AUCKLAND DISTRICT HEALTH BOARD

Annual Report 2017 | 2018

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

TABLE OF CONTENTS

OVERVIEW

CHAIR/CEO STATEMENT 1
TE TIRITI – PARTNERSHIP STATEMENT 3
ABOUT AUCKLAND DHB 4
OUR DIRECTION 5
KEY ACHIEVEMENTS 6

IMPROVING OUTCOMES

PERFORMANCE FRAMEWORK 8
HIGH LEVEL OUTCOMES 10
HEALTHY COMMUNITIES 11
- Healthy start 11
- Fewer deaths from amenable conditions 13

WORLD-CLASS HEALTHCARE 15
- Using health resources effectively 15
- Ensuring patient-centred care 17

ACHIEVED TOGETHER 19
- Keeping children out of hospital 19
- Youth are healthy, safe and supported 21

OUR PEOPLE, OUR PERFORMANCE

STATEMENT OF PERFORMANCE 24
- Overview 24
- National Health Targets 24
- Health Quality and Safety Commission markers 25
- Output class measures 25
- Output class 1: prevention services 26
- Output class 2: early detection and management 27
- Output class 3: intensive assessment and treatment 28
- Output class 4: rehabilitation and support services 30
- Cost of service statement 31

BEING A GOOD EMPLOYER 32
SUSTAINABILITY 36
ABOUT OUR ORGANISATION 37
- Auckland DHB Board members 37
- Statement of waivers 37
- Subsidiaries, associates and joint ventures 37
- Ministerial directions 38
- Vote health: health and disability support services – Auckland DHB appropriations 38

ASSET PERFORMANCE 39

FINANCIAL PERFORMANCE 43

AUDIT REPORT 83

CHAIR/CEO STATEMENT

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

Pat Snedden
Chair

Ailsa Claire, OBE
Chief Executive Officer

Auckland DHB funds and provides services for 530,000 people living in Auckland, Waiheke and Great Barrier Islands. We deliver more than one million patient contacts each year.

Our vision is to support the people we serve to achieve the health outcomes they want for themselves, their whānau and their communities. In addition Auckland DHB has a unique role in the New Zealand health sector as the provider of specialised services which include transplants, high risk obstetrics and some paediatric services.

Auckland DHB is also a large trainer of health professionals and plays a key role in advancing national and international research.

Life expectancy is a good overall measure of population health status and we have one of the highest life expectancies of any DHB in the country at 82.9 years. Life expectancy for our Māori population has increased by nearly 5 years over the last decade.

Whilst we can be rightly proud of this, we know that there is still a significant gap between the life expectancy of our Māori and Pacific communities, and other ethnic groups. This gap is largely due to deaths from cancers and chronic conditions including cardiovascular disease. In the last year we increased focus on carrying out cardiovascular risk assessments for Māori, with 89 per cent of all eligible Māori receiving a check.

To close the life expectancy gap, we know there is more to do to ensure that the way we provide services and interact with our population doesn't contribute to inequity. We need to walk alongside our communities and be more intentional and focused in engaging with Māori so they can help us to shape what we offer and how we offer it.

With our increased focus on equity we know we can do much better to ensure that every New Zealander has the opportunity to get high quality health services, in a way that is culturally responsive and addresses their needs regardless of their ethnicity or social economic position.

Health outcomes are determined by more than just the services we provide. They are linked to poverty, housing, education and environment. We will continue to work in partnership with other agencies and influence public policy to address inequities in health.

We are planning carefully with our neighbouring DHBs allowing us to look at better collaboration and providing for the future together.

Over the last year population growth has continued to put pressure on our system. In planning for winter we recruited additional clinical and support staff and increased the number of bureau staff. We also opened a brand new 24-bed Clinical Decision Unit in May.

The unit forms part of the Level 2 Acute Hub which consists of the Adult Emergency Department, Inpatient Short Stay Unit and Inpatient Ambulatory care area.

The unit provides a purpose built space for specialist assessment, which will provide a better environment for admitted patients and ensures the delivery of high quality care for patients.

The new Clinical Decision Unit provides a bright, modern space to assess patients arriving acutely at Auckland City Hospital.

Patient experience is an indicator of quality health services. During the last year 90 per cent of primary care practices in Auckland were participating in the primary care patient experience survey. The average score of those completing the survey was 8.8 out of 10.

As the largest employer in Auckland we take our impact on the environment seriously. We have reduced our carbon emissions by 21 per cent over the last year, and have diverted 163 tonnes of waste from going to landfill over the last three years.

Auckland DHB is its people. We are fortunate to have a very dedicated and skilled workforce who enable us to deliver on our priorities. We greatly appreciate the work they do and also the work of our community partners, NGOs, PHOs, volunteers and support groups.

Together, with a renewed focus on equity, we will continue to be the driving force for delivering 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 Officer
Auckland District Health Board

TE TIRITI - PARTNERSHIP STATEMENT

Tū Tonu ngā Manaakitanga!

Dame Rangimarie Naida Glavish, DNZM JP

Chief Advisor Tikanga

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.

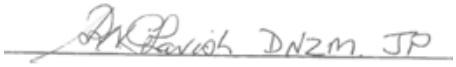
I am extremely pleased to note the efforts that are going into reducing obesity amongst our whānau, in particular our tamāriki. The health and development of the most vulnerable members of our whānau is crucial for the future of our communities. Increased numbers of tamāriki are being immunised, and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

As we acknowledge all of those who have contributed to a milestone year for Māori health, we also need to challenge ourselves to do more. Many indicators in this report show that Māori often suffer disproportionately from health conditions or are not accessing important health services compared to other groups in our communities. One only needs to view life expectancy data to get a sense of how immense the challenge to eliminate Māori health inequities is.

In Māori, the life expectancy gap is largely due to avoidable deaths from cancers, in particular lung cancer, and chronic conditions including cardiovascular disease. Smoking is a major contributing factor to these conditions. The combined efforts of hospital based services, primary care providers and community organisations have contributed to a dramatic drop in the number of our whānau smoking. In order to eliminate smoking from our communities completely, every part of the health and wider public sector must be mobilised and must work closely with our communities to bring this vision for a smokefree Aotearoa to fruition.

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

Te Rūnanga o Ngāti Whātua remains steadfast to our commitment to working in partnership with Auckland DHB. This annual report highlights the importance of our partnership, but, more importantly, it provides the basis for our partnership as we look forward to the years ahead. Albeit we have much work still to do together to lift the performance of the health system for our diverse but important Māori communities.



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

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

ABOUT AUCKLAND DHB

Who we are and what we do

Auckland DHB is the Government's funder and provider of health services to the 530,000 plus residents living in the Auckland district. We are the fourth largest, and one of the fastest growing, DHBs in the country, expecting more than 98,000 extra people in the next seven years.

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

More than 10,400 people are employed by Auckland DHB.

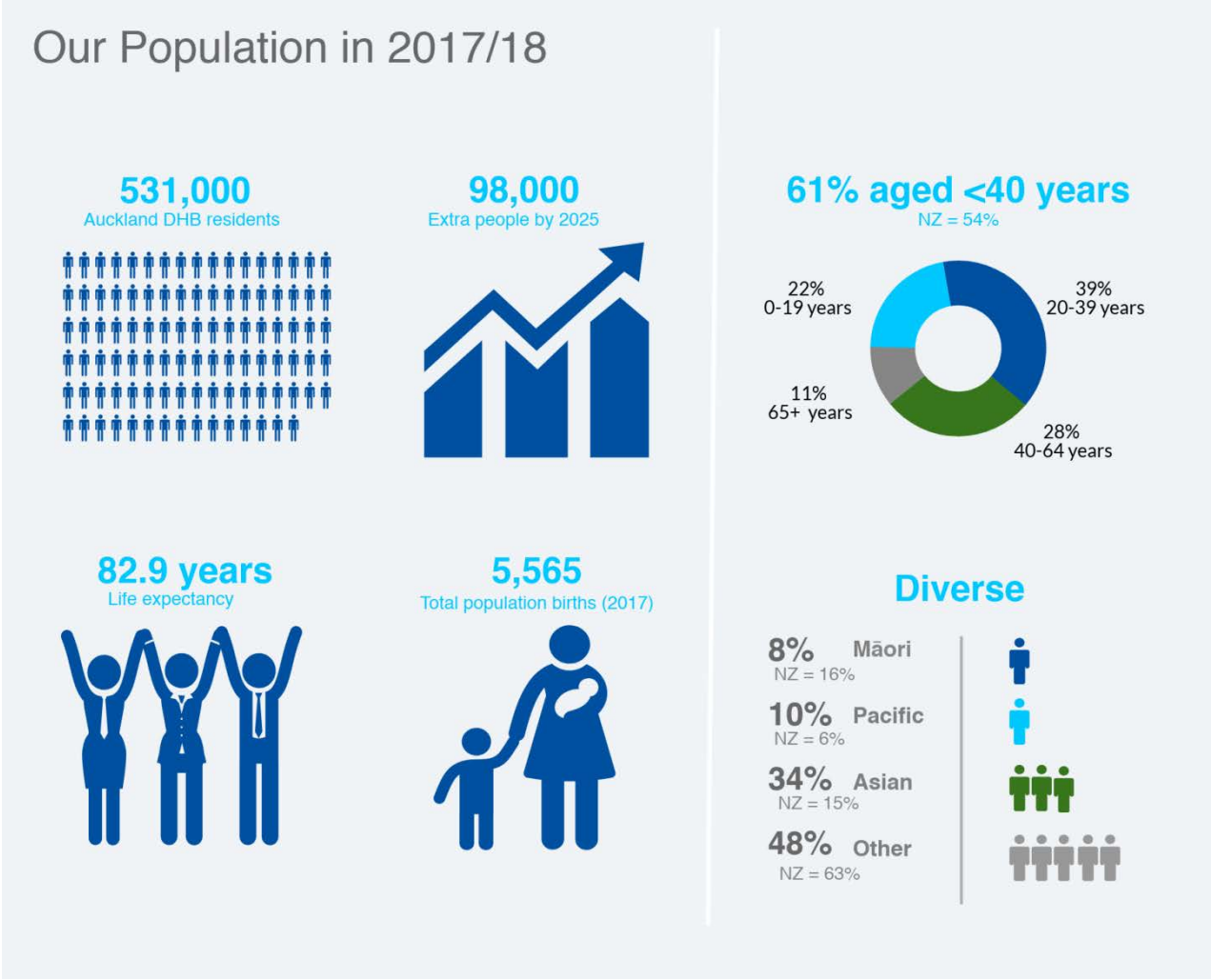
The DHB is responsible for the health of the population who live within the district. We provide a range of services ourselves as well as funding other services outside of our own facilities, including primary care and other community based providers. We also work with a number of other organisations 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 2017/18 was $2.2 billion.



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 upskill 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.

KEY ACHIEVEMENTS

Auckland DHB is one of the healthiest communities in New Zealand and we have performed well against our key indicators in 2017/18. We made progress against the national Health Targets, achieving four of the targets in quarter four, and we achieved a financial surplus of $1.0m.

Our achievements in 2017/18 include:

- The life expectancy of our population is higher than for New Zealand as a whole and the gap between ethnic groups is decreasing – life expectancy for our Māori population has increased by 4.6 years over the last decade
- Our smoking rate is the lowest in New Zealand
- We achieved 100% against the Raising Healthy Kids Health Target in Q4, meaning all children identified as obese were referred for further help. We achieved the target a year early and have maintained 100% for all of 2017/18
- We achieved both the Better Help for Smokers Health Targets in primary care patients and pregnant women
- Our amenable mortality rate is among the lowest in New Zealand
- Auckland DHB has the highest 5-year cancer survival rate in New Zealand and we achieved the Faster Cancer Treatment target over the full 2017/18 year
- We delivered 17,321 elective surgeries, an increase of 3% on last year
- Most inpatients rated their care as very good or excellent, and our average score in the HQSC inpatient survey has improved to 8.8 (out of 10).

Improving outcomes

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

PERFORMANCE FRAMEWORK

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

Our performance framework (over page) reflects key national and local priorities, and demonstrates our commitment to an outcome-based approach to measuring performance. Overall our results suggest we are delivering on our vision and we are a high performing DHB that is making a difference to the health of our population.

We have one of the highest life expectancies of any DHB in the country at 82.9 years

Our amenable mortality rate has reduced by 23% over the last 10 years, and is one of the lowest in New Zealand

Our children are staying out of hospital with ASH❖ rates for those aged 0-4 reducing over the last 3 years

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

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

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

System level measures (SLMs) and contributory measures were identified to support achievement of these overall goals. We based the SLMs in our performance framework on the SLMs set by the Ministry of Health, which align with the five strategic themes of the Health Strategy and other national strategic priorities. SLMs provide an opportunity for DHBs to work with their primary, secondary and community care providers to improve health outcomes of their local populations.

Contributory measures support the achievement of the SLMs and are front-line measurements of specific health processes or activity. The contributory measures included in our performance framework were selected from the set defined by our District Alliance and included in our SLM Improvement Plan.

The Statement of Performance, in the 'Our People, Our Performance' section of this report, details a list of service level indicators that form part of our overall performance framework. We monitor performance against these indicators quarterly.

Overall, the progress against our indicators suggests we are delivering on our vision of *Healthy Communities, World-class Healthcare, Achieved Together* and are making a positive difference to the health of our population.

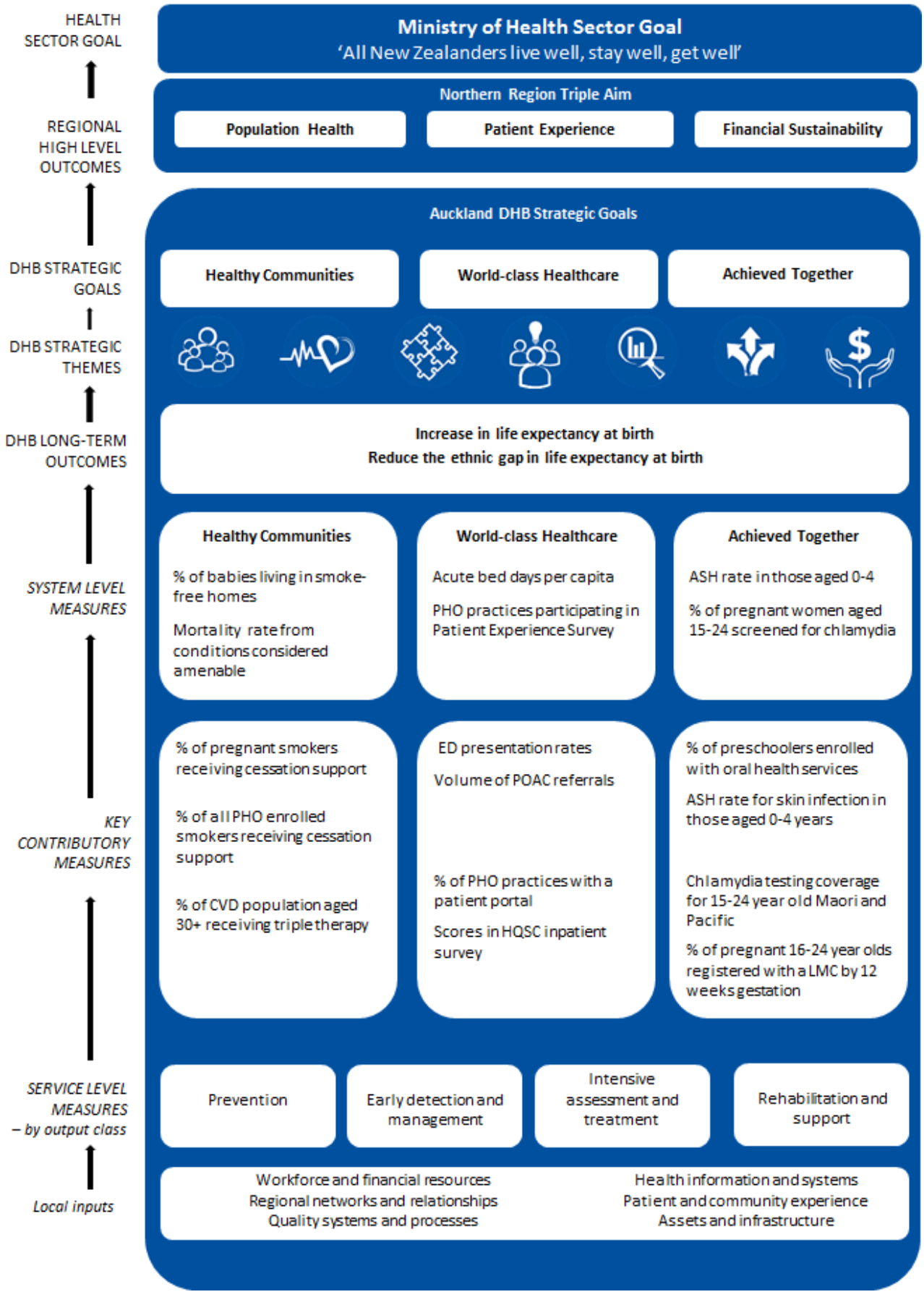
Life expectancy continues to improve, reaching 82.9 years (2015-17), one of the highest in the country and an increase of 1.9 years over the past decade. Life expectancy for our Māori population has risen by 4.6 years over the same time period, but remains 4.6 years lower than the non-Māori population. The gap for Pacific is even greater, at 8.0 years.

Amenable mortality - deaths potentially avoidable through healthcare intervention - is reducing, and in 2015 (the latest available data) 74.9 deaths per 100,000 population were considered amenable, lower than the national rate of 90.8. We estimate that 416 deaths (48% of all deaths in those aged under 75 years) in Auckland DHB were amenable in 2015.

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, have reduced 20% since 2015, thanks to interventions in primary and community care.

❖ Ambulatory sensitive hospitalisations (ASH) - admissions to hospital for a set of diseases and conditions that are potentially avoidable through prevention or management in primary care.

Auckland DHB Performance Framework



HIGH LEVEL OUTCOMES

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

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

LIFE EXPECTANCY HAS INCREASED
1.9 YEARS
OVER THE PAST DECADE

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

Note: The most recent life expectancy data available is for the 2017 calendar year. Three-year combined estimates are presented to reduce the effect of year to year variations in death rates.

Improving life expectancy for everyone

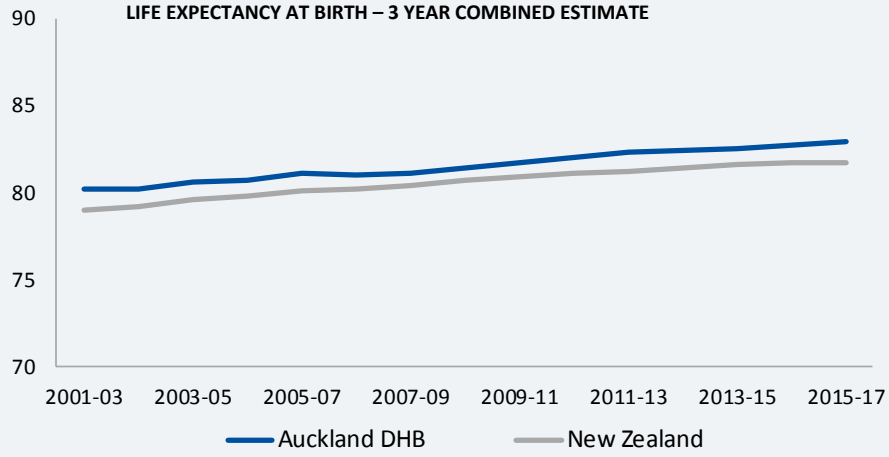
Life expectancy at birth (LEB) is recognised as an overall measure of population health status. We have one of the highest life expectancies in the country at 82.9 years (2015-17), which is 1.2 years higher than New Zealand as a whole. In Auckland, life expectancy has increased by 1.9 years over the last decade. Around half of this increase can be attributed to the reduction in amenable mortality.

Māori and Pacific people have a lower life expectancy than other ethnic groups in our district, with a gap of 4.6 years for Māori and 8.0 years for Pacific. However, life expectancy has increased in our Māori (4.6 years) and Pacific (2.0 years) populations over the past decade, and the gap has decreased significantly for Māori. In Māori, the life expectancy gap is largely due to mortality from cancers, in particular lung cancer, and chronic conditions including cardiovascular disease.

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

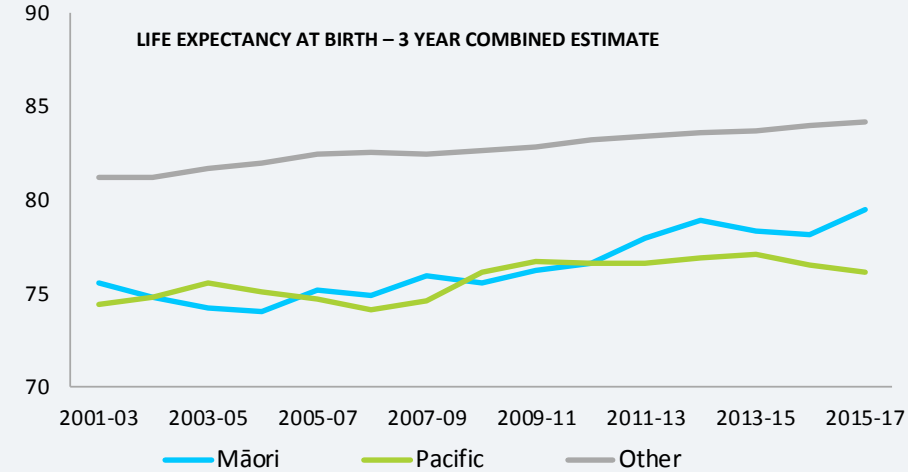
An increase in life expectancy at birth

The life expectancy of our population has increased 1.9 years over the last decade, to 82.9 years.



A reduction in the ethnic gap in life expectancy at birth

In the past decade, life expectancy in Māori and Pacific populations has increased, with the life expectancy gap reducing by nearly 3 years for Māori.



HEALTHY COMMUNITIES

To improve health outcomes and ensure health equity, we want to see Aucklanders take greater responsibility for their own health, at home and in their communities. Everyday lifestyle choices make a difference to individual health. Our focus is on reducing smoking and improved management of preventable or treatable conditions.

4.6%
OF BABIES HAD NO SMOKEFREE HOME STATUS RECORDED (TARGET <10%)

85%
OF BABIES LIVE IN SMOKEFREE HOMES (TARGET IS TO ESTABLISH BASELINE)

34%
OR 90 PREGNANT WOMEN WHO SMOKED RECEIVED SMOKING CESSATION SUPPORT (TARGET IS TO ESTABLISH BASELINE)

14,819
SMOKERS (31%) RECEIVED CESSATION SUPPORT FROM PRIMARY CARE (TARGET 27%)

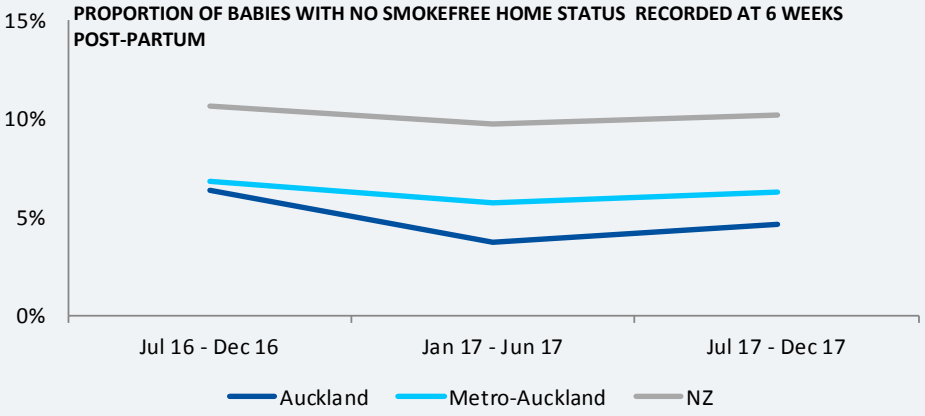
Healthy start

Auckland DHB has the lowest daily smoking rate of any DHB, at 11% of our adult population (52,766 people), 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 smoking in early childhood strongly influence pregnancy and early childhood health outcomes. Smoking among our Māori and Pacific populations is 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 and Pacific women and those living in areas of high deprivation.

Proportion of babies living in smokefree homes

2017/18 improvement target: improve data quality to <10% missing values

The focus for 2017/18 was to improve Well Child Tamariki Ora data quality for this measure. We worked with WCTO providers to ensure the smokefree home question was routinely asked and correctly recorded at the initial contact. By December 2017, only 4.6% of 6 week old babies had no information recorded about their smokefree home status, an improvement from 6.4% the previous year.



The improvements in the Well Child Tamariki Ora data now give us an accurate picture of the smokefree status of babies born in our district. In the 6 months to December 2017, 85% of 6 week old babies lived in smokefree homes (no person ordinarily resident in the home is a current smoker).

Smoking in pregnancy increases the mother's risk of miscarriage, premature birth and low birth weight, as well as their children's risk of asthma and sudden unexplained death in infants (SUDI). Pregnancy is a time when women are likely to be motivated to stop smoking and to encourage their whānau to stop smoking. Ensuring that pregnant smokers are prescribed cessation medication and/or referred to cessation support services are crucial steps in the pathway to them becoming smoke-free. In 2017/18, 34% of pregnant women were offered cessation support, achieving our goal of establishing a baseline so we can monitor our improvements in the future.

At the end of 2017/18, 31% of identified smokers registered with primary care received cessation support in the previous 15 months, either through a referral to 'quit smoking' services or by being provided with smoking cessation medication. This rate of support is lower than the national result of 34%, but exceeded our 10% improvement target.

Helping health professionals to help pregnant women quit

A new Auckland DHB and Waitemata DHB training initiative aims to give health professionals the skills and confidence to have challenging stop smoking conversations with pregnant women. It also aims to connect women with local stop smoking services to support them to quit.

The *Effective Stop Smoking Conversations with Pregnant Women* programme is designed for all health professionals who work with women during pregnancy and through the immediate post-natal period. It was specifically designed to encourage conversations with Māori and Pacific communities where smoking rates are disproportionately higher than the rest of the population.

Ministry of Health figures collated between 2011 and 2015 show around 800 pregnant smokers register with maternity providers across Auckland and Waitemata DHBs every year, 75% of whom are of Māori or Pacific ethnicity.

"The idea is to give health professionals some extra help to identify any barriers pregnant women have when quitting smoking," Project Clinical Lead and Public Health Registrar Dr Felicity Williamson says. "It also helps them turn various conversational cues into opportunities to discuss stopping smoking."

The online course presents a series of video scenarios to practice effective conversations with women who smoke in pregnancy and post-partum.

The training addresses the reasons why some women are not keen to quit, and helps teach how to initiate conversations in complex situations, how to handle myths and facts about smoking, and how to introduce helpful information.

The comprehensive and interactive training package is accessible online at the Ko Awatea Learn website. It is available to a diverse range of health sector workers, including GPs, midwives, lead maternity carers, obstetricians, Plunket and family planning workers and anyone else who works with pregnant women.

Professor of Public Health Interventions, Hayden McRobbie, and DHB Smokefree team members, Maria Lafaele, Leanne Catchpole and Dr Felicity Williamson, at the launch of the programme on World Smokefree Day.

74.9
AMENABLE DEATHS PER 100,000 (TARGET 70.7)

14,819
SMOKERS (31%) RECEIVED CESSATION SUPPORT FROM PRIMARY CARE (TARGET 27%)

51%
OF PATIENTS WITH A PRIOR CVD EVENT RECEIVED TRIPLE THERAPY (MAR-18) (TARGET 55%)

89%
OF MĀORI HAD THEIR CVD RISK ASSESSED (TARGET 90%)

95%
RECEIVED THEIR FIRST CANCER TREATMENT WITHIN 62 DAYS (TARGET 90%)

Note: The amenable mortality rates in this report have been calculated locally using 2015 mortality data and 2017 population projections.

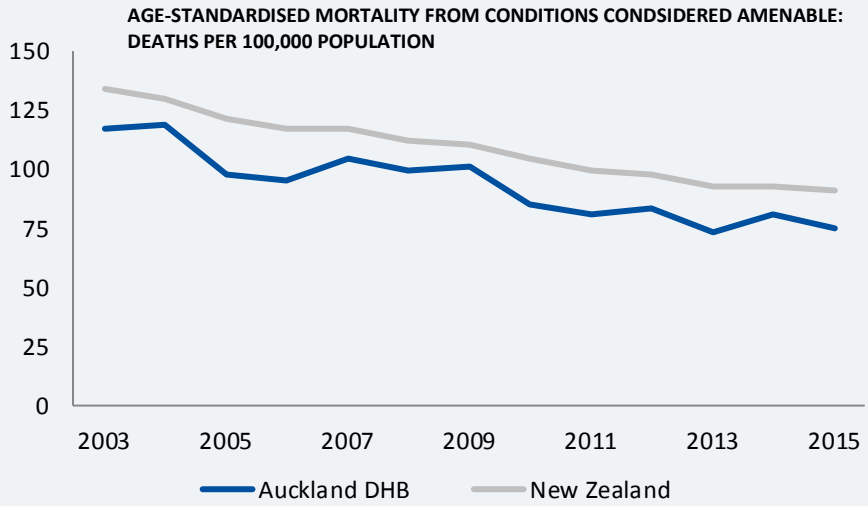
Fewer deaths from amenable conditions

Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist. Cardiovascular disease and some cancers account for more than half of all amenable deaths (27% each).

A reduction in mortality from conditions considered amenable

2017/18 improvement target: 3% reduction
(baseline = 72.9 deaths per 100,000 population, 2013)

The rate of amenable mortality is declining and is one of the lowest in New Zealand. In 2015, we estimate that 416 deaths (48% of all deaths in those aged under 75 years) in Auckland DHB were amenable – a rate of 74.9 deaths per 100,000 population. This was a decrease from the previous year, but did not meet our target of a 3% reduction from 2013.



Cardiovascular disease (CVD) is largely preventable and is associated with significant inequalities. There were 112 deaths from CVD in 2015 that were potentially avoidable 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. In 2017/18, 89% of eligible Māori had received a CVD risk assessment in the last 5 years; the coverage rate for the overall Auckland population was 92%.

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).

In the 12 months to March 2018, 51% of patients who had a previous CVD event were dispensed triple therapy medication (4,033 people).

Cancer is a leading cause of mortality and a significant proportion of cancer deaths are considered amenable. Early detection and rapid treatment of cancer improve the chance of survival. In 2017/18, 95% of patients who received their first cancer treatment were treated within 62 days of being referred with a high suspicion of cancer, an increase from 85% the previous year.

Auckland has the highest 5-year cancer survival rate in New Zealand, with 69% of people diagnosed with cancer in 2012-13 surviving at least five years after their diagnosis.

More heart and diabetes checks for Māori men

Māori adults have higher rates of most health conditions - including coronary heart disease, stroke and diabetes – leading to more time in hospital and more deaths.

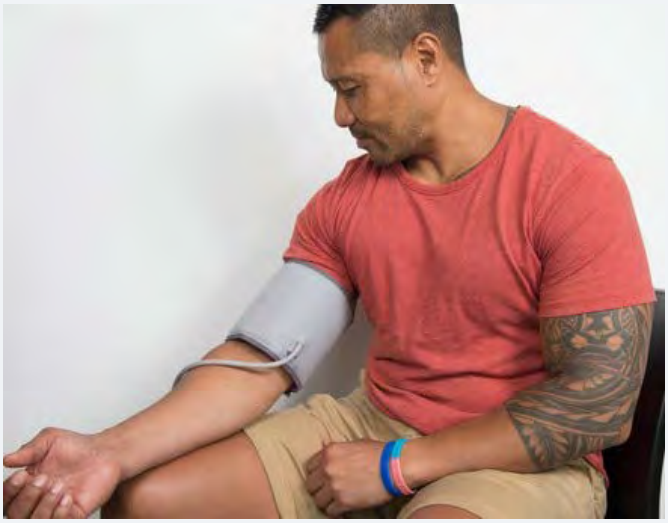
Māori, when compared to European New Zealanders are more than twice as likely to die from cardiovascular disease, 1.5 times as likely to be hospitalised for cardiovascular disease and twice as likely to die from ischaemic heart disease.

Much of the burden caused by cardiovascular disease (CVD) is preventable. Major modifiable risk factors include tobacco smoking, high blood pressure, high blood cholesterol, insufficient physical activity, overweight and obesity, diabetes, poor nutrition, and excessive intake of alcohol.

These risks can be reduced and diabetes and cardiovascular conditions respond well to being managed with appropriate care.

Risk assessment programmes help to identify and diagnose disease and reduce the development of more serious disease.

Māori develop diabetes and CVD earlier than non-Māori. Ideally, cardiovascular disease risk assessment (CVDRA) should be started ten years earlier in Māori (35 years for Māori men and 45 years for Māori women).



Blood pressure is one of the factors checked as part of a cardiovascular disease risk assessment.

PHOs reaching out to high needs populations

Auckland DHB's PHOs have been working to encourage Māori, in particular men aged 35-44 to come and get their cardiovascular disease risk check.

The Practice Network Team at Alliance Plus PHO initiated an incentive programme with their general practices. The scheme provided Rebel Sport vouchers for Māori males aged 35-44, who visited their GP for a CVDRA check.

Blood tests for cholesterol and glucose levels form part of the CVDRA. It has been identified that men are less likely to go to a lab for testing, so Auckland PHO have purchased portable devices that can perform these tests in GP practices. These machines are available to practices with high numbers of Māori men and/or those with significant numbers of patients who are not completing their blood tests.

Many of those missing out on risk assessment are in the very difficult to reach population – often those with a complete lack of contact details in the practice system.

Alliance Health Plus PHO Nurse Educator, Ranjeeta Lata, spent a number of days visiting local Marae, targeting Māori men, to get base line recordings of cholesterol and blood glucose levels.

At the end of June 2018, 89% of all eligible Māori had received a CVDRA check in the last 5 years, narrowly missing the 90% target. In the same period, 1,727 Māori men aged 35-44 had been checked - 76% of the eligible total.

Improving communication across cultures

Health literacy has been identified as a barrier to accessing healthcare for some high needs population groups.

To address this barrier practice staff at Auckland PHO are required to complete CALD (Culturally and Linguistically Diverse) training.

This training helps health care professionals communicate and interact effectively with people of different cultures.

Practice staff are required to ensure patients and their whānau are able to access, understand and act on information provided about their CVD risk. By ensuring patients have knowledge about the medicines they are prescribed and the lifestyle interventions they should undertake, patients and their whānau feel more confident about their ability to manage their CVD risk and to interact with their healthcare team.

WORLD-CLASS HEALTHCARE

We aim to provide rapid access to healthcare that is timely, equitable, high quality and safe, to reduce hospital stays and improve patient experience. In doing so, we will reduce the societal and economic burden poor health impacts.

THERE WERE

400

ACUTE HOSPITAL BED DAYS (PER 1,000 POPULATION) (TARGET <429)

203

PEOPLE OUT OF EVERY 1,000 ATTENDED AN EMERGENCY DEPARTMENT (TARGET <202)

6,028

PEOPLE WERE REFERRED TO PRIMARY OPTIONS FOR ACUTE CARE (TARGET 6,036)

89%

OF INPATIENTS RECEIVED CORONARY ANGIOGRAPHY WITHIN 3 DAYS (TARGET 70%)

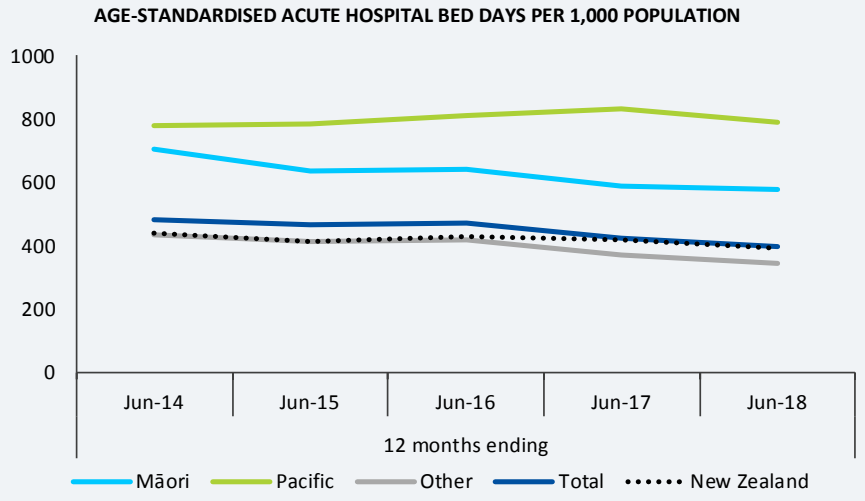
Using health resources effectively

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

A reduction in acute hospital bed days

2017/18 improvement target: 2% reduction
(baseline 438 acute bed days/1,000 pop – Metro Auckland)

Our standardised rate of acute bed days (400 per 1,000) is slowly declining and is now similar to the national rate. We have exceeded our target of a 2% reduction.



Emergency department attendances remained stable at 203 per 1,000 people in 2017/18. 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).

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. 2017/18 saw 6,028 patients referred to POAC, substantially meeting our target, and an increase of nearly 1,000 on the previous year.

Optimising patient flow within our hospitals, including reducing delays to diagnostic and treatment procedures, improves patient outcomes and reduces wasted bed days. For those admitted to hospital with ACS - acute coronary syndrome (e.g. unstable angina or heart attack) – it is important to perform coronary angiography quickly. In 2017/18, 657 ACS patients living in the Auckland DHB district received an angiogram, 89% within 72 hours, exceeding the 70% target.

Diagnostic testing in rural practices keeps patients out of hospital

The Auckland and Waitemata DHBs' Rural Alliance represents rural general practices covering the areas of Wellsford, Warkworth, West Rodney, Waiheke Island and Great Barrier Island, servicing an enrolled population of around 60,000 patients. It was set up in 2015 to improve care and services across rural Auckland and Waitemata, focusing on treating people in their communities and avoiding hospitalisations.

The first two major projects have been completed.

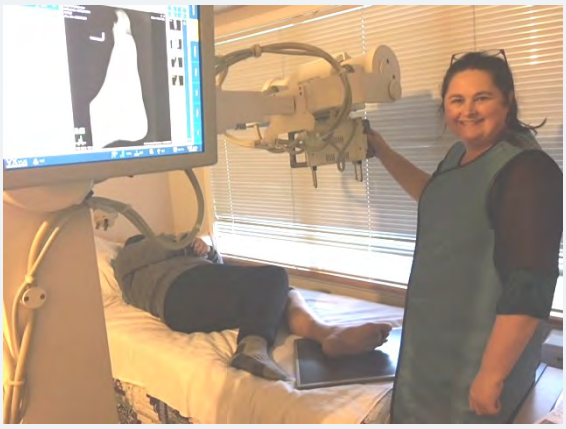
Upgrade of x-ray equipment on Great Barrier Island

Great Barrier Island lies in the outer Hauraki Gulf, 100km north-east of central Auckland. Aotea Health is the sole provider of primary care on Great Barrier, with an enrolled population of nearly 1,000 patients, 75% of which are high needs patients.

With the retirement of the doctor who had previously run the x-ray service, and reliance on out-dated technology, this service was in danger of discontinuation. This would have resulted in people needing to travel off the island to obtain x-ray services.

A new model of x-ray service delivery on Great Barrier Island was developed for patients who present with suspected uncomplicated fractures. X-rays are now performed on the island and sent to Auckland DHB for near real-time review by the radiology department. Specialist advice is then provided back to GPs on the island to support community patient management and avoid the need to transfer the patient to Auckland City Hospital.

The service is based on the nurse-led model developed by Canterbury DHB for their remote and rural general practices, including the Chatham Islands. Auckland DHB staff provided training to two nurses from Aotea Health on how to use the newly upgraded x-ray machine and the Auckland DHB radiology IT systems.



Rural Nurse, Wendy Millward, with the first digital x-ray taken on Great Barrier Island

Rural Point of Care Testing Service

Point of care testing (POCT) is diagnostic testing where the analysis of the result is carried out near the patient (e.g. in a GP surgery), rather than being sent to a laboratory.

The Rural Alliance identified the most clinically valuable POCT tests for the management of people presenting acutely unwell in a rural setting. The following POCT blood tests are now carried out by all rural general practices across Auckland DHB and Waitemata DHB areas:

- Troponin - a protein found in heart muscle and released into the blood when there is damage to the heart. This is a specific test for a suspected heart attack.
- D-dimer - a test used to rule out active blood clot formation for deep vein thrombosis and pulmonary embolism.
- International normalised ratio (INR) - checks the time taken for blood to clot. This test is used for patients taking warfarin to ensure that they are not at risk of bleeding.
- Full blood count - a broad screening test to check for conditions such as sepsis, anaemia, infection, and inflammatory disorders.

POCT in rural general practices provides rapid results to assist clinical diagnosis and decision making. Unnecessary emergency department presentations and/or hospitalisations are reduced as GPs can more confidently predict which patients require specialist care.

Feedback from practices has been very positive. Aotea Health on Great Barrier Island reports that the POCT analysers have assisted doctors when deciding whether it is clinically necessary to transfer a patient to hospital (often by helicopter).

> *A 69 year-old presented with right calf pain and swelling, indicating a possible blood clot. Unable to access an ultrasound on the island, the GP chose to perform a POCT d-dimer test, which showed a negative result. The GP was reassured that the patient was not at risk and felt that, without the POCT equipment, she would have transferred the patient off the island for ultrasound investigation.*

Ensuring patient-centred care

Patient experience is a good indicator of the quality of health services. Improved patient experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care.

90%

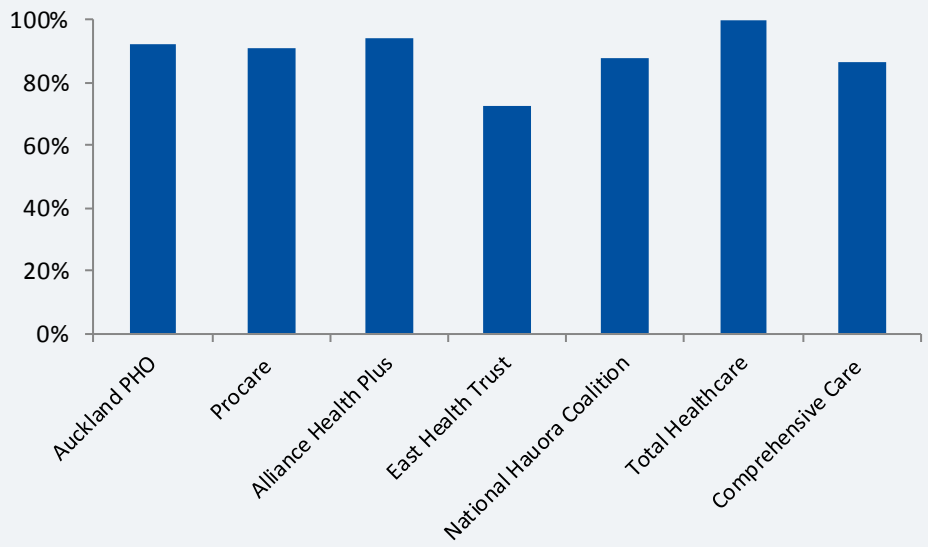
OF PHO PRACTICES ARE PARTICIPATING IN THE PHC PES – MAY 2018 (TARGET 50%)

Proportion of PHO practices participating in the primary health care Patient Experience Survey (PHC PES) by June 2018

2017/18 improvement target: 50%

The primary care patient experience survey was developed by HQSC to find out what patients' experience in primary care is like 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. By May 2018, 90% of practices in Metro Auckland were participating in the survey.

PROPORTION OF METRO AUCKLAND PHO PRACTICES PARTICIPATING IN THE PHC PES – MAY 2018



61%

OF PHO PRACTICES HAVE A PATIENT PORTAL (TARGET 55%)

19%

OF PHO-ENROLLED PATIENTS HAVE ACCESS TO PORTAL (TARGET 15%)

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.

The use of patient portals is associated with improvements in patient-provider communication and an increase in patients feeling that they were able to take a more active role in medical decision-making. For those with a chronic illness such as diabetes, patient portals can also provide a vehicle to receive ongoing self-management support. At the end of March 2018, 61% of Metro Auckland practices had an online portal and 19% of all PHO registered patients had signed up for access – exceeding our goals for the year.

8.8/10

AVERAGE SCORE IN THE HQSC INPATIENT SURVEY – MAY 2018 (TARGET 8.5)

The HQSC inpatient survey rates patient experience across four domains: communication, coordination, partnership, and physical and emotional needs. This measure will provide new information about how people experience health care, how integrated their care is and may highlight areas that we need to have a greater focus on.

Our average scores have improved since the survey was implemented and are similar to New Zealand as a whole. For patients treated in May 2018, our scores were: Communication 8.5: coordination 8.7; partnership 8.9; and physical and emotional needs 9.0.

Removing barriers to weight-loss surgery improves equity

Obesity is one of the main causes of poor health and premature death in New Zealand.

Surgery is an effective treatment for those who are severely or morbidly obese and have been unable to lose weight and maintain the weight loss. The procedures either restrict the amount of food people are able to eat, absorb or both. Surgery is not for everyone and it involves a degree of risk and also a commitment to a permanent lifestyle change.

Fewer Māori and Pacific people than expected undergo bariatric surgery, and this is something our DHB set out to address.

Patient experience drives service change

In 2015 we began a programme of work with Waitemata DHB to develop a standardised approach to bariatric surgery and improve access for Māori and Pacific people.

An audit identified that attrition rates were significantly higher for Pacific people than other ethnicities, with more than 70% of Pacific patients referred not completing surgery.

We consulted with Māori and Pacific people who have been engaged with bariatric services, to better understand their experiences and identify areas for improvement. The consultation feedback and audit results helped drive several service improvements. These include:

- The acceptance criteria were amended to no longer exclude smokers and the requirement to lose weight prior to surgery was abolished.
- The assessment process was streamlined with patients seen in a multidisciplinary one-stop-shop and provided with certainty about dates.
- Psychological support was strengthened, in response to patient feedback.

Early indications from the latest data show that the attrition rates for Pacific and for Māori patients have substantially reduced and are now similar to non-Māori non-Pacific rates. This means that more people are being supported to successful completion of surgery.

In 2017/18 68 people received bariatric surgery at Auckland DH, and of these 37 were Māori or Pacific.

"Surgery changed my life"

After research and a referral from his GP to surgeon Mr Nicholas Evennett, 49 year-old Mike* underwent bariatric surgery at Auckland City Hospital in June 2018.

After working hard to lose weight pre-surgery, and attending meetings with a specialist nurse, dietitian and psychologist, Mike qualified for the publicly funded surgery.

* name changed for privacy

Mike says he chose the bariatric surgery path after trying several diet plans and exercise regimes and, in his words, failing miserably.

"Surgery changed my life. It probably also extended it by up to 20 years. I have significantly reduced my chances of contracting [sic] diabetes, high blood pressure, heart disease and, hopefully, will reduce my need for a CPAP machine when sleeping. I look and feel healthier and I find it much easier to find clothes that fit. I'm also playing sport for longer and with less pain so I'm enjoying it much more."

Mike says he could not have gone through the whole process without the professional guidance and assistance of the Auckland DHB staff who facilitated his life-change.

"I know I came to the programme with my mind set on achieving results and I was as prepared as I could be, but I couldn't have done what I've done without the care and assistance of the Auckland DHB team, particularly that of bariatric nurse Elaine Yi, who went out of her way to accommodate my work schedule when it came to arranging appointments."

At his heaviest Mike weighed 136kg. His surgery weight was 116kg and he currently weighs 94kg. His goal weight is 85-90kg.

Mike has ongoing post-operative care including regular meetings with his dietitian, nurse and surgeon. He's also part of a pilot programme with the ExerScience Clinic which is examining whether it's feasible to implement a mandatory exercise component to the overall bariatric programme.

Mike's advice to anyone in a similar situation is simple.

"Seek advice from your GP, ask them to submit a referral to ascertain your eligibility for publicly funded bariatric surgery. Just do it!"

Mike, before and after his life-changing surgery

ACHIEVED TOGETHER

Ensuring that children and young people have the best start to life is crucial to the health of the total population. Promoting healthy behaviours and well integrated, accessible primary and community services can prevent health problems and improve health outcomes.

7,218
PER 100,000
ASH ADMISSIONS IN
0-4 YEAR OLDS
(TARGET <7,278)

787
PER 100,000
ASH ADMISSIONS IN
0-4 YEAR OLDS
FOR SKIN INFECTIONS
(TARGET <771)

92%
OF PRE-SCHOOL
CHILDREN WERE
ENROLLED WITH ORAL
HEALTH SERVICES
(TARGET 95%)

61%
OF CHILDREN WERE
DENTAL CARIES FREE AT
AGE 5 (2017)
(TARGET 65%)

94%
OF AUCKLAND CHILDREN
WERE FULLY IMMUNISED
BY 8 MONTHS OF AGE
(TARGET 95%)

Keeping children out of hospital

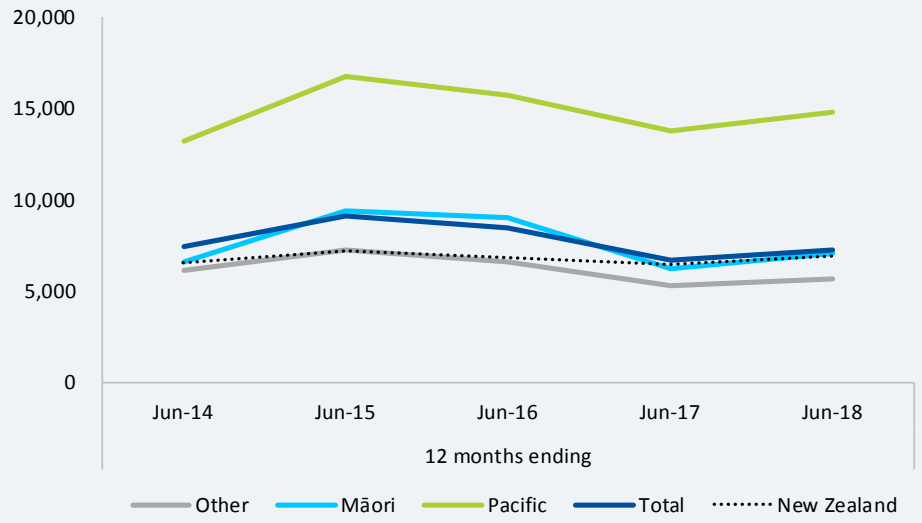
We seek to reduce admission rates to hospital for a set of diseases and conditions that are potentially avoidable through prevention or management in primary care (ambulatory sensitive hospitalisations – ASH). In children, these conditions are mainly respiratory illnesses, gastroenteritis, dental and skin conditions.

Ambulatory sensitive hospital admissions in those aged 0-4

2017/18 improvement target: 5% reduction
(baseline = 7,661 per 100,000, Sep 2016)

In the 12 months to June 2018, there were 7,218 admissions per 100,000 in our 0–4 year old population (2,063 events) that were considered ambulatory sensitive, substantially achieving our target. Rates for Pacific children are twice as high as other ethnicities, and in 2017/18 our efforts were focused on high need groups.

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



In 2017/18, 225 children were admitted to hospital with serious skin infections, including cellulitis, dermatitis and eczema. More than half of these children were Māori and Pacific. We worked with primary care, Well Child Tamariki Ora services, early childhood centres and community groups to promote key prevention messages to young families, with a particular focus on Pacific children. This has helped see a reduction in admissions for skin infections.

Hospitalisations due to dental conditions in the 0-4 age group make up about 10% of ASH admissions (199 events last year), and are increasing. Improving accessibility of oral health programmes will reduce the prevalence and severity of early childhood dental decay (caries), and reduce the numbers requiring treatment in hospital. At the end of December 2017, 92% of all pre-schoolers were enrolled with oral health services, although this figure was much lower for Māori (69%).

Immunisation prevents serious childhood diseases, including rotavirus and pneumococcal pneumonia that can result in hospitalisation. During 2017/18 we fully immunised 94% of children by eight months of age. Immunisation rates in Māori children are lower than the total population, at 85%, and closing this equity gap continues to be a focus.

Kainga Ora service helping make homes healthier

A warm, dry home can be a game changer when it comes to people's health, particularly as winter approaches.

Kainga Ora is a free Healthy Homes Initiative funded by the Ministry of Health to help low income families live in warm, dry healthy homes.

The shortage of affordable housing in Auckland has led to more families living in crowded, poor quality housing. Cold, damp, crowded homes contribute to recurrent and chronic respiratory illnesses, as well as preventable conditions, such as rheumatic fever and skin infections.

Unhealthy homes are a huge problem in New Zealand, Kainga Ora project lead Gaylene Leabourn says.

"You wouldn't believe some of the conditions families live in, and it can have devastating effects on their health. The quality of some houses is very poor and our most vulnerable families are living in these unhealthy homes," she says.

Patients in the Auckland and Waitemata District Health Board areas can be referred to Kainga Ora by health professionals.

The service targets children aged 0–5, all young people with rheumatic fever, pregnant women and new mothers. It works with people living in private rentals, social housing, as well as homeowners.

Once a referral is made, a social work team visits the family to identify changes needed to make the house warmer and drier.

The service helps with insulation, ventilation, heating, carpet, curtains and repairs. Help can also come in the form of education and social support.

Kainga Ora project co-ordinator Jean Golbin says the service also gives out blankets, kids' pyjamas, heaters, thermometers to gauge house temperature and humidity levels, and anti-mould kits.

The team will look at the whole family situation, not just the physical house. There can be a huge amount of complexity which impacts on the logistics of the family's day to day life. There may also be mental health issues, support may be needed with budgeting, information about WINZ entitlements or they may need help to navigate the process of applying for social housing.

In the year since Kainga Ora was launched, the service has helped 712 families, including 1,122 home interventions (e.g. curtains, carpet, and repairs) and helped 77 families move into social housing.

Kainga Ora staff (from left, Jean Golbin, Gaylene Leabourn, Ron Kuriyan) with some of the items available to families in need.

Youth are healthy, safe and supported

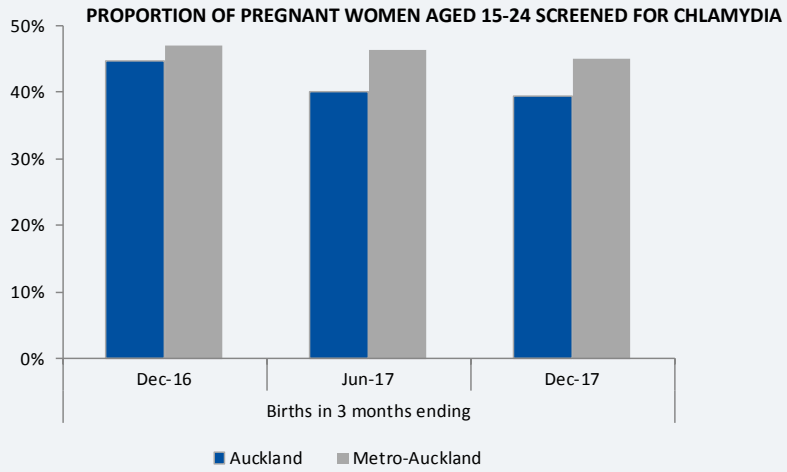
The youth System Level Measure consists of five domains, reflecting the complexity of issues impacting youth health and wellbeing. Auckland DHB has chosen to focus on the sexual and reproductive health domain, specifically on chlamydia screening with a focus on testing during pregnancy. Chlamydia is the most commonly reported sexually transmitted infection in Auckland, with the incidence highest in young people. Carriers often have no or non-specific symptoms. Left untreated, chlamydia in pregnancy can be passed on to the baby at delivery.

39%

OF PREGNANT WOMEN AGED 15-24 WERE SCREENED FOR CHLAMYDIA OCT-DEC 2017 (TARGET 80%)

Proportion of pregnant women aged 15-24 years screened for chlamydia
2017/18 improvement target: 80%

Of the 170 women aged 15-24 who gave birth between October and December 2017, 39% were screened for chlamydia (67 women), a slight decrease on the previous year and significantly below our target of 80% coverage. Data tools are being developed to help alert LMCs and primary care providers to women who have not yet been tested.



12%

OF METRO AUCKLAND MĀORI AND PACIFIC YOUTH (15-24 YEARS) WERE SCREENED FOR CHLYAMYDIA (TARGET IS TO ESTABLISH BASELINE)

In 2017, 12.2% of all 15-24 year old Māori and Pacific youth living in Metro Auckland were tested for chlamydia (9,632 people). This was slightly higher than the total youth population rate of 11.6%. While our goal for 2017/18 was to establish a baseline to measure improvement against, international modelling suggests testing coverage needs to be between 30–40% to begin to reduce prevalence of infection.
Testing rates for Auckland DHB were slightly lower than the other DHBs in the region at 10.8%. Youth PHO enrolment (71%) is low in Auckland DHB and this contributes to the lower domiciled population screening rate.

40%

OF WOMEN AGED 15-24 YEARS REGISTERED WITH AN LMC IN THE FIRST TRIMESTER OF PREGNANCY – 2015 (TARGET 80% by 2019)

Early engagement with a Lead Maternity Carer (LMC) is associated with healthy births and better pregnancy outcomes. LMCs are encouraged to offer chlamydia testing to all pregnant women, in line with Ministry of Health recommendations. Testing can also be carried out in Primary Care. Diagnosis earlier in pregnancy allows an infection to be treated before delivery, reducing the risk to both mother and baby. Rates of registration with an LMC during the first trimester of pregnancy are lower in younger women. In 2015, 40% of pregnant women aged 16-24 years registered with an LMC in the first trimester compared with 69% for all ages.

99%

OF YEAR 9 STUDENTS IN ELIGIBLE SCHOOLS RECEIVED A HEEADSSS ASSESSMENT (TARGET 95%)

Mental health and wellbeing is one of the 5 domains of youth health under the national youth SLM. HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) Assessment allows for early identification of mental health, alcohol and drug issues and other information to assist young people in their development. Assessments are carried out by School Based Health Services nurses for Year 9 students in low decile schools. In the 2017 school year, 99% of students at eligible schools received assessments.

School-based health services making a difference to kids in need

Auckland District Health Board is leading the way with youth friendly, confidential, and easy to access health services, based in high schools.

Young people attending lower decile secondary schools are less likely to be able to access youth appropriate primary health care when they need it. This can result in missed opportunities for preventative health care and poorly managed or untreated health conditions. As well as the negative impact on a young person's health it can affect educational outcomes.

Locating free health services in schools improves access to health care services for students by reducing some of the barriers to health care such as lack of transport and cost. And access is not just about location - because school based health services are culturally sensitive, youth-friendly, and clearly stated as confidential they also remove barriers around other common concerns for young people accessing health services. Students learn how to use health services in a friendly, private and developmentally appropriate environment.

Ten secondary schools and five Alternative Education and Teen Parent Units receive DHB funded student health services. This means a nurse is available at school, supported by a visiting general practitioner. Nurses and GPs alike are youth specialists, experienced and qualified in the area of youth health.

In 2019 this highly valued, youth friendly health service will expand to students in decile four schools, reflecting the on-going successful partnership between the DHB, Primary Healthcare Organisation and secondary schools.

Identifying problems early

A psychosocial health assessment is carried out for all students when they start secondary school at Year 9, and any newly arrived Year 10-13 students.

As well as assessing overall physical health, nurses ask about home, education/employment, eating, activities, drugs and alcohol, suicide and depression, sexuality and safety (HEEADSSS) with young people. Any unmet physical, mental or sexual health issues are identified. Students can then be treated or appropriately referred. Nurses coordinate services around the student to address the student's needs in conjunction with school counsellors, social workers, and other community primary and secondary health care providers.

In 2017 we provided HEEADSSS assessment to 99 per cent of the students in our school based programme.

Contributing to population health – School Based HPV Immunisation

This is the first year that the HPV immunisation programme has been introduced for boys, as HPV infections cause cancers in men as well as women. The vaccine is given via a school based programme. The target is currently set at 70% for girls and will move to include boys in June 2019 once a full birth cohort of 12 year old boys have been offered immunisation in school year 8.

Auckland DHB continues to lead the country with 83 per cent of 12 year old girls fully immunised, as well as demonstrating success in equitable coverage for Māori (84%) and Pacific (87%).

Some of the nurses working in Auckland schools as part of Enhanced School Based Health Services in 2017/18.

Registered Nurse, Marie Shepherd, swabs the throat of a student at Mt Roskill Grammar School.

Our people,
Our performance

Delivering on our plans

STATEMENT OF PERFORMANCE

Overview

The Statement of Performance (SP) presents a snapshot of the services provided for our population and how these services are performing, across the continuum of care provided. The SP is grouped into four output classes: Prevention services, Early Detection and Management, Intensive Assessment and Treatment, and Rehabilitation and Support Services. Measures that help to evaluate the DHB's performance over time are reported for each output class, recognising the funding received, Government priorities, national decision-making and Board priorities. These measures include the Minister of Health's six Health Targets.

Measuring our outputs helps us monitor progress towards our system level measure targets and overall outcome goals of an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Auckland DHB's population life expectancy is now 82.9 years, an increase of 1.9 years over the last decade. The life expectancy gap is 4.6 years for Māori and 8.0 years for Pacific. While the gap has decreased for Māori over this time to 4.6 years, it has got slightly wider for Pacific.

Our DHB is responsible for monitoring and evaluating service delivery, including audits, for the full range of funded services. Some of the measures in each section reflect the performance of the broader health and disability services provided to Auckland residents, not just those provided by the DHB. We have a particular focus on improving health outcomes and reducing health inequalities for Māori. Therefore, a range of measures throughout the SP monitor our progress in improving the health and wellbeing of our Māori population, as identified in the Auckland and Waitemata DHBs' Māori Health Plan 2017/18.

National Health Targets

2017/18 was a year of impressive achievements for our DHB. Focus on 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 four of the seven Health Targets, according to Ministry of Health assessment criteria.

Health Targets	Health Target Description	2017/18				
		Q1	Q2	Q3	Q4	Full Year
Shorter Stays in Emergency Departments	95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours	**90%**	**93%**	**90%**	**91%**	**91%**
Improved Access to Elective Surgery	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs)[1], target = 17,881	**4,497 (98%)**	**8,579 (94%)**	**12,513 (94%)**	**17,321 (97%)**	**17,321 (97%)**
Faster Cancer Treatment	90% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment[2]	**93%**	**99%**	**91%**	**91%**	**95%**
Increased Immunisation	95% of eight months olds will have their primary course of immunisation on time	**95%**	**93%**	**94%**	**94%**	**94%**
Better Help for Smokers to Quit	90% seen in primary care provided with advice to help quit	**88%**	**87%**	**89%**	**92%**	**92%**
	90% of newly registered pregnant women provided with advice to help quit	**100%**	**99%**	**98%**	**92%**	**97%**
Raising Healthy Kids	95% of obese children identified in the B4SC programme will be offered a referral to a health professional[3]	**100%**	**100%**	**100%**	**100%**	**100%**

[1] Auckland DHB's targeted increase (share of the New Zealand total additional 4,000 discharges) is 651 additional discharges; quarterly results are year to date.
[2] This result does not include patients that have not yet received their first treatment. Patients still waiting longer than 62 days as at the reporting date, will not be reported as a breach because the first treatment has not yet occurred. Quarterly results are for checks completed in the rolling 6-month period to the end of the quarter.

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. In 2017/18, we improved or maintained our compliance across a number of the HQSM markers:

Health Quality and Safety Markers	2016/17	2017/18
80% compliance with good hand hygiene practice	85%	85%
90% of older patients assessed for the risk of falling	93%	85%
% of patients assessed at risk of falling who received an individualised care plan	96%	92%
100% of hip and knee arthroplasty primary procedures given antibiotic in right time	95%	100%[1]
95% of hip and knee arthroplasty procedures given right antibiotic in right dose	95%	96%
95% of audits of surgical safety checklist engagement score levels of 5 or higher[2]	Sign in – 97% Time out – 97% Sign out – 89%	Sign in – 95% Time out – 95% Sign out – 89%

[1] Q3 2017/18

Output class measures

The criteria against which we measure our output performance for the year was revised in 2014/15 and we continue with this grading system for 2017/18. This has been applied to assess performance against each indicator in the Output Measures section. A rating has not been applied to demand driven indicators.

Criteria		Rating	
On target or better		Achieved	
95-99.9%	0.1% - 5% away from target	Substantially achieved	
90-94.9%	5.1% - 10% away from target, and improvement on previous year	Not achieved, but progress made	
<90%	>10% away from target, or 5.1-10% away from target and no improvement on previous year	Not achieved	

The following tables include our output measures from the 2017/18 Statement of Performance Expectations by Output Class. Outputs are goods or activities provided by the DHB and other entities and provide a snapshot of the services we deliver. Output measures are intended to reflect our performance for the year. The 'measure type' symbols define the type of measure and are included in brackets after the measure description. Some indicators do not have set quantitative targets, rather expected performance directions, and these have been assigned the below symbols in the target column.

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

[3] Quarterly results are for checks completed in the rolling 6-month period ending one month prior to the end of the quarter, as per MoH definition. The FY result is for the 12-month period Jun 2017 to May 2018 (thus the Q1 result is only partly represented in the FY result).

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. Outputs and activities provided by general practice (including cervical screening and immunisation) are covered under Primary Care in Output Class 2. A significant portion of the work of Primary Care is preventative.

Output measure	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Health promotion					
HT: % of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months (C)	91.2%[4]	92.2%	91.8%	90.0%	●
HT: % 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)	99.3%	97.0%	96.9%	90.0%	●
% of PHO-enrolled patients who smoke who received cessation support(Q)	24.7%[5]	26.7%	31.0%	27.2%	●
Raising Healthy Kids HT: % of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (Q)	38%[6]	98.7%	100%	95.0%	●
Number of clients engaged with Green Prescriptions (V)	New indicator	New indicator	4,316 (95.9%)	4,500	●
Increased Immunisation HT (C): - % of eight months olds will have their primary course of immunisation on time (total population) - % of eight months olds will have their primary course of immunisation on time (Māori)	 94% 88%	 94.7% 89.0%	 93.9% 85.8%[7]	 95.0% 95.0%	 ● ●
Rate of HPV immunisation coverage (2004 birth cohort) (C)	83.3%	81.3%	83.4%	75.0%	●
Population-based screening					
% of women aged 50-69 years having a breast cancer screen in the last 2 years (C)	64.7%	63.6%	63.4%[8]	70.0%	●
% of women aged 25-69 years having a cervical cancer screen in the last 3 years (C)	76.6%	68.6%	64.7%[9]	80.0%	●
HEEADSS assessment coverage in DHB-funded school health services (C)[10]	93%	93%	99%	95%	●
% of 4-year-olds receiving a B4 School Check (C)	95%	93%	91%	90%	●
Number/proportion of babies offered and screened within 1 month (newborn hearing) (V)	8,309 (98%)	100%	6,861 (97.1%)	90%	●
Auckland Regional Public Health Service[11]					
Number of tobacco retailer compliance checks conducted (V)	341	316	372	300	●
Number of license applications and renewals (on, off club and special) received and are risk assessed (V) (criteria change in year)	4,208	3,870	2,112	Ω	N/A
% of tuberculosis (TB) and latent TB infection cases who have started treatment and have a recorded start date for treatment (Q)	98%	94%	95%	95%	●
Number of assessments related to requirements of the Drinking-Water Standards (V)	45	57	57	57	●

[4] Result incorrectly reported as 88% in our 2017/18 annual plan.
[5] Result for Q1 2016/17.
[6] Result for the 6 months ending 31 March 2016.
[7] We have an active work programme with our PHO partners for initiatives to improve engagement and on-time immunisation for tamariki Māori. The high decline rate for Māori (around 7.9%) has been raised with PHOs and they have agreed to standardise a programme of data-matching with the PMSs and NIR.
[8] The decrease in coverage rate is partly due to increasing population denominator, and is particularly poor in Māori women. We are working with providers and NSU to improve data-matching processes to enable better invitation to the service and more effective recall for subsequent screens and increase promotion.
[9] We continue to promote screening and work to increase access with opportunistic screening, broader clinic hours, support for high priority women, community outreach and use of NSU data match lists to address the declining coverage rates; Māori and Pacific women remain a priority focus for promotion.
[10] 2015/16 baseline and 2016/17 result = CY 2016 result; 2017/18 = CY 2017 result.
[11] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.

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	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Primary health care					
Rate of primary care enrolment (Māori) (C)	78%	76%	76%[12]	90%	
Number of referrals to Primary Options for Acute Care (POAC) (V)	4,544	5,060	6,028	6,036	
% 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	New indicator	62.4%[13]	75.0%	
% of the eligible population who have had their CVD risk assessed in the last five years (Māori) (C)	89.3%	88.9%	89.1%	90.0%	
% of patients with CVD risk >20% on dual therapy (dispensed) (Q)[14]	41.6%	42.2%	41.6%[15]	44.9%	
Percentage of patients with prior CVD who are prescribed triple therapy (Q)[14]	52.7%	52.2%	51.1%[16]	55.3%	
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 0-4 year olds - skin infections subset (Q)	812[17]	663	787	771	
Pharmacy					
Number of prescription items subsidised (V)	6,787,090	6,863,281	6,868,238[18]	Ω	N/A
Community-referred testing and diagnostics					
Number of radiological procedures referred by GPs to hospital (V)	22,817	26,950	28,713	Ω	N/A
Number of community laboratory tests (V)	3,256,265	3,155,523	3,260,656	Ω	N/A
Oral health[19]					
% of preschool children enrolled in DHB-funded oral health services (C)	83%	83%	92%	95%	
Ratio of mean decayed, missing, filled teeth (DMFT) at Year 8 (Q) - 2017 - 2018	0.75	0.75	0.64	0.72 0.72	
% of children caries free at five years of age (Q) - 2017 - 2018	60%	60%	61%	65% 65%	
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years (C)	69%	69%	77%	85%	

[12] It has been identified that not all opportunities to ask about and promote enrolment with a GP are being utilised. The DHB has identified dedicated resource to support data matching between primary care and community providers. This will identify their shared populations and also any unenrolled people. Community providers are being encouraged to check with clients when accessing services to make sure they are enrolled.
[13] Auckland DHB and our PHOs are committed to improving diabetes outcomes with a specific focus on our high need and high risk populations, using a holistic system-wide targeted approach; the first step is being undertaken as part of the Diabetes Service Level Alliance flagship co-design project.
[14] 2015/16 baseline = result for 12 months to Sep 2016; 2016/17 result = result for 12 months to Mar 2017; 2017/18 result = result for 12 months to Mar 2018.
[15] The CVD risk equations changed in early 2018, signalling lower risks for many patients; until the new definition is implemented, we expect the number of patients receiving dual therapy to remain relatively unchanged. It might not always be clinically appropriate to prescribe these medications.
[16] We shifted our CVD funding model for PHOs in Jan 2018 to include a focus on CVD risk management; this is starting to improve triple therapy prescribing rates.
[17] Result for 12 months to Sep 2016.
[18] Result for 12 months to March 2018. June 2018 data not available at time of publication.
[19] 2015/16 baseline and 2016/17 result = result for CY 2016; 2017/18 = data for CY 2017.

Output Class 3: Intensive Assessment and Treatment

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

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary 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.

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

Output measure	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Acute Services					
ED presentation rate per 1,000 population (V)	206.3[20]	203.3	203.1	202.2	
Shorter stays in Emergency Departments HT: % of ED patients discharged admitted or transferred within six hours of arrival (T)	94.6%	94.9%	90.8%	95.0%	
Faster Cancer Treatment HT: % 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)	76.6%	84.6%	94.8%	90.0%	
% of eligible stroke patients thrombolysed (C)	9.8%	10.6%	11.8%	8.0%	
% of ACS inpatients receiving coronary angiography within 3 days (T)	86.8%	85.0%	89.5%	70%	
Maternity					
Number of births in Auckland DHB hospitals (V)	7,173	7,256	6,758	Ω	N/A
Proportion of women registering with LMCs ≤12 weeks (T)	69%[21]	70%[22]	N/A	80%	N/A
Elective (inpatient/outpatient)					
Improved Access to Elective Surgery HT: number of elective surgical discharges (V)	16,818 (100.7%)	16,822 (97.6%)	17,321 (96.9%)	17,881	
Surgical intervention rate (per 10,000 population) (C)					
- Major joints	18.9	15.2	19.28	21.0	
- Cataracts	40.9	37.3	44.82	27.0	
- Cardiac surgery	5.3	5.2	5.61[23]	6.5	
- Angioplasty (PCR)	11.5	11.7	12.12	12.5	
- Angiogram	31.1	29.5	32.17	34.7	
% of people receiving urgent diagnostic colonoscopy in 14 days (T)	96%	95%	99.6%	90.0%	
% of people receiving non-urgent diagnostic colonoscopy in 42 days (T)	79%	88%	73.5%	70.0%	
% of patients waiting longer than four months for their first specialist assessment (ESPI 2) (T) [24]	0.1%	0.3%	0.1%	0.0%	
% of accepted referrals receiving their scan within 6 weeks (T)					
- CT	98%	94.6%	92.9%	95.0%	
- MRI	52%	65.6%	68.0%[25]	90.0%	

[20] Data for year ending Sep 2016.
[21] CY2015 MOH MAT data. Independent LMCs only. Baseline in AP calculated using different method which we are unable to replicate with current data.
[22] CY2016 MOH Maternity Clinical Trends data. This is the most recent data made available by the MOH (LMC claims data has very long time lags).
[23] High transplant and complex volumes reduced capacity; we monitor patients closely and our overall wait times remain within MoH targets.
[24] Assessment of performance is based on Ministry of Health criteria. There have been some capacity restrictions and equipment failure along with higher than expected patient complexity.
[25] We experienced increased acute volumes and reduced capacity from staff vacancies and a 6-day scanner failure; we are outsourcing and adding evening sessions until new staff are in place.

Output measure	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Quality and patient safety					
Aggregated score for the four domains of the HQSC inpatient survey (Q)	8.3[26]	8.3	8.8	8.5	
% of opportunities for hand hygiene taken (Q)	84%[26]	84%	86%[27]	80%	
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days (Q)	0.14	0.21	0.21[28]	<0.12[29]	
% of falls risk patients who received an individualised care plan (Q)	96%[26]	94%	94%	90%	
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions (Q)	5.07	10.77	3.91	<8.0[30]	
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision (Q)	94%[26]	97%	97%[27]	100%	
% of hip and knee procedures given right antibiotic in right dose (Q)	94%[26]	97%	96%[27]	95%	
Surgical site infections per 100 hip and knee operations (Q)	1.56	0.5	0.78[27]	<0.8	
Mental health					
Percentage of population who access mental health services (C):					
- Age 0–19 years	3.21%	3.42%	3.31%	3.00%	
- Age 20–64 years	3.77%	3.61%	3.50%	3.70%	
- Age 65+ years	3.14%	2.99%	2.89%[31]	3.10%	
% of 0-19 year old clients seen within 3 weeks (T)					
- Mental Health	75.0%	72.9%	68.0%[32]	80.0%	
- Addictions	95.8%	96.3%	94.5%	80.0%	
% of 0-19 year old clients seen within 8 weeks (T)					
- Mental Health	89.4%	89.4%	88.5%[32]	95.0%	
- Addictions	100%	100%	97.8%	95.0%	

[26] 2015/16 baseline = Q2 CY 2016 result.
[27] 2017/18 result = YTD Q3 2017/18 result.
[28] Despite a stable rate of staphylococcus bacteraemia, hand hygiene remains a focus and we continue to comply with the hand hygiene process marker.
[29] Jan 2012 to Jun 2016 national medium result.
[30] Nov 2014 to Jun 2016 national medium result.
[31] The number of people seen has increased more than projected population figures; however, rates for Māori population are above targets at all age groups.
[32] Increased referrals in the winter months coincided with staff turnover and recruitment of new and more junior clinicians who require time to orient and achieve full capacity. A training programme for new staff has begun and is well received.

Output Class 4: Rehabilitation and Support Services

Rehabilitation and support are delivered following an assessment process and coordination input by Needs Assessment and Service Coordination (NASC) Services for various services (e.g. palliative care, home-based support, residential care).

By helping to restore function and independent living, the main contribution of rehabilitation and support services to health is in improving health-related quality of life. There is evidence this may also improve length of life. Ensuring rehabilitation and support services are targeted to those most in need helps to reduce health inequalities. Effective support services significantly contribute to people living at home for longer, thus not only improving their well-being but also reducing institutional care costs.

Output measure	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Home-based support					
Proportion 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) in the last 24 months (Q)	95.3%[33]	93.2%	88.9%[34]	95.0%	🔴
Palliative care					
Proportion of hospice patient deaths that occur at home (Q)	26%	26%	24%[35]	↑	🔴
Proportion of patients acutely referred who waited >48 hours for a hospice bed (T)	<1%	4.3%	2.1%[36]	1%	🔴
Number of Palliative Pathway Activations (PPAs) (V)	New indicator	New indicator	10[37]	200	🔴
Number of Hospice Proactive Advisory conversations between the Hospice Service, Primary Care and ARC health professionals with patients and whānau (V)	New indicator	New indicator	10[37]	200	🔴
Residential care					
ARC bed days (V)	960,118	960,259	931,284	Ω	N/A
% of LTCF clients admitted to an ARC facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first LTCF assessment (by facility) (Q)	New indicator	86%	89%	98%	🟡

[33] Mar 2016 result.
[34] We are meeting the MoH target of 95% of HCSS clients have had an interRAI assessment (at any point in time). We are reviewing the timeframes and approach for assessments of HCSS clients. The focus in the future will be on regular client reviews and reassessment when there is a change in a client's condition rather than a standard 24 month reassessment.
[35] The 26% baseline was set prior to a definition change, which now excludes patient deaths occurring at high and low level residential aged care facilities (28.3% and 1.1%, respectively, during 2017/18).
[36] The increase in the proportion of patients waiting >48 hours for a hospice bed was primarily due to high demand during Q1 and Q4.
[37] The new Regional Palliative Care Outcomes Initiative was launched in Nov 2017 to better support patients with a life-limiting illness and their whānau; while implementation of this new service has improved from Q3 to Q4, more time is needed to achieve target levels.

Cost of Service Statement – for year ended 30 June 2018

Summary of revenues and expenses by output class	Actual 2018 $000	Budget 2018 $000
Prevention		
Total revenue	25,281	25,762
Total expenditure	25,808	27,838
Net surplus/(deficit)	**(527)**	**(2,076)**
Early detection		
Total revenue	433,496	428,567
Total expenditure	395,129	415,939
Net surplus/(deficit)	**38,367**	**12,628**
Intensive assessment and treatment		
Total revenue	1,497,660	1,504,495
Total expenditure	1,535,595	1,515,567
Net surplus/(deficit)	**(37,934)**	**(11,072)**
Rehabilitation and support		
Total revenue	237,075	239,146
Total expenditure	235,969	238,626
Net surplus/(deficit)	**1,106**	**520**
Overall		
Total revenue	2,193,512	2,197,969
Total expenditure	2,192,499	2,197,969
Consolidated surplus/(deficit)	**1,013**	**0**

BEING A GOOD EMPLOYER

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

OUR EMPLOYEES:

10,846
PEOPLE EMPLOYED AT AUCKLAND DHB (8,769 FTE)

5% MĀORI

8% PACIFIC

87% OTHER ETHNICITIES

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. This year we have implemented an employee engagement survey to track the baseline set in 2016. As we value and encourage employees' views and ideas, this has become a standard programme of work which 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 begun to build on these with a culture initiative to hear and voice the stories of our people, when we and our collegial relationships are at our best. We have identified seven themes that touched all employees whether in one-to-one interviews, focus groups, walk-through galleries, drop-in centres or an organisation-wide survey. We are now working with our people to identify how they want the themes and supporting stories to be shared and utilised.

Auckland DHB continues to champion clinician leadership, with accountability for directorates held by a Director, nearly in all cases a clinician, who is ultimately accountable for delivering results. Our leadership development programme (LDP) has been running for over two years and, due to demand, has been extended from the original 150 clinical leaders to a further 150. Our pilot Management Development Programme (MDP) has now become a full programme, with 14 core management modules under design with a globally renowned eLearning firm. This programme will be available to all DHBs via the Ko Awatea LEARN online platform. The learnHR series to educate managers on HR process and practice is flourishing, with over 150 managers attending every month.

78% FEMALE

22% MALE

19% AGED <30

48% AGED 30-50

33% AGED 50+

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.

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

The second phase of our contemporary, streamlined HR Operating Model has further improved HR services, with the addition of excellent Reporting and Analytics and Systems and Compliance functions. These make available a depth of support to teams and managers that was previously lacking, and are proving to be a valuable collaboration focus for the region.

Auckland DHB has a successful self-service model, starting with myHR intranet pages through to a professional HR Service Centre accessible to all employees by phone and email, with strategic and complex matters dealt with in person by the team of HR Managers.

The culture at Auckland DHB demonstrates care for all our people through these services. A particular spotlight has been shone onto our lower-paid workforce with the introduction of the 'To Thrive' programme. Introduced in early 2018, the purpose of the Organisational Development (OD) Practice Leader - Supportive Employment role is fourfold:

1. Focus on operationalising support mechanisms and initiatives for the following four Auckland DHB employee groups:
    - people with disabilities
    - people with mental health needs
    - lower income employees
    - young people in our community who may or may not be work ready
2. Pull together all the components of the 'To Thrive' programme and facilitate their extension to these employee groups as relevant
3. Develop supportive employment mechanisms including:
    - how we bring people in to Auckland DHB
    - how we support them whilst they are here
    - sustaining strategies for any employees who may develop mental health needs during their employment here
    - career management/pathways to success (by their definition of success)
    - provide opportunities and employment pathways for them to self-select and self-manage for success
4. Develop and implement a plan to achieve the above.

Importantly, 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 therefore 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

Auckland DHB is currently on track to receive the Rainbow Tick, the first DHB to do so. The Rainbow Tick will provide us with a set of criteria to measure ourselves against and to demonstrate that we are an organisation that embraces diversity.

39%
WORK PART TIME
(4,269 PEOPLE)

58%
OF PART TIME
STAFF ARE NURSES

Recruitment, Selection and Induction

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

Building on past work with the Equal Employment Opportunities Trust to create a paragraph for inclusion in all job advertisements highlighting our commitment to a diverse workforce and encouraging applications from Māori and Pacific communities, the executive team have written to all employees outlining support for the mandatory shortlisting of all eligible Māori and Pacific candidates, whatever the role. In some quarters, we see 100% shortlisting with an average of 80% across the organisation, so there is still work to be done.

Orientation and onboarding have been continuously improved with the introduction of Taleo Transitions, an automated onboarding process which allows all employment paperwork to be completed online and reduces the time to on-board. Navigate - Kai Arahi warmly welcomes new employees to Auckland DHB, with an expo showing what we offer to care for our people, help them settle in quickly and feel part of this inspiring community. In addition, a series of guides have been produced, ensuring managers and new employees alike know how to make the most of the first few weeks at Auckland DHB. The expo element of this has now been extended to all employees on a twice a year basis.

The Rangatahi Programme has been developed for Māori and Pacific senior secondary school students to facilitate 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 continue to be provided for Māori and Pacific students undertaking their first tertiary qualification in health. The programme also aims to address workforce disparities by increasing our Māori and Pacific health workforce and reducing specific skill gaps in the health and disability workforce.

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 now hosts the recording and tracking of regular performance and development discussions to acknowledge progress and results, and identify support and development needs.
- A range of clinical, technical, and non-clinical internal training programmes and workshops are provided.
- Senior Medical Officers are able to take sabbatical leave for the purposes of strengthening or acquiring clinical knowledge or skills or undertaking an approved course of study or research in matters relevant to their clinical practice. It is also a time for reflection and personal development.
- The Pacific Nurse Educator provides clinical support, supervision and mentorship for our Pacific nursing undergraduate students, new graduate nurses and Ministry of Health funded post graduate programme students.
- Exit interviews and surveys conducted with departing staff have been reviewed and improved to get more useful feedback for the organisation.

22
EMPLOYEES HAVE DECLARED A DISABILITY

OCCUPATION TYPE:

43% NURSING

21% ALLIED HEALTH

17% MEDICAL

19% OTHER

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. All employees are now on the automated timesheet system. An FTE management tool has been trialled and rolled out in nursing across the DHB and has proven to be a valuable tool to improve 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
- The ANIVA Nursing Leadership programme funds 3-5 Pacific nurses annually to complete post–graduate programmes in leadership
- An Associate Nurse Director was appointed for the development of the Māori nursing and midwifery workforce
- Graduation event celebrating the achievement of cleaners who gained the NZQA accredited Certificate in Cleaning (Level 3)
- Health Excellence Awards to publically recognise and celebrate staff who deliver sustainable improvements for our patients and the organisation and inspire others by sharing excellence around the organisation and the wider health community
- 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 entitled to a free gym membership.

The majority of employees are on transparent Multi Employer Collective Agreements. Annual review of IEA remuneration is based on external market data and employee performance. Job size evaluation methods meet the New Zealand 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 has been formed and continues to support victims and accused alike. The programme and the supporter group are both clinician led.

Safe and Healthy Environment

A huge programme of work, Security for Safety, has focused on ensuring employees are safe and secure at work, with workstreams focusing on all aspects of safe working, from security ID, CCTV to a culture of keeping self and colleagues safe, including online training.

A well-researched and direct correlation between an employee's wellbeing and patient safety and wellbeing has led the DHB to establish a Wellbeing Steering Group to manage the numerous initiatives that sit under the banner of wellbeing. These include a Mindfulness-Based Stress Reduction (MBSR) programme in Mental Health Services, the World Health Organisation (WHO)'s Five Ways to Wellbeing, a kindness and compassion programme under which Auckland DHB has become Australasia's first Schwartz Centre hospital, with more to come.

SUSTAINABILITY

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

One of the themes of the Auckland DHB Strategy to 2020 is operational and financial sustainability, which means that all our work needs to be sustainable and that our long-term goals extend to reducing greenhouse gas emissions, energy use and waste.

We have made a great start in reducing our carbon emissions by 21% from our 2015 baseline, but there is more we can do to reach our '50/50 sustainability vision' of:

- Reducing energy use by 50%
- Producing 50% of our energy from on-site renewable sources by 2030
- Having zero landfill waste by 2040.

We partnered with the Energy Efficiency and Conservation Authority (EECA) to implement energy-saving measures at our sites. EECA provides guidance and support, shares best practices, facilitates conversations with technical experts, and provides co-funding for selected energy-efficiency projects at Auckland DHB.

Reviewing the oncology building's HVAC plan which has been optimised to save energy through the EECA collaboration

Energy-saving projects under way at Auckland DHB include:

- Auckland DHB energy policy ratified by the Board, which includes an Energy 50/50 Vision
- Launch of an Energy Dashboard on the staff intranet, which displays energy use at our main facilities
- Installation of additional energy meters to facilitate monitoring
- Optimisation of the heating, ventilation and air conditioning (HVAC) plant in the Auckland City Hospital oncology building
- Scoping the potential for LED lighting in the Auckland City Hospital Car Park A building
- Ensuring PCs will automatically go into sleep mode.

In November 2017, we hosted the 'Sustainability at Auckland DHB, our commitment to Papakainga Atawhai' symposium. The symposium provided a learning opportunity and call for action within the health sector to take a leadership role in policy and planning for climate change. The clear message was that we have an opportunity to provide an integrated view to influence strategies to improve the wellbeing of our community.

In June 2018, Associate Minister of Health Hon Julie Anne Genter visited Auckland DHB and had an opportunity to meet some of our sustainability champions and find out what we are doing to reduce our carbon footprint.

Ms Genter visited the Starship theatres to find out more about our Operating Room recycling initiative, which forms part of a wider programme for 'greener theatres'. She also met our wonderful team of waste orderlies who have diverted 163 tonnes of medical and general waste from landfill since 2015.

Associate Minister of Health Hon Julie Anne Genter and Chair of Auckland DHB Pat Snedden with some of the waste management team

As part of the 2020 Healthcare Climate Challenge, we signed a pledge to reduce our carbon emissions (by 2% per annum or 20% by 2025). We were delighted to be awarded the Silver Climate Champion Award in energy reduction, non-energy reduction and climate leadership.

It takes a team to be a sustainable health organisation – every small individual action makes a big difference.

Some of our sustainability champions with our 2020 Healthcare Climate Challenge Award

ABOUT OUR ORGANISATION

Auckland DHB Board members

Current Board members			
	Pat Snedden, Chair		Zoe Brownlie
	Gwen Tepania-Palmer		Dr Lee Mathias ONZM
	Jo Agnew		Robyn Northey
	Douglas Armstrong QSO		Sharon Shea
	Michelle Atkinson		Judith Bassett QSO

Statement of waivers

The New Zealand Public Health and Disability Act 2000 s 42(4) provides as follows:
For the purposes of s 151 (1)(j) of the Crown Entities Act 2004, the annual report of a DHB must disclose any interests to which a permission, waiver, or modification given under clause 36(4) or clause 37(1) of Schedule 3 or clause 38(4) or clause 39(1) of Schedule 4 relates, together with a statement of who gave the permission, waiver, or modification, and any conditions of amendments to, or revocation of, the permission, waiver, or modification. For the 2017/18 year there were no permissions, waivers or modifications given under the clauses of this legislation.

Subsidiaries, associates and joint ventures

Auckland DHB Charitable Trust (A+ Trust) is an independent charitable trust created by Auckland DHB, and consolidated for financial statement purposes. The DHB is also shareholder in a number of Crown Entities: Northern Regional Alliance Limited (NRA) New Zealand Health Innovation Hub Management Limited and healthAlliance N.Z. Limited. Canterbury, Counties Manukau, Waitemata and Auckland District Health Boards (DHBs) are limited partners in the New Zealand Health Innovation Hub Management Limited. The NRA is an amalgamation of two previous subsidiary companies, the Northern Region DHB Support Agency Limited and the Northern Regional Training Hub Limited. The NRA is owned in three equal shares by Waitemata, Auckland and Counties Manukau (DHBs). Auckland, Waitemata, Counties Manukau and Northland DHBs each own 25% A Class shares in healthAlliance N.Z. Limited.

NZ Health Partnerships Limited (NZHPL) is a crown entity company that was set up in 2010 to help the health sector save money by reducing administrative, support and procurement costs for DHBs. Any savings will go back into supporting frontline health services. NZHPL works with DHBs to achieve these aims. All DHBs across New Zealand own 5% A Class shareholding in NZHPL. There are no plans to acquire shares or interests in any other company, trusts and/or partnerships.

Ministerial directions

Directions issued by a Minister during the 2017/18 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 2017/18 appropriations is detailed below.

Appropriations allocated and scope

Health and Disability Support Services appropriation allocated to Auckland DHB is a non-departmental output expense incurred by the Crown. The funding of personal and mental health services included services for the health of older people, provision of hospital and related services and management outputs from Auckland DHB.

What is intended to be achieved with this appropriation?

The DHB provides services that align with:

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

How performance will be assessed and end of year reporting

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

Amount of appropriations

	2016/17		2017/18	
	Final Budgeted $000	Estimated Actual $000	Budget $000	Estimated Actual $000
Original appropriation	1,195,267	1,195,267	1,239,980	1,239,980
Supplementary estimates	-	-	-	12,101
Total appropriation revenue	1,195,267	1,195,267	1,239,980	1,252,081

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

Auckland DHB Debt appropriation

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

ASSET PERFORMANCE

Introduction

Auckland DHB is designated a Tier 1 entity for purposes of the Investor Confidence Rating (ICR) put in place by Treasury in 2016 in response to the Cabinet Circular C0(15) 5. 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. One of the requirements for Tier 1 entities is for asset performance reporting to be included in the Annual Report. Work is continuing in the DHB sector to further develop asset performance measures.

Overall, asset management is one of the core functions of managing Auckland DHB business as assets are a key enabler for the provision on health services. A comprehensive asset management improvement programme is in place and an Asset management plan is developed periodically. The Asset management Plan shows the assets owned or leased by Auckland DHB, their condition and plans for refurbishments, upgrades or replacement of these assets. The plan, together with the Long Terms Investment Plan indicates the capacity required to meet future demand for services and capital intentions to ensure that capacity is maintained.

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	Quantity/Capacity	Asset Value 30 June 2017	Replacement Cost (Indicative)
Property Key enabler for service provision in facilities that comply with relevant legislation, meet accreditation requirements, are fit for purpose and maintained in good working condition.	Includes land, buildings, plant, furniture & fittings and infrastructure mainly located at Auckland City Hospital, Greenlane Clinical Centre and Point Chevalier. From these properties the following capacity is available: • Beds: 1,096 inpatient beds, 92 Day surgery beds, 96 ED beds, 24 CDU,143 mental health beds, • Theatres: 41 physical theatres • Cancer: 77 chemo beds/chairs, 1 brachytherapy, • Renal: 5 dialysis units • 12 dental clinics • 37 properties leased (ADHB lessee) in the community	$906m	$2.3b
Clinical Equipment Key enabler for timely, safe, appropriate and quality service provision and need to be maintained to continuously meet equipment quality and safety standards.	Includes a wide range of clinical equipment fleets and single item assets used to deliver health services, noting that ADHB is also a provider of last resort (e.g. national organ transplants, paediatric services). • 6 LINACs, 4 MRIs, 3 Cardiac Catheter labs, 11 CT Scanners, 707 Physiological Monitoring equipment, 120 ventilators, 95 Ultrasounds, 106 X-ray machines and overall over 32,000 clinical equipment line items in our fixed asset register	$83m	$266m
Information Communications Technology (ICT) Key enabler for service delivery through availability, accessibility and functionality of systems and quality information that facilitates timely decision making.	Includes clinical and business Information systems and infrastructure comprising of: • Local hardware and software • Regionally shared hardware and software. • over 10,000 users	$3m	$10m
Auckland DHB also has other assets not included in this report, which are less significant in value and criticality but still play an important role in service delivery e.g. Vehicle fleet of 343 (including 10 special purpose equipped vehicles).			

Asset Performance

Property Asset Performance

Asset performance measures for Property summarised below are based on targets set for property condition, functionality and utilisation and considering age of property. Significant risk identified in relation to critical infrastructure is now being addressed through the Cabinet approved Facilities Infrastructure Remediation Programme. Capacity increases required to meet projected demand is being planned through various business cases being developed.

Measure	Indicator	2017/18 Target	2017/18 Actual
i. *Building floor space utilised versus total floor space available.* Percentage 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%	96.00%
ii. *Building condition grading measured by floor space.* Percentage 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.	*Condition*	85%	65.00%
iii. *Building condition grading measured by meeting building compliance requirements.* Percentage of Buildings used with valid Building Warrant of Fitness (BWOF) to total buildings in the portfolio. BWOF is a compliance requirement.	*Condition*	100%	100.00%
iv. *Seismic compliance.* Percentage of floor space assessed as being earthquake prone (i.e. 33% or less of New Building Strength (NBS). NB – Auckland DHB has a range of buildings on its campuses, some dating back to the late 1800s. 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 underway to vacate and demolish the remaining building still occupied (building 7 at ACH).	*Condition*	0.00%	1.40%
v. *Building Functionality grading measured by floor space.* Percentage of buildings (by floor space) graded as Moderate to Full functionality. Functionality Grading levels are: Unfit, Partial, Moderate, Good and Full.	*Functionality*	65%	67.00%

ICT Asset Performance

healthAlliance owns, manages and maintains the Northern Region DHB ICT assets. The following asset performance measures apply to the regional ICT portfolio and were set in the 2017/18 Service Level Agreement (SLA) between health Alliance and DHBs. A stabilisation programme is in place to address ICT assets related risks.

Measure	*Indicator*	*2017/18 Target*	*2017/18 Actual*
i. *Disruption to workforce* Average monthly application outage duration in minutes	*Utilisation*	<90 minutes	80 minutes
ii. *Currency of patching for server operating systems* The percentage of server operating systems instances that are patched to releases no older than 13 weeks will be greater than 75%. Result reported as average over the period. This measures the level of vulnerability to security issues and the currency of the IT environments serving the DHB. Number of server operating systems patched patch releases no older than 13 weeks / total number of server operating systems.	*Condition*	100%	75.00%
iii. *Availability of IT Services (systems and applications).* Availability of IT Services (systems and applications, will be better than 99.80%. Result reported as average over period. This measures the operational integrity, performance and stability of ICT infrastructure and application environments serving the DHB. Number of minutes each system is available in month (during its hours of service)/ Number of minutes each system is potentially available in month.	*Functionality*	100%	99.98%

Clinical Equipment Asset Performance

The following asset performance measures apply to some of the key service delivery clinical equipment items. Some of the targets are based on Ministry of Health targets (agreed as part of annual planning) and others are Auckland DHB determined. The measures apply to either assets we own or lease.

Measure		Indicator	2017/18 Target	2017/18 Actual
i.	*CT Scanners: Percentage of OP and GP Referrals Imaged and validated within 6 weeks* The MOH target is for 95% of all scans accepted referrals to be completed within 6 weeks. The upper limit is for all scans to be completed within 21 weeks of referral.	*Utilisation*	95%	93.00%
ii.	*CT Scanners Functionality grading using the ADHB functionality assessment criteria.* CT Scanners portfolio functionality graded as better than 2 (out of a scale of 1-5, where 1=best, 5=worst). Functionality grading is DHB defined criteria. Functionality Grading levels are: 1-New; 2-Operationally sound; 3-old technology; 4-discontinued; 5-obsolete.	*Functionality*	3	3
iii.	*CT Scanners Condition grading using ADHB criteria.* CT Scanners portfolio condition graded as better than 3 (out of a scale of 1-10, 1=best, 10=worst).	*Condition*	6	5
iv.	*LINACs Performance against Physical Capacity of the machine.* Percentage of planned LINAC hours that the LINAC is available for patient treatments. 87% of the working day is the expected average machine physical availability time for patient use, allowing 13% downtime for planned maintenance, breakdown & machine servicing, quality assurance, and development work.	*Utilisation*	87%	90.00%
v.	*LINACs: Maintenance hours* Number of units needing sustained increase in maintenance hours.	*Condition*	0	0
vi.	*LINACs Performance against ADHB Equipment specifications for patient treatment.* The LINACs have to meet ADHB specification to be used for treating patients. There is a comprehensive QA programme to ensure this. Note - The newer a LINAC is the better the functionality it has. Currently LINAC fleet ages range from 4 - 12 years.	*Functionality*	99%	100.00%
vii.	*MRI: Percentage of OP and GP Referrals Imaged and validated within 6 weeks.* MRI: MoH Target 95% to June 2017 - The MOH target is 95% for all referrals/scans accepted to be completed within 6 weeks. The upper limit is for all scans to be completed within 21 weeks of referral.	*Utilisation*	95%	68.00%
viii.	*MRI: Functionality grading using the DHB functionality assessment criteria.* MRI Scanners portfolio functionality graded as 3 (out of a scale of 1-5, 1=best, 5=worst). Functionality grading is DHB defined criteria. Functionality gradings are: 1-New; 2-Operationally sound; 3-old technology; 4-discontinued; 5-obsolete.	*Functionality*	3	3
ix.	*MRI: The condition grading using DHB criteria.* MRI Scanners portfolio condition graded as a 6 (out of a scale of 1-10, 1=best, 10=worst).	*Condition*	6	*6*

Financial performance

Where the money came from and what we spent it on

FINANCIAL PERFORMANCE

Statement of Responsibility

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

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

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Auckland District Health Board for the year ended 30 June 2018.

Signed on behalf of the Board:

Pat Snedden
Chair

Dated: 30 October 2018

Gwen Tepania-Palmer
Board Member

Dated: 30 October 2018

Statement of comprehensive revenue and expense for the year ended 30 June 2018

	Notes	Group			Parent		
		Budget 2018 $000	Actual 2018 $000	Actual 2017 $000	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Revenue							
Patient care revenue	2i	2,127,039	2,121,626	2,011,822	2,127,039	2,121,626	2,011,822
Interest Revenue		5,446	5,761	4,544	4,011	5,193	4,032
Other revenue	2ii	65,484	66,272	62,767	66,507	65,803	62,182
Total revenue		**2,197,969**	**2,193,659**	**2,079,133**	**2,197,557**	**2,192,622**	**2,078,036**
Expenses							
Personnel costs	3	951,730	962,102	913,789	951,730	962,102	913,789
Depreciation and amortisation costs	13, 14	47,916	47,565	50,402	47,916	47,565	50,402
Outsourced services		120,845	128,030	112,147	120,845	128,030	112,147
Clinical Supplies		254,008	254,485	240,087	254,008	254,485	240,087
Infrastructure and non-clinical expenses		74,619	76,040	74,833	74,427	76,037	74,830
Other district health boards		107,723	103,218	95,518	107,723	103,218	95,518
Non-health board provider expenses		545,358	513,804	489,033	545,358	513,804	489,033
Capital charge	4	55,184	55,406	39,433	55,184	55,406	39,433
Interest expense		475	0	11,110	475	0	11,110
Other expenses	5	40,111	51,849	49,801	40,246	51,564	49,434
Total expenses		**2,197,969**	**2,192,499**	**2,076,153**	**2,197,912**	**2,192,211**	**2,075,783**
Share of surplus of associate and joint venture surplus/(deficit)	15	0	(147)	182	0	0	0
Surplus/(deficit)		**0**	**1,013**	**3,162**	**(355)**	**411**	**2,253**
Other comprehensive revenue and expense							
Item that will not be reclassified to surplus/(deficit)							
Gains/(Losses) on property revaluations	20	0	0	6,641	0	0	6,641
Cash flow hedges	20	0	0	3,742	0	0	3,742
Total other comprehensive revenue and expense		0	0	10,383	0	0	10,383
Total comprehensive revenue and expense		**0**	**1,013**	**13,545**	**(355)**	**411**	**12,636**

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 2018

	Notes	Group Actual Budget 2018 $000	Group Actual Actual 2018 $000	Group Actual Actual 2017 $000	Parent Budget 2018 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Assets							
Current Assets							
Cash and cash equivalents	6	23,524	95,407	69,725	23,524	95,407	69,725
Investments	7	727	30,000	11,000	727	30,000	11,000
Trust/special funds	8	14,774	16,217	14,191	0	0	0
Restricted trust funds	9	0	1,275	1,263	0	1,275	1,263
Receivables	10	87,421	92,565	87,422	88,342	93,610	87,949
Prepayments		5,027	1,225	5,027	5,027	1,225	5,027
Inventories	11	13,882	13,853	13,737	13,882	13,853	13,737
Total Current Assets		**145,355**	**250,542**	**202,365**	**131,502**	**235,370**	**188,701**
Non-Current Assets							
Investments	7	0	0	0	0	0	0
Trust/special funds	8	14,625	15,308	14,625	0	0	0
Property, plant and equipment	13	1,092,897	1,021,657	1,024,021	1,091,996	1,020,718	1,023,121
Intangible assets	14	13,694	11,081	13,415	13,694	11,081	13,415
Investments in joint ventures & associates	15	61,196	63,990	58,621	60,513	63,452	57,936
Total Non-Current Assets		**1,182,412**	**1,112,036**	**1,110,682**	**1,166,203**	**1,095,251**	**1,094,472**
Total Assets		**1,327,767**	**1,362,578**	**1,313,047**	**1,297,705**	**1,330,621**	**1,283,173**
Liabilities							
Current Liabilities							
Payables & deferred revenue	16	155,781	163,278	154,265	154,844	159,192	151,660
Employee benefits	17	177,155	194,319	172,820	177,155	194,319	172,820
Provisions	18	1,274	2,407	3,140	0	2,407	3,140
Borrowings	19	2,894	764	494	2,894	764	494
Restricted trust funds	10	0	1,275	1,263	0	1,275	1,263
Total Current Liabilities		**337,104**	**362,043**	**331,982**	**334,893**	**357,957**	**329,377**
Non-Current Liabilities							
Employee benefits	17	41,774	56,094	41,774	41,774	56,094	41,774
Borrowings	19	9,973	4,510	373	9,973	4,510	373
Total Non-Current Liabilities		**51,747**	**60,604**	**42,147**	**51,747**	**60,604**	**42,147**
Total Liabilities		**388,851**	**422,647**	**374,129**	**386,640**	**418,561**	**371,524**
Net Assets		**938,916**	**939,931**	**938,918**	**911,065**	**912,060**	**911,649**
Equity							
Contributed Capital	20	881,298	881,298	881,298	881,298	881,298	881,298
Accumulated surplus/deficit	20	(485,199)	(484,349)	(484,614)	(485,872)	(484,877)	(485,288)
Property revaluation reserve	20	515,639	515,639	515,639	515,639	515,639	515,639
Trust/special funds	20	27,178	27,343	26,595	0	0	0
Total Equity		**938,916**	**939,931**	**938,918**	**911,065**	**912,060**	**911,649**

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 2018

GROUP	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Balance as at 1 July		**938,918**	**938,916**	**620,873**
Total comprehensive income/(expense) for the period		**1,013**	**0**	**13,545**
Owner Transactions				
Capital contributions from the Crown		0	0	304,500
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	20	**939,931**	**938,916**	**938,918**

PARENT	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Balance as at 1 July		**911,649**	**911,648**	**594,513**
Total comprehensive income/(expense) for the period		**411**	**(583)**	**12,636**
Owner Transactions				
Capital contributions from the Crown		0	0	304,500
Repayment of capital to the Crown		0	0	0
Balance as at 30 June	20	**912,060**	**911,065**	**911,649**

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 2018

	Notes	Group Actual			Parent Actual		
		Budget 2018 $000	Actual 2018 $000	Actual 2017 $000	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Cash flows from operating activities							
Cash receipts from Ministry of Health and patients		2,107,017	2,101,417	1,967,598	2,107,017	2,101,417	1,967,598
Other Receipts		85,499	78,347	82,106	84,699	75,109	79,608
Cash paid to employees		(949,156)	(926,588)	(889,719)	(949,156)	(926,588)	(889,719)
Cash paid to suppliers		(1,142,655)	(1,113,832)	(1,056,169)	(1,141,255)	(1,111,624)	(1,053,285)
GST (net)		0	478	1,298	0	496	1,129
Payments for Capital Charge		(55,184)	(55,406)	(39,433)	(55,184)	(55,406)	(39,433)
Net cash inflow from operating activities		**45,521**	**84,416**	**65,681**	**46,121**	**83,404**	**65,898**
Cash flows from investing activities							
Interest received		5,446	5,761	4,544	4,846	5,231	3,883
Proceeds from sale of property, plant and equipment		0	63	511	0	63	511
Decrease/(Increase) in investments and restricted trust funds		8,425	(23,259)	7,164	8,425	(21,755)	7,608
Purchase of property, plant and equipment		(105,071)	(44,489)	(29,198)	(105,071)	(44,451)	(29,198)
Purchase of intangible assets		0	(1,216)	(1,754)	0	(1,216)	(1,754)
Acquisition of investments		0	0	0	0	0	0
Net cash (outflow) from investing activities		**(91,200)**	**(63,140)**	**(18,733)**	**(91,800)**	**(62,128)**	**(18,950)**
Cash flows from financing activities							
Interest paid		(475)	0	(9,079)	(475)	0	(9,079)
Repayment of finance leases		0	(465)	(127)	0	(465)	(127)
Proceeds from borrowings/finance leases		0	4,871	0	0	4,871	0
Net cash inflow/(outflow) from financing activities		**(475)**	**4,406**	**(9,206)**	**(475)**	**4,406**	**(9,206)**
Net (decrease)/increase in cash and cash equivalents		**(46,154)**	**25,682**	**37,742**	**(46,154)**	**25,682**	**37,742**
Cash and cash equivalents at start of the year		**69,678**	**69,725**	**31,983**	**69,678**	**69,725**	**31,983**
Cash and cash equivalents at end of the year	**6**	**23,524**	**95,407**	**69,725**	**23,524**	**95,407**	**69,725**

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 2018 (continued)

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

	Notes	Group Actual 2018 $000	2017 $000	Parent Actual 2018 $000	2017 $000
Reported net surplus/(deficit) for the year		**1,013**	**3,162**	**411**	**2,253**
Add non-cash items:					
Share of associate and joint venture surplus	**15**	147	(182)	0	0
Depreciation and amortisation expense		47,565	50,402	47,565	50,402
Unrealised loss/(gain) on cash flow hedging instrument		0	3,742	0	3,742
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		333	1,388	333	1,388
Net loss/(gain) on disposal of financial assets		(1,203)	(1,131)	2	0
Net interest shown in investing and financing activities		(5,761)	4,536	(5,193)	5,048
Add movements in statement of financial position items:					
(Increase)/Decrease in debtors and other receivables		(5,145)	(25,372)	(5,486)	(27,026)
(Increase)/Decrease in prepayments		3,802	(3,348)	3,802	(3,348)
(Increase)/Decrease in inventories		(116)	357	(116)	357
Increase/(Decrease) in creditors and other payables		8,695	1,962	7,000	2,917
Increase in provision		(733)	1,590	(733)	1,590
Increase/(Decrease) in employee entitlements		35,819	28,575	35,819	28,575
Net cash inflow/(outflow) from operating activities		**84,416**	**65,681**	**83,404**	**65,898**

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

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

The group's primary objective is to deliver health, disability, and mental health services to the community within its district. 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 2018, and were approved by the Board on 30 October 2018.

BASIS OF PREPARATION

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

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.

Standards issued that are not yet effective and not early adopted

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

Impairment of revalued assets

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

Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted.

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

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for financial years beginning on or after 1 January 2021, with earlier application permitted.

1 Significant accounting policies (continued)

The main changes under the standard relevant to the DHB are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the Government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. The DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with the Crown's accounting policy for financial instruments. The DHB has not yet assessed in detail the impact of the new standard. Based on an initial assessment, the DHB anticipates that the standard will not have a material effect on the DHB's financial statements.

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

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

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 is 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.

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.

1 Significant accounting policies (continued)

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
- Identifying agency relationships -refer to discussion note below.

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.

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

2 Revenue (continued)

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 Grants
Research costs are recognised in the Statement of Comprehensive Revenue and Expense as incurred. Revenue received in respect of research projects is recognised in the Statement of Comprehensive Revenue and Expense in the same period as the related expenditure. Where requirements for Research income have not yet been met, funds are recorded as income in advance. The Trust receives income from organisations for scientific research projects. Under PBE IPSAS 9 funds are recognised as revenue when the conditions of the contracts have been met. A liability reflects funds that are subject to conditions that, if unfulfilled, are repayable until the condition is fulfilled.

Interest revenue
Interest revenue is recognised using the effective interest method.

Rental revenue
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.

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	
	2018 $000	2017 $000	2018 $000	2017 $000
Health & disability services (Crown appropriation revenue)	1,252,081	1,195,267	1,252,081	1,195,267
Other MoH and Government revenue	196,122	171,205	196,122	171,205
ACC contract revenue	20,799	20,809	20,799	20,809
Inter-district patient inflows	612,935	590,333	612,935	590,333
Revenue from other district health boards	19,678	14,036	19,678	14,036
Other patient care related revenue	20,011	20,172	20,011	20,172
Total patient care revenue	**2,121,626**	**2,011,822**	**2,121,626**	**2,011,822**

2 Revenue (continued)

ii Other revenue

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Donations and bequests	6,102	7,249	7,602	8,522
Gain on sale of property, plant & equipment	0	0	0	0
Gain on financial assets	1,205	1,131	0	0
Rental revenue	10,193	9,573	10,193	9,573
Accommodation revenue	772	729	772	729
Direct charges revenue	19,670	17,780	19,670	17,780
Drug trial revenue	659	585	659	585
Research grants	13,340	13,211	12,568	12,492
Other revenue	14,331	12,509	14,339	12,501
Total other revenue	**66,272**	**62,767**	**65,803**	**62,182**

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	2018 $000	2017 $000
Not later than one year	7,024	6,349
Later than one year and not later than five years	19,063	19,583
Later than five years	3,956	6,978
Total non-cancellable operating leases as lessor	**30,043**	**32,910**

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.

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.

Defined benefit schemes

The DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis of allocation. The scheme is therefore accounted for as a defined contribution scheme. Further information on this scheme is disclosed in note 21.

3 Personnel costs (continued)

Breakdown of personnel costs and further information

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Salaries and wages	897,969	855,173	897,969	855,173
Defined contribution plan employer contributions	29,818	28,316	29,818	28,316
Increase/(decrease) in liability for employee benefits	35,819	28,575	35,819	28,575
Restructuring expense for employee exit costs	(1,504)	1,725	(1,504)	1,725
Total personnel costs	**962,102**	**913,789**	**962,102**	**913,789**

Employee remuneration

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

Remuneration Range	Actual 2018	Actual 2017	Remuneration Range	Actual 2018	Actual 2017
$100,000-$109,999	339	301	$440,000-$449,999	4	4
$110,000-$119,999	234	219	$450,000-$459,999	5	1
$120,000-$129,999	140	146	$460,000-$469,999	4	2
$130,000-$139,999	103	115	$470,000-$479,999	2	1
$140,000-$149,999	100	87	$480,000-$489,999	2	1
$150,000-$159,999	64	65	$490,000-$499,999	1	3
$160,000-$169,999	59	55	$500,000-$509,999	3	2
$170,000-$179,999	59	46	$510,000-$519,999	3	1
$180,000-$189,999	47	46	$520,000-$529,999		2
$190,000-$199,999	41	42	$530,000-$539,999	1	1
$200,000-$209,999	51	51	$540,000-$549,999	1	4
$210,000-$219,999	49	43	$550,000-$559,999	2	2
$220,000-$229,999	39	43	$560,000-$569,999	2	
$230,000-$239,999	40	40	$570,000-$579,999	2	1
$240,000-$249,999	33	29	$580,000-$589,999	2	2
$250,000-$259,999	41	35	$590,000-$599,999	2	2
$260,000-$269,999	29	29	$600,000-$609,999	3	1
$270,000-$279,999	31	36	$610,000-$619,999	1	2
$280,000-$289,999	29	27	$630,000-$639,999	2	
$290,000-$299,999	22	19	$650,000-$659,999	2	
$300,000-$309,999	21	22	$690,000-$699,999	1	
$310,000-$319,999	24	25	$850,000-$859,999	1	1
$320,000-$329,999	31	21	$880,000-$889,999	1	
$330,000-$339,999	21	22	$890,000-$899,999		1
$340,000-$349,999	21	11	$980,000-$989,999		1
$350,000-$359,999	18	18	$990,000-$999,999		1
$360,000-$369,999	18	19	$1,030,000-$1,039,999	1	
$370,000-$379,999	18	20	$1,050,000-$1,059,999	1	
$380,000-$389,999	7	12	$1,110,000-$1,119,999		1
$390,000-$399,999	19	11	$1,270,000-$1,279,999		1
$400,000-$409,999	12	10	$1,300,000-$1,309,999	1	
$410,000-$419,999	5	3	$1,330,000-$1,339,999	1	
$420,000-$429,999	3	11			
$430,000-$439,999	9	3	**Grand Total**	**1,828**	**1,720**

During the year ended 30 June 2018, 142 (2017:133) employees received compensation and other benefits in relation to cessation totalling $4,191,982 (2017: $2,677,630).

3 Personnel costs (continued)

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

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

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

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

	Actual 2018 $000	Actual 2017 $000
Pat Snedden (Chair from 5 Jun 18)	5	0
Gwen Tepania-Palmer (Chair Feb18-May18)	38	27
Dr Lester Levy (Chair Jul16-January 18)	45	73
Dr Lee Mathias	32	34
Jo Agnew	32	31
Peter Aitken*	0	14
Doug Armstrong	31	29
Michelle Atkinson*	29	16
Judith Bassett	30	30
Zoe Brownlie*	28	15
Dr Chris Chambers*	0	13
James Le Fevre*	26	20
Robyn Northey	28	30
Sharon Shea*	30	16
Morris Pita*	0	13
Ian Ward*	0	13
Total board member remuneration	354	374

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

Co-opted committee members

	Actual 2018 $
Norman Wong (Finance, Risk and Assurance Committee)	2,313
Dame Paula Rebstock (Finance, Risk and Assurance Committee)	2,500
Total co-opted committee members	4,813

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $4,813.

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 (2017: $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 2018 was 6% (2017: 7% for six months to 31 December 2016; 6% for six months to 30 June 2017).

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.

Breakdown of other expenses and further information

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Fees to auditor				
- fees to Audit New Zealand for audit of financial statements	288	281	288	281
- prior period under provision	2	2	2	2
- fees to Audit New Zealand for audit of financial statements (Auckland DHB Charitable Trust)	17	17	17	17
Fees for other Audit services	92	300	92	300
Operating leases	7,256	5,559	7,256	5,559
Impairment of debtors/(provision released)*	(647)	(580)	(647)	(580)
Bad debts	4,757	3,089	4,757	3,089
Board members' fees	354	374	354	374
(Gains)/Loss on disposal of property, plant and equipment	333	1,388	333	1,388
Foreign currency gains/(losses)	(17)	10	(17)	10
Other financial assets gains/(losses)	(34)	(7)	(34)	(7)
Impairment of NOS rights	2,774	0	2,774	0
Other expenses	36,674	39,368	36,389	39,001
Total other expenses	**51,849**	**49,801**	**51,564**	**49,434**

* Please refer to note 10

5 Other expenses (continued)

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	2018 $000	2017 $000
Not later than one year	2,643	1,814
Later than one year and not later than five years	4,162	1,374
Later than five years	1,338	0
Total non-cancellable operating lease commitments as lessee	**8,143**	**3,188**

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 Lukes 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
- Care Park NZ Limited - Davis Cres is leased with an expiry date of 19 Feb 2019
- Segar House is leased with an expiry date of 30 Jun 2020
- Middlemore Dental is leased with an expiry date of 30 Jun 2020
- Thrive is leased with an expiry date of 31 Mar 2019
- Grafton Road is leased with an expiry date of 30 Jun 2023
- Medacs House is leased with an expiry date of 31 Mar 2028.

6 Cash & 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.

Breakdown of cash and cash equivalents and further information

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Current assets				
Bank balance & cash on hand	85	83	85	83
NZ Health Partnerships Limited	95,322	69,642	95,322	69,642
Cash & cash equivalents in the statement of cash flows	**95,407**	**69,725**	**95,407**	**69,725**

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 2018, this limit was $125.66 m (2017: $117.394m).

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.

Breakdown of investments and further information

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Current assets				
Term deposits	30,000	11,000	30,000	11,000
Non-Current assets				
Term deposits	0	0	0	0
Total Investments	**30,000**	**11,000**	**30,000**	**11,000**

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 $nil (2017: $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 impairment provision 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.

Breakdown of trust/special fund assets and further information

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Current assets				
Cash & cash equivalent				
Cash at bank and on hand (restricted)	1,367	868	0	0
Term deposits with maturities less than 3 months (restricted)	329	323	0	0
Cash & cash equivalent total (restricted)	1,696	1,191	0	0
Term deposits (restricted)	13,500	12,500	0	0
Investment Bonds (at market)/(restricted)	1,021	500	0	0
Portfolio Investments (restricted)	0	0	0	0
	16,217	**14,191**	**0**	**0**
Non – current assets				
Term deposits (restricted)	0	0	0	0
Investment Bonds (at market)/(restricted)	1,818	2,330	0	0
Portfolio Investments (restricted)	13,490	12,295	0	0
	15,308	**14,625**	**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 $1,818k (2017: $2,330k). 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 impairment provision 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	
	2018 $000	2017 $000	2018 $000	2017 $000
RESTRICTED TRUST FUNDS				
Current assets				
Restricted fund deposit	1,275	1,263	1,275	1,263
	1,275	**1,263**	**1,275**	**1,263**
Current liabilities				
Restricted fund deposit	1,275	1,263	1,275	1,263
	1,275	**1,263**	**1,275**	**1,263**

10 Receivables

Accounting policy

Short-term receivables are recorded at the amount due, less any provision for uncollectability.

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

Breakdown of receivables and further information

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Receivables from MoH	42,637	48,028	42,637	48,029
Other receivables	27,119	24,531	25,355	22,460
Other accrued income	25,539	18,240	28,348	20,837
Less: provision for uncollectability	(2,730)	(3,377)	(2,730)	(3,377)
Total receivables	**92,565**	**87,422**	**93,610**	**87,949**

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

GROUP Receivables

Debtors and other receivables	Gross 2018 $000	Provision for uncollect-ability 2018 $000	Gross 2017 $000	Provision for uncollecta-bility 2017 $000
Not past due	81,808	(52)	78,072	(155)
Past due 0-30 days	5,355	(457)	3,365	(316)
Past due 31-90 days	3,387	(399)	3,172	(1,108)
Past due 91-360 days	3,029	(927)	4,643	(1,321)
Past due more than 1 year	1,716	(895)	1,547	(477)
Total	**95,295**	**(2,730)**	**90,799**	**(3,377)**

10 Receivables

PARENT Receivables

Debtors and other receivables	Gross 2018 $000	Provision for uncollect-ability 2018 $000	Gross 2017 $000	Provision for uncollect-ability 2017 $000
Not past due	83,694	(52)	79,161	(155)
Past due 0-30 days	4,809	(457)	3,139	(316)
Past due 31-90 days	3,315	(399)	3,034	(1,108)
Past due 91-360 days	2,821	(927)	4,477	(1,321)
Past due more than 1 year	1,701	(895)	1,515	(477)
Total	**96,340**	**(2,730)**	**91,326**	**(3,377)**

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

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

Movement in the provision for uncollectability of receivables are as follows:

	GROUP 2018 Actual $000	GROUP 2017 Actual $000	PARENT 2018 Actual $000	PARENT 2017 Actual $000
Balance 1 July	3,377	3,958	3,377	3,958
Additional provision/(provision released)	(647)	(581)	(647)	(581)
Balance at 30 June	**2,730**	**3,377**	**2,730**	**3,377**

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 2018 $000	Actual 2017 $000
Pharmaceuticals	1,607	1,718
Surgical and medical supplies	12,246	12,019
Total Inventories	**13,853**	**13,737**

The amount of inventories recognised as an expense during the year was $236.673m (2017: $223.354 m), which is included in the clinical supplies line item of the statement of comprehensive revenue and expense.

The write-down of inventories amounted to $335k (2017: $444k). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2017: $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.

12 Non-current assets held for sale (continued)

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 (2017: 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.

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.

13 Property, plant and equipment (continued)

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) of Telfer Young (Auckland) Limited. The valuation is effective as at 30 June 2017.

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

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

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.

Buildings
Buildings, fit out and infrastructure were last revalued on 30 June 2016 by Telfer Young (Auckland) Ltd. Specialised buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

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

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

13 Property, plant and equipment (continued)

- 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.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. The following market rents and capitalisation rates were used in the 30 June 2016 valuation:

- Market rents range from $2,414 to $4,953 per square metre
- Capitalisation rates are market-based rates of return and range from 6.52% to 8.23%

Asbestos Impairment

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

Auckland DHB account for Buildings and Improvements at fair value, measured at their revaluation amount, less any subsequent accumulated depreciation and subsequent accumulated impairment losses. Buildings and Improvements were revalued at 30 June 2016. The estimated cost of remediation in buildings was not available at the time; hence there was no impairment of buildings for asbestos remediation. Asbestos impairment information on land was available and this was included in the 30 June 2016 revaluation of land.

While the presence of asbestos in Auckland DHB buildings does not constitute a commitment or a provision for remediation, it is however an indication that the buildings are impaired. The extent of the impairment for Auckland DHB buildings can be written off to the revaluation reserve to the extent of the net book value of the asset and the value of the revaluation reserve on a class of asset basis.

Auckland DHB has assessed the extent of the impairment required, based on the specialists estimates provided. The amount of impairment that was accounted for in the 30 June 2017 financial statements is $32m. Where the cost of remediation exceeded the NBV of the buildings, these buildings were impaired to a value of zero. There was no impairment this year.

Where the costs of removing asbestos have improved the service potential of the asset, they are capitalised.

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

Site	2018 Asbestos Impairment $ M	2017 Asbestos Impairment $ M
Auckland City Hospital	13.794	13.794
Greenland Clinical Centre	17.852	17.852
Buchanan Rehab	0.516	0.516
Total impairment	32.162	32.162

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 Improve-ments	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost						
Balance at 1 July 2016	282,803	619,397	306,049	667	45,236	1,254,152
Additions/ (Transfers)	0	0	0	0	28,537	28,537
Additions from Work in Progress	0	7,791	28,714	1,375	(37,880)	0
Disposals	0	0	(17,316)	0	0	(17,316)
Transfers	0	(3,608)	849	0	0	(2,759)
Revaluations	38,779	(32,162)	0	0	0	6,617
Balance at 30 June 2017	**321,582**	**591,418**	**318,296**	**2,042**	**35,893**	**1,269,231**
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**
Depreciation and impairment losses						
Balance at 1 July 2016	0	0	(213,885)	(662)	0	(214,547)
Depreciation charge for the year	0	(26,960)	(21,304)	(617)	0	(48,881)
Disposals	0	0	15,459	0	0	15,459
Transfers	0	3,694	(935)	0	0	2,759
Balance at 30 June 2017	**0**	**(23,266)**	**(220,665)**	**(1,279)**	**0**	**(245,210)**
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)**

13 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information (continued)

	Land	Buildings	Plant, equipment, vehicles	Leased Improve-ments	Work in progress	Total
	$000	$000	$000	$000	$000	$000
GROUP						
Carrying Amounts						
At 1 July 2016	282,803	619,397	92,164	5	45,236	1,039,605
At 30 June 2017	**321,582**	**568,152**	**97,631**	**763**	**35,893**	**1,024,021**
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**
PARENT						
Cost						
Balance at 1 July 2016	282,803	619,397	305,149	667	45,236	1,253,252
Additions	0	0	0	0	28,537	28,537
Additions from Work in Progress	0	7,791	28,714	1,375	(37,880)	0
Disposals	0	0	(17,316)	0	0	(17,316)
Transfers	0	(3,608)	849	0	0	(2,759)
Revaluations	38,779	(32,162)	0	0	0	6,617
Balance at 30 June 2017	**321,582**	**591,418**	**317,396**	**2,042**	**35,893**	**1,268,331**
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**
Accumulated depreciation and impairment losses						
Balance at 1 July 2016	0	0	(213,885)	(662)	0	(214,547)
Depreciation charge for the year	0	(26,960)	(21,304)	(617)	0	(48,881)
Disposals	0	0	15,459	0	0	15,459
Transfers	0	3,694	(935)	0	0	2,759
Balance at 30 June 2017	**0**	**(23,266)**	**(220,665)**	**(1,279)**	**0**	**(245,210)**
Accumulated 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)**
PARENT						
Carrying Amounts						
At 1 July 2016	282,803	619,397	91,264	5	45,236	1,038,705
At 30 June 2017	**321,582**	**568,152**	**96,731**	**763**	**35,893**	**1,023,121**
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**

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.

13 Property, plant and equipment (continued)

Capital commitments

GROUP AND PARENT	2018 $000	2017 $000
Capital commitments		
Buildings, fit out and infrastructure	2,352	13,933
Plant and Equipment	18,990	15,686
Total capital commitments	**21,342**	**29,619**

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 $322m (2017: $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 & PARENT	2018 $000	2017 $000
Buildings, fit outs and infrastructure	13,740	24,424
Plant, equipment and vehicles	8,766	11,468
Non-Current Assets	**22,506**	**35,892**

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

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

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

After initial recognition, goodwill is measured at cost less any accumulated impairment losses. Goodwill is tested annually for impairment.

14 Intangible assets (continued)

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 whether there is any indication of impairment.

Breakdown of intangible assets and further information
Movements for each class of intangibles are as follows:

GROUP & PARENT	NOS rights Cost $000	Software & development Cost $000	NCSP contract Cost $000	Total $000
Cost				
Balance at 1 July 2016	12,420	3,350	870	16,640
Additions	0	1,652	100	1,752
Disposals	0	(183)	0	(183)
Balance at 30 June 2017	**12,420**	**4,818**	**970**	**18,208**
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**
Accumulated amortisation & Impairment Losses				
Balance at 1 July 2016	0	(2,948)	(510)	(3,459)
Amortisation charge for the year	0	(1,102)	(419)	(1,521)
Disposals	0	184	0	184
Balance at 30 June 2017	**0**	**(3,866)**	**(929)**	**(4,796)**
Accumulated amortisation & 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)**
Carrying Amounts				
At 1 July 2016	12,420	402	360	13,181
At 30 June 2017	**12,420**	**954**	**41**	**13,413**
At 1 July 2017	12,420	954	41	13,413
At 30 June 2018	**9,646**	**1,418**	**17**	**11,081**

14 Intangible assets (continued)

NOS rights

The IT shared services project was undertaken for the purpose of reducing costs for the public health sector. The project is funded by the DHBs across the country. As at 30 June 2018, the group has paid $12.420 m (2017:12.420) as its share of the project funding, which represents its rights to use the systems when developed. These rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the group's share of the DRC of the underlying IT assets. An impairment of -$2.774m (2017:$nil) has been recognised.

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 & 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. Investment sin 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		2018 Interest held	2017 Interest held
Name of joint ventures	***Principal Activity***		
healthAlliance N.Z. Limited	Provider of shared services	25%	25%
NZ Health Innovation Hub Management Limited	Provision of services to grow NZ's health innovation sector	25%	25%
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 & associates (continued)

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

Year ended 30 June 2018 (unaudited)	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus/ (Deficit) $000
healthAlliance N.Z .Limited	193,794	33,135	160,659	136,513	(491)
NZ Health Innovation Hub Management Limited	573	47	526	56	(191)
NZ Health Partnership Limited	373,341	315,924	57,417	37,577	(4,263)
Northern Regional Alliance Limited	12,660	11,224	1,436	14,289	(107)
Total Investments	**580,368**	**360,330**	**220,038**	**188,435**	**(5,052)**

Year ended 30 June 2017	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus/ (Deficit) $000
healthAlliance N.Z. Limited	172,638	27,044	145,594	135,152	1,344
NZ Health Innovation Hub Management Limited	755	38	717	0	(342)
NZ Health Partnership Limited	349,139	287,459	61,680	50,541	862
Northern Regional Alliance Limited	10,322	8,767	1,555	14,469	40
Total Investments	**532,854**	**323,308**	**209,546**	**200,162**	**1,904**

healthAlliance N.Z. Limited
healthAlliance N.Z. Limited is a joint venture company that exists to provide a shared services agency to the four northern DHBs (25% each) in respect to information technology, procurement and financial processing.

NZ Health Innovation Hub Management Limited
The four largest District Health Boards (Counties Manukau, Auckland, Waitemata and Canterbury) have established a national Health Innovation Hub. The Hub will engage with the DHBs, clinicians and Industry to collaboratively realise and commercialise products and services that can make a material impact on healthcare in New Zealand and internationally. The Hub has been structured as a limited partnership, with the four foundation DHBs each having a 25% shareholding in the limited partnership and the general partner, New Zealand Health Innovation Hub Management Limited, which was incorporated on 26 June 2012.

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

Breakdown of investment in joint ventures & associates and further information

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Share of surplus of joint ventures & associates				
Share of post-acquisition surplus/(deficit)	(147)	182	0	0
Non -Current Assets				
Investments in Joint Ventures & Associates				
Class A Shares in healthAlliance N.Z. Ltd (joint venture)	200	200	200	200
Class C Shares in healthAlliance N.Z. Ltd (joint venture)	63,251	57,737	63,251	57,735
Other shares in joint ventures & associates	1	1	1	1
Share of post-acquisition retained surpluses	538	683	0	0
Total investments in joint ventures and associates	**63,990**	**58,621**	**63,452**	**57,936**

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 2018 is $63,251k (2017: $57,737k) which represents the baseline value of funding for IT projects implemented by healthAlliance and for IT projects implemented by Auckland DHB, with the resulting assets being transferred to healthAlliance on completion of the project.

16 Payables & deferred revenue

Accounting policy

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

Breakdown of payables and further information

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Current				
Payables under exchange transactions				
Creditors	127,135	117,614	127,122	117,555
Income in Advance	8,784	7,034	4,723	4,511
Total payables under exchange transactions	**135,919**	**124,648**	**131,845**	**122,066**
Payables under non-exchange transactions				
GST,PAYE & FBT payable	23,696	22,419	23,684	22,396
Capital charge due to Crown	0	0	0	0
Income in advance	3,663	7,198	3,663	7,198
Total payables under non exchange transactions	**27,359**	**29,617**	**27,347**	**29,594**
Total payables and deferred revenue	**163,278**	**154,265**	**159,192**	**151,660**

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

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

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

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

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

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

17 Employee entitlements (continued)

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 discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A weighted average discount rate of 3.55% (2017: 3.92%) and an inflation factor of 3.0% (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.

If the discount rate were to differ by 0.5% 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 $2.7m higher/lower.

If the salary inflation factor were to differ by 0.5% 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 $3.74m higher/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 88% (2017: 90%) of the full entitlement. This utilisation assumption is based on recent experience.

Breakdown of employee entitlements

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Current portion				
Liability for long service leave	2,391	1,935	2,391	1,935
Liability for sabbatical leave	500	500	500	500
Liability for retirement gratuities	9,328	7,812	9,328	7,812
Liability for annual leave	116,624	108,258	116,624	108,258
Liability for sick leave	678	627	678	627
Liability for continuing medical leave and expenses	23,475	23,592	23,475	23,592
Salaries and wage accrual	41,323	30,096	41,323	30,096
Total current	**194,319**	**172,820**	**194,319**	**172,820**
Non Current				
Liability for long service leave	2,533	2,146	2,533	2,146
Liability for retirement gratuities	53,561	39,628	53,561	39,628
Liability for continuing medical leave and expenses	0	0	0	0
Total non-current	**56,094**	**41,774**	**56,094**	**41,774**
Total employee entitlements	**250,413**	**214,594**	**250,413**	**214,594**

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 $41.3m (2017: $30.1m) salaries and wages accrual includes $21.8m (2017: $20.1m) which is made up of two major elements: Unpaid days of $22.0m (2017: $20.3m) and Salaries and wages for June paid in July of -$0.2m (2017: -$0.2m).

Compliance with the Holidays Act 2003

Many public and private sector entities, including the DHB, are continuing to investigate historic underpayment of holiday entitlements. For employers such as the DHB that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing compliance with the Act and determining the underpayment is time consuming and complicated. DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability.

Auckland DHB has estimated its liability as at 30 June 2018 to be $6.9m (2017: $6.9m). The estimate is based on the best information available to the DHB and our preliminary interpretation of the Holidays Act. The estimate is likely to be different due to the uncertainty surrounding the appropriate interpretation which is subject to the national process underway.

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 & 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.

Breakdown of provisions and further information

		Group Actual		Parent Actual	
		2018 $000	2017 $000	2018 $000	2017 $000
Current Portion					
ACC Partnership Programme		1,671	1,274	1,671	1,274
Litigation		480	106	480	106
Restructuring		256	1,760	256	1,760
Total Provisions		**2,407**	**3,140**	**2,407**	**3,140**
Movement for each class of provisions are as follows:					
ACC Partnership Programme					
Opening balance		1,274	1,514	1,274	1,514
Additional provisions made during year		1,354	241	1,354	241
Charged against provision for the year		(957)	(481)	(957)	(481)
Unused amounts reversed during year		0	0	0	0
Closing balance	(i)	**1,671**	**1,274**	**1,671**	**1,274**
Litigation & Onerous Contracts Provision					
Opening balance		106	1	106	1
Additional provisions made during year		480	106	480	106
Charged against provision for the year		(106)	(1)	(106)	(1)
Unused amounts reversed during year		0	0	0	0
Closing balance	(ii)	**480**	**106**	**480**	**106**
Restructuring Provision					
Opening balance		1,760	35	1,760	35
Additional provisions made during year		256	1,760	256	1,760
Charged against provision for the year		(887)	(35)	(887)	(35)
Unused amounts reversed during year		(873)	0	(873)	0
Closing balance	(iii)	**256**	**1,760**	**256**	**1,760**

Notes

(i) ACC Partnership Programme

18 Provisions (continued)

Liability valuation
An external independent Actuary, Simon Ferry, has calculated the liability as at 30 June 2018. 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 15% (2017:15%) 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 15% is the rate used by ACC.

The key assumptions used in determining the outstanding claims liability are:
- an average assumed rate of inflation of 1.77% for 30 June 2018 and 30 June 2018;
- a weighted average discount factor of 1.79% for 30 June 2018 and 2.02% for 30 June 2019 that has been applied to future payment streams; and
- claim inception rates based on analysis of historical claim experience of the DHB. It has been assumed that 80% will result in medical claims only, and 20% will result in an element of time off work
- the expected future Average Claim Payment per accident is $2,860.

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

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

A stop loss limit of 205% of the DHB Standard Levy is used. The stop loss limit means the DHB will carry the total cost of all claims only up to a total of $7,804,500 incurred in the cover period from 1 April 2018 to 31 March 2019 (2018/2019 ACC Claim Year). Auckland DHB has also contracted a High Cost Claims Cover with an excess of $1,500,000 per event.

(ii) Litigation & 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 $256k (2017: $1.76m) .The provision in 2018 is for $256k provisions for redundancy of Auckland DHB employees as a result of transitioning to a new 24/7 hospital functioning model of care. The provision in 2017 is for 1) $1,296k redundancy of Auckland DHB employees as a result of transitioning to a new 24/7 hospital functioning model of care, and 2) $464k voluntary redundancy of Auckland DHB employees following a change in staffing mix which resulted from the consultation process on the Sexual Health Services Staffing Model. These have resulted in payments agreed but unpaid at year end.

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.

19 Borrowings (continued)

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	
	2018 $000	2017 $000	2018 $000	2017 $000
Current portion				
Secured loans				
Loan -Energy Efficiency and Conservation Authority	97	0	97	0
Finance Leases	667	494	667	494
Total current portion	**764**	**494**	**764**	**494**
Non-current				
Secured loans				
Loan -Energy Efficiency and Conservation Authority	390	0	390	0
Finance Leases	4,121	373	4,121	373
Total non-current portion	**4,511**	**373**	**4,511**	**373**
Total Borrowings	**5,275**	**867**	**5,275**	**867**

Security and terms
The Energy Efficiency and Conservation Authority loan is interest free.

Conversion of existing Crown Loans to Crown equity
In September 2016, the Cabinet agreed that the DHB sector should no longer access Crown debt and for existing DHB Crown debt to be converted to Crown equity. On 15 February 2017, the DHB Crown loans of $304.5 million were converted into Crown equity. From that day onward, all Crown capital contributions to DHBs would be made via Crown equity injections. The termination of the Crown loan agreement and conversion of Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.

Fair Value
The fair value of finance leases is $4,787k (2017: $867k). 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%.

19 Borrowings (continued)

Analysis of finance leases

	Group Actual		Parent Actual	
	2018 $000	2017 $000	2018 $000	2017 $000
Minimum lease payments payable:				
No later than one year	773	494	773	494
Later than one year and not later than five years	3,111	373	3,111	373
Later than five years	1,865	0	1,865	0
Total minimum lease payments	**5,749**	**867**	**5,749**	**867**
Future finance charges	(961)	0	(961)	0
Present value of minimum lease payments	**4,788**	**867**	**4,788**	**867**
Present value of minimum lease payments payable:				
No later than one year	666	494	666	494
Later than one year and not later than five years	2,588	373	2,588	373
Later than five years	1,534	0	1,534	0
Total present value of minimum lease payments	**4,788**	**867**	**4,788**	**867**

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.
- 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.
- Ultrasounds. The lease is for a period of 6 years ending May 2024.

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 cash flow hedge; 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	
	2018 $000	2017 $000	2018 $000	2017 $000
A Contributed Capital				
Opening balance 1 July	881,298	576,798	881,298	576,798
Contributions from/(repayment to) the Crown	0	304,500	0	304,500
Balance at 30 June	**881,298**	**881,298**	**881,298**	**881,298**
B Accumulated surplus/(deficit)				
Opening balance 1 July	(484,614)	(487,048)	(485,288)	(487,541)
Operating surplus/(deficit)	1,013	3,162	411	2,253
Transfer to trust/special funds	(748)	(728)	0	0
Balance at 30 June	**(484,349)**	**(484,614)**	**(484,877)**	**(485,288)**
C Property revaluation reserves				
Opening balance 1 July	515,639	508,998	515,639	508,998
Net Movement	0	6,641	0	6,641
Balance at 30 June	**515,639**	**515,639**	**515,639**	**515,639**
D Cash Flow Hedge reserve				
Opening balance 1 July	0	(3,742)	0	(3,742)
Net Movement	0	3,742	0	3,742
Balance at 30 June	**0**	**0**	**0**	**0**
E Trust/special funds				
Opening balance 1 July	26,595	25,867	0	0
Transfer from accumulated deficits (Note 6b)	748	728	0	0
Balance at 30 June	**27,343**	**26,595**	**0**	**0**
Total Equity	**939,931**	**938,918**	**912,060**	**911,649**
Property revaluation reserves consist of				
Land	312,276	312,276	312,276	312,276
Buildings	203,363	203,363	203,363	203,363
Total property revaluation reserves	**515,639**	**515,639**	**515,639**	**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.

Property revaluation reserves

The revaluation reserve movement relates to the independent valuation of land as at 30 June 2017 & buildings as at 30 June 2016, fit out and infrastructure assets carried out by Telfer Young (Auckland) Ltd - see Note 13.

Trust/special funds

Trust/special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the Trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from retained earnings to trust funds**.**

All trust funds are held in bank accounts that are separate from Auckland DHB's normal banking facilities.

21 Contingencies

Contingent Liabilities

Lawsuits against the DHB

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

Superannuation Schemes

The 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 2018, the scheme had a past service surplus of $6.6m (exclusive of Employer Superannuation Contribution Tax) (2017: $8.0m). This surplus was calculated using a discount rate equal to the expected return on net 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 2018 (2017: 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 (2017: $nil)

Key management personnel compensation

GROUP & PARENT	2018 Actual	2017 Actual
Board Members		
Remuneration	$354k	$374k
Full-time equivalent members	1.5	1.7
Leadership Team		
Remuneration	$7,467k	$7,932k
Full-time equivalent members	20	20
Total key management personnel remuneration	**$7,821k**	**$8,306k**
Total full time equivalent personnel	**21.5**	**21.7**

The Leadership team comprises the Senior Leadership Team and the Clinical Directors of Services. The full-time equivalent for Board members has been determined on the frequency and length of Board meetings and the estimated time for Board members to prepare for meetings.

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

23 Events after the balance date

On 19 July 2018, Auckland Health Foundation (AHF) was incorporated under the Charitable Trusts Act 1957. AHF is a new fundraising charity set up to raise funds for all Adult Health services of the DHB. Auckland DHB is the sole beneficiary of AHF and therefore its financial statements will be consolidated in the group financial statements effective from the 2018/19 financial year.

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	
	2018 $000	2017 $000	2018 $000	2017 $000
Loans and receivables				
Cash and cash equivalents	95,407	69,725	95,407	69,725
Investments-term deposits	30,000	11,000	30,000	11,000
Trust/special funds - bank balances, term deposits, investment bonds and portfolio)	31,525	28,816	0	0
Receivables	92,565	87,422	93,610	87,949
Restricted trust funds	1,275	1,263	1,275	1,263
Total loans and receivables	**250,772**	**198,226**	**220,292**	**169,937**
Financial liabilities measured at amortised cost				
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	127,135	117,614	127,122	117,555
Borrowings / Finance Leases	5,274	867	5,274	867
Restricted trust funds	1,275	1,263	1,275	1,263
Total financial liabilities measured at amortised cost	**133,684**	**119,744**	**133,671**	**119,685**

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	Valuation technique			
		Total	Quoted market price	Observable inputs	Significant non-observable inputs
		$000	$000	$000	$000
GROUP 30 June 2018					
Financial Assets					
Portfolio Investments	8	13,490	13,490	0	0
Investment bonds	8	2,839	2,839	0	0
GROUP 30 June 2017					
Financial Assets					
Portfolio Investments	8	12,295	12,295	0	0
Investment bonds	8	2,830	2,830	0	0

24 Financial Instruments (continued)

24c Financial Instrument risks

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

Market risk

Price risk

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

Fair value interest rate risk

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

Bond FRA

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

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

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

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

Sensitivity analysis

As at 30 June 2018, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the surplus for the year would have been $1.621m lower/higher (2017 : $1.488m)

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 (2017: nil).

Sensitivity analysis

As at 30 June 2018, 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 (2017: $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 (23.6%: 2017 30.4%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

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

24 Financial Instruments (continued)

	2018 $000	2017 $000	2018 $000	2017 $000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalent, term deposits & investment bonds				
A+	0	2,000	0	0
AA-	49,395	26,867	31,359	12,346
Total cash, cash equivalent, term deposits & investment bonds	**49,395**	**28,867**	**31,359**	**12,346**
COUNTERPARTIES WITHOUT CREDIT RATINGS				
NZHPL -no defaults in the past	95,322	69,642	95,322	69,642
Portfolio Investments-no defaults in the past	13,490	12,295	0	0
Receivables				
Exiting counterparty with no defaults in the past	92,565	87,422	93,610	87,949
Exiting counterparty with defaults in the past	0	0	0	0
Total loans and receivables	**250,772**	**198,226**	**220,291**	**169,937**

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.

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

2018	Carrying Amount $000	Contractual Cash Flow $000	6 Months or less $000	6-12 Months $000	1-2 Years $000	2-5 Years $000	More than 5 years $000
Borrowings	5,275	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	**132,410**	**133,371**	**127,570**	**435**	**817**	**2,684**	**1,865**

2017	Carrying Amount $000	Contractual Cash Flow $000	6 Months or less $000	6-12 Months $000	1-2 Years $000	2-5 Years $000	More than 5 years $000
Borrowings	867	867	247	247	201	172	0
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	117,614	117,614	117,614	0	0	0	0
Total	**118,481**	**118,481**	**117,861**	**247**	**201**	**172**	**0**

24 Financial Instruments (continued)

Contractual maturity analysis of financial liabilities, excluding derivatives (continued)

PARENT

2018	Carrying Amount $000	Contractual Cash Flow $000	6 Months or less $000	6-12 Months $000	1-2 Years $000	2-5 Years $000	More than 5 years $000
Borrowings	5,275	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	**132,397**	**133,358**	**127,557**	**435**	**817**	**2,684**	**1,865**

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

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 surplus of $1.013m which was favourable over budget compared to the breakeven budget.

Major revenue variances:
Patient care revenue $5.7m under budget: mainly driven by lower than budget inter-district inflow revenue reflecting volumes delivered.

Major expenditure variances:
Personnel costs $10m over budget: mainly reflecting increases in estimated costs for expired MECAs and provisions for Long Service and Retirement Gratuity liabilities that are actuarially valued at year end. These increases are offset by FTEs being lower than anticipated. The lower FTE numbers are reflected in outsourced personnel being higher than budget.

Outsourced services $7m over budget: largely driven by higher than budget outsourced FTEs.

Payments to other district health boards and for non-health board provider expenses have a combined variance of $36m under budget. This reflects normally expected variations in business as usual factors across Funder NGO services which mostly arise out of monthly demand/utilisation variances in Community Pharmacy, Age Related Residential Care and Primary Health Organisations. The variance also includes upsides in inter-district outflow wash-up and service change for decrease in dental volumes.

Other expenses $12m over budget: the variance includes impairment costs on investment; increase in cost of goods sold for Retail Pharmacy, Bad and doubtful debts, feasibility study costs and increase in operating leases.

Property, Plant and Equipment variance under budget
Property, plant and equipment $71m under budget: this reflects capital expenditure tracking below budget for the year the year. Budgeted capital spend is based on timing of implementation of capital projects which may vary due to timing of capital approval, procurement and implementation timeframes.

26 Major variances from budget (continued)

Cash and Cash Equivalents over budget
Cash and Cash Equivalents $72m over budget: mainly reflects the impact of the delay in the capital programme on cash, lower than budgeted payments to providers / suppliers and favourable timing of MoH budgeted revenue received.

Receivables over budget
Receivables $5m over budget: this is mainly due to the timing of receipts from the Ministry of Health, the favourable timing is reflected in the higher than budgeted cash on hand balance**.**

Prepayments under budget
Prepayments are $3.8m under budget: prepayments this year do not include any provision for pay equity prepayments to providers.

Trade, Other Creditors, Provisions over budget
Trade, Other Creditors, Provisions unfavourable variance of $5m is due to higher costs accrued at the end of the year, mainly driven by timing and expected increases in costs.

Unfavourable Employee Entitlements
Employee entitlements $31m over budget: this reflects the provisions for staff related liabilities $18m, provision for annual leave entitlement $6m and MECA settlement costs provision $8m.

Borrowings under budget
Borrowings $8m 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 Statement of Performance Expectation (SPE), excluding forecast financial information on 27 April 2018 and this was submitted to the Ministry of Health on 30 April 2018. The forecast financial information was not complete in time due to the delay in receiving funding advice. 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 2018.

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 2018

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.

Opinion

We have audited:

- the financial statements of the Health Board and group on pages 44 to 82, that comprise the statement of financial position as at 30 June 2018, 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 on page 38.

In our opinion:

- the financial statements of the Health Board and group on pages 44 to 82:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; 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 on page 38:
    - presents fairly, in all material respects, the Health Board and group's performance for the year ended 30 June 2018, 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 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw attention to a matter in relation to compliance with the Holidays Act 2003. 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.

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 17 on page 71. Our opinion is not modified in respect of this matter.

Basis for our opinion

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

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

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

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'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'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 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 7 and 32 to 43, 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 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 group.

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

AUCKLAND DISTRICT HEALTH BOARD

Annual Report 2017 | 2018

MedPhoto&Graphics CC6633 ISSN 2382-1132 (Online) | ISSN 2382-1124 (Print)

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai