,375	0	0
Transfer from accumulated surplus /(deficits) (Note 21b)	2,069	2,254	0	0
Balance at 30 June	**24,698**	**22,629**	**0**	**0**
Total Equity	**546,909**	**519,019**	**521,503**	**495,884**
Property revaluation reserves consist of:				
Land	239,700	207,872	239,700	207,872
Buildings	198,757	198,757	198,757	198,757
Total property revaluation reserves consist of:	**438,457**	**406,629**	**438,457**	**406,629**

Property revaluation reserves
The revaluation reserve movement relates to the independent valuation of land carried out by Telfer Young (Auckland) Ltd at 30 June 2015 – see Note 12.

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.

22 CAPITAL COMMITMENTS AND OPERATING LEASES

GROUP AND PARENT	2015 $000	2014 $000
A Capital commitments		
Buildings, fitouts and infrastructure	23,709	31,722
Plant, equipment and vehicles	21,865	16,814
Intangible assets (FPSC rights)	0	561
Total capital commitments	**45,574**	**49,097**

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	2015 $000	2014 $000
Not later than one year	6,192	5,110
Later than one year and not later than five years	18,403	17,183
Later than five years	13,757	16,866
Total non-cancellable operating lease commitments as lessor	**38,352**	**39,159**

The majority of these commitments relate to leasing out sites to third parties.
The DHB leases out a number of buildings under operating leases. The details of the main leases as a lessor are as follows:

- The hospital car park with an expiry date of 30 June 2024.
- University of Auckland with an expiry date of 31 July 2017.

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	2015 $000	2014 $000
Not later than one year	1,427	1,973
Later than one year and not later than five years	1,503	2,343
Later than five years	153	240
Total non-cancellable operating lease commitments as lessee	**3,083**	**4,556**

The DHB leases a number of buildings, vehicles and office equipment under operating leases.

The details of the main property leases are as follows:

- St. Lukes Community Health Centre is leased with an expiry date of 15 October 2017, with a right of renewal out till 15 October 2023.
- Manaaki House is leased with an expiry date of 31 March 2018.
- Taylor Centre is leased out with an expiry of 31 October 2015, with a right of renewal out till 31 October 2021.

23 CONTINGENCIES

Contingent Assets

There are no contingent assets at 30 June 2015 (2014: Nil).

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 DHB 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 DHB could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, the DHB could be responsible for an increased share of the deficit.

As at 31 March 2015, the Scheme had a past service surplus of $37.582m (exclusive of Employer Superannuation Contribution Tax) (2014 $38.432m). 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 PBE IPSAS 25.

The actuary to the Scheme has recommended that the employer contributions are suspended with effect from 1 April 2015.

24 TRANSACTIONS WITH RELATED PARTIES

The DHB is a wholly owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the DHB would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel compensation

GROUP & PARENT	2015 Actual	2014 Actual
Board Members		
Remuneration	$384k	$385k
Full-time equivalent members	1.7	1.7
Leadership Team		
Remuneration	$7,562k	$6,609k
Full-time equivalent members	20	20
Total key management personnel remuneration	$7,946k	$6,994k
Total full time equivalent personnel	21.7	21.7

The Leadership team comprises the Senior Leadership Team and the Clinical Directors of Services.

The full-time equivalent for Board members has been determined on the frequency and length of Board meetings and the estimated time for Board members to prepare for meetings.

25 BOARD MEMBER REMUNERATION

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

	Actual 2015 $000	Actual 2014 $000
Dr Lester Levy (Chair)	69	70
Dr Lee Mathias	38	39
Jo Agnew	31	31
Peter Aitken	32	32
Doug Armstrong*	30	18
Judith Bassett	32	30
Susan Buckland**	0	13
Dr Chris Chambers	30	30
Rob Cooper**	0	11
Robyn Northey	31	33
Gwen Tepania-Palmer	30	30
Morris Pita*	30	17
Ian Ward	31	31
Total board member remuneration	**384**	**385**

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

Co-opted committee members

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $7,375:

Norman Wong (Audit and Finance Committee) $1,875
Mataroria Lyndon (MaGAC) $750
Matire Harwood (MaGAC) $500
Raymond Hall (MaGAC) $500
Anne Kolbe (Hospital Advisory Committee) $1,500
Dairne Kirton (DiSAC) $500
Russell Vickery (DiSAC) $750
Jan Moss (DiSAC) $750
Shayne WiJohn (DiSAC) $250

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.

26 EMPLOYEE REMUNERATION

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

Remuneration Range	Actual 2015	Actual 2014	Remuneration Range	Actual 2015	Actual 2014
$100,000-$110,000	162	228	$420,000-$430,000	2	1
$110,000-$120,000	179	143	$430,000-$440,000	2	4
$120,000-$130,000	107	105	$440,000-$450,000	1	2
$130,000-$140,000	81	92	$450,000-$460,000	4	4
$140,000-$150,000	82	77	$460,000-$470,000	1	4
$150,000-$160,000	63	56	$470,000-$480,000	7	
$160,000-$170,000	60	44	$480,000-$490,000	1	1
$170,000-$180,000	56	39	$490,000-$500,000	2	5
$180,000-$190,000	47	45	$500,000-$510,000	1	1
$190,000-$200,000	37	43	$510,000-$520,000	1	2
$200,000-$210,000	41	38	$520,000-$530,000	1	1
$210,000-$220,000	46	35	$530,000-$540,000	1	5
$220,000-$230,000	33	32	$540,000-$550,000	1	1
$230,000-$240,000	34	29	$550,000-$560,000	1	
$240,000-$250,000	37	19	$560,000-$570,000	2	
$250,000-$260,000	27	24	$570,000-$580,000	1	2
$260,000-$270,000	27	40	$580,000-$590,000	1	
$270,000-$280,000	35	29	$590,000-$600,000	2	
$280,000-$290,000	24	17	$610,000-$620,000		1
$290,000-$300,000	11	23	$620,000-$630,000	1	
$300,000-$310,000	17	18	$640,000-$650,000	2	
$310,000-$320,000	21	15	$650,000-$660,000		1
$320,000-$330,000	21	16	$660,000-$670,000	2	
$330,000-$340,000	19	24	$700,000-$710,000		1
$340,000-$350,000	23	23	$720,000-$730,000		1
$350,000-$360,000	12	12	$780,000-$790,000	1	
$360,000-$370,000	16	15	$1,010,000-$1,020,000		1
$370,000-$380,000	12	11	$1,080,000-$1,090,000	1	
$380,000-$390,000	15	7	$1,110,000-$1,120,000	1	
$390,000-$400,000	7	9	$1,120,000-$1,130,000		1
$400,000-$410,000	3	8	$1,130,000-$1,140,000		1
$410,000-$420,000	7	4	$1,160,000-$1,170,000	1	
			Grand Total	**1,403**	**1,360**

Note:

During the year ended 30 June 2015, 95 (2014:95) employees received compensation and other benefits in relation to cessation totalling $1,861,932 (2014: $2,135,728).

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.

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, back pay 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.

27 EVENTS AFTER BALANCE DATE

There were no significant events after the balance date.

On 1 July 2015, Health Benefits Limited's business and operations were transferred over to a newly formed entity, NZ Health Partnerships Limited.

All the assets and liabilities, including ADHBs interest in the FPSC rights transfer over to the new entity with no adjustment.

28 FINANCIAL INSTRUMENTS

28a Financial instrument categories

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

	GROUP		PARENT	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
GROUP 2015				
Fair value through surplus or deficit				
Derivative financial instrument assets	0	722	0	722
Derivative financial instrument liabilities	0	0	0	0
Loans and receivables				
Cash and Equivalent	83,858	90,210	83,858	90,210
Trust/Special funds –bank balances, term deposits, investment bonds and portfolio	27,943	27,170	0	0
Receivables	56,359	47,302	59,129	50,669
Patient and restricted trust funds	1,208	1,169	1,208	1,169
Total loans and receivables	***169,368***	***165,851***	***144,195***	***142,048***
Financial liabilities measured at amortised cost				
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	106,905	80,459	98,502	80,686

Borrowing – secured loans	306,954	307,170	306,954	307,170
Patient and restricted trust funds	1,208	1,169	1,208	1,169
Total financial liabilities measured at amortised cost	**415,067**	**388,798**	**415,308**	**389,025**

28 FINANCIAL INSTRUMENTS (continued)

28b 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 30 June 2015					
Financial Assets					
Term deposits		13,100	13,100	0	0
Portfolio Investments	8a	11,145	11,145	0	0
Investment bonds	8a	1,554	1,554	0	0
GROUP 30 June 2014					
Financial Assets					
Derivatives		722	722	0	0
Term deposits		9,901	9,901	0	0
Portfolio investments	8a	9,982	9,982	0	0
Investment bonds	8a	2,867	2,867	0	0

28c Financial Instrument risks

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

Market risk

Price risk

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

Fair value interest rate risk
Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. The DHB's exposure to fair value interest rate risk arises from bank deposits and bank loans that are at fixed rates of interest. The exposure to fair value interest rate risk is managed as follows:

Bond FRA
Auckland DHB entered into a Bond Forward Rate Agreement (FRA) with Westpac Bank on 3 Aug 2012. This was to hedge the interest rate repricing risk inherent in the maturity profile of the underlying Crown debt.

Each year the fair value of the Bond FRA is recognised in the accounts. The Bond FRA was closed when it matured on 15 April 15 with a settlement cost of ($4,407k) included in the accounts, (2014:$722k gain). Hedge accounting was applied to the Bond FRA, with the settlement position recognised in the accounts as a cashflow hedge reserve. This will be amortised over the term of the underlying loan associated with the Bond FRA that was drawn for 8 years, from 15 April 2015 to 15 April 2023.

Cash flow interest rate risk
Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits and NZDMO borrowings. The future exposure at maturity on the NZDMO fixed rate borrowings is managed by the Bond FRA as detailed in the previous paragraph. The exposure on the on-call deposits and floating rate borrowings is not considered significant and is not actively managed.

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 2015, it is estimated that a general increase of 1% in interest rates would increase the surplus or deficit by approximately $0.0m (2014: $3.7m). Interest rate swaps have been included in this calculation.

At 30 June 2015, it is estimated that a general decrease of 1% in interest rates would decrease the surplus or deficit by approximately $0.0m (2014: $4.1m). Interest rate swaps have been included in this calculation.

Currency risk
Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. As at year end the DHB had no direct exposure to foreign currency risk (2014: nil).

Sensitivity analysis
As at 30 June 2015, if the NZ dollar had weakened/strengthened against any foreign currency, the surplus for the year would have seen an insignificant impact.

The DHB has no outstanding foreign denominated payables at balance date (2014: $nil).

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

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

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

28 FINANCIAL INSTRUMENTS (continued)

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The MoH is the largest single debtor (2015 33%, 2014 47%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

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

Credit quality of financial assets

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

	GROUP		PARENT	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalent ,term deposits & investment bonds				
A+	1,500	1,500	0	0
AA-	100,364	107,067	85,066	91,379
Total cash, cash equivalent ,term deposits & investment bonds	**101,864**	**108,567**	**85,066**	**91,379**
COUNTERPARTIES WITHOUT CREDIT RATINGS				
Portfolio investments	11,145	9,982	0	0
Receivables				
Exiting counterparty with no defaults in the past	56,359	47,302	59,129	50,669
Exiting counterparty with defaults in the past	0	0	0	0
Total receivables	**56,359**	**47,302**	**59,129**	**50,669**

Liquidity risk

Management of liquidity risk

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

The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the treasury services agreement with Health Benefits Limited who maintain an overdraft facility. The DHB also receives funding from the MoH in advance of the 4th of each month.

Contractual maturity analysis of financial liabilities, excluding derivatives.

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

The amounts disclosed are the contractual undiscounted cash flows.

28 FINANCIAL INSTRUMENTS (continued)

GROUP

2015	Carrying Amount $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
Borrowings	306,954	364,929	9,963	87,840	7,576	128,071	131,479
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	106,905	106,905	106,905	0	0	0	0
Total	**413,859**	**471,834**	**116,868**	**87,840**	**7,576**	**128,071**	**131,479**

2014	Carrying Amount $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
Borrowings	307,170	375,173	8,118	18,092	85,713	123,340	139,910
Payables (excluding income in advance, taxes payable and grants received subject to conditions	80,459	80,459	80,459	0	0	0	0
Total	**387,629**	**455,632**	**88,577**	**18,092**	**85,713**	**123,340**	**139,910**

PARENT

2015	Carrying Amount $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
Borrowings	306,954	364,929	9,963	87,840	7,576	128,071	131,479
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	107,146	107,146	107,146	0	0	0	0
Total	**414,100**	**472,075**	**117,109**	**87,840**	**7,576**	**128,071**	**131,479**

2014	Carrying Amount $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
Borrowings	307,170	375,173	8,118	18,092	85,713	123,340	139,910
Payables (excluding income in advance, taxes payable and grants received subject to conditions	80,686	80,686	80,686	0	0	0	0
Total	**387,856**	**455,859**	**88,804**	**18,092**	**85,713**	**123,340**	**139,910**

28 FINANCIAL INSTRUMENTS (continued)

Contractual maturity analysis of derivative financial instruments

The table below analyses derivative financial liabilities that are settled and all gross settled derivatives into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flow.

GROUP AND PARENT

2015	Liability carrying Amount	Asset carrying amount	Contractual Cash Flows	Less than 6 months	6-12 months	1-2 Years
	$000	$000	$000	$000	$000	$000
Derivatives in gain (Mark to market)	0	0	0	0	0	0

2014	Liability carrying Amount	Asset carrying amount	Contractual Cash Flows	Less than 6 months	6-12 months	1-2 Years
	$000	$000	$000	$000	$000	$000
Derivatives in gain (Mark to market)	0	722	722	0	0	722

29 CAPITAL MANAGEMENT

Auckland DHB's capital is its equity which comprises Crown equity, reserves, trust funds and accumulated surplus/(deficit). 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.

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

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

30 MAJOR VARIATIONS FROM BUDGET

Statement of Financial Performance

Auckland DHB recorded a surplus of $0.355m which was $0.325m favourable to budget.

Major favourable variance:

Non-health board provider expenses $169m. 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 $141.3m 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 contribution of $141.3m 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 $129.7m. 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.

30 MAJOR VARIATIONS FROM BUDGET (continued)

Statement of Changes in Equity

Total Equity of $546.9m as at June 2015 was $66.5m favourable to budget, driven by the revaluation of land as at 30 June 2014 ($38.6m) and also as at 30 June 2015 ($31.8m) less the Cashflow hedge reserve ($4.3m).

Statement of Financial Position

Total Assets as at June 2015 were $1,183.2m which was above budget of $1,087.7m by $82.6m primarily driven by the revaluation of Land as at 30 June 2014 and 2015, offset by a lower capital spend than planned.

Statement of Cash Flows

Cash and Cash Equivalents of $83.8m at June 2015 were $32.3m favourable to budget driven by a lower than budgeted Capital Expenditure $24m, favourable operating cash position, fully offsetting a $5m unfavourable variance in the budgeted opening balance and a settlement payments for the Bond FRA of $4m.

31 KEY SOURCES OF ESTIMATED UNCERTAINTY

As indicated in Note 1, the preparation of financial statements in conformity with NZ GAAP 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 $23.644m as at 30 June 2015 (2014 $26.506m). The calculation of this accrual assumes that the utilisation of this annual entitlement, that can be accumulated over 3 years, will be 90% of the full entitlement (2014 – 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-Risk Buildings

Auckland DHB has four buildings that have been confirmed as “earthquake risk” 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. Building 7 at the Auckland campus is in the process of being vacated for demolition with resource consent having been obtained. Building 13 at the Auckland campus is 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 2013 valuation.

32 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.

33 ADJUSTMENTS ARISING ON TRANSITION TO THE NEW PBE ACCOUNTING STANDARDS

Reclassification adjustments

There have been no reclassifications on the face of the financial statements in adopting the new PBE accounting standards.

Recognition and measurement adjustments

The table below explains the recognition and measurement adjustments to the 30 June 2014 comparative information resulting from the transition to the new PBE accounting standards:

		GROUP			PARENT		
		NZ IFRS (PBE)	Adjustment	PBE accounting standards	NZ IFRS (PBE)	Adjustment	PBE accounting standards
		2014		2014	2014		2014
	Note	$000	$000	$000	$000	$000	$000
Balance as at 1 July							
Statement of Financial Position							
Assets							
Current assets		168,339	0	168,339	155,319	0	155,319
Non-current assets		962,273	0	962,273	950,332	0	950,332
Liabilities							
Current Liabilities		353,152	0	353,152	351,326	0	351,326
Non-current Liabilities		258,441	0	258,441	258,441	0	258,441
Equity		519,019	0	519,019	495,884	0	495,884
Statement of Comprehensive Revenue and Expense							
Revenue							
Total patient care revenue	**1a**	**1,796,665**	**4,655**	**1,801,320**	**1,796,665**	**4,655**	**1,801,320**
Total other care revenue	**1a**	**59,648**	**(4,655)**	**54,993**	**57,530**	**(4,655)**	**52,875**
Statement of Changes in Equity							
Balance 1 July		480,146	0	480,146	459,265	0	459,265
Total comprehensive revenue and expense		38,873	0	38,873	36,619	0	36,619
Capital contribution		0	0	0	0		0
Balance at 30 June		**519,019**	**0**	**519,019**	**495,884**	**0**	**495,884**

Explanatory notes - **1a** Revenue reclassification from exchange transactions to non-exchange transactions, totalled $4,655.

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 2015

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

We have audited:

- the financial statements of the Health Board and group on pages 45 to 89, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expense, 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 10 to 27, and 33 to 41.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board and group:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2015; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards.

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

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 performance information of the Health Board and group for the period ended 30 June 2015, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board and group on pages 10 to 27, and 33 to 41:

- presents fairly, in all material respects, the Health Board and group's performance for the year ended 30 June 2015, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 28 October 2015. 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 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 the 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 the performance information. We were unable to determine whether there are material misstatements in the statement of performance 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 the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the 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 in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Health Board and group's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

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

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Standards;
- present fairly the Health Board and group's financial position, financial performance and cash flows; and
- present fairly the Health Board and group's performance.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

The Board is 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 the performance information, whether in printed or electronic form.

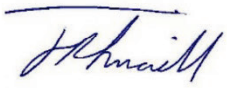
Responsibilities of the Auditor

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

Independence

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

Other than the audit, we have no relationship with or interests in the Health Board and group.



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

Auckland District Health Board

Annual Report 2014 | 2015

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai