AUCKLAND DISTRICT HEALTH BOARD

Annual Report 2015 | 2016

Welcome *Haere Mai* **Respect** *Manaaki* **Together** *Tūhono* **Aim High** *Angamua*

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

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CHAIRMAN/CEO STATEMENT

E ngā iwi, e ngā karangatanga, te iti me te rahi, tēnā koutou, tēnā tātou

Dr Lester Levy, CNZM
Chair

Ailsa Claire, OBE
Chief Executive Officer

We are the government's funder and provider of health services to 510,000 residents living in the Auckland isthmus and the islands of Waiheke and Great Barrier. Auckland DHB's population has been growing by approximately 40,000 people every five years and - by 2026 we estimate we will cater to an additional local population equivalent to the city of Palmerston North.

Our purpose at Auckland DHB is to lift health outcomes for all Aucklanders. We deliver services from Auckland City Hospital (New Zealand's largest public hospital), Greenlane Clinical Centre and the Buchanan Rehabilitation Centre. Auckland DHB is responsible for about one million patient contacts each year delivered within an annual budget of $2 billion.

This is a big job and would not be possible without the talent, experience and strong commitment of the people who work here at Auckland DHB, whether they are in the clinical frontline or within the many support services. There are approximately 10,200 staff employed by Auckland DHB and our achievements are the sum of the efforts of all of these people. Our staff are guided by the Auckland DHB values and are committed to delivering quality, safe care, and the best possible patient experience.

Our services extend well beyond the boundaries of Auckland DHB where we play a unique role in the New Zealand health sector. Auckland DHB provides national, tertiary and regional services; plays a significant role in research and education and also acts as an on-call adviser:

National service provider
Auckland DHB is the sole New Zealand provider of highly specialised care including heart, liver and lung transplants; paediatric services; epilepsy surgery; high risk obstetrics as well as being the northern region trauma centre. Many of our patients are those that other DHBs do not have the capability or capacity to provide treatment for.

Tertiary service provider
Auckland DHB is the largest provider of tertiary services in New Zealand. These specialised services require particular skillsets, equipment and facilities. As the tertiary services provider for the populations experiencing the greatest population growth, it is anticipated that the proportion of tertiary services to local services will increase further.

Regional service provider
Around 30% of Auckland DHB's patient population comes from the other Auckland region DHBs, in particular Waitemata and Counties Manukau DHBs. Whilst some of this provision is tertiary in nature, a proportion is secondary care that is more cost effective to provide from a single regional centre of excellence. This in turn requires greater investment in capital infrastructure by Auckland DHB than if it were focussed primarily on meeting the needs of its own geographical population.

Researcher and educator
Auckland DHB plays a key role in advancing national research and training of health professionals. Approximately 1,300 health professionals are currently in training at Auckland DHB. While there are other teaching hospitals in New Zealand, our unique case mix attracts more research and education activity than elsewhere, in turn driving capital expenditure that a non-teaching hospital would require.

On-call advisor
Auckland DHB's unique capability in tertiary services results in our workforce undertaking an advisory role for other health professionals across the country, for unusual or more complex cases.

This year has seen many highlights of which the following are examples:

- 100,000 people were treated in our Emergency Departments this year - on average, 275 people a day. The Emergency Department presentations have increased by 18% over the last four years.
- Six percent more patients than last year received elective surgery.
- Our population has the lowest smoking rate in New Zealand of 11%. The life expectancy in Auckland is higher than the national average.
- The life expectancy of our Māori population has increased 4.4 years over the last decade.
- 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.

Auckland DHB will continue to champion clinician leadership - moving decision-making as close as possible to the patient across all of our services. Collaboration with our partners - our Treaty partner Ngāti Whātua, our Primary Health Organisations (PHO) partners and Non-Governmental Organisations (NGOs) – underpins our work to create a seamless patient journey both in hospital and in the community.

It is pleasing to see us end the financial year with a small surplus. (See page 43) This is a credit to the partnership and collaboration of all our teams.

Guided by the Board's strategic themes and values, our focus remains single minded. Whether our work is in hospitals, clinics, the home or the community, our purpose is to help our population and patients achieve the health outcomes that matter to them, their whānau and family and their communities.

Whāia te iti kahurangi ki te tūohu koe me he maunga teitei.

Dr Lester Levy, CNZM

Chair
Auckland District Health Board

Ailsa Claire OBE

Chief Executive
Auckland District Health Board

MĀORI TE TIRITI - PARTNERSHIP STATEMENT

Tū Tonu ngā Manaakitanga!

R Naida Glavish ONZM
Chief Advisor Tikanga

When I look back over the past year, and all of its achievements, the theme that emerges is partnership.

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 91% of tamariki started school having completed their B4 School checks. The health and development of the most vulnerable members of our whānau is crucial for the future of our communities.

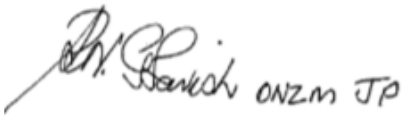
As we acknowledge all of those who have contributed to a milestone year for Māori health, we also need to challenge ourselves to do more. Many indictors in this report show that Māori often suffer disproportionately from health conditions compared to other groups in our communities. One only needs to 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 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



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

ABOUT AUCKLAND DHB

Who we are and what we do

Auckland DHB is the Government's funder and provider of health services to the more than 510,000 residents living in the Auckland district. We are the fourth largest and one of the fastest growing DHBs in the country, expecting an extra 70,000 people by 2025.

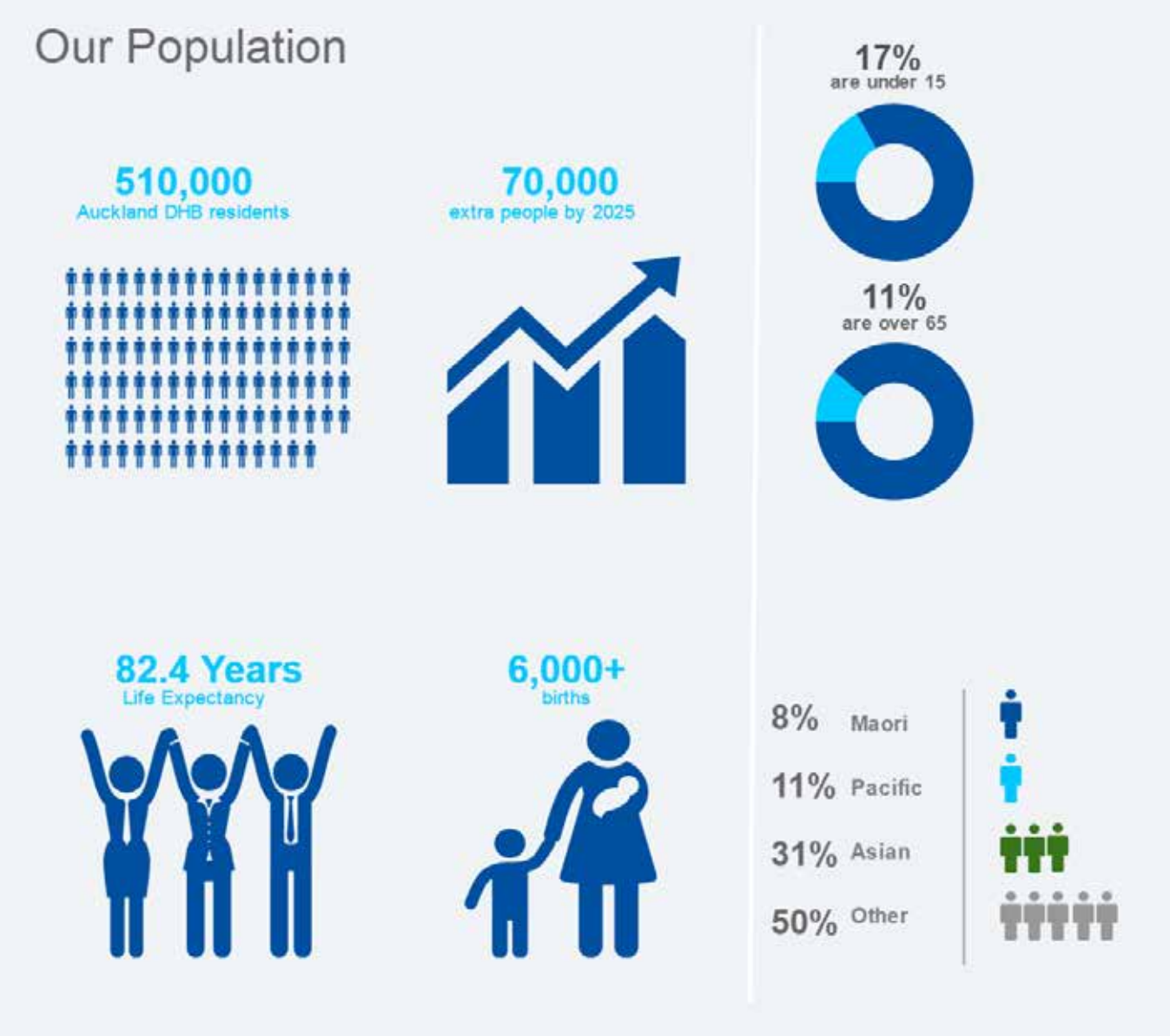
Auckland has a similar deprivation profile to New Zealand as a whole, almost one in five of our population live in the areas of the two lowest deciles and 23% in areas of the two wealthiest deciles.

Auckland DHB provides hospital and community services from multiple sites including Auckland City Hospital, Greenlane Clinical Centre and the Buchanan Rehabilitation Centre.

We provide community child and adolescent health and disability services, community mental health services and district nursing. We are the northern region's provider of some specialist tertiary services e.g. cardiac surgery and radiation oncology services.

We also provide specialist services not available within other DHBs including organ transplant services, specialist paediatric services, epilepsy services and high risk obstetrics.

Our budget in 2015/16 was $2 billion.



OUR DIRECTION

Healthy Communities, World-class Healthcare, Achieved Together

Our vision recognises that each individual has different experiences and aspirations for health and wellbeing. Our job is to help people achieve the outcomes that matter to them, to their whānau and their communities. This requires us to work with people, instead of doing things to them or for them. Only by working together, can we gain an understanding of how people want to be supported. Success depends on establishing relationships with our patients, whānau, iwi and communities, as well as with other providers and agencies whose policies support health and wellbeing.

People expect to be able to find their way around easily and for services to be oriented around their needs. Our challenge is to integrate services so well that it feels like one consolidated health system – Health Auckland.

Our district health board has built a firm foundation for supporting good health and for providing quality health services. We are proud of this role and aspire to the consistent delivery of world-class care. We will do more to upskill our workforce so staff can work in more people-centric and patient-centric ways.

Our strategic themes set the direction for activities over the next four to five years. These themes have become the basis of our Auckland DHB Strategy to 2020, setting our future direction. These replace the strategic priorities which were included in the draft version of the Strategy at the time of the development of the Annual Plan. The strategic themes tell us what to do and they keep us focused on the things that matter most. The strategic mandatories and our organisational values tell us how to work, making explicit the approaches that underpin everything we do and which characterise the Auckland DHB way.

Strategic themes

Community, whānau and patient-centred model of care

Patients, whānau and our community are at the centre of our health system. The quality of the patient and whānau experience, and their outcomes, should be the starting point for the way we think, act and invest.

Emphasis/investment on both treatment and keeping people healthy

We are investing in **our people, services and facilities** across the spectrum of care, with increasing investment in preventing ill health.

Service integration and/or consolidation

We need to **work collaboratively** to ensure that services are delivered by the best provider in the right place.

Intelligence and insight

The **dynamic use of data, information** and technology will improve clinical decision making and develop our health insights.

Evidence informed decision making and practice

Delivering **safe and high quality care** is an integral part of our culture. Evidence from research, clinical expertise, patients and whānau, and other resources drive our decisions.

Outward focus and flexible, service orientation

We put **patients first** and strive for fundamental standards of care. We must have an **openness to change**, improve and learn and be outward focused and flexible. **Strong clinical leadership** is embedded at all levels of the organisation.

Operational and financial sustainability

Operational and financial sustainability is critical to our ability to deliver on our organisational promise and purpose. We need a longer-term view.

KEY ACHIEVEMENTS

National Health Targets

We achieved four of the six National Health Targets in Q4 15/16

Shorter stays in Emergency Departments
95%

More Heart and Diabetes Checks
92%

Better help for Smokers to Quit
95% Hospitals
91% Primary Care

Improved access to Elective Surgery
16,818 procedures

Life Expectancy

Our life expectancy is consistently higher than that of New Zealand at 82.4 years with an increase of 2.8 years since 2001

Financial Performance

We lived within our means producing a financial surplus of $2.9m

$2.9m

Healthy communities

Health outcomes are improving with our mortality rates from cardiovascular disease and cancer among the lowest in the country and declining

Cardiovascular disease

Nine out of ten eligible people received their cardiovascular disease risk assessment

Cancer

We have among the highest five year cancer survival ratio in the country with nearly seven out of ten people surviving five or more years after their diagnosis

Childrens health

93%

93% of 8-month old children were fully immunused on-time

World-class healthcare

Our population have rapid access to healthcare and the services we provide are safe and effective.

99.9%

Almost all patients waited no longer than than four months for their first specialist assessment

85

Among the lowest hospital standardised mortality ratios in the country

Achieved together

We are working as active partners across the whole system. Our patients provide excellent feedback about our services

Nine out of ten patients felt staff always treated them with respect and dignity while in hospital*

Nine out of ten patients felt they always had confidence and trust in their doctor*

Nine out of ten patients felt they were always treated with kindness and understanding while in hospital*

*Results HQSC survey - February 2016

Improving outcomes

What difference have we made for the health of our population?

OUTCOMES FRAMEWORK

What difference have we made for the health of our population?

Our outcomes framework (next page) forms an essential part of the way we are held to account for making a difference to the health of our population. Overall the progress against our indicators suggests we are delivering on our vision and we are a high performing DHB that is truly making a difference to the health of our population.

We have one of the highest life expectancies of any DHB in the country at 82.4 years

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

The number of suicides in our region is declining, dropping by 10 (from 49 to 39) between 2012 and 2013

Our outcomes 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 improve quality of life (measured by life expectancy at birth)
- Reduce the difference in life expectancy between different ethnic groups (measured by the ethnic gap in life expectancy)

Our long-term outcomes are focused on developing and maintaining positive trends over time rather than achieving fixed annual targets. The nature of population health is such that the improvements in these outcomes will take years – sometimes even decades – to see marked change.

Sitting underneath the long-term outcome indicators, we have a set of impact measures which assess the direct impact of the services we provide over a shorter time period (one to five years).

General measures for the quality of life are not well developed therefore we have not identified a single measure of quality of life. Our output and impact measures contribute to overall health gain which is one domain of quality of life.

The Statement of Performance, in the Our people, our performance section of this report, provides a snapshot of the services provided for our population and comprises a set of cornerstone output indicators that contribute to our outcomes framework. We monitor performance against these indicators annually.

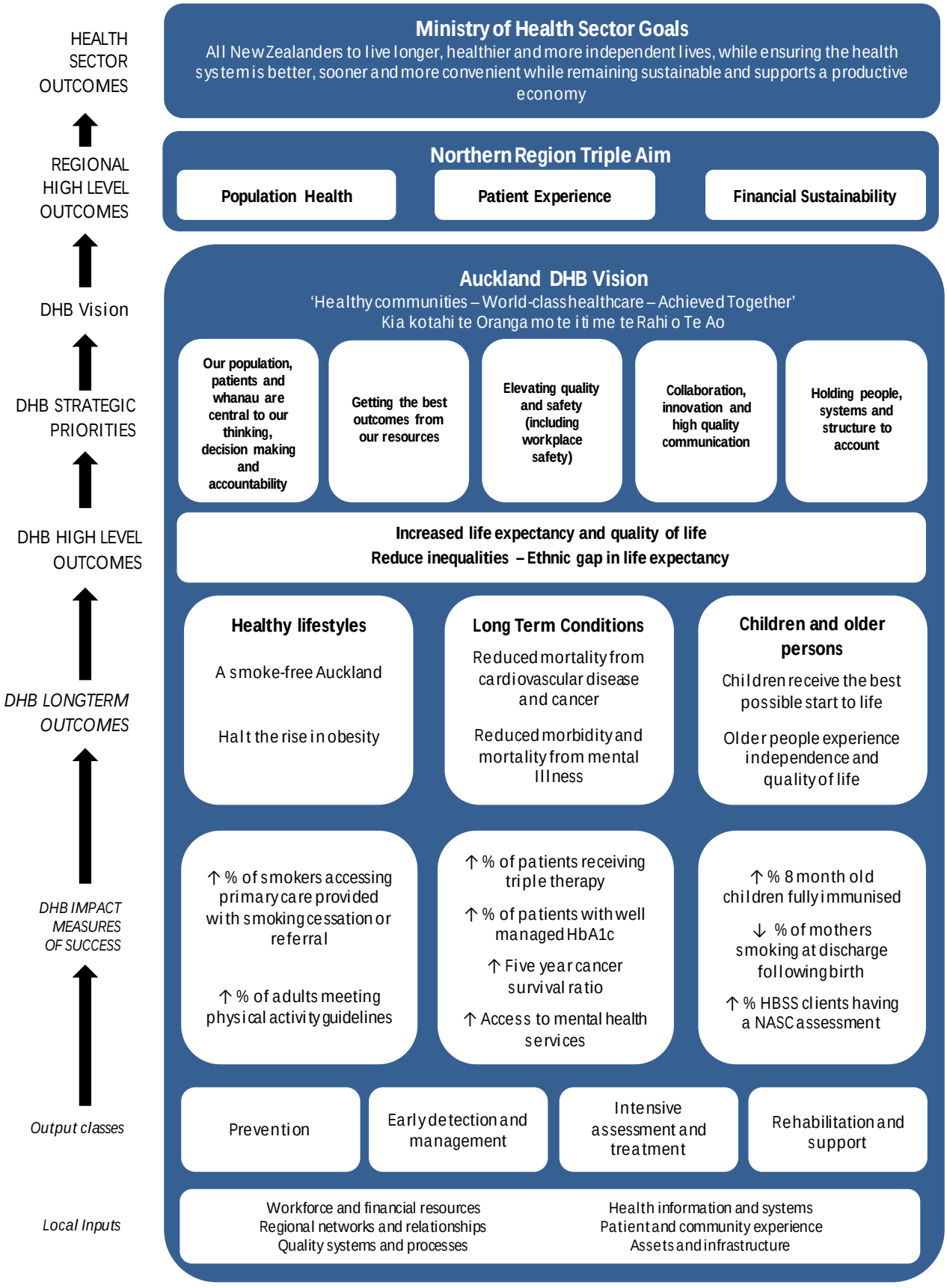
Our outcome measures show continued improvement for our population. Life expectancy continues to improve, reaching 82.4 years (2013-15), one of the highest in the country and an increase of 2.4 years over the past decade. The gap in life expectancy has improved for Māori, reducing by nearly 2 years, although the gap has risen slightly for Pacific.

Mortality rates from cardiovascular and cancer continue to decline to 100.6 and 107 per 100,000 population respectively – both lower than national rates.

Our suicide numbers and rates are declining – 7.9 per 100,000, with a drop of 10 between 2012 and 2013 (49 to 39).

Our infant mortality rate is amongst the lowest in the country at 4.4 per 1,000 live births (2012-13 two year combined rate) versus the national rate of 4.9 per 1,000 live births. This rate has consistently remained lower than the national rate.

Auckland DHB Outcomes Framework



HIGH LEVEL OUTCOMES

The high level outcomes that we aim to achieve are to increase life expectancy and quality of life and to reduce inequalities between different ethnic groups in our population. Our outcome and impact indicators can act as measures for overall health gain, which is one of the domains contributing to quality of life.

PEOPLE LIVE
1.6 YEARS
LONGER IN AUCKLAND THAN NEW ZEALAND AS A WHOLE

Improving life expectancy for everyone

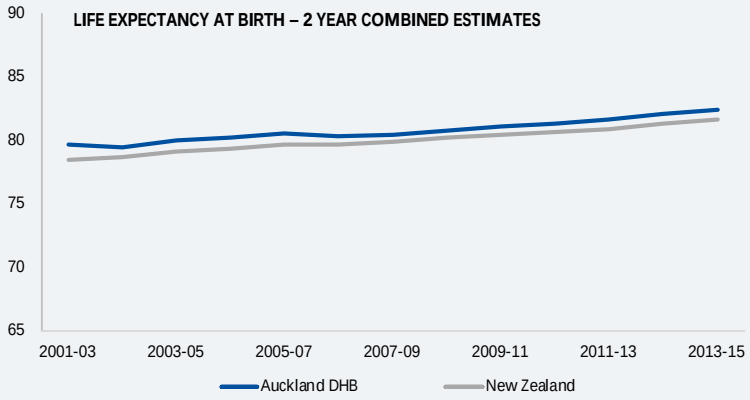
Life expectancy at birth (LEB) is recognised as a general measure of population health status. Overall, we have one of the highest life expectancies in the country at 82.4 years (2013–15), which is nearly 1 year higher than New Zealand as a whole. Half of this difference in life expectancy between New Zealand and Auckland is attributed to our lower mortality rates from cardiovascular disease and cancer. In Auckland, life expectancy has increased by 2.4 years over the last decade.

Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 4.9 years for Māori and 6.0 years for Pacific. Although life expectancy has increased in our Māori (4.4 years) and Pacific (2.0 years) populations over the past decade, the gap has increased slightly for our Pacific population and reduced by nearly 2 years in our Māori population. Mortality at a younger age from diseases of the circulatory system and cancers accounts for around 3.3 years of the life expectancy gap.

LIFE EXPECTANCY HAS INCREASED
2.4 YEARS
OVER THE PAST DECADE

An increase in life expectancy at birth

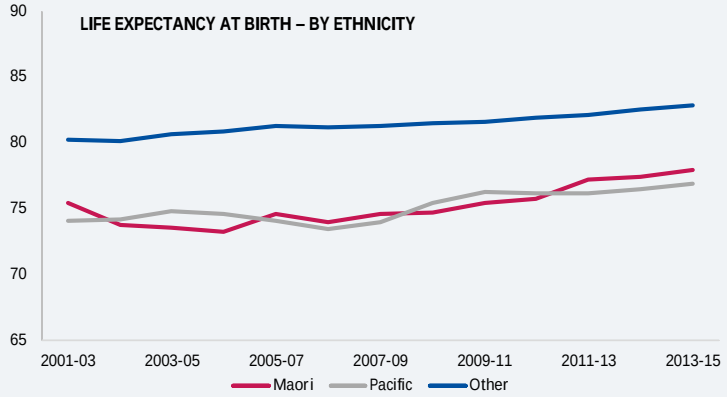
The life expectancy of our population has increased 2.4 years over the last decade, to 82.4 years.



INEQUALITIES ARE DECREASING - LIFE EXPECTANCY OF OUR MĀORI POPULATION HAS INCREASED
4.4 YEARS
OVER THE PAST DECADE

A reduction in the ethnic gap in life expectancy at birth

The life expectancy for Māori is 4.9 years lower than all other ethnicities, and 6.0 years lower for Pacific people.



*Note: The most recent life expectancy data available is for the 2015 calendar year. Three-year combined estimates have been presented to reduce the effect of year to year variations in death rates.

HEALTHY LIFESTYLES

'Support people to be healthier and take more responsibility for their health'

Supporting health at all stages of a person's life helps to increase life expectancy and adds to the number of years lived in good health. We aim to encourage people to take responsibility for their health by making healthy lifestyle choices, and engaging in preventative strategies such as disease risk assessments. Our focus is on the two largest causes of preventable ill health - smoking and obesity.

11%

OF ADULTS WERE ACTIVE SMOKERS IN 2013, A DECREASE FROM 19% IN 2001

53,065

SMOKERS (26%) RECEIVED CESSATION SUPPORT IN PRIMARY CARE, AN INCREASE FROM 14% IN Q1 2013/14

95%

OR 12,359 SMOKERS HOSPITALISED IN AUCKLAND FACILITIES RECEIVED SMOKING CESSATION ADVICE

99%

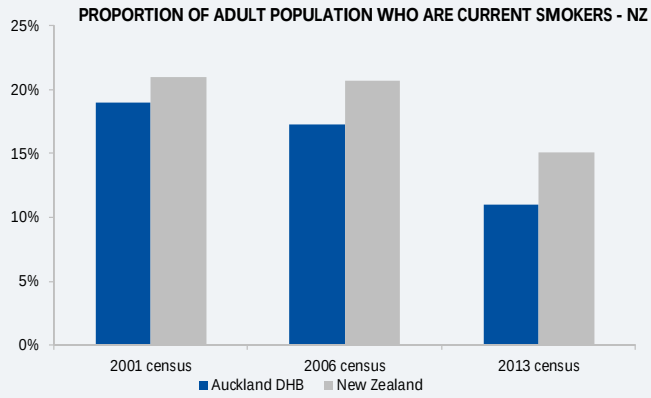
OR 265 PREGNANT WOMEN WHO SMOKED RECEIVED SMOKING CESSATION ADVICE

A smoke-free Auckland

New Zealand has comprehensive tobacco control policies and programmes, yet smoking remains the leading modifiable risk factor for many diseases. We estimate smoking directly results in the deaths of around 300 of our residents every year. Smoking among our Māori and Pacific populations is reducing, but the prevalence remains at least twice that of other ethnicities. Targeting smoking is an opportunity to significantly reduce health inequalities and drive improvements in the overall health of our population.

A reduction in the prevalence of smoking

Smoking rates in Auckland are declining, and are the lowest in NZ. 11% of adults identified as active smokers in the 2013 census, compared with 19% in 2001.



Providing smokers with brief advice to quit increases their chances of making a quit attempt. The chance of that quit attempt being successful is increased if medication and/or cessation support are also provided.

In 2015/16 we provided brief smoking cessation advice to 95% of smokers attending our hospitals, and 88% in primary care. PHO Smokefree co-ordinators work with GP practices to identify and assist their smoking patients. Our PHOs have programmes in place to text and phone patients to provide brief advice to those who do not regularly visit their GP.

One in four (26%) identified smokers accessing primary care are now provided with cessation support, either through a referral to 'quit smoking' services or provided with smoking cessation medication. This rate of support is improving but is lower than the national rate (31% in Q4 2015/16).

Throughout 2015/16 we have had a strong focus on supporting pregnant women to quit smoking. 99% of women registered with a DHB-employed midwife or Lead Maternity Carer were offered brief advice to quit. "Living Smokefree – It starts with YOU", our Smoking in Pregnancy Incentives programme, professional support to stop smoking, and incentive vouchers on the successful completion of the programme. Our Smokefree Pregnancy team worked with midwives, PHOs, early childhood workers and Plunket to encourage referrals to the programme.

Better help for smokers to quit

Building smokefree communities

91% of smokers were offered help to quit by their local GP team in Q4 2015/16.

Since 2012/13, Auckland DHB has met the national health target for giving help to smokers in hospital to quit. And at local GP level there is similar success, with primary care-based interventions hitting the target in Q4 2015/16.

Most smokers want to quit, but it's no easy mission. According to the Ministry of Health, approximately 80% of smokers wished they have never started and 65% have tried to quit in the last 5 years. Our part in them achieving success lies in ensuring we provide consistent advice and support across all parts of the health system i.e. local GPs, hospitals and other community health services, in supporting their attempts.

Smoking-related diseases are a significant drain on health resources and smoking kills about 5000 New Zealanders each year. That's why 'Better help for smokers to quit' is one of the Ministry of Health's six national targets for health sector performance.

For patients enrolled with primary health organisations (PHOs), the target is 90%. In quarter four 2015/16 PHOs recorded 91.2%, which represents 46,052 patients in primary care provided with advice to quit.

The continued success is down to a team effort involving PHOs and the leadership of the primary care support system for smokers trying to quit. Auckland DHB acknowledges their commitment in providing support to General Practices, so that doctors and other health professionals on the ground can directly support smokers with the advice and resources they need to overcome their addiction.

Last year's influential initiatives, such as giving advice via phone calls and text messages, were well received by patients.

Another success story is the WERO stop smoking team challenge. Smoking prevalence remains high amongst people using mental health and addictions services, and some mental health staff members also smoke. In September 2015 a WERO programme specifically for mental health services was launched. 31 teams from across Auckland competed and a large proportion of the participants were Māori and Pacific, with staff quitting alongside service users/tangata whaiora. After the 12 week programme 62% of the 114 participants were no longer smoking.

The Procare Mission Smokefree team – winners of an Auckland DHB health excellence award

Halt the rise in obesity

22%

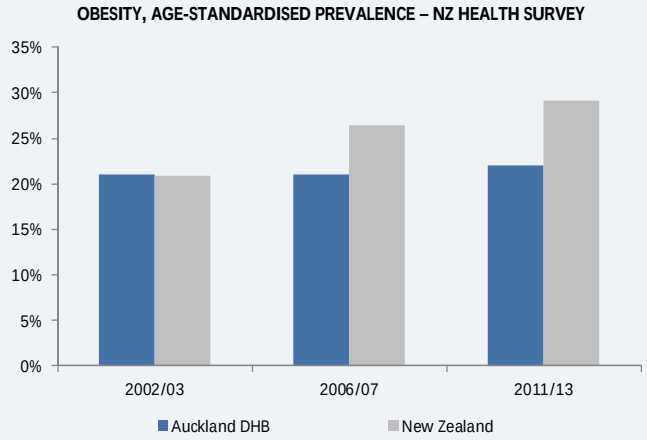
OF OUR ADULT POPULATION ARE OBESE, LESS THAN NZ AS A WHOLE (29%)

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand. Obesity impacts on quality of life and is a significant risk factor for many chronic conditions, including cardiovascular disease and some cancers. In Auckland DHB we estimate that 17% of all male deaths and 13% of female deaths in the 15+ age group are attributable to overweight and/or obesity.

Many of the drivers of obesity sit outside the direct control of health, however not outside of our influence. We support the creation of health promoting environments that encourage and aid people to adopt healthier lifestyle choices, and provide medical intervention where appropriate.

Outcome measure: Halt the rise in adult obesity

The prevalence of obesity in Auckland is increasing, however is lower than New Zealand as whole. Nearly one in four adults in Auckland DHB are considered to be obese (21.8% - NZ Health Survey 2011-13). Significantly higher rates of obesity are seen in our Māori (46%) and 61% of our Pacific (61%) communities.



48%

OF OUR ADULT POPULATION ARE MEETING RECOMMENDED PHYSICAL ACTIVITY GUIDELINES (NZHS 2011-14, AGE-STANDARDISED), AN INCREASE FROM 42% IN 2006/07

Our impact measure of the success of our obesity programmes is the proportion of adults meeting daily physical activity guidelines. In 2011-14, 48% of our adult population did at least 30 minutes of exercise on 5 or more days in a week, compared with 42% in 2006/07.

We have invested in a number of programmes to tackle obesity in our district, including lifestyle interventions such as Healthy Village Action Zones - a church and community group based health and exercise programme targeted at our Pacific population.

4,908

GREEN PRESCRIPTION REFERRALS WERE MADE, A DECREASE OF 2% FROM THE PREVIOUS YEAR

The Green Prescription (GRx) initiative supports inactive adults to make healthy lifestyle changes. Health professionals refer patients to GRx for support to increase their physical activity. GRx support staff assist patients to set achievable goals so they can be independently active. They're also supported to make healthy food choices and encouraged to attend local Green Prescription exercise classes and education sessions. Nearly 5,000 Aucklanders were referred to Green Prescription in 2015/16.

78%

OF MOTHERS WERE BREASTFEEDING AT DISCHARGE FOLLOWING BIRTH

Where lifestyle and diet modification and diet hasn't proved sufficient, we are also working to improve access to bariatric surgery.

13,675

INDIVIDUALS PARTICIPATED IN HEALTHY VILLAGE ACTION ZONES

We support healthy public policies, such as improving the built and food environments in which people live and work. One initiative is 'Healthy Auckland Together' which is an intersectoral, regional obesity prevention initiative and is focused on four initial key priorities; healthy food environments, children and young persons' settings, supporting Healthy Families NZ, and increasing physical activity through environmental change.

Healthy Auckland Together

Childhood obesity rates in Auckland are unacceptably high with nearly 9% of 4 year-olds identified as obese at their B4 School check. Rates are much higher in our Pacific children, with 20% obese.

Healthy Auckland Together (HAT) is a coalition of 21 organisations representing local government, mana whenua, health agencies – including Waitemata and Auckland DHBs - NGOs, university and consumer interest groups. We are working together to change policy and urban design, so that our environments can encourage physical activity and good nutrition.

Many drivers of obesity, inactivity and ill health exist outside the health sector, and changing these can be more effective than asking individuals to amend their ways.

Learning about healthy food

Oranga Kindergarten has tackled a lack of access to cheap fruit and vegetables in its community by growing and cooking its own.

Head Teacher Tanya Brand says the kindergarten recognised that healthy lunches could be a challenge because there was a lack of nutritious and affordable food available locally.

"While we promoted healthy eating at the kindergarten, there isn't a supermarket or grocery store easily accessible in the immediate area, and not all of our families have a car," Tanya says.

The kindergarten decided one way to take action and support education around healthy food was to establish new garden beds and cook the harvest with the children in the kitchen.

Teachers, children and their families share what they know about the growing and preparing of foods needed for healthy lives. Together teachers and children dig, plant seeds, water plants, inspect insects and learn how to grow produce such as cauliflower, spinach, peas and carrots.

As a result, the children are more knowledgeable about making healthier choices from their lunchboxes from home, teachers say, as well as eating the nutritious food prepared from the garden.

Any leftover food and vegetables are available to the families to take home at a small price or for free.

Children at Oranga Kindergarten learn about healthy food choices by growing and preparing their own food.

MANAGE LONG TERM CONDITIONS

'Support people to stay well with early detection and effective management'

Long term conditions such as cancer, CVD and diabetes comprise the major health burden for New Zealand, and as the population ages and lifestyles change, prevalence of these condition are likely to increase. We aim to improve the prevention, detection and management of long-term conditions as well improve the wellbeing of people suffering poor mental health.

101

PER 100,000
LOW CVD MORTALITY

53%

OF PATIENTS WITH CVD ARE RECEIVING TRIPLE THERAPY MEDICATION, A DECREASE FROM 54% THE PREVIOUS YEAR

539

CORONARY REVASCULARISATIONS WERE PERFORMED ADDING A TOTAL OF

846

QUALITY-ADJUSTED LIFE YEARS TO OUR POPULATION (841 IN 2014/15)

145,330

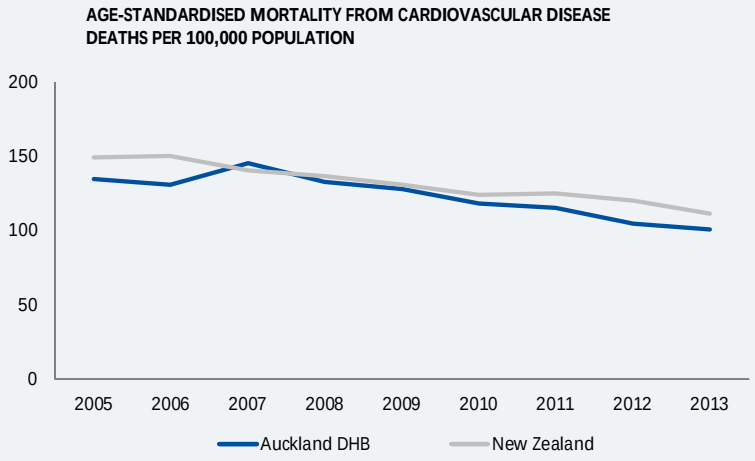
PEOPLE HAVE COMPLETED A CVD RISK ASSESSMENT IN THE LAST 5 YEARS, OR 92% OF TARGET POPULATION, AS AT JUNE 2016

The lowest mortality from cardiovascular disease

Cardiovascular disease (CVD) is a leading cause of mortality in Auckland and it contributes significantly to premature deaths. Early identification of those at risk, lifestyle advice and treatment can prevent the development or progression of CVD.

A reduction in mortality from cardiovascular disease

Mortality due to cardiovascular disease is steadily declining. The rate in Auckland (101 per 100,000 population) is lower than the national rate (112 per 100,000 population) and is amongst the lowest in the country.



We performed well in the detection and management of cardiovascular disease in 2015/16. 92% of our eligible population have had their cardiovascular disease risk assessed, exceeding the target of 90%. For those with CVD, there is strong evidence that treatment with triple therapy (aspirin, a statin and a blood pressure lowering drug) reduces the risk of future ischaemic CVD events. In the 12 months to March 2016, 53% of those with prior CVD received triple therapy medication.

For those in our population who required surgical intervention to treat their CVD, 846 coronary revascularisations (angioplasty and coronary artery bypass grafts) were performed. Quality-adjusted life years are a measure of health benefits – one QALY is equal to one year of life in perfect health. The 539 coronary revascularisations performed in 2015/16 resulted in an additional 846 quality-adjusted life years (QALYs) for our population.

Better outcomes for stroke patients

ADHB is providing optimal care for people with strokes and participating in exciting research.

A stroke can be a sudden, life-changing event for the person it happens to and those around them. The consequences can be devastating, but advances in technology along with a continued focus on evidence-based practice are having a profound impact on outcomes for patients of stroke.

The two key recommendations in the New Zealand Clinical Guidelines for Stroke Management 2010 are that all District Health Boards should provide organised stroke services; and all people admitted to hospital with stroke should expect to be managed in a stroke unit by a team of health practitioners with expertise in stroke and rehabilitation. More than 90% of ADHB's stroke patients are admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway.

Endovascular therapy shows 'huge' benefit for stroke

ADHB participated in a research study into endovascular therapy for ischemic stroke patients – a procedure where the clot blocking the blood vessel in the brain is removed using a stent retrieval device – showed promising results.

The Extending the Time for Thrombolysis in Emergency Neurological Deficits – Intra-arterial (EXTEND-IA) trial showed convincing evidence of benefit for endovascular therapy in selected stroke patients.

The investigators, led by Bruce Campbell, MD, Royal Melbourne Hospital, note that, until recently, trials of endovascular therapy for ischemic stroke have not managed to show a benefit of this approach.
But these latest studies have changed that by selecting patients with advanced imaging techniques, using the latest stent retriever devices, and performing the intervention earlier.

The standard treatment for ischemic strokes is tissue plasminogen activator (TPA), which works by dissolving the clot and improving blood flow to the affected part of the brain.

Dr Campbell commented to Medscape Medical News that tissue TPA does not work well on its own for this group. This is because the clot is too larger to be completely dissolved with thrombolysis. He said "In our study, 40% of patients had a good outcome with TPA alone. This was almost doubled with endovascular therapy was added in. This is a huge benefit. We are talking about transforming the outcome from severe paralysis to patients being able to care for themselves at home."

The study was presented at the International Stroke Conference (ISC) 2015 and published online in the New England Journal of Medicine. It also won an Auckland DHB Health Excellence Award in 2015 for Excellence in Research.

Members of the research team: Alan Barber, Ben McGuinness, Stefan Brew, Maurice Moriarty

107

PER 100,000 OUR CANCER MORTALITY RATE IS ONE OF THE LOWEST IN NZ

66%

OF PEOPLE DIAGNOSED WITH CANCER SURVIVE FIVE YEARS AFTER THEIR DIAGNOSIS, ONE OF THE HIGHEST SURVIVAL RATES IN NEW ZEALAND. THIS HAS INCREASED FROM 64% IN 2006/07

77%

OF PATIENTS RECEIVED THEIR FIRST CANCER TREATMENT (OR OTHER MANAGEMENT) WITHIN 62 DAYS OF BEING REFERRED WITH A HIGH SUSPICION OF CANCER (JAN-JUN 2016)*

102,831

AUCKLAND WOMEN AGED 25-69 HAVE BEEN SCREENED FOR CERVICAL CANCER

65%

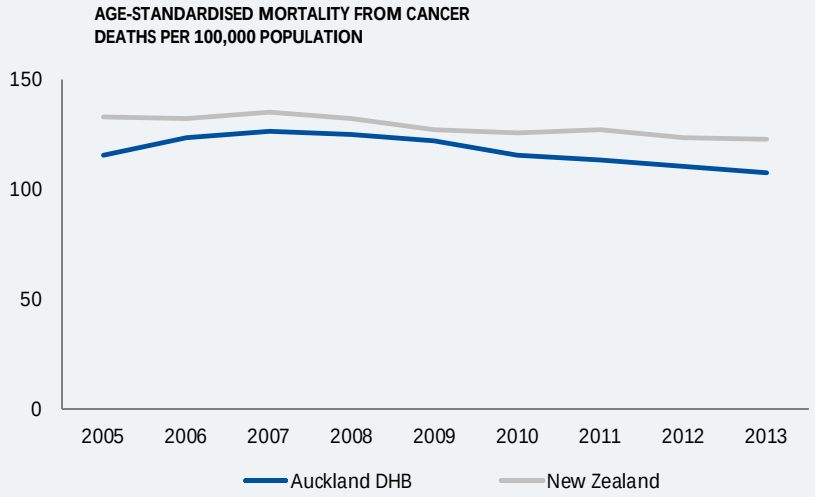
OF 50 TO 69 YEAR OLD WOMEN WERE SCREENED FOR BREAST CANCER (AS AT JUNE 2016)

Reduced mortality from cancer

Cancer is the second leading cause of mortality in Auckland DHB and contributes to a high proportion of 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.

A reduction in mortality from cancer

Mortality due to cancer is steadily declining. The rate in Auckland (107 per 100,000 population) is lower than the national rate (123 per 100,000 population), and is one of the lowest in the country.



Our five-year survival rates from cancer - our main impact measure in lowering our mortality rate from cancer – are some of the lowest in New Zealand. For individuals diagnosed with cancer in 2008-2009, the five year survival rate was 66%, an increase from 64% in 1998-1999.

We have made significant progress towards achieving the new cancer health target. 74% of patients who received their first cancer treatment (or other management) between January and June 2016 were treated within 62 days of being referred with a high suspicion of cancer compared with 60% in Q4 2014/15.

Cervical screening three-year-coverage rates have dropped slightly to 74%, from 75% in June 2014. However, we are making gains in reducing the ethnic inequalities. Between June 2014 and June 2016 and Pacific coverage increased from 72% to 75% and Asian coverage increased from 59% to 62%. Māori coverage has remained stable at 56%.

Breast screening coverage has remained stable at 65%. Coverage within our Pacific population (74%) remains above the national target of 70%, however breast screening rates in Māori are lower at only 60%.

*Note: this result does not include patients that have not yet received their first treatment. If a patient has been waiting for more than 62 days as at the reporting date, he/she will not be reported as a breach because the first treatment has not yet occurred

Faster Cancer Treatment

Patients with breast cancer are now receiving faster treatment and diagnosis.

Cancer is a leading cause of morbidity and mortality in New Zealand, accounting for nearly one third of all deaths. We want to improve the quality of care and the patient's experience across the cancer pathway. Prompt investigation, diagnosis and treatment is more likely to ensure better outcomes for cancer patients, and an assurance about the length of waiting time can reduce the stress on patients and families at a difficult time.

The faster cancer treatment health target - 85% of patients referred with a high risk of cancer to be seen within two weeks and to receive treatment within 62 days of the initial referral by June 2017 - aims to support improvements in access and patient experience through the cancer pathway, including the period of investigations before treatment begins.

The path towards faster breast cancer treatment

Breast cancer is the most common cancer for women, and the third most common cancer overall. One in nine New Zealand women will be diagnosed with breast cancer in their lifetime.

By working harder and smarter, a multi-disciplinary team has defined the issues, tested potential solutions and put in place a suite of initiatives to make significant progress towards delivering faster treatment for women with breast cancer.

Between January 2014 and July 2015 75% of patients referred to Auckland DHB with either a high suspicion of breast cancer or confirmed cancer waited longer than 14 days for a First Specialist Assessment (FSA) and 29% of these waited longer than 62 days to receive treatment. Some waited longer than 100 days

The project team developed an improved clinical pathway that is faster, more efficient and better for women with cancer or a high suspicion of cancer, while maintaining excellent, safe quality care. The team's commitment: ***"If we do what is right by our patients and stay focused on that, then the target will take care of itself."***

Improvements implemented in Phase 1 of the solution (up until April 2016) streamlined the referral and triage process, resulting in much shorter waits for first specialist assessment.

By April 2016, 88% of women waiting for their FSA were seen within 14 days, with the average wait 9 days, reduced from 22 days seen in an audit of patients treated between January 2014 and July 2015.

The second phase of the project, which ran until June 2016 has seen improvements to the patient pathway. A one stop shop has been created for patients to receive full work up and diagnosis in the same setting.

Appointments have been ring-fenced to ensure availability for cancer patients in under 14 days and reporting had been re-designed so waiting times are visible and can be managed as urgent where necessary.

By June, 90% of women were receiving treatment within 62 days, an increase from 71% in June 2015. These changes mean the service is aiming to see women treated within 42 days in the future.

The project is already working on the next steps which include booking women with confirmed cancers for surgery at triage, as opposed to waiting for their FSA, and additional streamlining of pre-admissions clinics to improve time to treatment further.

Women have benefitted enormously from the project, with faster diagnosis and treatment. By creating an efficient and sustainable clinical pathway, stress on staff has decreased. The lessons from this project are being shared with other services, other DHBs and the Ministry of Health.

The Auckland DHB Breast Cancer Project team

9.3

PER 100,000
OUR SUICIDE RATE IS
THE LOWEST IN NZ

3.21%

OF 0-19 YEAR OLDS AND

3.77%

OF 20-64 YEAR OLDS
ACCESSED MENTAL
HEALTH SERVICES
(2.99% OF 19 YEAR OLDS
AND 3.94% OF THOSE
20-64 IN 2013/14)

85%

OF ADULT MENTAL HEALTH
CLIENTS AND

88%

OF ADDICTIONS CLIENTS
WERE SEEN WITHIN THREE
WEEKS OF REFERRAL

96%

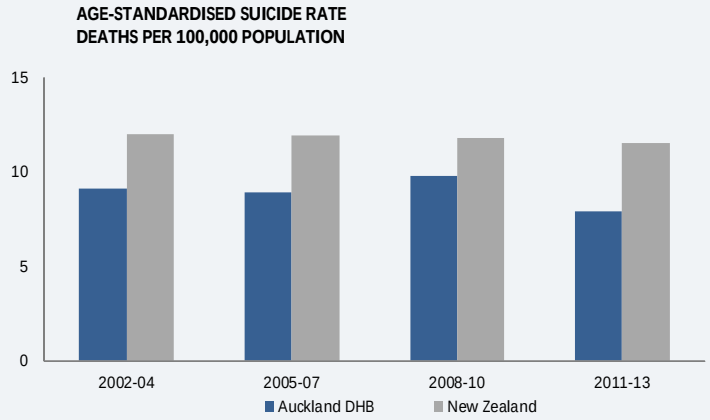
OF CHILDREN AND
YOUTH WERE
DISCHARGED FROM
COMMUNITY BASED
MENTAL HEALTH
SERVICES WITH A
TRANSITION
(DISCHARGE) PLAN

Reduced morbidity and mortality for people with 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 will have a positive impact on health and social outcomes for our population.

A reduction in suicide rates

Our three-year suicide rate (7.9 per 100,000 population) is the lowest in the country and has declined since 2008-2010. Our rate remains below the national rate (11.5 per 100,000 population). Between 2012 and 2013 the number of suicides declined with 49 in 2012 and 39 in 2013.



Access rates to mental health services, our main impact measure, have increased in 0-19 year olds from 1.99% in 2013/14 to 3.21% and decreased slightly from 3.94% in 2013/14 to 3.77% in our 20-64 year olds. We have exceeded waiting time targets for adult mental health (ages 20-64), with 85% seen within three weeks and 92% seen within eight weeks. Access rates to specialist alcohol and drug services are improving, with 88% of all clients accessing services within three weeks and 95% within eight weeks of referral.

To support our families, whānau and communities to prevent suicide, we delivered several SafeTALK workshops in 2015/16 for the general public as well rural areas and Māori, Pacific and Asian communities. One of our focus groups is currently developing a draft plan to improve the clinical pathway between ED and Primary care and ED and secondary Mental Health Services for people who attempt suicide or are at risk of suicide. We have nine frontline community workers trained as WAVE facilitators, who provide a referral pathway for the community to access support after a suicide has occurred. Our Suicide Prevention Inter-Agency Working Group is well established, and is developing a mechanism to notify GPs of a patient's death.

Our Mother and Baby Unit was operational from October 2015.

The Tamaki Mental Health and Wellbeing pilot for the integration of GP practices and NGOs began in September 2015, to be completed by September 2016.

Tamaki Health and Wellbeing

Creating wellbeing together in Tāmaki

The Tāmaki Mental Health and Wellbeing initiative is helping create a new experience of mental health and wellbeing support in Tāmaki.

The initiative focuses on the wellness of the whole person in their family, whānau and community, supported by integrated services. The local community, social agencies and local providers are working together to provide the best experience and outcomes possible for the people of Tāmaki using co-design and co-production methodology.

The focus of this approach has been to put the design of support in the hands of those that will use and provide it.

One of the first workstreams has been to create a preventative, early intervention approach for people with mental health issues by better integrating NGO support services with local GPs.

Previously GPs could only allocate NGO support hours when a person has been through specialist mental health services. This initiative targets those people who don't meet the threshold for specialist intervention but require more support than is able to be provided in traditional primary care to prevent escalation of illness.

Between October 2015 and June 2016 we worked with three non-government organisations (NGOs) and two local doctor surgeries, to develop a service that offers community based wellbeing support. This service, called Supporting Wellbeing was designed in partnership with members of the Tāmaki community, people who used the service, and people who provided the service (Auckland District Health Board, NGO and GP partners).

Workshops were held, focusing on how support could be accessed through GP practices.

People wanted support that was easily accessible, that supports them with goals that they identify and which includes a variety of support options.

We have worked closely with Mind and Body, Affinity Services and Pathways, three community-based NGO support services, to put together a prototype support service.

This service is being trialled through Panmure Medical Centre and East Tamaki Healthcare. The trial is now growing to the next stage where it will become embedded in 11 practices working with 7 NGOs in Tāmaki and beyond.

Some of the complex challenges faced by people in Tāmaki who are experiencing mental health issues.

FOCUS ON CHILDREN AND OLDER PEOPLE

'Children have the healthiest start to life and older people are supported to maintain their independence '

Ensuring that children have the best start to life is crucial to the health and wellbeing of the population. Many risk and protective factors and social patterns established in childhood and adolescence have a significant long-term impact on health. Healthy children are more likely to become healthy adults. As our population ages, health services play a crucial role in supporting our older population to experience independence and a high quality of life.

4.4 PER 1,000

OUR INFANT MORTALITY RATE IS LOWER THAN THE NATIONAL RATE

93%

OF AUCKLAND CHILDREN WERE FULLY IMMUNISED BY EIGHT MONTHS OF AGE, AN INCREASE FROM 90% 2012/13

96%

OF MOTHERS WERE SMOKEFREE AT POSTNATAL DISCHARGE

4,530

PEOPLE PARTICIPATED IN RHEUMATIC FEVER AWARENESS EVENTS

58%

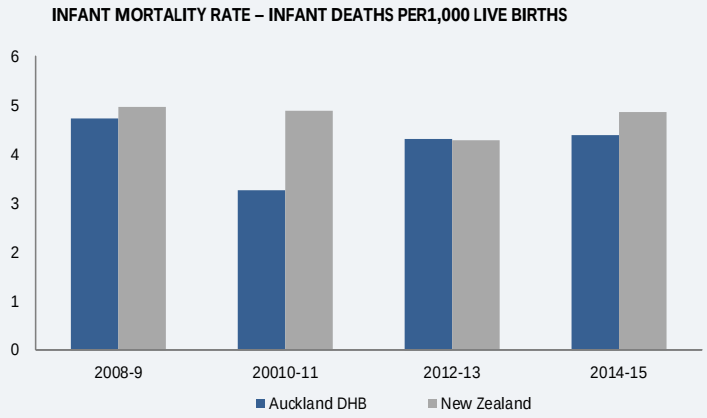
OF CHILDREN WERE DENTAL CARIES FREE AT AGE 5

Children get a great start to life

The creation of healthy generations of children, who can enjoy their lives to the fullest and reach their potential, 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.

A reduction in infant mortality

The infant mortality rate (death of a live-born baby within the first year of life) within Auckland was 4.4 per 1,000 live births (2014-15 two year combined rate), lower than the national rate of 4.9 per 1,000 live births.



During 2015/16 we fully immunised 93% of children by eight months of age compared to 90% in 2012/13. 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. The equity gap is also closing with the eight month immunisation rate in Māori children increasing from 81% in 2012/13 to 88% in 2015/16.

The Before School Check service is a universal, comprehensive screening and health education opportunity for four year old children. We achieved coverage rates of 91% in Māori, 98% in Pacific and 95% overall, well exceeding the 90% national target.

Through our Rheumatic Fever prevention programme we are reducing rheumatic fever in our population. There were 14 new cases of rheumatic fever reported in 2015, a rate of 2.9 per 100,000.

We provide free oral health care for children from birth to 17 years. A focus of the oral health service is to ensure that all eligible children are enrolled and seen on time. The service has recognised that many children are missing out on accessing dental services and are working to address this. In 2015 the service employed a preschool coordinator to promote the importance or dental care through a variety of channels including maternity wards and early childhood centres. We are trying to make it easier for families to access our oral health services by offering family appointments, increased utilisation of mobile vans in the school holidays and extended hours.

Increasing Immunisation

Kids Need Hugs Not Bugs

Our teams work closely with nurses, doctors and communities to maintain good immunisation rates.

Our aim is to protect as many children as possible from once common infectious diseases, at a time they are most vulnerable. We fully immunised 94% of 8 month olds in Q4 of 2015/16, falling just short of the national target. We have worked to close historic equity gaps with immunisation rates for Māori and Pacific babies increasing significantly since the target was launched in 2013.

We work with PHOs and nurses and doctors in the GP network across the district on initiatives including:

- Taking a whole-of-health service approach to ensure babies are offered immunisations whenever they come into contact with a health service.
- Developing general practice resources and providing education for midwives, general practice staff and secondary care staff.
- Developing robust referral processes to Outreach Immunisation Services (OIS) and working to ensure all children are enrolled with a GP as soon as possible after birth.

Immunisation Week took place in May 2016 with a key message – Protection starts in pregnancy – encouraging uptake of influenza and whooping cough (pertussis) immunisation antenatally. The campaign was a success with Maternity services seeing an increasing acceptability to recommend immunisations in pregnancy.

Our local primary care campaign 'Kids need Hugs – not Bugs' extended the promotion of on-time immunisation positive messages in communities.

We have had success with our rotavirus vaccine campaign, introduced in July 2014. At the time, rotavirus infection was the leading cause of hospitalisation for children with gastroenteritis. Taking a collaborative approach across the sector we quickly achieved a high uptake of the rotavirus vaccine. This year, children, parents and caregivers are reaping the rewards. Gastroenteritis presentations to Starship Emergency Department have decreased by at least 50%. That represents more than 200 Auckland children who stayed away from hospital this year, and countless more families and whānau who avoided a nasty bout of illness at home.

Older people experience independence and quality of life

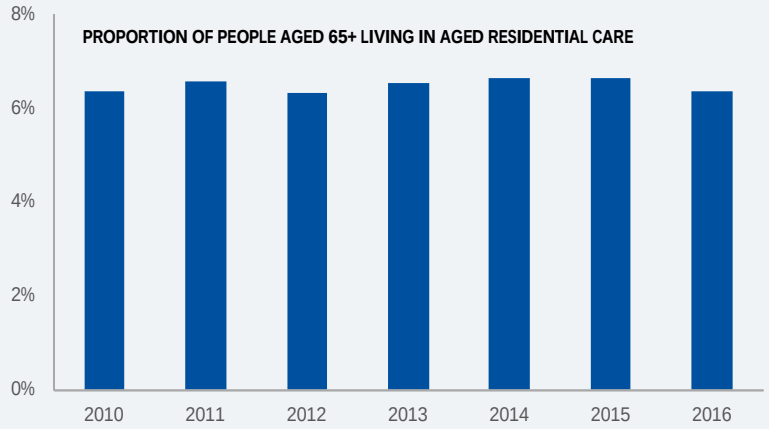
The number of older people in our district is increasing. By 2026, the number of people aged 65+ will have increased 50% to 81,000 - 14% of the total population. As our population ages, more support is required to stay healthy and independent.

6.4%

OF PEOPLE AGED 65+ LIVE IN AGED RESIDENTIAL CARE, A SIMILAR RATE TO THAT SEEN IN 2010

A decrease in the proportion of older people living in aged residential care

6.4% of people aged 65+ in our population lived in aged residential care facilities as at June 2016. This rate has remained stable over the last 6 years.



OUR OLDER POPULATION RECEIVED **388** HIP AND KNEE REPLACEMENTS, AND **992** CATARACT SURGERIES, ADDING A TOTAL OF

1,417

QUALITY ADJUSTED LIFE YEARS TO OUR POPULATION (1,420 IN 2014/15)

For a number of older people, the care they require can only be provided within an aged residential care (ARC) environment. However, those who are able to live in their own homes and remain connected with their local community generally have better long-term health outcomes. A decrease in the proportion of the 65+ population living in ARC is a potential proxy indicator for the health of the older population and how well the health system is managing age-related long-term conditions.

We have seen a relatively stable proportion of our 65+ population living in ARC. This suggests that our older population are gradually becoming healthier and are able to live more independently.

Cataract surgery as well as knee and hip replacements can significantly improve the independence and overall quality of life for those requiring and receiving them. Using previously estimated QALY values, we can estimate how many years of quality life are gained by our 65+ population through the aforementioned procedures.

In 2015/16 our 65+ population gained 1,417 QALYs from cataract surgery and hip and knee replacements. 80% of these additional quality years of life were gained through cataract surgery.

960,625

SUBSIDISED AGED RESIDENTIAL CARE BED DAYS WERE PROVIDED

4,288

PEOPLE WERE RECEIVING LONG TERM HOME-BASED SUPPORT SERVICES

Falls prevention – health of older people

Standing up to falls

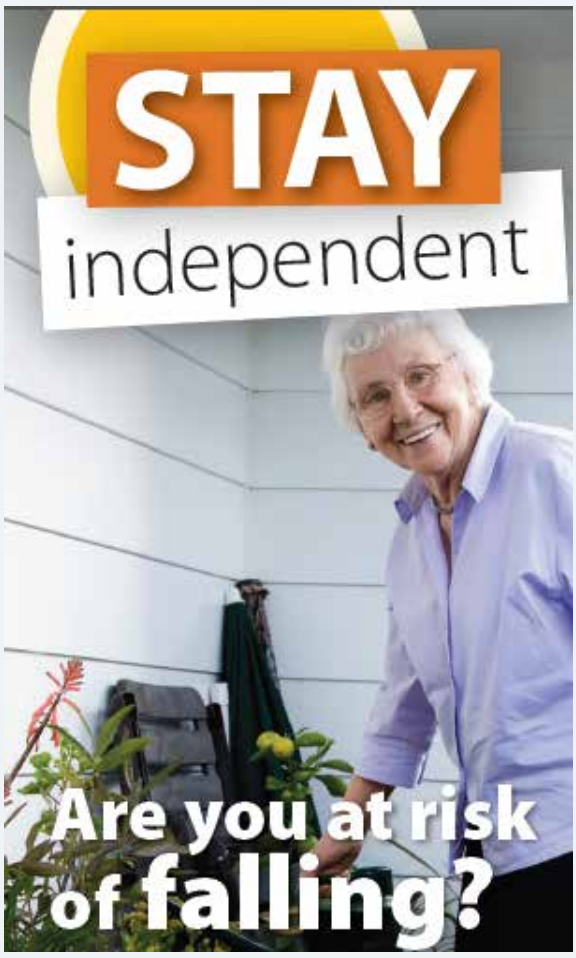
In-home and community exercise programmes are helping to prevent falls in our older population.

Falls in older people are very common and frequently lead to injury and hospitalisation. Each year about one third of people aged 65 years and older, and half of those aged 80 years and older, experience a fall.

Nearly 20% of acute admissions in people aged 80+ to Auckland Hospital involved a fall. In 2013 there were approximately 4,900 ACC fall claims in Auckland DHB for people aged 80+ and around 1,400 falls-related hospital admissions. Between 10-15% of falls in older people will result in significant injury.

Falls in older people also lead to loss of confidence, which reduces people's mobility, and therefore further increases risk of falls, and loss of independence. This can leading to early placement in aged residential care.

Prevention of falls is possible through a range of different interventions, particularly those involving strength and balance training in people's homes or in community groups. Fractures can also be prevented by ensuring that high risk people, particularly people with a recent fracture, receive assessment and treatment for osteoporosis.



Auckland and Waitemata DHBs have been working with ACC to plan a range of services to prevent falls and injuries in older people. These include:

- Extending the Fracture Liaison Service, which provides assessment and treatment for osteoporosis
- Establishing an in-home programme of strength and balance exercises for highest risk people, including a trial of an alternative model using Home and Community Support Services (HCSS) across ADHB and WDHB
- Facilitating the further development of group community strength and balance exercise programmes.

These falls prevention interventions will be co-ordinated via a clinical pathway that will supplement existing services. The establishment of in-home and community group strength and balance programmes will provide referral options for both primary care and secondary care clinicians that currently do not exist in Auckland.

Our people,
Our performance

Delivering on our plans

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.

Measuring our outputs helps us to understand how we are progressing towards our impacts, and high level outcomes set out in the Improving outcomes section of this report. The two high level health outcomes we want to achieve are 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 82.4 years, an increase of 2.4 years over the last decade. The life expectancy gap is 5.2 years for Māori and 6.5 years for Pacific.

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 2015/16.

National health targets

2015/16 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 full year's performance as well as the fourth quarter's result where relevant.

Health Targets		Target	Q4 2015/16	Full Year
Shorter Stays in Emergency Departments	95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours	95%	95%	95%
Improved Access to Elective Surgery	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs)*	16,700	n/a	16,818 (100.7%)
Faster Cancer Treatment	85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment.**	85%	77%	74%
Increased Immunisation	95% of eight months olds will have their primary course of immunisation on time.	95%	94%	93%
Better Help for Smokers to Quit	95% of hospitalised smokers provided with advice to help quit	95%	95%	95%
	90% seen in primary care provided with advice to help quit	90%	91%	88%
	90% of newly registered pregnant women provided with advice to help quit	90%	98%	99%
More Heart and Diabetes Checks	90% of the eligible population have had their cardiovascular risk assessed over the last five years	90%	n/a	92%

* Auckland DHB's targeted increase (share of the NZ total additional 4,000 discharges) was 499 additional discharges

**This result does not include patients that have not yet received their first treatment. If a patient has been waiting for more than 62 days as at the reporting date, he/she will not be reported as a breach because the first treatment has not yet occurred.

Health Quality and Safety Commission Markers

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 (HQSMs). We have aimed to improve in all areas of harm identified in the national patient safety campaign: Open for better care. During 2015/16 we improved or maintained our compliance across most of the HQSM markers:

Health Quality and Safety Markers	Q3 2012/13	Q4 2015/16
80% compliance with good hand hygiene practice	75%	84%
Health care associated staphylococcus aureus bacteraemia per 1000 bed days	0.17	0.17
90% of older patients assessed for the risk of falling	73%	95%
% of patients assessed at risk of falling who received an individualised care plan	91%	96%
Number of in hospital falls causing fractured neck of femur	3[1]	1
100% of hip and knee arthroplasty primary procedures given antibiotic in right time	97%[1]	94%[2]
95% of hip and knee arthroplasty procedures given right antibiotic in right dose	85%[1]	94%[2]
100% of hip and knee arthroplasty procedures given appropriate skin preparation	99%[1]	99%[2]
Surgical site infections per 100 hip and knee operations	1.41	2.11

[1] Q1 2013/14 [2] Q3 2015/16

Output class measures

The criteria against which we measure our output performance for the year was revised in 2014/15 and we continue with this grading system for 2015/16. This has been applied to assess performance against each indicator in the Output Measures section. 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 2015/16 Statement of Performance Expectations by Output Class. Outputs are goods or activities provided by the DHB and other entities and provide a snapshot of the services we deliver. Output measures are intended to reflect our performance for the year. The 'measure type' symbols define the type of measure and are included in brackets after the measure description. Some indicators do not have set quantitative targets, rather expected performance directions, and these have been assigned the below symbols in the target column.

Symbol	Definition	Symbol	Definition
Measure type		Target Symbols	
Q	Measure of quality	Ω	Demand driven measure – not appropriate to set target or grade the result
V	Measure of volume	$	A decreased number indicates improved performance
T	Measure of timeliness	#	An increased number indicates improved performance
C	Measure of coverage		
N/A	Not Available		

Output Class 1: Prevention Services

Preventative services help to protect and promote health in the whole population or identifiable sub-populations by targeting changes to physical and social environments that engage, influence and support people to make healthier choices, thereby reducing inequalities in health status. Prevention services include health promotion to help prevent the development of disease; 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.

Outputs and Activities provided by General Practice teams (including cervical screening and immunisation) are covered under Primary Care in the Early Detection and Assessment Output class. A significant portion of the work of Primary Care is preventive.

Output Measures	Baseline period	Baseline	2014/15 Results	2015/16 Target	2015/16 Results	Achievement
HEALTH PROMOTION						
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)	Q2 2014/15	96.2%	96%	95%	95%	
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care who are offered advice and support to quit smoking (Q)	Q2 2014/15	97.7%	98%	90%	88%[1]	
Number of people accessing Green Prescriptions (V)	Q2 14/15 (extrap)	4,878	5003	6,936	6,347[2]	
Enforcement of the Smokefree Environments Act 1990						
Number of retailer compliance checks conducted (V)	2013/14	302	284	300	341	
Proportion of retailers visited during Controlled Purchase Operations (CPOs) in which tobacco is sold to minors (Q)	2013/14	3%	3%	Ω	11%[3]	
HEALTH PROTECTION						
Tuberculosis (TB)[4]						
Number of TB contacts followed up (V)	2013/14	1,080	821	750	1,158	
Percentage of TB and LTBI (latent TB infection) cases who have started treatment and have a recorded start date for treatment (Q)	2013/14	83.6%	99.9%	≥85%	98%	
Percentage (and number) of eligible infants vaccinated with a BCG (vaccine against tuberculosis) (C)	2013/14	98.3% (4,613)	97.1%	≥98%	73%[5] (4,999)	
Refugee health screening service[4]						
Percentage of quota refugees commencing a vaccination programme as per NZ immunisation schedule (C)	2013/14	99.6%	100%	≥99%	100%	
POPULATION BASED SCREENING						
Breast Screening						
Coverage rates among eligible groups (45-69) (C)	Sep 14	68%	66%	70%	65%[6]	
Newborn Hearing Screening						
Number/proportion of babies offered screened within 1 month (C)	CY 2014	7,948 (98%)	8,452 (97%)	90%	8,309 (98%)	
Referral rate to audiology ≤4% (Q)	CY 2014	1.6%	1.79%	≤4%	1.9%	
Appropriate medical and audiological services initiated by 6 months of age for infants referred through the programme (T)	CY 2014	100%	100%	≥95%	100%	
Children						
Percentage of B4 School Checks completed	Q2 14/15 (extrap)	94%	96%	90%	95%	

[1] As of 2015/16 denominator no longer adjusted to only count those 'seen by a health practitioner' leading to a significant increase in the denominator volume.

[2] Includes adults and active families

[3] Target premises includes those in high deprivation areas and close to transport hub. Particular attention was paid to retailers who have previously failed a CPO. All retailers found to fail the CPO were issued $500 infringement notices by the MoH.

[4] The Smokefree Environments Enforcement and TB services are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. The data to support measures in these categories is for all three metro Auckland DHBs.

[5] There is ongoing worldwide shortage of BCG vaccine. The BCG programme was suspended between Dec 2015 and March 2016, and again since June 2016.

[6] Numbers of women screened have increased since 2014, however the estimated population has increased significantly resulting in a lower observed rate. The identification of under screening women through NHI matching is a key strategy to improve screening rates.

Output Class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals including general practice, community and Māori health services, pharmacist services, and child and adolescent oral health and dental services. 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, we can support people to maintain good health, and through prompt diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long term outcomes. These services also enable patients to maintain their functional independence and reduce complications or acute illness, reducing the need for specialist intervention.

Output Measures	Baseline period	Baseline	2014/15 Results	2015/16 Target	2015/16 Results	Achievement
PRIMARY HEALTH CARE						
Primary care enrolment rates (C)	Mar 2015	91%	91%	95%	88%[7]	
Percentage of children fully immunised at 5 years (C)	Q2 14/15	81%	82%	90%	84%	
HPV vaccination coverage dose 3 (C)	Dec 2014	76%	76%	65%	83%	
Seasonal influenza immunisation rates – 65+ (C)	Q1 14/15	65%		75%	n/a[8]	
Cervical screening coverage (C)	Dec 2014	79%	79%	80%	76.6%	
Percentage of diabetes patients receiving retinal screening (C)	2014/15	59%[9]	59%	60%	65%	
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years (C)	Q2 14/15	91.9%	92%	90%	92%	
COMMUNITY-REFERRED TESTING AND DIAGNOSTICS						
Number of community laboratory tests (V)	Oct 2013-Sept 2014	3,086,467	3,072,649	Ω	3,256,265	
Number of radiological procedures referred by GPs to hospital (V)	2013/14	44,365	46,790	Ω	50,021	
Number of complaints[10] (Q)	2014	LTA = 60	31	Ω	15	
Average waiting time in minutes for a sample of patients attending collection centres between 7am and 11am (T)	Jan 2015	8.5	7.7 mins	< 30 mins	7.4	
Percentage of accepted community referred scans receiving their scan within 6 weeks (T)	Dec 2014	CT 71% MRI 75%	CT 82% MRI 44%	CT 95% MRI85%	CT 98% MRI 95%	
ORAL HEALTH						
Enrolment rates in children under 5 by ethnicity[11] (C) - Māori - Pacific - Other - Total population	Dec 2014	75%	71%	85%	 60% 76% 76% 74%[12]	
Utilisation rates for adolescents (C)	CY 2013	85%	76%	87%	78%	
Arrears rates by ethnicity[11] (T) - Māori - Pacific - Other - Total population	Jan 2015	6.5%	 8.1% 7.0% 8.5% 8.1%	7%	 10.6% 10.6% 13.7% 10.8%[13]	
PHARMACY						
Number of prescription items subsidised (V)	2013/14	6,507,848	6,674,410	Ω	6,787,090	

[7] Numerator 2016-Q2 enrolments, denominator 2015/16 population projections (2015 update). Enrolments have increased 0.1% since 2014/15, however 2015/16 estimated population 5% higher than estimate used for 2014/15.
[8] Previously reported under the PHO Performance Programme, which transitioned to IPIF, however only included vaccinations provided by GPs. This indicator no longer reported under IPIF. Reporting (which will include all providers, e.g. pharmacy) is being developed by the National Immunisation Register
[9] Baseline/2014-15 and target values incorrectly entered in 2015/16 AP.
[10] Result for all 3 metro Auckland DHBs
[11] CY2015 rate (Oral health targets set for calendar years, not financial years)
[12] Multi-enrolment project commencing to increase enrolments. Enrolment co-ordinators visit maternity wards and pre-school co-ordinators prioritise visits to ECE centres with high proportions of Māori and Pacific children.
[13] Arrears = pre-school and primary children who are overdue for their planned recall dental examination. Extended hours and mobile clinics used to improve access and pathways introduced to support vulnerable families to attend appointments.

Output Class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by specialist providers in facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital' or surgery centre. These services 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.

These services are at the complex end of treatment services and focused on individuals. Equitable and timely access to intensive assessment and treatment improves outcomes for patients. Effective and prompt resolution of medical and surgical emergencies and acute conditions reduces mortality and elective surgery restores functional independence and improves health-related quality of life, thereby improving population health.

Output Measures	Baseline period	Baseline	2014/15 Results	2015/16 Target	2015/16 Results	Achievement
ACUTE SERVICES						
Number of ED attendances (V)	2013/14	103, 540	102,792	Ω	108,132	
Acute WIES[14] total (DHB Provider) (V)	2013/14	92,808	92,764	94,755	97,851	
Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival (Q)	Q2 2014/15	94%	94%	95%	95%	
Compliance with Faster Cancer Treatment national health target – 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016.[15] (T)	Q2 2014/15	57.6%	59.7%	85%	76.6%	
Percentage of eligible stroke patients thrombolysed (T)	Q1 2014/15	8.1%	11.1%	8%	9.8%	
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway (Q)	Q1 2014/15	80%		80%	91%	
Percentage of ACS inpatients receiving conronary angiography within 3 days (T)	Q2 2014/15	87%	86%[16]	70%	87%	
MATERNITY						
Number of births (V)	CY 2013	7223	7,427	Ω	7,173	
Proportion of all births delivered by caesarean section (Q)	CY 2013	34.7%	36%	$	36.3%	
Established exclusive breastfeeding at discharge excluding NICU admissions (Q)	CY 2013	79%	77%	75%	78%	
Third/fourth degree tears for all primiparous vaginal births (Q)	CY 2013	3.5%	4.7%	$	5.4%[17]	
Admission of term babies to NICU (Q)	CY 2013	6.0%	4.1%	$	6.3%	
Number of women booking before end of 1st trimester (Q)	2012	64%	68%	80%	69%[18]	
ELECTIVE (INPATIENT/OUTPATIENT)						
Delivery of health target for elective surgical discharges (V)		n/a	15,899[19]	16,700	16,818	
Patients waiting longer than four months for their FSA – ESPI 2 (T)	Jan 2015	0	0%	0	0.1%[20]	
Patients given a commitment to treatment but not treated within four months – ESPI 5 (T)	Jan 2015	0	0.5%	0	0.9%[21]	

[14] Weighted inlier equivalent separations (WIES) – relative cost measure for inpatient episodes
[15] This result does not include patients that have not yet received their first treatment. That is even if a patient has been waiting for more than 62 days as at the reporting date, he/she will not be reported as a breach because the first treatment has not yet occurred. Note: measure implemented from Q2 2014/15
[16] Jan-June 2015, Acute Coronary Syndrome
[17] Improved detection and documentation of perineal tears commenced in 2105 (Perineal Repair Record), possibly increasing number of tears reported.
[18] There is a shortage of LMCs in the Auckland area. ADHB has been working to support midwives to transition in to LMC practice in the central Auckland region, through the ADHB Community Midwifery team. ADHB also has a number of women moving to the city from overseas already pregnant, it is not possible for these women to register with an LMC in New Zealand before 12 weeks.
[19] Elective HT methodology changed in 2015/16. 2014/15 volume shown using 2015/16 definition.
[20] Rated yellow by MOH (as ESPI2 <0.39% and ESPI5 <0.99%)

Output Measures	Baseline Period	Baseline	2014/15 Results	2015/16 Target	2015/16 Results	Achievement
QUALITY AND PATIENT SAFETY						
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC (Q)	CY 2014	0.25	0.23	$	0.14	
Percentage of respondents who rate their care and treatment as very good or excellent (inpatients) (Q)	Feb 14-Jan 15	84%	85%	#[21]	86%	
ASSESSMENT TREATMENT AND REHABILIATION (INPATIENT)						
AT&R bed days (V)	2013/14	24,119	22,311	Ω	23,219	
Proportion waiting 4 days or less from waitlist date to admission to AT&R service (T)	2013/14	88%	76%	90%	81%	
MENTAL HEALTH						
Improving the health status of people living with severe mental illness						
Access to mental health services (C)						
0-19	Jan-Dec	3.01%	2.91%	3.0%	3.21%	
20-64	2014	3.84%	3.96%	4.0%	3.77%	
Over 65		3.55%	3.34%	4.0%	3.14%[22]	
Improving mental health services using transition (discharge) planning and employment						
Child and Youth with a Transition (discharge) plan (Q)	Q2 2014/15	82.9%	94%	95%	96%	
Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.						
% of clients seen within 3 weeks (T)						
- Mental Health	Oct 2013-Sept 2014	86%[23]	80%	80%	75%	
- Addictions		96%	96%		96%	
% of clients seen within 8 weeks (T)						
- Mental Health		98%	97%	95%	89%	
- Addictions		100%	100%		100%	

Output Class 4: Rehabilitation and Support Services

Rehabilitation and support are 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.

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.

Output Measures	Baseline Period	Baseline	2014/15 Results	2015/16 Target	2015/16 Results	Achievement
HOME-BASED SUPPORT						
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)	Q2 2014/15	94.6%	97%	95%	97%	
Percentage of NASC clients assessed within 6 weeks (T)	CY 2014	95%	93%	95%	89%[24]	

[21] Target incorrectly shown as $in 2015/16 Annual Plan.
[22] Only about 55% of access is delivered by hospital services, so it can be challenging to understand the relative performance of different services. Entry pathway redesign and additional resource within the provider arm has been identified to improve access for the 65+ age group.
[23] Baseline values incorrectly entered in 2015/16 Annual Plan
[24] Rapidly growing 65+ population is putting increased demand on service providers.

Output Measures	Baseline Period	Baseline	2014/15 Results	2015/16 Target	2015/16 Results	Achievement
PALLIATIVE CARE						
Number of Advance Care Plan conversations recorded in Collaborative Care Management System (CCMS) will increase by 20% (Q)	Target for 2014/15	3,101	2,588	3,721	6,100	●
Number completing at least one module of training as Level 1 practitioners each year	Jul 14-Feb 15	160	216	200	449	●
Proportion of hospice patient deaths that occur at home (Q)	Apr 14-Feb 15	24%	25%	#	26%	●
Proportion of patients acutely referred who waited >48 hours for a hospice bed (T)	Apr 14-Feb 15	1%	<1%	$	<1%	●
RESIDENTIAL CARE						
Total number of subsidised aged residential care bed days (V) - Rest homes - Hospitals - Dementia - Psychogeriatric	12 months to Sep 2014	981,671 318,161 556,324 94,898 12,288	982,309	Ω	960,118 289,609 563,605 94,652 12,252	
Proportion of aged care providers with 4 year audit certification (Q)[25]	Feb 2014	23%	26%	#	29%	●

Cost of Service Statement – for year ending 30 June 2016

During the reporting year, ADHB acts as the lead DHB for the ProCare and LabTest contracts within the Auckland region. Consequently, ADHB receives some $59.4M by way of contribution from Counties Manukau DHB. In the actual results the contribution of $59.4M was treated as an offset of expenditure in Early Detection & Management Output Class. At the time the budgets were prepared for the annual plan the contribution from Counties Manukau DHB was regarded as revenue.

	Prevention Services $000		Early Detection & Management $000		Intensive Assessment & Treatment $000		Rehabilitation and Support $000		Total $000	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**25,673**	**23,430**	**400,229**	**450,426**	**1,356,991**	**1,358,447**	**207,125**	**200,641**	**1,990,018**	**2,032,944**
Expenditure										
Personnel	17,722	18,489	2,657	2,646	811,335	800,031	35,513	36,574	867,227	857,740
Outsourced Services	1,448	718	(3)	2	99,755	94,093	4,641	874	105,842	95,687
Clinical Supplies	181	303	162	79	239,754	233,799	4,686	4,916	244,783	239,097
Infrastructure & Non-Clinical Supplies	3,344	3,395	852	795	181,120	174,765	6,543	8,025	191,858	186,980
Payments to Providers	2,131	2,053	368,033	441,938	57,865	57,967	149,408	149,115	577,437	651,073
Total Expenditure	**24,825**	**24,958**	**371,701**	**445,460**	**1,389,829**	**1,360,655**	**200,791**	**199,504**	**1,987,146**	**2,030,577**
Net Surplus / (Deficit)	**847**	**(1,528)**	**28,528**	**4,966**	**(32,838)**	**(2,208)**	**6,334**	**1,137**	**2,872**	**2,367**

[25] 4 year certification is infrequently awarded and considered 'gold standard'. Facilities must first demonstrate several years of continuous improvement. >80% of providers are achieving 3 year certification.

BEING A GOOD EMPLOYER

'As an employer, we are committed to: providing outstanding professional and personal development opportunities for all; championing employee physical and mental wellbeing to ensure a mindful, safe and healthy workforce, role modelling the health practices we champion in our communities; transparently and fairly fulfilling our employment promises, and living our values – consistently getting the basics right'. – Our employee value proposition

OUR EMPLOYEES:

10,200
PEOPLE EMPLOYED AT AUCKLAND DHB (8,200 FTE)

3% MĀORI
7% PACIFIC
72% OTHER ETHNICITIES

78% FEMALE
22% 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.

We strive to:

- 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 believe 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 clinician leadership, with accountability for directorates held by a Director, nearly in all cases a clinician, who is ultimately accountable for delivering results.

The DHB launched a new leadership development programme including sessions, an online platform, small group discussions, a 360 development planning tool and coaching designed to develop and enable Clinician leaders to grow their impact as a leader, lead people and teams, lead together and sustain change. Other new leadership development programmes include Coaching Conversations and team workshops to lead out values discussions and embed our values into our everyday actions.

18% AGED <30

49% AGED 30-50

34% AGED 50+

46%
WORK PART TIME
(4,700 PEOPLE)

0.25%
OF OUR EMPLOYEES HAVE DECLARED A DISABILITY

The DHB is phasing in a new Mindfulness-Based Stress Reduction (MBSR) programme to support our staff to take care of themselves and live healthier and more adaptive lives.

The DHB participates in the HWNZ Leadership and Management Workstream.

Recruitment, Selection and Induction

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 Māori and Pacific students undertaking their first tertiary qualification in health, targeting current Auckland DHB employees and secondary school students form schools with the Auckland DHB zone. The programme is also aimed at addressing workforce disparities including a focus on increasing the Māori and Pasifika health workforce and reducing specific skill gaps in the health and disability workforce identified by Auckland DHB. The secondary school aspect of the scholarship programme is organised in partnership with the First Foundation. The First Foundation is a charitable trust created in 1997 with a vision of assisting academically talented and financially disadvantaged New Zealand students to achieve their potential through tertiary education and to prepare them to positively influence and benefit their communities.

Employee development, promotion and exit

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

- Regular performance and development discussions are encouraged to acknowledge progress and results, and identify support and development needs. Various 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
- A+ Trust Nursing and Midwifery Awards recognising the quality of achievement from our nurses and midwives.

OCCUPATION TYPE:

41% NURSING

22% ALLIED HEALTH

17% MEDICAL

18% OTHER

- Celebrating the achievement of Orderlies who gained the new NZQA accredited Certificate in Health and Wellbeing (level 3). Auckland DHB is one of the first to take part in the training offered to orderlies at DHBs throughout the country.
- Health Excellence Awards to publically recognise and celebrate staff who deliver sustainable improvements for our patients and the organisation and inspire others by sharing excellence around the organisation and the wider health community.
- Long service awards
- Tributes to retiring staff through a tribute in NOVA.

A highly subsidised gym membership rate is offered to staff, and staff earning less than $55,000 per year have a free gym membership.

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.

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.

Volunteers

At Auckland DHB there are approximately 400 people actively volunteering across three sites: Starship Children's Hospital, Auckland City Hospital including the Acute Mental Unit Te Whetu Tawera and at Greenlane Clinical Centre.

Blue Coats, Info Desk-, School assistant-, Playroom-, Toy Library, Pet Programme-, Hospital Grandparent-, Church- and Music/Play therapy volunteers are managed through Auckland DHB's Volunteering Services. External organisations such as St John manage Friends of Emergency Department (FEDS), Cancer Society manages Drivers and Yellow Shirt volunteers at Oncology, Red Cross manages Trolley volunteers and Radio Lollipop comes into Starship Hospital every weeknight to entertain its little patients.

A Volunteers Services Survey held in September 2015 amongst patients (48%), friends and family/whānau (12%), staff (14%), volunteers (18%) and others (8%) concluded that the nature of volunteering is changing to meet new needs. Improvements and innovations challenge traditional concepts of volunteering which can be seen as one way relationships towards more collaborative relationships between staff and volunteers. Our Volunteering work is seen as values based and people centred.

One such improvement is the establishment of a new Companion Volunteering role which is currently a trial project at Reablement Services. Another improvement is the establishment of working relationships between the ADHB Volunteers Services and educational institutes in Auckland, and there are many other exciting initiatives underway.

PATIENT EXPERIENCE

Auckland DHB is committed to improving patient experience and empowering patients and families to take more control of their health and health care. We do this by listening to patients' experiences of care and what patients, their whānau and people out in the community want from our health care providers. We find out what kinds of information, resources and services people are looking for, where health care services need to improve and how we might best do that from service users' perspectives.

Measuring 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. Each week we invite inpatients who have been discharged and outpatients who have attended a consultation to find out about their experience. The survey covers all the core dimensions that evidence shows most directly impact on patient experience of care and allows each patient to provide more in-depth information about the areas that are most important to them. The percentage of inpatients rating their care as very good or excellent has increased from to 84.7% in 2014/15 to 85.7% in 2015/16.

Improving services together

Co-design

It is important to ensure consumer views and interests are heard in the monitoring, planning and delivery of healthcare services. Auckland DHB strives to ensure that any project or committee that has a direct impact on consumers has meaningful input from consumers. One way we do this is through using co-design, a service improvement method which involves capturing and understanding people's experiences of services, identifying improvements and then making changes together.

Co-design in action: Improving services provided to people with relapsing-remitting multiple sclerosis

Multiple Sclerosis nursing staff were concerned at the low number of reported relapse episodes each month. They knew that in order to deliver meaningful change they needed to listen to their patients, their families and groups working in the community with people with MS. They needed to understand people's experience of their service, barriers to prompt reporting and improvements that could be developed with the users of their service.

The Multiple Sclerosis Service and Multiple Sclerosis Auckland partnered together and worked with patients and whānau to identify and implement a range of improvements that have dramatically improved relapse reporting, patient access to services and engagement with primary care.

Consumer representatives

Consumer representation on improvement projects, committees and key initiatives is another way of ensuring the consumer voice is included in the planning, implementation and evaluation of services. Auckland DHB is currently working on streamlining its systems and processes to make it easier for consumer representatives to become involved in our work.

Making greater links with the community

Seeking community feedback: Reo Ora Health Voice

Auckland DHB recognises the importance of connecting with the wider community it serves. One ways we do this is through Reo Ora Health Voice. This online community allows staff to seek targeted feedback about their plans, services or initiatives. Members participate in confidential online surveys and discussions and are invited to consultation events. Membership is open to anyone. There are currently more than 1,100 members and this year members have been invited to be involved in a range of activities, including consultation about Waiheke Island Health services, the New Zealand Health strategy and the design of the new Auckland DHB website.

Working side-by-side: Creating Wellbeing Together in Tāmaki

Auckland DHB is exploring innovative way of working alongside communities to develop services together. One example of this is Creating Wellbeing Together in Tāmaki – see story page 20.

SUSTAINABILITY

Auckland DHB is a large energy user and generator of waste from its 24/7 operations creating carbon emissions which in turn contribute towards global warming.

We are conscious that we have a social responsibility to the wider community to minimise the impact on the environment and are committed to sustainability as part of our strategy and vision to meet the needs of today without adversely impacting on the needs of the future generation. The DHB is committed to using resources responsibly in the most sustainable manner and will be proactive in adopting carbon reduction strategies to protect the community and environment for future generations.

While there are challenges in managing increased demand for services and reducing carbon emissions, as a leading health provider we also have an opportunity to take a key role in addressing the impact of climate change within the sector. In response to these challenges, we will continue to look to innovation and collaboration within our community to reduce our carbon footprint with improved energy efficiencies and waste minimisation strategies.

Learning from the best

Our monthly sustainability forums have received wide support by our staff and external stakeholders. The guest speakers represent a growing community of individuals and organisations who are concerned about global warming and the potential impact on the planet. They understand the drivers for change in a broader sense to help us on our own journey towards more sustainable thinking and practice.

In 2015 the Board achieved Carbon Emissions Measurement and Reduction Scheme certification (CEMARS). This was a major milestone to actively measure, manage and mitigate carbon emissions. Under this programme, we established key priorities and goals to reduce carbon emissions, minimise the impact on the environment and drive sustainable practice within the hospital setting.

The monitoring of our emissions alongside the reduction plan will help address the challenges in an increasingly resource-constrained environment and impact on operations and supply chain due to climate change. The reduction plan is to reduce emissions by 20% over the next 10 years compared with the 2014/15 baseline. This equates to 5,500 tonnes of carbon dioxide equivalent.

A number of sustainability initiatives are already underway or under development. These include the sustainable transport (bike to work, e-bikes, public transport, electric vehicles, waste reduction, waste recycling, PVC recycling, e-waste and the collaboration agreement with Energy Efficiency & Conservation Authority (ECCA) to help improve energy efficiencies at our Grafton and Greenlane sites.

ABOUT OUR ORGANISATION

Auckland DHB attendance at Board and Committee meetings: July 2015 – June 2016

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

x *not a member of the committee*
* *ex-officio member*
^ *leave of absence*

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 2015/16 year there were no permissions, waivers or modifications given under the clauses of this legislation.

Subsidiaries, associates and joint ventures

Auckland DHB Charitable Trust (A+ Trust) is an independent charitable trust created by Auckland DHB, and consolidated for financial statement purposes.

The DHB is also shareholder in a number of Crown Entities: Northern Regional Alliance Limited (NRA) New Zealand Health Innovation Hub Management Limited and healthAlliance N.Z. Limited. Canterbury, Counties Manukau, Waitemata and Auckland District Health Board's (DHBs) are limited partners in the New Zealand Health Innovation Hub Management Limited. The NRA 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 three equal shares by Waitemata, Auckland and Counties Manukau (DHBs). Auckland, Waitemata, Counties Manukau and Northland DHBs each own 25% A Class shares in healthAlliance N.Z. Limited.

NZ Health Partnerships Limited (NZHPL) (formerly Health Benefits Ltd (HBL)) is a crown entity 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. NZHPL works with DHBs to achieve these aims. All DHBs across NZ own 5% A Class shareholding in NZHPL.

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 2015/16 financial year, or that remain current are as follows:

- Direction to support a whole of government approach as to implementation of a NZ Business Number, issued in May 2016 under section 107 of the Crown Entities Act
  http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn
- 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

Vote Health: Health and Disability Support Services – Auckland DHB Appropriation

An appropriation is a statutory authority from Parliament allowing the Crown or an Office of Parliament to incur expenses or capital expenditure. The Minster of Health is responsible for appropriations in the health sector. Each year, the Ministry of Health allocates the health sector appropriations through 'Vote Health' to DHBs, who use this funding to plan, purchase and provide health services, including public hospitals and the majority of public health services, within their areas.

An assessment of what has been achieved with Auckland DHB's 2015/16 appropriations is detailed below:

Appropriations allocated and scope

Health and Disability Support Services appropriation allocated to Auckland DHB is a non-departmental output expenses incurred by the Crown.

The funding of personal and mental health services included services for the health of older people, provision of hospital and related services and management outputs from Auckland DHB.

What is intended to be achieved with this appropriation?

The DHB provides services that align with:

- the Government priorities;
- the strategic direction set for the health sector by the Ministry of Health;
- the needs of the district's population; and
- regional considerations.

How performance will be assessed and end of year reporting

The performance measures outlined in Auckland DHB's Annual Plan are used to assess our performance. For performance results, refer to our Statement of Performance.

Amount of appropriations

	2014/15		2015/16		
	Budgeted $000	Estimated Actual $000	Estimates $000	Supplementary estimates[26] $000	Total $000
Total appropriations (revenue)	1,092,299	1,092,299	1,115,555	2,742	1,118,297
Expenditure		1,092,299			1,118,297

The appropriation revenue received by Auckland DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act 1989.

ADHB Debt appropriation

In terms of the Vote Health Appropriation "Refinance of DHB Private Debt (M36)", $50M of the ADHB private sector debt, "credit wrapped" bonds, matured on 15 September 2015 and was refinanced with three fixed rate Crown Loans.

[26] Reasons for change in appropriation can be found in Vote Health – Supplementary Estimates of Appropriations 2015/16.

Financial performance

Where the money came from and what we spent it on

FINANCIAL PERFORMANCE

Statement of Responsibility

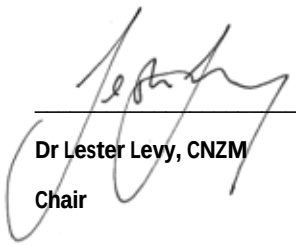
We are responsible for the preparation of the Auckland District Health Board and group's financial statements and the statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by Auckland District Health Board under section 19A 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 the Auckland District Health Board for the year ended 30 June 2016.

Signed on behalf of the Board:



Dr Lester Levy, CNZM

Chair

Dated: 26 October 2016

Ian Ward

Chair, Audit and Finance Committee

Dated: 26 October 2016

Statement of comprehensive revenue and expense for the year ended 30 June 2016

	Notes	Group Budget 2016 $000	Group Actual 2016 $000	Group Actual 2015 $000	Parent Budget 2016 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Revenue							
Patient care revenue	2	1,973,290	1,926,555	1,847,991	1,973,290	1,926,555	1,847,991
Interest Revenue		7,830	5,455	7,902	7,830	4,811	7,191
Other revenue	3	51,824	57,965	61,326	48,453	57,397	61,164
Total revenue		**2,032,944**	**1,989,975**	**1,917,219**	**2,029,573**	**1,988,763**	**1,916,346**
Expenses							
Personnel costs	4	857,742	867,225	830,230	857,742	867,225	830,230
Depreciation and amortisation costs	13,14	43,729	45,494	41,373	43,729	45,494	41,373
Outsourced services		95,687	105,839	103,650	95,687	105,839	103,650
Clinical Supplies		224,138	226,635	222,633	224,152	226,635	222,628
Infrastructure and non-clinical expenses		66,988	70,462	59,597	66,989	70,460	59,593
Other district health boards		111,229	111,776	110,189	111,229	111,776	110,189
Non-health board provider expenses		539,844	465,662	448,783	539,844	465,662	448,783
Capital charge	5	40,914	42,905	40,478	40,914	42,905	40,478
Interest expense		13,508	12,952	15,949	13,508	12,952	15,949
Other expenses	6	36,798	38,195	44,184	35,246	37,897	45,389
Total expenses		**2,030,577**	**1,987,145**	**1,917,066**	**2,029,040**	**1,986,845**	**1,918,262**
Share of associate and joint venture surplus/(deficit)	15	0	42	202	0	0	0
Surplus/(deficit)		**2,367**	**2,872**	**355**	**533**	**1,918**	**(1,916)**
Other comprehensive revenue and expense							
Item that will not reclassified to surplus/(deficit)							
Gains/(losses) on property revaluations	21	0	70,541	31,828	0	70,541	31,828
Cash flow hedges	21	553	551	(4,293)	553	551	(4,293)
Total other comprehensive revenue and expense		553	71,092	27,535	553	71,092	27,535
Total comprehensive revenue and expense		**2,920**	**73,964**	**27,890**	**1,086**	**73,010**	**25,619**

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

Statement of financial position as at 30 June 2016

	Notes	Group Budget 2016 $000	Group Actual 2016 $000	Group Actual 2015 $000	Parent Budget 2016 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Assets							
Current Assets							
Cash and cash equivalents	7	72,650	31,983	83,858	64,355	31,983	83,858
Investments	8	5,105	15,000	0	0	15,000	0
Trust/special funds	9	7,700	12,738	10,644	0	0	0
Patient & restricted trust funds	10	0	1,239	1,208	0	1,239	1,208
Receivables	11	35,096	62,049	56,359	33,397	61,271	59,129
Prepayments		1,166	1,679	1,035	1,166	1,679	1,035
Inventories	12	12,723	14,239	13,154	12,723	14,239	13,154
Total Current Assets		**134,440**	**138,927**	**166,258**	**111,641**	**125,411**	**158,384**
Non-Current Assets							
Investments	8	0	5,000	0	0	5,000	0
Trust/special funds	9	14,548	14,495	17,299	5,748	0	0
Property, plant and equipment	13	963,783	1,039,605	952,323	962,881	1,038,705	951,423
Intangible assets	14	21,909	13,182	13,330	7,856	13,182	13,330
Investments in joint ventures & associates	15	47,430	53,606	42,632	61,483	53,103	42,172
Total Non-Current Assets		**1,047,670**	**1,125,888**	**1,025,584**	**1,037,968**	**1,109,990**	**1,006,925**
Total Assets		**1,182,110**	**1,264,815**	**1,191,842**	**1,149,609**	**1,235,401**	**1,165,309**
Liabilities							
Current Liabilities							
Payables & deferred revenue	16	138,457	147,929	145,707	135,088	144,875	144,580
Employee benefits	17	180,711	148,366	159,463	182,554	148,366	159,463
Provisions	18	1,843	1,550	1,516	0	1,550	1,516
Borrowings	19	1,442	2,140	52,454	1,442	2,140	52,454
Patient & restricted trust funds	10	1,169	1,239	1,208	1,169	1,239	1,208
Total Current Liabilities		**323,622**	**301,224**	**360,348**	**320,253**	**298,170**	**359,221**
Non-Current Liabilities							
Employee benefits	17	32,575	37,653	30,085	32,575	37,653	30,085
Borrowings	19	304,500	305,065	254,500	304,500	305,065	254,500
Derivative financial instruments		3,693	0	0	3,693	0	0
Total Non-Current Liabilities		**340,768**	**342,718**	**284,585**	**340,768**	**342,718**	**284,585**
Total Liabilities		**664,390**	**643,942**	**644,933**	**661,021**	**640,888**	**643,806**
Net Assets		**517,720**	**620,873**	**546,909**	**488,588**	**594,513**	**521,503**
Equity							
Public equity	21	576,798	576,798	576,798	576,798	576,798	576,798
Accumulated surplus/deficit	21	(462,014)	(487,048)	(488,751)	(491,146)	(487,541)	(489,459)
Property revaluation reserve	21	406,629	508,998	438,457	402,936	508,998	438,457
Cash flow hedge reserve	21	(3,693)	(3,742)	(4,293)	0	(3,742)	(4,293)
Trust/special funds	21	0	25,867	24,698	0	0	0
Total Equity		**517,720**	**620,873**	**546,909**	**488,588**	**594,513**	**521,503**

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

Statement of changes in equity for the year ended 30 June 2016

GROUP	Notes	Actual 2016 $000	Budget 2016 $000	Actual 2015 $000
Balance as at 1 July		**546,909**	**514,800**	**519,019**
Total comprehensive revenue/(expense) for the period		73,964	2,920	27,890
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	**620,873**	**517,720**	**546,909**

PARENT	Notes	Actual 2016 $000	Budget 2016 $000	Actual 2015 $000
Balance as at 1 July		**521,503**	**487,502**	**495,884**
Total comprehensive revenue/(expense) for the period		73,010	1,086	25,619
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	**594,513**	**488,588**	**521,503**

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

Statement of cash flows for the year ended 30 June 2016

	Notes	Budget 2016 $000	Actual 2016 $000	Actual 2015 $000	Budget 2016 $000	Actual 2016 $000	Actual 2015 $000
Cash flows from operating activities							
Cash receipts from Ministry of Health and patients		1,963,503	1,957,367	1,977,208	1,963,503	1,957,367	1,977,208
Other Receipts		69,441	71,715	73,507	67,506	71,091	71,661
Cash paid to employees		(840,587)	(870,163)	(825,171)	(840,587)	(870,163)	(825,171)
Cash paid to suppliers		(1,064,382)	(1,068,782)	(1,114,116)	(1,062,830)	(1,067,007)	(1,110,784)
GST (net)		0	(2,134)	2,536	0	(1,968)	2,319
Payments for Capital Charge		(40,344)	(42,905)	(40,478)	(40,344)	(42,905)	(40,478)
Net cash inflow from operating activities	20	**87,631**	**45,098**	**73,486**	**87,248**	**46,415**	**74,755**
Cash flows from investing activities							
Interest received		8,762	5,455	7,902	7,326	4,875	7,009
Proceeds from sale of property, plant and equipment		0	189	28	0	189	28
Decrease/(Increase) in investments and restricted trust funds		(9,238)	(30,232)	(1,917)	(15,714)	(30,969)	(2,293)
Purchase of property, plant and equipment		(90,861)	(59,855)	(63,795)	(90,861)	(59,855)	(63,795)
Purchase of intangible assets			(380)	(600)		(380)	(600)
Acquisition of investments		0	0	(1,000)	0	0	(1,000)
Net cash (outflow) from investing activities		**(91,337)**	**(84,823)**	**(59,382)**	**(99,249)**	**(86,140)**	**(60,651)**
Cash flows from financing activities							
Interest paid		(13,662)	(13,145)	(16,051)	(13,662)	(13,145)	(16,051)
Repayment of loans		0	(50,000)	(80,000)	0	(50,000)	(80,000)
Proceeds from borrowings		0	50,995	80,000	0	50,995	80,000
Proceeds from capital contributed/(repaid)		0	0	0	0	0	0
Cash flow hedge		0	0	(4,405)	0	0	(4,405)
Net cash inflow/(outflow) from financing activities		**(13,662)**	**(12,150)**	**(20,456)**	**(13,662)**	**(12,150)**	**(20,456)**
Net (decrease)/increase in cash and cash equivalents		**(17,368)**	**(51,875)**	**(6,352)**	**(25,663)**	**(51,875)**	**(6,352)**
Cash and cash equivalents at start of the year		**90,018**	**83,858**	**90,210**	**90,018**	**83,858**	**90,210**
Cash and cash equivalents at end of the year	**7**	**72,650**	**31,983**	**83,858**	**64,355**	**31,983**	**83,858**

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

The accompanying notes form part of these financial statements.

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 15 for listing).

The financial statements for the DHB are for the year ended 30 June 2016, and were approved by the Board on 26 October 2016.

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.

The comparative financial statements were the first financial statements presented in accordance with the new PBE accounting standards.

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).

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 2016 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. There has been no change in applying these updated accounting standards.

Standards issued that are not yet effective and not early adopted

In 2015, the External Reporting Board issued Disclosure Initiative (Amendments to PBE IPSAS 1), 2015 Omnibus Amendments to PBE Standards, and Amendments to PBE Standards and Authoritative Notice as a Consequence of XRB A1 and Other Amendments. These amendments apply to PBEs with reporting periods beginning on or after 1 January 2016. ADHB will apply these amendments in preparing its 30 June 2017 financial statements. ADHB expects there will be no effect in applying these amendments.

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 Ngāti Whātua. 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 Auckland, Counties-Manukau, Northland and Waitemata DHBs (25% each, 2015: 20%) 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.

NRA 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 contract 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 date, based on the actual service provided as a percentage of the total services to be provided.

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; and
- 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)	4-137 years	0.73%-25%
• Plant, equipment and vehicles	5-20 years	5.00%-20%
• Leasehold improvements	5 years	20%

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.

National Oracle Solution (NOS)
The NOS (previously Finance, Procurement and Supply Chain (FPSC)) rights represent the DHB's right to access, under a service level agreement, shared NOS 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 NOS Programme, a national initiative, facilitated by NZ Health Partnerships Limited (NZHPL) (previously 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 NZHPL through the on-charging of depreciation on the NOS assets to the DHBs will be used to, and is sufficient to, maintain the NOS assets standard of performance or service potential indefinitely.

As the NOS 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 on commercial terms are initially recognised at the amount borrowed plus transactions costs. Interest due on the borrowings is subsequently accrued and added to the borrowing balance.

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 13.

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 programmes;
- 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 17 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.

2 Patient revenue

	Group Actual		Parent Actual	
	2016 $000	2015 $000	**2016 $000**	**2015 $000**
Health & disability services (Crown appropriation revenue)	1,118,297	1,092,299	1,118,297	1,092,299
Other MoH and Government revenue	166,707	158,901	166,707	158,901
ACC contract revenue	16,767	18,297	16,767	18,297
Inter-district patient inflows	588,806	545,146	588,806	545,146
Revenue from other district health boards	17,000	15,673	17,000	15,673
Other patient care related revenue	18,978	17,675	18,978	17,675
Total patient care revenue	**1,926,555**	**1,847,991**	**1,926,555**	**1,847,991**

3 Other revenue

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Donations and bequests	4,932	7,360	5,236	8,322
Gain on sale of property, plant & equipment	0	28	0	28
Gain on financial assets	27	1,186	0	0
Rental revenue	8,797	8,019	8,797	8,019
Accommodation revenue	629	510	629	510
Direct charges revenue	17,802	16,281	17,802	16,281
Drug trial revenue	809	616	809	616
Research grants	12,459	12,225	11,614	12,287
Other revenue	12,510	15,101	12,510	15,101
Total other revenue	**57,965**	**61,326**	**57,397**	**61,164**

4 Personnel costs

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Wages and salaries	843,928	801,295	843,928	801,295
Contributions to defined contribution plans	26,791	25,352	26,791	25,352
Increase/(decrease) in liability for employee benefit	(3,529)	3,806	(3,529)	3,806
Restructuring provision for employee costs	35	(223)	35	(223)
Total personnel costs	**867,225**	**830,230**	**867,225**	**830,230**

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 2016 was 8% (2015:8%)

6 Other expenses

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Fees to auditor				
· fees to Audit New Zealand for audit of financial statements	272	265	272	265
· Prior period under provision	27	0	27	0
· fees to Audit New Zealand for audit of financial statements (Auckland DHB Charitable Trust)	16	16	16	16
Fees for other Audit services	254	0	254	0
Operating leases	4,540	5,545	4,540	5,545
Impairment of debtors	1,630	200	1,630	200
Bad debts	2,437	2,345	2,437	2,345
Board members' fees	384	394	384	394
Loss on disposal of property, plant and equipment	33	0	33	0
Loss on derivatives – financial instruments	0	722	0	722
Foreign currency loss	6	15	6	15
Other expenses	28,596	34,682	28,298	35,887
Total other expenses	**38,195**	**44,184**	**37,897**	**45,389**

7 Cash & cash equivalents

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Current assets				
Bank balance	96	81	96	81
NZ Health Partnerships Limited (previously Health Benefits Limited)	31,887	83,777	31,887	83,777
Cash & cash equivalents in the statement of cash flows	**31,983**	**83,858**	**31,983**	**83,858**

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

Auckland DHB entered as a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHPL) (previously Health Benefits Limited (HBL)) and the participating DHBs on 12 November 2012. This Agreement enables NZHPL 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 NZHPL, which will incur interest at on-call interest rate received by NZHPL 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 $113.377m (2015:$108.893m).

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 Investments

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Current assets				
Term deposits	15,000	0	15,000	0
Non-Current assets				
Term deposits	5,000	0	5,000	0
Total Investments	**20,000**	**0**	**20,000**	**0**

The carrying value of term deposits with maturities less than 12 months approximate their face value.
There is no impairment provision for investments.

9 Trust/special fund assets

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Current assets				
Bank balances (restricted)	1,238	2,144	0	0
Short term deposits (restricted)	11,500	8,500	0	0
	12,738	**10,644**	**0**	**0**
Non – current assets				
Long term deposits (restricted)	500	4,600	0	0
Investment Bonds (at market)/(restricted)	2,861	1,554	0	0
Portfolio Investments	11,134	11,145	0	0
	14,495	**17,299**	**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 $3,361k (2015: $6,154k). 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.

10 Patient & restricted trust funds

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
PATIENT AND RESTRICTED TRUST FUNDS				
Current assets				
Patient trust	0	0	0	0
Restricted fund deposit	1,239	1,208	1,239	1,208
	1,239	**1,208**	**1,239**	**1,208**
Current liabilities				
Patient trust	0	0	0	0
Restricted fund deposit	1,239	1,208	1,239	1,208
	1,239	**1,208**	**1,239**	**1,208**

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, Ngāti Whātua.

11 Receivables

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Receivables (gross)	66,007	58,687	65,229	61,457
Less: provision for impairment	(3,958)	(2,328)	(3,958)	(2,328)
Total receivables	**62,049**	**56,359**	**61,271**	**59,129**
Total receivables comprise:				
Ministry of Health receivables (non-exchange transactions)	21,751	21,946	21,751	21,946
Other accrued income (exchange transactions)	40,298	34,413	39,520	37,183
	62,049	**56,359**	**61,271**	**59,129**

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

GROUP Receivables

Debtors and other receivables	Gross 2016 $000	Impairment 2016 $000	Gross 2015 $000	Impairment 2015 $000
Not past due	51,444	(7)	43,571	(28)
Past due 0-30 days	2,542	(265)	5,425	(196)
Past due 31-90 days	2,718	(411)	3,897	(455)
Past due 91-360 days	7,440	(1,587)	4,676	(1,298)
Past due more than 1 year	1,863	(1,688)	1,118	(351)
Total	**66,007**	**(3,958)**	**58,687**	**(2,328)**

11 Receivables (continued)

PARENT Receivables

Debtors and other receivables	Gross 2016 $000	Impairment 2016 $000	Gross 2015 $000	Impairment 2015 $000
Not past due	51,809	(7)	46,593	(28)
Past due 0-30 days	2,278	(265)	5,524	(196)
Past due 31-90 days	2,321	(411)	3,782	(455)
Past due 91-360 days	6,971	(1,587)	4,449	(1,298)
Past due more than 1 year	1,850	(1,688)	1,109	(351)
Total	**65,229**	**(3,958)**	**61,457**	**(2,328)**

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	GROUP		PARENT	
	2016 Actual $000	2015 Actual $000	2016 Actual $000	2015 Actual $000
Opening balance	2,328	2,128	2,328	2,128
Increase/(decrease) in doubtful debts	1,630	200	1,630	200
Closing balance	**3,958**	**2,328**	**3,958**	**2,328**

12 Inventories

	Gross 2016 $000	Impairment 2016 $000	Gross 2015 $000	Impairment 2015 $000
Pharmaceuticals	1,811	1,901	1,811	1,901
Surgical and medical supplies	12,428	11,253	12,428	11,253
Total Inventories	**14,239**	**13,154**	**14,239**	**13,154**

The write-down of inventories amounted to $673k (2015:$1,399k). No inventories are pledged as security for liabilities. (2014: Nil). However, some inventories are subject to retention of title clauses.

13 Property, plant and equipment

GROUP	Land	Buildings, fitouts & infrastructure (at valuation)	Plant, equipment and vehicles	Leased Improvements	Work in progress	Total
	$000	$000	$000	$000	$000	$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**
Cost						
Balance at 1 July 2015	249,006	635,019	293,335	758	39,821	1,217,939
Additions/ (Transfers)	0	0	0	0	61,909	61,909
Additions from Work in Progress	0	30,214	26,277	3	(56,494)	0
Disposals	0	0	(24,708)	(94)	0	(24,802)
Transfers	0	(11,145)	11,145	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	33,797	(34,691)	0	0	0	(894)
Balance at 30 June 2016	**282,803**	**619,397**	**306,049**	**667**	**45,236**	**1,254,152**
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)
Reclassifications	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0
Balance at 30 June 2015	**0**	**(50,743)**	**(214,124)**	**(749)**	**0**	**(265,616)**
Depreciation and impairment losses						
Balance at 1 July 2015	0	(50,743)	(214,124)	(749)	0	(265,616)
Depreciation charge for the year	0	(25,886)	(19,074)	(7)	0	(44,967)
Disposals	0	0	24,507	94	0	24,601
Transfers	0	5,194	(5,194)	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	0	71,435	0	0	0	71,435
Balance at 30 June 2016	**0**	**0**	**(213,885)**	**(662)**	**0**	**(214,547)**

GROUP						
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**
Carrying Amounts						
At 1 July 2015	249,006	584,276	79,211	9	39,821	952,323
At 30 June 2016	**282,803**	**619,397**	**92,164**	**5**	**45,236**	**1,039,605**

13 Property, plant and equipment (continued)

PARENT	Land	Buildings, fitouts & infrastructure (at valuation)	Plant, equipment and vehicles	Leased Improvements	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost						
Balance at 1 July 2014	211,564	618,835	284,258	758	20,269	1,135,684
Additions	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**
Cost						
Balance at 1 July 2015	249,006	635,019	292,435	758	39,821	1,217,039
Additions	0	0	0	0	61,909	61,909
Additions from Work in Progress	0	30,214	26,277	3	(56,494)	0
Disposals	0	0	(24,708)	(94)	0	(24,802)
Transfers	0	(11,145)	11,145	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	33,797	(34,691)	0	0	0	(894)
Balance at 30 June 2016	**282,803**	**619,397**	**305,149**	**667**	**45,236**	**1,253,252**
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)
Reclassifications	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0
Balance at 30 June 2015	**0**	**(50,743)**	**(214,124)**	**(749)**	**0**	**(265,616)**
Depreciation and impairment losses						
Balance at 1 July 2015	0	(50,743)	(214,124)	(749)	0	(265,616)
Depreciation charge for the year	0	(25,886)	(19,074)	(7)	0	(44,967)
Disposals	0	0	24,507	94	0	24,601
Transfers	0	5,194	(5,194)	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	0	71,435	0	0	0	71,435
Balance at 30 June 2016	**0**	**0**	**(213,885)**	**(662)**	**0**	**(214,547)**

PARENT						
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**
Carrying Amounts						
At 1 July 2015	249,006	584,276	78,311	9	39,821	951,423
At 30 June 2016	**282,803**	**619,397**	**91,264**	**5**	**45,236**	**1,038,705**

13 Property, plant and equipment (continued)

Valuation Information

ADHB owns land with a carrying value of $283m (2015:$249m) 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 2016.

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 2016 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 are detailed below:

GROUP & PARENT	2016 $000	2015 $000
Buildings, fitouts and infrastructure	23,959	30,966
Plant, equipment and vehicles	21,277	8,855
Non Current Assets	**45,236**	**39,821**

Leased assets

The group has entered into finance leases for the lease of clinical power tool equipment. The net carrying amount of the leased items within each class of property, plant, and equipment is shown above.

Refer finance leasing arrangements in Note 19.

14 Intangible assets

GROUP & PARENT	FPSC rights Cost $000	Software & development Cost $000	NCSP contract Cost $000	Total $000
Cost				
Balance at 1 July 2014	11,858	2,933	0	14,791
Additions	562	38	870	1,470
Disposals	0	0	0	0
Transfer to Non-current assets held for sale	0	0	0	0
Reclassifications	0	0	0	0
Balance at 30 June 2015	**12,420**	**2,971**	**870**	**16,261**
Balance at 1 July 2015	12,420	2,971	870	16,261
Additions	0	379	0	379
Disposals	0	0	0	0
Reclassifications	0	0	0	0
Balance at 30 June 2016	**12,420**	**3,350**	**870**	**16,640**
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)**
Amortisation & Impairment Losses				
Balance at 1 July 2015	**0**	**(2,780)**	**(151)**	**(2,931)**
Amortisation charge for the year	0	(168)	(359)	(527)
Disposals	0	0	0	0
Reclassifications	0	(0)	0	(0)
Balance at 30 June 2016	**0**	**(2,948)**	**(510)**	**(3,458)**
Carrying Amounts				
At 1 July 2014	11,858	308	0	12,166
At 30 June 2015	**12,420**	**191**	**719**	**13,330**
At 1 July 2015	12,420	191	719	13,330
At 30 June 2016	**12,420**	**402**	**360**	**13,182**

At 30 June 2016, the DHB had made payments totalling $0k (2015: nil) to NZHPL in relation to the NOS programme, which was in progress at year end. This is a national initiative facilitated by NZHPL. In return for these payments, the DHB gains NOS rights. In the event of liquidation or dissolution of NZHPL, 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 NOS rights that have been issued.

In 2014 the government agreed to a proposal from DHBs to move the implementation of the shared services programmes to a DHB owned vehicle (NZHPL). This was agreed to be completed by 30 June 2015. DHB NOS rights in HBL were transferred into the new DHB owned vehicle (NZHPL).

These NOS 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 NOS assets.

A revised NOS programme business case was approved by all DHBs by 30 June 2015 and all DHBs have committed to providing funding required to complete the NOS programme. The programme will be implemented by a DHB owned vehicle (NZHPL), in which all DHBs own equal "A" class voting shareholding of 5%. The investment in the NOS 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 DRC of the NOS rights is considered to equate, in all material respects, to the costs capitalised to date such that the NOS 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 (2015: Nil).

14 Intangible assets (continued)

Goodwill

During the 2014/15 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 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 $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.

15 Investments in joint venture & associates

General Information		2016 Interest held	2015 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%	0%
healthAlliance N.Z. Limited	Provider of shared services	25%	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%

Year end 30 June 2016	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus $000
healthAlliance N.Z .Limited	154,951	26,549	128,402	125,839	(900)
NZ Health Innovation Hub Management Limited	1,759	699	1,060	500	(602)
Northern Regional Alliance Limited	10,556	8,831	1,725	15,587	215
Total Investments	**167,266**	**36,079**	**131,187**	**141,926**	**(1,287)**

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	195	962	699	(398)
Northern Regional Alliance Limited	11,627	10,117	1,510	14,969	124
Total Investments	**138,173**	**33,804**	**104,369**	**138,944**	**(311)**

15 Investments in joint venture & associates (continued)

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Share of surplus of joint ventures & associates				
Share of post-acquisition surplus	42	202	0	0
Non -Current Assets				
INVESTMENTS IN JOINT VENTURES & ASSOCIATES				
Class A Shares in healthAlliance N.Z. Ltd (joint venture)	200	200	200	200
Class C Shares in healthAlliance N.Z. Ltd (joint venture)	52,904	41,971	52,902	41,971
Other shares in joint ventures & associates	1	1	1	1
Share of post-acquisition retained surpluses	501	460	0	0
Total investments in joint ventures and associates	**53,606**	**42,632**	**53,103**	**42,172**

A Memorandum of Understanding was signed between healthAlliance N.Z. Ltd and Auckland DHB, Counties Manukau DHB and Northland DHB that C Class shares are to be issued by healthAlliance N.Z. Ltd in exchange for the transfer of ownership of DHBs' IT assets (and other ancillary assets). Total value issued at 30 June 2016 is $52,904k (2015: $41,971k) represents the baseline value of ADHB's IT assets transferred.

16 Payables & deferred revenue

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Current				
Payables under exchange transactions				
Creditors	111,302	106,905	110,996	107,146
Income in Advance	7,185	6,262	4,291	4,805
Total payables under exchange transactions	118,487	113,167	115,287	111,951
Payables under non-exchange transactions				
GST,PAYE & FBT payable	27,101	28,703	27,247	28,792
Income in advance	2,341	3,837	2,341	3,837
Total payables under non exchange transactions	29,442	32,540	29,588	32,629
Total payables and deferred revenue	147,929	145,707	144,875	144,580

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.

17 Employee entitlements

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Current portion				
Liability for long service leave	1,701	1,534	1,701	1,534
Liability for sabbatical leave	500	500	500	500
Liability for retirement gratuities	7,739	6,761	7,739	6,761
Liability for annual leave	93,381	90,875	93,381	90,875
Liability for sick leave	618	1,076	618	1,076
Liability for continuing medical leave and expenses	23,856	23,644	23,856	23,644
Salaries and wage accrual	20,571	35,073	20,571	35,073
Total current	**148,366**	**159,463**	**148,366**	**159,463**
Non Current				
Liability for long service leave	2,165	1,928	2,165	1,928
Liability for retirement gratuities	35,488	28,157	35,488	28,157
Liability for continuing medical leave and expenses	0	0	0	0
Total non-current	**37,653**	**30,085**	**37,653**	**30,085**
Total employee entitlements	**186,019**	**189,548**	**186,019**	**189,548**

17 Employee entitlements (continued)

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 $16.6m (2015: $24.9m) are unpaid days $16.8m (2015: $10.6m) and -$0.2m (2015: $14.3m) 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 3.13% (2015: 4.39%) and an inflation factor of 1.0% (2015: 1.5%) were used.

18 Provisions

	Notes	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Current Portion					
ACC Partnership Programme		1,514	1,488	1,514	1,488
Litigation		1	28	1	28
Restructuring		35	0	35	0
Total Provisions		**1,550**	**1,516**	**1,550**	**1,516**
Movement for each class of provisions are as follows:					
ACC Partnership Programme					
Opening balance		1,488	1,541	1,488	1,541
Additional provisions made during year		512	502	512	502
Charged against provision for the year		(486)	(555)	(486)	(555)
Unused amounts reversed during year		0	0	0	0
Closing balance	(i)	**1,514**	**1,488**	**1,514**	**1,488**
Litigation Provision					
Opening balance		28	6	28	6
Additional provisions made during year		1	28	1	28
Charged against provision for the year		(28)	(6)	(28)	(6)
Unused amounts reversed during year		0	0	0	0
Closing balance	(ii)	**1**	**28**	**1**	**28**
Restructuring Provision					
Opening balance		0	223	0	223
Additional provisions made during year		35	0	35	0
Charged against provision for the year		0	(223)	0	(223)
Unused amounts reversed during year		0	0	0	0
Closing balance	(iii)	**35**	**0**	**35**	**0**

Notes

(i) ACC Partnership Programme

Liability valuation

An external independent Actuary, MA Lardies FNZSA, has calculated the liability as at 30 June 2016. 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% (2015:11%) 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.

18 Provisions (continued)

Key assumptions

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

- an average assumed rate of inflation of 1.7% for 30 June 2017 and 30 June 2018;
- a weighted average discount factor of 4.2% for 30 June 2017 and 30 June 2018 that 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 $3,040.

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 183% 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 $5,535,018 incurred in the cover period from 1 April 2016 to 31 March 2017 (2016/2017 ACC Claim Year). ADHB has also contracted a High Cost Claims Cover with an excess of $1,500,000 per event.

(ii) Litigation

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

(iii) Restructuring

Provision $35k (2015:$0k). The provision is for redundancy on termination of ADHB/WDHB contracts for Pacific Quit Smoking at 30 June 16. This resulted in payments due but unpaid at year end.

19 Borrowings

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Current portion				
Secured loans				
Finance Leases	429	0	429	0
Crown Loan	0	0	0	0
15 year Capital Bonds, maturing 15 September 2015	0	50,000	0	50,000
Interest on Borrowings	1,711	2,454	1,711	2,454
Total current portion	**2,140**	**52,454**	**2,140**	**52,454**
Non-current				
Secured loans				
Finance Leases	565	0	565	0
Crown Loan	304,500	254,500	304,500	254,500
Total non-current portion	**305,065**	**254,500**	**305,065**	**254,500**
Total borrowings	**307,205**	**306,954**	**307,205**	**306,954**
Interest rate summary	**% pa**	**% pa**	**% pa**	**% pa**
Crown Loan	2.75-5.32	3.20-5.32	2.75-5.32	3.20-5.32
Capital Bonds	0	7.75	0	7.75
Borrowing Facilities				
Crown Loan	304,500	254,500	304,500	254,500
Capital Bonds	0	50,000	0	50,000
Working Capital	0	0	0	0

19 Borrowings (continued)

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 was refinanced by Crown Loan on 15 September 2015.

Working capital facility
Auckland DHB entered as a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHPL) (previously Health Benefits Limited (HBL)) and the participating DHBs on 12 November 2012. This Agreement enables NZHPL 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 NZHPL, which will incur interest at on-call interest rate received by NZHPL 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 $113.377m (2015:$108.893m)

The fair value of Crown loans is $326.435m (2015:$261.628m). Fair value has been determined using contractual cash flow discounted using by the Government bond rate plus 15 basis points.

Analysis of finance leases

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
Minimum lease payments payable:				
No later than one year	429	0	429	0
Later than one year and not later than five years	106	0	106	0
Later than five years	459	0	459	0
Total minimum lease payments	994	0	994	0

Description of finance leasing arrangements
The group has entered into finance leases for the lease of clinical power tool equipment. The net carrying amount of the leased items within each class of property, plant, and equipment is shown in Note 13.

The lease is for an initial period of seven years ending February 2019.

There are no restrictions placed on the group by any of the finance leasing arrangements.

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment.

20 Reconciliation of reported operating surplus/ (deficit) with net cash inflow/ (outflow) from operating activities

	Notes	Group Actual		Parent Actual	
		2016 $000	2015 $000	2016 $000	2015 $000
RECONCILIATION OF REPORTED OPERATING SURPLUS/(DEFICIT) AFTER TAXATION WITH NET CASH INFLOW (OUTFLOW) FROM OPERATING ACTIVITIES					
Reported net surplus/(deficit) for the year		**2,872**	**355**	**1,918**	**(1,916)**
Add non-cash items:					
Share of associate and joint venture surplus	14	(42)	(202)	0	0
Depreciation and amortisation expense		45,494	41,373	45,494	41,373
Net loss/(gain) on derivative financial instruments		0	722	0	722
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		33	(28)	33	(28)
Net loss/(gain) on disposal of financial assets		(27)	(1,186)	0	0
Net interest shown in investing and financing activities		7,498	8,263	8,142	9,156
Add movements in statement of financial position items:					
(Increase)/Decrease in debtors and other receivables		(14,871)	(7,057)	(11,907)	(7,511)
(Increase)/Decrease in prepayments		(644)	25	(644)	25
(Increase)/Decrease in inventories		(1,085)	(943)	(1,085)	(943)
Increase/(Decrease) in creditors and other payables		8,834	30,418	7,428	32,131
Increase in provision		34	(31)	34	(31)
Increase/(Decrease) in employee entitlements		(2,998)	1,777	(2,998)	1,777
Net cash inflow/(outflow) from operating activities		**45,098**	**73,486**	**46,415**	**74,755**

21 Equity

	Group Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $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	(488,751)	(487,037)	(489,459)	(487,543)
Operating surplus/(deficit)	2,872	355	1,918	(1,916)
Transfer to trust/special funds	(1,169)	(2,069)	0	0
Balance at 30 June	**(487,048)**	**(488,751)**	**(487,541)**	**(489,459)**
C Property revaluation reserves				
Opening balances	438,457	406,629	438,457	406,629
Net Movement	70,541	31,828	70,541	31,828
Balance at 30 June	**508,998**	**438,457**	**508,998**	**438,457**
D Cash Flow Hedge reserve				
Opening balance 1 July	(4,293)	0	(4,293)	0
Net Movement	551	(4,293)	551	(4,293)
Balance at 30 June	**(3,742)**	**(4,293)**	**(3,742)**	**(4,293)**
E Trust/special funds				
Opening balance 1 July	24,698	22,629	0	0
Transfer from accumulated deficits (Note 21b)	1,169	2,069	0	0
Balance at 30 June	**25,867**	**24,698**	**0**	**0**
Total Equity	**620,873**	**546,909**	**594,513**	**521,503**
Property revaluation reserves consist of				
Land	273,497	239,700	273,497	239,700
Buildings	235,501	198,757	235,501	198,757
Total property revaluation reserves	**508,998**	**438,457**	**508,998**	**438,457**

21 Equity (continued)

Property revaluation reserves
The revaluation reserve movement relates to the independent valuation of land & buildings, fitout and infrastructure assets carried out by Telfer Young (Auckland) Ltd at 30 June 2016– see Note 13.

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

A Capital commitments

GROUP AND PARENT	2016 $000	2015 $000
Buildings, fitouts and infrastructure	3,288	23,709
Plant and Equipment	7,966	21,865
Total capital commitments	**11,254**	**45,574**

Contractual Capital Commitments for projects which have an approved budget, but the outer year spend is less than $500k have not been assessed. Therefore, contractual capital commitments may be higher than disclosed, but not material for disclosure purposes.

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	2016 $000	2015 $000
Not later than one year	5,659	6,192
Later than one year and not later than five years	16,511	18,403
Later than five years	10,193	13,757
Total non-cancellable operating lease commitments as lessor	**32,363**	**38,352**

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
- Procare House, 50 Grafton Road, 2 leases expiring in 2020.

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	2016 $000	2015 $000
Not later than one year	2,284	1,427
Later than one year and not later than five years	1,139	1,503
Later than five years	66	153
Total non-cancellable operating lease commitments as lessee	**3,489**	**3,083**

22 Capital commitments and operating leases (continued)

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
- Carbine Road is leased with an expiry of 30 September 2017
- Glanville Terrace in Parnell is leased with an expiry of 31 March 2017.

23 Contingencies

Contingent Assets

There are no contingent assets at 30 June 2016 (2015: 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.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine, from the terms of the Scheme, the extent to which the deficit will affect future contributions by employers, as there is no prescribed basis for will affect future contributions by employers, as there is no prescribed basis for allocation.

As at 31 March 2016, the Scheme had a past service surplus of $11.7 million (2015: $37.582m) (7.4% of the liabilities). This amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 25.

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

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	2016 Actual	2015 Actual
Board Members		
Remuneration	$384k	$384k
Full-time equivalent members	1.7	1.7
Leadership Team		
Remuneration	$7,343k	$7,562k
Full-time equivalent members	20	20
Total key management personnel remuneration	$7,727k	$7,946k
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 2016 $000	Actual 2015 $000
Dr Lester Levy (Chair)	69	69
Dr Lee Mathias	38	38
Jo Agnew	31	31
Peter Aitken	32	32
Doug Armstrong*	30	30
Judith Bassett	32	32
Dr Chris Chambers	31	30
Robyn Northey	31	31
Gwen Tepania-Palmer	29	30
Morris Pita*	30	30
Ian Ward	31	31
Total board member remuneration	384	384

Co-opted committee members

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $8,000:

Norman Wong (Audit and Finance Committee) $2,000
Mataroria Lyndon (MaGAC) $750
Matire Harwood (MaGAC) $250
Raymond Hall (MaGAC) $1,000
Anne Kolbe (Hospital Advisory Committee) $1,500
Dairne Kirton (DiSAC) $500
Russell Vickery (DiSAC) $750
Jan Moss (DiSAC) $500
Shayne WiJohn (DiSAC) $250
Jade Farrar (DiSAC) $500

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 affected 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 2016	Actual 2015	Remuneration Range	Actual 2016	Actual 2015
$100,000-$110,000	190	162	$420,000-$430,000	10	2
$110,000-$120,000	191	179	$430,000-$440,000	1	2
$120,000-$130,000	130	107	$440,000-$450,000	5	1
$130,000-$140,000	109	81	$450,000-$460,000		4
$140,000-$150,000	72	82	$460,000-$470,000	2	1
$150,000-$160,000	66	63	$470,000-$480,000	2	7
$160,000-$170,000	60	60	$480,000-$490,000	2	1
$170,000-$180,000	56	56	$490,000-$500,000	2	2
$180,000-$190,000	51	47	$500,000-$510,000	2	1
$190,000-$200,000	38	37	$510,000-$520,000		1
$200,000-$210,000	45	41	$520,000-$530,000	6	1
$210,000-$220,000	35	46	$530,000-$540,000		1
$220,000-$230,000	38	33	$540,000-$550,000	2	1
$230,000-$240,000	34	34	$550,000-$560,000		1
$240,000-$250,000	35	37	$560,000-$570,000		2
$250,000-$260,000	22	27	$570,000-$580,000	1	1
$260,000-$270,000	32	27	$580,000-$590,000	3	1
$270,000-$280,000	30	35	$590,000-$600,000	2	2
$280,000-$290,000	23	24	$610,000-$620,000	3	
$290,000-$300,000	23	11	$620,000-$630,000	1	1
$300,000-$310,000	18	17	$640,000-$650,000		2
$310,000-$320,000	29	21	$660,000-$670,000	1	2
$320,000-$330,000	22	21	$670,000-$680,000	1	
$330,000-$340,000	25	19	$750,000-$760,000	1	
$340,000-$350,000	11	23	$780,000-$790,000		1
$350,000-$360,000	23	12	$850,000-$860,000	1	
$360,000-$370,000	13	16	$910,000-$920,000	1	
$370,000-$380,000	12	12	$1,080,000-$1,090,000		1
$380,000-$390,000	14	15	$1,110,000-$1,120,000		1
$390,000-$400,000	12	7	$1,140,000-$1,150,000	1	
$400,000-$410,000	7	3	$1,160,000-$1,170,000		1
$410,000-$420,000	6	7	**Grand Total**	**1,522**	**1,403**

Note:
During the year ended 30 June 2016, 95 (2015:95) employees received compensation and other benefits in relation to cessation totalling $2,055,618 (2015: $1,861,932).

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

26 Employee remuneration (continued)

call that 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

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 Actual		Parent Actual	
	2016	2015	2016	2015
	$000	$000	$000	$000
Loans and receivables				
Cash and cash equivalents	31,983	83,858	31,983	83,858
Investments-term deposits	20,000	0	20,000	0
Trust/special funds - bank balances, term deposits, investment bonds and portfolio)	27,233	27,943	0	0
Receivables	62,049	56,359	61,271	59,129
Patient and restricted trust funds	1,239	1,208	1,239	1,208
Total loans and receivables	**142,504**	**169,368**	**114,493**	**144,195**
Financial liabilities measured at amortised cost				
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	111,302	106,905	110,996	107,146
Borrowing-secured loans	307,205	306,954	307,205	306,954
Patient and restricted trust funds	1,239	1,208	1,239	1,208
Total financial liabilities measured at amortised cost	**419,746**	**415,067**	**419,440**	**415,308**

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.

28 Financial instruments (continued)

The following table analyses the basis of the valuation of classes of financial instruments measured at fair value in the Statement of Financial Position:

	Notes	Total	Valuation technique: Quoted market price	Valuation technique: Observable inputs	Valuation technique: Significant non-observable inputs
		$000	$000	$000	$000
GROUP 30 June 2016					
Financial Assets					
Term deposits	8, 9	32,000	32,000	0	0
Portfolio Investments	9	11,134	11,134	0	0
Investment bonds	9	2,861	2,861	0	0
GROUP 30 June 2015					
Financial Assets					
Term deposits	8, 9	13,100	13,100	0	0
Portfolio Investments	9	11,145	11,145	0	0
Investment bonds	9	1,554	1,554	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

As at 30 June 2016, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the surplus for the year would have been $1.310m lower/higher (2015:$1.651m)

28 Financial instruments (continued)

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. As at year end the DHB had no direct exposure to foreign currency risk (2015: nil).

Sensitivity analysis

As at 30 June 2016, 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 (2015: $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 NZHPL (previously HBL) who invest with registered banks.

In the normal course of business, exposure to credit risk arises from demand funds with NZHPL, 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 NZHPL who enters into investments with registered banks that have a Standard and Poor's credit rating of at least A+. The DHB has experienced no defaults for demand funds.

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The MoH is the largest single debtor (2016: 38.5%, 2015: 33%). 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 Actual		Parent Actual	
	2016 $000	2015 $000	2016 $000	2015 $000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalent, term deposits & investment bonds				
A+	2,500	1,500	0	0
AA-	34,934	16,587	21,335	1,289
Total cash, cash equivalent, term deposits & investment bonds	**37,434**	**18,087**	**21,335**	**1,289**
COUNTERPARTIES WITHOUT CREDIT RATINGS				
NZHPL (previously HBL)-no defaults in the past	31,887	83,777	31,887	83,777
Portfolio Investments-no defaults in the past	11,134	11,145	0	0
Receivables				
Exiting counterparty with no defaults in the past	62,049	56,359	61,271	59,129
Exiting counterparty with defaults in the past	0	0	0	0
Total receivables	**62,049**	**56,359**	**61,271**	**59,129**

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 NZHPL.

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

28 Financial instruments (continued)

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.

GROUP

2016	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	307,205	362,834	5,920	5,851	60,448	118,081	172,534
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	111,302	111,302	111,302	0	0	0	0
Total	**418,507**	**474,136**	**117,222**	**5,851**	**60,448**	**118,081**	**172,534**

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	306,955	364,930	9,964	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	**413,860**	**471,835**	**116,869**	**87,840**	**7,576**	**128,071**	**131,479**

PARENT

2016	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	307,205	362,834	5,920	5,851	60,448	118,081	172,534
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	110,996	110,996	110,996	0	0	0	0
Total	**418,201**	**473,830**	**116,916**	**5,851**	**60,448**	**118,081**	**172,534**

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	306,955	364,930	9,964	87,840	7,576	128,071	131,479
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	107,145	107,145	107,145	0	0	0	0
Total	**414,100**	**472,075**	**117,109**	**87,840**	**7,576**	**128,071**	**131,479**

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 $2.87m which was $0.504m favourable to budget.

Major favourable expenditure variance
Non-health board provider expenses $74m. 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 $59.4m by way of contribution to these contracts from Counties Manukau DHB. This is in effect an agency arrangement. Accordingly, in the actual results the contribution of $59.4M was treated as an offset of expenditure. At the time the budgeted results were prepared the contribution from Counties Manukau DHB was regarded as revenue.

Non-health Board provider expenses are also favourable by $14.7m for the year and mainly driven by favourable variances from demand type services and release of service commitments not expensed for 2015/16. Also included are previous months' favourable 2014/15 adjustments for Personal Health, Mental Health, Community Labs, Pharmac GST claims and Pharmac drug rebates. These were partly offset by adverse variances from additional expenditure for funded initiatives which are accompanied by equivalent additional revenue.

Favourable Property, Plant and Equipment variance
The full revaluation of land completed at 30 June 2015 resulted in an increase in revaluation reserve of $31.8m that was not included in the budget for 2015/16. The full land and buildings revaluation completed as at 30 June 2016 resulted in an increase in the revaluation reserve of $70.5m, increasing the year end Equity position that was not included in the budget. This is offset by capital spend being $30.6m below forecast budget spend.

Major unfavourable variances
Patient Care Revenue $47m. 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.

Unfavourable Cash and Cash Equivalents
Actual cash at month end is lower than budget cash and cash equivalents mainly due to favourable investments in term deposits. $5m matures within a year and $15m matures beyond a year. There was also a cashflow impact of $4.6m for investment in healthAlliance relating to regional IT projects approved in prior years but funded in 2015/16.

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 $23.856m as at 30 June 2016 (2015: $23.644m). 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: 90%).

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.

31 Key sources of estimated uncertainty (continued)

Earthquake-Risk Buildings

Auckland DHB has four buildings that have been confirmed as "earthquake prone" under the relevant legislation by structural engineers. These will require action to demolish or strengthen within the next 15 years. Two of these are at the Greenlane campus (the Costley Block and Building 5) and are currently vacant with long term plans still to be confirmed. 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 2016 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.

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 2016

The Auditor-General is the auditor of Auckland District Health Board (the Health Board) and group. The Auditor-General has appointed me, J.R Smaill, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and 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 43 to 81, that comprise the statement of financial position as at 30 June 2016, 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 8 to 24, 26 to 32 and 39 to 40.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board and group on pages 43 to 81:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2016; 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 Reporting 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 the 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 8 to 24, 26 to 32 and 39 to 40:

- presents fairly, in all material respects, the Health Board and group's performance for the year ended 30 June 2016, 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 26 October 2016. 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 Reporting 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.

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

Notes:

AUCKLAND DISTRICT HEALTH BOARD

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AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai