AUCKLAND DISTRICT HEALTH BOARD

Annual Report 2018 | 2019

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

CONTENTS

MESSAGE FROM OUR CHAIR AND CEO

Meeting the challenges of a growing and diverse population

Pat Snedden
Chair

Ailsa Claire, OBE
Chief Executive Officer

We must take every chance to collaborate across all parts of the health system. By working differently, we can deliver more timely and appropriate services to those who need care.

Kia ora koutou katoa.

It is our great privilege to lead the Board and Executive Leadership Team of Auckland DHB, who are committed to serve our central city population and all of the people who use our services from around New Zealand. Our reach is large: we fund and provide services for 542,000 people living in Auckland, Waiheke Island and Great Barrier Islands.

Our clear and direct vision is to support the people we serve to achieve the health outcomes they want for themselves, their whānau and their communities. We also look after all of the New Zealand population's needs as the provider of specialised services, including organ transplant services, specialist paediatric services and high risk obstetrics.

We do not do this alone, as a large part of the care that our community receives is delivered by primary and community providers, outside of the hospital system. Although these services are also under pressure, we know that they are often the most appropriate care for people. Primary and community care organisations play a huge part in keeping our population from unnecessary hospital visits, and in keeping us well and as close as possible to our homes.

Over the last year, the Waitangi Tribunal heard submissions on the state of Māori health. Their findings were clear. It is undisputable that Māori health outcomes do not match those of non-Māori. This disparity remains the case even as the health of non-Māori has improved.

We decided to be more active in addressing these challenges directly with our Māori communities. The three metro Auckland DHBs, Auckland, Counties Manukau and Waitematā, agreed to joint governance arrangements on decision-making with iwi tribal groups to improve Māori health outcomes. This will take effect in 2020/21.

We know there are similar disparities in health outcomes for our Pacific populations. We are working closely with our Pacific communities to address these and will continue to do so. The Government's emphasis on wellbeing and equity is welcome and commits us to change our practice to lift our population's health outcomes.

We want our communities to experience confidence that they can access all of the health services they need, at the right level and at the right time, regardless of their ethnicity or social economic position.

To continue to meet population growth requires us to work more collaboratively with other DHBs and with our primary care partners. This necessary collaboration is supported by the findings of the interim Health and Disability System review. We must use every opportunity to collaborate across all parts of the health system. We cannot let our large size impede our vision; by working differently, we can deliver more timely and appropriate services to those who need care.

The quality of care patients receive in our hospitals is a credit to the 11,000 people working to improve health outcomes and doing the right thing for everyone.

Our workforce is skilled, generous and committed to be of service.

This was exemplified last year as staff supported their colleagues affected by the Canterbury mosque shootings and the public who were injured and evacuated to Auckland. Employees came together to witness mosque prayers a week after the shootings. That single act of solidarity spoke volumes of the care they had for their colleagues and all who come into their care.

Health outcomes are linked to poverty, housing, education and the environment. We will continue to work in partnership with other agencies and influence public policy to address inequities in health. Life expectancy is a good overall measure of population health status. We have one of the highest life expectancies of any DHB in the country, at 83.2 years. While we are proud of this achievement, an equity gap remains for our Māori and Pacific populations.

The To Thrive programme was implemented to support people who may have limited qualifications or are struggling to succeed in employment. Through this programme, employees and their whānau receive additional benefits, health checks, education and career pathways to help them thrive at work and at home.

We made a commitment to become carbon neutral by 2050 and are making great progress. In three years, we reduced our carbon emissions by 21% and diverted 163 tonnes of waste from landfill. This year, our efforts were recognised nationally at the Enviro-Mark Solutions Awards, where we won the climate action category.

Auckland DHB is its people and we greatly appreciate the commitment and dedication of our workforce and the work of our primary and community partners, NGOs, PHOs, volunteers and support groups. Together, we deliver world-class healthcare and healthy communities for the people of Auckland and New Zealand.

Pat Snedden

Chair
Auckland District Health Board

Ailsa Claire OBE

Chief Executive
Auckland District Health Board

Working together to achieve Māori health gain

Dame Rangimarie Naida Glavish, DNZM JP
Co-Chair, Te Rūnanga o Ngāti Whātua

Tū Tonu ngā Manaakitanga!

This whakatauākī represents the sacred obligation of Ngāti Whātua 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 in improving health outcomes among our whānau, in particular our tamāriki. The health and development of the most at-risk members of our whānau is crucial for the future of our communities. Significant work is being done by our primary and community care partners to ensure our tamāriki receive health services when and where they need them. The effort put in to immunisation, dental care and school health services has contributed to fewer Māori children being admitted to hospital for conditions that are potentially avoidable.

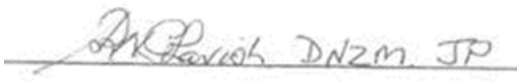
As we acknowledge all those who contributed to a milestone year for Māori health, we also need to challenge ourselves to do more. Many indicators in this report show that Māori often suffer disproportionately from health conditions or are not accessing important health services at the same rate as others in our community. One only needs to view life expectancy data to get a sense of the immense challenge of eliminating Māori health inequities.

For Māori, the life expectancy gap is largely due to avoidable deaths from cancers, in particular lung cancer, and chronic conditions including cardiovascular disease (CVD). Smoking is a major contributing factor to these conditions, and also has a detrimental effect on our tamāriki. The combined efforts of hospital-based services, primary care providers and community organisations have contributed to a drop in the number of our whānau smoking. The burden of CVD weighs heavily on Māori. Auckland DHB is helping those at risk of CVD and other chronic conditions make lifestyle changes to improve their wellbeing.

As the Tiriti o Waitangi partner, Te Rūnanga o Ngāti Whātua understands the importance of having a strong and trusting relationship with the DHB to achieve Māori health gain. The completion of the Auckland DHB and Waitematā 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%. 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. We all need to reflect on the role we play at all levels of the health system, and consider how we can improve the wellbeing of Māori, whether this is for the small whānau in front of you who are in need of your warmth and care, or you have the ability to influence the entire system so that the staff members, whānau and communities seeking leadership feel empowered to achieve wellbeing and their own tino rangatiratanga: how can you improve the wellbeing of Māori? Ask this question of yourself, and if you cannot find an answer, we will find it together in partnership.

Our Te Tiriti o Waitangi Partner
Te Rūnanga o Ngāti Whātua



Dame Rangimarie Naida Glavish DNZM JP
Chief Advisor Tikanga

Who we are and what we do

Auckland DHB is the Government's funder and provider of health services to the 542,000 residents living in the Auckland district. We are the fourth largest and one of the fastest growing DHBs in the country, and are expecting nearly 100,000 extra people by 2030.

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 11,000 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.

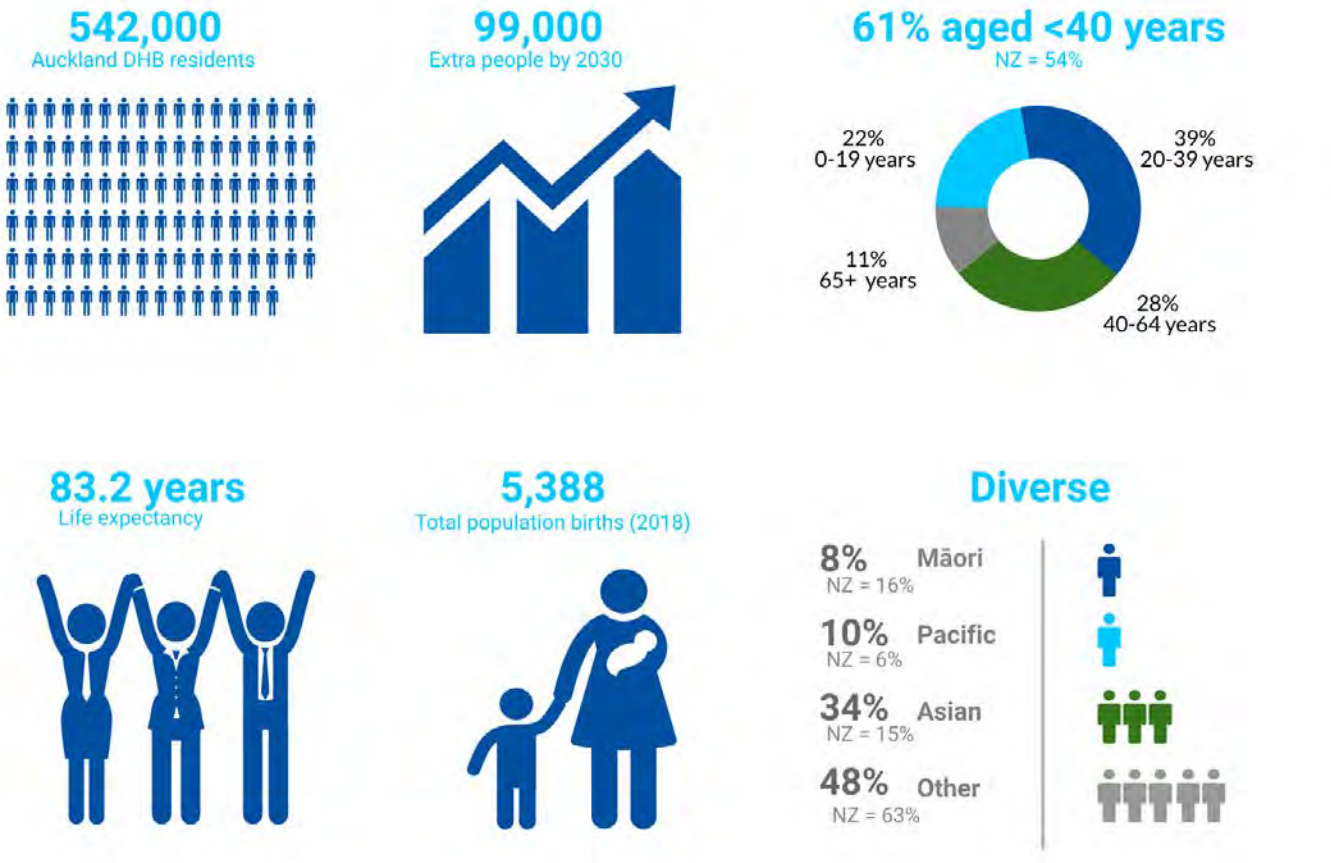
The performance measures we monitor reflect those we directly deliver on as an organisation, those that we fund other organisations to deliver and some that more broadly reflect the health of our population that we and others contribute to.

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 2018/19 was $2.3 billion.

Our population in 2018/19



Our direction

Healthy Communities, World-class Healthcare, Achieved Together

Our **vision** is *Healthy Communities, World-class Healthcare, Achieved Together*. 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 up skill our workforce so staff can work in more people-centric and patient-centric ways.

Our **strategic themes** outlined below provide an overarching framework for the way our services will be planned, delivered, and developed to deliver our vision.

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

Healthy Equity

Auckland DHB is committed to achieving health equity for all those in our community, in particular for Māori, who make up 8% of our population. The health status of the majority of our residents is very good and we are a relatively affluent population. However, some of our population experience inequalities in health outcomes and ethnicity is the strongest equity parameter. Nearly one in five (18%) of our total population are Māori or Pacific, but 27% of Māori and 40% of Pacific people live in areas ranked as highly deprived, concentrated in parts of Avondale, Mt Roskill and the CBD, and eastern and southern areas from Glen Innes to Mt Wellington and Otahuhu. Individuals living in these areas tend to experience poorer health outcomes than those living elsewhere.

We are proud of our progress towards health equity, demonstrated by the increase in life expectancy observed for most population groups. Auckland DHB has the one of the highest Māori life expectancies in the country, at 79.7 years; the rate of increase in Māori life expectancy is more than twice that of non-Māori life expectancy.

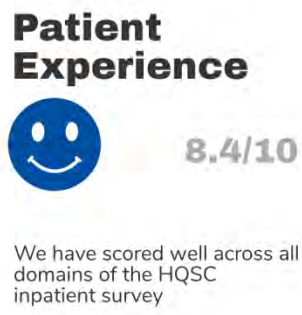
We work with our Memoranda of Understanding (MOU) partner, Te Rūnanga o Ngāti Whātua, in the planning and provision of healthcare services to further Māori health gain. We are developing strong partnerships focused on health equity. Collaboration with our partners will allow us to offer models of care that are whānau-centric, comprehensive and holistic. Equity is an over-arching priority in our performance framework, detailed in the next section of this annual report.

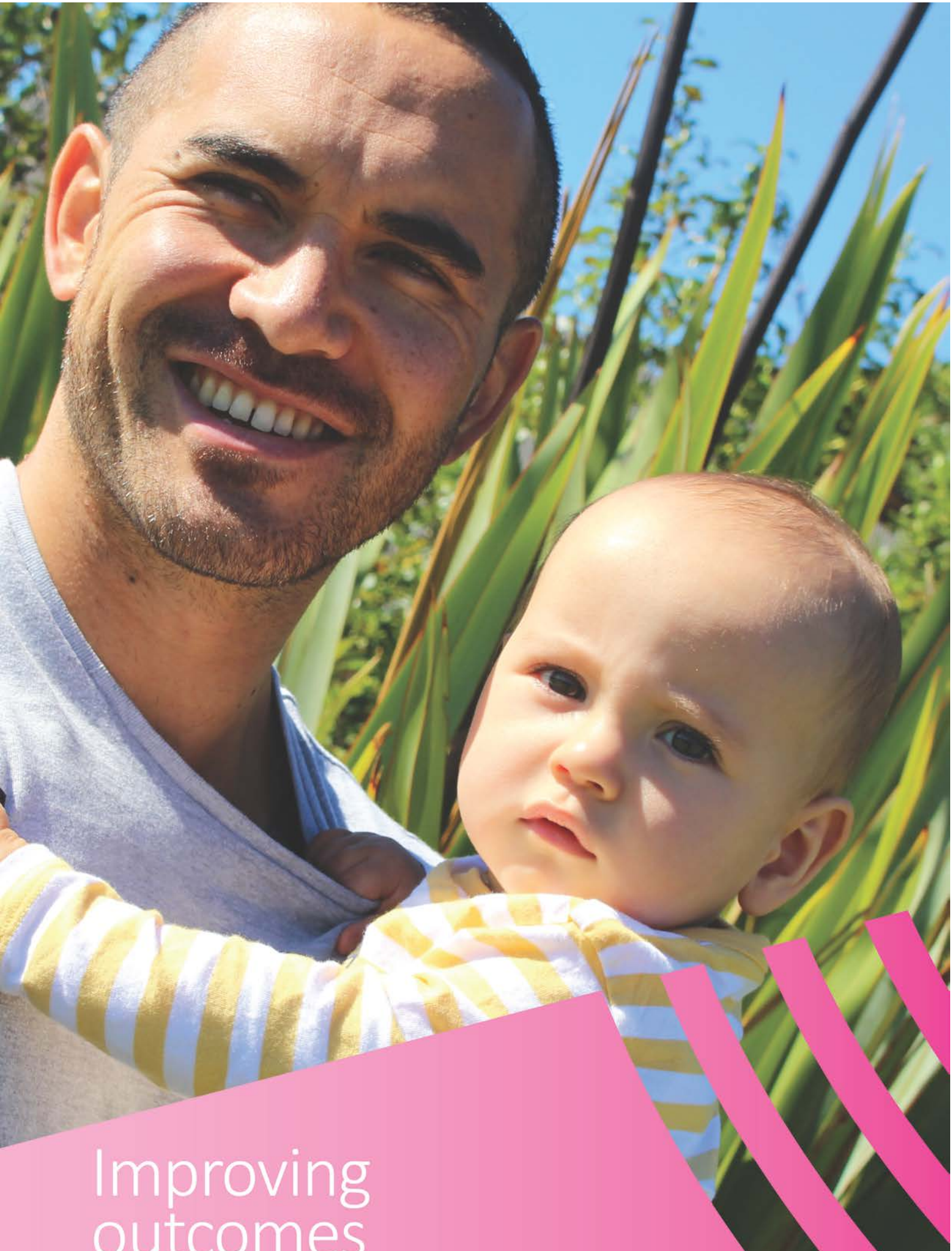
2018/19 Highlights

Auckland DHB is one of the healthiest communities in New Zealand and we performed well against our key indicators in 2018/19. We made progress against the national Health Targets, achieving three of the targets in quarter four.

Our achievements in 2018/19 include:

- The life expectancy of our population is higher than the New Zealand average and the gap between ethnic groups is decreasing. Life expectancy for our Māori population increased by nearly 5 years over the last decade
- Our smoking rate is the lowest in New Zealand (2013 Census) and we continue to help more smokers to quit. 98% of pregnant women and 89% of PHO-registered smokers were given advice and help to quit smoking. 85% of all six-week old babies live in smokefree homes
- Children are spending less time in hospital with ambulatory sensitive hospitalisation (ASH) rates in children aged 0-4 reducing by 16% over the last three years, and rates for Māori dropping by nearly 25%
- We achieved 100% against the raising healthy kids Health Target, meaning all children identified as obese were referred for further support
- Amenable mortality has steadily declined over the past decade, and our rate is the lowest in New Zealand at 69.6 per 100,000 population
- Auckland DHB has the highest 5-year cancer survival rate in New Zealand and we achieved the faster cancer treatment Health Target
- Our immunisation rates are among the highest in New Zealand, with 94% of 8 month old babies fully immunised in 2018/19
- We delivered 17,413 elective surgical procedures.





Improving outcomes

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

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

- maintain high life expectancy compared with New Zealand overall;
- reduce the difference in health outcomes between ethnic groups.

The outcome measures are long-term indicators; the aim is for a measurable change in health status over time, rather than a fixed target.

The System Level Measures (SLMs) framework supports achievement of these overall goals. The SLMs in our performance framework are based on those set by the Ministry of Health, which align with the five strategic themes of the Health Strategy and other national strategic priorities. Our SLMs recognise that DHBs must work together with primary, secondary and community care providers to improve health outcomes. Improvement milestones were set to measure our progress in improving the SLMs.

Contributory measures report on the activities we are undertaking to help improve the SLMs and are front-line measurements of specific health processes or activity. The contributory measures included in our performance framework are based on the needs and priorities of our local communities and health services.

Performance against our SLM improvement milestones and contributory measures are reported in the following section. Movement against each indicator's baseline is shown in the highlight boxes. The baseline is generally December 2017 for SLM and contributory measures, and 2016/17 for other measures.

The Statement of Performance (SP), 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. We monitor performance against these indicators quarterly.

Overall, the progress against our indicators suggests we are delivering on our promise of healthy communities and world-class care, and are making a positive difference to the health of our population.

AUCKLAND DHB RESIDENTS HAVE ONE OF THE HIGHEST LIFE EXPECTANCIES IN THE COUNTRY, AT 83.2 YEARS

Our life expectancy continues to improve, reaching 83.2 years (2016-18), the second highest in the country and an increase of 2.2 years over the past decade. Life expectancy for our Māori population increased by 4.8 years over the same time period, but remains nearly 5 years lower than that for the non-Māori population. The gap for Pacific is even greater, at 8.6 years.

OUR AMENABLE MORTALITY RATE REDUCED BY 25% OVER THE LAST 10 YEARS AND IS ONE OF THE LOWEST IN NEW ZEALAND

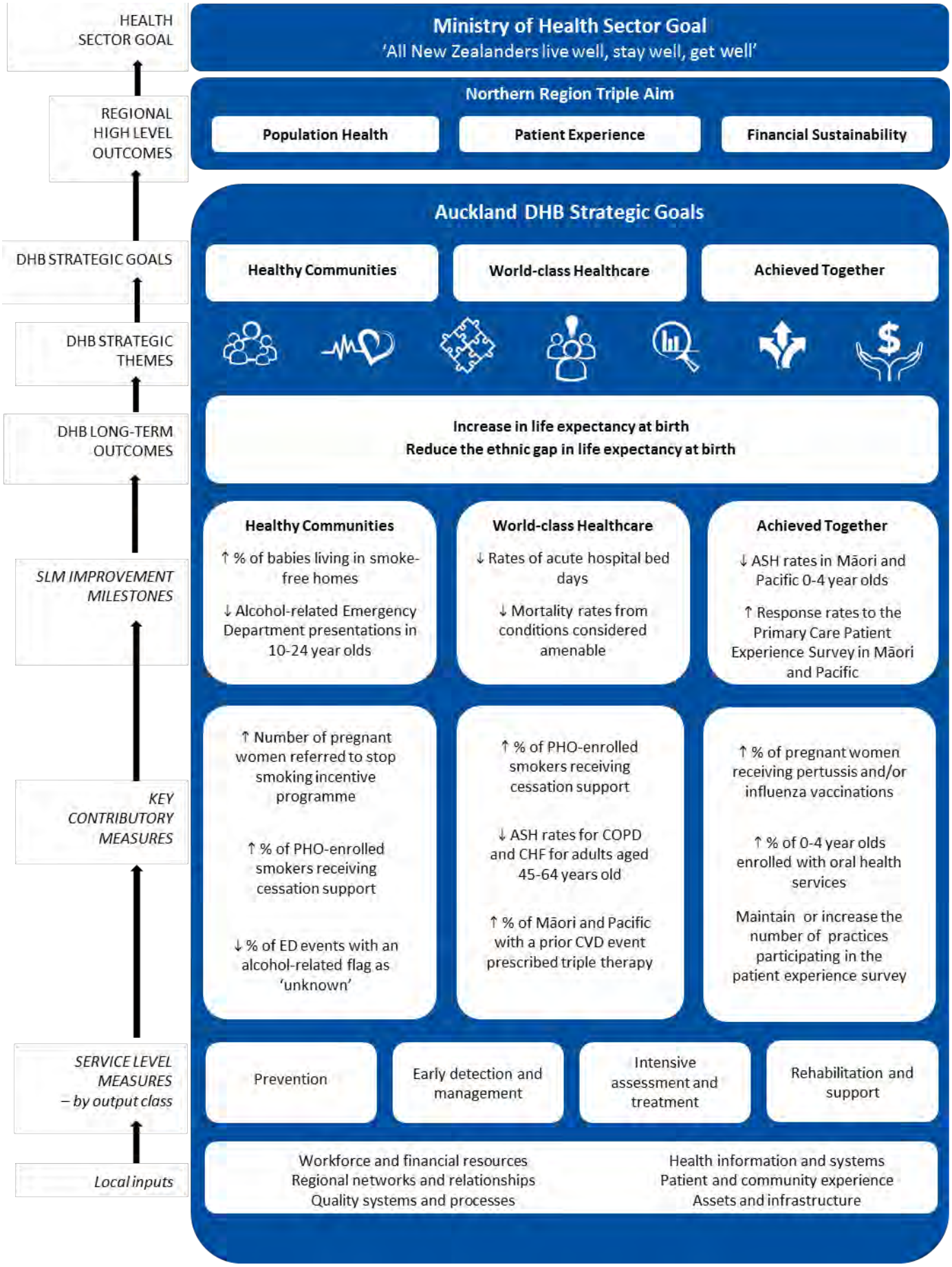
Amenable mortality (deaths potentially avoidable through healthcare intervention) is reducing, and in 2016 (the latest available data), 70 deaths out of every 100,000 were considered amenable, lower than the national rate of 88. An estimated 399 deaths (47% of all deaths in those aged under 75 years) in Auckland DHB were amenable in 2016.

OUR CHILDREN ARE STAYING OUT OF HOSPITAL WITH ASH[1] RATES FOR THOSE AGED 0-4 YEARS REDUCED BY 16% OVER THE LAST 3 YEARS

Our children are receiving a great start to life. The number of preschool children admitted to hospital for conditions that are potentially avoidable (ASH), such as respiratory illnesses, gastroenteritis, dental and skin conditions, are low compared with New Zealand overall. Our rate for Māori children is also lower than the national rate, although rates for Pacific children are twice as high as those for other ethnicities in Auckland DHB.

[1] Ambulatory sensitive hospitalisations (ASH).

PERFORMANCE FRAMEWORK



Improving life expectancy for everyone

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 the ethnic gap in life expectancy).

Life expectancy at birth (LEB) is recognised as an overall measure of population health status. Life expectancy at birth is defined as how long, on average, a newborn is expected to live, if current death rates do not change. Gains in life expectancy at birth can be attributed to a number of factors, including greater access to quality health services and healthier lifestyles.

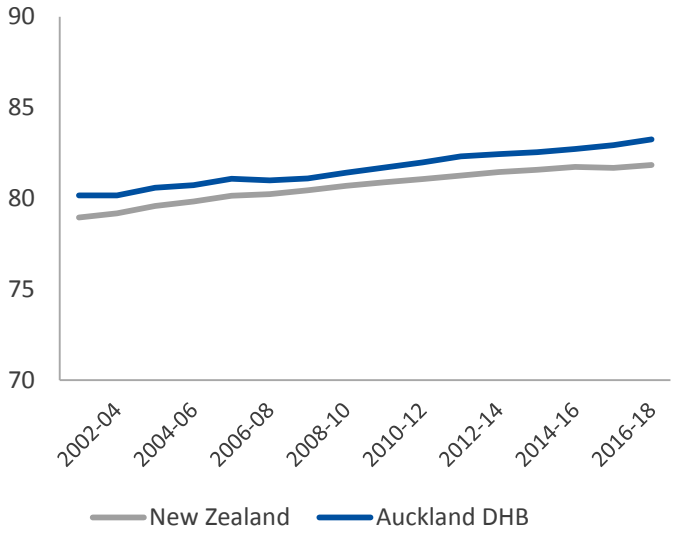
PEOPLE LIVE 1.4 YEARS LONGER IN AUCKLAND THAN NEW ZEALAND OVERALL

We have one of the highest life expectancies in New Zealand at 83.2 years (2016-18[2]), which is 1.4 years higher than New Zealand as a whole.

LIFE EXPECTANCY INCREASED BY 2.2 YEARS OVER THE LAST DECADE

In Auckland, life expectancy increased by 2.2 years over the last decade. Around half of this increase can be attributed to the reduction in amenable mortality.

LIFE EXPECTANCY AT BIRTH – 3 YEAR COMBINED ESTIMATE



Life expectancy differs significantly between ethnic groups in our district. Māori and Pacific people have a lower life expectancy than other ethnic groups, with a gap of 4.8 years for Māori and 8.6 years for Pacific.

INEQUALITIES ARE DECREASING - LIFE EXPECTANCY OF OUR MĀORI POPULATION INCREASED BY NEARLY 5 YEARS OVER THE LAST DECADE

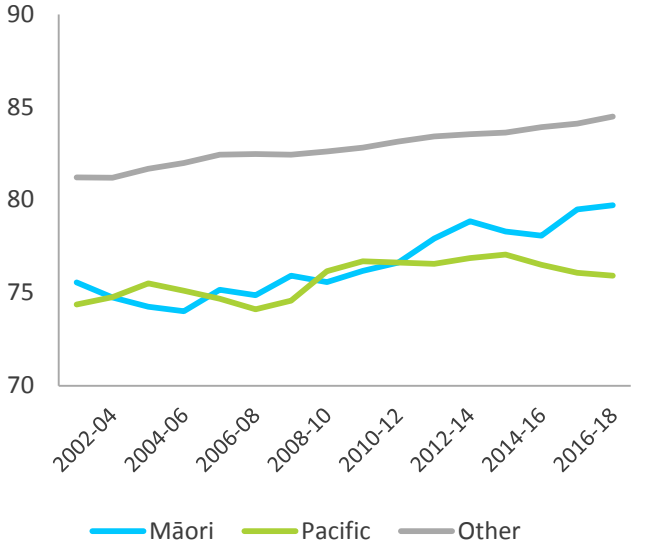
Life expectancy has increased in our Māori (4.8 years) and Pacific (1.8 years) populations over the past decade, and the life expectancy gap decreased significantly between Māori and other populations. Māori now have a life expectancy of 79.7 years, 4.8 years less than other ethnicities.

Life expectancy for Pacific remains significantly lower than other ethnicities at 75.9 years, with an increase of nearly 2 years over the past decade. There was little reduction in the gap between the life expectancy of our Pacific community and other ethnicities.

In Māori, the life expectancy gap is largely due to mortality from cancers, in particular lung cancer, and chronic conditions, including cardiovascular disease. Smoking is a major contributory factor to these conditions, and the Māori smoking rate is more than double that of the total DHB rate (26% vs. 11%).

Coronary heart disease is the largest contributor to the life expectancy gap between our Pacific and total populations; avoidable cancers and chronic conditions, such as diabetes, are also significant factors.

LIFE EXPECTANCY AT BIRTH, BY ETHNICITY – 3 YEAR COMBINED ESTIMATE



[2] The most recent life expectancy data available is for deaths occurring in the 2018 calendar year. Three-years combined estimates were produced to reduce the effect of year-to-year variations in death rates, especially when considering the smaller numbers seen at ethnicity level.

Healthy start

Smoking during pregnancy and exposure to cigarette smoke in infancy strongly influence pregnancy and childhood health outcomes. We are focusing attention beyond maternal smoking to the home and family/whānau environment, driving improvements in the health of all our population.

New Zealand has comprehensive tobacco control policies 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 during pregnancy and exposure to cigarette smoke in infancy is associated with a range of poor neonatal and child health outcomes, such as miscarriage, premature birth and low birth weight, sudden unexpected death in infancy (SUDI) and asthma. Children are more likely to become smokers if they grow up in a smoking household.

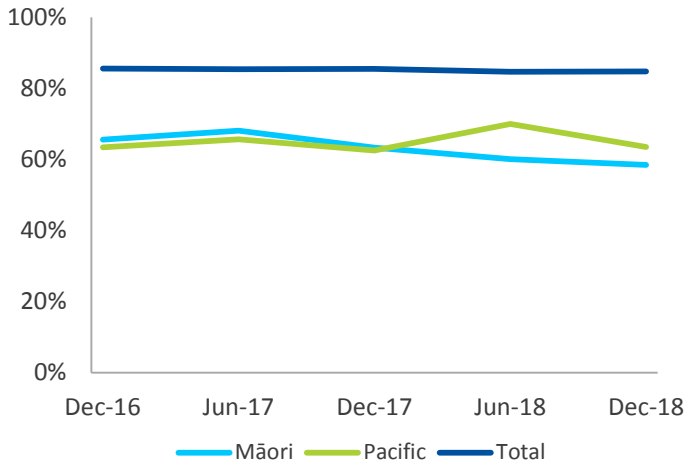
Smoking rates among our Māori and Pacific populations are reducing, but the prevalence remains at least twice that of other ethnicities. The rate of smoking in pregnancy, and worse pregnancy outcome for mothers and babies, is higher among Māori women and those living in areas of high deprivation. In 2018/19, 206 women in our community smoked when first pregnant, and 65% of them were Māori.

More babies living in smokefree homes

85% OF BABIES LIVE IN SMOKEFREE HOMES AT 6 WEEKS OLD[3] — 1% ⬇

Well Child Tamariki Ora (WCTO) service providers ask about smoking status at babies' 6-week postnatal check. In the 6 months to December 2018, 85% of 6 week old babies in our district lived in smokefree homes (i.e. no person ordinarily residing in the home is a current smoker).

PROPORTION OF WCTO REGISTERED BABIES LIVING IN SMOKEFREE HOMES AT 6 WEEKS POST-PARTUM



This result is a slight decrease on December 2017, meaning we did not achieve our 2% improvement target.

More Māori and Pacific babies are exposed to smoking in their homes, with only 58% of Māori and 63% of Pacific babies living in smokefree homes.

Improvement activities

Pregnancy is a time when women are likely to be highly motivated to stop smoking themselves and to encourage their whānau to stop smoking. Evidence suggests that incentive-based smoking cessation programmes can reduce smoking rates during pregnancy and the incidence of low birth weight babies.

95 WOMEN WERE REFERRED TO OUR INCENTIVE-BASED SMOKING CESSATION PROGRAMME — 40% ⬆

Our Ready Steady Quit service helps expectant mothers and whānau quit, with a free 12-week programme providing support, quitting aids and up to $350 in shopping vouchers for those who are successful. Across Metro Auckland DHBs, 85 women who participated in the programme successfully quit smoking, validated by carbon monoxide testing.

In 2018/19, 95 women were referred to the programme, 40% more than the number referred in the 12 months to March 2017. Even though referrals increased significantly, we did not meet our ambitious target of 184 referrals. We are changing our referral processes to make it easier for GPs and midwives to refer women to the programme, including an opt-off approach, whereby women who smoke are routinely referred to the programme unless they specify an objection.

14,195 SMOKERS (31%) RECEIVED CESSATION SUPPORT FROM PRIMARY CARE — 19% ⬆

Offering cessation support is important to assist whānau members to become smoke-free. Support includes referral to a smoking cessation programme, prescribing nicotine replacement therapy or other medicines, or providing behavioural support.

In the 15 months to June 2019, 31% of smokers received cessation support in primary care, exceeding our target of a 10% increase on the December 2017 baseline.

This contributory measure also sits under the amenable mortality SLM.

[3] The denominator for this measure is the total number of babies enrolled with WCTO providers. The 2019/20 methodology uses the total number of registered births as the denominator.

Working together to help whānau live smokefree

Auckland DHB has several programmes dedicated to helping pregnant women and whānau become smokefree to create a healthier environment for babies.

Maternity Incentive Programme making a difference

The Ready Steady Quit stop smoking service, funded by Auckland DHB and the Ministry of Health, extended its focus and is now providing dedicated support for pregnant women who want to start their smokefree journey.

The free Maternity Incentives programme provides support, including a post-partum visit and quitting aids for pregnant women and their whānau.

Enrolled pregnant women can obtain up to $350 in shopping vouchers over the 12-week programme if they successfully quit smoking. Whānau and others residing in the same household are encouraged to be part of the smokefree journey, with the potential to obtain up to $200 in vouchers through a shortened programme. QuitMist spray (oral nicotine replacement therapy spray) is also available.

Engagement in the service and outcomes improved dramatically since the introduction of the incentive programme. In 2018/19, 143 pregnant women across Auckland enrolled with the programme and 85 of those were smokefree (as measured by CO testing) four weeks after their quit date. This is more than double the number of women who successfully quit in the previous year.

Kara was expecting her third child when she was referred to the Ready Steady Quit Programme by her midwife. Kara is now smokefree thanks to the dedicated one-to-one help of her Ready Steady Quit Smokefree Practitioner Pep Tau.

“Having a Māori smoke free coach, Pep, come into my home made this journey much easier. Having her share a bit of her story meant there was no judgement” says Kara.

Kara knew she needed to give up smoking but was finding it hard. The programme taught her about her body’s response to nicotine and how to have a plan to help beat the cravings. The rewards gave her short-term goals to look forward to.

“Being part of the Hapu Mama programme has really helped give me motivation. My husband is so proud of me and has now asked for help to quit too.”

Smokefree homes key to keeping babies safe

Sudden unexpected death in infancy (SUDI) affects Māori families more than any other group in New Zealand. In 2015, there were 41 SUDI deaths in New Zealand, with three quarters occurring in Māori and Pacific families. Auckland DHB is working to reduce these numbers.

A smokefree environment and safe sleeping practices are vital for every baby, and supporting families to understand this message in a culturally appropriate setting is the focus of the new SUDI prevention programme.

When combined, smoking while pregnant and bed sharing increases the risk of SUDI by 32 fold.

Our sleep programme began as a pilot in 2015, offering Pēpi-Pod® safe sleep devices to women booked under the care of Auckland DHB midwives. It now offers various safe sleep bed options for at-risk babies in Auckland DHB. Education on SUDI prevention, including safe sleep practices and smoking cessation, is provided to families by their lead maternity carer (LMC), through education programmes during the antenatal period, as inpatients on the postnatal wards and home visits when mum and baby are discharged home.

As a result of all DHBs’ ongoing efforts, the latest available combined national SUDI rate is 0.76 per 1,000 live births (2013-17 data), half that reported in 2000. The Auckland DHB SUDI rate is considerably lower, at 0.43 per 1,000 live births. We hope to make further reductions with programmes specific to Māori and Pacific families, showcasing community safe sleep champions and social media campaigns to ‘make every sleep a safe sleep’.

Clinical charge midwife Lisa Mackey and Auckland DHB lactation consultant Shennaz Desai at our Safe Sleep promotion day

Keeping children out of hospital

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 prevent health problems and improve health outcomes.

In New Zealand children, around 30% of all unplanned admissions to hospital are for conditions that are potentially avoidable through prevention or management in primary care (ambulatory sensitive hospitalisations – ASH). These conditions are mainly respiratory illnesses, gastroenteritis, dental conditions and skin infections.

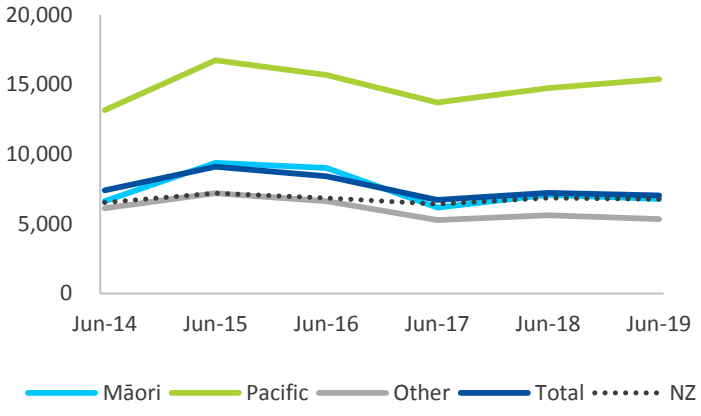
ASH rates are much higher for Māori and Pacific children. Primary health care access and quality, as well as underlying determinants of health (e.g. housing quality and crowding, exposure to second-hand cigarette smoke, poverty) may influence the incidence of ASH.

Fewer children are admitted to hospital with preventable conditions

7,051 AMBULATORY SENSITIVE ADMISSIONS PER 100,000 — 4% ⬆

In the 12 months to June 2019, there were 7,051 admissions per 100,000 children in our 0-4 year old population (2,061 events) that were considered ambulatory sensitive. This was a 16% decrease since June 2016, but a slight increase on our December 2017 baseline. Rates for Māori have dropped nearly 25%, but ASH rates in the Pacific population are three times as high as other ethnicities and have seen little improvement. In 2018/19 our efforts were focused on high need groups.

AMBULATORY SENSITIVE HOSPITAL ADMISSIONS IN THOSE AGED 0-4 YEARS, PER 100,000 POPULATION



Improvement activities

Hospitalisations due to dental conditions make up about 9% of ASH admissions, and are increasing. Improving accessibility of oral health programmes will reduce the prevalence and severity of decay (caries), and those requiring treatment in hospital.

187 CHILDREN WERE ADMITTED TO HOSPITAL FOR DENTAL CONDITIONS (640 PER 100,000 POP) — 3% ⬆

The Auckland Regional Dental Service (ARDS) provides oral health promotion, education and treatment to over 300,000 children from birth to school year 8 across greater Auckland.

90% OF PRESCHOOLERS WERE ENROLLED WITH ORAL HEALTH SERVICES — 2% ⬇

To ensure that children are seen by ARDS, we have focused on early enrolment. At the end of December 2018, 90% of all pre-schoolers were enrolled with oral health services, although this figure was much lower for Māori (67%). To make it easier for children and whānau to access dental care, ARDS is implementing an outreach programme and extending after hours clinics.

In 2018, 62% of the 5 year old children examined in the period had no dental decay (caries free), with higher rates of decay seen for Māori (49% caries free) and Pacific (33% caries free) children. A change in practice to support high-risk children to be seen more frequently may have led to higher caries rates being observed in the examined population, but this process is expected to improve long-term outcomes for these children.

57% OF PREGNANT WOMEN RECEIVED PERTUSSIS VACCINATION DURING PREGNANCY — 20% ⬆
AND 43% RECEIVED INFLUENZA VACCINATION — 42% ⬆

Respiratory conditions are the largest contributor to paediatric ASH rates in Auckland DHB. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants, and can lead to further respiratory complications. Vaccination during pregnancy protects both mother and baby against the diseases for the first few months of life.

For babies born in 2018/19, 57% of mothers had received pertussis vaccination during pregnancy, and 43% received influenza vaccination. This is a significant improvement, but rates remain lower for Māori and Pacific groups.

Children who were hospitalised for respiratory illness are offered influenza vaccination. In CY2018, 17% of eligible children received the vaccination. Although the overall uptake increased compared with the previous year, it was hampered by the national vaccine shortage.

Relocatable clinic brings health care to primary school students

By providing safe, fit-for-purpose, easily accessible care to children at school, health issues are detected early and managed in the community, helping all children stay healthy and ready to learn.

Whare Hauora, an in-school, relocatable health clinic, was launched at Panmure Bridge School in August 2018.

The clinic is a fit-for-purpose facility that provides a space for healthcare services to be delivered alongside education in the school environment for some of our most disadvantaged children.

Starship Community currently provides healthcare services at 115 primary schools in Auckland. Nurse-led clinics are run at least two days a week at 39 decile 1-3 schools, providing care for 11,000 children. The service provides support for children with chronic conditions (including respiratory issues, eczema, and diabetes) and carries out screening. Throat swabs and skin checks are performed to help prevent rheumatic fever and severe skin infections. By providing easily accessible care to children at school, conditions are detected and treated earlier, reducing the chance of hospitalisation.

Nurses look after children with disability and developmental delay, as well as linking whānau with complex health and social needs to wider supports.

Dr Mike Shepherd, Director of Starship Medical and Community, says: "We want to make healthcare delivery as easy and as accessible as possible. We know that delivering healthcare in schools is great for children and their whānau; getting treatment faster, reducing travel costs, reducing the need for whānau to take time off work. An in-school facility means that we can deliver even better healthcare in schools."

Whare Hauora is the brainchild of Nurse Consultant Sarah Williams, who saw first-hand the need for appropriate spaces for healthcare within schools and has worked on the project from conception through to reality.

Sarah was a full-time school nurse in a Mount Roskill decile 1 school who first worked out of an old dental clinic, and then a classroom. These settings posed challenges for privacy so Sarah started to investigate the facilities our school nurses were working in and saw the need for improvement.

This project provided an ideal opportunity for community collaboration between health, education and local business. A space was owned by health, funded by local business and housed by education, in the community, for the community.

Whare Hauora contains a small waiting area, a private treatment space where patients are seen and office space at the rear for administration. It is a similar size to a shipping container, making it easily relocatable.

Whare Hauora provides a safe, fit-for-purpose facility for health staff and has improved service delivery and enhanced patient experience by enabling quality healthcare to be delivered in the community for the community. Access to specialist outpatient services are also provided by utilising the space as a satellite clinic for other health services.

While Whare Hauora visits are currently only available to Panmure Bridge school students, this is just the beginning of the journey, with two more Whare Hauora planned in future.

The new, fit-for-purpose, health facility at Panmure Bridge School

Nurse consultant Sarah Williams sees a young patient as part of the Starship Community school-based health service

Youth are healthy, safe and supported

Promoting healthy behaviours during adolescence and taking steps to better protect young people from health risks are critical in preventing health problems and poor life outcomes in adulthood.

The youth System Level Measure consists of five domains reflecting the complexity and breadth of issues impacting youth health and wellbeing: Youth experience of the health system; Sexual and reproductive health; Mental health; Alcohol and drugs; and Access to preventative services. Auckland DHB has chosen to focus on the impact of alcohol at both an individual and health system level.

Alcohol is the most commonly used recreational drug in New Zealand. Alcohol contributes to violence, self-harm, injuries and many medical conditions, and is responsible for over 1,000 deaths and 12,000 years of life lost each year in New Zealand. Young people are among those experiencing the highest impact of alcohol-related harm.

Fewer young people are seen in Emergency Departments because of alcohol

Identifying and monitoring alcohol-related Emergency Department (ED) presentations enables DHBs to better understand the impact excessive alcohol consumption has on young people. It is a starting point to encourage DHBs to move toward more extensive screening, brief intervention and referrals to primary and community care.

In 2018/19 our target was to improve data collection to the point where we could establish a baseline.

Significant quality improvement work has taken place to ensure consistent and accurate collection of this information. The mandatory question in our ED system states: 'Is alcohol associated with this event?' Possible answers are: Yes, No, Unknown and Secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved).

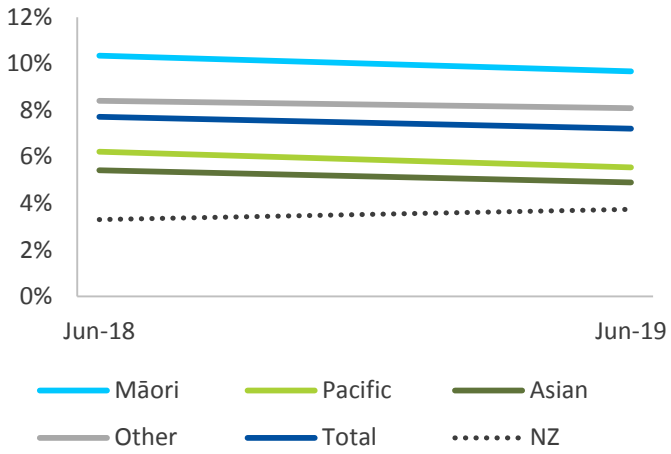
2.8% OF YOUTH EMERGENCY DEPARTMENT PRESENTATIONS HAD 'UNKNOWN' RECORDED IN THE ALCOHOL FIELD — 1% ⬆

Auckland DHB is currently reporting very low numbers (2.8%) of ED events with 'unknown' alcohol flags recorded. This is a slight increase on the March 2018 baseline result.

In the 12 months to June 2019, our emergency departments were attended nearly 20,000 times by young people aged 10 to 24 years. Of these attendances, 7.2% (1,439) were alcohol related, a decrease on the previous year. ED attendances by Māori youth were more likely to be alcohol related (10% of presentations) than any other ethnic group.

1,439 EMERGENCY DEPARTMENT PRESENTATIONS BY 10-24 YEAR OLDS WERE ALCOHOL RELATED (7.2%) — 6% ⬇

PROPORTION OF ED PRESENTATIONS IN 10-24 YEAR OLDS THAT WERE ALCOHOL RELATED



Improvement activities

HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) Assessments are carried out by School Based Health Services nurses for Year 9 students in low decile schools. The assessments allow for early identification of mental health, alcohol and drug issues and other information to assist young people in their development. In the 2018 school year, 90% of students at eligible schools received an assessment.

3.2% OF 0-19 YEAR OLDS ACCESSED MENTAL HEALTH SERVICES — 6% ⬇

In the 12 months to June 2019, 3.2% of our population aged 0-19 years accessed mental health services. This is slightly lower than the national rate of 3.9%. The proportion of Māori youth receiving mental health support was much higher, at 6.2%.

4,153 ALCOHOL LICENCE APPLICATIONS WERE RISK ASSESSED — 7% ⬆

The Auckland Regional Public Health Service (ARPHS) has a statutory role in ensuring that the harms from excessive alcohol consumption are minimised in Auckland. In 2018/19, ARPHS reviewed and risk assessed 4,153 applications for new or renewed liquor licenses to ensure the safe and responsible sale, and consumption of alcohol.

Supporting young people to get through tough times

Supporting youth to respond to distress, improve resilience and engage with the services they need builds hope and reduces the stigma attached to mental health issues.

Paired up is a peer-led support service located at Tamaki College and piloted in 2018.

Tamaki College is a decile 1 school with a largely Māori and Pacific roll that experiences high levels of inequity and over representation in several significant negative measures around their social and family environment.

In response to the high needs of the students, and following the suicide of two students in 2017, Auckland DHB commissioned the pilot service to support the students.

Delivered by the NGO Connect Supporting Recovery, Paired Up is based on a peer framework and the service uses peer support as a means of responding to distress, raising resilience and helping youth engage with support and influence change in their community.

Paired Up aims to raise young people's feelings of hope, reduce stigma around mental health issues ("it's ok to not be ok") and build resiliency. It also enables students to become actively involved in supporting one another and engaging in the wider community.

Paired Up undertakes this through a variety of activities, including one-to-one peer support, drop-in facilities and groups known as activations.

There are no referral criteria to access peer support, meaning it can happen anytime and anywhere. Peer support workers are available during school hours and in the evenings and holidays.

Young people come to Paired Up to talk about their experiences of mental distress, depression, anxiety, suicidal thoughts, family relationships and friendships, school issues, body image, bullying, loneliness, cultural and rainbow identities, and anger issues.

The initial evaluation of the pilot indicates that Paired Up is a success. In total, Paired Up reached 110, predominantly Māori and Pacific, students between March and December 2018. This is approximately one in six Tamaki College students.

There was a very high demand for the service and positive feedback from youth, whānau and teachers.

Paired Up facilitated 92 activations (groups or one-off health promotion activities), identified by youth and primarily led by youth activators that actively encourage conversations around mental wellbeing.

The health mural created by students in the Creative Arts activation

A range of activations were delivered, with four regularly occurring: Phenomenal Young Women, Solace (LGBTQI group), Physical Health, and Youth Council.

Another significant focus for Paired Up is building better multi-agency and community collaboration with the young person at the centre. This should work across the cultural, educational and health processes to support all young people and their whānau.

Paired Up brought all of these elements together with the activation 'Phenomenal Young Women, this is me'. A team of female youth activators (students) created a series of activations focused on building connections to people and culture as well as focusing on wellbeing. Over 50 young women attended the event. This project was in collaboration with Auckland Libraries, Rakaru Tautoko and Community Action on Youth and Drugs (CAYAD). All of the Year 13 students involved in Phenomenal Young Women used their involvement in the design and delivery on their university applications.

Students in one activation group worked together to create a vegetable garden outside the Paired Up office at Tamaki College

Preventing and detecting disease early

Preventative care is centred around keeping people healthy, identifying and treating problems quickly, and empowering people to manage their own health. Our aim is for fewer people to die from potentially avoidable conditions, such as cardiovascular disease, some cancers and diabetes.

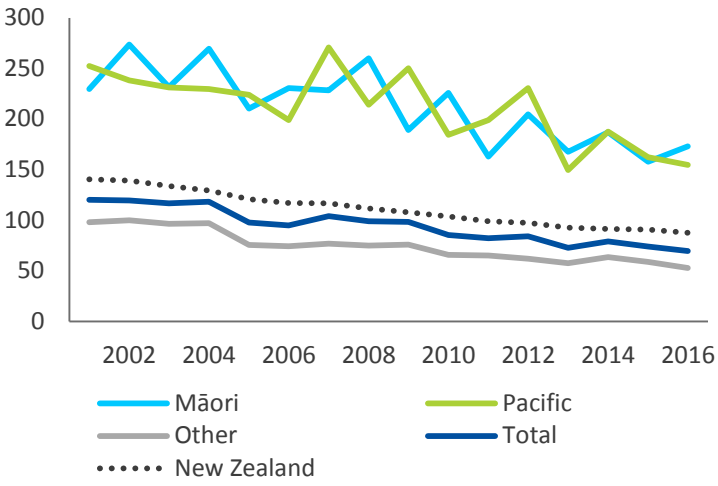
Amenable mortality rates measure the number of deaths that could be avoided through effective health prevention, detection and management interventions at an individual or population level. Amenable mortality rates are higher in Māori and Pacific people.

Fewer people die from preventable causes

OUR AMENABLE MORTALITY RATE WAS 69.6 PER 100,000 POPULATION — 5% ⬇

The rate of amenable mortality is declining and is one of the lowest in New Zealand. In 2016, it's estimated that 399 deaths (47% of all deaths in those aged under 75 years) in Auckland DHB were amenable – a rate of 69.6 deaths per 100,000 population. This exceeded our target of a 4% reduction from 2013.

MORTALITY RATE FROM CONDITIONS CONSIDERED AMENABLE, PER 100,000 POPULATION



Amenable mortality rates in Māori and Pacific are higher than other ethnicities, but are decreasing at a similar rate. The rates for Māori and Pacific are subject to fluctuation as the smaller numbers of Māori and Pacific people in our community mean any natural variation appears more obvious.

Improvement activities

Auckland DHB has the lowest daily smoking rate of any DHB, with only 11% of our adult population considered daily smokers, yet smoking remains the leading modifiable risk factor for many diseases. It is the leading cause of disparity in health outcomes, contributing to significant socioeconomic and ethnic inequalities in health.

14,195 SMOKERS (31%) RECEIVED CESSATION SUPPORT IN PRIMARY CARE — 19% ⬆

Offering cessation support is important to assist people to become smoke-free. Support includes referral to a smoking cessation programme, prescribing nicotine replacement therapy or other medicines, or providing behavioural support.

In the 15 months to June 2019, 30.6% of smokers received cessation support in primary care, exceeding our target of a ten per cent increase.

This contributory measure also sits under the babies living in smokefree homes SLM.

87% OF ELIGIBLE MĀORI HAD THEIR CVD RISK ASSESSED — 2% ⬇

Cardiovascular disease (CVD) is largely preventable through early detection and effective management.

The CVD burden weighs more heavily on Māori than other ethnicities. By identifying those at risk of CVD early, lifestyle and drug interventions can reduce the risk and severity of further disease. As at June 2019, 87% of eligible Māori had received a CVD risk assessment in the last 5 years; the coverage rate for the overall Auckland population was 91%.

Coverage rates have dropped slightly this year. This is due in part to the large numbers of people screened in 2014 (in a concerted effort to boost coverage) who are now due for re-assessment. The PHOs continue to actively work to achieve this target.

64% OF MĀORI AND PACIFIC PEOPLE WITH CVD WERE PRESCRIBED TRIPLE THERAPY MEDICATION — 8% ⬆

New Zealand guidelines recommend that, where appropriate, people who experience a heart attack or stroke should be treated with a combination of medication known as triple therapy (aspirin or another antiplatelet/ anticoagulant agent, a beta-blocker and a statin).

As at June 30 2019, 62% of all patients who had a previous CVD event were dispensed triple therapy medication (6,640 people). Rates for Pacific individually were higher than the total population at 64%, but Māori were slightly lower at 59%. Combined, there was an increase of 8% on the December 2017 baseline.

Small lifestyle changes bring big rewards

The solution to improved health often lies in simple, small lifestyle changes, and Green Prescription helps people make these changes.

What is Green Prescription (GRx)?

Being active and eating well are key to maintaining good health and a sense of wellbeing. Healthy lifestyles reduce the risk of a range of health conditions and help manage existing ones.

A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active and eat healthier, as part of the patient's overall health management. It is a smart and cost-effective way to help people stay healthy.

Sport Auckland delivers the Green Prescription programme for Auckland DHB. The initiative consists of two components: GRx (for adults) and the GRx Active Families programme, which aims to increase physical activity for children, young people and their families.

Many adult referrals for GRx are to support patients with chronic disease and long-term conditions (such as cardiovascular disease and diabetes) to better manage their conditions to improve their quality of life and prevent deterioration.

Health professionals refer patients to GRx for support to increase their physical activity and improve nutrition. GRx support staff assist patients to set achievable goals to be independently active. Participants are also supported to make healthy food choices and encouraged to attend local GRx exercise classes and education sessions. Nearly 4,000 Aucklanders participated in GRx in 2018/19.

GRx clients in action at a weekly workshop focused on strength, balance and home-based exercise

Over 100 GRx clients walked to the summit of Rangitoto with the Sport Auckland team

Support to make a change for good

Angela was in chronic pain with a frozen shoulder and limited mobility in her ankle. She found regular physical activity challenging and lacked motivation. The chronic pain and lack of mobility was impacting on Angela's mental health.

After visiting the physiotherapist at The Auckland Regional Pain Service, Angela was referred to the Sport Auckland GRx programme. Their goal was to help Angela participate in suitable activity options to increase her mobility, fitness and energy levels.

Angela met with a GRx Healthy Lifestyle Advisor and began attending two GRx exercise sessions a week along with the GRx weekly health and nutrition workshops. Angela's motivation increased and she began training at the Tamaki Recreation Centre gym several times a week, too.

Angela found the programme hugely beneficial. She is now active every day of the week and feels much more positive and energetic.

"That was my turning point, I am excelling now. The workshops have been amazing, the group association and accountability of meeting others on the same journey has been so encouraging," she says.

Using health resources effectively

The demands on New Zealand's acute care services are increasing due to our growing and ageing population, and long-term conditions like cardiovascular disease and diabetes. We need to strengthen our ability to manage acute demand and deliver more planned care in the community, rather than unplanned care in hospitals, in order to more effectively use the available health resources.

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.

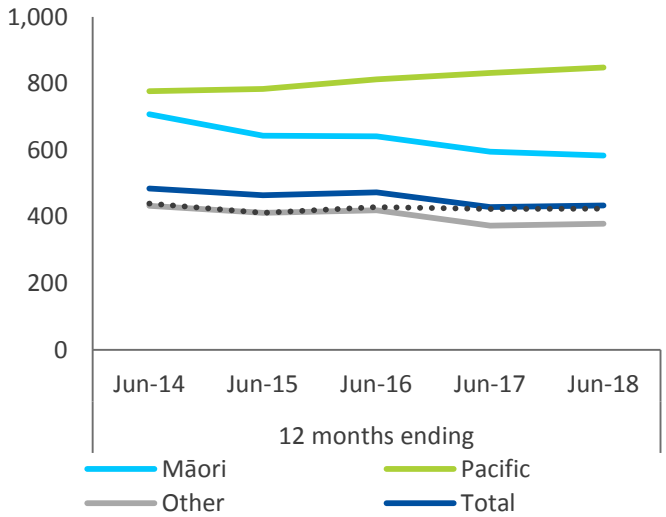
People spend less time in hospital

403 ACUTE HOSPITAL BED DAYS PER 1,000 POPULATION **0%** ⬆

Although our standardised rate of acute bed days has slowly declined since 2014, it remains higher than the national rate (403 versus 398 per 1,000 population in the 12 months to June 2019). There has been little movement from the December 2017 baseline, meaning we did not achieve our 3% target reduction.

The rate of acute bed day use is higher for Māori and Pacific people.

ACUTE HOSPITAL BED DAYS PER 1,000 POPULATION



Improvement activities

In 2018/19, we implemented targeted initiatives to improve the health status of our Māori and Pacific populations, as these groups are most likely to be admitted to hospital and focused on the prevention and treatment of conditions that contribute most to acute bed days. High priority conditions included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and cellulitis.

ASH ADMISSIONS PER 100,000 POPULATION -
196 COPD **12%** ⬆
115 CONGESTIVE HEART FAILURE **7%** ⬇

Congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) are long-term debilitating conditions that are responsible for a significant number of acute hospitalisations and overall bed days.

Both conditions can often be well managed with intensive treatment and follow-up in primary care along with patient and family education, potentially preventing the need for hospitalisation. Should hospitalisation be required, often those receiving effective management in primary care have a shorter length of stay and lower risk of readmission.

In the 12 months to June 2019, there were 196 admissions for COPD and 115 for CHF per 100,000 population (aged 45 to 64 years), which equates to 370 potentially ambulatory sensitive hospitalisations. We met our 2% reduction target for CHF admissions, but not for COPD. Auckland DHB and the Laura Fergusson Trust provide pulmonary rehabilitation to help patients manage their COPD, reducing the risk of hospitalisation.

121,946 EMERGENCY DEPARTMENT PRESENTATIONS **7%** ⬆

There were more than 120,000 attendances at our emergency departments in 2018/19, an 7% increase on 2016/17.

We have a number of programmes underway to reduce the volume of people presenting acutely to hospital, such as point-of-care testing in rural GPs, after-hours arrangements, and Primary Options for Acute Care (POAC).

5,984 PEOPLE WERE REFERRED TO PRIMARY OPTIONS FOR ACUTE CARE **18%** ⬆

Primary Options for Acute Care (POAC) is a service providing healthcare professionals access to investigations, care, or treatment for patients in the community, preventing an ED attendance and possible hospital admission, and assisting earlier discharge. PHOs worked together with the POAC team to support GPs to better utilise POAC. In 2018/19, 5,984 patients were referred to POAC. This was nearly a 20% increase on the 2016/17 baseline, but just short of our target.

Getting patients home on time

Discharge planning is a key part of hospital bed management. Poor planning puts pressure on emergency departments, theatres and wards. Good planning minimises wait times and gets patients home faster.

Unlocking the problem

With demand for beds rising 3% every year, there is a growing focus on finding ways to improve ward discharge processes.

Working with the orthopaedic wards, a team was set up to uncover the reason for delays in discharges and improvements to free up more beds. The team found that only 15% of patients suitable for discharge were being discharged by midday. The most common causes for delays in discharge were:

- Physiotherapists and Occupational Therapists unable to complete assessments in time due to difficulties planning work flow.
- Late paperwork meaning patients missed the 'window' to move safely to the Transition Lounge
- Unclear processes to transfer patients to reablement wards
- Urgent clinical tasks taking priority over discharges.

Re-thinking the approach

The multidisciplinary project team included three Charge Nurses, the Nurse Unit Manager, Physiotherapists, Occupational Therapists and an orthopaedic House Surgeon. The project team agreed the aim of the project (to improve key measures) and the process to be undertaken. They also introduced a weekly team meeting focusing on discharge planning and used a number of simple stakeholder analysis tools to understand how to involve staff.

Initially, there was limited understanding of why performance against key discharge planning measures is poor. A brainstorming session generated a range of causes and effects. A simple data collection helped to validate the key causes identified and drove the four areas of improvement.

"The work required to make the improvements was quite repetitive at first, following up with staff and reminding them to schedule patients to the Transition Lounge. Now we routinely discuss at our Daily Ward Meetings and have 'discharges before noon' as one of our targets. We eagerly await the weekly discharge report."

Staff Nurse (Orthopaedic Ward)

Changing the way we work

The team introduced afternoon huddles, a 10-minute catch-up on patient plans. These complemented morning Daily Rapid Rounds and sped up decision making that resulted in four key changes:

1. **Changing the therapist schedule:** next-day discharges were identified so the Physiotherapists changed their workflow, arriving earlier to provide quicker decisions about patients. This meant that Occupational Therapists received their information on time to complete their assessments and provide education and equipment earlier.
2. **Setting a time and sticking to it:** patients cleared for discharge to the Transition Lounge but awaiting paperwork occupied bed space needed for acute admissions or post-operative patients. Morning or afternoon huddles were invaluable to identify patients ready for discharge and could wait safely in the Transition Lounge. They were scheduled to be transferred at a set time and the team worked to it.
3. **Standardising transfer processes to reablement wards:** confusing times, handovers and inefficient communication causes delays. By introducing a standardised process, it gave staff clarity on which actions were required when.
4. **Last things put first:** historically, other clinical tasks were often prioritised over discharge tasks, regardless of clinical need. Putting discharges first improved patient flow, getting new admissions (acute and post-operative) into a ward bed sooner and patients safe for discharge home earlier.

Key improvements

By introducing these changes, at least one additional bed is now available before midday for new patients. Staff feel less stressed because processes are clearer and more efficient.

The process change for Reablement transfers was particularly popular and helpful for staff. They can handover and book an orderly to collect the patient at 1100, meaning new patients can be admitted earlier.

The improvements were positive for patients too, as survey results showed that they felt more aware and informed earlier about discharge plans and did not feel rushed or confused.

Ensuring patient-centred care

Patient experience is a good indicator of the quality of health services. Improved patient experience of care reflects better integration of health services, better access to information and more timely care. Positive patient experience is associated with adherence to recommended medication and treatments, engagement in preventive care (such as screening services and immunisations) and ability to use the health resources available effectively.

The primary care patient experience survey was developed by HQSC to provide new information about how people experience primary health care, and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. The information will be used to improve the quality of service delivery and patient safety.

11.8% OF MĀORI AND 8.4% OF PACIFIC INVITEES RESPONDED TO THE PHC PES

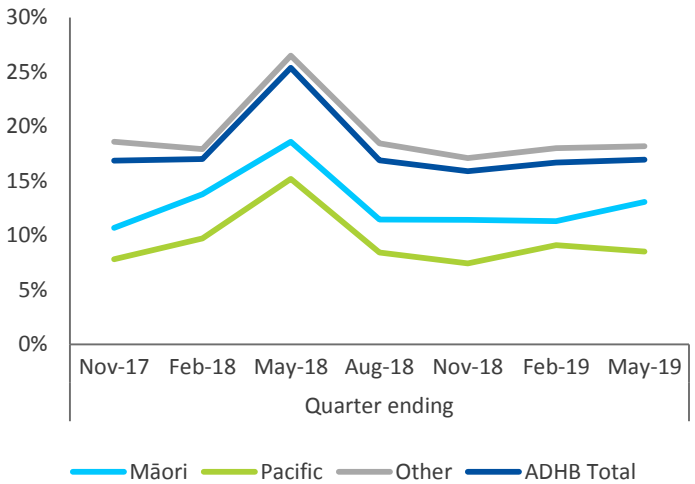
1% ↑

There is a regional focus on improving response rates to the primary care survey to ensure that the perspective of all patients can be captured and the findings from the survey can be generalised to the patient population, particularly in Māori and Pacific patients.

In 2018/19, nearly 5,000 Māori and Pacific people registered with Auckland PHOs were invited to participate in the primary care survey. Ten per cent responded, a 1% absolute increase on the baseline. The Metro Auckland DHBs collectively achieved the 2% improvement targets for Māori and Pacific with response rates of 11.2% and 8.0% respectively.

Feedback from primary care, focus groups, and research have highlighted that the electronic survey format is unlikely to engage Māori and Pacific participants. The principal reason is a preference for face-to-face discussion. Alternative ways to engage with Māori and Pacific are now being investigated.

PRIMARY CARE PATIENT EXPERIENCE SURVEY RESPONSE RATES



88% OF PHO PRACTICES ARE PARTICIPATING IN THE PHC PES

105% ↑

Participation in the PES by practices increased significantly since it was implemented in 2017 as PHOs complete the developmental work required to successfully implement the survey, including infrastructure, practice engagement, capacity building, and patient communication.

As at June 2019, 88% of all Metro Auckland practices were participating in the survey, more than double the baseline result from November 2017 (43%), and exceeding our 50% target.

24% OF PHO-ENROLLED PATIENTS HAVE LOGIN ACCESS TO A PORTAL

41% ↑

Patient e-portals are secure online sites provided by GPs where people can access their health information and interact with their general practice. Using a portal, people can better manage their own health care and patient-provider communication is improved.

At the end of June 2019, 67% of Metro Auckland practices had an online portal and 24% of all PHO-registered patients had signed up for access, exceeding our goals for the year.

WE SCORED AN AVERAGE OF 8.4/10 IN THE HQSC INPATIENT SURVEY

1% ↑

Patient experience measures are now routinely in place for hospitals. Feedback about the care received in public hospitals is a valuable indicator of how well health services are working for patients and their families.

A selection of adult patients who spent at least one night in hospital are sent an invitation via email, text or post to participate in the national survey on at least a quarterly basis. The survey covers four key domains of patient experience: communication, partnership, co-ordination and physical and emotional needs.

Our average scores improved since the survey was implemented and are similar to New Zealand as a whole. For patients treated in May 2019, our scores were: Communication 8.4; coordination 8.1; partnership 8.7; and physical and emotional needs 8.5. The average score across all four domains is 8.4.

Improving patient experience

A good patient experience is made up of four domains: Communication, coordination, partnership and physical and emotional needs. In 2018/19 we focused on helping all our patients navigate the health system and enhancing the cultural competency of our staff.

Navigation support for mental health

We are helping patients find their way through the health system and other support agencies.

The Awhi Ora – Supporting Wellbeing service began as a co-design initiative in Tāmaki in 2013. It aimed to provide a new experience of mental health and wellbeing support, based on the needs of the community. In 2018, the vision altered to widen the focus to health and wellbeing.

Awhi Ora is now provided across Auckland by seven NGOs in partnership with 27 general practices and 10 other organisations.

'Walk alongside' support helps people identify and work on the personal/practical challenges that are important to them. These needs commonly relate to physical and emotional health, problem drinking, drug use or gambling, and family and whānau, money, and housing problems.

One of the key streams of activity is the Linkage Service. This work stream provides information about, and introductions to, a wide range of appropriate support services such as health, accommodation and employment, for people with complex health and social issues.

Awhi Ora team members with the Auckland DHB Clinical Excellence award they won in 2017

Cancer and blood pharmacy hub

This new pharmacy hub provides a new service to Oncology patients, making it easier and safer for them to receive their oral chemotherapy medicines.

The hub will allow patients to choose to pick up their prescriptions at Building 8 while they wait or have them couriered directly to their home address for free.

This is an exciting move to further improve our patient-centric model of care, improve patient access to treatment, and provide safer drug dispensing.

New roles to further support Māori and Pacific health and wellbeing

We established two new positions to support two of our priority populations. One is a Māori patient and whānau experience lead, who will support staff capacity on engagement with Māori in understanding their health experience and outcomes, and work together to use feedback from traditional and non-traditional sources to develop practices to enhance engagement and experience.

The other is a Pacific equity programme director, who will identify the best way for us to improve Pacific equity in healthcare and outcomes, support our DHB leaders to build equity approaches into their work, and undertake transformative initiatives to eliminate Pacific inequity in health care practices and outcomes.

Te reo class and app for staff

Auckland and Waitematā DHBs jointly launched free te reo Māori language classes (on site at Greenlane) and a mobile app, Āke Āke, for staff. In addition to learning the language, these initiatives raise cultural awareness in the workplace and improve how staff work with Māori patients and whānau. The classes were developed in partnership with Te Whare Wānanga o Awanuiārangi and the app was developed with KIWA Digital.

Chief Advisor of Tikanga at Auckland and Waitematā DHBs, Dame Rangimarie Naida Glavish says, "We know there are inequities for Māori in our health system and barriers to treatment for some of the people who need it most. "We believe encouraging our staff to learn te reo is a move in the right direction towards bridging that gap. We are so pleased we are now able to do that in a way that is totally accessible, convenient and achievable."

Te reo classes have proved very popular with staff at Auckland DHB

Our people, our 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 seven national Health Targets.

Measuring our outputs helps us to understand how we are progressing towards our system level measure targets and overall outcome goals set out in the Improving Outcomes section of this report. The two high level health outcomes we want to achieve are an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Auckland DHB population is now 83.2 years, an increase of 2.2 years over the last decade. The life expectancy gap is 4.8 years for Māori and 8.6 years for Pacific, compared to all other ethnicities.

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.

Output class measures

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 criteria against which we measure our output performance is applied to assess progress against each indicator in the Output Measures section. A rating is not applied to demand-driven indicators.

Criteria	Rating
On target or better	Achieved
0.1-5% away from target	Substantially achieved
>5% to 10% away from target and improvement on previous year	Not achieved but progress made
>10% away from target, or >5% to 10% away from target and no improvement on previous year	Not achieved

The tables on the following pages report our output measures from the 2018/19 Statement of Performance Expectations by Output Class. 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. While for most measures, exceeding the stated target denotes improvement, for a small number of measures, a result less than the stated target denotes improvement. To distinguish the latter, we added the symbol '<' to the targets, which may not have been stated in the Statement of Performance Expectations in our 2018/19 Annual Plan.

Measure type		Target symbol	
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

Prevention services help to protect and promote health in our population. 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.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
Health promotion					
% of PHO-enrolled patients who smoke have been offered help to quit in the last 15 months (C)	92%	92%	89%	90%	
% of PHO-enrolled patients who smoke who received cessation support (Q)	27%	31%	31%	28%	
% of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking (C)	97%	97%	98%	90%	
Number of pregnant women smokers referred to the stop smoking incentive programme (Q)	n/a	93 (CY2018)	95[4]	184	
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (Q)	99%	100%	100%	95%	
Number of clients engaged with Green Prescriptions (V)	n/a	4,316 (96%)	4,398 (98%)	4,500	
Immunisation					
% of pregnant women receiving pertussis vaccination in pregnancy (C)	43%	51%	57%	50%	
Influenza vaccination coverage for children aged 0-4 years who are hospitalised for respiratory illness (C)[5]					
- Māori	6%	7%	9%[6]	15%	
- Pacific	13%	10%	12%[6]	15%	
- Total	14%	11%	17%	15%	
% of eight months olds will have their primary course of immunisation on time (C)					
- Total	95%	94%	94%	95%	
- Māori	89%	86%	84%[7]	95%	
Rate of HPV immunisation coverage (C)	81%	83%	74%	75%	
Population-based screening					
% of women aged 50-69 years having a breast cancer screen in the last 2 years (C)	64%	63%	64%	70%	
% of women aged 25-69 years having a cervical cancer screen in the last 3 years (C)	69%	65%	62%[8]	80%	
HEEADSS assessment coverage in DHB-funded school health services (C)[5]	93%	99%	90%	95%	
% of 4-year-olds receiving a B4 School Check (C)	93%	91%	89%	90%	
Proportion of newborn babies offered and received completed hearing screening within 1 month (V)	100%	97%	96%	90%	
% of people aged 15-24 years tested for chlamydia (C)	11% (Dec-17)	11%	10%[9] (Dec-18)	15%	

[4] See p11 for discussion of initiatives to improve uptake. Our 2019/20 target is reduced to 110 to reflect the lower number of women smoking when first pregnant.
[5] All results are for the calendar year prior to the end of each financial year.
[6] See p13 for comment.
[7] Nationally immunisation rates for Māori are falling. We are collaborating with PHOs to improve coverage and our Treaty partners to better engage Māori with immunisation. Co-designed posters with a Māori focus are being distributed to primary care practices. The collaboration with Plunket for an additional outreach immunisation service focusing on Māori and Pacific babies is extended to the end of 2019.
[8] We continue to see declining coverage, consistent with national declines in all ethnic groups over the past three years. We continue to work with primary health care to focus on improving screening coverage in women at greatest clinical risk.
[9] We will further monitor this apparent drop to determine whether this is a data quality issue or a real decline. While the target of 15% coverage was not achieved for the total population in Metro Auckland DHBs, it was achieved for females alone, at 18%.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
Auckland Regional Public Health Service (ARPHS)[10]					
Number of tobacco retailer compliance checks conducted (V)	316	372	432	300	●
Number of license applications and renewals (on, off club and special) received and are risk assessed (V)	3,870	2,112	4,153	Ω	N/A
% of tuberculosis (TB) and latent TB infection cases who have started treatment and have a recorded start date for treatment (Q)	94%	95%	96%	90%	●
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol (Q)	New indicator	80%	89%	85%	●

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 focus 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	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
Primary health care					
Rate of primary care enrolment (Māori) (C)	76%	76%	74%[11]	90%	●
Number of referrals to Primary Options for Acute Care (POAC) (V)	5,060	6,028	5,984	6,036	●
POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions (Q)	1.7% (Oct-16 to Sep-17)	1.8%	1.6%[12]	3.0%	●
% of people with diabetes aged 15-74 years enrolled with Auckland DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol (Q)	New indicator	62%	61%	62%	●
% of the eligible population who have had their CVD risk assessed in the last five years (Māori) (C)	89%	89%	87%	90%	●
% of Māori patients with prior CVD who are prescribed triple therapy (Q)	New indicator	58%	59%	63%	●
% of Pacific patients with prior CVD who are prescribed triple therapy (Q)	New indicator	65%	66%	66%	●
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds (Q)					
- Māori	7,017	6,936	6,880	<6,877	●
- Pacific	9,019	8,394	8,791	<8,839	●
- Chronic obstructive pulmonary disease (COPD)	175	183	196[13]	<172	●
- Congestive heart failure (CHF)	124	106	115	<122	●
% of PHO enrolled population who have login access to a portal (C)[14]	17% (CY2017)	21%	24%	20%	●
% of practices participating in Primary Care Patient Experience survey (C)[14]	43% (Dec-16 to Nov-17)	90%	88%	≥ Jun 2018 result	●
Primary Care Patient Experience survey response rate (C)					
- Māori (based on DHB of practice)	9.5%	15.2%	11.8%[15]	12.7%	●
- Pacific (based on DHB of practice)	7.4%	10.7%	8.4%[15]	9.8%	●

[10] Services are delivered by ARPHS on behalf of the three Metro Auckland DHBs. Reported results are for all three DHBs.
[11] We are collaborating with Māori health providers, primary care, PHOs and Waitematā DHB to develop a facilitated enrolment process for Māori hospital patients who are not enrolled with primary care.
[12] Result for 12 months to Mar-19. We suspect this indicator is under-reported as not all patients with ASH conditions are identifiable in primary care systems. Improvements to coding are planned. We are working with PHOs to increase POAC utilisation with a focus on high needs groups.
[13] Auckland DHB and Laura Fergusson Trust continue to provide pulmonary rehabilitation for patients with COPD, one of the most clinically effective therapies.
[14] Metro Auckland DHBs result.
[15] This is a Metro Auckland DHB measure from the 2018/19 SLM improvement plan and the regional targets (10.5% for Māori, 7.4% for Pacific) were met.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
Pharmacy					
Number of prescription items subsidised (V)	6,863,281	6,868,238	6,976,610[16]	Ω	N/A
Community-referred testing and diagnostics					
Number of radiological procedures referred by GPs to hospital (V)	26,950	28,713	31,562	Ω	N/A
Number of community laboratory tests (V)	3,155,523	3,260,656	3,386,045[16]	Ω	N/A
Oral health[17]					
% of preschool children enrolled in DHB-funded oral health services(C)	83%	91%	90%	95%	
Ratio of mean decayed, missing, filled teeth (DMFT) at Year 8 (Q)	0.75	0.64	0.65	<0.67	
% of children caries free at five years of age (Q)	60%	61%	62%	61%	
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years (C)	69%	77%	81%	85%	

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. These services include: ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventative, 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. Effective and prompt resolution of medical and surgical emergencies and acute conditions reduces mortality and elective surgery restores functional independence and improves health-related quality of life, thereby improving population health.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
Acute services					
Number of ED attendances (V)	114,473	117,019	121,946	Ω	N/A
% of ED patients discharged admitted or transferred within six hours of arrival (T)	94.9%	90.8%	91.1%	95.0%	
% of ED admissions in 10-24 year olds where alcohol-related ED presentation status is 'unknown' (Q)	New indicator	2.0%	2.8%	<10%	
% of patients who 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 (T)	85%	95%	93%	90%	
% of eligible stroke patients thrombolysed (C)	11%	12%	13%	10%	
% of ACS inpatients receiving coronary angiography within 3 days (T)	85%	90%	84%	70%	
Maternity					
Number of births in Auckland DHB hospitals (V)	7,256	6,758	6,594	Ω	N/A
Elective (inpatient/outpatient)					
Number of elective surgical discharges (V)	16,822 (98%)	17,321 (97%)	17,413[18] (95%)	18,436	
Surgical intervention rate (per 10,000 population) (C)[19]					
- Major joints	15.2	19.3	19.9	21.0	
- Cataracts	37.3	44.8	47.1	27.0	
- Cardiac surgery	5.2	5.6	5.3[20]	6.5	
- Angioplasty (PCR)	11.7	12.1	11.9	12.5	
- Angiogram	29.5	32.2	31.9[21]	34.7	
% of people receiving urgent diagnostic colonoscopy in 14 days (T)	95%	100%	95%	90%	
% of people receiving non-urgent diagnostic colonoscopy in 42 days (T)	88%	74%	59%[22]	70%	
% of patients waiting longer than four months for their first specialist assessment (ESPI 2) (T)[23]	0.3%	0.1%	0.6%[24]	0.0%	

[16] Results for 12 months to Mar-19, as Jun-19 data not available at time of publication.
[17] All results are for the calendar year prior to the end of each financial year.
[18] Industrial action was the key driver for under delivery. Additional weekend activity and outsourcing were utilised where available to mitigate shortfall.
[19] These measures are discontinued by MoH; the latest available results (12 months to Mar-19) are shown.
[20] The service experienced high complexity and volumes; the MoH upper limit was not breached and no patients waited >120 days.
[21] Patients accessing coronary angiography procedures are seen well within target wait times; there is no barrier to referral or access to the service. A review of scheduling is underway to ensure appropriate capacity to meet clinical demand for all sub-specialities.
[22] We continue to progress with our recovery plan and focus on patients waiting the longest. We expect to achieve the target in Q1-2 2019/20.
[23] Assessment of performance is based on Ministry of Health criteria.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
% of accepted referrals receiving their scan within 6 weeks (T)					
- CT	95%	93%	93%	95%	
- MRI	66%	68%	71%[25]	90%	
Quality and patient safety					
% of opportunities for hand hygiene taken (Q)	84%	86%	86%	80%	
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days (Q)	0.21	0.21	0.26[26]	<0.11	
% of falls risk patients who received individualised care plan (Q)	94%	94%	79%[27]	90%	
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions (Q)	10.8	3.9	9.5[28]	<8.4	
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision (Q)	97%	97%	98%[29]	100%	
% of hip and knee procedures given right antibiotic in right dose (Q)	97%	96%	97%[29]	95%	
Surgical site infections per 100 hip and knee operations (Q)	0.5	0.8	1.49[29,30]	<0.93	
Mental health					
Percentage of population who access mental health services (C)					
- Age 0–19 years	3.4%	3.9%	3.2%[31]	3.4%	
- Age 20–64 years	3.6%	3.6%	3.6%	3.7%	
- Age 65+ years	3.0%	3.0%	2.8%[31]	3.2%	
% of 0-19 year old clients seen within 3 weeks (T)					
- Mental Health	73%	68%	66%[32]	80%	
- Addictions	96%	95%	82%[32]	95%	
% of 0-19 year old clients seen within 8 weeks (T)					
- Mental Health	89%	89%	94%	80%	
- Addictions	100%	98%	100%	95%	

[24] Industrial action was the key driver for under delivery. We achieved the yellow level of compliance in eight months of the year.
[25] Increased acute volumes added pressure to our available capacity; high numbers of staff vacancies also contribute to reduced capacity. We are continuing with outsourcing and additional evening sessions until newly appointed staff are appropriately trained.
[26] Result for 11 months to May-19 as Jun-19 not available at the time of publication. We provide care for the most complex cases in New Zealand which is reflected in our rate. Ongoing work to reduce these events include quality improvements to reduce peripheral intravascular line-related infections and using an intervention bundle to reduce surgical site infections in adult cardiac surgery. We will review the 2019/20 target in place of using the national medium.
[27] The decreased performance (63% in Q2 and 67% in Q3 vs. 92% in Q1) is attributed to a complex paper-based tool used for data collection, which is being replaced by electronic audits. Our Q4 result is back to compliance at 90%.
[28] Our rate is congruent with previous years dating back to 2014/15 (the 2017/18 result appears to be anomalous); our number of fracture falls have steadily decreased since 2014/15. We remain focused on reducing the number of patients experiencing this harm, including those with fractured neck of femur.
[29] Result for Q1-3 as Q4 not available at the time of publication.
[30] A number of outsourced procedures are not included in the data provided to HQSC and reported here. We are in the process of capturing this data.
[31] The number of unique patients seen increased between Jun-18 and Jun-19 in all age groups, however the large increase in the 2019 population estimate resulted in an apparent reduction in the proportion of the population seen. Release of the 2018 Census data should rectify this issue.
[32] We experienced increased demand due to a winter surge in referrals and reduced workforce capacity due to national industrial action which impacted wait times.

Output Class 4: Rehabilitation and Support Services

Rehabilitation and support are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for services including palliative care, home-based support and 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 make a major contribution to enabling people to live at home for longer, improving their well-being and reducing the burden of institutional care costs on the health system.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
Home-based support					
% of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI) (Q)	97%	97%	94%[33]	95%	●
Palliative care					
Proportion of hospice patient deaths that occur at home (Q)	26%	24%	21%[34]	↑	●
% of patients acutely referred who waited >48h for a hospice bed (T)	4%	2%	2%	<4%	●
Residential care					
ARC bed days (V)	960,259	931,284	952,854	Ω	N/A

[33] Result 12 months to Mar-19 as Jun-19 data not available at time of publication.

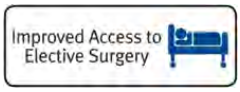
[34] The quarterly results for this measure fall between 21% and 24% in 2017/18 and 2018/19 (19% for Q4 2018/19). The target for this measure was set on the assumption that patients with palliative care needs prefer to die at their normal place of residence. We plan to investigate the value of this measure in 2019/20.

Cost of Service Statement – for year ended 30 June 2019

Summary of revenues and expenses by output class	Actual 2019 $000	Budget 2019 $000
Prevention		
Total revenue	25,702	24,916
Total expenditure	29,538	29,696
Net surplus/(deficit)	(6,086)	(4,780)
Early detection		
Total revenue	481,623	456,922
Total expenditure	412,836	426,125
Net surplus/(deficit)	68,787	30,797
Intensive assessment and treatment		
Total revenue	1,584,644	1,571,925
Total expenditure	1,874,528	1,600,394
Net surplus/(deficit)	(289,884)	(28,469)
Rehabilitation and support		
Total revenue	249,901	249,032
Total expenditure	254,685	246,580
Net surplus/(deficit)	(4,784)	2,452
Overall		
Total revenue	2,341,870	2,302,795
Total expenditure	2,573,837	2,302,795
Consolidated surplus/(deficit)	(231,967)	0

Health targets

2018/19 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 each quarter's and full year performance, where relevant. In quarter four, we achieved three of the seven Health Targets.

Health Targets		2018/19 Q1	Q2	Q3	Q4	Full year
	95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours	89%	91%	93%	90%	91%
	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs), target = 18,436	86% (4,038)	93% (8,601)	93% (12,702)	95% (17,413)	95% (17,413)
	90% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment	95%	93%	92%	94%	93%
	95% of eight months olds will have their primary course of immunisation on time	95%	95%	94%	93%	94%
	90% seen in primary care provided with advice to help quit	89%	88%	87%	89%	89%
	90% of newly registered pregnant women provided with advice to help quit	100%	98%	97%	96%	98%
	95% of obese children identified in the B4SC programme will be offered a referral to a health professional	100%	100%	100%	100%	100%

Health Quality and Safety Commission Markers

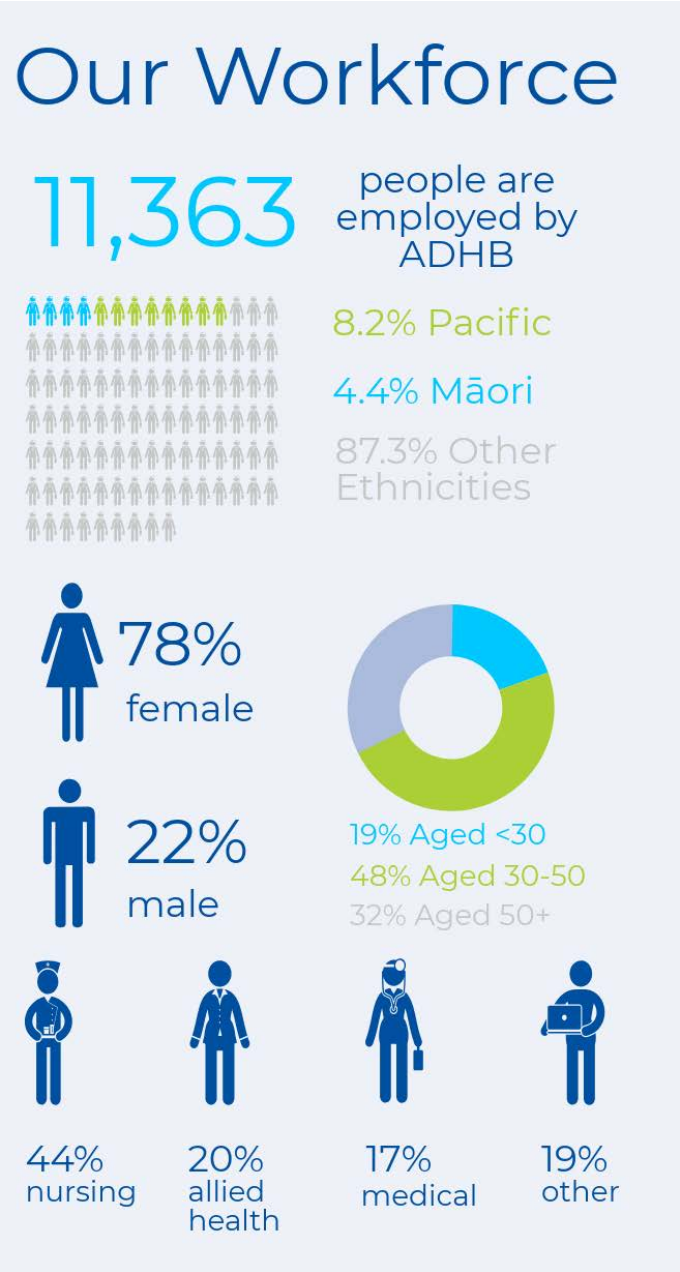
The Quality and Safety Markers (QSMs) are used by the Health Quality and Safety Commission to evaluate the success of its national patient safety campaign, Open for better care, and determine whether the desired changes in practice and reductions in harm and cost have occurred. During 2018/19, we improved or maintained our compliance across most of the HQSM markers, as shown below.

Health Quality and Safety markers	Q4 2017/18	Q4 2018/19
80% compliance with good hand hygiene practice	85%	86%
90% of older patients assessed for risk of falling	85%	89%
% of patients assessed at risk of falling who received an individualised care plan	92%	90%
100% of hip and knee arthroplasty primary procedures given antibiotic in right time[35]	100%	98%
95% of hip and knee arthroplasty procedures given right antibiotic in right dose[35]	96%	96%
95% of audits of surgical safety checklist engagement score levels of 5 or higher	Sign in: 95% Time out: 95% Sign out: 89%	Sign in: 99% Time out: 92% Sign out: 95%

[35] Q3 result for both 2017/18 and 2018/19 years.

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*



Auckland DHB is committed to meeting its statutory, legal and ethical obligations to be a good employer, including providing equal employment opportunities at all ages and stages of our employees' careers. This is supported by policy and our good employer practices relating to the life cycle and work conditions of all employees.

We strive to:

- Recognise the aims, aspirations, cultural differences and employment requirements of our 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 people with disabilities
- Provide opportunities for individual employee development and career advancement.

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

Leadership, Accountability and Culture

We believe a high performance organisation begins with culture. An employee engagement survey to track the baseline set in 2016 was conducted in late 2018. We value and encourage employees' views and ideas, and this allows employees to review and improve their workplace and team environment. There is 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. We have built on these with a culture initiative to hear and voice the success stories of our people through one-to-one interviews, focus groups, walk-through galleries, drop-in centres or an organisation-wide survey.

In August 2018 we introduced our book, Te tino o mātou – *Us at our best*, which has been inspired by the stories our people shared to describe how we are and when we are at our best with each other.

Auckland DHB champions clinician leadership, with accountability for directorates held by a Director, in most cases a clinician. Our leadership development programme was extended in 2018 from the original 150 clinical leaders to a further 150. The Management Development Programme has now become a full programme, with 8 of a proposed 14 core management modules delivered in 2019 and the remaining continuing to be developed. This programme is available to all DHBs via the Ko Awatea LEARN online platform. The learnHR series to educate managers on HR process and practice sees over 150 managers attending every month.

A panel of coaches and a defined selection process is now available for all people leaders to source and connect with an executive coach for their development.

The culture at Auckland DHB demonstrates care for all our people. The Organisational Development Practice Leader - Supportive Employment role was created in 2018. The role's focus is to develop support mechanisms for higher need employee groups including those with disabilities, mental health needs, lower incomes and young people.

Our 'To Thrive' programme is a series of initiatives to specifically support our lower income employees to maximise their career pathways and financial understanding and improve their health and wellbeing.

The launch of the To Thrive programme in mid-2018. Our cleaners and orderlies were the first group to take part, benefitting from free health checks, allowances for shoes and laundry and the opportunity to learn new skills and develop career pathways.

This work develops our push for equity by:

- Increasing our Māori and Pacific workforce to better reflect the communities we serve
- Helping raise the number of opportunities for our Māori and Pacific employees
- Helping prevent our own employees falling into poverty and potentially ill health
- Supporting our employees dealing with mental health issues
- Enhancing our reputation as an employer committed to greater social responsibility
- Providing equitable, fulfilling employment opportunities for our disabled people

At Auckland DHB we celebrate the rich diversity we have in our team and valuing inclusion is part of who we are. Auckland DHB received the Rainbow Tick in December 2018, the first DHB to do so. The Tick provides a set of criteria to measure ourselves against and ensures we continually improve our processes, environment and culture.

Celebrating our Rainbow Tick certification

In December 2018, Auckland DHB became one of the first organisations in New Zealand to be awarded the Accessibility Tick — a programme helping employers be part of the solution in creating a more accessible and inclusive New Zealand for people with disabilities. 0.2% of our staff have declared that they have a disability.

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 Children's Act questions.

We are committed to a diverse workforce and encourage applications from Māori and Pacific communities. We support the mandatory shortlisting of all eligible Māori and Pacific candidates, whatever the role. In some areas, we are seeing 100% shortlisting of Māori and Pacific candidates. Plans are in place to conduct a review for Māori recruitment outcomes in order to help understand how to gain further improvement.

An automated orientation and on boarding process was introduced in 2018. Navigate - Kai Arahi welcomes new employees to Auckland DHB, with an expo showing what we offer to care for our people, help them settle in and feel part

of our community. 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 facilitates Māori and Pacific student recruitment and retention in secondary school, tertiary education, and transition into the health workforce. It has been expanded to include the business side of health for non-clinical roles.

A+ Trust Scholarships are available for Māori and Pacific students undertaking their first tertiary qualification in health.

Employee Development, Promotion and Exit

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

- A centralised tool on our employee Kiosk hosts the tracking of regular performance and development progress and support needs.
- A range of internal training programmes are provided.
- Senior Medical Officers are able to take sabbatical leave to strengthen clinical knowledge or skills or undertake a course of study or research.
- The Pacific Nurse Educator provides clinical support, supervision and mentorship for our Pacific nursing students and new graduates.
- We have an Associate Nurse Director responsible for the development of the Māori nursing and midwifery workforce.
- The ANIVA Nursing Leadership programme funds 3-5 Pacific nurses annually to complete post–graduate programmes in leadership.
- A new process for exit interviews and surveys was introduced in 2019 with quarterly reports due to become available which will provide more useful feedback for the organisation.

Flexibility and Work Design

The DHB offers flexible rostering practices, subject to clinical requirements, and this is demonstrated by our large part time workforce. An automated rostering system is being introduced to simplify rosters for managers. A nursing FTE management tool has proven to be valuable in improving recruitment forecasting. A staff crèche/early learning centre is provided on each of the two major sites.

Remuneration, Recognition and Conditions

Auckland DHB recognises the valuable contribution our employees make to patient care through recognition programmes and/or awards:

- Our 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 recognise the quality of achievement from our nurses and midwives
- 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
- Annual profession-specific recognition events are now held for Nursing and Midwifery, and Allied Health Scientific and Technical employees respectively
- Long service awards and tributes to retiring staff in NOVA.

There is an increased uptake of a highly subsidised gym membership rate for 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. Annual review of IEA (Individual Employment Agreement) remuneration is based on external market data and employee performance. Job size evaluation methods meet the NZ standard for gender neutrality.

Harassment and Bullying Prevention

The Speak Up - Kaua ē patu wairua (do not offend my spirit or my soul) programme, designed to support all employees to speak up when they experience, witness or are accused of bullying, discrimination or harassment goes from strength to strength. A 40-strong group of Speak Up supporters known as ‘Navigators’ help victims and accused alike to navigate and be supported appropriately through a complaint. The programme and the Navigator group are both clinician led.

Safe and Healthy Environment

Our Security for Safety programme ensures employees are safe and secure at work, with work streams focusing on all aspects of safe working, from security ID, Lone Worker initiatives, CCTV to a culture of keeping self and colleagues safe, including online training.

A Wellbeing Steering Group manages the numerous initiatives that sit under the banner of wellbeing. These include a Mindfulness-Based Stress Reduction programme in Mental Health Services, and the World Health Organisation’s Five Ways to Wellbeing, a kindness and compassion programme under which Auckland DHB has become Australasia’s first Schwartz Centre hospital.

The Accessibility Tick acknowledges our efforts to make our work place more accessible and inclusive for people with disabilities.

Sustainability

Auckland DHB made significant strides towards its commitment to reduce greenhouse gas emissions and transition towards a low-carbon organisation.

Our sustainability strategy is closely aligned with the UN Sustainable Development Goals (SDGs), moving from a focus of carbon mitigation and reduction to a wider focus on sustainability that provides quality healthcare and mitigates the effects of climate change. We are currently undertaking an SDG alignment project with stakeholder engagement to identify priority SDGs.

Our efforts resulted in an absolute reduction in emissions of 28% against the 2015 baseline, certified as part of the Carbon Emissions Management and Reduction Scheme (CEMARS).

A special environmental event was held to formally receive our CEMARS certification

We are one of the top 200 energy users in New Zealand. In partnership with Energy Efficiency and Conservation Authority (EECA), we reduced our energy consumption by 36% since it started measuring carbon emissions with Enviro-Mark Solutions in 2015.

These reductions are attributed to projects in the Energy 50/50 strategy to cut energy use in half and produce 50% on-site renewable energy requirements by 2030.

Highlights of Energy 50/50 include:

- 1,160 LED lights fittings or lamps were upgraded, resulting in reduced energy by approximately 64,000 kWh
- PC sleep software installed on almost 4,000 computers, equating to energy savings of approximately 554,000 kWh per year
- Starship patient lift upgraded with energy-efficient motors
- Air Handling Unit (AHU) optimisation to improve efficiency of the unit and controls
- Kids Domain lighting conversion with LEDs
- Additional energy monitoring systems to capture all energy usage at Grafton.

The energy programme and savings were recognised by the EECA Business Awards 2018 with a commendation. At the NZI Sustainable Business Network awards, we were finalists in four categories, gaining commendation for Efficiency Champion.

In November 2018, Auckland DHB successfully bid for funding from the Waste Minimisation Fund of $78,000 for additional recycling tri-bins. This project is now underway to purchase 120 recycling tri-bins.

A food waste pilot for composting commenced in January 2019. This revealed large volumes of patient plate and food preparation waste. To date, almost 22,000kg of food waste has been sent to the local composting plant at Tuakau. Previously, this waste was macerated into the waste water stream.

In partnership with Johnson & Johnson (J&J), we concluded a single use surgical instruments recycling pilot on Level 8 operating rooms and birthing suites. This came about when J&J were challenged by an Auckland DHB clinician to find a sustainable solution for single-use medical devices. It was determined that metal and plastic can be separated and the materials recycled locally.

Some of the 800kg of surgical instruments recycled

We are proud of our efforts so far, but are committed to going even further so that Auckland DHB can be a leader in sustainable healthcare in New Zealand.

Recycle Week was held in October, with a theme of recycle, reuse and reduce waste. Waste Management was one of the key stakeholders who participating with an information stand.

Auckland DHB Board members

Current Board members


Pat Snedden, Chair


Michelle Atkinson


Robyn Northey


Gwen Tepania-Palmer


Zoe Brownlie


Sharon Shea


Jo Agnew


Dr Lee Mathias ONZM


Judith Bassett QSO


Douglas Armstrong QSO

Note: Penelope Ginnen served as Deputy Board Chair from 19 October 2018 until 3 July 2019

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 2018/19 year there were no permissions, waivers or modifications given under the clauses of this legislation.

Subsidiaries, associates and joint ventures

Auckland DHB has two independent charitable trusts that are consolidated into the DHB Group financial statements, i.e. Auckland DHB Charitable Trust (A+ Trust) and Auckland Health Foundation. The DHB is also a shareholder in a number of Crown Entities: healthAlliance N.Z. Limited (owned by Auckland, Waitematā, Counties Manukau and Northland DHBs, each with a 25% A Class Shareholding); Northern Regional Alliance Limited (owned equally by Auckland, Waitematā and Counties Manukau DHBs); and New Zealand Health Innovation Hub Management Limited (equal limited partners are Auckland, Waitematā, Counties Manukau and Canterbury DHBs). Post balance date, Auckland DHB transferred its shares in the Health Innovation Hub to Canterbury DHB for $1 on 1 July 2019).

Ministerial directions

Directions issued by a Minister during the 2018/19 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 2018/19 appropriations is detailed below.

Appropriations allocated and scope

This appropriation is limited to personal and public health services and management outputs from Auckland DHB.

What is intended to be achieved with this appropriation?

This appropriation is intended to achieve services provided by the DHB that align with: 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

Each DHB has a statutory responsibility to prepare:

- an Annual Plan for approval by the Minister of Health (Section 38 of the New Zealand Public Health and Disability Act 2000) - providing accountability to the Minister of Health
- a Statement of Performance Expectations (Section 149C of the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013) - providing financial accountability to Parliament and the public annually
- a Statement of Intent (Section 139 of the Crown Entities Act) - providing accountability to Parliament and the public at least triennially.

These documents are brought together into a single DHB Annual Plan with the Statement of Intent and Statement of Performance Expectations, and are known as the 'Annual Plan'.

The Statement of Performance Expectations provides specific measures/targets for the coming year, with comparative prior year and current year forecast (at a minimum).

Four Output Classes are used by all DHBs to reflect the nature of services provided:

- Prevention
- Early Detection and Management
- Intensive Assessment and Treatment
- Rehabilitation and Support.

Amount of appropriations

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.

	2017/18		2018/19	
	Final budgeted $000	Actual $000	Budget $000	Actual $000
Original appropriation	1,239,980	1,239,980	1,320,417	1,320,417
Supplementary estimates	-	12,101		9,772
Total appropriation revenue	1,239,980	1,252,081	1,320,417	1,330,189

Introduction

The performance of Auckland DHB's assets, in particular our critical assets, is critical to our ability to provide sustainable and high quality health services. Some of our assets are of strategic importance to New Zealand, as we are a major tertiary services provider and a provider of last resort of specific specialist health services for the country. Measuring the actual performance of our critical assets against our target expectations helps to identify and manage asset-related risks and enable effective planning and timely implementation of capacity step increases needed to continue meeting the growth in service demand.

Auckland DHB is designated a Tier 1 entity for the purposes of the Investor Confidence Rating (ICR) implemented by Treasury in 2016 in response to the Cabinet Circular C0(15) 5: *investment Management and Asset Performance in the State Services*. The Circular gives effect to Cabinet's intention that there is active stewardship of government resources and strong alignment between individual investments and the government's long-term priorities. In line with Cabinet's intentions, Auckland DHB is required to report annually on the performance of its significant asset portfolios, which compromise Property, Clinical Equipment and Information Communication Technology (ICT).

Managing our assets is one of the core functions of managing Auckland DHB's business. We have a comprehensive asset management system improvement programme to continuously increase our asset management maturity. We periodically review and update our 10-year Asset Management Plan, which describes the assets we currently use (owned and leased), their condition, utilisation, functionality, any risks associated with them, the major maintenance programmes, plans for refurbishments, upgrades or renewal of these assets and associated costs.

The 20-year Northern Region Long Term Investment Plan (NRLTIP) outlines the additional capacity required in our assets to meet the projected future demand for health services. The plan outlines key investments required to address asset condition, quality, compliance issues and risks, increase capacity and improve technology. Asset performance measures enable us to monitor effectiveness and adequacy of our assets in delivering expected levels of service and to allow for timely upgrades and/or replacement.

Auckland DHB's Asset Portfolios

Auckland DHB's main asset portfolios and their purpose, capacity and values are summarised below.

Asset portfolio, description and purpose	Capacity
Property Book Value 30 June 2019 - $977m (2018 - $906m). Replacement Cost (Indicative) $2.4 billion. The performance of our property portfolio is a key enabler for the: efficient movement of people through our campuses and buildings; sustained delivery and quality of our water, electricity, steam, heating, cooling, ventilation, fresh air, lighting and medical gasses; control and management of infections. It is important that our infrastructure, buildings, plant and services comply with relevant legislation and regulations, meet accreditation requirements, are fit for purpose and are properly maintained. Well maintained and performing facilities translates to improved patient care and shorter days stayed in hospital for our patients.	Includes land, infrastructure, buildings and related plant and services, mainly located at Auckland City Hospital, Starship Children's Hospital, Greenlane Clinical Centre and Point Chevalier. These facilities currently deliver the following capacity: • 1,173 inpatient beds, including ICU, HDU, CCU, PICU and maternity; • 42 surgical theatres, 25 procedure rooms and 100 day bed/chairs; • 110 Emergency Department beds/trolleys and treatment rooms; • 143 mental health beds; • Cancer: 80 chemotherapy beds/chairs, 1 brachytherapy; • Renal: 5 dialysis units; • 12 dental clinics; • 37 community-based properties leased by Auckland DHB. **Key infrastructure:** includes main site incomers for gas and electricity, site HV electrical rings, site steam and hot water networks, site services tunnels and plant rooms, and site water bores. **Key plant:** includes gas boilers, cogeneration plant, central plant chillers and cooling towers, and emergency power generators. **Key building services:** includes domestic hot and cold water and waste water networks, fire protection systems, medical gas reticulation, heating, ventilation and air-conditioning systems, and electrical networks.

Asset portfolio, description and purpose	Capacity
Clinical equipment Book Value 30 June 2019 - $79m (2018 - $83m). Replacement Cost (Indicative) $279m. Clinical equipment is a key enabler for: patient care and comfort; timely interventions, quality analysis and diagnostics and, surgical procedures Most of the clinical equipment (87%) is maintained in-house by our resident clinical engineering team with the balance under external maintenance agreements. All equipment is managed under a preventative maintenance programme of regular inspections and testing. Equipment is maintained to a high standard to meet our own internal clinical quality standards and also to ensure they fully comply with national electrical, radiation safety regulations.	Clinical Equipment includes a wide range of equipment fleets and single item assets. Auckland DHB is also a provider of last resort with specialist services and equipment not used in other DHBs, e.g. national organ transplants, paediatric services. Our clinical equipment includes: • 6 linear accelerators (LINACs) • 4 MRIs • 6 CT scanners • 95 ultrasounds • 102 x-ray machines • 120 ventilators • 700+ patient physiological monitors. There are more than 29,000 items of clinical equipment in our asset management information systems.
Information Communications Technology (ICT) Book Value 30 June 2019 - $4m (2018 - $3m). Replacement Cost (Indicative) $10m. ICT is a key enabler supporting both the clinical service delivery to our patients and the non-clinical aspects of running a hospital. 24/7 availability, accessibility and functionality of critical clinical applications and information systems is a key priority for our staff. Fast, reliable and quality information facilitates timely decision making which also translates to improved patient care and shorter days stayed in hospital for our patients.	There are over 10,000 ICT users at Auckland DHB and in total 26,000 healthcare workers over the northern region who are all supported by healthAlliance (our shared service agent). The majority of our ICT assets are owned and managed by healthAlliance and are not included in the book or replacement values shown here. Auckland DHB ICT assets which form part of the book and replacement values include: • clinical and business applications • hard wired and Wi-Fi networking infrastructure • IT devices.

Auckland DHB also has other assets not included above, which are less significant in value and criticality but play an important role in our service delivery, e.g. vehicle fleet of 343, including 10 special purpose vehicles.

Property Asset Performance

Auckland DHB has a range of buildings on its campuses, some dating back to the late 1800s. The age and condition of the DHB's critical infrastructure, plant, building services and some buildings was previously identified as a major risk to the continuity of our services. We are currently implementing Tranche 1 of 5 of the Facilities Infrastructure Remediation Programme (FIRP) for renewing our aged critical infrastructure (planned to take 10 years to complete).

The FIRP programme will provide the renewed infrastructure and resilience in our building plant and services systems, which is needed to allow for any new development on our two hospital campuses, Auckland City and Greenlane. This critical programme of works will enable Auckland DHB to provide for the wellbeing of future generations. Asset Performance Measures are provided below, including comparatives.

Measure	Indicator	2018/19 target	2018/19 target	2017/18 target	2017/18 actual
Building floor space utilised versus total floor space available % of floor space utilised in buildings on all campuses versus total space available in buildings on all campuses (space is identified in Asset Revaluation reports).	Utilisation	85%	97%	85%	96%
Building condition grading measured by floor space % of campus floor space graded as Average to Very Good to total campus floor space. Condition Grading levels are: Very Poor, Poor, Average, Good and Very Good; refer to comments in opening paragraph.	Condition	85%	67%	85%	65%
Building condition grading measured by meeting building compliance requirements % of Buildings used with valid Building Warrant of Fitness (BWOF) to total buildings in the portfolio. BWOF is a compliance requirement.	Condition	100%	100%	100%	100%
Seismic compliance % of floor space assessed as being earthquake prone (i.e. 33% or less of New Building Strength (NBS)).	Condition	0%	1.4%[36]	0%	1.4%
Building Functionality grading measured by floor space % of buildings (by floor space) graded as Moderate to Full functionality. Functionality Grading levels are: Unfit, Partial, Moderate, Good and Full.	Functionality	65%	68%	65%	67%

[36] An expert assessment completed in 1999 identified 10 buildings with seismic issues, 7 of these have since been demolished, two are not occupied, and planning is in progress to vacate and demolish the remaining occupied building 7 at Auckland City Hospital.

ICT Asset Performance

healthAlliance owns, manages and maintains the Northern Region ICT assets. In 2018, the Information Systems Strategic Plan (ISSP) was released as part of the NRLTIP and this identifies the ICT investment plan, which includes a strategic project prioritised for the Auckland DHB Hospital Administration Replacement System (HARP); a business case is being developed.

The regional ICT portfolio asset performance measures were extended to a more detailed level and there are now 17 measures (which include eight availability performance measures) that are documented in the 2017/18 Service Level Agreement (SLA) between healthAlliance and DHBs. The performance measures are reported to DHB management and Board every monthly and quarterly, respectively.

The agreed Condition, Functionality and Utilisation measures are presented in the table below. Actuals are an average of the four quarters, except where noted. Comparatives are provided where the same measure was used in the prior year and not applicable (N/A) denotes where prior year measures were changed.

Asset performance measure and description	Indicator	2018/19 target	2018/19 actual	2017/18 target	2017/18 actual
% of devices compliant with asset age replacement policy >75% of devices are within the DHB asset age replacement policy.	Condition	>75%	75.33%	N/A	N/A
% of SOEs compliant with security update policy >80% of EUD have signature updates that are <30 days as at the end of the quarter.	Condition	>80%	99.09%	N/A	N/A
% of apps with installed version no older than n-1 >55% of apps with installed version no older than n-1 across 'Top 55' (Critical Tier) apps.	Condition	>55%	58%	N/A	N/A
Number of SLA breaches ('service interruptions') recorded against application asset over a 12-month period >80% of 'Top 55' apps did not experience 2 or more SLA breaches over the last 12 months.	Condition	>80%	99.99%	N/A	N/A
Number of Apps Is asset architected for redundancy or resiliency >30% of 'Top 55' apps are deployed compliant with TIER 1 architecture guidelines.	Functionality	>30%	17.62%[37]	N/A	N/A
Number of Apps Is asset supportable under TIER 1 SLA guidelines >30% of 'Top 55' apps can be supported under TIER 1 SLA guidelines.	Functionality	>30%	37.58%	N/A	N/A
% of Windows systems checked and patched, across all PROD and non-PROD environments. >75% of technology platforms is patched to 13 weeks or less.	Condition	>75%	100%	75%	100%
Number of SLA breaches ('service interruptions') recorded against application asset over a 12-month period An average of <20 unplanned service interruptions.	Condition	<20%	3.11	N/A	N/A
% staff have accessed clinical/non-clinical system platforms remotely >35% of users have accessed citrix/remote platform in the last 12 months.	Utilisation	>35%	40.51%	N/A	N/A

[37] Out of the regional 'Top 55' apps, Auckland DHB has 28, of which five are deployed compliant with Tier 1 architecture.

Clinical Equipment Asset Performance

Auckland DHB implemented the nationally developed clinical equipment criticality and asset performance measures framework in its asset management system in 2018/19. This will be validated by services for full adoption in 2019/20. The framework will improve the ability to review and compare all assets at a glance and will assist in prioritising our replacement planning at an enterprise level across this portfolio. The following asset performance measures apply to critical clinical equipment items in our Cancer and Blood and Radiology Services. Comparatives are provided where the same measure was used in the prior year and not applicable (N/A) denotes where prior year measures were changed.

Asset performance measure and description	Indicator	2018/19 target	2018/19 actual	2017/18 target	2017/18 actual
LINAC fleet: maintenance hours Number of units needing a sustained increase in maintenance hours.	Condition	0	0	0	0
LINAC fleet: performance against Auckland DHB equipment specifications for patient treatment LINAC fleet to pass the comprehensive QA programme and be operable for work for ≥98% of the planned treatment hours.	Functionality	98%	97%[38]	99%	100
LINAC fleet: performance against physical capacity of the fleet LINAC fleet % of total downtime hours ≤13% of the operable hours.	Utilisation	13%	2.8%	N/A	N/A
MRI fleet: average condition grading using Auckland DHB criteria MRI scanner fleet condition graded as ≤3 on a scale of 1-10 (1 = best; 10 = worst).	Condition	3	6.3	6	6
MRI fleet: average functionality grading using Auckland DHB criteria MRI scanners fleet functionality (fit for purpose) graded ≤2.5 on a scale of 1-5 (1 = new; 2 = operationally sound; 3 = old technology; 4 =discontinued; 5 =obsolete).	Functionality	2.5	2.7	3	3
MRI fleet: total fleet unplanned downtime for the MRI scanner portfolio <25.6 hours (1%) of operable hours are spent on unplanned maintenance.	Utilisation	26hrs	8hrs	N/A	N/A
CT scanner fleet: average condition grading using Auckland DHB criteria CT scanners fleet condition graded as <3 on a scale of 1-10 (1 = best; 10 = worst).	Condition	3	5.8	6	5
CT scanner fleet: average functionality grading using Auckland DHB criteria CT scanner fleet functionality (fit for purpose) graded as ≤2.5 on a scale of 1-5 (1 = new; 2 = operationally sound; 3 = old technology; 4 =discontinued; 5 =obsolete).	Functionality	2.5	2.8	3	3
CT scanner fleet: total fleet unplanned downtime for the CT scanner portfolio <34.6 hours (1%) of operable hours are spent on unplanned maintenance**.**	Utilisation	35hrs	120hrs[39]	N/A	N/A

[38] The two new LINACs in 2018 are new technology for the department and had some teething issues. The expectation is that these units now meet or exceed the downtime specification; the service contract contains a penalty clause should the specification not be met.

[39] The excessive maintenance hours relates predominantly to the CT scanner located in the Emergency Department. The scanner runs 24/7, is 8 years old, at the end of its life and is prioritised for replacement as soon as possible.

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 2019.

Signed on behalf of the Board:

Pat Snedden

Chair

Dated: 31 October 2019

Gwen Tepania-Palmer

Board Member

Dated: 31 October 2019

Statement of comprehensive revenue and expense for the year ended 30 June 2019

	Notes	Group			Parent		
		Budget 2019 $000	Actual 2019 $000	Actual 2018 $000	Budget 2019 $000	Actual 2019 $000	Actual 2018 $000
Revenue							
Patient care revenue	2i	2,228,977	2,263,859	2,121,626	2,228,977	2,263,859	2,121,626
Interest Revenue		5,446	5,867	5,761	4,511	5,303	5,193
Other revenue	2ii	68,372	71,745	66,272	70,260	70,968	65,803
Total revenue		**2,302,795**	**2,341,471**	**2,193,659**	**2,303,748**	**2,340,130**	**2,192,622**
Expenses							
Personnel costs	3	1,026,473	1,268,450	962,102	1,026,475	1,267,898	962,102
Depreciation and amortisation costs	13,14	46,925	47,968	47,565	46,925	47,968	47,565
Outsourced services		123,354	141,366	128,030	123,354	141,366	128,030
Clinical Supplies		258,836	281,287	254,485	258,851	281,287	254,485
Infrastructure and non-clinical expenses		78,254	82,328	76,040	78,252	82,265	76,037
Other district health boards		106,766	100,167	103,218	106,766	100,167	103,218
Non-health board provider expenses		563,120	546,962	513,804	563,120	546,962	513,804
Capital charge	4	54,846	54,278	55,406	54,846	54,278	55,406
Interest expense		1,200	410	0	1,200	410	0
Other expenses	5	43,021	50,621	51,849	44,379	50,552	51,564
Total expenses		**2,302,795**	**2,573,837**	**2,192,499**	**2,304,168**	**2,573,153**	**2,192,211**
Share of surplus of associate and joint venture surplus/(deficit)	15	0	399	(147)	0	0	0
Surplus/(deficit)		**0**	**(231,967)**	**1,013**	**(420)**	**(233,023)**	**411**
Other comprehensive revenue and expense							
Item that will not be reclassified to surplus/(deficit)							
Gains/(Losses) on property revaluations	20	0	83,512	0	0	83,512	0
Total other comprehensive revenue and expense		0	83,512	0	0	83,512	0
Total comprehensive revenue and expense		**0**	**(148,455)**	**1,013**	**(420)**	**(149,511)**	**411**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2019

	Notes	Group Actual			Parent		
		Budget 2019 $000	Actual 2019 $000	Actual 2018 $000	Budget 2019 $000	Actual 2019 $000	Actual 2018 $000
Assets							
Current Assets							
Cash and cash equivalents	6	81,629	94,192	95,407	81,629	94,192	95,407
Investments	7	24,000	15,000	30,000	24,000	15,000	30,000
Trust/special funds	8	16,264	14,847	16,217	0	0	0
Restricted trust funds	9	1,275	1,308	1,275	1,275	1,308	1,275
Receivables	10	92,565	86,868	92,565	94,314	88,191	93,610
Prepayments		1,225	996	1,225	1,225	996	1,225
Inventories	11	13,853	14,356	13,853	13,853	14,356	13,853
Total Current Assets		**230,811**	**227,567**	**250,542**	**216,296**	**214,043**	**235,370**
Non-Current Assets							
Investments	7	0	15,000	0	0	15,000	0
Trust/special funds	8	15,308	17,200	15,308	0	0	0
Property, plant and equipment	13	1,056,472	1,117,387	1,021,657	1,055,533	1,116,448	1,020,718
Intangible assets	14	10,900	8,524	11,081	10,900	8,524	11,081
Investments in joint ventures and associates	15	64,280	71,003	63,990	63,924	70,066	63,452
Total Non-Current Assets		**1,146,960**	**1,229,114**	**1,112,036**	**1,130,357**	**1,210,038**	**1,095,251**
Total Assets		**1,377,771**	**1,456,681**	**1,362,578**	**1,346,653**	**1,424,081**	**1,330,621**
Liabilities							
Current Liabilities							
Payables and deferred revenue	16	165,325	164,519	163,278	162,499	160,872	159,192
Employee benefits	17	194,918	409,422	194,319	194,918	409,396	194,319
Provisions	18	0	1,820	2,407	0	1,820	2,407
Borrowings	19	3,764	1,176	764	3,764	1,176	764
Restricted trust funds	9	0	1,308	1,275	0	1,308	1,275
Total Current Liabilities		**364,007**	**578,245**	**362,043**	**361,181**	**574,572**	**357,957**
Non-Current Liabilities							
Employee benefits	17	57,421	69,895	56,094	57,421	69,895	56,094
Borrowings	19	16,413	8,983	4,510	16,413	8,983	4,510
Total Non-Current Liabilities		**73,834**	**78,878**	**60,604**	**73,834**	**78,878**	**60,604**
Total Liabilities		**437,841**	**657,123**	**422,647**	**435,015**	**653,450**	**418,561**
Net Assets		**939,930**	**799,558**	**939,931**	**911,638**	**770,631**	**912,060**
Equity							
Contributed Capital	20	881,298	889,380	881,298	881,298	889,380	881,298
Accumulated surplus/(deficit)	20	(484,043)	(717,130)	(484,349)	(485,299)	(717,900)	(484,877)
Property revaluation reserve	20	515,639	599,151	515,639	515,639	599,151	515,639
Trust/special funds	20	27,036	28,157	27,343	0	0	0
Total Equity		**939,930**	**799,558**	**939,931**	**911,638**	**770,631**	**912,060**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2019

GROUP	Notes	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Balance as at 1 July		**939,931**	**939,930**	**938,918**
Total comprehensive income/(expense) for the period		**(148,455)**	**0**	**1,013**
Owner Transactions				
Capital contributions from the Crown		8,082	0	0
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	20	**799,558**	**939,930**	**939,931**

PARENT	Notes	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Balance as at 1 July		**912,060**	**912,058**	**911,649**
Total comprehensive income/(expense) for the period		**(149,511)**	**(420)**	**411**
Owner Transactions				
Capital contributions from the Crown		8,082	0	0
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	20	**770,631**	**911,638**	**912,060**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2019

	Notes	Group Actual			Parent Actual		
		Budget 2019 $000	Actual 2019 $000	Actual 2018 $000	Budget 2019 $000	Actual 2019 $000	Actual 2018 $000
Cash flows from operating activities							
Cash receipts from Ministry of Health and patients		2,208,695	2,252,016	2,101,417	2,208,695	2,252,016	2,101,417
Other Receipts		88,648	72,041	78,347	86,148	71,684	75,109
Cash paid to employees		(1,026,473)	(1,034,016)	(926,588)	(1,026,473)	(1,034,016)	(926,588)
Cash paid to suppliers		(1,173,348)	(1,188,361)	(1,113,832)	(1,171,149)	(1,186,653)	(1,111,624)
GST (net)		0	(14)	478	0	166	496
Payments for Capital Charge		(54,845)	(54,278)	(55,406)	(54,845)	(54,278)	(55,406)
Net cash inflow/(outflow) from operating activities		**42,677**	**47,388**	**84,416**	**42,377**	**48,919**	**83,404**
Cash flows from investing activities							
Interest received		5,447	5,867	5,761	4,917	5,259	5,231
Proceeds from sale of property, plant and equipment		0	113	63	0	113	63
Decrease/(Increase) in investments and restricted trust funds		6,000	(1,488)	(23,259)	6,830	(2,411)	(21,755)
Purchase of property, plant and equipment		(81,557)	(62,451)	(44,489)	(81,557)	(62,451)	(44,451)
Purchase of intangible assets		0	(3,202)	(1,216)	0	(3,202)	(1,216)
Acquisition of investments		0	0	0	0	0	0
Net cash inflow/(outflow) from investing activities		**(70,110)**	**(61,161)**	**(63,140)**	**(69,810)**	**(62,692)**	**(62,128)**
Cash flows from financing activities							
Interest paid		(1,200)	(410)	0	(975)	(410)	0
Repayment of loans		0	4,983	(465)	0	4,983	(465)
Proceeds from borrowings		14,903	(97)	4,871	14,903	(97)	4,871
Proceeds from capital contributed/(repaid)		0	8,082	0	0	8,082	0
Net cash inflow/(outflow) from financing activities		**13,703**	**12,558**	**4,406**	**13,703**	**12,558**	**4,406**
Net (decrease)/increase in cash and cash equivalents		**(13,729)**	**(1,215)**	**25,682**	**(13,729)**	**(1,215)**	**25,682**
Cash and cash equivalents at start of the year		**97,105**	**95,407**	**69,725**	**97,105**	**95,407**	**69,725**
Cash and cash equivalents at end of the year	**6**	**83,376**	**94,192**	**95,407**	**83,376**	**94,192**	**95,407**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2019 (continued)

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

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

	Notes	Group Actual		Parent Actual	
		2019 $000	2018 $000	2019 $000	2018 $000
Reported net surplus/(deficit) for the year		**(231,967)**	**1,013**	**(233,023)**	**411**
Add non-cash items:					
Share of associate and joint venture surplus	15	(399)	147	0	0
Depreciation and amortisation expense		47,967	47,565	47,967	47,565
Unrealised loss/(gain) on cash flow hedging instrument		0	0	0	0
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		398	333	398	333
Net loss/(gain) on disposal of financial assets		(870)	(1,203)	0	2
Net interest shown in investing and financing activities		(5,457)	(5,761)	(4,893)	(5,193)
Add movements in statement of financial position items:					
(Increase)/Decrease in debtors and other receivables		5,698	(5,145)	6,121	(5,486)
(Increase)/Decrease in prepayments		229	3,802	229	3,802
(Increase)/Decrease in inventories		(504)	(116)	(504)	(116)
Increase/(Decrease) in creditors and other payables		3,976	8,695	4,307	7,000
Increase in provision		(587)	(733)	(587)	(733)
Increase/(Decrease) in employee entitlements		228,904	35,819	228,904	35,819
Net cash inflow/(outflow) from operating activities		**47,388**	**84,416**	**48,919**	**83,404**

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 relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. 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.

The consolidated financial statements of Auckland DHB for the year ended 30 June 2019 comprise Auckland DHB and its subsidiaries (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, Auckland DHB Charitable Trust and Auckland Health Foundation. 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.

Auckland DHB's activities range from delivering health and disability services through its internal provider arm, shared services including Funding and Planning administration, as well as funding services purchased from external providers (e.g. from non-governmental organisations and other community services). The group's primary objective is to deliver health, disability, and mental health services to the community within its district as well as to deliver regional and national services. The group does not operate to make a financial return. The group is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice.

The financial statements for the DHB are for the year ended 30 June 2019, and were approved by the Board on 31 October 2019.

BASIS OF PREPARATION

Going concern

The financial statements have been prepared on a going concern basis. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2018/19 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Annual Plan). The key considerations are set out below.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for Crown approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2019/20 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 17 within the period of one year from signing the 2018/19 financial statements, additional financial support would be needed from the Crown.

Letter of comfort

The Board has received a letter of comfort dated 21 October 2019 from the Ministers of Health and Finance. The letter of comfort states that the Government is committed to working with Auckland DHB over the medium term to maintain its financial viability and acknowledges that the Crown will provide equity support where necessary to maintain viability.

Statement of compliance

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

Presentation currency and rounding

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

Other changes in accounting policies

There have been no changes in the group's accounting policies since the date of the last audited financial statements. The accounting policies have been applied consistently throughout the year.

1 Significant accounting policies (continued)

Standard early adopted

In line with the Financial Statements of the Government, Auckland DHB has elected to early adopt PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Information about the adoption of PBE IFRS 9 is provided in Note 28.

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

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

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. Auckland DHB does not intend to early adopt the amendment.

PBE IPSAS 34-38

PBE IPSAS 34-38 replace the existing standards for interests in other entities (PBE IPSAS 6-8). These new standards are effective for annual periods beginning on or after 1 January 2019. Auckland DHB will apply these new standards in preparing the 30 June 2020 financial statements. No effect is expected as a result of this change.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Auckland DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. Auckland DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the notes to which they relate. Significant accounting policies that do not relate to a specific note are outlined below.

Basis of consolidation

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 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 DHB's 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. The Auckland District Health Board Charitable Trust and Auckland Health Foundation are controlled by the DHB.

Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ dollars (the functional currency) using the exchange rates prevailing 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.

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.

1 Significant accounting policies (continued)

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 Performance Expectations 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 Board has made estimates and assumptions concerning the future. These estimates and assumptions might 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 in respect of:

- Estimating the fair value of land and buildings – refer to Note 13.
- Measuring long service leave and retirement gratuities – refer to Note 17.
- Classification of leases – refer to Note 19.
- Estimated liability to comply with the Holidays Act pay – refer to Note 17.

Critical judgements in applying accounting policies

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 Revenue

Accounting Policy

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

MoH population-based revenue
The DHB receives annual funding from the Ministry of Health (MoH), which is based on population levels within Auckland DHB district. MoH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

2 Revenue (continued)

MoH contract revenue

The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future years is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Inter-district flows

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.

ACC contracted revenue

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

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.

Grants revenue

Revenue 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 revenue

For an exchange research contract, revenue is recognised on a percentage completion basis. The percentage of completion is measured by reference to the actual research expenditure incurred as a proportion to total expenditure expected to be incurred.

For a non-exchange research contract, the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to complete research to the satisfaction of the funder to retain funding or return unspent funds. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as contract monitoring mechanisms of the funder and the past practice of the funder.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Rental revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Provision of other services

Revenue derived through the provision of other services to third parties is recognised in proportion to the stage of completion at the balance date, based on the actual service provided as a percentage of the total services to be provided.

2 Revenue (continued)

Donations and bequests

Donated and bequeathed financial assets are recognised as revenue, unless there are substantive use or return conditions. A liability is recorded if there are substantive use or return conditions and the liability released to revenue as the conditions are met. For example, as the funds are spent for the nominated purpose.

Breakdown of patient care and other revenue

i Patient care revenue	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Health and disability services (Crown appropriation revenue)	1,330,189	1,252,081	1,330,189	1,252,081
Other MoH and Government revenue	227,313	196,122	227,313	196,122
ACC contract revenue	24,472	20,799	24,472	20,799
Inter-district patient inflows	643,399	612,935	643,399	612,935
Revenue from other district health boards	16,969	19,678	16,969	19,678
Other patient care related revenue	21,517	20,011	21,517	20,011
Total patient care revenue	**2,263,859**	**2,121,626**	**2,263,859**	**2,121,626**

ii Other revenue	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Donations and bequests	9,910	6,102	10,680	7,602
Gain on sale of property, plant and equipment	0	0	0	0
Gain on financial assets	870	1,205	0	0
Rental revenue	10,253	10,193	10,253	10,193
Accommodation revenue	857	772	857	772
Direct charges revenue	22,561	19,670	22,561	19,670
Drug trial revenue	524	659	524	659
Research grants	13,691	13,340	13,013	12,568
Other revenue	13,079	14,331	13,080	14,339
Total other revenue	**71,745**	**66,272**	**70,968**	**65,803**

Non-cancellable leases as a lessor

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

GROUP and PARENT	2019 $000	2018 $000
Not later than one year	6,327	7,024
Later than one year and not later than five years	16,680	19,063
Later than five years	22	3,956
Total non-cancellable operating lease commitments as lessor	**23,029**	**30,043**

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
- 2 Kari Street, 2 leases, one expiring in 2019 and another expiring in 2020 (both with rights of renewal).

3 Personnel costs

Accounting policy

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

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.

3 Personnel costs (continued)

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.

Breakdown of personnel costs and further information

	Group Actual		Parent Actual	
	2019	2018	2019	2018
	$000	$000	$000	$000
Salaries and wages	1,006,521	897,969	1,005,969	897,969
Defined contribution plan employer contributions	33,281	29,818	33,281	29,818
Increase/(decrease) in liability for employee benefit	228,904	35,819	228,904	35,819
Restructuring expense for employee exit costs	(256)	(1,504)	(256)	(1,504)
Total personnel costs	**1,268,450**	**962,102**	**1,267,898**	**962,102**

3 Personnel costs (continued)

Employee remuneration

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

Remuneration range	Actual 2019	Actual 2018	Remuneration range	Actual 2019	Actual 2018
$100,000-$109,999	673	339	$470,000-$479,999	6	2
$110,000-$119,999	339	234	$480,000-$489,999	2	2
$120,000-$129,999	235	140	$490,000-$499,999	2	1
$130,000-$139,999	155	103	$500,000-$509,999	3	3
$140,000-$149,999	135	100	$510,000-$519,999	2	3
$150,000-$159,999	96	64	$520,000-$529,999	1	
$160,000-$169,999	103	59	$530,000-$539,999	2	1
$170,000-$179,999	74	59	$540,000-$549,999	2	1
$180,000-$189,999	67	47	$550,000-$559,999		2
$190,000-$199,999	35	41	$560,000-$569,999	2	2
$200,000-$209,999	52	51	$570,000-$579,999	3	2
$210,000-$219,999	41	49	$580,000-$589,999	3	2
$220,000-$229,999	40	39	$590,000-$599,999		2
$230,000-$239,999	39	40	$600,000-$609,999	1	3
$240,000-$249,999	42	33	$610,000-$619,999		1
$250,000-$259,999	46	41	$620,000-$629,999	2	
$260,000-$269,999	43	29	$630,000-$639,999		2
$270,000-$279,999	38	31	$640,000-$649,999	1	
$280,000-$289,999	28	29	$650,000-$659,999	3	2
$290,000-$299,999	32	22	$660,000-$669,999	2	
$300,000-$309,999	20	21	$680,000-$689,999	1	
$310,000-$319,999	19	24	$690,000-$699,999	1	1
$320,000-$329,999	20	31	$710,000-$719,999	1	
$330,000-$339,999	32	21	$830,000-$839,999	1	
$340,000-$349,999	24	21	$850,000-$859,999		1
$350,000-$359,999	20	18	$860,000-$869,999	2	
$360,000-$369,999	11	18	$880,000-$889,999		1
$370,000-$379,999	10	18	$910,000-$919,999	1	
$380,000-$389,999	16	7	$990,000-$999,999	1	
$390,000-$399,999	18	19	$1,010,000-$1019,999	1	
$400,000-$409,999	13	12	$1,030,000-$1039,999		1
$410,000-$419,999	14	5	$1,050,000-$1,059,999		1
$420,000-$429,999	9	3	$1,070,000-$1079,999	1	
$430,000-$439,999	7	9	$1,290,000-$1299,999	1	
$440,000-$449,999	6	4	$1,300,000-$1,309,999		1
$450,000-$459,999	5	5	$1,330,000-$1339,999		1
$460,000-$469,999	4	4	$1,340,000-$1,349,999	1	
			Grand Total	2,610	1,828

During the year ended 30 June 2019, 113 (2018:142) employees received compensation and other benefits in relation to cessation totalling $2,566,318 (2018: $4,191,982).

Note:

The highest earners in this chart are all surgeons who work in a particular model of care for the DHB. 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.

3 Personnel costs (continued)

Board member remuneration

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

	Actual 2019 $000	Actual 2018 $000
Pat Snedden (Chair from 5 Jun 2018)	56	5
Gwen Tepania-Palmer (Chair Feb 2018 to May 2018)	31	38
Dr Lester Levy (Chair Jul 2016 to January 2018)	0	45
Dr Lee Mathias	31	32
Jo Agnew	31	32
Doug Armstrong	30	31
Michelle Atkinson	29	29
Judith Bassett	29	30
Zoe Brownlie	27	28
James Le Fevre*	0	26
Penelope Ginnen	24	0
Robyn Northey	28	28
Sharon Shea	30	30
Total board member remuneration	346	354

*Served 6 months as a result of Local Body Elections 2017.

	Actual 2019 $
Norman Wong (Finance, Risk and Assurance Committee)	1,875
Dame Paula Rebstock (Finance, Risk and Assurance Committee)	2,375
Total co-opted committee members	4,250

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $4,250.

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

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

No Board members received compensation or other benefits in relation to cessation (2018: $nil).

4 Capital charge

Accounting policy

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

Further information

The DHB pays a capital charge every six months to the Crown. The charge is based on the previous six month actual closing equity balance at 31 December and 30 June. The capital charge rate for the year ended 30 June 2019 was 6% (2018:6%).

5 Other expenses

Accounting policy

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.

5 Other expenses (continued)

Breakdown of other expenses and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Fees to auditor				
- fees to Audit New Zealand for audit of financial statements	300	288	300	288
- prior period under provision	5	2	5	2
- fees to Audit New Zealand for audit of financial statements (Auckland DHB Charitable Trust and Auckland Health Foundation)	36	17	36	17
Fees for other Audit services	50	92	50	92
Operating leases	7,754	7,256	7,754	7,256
Impairment of debtors/(provision released)*	611	(647)	611	(647)
Bad debts	3,843	4,757	3,843	4,757
Board members' fees	346	354	346	354
Gains/(Loss) on disposal of property, plant and equipment	398	333	398	333
Foreign currency loss gains/(losses)	(9)	(17)	(9)	(17)
Other financial assets gains/(losses}	(55)	(34)	(55)	(34)
Impairment of FPIM (previously NOS) rights	4,339	2,774	4,339	2,774
Other expenses	33,003	36,674	32,934	36,389
Total other expenses	**50,621**	**51,849**	**50,552**	**51,564**

* Please refer to note 10.

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	2019 $000	2018 $000
Not later than one year	3,362	2,643
Later than one year and not later than five years	6,233	4,162
Later than five years	966	1,338
Total non-cancellable operating lease commitments as lessee	**10,561**	**8,143**

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

The details of the main property leases are as follows:

- Community Mental Health Clinic is leased with an expiry date of 31 Jan 2036
- Carbine Road is leased with an expiry date of 30 Sep 2019
- Taylor Centre is leased with an expiry date of 31 Oct 2021
- St Luke's Community Health Centre is leased with an expiry date of 15 Oct 2023
- Manaaki House is leased with an expiry date of 31 Mar 2026
- Segar House is leased with an expiry date of 30 Jun 2020
- Middlemore Dental is leased with an expiry date of 30 Jun 2020
- Grafton Road is leased with an expiry date of 30 Jun 2023
- Medacs House is leased with an expiry date of 31 Mar 2028.
- 95 Great South Road, Greenlane is leased with an expiry date of 31 Mar 2026.
- 160 Grafton Road (First floor) is leased with an expiry date of 31 July 2023.
- 161 Grafton Road (Ground floor) is leased with an expiry date of 31 May 2024.

6 Cash and cash equivalents

Accounting policy

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

6 Cash and cash equivalents (continued)

Breakdown of cash and cash equivalents and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Current assets				
Bank balance and cash on hand	89	85	89	85
NZ Health Partnerships Limited	94,103	95,322	94,103	95,322
Cash and cash equivalents in the statement of cash flows	**94,192**	**95,407**	**94,192**	**95,407**

The DHB is party to a DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHPL) and 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 the credit interest rate received by NZHPL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST. As at 30 June 2019, this limit was $131.66 m (2018: $125.69m).

Financial assets recognised subject to restrictions.
Included in cash and cash equivalents and investments (refer to Note 7) are unspent funds with restrictions that relate to the delivery of health services by the DHB. Other than for trust funds, it is not practicable for the DHB to provide further detailed information about the restrictions. Further information about trust funds is provided in Note 20.

7 Investments

Accounting policy

Bank term deposits

Bank term deposits are initially measured at the amount invested. Interest is subsequently accrued and added to the investment balance. A loss allowance for expected credit losses is recognised if the estimated loss allowance is not trivial.

Breakdown of investments and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Current assets				
Term deposits	15,000	30,000	15,000	30,000
Non-Current assets				
Term deposits	15,000	0	15,000	0
Total Investments	**30,000**	**30,000**	**30,000**	**30,000**

The carrying value of term deposits with maturities less than 12 months approximate their face value. The fair value of term deposits with a remaining duration greater than 12 months is $15m (2018: $nil). The fair value has been calculated based on discounted cash flows, using market quoted interest rates for term deposits with terms to maturity similar to the relevant investments. There is no loss allowance for investments.

8 Trust/special fund assets

Accounting policy

Trust/special fund assets

The assets are funds held by the Auckland DHB Charitable Trust, and comprise 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.

8 Trust/special fund assets (continued)

Breakdown of trust/special fund assets and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Current assets				
Cash and cash equivalent				
Cash at bank and on hand (restricted)	2,512	1,367	0	0
Tern deposits with maturities less than 3 months (restricted)	335	329	0	0
Cash and cash equivalent total (restricted)	2,847	1,696	0	0
Term deposits (restricted)	12,000	13,500	0	0
Investment Bonds (at market)/(restricted)	0	1,021	0	0
	14,847	**16,217**	**0**	**0**
Non-current assets				
Term deposits (restricted)	1,000	0	0	0
Investment Bonds (at market)/(restricted)	1,863	1,818	0	0
Portfolio Investments (restricted)	14,337	13,490	0	0
	17,200	**15,308**	**0**	**0**
Total trust/special fund	**32,047**	**31,525**	**0**	**0**

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 $2,863k (2018: $1,818k). The fair values are based on discounted cash flows using market quoted interest rates for term deposits with terms to maturity similar to the relevant investments. There is no loss allowance for investments.

9 Restricted trust funds

Accounting policy

This interest earning fund was from sale proceeds on an endowment property, to be used in conjunction with Auckland DHB Treaty partner, Ngāti Whātua

Breakdown of Restricted fund assets and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
RESTRICTED TRUST FUNDS				
Current assets				
Restricted fund deposit	1,308	1,275	1,308	1,275
	1,308	**1,275**	**1,308**	**1,275**
Current liabilities				
Restricted fund deposit	1,308	1,275	1,308	1,275
	1,308	**1,275**	**1,308**	**1,275**

10 Receivables

Accounting policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses.

Auckland DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables. In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due. Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

Previous accounting policy for impairment of receivables

In the previous year, the allowance for credit losses was based on the incurred credit loss model. An allowance for credit losses was recognised only when there was objective evidence that the amount due would not be fully collected.

10 Receivables (continued)

Breakdown of receivables and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Receivables from MoH	37,519	42,637	37,519	42,637
Other receivables	24,607	27,119	22,298	25,355
Other accrued income	28,083	25,539	31,715	28,348
Less: Allowance for credit to losses	(3,341)	(2,730)	(3,341)	(2,730)
Total receivables	**86,868**	**92,565**	**88,191**	**93,610**

The expected credit loss rates for receivables at 30 June 2019 and 1 July 2018 are based on the payment profile of revenue on credit over the prior 2 years at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and forward-looking macroeconomic factors that might affect the recoverability of receivables. Given the short period of credit risk exposure, the impact of macroeconomic factors is not considered significant.

There have been no changes during the reporting in the estimation techniques or significant assumptions used in measuring the loss allowance.

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

GROUP receivables

Receivable days past due	Gross 2019 $000	Life expected credit loss 2019 $000	Gross 2018 $000	Life expected credit loss 2018 $000
Not past due	74,140	(69)	81,808	(51)
Past due 0-30 days	3,622	(516)	5,355	(457)
Past due 31-90 days	7,269	(1,093)	3,387	(399)
Past due 91-360 days	3,411	(905)	3,029	(927)
Past due more than 1 year	1,767	(758)	1,716	(896)
Total	**90,209**	**(3,341)**	**95,295**	**(2,730)**

PARENT receivables

Receivable days past due	Gross 2019 $000	Life expected credit loss 2019 $000	Gross 2018 $000	Life expected credit loss 2018 $000
Not past due	76,981	(69)	83,694	(51)
Past due 0-30 days	2,615	(516)	4,809	(457)
Past due 31-90 days	7,075	(1,093)	3,315	(399)
Past due 91-360 days	2,831	(905)	2,821	(927)
Past due more than 1 year	1,750	(758)	1,701	(896)
Total	**91,252**	**(3,341)**	**96,340**	**(2,730)**

Movement in the allowance for credit losses is as follows:

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Balance 1 July	2,730	3,377	2,730	3,377
Increase/(decrease) in allowance made during the year	611	(647)	611	(647)
Balance at 30 June	**3,341**	**2,730**	**3,341**	**2,730**

11 Inventories

Accounting policy

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**.** 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.

Breakdown of inventories and further information

	Actual 2019 $000	Actual 2018 $000
Pharmaceuticals	1,881	1,607
Surgical and medical supplies	12,475	12,246
Total Inventories	**14,356**	**13,853**

The amount of inventories recognised as an expense during the year was $260.592m (2018: $236.673m), which is included in the clinical supplies line item of the statement of comprehensive revenue and expense. The write-down of inventories amounted to $721k (2018: $335k). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2018: $nil). However, some inventories are subject to retention of title clauses.

12 Non-current assets held for sale

Accounting policy

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. There are no non-current assets held for sale (2018: nil).

13 Property, plant and equipment

Accounting policy

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

- Land;
- Buildings (including fit out and underground infrastructure);
- Leasehold Improvements; and
- Plant, equipment and vehicles.

Owned Assets

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses. The cost of property, plant and equipment acquired in a business combination is their fair value at the date of acquisition.

Revaluations

Land and buildings 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.

13 Property, plant and equipment (continued)

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.

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 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.

The total impairment is recognised in the surplus or deficit. The reversal of an impairment loss is 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.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

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) and Logan Holyoake (B Prop; MPINZ) of Telfer Young (Auckland) Limited. The valuation is effective as at 30 June 2019.

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 and 2 Kari Street, Grafton; 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).

13 Property, plant and equipment (continued)

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, fit out and infrastructure were revalued at 30 June 2019 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 after considering factors such as the condition of the asset, DHB's future maintenance and replacement plans, and experience with similar buildings
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.
- The estimated cost of asbestos remediation in Auckland DHB's buildings has been deducted off the depreciated replacement cost in estimating fair value.

Non-specialised buildings are valued at fair value using market-based evidence. The following market values, market rents and capitalisation rates were used in the 30 June 2019 valuation:

- Land market values range from $3,000 to $4,000 per square metre depending on location
- Office market rents range from $245 to $260 per square metre
- Capitalisation rates are market-based rates of return and range from 3.00% to 7.50%.

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.

13 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

Movements for each class of property, plant and equipment are as follows.

GROUP	Land	Buildings	Plant, equipment and vehicles	Leased improvements	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost						
Balance at 1 July 2017	321,582	591,418	318,296	2,042	35,893	1,269,231
Additions/(Transfers)	0	0	0	0	44,900	44,900
Additions from Work in Progress	0	33,563	24,723	1	(58,287)	0
Disposals	0	2	(9,673)	0	0	(9,671)
Transfers	0	(1,509)	1,509	0	0	0
Revaluations	0	0	0	0	0	0
Balance at 30 June 2018	**321,582**	**623,474**	**334,855**	**2,043**	**22,506**	**1,304,460**
Cost						
Balance at 1 July 2018	321,582	623,474	334,855	2,043	22,506	1,304,460
Additions/(Transfers)	0	0	0	0	59,806	59,806
Additions from Work in Progress	1,000	12,895	15,130	1,064	(30,089)	0
Disposals	0	(312)	(11,285)	(90)	0	(11,687)
Transfers	0	(1,173)	1,173	0	0	0
Revaluations	24,539	(13,135)	0	0	0	11,404
Balance at 30 June 2019	**347,121**	**621,749**	**339,873**	**3,017**	**52,223**	**1,363,983**
Depreciation and impairment losses						
Balance at 1 July 2017	0	(23,266)	(220,665)	(1,279)	0	(245,210)
Depreciation charge for the year	0	(24,921)	(21,460)	(224)	0	(46,605)
Disposals	0	0	9,012	0	0	9,012
Transfers	0	995	(995)	0	0	0
Balance at 30 June 2018	**0**	**(47,192)**	**(234,108)**	**(1,503)**	**0**	**(282,803)**
Depreciation and impairment losses						
Balance at 1 July 2018	0	(47,192)	(234,108)	(1,503)	0	(282,803)
Depreciation charge for the year	0	(25,172)	(21,332)	(227)	0	(46,731)
Disposals	0	256	10,486	88	0	10,830
Transfers	0	0	0	0	0	0
Elimination on revaluation	0	72,108	0	0	0	72,108
Balance at 30 June 2019	**0**	**0**	**(244,954)**	**(1,642)**	**0**	**(246,596)**

GROUP						
Carrying Amounts						
At 1 July 2017	321,582	568,152	97,631	763	35,893	1,024,021
At 30 June 2018	**321,582**	**576,282**	**100,747**	**540**	**22,506**	**1,021,657**
Carrying Amounts						
At 1 July 2018	321,582	576,282	100,747	540	22,506	1,021,657
At 30 June 2019	**347,121**	**621,749**	**94,919**	**1,375**	**52,223**	**1,117,387**

13 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

Movements for each class of property, plant and equipment are as follows.

PARENT	Land	Buildings	Plant, equipment and vehicles	Leased Improvements	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost						
Balance at 1 July 2017	321,582	591,418	317,396	2,042	35,893	1,268,331
Additions	0	0	0	0	44,861	44,861
Additions from Work in Progress	0	33,563	24,684	1	(58,248)	0
Disposals	0	2	(9,673)	0	0	(9,671)
Transfers	0	(1,509)	1,509	0	0	0
Revaluations	0	0	0	0	0	0
Balance at 30 June 2018	**321,582**	**623,474**	**333,916**	**2,043**	**22,506**	**1,303,521**
Cost						
Balance at 1 July 2018	321,582	623,474	333,916	2,043	22,506	1,303,521
Additions	0	0	0	0	59,806	59,806
Additions from Work in Progress	1,000	12,895	15,130	1,064	(30,089)	0
Disposals	0	(312)	(11,285)	(90)	0	(11,687)
Transfers	0	(1,173)	1,173	0	0	0
Revaluations	24,539	(13,135)	0	0	0	11,404
Balance at 30 June 2019	**347,121**	**621,749**	**338,934**	**3,017**	**52,223**	**1,363,044**
Depreciation and impairment losses						
Balance at 1 July 2017	0	(23,266)	(220,665)	(1,279)	0	(245,210)
Depreciation charge for the year	0	(24,921)	(21,460)	(224)	0	(46,605)
Disposals	0	0	9,012	0	0	9,012
Transfers	0	995	(995)	0	0	0
Balance at 30 June 2018	**0**	**(47,192)**	**(234,108)**	**(1,503)**	**0**	**(282,803)**
Depreciation and impairment losses						
Balance at 1 July 2018	0	(47,192)	(234,108)	(1,503)	0	(282,803)
Depreciation charge for the year	0	(25,172)	(21,332)	(227)	0	(46,731)
Disposals	0	256	10,486	88	0	10,830
Transfers	0	0	0	0	0	0
Elimination on revaluation	0	72,108	0	0	0	72,108
Balance at 30 June 2019	**0**	**0**	**(244,954)**	**(1,642)**	**0**	**(246,596)**
PARENT						
Carrying Amounts						
At 1 July 2017	321,582	568,152	96,731	763	35,893	1,023,121
At 30 June 2018	**321,582**	**576,282**	**99,808**	**540**	**22,506**	**1,020,718**
Carrying Amounts						
At 1 July 2018	321,582	576,282	99,808	540	22,506	1,020,718
At 30 June 2019	**347,121**	**621,749**	**93,980**	**1,375**	**52,223**	**1,116,448**

Leased assets

The DHB has entered into finance leases for the lease of equipment. The net carrying amount of the leased items within each class of property, plant and equipment is included above. Refer finance leasing arrangements in Note 19.

Capital commitments

GROUP and PARENT	2019	2018
	$000	$000
Capital commitments		
Buildings, fit-out and infrastructure	28,968	2,352
Plant and Equipment	11,853	18,990
Total capital commitments	**40,821**	**21,342**

13 Property, plant and equipment (continued)

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. Auckland DHB owns land with a carrying value of $347m (2018: $322m), which has been assessed as having its highest and best use activity for hospital purposes

Work in progress

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

GROUP AND PARENT	2019 $000	2018 $000
Buildings, fit-out and infrastructure	34,969	13,740
Plant, equipment and vehicles	17,254	8,766
Non-Current Assets	52,223	**22,506**

14 Intangible assets

Accounting policy

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 of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset. 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. This 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.

Information technology shared services rights

The DHB has provided funding for the development of information technology (IT) shared services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of the group's capital investment.

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, and are tested annually for impairment.

Impairment of intangible assets

Refer to the policy for impairment of property, plant, and equipment in Note 13. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development. Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of any indication of impairment.

14 Intangible assets (continued)

Breakdown of intangible assets and further information

Movements for each class of intangibles are as follows:

GROUP	FPIM/(NOS) rights Cost $000	Software and development Cost $000	NCSP contract Cost $000	Total $000
Cost				
Balance at 1 July 2017	12,420	4,818	970	18,208
Additions	0	1,400	0	1,400
Impairment	(2,774)	0	0	(2,774)
Balance at 30 June 2018	**9,646**	**6,219**	**970**	**16,835**
Balance at 1 July 2018	9,646	6,219	970	16,835
Additions	1,407	1,818	(1)	3,224
Impairment	(4,339)	0	0	(4,339)
Balance at 30 June 2019	**6,714**	**7,832**	**969**	**15,515**
Amortisation and Impairment Losses				
Balance at 1 July 2017	0	(3,864)	(929)	(4,793)
Amortisation charge for the year	0	(936)	(24)	(960)
Disposals	0	0	0	0
Reclassifications	0	(1)	0	(1)
Balance at 30 June 2018	**0**	**(4,801)**	**(953)**	**(5,754)**
Amortisation and Impairment Losses				
Balance at 1 July 2018	**0**	**(4,801)**	**(953)**	**(5,754)**
Amortisation charge for the year	0	(1,220)	(16)	(1,236)
Disposals	0	0	0	0
Reclassifications	0	(1)	0	(1)
Balance at 30 June 2019	**0**	**(6,022)**	**(969)**	**(6,991)**
Carrying Amounts				
At 1 July 2017	12,420	954	41	13,415
At 30 June 2018	**9,646**	**1,418**	**17**	**11,081**
At 1 July 2018	9,646	1,418	17	11,081
At 30 June 2019	**6,714**	**1,809**	**0**	**8,524**

FPIM (previously NOS) rights

The FPIM rights were tested for impairment at 30 June 2019, by comparing the carrying amount of the intangible asset to its recoverable service amount. For the year ended 30 June 2019, the following impairment indicators were determined to exist:

- There was a delay in government's decision on the business case;
- 10 out of the 20 DHBs decided not to continue participating in the programme; and
- The project's scope was further reduced and is expected to result in a revised level of economic benefits or service potential.

The process to determine the recoverable service amount of the assets related to the project involved:

- Derecognising components of the asset that are no longer expected to be used by reviewing the cost of each work stream and activity that has been previously capitalised; and
- Determining the revised recoverable service amount of the remaining assets based on the re-scoped project and writing the carrying value down to that value.

To support the estimate of the Optimised Depreciated Replacement Cost of the programme assets, the estimated present value of benefits the remaining DHBs expect to generate from the programme once it is completed and fully implemented has been determined. It has been concluded that a further impairment of $4.339m (2018: $2.774m) of the FPIM carrying amount was required for the year ended 30 June 2019. In July 2019, the Minister of Health confirmed that the FPIM preferred option business case presented to Cabinet in June 2019 was approved to proceed for 10 DHBs (including Auckland DHB). The MoH will assume interim responsibility for the programme, and the programme will transfer to another entity or entities on a permanent basis (from NZHPL) by the end of 2019.

14 Intangible assets (continued)

NCSP contract

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**

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

15 Investments in joint venture and associates

Accounting policy

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 jointly controlled entities, using the equity method, from the date that joint control commences until the date that joint control ceases. Investments in jointly controlled entities are carried at cost in the DHB's parent entity financial statements.

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. 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.

General Information		Interest held	
		2019	2018
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	32%	25%
NZ Health Partnership Limited	Provision of services to provide savings to the NZ Health Sector	5%	5%
Name of associate	***Principal Activity***		
Northern Regional Alliance Limited	Provision of health support services	33%	33%

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

15 Investments in joint venture and associates (continued)

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

Year end 30 June 2019 (unaudited)	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus/(Deficit) $000
healthAlliance N.Z. Limited	212,935	31,366	181,570	155,137	291
NZ Health Innovation Hub Management Limited	289	88	201	80	(327)
NZ Health Partnership Limited	287,185	258,271	28,914	34,345	(38,029)
Northern Regional Alliance Limited	22,347	19,891	2,456	14,897	913
Total Investments	**522,756**	**309,616**	**213,141**	**204,459**	**(37,152)**
Year end 30 June 2018	**Assets $000**	**Liabilities $000**	**Equity $000**	**Revenues $000**	**Surplus/(Deficit) $000**
healthAlliance N.Z. Limited	191,997	31,338	160,659	137,004	(492)
NZ Health Innovation Hub Management Limited	579	51	528	59	(190)
NZ Health Partnership Limited	372,867	315,924	56,943	37,103	(4,737)
Northern Regional Alliance Limited	12,756	11,213	1,543	14,183	0
Total Investments	**578,199**	**358,526**	**219,673**	**188,349**	**(5,419)**

The 2019 financial information is unaudited. The 2018 financial information has been restated to reflect the final result.

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 DHBs (Counties Manukau, Auckland, Waitematā 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. In July 2019 Auckland DHB transferred all its shares in the NZ Health Innovation Hub Limited to Canterbury DHB for a nominal value of $1.00.

Northern Regional Alliance Limited
NRA is an associate with Auckland, Counties Manukau and Waitematā 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.

Breakdown of investment in joint ventures and associates and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Share of surplus of joint ventures and associates				
Share of post-acquisition surplus/(deficit)	399	(147)	0	0
Non -Current Assets				
Investments in Joint Ventures and 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)	69,865	63,251	69,865	63,251
Other shares in joint ventures and associates	1	1	1	1
Share of post-acquisition retained surpluses	937	538	0	0
Total investments in joint ventures and associates	**71,003**	**63,990**	**70,066**	**63,452**

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 2019 is $69,865k (2018: $63,251k), 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 and deferred revenue

Accounting policy

Payables

Short-term payables are recorded at their face value.

Breakdown of payables and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Current				
Payables under exchange transactions				
Creditors	124,915	127,135	124,740	127,122
Income in Advance	7,562	8,784	3,962	4,723
Total payables under exchange transactions	**132,477**	**135,919**	**128,702**	**131,845**
Payables under non-exchange transactions				
GST,PAYE and FBT payable	29,570	23,696	29,698	23,684
Capital charge due to Crown	0	0	0	0
Income in advance	2,472	3,663	2,472	3,663
Total payables under non exchange transactions	**32,042**	**27,359**	**32,170**	**27,347**
Total payables and deferred revenue	**164,519**	**163,278**	**160,872**	**159,192**

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

Accounting policy

Short-term employee entitlements

Employee benefits 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 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.

Critical accounting estimates and assumptions

Long service leave and retirement gratuities

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 these liabilities are 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 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 was determined after considering historical salary inflation patterns and obtaining advice from an independent actuary.

17 Employee entitlements (continued)

A discount rate of 1.26% in year one, 1.03% in year two and an average discount rate of 2.23%p.a (2018: 3.55%) in years three and above, and an inflation factor of 3.0% p.a. in year one and 2.0% p.a. in year two and beyond (2017: 2.5%) were used. The discount rates used are those advised by the Treasury. The salary inflation factor is the group's best estimate forecast of salary increments.

The retirement age has changed from 65 to 68 with 20% probability of early retirement at each age from 65 to 67. If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $11.8 higher/$9.5m lower. If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $9.6m higher/$11.7m lower.

Continuing medical education leave

The continuing medical education leave liability assumes that the utilisation of the annual entitlement, which can be accumulated up to 3 years, will on average be 90% (2018: 88%) of the full entitlement. This utilisation assumption is based on recent experience.

Breakdown of employee entitlements

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Current portion				
Liability for long service leave	3,049	2,391	3,048	2,391
Liability for sabbatical leave	500	500	500	500
Liability for retirement gratuities	5,970	9,328	5,970	9,328
Liability for annual leave	347,361	116,624	347,339	116,624
Liability for sick leave	671	678	668	678
Liability for continuing medical leave and expenses	24,700	23,475	24,700	23,475
Salaries and wage accrual	27,170	41,323	27,170	41,323
Total current	**409,421**	**194,319**	**409,395**	**194,319**
Non-Current				
Liability for long service leave	3,215	2,533	3,215	2,533
Liability for retirement gratuities	66,681	53,561	66,681	53,561
Liability for continuing medical leave and expenses	0	0	0	0
Total non-current	**69,896**	**56,094**	**69,896**	**56,094**
Total employee entitlements	**479,317**	**250,413**	**479,291**	**250,413**

Salaries and wages accrual

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 $27.1m (2018: $41.3m) salaries and wages accrual includes $21.7m (2018: $21.8m) which is made up of two major elements: Unpaid days of $12.2m (2018: $22.0m) and Salaries and wages for June paid in July of $9.5m (2018: -$0.2m).

Compliance with the Holidays Act 2003

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ('the Act').

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

17 Employee entitlements (continued)

Notwithstanding, as at 30 June 2019, in preparing these financial statements, Auckland DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

The indicative best estimate range of the liability for Auckland DHB on this basis is $218.6m to $276.4m. A provision for non-compliance with the Holidays Act has been made in the Auckland DHB accounts as at 30 June 2019 at the lower level of the range ($218.6m). However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and may result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

18 Provisions

Accounting policy

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 an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or has already started being implemented.

Legal and onerous contracts

A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract. Legal provisions are recognised for contractual disputes, internal investigation and tax audit advice.

ACC Accredited Employers Programme

The group belongs to the ACC Accredited Employers Programme (the "Full Self Cover Plan") whereby the group accepts the management and financial responsibility for employee work-related illnesses and accidents.

Under the programme, the group is liable for all claims costs for a period of two years after the end of the cover period in which the injury occurred. At the end of the two-year period, the group pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Accredited Employers Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the 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 at balance date on government bonds with terms to maturity that match, as closely to possible, the estimated future cash outflows.

18 Provisions (continued)

Breakdown of provisions and further information

		Group Actual		Parent Actual	
		2019 $000	2018 $000	2019 $000	2018 $000
Current Portion					
ACC Partnership Programme		1,592	1,671	1,592	1,671
Litigation		228	480	228	480
Restructuring		0	256	0	256
Total Provisions		**1,820**	**2,407**	**1,820**	**2,407**
Movement for each class of provisions are as follows					
ACC Partnership Programme					
Opening balance		1,671	1,274	1,671	1,274
Additional provisions made during year		773	1,354	773	1,354
Charged against provision for the year		(852)	(957)	(852)	(957)
Unused amounts reversed during year		0	0	0	0
Closing balance	(i)	**1,592**	**1,671**	**1,592**	**1,671**
Litigation and Onerous Contracts Provision					
Opening balance		480	106	480	106
Additional provisions made during year		0	480	0	480
Charged against provision for the year		(252)	(106)	(252)	(106)
Unused amounts reversed during year		0	0	0	0
Closing balance	(ii)	**228**	**480**	**228**	**480**
Restructuring Provision					
Opening balance		256	1,760	256	1,760
Additional provisions made during year		0	256	0	256
Charged against provision for the year		(88)	(887)	(88)	(887)
Unused amounts reversed during year		(168)	(873)	(168)	(873)
Closing balance	(iii)	**0**	**256**	**0**	**256**

Notes

(i) ACC Partnership Programme

Liability valuation

An external independent Actuary, Simon Ferry, has calculated the liability as at 30 June 2019. 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 prudential margin of 11.6% (2018:15%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability. A 'prudential margin' is required in terms of NZ IFRS 4 (PBE) and 11.6% is the rate used by ACC. The key assumptions used in determining the outstanding claims liability are:

- an average assumed rate of inflation of 1.52% p.a. for 30 June 2019 and 30 June 2020;
- an average discount rate of 1.83% p.a. for 30 June 2019 and the same has been applied to future payment streams over the next 5 years. The discount rates used are Treasury-issued risk-free future rates as at 31 January 2019; and
- the expected future Average Claim Payment per accident is $2,802.

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 220% of the DHB Standard Levy is used (i.e. 250% of the risk). The stop loss limit means the DHB will carry the total cost of all claims up to a total of $8,200,749 incurred in the cover period from 1 April 2019 to 31 March 2020 (2019/2020 ACC Claim Year). Auckland DHB has also contracted a High Cost Claims Cover with an excess of $1,500,000 per event.

18 Provisions (continued)

(ii) Litigation and onerous contracts

The DHB has a non-cancellable lease for clinic space that is no longer used by the DHB due to restructuring. The lease does not expire until 30 September 2020. A provision has been recognised for the obligation of the future discounted rental payments.

(iii) Restructuring

Provision $Nil (2018:$256k).The provision in 2018 is for redundancy costs of $256k for Auckland DHB employees as a result of transitioning to a new 24/7 hospital functioning model of care.

19 Borrowings

Accounting policy

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.

Overdraft facility

Amounts drawn under the NZHPL banking facility are recorded at the amount payable plus accrued interest.

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.

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 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.

Breakdown of borrowings and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Current portion				
Secured loans				
Loan - Energy Efficiency and Conservation Authority	97	97	97	97
Finance Leases	1,079	667	1,079	667
Total current portion	**1,176**	**764**	**1,176**	**764**
Non-current				
Secured loans				
Loan - Energy Efficiency and Conservation Authority	292	390	292	390
Finance Leases	8,691	4,120	8,691	4,120
Total non-current portion	**8,983**	**4,510**	**8,983**	**4,510**
Total Borrowings	**10,159**	**5,274**	**10,159**	**5,274**

Security and terms

The Energy Efficiency and Conservation Authority loan is interest free.

19 Borrowings (continued)

Fair Value

The fair value of finance leases is $9,770k (2018: $4,787k). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 3% to 5%.

Analysis of finance leases

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
Minimum lease payments payable				
No later than one year	1,550	773	1,550	773
Later than one year and not later than five years	6,003	3,111	6,003	3,111
Later than five years	4,528	1,865	4,528	1,865
Total minimum lease payments	**12,081**	**5,749**	**12,081**	**5,749**
Future finance charges	(2,310)	(961)	(2,310)	(961)
Present value of minimum lease payments	**9,771**	**5,275**	**9,771**	**6,653**
Present value of minimum lease payments payable				
No later than one year	1,079	666	1,079	666
Later than one year and not later than five years	4,644	2,588	4,644	2,588
Later than five years	4,048	1,534	4,048	1,534
Total present value of minimum lease payments	**9,771**	**4,788**	**9,771**	**4,788**

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.
- Ultrasounds. The lease is for a period of 6 years ending May 2024.
- Elekta Linear Accelerator. The lease is for a period of 10 years ending March 2028.
- Catalyst. The lease is for a period of 10 years ending March 2028.
- Digital X-ray equip. The lease is for a period of 10 years ending June 2028.
- Gamma Camera. The lease is for a period of 10 years ending September 2028.
- Elekta Linear Accelerator. The lease is for a period of 10 years ending Oct 2024.
- 4x Ultrasounds. The lease is for a period of 6 years ending October 2024.
- 3x Ultrasounds. The lease is for a period of 6 years ending October 2024.
- Laboratory ddPCR Machine. The lease is for a period of 8 years ending December 2026.
- 2x Image Intensifiers. The lease is for a period of 8 years ending March 2027.
- Gamma Camera. The lease is for a period of 10 years ending April 2029.

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

Accounting policy

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
- Trust funds.

Property Revaluation Reserves

These reserves relate to the revaluation of property, plant, and equipment to fair value.

Trust funds

This reserve records the unspent amount of restricted donations and bequests provided to the group. The restrictions generally specify how the donations and bequests are required to be spent in providing specified deliverables of the bequest.

The receipt of, and investment revenue earned on, trust funds is recognised as revenue and then transferred to the trust funds' reserve from accumulated surpluses/(deficits). Application of trust funds on the specified purpose is recognised as an expense, with an equivalent amount transferred to accumulated surpluses/(deficits) from the trust funds' reserve.

20 Equity (continued)

Breakdown of equity and further information

	Group Actual		Parent Actual	
	2019 $000	2018 $000	2019 $000	2018 $000
A Contributed Capital				
Opening balance 1 July	881,298	881,298	881,298	881,298
Contributions from/(repayment to) the Crown	8,082	0	8,082	0
Balance at 30 June	**889,380**	**881,298**	**889,380**	**881,298**
B Accumulated surplus/(deficit)				
Opening balance 1 July	(484,349)	(484,614)	(484,877)	(485,288)
Operating surplus/(deficit)	(231,967)	1,013	(233,023)	411
Transfer to trust/special funds	(814)	(748)	0	0
Balance at 30 June	**(717,130)**	**(484,349)**	**(717,900)**	**(484,877)**
C Property revaluation reserves				
Opening balance 1 July	515,639	515,639	515,639	515,639
Net Movement	83,512	0	83,512	0
Balance at 30 June	**599,151**	**515,639**	**599,151**	**515,639**
D Trust/special funds				
Opening balance 1 July	27,343	26,595	0	0
Transfer from accumulated deficits (Note 6b)	814	748	0	0
Balance at 30 June	**28,157**	**27,343**	**0**	**0**
Total Equity	**799,558**	**939,931**	**700,631**	**912,060**
Property revaluation reserves consist of				
Land	336,815	312,276	336,815	312,276
Buildings	262,336	203,363	262,336	203,363
Total property revaluation reserves	**599,151**	**515,639**	**599,151**	**515,639**

Capital management

The group's capital is its equity, which consists of Crown equity, accumulated surpluses/(deficits), property revaluation reserves, and trust funds. Equity is represented by net assets. The group is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives. The group manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purposes while remaining a going concern.

Contributions from/(repayment to) the Crown

Auckland DHB Crown approved projects funding in the 2019/20 financial year.

Property revaluation reserves

The revaluation reserve movement relates to the independent valuation of land and buildings as at 30 June 2019 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 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.

21 Contingencies (continued)

Superannuation Scheme
The group 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 group could be responsible for any deficit of the scheme. Similarly, if a number of employers ceased to participate in the scheme, the group could be responsible for an increased share of any deficit.

As at 31 March 2019, the Scheme had a past service deficit of $1.8m (1.9% of the liabilities). This amount is exclusive of Employer Superannuation Contribution Tax. This deficit was calculated using a discount rate equal to the expected return on the assets but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 25.

The actuary of the Scheme has recommended that the employer contributions be suspended with effect from 1 April 2017. Employer contributions were stopped from 1 April 2017.

Contingent Assets

There are no contingent assets at 30 June 2019 (2018: nil).

22 Related party transactions

The DHB is controlled by the Crown.

Related party disclosures have not been made for transactions with related parties, including associates, that are:

- within a normal supplier or client/recipient relationship; and
- on terms and conditions no more or less favourable than those that it is reasonable to expect that the group 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.

Related party transactions required to be disclosed
$nil (2018: $nil)

Key management personnel compensation

GROUP AND PARENT	2019 Actual	2018 Actual
Board Members		
Remuneration	$346k	$354k
Full-time equivalent members	1.6	1.5
Leadership Team		
Remuneration	$7,946k	$7,467k
Full-time equivalent members	20	20
Total key management personnel remuneration	**$8,292k**	**$7,821k**
Total full time equivalent personnel	**21.6**	**21.5**

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.

An analysis of Board member remuneration is provided in Note 3.

23 Events after the balance date

In July 2019 Auckland DHB has transferred all its shares in the NZ Health Innovation Hub Limited to Canterbury DHB for a nominal value of $1.00. There were no other 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	
	2019 $000	2018 $000	2019 $000	2018 $000
Financial assets measured at amortised cost				
Cash and cash equivalents	94,192	95,407	94,192	95,407
Investments-term deposits	30,000	30,000	30,000	30,000
Trust/special funds - bank balances, term deposits, investment bonds and portfolio)	15,847	15,196	0	0
Receivables	86,868	92,565	88,191	93,610
Patient and restricted trust funds	1,308	1,275	1,308	1,275
Total financial assets measured at amortised cost	**228,215**	**234,443**	**213,691**	**220,292**
Financial assets measured at fair value through surplus or deficit				
Investment bonds and portfolio	16,200	16,329	0	0
Total financial assets measured at fair value through surplus or deficit	**16,200**	**16,329**	**0**	**0**
Financial liabilities measured at amortised cost				
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	124,915	127,135	124,740	127,122
Borrowing-secured loans	10,159	5,274	10,159	5,274
Patient and restricted trust funds	1,308	1,275	1,308	1,275
Total financial liabilities measured at amortised cost	**136,382**	**133,684**	**136,207**	**133,671**

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:

- Quoted 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	Observable inputs	Significant non-observable inputs
GROUP 30 June 2019					
Financial Assets					
Portfolio Investments	8	14,337	14,337	0	0
Investment bonds	8	1,863	1,863	0	0
GROUP 30 June 2018					
Financial Assets					
Portfolio Investments	8	13,490	13,490	0	0
Investment bonds	8	2,839	2,839	0	0

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.

24 Financial Instruments (continued)

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 that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the group, as bank deposits are generally held to maturity.

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. This exposure is not considered significant and is not actively managed.

Sensitivity analysis

As at 30 June 2019, 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 $2.073m lower/higher (2018 : $1.621m)

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 (2018: nil).

Sensitivity analysis

As at 30 June 2019, if the New Zealand dollar had weakened/strengthened against any foreign currency, there would have been an insignificant impact on the surplus for the year. The DHB has no outstanding foreign denominated payables at balance date (2018: $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 the DHB's cash inflows and outflows, surplus cash is invested with registered banks or NZHPL. In the normal course of business, exposure to credit risk arises from cash and term deposits with banks and NZHPL, receivables, and forward foreign exchange contracts in an asset position. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position. The amount of credit exposure to any one financial institution for term deposits is limited to no more than 25% of total investments held. Investments and forward foreign exchange contracts are entered into only with registered banks that have a Standard and Poor's credit rating of at least A2 for short-term investments and A- for long-term investments. The group has experienced no defaults of interest or principal payments for term deposits and forward foreign exchange contracts.

Concentrations of credit risk for receivables are limited due to the large number and variety of customers. The MoH is the largest debtor (34.0%: 2018 23.6%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services. No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

Credit quality of financial assets

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

	Group actual		Parent actual	
	2019 $000	2018 $000	2019 $000	2018 $000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalent, term deposits and investment bonds				
A+	1,500	0	0	0
AA-	47,607	49,395	31,397	31,360
Total counterparties with credit ratings	**49,107**	**49,395**	**31,397**	**31,360**
COUNTERPARTIES WITHOUT CREDIT RATINGS				
NZHPL - no defaults in the past	94,103	95,322	94,103	95,322
Portfolio Investments - no defaults in the past	14,337	13,490	0	0
Receivables				
Exiting counterparty with no defaults in the past	86,868	92,565	88,191	93,610
Exiting counterparty with defaults in the past	0	0	0	0
Total counterparties without credit ratings	**86,868**	**92,565**	**88,191**	**93,610**

24 Financial Instruments (continued)

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that the group will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions.

The group mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility.

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. The amounts disclosed are the contractual undiscounted cash flows and include interest cash outflows.

GROUP

2019	Carrying amount	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Borrowings	10,159	12,451	824	824	1,647	4,637	4,519
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	124,915	124,915	124,915	0	0	0	0
Total	**135,074**	**137,366**	**125,739**	**824**	**1,647**	**4,637**	**4,519**

2018	Carrying amount	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Borrowings	5,274	6,236	435	435	817	2,684	1,865
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	127,135	127,135	127,135	0	0	0	0
Total	**132,409**	**133,371**	**127,570**	**435**	**817**	**2,684**	**1,865**

PARENT

2019	Carrying amount	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Borrowings	10,159	12,451	824	824	1,647	4,637	4,519
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	124,740	124,740	124,740	0	0	0	0
Total	**134,899**	**137,191**	**125,564**	**824**	**1,647**	**4,637**	**4,519**

2018	Carrying amount	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Borrowings	5,274	6,236	435	435	817	2,684	1,865
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	127,122	127,122	127,122	0	0	0	0
Total	**132,396**	**133,358**	**127,557**	**435**	**817**	**2,684**	**1,865**

25 Patient trust

Auckland DHB does not administer funds on behalf of patients.

26 Major variances from budget

Statement of Comprehensive Revenue and Expense

Auckland DHB recorded a deficit of $231.97m which was unfavourable to a breakeven budget. The key drivers for the deficit are an increase in Auckland DHB's provision for non-compliance with the Holidays Act (refer variance explanation for Personnel costs) and a write off of the FPIM investment.

26 Major variances from budget (continued)

Major revenue variances

Patient care revenue is higher than budget, mainly funding from the Ministry of Health for funded initiatives which include funding for MECA settlements, Mental Health Pay Equity settlement, Funding for new Primary Health Initiatives and PHARMAC funding relating to new MOH combined Pharmaceutical Budget strategy.

Major expenditure variances

- **Personnel costs $242m over budget:** mainly driven by a $212m increase in the Holiday Pay Act provision, staff related liabilities that are actuarially valued at the end of each year and costs of MECA agreements settled above budgeted levels.
- **Outsourced services $18m over budget:** mainly driven by higher than budget outsourced FTEs and outsourced clinical services.
- **Clinical supplies $23m over budget:** mainly driven by higher volumes, usage and product costs in clinical services. The volumes and usage reflect services delivered and the higher price varies between products.
- **Infrastructure costs $9m over budget:** mainly due to the write off of the FPIM investment.
- **Payments to other district health boards and non-health board providers $23m favourable to budget.** This mainly reflects performance to contracts and demand driven expenditure across Personal Health, Age Related Residential Care, Mental Health and Public Health services.

Cash and Cash Equivalents over budget

Cash and Cash Equivalents $13m over budget: mainly reflects the impact of the delay in the capital programme on cash, lower than budgeted payments to providers/suppliers and timing of MoH budgeted revenue received.

Current and Non-current Investments over budget

$30m term deposit matured in the financial year. The funds have been reinvested with a total of $15m maturing in February 2020 and March 2020 and the balance of $15m maturing in September 2020 and February 2021.

Property, Plant and Equipment variance over budget

The full land and building revaluation completed as at 30 June 2019 resulted in an increase in the revaluation reserve of $83.5m, increasing the year end Equity position that was not included in the budget. This is offset by capital spend being below forecast budget spend.

Employee benefits over budget

Employee benefits $227m over budget is driven by increase in the Holiday Pay Act non-compliance provision of $212m and staff related year end provisions.

Borrowings under budget

Borrowings $10m under budget: this is due to the number of leasing finance entered into during the year being lower than anticipated.

27 Compliance with the Crown Entities Act 2004

The Auckland DHB Board approved a draft 2019/20 Statement of Performance Expectation (SPE), excluding forecast financial information on 20 March 2019 and this was submitted to the Ministry of Health in April 2019. The final SPE was not complete at 1 July 2019 due to the delay in receiving funding and key performance advice from the Ministry. The DHB did not comply with the requirements of the Crown Entities Act 2004 to have a complete SPE before 1 July each year. The Board completed its SPE on 25 October 2019.

28 Adoption of PBE IFRS 9 Financial Instruments

In accordance with the transitional provisions of PBE IFRS 9, Auckland DHB has elected not to restate the information for previous years to comply with PBE IFRS 9. Adjustments arising from the adoption of PBE IFRS 9 are recognised in opening equity at 1 July 2018.

Accounting policies have been updated to comply with PBE IFRS 9. The main updates are:

- Note 10 Receivables: This policy has been updated to reflect that the impairment of short-term receivables is now determined by applying an expected credit loss model.
- Note 7 Investments:
  - Term deposits: This policy has been updated to explain that a loss allowance for expected credit losses is recognised only if the estimated loss allowance is not trivial.

On the date of initial application of PBE IFRS 9, being 1 July 2018, the classification of financial instruments under PBE IPSAS 29 and PBE IFRS 9 is as follows:

28 Adoption of PBE IFRS 9 Financial Instruments (continued)

GROUP

	Measurement category		Carrying amount		
	PBE IPSAS 29	PBE IFRS 9	30-Jun-18	Adoption of PBE IFRS 9	01-Jul-18
	$000	$000	$000	$000	$000
Financial assets					
Cash and cash equivalents	Loans and receivables	Amortised cost	97,103	0	97,103
Investments-term deposits	Loans and receivables	Amortised cost	43,500	0	43,500
Investment bonds and portfolio	FVTSD	FVTSD	16,329	0	16,329
Receivables	Loans and receivables	Amortised cost	92,565	0	92,565
Patient and restricted trust funds	Loans and receivables	Amortised cost	132,396	0	132,396
Total Financial assets			**381,893**	**0**	**381,893**

PARENT

	Measurement category		Carrying amount		
	PBE IPSAS 29	PBE IFRS 9	30-Jun-18	Adoption of PBE IFRS 9	01-Jul-18
	$000	$000	$000	$000	$000
Financial assets					
Cash and cash equivalents	Loans and receivables	Amortised cost	95,407	0	95,407
Investments-term deposits	Loans and receivables	Amortised cost	30,000	0	30,000
Receivables	Loans and receivables	Amortised cost	93,610	0	93,610
Total Financial assets			**219,017**	**0**	**219,017**

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Auckland District Health Board and Group's financial statements and performance information for the year ended 30 June 2019

The Auditor-General is the auditor of Auckland District Health Board (the 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 Health Board and Group on his behalf.

We have audited:

- the financial statements of the Health Board and Group on pages 45 to 83, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board and Group on pages 8 to 31 and 37.

Qualified opinion – our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the Basis for our qualified opinion section of our report:

- the financial statements of the Health Board and Group on pages 45 to 83:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; and
        - its 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; and
- the performance information of the Health Board and Group on pages 8 to 31 and 37:
    - presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2019, 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; and
        - 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 31 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Group being reliant on financial support from the Crown. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

As outlined in note 17 on pages 72 and 73, the Group has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Group has estimated a liability as at 30 June 2019 of $218.6 million to remediate these issues. However, until further work is undertaken by the Group, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the liability.

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.

The Group is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in note 1 on page 50 that explain Crown support would be required if the Group was required to settle the estimated Holidays Act 2003 liability within the period of one year from approving the financial statements. The Group has determined that it is a going concern, because it has obtained a letter of comfort from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Group with financial support, where necessary, to maintain viability. We consider these disclosures to be adequate.

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

The Board is responsible on behalf of the 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 Health Board and Group for assessing the 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 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.

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 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 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 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 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 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 achieves fair presentation.
- We obtain sufficient appropriate audit 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, 32 to 36, and 38 to 44, 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 Health Board and 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 Health Board or any of its subsidiaries.

Karen MacKenzie

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


RAINBOW TICK
This is to certify that
Auckland DHB
Has demonstrated it is a safe and welcoming space for employees from the Rainbow Community
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12th December 2018
Date
Programme Manager

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