AUCKLAND DISTRICT HEALTH BOARD

Annual Report 2016 | 2017

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

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004

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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

Auckland DHB funds and provides services to 515,000 residents living in the Auckland isthmus and on Waiheke and Great Barrier Islands. Our annual budget is $2.1 billion, which supports around one million patient contacts each year. Our services are delivered from New Zealand's largest public hospital, Auckland City Hospital, as well as the Greenlane Clinical Centre, the Buchanan Rehabilitation Centre and a range of community settings.

Auckland DHB's purpose is to support our population in maximising their health and well-being, ensuring there are appropriate services available for them to access and to deliver world-class health care services. In addition to providing health services to our own population, we provide tertiary services to the northern region DHBs as well as national services for the country.

As part of Auckland DHB's unique role in the New Zealand health sector, it is the sole New Zealand provider of certain highly specialised services, which include heart, liver and lung transplants; certain paediatric services; epilepsy surgery; high risk obstetrics as well as being the northern region's DHB trauma centre.

Auckland's population has been growing, and continues to grow very rapidly as well as changing demographically. The population aged 65 years and older is quickly increasing with a consequent heightening increase in service demand. In 2016, Auckland's overall population grew by nearly 45,000 people, which is equivalent to the population of Nelson.

An expected result of rapid population growth would be an increased number of presentations to our Emergency Department. This has indeed been the case with presentations increasing by 18% over the last four years, which is double the population growth. This is a good indicator of the scale of the increasing workload across the Auckland DHB health system.

From an outcome perspective, life expectancy for the Auckland DHB population continues to increase, mortality rates for preventable conditions are among the lowest in the country and the five-year survival rate for cancer patients is the highest. A very positive outcome is that the life expectancy of our Māori population has increased by three years over the last decade, which is in advance of the Pakeha life expectancy increase over this time.

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 and while there are other teaching hospitals in New Zealand, our unique case mix attracts more research and education activity than elsewhere.

Improving patient safety is a key priority for our DHB. Over the past 12 months we have introduced a new Patient at Risk Service, with dedicated clinical staff trained to manage the needs of at-risk patients. We have also trialed a new early warning score as part of a Health Quality and Safety Commission initiative.

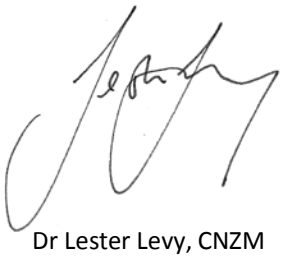
We are also making sure our patients and their whānau play a bigger role in deciding how and when healthcare is delivered to them, and what those healthcare options look like. While this is a long-term goal, some of the projects we have put in place are already making big improvements through small but important changes. For example, we have streamlined the process for our cardiology clinics reducing wait times for patients and putting them at the centre of care.

Respectful collaboration with our Treaty partner Ngāti Whātua, our Primary Health Organisation (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, which is a credit to the collaboration of all our teams.

Whether our work is in hospitals, clinics, the home or the community we continue to focus on helping our population and patients achieve the health outcomes that matter to them, their whānau and their communities.

What we do at Auckland DHB matters a great deal, to a great many people and would not be possible without the talent, experience and strong commitment of our 10,300 people. Together our staff continue to deliver safe, high quality care and the best possible patient experience – for this we are truly grateful and thank them on behalf of us and all those who benefit from their expertise and dedication.



Dr Lester Levy, CNZM

Chair
Auckland District Health Board

Ailsa Claire OBE

Chief Executive
Auckland District Health Board

TE TIRITI - PARTNERSHIP STATEMENT

Tū Tonu ngā Manaakitanga!

R. NAIDA GLAVISH, ONZM. JP

CHIEF ADVISOR TIKANGA

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

I am extremely pleased to note the efforts that are going into reducing obesity amongst our whānau, in particular our tamariki. The health and development of the most vulnerable members of our whānau is crucial for the future of our communities. Increased numbers of tamariki are being immunised, and work is being done to make sure new babies are enrolled with a Primary Health Organisation. The effort put in by our primary and community care partners has contributed to fewer Māori children being admitted to hospital for conditions that are potentially avoidable.

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 indicators in this report show that Māori often suffer disproportionately from health conditions or are not accessing important health services 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 Māori health inequities is.

In Māori, the life expectancy gap is largely due to avoidable deaths from cancers, in particular lung cancer, and chronic conditions including cardiovascular disease. Smoking is a major contributing factor to these conditions. 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 and wider public sector must be mobilised and must work closely with our communities to bring this vision for a smokefree Aotearoa to fruition.

As the Tiriti o Waitangi partner, Te Rūnanga o Ngāti Whātua understands the importance of having a strong and trusting relationship with the DHB 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 gives me greater confidence 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. Albeit we have much work still to do together to lift the performance of the health system for our diverse but important Māori communities.

Our Te Tiriti o Waitangi Partner:
Te Rūnanga o Ngāti Whātua

R. Naida Glavish ONZM. JP
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 515,000 residents living in the Auckland district. We are the fourth largest and one of the fastest growing DHBs in the country, expecting more than 90,000 extra 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.

More than 10,000 people are employed by Auckland DHB.

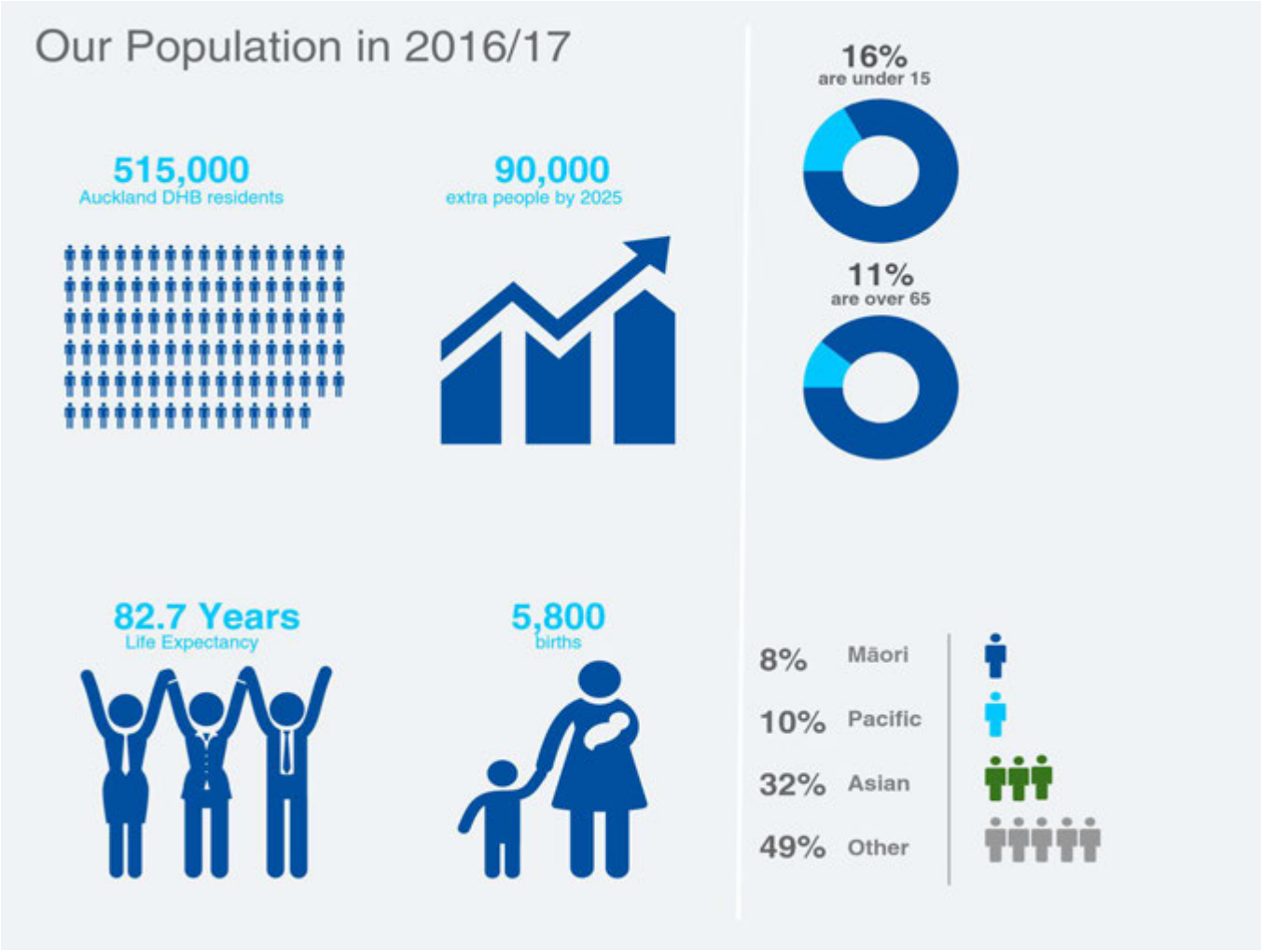
The DHB is responsible for the health of the population who live within the district. We provide a range of services ourselves as well as funding other services outside of our own facilities, including primary care and other community based providers. We also work with a number of other organisations such as Auckland Council to improve outcomes for our population.

The performance measures we monitor reflect those we directly deliver on as an organisation, those that we fund other organisations to deliver and some that more broadly reflect the health of our population that we and others contribute to.

As an organisation, 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 2016/17 was $2.1 billion.



OUR DIRECTION

Healthy Communities, World-class Healthcare, Achieved Together

Our **vision** - *Healthy Communities, World-class Healthcare, Achieved Together* - recognises that each individual has different experiences and aspirations for health and wellbeing. This means we are working to achieve the best outcomes for the populations we serve, people have rapid access to healthcare that is high quality and safe and that we work as active partners across the whole system with staff, patients, whānau, iwi, communities, and other providers and agencies.

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. 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.

Our **values** shape our behaviour and describe the internal culture that we strive for.

KEY ACHIEVEMENTS

Auckland DHB is one of the healthiest communities in New Zealand and we have performed well against our key indicators in 2016/17. We made progress against the national health targets, achieving four of the seven in quarter four, and we achieved a financial surplus of $3.2m.

Our achievements in 2016/17 include:

- The life expectancy of our population is higher than the New Zealand average and the gap between ethnic groups is decreasing
- Our smoking rate is the lowest in New Zealand
- We achieved 100% against the Raising Healthy Kids health target in Q4, meaning all children identified as obese were referred for further help. We achieved the target a year early and were the second DHB in the country to achieve it
- We achieved the Increased Immunisation and Better Help for Smokers health targets
- Our amenable mortality rate is among the lowest in New Zealand
- Auckland DHB now has the highest 5-year cancer survival rate in New Zealand and we achieved the Faster Cancer Treatment target over the full 2016/17 year
- We delivered 16,822 elective surgeries, an increase of 6% on last year
- Ambulatory sensitive hospitalisation (ASH) rates for children aged 0-4 have declined for all ethnic groups
- Most inpatients rated their care as very good or excellent, and our average score in the HQSC inpatient survey was 8.3 (out of 10).

Improving outcomes

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

PERFORMANCE FRAMEWORK

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

Our performance framework (over page) reflects key national and local priorities, and demonstrates our commitment to an outcome-based approach to measuring performance. 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 82.7 years

Our amenable mortality rate has reduced by 1/3 over the last 10 years, and is one of the lowest in New Zealand

Our children are staying out of hospital with ASH rates for those aged 0-4 reducing over the last 2 years

Our performance framework focuses on our two overall long-term population health outcome goals. These are:

- Maintain the highest life expectancy in New Zealand
- Reduce the difference in life expectancy between different ethnic groups.

Outcome measures and supporting impact indicators have been identified that will support achievement of these goals. Our outcome measures are based on the 2016/17 System Level Measures (SLMs) set by the Ministry of Health. The outcome measures are long-term indicators; therefore, the aim is for a measurable change in health status over time, rather than a fixed target.

Impact measures sit underneath the long-term outcome indicators and assess the direct impact of the services we provide over a shorter time period.

The Statement of Performance, in the 'Our People, our performance' section of this report, details a list of service level indicators that form part of our overall performance framework. These comprise a range of in-year measures to monitor DHB service performance within a set of four output classes that contribute to the success of the system as a whole. We monitor performance against these indicators annually.

Overall the progress against our indicators suggests we are delivering on our vision and we remain a high performing DHB that is truly making a difference to the health of our population.

Life expectancy continues to improve, reaching 82.7 years (2014-16), one of the highest in the country and an increase of 1.6 years over the past decade. Life expectancy for our Māori population has risen by nearly 3 years over the past decade, but remains 5.8 years lower than the non-Māori population. The gap for Pacific is even greater, at 7.4 years.

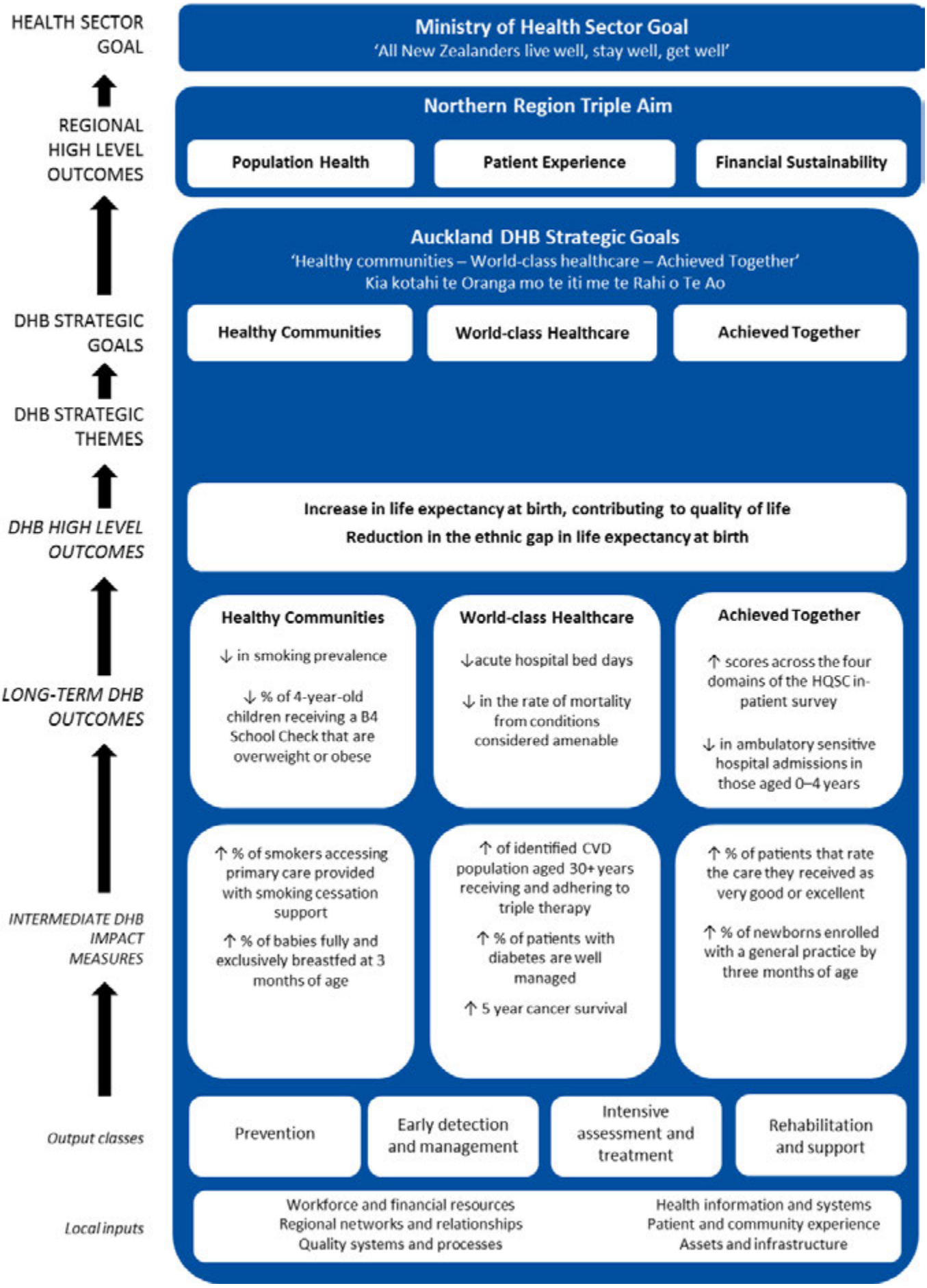
Amenable mortality - deaths potentially avoidable through healthcare intervention - is reducing, and in 2014 (the latest available data) 80.6 deaths out of every 100,000 were considered amenable, lower than the national rate of 92.9. We estimate that 433 deaths (46.7% of all deaths in those aged under 75 years) in Auckland DHB were amenable in 2014.

Our smoking prevalence is the lowest in New Zealand, at 11% (as at the 2013 Census).

Our children are receiving a great start to life. The number of children admitted to hospital for conditions that are potentially avoidable (e.g. respiratory illnesses, gastroenteritis, dental conditions, and cellulitis) have reduced, thanks to interventions in primary and community care.

While around 30% of our 4-year-olds are classified as overweight or obese at their B4 School Check, nearly all (99%) obese children were referred on for further nutrition and lifestyle help.

Auckland DHB Performance Framework



HIGH LEVEL OUTCOMES

The overall outcomes that we aim to achieve are an increase in life expectancy (measured by life expectancy at birth) and a reduction in inequalities between different ethnic groups in our population (measured by ethnic gap in life expectancy).

PEOPLE LIVE
1 YEAR
LONGER IN AUCKLAND THAN NEW ZEALAND AS A WHOLE

LIFE EXPECTANCY HAS INCREASED
1.6 YEARS
OVER THE PAST DECADE

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

Note: The most recent life expectancy data available is for the 2016 calendar year. Three-year combined estimates have been presented to reduce the effect of year to year variations in death rates.

Improving life expectancy for everyone

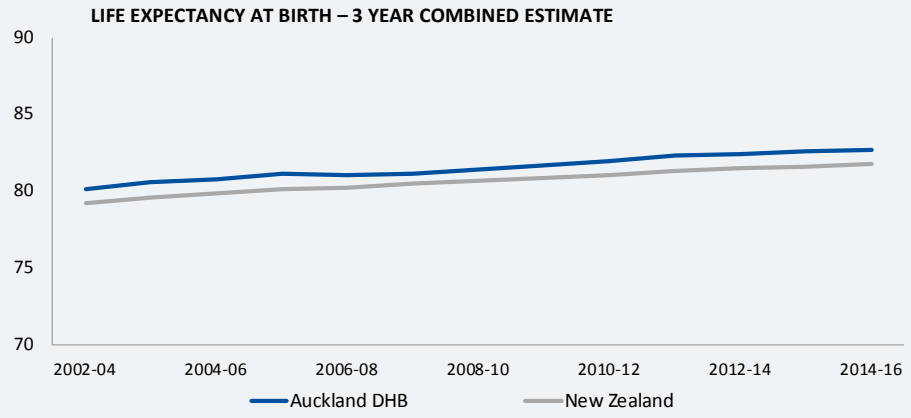
Life expectancy at birth (LEB) is recognised as an overall measure of population health status. We have one of the highest life expectancies in the country at 82.7 years (2014-16), which is nearly 1 year higher than New Zealand as a whole. In Auckland, life expectancy has increased by 1.6 years over the last decade. Over half of this increase can be attributed to the reduction in amenable mortality.

Māori and Pacific people have a lower life expectancy than other ethnic groups in our district, with a gap of 5.8 years for Māori and 7.4 years for Pacific. However life expectancy has increased in our Māori (2.9 years) and Pacific (1.8 years) populations over the past decade, and the gap has decreased slightly. In Māori, the life expectancy gap is largely due to avoidable mortality from cancers, in particular lung cancer, and chronic conditions including cardiovascular disease.

Coronary heart disease is the single biggest contributor to the life expectancy gap for our Pacific people, with avoidable cancers and other chronic conditions also significant factors.

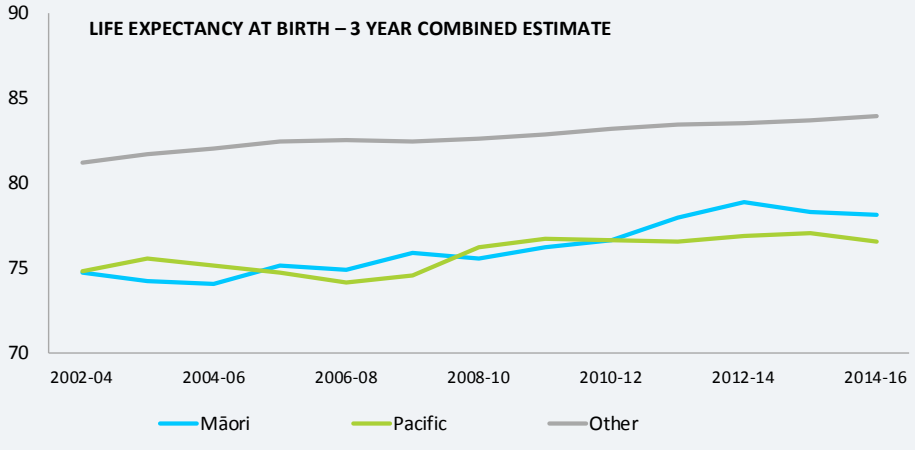
An increase in life expectancy at birth

The life expectancy of our population has increased 1.6 years over the last decade, to 82.7 years.



A reduction in the ethnic gap in life expectancy at birth

In the past decade, life expectancy in Māori and Pacific populations has increased, with the life expectancy gap reducing by 1.5 years for Māori and 0.4 years for Pacific.



HEALTHY COMMUNITIES

To improve health outcomes and ensure health equity, we want to see Aucklanders take greater responsibility for their own health, at home and in their communities where real health belongs. Everyday lifestyle choices make a difference to individual health. Our focus is on smoking and childhood obesity. Our aim is to create health-promoting physical and social environments, which support people to take more responsibility for their own health and make healthier lifestyle choices.

11%

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

50,769

SMOKERS (26%) RECEIVED CESSATION SUPPORT IN PRIMARY CARE, SIMILAR TO 2015/16

89%

OF PHO-ENROLLED SMOKERS RECEIVED BRIEF ADVICE TO QUIT

97%

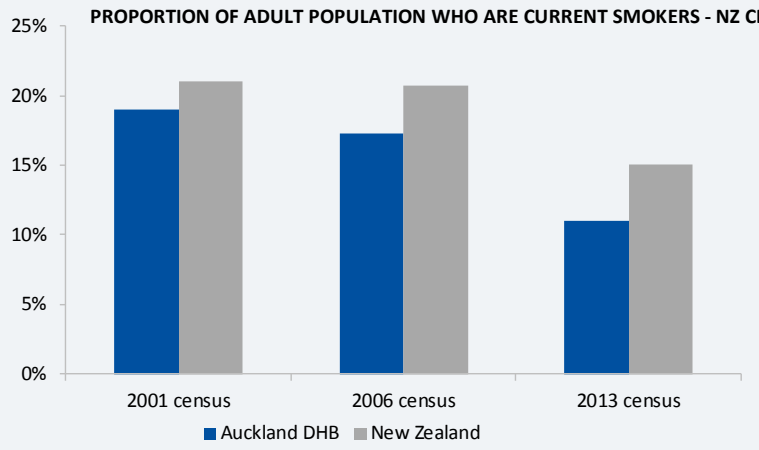
OR 225 PREGNANT WOMEN WHO SMOKED RECEIVED SMOKING CESSATION ADVICE

A smoke-free Auckland

New Zealand has comprehensive tobacco control policies and programmes in place, yet smoking remains the leading modifiable risk factor for many diseases. We estimate smoking directly results in the death of approximately 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 New Zealand. 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 likelihood of that quit attempt being successful is increased if medication and/or cessation support are also provided.

In 2016/17, we provided brief smoking cessation advice to 89% of smokers registered with primary care services, and in Q4 the DHB met the 90% target. 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. In 2016/17, PHOs increased their staffing and performed additional activities to support general practices to work towards the 90% target.

One in four (26%) identified smokers accessing primary care are now provided with cessation support, either through a referral to 'quit smoking' services or by being provided with smoking cessation medication. This rate of support is lower than the national rate (32% in Q4 2016/17), and little change has been seen over the past two years.

Smoking cessation was selected as a contributory measure for the System Level Measure – Amenable Mortality. The focus in 2016/17 was on identifying the clinical indicators and the high level actions required to increase uptake. In 2017/18 we plan to improve pathways to smoking cessation providers, and improve our data reporting process.

Better help for smokers to quit

Auckland DHB has the lowest daily smoking rate of any DHB, at 11.1% of our adult population (52,766 people); however we continue to focus on supporting the smokers in our population to quit.
We aim to achieve the Ministry's goal of being smokefree by 2025.

Helping pregnant women to kick the habit

A pilot programme providing vouchers as incentives to pregnant women who successfully quit smoking ended in December 2016. Evaluation showed that this is an effective way to engage with pregnant women and it led to higher quit rates than traditional approaches.

In-hospital support to quit

In 2016/17, 12,715 smokers were admitted to our wards. Nearly all of these were offered brief advice and help to quit, meeting the national target of 95%. For some this brief advice was motivation enough to stop smoking, while for others smoking is so entrenched in their lives they find it very difficult to quit. Many people with health problems continue to smoke even though they know smoking is impacting on their health condition. Being admitted to hospital can be a time patients are more motivated to quit so it's vital our Smokefree Services reach as many people as possible.

Supported patients stay motivated to quit after leaving the hospital

For patients who stop smoking during their hospital stay, sustaining this once they are discharged can be difficult.

During January to June 2016, we conducted an audit of 195 eligible smokers discharged from the Emergency Department of Auckland City Hospital who had received brief advice to quit smoking. Each patient was contacted for an interview at 4-6 weeks after their hospital admission.

Of these patients, 50% now smoked less than usual, with 15% reducing their daily intake by 10 cigarettes or more per day and 14% reducing by 5-9 cigarettes per day.

While up to half of patients demonstrated some intent or action following their visit to A&E, with 50% cutting down their daily consumption, 30% actually attempted to quit (smoke free for at least 1 day). Three percent of those attempting to quit were smoke free at the time of interview.

Community-based quit smoking services

A range of services are available in the community to support those wishing to quit smoking.

To help Aotearoa become smokefree by 2025, the Ministry of Health has introduced new, regional stop smoking services, which came into effect on 1 July 2016.

In the Auckland and Waitemata DHB regions, the Ready, Steady, Quit Stop Smoking Service is being delivered collaboratively by ProCare, The Fono and Ngāti Whātua Ōrākei Whai Maia Limited.

The free service consists of a four-week, face-to-face programme in which people are supported through their quit journey. People can choose either group-based sessions with peer support and expert advice or one-to-one sessions. As well as behavioural support, nicotine replacement therapy (eg gum, patches, lozenges) can be provided.

Quitline's telephone advisors are available 24/7, providing free support and advice and can arrange for subsidised nicotine replacement therapy. Online, text and referrals to face-to-face services are also available.

In May and June 2017 Quitline ran a campaign targeted at Pacific Peoples. The campaign was fronted by high profile Samoan comedian Tofiga Fepulea'i and aimed to encourage Pacific Peoples to contact Quitline to begin their stop smoking journey.

Advertisements ran in Pacific media, postcards were mailed out to 20,000 South Auckland homes and posters were placed outside dairies in areas with high smoking rates.

30%

OF 4 YEAR OLDS ARE OVERWEIGHT OR OBESE, NO CHANGE FROM 2015

65%

OF BABIES WERE FULLY BREASTFED AT 3 MONTHS OF AGE (JAN-JUN 2017, AN INCREASE FROM 60% IN 2014/15

93%

OF FOUR YEAR OLD CHILDREN RECEIVED A BEFORE SCHOOL CHECK

99%

OF OBESE CHILDREN (392 4-YEAR OLDS) WERE OFFERED A REFERRAL TO A HEALTH PROFESSIONAL FOR ASSESSMENT AND INTERVENTION

27

PREGNANT WOMEN WITH GESTATIONAL DIABETES WERE REFERRED TO GREEN PRESCRIPTION

Halt the rise in obesity

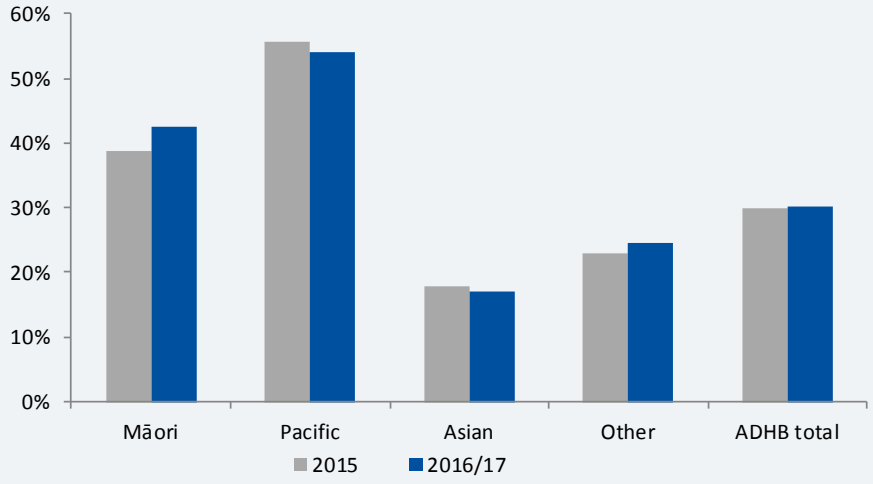
Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand. Overweight or obese children are at higher risk of obesity throughout their lives and childhood obesity is associated with a wide range of health complications and an earlier onset of illness such as diabetes and heart disease. In Auckland DHB we estimate that 17% of all male deaths and 13% of female deaths in the 15+ age group are attributable to being overweight and/or obese.

Intervening early to reduce the prevalence of obesity will have long-term positive effects for population health. We support the creation of health promoting environments that encourage and aid people to adopt healthier lifestyles, and provide medical intervention where appropriate.

Reducing obesity

30% of 4 year olds in Auckland are considered obese or overweight (>=85th percentile, when measured at their B4 School Check), a similar proportion to that seen in 2015. Significantly higher rates of obesity are seen in our Māori (42%) and Pacific (64%) children.

FOUR YEAR OLD CHILDREN RECEIVING A BEFORE SCHOOL CHECK WHO ARE OVERWEIGHT OR OBESE



Together with targeted nutrition and lifestyle interventions and healthy public policy, breastfeeding can reduce the risk of overweight and obese children. Breastfeeding provides the nutrition required for healthy development as well as helping to protect against common childhood infections and non-communicable diseases (such as diabetes and asthma) later in life. The Ministry of Health recommends that infants be breastfed exclusively for around the first six months of life. In the first six months of 2017, 65% of babies were fully and exclusively breastfed at 3 months of age, an increase from 60% in 2014/15.

In the 2016/17 year Auckland DHB achieved 99% against the Raising Healthy Kids health target, meaning all children identified as obese were either referred to their General Practice, already under care, or declined care.

A regional strategy has been developed in the form of the Metro-Auckland Healthy Weight Action Plan for Children. This has included the design and implementation of the regional child healthy weight referral pathway for general practice. A family based nutrition, physical activity, and parenting programme is currently being designed with support from the Māori and Pacific health gains teams, paediatricians, and dietitians. This programme will be available to all children identified by the Target, and their families.

The DHB implemented the National Healthy Food and Drinks Policy in 2016/17. The Policy demonstrates commitment to the health and wellbeing of staff, visitors and the general public by providing healthy food and drink options.

Raising Healthy Kids

A new health target aimed at helping to reduce childhood obesity was launched in 2016/17.

Auckland DHB is starting to see the first signs of success from efforts to reduce obesity in pre-school children. The B4 School Check screening identified 7.5% of children sitting on or above the 98th centile for BMI in 2016/17. This is an improvement from 9% at the same time last year.

The Raising Healthy Kids health target focuses on intervening in the early stages of life to ensure positive, sustained effects on health. The programme sees four year olds identified as obese at their B4 School Check offered a referral to the services they and their family need to support healthy eating and activity.

Be Well with BeSmarter

As part of the work towards Raising Healthy Kids, Auckland DHB needed to establish a referral pathway for children identified under the target. As the Before School Provider, Plunket was ideally placed to deliver ongoing support for families already engaged in their service.

Together, the DHB and Plunket have adopted the Waikato BeSmarter brief intervention, to be delivered by a trained Health Worker. The BeSmarter tool is designed to identify an area the family can work on from a suite of options such as getting enough sleep, healthy drinks, portion sizes and increasing physical activity.

Primary care practitioners are also receiving training in how to utilise the BeSmarter resource, through the Auckland Community Dietitians. This helps GPs and practice staff to provide ongoing support to families referred through the target as well as families identified through general practice.

The results have been positive, with many families opting to utilise the resource and make sustained changes.

Success

One such success was four year old Grace* and her family. Grace is the youngest of five children and often had her dinner late at night when the rest of the family was eating. She was watching television up to 11pm at night and then waking up tired and grumpy the next day, with no desire to eat breakfast.

The Plunket health worker took Grace's mum through the BeSmarter tool and Grace's mum started by identifying bed time as being an issue. The health worker supported the family to provide Grace with an earlier dinner time, which helped her get to bed on time and wake up with more energy. She even started eating breakfast. As part of other BeSmarter goals Grace's family has also cut down on fizzy drink and sweets.

**Name changed for privacy*

A Well Child nurse carries out a B4 School health and development check. The check aims to identify and address any behavioural, developmental or health concerns before a child starts school.

WORLD-CLASS HEALTHCARE

We aim to provide rapid access to healthcare that is timely, reliable, equitable, high quality and safe, to reduce the societal and economic burden of poor health impacts. Many conditions, such as CVD, some cancers and diabetes, are considered preventable or treatable through the provision of timely and high quality healthcare and we aim to improve our management of these to reduce hospital stays and avoidable deaths.

80.6

AMENABLE DEATHS PER 100,000
A DECREASE FROM 85.4 IN 2010

69%

OF PEOPLE DIAGNOSED WITH CANCER IN 2012-13 SURVIVED FIVE YEARS AFTER THEIR DIAGNOSIS, THIS HAS INCREASED FROM 66% IN 2008/09

85%

RECEIVED THEIR FIRST CANCER TREATMENT WITHIN 62 DAYS

92%

OF OUR ELIGIBLE POPULATION HAD THEIR CARDIOVASCULAR RISK ASSESSED

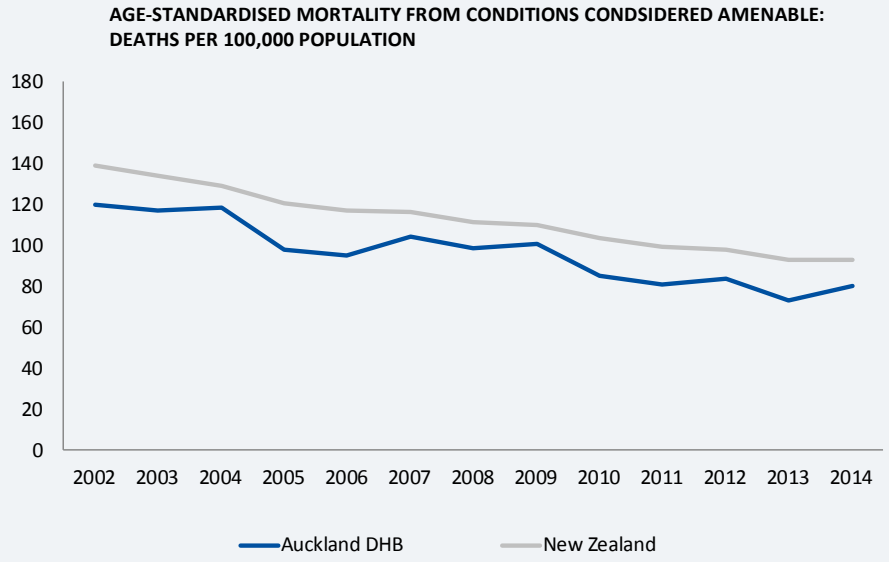
85%

% OF ACS INPATIENTS RECEIVED CORONARY ANGIOGRAPHY WITHIN 3 DAYS

Fewer deaths from amenable conditions

Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist.

A reduction in mortality from conditions considered amenable
The rate of amenable mortality has steadily decreased over the past decade and is among the lowest in New Zealand at 80.6 per 100,000 population. In 2014, we estimate that 433 deaths (47% of all deaths in those aged under 75 years) in Auckland DHB were amenable.



Our five-year survival rates from cancer are the highest in New Zealand. For individuals diagnosed with cancer in 2012/13, the five year survival rate was 69%, an increase from 64% in 2006/07.

We have achieved the Faster Cancer Treatment health target. 85% of patients who received their first cancer treatment (or other management) in 2016/17 were treated within 62 days of being referred with a high suspicion of cancer compared with 60% in Q4 2014/15.

Cardiovascular disease is largely preventable and is associated with large inequalities. Early detection and management of risk factors can lead to a reduction in sickness and premature death. 92% of our eligible population have had their cardiovascular disease risk assessed, exceeding the target of 90% set by the Ministry of Health.

Many people in our district require surgical intervention to treat their cardiovascular disease. For those admitted to hospital with ACS - acute coronary syndrome (sudden, reduced blood flow to the heart, e.g. unstable angina or heart attack) – it is important to perform coronary angiography quickly to inform further treatment options and prevent additional cardiovascular events. In 2016/17, 625 ACS patients living in the Auckland DHB district received an angiogram, 85% within 72 hours, exceeding the 70% target.

Supporting people to stay well

Auckland DHB's cardiac rehabilitation team has partnered with local Whānau ora provider, Te Hononga O Tāmaki Me Hoturoa, to enable better rehabilitation for Māori and Pacific Island patients with heart disease.

Te Hononga O Tāmaki Me Hoturoa is a kaupapa Māori Whānau Ora Non-Government Organisation (NGO), delivering services to predominantly 'high need' populations in the Auckland and Counties-Manukau District Health Board areas. Health priorities for this service are obesity, cardiovascular disease, diabetes and respiratory disease. Te Hononga O Tāmaki Me Hoturoa also delivers Toi Tu Kids, providing community based child health care for Māori, in partnership with Starship Children's Hospital.

Whānau Ora approach lifts uptake of cardiac rehabilitation

After a cardiac event, it is best practice for patients to start a regular, guided community exercise programme. However, uptake of these programmes are low nationwide, with Māori and Pacific Island patients most at risk of not participating.

To help improve this rate, over the past year Auckland DHB's cardiac rehabilitation team has worked with Te Hononga O Tāmaki Me Hoturoa to form a multidisciplinary team to support Māori and Pacific Island heart patients to stay well.

Patients attend the community based exercise programme, supervised by Te Hononga and Auckland DHB staff, twice a week, with 12 Māori and Pacific Island patients per session. Each patient receives an individual programme based on best practice guidelines. After the eight-week programme has been completed, the patients move on to a public gym, with continuing support from the Te Hononga multidisciplinary team of registered nurses, lifestyle coaches and social workers.

This innovative holistic approach to exercise has facilitated the transition to long-term management of risk factors for heart disease for the most vulnerable patients.

Francis, a 60-year-old Māori man with asthma, severe gout, and impaired glucose tolerance (pre-diabetes), had a heart attack. Hospital treatment, including multiple stents, enabled him to return home.

Francis is a single parent raising a 2 year-old child. Prior to his heart attack, Francis had been active with ocean swimming and Waka Ama (outrigger canoeing).

The cardiac rehabilitation team asked Te Hononga O Tāmaki Me Hoturoa to work with Francis, providing integrated care along with his GP. The goals were to help Francis learn to better manage his health conditions and make some healthy lifestyle changes so he could return to his active lifestyle.

2 months after his heart attack, Francis started an exercise progamme with Te Hononga O Tāmaki Me Hoturoa, progressing on to an intensive monitoring programme run by Auckland University.

Francis worked with a Te Hononga lifestyle coach to make healthy changes to his diet, with a positive effect on his weight and blood glucose levels. A registered nurse has provided support to help Francis understand and manage his health conditions.

Francis is now highly motivated to remain healthy. His extra activities have led to extended social networks and in April 2017 he competed with Waka Ama at the Masters Games in Auckland.

Francis attending a cardiac rehabilitation exercise programme run by Te Hononga O Tāmaki Me Hoturoa.

THERE WERE

372

ACUTE HOSPITAL BED DAYS (PER 1,000 POP), A DECREASE FROM 397 THE PREVIOUS YEAR

52%

OF PATIENTS WITH CVD ARE RECEIVING TRIPLE THERAPY MEDICATION, A SLIGHT DECREASE FROM 54% JUN-14

55%

OF PEOPLE WITH DIABETES ARE WELL MANAGED

5,060

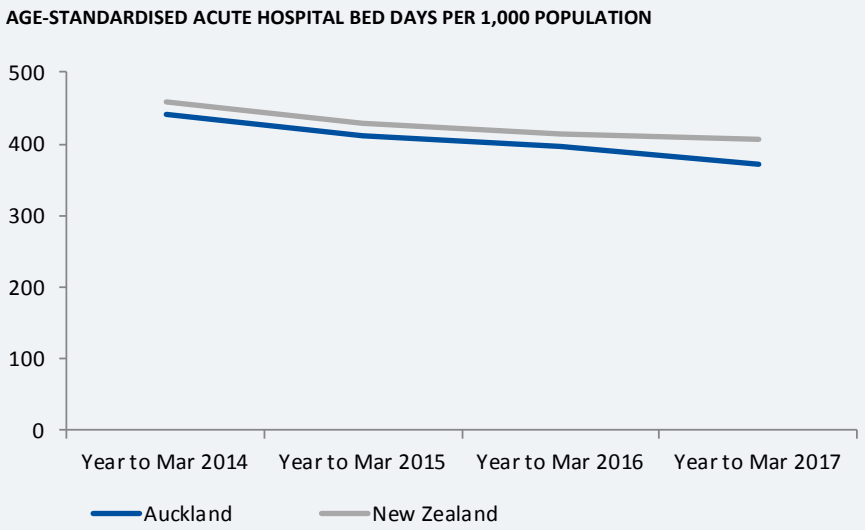
PEOPLE WERE REFERRED TO POAC FOR ACUTE CARE

Addressing the demand for acute care

The rate of acute hospital bed days per capita is a measure of the use of acute services in secondary care. The demand for acute care could be reduced by effective management in primary care, optimising patient flow within the hospital, discharge planning, community support services and good communication between healthcare providers. Reducing the number of acute hospital bed days will allow more effective use of our health resources.

A reduction in acute hospital bed days

Our standardised rate of acute bed days is slowly declining and is less than the National rate at 372 per 1,000 population compared with 405 per 1,000 population nationally.



Current New Zealand guidelines recommend that people who experience a heart attack or stroke (where appropriate) should be treated with a combination of medication known as triple therapy (aspirin or another antiplatelet/anticoagulant agent, a beta blocker and a statin), to reduce the risk of another event. In the 12 months to March 2017, 52% of our population who have had a CVD event received triple therapy medication.

Diabetes is a chronic illness that requires continuous medical care, patient self-management and education to reduce the risk of acute and long-term complications. How well a patient is managing their diabetes can be monitored through regular assessment of their HbA1c (an indicator of glycaemic control). In 2016/17 55% of patients estimated to have diabetes (VDR) had HbA1c readings of less than 64mmols, an indication that their diabetes was well managed.

There are a number of issues around extracting data from GP practices and this is impacting our ability to accurately report diabetes data. We believe that the reported proportion of patients with good diabetes management is understated. Diabetes is a priority area for Auckland DHB and we are working to resolve these data issues. The Auckland Waitemata Diabetes Service Level Alliance (DSLA) has developed a 5-year action activity plan to improve the health of people with diabetes, which was endorsed in April 2017.

Primary Options for Acute Care (POAC) is a service providing healthcare professionals access to investigations, care, or treatment for their patient, where the patient can be safely managed in the community, preventing an ED attendance and possible hospital admission. In 2016/17 5,060 patients were referred to POAC.

Care closer to home reduces hospital stays

The Auckland DHB Rapid Community Access Team (R-CAT) provides nursing care, assessment and treatment in the community to enable patients to have an earlier or more supported transition from hospital to home or to help avoid an admission to hospital.

The R-CAT service sits with all Auckland DHB Community Services under the banner of 'Care closer to home', highlighting that the services provide quality, patient centred, self-directed care as close to home as possible, and in-line with the Ministry of Health's focus on keeping New Zealanders healthy and out of hospital.

The nurse-led Rapid Community Access Team was first launched in June 2015 to respond to referrals from within the hospital for patients who were discharged, but needed follow up in the community to stay well at home.

The service bridges the gap between hospital and home by providing in-home care and support for adult patients for up to five days upon returning from hospital. It interacts across all community services to ensure patients receive wrap-around care and aims to support safe and earlier discharge from hospital and reduce readmission.

The R-CAT service receives between 50-60 new referrals from Auckland City Hospital each month and undertakes approximately 670 follow-ups a month.

Rapid response service begins next phase

In May 2016, the Team extended its service to patients in aged residential care facilities, GP practices and the St John service. The R-CAT team deliver intensive nursing support to people with specific health needs, as well as providing access to allied services to maintain and further improve patient health.

"Community facilities and GPs can call the Rapid Response Team for help to enable a patient to safely remain where they are living," says Sam Abbott, Clinical Nurse Specialist.

The service has been a well-used and valued resource by clinicians, patients and their families.

As one patient wrote:

"It was a real comfort to know that professional staff were coming to visit over the critical days following my father's discharge.

Long may the Rapid Response Team continue!"

Achieving better outcomes

Mrs Cunningham* is one of the many patients the R-CAT service has helped to remain safely at home.

The hospital was busy and the Nurse Unit Manager from Older People's Health approached R-CAT with the wait list for admissions to identify patients who could potentially be supported at home.

One of the R-CAT nurses went to visit Mrs Cunningham in her home. Having carried out a 'top to toe' assessment, she had a discussion with Mrs Cunningham, her family and caregivers, providing advice and a care plan. She also discussed this with Mrs Cunningham's GP.

Two visits and one phone call later, Mrs Cunningham was discharged without having to go to hospital; a better outcome for all.

*name changed for privacy

Cellulitis champions

Now in 2017, the Service has adopted the role of cellulitis pathway champions.

GPs can phone Clinical Nurse Specialists for advice about the regional pathway for cellulitis. Patients with an identified non-complex cellulitis who might previously have attended the Emergency Department or been referred to APU or a ward, can then be seen at home and a process started to enable treatment in the home or in community.

Some of the members of the Auckland DHB Rapid Community Access Team.

ACHIEVED TOGETHER

People are at the centre of our work. Models of care need to be designed around the patient and coordinated so that patients get what they need, in the right place at the right time. Our focus in this area is on ensuring our patients have an improved experience of health care services and that our children are engaged early with high quality primary and community services, to ensure they get the best start in life.

6,949
PER 100,000 ASH ADMISSIONS IN 0-4 YEAR OLDS

74%
OF BABIES* WERE ENROLLED WITH A PHO BY 3 MONTHS OF AGE, AN INCREASE FROM 69% Q4 2014/15
*born 20/5/17-19/5/17

94%
OF AUCKLAND CHILDREN WERE FULLY IMMUNISED BY EIGHT MONTHS OF AGE, NO CHANGE FROM Q4 2014/15

93%
OF 4 YEAR OLDS RECEIVED A BEFORE SCHOOL CHECK

60%
OF CHILDREN WERE DENTAL CARIES FREE AT AGE 5 (CY2016)

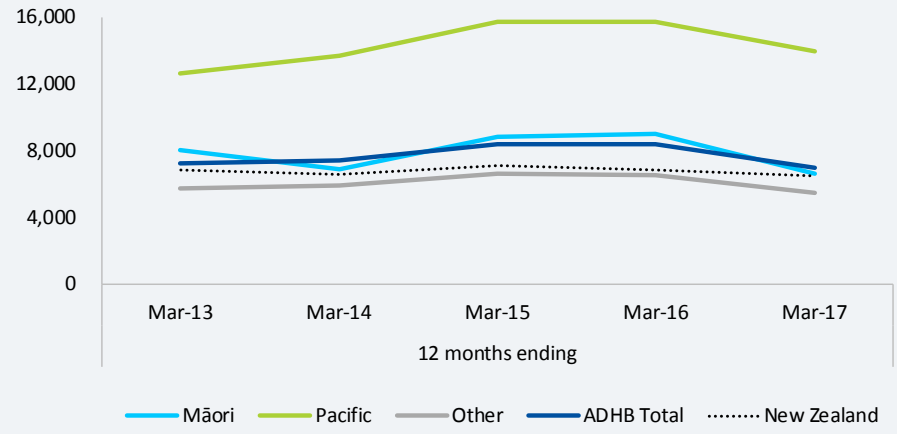
Children get a great start to life

Ensuring that children have the best start to life is crucial to the health and wellbeing of the population. Well integrated, high quality primary and community services can maintain good health, prevent health problems and improve health outcomes.
We seek to reduce admission rates to hospital for a set of diseases and conditions that are potentially avoidable through prevention or management in primary care (ambulatory sensitive hospitalisations – ASH). In children, these conditions are mainly respiratory illnesses, gastroenteritis, dental conditions, and cellulitis.

Keeping children out of hospital

In the 12 months to March 2017, there were 6,949 admissions per 100,000 in our 0–4 year old population (2,283 events) that were considered ambulatory sensitive, a decline on the previous two years. Rates in the Pacific population are twice as high as other ethnicities.

AMBULATORY SENSTIVE HOSPITALISATIONS PER 100,000 IN THOSE AGED 0-4 YEARS



Early enrolment with a GP/practice enables newborn babies to receive timely immunisation and other health checks. In 2016/17, 74% of babies born in our area were enrolled with a GP by 3 months of age. Auckland DHB has collaborated with PHOs in the region through our Q4 Journey quality improvement project. We travelled with these babies, completing a review of all systems. General practices and the hospital Maternity services have streamlined and improved how we communicate early enrolment with new parents and caregivers.

Immunisation remains a focus for Auckland DHB. During 2016/17 we fully immunised 94% of children by eight months of age, and reached the 95% target in Q4. The Q4 Journey project saw the babies turning 8 months in Q4 followed from birth, and through each primary immunisation event. Babies overdue for immunisations at any point were actively followed up by immunisation coordinators.

Immunisation rates in Māori children are lower than the total population, at 89%. Our Māori case review group meets monthly with Ngāti Whātua, Well Child Tamariki Ora, oral health, immunisation services and the DHB to share information and support whānau and tamariki who are overdue for immunisations.

Oral healthcare starts early

To set children up for lifelong oral health, the Auckland Regional Dental Service is focusing on boosting the numbers of pre-schoolers engaged with the service.

Maintaining good oral health in the first five years of a child's life is important for lifelong oral health. In contrast, poor oral health and dental decay at an early age can significantly affect physical, psychological and social development, leaving children susceptible to poor oral and general health throughout their lives.

Poor oral health is the cause of a significant number of hospital admissions in children. In the 12 months to March 2017, 199 children aged 0-4 were admitted to hospital for dental conditions.

In 2016, 60% of all 5-year old children had no dental decay (caries free), with higher rates of decay seen for Māori (43% caries free) and Pacific (32% caries free).

The Auckland Regional Dental Service (ARDS) provides oral health promotion, education and treatment to over 300,000 children across greater Auckland each year. All pre-school children and school year 1-8 children living in the metro Auckland area are eligible for enrolment with the service.

Improving preschool enrolment

To ensure that children are seen by ARDS, we have focused on early enrolment. This focus has seen enrolment increase by 10-15% for all ethnicities in the last 6 years. As at the end of December 2016, 83% of all children aged 0-4 years and living in Auckland were enrolled with our oral health service.

Activities to increase enrolment have included an automatic enrolment process into the service from birth across all three Metro Auckland DHBs and working with community providers, such as Well Child Tamariki Ora providers to ensure contact details are updated.

ARDS is working to ensure that preschool children are seen before they turn one year of age so that oral health care can start early.

In partnership with Plunket, ARDS is exploring opportunities to jointly deliver services (e.g. have a mobile dental clinic on site when a well-child clinic is being provided) to allow families access to both services at the same time.

ARDS also works with other child health providers so that at-risk children (those who have not attended appointments or where there are concerns for their oral health) are identified and referred to the service. ARDS can then support the families to attend appointments.

In the future, we plan to implement an outreach programme where staff provide fluoride varnish (a preventative treatment) to high needs children in the community.

Mobile clinics make it easier for families to access oral health services.

Improved experience of healthcare services

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, tailoring services to meet patient and whānau needs, and engaging them as partners in their care.

8.3/10

AVERAGE SCORE IN THE HQSC INPATIENT SURVEY, NO CHANGE FROM JUNE 2016

86%

OF INPATIENTS RATED THEIR CARE AS VERY GOOD OR EXCELLENT, NO CHANGE FROM 2015/16

84%

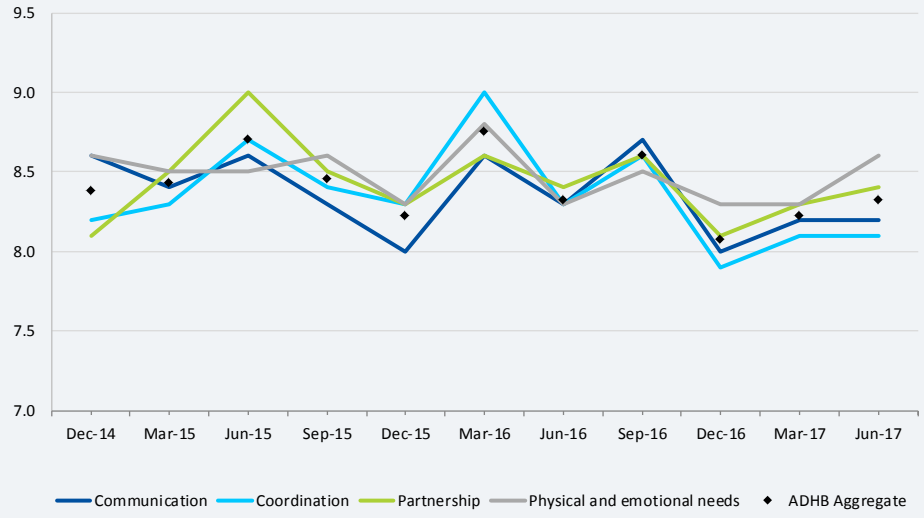
OF INPATIENTS FELT STAFF ALWAYS TREATED THEM WITH DIGNITY AND RESPECT

88%

OF OUTPATIENTS RATED THEIR CARE AS VERY GOOD OR EXCELLENT (APR-16 TO MAR-17)

An increase in the average score across the four domains of the Health Quality and Safety Commission (HQSC) inpatient survey

The HQSC inpatient survey rates patient experience across four domains: communication, coordination, partnership, and physical and emotional needs. Our average scores out of ten have remained above 8/10 since the survey was implemented and are similar to New Zealand as a whole.



Patient experience measures are now routinely in place for hospitals. Our patient experience surveys allow us insight into what patients say makes the most difference to their care and treatment. We can also use their responses to understand the dimensions where making improvements would have the most positive impact on patient experience.

Patients who feel that all aspects of their health care experience have been well managed are more likely to rate their care as very good or excellent. The percentage of our inpatients rating the care they received as 'very good' or 'excellent' remains at 86% in 2016/17.

Our inpatient survey respondents rated Communication as the dimension of care that mattered most for them. 74% said that, when they had important questions to ask, they always received clear answers that they could understand.

Patient surveys are also carried out in our outpatient departments. 88% of our outpatient survey respondents rated their care as very good or excellent. The dimension of care that matters most to our outpatients is Information. 76% said that the information they received about their care and treatment was very good or excellent.

Better experiences for our patients and their families

Spending time in hospital can be stressful for our patients and their families. We're taking many steps to improve the experience our patients have while under our care.

Communication cards

Communication is an important dimension of care to our patients, particularly those with limited or no English. While Interpreting services are available, we wanted to further support patient care, safety and quality of experience around the clock with an easy-to-use tool.

With our Design for Health & Wellbeing Lab, we developed a simple system to help limited or non-English speakers express their priority needs around pain, positioning, environment, and personal requirements, in the form of communication cards containing icons that patients can point to if they have difficulty communicating. The icons were selected using feedback from patients, families, clinical staff and the Interpreting Service.

Following trials on six different wards, the cards were made available to all staff on our intranet in November 2016, enabling cards to be printed and left at the patient's bedside for use as required. Staff feedback has been very positive. The cards are also available on our public website for use by other service providers.

The cards are available in 12 languages and a blank version to write in the translations for other languages.

Virtual reality helps children prepare for medical procedures

Virtual reality technology is being developed to help young patients prepare for their hospital visit through virtual preparation experiences. The project aims to improve the overall hospital experience for child patients, reduce the need for medication to manage anxiety and so help achieve better clinical outcomes.

Auckland DHB's Clinical Director, Starship Radiology Dr Sally Vogel says "Some young patients require dozens of procedures and the headsets allow them to explore the surgical or radiology environment with a nurse or play specialist, ask questions and direct their own learning."

Through a headset, a robot guides children through procedures such as radiation therapy, theatre (from pre-operation to recovery), MRI, CT, and X-Ray. Together they are introduced to medical professionals, clinical equipment, questions, and sounds they will experience on the day. The child's reactions, and their ability to follow instructions such as 'stay still' and 'hold your breath', help the clinical teams determine whether sedation or general anaesthetic will be required during the real procedure. Parents and whānau of patients are also encouraged to go through the VR experience.

The project transitions from product development to implementation in March 2017.

A child with a virtual reality headset, similar to that used to prepare for medical procedures at Starship Hospital

Surgical transition lounge

Checking in for surgery can be a stressful time for patients. Since 2003, patients having surgery at Auckland City Hospital have reported to the main reception to wait to be called to theatre. This was not a reassuring environment for those about to undergo a major procedure.

As part of the Healing Environments initiative, the surgical transition lounge (historically used only to transition patients out of surgery) is now being put to use as a private waiting space for patients checking in for surgery. This small but significant change provides patients with the respect they deserve.

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. Measures that help to evaluate the DHB's performance over time are reported for each output class, 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 monitor progress 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. Auckland DHB population life expectancy is now 82.7 years, an increase of 1.6 years over the last decade. The life expectancy gap is 5.8 years for Māori and 7.4 years for Pacific, a decrease of 1.5 years over the last decade for Māori, and 0.4 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 2016/17.

National health targets

2016/17 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. For quarter four we achieved four of the six health targets according to Ministry of Health assessment criteria.

Health Targets	Health Target Description	2016/17				
		Q1	Q2	Q3	Q4	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%	93%	94%
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)[1] Target = 17,230	4,200 (93%)	8,481 (97%)	12,248 (96%)	16,822 (98%)	16,822 (98%)
Faster Cancer Treatment	85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment[2]	79%	88%	87%	81%	85%
Increased Immunisation	95% of eight months olds will have their primary course of immunisation on time	94%	95%	94%	95%	94%
Better Help for Smokers to Quit	90% seen in primary care provided with advice to help quit	87%	88%	88%	92%	89%
	90% of newly registered pregnant women provided with advice to help quit	98%	94%	97%	100%	97%
Raising Healthy Kids	95% of obese children identified in the B4SC programme will be offered a referral to a health professional[3]	79%	97%	99%	100%	99%

[1] Auckland DHB's targeted increase (share of the NZ total additional 4,000 discharges) was 651 additional discharges, quarterly results are year to date.
[2] 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
[3] Quarterly results are for checks completed in the rolling 6 month period ending one month prior to the end of the quarter, as per MOH definition. I.e. Q1=Mar-Aug16; Q2=Jun-Nov16; Q3=Sep16-Feb17; Q4=Dec16-May17. The FY result is for the 12 month period Jun16-May17 (thus Q1 result only partly represented in FY result).

Health Quality and Safety Commission Markers

The Quality and Safety Markers (QSMs) are used by the Health Quality and Safety Commission to evaluate the success of its national patient safety campaign, Open for better care, and determine whether the desired changes in practice and reductions in harm and cost have occurred. During 2016/17 we improved or maintained our compliance across most of the HQSM markers:

Health Quality and Safety Markers	Q4 2015/16	Q4 2016/17
80% compliance with good hand hygiene practice	84%	85%
Health care associated staphylococcus aureus bacteraemia per 1000 bed days	0.17	0.06
90% of older patients assessed for the risk of falling	95%	93%
% of patients assessed at risk of falling who received an individualised care plan	96%	96%[1]
Number of in hospital falls causing fractured neck of femur, per 100,00 admissions	4.03	3.76
100% of hip and knee arthroplasty primary procedures given antibiotic in right time	97%	98%[1]
95% of hip and knee arthroplasty procedures given right antibiotic in right dose	95%	98%[1]
Surgical site infections per 100 hip and knee operations	0.58	0[1]
95% of audits of surgical safety checklist engagement score levels of 5 or higher [2]	sign in – 97% time out – 97% sign out – 89%	

[1]Q3 2016/17 [2]New indicator, focus currently on embedding programme and auditing method

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 2016/17. This has been applied to assess performance against each indicator in the Output Measures section. A rating has not been applied 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, and improvement on previous year	Not achieved, but progress made	
<90%	>10% away from target, or 5.1-10% away from target and no improvement on previous year	Not achieved	

The following tables include our output measures from the 2016/17 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 measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	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 2015/16	96%	95%	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 2015/16	86%	88%	90%	89%	
Percentage of pregnant women who identify as smokers upon registration with a DHB-midwife or LMC are offered brief advice and support to quit smoking	Q2 2015/16	100%	99%	90%	97%	
Raising Healthy Children HT: Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (Q)	-	new indicator	-	95%	99%[4]	
Number of adults referred to Green Prescriptions (V)	2014/15	5,003	6,347	6,152	5,390[5]	
Enforcement of the Smokefree Environments Act 1990[6]						
Number of retailer compliance checks conducted (V)	2014/15	284	341	300	316	
HEALTH PROTECTION						
Tuberculosis (TB)[6]						
Percentage of TB and LTBI (latent TB infection) cases who have started treatment and have a recorded start date for treatment (Q)	2014/15	99.9%	98%	≥85%	98%	
POPULATION BASED SCREENING						
Breast Screening						
Coverage rates among eligible groups (45-69) (C)	Sep-15	65%	65%	70%	64%[7]	
Newborn Hearing Screening						
Number/proportion of babies offered screened within 1 month (C)	CY 2015	97.15%	8,309 (98%)	90%	100%	
Referral rate to audiology ≤4% (Q)	CY 2015	2.1%	1.9%	≤4%	1.0%	
Appropriate medical and audiological services initiated by 6 months of age for infants referred through the programme (T)	CY 2015	100%	100%	≥95%	100%	
Children						
Percentage of B4 School Checks completed	Q2 2015/16	96%	95%	90%	93%	

[4] 12 months to May 2017.
[5] Performance has improved in recent years and is offset by the Active Families programme exceeding target by 23%. This indicator is to be replaced with a new service specification with a target on engaged clients rather than referrals.
[6] These services are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. These results are for all 3 DHBs.
[7] Coverage rates have decreased, partly due to increasing population denominators. We are working with providers to improve data matching and uptake.

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 measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	Achievement
PRIMARY HEALTH CARE						
Primary care enrolment rates (C)	Sep-15	91%	88%	95%	84%[8]	🔴
Number of referrals to Primary Options for Acute Care (POAC) (V)	Apr-15 to Mar-16	4,539	4,595	7,000	5,060[9]	🔴
Increased immunisation HT: percent of eight months olds will have their primary course of immunisation on time (C)	Q3 2015/16	94%	84%	95%	94%	🔵
HPV vaccination coverage dose 3 (C)	Q2 2015/16	82%	83%	70%	81%	🟢
Seasonal influenza immunisation rates – 65+ (C)	Q1 2015/16	65%	45%[10]	75%	52%[11]	🔴
Cervical screening coverage (C)	Q2 2015/16	80%	73%	80%	69%[12]	🔴
Percentage of people with diabetes whose HbA1c at their annual review was ≤64 mmol/mol	Q2 2015/16	60%	65%[13]	61%	n/a[14]	n/a
Percentage of patients with prior CVD who are prescribed triple therapy	Oct-14 to Sep-15	53.5%	52.8%[15]	70%	52.2%[15]	🔴
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years (C)	Q2 2015/16	92%	92%	90%	92%	🟢
COMMUNITY-REFERRED TESTING AND DIAGNOSTICS						
Number of radiological procedures referred by GPs to hospital (V)	CY2015	46,794	50,021	Ω	56,668	n/a
Percentage of accepted community referred scans receiving their scan within 6 weeks (T)	Q2 2015/16	CT 96% MRI 52%	CT 98% MRI 95%	CT 95% MRI 85%	CT 95% MRI 66%[16]	🟢 🔴
ORAL HEALTH						
Mean decayed, missing, filled teeth (DMFT) at year 8 ratio (Q)	CY2015	0.84	0.84	0.85	0.75[17]	🟢
Children caries free at five years of age (Q)	CY2015	58%	58%	70%	60%[17,18]	🔴

[8] Patient enrolment with general practices is not keeping up with the population growth rate, including that of migrants. A number of strategies are in place.
[9] Ongoing work is occurring with Auckland Hospital ED and inner city general practices to improve POAC utilisation.
[10] CY2015 flu season result.
[11] CY2016 flu season result. Provision of funded vaccinations at pharmacies and continued focus between PHOs and general practices should increase 2017 performance; both activities are recorded on the National Immunisation Register and expected to improve data capture and accuracy.
[12] Stats NZ population estimate for Jun-17 is 11% higher than that used in Dec-15. We continue to promote screening, and work to increase access with opportunistic screening, broader clinic hours, support for high priority women, community outreach and the use of NSU data match lists.
[13] Q4 2015/16 result, patients receiving an annual diabetes review in Q4 2015/16.
[14] Data no longer available as this indicator has been changed by the Ministry to the most recent HbA1c measurement in the last 12 months.
[15] March 2016 result for 2015/16; March 2017 result for 2016/17. A proposal to improve CVD risk management in our population has been endorsed by the Auckland and Waitemata Alliance Leadership Team, with implementation planned to start in January 2018.
[16] Underperformance was due to increased acute volumes and MRT vacancies. Options are in place for outsourcing during high demand periods and majority of vacancies have been filled, with training in progress and additional capacity planned from Sep 2017.
[17] CY2016 (oral health targets set for calendar years).
[18] A preschool oral health strategy has been developed, with a focus on reducing inequities for Māori and Pacific children.

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 are complex treatment services and focus on individuals. Equitable and timely access to intensive assessment and treatment improves patient outcomes. Effective and prompt resolution of emergencies and acute conditions reduces mortality; elective surgery restores functional independence and improves health-related quality of life, thus improving population health.

Output measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	Achievement
ACUTE SERVICES						
Number of ED attendances (V)	CY2015	102,089	108,132	Ω	114,473	n/a
Acute WIES[19] total (DHB Provider) (V)	CY2015	94,280	97,851	94,755	100,399	
Shorter stays in Emergency Departments HT: % of ED patients discharged admitted or transferred within six hours of arrival (Q)	Q2 2015/16	95%	95%	95%	94%	
Compliance with Faster Cancer HT: 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[20] (T)	Q2 2015/16	69.2%	76.6%	85%	85%	
Percentage of eligible stroke patients thrombolysed (T)	Q1 2015/16	10.8%	9.8%	10%	11%	
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway (Q)	Q2 2015/16	86%	91%	80%	89%	
Percentage of ACS inpatients receiving coronary angiography within 3 days (T)	Q2 2015/16	89.3%	87%	70%	85%	
MATERNITY						
Number of births in Auckland DHB hospitals (V)	CY2015	7,076	7,173	Ω	7,256	n/a
Third/fourth degree tears for all primiparous vaginal births (Q)	CY2015	5.3%	5.4%	↓	5.1%	
Number of women booking before end of 1st trimester (Q)	CY2015	46%[21]	69%[21]	80%	n/a[21]	n/a
ELECTIVE (INPATIENT/OUTPATIENT)						
Delivery of health target for elective surgical discharges (V)	2014/15	15,899	16,818	17,230	16,822	
Patients waiting longer than four months for FSA - ESPI 2 (T)	Jan-16	0.2%	0.1%	0	0.3%	[22]
Patients given a commitment to treatment but not treated within four months – ESPI 5 (T)	Jan-16	1.4%	0.9%	0	6.1%[23]	
Surgical intervention rate (per 10,000 population)	2015/16					
- Major Joints		17.7	17.7	21	15.2[24]	
- Cataracts		36.6	36.6	27	37.3	
- Cardiac surgery		5.2	5.2	6.5	5.2[25]	
- Angioplasty		11.2	11.2	12.5	11.7	
- Angiogram		30.8	30.8	34.7	29.5[26]	
% of people receiving urgent diagnostic colonoscopy in 14 days	Mar-16	98%	94%	85%[27]	95%	
Percentage of people receiving non-urgent diagnostic colonoscopy in 42 days		56%	74%	70%	88%	

[19] Weighted inlier equivalent separations (WIES) – relative cost measure for inpatient episodes.
[20] 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.
[21] MoH MAT data 2015. Independent LMCs only. MOH have not released any later data. Baseline incorrect in 2016/17 Annual Plan.
[22] Assessment of performance is based on Ministry of Health criteria.
[23] This is almost entirely due to underperformance in Adult Orthopaedics. A recovery plan is in place.
[24] Our volume of acute workload is affecting our elective surgery capacity; we have an outsourcing strategy underway and are reviewing our patients' needs.
[25] Acute complex referrals remain high and we plan and manage the wait list daily; our wait times remain within MoH targets and are stable.
[26] Despite increase in acute demand, we continue to monitor waitlists and patient waiting times and are within MoH timeframes.
[27] Baseline and target values transposed in 2016/17 Annual Plan.

Output measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	Achievement
QUALITY AND PATIENT SAFETY						
Percentage of opportunities for hand hygiene taken	Q2 2015/16	80%	84%	80%	84%	
Percentage of older patients assessed for risk of falling	Q2 2015/16	92%	95%	90%	93%	
Percentage of operations (hip and knee arthroplasties) where antibiotic given in hour before incision	Q2 2015/16	96%	96%	100%	97%	
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC (Q)	CY 2015	0.18	0.14	↓	0.21[28]	
Percentage of respondents who rate their care and treatment as very good or excellent (inpatients) (Q)	Q2 2015/16	84.3%	86%	↑	86%	
MENTAL HEALTH						
Percentage of population who access mental health services (C): Age 0–19 years Age 20–64 years Age 65+ years (total)	Oct-14 to Sep-15	 2.88% 3.75% 3.04%	 3.21% 3.77% 3.14%	 3.0% 3.7% 3.1%	 3.4% 3.6% 4.0%	
% of clients seen within 3 weeks (T) - Mental Health - Addictions % of clients seen within 8 weeks (T) - Mental Health - Addictions	Oct-14 to Sep-15	 77.3% 93% 96% 96%	 75% 96% 89% 100%	 80% 95%	 73%[29] 96% 89%[29] 100%	

Output Class 4: Rehabilitation and Support Services

Rehabilitation and support are delivered following an assessment process and coordination input by Needs Assessment and Service Coordination (NASC) Services for various services (e.g. palliative care, home-based support, residential care). 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 significantly contribute to people living at home for longer, thus not only improving their well-being but also reducing institutional care costs.

Output measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	Achievement
HOME-BASED SUPPORT						
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)	Q1 2015/16	96%	97%	95%	97.8%	
% of urgent interRAI referrals assessed within 5 working days % of non-urgent interRAI referrals assessed within 15 working days (T)	Q3 2015/16	100% 76%	70%[30] 81%	90% 90%	n/a[31]	n/a n/a
PALLIATIVE CARE						
Number of contacts	2015/16	10,677	10,677	Ω	9,805	n/a
Proportion of hospice patient deaths that occur at home (Q)	2014/15	24%	26%	↑	26%	
Proportion of patients acutely referred who waited >48 hours for a hospice bed (T)	2014/15	1%	<1%	↓	4%[32]	
RESIDENTIAL CARE						
Proportion of aged care providers with 4 year audit certification (Q)[33]	2014/15	23%	29%	↑	29%	

[28] The rate of staphylococcus bacteraemia has increased, yet hand hygiene is a focus for ADHB and we continue to comply with the hand hygiene process marker
[29] We have persistent increases in referrals in the past several years and are working to understand our demographic and develop appropriate options.
[30] Q2-4 2015/16.
[31] Data quality for these indicators is a national issue and is currently being investigated.
[32] The increase in the proportion of patients waiting >48 hours for a hospice bed was primarily due to high demand during Q4.
[33] 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.

Cost of Service Statement – for year ending 30 June 2017

During the reporting year, Auckland DHB acts as the lead DHB for the ProCare and LabTest contracts within the Auckland region. Consequently, Auckland DHB 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 and 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		Early Detection & Management		Intensive Assessment & Treatment		Rehabilitation and Support		Total	
	$000		$000		$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**24,651**	**25,339**	**419,122**	**479,562**	**1,423,800**	**1,410,674**	**211,741**	**209,646**	**2,079,314**	**2,125,221**
Expenditure										
Personnel	16,859	18,745	2,555	2,459	858,983	829,498	35,392	38,503	913,790	889,205
Outsourced Services	2,559	985	2	2	104,375	93,657	5,210	4,170	112,147	98,814
Clinical Supplies	134	238	147	142	256,756	249,161	5,532	5,443	262,569	254,984
Infrastructure & Non-Clinical Supplies	3,068	3,749	593	736	190,752	178,749	8,683	7,978	203,096	191,212
Payments to Providers	2,219	3,428	372,191	467,629	61,108	61,328	149,032	154,121	584,551	686,507
Total Expenditure	**24,839**	**27,145**	**375,488**	**470,968**	**1,471,975**	**1,412,393**	**203,850**	**210,215**	**2,076,152**	**2,120,722**
Net Surplus/ (Deficit)	**(188)**	**(1,806)**	**43,634**	**8,594**	**(48,176)**	**(1,719)**	**7,891**	**(569)**	**3,162**	**4,500**

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:

10,367
PEOPLE EMPLOYED AT AUCKLAND DHB (8,200 FTE)

4% MĀORI

9% PACIFIC

87% OTHER ETHNICITIES

78% FEMALE

22% MALE

We strive to be a good employer at all ages and stages of our employees' careers. Auckland DHB 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 people, and those 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.

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. In support of this, the DHB held its first organisation-wide employee survey since 1997. As a consequence, significant action plans are in place at organisational and local team levels, with regular reporting on progress to the Board.

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 has just completed a leadership development programme (LDP) designed to develop and enable Clinician leaders to lead people and teams, and sustain change. 150 clinician leaders have attended. We have piloted a Management Development Programme (MDP) to add to our development offerings. We identified 14 core management practices from research with Managers across our organisation and with external organisations. This research also unearthed a need for education on HR processes, so the learnHR series was born.

19% AGED <30

48% AGED 30-50

33% AGED 50+

46%
WORK PART TIME
(4,800 PEOPLE)

28
EMPLOYEES HAVE DECLARED A DISABILITY

Bringing in external experts to complement our internal expertise, learnHR is held monthly addressing core HR processes and practices throughout the lifecycle of an employee.

An innovative Coach Selection event was held for senior clinicians to allow them to source and connect with an executive coach for their development.

The DHB has established its own Mindfulness-Based Stress Reduction (MBSR) programme in Mental Health Services and plans to extend this across the organisation to support our staff to take care of themselves and live healthier and more adaptive lives.

Auckland DHB has taken an active role in work at national, regional and individual DHB level to implement the State Services Commission's framework for Leadership and Talent Development across the health sector and continues to participate in the HWNZ Leadership and Management Workstream.

Arguably the most significant culture initiative over the last 12 months has been the Speak Up - Kaua ē patu wairua (do not offend my spirit or my soul) programme. This programme is designed to support all employees to speak up when they experience, witness or are accused of bullying, discrimination or harassment. A 40-strong group of Speak Up Supporters has been formed. The programme and the supporter group are both led by respected clinicians.

A streamlined, contemporary HR Operating Model was introduced in March 2017, offering an improved HR service. Issues that are unresolved through self-service myHR intranet pages can be escalated to a professional HR Service Centre accessible to all employees by phone and email. Strategic and complex matters continue to be dealt with in person by the team of HR Managers.

Recruitment, Selection and Induction

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

The DHB has worked with the Equal Employment Opportunities Trust to create a paragraph for inclusion in all job advertisements highlighting our commitment to a diverse workforce and encouraging applications from Māori and Pacific communities.

Orientation and onboarding have been refreshed and improved with introduction of Navigate – Kai Arahi. Brought back on site in Auckland City Hospital's Clinical Education Centre, it is a warm welcome to Auckland DHB showing what we offer to care for our people, help them settle in quickly and feel part of this inspiring community. In addition, a series of guides have been produced, ensuring managers and new employees alike know how to make the most of the first few weeks at Auckland DHB.

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. The programme was a finalist in the HR Institute of New Zealand's inaugural Diversity Awards in February 2017.

A+ Trust Scholarships continue to be provided for Māori and Pacific students undertaking their first tertiary qualification in health. The programme also aims to address workforce disparities including by increasing the Māori and Pacific health workforce and reducing specific skill gaps in the health and disability workforce.

OCCUPATION TYPE:

43% NURSING

22% ALLIED HEALTH

18% MEDICAL

18% OTHER

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. Building consistent practice and approaches to developing our people has been emphasised by the introduction of a centralised system for planning and recording performance and development conversations between people leaders and their team members.
- 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 Ministry of Health funded post graduate programme students.
- Exit interviews and surveys conducted with departing staff have been reviewed and improved to get more useful feedback for the organisation.

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

Auckland DHB recognises the valuable contribution our employees 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.
- The ANIVA Nursing Leadership programme funds 3-5 Pacific nurses annually to complete post–graduate programmes in Leadership.
- An Associate Nurse Director was appointed for the development of the Māori nursing and midwifery workforce.
- Celebrating the achievement of Cleaners who gained the new NZQA accredited Certificate in Cleaning (Level 3).
- 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 employees, with those earning less than $55,000 per year having a free gym membership.

The majority of employees 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.

SUSTAINABILITY

One of the themes of the Auckland DHB Strategy to 2020 is Operational and Financial Sustainability. Our long term-strategy extends to reducing greenhouse gas emissions, energy use and waste.

At Auckland DHB we are committed to reducing our carbon footprint. By reducing our footprint we have a positive impact on our energy use, our environment, and the health and wellbeing of the communities in which we all live and work.

We work collaboratively with our external providers on sustainable initiatives that reduce our carbon footprint. Our Sustainability and Waste Minimisation Strategies align with the Government and Local Body objectives in reducing the carbon footprint and less reliance on landfill.

Increase in population will inevitably place a greater demand for our healthcare services. This upward trend also increases use of energy, clinical supplies, transport, water etc. We are consciously taking a social stand for the population we serve in reducing the environmental impact from our services.

We are also encouraging discussions with the wider community and our networks to promote sustainability, environmental awareness and innovation in order to reduce greenhouse emissions. All of these efforts will contribute, over time, to improved population health.

Our vision is to:

- Reduce energy use by 50%
- Produce 50% of our energy from on-site renewable sources by 2030
- Have zero landfill waste by 2040.

In 2015, Auckland DHB became certified under the Carbon Emissions Management and Reduction Plan (CEMARS). Under this Plan, we committed to reduce annual emissions by a minimum of 2% per annum to achieve a total of 20% reduction by 2025. In 2016, we were re-certified under CEMARS.

Auckland City Hospital and Greenlane Clinical Centre's emissions in 2016 were 13% lower than in 2015. These savings are equivalent to 4,280 return economy flights from Auckland to London or driving from Auckland to Wellington in an average size car 31,999 times.

On 8th December 2016 Auckland DHB hosted a symposium titled "Sustainability in the Health Sector" with senior clinicians highlighting the need for action to avert climate change and its impact on the health sector. The event was well supported with key representation from organisations and staff from various services and disciplines.

Our journey to go green

We aim to reduce our waste to landfill by introducing small 'desk cubes' in offices so people can see the waste they are producing and increasing the number of 'tri bins' around our sites so recycling is made easy.

We have recycled a total of 3,000 kg of PVC (e.g. oxygen masks, tubing, IV fluid bags) since 2016. Old equipment is being recycled.

An ongoing programme helps staff to reduce their reliance on cars to get to and from work. Initiatives are underway to encourage and support staff to bike to work and use public transport and electric vehicles.

Auckland Bike Challenge month, February 2017

All upgraded or new lifts are now equipped with green technology such as high efficiency motors and regenerative braking.

We have an agreement with the Energy Efficiency and Conservation Authority (ECCA) to improve energy efficiencies at our Grafton and Greenlane sites. Our new energy management system now means we can watch our energy consumption real time and implement savings.

ABOUT OUR ORGANISATION

Auckland DHB Board members

Current Board members			
	Dr Lester Levy CNZM, Chair		Zoe Brownlie
	Dr James Le Fevre, Deputy Chair		Dr Lee Mathias ONZM
	Jo Agnew		Robyn Northey
	Douglas Armstrong QSO		Sharon Shea
	Michelle Atkinson		Gwen Tepania-Palmer
	Judith Bassett QSO		

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 2016/17 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) 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 New Zealand 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 2016/17 financial year, or those that remain current, are as follows:

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May-16 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 Apr-14 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 Jul-08, 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 2016/17 appropriations is detailed below.

Appropriations allocated and scope

Health and Disability Support Services appropriation allocated to Auckland DHB is a non-departmental output expense 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

	2016/17			2015/16		
	Budgeted $000	Supplementary estimates[34] $000	Total Actual $000	Budgeted $000	Supplementary estimates[35] $000	Total Actual $000
Total appropriations (Revenue)	1,168,145	27,122	1,195,267	1,115,555	2,742	1,118,297
Expenditure			1,195,267			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.

Auckland DHB Debt appropriation

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

[34] Reasons for change in appropriation can be found in Vote Health – Supplementary Estimates of Appropriations 2016/17.

[35] 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

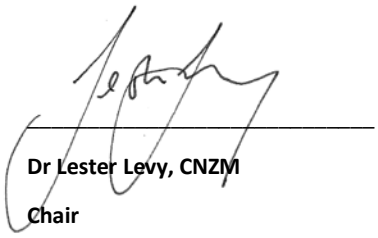
We are responsible for the preparation of the Auckland District Health Board and group's financial statements and the statement of performance, and for the judgements made in them.

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 2017.

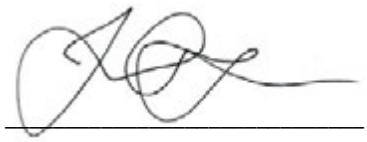
Signed on behalf of the Board:



Dr Lester Levy, CNZM

Chair

Dated: 30 October 2017



Dr James Le Fevre

Deputy Board Chair

Dated: 30 October 2017

Statement of comprehensive revenue and expense for the year ended 30 June 2017

	Notes	Group			Parent		
		Budget 2017 $000	Actual 2017 $000	Actual 2016 $000	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Revenue							
Patient care revenue	2	2,059,992	2,011,822	1,926,555	2,068,526	2,011,822	1,926,555
Interest Revenue		7,830	4,544	5,455	7,830	4,032	4,811
Other revenue	3	57,399	62,767	57,965	48,453	62,182	57,397
Total revenue		**2,125,221**	**2,079,133**	**1,989,975**	**2,124,809**	**2,078,036**	**1,988,763**
Expenses							
Personnel costs	4	889,207	913,789	867,225	889,207	913,789	867,225
Depreciation and amortisation costs	13,14	47,474	50,402	45,494	47,474	50,402	45,494
Outsourced services		98,814	112,147	105,839	98,814	112,147	105,839
Clinical Supplies		237,235	240,087	226,635	237,235	240,087	226,635
Infrastructure and non-clinical expenses		72,318	74,833	70,462	73,748	74,830	70,460
Other district health boards		114,800	95,518	111,776	114,800	95,518	111,776
Non-health board provider expenses		571,707	489,033	465,662	571,707	489,033	465,662
Capital charge	5	43,140	39,433	42,905	43,140	39,433	42,905
Interest expense		12,297	11,110	12,952	12,297	11,110	12,952
Other expenses	6	33,729	49,801	38,195	33,729	49,434	37,897
Total expenses		**2,120,721**	**2,076,153**	**1,987,145**	**2,122,151**	**2,075,783**	**1,986,845**
Share of surplus of associates and joint ventures	15	0	182	42	0	0	0
Surplus/(deficit)		**4,500**	**3,162**	**2,872**	**2,658**	**2,253**	**1,918**
Other comprehensive revenue and expenses							
Items that will not be reclassified to surplus/(deficit)							
Gains/(Losses) on property revaluations	20	0	6,641	70,541	0	6,641	70,541
Cash flow hedges	20	552	3,742	551	552	3,742	551
Total other comprehensive revenue and expenses		552	10,383	71,092	552	10,383	71,092
Total comprehensive revenue and expenses		**5,052**	**13,545**	**73,964**	**3,210**	**12,636**	**73,010**

Explanations of major variances against budget are provided in note 25.

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2017

	Notes	Group Budget 2017 $000	Group Actual 2017 $000	Group Actual 2016 $000	Parent Budget 2017 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Assets							
Current Assets							
Cash and cash equivalents	7	36,760	69,725	31,983	36,760	69,725	31,983
Investments	8	1,835	11,000	15,000	1,835	11,000	15,000
Trust/special funds	9	17,200	14,191	12,738	0	0	0
Patient & restricted trust funds	10	0	1,263	1,239	0	1,263	1,239
Receivables	11	62,049	87,422	62,049	61,810	87,949	61,271
Prepayments		1,679	5,027	1,679	1,679	5,027	1,679
Inventories	12	14,239	13,737	14,239	14,239	13,737	14,239
Total Current Assets		**133,762**	**202,365**	**138,927**	**116,323**	**188,701**	**125,411**
Non-Current Assets							
Investments	8	0	0	5,000	0	0	5,000
Trust/special funds	9	14,494	14,625	14,495	2,145	0	0
Property, plant and equipment	13	991,766	1,024,021	1,039,605	990,866	1,023,121	1,038,705
Intangible assets	14	13,873	13,415	13,182	13,873	13,415	13,182
Investments in joint ventures & associates	15	53,606	58,621	53,606	53,146	57,936	53,103
Total Non-Current Assets		**1,073,739**	**1,110,682**	**1,125,888**	**1,060,030**	**1,094,472**	**1,109,990**
Total Assets		**1,207,501**	**1,313,047**	**1,264,815**	**1,176,353**	**1,283,173**	**1,235,401**
Liabilities							
Current Liabilities							
Payables & deferred revenue	16	149,983	154,265	147,929	146,393	151,660	144,875
Employee entitlements	17	151,333	172,820	148,366	151,333	172,820	148,366
Provisions	18	1,514	3,140	1,550	1,514	3,140	1,550
Borrowings	19	52,752	494	2,140	52,752	494	2,140
Patient & restricted trust funds	10	0	1,263	1,239	1,169	1,263	1,239
Total Current Liabilities		**355,582**	**331,982**	**301,224**	**353,161**	**329,377**	**298,170**
Non-Current Liabilities							
Employee entitlements	17	37,653	41,774	37,653	37,653	41,774	37,653
Borrowings	19	259,353	373	305,065	259,353	373	305,065
Derivative financial instruments		0	0	0	0	0	0
Total Non-Current Liabilities		**297,006**	**42,147**	**342,718**	**297,006**	**42,147**	**342,718**
Total Liabilities		**652,588**	**374,129**	**643,942**	**650,167**	**371,524**	**640,888**
Net Assets		**554,913**	**938,918**	**620,873**	**526,186**	**911,649**	**594,513**
Equity							
Contributed capital	20	576,798	881,298	576,798	576,798	881,298	576,798
Accumulated surplus/deficit	20	(485,165)	(484,614)	(487,048)	(485,880)	(485,288)	(487,541)
Property revaluation reserve	20	438,457	515,639	508,998	438,457	515,639	508,998
Cash flow hedge reserve	20	(3,189)	0	(3,742)	(3,189)	0	(3,742)
Trust/special funds	20	28,012	26,595	25,867	0	0	0
Total Equity		**554,913**	**938,918**	**620,873**	**526,186**	**911,649**	**594,513**

Explanations of major variances against budget are provided in note 25.
The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2017

GROUP	Notes	Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Balance as at 1 July		**620,873**	**549,861**	**546,909**
Total comprehensive income/(expense) for the period		**13,545**	**5,052**	**73,964**
Owner Transactions				
Capital contributions from the Crown		304,500	0	0
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	20	**938,918**	**554,913**	**620,873**

PARENT	Notes	Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Balance as at 1 July		**594,513**	**522,976**	**521,503**
Total comprehensive income/(expense) for the period		**12,636**	**3,210**	**73,010**
Owner Transactions				
Capital contributions from the Crown		304,500	0	0
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	20	**911,649**	**526,186**	**594,513**

Explanations of major variances against budget are provided in note 25.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2017

	Notes	Group Budget 2017 $000	Group Actual 2017 $000	Group Actual 2016 $000	Parent Budget 2017 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Cash flows from operating activities							
Cash receipts from Ministry of Health and patients		2,040,786	1,967,598	1,957,367	2,040,786	1,967,598	1,957,367
Other Receipts		76,606	82,106	71,715	75,030	79,608	71,091
Cash paid to employees		(885,939)	(889,719)	(870,163)	(885,939)	(889,719)	(870,163)
Cash paid to suppliers		(1,126,218)	(1,056,169)	(1,068,782)	(1,124,648)	(1,053,285)	(1,067,007)
GST (net)		0	1,298	(2,134)	0	1,129	(1,968)
Payments for Capital Charge		(43,140)	(39,433)	(42,905)	(43,140)	(39,433)	(42,905)
Net cash inflow from operating activities		**62,095**	**65,681**	**45,098**	**62,089**	**65,898**	**46,415**
Cash flows from investing activities							
Interest received		7,830	4,544	5,455	6,394	3,883	4,875
Proceeds from sale of property, plant and equipment		0	511	189	0	511	189
Decrease/(Increase) in investments and restricted trust funds		15,000	7,164	(30,232)	16,442	7,608	(30,969)
Purchase of property, plant and equipment		(70,867)	(29,198)	(59,855)	(70,867)	(29,198)	(59,855)
Purchase of intangible assets		0	(1,754)	(380)	0	(1,754)	(380)
Acquisition of investments		0	0	0	0	0	0
Net cash (outflow) from investing activities		**(48,037)**	**(18,733)**	**(84,823)**	**(48,031)**	**(18,950)**	**(86,140)**
Cash flows from financing activities							
Interest paid		(11,972)	(9,079)	(13,145)	(11,972)	(9,079)	(13,145)
Repayment of loans		0	(127)	(50,000)	0	(127)	(50,000)
Proceeds from borrowings		4,900	0	50,995	4,900	0	50,995
Proceeds from capital contributed/(repaid)		0	0	0	0	0	0
Net cash inflow/(outflow) from financing activities		**(7,072)**	**(9,206)**	**(12,150)**	**(7,072)**	**(9,206)**	**(12,150)**
Net (decrease)/increase in cash and cash equivalents		**6,986**	**37,742**	**(51,875)**	**6,986**	**37,742**	**(51,875)**
Cash and cash equivalents at start of the year		**29,774**	**31,983**	**83,858**	**29,774**	**31,983**	**83,858**
Cash and cash equivalents at end of the year	7	**36,760**	**69,725**	**31,983**	**36,760**	**69,725**	**31,983**

Explanations of major variances against budget are provided in note 25.

The accompanying notes form part of these financial statements.

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

	Notes	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
RECONCILIATION OF REPORTED OPERATING SURPLUS/(DEFICIT) AFTER TAXATION WITH NET CASH INFLOW (OUTFLOW) FROM OPERATING ACTIVITIES					
		3,162	**2,872**	**2,253**	**1,918**
Add non-cash items:					
Share of associate and joint venture surplus	15	(182)	(42)	0	0
Depreciation and amortisation expense		50,402	45,494	50,402	45,494
Unrealised loss/(gain) on cash flow hedging instrument		3,742	551	3,742	551
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		1,388	33	1,388	33
Net loss/(gain) on disposal of financial assets		(1,131)	(27)	0	0
Net interest shown in investing and financing activities		4,536	7,498	5,048	8,142
Add movements in statement of financial position items:					
(Increase)/Decrease in debtors and other receivables		(25,372)	(14,227)	(27,026)	(11,263)
(Increase)/Decrease in prepayments		(3,348)	(644)	(3,348)	(644)
(Increase)/Decrease in inventories		357	(1,085)	357	(1,085)
Increase/(Decrease) in creditors and other payables		1,962	7,639	2,917	6,233
Increase in provision		1,590	34	1,590	34
Increase/(Decrease) in employee entitlements		28,575	(2,998)	28,575	(2,998)
Net cash inflow/(outflow) from operating activities		**65,681**	**45,098**	**65,898**	**46,415**

Notes to the Financial Statements

1 Significant accounting policies

REPORTING ENTITY

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

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

Auckland DHB'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 of Auckland DHB comprise Auckland DHB and its subsidiary (together referred to as 'Group') and Auckland DHB's interest in associates and jointly controlled entities. The Auckland DHB group consists of the parent, Auckland DHB and Auckland District Health Board Charitable Trust (controlled by Auckland DHB). Joint ventures are healthAlliance N.Z. Limited (25%) and NZ Health Innovation Hub Management Limited (25%). Associates are Northern Regional Alliance Limited (33.3%). The DHB's subsidiary, associates and joint venture are incorporated and domiciled in New Zealand.

The financial statements for the DHB are for the year ended 30 June 2017, and were approved by the Board on 30 October 2017.

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.

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. Auckland DHB has applied these amendments in preparing its 30 June 2017 financial statements. There has been no effect in applying these amendments.

Presentation currency and rounding

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

Standards issued that are not yet effective that have been early adopted

Impairment of Revalued Assets
In April 2017, the XRB issued Impairment of Revalued Assets, which now scopes in revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment assets measured at cost were scoped into the impairment accounting standards.

Auckland DHB has early adopted this amendment in preparing its 30 June 2017 financial statements. From the 30 June 2017 year onwards, Auckland DHB is required to assess at each reporting date whether there is any indication that an asset may be impaired. If any indication exists, Auckland DHB is required to assess the recoverable amount of that asset and recognise an impairment loss if the recoverable amount is less than the carrying amount. Auckland DHB can therefore impair a revalued asset without having to revalue the entire class of asset to which the asset belongs.

Other changes in accounting policies

There have been no other changes in accounting policies.

Standards issued that are not yet effective and not early adopted

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

Interests in other entities
In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 - 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6 - 8). The new standards are effective for annual periods beginning on or after 1 January 2019, with early application permitted.

Auckland DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. Auckland DHB has not yet assessed the effects of these new standards.

Financial instruments
In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.
- Revised hedge accounting requirements to better reflect the management of risks.

Auckland DHB plans to apply this standard in preparing its 30 June 2022 financial statements. Auckland DHB has not yet assessed the effects of the new standard.

Basis for consolidation

Subsidiaries
Auckland DHB consolidates in the group financial statements all entities where the DHB has the capacity to control their financing and operating policies so as to obtain benefits from the activities of the subsidiary. This power exists where the DHB controls the majority voting power on the governing body or where financing and operating policies have been irreversibly predetermined by the DHB or where the determination of such policies is unable to materially affect the level of potential ownership benefits that arise from the activities of the subsidiary.

Auckland DHB is the main beneficiary of the Auckland District Health Board Charitable Trust and has control. Consistent accounting policies have been used for both Auckland DHB 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.

Auckland DHB will recognise goodwill where there is an excess of the consideration transferred over the net identifiable assets acquired and liabilities assumed. This difference reflects the goodwill to be recognised by the DHB. If the consideration transferred is lower than the net fair value of the DHBs interest in the identifiable assets acquired and liabilities assumed, the difference will be recognised immediately in the surplus or deficit.

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

Joint Ventures
A joint venture is a binding arrangement whereby two or more parties are committed to undertake an activity that is subject to joint control. Joint control is the agreed sharing of control over an activity. The consolidated financial statements include Auckland DHB'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.

healthAlliance N.Z. Limited
healthAlliance N.Z. Limited is a joint venture company that exists to provide a shared services agency to the four northern DHBs (25% each) 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 New Zealand 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, New Zealand Health Innovation Hub Management Limited, which was incorporated on 26 June 2012.

Associates
An associate is an entity over which the DHB has significant influence and that is neither a subsidiary nor an interest in a joint venture. Auckland DHB holds a 33% shareholding in Northern Regional Alliance Limited (NRA). Associates are accounted for at the original cost of the investment plus Auckland DHB'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 Auckland DHB's share of losses exceeds its interest in an associate, Auckland DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Auckland DHB 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 and 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
Auckland DHB 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, Auckland DHB 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 cost (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 and impairment losses. 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 (including fitout 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 any accumulated impairment losses. Goodwill is tested annually for impairment.

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.

Finance Procurement Supply Chain (FPSC) programme, including the National Oracle Solution (NOS)
The FPSC which includes the NOS is a national initiative, funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Auckland DHB holds an asset at the cost of capital invested by Auckland DHB in the FPSC programme. This investment represents the DHB's right to access the FPSC assets under a service level agreement. The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely. 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 is tested for impairment annually.

Impairment of property, plant, and equipment and intangible assets
Auckland DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

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

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 21.

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.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in finance costs.

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 revaluation 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 in note 26 and 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 care revenue

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
Health & disability services (Crown appropriation revenue)	1,195,267	1,118,297	1,195,267	1,118,297
Other MoH and Government revenue	171,205	166,707	171,205	166,707
ACC contract revenue	20,809	16,767	20,809	16,767
Interdistrict patient inflows	590,333	588,806	590,333	588,806
Revenue from other district health boards	14,036	17,000	14,036	17,000
Other patient care related revenue	20,172	18,978	20,172	18,978
Total patient care revenue	**2,011,822**	**1,926,555**	**2,011,822**	**1,926,555**

3 Other revenue

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
Donations and bequests	7,249	4,932	8,522	5,236
Gain on sale of property, plant & equipment	0	0	0	0
Gain on financial assets	1,311	27	0	0
Rental revenue	9,573	8,797	9,573	8,797
Accommodation revenue	729	629	729	629
Direct charges revenue	17,780	17,802	17,780	17,802
Drug trial revenue	585	809	585	809
Research grants	13,211	12,459	12,492	11,614
Other revenue	12,509	12,510	12,501	12,510
Total other revenue	**62,767**	**57,965**	**62,182**	**57,397**

Non-cancellable operating leases as lessor

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

GROUP AND PARENT	2017 $000	2016 $000
Not later than one year	6,349	5,659
Later than one year and not later than five years	19,583	16,511
Later than five years	6,978	10,193
Total non-cancellable operating leases as lessor	**32,910**	**32,363**

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

4 Personnel costs

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
Wages and salaries	855,173	843,928	855,173	843,928
Contributions to defined contribution plans	28,316	26,791	28,316	26,791
Increase/(decrease) in liability for employee benefits	28,575	(3,529)	28,575	(3,529)
Restructuring provision for employee costs	1,725	35	1,725	35
Total personnel costs	**913,789**	**867,225**	**913,789**	**867,225**

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.

Board member remuneration

	Actual 2017 $000	Actual 2016 $000
Dr Lester Levy (Chair)	73	69
Dr Lee Mathias	34	38
Jo Agnew	31	31
Peter Aitken*	14	32
Doug Armstrong	29	30
Michelle Atkinson*	16	0
Judith Bassett	30	32
Zoe Brownlie*	15	0
Dr Chris Chambers*	13	31
Dr James Le Fevre*	20	0
Robyn Northey	30	31
Sharon Shea*	16	0
Gwen Tepania-Palmer	27	29
Morris Pita*	13	30
Ian Ward*	13	31
Total board member remuneration	374	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 $5,938.

Norman Wong (Finance, Risk and Assurance Committee) $1,500
Dame Paula Rebstock* (Finance, Risk and Assurance Committee) $938
Mataroria Lyndon* (MaGAC) $500
Matire Harwood* (MaGAC) $250
Anne Kolbe* (Hospital Advisory Committee) $750
Dairne Kirton* (DiSAC) $750
Russell Vickery* (DiSAC) $500
Jan Moss* (DiSAC) $250
Jade Farrar* (DiSAC) $500

Note

* Served 6 months as a result of the Local Body Elections

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

4 Personnel costs (continued)

Employee remuneration

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

Remuneration Range	Actual 2017	Actual 2016	Remuneration Range	Actual 2017	Actual 2016
$100,000-$110,000	301	190	$420,000-$430,000	11	10
$110,000-$120,000	219	191	$430,000-$440,000	3	1
$120,000-$130,000	146	130	$440,000-$450,000	4	5
$130,000-$140,000	115	109	$450,000-$460,000	1	
$140,000-$150,000	87	72	$460,000-$470,000	2	2
$150,000-$160,000	65	66	$470,000-$480,000	1	2
$160,000-$170,000	55	60	$480,000-$490,000	1	2
$170,000-$180,000	46	56	$490,000-$500,000	3	2
$180,000-$190,000	46	51	$500,000-$510,000	2	2
$190,000-$200,000	42	38	$510,000-$520,000	1	
$200,000-$210,000	51	45	$520,000-$530,000	2	6
$210,000-$220,000	43	35	$530,000-$540,000	1	
$220,000-$230,000	43	38	$540,000-$550,000	4	2
$230,000-$240,000	40	34	$550,000-$560,000	2	
$240,000-$250,000	29	35	$570,000-$580,000	1	1
$250,000-$260,000	35	22	$580,000-$590,000	2	3
$260,000-$270,000	29	32	$590,000-$600,000	2	2
$270,000-$280,000	36	30	$600,000-$610,000	1	
$280,000-$290,000	27	23	$610,000-$620,000	2	3
$290,000-$300,000	19	23	$620,000-$630,000		1
$300,000-$310,000	22	18	$660,000-$670,000		1
$310,000-$320,000	25	29	$670,000-$680,000		1
$320,000-$330,000	21	22	$750,000-$760,000		1
$330,000-$340,000	22	25	$850,000-$860,000	1	1
$340,000-$350,000	11	11	$890,000-$900,000	1	
$350,000-$360,000	18	23	$910,000-$920,000		1
$360,000-$370,000	19	13	$980,000-$990,000	1	
$370,000-$380,000	20	12	$990,000-$1,000,000	1	
$380,000-$390,000	12	14	$1,110,000-$1,120,000	1	
$390,000-$400,000	11	12	$1,140,000-$1,150,000		1
$400,000-$410,000	10	7	$1,270,000-$1,280,000	1	
$410,000-$420,000	3	6	**Grand Total**	**1,720**	**1,522**

Note

During the year ended 30 June 2017, 133 (2016 : 95) employees received compensation and other benefits in relation to cessation totalling $2,677,630 (2016 : $2,055,618).

4 Personnel costs (continued)

Total remuneration over $100,000 a year

Each year, as required by the Crown Entities Act, our annual report shows numbers of employees receiving total remuneration over $100,000 per year, in bands over $10,000.

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

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

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

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 period of first six months to 31 December 2016 was 7% (2016 : 8%). The rate for the period of second six months to 30 June 2017 was 6% (2016 : 8%).

6 Other expenses

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
Fees to auditor				
- fees to Audit New Zealand for audit of financial statements	281	272	281	272
- prior period under provision	2	27	2	27
- fees to Audit New Zealand for audit of financial statements (Auckland DHB Charitable Trust)	17	16	17	16
Fees for other Audit services	300	254	300	254
Operating leases	5,559	4,540	5,559	4,540
Impairment of debtors	(580)	1,630	(580)	1,630
Bad debts	3,089	2,437	3,089	2,437
Board members' fees	374	384	374	384
Loss on disposal of property, plant and equipment	1,388	33	1,388	33
Foreign currency loss	3	6	3	6
Other expenses	39,368	28,596	39,001	28,298
Total other expenses	**49,801**	**38,195**	**49,434**	**37,897**

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	2017 $000	2016 $000
Not later than one year	1,814	2,284
Later than one year and not later than five years	1,374	1,139
Later than five years	0	66
Total non-cancellable operating lease commitments as lessee	**3,188**	**3,489**

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

6 Other expenses (continued)

The details of the main property leases are as follows:
- Segar House is leased with an expiry date of 30 June 2020.
- Taylor Centre is leased out with an expiry of 31 October 2018, with a right of renewal out till 31 October 2021.
- Carbine Road is leased with an expiry of 30 September 2018.
- Peach House is leased with an expiry date of 28 Feb 2020.
- Grafton Road (Multi Agency Centre) is leased with an expiry date of 30 June 2020.
- Medacs House is leased with an expiry date of 31 March 2022.

7 Cash & cash equivalents

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
Current assets				
Bank balance & cash on hand	83	96	83	96
NZ Health Partnerships Limited (previously Health Benefits Limited)	69,642	31,887	69,642	31,887
Cash & cash equivalents in the statement of cashflows	**69,725**	**31,983**	**69,725**	**31,983**

Auckland DHB is party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHPL) (previously Health Benefits Limited (HBL)) and the participating DHBs. 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 rates 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 $117.394m (2016 : $113.377m).

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	
	2017 $000	2016 $000	2017 $000	2016 $000
Current assets				
Term deposits	11,000	15,000	11,000	15,000
Non-Current assets				
Term deposits	0	5,000	0	5,000
Total Investments	**11,000**	**20,000**	**11,000**	**20,000**

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

9 Trust/special fund assets

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
Current assets				
Bank balances (restricted)	1,191	1,238	0	0
Short term deposits (restricted)	12,500	11,500	0	0
Investment Bonds (at market)/(restricted)	500	0	0	0
	14,191	**12,738**	**0**	**0**
Non – current assets				
Long term deposits (restricted)	0	500	0	0
Investment Bonds (at market)/(restricted)	2,330	2,861	0	0
Portfolio Investments	12,295	11,134	0	0
	14,625	**14,495**	**0**	**0**

9 Trust/special fund assets (continued)

The above assets are trust funds and are held by the Auckland DHB 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.

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 $2,330k (2016 : $3,361k).

10 Patient & restricted trust funds

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
PATIENT AND RESTRICTED TRUST FUNDS				
Current assets				
Patient trust	0	0	0	0
Restricted fund deposit	1,263	1,239	1,263	1,239
	1,263	**1,239**	**1,263**	**1,239**
Current liabilities				
Patient trust	0	0	0	0
Restricted fund deposit	1,263	1,239	1,263	1,239
	1,263	**1,239**	**1,263**	**1,239**

Patient trust
Auckland DHB 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 Auckland DHB Treaty partner, Ngāti Whātua.

11 Receivables

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
Receivables (gross)	90,799	66,007	91,326	65,229
Less: provision for impairment	(3,377)	(3,958)	(3,377)	(3,958)
Total receivables	**87,422**	**62,049**	**87,949**	**61,271**
Total receivables comprise:				
Ministry of Health receivables (non-exchange transactions)	48,028	21,751	48,028	21,751
Other accrued income (exchange transactions)	39,394	40,298	39,921	39,520
	87,422	**62,049**	**87,949**	**61,271**

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

GROUP Receivables

Debtors and other receivables	Gross 2017 $000	Impairment 2017 $000	Gross 2016 $000	Impairment 2016 $000
Not past due	78,072	(155)	51,444	(7)
Past due 0-30 days	3,365	(316)	2,542	(265)
Past due 31-90 days	3,172	(1,108)	2,718	(411)
Past due 91-360 days	4,643	(1,321)	7,440	(1,587)
Past due more than 1 year	1,547	(477)	1,863	(1,688)
Total	**90,799**	**(3,377)**	**66,007**	**(3,958)**

11 Receivables (continued)

Parent Receivables

Debtors and other receivables	Gross 2017 $000	Impairment 2017 $000	Gross 2016 $000	Impairment 2016 $000
Not past due	79,161	(155)	51,809	(7)
Past due 0-30 days	3,139	(316)	2,278	(265)
Past due 31-90 days	3,034	(1,108)	2,321	(411)
Past due 91-360 days	4,477	(1,321)	6,971	(1,587)
Past due more than 1 year	1,515	(477)	1,850	(1,688)
Total	**91,326**	**(3,377)**	**65,229**	**(3,958)**

All receivables greater than 30 days in age are considered to be past due.
Due to the 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 2017 Actual $000	Group 2016 Actual $000	Parent 2017 Actual $000	Parent 2016 Actual $000
Opening balance	3,958	2,328	3,958	2,328
Increase/(decrease) in doubtful debts	(581)	1,630	(581)	1,630
Closing balance	**3,377**	**3,958**	**3,377**	**3,958**

12 Inventories

	Gross 2017 $000	Impairment 2017 $000	Gross 2016 $000	Impairment 2016 $000
Pharmaceuticals	1,718	1,811	1,718	1,811
Surgical and medical supplies	12,019	12,428	12,019	12,428
Total Inventories	**13,737**	**14,239**	**13,737**	**14,239**

The write-down of inventories amounted to $299k (2016 : $673k). No inventories are pledged as security for liabilities. (2016: 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 2015	249,006	635,019	293,335	758	39,821	1,217,939
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**	**306,049**	**667**	**45,236**	**1,254,152**
Cost						
Balance at 1 July 2016	282,803	619,397	306,049	667	45,236	1,254,152
Additions/ (Transfers)	0	0	0	0	28,537	28,537
Additions from Work in Progress	0	7,791	28,714	1,375	(37,880)	0
Disposals	0	0	(17,316)	0	0	(17,316)
Transfers	0	(3,608)	849	0	0	(2,759)
Reclassifications	0	0	0	0	0	0
Revaluations / (impairment)	38,779	(32,162)	0	0	0	6,617
Balance at 30 June 2017	**321,582**	**591,418**	**318,296**	**2,042**	**35,893**	**1,269,231**
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)**
Depreciation and impairment losses						
Balance at 1 July 2016	0	0	(213,885)	(662)	0	(214,547)
Depreciation charge for the year	0	(26,960)	(21,304)	(617)	0	(48,881)
Disposals	0	0	15,459	0	0	15,459
Transfers	0	3,694	(935)	0	0	2,759
Reclassifications	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0
Balance at 30 June 2017	**0**	**(23,266)**	**(220,665)**	**(1,279)**	**0**	**(245,210)**
GROUP						
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**
Carrying Amounts						
At 1 July 2016	282,803	619,397	92,164	5	45,236	1,039,605
At 30 June 2017	**321,582**	**568,152**	**97,631**	**763**	**35,893**	**1,024,021**

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 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**
Cost						
Balance at 1 July 2016	282,803	619,397	305,149	667	45,236	1,253,252
Additions	0	0	0	0	28,537	28,537
Additions from Work in Progress	0	7,791	28,714	1,375	(37,880)	0
Disposals	0	0	(17,316)	0	0	(17,316)
Transfers	0	(3,608)	849	0	0	(2,759)
Reclassifications	0	0	0	0	0	0
Revaluations / (impairment)	38,779	(32,162)	0	0	0	6,617
Balance at 30 June 2017	**321,582**	**591,418**	**317,396**	**2,042**	**35,893**	**1,268,331**
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)**
Depreciation and impairment losses						
Balance at 1 July 2016	0	0	(213,885)	(662)	0	(214,547)
Depreciation charge for the year	0	(26,960)	(21,304)	(617)	0	(48,881)
Disposals	0	0	15,459	0	0	15,459
Transfers	0	3,694	(935)	0	0	2,759
Reclassifications	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0
Balance at 30 June 2017	**0**	**(23,266)**	**(220,665)**	**(1,279)**	**0**	**(245,210)**
PARENT						
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**
Carrying Amounts						
At 1 July 2016	282,803	619,397	91,264	5	45,236	1,038,705
At 30 June 2017	**321,582**	**568,152**	**96,731**	**763**	**35,893**	**1,023,121**

13 Property, plant and equipment (continued)

Capital commitments

GROUP AND PARENT	2017 $000	2016 $000
Capital commitments		
Buildings, fitouts and infrastructure	13,933	3,288
Plant and Equipment	15,686	7,966
Total capital commitments	**29,619**	**11,254**

Contractual Capital Commitments for projects which have an approved budget, but the outer year spend is less than $250k have not been assessed. Therefore, contractual capital commitments may be higher than disclosed, but not material for disclosure purposes.

Valuation Information
Auckland DHB owns land with a carrying value of $322m (2016 : $286m), which has been assessed as having its highest and best use activity for hospital purposes.

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 2017.

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 Auckland DHB's ability to sell land would normally not impair the value of the land because Auckland DHB 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 Auckland DHB'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.

Asbestos Impairment
Auckland DHB has established an asbestos register and commissioned specialist surveys to be completed to estimate the cost of asbestos remediation in all Auckland DHB buildings. The assessment performed during 2016/17 indicates significant costs to remove asbestos.

Auckland DHB account for Buildings and Improvements at fair value, measured at their revaluation amount, less any subsequent accumulated depreciation and subsequent accumulated impairment losses. Auckland DHB Land, Buildings and Improvements were revalued at 30 June 2016. The estimated cost of remediation in buildings was not available at the time, hence there was no impairment of buildings for asbestos remediation. Asbestos impairment information on land was available and this was included in the 30 June 2016 revaluation of land.
While the presence of asbestos in Auckland DHB buildings does not constitute a commitment or a provision for remediation, it indicates that the buildings are impaired. The impairment for Auckland DHB buildings can be written off to the revaluation reserve to the extent of the net book value of the asset and the value of the revaluation reserve on a class of asset basis.

13 Property, plant and equipment (continued)

Auckland DHB has assessed the extent of the impairment required on the buildings and improvements based on the specialists estimates provided. The amount of impairment that has been accounted for in the 30 June 2017 financial statements is $32M. Where the cost of remediation exceeded the NBV of the buildings, these buildings were impaired to a value of zero.

A summary of the impairment at campus level is summarised in the table below:

Site	2016/17 asbestos Impairment
Auckland City Hospital	$13.794M
Greenland Clinical Centre	$17.852M
Buchanan Rehab	$0.516M
Total impairment	**$32.162M**

Work in progress

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

GROUP & PARENT	2017 $000	2016 $000
Buildings, fitouts and infrastructure	24,424	23,959
Plant, equipment and vehicles	11,468	21,277
Non Current Assets	**35,892**	**45,236**

Leased assets

The group has entered into finance leases for the lease of clinical power tool equipment and a CT scanner. The net carrying amount of the leased items within each class of property, plant, and equipment is shown above. Refer to finance leasing arrangements in Note 19.

14 Intangible assets

GROUP & PARENT	NOS rights Cost $000	Software & development Cost $000	NCSP contract Cost $000	Total $000
Cost				
Balance at 1 July 2015	12,420	2,971	870	16,261
Additions	0	379	0	379
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 2016	**12,420**	**3,350**	**870**	**16,640**
Balance at 1 July 2016	12,420	3,350	870	16,640
Additions	0	1,652	100	1,752
Disposals	0	(183)	0	(183)
Reclassifications	0	0	0	0
Balance at 30 June 2017	**12,420**	**4,818**	**970**	**18,208**
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)**
Amortisation & Impairment Losses				
Balance at 1 July 2016	**0**	**(2,948)**	**(510)**	**(3,459)**
Amortisation charge for the year	0	(1,102)	(419)	(1,521)
Disposals	0	184	0	184
Reclassifications	0	0	0	0
Balance at 30 June 2017	**0**	**(3,864)**	**(929)**	**(4,793)**
Carrying Amounts				
At 1 July 2015	12,420	191	719	13,330
At 30 June 2016	**12,420**	**402**	**360**	**13,182**
At 1 July 2016	12,420	402	360	13,182
At 30 June 2017	**12,420**	**954**	**41**	**13,415**

New Zealand Health Partnerships Limited (NZHPL) has issued B Class shares to DHBs to fund the development of the Finance, Procurement and Supply Chain (FPSC) programme. In return for these payments, Auckland DHB gained access to the FPSC asset including NOS rights. In the event of liquidation or dissolution of NZHPL, Auckland DHB shall be entitled to be paid from the surplus assets, an amount equal to, Auckland DHB's proportionate share of the liquidation value based on its proportional share of the total NOS rights that have been issued.

These FPSC/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 Auckland DHB's share of the DRC of the underlying FPSC/NOS assets.

The current expectation is that the FPSC/ NOS programme will proceed as planned. In this scenario, the DRC of the FPSC/NOS rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC/NOS rights are not impaired.

The carrying amounts of all property, plant and equipment are reviewed on an ongoing basis. Any impairment in value is recognised immediately. A review of computer software resulted in a nil impairment movement (2016 : nil).

14 Intangible assets (continued)

Goodwill
During the 2014/15 year, Auckland DHB purchased the Diagnostic Medlab (DML) Cervical Screening business. Goodwill was recognised to the extent that the purchase price exceeded the identifiable assets and liabilities. The fair value of the purchase was assessed as the Net Present Value of the future cash flows over the next 3 years.

The goodwill was recognised based on the expected cash flows resulting from the National Cervical Screening Programme (NCSP) contract underlying the business acquisition. This is a 3 year contract that was effective 1 July 2014.
During the year 2016/17, a further $100k goodwill was recognised regarding the DML business acquisition. The NCSP revenue contract has been renewed for a further 2 years.

	Fair value at acquisition $000
Property , plant and equipment	130
Goodwill arising on acquisition	970
Purchase consideration transferred	**1,100**

15 Investments in joint venture & associates

General Information		2017 Interest held	2016 Interest held
Name of joint ventures	***Principal Activity***		
healthAlliance N.Z. Limited	Provider of shared services	25%	25%
NZ Health Innovation Hub Management Limited	Provision of services to grow NZ's health innovation sector	25%	25%
Name of associate Northern Regional Alliance Limited	***Principal Activity***		
	Provision of health support services	33%	33%

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

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

Year end 30 June 2017 (unaudited)	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus/ (Deficit) $000
healthAlliance N.Z. Limited	172,978	27,394	145,584	135,152	1,334
NZ Health Innovation Hub Management Limited	755	(2)	757	0	(303)
Northern Regional Alliance Limited	10,322	8,767	1,555	14,469	40
Total Investments	**184,055**	**36,159**	**147,896**	**149,621**	**1,071**

Year end 30 June 2016 (audited)	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus/ (Deficit) $000
healthAlliance N.Z. Limited	154,202	25,800	128,402	125,840	(900)
NZ Health Innovation Hub Management Limited	1,759	699	1,060	500	(602)
Northern Regional Alliance Limited	10,556	9,041	1,515	15,587	5
Total Investments	**166,517**	**35,540**	**130,977**	**141,927**	**(1,497)**

15 Investments in joint venture & associates (continued)

	Group Actual		Parent Actual	
	2017	2016	2017	2016
	$000	$000	$000	$000
Share of surplus of joint ventures & associates				
Share of post-acquisition surplus	182	42	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)	57,737	52,904	57,735	52,902
Other shares in joint ventures & associates	1	1	1	1
Share of post-acquisition retained surpluses	683	501	0	0
Total investments in joint ventures and associates	**58,621**	**53,606**	**57,936**	**53,103**

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 2017 is $57,737k (2016 : $52,904k), which represents the baseline value of funding for IT projects implemented by healthAlliance and for IT projects implemented by Auckland DHB, with the resulting assets being transferred to healthAlliance on completion of the project.

16 Payables & deferred revenue

	Group Actual		Parent Actual	
	2017	2016	2017	2016
	$000	$000	$000	$000
Current				
Payables under exchange transactions				
Creditors	117,614	111,302	117,555	110,996
Income in Advance	7,034	7,185	4,511	4,291
Total payables under exchange transactions	**124,648**	**118,487**	**122,066**	**115,287**
Payables under non-exchange transactions				
GST,PAYE & FBT payable	22,419	27,101	22,396	27,247
Capital charge due to Crown	0	0	0	0
Income in advance	7,198	2,341	7,198	2,341
Total payables under non exchange transactions	**29,617**	**29,442**	**29,594**	**29,588**
Total payables and deferred revenue	**154,265**	**147,929**	**151,660**	**144,875**

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	
	2017 $000	2016 $000	2017 $000	2016 $000
Current portion				
Liability for long service leave	1,935	1,701	1,935	1,701
Liability for sabbatical leave	500	500	500	500
Liability for retirement gratuities	7,812	7,739	7,812	7,739
Liability for annual leave	108,258	93,381	108,258	93,381
Liability for sick leave	627	618	627	618
Liability for continuing medical leave and expenses	23,592	23,856	23,592	23,856
Salaries and wage accrual	30,096	20,571	30,096	20,571
Total current	**172,820**	**148,366**	**172,820**	**148,366**
Non Current				
Liability for long service leave	2,146	2,165	2,146	2,165
Liability for retirement gratuities	39,628	35,488	39,628	35,488
Liability for continuing medical leave and expenses	0	0	0	0
Total non-current	**41,774**	**37,653**	**41,774**	**37,653**
Total employee entitlements	**214,594**	**186,019**	**214,594**	**186,019**

The private and public sector have experienced widespread payroll issues relating to the Holiday's Act and employment agreements. This is particularly for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a long term pay process solution is currently being undertaken by management to identify risk areas focusing on systems, reporting & analytics, people and processes.
Since the issues are currently being reviewed the holiday pay provision recognised is estimated based on the best information available at the date of this annual report. Once the issues have been resolved the actual liability may be different. Based on the impact in other sectors who have staff with variable work patterns, we estimate the impact over the last six years to be $6.9m (2016 : nil)

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 $30.1m (2016: $20.6m) salaries and wages accrual includes $20.1m (2016: $16.6m) which is made up of two major elements: Unpaid days of $20.3m (2016: $16.8m) and Salaries and wages for June paid in July of -$0.2m (2016: -$0.2m).

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 3.92% (2016 : 3.13%) and an inflation factor of 2.5% (2016 : 1.0%) were used.

18 Provisions

		Group Actual		Parent Actual	
		2017 $000	2016 $000	2017 $000	2016 $000
Current Portion					
ACC Partnership Programme		1,274	1,514	1,274	1,514
Litigation		106	1	106	1
Restructuring		1,760	35	1,760	35
Total Provisions		**3,140**	**1,550**	**3,140**	**1,550**
Movement for each class of provisions are as follows:					
ACC Partnership Programme					
Opening balance		1,514	1,488	1,514	1,488
Additional provisions made during year		241	512	241	512
Charged against provision for the year		(481)	(486)	(481)	(486)
Unused amounts reversed during year		0	0	0	0
Closing balance	(i)	**1,274**	**1,514**	**1,274**	**1,514**
Litigation Provision					
Opening balance		1	28	1	28
Additional provisions made during year		106	1	106	1
Charged against provision for the year		(1)	(28)	(1)	(28)
Unused amounts reversed during year		0	0	0	0
Closing balance	(ii)	**106**	**1**	**106**	**1**
Restructuring Provision					
Opening balance		35	0	35	0
Additional provisions made during year		1,760	35	1,760	35
Charged against provision for the year		(35)	0	(35)	0
Unused amounts reversed during year		0	0	0	0
Closing balance	(iii)	**1,760**	**35**	**1,760**	**35**

Notes

(i) ACC Partnership Programme

Liability valuation

An external independent Actuary, MA Lardies FNZSA, has calculated the liability as at 30 June 2017. 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 15% (2016:11%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability. The risk margin has been determined after consideration of past claims history, costs, and trends.
The risk margin is intended to achieve a 75% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

Key assumptions

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

- an average assumed rate of inflation of 1.74% for 30 June 2017 and 30 June 2018;
- a weighted average discount factor of 2.05% 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; and
- the expected future Average Claim Payment per accident is $3,050.

18 Provisions (continued)

Insurance risk
The DHB operates the Full Self Cover Plan. Under this plan, it assumes full financial and injury management responsibility for work-related injuries and illnesses for a selected management period and continuing financial liability for the life of the claim to a pre-selected limit.
The DHB is responsible for managing claims for a period of up to 48 months following the end of the 12 months period of cover in which the claim has occurred. At 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 205% 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 $7,294,600 incurred in the cover period from 1 April 2017 to 31 March 2018 (2017/2018 ACC Claim Year). Auckland DHB 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 $1.76m (2016 : $35k). The provision in 2017 is for 1) $1.296m redundancy of Auckland DHB employees as a result of transitioning to a new 24/7 hospital functioning model of care, and 2) $464k voluntary redundancy of Auckland DHB employees following a change in staffing mix which resulted from the consultation process on the Sexual Health Services Staffing Model. These have resulted in payments agreed but unpaid at year end. The 2016 provision was for redundancy on termination of Auckland/Waitemata DHB contracts for Pacific Quit Smoking.

19 Borrowings

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
Current portion				
Secured loans				
Finance Leases	494	429	494	429
Interest on Borrowings	0	1,711	0	1,711
Total current portion	**494**	**2,140**	**494**	**2,140**
Non-current				
Secured loans				
Finance Leases	373	565	373	565
Crown Loan	0	304,500	0	304,500
Total non-current portion	**373**	**305,065**	**373**	**305,065**
Total non-current portion	**867**	**307,205**	**867**	**307,205**
Interest rate summary	**% pa**	**% pa**	**% pa**	**% pa**
Crown Loan	2.75-5.32	2.75-5.32	2.75-5.32	2.75-5.32
Borrowing Facilities				
Crown Loan	0	304,500	0	304,500

Conversion of existing Crown Loans to Crown equity
In September 2016 Cabinet agreed that DHB sector should no longer access Crown debt and for existing DHB Crown debt to be converted to Crown equity. On 15 February 2017, Auckland DHB Crown loans of $304.5m were converted into Crown equity. From that day onward all Crown capital contributions to DHBs would be made via Crown equity injections. The termination of the Crown loan agreement and conversion of Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date. As a result, there was been a decrease in 2016/17 interest costs from the conversion date until 30 June 2017 and, increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

Working capital facility
Auckland DHB is party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHPL) (previously Health Benefits Limited (HBL)) and the participating DHBs. 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 rates 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 $117.394m (2016 : $113.377m)

19 Borrowings (continued)

Security and terms

The fair value of Crown loans is nil (2016 : $326.435m). 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	
	2017 $000	2016 $000	2017 $000	2016 $000
Minimum lease payments payable:				
No later than one year	494	429	494	429
Later than one year and not later than five years	373	106	373	106
Later than five years	0	459	0	459
Total minimum lease payments	**867**	**994**	**867**	**994**

Description of finance leasing arrangements

The group has entered into finance leases for the lease of:

- Clinical power tool equipment. The lease is for an initial period of seven years ending February 2019.
- CT scanner. The lease is for an initial period of five years ending March 2022.

The net carrying amount of the leased items within each class of property, plant, and equipment is shown in Note 13.

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 Equity

	Group Actual		Parent Actual	
	2017 $000	2016 $000	2017 $000	2016 $000
A Contributed Capital				
Opening balance 1 July	576,798	576,798	576,798	576,798
Contributions from/(repayment to) the Crown	304,500	0	304,500	0
Balance at 30 June	**881,298**	**576,798**	**881,298**	**576,798**
B Accumulated surplus/(deficit)				
Opening balance 1 July	(487,048)	(488,751)	(487,541)	(489,459)
Surplus/(deficit)	3,162	2,872	2,253	1,918
Transfer to trust/special funds	(728)	(1,169)	0	0
Balance at 30 June	**(484,614)**	**(487,048)**	**(485,288)**	**(487,541)**
C Property revaluation reserves				
Opening balances	508,998	438,457	508,998	438,457
Net Movement	6,641	70,541	6,641	70,541
Balance at 30 June	**515,639**	**508,998**	**515,639**	**508,998**
D Cash Flow Hedge reserve				
Opening balance 1 July	(3,742)	(4,293)	(3,742)	(4,293)
Net Movement	3,742	551	3,742	551
Balance at 30 June	**0**	**(3,742)**	**0**	**(3,742)**
E Trust/special funds				
Opening balance 1 July	25,867	24,698	0	0
Transfer from accumulated deficits (Note 6b)	728	1,169	0	0
Balance at 30 June	**26,595**	**25,867**	**0**	**0**
Total Equity	**938,918**	**620,873**	**911,649**	**594,513**
Property revaluation reserves consist of				
Land	312,276	273,497	312,276	273,497
Buildings	203,363	235,501	203,363	235,501
Total property revaluation reserves	**515,639**	**508,998**	**515,639**	**508,998**

20 Equity (continued)

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. Auckland DHB 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.

Conversion of existing Crown Loans to Crown equity
In September 2016 Cabinet agreed that DHB sector should no longer access Crown debt and for existing DHB Crown debt to be converted to Crown equity. On 15 February 2017, Auckland DHB Crown loans of $304.5m were converted into Crown equity. From that day onward all Crown capital contributions to DHBs would be made via Crown equity injections. The termination of the Crown loan agreement and conversion of Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date. As a result, there was been a decrease in 2016/17 interest costs from the conversion date until 30 June 2017 and, increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

Property revaluation reserves
The revaluation reserve movement relates to the independent valuation of land as at 30 June 2017 & buildings as at 30 June 2016, fitout and infrastructure assets carried out by Telfer Young (Auckland) Ltd - 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 Auckland DHB's normal banking facilities.

21 Contingencies

Contingent Assets
There are no contingent assets at 30 June 2017 (2016 : nil).

Contingent Liabilities
Lawsuits against the DHB. Auckland DHB 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 allocation.
As at 31 March 2017, the Scheme had a past service surplus of $8.0 million (2016 : $11.7m) (6.2% 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 IPSAS25.
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.

22 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	2017 Actual	2016 Actual
Board Members		
Remuneration	$374k	$384k
Full-time equivalent members	1.7	1.7
Leadership Team		
Remuneration	$7,932k	$7,343k
Full-time equivalent members	20	20
Total key management personnel remuneration	**$8,306k**	**$7,727k**
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.

23 Events after the balance date

There were no significant events after the balance date.

24 Financial instruments

24a 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	
	2017 $000	2016 $000	2017 $000	2016 $000
Loans and receivables				
Cash and cash equivalents	69,725	31,983	69,725	31,983
Investments-term deposits	11,000	20,000	11,000	20,000
Trust/special funds - bank balances, term deposits, investment bonds and portfolio)	28,816	27,233	0	0
Receivables	87,422	62,049	87,949	61,271
Patient and restricted trust funds	1,263	1,239	1,263	1,239
Total loans and receivables	**198,226**	**142,504**	**169,937**	**114,493**
Financial liabilities measured at amortised cost				
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	117,614	111,302	117,555	110,996
Borrowing-secured loans	867	307,205	867	307,205
Patient and restricted trust funds	1,263	1,239	1,263	1,239
Total financial liabilities measured at amortised cost	**119,744**	**419,746**	**119,685**	**419,440**

24b Fair value hierarchy disclosures

For those instruments recognised at fair value in the Statement of Financial Position, fair values are determined according to the following hierarchy:

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

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

	Notes	Total	Valuation technique: Quoted market price	Valuation technique: Observable inputs	Valuation technique: Significant non-observable inputs
		$000	$000	$000	$000
GROUP 30 June 2017					
Financial Assets					
Portfolio Investments	9	12,295	12,295	0	0
Investment bonds	9	2,830	2,830	0	0
GROUP 30 June 2016					
Financial Assets					
Portfolio Investments	9	11,134	11,134	0	0
Investment bonds	9	2,861	2,861	0	0

24 Financial instruments (continued)

24c 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. Hedge accounting was applied to the Bond FRA, with the settlement position recognised in the accounts as a cashflow hedge reserve. This would have been 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. In terms of Government Policy on 15 Feb 2017, all Crown Debt was converted to Crown Equity. This included the write off of the Cash Flow Hedge Reserve, which was funded by revenue from the MoH.

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 2017, 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 $1.488m lower/higher (2016 : $1.310m).

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 (2016 : nil).

Sensitivity analysis

As at 30 June 2017, if the New Zealand 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 (2016 : $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 NZ Health Partnerships Limited (previously Health Benefits Limited) who invest with registered banks.

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

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

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The MoH is the largest single debtor (2017 : 30.4%, 2016 : 38.5%). 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.

24 Financial instruments (continued)

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	
	2017 $000	2016 $000	2017 $000	2016 $000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalent, term deposits & investment bonds				
A+	2,000	2,500	0	0
AA-	26,867	34,934	12,346	21,335
Total cash, cash equivalent, term deposits & investment bonds	**28,867**	**37,434**	**12,346**	**21,335**
COUNTERPARTIES WITHOUT CREDIT RATINGS				
NZHPL (previously HBL)-no defaults in the past	69,642	31,887	69,642	31,887
Portfolio Investments-no defaults in the past	12,295	11,134	0	0
Receivables				
Exiting counterparty with no defaults in the past	87,422	62,049	87,949	61,271
Exiting counterparty with defaults in the past	0	0	0	0
Total receivables	**87,422**	**62,049**	**87,949**	**61,271**

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 New Zealand Health Partnerships Limited.

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

Contractual maturity analysis of financial liabilities, excluding derivatives

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

GROUP

2017	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	867	867	247	247	201	172	0
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	117,614	117,614	117,614	0	0	0	0
Total	**118,481**	**118,481**	**117,861**	**247**	**201**	**172**	**0**

24 Financial instruments (continued)

2016	Carrying Amount	Contractual Cash Flow	6 Months or less	6-12 Months	1-2 Years	2-5 Years	More than 5 years
	$000	$000	$000	$000	$000	$000	$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**

PARENT

2017	Carrying Amount	Contractual Cash Flow	6 Months or less	6-12 Months	1-2 Years	2-5 Years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Borrowings	867	867	247	247	201	172	0
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	117,555	117,555	117,555	0	0	0	0
Total	**118,422**	**118,422**	**117,802**	**247**	**201**	**172**	**0**

2016	Carrying Amount	Contractual Cash Flow	6 Months or less	6-12 Months	1-2 Years	2-5 Years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Borrowings	307,205	363,828	6,134	6,066	60,877	118,217	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**	**474,824**	**117,130**	**6,066**	**60,877**	**118,217**	**172,534**

25 Major variations from budget

Statement of Financial Performance
Auckland DHB recorded a surplus of $3.162m which was $1.338m unfavourable to budget.

Major unfavourable revenue variance:
Patient care revenue $48.1M unfavourable mainly due to a difference in accounting treatment for agency arrangements reducing IDF inflows by $62.8M, partially offset by favourable IDF wash-up provisions for over-delivery of volumes.

Major expenditure variance:
Personnel/Outsourced Personnel costs $37.9M: reflecting one- off restructuring costs $2.4M, provisions for staff related liabilities $18.1M, MECA settlement costs provision $3.7M and annual leave taken for the year ($7.3M lower compared to the cost of annual leave accrued/earned). The balance of this variance $5.6M reflects unfavourable FTE above budget due to FTE savings targets incorporated into the budget, partially offset by lower cost per FTE (reflecting reductions in overtime and other premium payments).
Funder Payments to NGOs and for IDF outflows have a combined favourable variance of $102M. This includes the $62.8M difference in accounting treatment for agency arrangements. The balance of the favourable variance reflects normally expected variations in business as usual factors across Funder NGO services:

- These mostly arise out of demand/utilisation variances in Age Related Residential Care services and Primary Health Organisation services and Community Pharmacy. PHARMAC provided a revised rebate forecast in June that has a retrospective adverse impact offsetting the favourable variance.

- The remainder of the favourable variance results from a combination of one off upsides relating to prior year accounting adjustments as well as budget realignments that have taken place subsequent to the submission of the financial plan (the budget compilation for submission occurs well in advance of the financial planning year).

Favourable Property, Plant and Equipment variance
The full revaluation of land and buildings completed at 30 June 2016 resulted in an increase in revaluation reserve of $70.5M ($33.8M for land and $36.7M for buildings), these revaluation adjustments were not accounted for in the 2016/17 budget. The valuation of land for 30 June 2017 resulted in an increase in fair value of $38.7M, offset by an impairment adjustment in buildings for Asbestos remediation of $32M. This is offset by less spend of capital expenditure against budget of $36M due to the delayed approval of the Capex Budget by the Board as a result of an extensive Capex prioritisation process for the 2016/17 Capex Budget.

Favourable Cash and Cash Equivalents
Capex spend is $36M behind, due to delayed Board approval of 2016/17 capex budget. $97M favourable variance in payments to NGO funder providers. These are offset by $4.8M investment in healthAlliance for the transfer of IT assets C class shares which was not in the budget and $60M less revenue mainly due to under delivery of inpatient and additional electives volume. Payments to suppliers are also $38M unfavourable to budget.

Favourable Receivables
$3.8m increase in undischarged patients and $16.8 movement in the IDF wash-up receivable.

Unfavourable Employee Entitlements
One off restructuring costs $2.4M, provisions for staff related liabilities $18M, MECA settlement costs provision $6M.

Favourable Borrowings
In terms of Government Policy on 15 Feb 2017, all Crown Debt $304.5M was converted to Crown Equity. This included the write off of the Cash Flow Hedge Reserve $3.2M, which was funded by revenue from the MoH.

Favourable Property Revaluation Reserve
The full revaluation of land and buildings completed at 30 June 2016 resulted in an increase in revaluation reserve of $70.5M ($33.8M for land and $36.7M for buildings). These revaluation adjustments were not accounted for in the 2016/17 budget. The valuation of land for 30 June 2017 resulted in an increase in fair value of $38.7M, offset by an impairment adjustment in buildings for Asbestos remediation of $32M.

26 Key sources of estimation uncertainty

As indicated in Note 1, the preparation of financial statements in conformity with NZ GAAP requires management to make 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 estimates and assumptions are made:

Accrual of continuing medical education leave and expenses in employee benefits
The provision for the above is $23.592m as at 30 June 2017 (2016 $23.856m). 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 (2016 – 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.

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. The Board has approved capex to relocate HV electrical switchgear from the Central Plant Building 6 at the Auckland Campus to a new substation being constructed elsewhere on the site in the next 12 months. Other critical plant items are also likely to be relocated from this building in the next few years as part of the major Facilities Remediation Programme being planned by Auckland DHB. This building still had a value of $1.3m assessed in the desktop assessment performed as at 30 June 2017.

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 2017

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

We have audited:

- the financial statements of the District Health Board and group on pages 39 to 79, that comprise the statement of financial position as at 30 June 2017, 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 District Health Board and group on pages 7 to 30 and on page 36.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the District Health Board and group on pages 39 to 79:

- present fairly, in all material respects:
    - the financial position as at 30 June 2017; and
    - the financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand 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 in the prior year

In respect of the 30 June 2016 comparative information only, some significant performance measures of the District Health Board and group (including some of the national health targets, and the corresponding district health board sector averages used as comparators), relied on information from third-party health providers, such as primary health organisations. The District Health Board and group's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year, however, the limitation cannot be resolved for the 30 June 2016 year, which means that the District Health

Board and group's performance information reported in the statement of performance for the 30 June 2017 year, may not be directly comparable to the 30 June 2016 performance information.

In our opinion, except for the matters described above, the performance information of the District Health Board and group on pages 7 to 30 and on page 36:

- presents fairly, in all material respects, the District Health Board and group's performance for the year ended 30 June 2017, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - 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 appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 30 October 2017. This is the date at which our opinion is expressed.

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

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

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

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the District Health Board and group for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the District Health Board and group for assessing the District Health Board and group's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the District Health Board and group or there is no realistic alternative but to do so.

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.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these 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.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the District Health Board and group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit 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 District Health Board and group's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the District Health Board and group's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the District Health Board and group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the District Health Board and group to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the

performance information represent the underlying transactions and events in a manner that achieved fair presentation.

- We obtain sufficient appropriate evidence regarding the financial statements and the performance information of the entities or business activities within the group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the group audit. We remain solely responsible for our audit opinion.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 6 and 31 to 38, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Group in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

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

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

2016/17 marks the fifth anniversary of the Helicopter Emergency Service (HEMS).

This special partnership between Auckland DHB and the Auckland Rescue Helicopter Trust (ARHT) means that Emergency Specialist Doctors fly as part of the clinical team on rescue missions in the Auckland and Coromandel regions. This is a unique initiative in New Zealand, setting the standard for emergency pre-hospital patient care in the nation's aeromedical sector.

From left to right:

Marcel Driessen, Intensive Care Paramedic (ARHT); Dr Chris Denny, Medical Director (HEMS); John Stanton, Pilot (ARHT); Dr Dean Bunbury, Specialist in Anaesthesia (HEMS); Dr Emily Junck, fellow (HEMS); Ati Wynyard, Crewman (ARHT); Dr Ula Heywood, Specialist in Emergency Medicine (HEMS); Casey Drum, Intensive Care Paramedic (ARHT).

AUCKLAND DISTRICT HEALTH BOARD

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Te Toka Tumai